Community Affairs Committee

Examination of Budget Estimates 2006-2007

Additional Information Received
CONSOLIDATED VOLUME 3

HEALTH AND AGEING PORTFOLIO

Outcomes: Outcomes 4 to 15

OCTOBER 2006

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 2006-2007

Included in this volume are answers to written and oral questions taken on notice and tabled papers relating to the budget estimates hearings on 31 May and 1 June 2006

*** Please note that the tabling date of 19 October 2006 is the proposed tabling date for answers where this date is indicated**

HEALTH AND AGEING PORTFOLIO

Senator	Quest. No.	Outcome 4: Aged Care and Population Ageing	Vol. 3 Page No.	Date tabled in the Senate*
McLucas	66	Police checks for volunteers not with Community Visitors Scheme (CVS)	1	17.08.06
McLucas	70	Commonwealth Government aged care subsidies	2-3	17.08.06
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McLucas	88	Optical health support	20	17.08.06
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McLucas	222	Fire safety/sanctions	23	17.08.06
McLucas	223, 224	Fire safety/1999 standards	24-25	17.08.06
McLucas	73	Sanctions	26-27	17.08.06
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McLucas	83	CACP waiting times	30	17.08.06
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McLucas	78	Hogan review	34	17.08.06
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McLucas	74	Complaints Resolution Scheme	48-50	14.09.06
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McLucas	81	Additional Aboriginal and Torres Strait Islander aged care places	56	14.09.06
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McLucas	85	Consultancies	58-67	19.10.06
McLucas	227	Hogan Review/2005 budget	68	19.10.06
	DoHA letter 28.09.06	June 2006 stocktakes of aged care places provided in response to QE05-000189 Budget Estimates 2004-05	69-82	19.10.06

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2006-2007, 31 May - 1 June 2006

Question: E06-066

OUTCOME 4: Aged Care and Population Ageing

Topic: POLICE CHECKS FOR VOLUNTEERS NOT WITH THE COMMUNITY VISITORS SCHEME (CVS)

Written Question on Notice

Senator McLucas asked:

Is the Department proposing to require police checks for volunteers who are not CVS volunteers?

Answer:

The Minister for Ageing has announced that police checks should be conducted on staff and volunteers under the CVS. The precise nature and extent of this requirement in relation to other volunteers, however, is still the subject of consultation and further consideration.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2006-2007, 31 May - 1 June 2006

Question: E06-070

OUTCOME 4: Aged Care and Population Ageing

Topic: COMMONWEALTH GOVERNMENT AGED CARE SUBSIDIES

Written Question on Notice

Senator McLucas asked:

How much in Commonwealth Government aged care subsidies have the following aged care facilities received from 1998-99 to 2005-06?

Redcliffe Aged Care Service,
Peninsular Nursing Home, Mona Vale, NSW
Rothwell Aged Care Service, Rothwell, Qld
Mt Coolum Nursing Home
Mt Coolum Hostel
Banksia Court Private Nursing Home
Knoxville Hostel

Answer:

See attached table.

The following table sets out total Australian Government aged care subsidies and supplements paid to the aged care homes listed in the question in each of the specified financial years. Note that the amounts for 2005-06 are incomplete.

	1998-99	1999-2000	2000-01	2001-02	2002-03	2003-04	2004-05	2005-06 (*)
Banksia Court Private Nursing Home, Croydon, Vic	$2,211,336	$2,153,830	$2,148,479	$2,560,247	$2,757,372	$2,993,388	$2,967,539	$2,439,637
Knoxville Hostel, Knoxville, Vic	$687,871	$657,362	$687,861	$752,123	$764,033	$1,206,168	$1,144,214	$975,507
Mt Coolum Aged Care Service (Hostel), Mt. Coolum, Qld.	$1,202,496	$1,230,494	$1,392,337	$1,533,933	$1,593,466	$2,172,481	$2,149,605	$1,634,786
Mt Coolum Aged Care Service (Nursing Home), Mt. Coolum, Qld	$1,093,825	$1,275,139	$1,409,055	$1,567,639	$1,610,971	$1,833,433	$1,852,654	$1,349,190
Peninsular Nursing Home, Mona Vale, NSW	$2,492,708	$2,802,081	$2,569,926	$2,698,494	$2,799,580	$3,085,679	$3,030,897	$2,609,802
Redcliffe Aged Care Service Clontarf, Qld	$1,616,491	$1,733,636	$2,218,097	$2,401,436	$2,592,264	$2,967,416	$2,772,157	$2,421,122
Rothwell Aged Care Service, Rothwell, Qld	$1,638,784	$1,781,432	$2,141,411	$2,315,126	$2,514,307	$2,833,667	$2,742,137	$2,168,141

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2006-2007, 31 May - 1 June 2006

Question: E06-077

OUTCOME 4: Aged Care and Population Ageing

Topic: BARTONVALE/ST DAVIDS

Written Question on Notice

Senator McLucas asked:

When Karoona Pty Ltd made the decision to close St David's in SA in April 2003 what new residential aged care services(s) were the residents of St David's transferred to?

Answer:

The residents elected to move to Marron Nursing Home and Ridleyton Greek Home for the Aged.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2006-2007, 31 May - 1 June 2006

Question: E06-079

OUTCOME 4: Aged Care and Population Ageing

Topic: AGED CARE STAFF SKILLS BASE

Written Question on Notice

Senator McLucas asked:

How will the "Encouraging best practice" measure announced in the Budget be implemented?

Answer:

The implementation of the "Aged Care - Encouraging Best Practice" measure is currently being considered by the Department of Health and Ageing.

Organisations will be asked to submit applications through a tender process later this calendar year.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2006-2007, 31 May - 1 June 2006

Question: E06-080

OUTCOME 4: Aged Care and Population Ageing

Topic: COAG HEALTH SERVICES - IMPROVING

Written Question on Notice

Senator McLucas asked:

a) How is the Department going to implement the additional funding to improve assessments by Aged Care Assessment Teams?

b) What increase in staffing numbers is proposed? For what areas will new staff be required?

c) What is the average waiting time for an ACAT assessment by State and Territory?

d) What is the average waiting time for an assessment by State and Territory if a person wants to transfer to another aged care facility?

e) What are the criteria used in the ACAT Assessment?

f) Have the criteria changed in recent times?

g) Are there any questions related to Australian residency? How does the Department ensure that services are going to Australian residents?

h) For how long is an assessment valid?

i) What is the penalty if an aged care facility admits a new resident if the ACAT assessment is not current?

j) What is happening with the ACAT Evaluation Program?

k) Please provide an update of the implementation of The Way Forward: A new strategy for community care.

Answer:

a) The Council of Australian Governments (COAG) agreed that initiatives to improve the Aged Care Assessment Program (ACAP) be implemented through Community Care Officials, a joint Australian Government, states and territories committee.

b) The Australian Government does not have information for ACAT staff members.

c) *Average waiting times by State/Territory – Quarter 1, 2005-06*

	Average time (days) from Referral to:	
	First face-to-face contact	End of Assessment
NSW	20.1	26.4
Vic	14.1	17.1
Qld	22.3	26.9
SA	12.3	17.9
WA	10.2	13.4
Tas	16.4	21.6
NT	11.7	18.3
ACT	41.1	41.7

Data obtained from the National Data Repository ACAP Minimum Data Set Report, Quarter 1, 2005-06

d) A new ACAT assessment is not required if a person moves from one aged care facility to another at the same care level, as long as there is no break in care.

e) ACATs comprehensively assess older people's care needs and refer them to the most appropriate services available to meet those needs. In undertaking an assessment, ACATs must take into consideration the restorative, physical, medical, psychological, cultural and social dimensions of a person's care needs.

Eligibility criteria are outlined in Divisions 21 and 22 of the Act and the associated *Aged Care Principles* (the Principles).

f) No.

g) The *Aged Care Act 1997* does not specify that clients must be an Australian resident to receive an ACAT assessment.

h) An ACAT assessment is valid for a twelve-month period, unless an earlier end-date has been specified. An approval to enter transition care remains valid for four weeks from the day after approval is given.

i) If an aged care facility admits a new resident with an ACAT assessment that is not current, the aged care facility is not eligible to receive a Commonwealth funded subsidy for any care provided.

j) The Australian Government provides annual funding to the States and Territories, for the management of Evaluation Units. The Units collect and analyse ACAT data on a quarterly basis, and prepare both quarterly and annual data reports.

The Australian Government also funds the collection and analysis of ACAT data at a national level.

k) The Department of Health and Ageing and state and territory government officials are continuing work on a number of projects to support the development of the common arrangements identified in *A New Strategy for Community Care - The Way Forward.*

A new HACC Agreement is being developed. Field trials of the proposed assessment tool for basic care and assessment of carers' needs, are scheduled to commence during July 2006.

At its February 2006 meeting, the Council of Australian Governments (COAG) endorsed the work under *The Way Forward* relating to entry/access points, eligibility, assessment and referral.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2006-2007, 31 May - 1 June 2006

Question: E06-212

OUTCOME 4: Aged Care and Population Ageing

Topic: CVS REVIEW

Hansard Page: CA 52

Senator McLucas asked:

Could you please provide a copy of the CVS Review to the Committee?

Answer:

Yes, copy attached

[Note: the attachment has not been included in the electronic volume]

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2006-2007, 31 May - 1 June 2006

Question: E06-069

OUTCOME 4: Aged Care and Population Ageing

Topic: INVESTIGATION OF KERRY AND MALCOLM BISHOP

Written Question on Notice

Senator McLucas asked:

a) What is the nature of the investigation of Kerry and Malcolm Bishop by the Fraud Control Unit of the Department of Health and Ageing?
b) Why was the investigation instigated?
c) When was the investigation instigated?
d) Can the Department provide the report when it is completed?
e) How does the Department ensure that nursing home owners who advise they are not "Key Personnel" are not acting in a "Key Personnel" role in an aged care facility?

Answer:

a) There is an investigation in progress to see if Ms Kerry Bishop is performing the functions of a key personnel.

b) The investigation commenced as a result of allegations made to the Department.

c) March 2006.

d) It would not be appropriate to make a decision about providing a copy of a report until all matters arising from the report are concluded.

e) The Department will commence an investigation whenever it receives information that such a person may be acting in a role which might meet the definition of a key personnel.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2006-2007, 31 May - 1 June 2006

Question: E06-071

OUTCOME 4: Aged Care and Population Ageing

Topic: MALNUTRITION IN AGED CARE FACILITIES

Written Question on Notice

Senator McLucas asked:

Given recent published research on the prevalence of malnutrition in residential aged care has the Department reviewed the effectiveness of its systems designed to ensure adequate nutrition and hydration?

Answer:

The Australian Government has in place a system for monitoring of residential aged care homes for compliance with their obligations under the *Aged Care Act 1997*. Approved Providers must meet their requirements under the Accreditation Standards and the Quality of Care, Schedule 1(Specified Care and Services).

The system of accreditation is outcomes focussed and designed to ensure continued review of individual needs of residents, including nutrition and hydration. Additionally, the Schedule of Specified Care and Services requires that each resident is provided with meals of adequate variety, quality and quantity and that any special dietary requirements are met.

The Aged Care Standards and Accreditation Agency monitors homes against the Accreditation Standards and compliance action may be taken where approved providers have breached their responsibilities.

If residents, their families, or representatives have concerns about the care provided to a resident, including nutrition and hydration, they should contact the Aged Care Complaints Resolution Scheme on freecall 1800 550 552.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2006-2007, 31 May - 1 June 2006

Question: E06-082

OUTCOME 4: Aged Care and Population Ageing

Topic: RESIDENTIAL AGED CARE

Written Question on Notice

Senator McLucas asked:

1) Can you please provide residential aged care vacancy rates, by state and territory from 1995/96 to 04/05?
2) What is the number and proportion of newly admitted residents paying accommodation bonds by Aged Care Planning Region?
3) What monitoring is there that ethnic specific places are actually used by people of an ethnic origin on an ongoing basis?
4) Can you please provide the latest data on the population 70+ in each Aged Care Planning Region?
5) Has the Department received any specific complaints from relatives who have been asked to sign a personal guarantee against "all debts and liabilities" that a resident may occur?
6) Under what circumstances can an aged care provider require a Deed of Guarantee from a relative of a resident?

Answer:

1) See Table 1 in Attachment A. Data calculated on comparable basis are not readily available for 1995-96 and 1996-97.

2) See Table 2 in Attachment A. The information is an estimate based on a National Survey.

For 2004-05, for each aged care planning region the table shows the estimated number of new entrants to permanent care within the region who paid or agreed to pay a bond.

For some of the smaller regions, the proportion of responses received was too small to provide a statistically valid response or the number of responses was too few to allow results to be published at a regional level without breaching the confidentiality of the approved provider. These instances are indicated by an asterisk (*).

3) Under the *Aged Care Act 1997* (the Act), it is an approved provider's responsibility to comply with any conditions to which an allocation is subject. Breaches of conditions are investigated by the Department. Systems and procedures for monitoring conditions of allocation are being strengthened progressively.

4) See Table 3 in Attachment A. These figures are calculated from small area projections prepared by the Australian Bureau of Statistics (ABS) and based upon ABS Population Projections, Australia (3222.0), series B.

5) The Aged Care Complaints Resolution Scheme has received a small number of calls but as this is not a breach of an approved provider's responsibilities under the Act, it would not be dealt with as a complaint.

6) It would not be a breach of an approved provider's responsibilities under the Act for an approved provider to require a Deed of Guarantee from a relative of a resident to ensure that agreed fees that may lawfully be charged under the Act are paid.

ATTACHMENT A

Table 1: Vacancy rates in Australian Government funded residential aged care services from 1998-99 to 2004-05 for each State and Territory.

	1998-99	1999-00	2000-01	2001-02	2002-03	2003-04	2004-05
NSW	3.9%	3.9%	3.6%	3.3%	3.6%	3.9%	4.8%
VIC	6.3%	5.7%	4.7%	4.5%	5.3%	5.6%	5.9%
QLD	3.4%	3.8%	3.3%	3.1%	3.6%	3.5%	3.8%
SA	3.1%	2.5%	2.1%	2.1%	2.7%	2.8%	2.5%
WA	4.9%	4.9%	4.6%	4.8%	4.4%	4.3%	5.2%
TAS	5.4%	5.6%	2.0%	1.9%	2.2%	2.5%	3.1%
NT	- #	4.2%	3.7%	3.8%	5.3%	9.1%	6.1%
ACT	5.0%	5.3%	3.8%	2.4%	2.3%	2.0%	1.7%

not available

Table 2: Number and proportion of newly admitted residents paying accommodation bonds by Aged Care Planning Region, 2004-05 (*)

Aged Care Planning Region	
ACT	193
Alice Springs, NT	*
Barkly, NT	*
Barwon-South Western, Vic.	539
Brisbane North, Qld.	358
Brisbane South, Qld.	509
Cabool, Qld.	262
Central Coast, NSW	421
Central West, NSW	145
Darling Downs, Qld.	176
Darwin, NT	5
Eastern Metro, Vic.	1,252
Eyre Peninsula, SA	*
Far North Coast, NSW	246
Far North, Qld.	149
Fitzroy, Qld.	88
Gippsland, Vic.	239
Goldfields, WA	*
Grampians, Vic.	197
Great Southern, WA	62
Hills, Mallee & Southern, SA	96
Hume, Vic.	293
Hunter, NSW	574
Illawarra, NSW	392
Inner West, NSW	160
Katherine, NT	*
Kimberley, WA	0
Loddon-Mallee, Vic.	297
Logan River Valley, Qld.	129
Mackay, Qld.	61

Metropolitan East, SA	414
Metropolitan East, WA	283
Metropolitan North, SA	249
Metropolitan North, WA	561
Metropolitan South East, WA	221
Metropolitan South West, WA	294
Metropolitan South, SA	415
Metropolitan West, SA	179
Mid North Coast, NSW	357
Mid North, SA	20
Mid West, WA	*
Nepean, NSW	150
New England, NSW	174
North West, Qld.	*
North Western, Tas.	80
Northern Metro, Vic.	604
Northern Sydney, NSW	1,251
Northern, Qld.	91
Northern, Tas.	97
Orana Far West, NSW	87
Pilbara, WA	*
Riverina/Murray, NSW	256
Riverland, SA	39
South Coast, Qld.	371
South East Sydney, NSW	673
South East, SA	61
South West Sydney, NSW	453
South West, Qld.	11
South West, WA	77
Southern Highlands, NSW	215
Southern Metro, Vic.	1,269
Southern, Tas.	170
Sunshine Coast, Qld.	355
West Moreton, Qld.	91
Western Metro, Vic.	411
Western Sydney, NSW	246
Wheatbelt, WA	*
Whyalla, Flinders & Far North, SA	*
Wide Bay, Qld.	190
Yorke, Lower North & Barossa, SA	93

Source: 2005 Survey of Aged Care Homes

(*) Note that the data are based on the region in which the aged care service is located, not the usual place of residence of the resident.

Table 3: Projected population 70+ years old in each Aged Care Planning Region at 30 June 2006

NSW	Central Coast	41,955
	Central West	18,093
	Far North Coast	36,691
	Hunter	62,978
	Illawarra	43,278
	Inner West	41,555
	Mid North Coast	41,332
	Nepean	20,909
	New England	18,772
	Northern Sydney	83,524
	Orana Far West	15,466
	Riverina/Murray	28,324
	South East Sydney	83,563
	South West Sydney	61,630
	Southern Highlands	22,637
	Western Sydney	53,085
	NSW	673,792
VIC	Barwon-South Western	41,260
	Eastern Metro	99,505
	Gippsland	28,685
	Grampians	23,441
	Hume	27,388
	Loddon-Mallee	33,828
	Northern Metro	70,776
	Southern Metro	120,148
	Western Metro	51,888
	VIC	496,919
QLD	Brisbane North	41,192
	Brisbane South	55,963
	Cabool	26,419
	Central West	982
	Darling Downs	22,657
	Far North	16,829
	Fitzroy	14,998
	Logan River Valley	15,362
	Mackay	9,065
	North West	1,560
	Northern	15,777
	South Coast	45,266
	South West	2,048

	Sunshine Coast	37,813
	West Moreton	13,012
	Wide Bay	25,430
	QLD	344,373
SA	Eyre Peninsula	3,550
	Hills, Mallee & Southern	13,008
	Metropolitan East	35,264
	Metropolitan North	25,369
	Metropolitan South	39,158
	Metropolitan West	29,189
	Mid North	3,571
	Riverland	4,616
	South East	6,308
	Whyalla, Flinders & Far North	3,909
	Yorke, Lower North & Barossa	10,262
	SA	174,204
WA	Goldfields	2,572
	Great Southern	7,288
	Kimberley	1,151
	Metropolitan East	25,674
	Metropolitan North	43,534
	Metropolitan South East	27,992
	Metropolitan South West	38,377
	Mid West	4,784
	Pilbara	669
	South West	12,104
	Wheatbelt	4,996
	WA	169,141
TAS	North Western	11,660
	Northern	14,619
	Southern	24,404
	TAS	50,683
NT	Alice Springs	982
	Barkly	118
	Darwin	3,478
	East Arnhem	156
	Katherine	410
	NT	5,144
ACT	ACT	22,292
	ACT	22,292
Australia		1,936,548

Source: Small area projections prepared by the Australian Bureau of Statistics (ABS), based upon ABS Population Projections, Australia (3222.0), series B.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2006-2007, 31 May - 1 June 2006

Question: E06-084

OUTCOME 4: Aged Care and Population Ageing

Topic: RESIDENT CLASSIFICATION SCALE (RCS) REVIEWS

Written Question on Notice

Senator Jan McLucas asked:

a) Please provide RCS review figures for the six months ending June 2005.
b) What is the proportion of the residents of aged care facilities values of downgrades/upgrades?

Answer:

a) A total of 10,698 RCS Reviews were conducted over the six months ending 30 June 2005.

b) There were 477 upgrades and 3,840 downgrades.

Data regarding RCS reviews is available on the Department of Health and Ageing web-site at:
http://www.health.gov.au/acc/rcspage/rcsstats.htm

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2006-2007, 31 May - 1 June 2006

Question: E06-087

OUTCOME 4: Aged Care and Population Ageing

Topic: CONDITIONAL ADJUSTMENT PAYMENT (CAP)

Written Question on Notice

Senator McLucas asked:

In an answer to Question on Notice (E06-034) the Department stated that as at February 2006 the number that did not comply with the CAP requirement was eight providers (corresponding to 10 services). How did they not comply?

Answer:

In February 2006, six providers (corresponding to seven services) did not receive CAP as they had advised that they did not wish to participate in CAP. Two providers (corresponding to three services) did not lodge their 2004-05 Annual Notice by the due date and therefore were not eligible for CAP in February 2006. The Annual Notice is the document on which providers declare whether they are compliant with the audited financial reporting requirements of CAP.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2006-2007, 31 May - 1 June 2006

Question: E06-088

OUTCOME 4: Aged Care and Population Ageing

Topic: OPTICAL HEALTH SUPPORT

Written Question on Notice

Senator McLucas asked:

In the 2006-07 Budget the Government announced $13.8 million over four years to promote eye health and reduce avoidable blindness and loss of vision. How will this program be Implemented?

Answer:

The program will be based upon the *National Framework for Action to Promote Eye Health and Prevent Avoidable Blindness and Vision Loss* which was released by Health Ministers in November 2005. A suite of national initiatives will be developed in consultation with the eye care sector.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2006-2007, 31 May - 1 June 2006

Question: E06-218

OUTCOME 4: Aged Care & Population Ageing

Topic: SANCTIONS

Hansard Page: CA 64/65

Senator McLucas asked:
Would you have a look back over the last few years and simply provide the committee with the number of homes that were found to be non-compliant with 44 out of 44 outcomes, and the number of sanctions that have been imposed after that period of time?

Has there been any change in the trends in applying sanctions to the number of facilities that have been sanctioned over time. Are there trends appearing in the application of sanctions?

Answer:

No home was found to be non-compliant with all 44 Expected Outcomes of the Accreditation Standards.

From 1 July 2004 to 20 June 2006 the Department of Health and Ageing has imposed a total of 22 sanctions on 19 approved providers of residential aged care homes. Of the imposed sanctions:

- 17 were imposed as a result of the approved provider not complying with all its responsibilities in relation to the Accreditation Standards, the Aged Care Standards and Accreditation Agency identified serious risk at the home and the Department determined that there was also an immediate and severe risk to the health, safety or well-being of care recipients at the home; and
- four were imposed as the approved provider failed to remedy identified non-compliance within the specified timeframes; and
- one was imposed as a result of the approved provider failing to allow the Aged Care Standards and Accreditation Agency (ACSAA) access to the home in order to undertake its monitoring role.

The *Aged Care Act 1997* sets out the legislated processes by which the Department may impose sanctions. Only in cases where a determination of an immediate and severe risk to the health, safety or well-being of care recipients at the home is made can sanctions be imposed without the Department first having to issue the approved provider with a Notice of Non-Compliance providing them with the opportunity to address the areas of non-compliance.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2006-2007, 31 May - 1 June 2006

Question: E06-219

OUTCOME 4: Aged Care and Population Ageing

Topic: CRS/DATA SET

Hansard Page: CA 71

Senator McLucas asked:

I would just like you to follow up and find out if the form ever identified which electorate the facility was located in?

Answer:

No. The complaints database has never captured electorate data information when contacts are recorded.

The majority of complaints received by the Aged Care Complaints Resolution Scheme are from either telephone contact or in writing from complainants. Neither of these involves the use of a proforma.

There is an on-line complaints proforma for use by people wishing to lodge their complaint via email. This proforma does not contain or require electorate details.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2006-2007, 31 May - 1 June 2006

Question: E06-222

OUTCOME 4: Aged Care & Population Ageing

Topic: FIRE SAFETY/SANCTIONS

Hansard Page: CA 82

Senator McLucas asked:
What was the total number of facilities that were non-compliant at the time of the 2005 March declaration?

Answer:
A total of 20 residential aged care services declared that they were non-compliant with relevant state and local government fire safety laws as at 31 December 2005.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2006-2007, 31 May - 1 June 2006

Question: E06-223

OUTCOME 4: Aged Care & Population Ageing

Topic: FIRE SAFETY/1999 STANDARDS

Hansard Page: CA 82/83

Senator McLucas asked:
How many of those facilities in the five deadlines for compliance – let us call it – are rebuilds.

Answer:
The number of services that have indicated to the Department that they are rebuilding and due for completion between January 2007 and December 2008 is 43.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2006-2007, 31 May - 1 June 2006

Question: E06-224

OUTCOME 4: Aged Care & Population Ageing

Topic: FIRE SAFETY / 1999 STANDARDS

Hansard Page: CA 83

Senator McLucas asked:
How many beds are in each of the four facilities?

Answer:
In total, there are 190 beds across all four facilities that are yet to provide information on the expected completion date of building works to meet the fire safety requirements of the 1999 Certification Assessment Instrument.

Service 1	-	20
Service 2	-	76
Service 3	-	44
Service 4	-	50

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2006-2007, 31 May - 1 June 2006

Question: E06-073

OUTCOME 4: Aged Care & Population Ageing

Topic: SANCTIONS

Written Question on Notice

Senator McLucas asked:

a) At what level in the Department is the decision about whether a home is sanctioned or not made and what are the criteria used?
b) Please provide that statistics since 1997 to the present on the aged care facilities that have failed Accreditation Outcomes, the number of outcomes failed for each aged care facility, and those that have received sanctions and those that have not.
c) How does the Department ensure consistency in the application of sanctions?

Answer:

a) The Secretary's power under section 65-1 of the *Aged Care Act 1997* (the Act) to impose sanctions on an approved provider is generally exercised by the relevant Assistant State or Territory Manager or State or Territory Manager as delegate of the Secretary.

Section 65-1 of the Act specifies that the Secretary may impose sanctions on an approved provider if: the provider has not complied, or is not complying, with one or more of its responsibilities under Part 4.1, 4.2 or 4.3 of the Act; and the Secretary is satisfied that it is appropriate to impose sanctions; and the Secretary complies with specified procedural requirements.

The Act sets out the procedural requirements that must normally be followed before sanctions are imposed.

b) Accreditation did not commence until 1 January 2001.

The Aged Care Standards and Accreditation Agency did not assess residential aged care homes against individual expected outcomes of the Accreditation Standards until Round 2 of accreditation which commenced in May 2002.

Data in the financial years following the commencement of the Round 2 of accreditation are as follows:
- 2002-03: 96% of homes were compliant with all 44 expected outcomes and the

Department imposed 15 sanctions;
- 2003-04: 95% of homes were compliant with all 44 expected outcomes and the Department imposed 19 sanctions; and
- 2004-05: 98.7% of homes were compliant with all 44 expected outcomes and the Department imposed 12 sanctions.

c) The measures the Department has adopted to ensure consistency in the application of sanctions include:
- training in administrative law principles and good-decision-making for all Departmental officers involved in the compliance program;
- development of a procedures manual for compliance officers;
- centralised quality control by two senior officers of all draft notices prepared in State and Territory offices; and
- central clearance of all notices by a Legal Officer.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2006-2007, 31 May - 1 June 2006

Question: E06-216

OUTCOME 4: Aged Care and Population Ageing

Topic: BUDERIM AGED CARE FACILITY

Hansard Page: CA 60

Senator McLucas asked:

Do we have any understanding of what the level of conviction of people who are charged with assault of older Australians is compared with the level of conviction of people charged with assault of people who are not old? Is it an issue that you are contemplating? Are you thinking about developing a response to the allegations that we have heard?

Answer:

There are no data readily available to the Department on this subject.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2006-2007, 31 May - 1 June 2006

Question: E06-226

OUTCOME 4: Aged Care and Population Ageing

Topic: WORKFORCE/NURSES IN RESIDENTIAL AGED CARE

Hansard Page: CA 90

Senator McLucas asked:

Does the government track wages of personal care workers in aged care?

Answer:

The Department of Health and Ageing does not track the wages of personal care workers in aged care.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2006-2007, 31 May - 1 June 2006

Question: E06-083

OUTCOME 4: Aged Care & Population Ageing

Topic: CACP WAITING TIMES

Written Question on Notice

Senator McLucas asked:

a) How many people are currently waiting to receive a CACP?

b) What are the current waiting time figures for Community Aged Care Packages by State and Territory and by planning region?

c) How does the Department measure the waiting lists for CACPs?

d) Have there been any requests for transfer of CACPs packages? Please provide details of any transfers of CACPs in the last three years.

Answer

a) (b) and (c)
The Department does not have information on waiting lists or waiting times for Community Aged Care Packages (CACPs).

d) Yes. In the last three years, the Department received applications to transfer the following numbers of CACPs:

2003 - 492 places
2004 - 636 places
2005 - 365 places

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2006-2007, 31 May - 1 June 2006

Question: E06-072

OUTCOME 4: Aged Care and Population Ageing

Topic: RESIDENTIAL AGED CARE ABUSE TASKFORCE

Written Question on Notice

Senator McLucas asked:

a) Who is represented on the Residential Aged Care Abuse Taskforce?
b) Are any consumer groups represented and if not, why not?

Answer:

a) The Residential Aged Cage Abuse Taskforce comprises staff within the Department. It was established to receive, process and analyse responses sought by the Minister for Ageing as part of widespread consultation on the issue of physical and sexual abuse in aged care homes.

b) There are no consumer groups or other organisations represented on the Residential Aged Care Abuse Taskforce. The Taskforce is a departmental body established as a rapid response to collect and respond to stakeholder feedback on the issue of abuse in residential aged care. The Taskforce has considered submissions and correspondence from approximately 300 individuals and organisations, including consumer representatives. Details of the submissions received have been provided to the Aged Care Advisory Committee

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2006-2007, 31 May - 1 June 2006

Question: E06-075

OUTCOME 4: Aged Care and Population Ageing

Topic: NATIONAL AGED CARE WORKFORCE STRATEGY

Written Question on Notice

Senator McLucas asked:

Please provide the Committee with an update on the activities associated with the National Aged Care Workforce Strategy.

Answer:

The National Aged Care Workforce Strategy is a tool for the aged care sector to use to ensure the availability of an effective and appropriately skilled workforce to deliver quality care to older Australians. The Australian Government has implemented significant programs to support the aged care sector in attracting and skilling staff.

Since 2002, the Australian Government has allocated $229 million for workforce initiatives designed to increase overall staff supply, to provide additional training opportunities for existing staff and to create better career pathways for all care workers. These initiatives support providers in meeting their responsibilities under the Aged Care Act.

They include such commitments as assisting:
- 15,750 care workers to access recognised education and training opportunities such as Certificate Level III to Enrolled Nurse qualifications;
- 8,000 aged care workers to access the Workplace English Language and Literacy (WELL) program;
- 5,250 Enrolled Nurses to access recognised and approved medication administration education and training programs;
- 1,600 (full/part-time) new nursing places at Universities that demonstrate their ability to meet aged care nursing education benchmarks;
- to encourage more people to enter or re-enter aged care nursing, especially in rural and regional areas, through the offering of 1,000 scholarships from 2006-07, with 1,000 scholarships already taken up since 2002-03; and
- the training of 2700 community aged care workers primarily involved in the delivery of care to recipients of *Extended Aged Care at Home* packages and *Extended Aged Care at Home Dementia* packages.

In addition, through the 2005 budget, the Australian Government provided a total of $320.6 million in funding for dementia related initiatives. This includes $25 million over four years for dementia training – including training of 7,000 community workers, such as police and ambulance workers, and 17,000 aged care workers. Originally this funding was only expected to result in training of around 9,000 workers. However, the efficiency of the training delivery means that an extra 8000 aged care workers will be able to have this training at no extra cost.

On 27 June 2005, the Australian Government announced that aged care homes across Australia would receive an extra $1,000 per resident in a one-off payment to target specific issues that will help ensure they remain sustainable in the long term. These payments, totalling $152 million, were to help aged care providers to improve their efficiency in management and administration with the potential to both improve clinical care for older Australians and reduce paperwork for aged care staff, enabling them to spend less time on administration and more time on care.

Work has also commenced on the 2007 residential aged care workforce census and survey. During the course of the 2006-07 Budget, the Australian Government also announced funding for a Community Care census and survey with work to commence in 2006.

The *Minister's Awards for Excellence in Aged Care 2005* also served to increase the profile of the aged care workforce by showcasing best practice in the industry. Winners of the Minister's Awards for Excellence in Aged Care 2005 are required to present at the Aged Care Accreditation Agency's Better Practice seminars during the course of 2006 and 2007.

The Department is also funding a number of trials of nurse practitioners in aged care across a number of sites around Australia. The trials will determine whether nurse practitioners have a role in improving care to residents of aged care homes.

Recently the Department of Health and Ageing provided sponsorship for the Community Services and Health Industry Skills Council's "Making a Difference… 2006 Conference – Building the Future CS&H Workforce" to demonstrate its leadership not only in the area of aged care but also its support of skills development of the aged care workforce.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2006-2007, 31 May - 1 June 2006

Question: E06-078

OUTCOME 4: Aged Care and Population Ageing

Topic: HOGAN REVIEW

Written Question on Notice and Hansard Page: CA 91 – 31 May

Senator McLucas asked:

I understand Mr Carlton is heading up a committee. Can you tell me who else is on that committee?

Answer:

The following are members of the Reference Group on the Longer Term Reform of Aged Care.

The Hon Jim Carlton AO (Chair)

Mr David Armstrong, CEO, Amity Group Pty Ltd

Mr Ross Bradshaw, CEO, Silverchain Nursing Association Inc

Mr Henry Ergas, Director, Asia Pacific, CRA International

Ms Sally Evans, Healthcare Director, Asia-Pacific, Eurest

Mr John Ireland, CEO, Southern Cross Care (NSW) Inc

Ms Helen Kurincic, Director, DCA Group Limited; former CEO of Benetas

Professor John McCallum, Deputy Vice Chancellor, Victoria University

Ms Irene Mills, Farmer, Pithara, Western Australia

Dr Mike Rungie, CEO, Aged Care Housing Group, South Australia

Mr Ian Yates AM, Executive Director, Council on the Ageing, South Australia

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates June 2006-2007, 31 May – 1 June 2006

Question: E06-217

OUTCOME 4: Aged Care and Population Ageing

Topic: AUDIT REPORTS/WEBSITE

Hansard Page: CA 63 – 31 May

Senator McLucas asked:

What is the average amount of time that it takes to place the report on the website?

Answer:

The *Accreditation Grant Principles 1999* provide that certain information including the executive summary of the audit report cannot be published until after the expiration of the period in which an application for reconsideration may be lodged.

The information must be published within 28 days of that date.

In the nine months to end March 06, there were 618 decisions posted to the web site in respect of homes that did not lodge an application for reconsideration.

Over this period, the average time from expiration of the reconsideration period to placement on the web site was 20 days.

During this time, the Agency is required to examine the report for information that may identify individual residents and authorise release of protected information before placement on the web site.

Where there is an application for reconsideration, the Agency does not post audit reports to its web site (including the executive summaries) until the expiration of the period in which the provider may request review of the reconsidered decision by the Administrative Appeals Tribunal. That period is 28 days after the provider has been notified of the reconsidered decision.

In the nine months to end March, there were ten applications for reconsideration.
The average time between the earliest date on which the information could be published and when it was placed on the web site was 13 days.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2006-2007, 31 May - 1 June 2006

Question: E06-220

OUTCOME 4: Aged Care and Population Ageing

Topic: MANDATORY REPORTING

Hansard Page: CA 73-74 – 31 May

Senator Fielding asked:

What research or studies have been done on mandatory reporting, other than you looking at the UK?

Answer:

See Attachment A.

ATTACHMENT A

BRIEFING ON MANDATORY REPORTING

Mandatory reporting requirements for child protection

- Legislation which specifies who is required by law to report suspected cases of child abuse and neglect is known as mandatory reporting. The people mandated to report varies across the different states and territories.

- All jurisdictions, apart from Western Australia, have mandatory reporting for abuse of children. In Victoria, the introduction of mandatory reporting has led to significant increases in notifications, with the majority of the increase relating to emotional abuse and neglect, rather than physical and sexual abuse. Prosecutions have generally not been successful.

- In the Victorian context, it has been suggested that mandatory reporting does not necessarily protect those most in need of protection and that administrative processes such as education and training and the use of sanctions against organisations can be more effective.

- This view is supported by Western Australia where research has indicated that better outcomes are achieved when key providers of services participate in the development and delivery of responses to children in need, and when there are legislative protections to those who report.

- While the introduction of mandatory reporting requirements in each state has increased a community's awareness of child abuse, in many instances it results in a substantial increase in reports being made to child protection departments.

- If inadequate funding accompanies the introduction of mandatory reporting, then the demand on child protection departments may result in services being overwhelmed with cases to investigate, without sufficient staffing to do so.

- In order to cope with this influx of reports, some child protection departments have 'raised the bar' or level of seriousness of reports which they will investigate, while those cases considered to be less serious may not be investigated at all.

- When mandated people report suspected cases of child abuse or neglect they expect the child protection department to investigate and take action regarding their report. When this does not occur due to a lack of resources in the department, those who have made reports may become disillusioned and therefore cease to make reports to the department.

- Internationally, there is evidence that only a small proportion of cases of child maltreatment are reported to authorities, even where mandatory reporting exists (WHO 2002).

- A child abuse model of legal intervention is not directly applicable to elder abuse. Unlike children, who are deemed to be legally incompetent, the abused older person is a mature adult with full citizenship rights. The law assumes adults have the right and the ability to make their own decisions, with appropriate help, concerning their own lives.

National research on mandatory reporting of elder abuse

- An Elder Abuse Prevention Project conducted in Victoria in 2005 considered the issue of mandatory reporting of elder abuse. The project focused on elder abuse in the community. The Advisory Committee recommended against mandatory reporting, considering that interventions in suspected elder abuse situations need to be based on an understanding of the rights and decision making capacities of the older person. It recognised the risk that a mandatory reporting system may become a crisis response service with little or no emphasis on preventative activities.

- A Queensland Law Society Elder Abuse Forum reported that there is no persuasive evidence that mandatory reporting aids a successful outcome for older persons suffering abuse and considered it a retrograde step in that it may prevent victims of abuse seeking help because of the legal and cultural ramifications such reporting holds for them and the perpetrator of the abuse. On the question of whether mandatory reporting should apply in cases where the victim has lost capacity, the forum considered that the notion of capacity is like an 'elastic band': incapacity, like dementia, exists to varying degrees and mandatory reporting does not add anything in this regard.

- The Australian Society of Geriatric Medicine in a position statement on elder abuse 2003 also noted that mandatory reported stops older people making decisions for themselves, endangers their autonomy and represents an invasion of privacy. The paper also noted that mandatory reporting would create expectations that when a report of abuse is made, demands for services and other resources will be met. It proposed more resources for research, education and prevention programs.

Elder Abuse – Community Approaches

- In Australia, the extent of elder abuse has been difficult to estimate as there is a high level of sensitivity around the issue with many barriers to identification, including definitional inconsistency.

- Studies over the past decade that have been done to establish a prevalence rate for Australia have estimated that between 2% and 5% of older people may be abused in some way. This is consistent with estimated rates overseas.

- The incidence and prevalence of abuse in long term care settings, either in Australia or overseas, are not known, primarily due to differences in how abuse is reported, and because of the number of incidents that are not reported.

- Currently, no Australian state or territory has legislated for mandatory reporting of abuse of the elderly. As state and territory governments have primary responsibility for services relating to elder abuse in the community, introducing broad national mandatory reporting is outside of the Commonwealth jurisdiction and would require changes to state and territory legislation.

- The Australian Government works with state and territory governments as part of the *Commonwealth, State and Territory Strategy on Healthy Ageing 2000,* to encourage each jurisdiction to further develop their responses to elder abuse.

- States and territories have generally adopted a broad approach to abuse of the elderly in the community, implementing initiatives ranging from information publications, provision of advocacy services, abuse of the elderly prevention telephone lines; assistance to organisations in developing and implementing protocols to guide interventions with elderly victims of abuse; training programs, alternate living arrangements and investigations into specific instances of alleged abuse.

- Legal interventions include criminal law, domestic violence legislation, substituted decision making legislation and guardianship legislation.

- Currently, the Australian Government is working with state and territory governments in developing a national policy framework, to ensure a consistent response to elder abuse prevention across Australia. The framework includes nationally consistent definitions of elder abuse and national data collection in its scope.

- Formal care settings, such as residential aged care, are not within the scope of this project as a comprehensive regulatory and complaints framework already exists in Australian Government subsidised aged care homes.

Addressing issues of assault in residential aged care

- Quality care and safety of older Australians in residential aged care is a priority for the Australian Government.
- The Australian Government has a comprehensive regulatory framework under the *Aged Care Act 1997* (the Act) to ensure the safety, health, and well being of residents of Australian Government subidised aged care homes. This includes ensuring residents are treated with dignity and respect, and are able to live without exploitation, abuse or neglect.

- Both the Department of Health and Ageing and the Aged Care Standards and Accreditation Agency monitor homes to ensure compliance with legislated standards.

- The Aged Care Complaints Resolution Scheme provides residents, their families or representatives free, accessible and effective means of having their concerns about aged care standards and services resolved. A review is currently underway to make the scheme more easily accessible and to enable comprehensive investigation of all complaints and information provided to the Department.

- The Department and the Scheme ensure that all cases of abuse reported to them are referred to the police.

- Many approved providers already inform the Department of Health and Ageing about incidents of sexual and physical assault, but this is not currently a requirement under the *Aged Care Act 1997* (the Act).

- While governments have a role to play in ensuring the safety of frail aged people in care, it is ultimately the responsibility of the industry to provide security and protection for elderly Australians and their families.

International research on mandatory reporting of elder abuse

Current situation on elder abuse and mandatory reporting

- The incidence of elder abuse (including neglect) has been reported as a growing policy concern in several countries (e.g., House of Commons Health Committee, 2004, for the United Kingdom; Beers and Berkow, 2000, for a comparative review). In terms of reported lapses from quality standards in nursing homes in OECD countries, neglect and abuse are listed as one of nine concerns (OECD 2005).

- The Madrid International Plan of Action on Ageing 2002, adopted unanimously at the United Nations second world assembly on ageing, recognises the extent of the problem of elder abuse and proposes as objectives the elimination of all forms of violence, abuse, and neglect against older people and the establishment of sustaining services to address elder abuse.

- Abuse of the elderly has been recognised legally in the United States via the Older Americans Act Title VII Vulnerable Elder Rights Protection provisions. Most states in the USA have mandatory reporting legislation with Adult Protective Services established to investigate and intervene in cases of community-based abuse of the elderly and long-term care ombudsman for investigation of abuse and other issues in residential care settings (National Center on Elder Abuse 2006b). Failure to report such cases may result in a fine or even loss of license.

- Many provinces in Canada have also adopted mandatory reporting legislation, though the reports go to social services or health agencies rather than separate Adult Protection Services (Canadian Network for the Prevention of Elder Abuse 2005).

- In Japan, one of the countries with the highest percentage of people aged over 60 years, specific laws on child abuse and domestic violence do exist, but there is still no law on elder abuse. Efforts are underway to stem abuse with laws on elder abuse proposed.

- In the United Kingdom, the focus has been on development of multi-agency protocols to protect vulnerable adults from abuse (UK Department of Health 2000), the introduction of a Protection of Vulnerable Adults Scheme which lists people who are unsuitable for employment in aged care and a decision to move to licensing for all residential and domiciliary care workers (UK Secretary of State for Health 2004), and development of national reporting requirements and performance indicators for adult protection (UK Department of Health 2005).

- A major study into the abuse of elderly people was launched in February 2006 by the UK Department of Health and Comic Relief, a charity organisation, and is due to be completed in 2007. The project is the result of a Health Select Committee report that called for more research into the issue.

- In other nations in Europe, Asia, South America and Africa, policy responses tend to be at earlier stages, with a focus on research and training rather than legislation (World Health Organisation 2002).

Implementation of mandatory reporting in the United States

- Experience from the United States (US), where mandatory reporting laws are in place, shows that there is no clear evidence that mandatory reporting ensures a better outcome for the abused person than voluntary intervention.

- In the US, reporting of abuse is mandatory by some persons, but the requirements vary widely across states. The people who are required to report elder abuse who fail to fulfil their responsibilities may be found guilty of a misdemeanour and either jailed or fined.

- Some state laws provide that such a person may be held liable for damages incurred by an abused person as a result of failure to make a report. In addition, some statutes specify that a mandated reporter who is a licensed professional may be reported to the appropriate licensing authority for failure to report. Some states, on the other hand, impose no sanctions.

- Every state has at least one statute providing immunity from civil and/or criminal liability to anyone who makes a report of abuse in good faith. Most such statutes also provide that the immunity doesn't apply if the person making the report is also the person who committed the abuse that was reported (American Bar Association Commission on Law and Aging for the National Center on Elder Abuse).

- The National Ombudsman Reporting System (NORS) is the national long term care ombudsman reporting system. A category of reported complaints includes seven subcategories of abuse.

- All states have laws authorising the Long Term Care Ombudsman Program (LTCOP), which is responsible for advocating on behalf of long term care facility residents who experience abuse, violations of their rights, or other problems.

- The LTCOP is mandated in each state as a condition of receiving federal funds under the Older Americans Act. LTCOPs are an integral part of the systemic response to elder abuse. LTCOPs may discover an abusive situation when responding to complaints within a facility and then, if appropriate, make a referral to a state Adult Protective Service (APS) program or the agency responsible for investigating institutional abuse, a law enforcement agency, or the agency responsible for licensing and certifying such facilities. Moreover, in some states, the LTCOP actually fulfils the APS function and has the legal authority to investigate and respond to abuse occurring within long term care facilities.

Effectiveness of Mandatory reporting of elder abuse

- The World Health Organization (WHO 2002) reports that to date, few intervention programs dealing with abuse of the elderly have been evaluated and it is not possible to say which approaches have had the most success.

- As with child abuse reporting laws, all the existing laws on elder abuse were introduced to prevent incidences of abuse from going unnoticed. Mandatory reporting was considered a valuable tool, particularly in situations where victims were unable to report and professionals were reluctant to refer cases.

- While research on the impact of existing mandatory reporting does not yet provide a conclusive answer, the indications are that whether a case is reported or not has less to do

with legal requirements than with organisational, ethical, cultural and professional factors (Wolf 1996).

- Little is documented on the efficacy of mandatory reporting and that which is recorded only highlights the negative aspect of the process. Opponents of mandatory reporting allege that too much time will be wasted on 'false' reports. This presupposes that without mandatory reporting, only 'true' reports will be made.

- Even in countries where there are mandatory reporting laws, experts estimate that there may be as many as five times the cases that have not been reported.

- The literature notes that a number of underlying problems can be seen when looking at the way the process has been working overseas, most notably, the United States:
  - Autonomy of older persons is seen as being jeopardised.
  - Mandatory reporting creates expectations and a demand for health and social services or other resources that communities may be unable to meet.
  - In situations in which an older person is suffering mental ill-health and is in need of assessment, resort to the law may be contraindicated.
  - A major difficulty is that mandatory reporting becomes a crisis response service with little or no emphasis on preventative activities.
  - Lack of common definitions and lack of awareness of elder abuse and in identifying abuse.
  - Widespread underreporting, particularly of abuse, among residents and families, regulatory agencies, ombudsmen, and health professionals, particularly in relation to fear of retribution.
  - Professionals such as physicians, social workers and nurses where they are legally required to report cases of suspected abuse of older persons are reluctant to report cases, resulting in low compliance.
  - Delayed reporting when prompt reporting is especially crucial given the often-limited evidence available. Staff fear losing their jobs or facing recrimination from co-workers and nursing home management. Similarly, they also said that nursing home management is sometimes reluctant to risk adverse publicity or sanctions from the state. (GAO 2002).
  - No uniform mechanism and differing policy for referring instances of suspected abuse to law enforcement officials (GAO 2002).

Improving the effectiveness of mandatory reporting

- In countries where mandatory reporting for elder abuse does exist, a number of reports have identified areas for improving its implementation:
  - stricter enforcement of mandatory reporting (National Center on Elder Abuse (NCEA) 2002)
  - improving consumer education, particularly where there is a designated number for reporting complaints, for residents and family members (NCEA 2002; GAO 2002)
  - nursing home residents need both stronger and more immediate protections (GAO 2002)
  - promoting education and training of professionals in the identification, treatment, and prevention of elder abuse (International Network for the Prevention of Elder Abuse).
  - mandatory reporting was generally viewed as a removal of people's rights and an unnecessary stigmatisation. A system of mandatory referral to supportive services has been suggested as an alternative. The full protection of the law would be available to anyone regardless of his or her age or cognitive ability.

- specific and comprehensive legislation on the abuse of older people to imply a stronger commitment (WHO 2002).

- In the United States, a bill - Elder Justice Act 2006 - was introduced in the 109th U.S. Congress (2005-2006) on Mar 16, 2006 - aimed at increasing the detection, prevention, and prosecution of elder abuse.

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Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2006-2007, 31 May - 1 June 2006

Question: E06-225

OUTCOME 4: Aged Care & Population Ageing

Topic: APPROVED PROVIDER/APPLICATIONS

Hansard Page: CA 84 – 31 May

Senator McLucas asked:

Could you give me an indication, say on an annual basis, how many applicants you have, how many are accepted, how many are refused and an indication of the nature of the reasons they are refused? How many applications for transfer of licenses are not approved?

Answer:

For the period 1 July 2005 to 22 June 2006, 192 applications for Approved Provider status were received.

Of the applications received:

- 113 applications were approved
- 17 applications were not approved of which:
  - 10 applications were incomplete
  - in six cases the Secretary could not be satisfied that the applicant was suitable to provide aged care
  - in one case the applicant was not a corporation
- 35 assessments have not been completed
- 27 applications have been withdrawn

For the 2005-06 financial year, two applications for transfer of places were not approved.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2006-2007, 31 May - 1 June 2006

Question: E06-068

OUTCOME 4: Aged Care and Population Ageing

Topic: POLICE CHECKS FOR STAFF IN RESIDENTIAL AGED CARE

Written Question on Notice

Senator McLucas asked:

d) Which staff members in aged care facilities will the police checks apply to?
e) What crimes would result in an applicant's unsuccessful application?
f) If the department was to find that a current employee had committed a crime that was deemed unacceptable to the Department what will happen to that staff member?

Answer:

d) Compulsory police checks will be required for all staff employed by the approved provider and volunteers under the Community Visitors Scheme.
e) Convictions that would preclude employment include convictions for sexual and serious physical assault of a vulnerable person.
f) The Department, in consultation with the Aged Care Advisory Committee, is currently working through the detail of the implementation of police checks in aged care. Further information, including advice on relevant changes to legislation and guidelines for administration as appropriate will be distributed to approved providers within the coming months.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2006-2007, 31 May - 1 June 2006

Question: E06-074

OUTCOME 4: Aged Care and Population Ageing

Topic: COMPLAINTS RESOLUTION SCHEME

Written Question on Notice

Senator McLucas asked:

a) When is the Government going to instigate providing the Complaints Resolution Scheme with powers of investigation?
b) How will aged-care consumers and their families be consulted in the process?
c) What training in aged care do the people who answer the phones at the CRS have?
d) How is the decision made as to whether a complaint is accepted or not accepted?
e) Who makes that decision? What is taken into consideration?
f) Do specific criteria apply when Complaints officers decide whether to deal with complaints?
g) What information is placed on the complaint file? Please provide a copy of the complaint receiving form.
h) What policies and practices are in place to protect staff whistleblowers when they contact the scheme?
i) How many complainants seek to appeal a decision outside the 14 day appeal period?
j) How many of the issues dealt with by the Advocacy Services get passed onto the Complaints Resolution Scheme?
k) If a complaint is "accepted" it can then later be "not accepted" and dealt with agencies other than the Scheme. Under what circumstances would that occur?
l) What other options do people have to make a complaint other than the CRS and the Aged Care Advocacy Service?

Answer:

a) On 27 July 2006 the Minister announced that the Government has agreed to additional funding of $90.2 million for a new aged care complaints handling mechanism, including the establishment of a new Aged Care Commissioner.

   These reforms will replace the existing Scheme with a new Office of Aged Care Quality and Compliance within the Department of Health and Ageing. The Office will:
   - have the power to investigate all complaints and information;
   - have nationally centralised intake and prioritising of all contacts by high level, specifically trained staff;
   - have powers to determine whether a breach of the approved provider's responsibilities has occurred and, where a breach is identified, take appropriate action to remedy the breach;

- have the capacity to issue Notices of Required Action to providers who have breached their responsibilities, and take compliance action where the provider fails to remedy the issue; and
- provide feedback to the complainant on the outcome.

It is anticipated that changes will be implemented in April 2007, subject to the necessary legislative amendments.

b) Aged care consumers and their families have been consulted by the Commissioner for Complaints, in conjunction with the Department, as part of a review of the Complaints Resolution Scheme. This involved participation in satisfaction surveys and focus groups and the voicing of concerns about the need for the Scheme to improve its complaints handling processes, through representatives on the Aged Care Advisory Committee (ACAC).

In addition, the Minister recently sought submissions to improve consumer protections from carers, relatives, advocacy groups, providers and other professionals with a specific interest in residential aged care. All feedback was considered prior to a decision announced on 27 July 2006.

c) All Aged Care Complaints Resolution Scheme Officers attend the Complaint Scheme's National Induction Training Program that provides them with policy, procedural, legal and technical training to effectively perform their jobs. In addition, they are provided with on-the-job induction and training and are supported in their roles by a national Procedures Manual. Under the new complaints handling process intake of all contacts with the Scheme will be centralised and all officers within the centralised intake centre will be specially trained.

d) The Committee Principles 1997, made under the *Aged Care Act 1997*, prescribe the process for assessing and accepting or not accepting a complaint. Legislative amendments will be required before processes can be defined under the new arrangements.

e) A delegate of the Secretary makes the decision to accept or not accept a complaint in accordance with considerations prescribed in the relevant legislation. The criteria is defined under Section 10.38 of the Committee Principles 1997. Legislative amendments will be required before processes can be defined under the new arrangements.

f) Yes. Where a delegate decides to deal with a complaint they are also required to decide how the complaint should be dealt with in accordance with the Committee Principles 1997. Legislative amendments will be required before processes can be defined under the new arrangements.

g) All information provided to the Scheme by parties to a complaint that is relevant to the matter of concern is recorded. A copy of a "complaint advice form" that may be used as a template by complaints officers to assist with initial intake details for a complaint is provided (Attachment A). In addition, detailed file notes of all contacts with parties to a complaint are included within the Scheme's case management database together with copies of all written correspondence.

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

h) The legislation allows for contacts to be made to the Scheme by anyone, including staff, on an open, confidential or anonymous basis. Where a complaint is made confidentially or anonymously, the Scheme is legislatively bound not to disclose any specific details about the complainant to another party. Under the new arrangements, there will be protections for complainants built into the legislation. Legislative amendments are required before processes can be defined under the new arrangements.

i) For 2005-06, the following have been lodged outside the 14-day appeal period:
    - Appeal against a decision not to accept: 8
    - Appeal against cease to deal decision: 2

j) Data supplied by National Aged Care Advocacy Program (NACAP) services indicate that 203 matters were referred to the Complaints Resolution Scheme in the 2004-05 financial year.

k) Once a complaint is accepted, it cannot then be not accepted. Section 10.47AA of the Committee Principles also allows the Secretary to decide not to deal any further with a complaint under certain circumstances, such as when a matter becomes subject to a legal proceeding, if the legislated process is followed and written reasons given. With the agreement of the complainant, the legislation allows the Scheme to finalise a complaint following referral of the matter to another agency, as defined at Section 10.49 of the Committee Principles 1997, if that agency can more appropriately deal with the concern.

l) People with a complaint about the care and services provided in a residential aged care service can always raise their concerns with the service. Depending on the nature of the concern, they may wish to raise the matter with another relevant agency, such as the police, a health professional regulatory body, a State Government complaints commission or the Coroner.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2006-2007, 31 May - 1 June 2006

Question: E06-076

OUTCOME 4: Aged Care and Population Ageing

Topic: AGED CARE STANDARDS AND ACCREDITATION AGENCY

Written Question on Notice

Senator McLucas asked:

1) Does the Agency assess whether it has improved standards of care in the residential aged care?
2) Who decides when and how notice of each type of visit is given to a residential aged care facility?
3) Do you ask the residents how they thought the accreditation process went? Do you survey them?
4) Are interpreters available for culturally and linguistically diverse residents when inspections occur?
5) What percentage of residents are interviewed during the accreditation process? How are those residents selected?
6) What processes are in place to ensure that consistency of accreditation is achieved across the Agency?
7) Does ACSAA receive complaints about residential aged care facilities, if so, how many, and what does the Agency do with the complaints?
8) Are the Timetables for Improvement available to the public? If so, please provide those that are currently active?
9) Do the assessors make detailed team reports on aged care facilities other than those that are posted on the Agency website?
10) What qualifications are the assessors required to possess?
11) Do assessors make evening visits to evaluate actual staffing compared with the staffing roster?
12) How many staff are employed by the Agency in the head office in Parramatta?
13) What qualifications in aged care are required?
14) What was the staff turnover at the head office in Parramatta in the last 12 months?
15) Does ACSAA undertake independent exit interviews to determine why people leave?
16) Is it possible for an auditor to work in an accreditation team for the Agency, even while running a private business as an accreditation adviser?
17) Is it possible for an auditor and private accreditation adviser to be appointed as an adviser panel member from which the nurse advisers appointed to sanctioned facilities are selected?

18) Why is the ACSAA exempt from the Freedom of Information Act?
19) Could ACSAA please explain why the following reports are not available on the Agency's website:
    - Mary MacKillop Hostel Carrington Retirement Village
    - Lerwin Nursing Home
    - Gwen Hardie Lodge
    - Evangelina by the Sea
    - Kirralee Residnetial Aged Care Facility
    - Bangalor Retreat
    - Darwin Nursing Home
    - Weinholt Nursing Care Unit
    - Wyndham Manor Aged Care Facility
    - Umina Park Home for the Aged
    - The Kalbee Community Residence
    - Portland Aged Care Facility
    - Netherlands Retirement Village

Answer:

1) In its role as the 'accreditation body' appointed under the *Aged Care Act 1997*, the Agency assesses residential nursing homes' performance against the Accreditation Standards.

   The Agency's data shows that in round one, 66 per cent of homes were assessed as complying with all 44 expected outcomes. In round two, the figure was 87 per cent. This indicates improved performance by the sector.

2) Employees of the Agency authorised by the Chief Executive Officer exercising his authority under s 1.5 of the *Accreditation Grant Principles 1999* decide when and how notice of each visit is given to a residential aged care facility. Decisions are made taking into account the provisions of the Aged Care Principles.

   State Managers, Assessment Managers in each State, and the General Manager Accreditation are authorised persons for this purpose.

3) Agency assessors interview residents during site audits and support contact visits. These interviews focus on the level of care provided to residents. The Agency does not undertake follow-up interviews with residents, but receives feedback from time to time.

4) Interpreters are used as required.

5) The *Accreditation Grant Principles 1999* s 2.24 (2) states "the team must also meet with at least 10 per cent of the persons receiving care through the service (or the representatives of the persons) during the site audit to discuss the audit." Each assessment team (audit) report includes information about the number of residents interviewed during the audit and the number of beds allocated to the home. Assessors regularly interview more than 10 per cent of residents.

   The Agency's Audit Handbook for assessors sets out procedures to be followed. The selection of residents to be interviewed is made taking into account the resident mix and types of residents in the home. Assessors also meet with those residents who have specifically requested to speak to the assessment team.

6) There are a limited number of decision-makers. The employees authorised to make decisions about accreditation are provided with appropriate training.

Decision-making is monitored through reviews of decisions as part of the internal quality assurance.

Accreditation decisions are subject to reconsideration by another Agency decision-maker and review by the Administrative Appeals Tribunal.

Audits are conducted and audit reports prepared by registered aged care quality assessors who have successfully completed the assessor course that is a prerequisite to registration through RABQSA. Assessors follow a standardised audit methodology as set out in the Audit Handbook for Assessors and receive update training. The Audit Handbook and other resources are available on the 'for assessors' section on the Agency's web site, www.accreditation.org.au.

7) The Agency receives information from a variety of sources. The Department of Health and Ageing routinely refers information to the Agency, including information lodged with the Complaints Resolution Scheme (CRS).

The Agency receives feedback through its website, and through a 1800 number, 1800 288 025. The Agency takes into account all information it receives in managing homes' compliance with the Accreditation Standards.

When the information received suggests systemic failure, the Agency considers it as part of the case management arrangements.

Where the information appears to be within the remit of the CRS, we refer it to the CRS and recommend the complainant does the same.

8) No. Timetables for improvement are 'protected information' under Part 6-2 of Chapter 6 of the *Aged Care Act 1997.*

9) Yes. The information posted to the Agency's web site addresses only the requirements as set out in Part 9 of the *Accreditation Grant Principles 1999.*

10) The *Accreditation Grant Principles 1999* requires that all aged care quality assessors be registered with the registrar. This body is the RABQSA. The required qualifications are set out in Part 8 of the *Accreditation Grant Principles 1999.*

In order to be considered for registration as an aged care quality assessor applicants have to demonstrate that they possess the following:

(a) Have successfully completed the approved Aged Care Quality Assessor training course with an approved training course provider.
(b) Education and formal qualifications
   - Secondary education OR
   - Diploma level or above post secondary OR
   - Evidence of current studies to meet the above.
(c) Evidence of 4 years work experience in one or more of
   - Professional or management position
   - Registered nurse
   - Relevant experience implementing and /or operation a quality management system.

(d) A written submission of demonstrated competence contained in the written application form. Two written references (a work and a character reference) plus a signed acceptance of the code of conduct for registered assessors.
(e) Applicants are required to attend a panel interview, where they are required to demonstrate competence around the personal attributes for the role.

This information is outlined in the RABQSA requirements for Aged care quality assessor registration which can be located on the RABQSA web site, www.rabqsa.com.

11) Yes. Assessors make 'out of hours' visits.

12) As at 30 June 2006 the FTE for head office is 35.6.

13) The Agency is an accreditation body. Staff are required to have the skills and experience relevant to their role.

14) Seven people resigned during the year.

15) Yes.

16) The *Accreditation Grant Principles 1999* s 2.45 (3) states "The accreditation body must not include a quality assessor in the team if the assessor helped the applicant implement a quality management system for a residential care service, or if a residential care service operated by key personnel of the applicant, in the three years before the team is created."

The *Accreditation Grant Principles 1999* s 2.45 (4) states: "The accreditation body must not include a quality assessor in the team if the assessor has a pecuniary or other interest that could conflict with a proper audit of the applicant."

17) Yes. A person may be appointed to either the administrator or adviser panel lists if they meet the criteria set out under Section 66A-1 of the *Aged Care Act 1997*.

18) The *Freedom of Information Act 1982* (the FOI Act) does not apply to the Aged Care Standards and Accreditation Agency (the Agency) because it is not a Department of the Australian Public Service and it has not been declared by the FOI Regulations to be a 'prescribed authority' for the purposes of the FOI Act.

The *Accreditation Grant Principles 1999* (the Principles) specify the information that the Agency must publish and also state that the Agency must not publish, or otherwise make available, a document that contains 'protected information' for Part 6-2 of Chapter 6 of the *Aged Care Act 1997* unless the publication is authorised under that Part.

'Protected information' includes information about the affairs of an approved provider. This means that even if the Agency were to be declared by the FOI Regulations to be a 'prescribed authority' for the purposes of the FOI Act, any document of the Agency containing information about the affairs of an approved provider, other than a document that the Agency is required by the Principles to publish, would be an exempt document under section 38 of the FOI Act.

The Agency is subject to the disclosure requirements of both the *Commonwealth Authorities and Companies Act 1997* and the *Corporations Act 2001* in relation to information about its business affairs.

19) In relation to Mary MacKillop Hostel Carrington Village, Lerwin Nursing Home, Gwen Hardie Lodge, Evangelia By The Sea, Wienholt Nursing Care Unit, The Kalkee Community Residence and Portland Aged Care Facility, the information on the Agency's web site as at 31 May 2006 did not include the assessment team's report of the most recent audit as the approved provider had applied for reconsideration of the Agency's accreditation decision. Following the reconsideration decision and the expiry of a 28-day period within which the approved provider may seek to appeal to the Administrative Appeals Tribunal, the Agency placed the original report on its web site.

Following a decision on accreditation the approved provider may request reconsideration of the decision within seven days of receiving notification of the decision (or 14 days if the decision was to refuse accreditation). The Agency does not place reports on the web site until the expiry of the period in which a reconsideration can be requested. Further, a report cannot be placed on the web site until any information that could identify a resident is removed and authorisation to release the report is given by an officer with the delegation to release protected information under Part 6.2 of the *Aged Care Act 1997*.

Reports on Wyndham Manor Aged Care Facility, Kirralee Residential Aged Care Facility, and Bangalor Retreat were available on the Agency's web site as at 31 May 2006.

Reports on Darwin Nursing Home and Umina Park Home for the Aged are not available on the Agency's web site as the approved provider has appealed the Agency's decision to the Administrative Appeals Tribunal.

The report on Netherlands Retirement Village was still subject to the Agency's quality assurance processes as at 31 May 2006. This includes a review of the assessment team report to remove references which may identify residents. The report has since been placed on the Agency's web site.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2006-2007, 31 May - 1 June 2006

Question: E06-081

OUTCOME 4: Aged Care & Population Ageing

Topic: ADDITIONAL ABORIGINAL AND TORRES STRAIT ISLANDER AGED CARE PLACES

Written Question on Notice

Senator McLucas asked:

The budget fact sheet indicates:
"The additional places will increase Government funding for Aboriginal and Torres Strait Islander aged care by $15.1 million over four years."

a) Please provide a breakdown of this funding by program for 06/07 – 09/10.

b) Will the announced flexible aged care places be administered under the Aged Care Act? If not how will they be administered?

c) Will they be covered by the same quality and accreditation standards as other facilities?

d) How will the places be allocated?

Answer:

a) Funding for the additional Aboriginal and Torres Strait Islander aged care places is as follows:

2006-07	**2007-08**	**2008-09**	**2009-10**	**Total**
$1.9 million	$3.3 million	$4.9 million	$5.0 million	$15.1 million

b) The flexible aged care places will not be administered under the Aged Care Act. The places will be administered under the National Aboriginal and Torres Strait Islander Aged Care Strategy.

c) Quality and standards are incorporated in the signed funding agreements that specify aged care deliverables.

d) The Strategy for allocation of places is under development in the Department for consideration by the Minister in the near future.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2006-2007, 31 May - 1 June 2006

Question: E06-213

OUTCOME 4: Aged Care & Population Ageing

Topic: POLICE CHECKS/SPENT CONVICTIONS

Hansard Page: CA 54

Senator McLucas asked:
You indicated, I think, that after 10 years some types of convictions would be spent. What types of convictions are they? Does it depend on the amount of time the person was sentenced to for the crime, or is it defined by the actual crime itself?

Answer:
There are differences between states and territories as to which convictions can become spent. In all jurisdictions except WA, spent convictions regimes only apply to less serious offences. In WA, some serious convictions can become spent upon application to and approval by a District Court judge.

In general, whether a conviction can become spent depends on the length of time the person was sentenced for the crime. The length of time varies from a six month sentence or less in some jurisdictions (NSW, Tas, NT, ACT), to 12 months or less (WA) and 30 months or less (Commonwealth, Qld, SA). In NSW, Tas, NT and ACT, convictions for sexual offences can never become spent. In Vic, police refer to administrative guidelines when deciding what information should be disclosed through a criminal history check.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2006-2007, 31 May - 1 June 2006

Question: E06-085

OUTCOME 4: Aged Care and Population Ageing

Topic: CONSULTANCIES

Written Question on Notice

Senator McLucas asked:

a) Which of the following reports are publicly available, and could you please advise where they are available?

b) If any of the above reports are not publicly available could you please provide them?

Consultant Name	**Description**	**Contact Price $AUD (GST incl)**
ACIL Tasman Pty Ltd	Analysis of existing financial reporting requirements imposed on aged care homes and recommendations for a suite of financial reporting guidelines for the homes.	44,000
Alt Beatty Consulting	Trial with service providers of the Quality Reporting tools.	48,469
Alt Beatty Consulting	Review and report on the eligibility criteria used in Australia and internationally for community care and other social programs.	49,455
APIS Consulting Group	Advice on the development of information and data management strategies for community care, including implementation of projects that support *The Way Forward.*	165,000
APIS Consulting Group	Specialist business analysis to develop and coordinate information and data management strategies and projects that support *The Way Forward.*	80,000
Applied Aged Care Solutions	Development and comparison of new funding models from the reduced question set for the Residential Classification Scale.	213,187

Applied Aged Care Solutions	National trial of a new aged care funding instrument.	953,775
Australian Healthcare Associates Pty Ltd	Development and provision of a training package for Quality Review staff in State and Territory Offices.	99,752
Campbell Research & Consulting Pty Ltd	Evaluation of the impact of accreditation on the delivery of quality of care and life to residents of aged care homes.	1,261,449
Centre for Efficiency and Productivity Analysis, University of Queensland	Advice and report on elements for inclusion in a minimum data set of financial and other information to be collected from aged care providers for benchmarking purposes.	32,000
Centre for Health Service Development, University of Wollongong	Development of a national system of intake assessment for all community care programs.	276,852
Gevers Goddard Jones Pty Ltd	Operational viability review of the Aboriginal Elders Village.	29,412
Inside Story Unit Trust	Evaluation, analysis and definition of the requirements of the target audience and other stakeholders for the Aged Care Choices Project.	145,915
Lincoln Centre for Ageing and Community Care Research, La Trobe University	Development and definition of case management within the boundary of existing Aged Care Assessment Team functions, with guidelines and data elements to measure this activity.	39,518
Lincoln Centre for Ageing and Community Care Research, La Trobe University	Development of a national system of comprehensive assessment for the aged and community care sector.	82,885
Price Waterhouse Coopers	Review of 2002 Budget measures implemented through the Commonwealth Carer Respite Centres.	34,095
Price Waterhouse Coopers	Evaluation and performance review of the Commonwealth Carelink and Commonwealth Carer Respite Centres.	78,474
Price Waterhouse Coopers	Review of the viability supplement paid to rural and remote aged care homes.	98,372

SMS Consulting Group Ltd	Information architecture advice on effective structuring of information that may appear on the Aged Care Choices website.	146,300
The Allen Consulting Group	Development of alternative funding options for the Community Visitors Scheme.	70,390
University of Wollongong	Supplementary evaluation of outcomes for Innovative Care Rehabilitation Services.	19,999
University of Wollongong	Development of a structure for eligibility and assessment criteria for the National Respite for Carers Program, in line with the program's aims and the guiding principles of *The Way Forward*.	109,732
Urbis Keys Young	Development of an evaluation framework for the Community Partners Program and the Partners in Culturally Appropriate Care Initiative.	143,416
WestWood Spice	Development of a strategy to communicate the Quality Reporting tools to providers and delivery of information sessions to them.	440,000
TOTAL		**4,662,447**

Answer:

Consultant Name	**Description**	**Senator McLucas asked:** **a) Which of the following reports are publicly available, and could you please advise where they are available?** **b) If any of the above reports are not publicly available could you please provide them?**	**Contact Price $AUD** **(GST incl)**
ACIL Tasman Pty Ltd	Analysis of existing financial reporting requirements imposed on aged care homes and recommendations for a suite of financial reporting guidelines for the homes.	a) This report has been released into the public domain but has not been published. b) A copy is attached (1).	44,000
Alt Beatty Consulting	Trial with service providers of the Quality Reporting tools.	a) Not publicly available. b) A copy is attached (9).	48,469
Alt Beatty Consulting	Review and report on the eligibility criteria used in Australia and internationally for community care and other social programs.	a) Not publicly available. b) The report is being considered by the Australian Government and State and Territory Governments.	49,455
APIS Consulting Group	Advice on the development of information and data management strategies for community care, including implementation of projects that support *The Way Forward.*	a) There was no report, this was a contract for services. This work is contributing to drafting an IM/IT Strategic Plan. When the Plan is finalised it will be released. b) Not applicable.	165,000

Consultant Name	Description	Senator McLucas asked: **a) Which of the following reports are publicly available, and could you please advise where they are available?** **b) If any of the above reports are not publicly available could you please provide them?**	Contact Price $AUD (GST incl)
APIS Consulting Group	Specialist business analysis to develop and coordinate information and data management strategies and projects that support *The Way Forward.*	a) There was no report, this was a contract for services. This work is contributing to drafting an IM/IT Strategic Plan. When the Plan is finalised it will be released. b) Not applicable.	80,000
Applied Aged Care Solutions	Development and comparison of new funding models from the reduced question set for the Residential Classification Scale.	a) Not publicly available. b) This report is currently being considered by the Government.	213,187
Applied Aged Care Solutions	National trial of a new aged care funding instrument.	a) Not publicly available. b) This report is currently being considered by the Government.	953,775
Australian Healthcare Associates Pty Ltd	Development and provision of a training package for Quality Review staff in State and Territory Offices.	a) Not publicly available. b) This report has been prepared to assist with internal Departmental processes and procedures for assessing the performance of community care providers and is not externally available.	99,752

Consultant Name	Description	Senator McLucas asked: **a) Which of the following reports are publicly available, and could you please advise where they are available?** **b) If any of the above reports are not publicly available could you please provide them?**	Contact Price $AUD **(GST incl)**
Campbell Research & Consulting Pty Ltd	Evaluation of the impact of accreditation on the delivery of quality of care and life to residents of aged care homes.	a) Report not yet finalised. b) Not applicable.	1,261,449
Centre for Efficiency and Productivity Analysis, University of Queensland	Advice and report on elements for inclusion in a minimum data set of financial and other information to be collected from aged care providers for benchmarking purposes.	a) The report has not been published. b) A copy of the report is attached (2).	32,000
Centre for Health Service Development, University of Wollongong	Development of a national system of intake assessment for all community care programs.	a) The report has not yet been finalised. b) Not applicable. Survey and consultation papers can be found on the Centre for Health Service Development website: www.uow.edu.au/commerce/chsd/cap.html A copy of the consultation papers and survey are attached (10).	276,852

Consultant Name	Description	Senator McLucas asked: **a) Which of the following reports are publicly available, and could you please advise where they are available?** **b) If any of the above reports are not publicly available could you please provide them?**	Contact Price $AUD (GST incl)
Gevers Goddard Jones Pty Ltd	Operational viability review of the Aboriginal Elders Village.	a) Not publicly available. b) This report was primarily produced to assist the Aboriginal Elders Village and the Department of Health and Ageing has written to the service asking whether they will agree to the release – the Village has not agreed to the release of the report.	29,412
Inside Story Unit Trust	Evaluation, analysis and definition of the requirements of the target audience and other stakeholders for the Aged Care Choices Project.	a) Not publicly available. b) Eight reports were delivered and are attached (3).	145,915
Lincoln Centre for Ageing and Community Care Research, La Trobe University	Development and definition of case management within the boundary of existing Aged Care Assessment Team functions, with guidelines and data elements to measure this activity.	a) Not currently publicly available. b) A copy of the report is attached (11).	39,518

Consultant Name	Description	Senator McLucas asked: **a) Which of the following reports are publicly available, and could you please advise where they are available?** **b) If any of the above reports are not publicly available could you please provide them?**	Contact Price $AUD (GST incl)
Lincoln Centre for Ageing and Community Care Research, La Trobe University	Development of a national system of comprehensive assessment for the aged and community care sector.	a) The report has not yet been finalised. b) Not applicable.	82,885
Price Waterhouse Coopers	Review of 2002 Budget measures implemented through the Commonwealth Carer Respite Centres.	a) Not publicly available. b) This report contains information about individual service providers and therefore, will not be released publicly.	34,095
Price Waterhouse Coopers	Evaluation and performance review of the Commonwealth Carelink and Commonwealth Carer Respite Centres.	a) Not publicly available. b) This report contains information about individual service providers and therefore, will not be released publicly.	78,474
Price Waterhouse Coopers	Review of the viability supplement paid to rural and remote aged care homes.	a) Not publicly available. b) A copy of the report is attached (4).	98,372

Consultant Name	Description	Senator McLucas asked: **a) Which of the following reports are publicly available, and could you please advise where they are available?** **b) If any of the above reports are not publicly available could you please provide them?**	Contact Price $AUD (GST incl)
SMS Consulting Group Ltd	Information architecture advice on effective structuring of information that may appear on the Aged Care Choices web site.	a) Not publicly available. b) A copy of the report is attached (5).	146,300
The Allen Consulting Group	Development of alternative funding options for the Community Visitors Scheme.	a) A copy of the report has been provided with Question E06-212. b) Not applicable.	70,390
University of Wollongong	Supplementary evaluation of outcomes for Innovative Care Rehabilitation Services.	a) The report has not been published. b) A copy of the report is attached (6).	19,999
University of Wollongong	Development of a structure for eligibility and assessment criteria for the National Respite for Carers Program, in line with the program's aims and the guiding principles of *The Way Forward*.	a) Relevant reports are available on the University of Wollongong's web site at http://www.uow.edu.au/commerce/chsd/cap.html and hard copies have also been provided (7). b) Not applicable.	109,732

Consultant Name	**Description**	**Senator McLucas asked:** **a) Which of the following reports are publicly available, and could you please advise where they are available?** **b) If any of the above reports are not publicly available could you please provide them?**	**Contact Price $AUD** **(GST incl)**
Urbis Keys Young	Development of an evaluation framework for the Community Partners Program and the Partners in Culturally Appropriate Care Initiative.	a) Not publicly available. b) A copy of the report is attached (8).	143,416
WestWood Spice	Development of a strategy to communicate the Quality Reporting tools to providers and delivery of information sessions to them.	a) Not publicly available. b) A copy of the report is attached (12).	440,000
TOTAL			**4,662,447**

[Note: the attachments were tabled in the Senate on 19.10.06 and have not been included in the electronic/printed volume]

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2006-2007, 31 May - 1 June 2006

Question: E06-227

OUTCOME 4: Aged Care and Population Ageing

Topic: HOGAN REVIEW/2005 BUDGET

Hansard Page: CA90

Senator McLucas asked:

I understand that $1.3 million was spent in the 2005 budget for the consultation on the Hogan recommendations?

Answer:

A total of $1.343 million was provided in the 2005-06 Budget to support consultations on the longer term reform of aged care (*2005-06 Budget Paper No.1.11*, page 32).

During 2005-06 a total of $920,000 was spent developing materials to support consultation on the longer term reform of aged care and on meetings with an Industry Reference Group. A further $423,000 remains for any further consultation.

Australian Government

Department of Health and Ageing

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

Dear Mr Humphery

Question E05-000189: Provision of June 2006 Stocktake Data
Outcome 4 – Enhanced Quality of Care for Older Australians

The response to question E05-000189 in the Budget Estimates 2004-2005 Hearing of the Senate Community Affairs Legislation Committee on 2 June 2005 advised that figures for the June Stocktakes of aged care places would be forwarded to the Committee on completion.

The June 2006 Stocktake figures are attached.

Yours sincerely

Stephen Dellar
Assistant Secretary
Residential Program Management Branch
September 2006

Total Allocated Places by State / Territory

as at 30 June 2006

State / Territory	High care	Low care	Total Residential	Community Care	Transition Care	TOTAL PLACES
NSW	32,289	33,119	**65,408**	13,120	550	**79,078**
VIC	22,365	26,310	**48,675**	9,997	376	**59,048**
QLD	15,443	17,663	**33,106**	6,554	273	**39,933**
SA	8,371	8,588	**16,959**	3,472	121	**20,552**
WA	7,420	8,745	**16,165**	3,485	100	**19,750**
TAS	2,498	2,334	**4,832**	1,078	52	**5,962**
NT	328	236	**564**	695	-	**1,259**
ACT	918	1,308	**2,226**	541	35	**2,802**
Australia	**89,632**	**98,303**	**187,935**	**38,942**	**1,507**	**228,384**

Total Allocated Ratio by State / Territory

as at 30 June 2006

State / Territory	High care	Low care	Total Residential	Community Care	Transition Care	TOTAL PLACES
NSW	47.9	49.2	**97.1**	19.5	0.8	**117.4**
VIC	45.0	52.9	**98.0**	20.1	0.8	**118.8**
QLD	44.8	51.3	**96.1**	19.0	0.8	**116.0**
SA	48.1	49.3	**97.4**	19.9	0.7	**118.0**
WA	43.9	51.7	**95.6**	20.6	0.6	**116.8**
TAS	49.3	46.1	**95.3**	21.3	1.0	**117.6**
NT	63.8	45.9	**109.6**	135.1	0	**244.8**
ACT	41.2	58.7	**99.9**	24.3	1.6	**125.7**
Australia	**46.3**	**50.8**	**97.0**	**20.1**	**0.8**	**117.9**

Notes:

Tables include flexible care places: Transition Care (TC), Extended Aged Care at Home (EACH) and EACH Dementia, Multi-Purpose Services (MPS), permanently allocated Innovative Care (IC) places and places under the National Aboriginal and Torres Strait Islander Aged Care Strategy (ATSI).

MPS, IC and ATSI flexible care places are notionally allocated as high care, low care and community aged care packages.

Community care includes Community Aged Care Packages (CACP), EACH and EACH Dementia places

State / Territory	Aged Care Planning Region	30 June 2006 - Total Allocated Places						30 June 2006 - Total Allocated Ratio					
		HIGH	LOW	RESI	Community Care	Transition Care	TOTAL PLACES	HIGH	LOW	RESI	Community Care	Transition Care	TOTAL
NSW	Central Coast	1,660	1,988	**3,648**	891	-	**4,539**	39.6	47.4	**87.0**	21.2	-	**108.2**
	Central West	789	941	**1,730**	345	-	**2,075**	43.6	52.0	**95.6**	19.1	-	**114.7**
	Far North Coast	1,498	1,932	**3,430**	725	-	**4,155**	40.8	52.7	**93.5**	19.8	-	**113.2**
	Hunter	2,752	3,150	**5,902**	1,178	-	**7,080**	43.7	50.0	**93.7**	18.7	-	**112.4**
	Illawarra	1,744	2,366	**4,110**	955	-	**5,065**	40.3	54.7	**95.0**	22.1	-	**117.0**
	Inner West	3,259	1,677	**4,936**	789	-	**5,725**	78.4	40.4	**118.8**	19.0	-	**137.8**
	Mid North Coast	1,683	2,253	**3,936**	851	-	**4,787**	40.7	54.5	**95.2**	20.6	-	**115.8**
	Nepean	1,268	902	**2,170**	419	-	**2,589**	60.6	43.1	**103.8**	20.0	-	**123.8**
	New England	829	970	**1,799**	366	-	**2,165**	44.2	51.7	**95.8**	19.5	-	**115.3**
	Northern Sydney	4,637	4,300	**8,937**	1,418	-	**10,355**	55.5	51.5	**107.0**	17.0	-	**124.0**
	Orana Far West	596	911	**1,507**	385	-	**1,892**	38.5	58.9	**97.4**	24.9	-	**122.3**
	Riverina/Murray	1,210	1,510	**2,720**	549	-	**3,269**	42.7	53.3	**96.0**	19.4	-	**115.4**
	South East Sydney	3,889	3,702	**7,591**	1,666	-	**9,257**	46.5	44.3	**90.8**	19.9	-	**110.8**
	South West Sydney	2,782	2,948	**5,730**	1,192	-	**6,922**	45.1	47.8	**93.0**	19.3	-	**112.3**
	Southern Highlands	834	1,307	**2,141**	431	-	**2,572**	36.8	57.7	**94.6**	19.0	-	**113.6**
	Western Sydney	2,859	2,262	**5,121**	960	-	**6,081**	53.9	42.6	**96.5**	18.1	-	**114.6**
NEW SOUTH WALES TOTAL		**32,289**	**33,119**	**65,408**	**13,120**	**550**	**79,078**	**47.9**	**49.2**	**97.1**	**19.5**	**0.8**	**117.4**
VIC	Barwon-South Western	1,847	2,186	**4,033**	835	-	**4,868**	44.8	53.0	**97.7**	20.2	-	**118.0**
	Eastern Metro	4,356	5,354	**9,710**	1,945	-	**11,655**	43.8	53.8	**97.6**	19.5	-	**117.1**
	Gippsland	1,191	1,554	**2,745**	598	-	**3,343**	41.5	54.2	**95.7**	20.8	-	**116.5**
	Grampians	1,026	1,253	**2,279**	487	-	**2,766**	43.8	53.5	**97.2**	20.8	-	**118.0**
	Hume	1,202	1,537	**2,739**	580	-	**3,319**	43.9	56.1	**100.0**	21.2	-	**121.2**
	Loddon-Mallee	1,404	1,813	**3,217**	667	-	**3,884**	41.5	53.6	**95.1**	19.7	-	**114.8**
	Northern Metro	3,436	3,591	**7,027**	1,508	-	**8,535**	48.5	50.7	**99.3**	21.3	-	**120.6**
	Southern Metro	5,533	6,198	**11,731**	2,304	-	**14,035**	46.1	51.6	**97.6**	19.2	-	**116.8**
	Western Metro	2,370	2,824	**5,194**	1,073	-	**6,267**	45.7	54.4	**100.1**	20.7	-	**120.8**
VICTORIA TOTAL		**22,365**	**26,310**	**48,675**	**9,997**	**376**	**59,048**	**45.0**	**52.9**	**98.0**	**20.1**	**0.8**	**118.8**

		30 June 2006 - Total Allocated Places						30 June 2006 - Total Allocated Ratio					
State / Territory	**Aged Care Planning Region**	**HIGH**	**LOW**	**RESI**	**Community Care**	**Transition Care**	**TOTAL PLACES**	**HIGH**	**LOW**	**RESI**	**Community Care**	**Transition Care**	**TOTAL**
QLD	Brisbane North	2,169	2,049	**4,218**	720	-	**4,938**	52.7	49.7	**102.4**	17.5	-	**119.9**
	Brisbane South	2,775	2,831	**5,606**	989	-	**6,595**	49.6	50.6	**100.2**	17.7	-	**117.8**
	Cabool	1,179	1,399	**2,578**	468	-	**3,046**	44.6	53.0	**97.6**	17.7	-	**115.3**
	Central West	68	54	**122**	64	-	**186**	69.2	55.0	**124.2**	65.2	-	**189.4**
	Darling Downs	1,063	1,159	**2,222**	407	-	**2,629**	46.9	51.2	**98.1**	18.0	-	**116.0**
	Far North	666	840	**1,506**	422	-	**1,928**	39.6	49.9	**89.5**	25.1	-	**114.6**
	Fitzroy	668	796	**1,464**	319	-	**1,783**	44.5	53.1	**97.6**	21.3	-	**118.9**
	Logan River Valley	632	891	**1,523**	282	-	**1,805**	41.1	58.0	**99.1**	18.4	-	**117.5**
	Mackay	364	437	**801**	181	-	**982**	40.2	48.2	**88.4**	20.0	-	**108.3**
	North West	59	78	**137**	99	-	**236**	37.8	50.0	**87.8**	63.5	-	**151.3**
	Northern	784	787	**1,571**	303	-	**1,874**	49.7	49.9	**99.6**	19.2	-	**118.8**
	South Coast	1,888	2,245	**4,133**	819	-	**4,952**	41.7	49.6	**91.3**	18.1	-	**109.4**
	South West	74	149	**223**	97	-	**320**	36.1	72.8	**108.9**	47.4	-	**156.3**
	Sunshine Coast	1,472	1,931	**3,403**	671	-	**4,074**	38.9	51.1	**90.0**	17.7	-	**107.7**
	West Moreton	491	738	**1,229**	223	-	**1,452**	37.7	56.7	**94.5**	17.1	-	**111.6**
	Wide Bay	1,091	1,279	**2,370**	490	-	**2,860**	42.9	50.3	**93.2**	19.3	-	**112.5**
QUEENSLAND TOTAL		**15,443**	**17,663**	**33,106**	**6,554**	**273**	**39,933**	**44.8**	**51.3**	**96.1**	**19.0**	**0.8**	**116.0**
SA	Eyre Peninsula	125	182	**307**	83	-	**390**	35.2	51.3	**86.5**	23.4	-	**109.9**
	Hills, Mallee & Southern	562	613	**1,175**	295	-	**1,470**	43.2	47.1	**90.3**	22.7	-	**113.0**
	Metropolitan East	2,289	1,882	**4,171**	563	-	**4,734**	64.9	53.4	**118.3**	16.0	-	**134.2**
	Metropolitan North	1,459	1,176	**2,635**	412	-	**3,047**	57.5	46.4	**103.9**	16.2	-	**120.1**
	Metropolitan South	1,733	1,834	**3,567**	802	-	**4,369**	44.3	46.8	**91.1**	20.5	-	**111.6**
	Metropolitan West	1,254	1,286	**2,540**	585	-	**3,125**	43.0	44.1	**87.0**	20.0	-	**107.1**
	Mid North	69	227	**296**	87	-	**383**	19.3	63.6	**82.9**	24.4	-	**107.3**
	Riverland	146	238	**384**	118	-	**502**	31.6	51.6	**83.2**	25.6	-	**108.8**
	South East	189	358	**547**	138	-	**685**	30.0	56.8	**86.7**	21.9	-	**108.6**
	Whyalla, Flinders & Far North	142	209	**351**	153	-	**504**	36.3	53.5	**89.8**	39.1	-	**128.9**
	Yorke, Lower North & Barossa	403	583	**986**	236	-	**1,222**	39.3	56.8	**96.1**	23.0	-	**119.1**
SOUTH AUSTRALIA TOTAL		**8,371**	**8,588**	**16,959**	**3,472**	**121**	**20,552**	**48.1**	**49.3**	**97.4**	**19.9**	**0.7**	**118.0**

State / Territory	Aged Care Planning Region	30 June 2006 - Total Allocated Places						30 June 2006 - Total Allocated Ratio					
		HIGH	LOW	RESI	Community Care	Transition Care	TOTAL PLACES	HIGH	LOW	RESI	Community Care	Transition Care	TOTAL
WA	Goldfields	132	135	**267**	71	-	**338**	51.3	52.5	**103.8**	27.6	-	**131.4**
	Great Southern	293	381	**674**	165	-	**839**	40.2	52.3	**92.5**	22.6	-	**115.1**
	Kimberley	68	92	**160**	60	-	**220**	59.1	79.9	**139.0**	52.1	-	**191.1**
	Metropolitan East	1,196	1,385	**2,581**	460	-	**3,041**	46.6	53.9	**100.5**	17.9	-	**118.4**
	Metropolitan North	1,745	2,318	**4,063**	872	-	**4,935**	40.1	53.2	**93.3**	20.0	-	**113.4**
	Metropolitan South East	1,642	1,477	**3,119**	641	-	**3,760**	58.7	52.8	**111.4**	22.9	-	**134.3**
	Metropolitan South West	1,504	1,792	**3,296**	636	-	**3,932**	39.2	46.7	**85.9**	16.6	-	**102.5**
	Mid West	178	223	**401**	139	-	**540**	37.2	46.6	**83.8**	29.1	-	**112.9**
	Pilbara	30	53	**83**	50	-	**133**	44.8	79.2	**124.1**	74.7	-	**198.8**
	South West	471	709	**1,180**	263	-	**1,443**	38.9	58.6	**97.5**	21.7	-	**119.2**
	Wheatbelt	161	180	**341**	128	-	**469**	32.2	36.0	**68.3**	25.6	-	**93.9**
WESTERN AUSTRALIA TOTAL		**7,420**	**8,745**	**16,165**	**3,485**	**100**	**19,750**	**43.9**	**51.7**	**95.6**	**20.6**	**0.6**	**116.8**
TAS	North Western	500	512	**1,012**	227	-	**1,239**	42.9	43.9	**86.8**	19.5	-	**106.3**
	Northern	814	643	**1,457**	336	-	**1,793**	55.7	44.0	**99.7**	23.0	-	**122.6**
	Southern	1,184	1,179	**2,363**	515	-	**2,878**	48.5	48.3	**96.8**	21.1	-	**117.9**
TASMANIA TOTAL		**2,498**	**2,334**	**4,832**	**1,078**	**52**	**5,962**	**49.3**	**46.1**	**95.3**	**21.3**	**1.0**	**117.6**
NT	Alice Springs	110	56	**166**	196	-	**362**	112.0	57.0	**169.0**	199.6	-	**368.6**
	Barkly	17	2	**19**	42	-	**61**	144.1	16.9	**161.0**	355.9	-	**516.9**
	Darwin	169	131	**300**	307	-	**607**	48.6	37.7	**86.3**	88.3	-	**174.5**
	East Arnhem	5	6	**11**	72	-	**83**	32.1	38.5	**70.5**	461.5	-	**532.1**
	Katherine	27	41	**68**	78	-	**146**	65.9	100.0	**165.9**	190.2	-	**356.1**
NORTHERN TERRITORY TOTAL		**328**	**236**	**564**	**695**	**0**	**1,259**	**63.8**	**45.9**	**109.6**	**135.1**	**0**	**244.8**
ACT	Australian Capital Territory	918	1,308	2,226	541	-	**2,802**	41.2	58.7	**99.9**	24.3	-	**124.1**
AUSTRALIAN CAPITAL TERRITORY TOTAL		**918**	**1,308**	**2,226**	**541**	**35**	**2,802**	**41.2**	**58.7**	**99.9**	**24.3**	**1.6**	**125.7**
AUSTRALIA TOTAL		**89,632**	**98,303**	**187,935**	**38,942**	**1,507**	**228,384**	**46.3**	**50.8**	**97.0**	**20.1**	**0.8**	**117.9**

Total Allocated Places by Service Type as at 30 June 2006

Mainstream allocated places
Residential and community care places under the *Aged Care Act 1997*

State / Territory	High care	Low care	Total Residential	Community Care*	Transition Care	TOTAL
NSW	31,778	32,877	**64,655**	11,913		**76,568**
VIC	22,170	26,176	**48,346**	9,030		**57,376**
QLD	15,219	17,502	**32,721**	5,890		**38,611**
SA	8,218	8,422	**16,640**	3,125		**19,765**
WA	7,088	8,401	**15,489**	3,037	**NA**	**18,526**
TAS	2,444	2,301	**4,745**	935		**5,680**
NT	283	182	**465**	559		**1,024**
ACT	918	1,308	**2,226**	456		**2,682**
Australia	**88,118**	**97,169**	**185,287**	**34,945**		**220,232**

Aboriginal and Torres Strait Islander Flexible Aged Care allocated places
Not allocated under the *Aged Care Act 1997*
Notionally allocated as high care, low care and community care

State / Territory	High care	Low care	Total Residential	Community Care	Transition Care	TOTAL
NSW	6	15	**21**	34		**55**
VIC	15	10	**25**	69		**94**
QLD	41	32	**73**	6		**79**
SA	58	42	**100**	45		**145**
WA	6	8	**14**	2	**NA**	**16**
TAS	0	0	**0**	41		**41**
NT	45	54	**99**	66		**165**
ACT	0	0	**0**	0		**0**
Australia	**171**	**161**	**332**	**263**		**595**

Multi-Purpose Services allocated places
Flexible places under the *Aged Care Act 1997*.
Notionally allocated as high care, low care and community care

State/ territory	High care	Low care	Total Residential	Community Care	Transition Care	TOTAL
NSW	505	227	**732**	74		**806**
VIC	180	124	**304**	14		**318**
QLD	183	129	**312**	104		**416**
SA	95	124	**219**	14		**233**
WA	305	310	**615**	153	**NA**	**768**
TAS	54	33	**87**	7		**94**
NT	0	0	**0**	0		**0**
ACT	0	0	**0**	0		**0**
Australia	**1,322**	**947**	**2,269**	**366**		**2,635**

Extended Aged Care at Home (EACH) allocated places
Flexible places under the *Aged Care Act 1997*
Notionally allocated as community care

State / Territory	High care	Low care	Total Residential	Community Care	Transition Care	TOTAL
NSW				874		**874**
VIC				718		**718**
QLD				439		**439**
SA				230		**230**
WA		**NA**		235	**NA**	**235**
TAS				75		**75**
NT				60		**60**
ACT				70		**70**
Australia				**2,701**		**2,701**

Notes:
NA = not applicable
***These Community Care places are Community Aged Care Packages only.**

Total Allocated Places by Service Type as at 30 June 2006

EACH Dementia
Flexible places under the *Aged Care Act 1997*
Notionally allocated as community care

State / Territory	High care	Low care	Total Residential	Community Care	Transition Care	TOTAL
NSW				225		**225**
VIC				166		**166**
QLD				115		**115**
SA				58		**58**
WA		**NA**		58	**NA**	**58**
TAS				20		**20**
NT				10		**10**
ACT				15		**15**
Australia				**667**		**667**

Transition Care allocated places
Flexible places under the *Aged Care Act 1997*

State / Territory	High care	Low care	Total Residential	Community Care	Transition Care	TOTAL
NSW					550	**550**
VIC					376	**376**
QLD					273	**273**
SA					121	**121**
WA			**NA**		100	**100**
TAS					52	**52**
NT					0	**0**
ACT					35	**35**
Australia					**1,507**	**1,507**

Innovative Care allocated places
Flexible places under the *Aged Care Act 1997*
Notionally allocated as high care and low care

State / Territory	High care	Low care	Total Residential	Community Care	Transition Care	TOTAL
NSW	0	0	**0**			**0**
VIC	0	0	**0**			**0**
QLD	0	0	**0**			**0**
SA	0	0	**0**			**0**
WA	21	26	**47**		**NA**	**47**
TAS	0	0	**0**			**0**
NT	0	0	**0**			**0**
ACT	0	0	**0**			**0**
Australia	**21**	**26**	**47**			**47**

Total Operational Places by State / Territory

as at 30 June 2006

State / Territory	High care	Low care	Total Residential	Community Care	Transition Care	TOTAL PLACES
NSW	29,936	26,754	**56,690**	12,935	304	**69,929**
VIC	19,734	23,025	**42,759**	9,957	42	**52,758**
QLD	13,631	15,822	**29,453**	6,510	84	**36,047**
SA	7,944	8,050	**15,994**	3,472	90	**19,556**
WA	6,519	7,799	**14,318**	3,347	50	**17,715**
TAS	2,272	2,168	**4,440**	1,043	15	**5,498**
NT	306	228	**534**	695	0	**1,229**
ACT	663	931	**1,594**	533	10	**2,137**
Australia	**81,005**	**84,777**	**165,782**	**38,492**	**595**	**204,869**

Total Operational Ratio by State / Territory

as at 30 June 2006

State / Territory	High care	Low care	Total Residential	Community Care	Transition Care	TOTAL PLACES
NSW	44.4	39.7	**84.1**	19.2	0.5	**103.8**
VIC	39.7	46.3	**86.0**	20.0	0.1	**106.2**
QLD	39.6	45.9	**85.5**	18.9	0.2	**104.7**
SA	45.6	46.2	**91.8**	19.9	0.5	**112.3**
WA	38.5	46.1	**84.7**	19.8	0.3	**104.7**
TAS	44.8	42.8	**87.6**	20.6	0.3	**108.5**
NT	59.5	44.3	**103.8**	135.1	0	**238.9**
ACT	29.7	41.8	**71.5**	23.9	0.4	**95.9**
Australia	**41.8**	**43.8**	**85.6**	**19.9**	**0.3**	**105.8**

Notes:

Tables include flexible care places: Transition Care (TC), Extended Aged Care at Home (EACH) and EACH Dementia, Multi-Purpose Services (MPS), permanently allocated Innovative Care (IC) places and places under the National Aboriginal and Torres Strait Islander Aged Care Strategy (ATSI).

MPS, IC and ATSI flexible care places are notionally allocated as high care, low care and community aged care packages.

Community care includes Community Aged Care Packages (CACP), EACH and EACH Dementia places

State / Territory	Aged Care Planning Region	30 June 2006 - Total Operational Places						30 June 2006 - Total Operational Ratio					
		HIGH	LOW	RESI	Community Care	Transition Care	TOTAL PLACES	HIGH	LOW	RESI	Community Care	Transition Care	TOTAL PLACES
NSW	Central Coast	1,543	1,555	**3,098**	891	-	**3,989**	36.8	37.1	**73.8**	21.2	-	**95.1**
	Central West	779	898	**1,677**	331	-	**2,008**	43.1	49.6	**92.7**	18.3	-	**111.0**
	Far North Coast	1,314	1,553	**2,867**	725	-	**3,592**	35.8	42.3	**78.1**	19.8	-	**97.9**
	Hunter	2,521	2,628	**5,149**	1,143	-	**6,292**	40.0	41.7	**81.8**	18.1	-	**99.9**
	Illawarra	1,467	1,535	**3,002**	955	-	**3,957**	33.9	35.5	**69.4**	22.1	-	**91.4**
	Inner West	3,189	1,451	**4,640**	789	-	**5,429**	76.7	34.9	**111.7**	19.0	-	**130.6**
	Mid North Coast	1,331	1,741	**3,072**	841	-	**3,913**	32.2	42.1	**74.3**	20.3	-	**94.7**
	Nepean	1,229	712	**1,941**	397	-	**2,338**	58.8	34.1	**92.8**	19.0	-	**111.8**
	New England	722	867	**1,589**	366	-	**1,955**	38.5	46.2	**84.6**	19.5	-	**104.1**
	Northern Sydney	4,481	3,989	**8,470**	1,411	-	**9,881**	53.6	47.8	**101.4**	16.9	-	**118.3**
	Orana Far West	572	834	**1,406**	384	-	**1,790**	37.0	53.9	**90.9**	24.8	-	**115.7**
	Riverina/Murray	1,025	1,280	**2,305**	529	-	**2,834**	36.2	45.2	**81.4**	18.7	-	**100.1**
	South East Sydney	3,536	2,578	**6,114**	1,646	-	**7,760**	42.3	30.9	**73.2**	19.7	-	**92.9**
	South West Sydney	2,717	2,299	**5,016**	1,192	-	**6,208**	44.1	37.3	**81.4**	19.3	-	**100.7**
	Southern Highlands	704	1,076	**1,780**	417	-	**2,197**	31.1	47.5	**78.6**	18.4	-	**97.1**
	Western Sydney	2,806	1,758	**4,564**	918	-	**5,482**	52.9	33.1	**86.0**	17.3	-	**103.3**
NEW SOUTH WALES TOTAL		**29,936**	**26,754**	**56,690**	**12,935**	**304**	**69,929**	**44.4**	**39.7**	**84.1**	**19.2**	**0.5**	**103.8**
VIC	Barwon-South Western	1,722	1,977	**3,699**	835	-	**4,534**	41.7	47.9	**89.7**	20.2	-	**109.9**
	Eastern Metro	3,806	4,833	**8,639**	1,945	-	**10,584**	38.2	48.6	**86.8**	19.5	-	**106.4**
	Gippsland	1,036	1,339	**2,375**	598	-	**2,973**	36.1	46.7	**82.8**	20.8	-	**103.6**
	Grampians	921	1,107	**2,028**	487	-	**2,515**	39.3	47.2	**86.5**	20.8	-	**107.3**
	Hume	1,144	1,381	**2,525**	580	-	**3,105**	41.8	50.4	**92.2**	21.2	-	**113.4**
	Loddon-Mallee	1,313	1,637	**2,950**	647	-	**3,597**	38.8	48.4	**87.2**	19.1	-	**106.3**
	Northern Metro	2,860	2,974	**5,834**	1,508	-	**7,342**	40.4	42.0	**82.4**	21.3	-	**103.7**
	Southern Metro	4,913	5,393	**10,306**	2,304	-	**12,610**	40.9	44.9	**85.8**	19.2	-	**105.0**
	Western Metro	2,019	2,384	**4,403**	1,053	-	**5,456**	38.9	45.9	**84.9**	20.3	-	**105.1**
VICTORIA TOTAL		**19,734**	**23,025**	**42,759**	**9,957**	**42**	**52,758**	**39.7**	**46.3**	**86.0**	**20.0**	**0.1**	**106.2**

State / Territory	Aged Care Planning Region	30 June 2006 - Total Operational Places						30 June 2006 - Total Operational Ratio					
		HIGH	LOW	RESI	Community Care	Transition Care	TOTAL PLACES	HIGH	LOW	RESI	Community Care	Transition Care	TOTAL PLACES
QLD	Brisbane North	2,018	1,979	**3,997**	705	-	**4,702**	49.0	48.0	**97.0**	17.1	-	**114.1**
	Brisbane South	2,500	2,560	**5,060**	989	-	**6,049**	44.7	45.7	**90.4**	17.7	-	**108.1**
	Cabool	986	1,170	**2,156**	468	-	**2,624**	37.3	44.3	**81.6**	17.7	-	**99.3**
	Central West	63	49	**112**	61	-	**173**	64.2	49.9	**114.1**	62.1	-	**176.2**
	Darling Downs	974	1,112	**2,086**	407	-	**2,493**	43.0	49.1	**92.1**	18.0	-	**110.0**
	Far North	613	803	**1,416**	413	-	**1,829**	36.4	47.7	**84.1**	24.5	-	**108.7**
	Fitzroy	585	776	**1,361**	314	-	**1,675**	39.0	51.7	**90.7**	20.9	-	**111.7**
	Logan River Valley	418	586	**1,004**	282	-	**1,286**	27.2	38.1	**65.4**	18.4	-	**83.7**
	Mackay	350	403	**753**	181	-	**934**	38.6	44.5	**83.1**	20.0	-	**103.0**
	North West	46	78	**124**	94	-	**218**	29.5	50.0	**79.5**	60.3	-	**139.7**
	Northern	747	779	**1,526**	303	-	**1,829**	47.3	49.4	**96.7**	19.2	-	**115.9**
	South Coast	1,596	1,973	**3,569**	817	-	**4,386**	35.3	43.6	**78.8**	18.0	-	**96.9**
	South West	72	149	**221**	97	-	**318**	35.2	72.8	**107.9**	47.4	-	**155.3**
	Sunshine Coast	1,281	1,647	**2,928**	671	-	**3,599**	33.9	43.6	**77.4**	17.7	-	**95.2**
	West Moreton	481	675	**1,156**	223	-	**1,379**	37.0	51.9	**88.8**	17.1	-	**106.0**
	Wide Bay	901	1,083	**1,984**	485	-	**2,469**	35.4	42.6	**78.0**	19.1	-	**97.1**
QUEENSLAND TOTAL		**13,631**	**15,822**	**29,453**	**6,510**	**84**	**36,047**	**39.6**	**45.9**	**85.5**	**18.9**	**0.2**	**104.7**
SA	Eyre Peninsula	112	182	**294**	83	-	**377**	31.5	51.3	**82.8**	23.4	-	**106.2**
	Hills, Mallee & Southern	507	553	**1,060**	295	-	**1,355**	39.0	42.5	**81.5**	22.7	-	**104.2**
	Metropolitan East	2,251	1,876	**4,127**	563	-	**4,690**	63.8	53.2	**117.0**	16.0	-	**133.0**
	Metropolitan North	1,270	1,010	**2,280**	412	-	**2,692**	50.1	39.8	**89.9**	16.2	-	**106.1**
	Metropolitan South	1,620	1,643	**3,263**	802	-	**4,065**	41.4	42.0	**83.3**	20.5	-	**103.8**
	Metropolitan West	1,244	1,192	**2,436**	585	-	**3,021**	42.6	40.8	**83.5**	20.0	-	**103.5**
	Mid North	65	224	**289**	87	-	**376**	18.2	62.7	**80.9**	24.4	-	**105.3**
	Riverland	146	238	**384**	118	-	**502**	31.6	51.6	**83.2**	25.6	-	**108.8**
	South East	189	358	**547**	138	-	**685**	30.0	56.8	**86.7**	21.9	-	**108.6**
	Whyalla, Flinders & Far North	137	191	**328**	153	-	**481**	35.0	48.9	**83.9**	39.1	-	**123.0**
	Yorke, Lower North & Barossa	403	583	**986**	236	-	**1,222**	39.3	56.8	**96.1**	23.0	-	**119.1**
SOUTH AUSTRALIA TOTAL		**7,944**	**8,050**	**15,994**	**3,472**	**90**	**19,556**	**45.6**	**46.2**	**91.8**	**19.9**	**0.5**	**112.3**

State / Territory	Aged Care Planning Region	30 June 2006 - Total Operational Places						30 June 2006 - Total Operational Ratio					
		HIGH	LOW	RESI	Community Care	Transition Care	TOTAL PLACES	HIGH	LOW	RESI	Community Care	Transition Care	TOTAL PLACES
WA	Goldfields	125	134	**259**	69	-	**328**	48.6	52.1	**100.7**	26.8	-	**127.5**
	Great Southern	288	371	**659**	162	-	**821**	39.5	50.9	**90.4**	22.2	-	**112.7**
	Kimberley	48	82	**130**	60	-	**190**	41.7	71.2	**112.9**	52.1	-	**165.1**
	Metropolitan East	1,164	1,302	**2,466**	445	-	**2,911**	45.3	50.7	**96.1**	17.3	-	**113.4**
	Metropolitan North	1,439	1,943	**3,382**	862	-	**4,244**	33.1	44.6	**77.7**	19.8	-	**97.5**
	Metropolitan South East	1,498	1,374	**2,872**	596	-	**3,468**	53.5	49.1	**102.6**	21.3	-	**123.9**
	Metropolitan South West	1,237	1,643	**2,880**	606	-	**3,486**	32.2	42.8	**75.0**	15.8	-	**90.8**
	Mid West	144	181	**325**	121	-	**446**	30.1	37.8	**67.9**	25.3	-	**93.2**
	Pilbara	30	20	**50**	50	-	**100**	44.8	29.9	**74.7**	74.7	-	**149.5**
	South West	408	585	**993**	260	-	**1,253**	33.7	48.3	**82.0**	21.5	-	**103.5**
	Wheatbelt	138	164	**302**	116	-	**418**	27.6	32.8	**60.4**	23.2	-	**83.7**
WESTERN AUSTRALIA TOTAL		**6,519**	**7,799**	**14,318**	**3,347**	**50**	**17,715**	**38.5**	**46.1**	**84.7**	**19.8**	**0.3**	**104.7**
TAS	North Western	490	459	**949**	227	-	**1,176**	42.0	39.4	**81.4**	19.5	-	**100.9**
	Northern	705	573	**1,278**	336	-	**1,614**	48.2	39.2	**87.4**	23.0	-	**110.4**
	Southern	1,077	1,136	**2,213**	480	-	**2,693**	44.1	46.5	**90.7**	19.7	-	**110.4**
TASMANIA TOTAL		**2,272**	**2,168**	**4,440**	**1,043**	**15**	**5,498**	**44.8**	**42.8**	**87.6**	**20.6**	**0.3**	**108.5**
NT	Alice Springs	100	56	**156**	196	-	**352**	101.8	57.0	**158.9**	199.6	-	**358.5**
	Barkly	17	2	**19**	42	-	**61**	144.1	16.9	**161.0**	355.9	-	**516.9**
	Darwin	157	123	**280**	307	-	**587**	45.1	35.4	**80.5**	88.3	-	**168.8**
	East Arnhem	5	6	**11**	72	-	**83**	32.1	38.5	**70.5**	461.5	-	**532.1**
	Katherine	27	41	**68**	78	-	**146**	65.9	100.0	**165.9**	190.2	-	**356.1**
NORTHERN TERRITORY TOTAL		**306**	**228**	**534**	**695**	**0**	**1,229**	**59.5**	**44.3**	**103.8**	**135.1**	**0**	**238.9**
ACT	Australian Capital Territory	663	931	**1,594**	533	-	**2,127**	29.7	41.8	**71.5**	23.9	-	**95.4**
AUSTRALIAN CAPITAL TERRITORY TOTAL		**663**	**931**	**1,594**	**533**	**10**	**2,137**	**29.7**	**41.8**	**71.5**	**23.9**	**0.4**	**95.9**
AUSTRALIA TOTAL		**81,005**	**84,777**	**165,782**	**38,492**	**595**	**204,869**	**41.8**	**43.8**	**85.6**	**19.9**	**0.3**	**105.8**

Total Operational Places by Service Type as at 30 June 2006

Mainstream operational places
Residential and community care places under the *Aged Care Act 1997*

State / Territory	High care	Low care	Total Residential	Community Care*	Transition Care	TOTAL
NSW	29,559	26,548	**56,107**	11,857		**67,964**
VIC	19,539	22,891	**42,430**	8,990		**51,420**
QLD	13,446	15,678	**29,124**	5,876		**35,000**
SA	7,791	7,884	**15,675**	3,125		**18,800**
WA	6,250	7,500	**13,750**	2,977	**NA**	**16,727**
TAS	2,218	2,135	**4,353**	925		**5,278**
NT	261	174	**435**	559		**994**
ACT	663	931	**1,594**	451		**2,045**
Australia	**79,727**	**83,741**	**163,468**	**34,760**		**198,228**

Aboriginal and Torres Strait Islander Flexible Aged Care operational places
Not allocated under the *Aged Care Act 1997*.
Notionally allocated as high care, low care and community care

State / Territory	High care	Low care	Total Residential	Community Care	Transition Care	TOTAL
NSW	6	15	**21**	19		**40**
VIC	15	10	**25**	69		**94**
QLD	41	32	**73**	6		**79**
SA	58	42	**100**	45		**145**
WA	6	8	**14**	2	**NA**	**16**
TAS	0	0	**0**	41		**41**
NT	45	54	**99**	66		**165**
ACT	0	0	**0**	0		**0**
Australia	171	161	**332**	248		**580**

Multi-Purpose Services operational places
Flexible places under the *Aged Care Act 1997*.
Notionally allocated as high care, low care and community care

State / Territory	High care	Low care	Total Residential	Community Care	Transition Care	TOTAL
NSW	371	191	**562**	69		**631**
VIC	180	124	**304**	14		**318**
QLD	144	112	**256**	89		**345**
SA	95	124	**219**	14		**233**
WA	247	276	**523**	115	**NA**	**638**
TAS	54	33	**87**	7		**94**
NT	0	0	**0**	0		**0**
ACT	0	0	**0**	0		**0**
Australia	**1,091**	**860**	**1,951**	**308**		**2,259**

Extended Aged Care at Home (EACH) operational places
Flexible places under the *Aged Care Act 1997*. Notionally allocated as community care

State / Territory	High care	Low care	Total Residential	Community Care	Transition Care	TOTAL
NSW	-	-	-	816		**816**
VIC	-	-	-	718		**718**
QLD	-	-	-	424		**424**
SA	-	-	-	230		**230**
WA	-	-	-	205	**NA**	**205**
TAS	-	-	-	55		**55**
NT	-	-	-	60		**60**
ACT	-	-	-	67		**67**
Australia	**-**	**-**	**-**	**2,575**		**2,575**

Notes:
NA = not applicable

***These Community Care places are Community Aged Care Packages only.**

Total Operational Places by Service Type as at 30 June 2006

EACH Dementia operational places

Flexible places under the *Aged Care Act 1997*. Notionally allocated as community care

State / Territory	High care	Low care	Total Residential	Community Care	Transition Care	TOTAL
NSW				174		**174**
VIC				166		**166**
QLD				115		**115**
SA				58		**58**
WA		**NA**		48	**NA**	**48**
TAS				15		**15**
NT				10		**10**
ACT				15		**15**
Australia				**601**		**601**

Transition Care operational places

Flexible places under the *Aged Care Act 1997*

State / Territory	High care	Low care	Total Residential	Community Care	Transition Care	TOTAL
NSW					304	**304**
VIC					42	**42**
QLD					84	**84**
SA					90	**90**
WA			**NA**		50	**50**
TAS					15	**15**
NT					0	**0**
ACT					10	**10**
Australia					**595**	**595**

Innovative Care operational places

Flexible places under the *Aged Care Act 1997*. Notionally allocated as high care and low care

State / Territory	High care	Low care	Total Residential	Community Care	Transition Care	TOTAL
NSW	0	0	**0**			**0**
VIC	0	0	**0**			**0**
-QLD	0	0	**0**			**0**
SA	0	0	**0**			**0**
WA	16	15	**31**	**NA**		**31**
TAS	0	0	**0**			**0**
NT	0	0	**0**			**0**
ACT	0	0	**0**			**0**
Australia	**16**	**15**	**31**			**31**

Offline places by State / Territory

as at 30 June 2006

State / Territory	High care	Low care	Total Residential	Community Care	Transition Care	TOTAL PLACES	% of Total
NSW	650	433	**1,083**	15	0	**1,098**	**40.0%**
VIC	424	519	**943**	0	0	**943**	**34.4%**
QLD	184	98	**282**	7	0	**289**	**10.5%**
SA	66	6	**72**	0	0	**72**	**2.6%**
WA	164	168	**332**	0	0	**332**	**12.1%**
TAS	0	0	**0**	0	0	**0**	**0.0%**
NT	0	0	**0**	0	0	**0**	**0.0%**
ACT	0	10	**10**	0	0	**10**	**0.4%**
Australia	**1,488**	**1,234**	**2,722**	**22**	**0**	**2,744**	**100.0%**

Note: Table includes flexible care places: Transition Care (TC), Extended Aged Care at Home (EACH) and EACH Dementia, Multi-Purpose Services (MPS), permanently allocated Innovative Care (IC) places and places under the National Aboriginal and Torres Strait Islander Aged Care Strategy (ATSI). EACH and EACH Dementia places are notionally allocated as community care while MPS,IC and ATSI flexible care places are notionally allocated as high care, low care and community care packages.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2006-2007, 31 May - 1 June 2006

Question: E06-067

OUTCOME 4: Aged Care and Population Ageing

Topic: NURSING HOMES THAT DO NOT FALL WITHIN ACCREDITATION AND CERTIFICATION PROCESS

Written Question on Notice

Senator McLucas asked:

a) When did each of the 20 aged care facilities that have not passed State and local government fire safety standards fail?
b) Have any of them had their accreditation reviewed, and if not, why not?
c) Given these 20 facilities would now not comply with aged care certification, how are they able to receive Government funding?
d) What is the Department planning to do in relation to each of these facilities?

Answer:

a) The 20 facilities declared in their 2005 Fire Safety Declaration that they did not meet state and local government fire safety regulations. The Declarations were submitted to the Department on or before 1 March 2006.
b) The Department referred all 20 services to the Aged Care Standards and Accreditation Agency for its information and consideration in its ongoing monitoring and assessment of services against the Accreditation Standards. The Agency has conducted full and comprehensive Accreditation Site Audits of 19 of the 20 services during 2005-2006 and found that all have met the required standards for accreditation; the remaining home is scheduled to be assessed in 2007, however the Agency has conducted a support contact visit to this home during 2006.
c) In order to be certified a service must achieve a minimum score calculated across a range of factors relating to the overall physical standard of the home, including fire safety, hazards, resident privacy and space, heating and cooling, ventilation and lighting. All homes have met the minimum standards for certification and are certified under the *Aged Care Act 1997* and are therefore entitled to receive bonds and charges from residents and Australian Government concessional resident supplements. In 1999, new and higher standards for certification were introduced and incorporated in a revised certification assessment instrument *(the 1999 Certification Assessment Instrument)*. This instrument introduced a minimum score for fire and safety as well as an increase in the overall score for the building. All homes remain certified but those that have not yet met the requirements of the 1999 instrument are being actively assisted to meet the higher standards. In addition all 20 homes are accredited and are therefore entitled to receive Australian Government subsidies.

d) The Department actively monitored each home to ensure that there were adequate safeguards to ensure that resident safety is not compromised. In addition all 20 facilities have been referred to the relevant local government authorities for their follow-up action and have also been referred to the Aged Care Standards and Accreditation Agency. Consequently there is currently only one home that is still to complete necessary building works. The Department and the Agency are continuing to monitor this home.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2006-2007, 31 May - 1 June 2006

Question: E06-086

OUTCOME 4: Aged Care and Population Ageing

Topic: PROVISIONAL ALLOCATIONS

Written Question on Notice

Senator McLucas asked:

a) Is the Department aware of cases where an approved provider company in possession of provisionally allocated places is sold, allowing those provisional allocations to effectively be transferred?

b) If yes, how many such sales is the Department aware occurred in 2004 and 2005?

c) Could you please provide the names of those companies that have been sold while holding provisional licences?

d) Does the approved provider have to notify the Department where such sales take place?

e) Does the approved provider have to seek approval from the Department where such sales take effect to allow the provisional allocations to remain with the approved provider?

f) Don't such sales circumvent the provisions of the Act which do not allow the direct sale of provisional allocations?

g) How can the Department ensure that provisional allocations are passed onto people of sound character if they are on sold through a holding company?

Answer:

a) Yes.

b) Two.

c) This is protected information under Division 86 of the *Aged Care Act 1997*.

d) and e) A sale of an Approved Provider will usually result in a change of its Directors and/or senior management. Under the *Aged Care Act 1997* (the Act), an Approved Provider must notify the Department of any change to its key personnel within 28 days of the change taking place. Company Directors/senior managers are key personnel for the purposes of the Act.

f) This is not a situation where provisional allocations are being directly sold from one provider to another. Ownership of the provisional allocations changes as a result of the sale of the provider, which continues to hold the provisional allocation.

g) Directors of an Approved Provider are key personnel and must not be disqualified individuals. An individual is considered a disqualified individual under section 10A-1 of the *Aged Care Act 1997* (the Act) if the individual:

(a) has been convicted of an indictable offence; or
(b) is an insolvent under administration; or
(c) is of unsound mind.

If a key personnel of an Approved Provider is found to be a disqualified individual, section 10A-3(2) of the Act provides for the Federal Court to make such orders as the court considers appropriate for the purpose of ensuring that that situation ceases to exist.

The Secretary must revoke an approval if the Secretary is satisfied that the Approved Provider has ceased to be suitable to provide aged care.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2006-2007, 31 May - 1 June 2006

Question: E06-247

OUTCOME 5: Primary Care

Topic: RRMA CLASSIFICATION SYSTEM

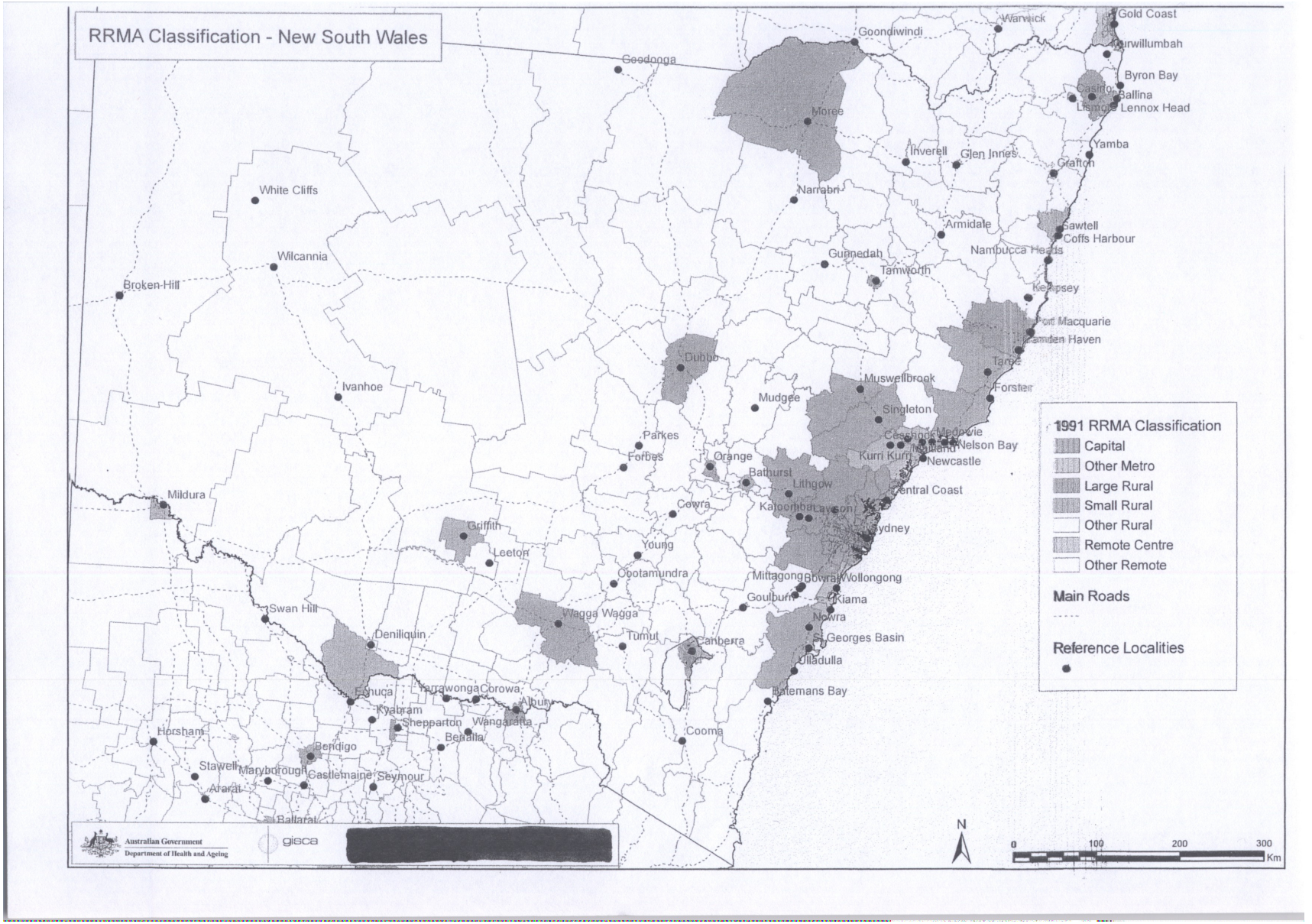
Hansard Page: CA 120

Senator McLucas asked:

Mr Eccles, could you provide me with a map of Queensland with the RRMA areas. If I say Queensland I should probably do the rest of Australia

Answer:

Maps of individual States and Territories with RRMA classifications identified are at Attachment A.


RRMA Classification - New South Wales
Goondiwindi
Warwick
Gold Coast
Tweed Heads
Murwillumbah
Byron Bay
Casino
Ballina
Lismore
Lennox Head
Yamba
Grafton
Inverell
Glen Innes
Moree
Narrabri
White Cliffs
Wilcannia
Broken Hill
Armidale
Sawtell
Coffs Harbour
Nambucca Heads
Gunnedah
Tamworth
Kempsey
Port Macquarie
Camden Haven
Taree
Forster
Dubbo
Muswellbrook
Singleton
Mudgee
Ivanhoe
Parkes
Forbes
Orange
Bathurst
Lithgow
Kurri Kurri
Newcastle
Nelson Bay
Central Coast
Katoomba
Lawson
Sydney
Mildura
Griffith
Leeton
Cowra
Young
Cootamundra
Mittagong
Bowral
Wollongong
Goulburn
Kiama
Nowra
Georges Basin
Ulladulla
Batemans Bay
Swan Hill
Wagga Wagga
Deniliquin
Tumut
Canberra
Cooma
Echuca
Yarrawonga
Corowa
Albury
Kyabram
Shepparton
Wangaratta
Benalla
Horsham
Bendigo
Stawell
Maryborough
Castlemaine
Seymour
Ararat
Ballarat
1991 RRMA Classification
Capital
Other Metro
Large Rural
Small Rural
Other Rural
Remote Centre
Other Remote
Main Roads
Reference Localities
Australian Government
Department of Health and Ageing
gisca
N
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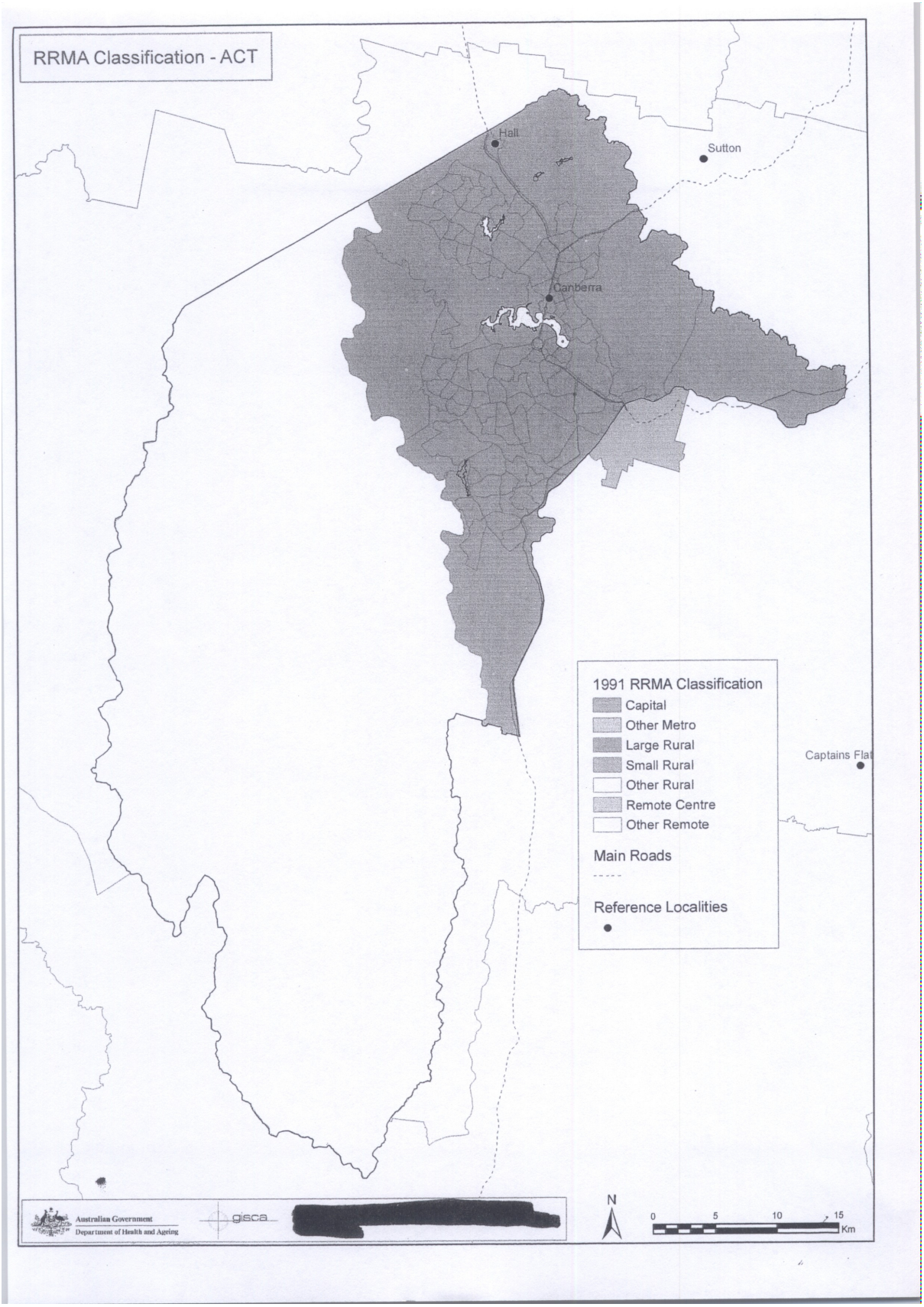
Km


RRMA Classification - ACT
Hall
Sutton
Canberra
Captains Flat
1991 RRMA Classification
Capital
Other Metro
Large Rural
Small Rural
Other Rural
Remote Centre
Other Remote
Main Roads
Reference Localities
Australian Government
Department of Health and Ageing
gisca
[redacted]
N
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15
Km

RRMA Classification - Victoria
1991 RRMA Classification
Capital
Other Metro
Large Rural
Small Rural
Other Rural
Remote Centre
Other Remote
Main Roads
Reference Localities
Bathurst
Goulburn
Canberra
Cowra
Cooma
Griffith
Leeton
Wagga Wagga
Albury
Wangaratta
Benalla
Deniliquin
Echuca
Kyabram
Shepparton
Seymour
Swan Hill
Bendigo
Castlemaine
Maryborough
Ballarat
Ararat
Stawell
Horsham
Mildura
Hamilton
Mount Gambier
Portland
Warrnambool
Colac
Sale
Bairnsdale
Lakes Entrance
Traralgon
Morwell
Moe
Warragul
Drouin
Pakenham
Wonthaggi
Healesville
Sunbury
Hurstbridge
Melbourne
Frankston
Dandenong
Lara
Geelong
Torquay
Bacchus Marsh
Werribee
Sorrento
Emerald
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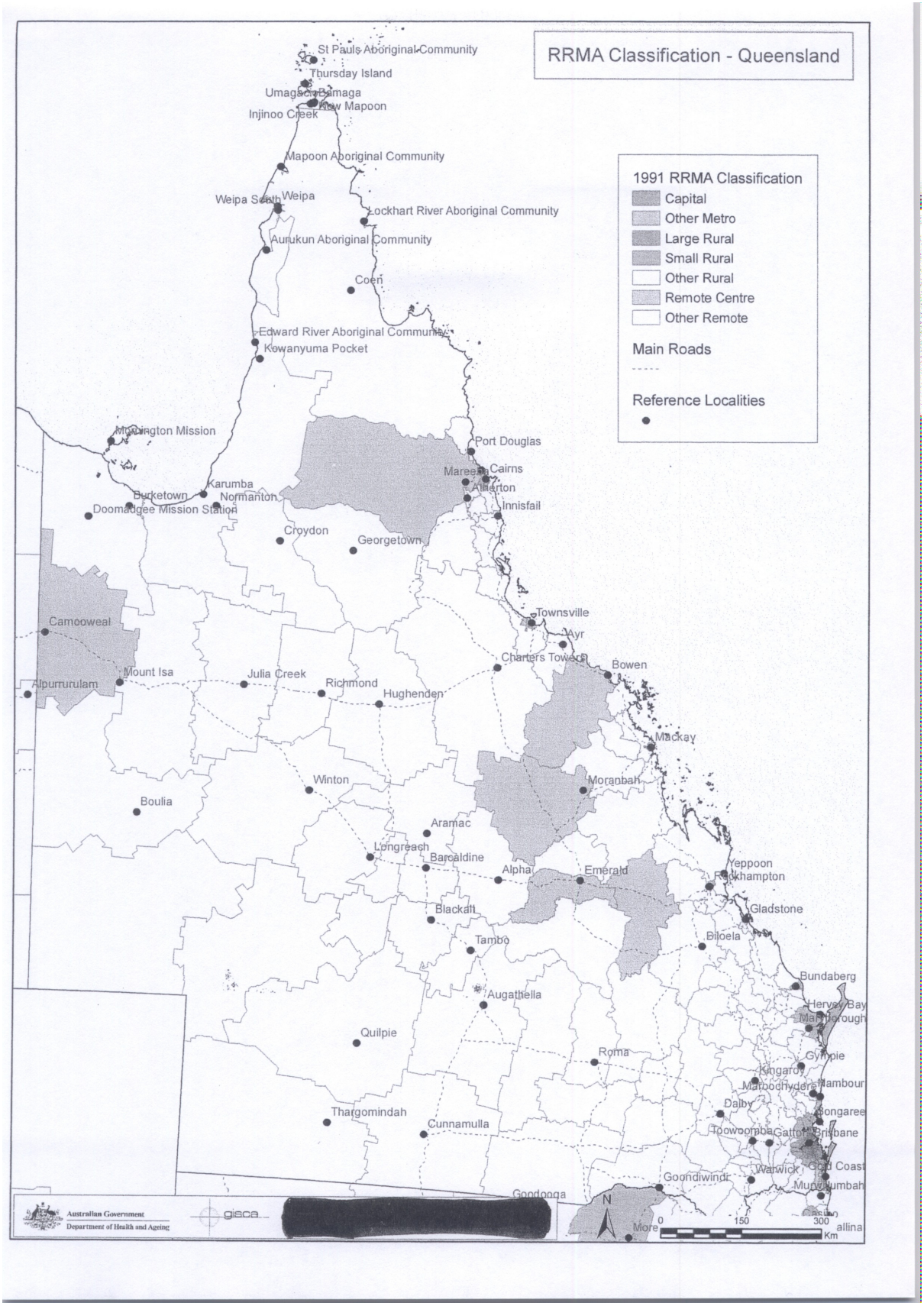
Australian Government
Department of Health and Ageing
gisca


RRMA Classification - Queensland
1991 RRMA Classification
Capital
Other Metro
Large Rural
Small Rural
Other Rural
Remote Centre
Other Remote
Main Roads
Reference Localities
St Pauls Aboriginal Community
Thursday Island
Umagico
Bamaga
New Mapoon
Injinoo Creek
Mapoon Aboriginal Community
Weipa South
Weipa
Lockhart River Aboriginal Community
Aurukun Aboriginal Community
Coen
Edward River Aboriginal Community
Kowanyuma Pocket
Mornington Mission
Port Douglas
Mareeba
Cairns
Atherton
Innisfail
Karumba
Burketown
Normanton
Doomadgee Mission Station
Croydon
Georgetown
Townsville
Ayr
Charters Towers
Bowen
Camooweal
Mount Isa
Alpurrurulam
Julia Creek
Richmond
Hughenden
Mackay
Moranbah
Winton
Boulia
Aramac
Longreach
Barcaldine
Alpha
Emerald
Yeppoon
Rockhampton
Blackall
Gladstone
Tambo
Biloela
Bundaberg
Augathella
Hervey Bay
Maryborough
Quilpie
Roma
Gympie
Kingaroy
Maroochydore
Nambour
Dalby
Toowoomba
Gatton
Brisbane
Thargomindah
Cunnamulla
Warwick
Gold Coast
Goondiwindi
Murwillumbah
Goodooga
Australian Government
Department of Health and Ageing
gisca
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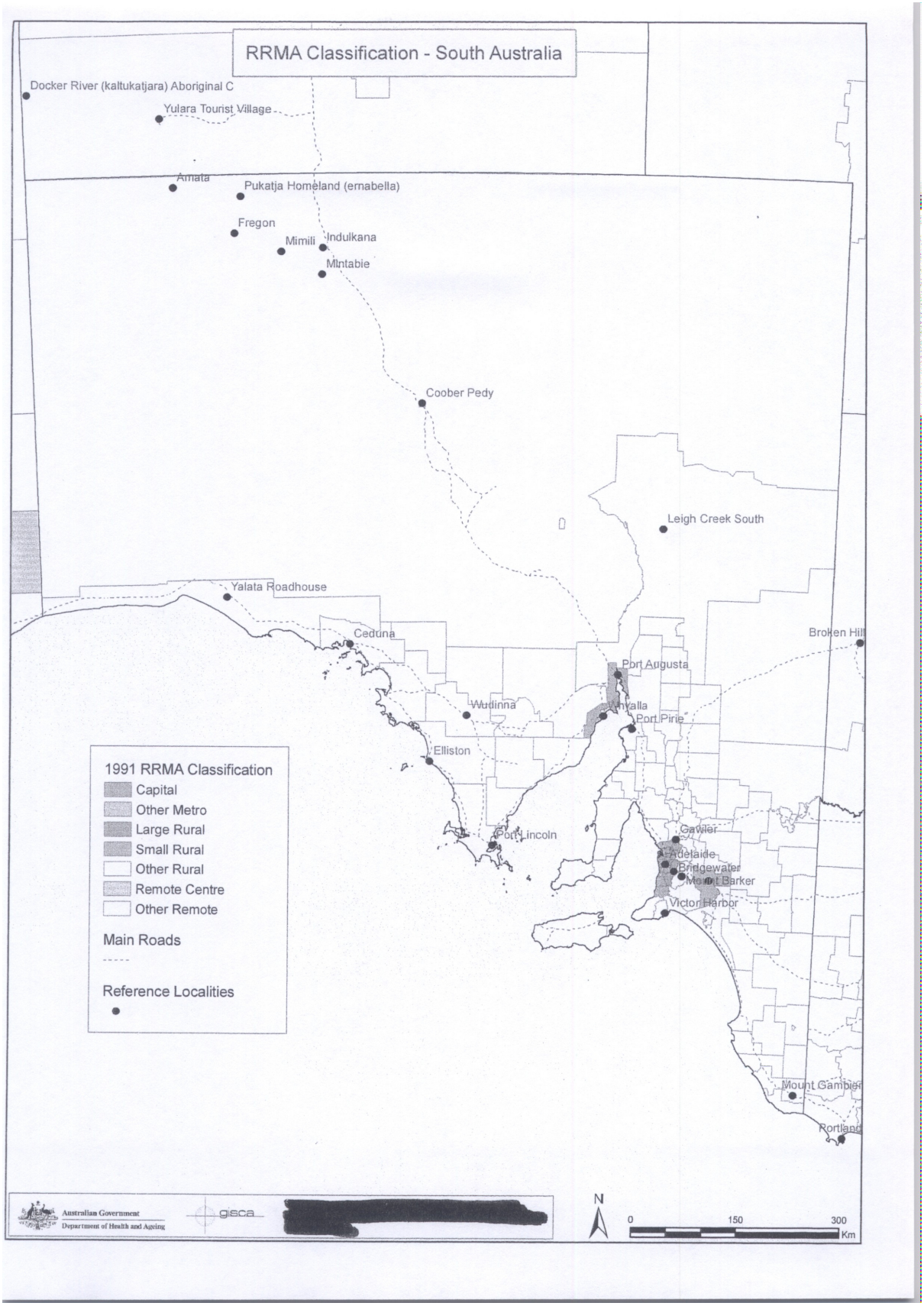
Km


RRMA Classification - South Australia
Docker River (kaltukatjara) Aboriginal C
Yulara Tourist Village
Amata
Pukatja Homeland (ernabella)
Fregon
Mimili
Indulkana
Mintabie
Coober Pedy
Leigh Creek South
Yalata Roadhouse
Ceduna
Broken Hill
Port Augusta
Wudinna
Whyalla
Port Pirie
Elliston
Port Lincoln
Gawler
Adelaide
Bridgewater
Victor Harbor
Mount Gambier
Portland
1991 RRMA Classification
Capital
Other Metro
Large Rural
Small Rural
Other Rural
Remote Centre
Other Remote
Main Roads
Reference Localities
Australian Government
Department of Health and Ageing
gisca
N
0
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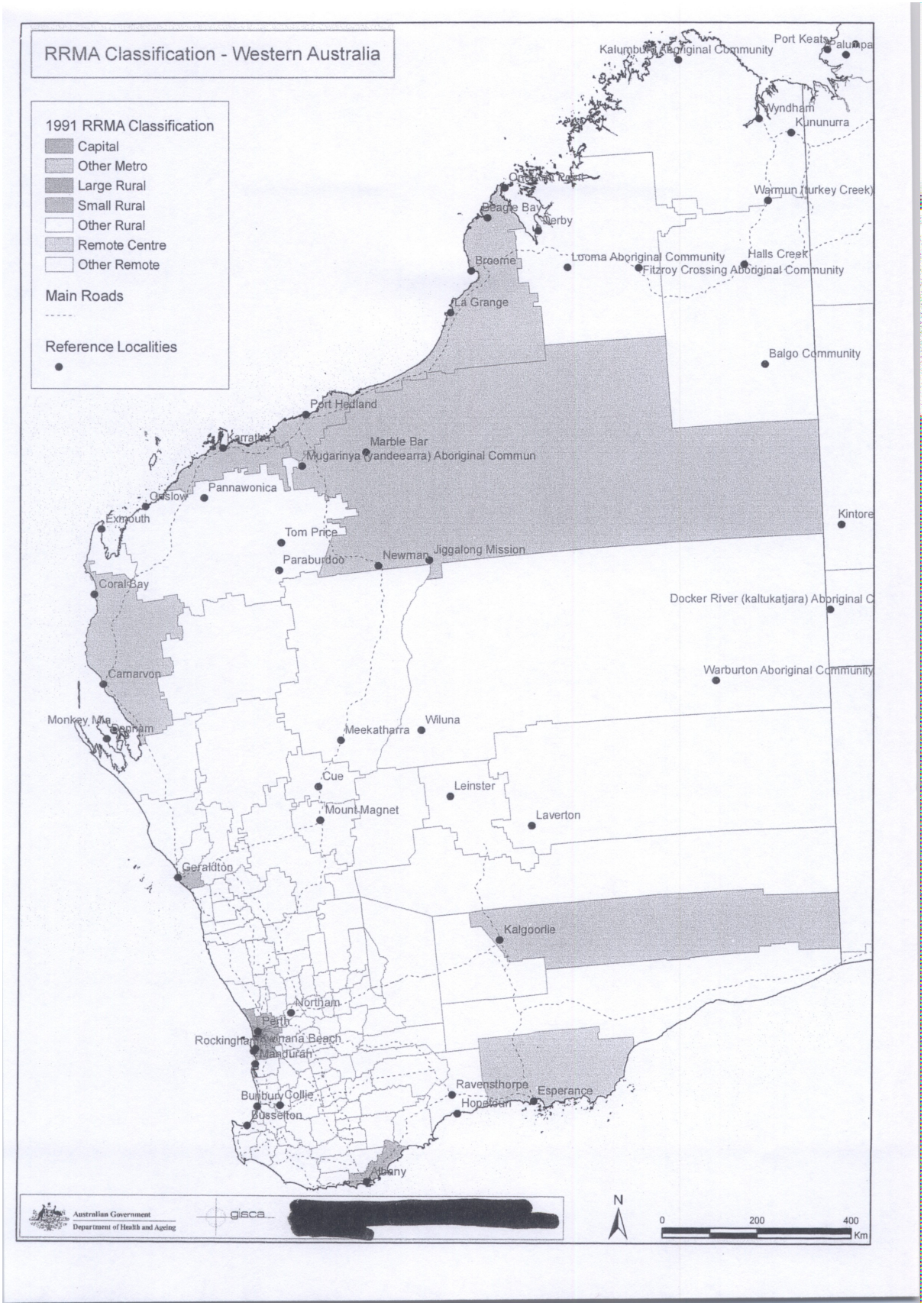
Km


RRMA Classification - Western Australia
1991 RRMA Classification
Capital
Other Metro
Large Rural
Small Rural
Other Rural
Remote Centre
Other Remote
Main Roads
Reference Localities
Kalumburu Aboriginal Community
Port Keats
Wyndham
Kununurra
Warmun (Turkey Creek)
Broome
Derby
Looma Aboriginal Community
Halls Creek
Fitzroy Crossing Aboriginal Community
La Grange
Balgo Community
Port Hedland
Karratha
Marble Bar
Mugarinya (Yandeearra) Aboriginal Commun
Pannawonica
Onslow
Exmouth
Tom Price
Paraburdoo
Newman
Jiggalong Mission
Kintore
Coral Bay
Docker River (kaltukatjara) Aboriginal C
Carnarvon
Warburton Aboriginal Community
Monkey Mia
Denham
Meekatharra
Wiluna
Cue
Leinster
Mount Magnet
Laverton
Geraldton
Kalgoorlie
Northam
Perth
Rockingham
Mandurah
Ravensthorpe
Esperance
Hopetoun
Bunbury
Collie
Busselton
Albany
Australian Government
Department of Health and Ageing
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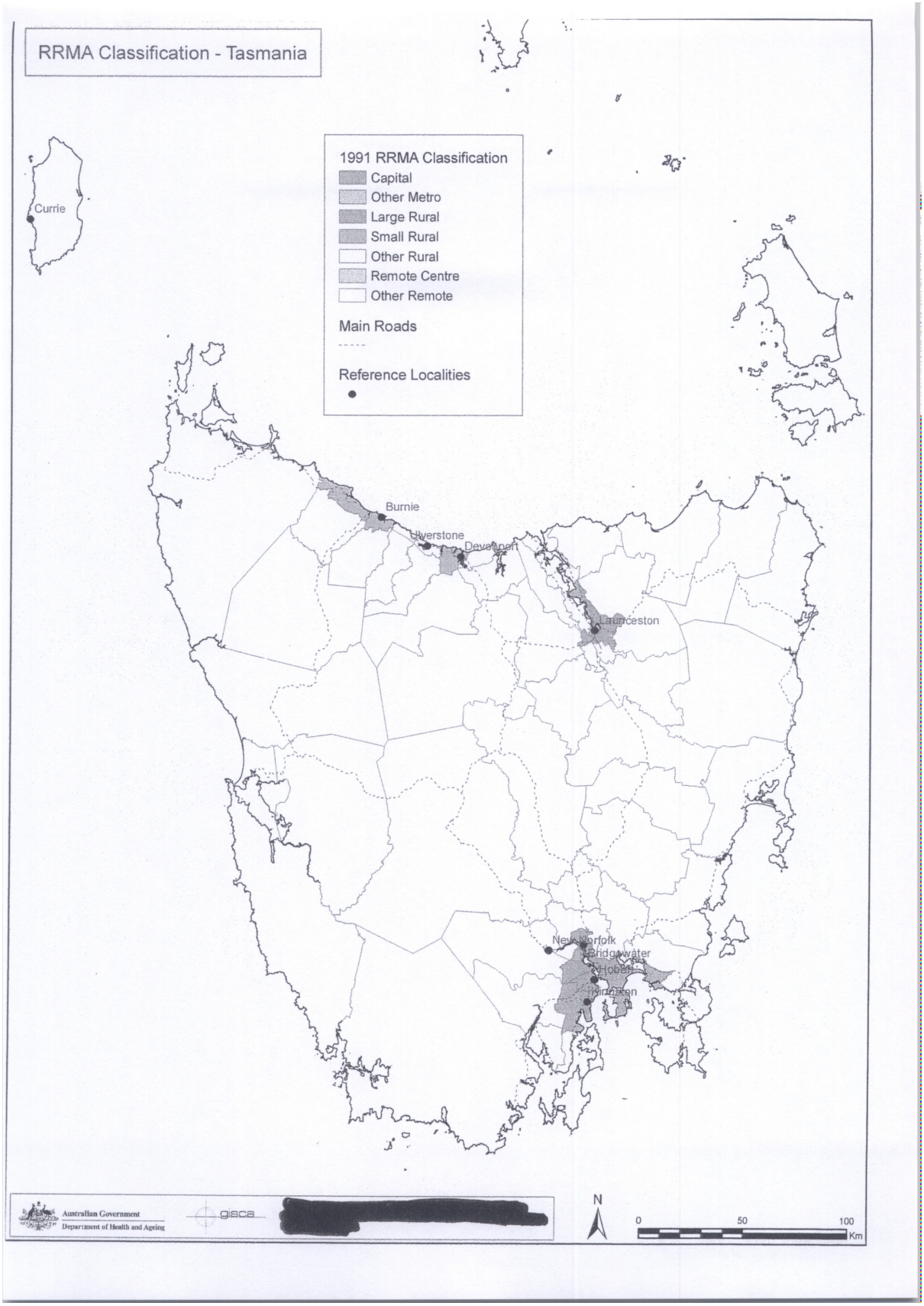
RRMA Classification - Tasmania
1991 RRMA Classification
Capital
Other Metro
Large Rural
Small Rural
Other Rural
Remote Centre
Other Remote
Main Roads
Reference Localities
Currie
Burnie
Ulverstone
Devonport
Launceston
New Norfolk
Bridgewater
Hobart
Australian Government
Department of Health and Ageing
gisca
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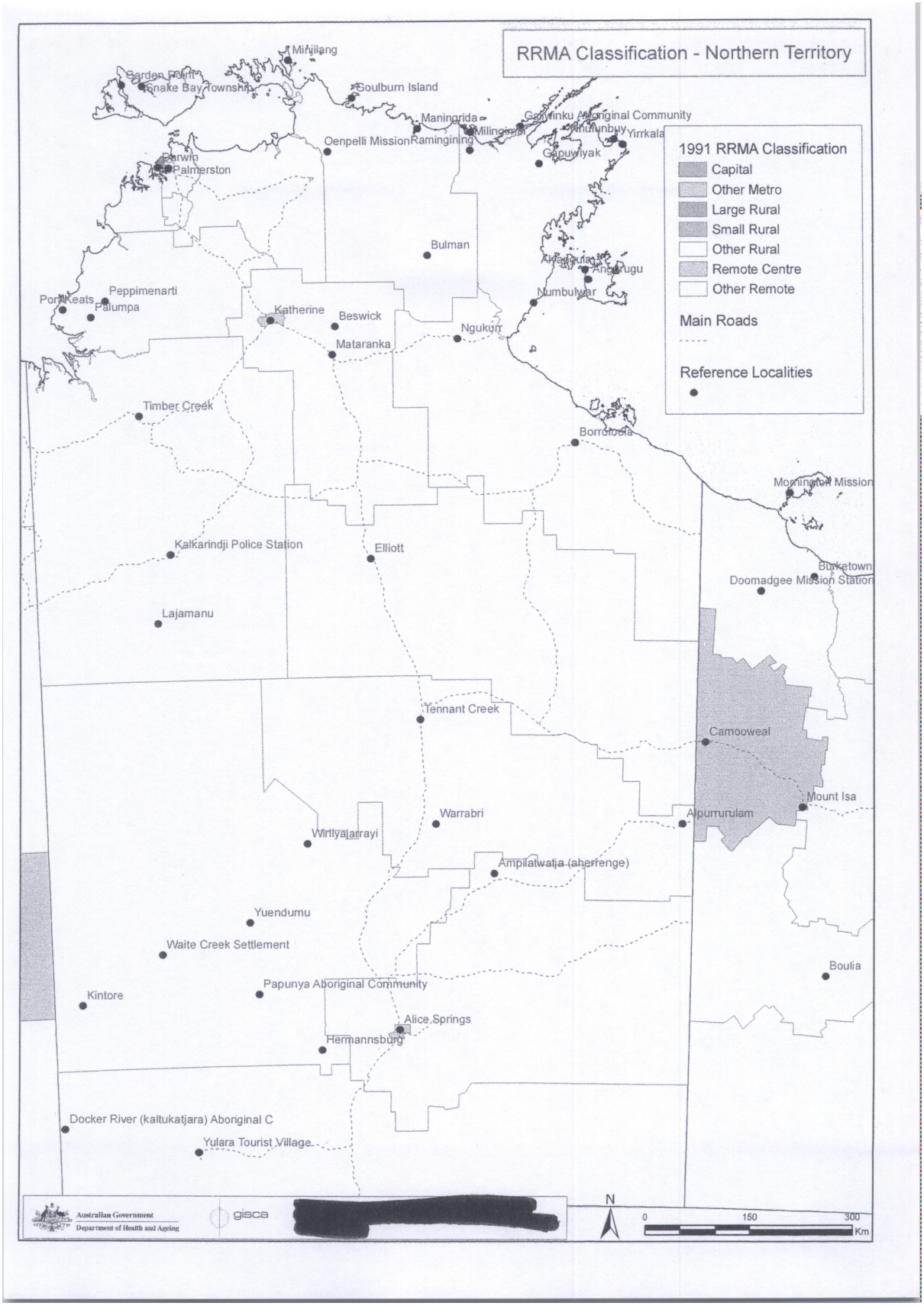
100
Km


RRMA Classification - Northern Territory
1991 RRMA Classification
Capital
Other Metro
Large Rural
Small Rural
Other Rural
Remote Centre
Other Remote
Main Roads
Reference Localities
Minjilang
Garden Point
Snake Bay Township
Goulburn Island
Maningrida
Milingimbi
Ramingining
Oenpelli Mission
Darwin
Palmerston
Gapuwiyak
Yirrkala
Bulman
Numbulwar
Peppimenarti
Palumpa
Katherine
Beswick
Mataranka
Ngukurr
Timber Creek
Borroloola
Kalkarindji Police Station
Elliott
Lajamanu
Tennant Creek
Camooweal
Mount Isa
Warrabri
Wirliyajarrayi
Ampilatwatja (aherrenge)
Yuendumu
Waite Creek Settlement
Papunya Aboriginal Community
Kintore
Alice Springs
Hermannsburg
Docker River (kaltukatjara) Aboriginal C
Yulara Tourist Village
Doomadgee Mission Station
Burketown
Boulia
Australian Government
Department of Health and Ageing
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Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2006-2007, 31 May - 1 June 2006

Question: E06-242

OUTCOME 5: Primary Care

Topic: MENTAL HEALTH NURSES

Hansard Page: CA 32

Senator Allison asked:

Do you have a ramping up that you could make available to the committee? If it is 400 by the fifth year, what is it in other years?

Answer:

Take-up is expected to increase gradually following commencement in July 2007. It is difficult to predict exact levels of take-up, however the aim, through this and other initiatives in the COAG mental health package, is by 2010-11 to support more than 36,000 patients with severe mental disorders each year.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2006-2007, 31 May - 1 June 2006

Question: E06-243

OUTCOME 5: Primary Care

Topic: MENTAL HEALTH NURSES

Hansard Page: CA 32

Senator Allison asked:

How many privately practicing psychiatrists are there?

Answer:

We do not know how many privately practicing psychiatrists there are. However, based on Medicare claims data from the 2004-05 financial year and advice from the Australian and New Zealand College of Psychiatrists, there are around 1800 privately practicing psychiatrists.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2006-2007, 31 May - 1 June 2006

Question: E06-244

OUTCOME 5: Primary Care

Topic: MENTAL HEALTH NURSES

Hansard Page: CA 33

Senator Allison asked:

So it will be spread across a number of practices dealing with people with the most serious mental illness in mental health.

a) How many do you expect such a nurse to have on her books? It probably will be a her, but it may be a him.
b) What sort of caseload are we talking about here? You did develop caseloads for the personal carers, I understand, of 60 per person.
c) What do you anticipate will be the case load for a mental health nurse?

Answer:

(a,b & c)
There is no set patient caseload. These will be worked up in consultation with relevant professional groups.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2006-2007, 31 May - 1 June 2006

Question: E06-107

OUTCOME 5: Primary Care

Topic: HEALTH ASSESSMENT FOR REFUGEES AND OTHER HUMANITARIAN ENTRANTS

Written Question on Notice

Senator McLucas asked:

The Minister's 1 May media release says that:
"The health assessment will also introduce new refugees and humanitarian entrants to the Australian health care system, including preventative healthcare programs like immunisation, maternal and child care, and breast and cervical screening"

a) What is the anticipated additional cost to these programs?
b) If they say there is none, push them on the fact that the media release essentially acknowledges that currently these people do not have good access to these programs.
c) Will the States and Territories be given additional funding (through the PHOFAs) for to enable these public programs to meet the increased needs?
d) Where is the additional funding for vaccine catch up programs for refugees and humanitarian entrants?

Answer:

(a) and (b)
A new Medicare health assessment item for refugees and other humanitarian entrants was introduced on 1 May 2006. This item is estimated to cost approximately $3.1 million over five years.

This item provides a rebate for GPs to undertake an initial voluntary health assessment for refugees and other humanitarian entrants. It also provides an opportunity to introduce people to the Australian primary health care system and preventive healthcare as soon as possible after their arrival in Australia.

There is no separate or additional funding for preventive healthcare programs as a result of the introduction of this health assessment item. Refugees and other humanitarian entrants will be eligible to access Medicare and other relevant Commonwealth and state/territory programs as part of the broader population.

(c)
No additional funding is provided under the PHOFAs.

(d)
Responsibility for health service delivery for refugees and persons held in immigration detention lies with the Department of Immigration and Multicultural Affairs (DIMA). These services are funded by DIMA and provided by contracted detention centre managers and state and territory health authorities. Initial screening and vaccination is provided to refugees on their arrival in Australia by the contracted detention centre managers who arrange for additional medical personnel, usually drawn from the relevant state or territory health authority, to administer these services if large numbers of refugees arrive at the one time. Vaccination is offered to refugees in accordance with the National Immunisation Program Schedule using accelerated schedules to ensure maximum protection as quickly as possible.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2006-2007, 31 May - 1 June 2006

Question: E06-246

OUTCOME 5: Primary Care

Topic: STRENGTHENING MEDICARE PRACTICE NURSES INITIATIVE

Hansard Page: CA 116

Senator Polley asked:

In April, the Minister announced that the government was subsidising the employment of practice nurses in urban areas of workforce shortage. This is to be funded as part of the $80 million Strengthening Medicare practice nurse initiative, which seems to indicate that this program is under budget. How many additional GP practices will be eligible for this incentive?
Mr Andreatta - 650
Polley - Can you give me those by State?
Polley - My understanding is that the ACT was not included. Is that right? If not why isn't it?

Answer:

The total number of newly eligible practices is 660 as follows:

Jurisdiction	Number of practices
NSW	230
VIC	150
Qld	78
SA	67
WA	123
TAS	9
ACT	2*
NT	1
Australia	660

* As most of the ACT was already considered to be an area of workforce shortage in 2004 when the initiative was first implemented, only a small number of practices in the ACT have become eligible with the extension to the urban practice nurse initiative in areas of workforce shortage.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2006-2007, 31 May - 1 June 2006

Question: E06-006

OUTCOME 5: Primary Care

Topic: RRMA CLASSIFICATION SYSTEM

Written Question on Notice

Senator Crossin asked:

The Department of Health RRMA review web page until at least March had a message there from last October saying the review was to be released soon. Public submissions closed the previous April over a year ago. DHA have updated the web page saying:

The RRMA review is currently on-going and further work is being done to find reliable ways to measure need across the entire country using more robust and up-to-date data. Due to this, no timelines have been set for the completion.

a) Why has the review effectively been shelved?

b) Is RRMA still used at all?

c) Can regions still ask for reclassification or is it all irrelevant and left to the Minister's discretion to decide?

Answer:

a) The review of the Rural, Remote and Metropolitan Areas (RRMA) classification system has not been shelved and is currently on-going. The Government is not convinced that an alternative system would be a clear improvement. Options to resolve issues with the use of RRMA are being considered by the Review.

b) RRMA is used by approximately 24 programs managed by the Australian Government Department of Health and Ageing.

c) There is no formal process to seek a re-classification under RRMA. Regions may continue to express their view on their access to government programs, including their RRMA classification.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2006-2007, 31 May - 1 June 2006

Question: E06-109

OUTCOME 5: Primary Care

Topic: COAG HEALTH ASSESSMENT ITEM

Written Question on Notice

Senator McLucas asked:

Please provide the following details of the Medicare Item(s) associated with the COAG Health services measures, and in particular the measure titled "COAG Health Measures - promoting good health, prevention and early intervention"

a) What are these Medicare items?
b) Who will be able to access these items?
c) What is the dollar value of each of these items?
d) When will these items be introduced?
e) If they have not yet been finalised, when will they be finalised?
f) How are these items being developed, and who is involved?

Answer:

a) The COAG *Australian Better Health Initiative* includes a new Medicare Benefits Schedule item for general practitioners to provide a health check to eligible patients.
b) It is intended that people around 45 years of age who are at risk of developing a chronic disease will be eligible for this item.
c) The fee for the new item has not been finalised.
d) The new item will be introduced on 1 November 2006.
e) The item will be finalised following consultations with the medical profession. Regulations creating the item are expected to be made in October 2006.
f) The clinical content of the item is being developed in consultation with the medical profession through a Medicare Benefits Consultative Committee (MBCC) process. The MBCC is chaired by the Australian Medical Association and includes representatives from other GP groups, the Department of Health and Ageing and Medicare Australia. State and Territory Governments are also being consulted.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2006-2007, 31 May - 1 June 2006

Question: E06-140

OUTCOME 5: Primary Care

Topic: ROUND THE CLOCK MEDICARE

Written Question on Notice

Senator Jan McLucas asked:

List the locations of the After Hours GP services announced in 2004-05
a) Which of these locations is operating?
b) Have any locations closed operating?
c) How many of these clinics are co-located with public hospitals, if so, name them?
d) How many clinics are yet to open?

Answer:

In September 2004 the Government announced that in 2004-05 $200,000 would be provided for initial "well-located" after-hours clinics, run by local GPs, in:

- Kallangur (Qld);
- Tweed Heads (NSW);
- Ryde (NSW);
- Glenside (SA); and
- Williamstown (Vic).

a) Agreements have been executed with each of Chevron After Hours Service (Tweed Heads), Melbourne Medical Service (Williamstown) and Adelaide Central Eastern Division (Glenside). These three clinics are now operating or are expected to be by end of July 2006.
b) No.
c) None.
d) Negotiations are continuing for clinics for Ryde (NSW) and Kallangur (Qld).

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2006-2007, 31 May - 1 June 2006

Question: E06-142

OUTCOME 5: Primary Care

Topic: ROUND THE CLOCK MEDICARE

Written Question on Notice

Senator Jan McLucas asked:

For the Investing in After Hours GP Services – Operating Subsidies please provide:

a) How many of operating subsidies have been allocated? How much has each received in funding?
b) Of those allocated and funded, where are they located?
c) Are there any funded but not yet established? If so where?
d) How have these operating subsidies been allocated?
e) What is the calendar year and financial year (including year to date) spending on the program?
f) What number of subsidies has actually been delivered on a calendar year and financial year (including year to date)?
g) How much was originally budgeted for this measure, per year, over the forward estimates?
h) How much is budgeted now for this measure, per year, over the current forward estimates?
i) How much has been spent so far, as a total, and per year (both calendar and financial) since its commencement?

Answer:

a) The Government has announced two operating subsidies for after hours services to date.
Each operating subsidy receives up to $200,000 per year for up to three years.

b) They are located in Penrith, NSW and Liverpool, NSW.

c) Both projects include an establishment phase prior to the opening of these new clinics.

d) Operating subsidies were allocated through a competitive selection process. Applications were assessed against selection criteria which were developed in consultation with key GP organisations. Applicants were required to meet minimum benchmarks against these criteria.

e) Expenditure to date and future commitments for the Nepean and Liverpool operating subsidies are as follows:

Financial Year	**2005-06**	**2006-07**	**2007-08**	**2008-09**	**Total**
	$ 196,818	$ 424,141	$ 354,668	$ 174,373	$ 1,150,000
Calendar Year	**2006**	**2007**	**2008**	**2009**	**Total**
	$ 441,868	$ 356,486	$ 315,282	$ 36,364	$ 1,150,000

f) The Nepean and Liverpool operating subsidies were announced in 2006 (calendar year) and 2005–06 (financial year).

g) The original budget allocation and forward estimates for the Investing in After Hours GP Services Program (all components) were:

2004-05	**2005-06**	**2006-07**	**2007-08**	**2008-09**
$2,000,000	$10,500,000	$16,000,000	$17,000,000	$17,000,000

h) The current budget allocation and forward estimates for the Investing in After Hours GP Services Program (all components) are:

2006-07	**2007-08**	**2008-09**
$19,271,000	$22,393,000	$17,000,000

i) See (e) above.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2006-2007, 31 May - 1 June 2006

Question: E06-143

OUTCOME 5: Primary Care

Topic: ROUND THE CLOCK MEDICARE

Written Question on Notice

Senator Jan McLucas asked:

For the Investing in After Hours GP Services – Start Up Grants please provide:

j) How many of start up grants have been allocated?
k) Of those allocated and funded, where are they located?
l) Are there any funded but not yet established? If so where?
m) How have these sites been selected?
n) What is the calendar year and financial year (including year to date) spending on the program?
o) What number of subsidies has actually been delivered on a calendar year and financial year (including year to date)?
p) How much was originally budgeted for this measure, per year, over the forward estimates?
q) How much is budgeted now for this measure, per year, over the current forward estimates?
r) How much has been spent so far, as a total, and per year (both calendar and financial) since its commencement?

Answer:

a) The Government has announced five start-up grants to date.
b) They are located at Happy Valley, SA; Sale, VIC; Fremantle, WA; St Albans, VIC; and Mulgrave, VIC.
c) Start-up grants are provided for the establishment of new services or to extend existing services. All announced projects include an establishment phase.
d) Start-up grants were allocated through a competitive selection process. Applications were assessed against selection criteria which were developed in consultation with key GP organisations. Applicants were required to meet minimum benchmarks against these criteria.
e) Expenditure to date and future commitments for the five announced start-up grants are as follows:

	2005-06	**2006-07**	**2007-08**	**Total**
Financial Year	$371,350	$416,250	$212,400	$1,000,000
Calendar Year	$581,463	$331,605	$86,932	$1,000,000

f) The five start-up grants were announced in 2006 (calendar year) and 2005-06 (financial year).
g) The original budget allocation and forward estimates for the Investing in After Hours GP Services Program (all components) were:

2004-05	**2005-06**	**2006-07**	**2007-08**	**2008-09**
$2,000,000	$10,500,000	$16,000,000	$17,000,000	$17,000,000

h) The current budget allocation and forward estimates for the Investing in After Hours GP Services Program (all components) are:

2006-07	**2007-08**	**2008-09**
$19,271,000	$22,393,000	$17,000,000

i) See (e) above.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2006-2007, 31 May - 1 June 2006

Question: E06-144

OUTCOME 5: PRIMARY CARE

Topic: ROUND THE CLOCK MEDICARE

Written Question on Notice

Senator McLucas asked:

For the Investing in After Hours GP Services – Supplementary Grants please provide:

s) How many of supp grants been allocated?
t) Where have these grants been allocated?
u) For each supp grant, please provide the reason for its allocation.
v) What is the calendar year and financial year (including year to date) spending on the program?
w) How much was originally budgeted for this measure, per year, over the forward estimates?
x) How much is budgeted now for this measure, per year, over the current forward estimates?
y) How much has been spent so far, as a total, and per year (both calendar and financial) since its commencement?
z) With respect to all initiatives, were the States and Territories consulted on needs, locations etc?
aa) What funding has been committed to After Hours GP at Lismore?
bb) What is the current status of After Hours GP Care at Lismore?

Answer:

a) The Government has announced 37 supplementary grants to date.

b)

Ashgrove West, QLD	Foster, VIC	Orbost, VIC
Australind, WA	Geelong, VIC	Camperdown, NSW
Ballajura, WA	Shepparton, VIC	Guildford, WA
Bannockburn, VIC	Gumeracha, SA	Pittsworth, QLD
Banora Point, NSW	Hazelbrook, NSW	Point Lonsdale, VIC
Belair, SA	Daylesford, VIC	Sefton Park, SA
Murray Bridge, SA	Ingham, QLD	Capalaba, QLD
Bundaberg, QLD	Kiama, NSW	Hurstville, NSW
Armadale, WA	Maffra, VIC	St Albans, VIC
Stuart Park, NT	Mallacoota, VIC	Tatura, VIC
Edgecliff, NSW	Mount Beauty, VIC	West Perth, WA
Port Macquarie, NSW	Mt. Hotham, VIC	Woy Woy, NSW
Spring Hill, QLD		

c) Supplementary grants were allocated through a competitive selection process. Applications were assessed against selection criteria which were developed in consultation with key GP organisations. Applicants were required to meet minimum benchmarks against these criteria.

d) Expenditure to date and future commitments for the 37 announced supplementary grants are as follows:

Financial Year	**2005-06**	**2006-07**	**2007-08**	**Total**
$1,185,130	$1,560,469	$704,564		$3,450,163
Calendar Year	**2006**	**2007**	**2008**	**Total**
	$1,970,685	$1,311,699	$167,779	$3,450,163

e) The original budget allocation and forward estimates for the Investing in After Hours GP Services Program (all components) were:

2004-05	2005-06	2006-07	2007-08	2008-09
$2,000,000	$10,500,000	$16,000,000	$17,000,000	$17,000,000

f) The current budget allocation and forward estimates for the Investing in After Hours GP Services Program (all components) are:

2006-07	2007-08	2008-09
$19,271,000	$22,393,000	$17,000,000

g) See (d) above.

h) No. Grants were offered based on an open, competitive selection process. In addition, States and Territories, through their area health services and hospitals, were able to apply for funding under the program.

i) None.

j) The Australian Government does not currently fund any after hours services in Lismore through the After Hours Primary Medical Care Program or the Round the Clock Medicare: Investing in After Hours GP Services Program.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2006-2007, 31 May - 1 June 2006

Question: E06-245

OUTCOME 5: Primary Care

Topic: ALLIED HEALTH ITEMS

Written Question on Notice

Senator Moore asked:

With the diabetes program, has there been any particular attempt to have a look at the take-up of Aboriginal and Islander people?

Answer:

Under the Medicare Allied Health and Dental Care Initiative, there are a number of allied health items that can be used to manage and support people with diabetes. These include services provided by dietitians, exercise physiologists, diabetes educators, podiatrists, chiropodists and psychologists. However, it is not possible to look at the take-up of the allied health items by patients, including Aboriginal and Torres Strait Islander people, with specific chronic conditions. Information about the nature of the patient's chronic condition is not available from the Medicare claiming data.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2006-2007, 31 May - 1 June 2006

Question: E06-248

OUTCOME 5: Primary Care

Topic: ALLIED HEALTH AND DENTAL CARE INITIATIVE

Hansard Page: CA 110 – 1 June

Senator Polley asked:

a) What is the breakdown of the numbers of the allied health and dental services provided at the cost of this by the relevant Medicare number versus the expected?

b) What were the out-of-pocket costs for the AHS?

Answer:

a) and (b)

Below is the uptake of the allied health and dental care items and average out-of-pocket expenses for the first 9 months of 2005-06 (based on date of service data). Under the Allied Health and Dental Care Initiative, there are no estimates of uptake for individual items or services.

Allied Health and Dental Care Initiative - Uptake: 1 July 2005 – 31 March 2006* (9 months)

Item Descriptor	No. of services	Medicare benefit paid ($)	Average out-of-pocket cost per service ** ($)
Aboriginal Health Worker 10950	1	46	0
Diabetes Educator 10951	4,812	218,901	9.56
Audiology 10952	205	10,015	22.83
Exercise Physiologist 10953	643	29,495	10.40
Dietitian 10954	47,470	2,165,051	10.51
Mental Health Worker 10956	1,638	82,182	30.37
Occupational therapy 10958	2,837	138,644	19.84
Physiotherapy 10960	126,026	5,736,132	5.03
Chiropody/ Podiatry 10962	92,683	4,193,370	3.41
Chiropractic 10964	12,073	528,567	2.71
Osteopathy 10966	5,870	269,585	10.75
Psychology 10968	26,663	1,352,579	37.55
Speech Pathology 10970	6,942	342,976	15.82
Dental Assessment 10975	1,625	121,487	26.02
Dental treatment 10976	1,910	262,617	73.03
Assessment or treatment by Dental specialist - 10977	23	35,572	524.96
TOTAL	**331,421**	**$15.5 m**	

* Date of service data

** Average out-of-pocket costs relate only to services which are not bulk billed

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2006-2007, 31 May - 1 June 2006

Question: E06-124

OUTCOME 5: Primary Care

Topic: BETTER ACCESS TO PSYCHIATRISTS, PSYCHOLOGISTS AND GENERAL PRACTITIONERS THROUGH THE MEDICARE BENEFITS SCHEDULE (MBS)

Written Question on Notice

Senator McLucas asked:

a) How will these services be provided?
b) Will psychologists now have direct access to Medicare?
c) Will these services be provided through the Better Outcomes in Mental Health Program?
d) If so, what will be done to improve access under this program?
e) [According to the measure fact sheets] Why are psychiatric services expressed in terms of people and psychology services expressed in terms of services?
f) How many psychiatric services a year does Medicare currently provide?
g) How many psychology services a year does Medicare currently provide (through BOiMH and CDM)?
h) How will these services be made available to those in regional, rural and remote areas, where private psychiatric services are essentially non-existent?

Answer:

a) This initiative will introduce a number of new Medicare items to improve access and encourage a multidisciplinary approach to care for people with mental disorders. It will also support GPs and primary care service providers with education and training to better diagnose and treat mental illness. It is envisaged that a range of services will be provided, including:

- New Medicare rebates for preparation of structured care plans, management and review services by appropriately trained GPs.

- A new initial psychiatric consultation MBS item to encourage psychiatrists to increase the number of referred new patients they see.

- New clinical psychology MBS items primarily for provision of up to 12 psychological therapy sessions on referral by a psychiatrist, or by an appropriately trained GP who is managing the patient under a GP mental health plan.

- New allied mental health professional MBS items for provision of up to 12 psychological therapy sessions on referral by an appropriately trained GP who is managing the patient under a GP mental health plan.

b) Yes, Medicare rebates will be available for services provided by eligible psychologists on referral by appropriately trained GPs or psychiatrists.

c) No, however it is envisaged that the increased range of referral pathways and services will complement the range of initiatives funded under the Better Outcomes in Mental Health Care Program, specifically the Access to Allied Psychological Services (ATAPS) and the GP Focussed Psychological Strategies MBS items, with the new MBS funded psychology and allied mental health services being provided in addition to these existing services.

d) Not applicable.

e) The new psychiatry MBS item provides one service per patient, therefore the number of services and patients are the same. Whereas a patient can access up to 12 of the new clinical psychology services in a calendar year it was deemed more appropriate to represent the clinical psychology uptake in service, rather than patient numbers.

f) In 2004-05 (year of processing), Medicare Australia processed claims for 2,007,218 psychiatric services.

g) Medicare funded psychology services are currently only available through the Chronic Disease Management (CDM) MBS items, where psychologists can claim for services referred to them by a GP who is managing the patient under an Enhanced Primary Care (EPC) plan.

In 2004-05 (year of processing), Medicare Australia processed claims for 23,092 psychology services under the CDM items.

According to the national database for the Access to Allied Psychological Services component of the Better Outcomes in Mental Health Care Program, over 69,000 sessions of psychological therapy from allied health professionals were recorded for 2004-05.

h) The new clinical psychology and other allied mental health MBS items for provision of up to 12 referred psychological related sessions per calendar year will be available to patients living in regional, rural and remote areas. The MBS funded services will complement the ATAPS element of the Better Outcomes in Mental Health Care Program, which allows GPs to refer to a specific allied health professional for the provision of up to 12 sessions of Focused Psychological Strategies for patients with mental disorders. Funding for ATAPS services is managed by participating Divisions of General Practice, who have a good understanding of the available rural workforce resources and service delivery alternatives within their specified service delivery boundaries.

In addition, the COAG Mental Health "Mental Health Services in Rural and Remote Areas" measure will provide additional resources to rural and remote communities that have difficulty accessing private psychiatric and psychological services. The Australian Government will provide $51.7 million over five years for additional mental health services by psychologists and other appropriately mental health workers such as Aboriginal health workers, social workers and occupational therapists.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2006-2007, 31 May - 1 June 2006

Question: E06-114

OUTCOME 5: Primary Care

Topic: PRIMARY CARE DIVISION (PCD)

Written Question on Notice

Senator McLucas asked:

a) With the restructure of the outcomes, where does Primary Care now sit?

b) How can an across-the- board assessment of the work of the Primary Care Division be made with responsibilities spread across several outcomes?

c) Please provide:
   i. the total administered appropriations
   ii. the departmental appropriations
   iii. the number of funding agreements
   iv. the number of programs and initiatives
   v. the number of FTE staff
   for the Primary Care Division each financial year since 2000-01.

d) How many reports does the PCD currently receive from organisations funded under primary care agreements?

e) For a multi-year funding agreement, how often are reports required?

f) In the absence of clearly defined performance targets, timelines, reporting requirements and assessment of reports, how does the PCD make decisions about the success or otherwise of a specific funding agreement or a specific initiative?

g) Given that many of these programs involve developmental work (eg new approaches to treating and managing chronic disease, after hours services), how is the information learned about works and what doesn't feed into future funding decisions?

h) How does the PCD know when a program is underspent and what happens to that money?

i) The ANAO says that the Department should not wait until 2009 to address these weaknesses. What action will be taken?

Answer:

a) Primary Care Division (now Primary and Ambulatory Care Division) is covered by Outcome 5 and also has responsibilities in Outcome 10 Health System Capacity and Quality and Outcome 6 Rural Health.

b) Each year, the Department places a very high priority upon developing a business plan for the coming 12 months and beyond. The Divisional business plan addresses all areas of responsibility for the Primary and Ambulatory Care Division. The internal reporting structures, such as the accounting system, are structured along the line of business themes to enable reporting and monitoring of priority areas developed as part of the business planning cycle. The outcomes of these priorities are reported upon in the annual report.

c)

i), ii), iii), iv) & (v) Primary Care Division was established during the 2002-03 financial year. Figures below are given for 2002-03 to 2005-06.

	2002-03	**2003-04**	**2004-05**	**2005-06**
Primary Care Division	Allocation $'000	Allocation $'000	Allocation $'000	Allocation $'000
Administered appropriations	675,540	800,919	826,537	798,368
Departmental appropriations	20,085	24,546	20,146	24,155
Actual staff as at 30 June	225	218	200	209
Funding Agreements	740	425	466	367
Number of Programs	4	4	4	4
Number of Initiatives (1)	26	40	36	38

(1) Number of initiatives is calculated as the number of Budget and Reporting Elements (BRE) relating to Outcome 5. A BRE represents an accumulation of like Government decisions.

d) & e) This varies from quarterly to six-monthly during the project period, and depending on the nature of the activities, reports are also required on specific deliverables. Additionally, the terms and conditions of funding agreements require financial reporting at the end of every financial year covered in a project period, and after the project has ceased.

f) There are a range of methods that program managers use to assess the progress and performance of funded organisations. These include:
- examination of progress reports including comparisons with previous reports;
- comparison of performance data across participants or to previous periods;
- workshops to review reported information;
- analysis of expenditure statements against activities;
- regular contact and ongoing dialogue with funded organisations, including attending meetings and/or project events, forums and committee meetings; and
- independent evaluations of funded organisations and activities.

g) The answer at f) above provides information on the nature of information Primary and Ambulatory Care Division receives about funded activities which will inform any subsequent decisions.

h) The current year budget estimates and expenditure are monitored on a regular basis throughout the year. Should a measure be underspent at 30 June then the unspent administered funding is returned to Consolidated Revenue, except where approval for rephrasing/reprofiling is obtained through Budget or Additional Estimates processes.

i) Established Primary and Ambulatory Care Division quality assurance processes, advice and guidance have been revised to strengthen the requirement for compliance with both Divisional and Departmental guidance on all issues identified in the Audit.

   Information sessions on the implementation of the Audit outcomes for Primary and Ambulatory Care Division program managers and delegates are scheduled for the latter half of 2006.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2006-2007, 31 May - 1 June 2006

Question: E06-178

OUTCOME 6: Rural Health

Topic: COAG MEASURE - BETTER MANAGEMENT OF RURAL HEALTH PROGRAMS

Hansard Page: CA 121

Senator Polley asked:

Would you be able to provide some examples of communities with populations of under 7,000 who may benefit from this measure?

Answer:

The following are towns with populations of under 7,000 that currently receive services under the Rural Health Strategy and that may benefit from the measure:

- Bega, Nimbin or Wilcannia in New South Wales;
- Cloncurry, Charleville or Quilpie in Queensland;
- Halls Creek, Merredin or Margaret River in Western Australia;
- Corryong or Orbost in Victoria;
- Coober Pedy or Ceduna in South Australia;
- Beaconsfield in Tasmania; and
- Tennant Creek in the Northern Territory.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2006-2007, 31 May - 1 June 2006

Question: E06-125

OUTCOME 6: Rural Health

Topic: MENTAL HEALTH SERVICES IN RURAL AND REMOTE AREAS

Written Question on Notice

Senator McLucas asked:

a) How will these services be delivered? Will it involve Better Outcomes in Mental Health (BOiMH) or More Allied Health Services (MAHS) Programs?
b) Will it require referral from a GP?
c) How many services are expected to be delivered each year when fully up and running?
d) What mental health services are currently provided under MAHS for 2005 and for YTD 2005-06?
e) Please provide details about (1) the number and type of mental health professionals funded under MAHS, and (2) number of services provided in each category for the past four years?
f) Is it possible to get this information further broken down by state and/or RRMA?
g) What initiatives are underway to ensure that there are more mental health professionals in regional and rural areas?

Answer:

a) While the service delivery model for the mental health services in rural and remote areas initiative is being finalised, it is envisaged that the initiative will build on the Access to Allied Psychological Services (ATAPS) component of the BOiMH and MAHS Programs and will provide additional mental health services to rural and remote communities.

Divisions of General Practice that administer the ATAPS and MAHS Programs will play a role in administering the Program, given their proven track record in delivering similar services and networking skills in the mental health sector.

The Australian Government will work with the Divisions of General Practice to strengthen collaborative arrangements between general practitioners, allied health and mental health nurse services.

b) While the service delivery model is yet to be finalised, it is likely that, similar to ATAPS and MAHS Program guidelines, GP referred services will be the focus of the mental health services in rural and remote areas initiative.

c) Service targets have not been estimated on the uptake of the Program. However, an on-going data collection will be put in place to support the Program and to inform the progressive uptake and derive base-line data for benchmarking purposes.

d) MAHS funds services provided by psychologists, Aboriginal Mental Health Workers, occupational therapists, counsellors, registered nurses specialised in mental health and social workers. It is important to note that services provided under MAHS by these professionals may not necessarily relate to a mental health issue or diagnosis.

e) 1) Number and type of professionals funded under MAHS who may have provided mental health services

Profession	**Total number of Full Time Equivalent (FTE) professionals funded under MAHS 2001/02 – 2004/05 (aggregated data)**
Psychologists/counsellors	**181.38 FTE**
Social workers	**41.63 FTE**
Registered Nurses (Mental Health)	**25.22 FTE**
Aboriginal mental health workers	**23.76 FTE**
Counsellors	**33.42 FTE**
Occupational therapists	**14.77 FTE**

2) Number of mental health services

Information regarding the number of mental health services is not collected under MAHS.

As noted above, services provided under MAHS by these professionals may not necessarily relate to a mental health issue or diagnosis.

f) Please see answer to question e) above.

g) The Program will mainly fund treatment services by qualified psychologists and other mental health workers.

From 1 January 2007, the Australian Government will fund over 400 additional mental health nursing places and over 200 clinical psychology places a year. Additional education and training options will be available to allied health professionals to update their skills in mental health. Experience with current programs indicates that there are some under-employed allied health professionals in some regional areas who see the Divisions of General Practice offering another choice of employer.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2006-2007, 31 May - 1 June 2006

Question: E06-236

OUTCOME 6: Rural Health

Topic: MEDICAL SPECIALIST OUTREACH ASSISTANCE PROGRAM (MSOAP)

Hansard p.CA125 1 June 2006

Senator Adams asked:

What is the number of services funded under MSOAP in the 2005-2006 financial year?

Answer:

In the period from 1 July 2005 to 31 December 2005 the number of services funded under the MSOAP was 1079.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2006-2007, 31 May - 1 June 2006

Question: E06-008

OUTCOME 7: Hearing Services

Topic: AUSTRALIAN HEARING

Written Question on Notice

Senator Crossin asked:

The PBS says:

A major focus for the delivery of CSO services will be ensuring that Indigenous Australians aged 50 years and over and Community Development Employment Projects participants, who were granted eligibility in the 2004-05 Budget, are making use of the hearing services provided by Australian Hearing.

a) How many Australians aged 50 years and over and Community Development Employment Projects (CDEP) participants, who were granted eligibility in the 2004-05 Budget have gained access or made use of the hearing services provided by Australian Hearing?
b) How is this being done?
c) Has there been a problem with the uptake of the new services?

Answer:

a) Number of eligible clients who accessed hearing services under the 2005-06 Budget measure in the first five months of implementation (1 December 2005 to 30 April 2006):

   - 247 Indigenous Australians aged 50 years and over; and
   - 55 Indigenous Australians participating in CDEP.

b) The services are being delivered to eligible clients by Australian Hearing, the public provider of hearing services, as part of the Australian Government's Hearing Services Program's Community Service Obligations. Australian Hearing commenced implementing a focused promotional campaign in October 2005, to raise awareness of the availability of hearing services under the Budget measure. It is continuing to advertise and promote the measure through Indigenous media on a regular basis.

   Australian Hearing is also actively liaising and consulting with Indigenous organisations and communities to raise awareness and negotiate Service Level Agreements which will assist with identifying potential clients.

The Office of Hearing Services, in conjunction with Australian Hearing, is working with key agencies, especially within state and territory governments, to establish additional networks that will assist in the further implementation of the measure.

c) Initial take-up of the hearing services under the measure has been lower than estimated. However, the rate is expected to increase in line with expanding awareness of the measure and increasing acceptance of hearing services amongst Indigenous communities.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2006-2007, 31 May - 1 June 2006

Question: E06-204

OUTCOME 7: Hearing Service

Topic: NATIONAL ACOUSTIC LABORATORIES – RESEARCH

Hansard Page: CA 130

Senator McLucas asked:

Could you provide us with a list of the research plan from NAL, let us say, over the last five years?

Answer:

A comprehensive list of NAL's research items from 2001-2006 is included below in four broad areas:

Hearing loss assessment: To better assess and understand hearing loss

No.	Project	Aim
AS00.1	Screening by post-auricular muscle response	To evaluate whether the post-auricular muscle response can be used to objectively detect hearing loss in infants
AS01.1	Discriminative potentials for reading delay	To devise tests for diagnosing types of reading delay related to problems with hearing
AS02.1	Hearing aid effect: cross-cultural study	To understand why many Aboriginal children forego hearing aid use
AS02.2	Literacy outcomes for Aboriginal children	To understand the barriers to literacy in Aboriginal children
AS05.1	Detecting and diagnosing auditory processing disorders	To devise improved methods for detecting auditory processing disorders in children
AS05.2	Sentence-based testing of auditory processing disorders	To devise and evaluate a clinically feasible method for detecting and diagnosing auditory processing disorders in children
CRC C3.5	Computer-aided assessment of infants	To devise more efficient tests and stimuli for behaviourally testing the hearing of infants
CRC C3.10	Computer-based audiological tester	To make new audiological tests devised by NAL and other research centres available to clinicians in a timely and cost-effective manner
CRC C7	Development of hearing test materials and protocols	To devise most efficient tests of speech understanding in noise
HLP98.2	Binaural assessment using otoacoustic emissions	To devise a test of brainstem afferent and efferent functions involved in hearing
HLP99.1	Cochlear model for emissions	To better understand the source of otoacoustic emissions
HLP02.1	Evaluation of click evoked otoacoustic emissions latency	To examine the effects of static ear pressure on transient otoacoustic emissions

Prevention of hearing loss: To better prevent hearing loss

No.	Project	Aim
CRC B5	Minimising acoustic shock	To protect call-centre workers from acoustic shock
Prev 00.1	Effective training for noise reduction	To devise and evaluate a method for changing workers' behaviour towards protecting their hearing
Prev 00.2	Improving Occupational Health and Safety training via otoacoustic emissions	To devise and evaluate a method for changing workers' behaviour towards protecting their hearing using objective hearing test methods
Prev 00.3	Noise exposure in film and broadcasting	To evaluate the extent of noise exposure amongst workers in the broadcasting and film industry
Prev 02.1	Personal stereo noise exposure	To evaluate and publicise the danger of personal stereo use
Prev 02.3	Attenuation results of hearing protectors	To devise and evaluate an improved method for quantifying the performance of hearing protectors
Prev 03.1	Barriers to occupational noise exposure reduction	To determine why many individuals do not protect their hearing
Prev 05.1	Factors affecting hearing protector performance	To identify how design factors affect the performance of hearing protectors
HLP92.1	Longitudinal studies of noise-exposure	To assess the use of emissions as an early warning of loss
HLP98.1	Methodology for fast assessment of risk	To devise a method of assessing individual susceptibility to noise
HLP99.2	Analysis software for Transient Evoked Otoacoustic Emissions data	To devise and make available improved methods for analysing otoacoustic emissions

Hearing aids and rehabilitation devices: To devise improved features for hearing aids

No.	Project	Aim
CRC B1.1	Trainable hearing aid	To devise a hearing aid that can be trained by the user
CRC B1.2	Determination of optimal characteristics	To obtain information useful for programming automatic hearing aids
CRC B2	Acoustically transparent hearing aid	To remove the blocked-ear sensation accompanying hearing aids
CRC B3.4	Noise-sensitive adaptive amplification	To devise optimal adaptations in hearing aids in noisy places
CRC B3.5	Linked binaural noise reduction	To devise more effective noise reduction algorithms
CRC B4	Polymer sandwich microphone	To devise a more effective, lower cost, more precise microphone
CRC B6	Effect of gain mismatch on localisation	To measure whether maladjusted hearing aids compromise aid wearers' ability to localise sounds
Eng 00.1	1800 MHz Global System for Mobile Communication (GSM) interference	To quantify the interference of hearing aids by GSM mobile phones

Eng 00.2	800 MHz Code Division for Multiple Access (CDMA) interference	To quantify the interference of hearing aids by CDMA mobile phones
HA 00.1	Reduction of wind noise in hearing aids	To reduce the adverse effects of wind on hearing aids
SPONS 02.1	Real time signal processing study	To investigate the sound quality of different hearing aid processing schemes
SPONS 03.1	Localisation research	To understand and improve the ability of people with hearing loss to tell where sounds come from
SPONS 03.4	Acoustix device testing	To test the benefits of a new temporary vented ear mould
HA 05.2	Fitting conductive hearing loss	To devise a more efficient and accurate process for prescribing and adjusting hearing aids for people with conductive hearing loss

Rehabilitation procedures: To devise improved rehabilitation procedures

No.	**Project**	**Aim**
CRC C1.2	Hearing aid electrophysiological assessment	To devise methods for evaluating the aided functioning of infants
CRC C1.7	Electrophysiological evaluation of cochlear implants	To better understand the benefits of binaural cochlear implants
CRC C1.8	Auditory neuropathy outcomes	To devise evidence-based guidelines for managing infants with auditory neuropathy
CRC C3.1	Normalisation of overall loudness	To determine appropriate loudness goals for hearing aid fitting
CRC C3.2	Hearing aid fitting with cochlear implants	To determine how to combine hearing aids and cochlear implants
CRC C3.7	Functional assessment of infants	To devise improved methods for behaviourally assessing aided children
CRC C3.8	Hearing aid prescription for children	To assess the effectiveness of alternative methods for prescribing amplification for children
CRC C3.9	Factors affecting speech intelligibility	To understand how the speech perception abilities of hearing-impaired people vary with different aspects of hearing loss
CRC C3.11	Derivation of NAL-NL2	To improve the NAL-NL1 formula for prescribing hearing aids
CRC C3.13	Paediatric features	To determine the age at which children benefit from directional microphones
CRC C6.3	Outcomes for aided children	To understand the factors that affect the long-term abilities of children with hearing loss
HA 00.2	Classroom F.M.amplification	To quantify the educational benefits of classroom FM systems
HA 01.1	Evaluation of guidelines on fitting multi-memory aids	To evaluate the effectiveness of NAL's multimemory hearing aid fitting guidelines
HA 02.2	Paired comparison of compression	To determine optimal compression thresholds in multi-band hearing aids

HA 03.1	Normative horizontal localisation data	To establish normative performance on a new localisation test
HA 04.1	Completely-in-the-canal localisation	To determine whether completely-in-the-canal hearing aids offer superior localisation
HA 05.1	Improved bone conduction hearing aids	To devise a more comfortable, more effective, and more aesthetic bone-conduction hearing aid.
SPONS 02.2	Compression for severe to profound loss: phase I	To determine compression parameters for severe-profound losses
SPONS 03.2	Subjective loudness measure	To provide benchmark data on the loudness of TV advertisements
SPONS 04.1	Compression for severe to profound loss: phase II	To improve prescription procedures for people with severe-profound loss
SPONS 04.2	Optimal vent compensation	To improve prescription procedures for advanced noise-reduction hearing aids
SPONS 04.3	Paediatric protocols	To gather, document and trial efficient workflow procedures for paediatric fittings
SPONS 04.4	Temporal acclimatisation	To determine whether prescriptions need to allow for user experience
SPONS 05.1	Spatial hearing aid technology	To determine whether spatial processing improves speech perception in noise
SPONS 05.2	Relationship of hearing loss to aid benefit	To determine how the benefit from hearing aids varies with degree of loss and other factors

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2006-2007, 31 May-1 June 2006

Question: E06-005

OUTCOME 8: Indigenous Health

Topic: SPECTACLES IN INDIGENOUS COMMUNITIES

Senator Crossin asked:

a) In communities where we are struggling just trying to address Trachoma how much attention can be directed to issues like whether a child needs glasses?
b) What is the unmet need for glasses in the indigenous community?

Answer:

a) All state and territory governments provide subsidised spectacle schemes and initiatives that facilitate access to optometric screening services.

   A new Medicare-funded health check for Aboriginal and Torres Strait Islander children was also listed on the Medicare Benefits Schedule on 1 May 2006. This will help ensure that Aboriginal and Torres Strait Islander children from birth to 14 years receive optimum health care by encouraging early detection, diagnosis and treatment of common and treatable conditions, including vision impairments.

b) The supply and need for spectacles is the responsibility of state and territory governments. The Australian Government does not have any data on the level of unmet need.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2006-2007, 31 May-1 June 2006

Question: E06-007

OUTCOME 8: Indigenous Health

Topic: OTITIS MEDIA GUIDELINES

Written Question on Notice

Senator Crossin asked:

The South Australian project on improving the Otitis Media Guidelines uptake, you said in answer E06-096, was due to be finalised this financial year. Can you advise where it is up to and any results?

Answer:

The South Australian Otitis Media Clinical Support Systems Project has been extended until the end of June 2007. The project will be completed with the original funding provided.

Data collection is continuing, and the results will be included in the evaluation report due at the end of 2006-07. Progress to date includes the training of health workers, nurses and doctors in the *Clinical Care Guidelines on the management of otitis media in Aboriginal and Torres Strait Islander populations,* the project launch, and an awareness raising campaign of ear health in the community.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2006-2007, 31 May-1 June 2006

Question: E06-056

OUTCOME 8: Indigenous Health

Topic: BRINGING THEM HOME PROGRAM

Written Question on Notice

Senator Siewert asked:

a) What is the length of funding cycles for projects under this program, ie, are they one year, two, three?
b) How are the projects evaluated?
c) How is the program evaluated?

Answer:

a) The funding is ongoing, but is provided through one-year funding agreements.

b) The Department monitors key outcomes through regular reporting processes required under the single funding agreement and the service delivery reporting framework.

c) An independent, multi-program evaluation of the related Bringing Them Home (BTH) and Mental Health programs including, the BTH Counsellors, Social and Emotional Well Being Regional Centres, Link-Up services and Mental Health service delivery projects, is in progress. The evaluation report is due for completion by the end of December 2006.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2006-2007, 31 May-1 June 2006

Question: E06-058

OUTCOME 8: Indigenous Health

Topic: PETROL SNIFFING

Written Question on Notice

Senator Evans asked:

On 10 February 2006 the Minister for Health and Ageing announced the roll-out of *Opal* to BP Alice City (in Alice Springs). Is the Alice Springs roll-out funded under the 2005-06 budget measure, or the 2006-07 one?

Answer:

BP Alice City Service Station is funded out of the Central Desert Region additional funding announced by the Minister on 12 September 2005, and funded through the 2005 Additional Estimates, as it is supporting the designated central desert region.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2006-2007, 31 May-1 June 2006

Question: E06-059

OUTCOME 8: Indigenous Health

Topic: PETROL SNIFFING

Written Question on Notice

Senator Evans asked:

On 22 February 2006 the Minister issued a press release regarding a 'new strategic approach' to petrol sniffing in Central Australia agreed with the NT, SA and WA governments.

a) How much of the $9.5 million for this strategic approach is being contributed by the Commonwealth?

b) Does this money come from Petrol Sniffing Prevention Program resources or is it separate?

Answer:

a) The $9.5 million, including $3 million from the Aboriginal Benefit Account, is being contributed by the Commonwealth.

b) $6.5 million of the $9.5 million is new money provided as a part of the Petrol Sniffing Prevention Program resources. This is additional to the funding provided in the 2005-06 and 2006-07 Budget measures.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2006-2007, 31 May-1 June 2006

Question: E06-060

OUTCOME 8: Indigenous Health

Topic: PETROL SNIFFING

Written Question on Notice

Senator Evans asked:

Regarding the Petrol Sniffing Prevention Program communications strategy:

a) What is the funding allocation for the Petrol Sniffing Prevention Program communications strategy?
b) What does the proposed strategy consist of? Please provide brief overview
c) How long will it run for?

Answer:

a) A total of $1.958 million has been provided for the communication strategy over 5 years for 2005-06 to 2009-10.

b) The communication strategy is a broad framework for the communication of information about all components of the Petrol Sniffing Prevention Program. The strategy will utilise a range of media types, including: television, radio, printed materials, internet sites and event sponsorship.

   The communication strategy has a number of goals ranging from providing factual information about *Opal* fuel, through to generating broader community support for the Eight Point Plan in the designated area of the Central Desert Region.

c) Communications strategy activities have commenced and will continue until 2009.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2006-2007, 31 May-1 June 2006

Question: E06-061

OUTCOME 8: Indigenous Health

Topic: BRINGING THEM HOME PROGRAMS

Written Question on Notice

Senator Evans asked:

a) According to last year's PBS, the Department was going to tender for a 'multi-program evaluation of three related Bringing Them Home (BTH) programs -BTH Counsellors, Regional Centres, and Link-up. The purpose of evaluation will be to review previous evaluations and establish an appropriate methodology suited to each program, to inform future program development. The evaluation is expected to be completed by April 2006'. According to this year's PBS, a national evaluation of all OATSIH-funded social health programs (including BTH programs) is due to be completed in September 2006. Are the evaluations referred to in last year's and this year's PBSs the same thing?

b) Will the evaluation report/s be made public?

c) Are the BTH programs ongoing or are they lapsing programs? If the latter, is the future of the programs contingent on the outcome of the evaluation report/s?

d) Please provide updated figures on funding allocations for BTH programs for the 2006-07 financial year and the out-years.

Answer:

a) Yes.

b) Yes.

c) The BTH programs, (ie the BTH Counsellors and Link Up services) are ongoing.

d) Funding allocations for 2006-07, broken down into program areas, are not available at this time.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2006-2007, 31 May-1 June 2006

Question: E06-062

OUTCOME 8: Indigenous Health

Topic: Indigenous medical workforce

Written Question on Notice

Senator Evans asked:

Does the Department collect any of its own data on medical staff employed in AMSs and ACCHOs? Or does it rely on data from external sources, such as the Australian Medical Workforce Advisory Committee?

Answer:

Yes - the Service Activity Reporting (SAR) data collection is a joint collection project of the National Aboriginal Community Controlled Health Organisation (NACCHO) and the Department. This collection includes data on staff employed by Australian Government funded Aboriginal and Torres Strait Islander primary health care services.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2006-2007, 31 May-1 June 2006

Question: E06-063

OUTCOME 8: Indigenous Health

Topic: Indigenous medical workforce

Written Question on Notice

Senator Evans asked:

a) Please provide an overview of the dataset the Department uses to monitor workforce in Indigenous medical services and community controlled health services.
   i) For example, where is the data collected from?
   ii) What are the main elements of the dataset?
   iii) Can the data be disaggregated by state and region?

Answer:

a) The Service Activity Reporting (SAR) data collection is a joint collection project of the National Aboriginal Community Controlled Health Organisation (NACCHO) and the Department.
   i) Data covering a twelve month period are collected by questionnaire from Australian Government funded Aboriginal and Torres Strait Islander primary health care services.
   ii) The main data elements of the dataset are:
      - service level data on episodes of health care
      - staffing
      - health related activities
      - substance use
      - emotional and social wellbeing
   iii) The data can be disaggregated by state and region. Disaggregated data by state and region is provided in response E06000064.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2006-2007, 31 May-1 June 2006

Question: E06-064

OUTCOME 8: Indigenous Health

Topic: INDIGENOUS MEDICAL WORKFORCE

Written Question on Notice

Senator Evans asked:

Can the Department provide the following:

a) Number of medical staff employed in Aboriginal medical services and community controlled health services, in each year for the last 3 years, disaggregated by state and region if possible

b) Number of non-medical health staff (e.g. Aboriginal Health Workers) employed in Aboriginal medical services and community controlled health services, in each year for the last 3 years, disaggregated by state and region if possible.

Answer:

(a & b)

The Service Activity Reporting (SAR) does not collect the actual number of staff employed by Aboriginal and Torres Strait Islander primary health care services but rather the number of 'full time equivalent' (FTE) positions. The number of staff will therefore be higher than the numbers reported (attached).

The most recent year for which data are available is 2003-04 due to the fact that the survey is conducted after the end of the financial year and is followed by a significant task of checking and processing data prior to release. It is anticipated that the 2004-05 SAR data will be released by August 2006.

Number of 'full time equivalent' health staff employed by respondent Aboriginal and Torres Strait Islander primary health care services as at 30 June 2004 by State/Territory

		2001-02	2002-03	2003-04
NSW & ACT	Doctors	39	52	52
	Nurses	37	51	61
	Aboriginal and Torres Strait Islander Health Workers	118	110	116
	Other health staff	106	128	164
VIC & Tas	Doctors	16	12	17
	Nurses	22	18	16
	Aboriginal and Torres Strait Islander Health Workers	88	69	67
	Other health staff	57	80	82
QLD	Doctors	34	39	38
	Nurses	29	27	30
	Aboriginal and Torres Strait Islander Health Workers	95	86	99
	Other health staff	114	109	111
SA	Doctors	11	12	13
	Nurses	31	34	35
	Aboriginal and Torres Strait Islander Health Workers	88	82	71
	Other health staff	63	58	62
WA	Doctors	38	44	43
	Nurses	67	74	69
	Aboriginal and Torres Strait Islander Health Workers	139	154	148
	Other health staff	83	109	95
NT	Doctors	38	33	37
	Nurses	59	56	64
	Aboriginal and Torres Strait Islander Health Workers	122	105	131
	Other health staff	105	97	92
Australia	Doctors	176	192	201
	Nurses	245	259	275
	Aboriginal and Torres Strait Islander Health Workers	650	606	632
	Other health staff	529	581	605

Source: Australian Government Department of Health and Ageing 2003–04 Service Activity Reporting

Number of 'full time equivalent' health staff employed by respondent Aboriginal and Torres Strait Islander primary health care services as at 30 June 2004 by Remoteness Area (a)

		2001-02	2002-03	2003-04
Major Cities of Australia	Doctors	37	44	53
	Nurses	32	34	40
	Aboriginal and Torres Strait Islander Health Workers	113	89	115
	Other health staff	123	135	131
Inner Regional Australia	Doctors	29	36	32
	Nurses	33	34	41
	Aboriginal and Torres Strait Islander Health Workers	107	90	87
	Other health staff	84	115	135
Outer Regional Australia	Doctors	45	49	47
	Nurses	36	45	43
	Aboriginal and Torres Strait Islander Health Workers	148	176	157
	Other health staff	112	136	119
Remote Australia	Doctors	35	34	36
	Nurses	68	68	47
	Aboriginal and Torres Strait Islander Health Workers	126	125	117
	Other health staff	117	106	99
Very Remote Australia	Doctors	30	30	33
	Nurses	76	79	103
	Aboriginal and Torres Strait Islander Health Workers	156	125	156
	Other health staff	93	89	122
Australia	Doctors	176	192	201
	Nurses	245	259	275
	Aboriginal and Torres Strait Islander Health Workers	650	606	632
	Other health staff	529	581	605

(a) Refer to Australian Bureau of Statistics, 2001, *Statistical Geography Volume 1: Australian Standard Geographical Classification (ASGC) 2001 (cat. no. 1216.0),* Canberra

Source: Australian Government Department of Health and Ageing 2003–04 Service Activity Reporting

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2006-2007, 31 May-1 June 2006

Question: E06-065

OUTCOME 8: Indigenous Health

Topic: COAG MENTAL HEALTH

Written Question on Notice

Senator Evans asked:

a) Please provide a breakdown of funding allocated to the different components of the $20.8 million over 5 years allocated to 'improving the capacity of health workers in Indigenous communities' as part of the COAG Mental Health package.
b) How will the mental health training programmes and resources be delivered?
c) How will the distribution of the 10 additional mental health worker positions in Indigenous communities be determined?

Answer:

a) The final breakdown of expenditure per component is yet to be determined.

b) The mental health training programs and resources will be delivered through a range of providers, including Social and Emotional Wellbeing Regional Centres.

c) The process for distribution of the 10 additional mental health worker positions in Indigenous communities is yet to be determined.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2006-2007, 31 May-1 June 2006

Question: E06-115

OUTCOME 8: Indigenous Health

Topic: Improving the Capacity of Indigenous Health.

Written Question on Notice

Senator McLucas asked:

a) How many scholarships are currently provided under the Puggy Hunter Scheme?
b) When does the current funding for this scheme lapse?
c) Is the provision in the Budget in addition to a continuing commitment to this scholarship scheme in the years from 2007?
d) How many Aboriginal mental health workers are there?
e) Is it expected that all Aboriginal mental health workers will get mental health training?
f) What provisions will be made for these workers to be able to get time off and travel to get this training?
g) Does this initiative provide only 10 new mental health worker positions or is it 10 positions / year?
h) Are funds provided for their education and training?
i) If not, where will people to fill these new positions come from?
j) Where will these new positions be provided?

Answer:

a) There are currently 103 students receiving Puggy Hunter Scholarships in 2006.

b) In October 2001, the Minister for Health and Ageing, approved the use of uncommitted funds for the Puggy Hunter Scholarship Scheme over a period of five academic years.

In the 2004-05 budget funding for 10 scholarships a year was approved as ongoing.

In the 2005-06 Budget, funding was approved for 86 scholarships as part of the Healthy for Life initiative (26 in 2005-06, 31 in 2006-07, 13 in 2007-08 and 24 in 2008-09) which lapses in June 2009.

The 2006-07 Budget funded 25 new scholarships over five years and will lapse in June 2010. Under this measure, 5 new scholarships will be provided per annum for students undertaking studies in a mental health discipline.

c) Yes.

d) As at 30 June 2004 there were 141 Aboriginal and Torres Strait Islander emotional and social well being staff employed by primary health care services funded by OATSIH.

e) No. There is funding of $20.8 million over five years and will provide Indigenous health workers with opportunities for training. It will also benefit Aboriginal Health Services nationally and provide increased access to trained professionals and better referral and treatment options.

f) The health services will determine the arrangements for release of staff.

g) The mental health initiative provides for a total of 10 new mental health worker positions.

h) Yes. The new mental health workers located in OATSIH funded services will have education and training costs built into their base funding. In addition, they will also benefit from the training and professional development opportunities offered under this measure.

i) Not applicable.

j) The process to determine the location of the new mental health workers is yet to be finalised.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2006-2007, 31 May-1 June 2006

Question: E06-183

OUTCOME 8: Indigenous Health

Topic: Indigenous Health

Hansard Page: CA44

Senator Crossin asked:

Can I have a list of all the department expenditure on the AP trial since it began? I am actually after a breakdown of expenditure by initiative and program. Year–by–year allocations, including projections for out years, if possible. Also departmental versus administered allocations.

Are you able to provide me with a list of all Commonwealth expenditure on the AP Lands?

Answer:

The Department of Health and Ageing administered expenditure details by activity for the Anangu Pitjantjatjara Lands (AP Lands) COAG trial are detailed in Table A.

A summary of the Department of Health and Ageing departmental and administered expenditure for the 2003-04, 2004-05 and 2005-06 financial years for the AP Lands COAG trial are detailed in Table B.

The Department of the Prime Minister and Cabinet has taken responsibility for compiling expenditure details of all Australian Government agencies expenditure relating to all trial sites.

A. Department of Health and Ageing Administered Expenditure in the AP Lands

PROGRAMME AND PROJECT	2003-04 Admin expend.	2004-05 Admin expend.	2005-06 Admin expend.	2006-07 Admin allocated	2007- 08 Admin allocated *
Nganampa Health Council	$5,789,842	$6,136,440	$6,785,453	$6,471,025	
Aged Care Services	$979,474	$1,022,792	$1,099,727	$1,100,000	
National Suicide Prevention	$42,800	$42,800	$49,300	$12,000	
Alice Springs Aged Care Division to NPY Women's Council: Cross Border Carer Respite Centre & Service				$404,679	
Reimbursing Subsidy for Avgas/Opal 04/05				$217,995	
Aged & Disability Project thru Dept Families & Communities to Nganampa Health Service)		$641,560	$665,600		
Home and Community Care (HACC)- Ngaanyatjarra Pitjantjatjara Yankunytjatjara Aged Support (joint funding arrangement)			$226,800		
HACC- Tjilpi Pampa Tjatala Festival (joint funding arrangement)		$20,200	$20,600		
OATSIH - Alice Springs Territory Office to NPY Women's Council (joint funding arrangement). Funds to NPY Women's Council are not solely for APY Lands as it covers SA & NT cross-border services.			$486,171		
Pop Health - Alice Springs to NPY Women's Council (joint funding arrangement). Funds to NPY Women's Council are not solely for APY Lands as it covers SA & NT cross-border services.			$250,500		
PY Media - Provision of funding to PY Media to develop and form a structure for a senior management Committee for the PY Ku Network and a streamlined reporting mechanism to the Board of Management of PY Media and the APY Lands COAG Steering Committee.	$178,206		$102,868		
COAG miscellaneous (eg workshops, catering, TKP Secretariat support etc)	$33,366	$27,554	$57,055		
Consultant	$22,393	$103,078			
Contractor	$76,509				
Mai Wiru Regional Healthy Stores Policy	$90,000	$290,642	$250,642	$240,642	$374,332

PROGRAMME AND PROJECT	2003-04 Admin expend.	2004-05 Admin expend.	2005-06 Admin expend.	2006-07 Admin allocated	2007- 08 Admin allocated
Anangu Pitjantjatjara Inc. (Rural Transactions Centre Submission)	$65,455				
Designing APY Lands brochures and web page			$11,364		
Feasibility Study of proposed construction of a swimming pool at Watarru			$15,000		
Capital Works Program - Nganampa	$294,809	$1,507,950	$913,000	$1,224,500	$18,500
Workforce - regional Aboriginal Health Worker training program managed by Nganampa Health Council	$245,000	$209,100	$213,700		
Patient Information Recall System - specialist support	$16,000				
Mental Health - at risk youth and suicide prevention workshop		$11,000			
Service Development Reporting Framework. Two elements; Performance and Quality; and, Strategic and Action Planning		$15,000	$10,000		
National Drug Action Week Initiatives		$16,000	$8,000		
Healthy for Life - Chronic Disease and Child Health			$85,000		
Pukatja wheeelchair access and Kalka community ambulance			$81,050		
For the purchase of 14 Commonwealth Games Villas to house Indigenous Community Volunteers and visiting Anangu PY Ku staff attending training at the regional centre.			$599,045	$1,985,874	
Set up costs for network operations of PY Ku (regional transaction centers)			$569,543		
Watarru Swimming Pool. Funding amount to be confirmed.				$1,350,000	
TOTAL *All figures are GST exclusive*	**$7,833,854**	**$10,044,116**	**$12,500,417**	**$13,006,715**	**$392,832**

* *While formal allocations for 2007-08 have not been made much of this funding is considered ongoing.*

B. Department of Health and Ageing Departmental and Administered Expenditure in the AP Lands

(expenditure at 30 May 2006)

Administered	2003-04	2004-05	2005-06 (expended)
All Indigenous – specific expenditure in the APY Lands (not necessarily COAG specific)	**$7,833,854**	**$10,044,116**	**$12,500,417**
Departmental	2003-04	2004-05	2005-06
	$203,164	**$282,353**	**$234,972**
TOTAL	$8,037,018	$10,326,469	$12,735,389

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2006-2007, 31 May-1 June 2006

Question: E06-186

OUTCOME 8: Indigenous Health

Topic: AUSTRALIAN GOVERNMENT INDIGENOUS SPECIFIC HEALTH EXPENDITURE

Hansard Page: CA 51

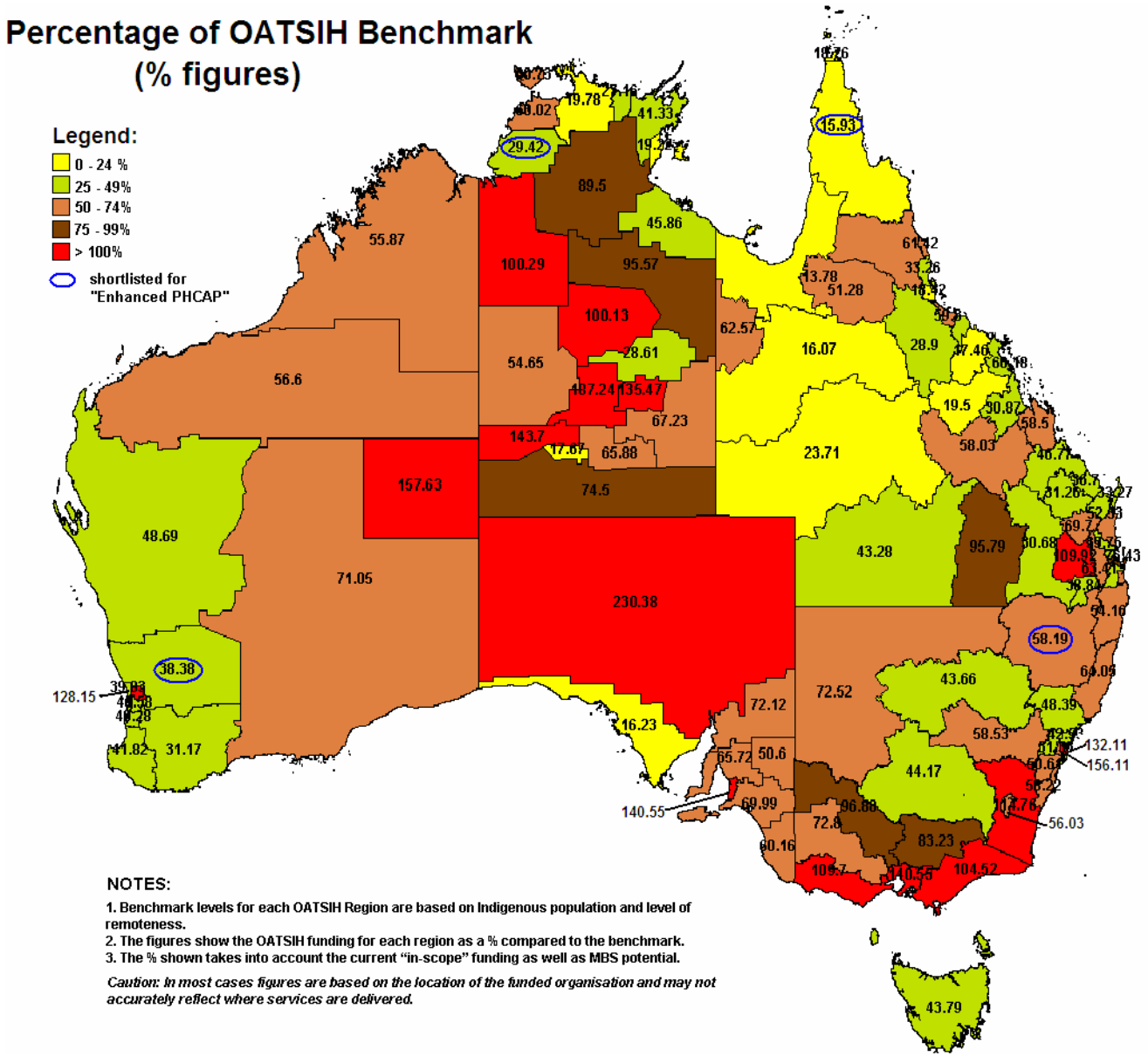
Senator Crossin asked:

Are you able to give the committee the list of where you might target these positions?

Answer:

The attached map represents the level of government expenditure (expressed as a proportion of the planning benchmark) on Indigenous specific primary health care services across planning regions as of December 2005. The benchmark is calculated as three times the average per capita Medical Benefits Scheme expenditure for all Australians. It is then adjusted to reflect the distribution of the Indigenous population across Australia and cost relativities due to remoteness.

The size of the gap between actual expenditure in a planning region and the benchmark is a significant factor in decisions about future investment of Australian Government expenditure in Indigenous specific primary health care.


Percentage of OATSIH Benchmark
(% figures)
Legend:
0 - 24 %
25 - 49%
50 - 74%
75 - 99%
> 100%
shortlisted for "Enhanced PHCAP"
NOTES:
1. Benchmark levels for each OATSIH Region are based on Indigenous population and level of remoteness.
2. The figures show the OATSIH funding for each region as a % compared to the benchmark.
3. The % shown takes into account the current "in-scope" funding as well as MBS potential.
Caution: In most cases figures are based on the location of the funded organisation and may not accurately reflect where services are delivered.
15.93
29.42
89.5
41.33
19.78
45.86
55.87
100.29
95.57
61.42
33.26
13.78
51.28
100.13
62.57
16.07
28.9
47.46
54.65
28.61
56.6
487.24
135.47
19.5
30.87
58.5
67.23
143.7
17.67
65.88
58.03
23.71
157.63
74.5
48.69
71.05
43.28
95.79
230.38
58.19
38.38
72.52
43.66
72.12
48.39
16.23
58.53
65.72
50.6
44.17
140.55
69.99
96.88
72.8
83.23
60.16
104.52
128.15
41.82
31.17
132.11
156.11
56.03
43.79

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2006-2007, 31 May-1 June 2006

Question: E06-187

OUTCOME 8: Indigenous Health

Topic: PRIMARY HEALTH CARE ACCESS PROGRAM (PHCAP)

Hansard Page: CA 52

Senator Crossin asked:

(a) Can you provide me then with updated figures on the PHCAP allocations for 2005-06, 2006-07 and the out years in this budget?

(b) Can I also have an update on the list of projects and sites funded under PHCAP so far this year?

Answer:

(a)

ADMINISTERED	2005-06 Budget ($m)	2006-07 Budget ($m)	2007-08 (FE1) ($m)	2008-09 (FE2) ($m)	2009-10 (FE3) ($m)
BRE 188 – Primary Health Care Access Program	**70.5**	**94.7***	**84.0***	**88.6**	**96.9**

* Includes re-phased funds of $22.3m (2006-07) and $6.2m (2007-08) respectively

(b) In addition to projects committed in prior years as identified in the answer to Question E04000028, 2005-06 PHCAP funds were allocated to the following new projects (as at 31 May 2006):

State	OATSIH Planning Region	Organisation	Project Description	Total
ACT	ACT	Carers ACT Incorporated	Services -staffing (Indigenous support worker)	24,000
		Winnunga Nimmityjah Aboriginal Health Clinic/Health Service (ACT) Incorporated	Workforce capacity and development project	25,000
			Capital works – clinic, nurse room	35,000
			Services – staffing (business manager, GP), health worker training, operational costs (security, computer system, and photocopier upgrade)	201,000
			ACT Total	**285,000**

NSW	Central Coast	Ngaimpe Aboriginal Corporation (The Glen)	Services – staffing (AHW and program/recreational Worker)	27,002
		Yerin Aboriginal Health Service	Services – staffing (assistant manager)	36,600
			Capital works - office	25,160
	Far West	Bourke Aboriginal Health Service	Services – staffing (accountant, mental health worker, psychologist and clinical coordinator), equipment (clinical, office) and operational costs	201,502
			QMS Accreditation	34,218
		Coomealla Health Aboriginal Corporation	Services – staffing (p/t AHW), equipment (clinical)	23,104
			Increased operational and administrative costs capital works	73,000
		Greater Western Area Health Service	Health planning and consultation activities in the Murdi Paaki region	150,000
			IT equipment	1,990
		Maari Ma Health Aboriginal Corporation	Staffing - registered nurse	45,000
		Orana Haven Aboriginal Corporation	Services - staffing (female drug & alcohol worker) and health promotion material	17,718
			Funding for a Substance Abuse service.	9,805
		Walgett Aboriginal Medical Service Co-operative Ltd	Services - staffing (accountant and practice nurse manager including establishment costs)	103,635
		Weimija Aboriginal Corporation	Staffing -female Aboriginal health worker including establishment costs	38,000
	Greater Murray	Griffith Aboriginal Medical Service	Services – staffing (CEO, social & emotional health education officer including establishment costs) and vehicle purchase	95,500
		Riverina Medical and Dental Aboriginal Corporation	Domestic Violence prevention project	80,000
	Hunter	Awabakal Newcastle Aboriginal Co-op	Services – staffing (accountant and registered nurse)	75,000
	Illawarra	Illawarra Aboriginal Medical Service	Services – staffing (assistant finance officer and administrative assistant including establishment costs, and IT support worker)	74,880
			Dapto Clinic operational costs	10,415
			Substance use resources	20,000
		Oolong Aboriginal Corporation Incorporated	Services – staffing (2 x drugs and alcohol workers and executive support officer) and equipment (office)	90,166
		South Coast Medical Service Aboriginal Corporation	Services – staffing (AHW, registered nurse, and transport officer including establishment costs; and accountant), resources (accounting software)	149,721
			Nicotine Therapy program, IT and Training.	57,868
			Capital works	59,506
		Waminda South Coast Womens Health and Welfare Aboriginal Corporation	Office Equipment	8,757

Macquarie	Wellington Aboriginal Corporation Health Service	Services - staffing (accountant, p/t GP, AHW, p/t receptionist & operational costs), and equipment at outreach clinic (clinical and administrative)	377,500
		SEWB regional activities	8,625
Mid North Coast	Benelong's Haven Limited	Capital works (building repairs, maintenance and refurbishment of medical room)	29,213
	Biripi Aboriginal Corporation Medical Centre	Services – staffing (assistant finance officer and GP), and equipment (IT)	109,750
	Durri Aboriginal Corporation Medical Service	Services – staffing (accountant, p/t psychiatrist, medical clerk, mental health worker, receptionists, male AHW at Bowraville & Nambucca, establishment of a mental health team at Bowraville); equipment (IT); business planning and capacity building activities; and HR Consultant at North Coast AMS	513,319
		Capital Works; and security fencing at Bowraville	56,578
Mid Western	Condobolin Aboriginal Medical Service	Services – staffing (finance officer and nurse practitioner including establishment costs), and administrative expenses	121,000
	Weigelli Centre Aboriginal Corporation	Capital works - 4br home	28,800
		Patient transportation and equipment (clinical)	44,373
	Wellington Aboriginal Corporation Health Service	Services - registered nurse	30,000
New England	Armidale and District Services Inc	Services - mental health worker and on-costs	22,750
		Capital works – repairs and maintenance	8,488
	Pius X Aboriginal Corporation	Services - ENT Services, f/t mental health liaison and vocational support officer, GP, registered nurse, ophthalmologist sessions; equipment (ophthalmology, sterilisation, and administrative)	243,888
		Services - establish a new primary health care service (salaries and operational costs) in the Toomelah region	206,701
	Roy Thorne Substance Misuse Rehabilitation Centre	Services – staffing (management support position including one-off costs) and equipment (administrative)	27,555
	Walhallow Aboriginal Corporation	Services – staffing (mental health worker and on-costs) and equipment (administrative)	90,080
Northern Rivers	Bulgarr Ngaru Medical Aboriginal Corporation	Services – staffing (paediatrician, male mental health worker, program manager, IT support including one-off support costs); and equipment (medical)	125,790
	Bundajulung Tribal Society Limited	Services – staffing (finance officer and psychologist to provide clinical	30,520

			supervision at Namatjira Haven)	
		Dharah Gibinj Aboriginal Medical Service Aboriginal Corporation	Services - funding for additional psychology services, staffing (nurse practitioner, sessional GP/Outreach, vascular health registered nurse, receptionist/admin support, IT Support)	178,430
			Capital works	119,846
		North Coast Area Health Service	Services - child & family nurse and male support worker	46,327
	South East Sydney	Aboriginal Health & Medical Research Council of NSW	Services - hepatitis C workforce project officer	94,987
			HIV/AIDS research project	93,201
		Aboriginal Medical Service Co-operative Limited	Services - psychiatry	40,240
		The Health Worker Aboriginal Corporation	IT Equipment	11,850
	South West Sydney	Tharawal Aboriginal Corporation	Services - clinical supervision, GP, social worker, speech therapist; and mental health activities	163,317
	Southern	Katungul Aboriginal Corporation Community and Medical Services	Services – staffing (AHW and executive support officer); and equipment (IT)	88,906
	State wide	Aboriginal Health & Medical Research Council of NSW	Financial Management Training Project	40,000
			Workforce Activities	62,100
		Alliance of NSW Divisions Limited	General Practice Accreditation project for 10 AMS.	100,850
		Linkup NSW Aboriginal Corporation	Staffing (admin support position) and operational expenses	37,756
			Capital works	13,188
	Western Sydney	Daruk Aboriginal Community Controlled Medical Service Co-operative Limited	Accountant	41,578
			NSW Total	**4,716,053**
NT	Central Barkley	Anyinginyi Health Aboriginal Corporation	Development of a Position Paper on Regional Health Services and Development Model for the Central Barkly region.	50,000
	Darwin	NT Dept of Health and Community Services	Services - audiology and podiatry services in the Top End, and staffing (men's health co-ordinator in Luritja-Pintubi zone and nutritionist positions for Eastern Arrernte, Anmatjere, Luritja-Pintubi and Top End West Zones)	387,438
	Katherine East	Wurli Wurlinjang Health Service	Services - childhood immunisation, staffing - increase in nursing staff from 1.5 to 2.0 FTE; equipment (medical)	48,766
			Capital works - clinic	14,080
	Luritja-Pintupi	NT Dept of Health and Community Services	Purchase of a defibrillator; PIRS training; and capital works- clinic and staff housing	94,630

	Pintubi Homelands Health Service	Purchase of medical equipment and defibrillator; PIRS training; and capital works- clinic and staff housing	117,295
	Western Desert Nganampa Walytja Palyantjaku Tjutaku	Patient transportation - renal dialysis patients	80,000
Maningrida	Malabam Health Board Aboriginal Corporation	Services - 2 community health workers to support substance misuse/mental health program, GP and clinic driver	209,273
		Capital works - construction of a shed, installation of air-conditioning, and fit-out of GP accommodation, and construction of a youth and family wellbeing centre	196,000
North East Arnhem	Laynhapuy Homelands Association Incorporated	Medical and administrative equipment	29,350
	Marngarr Community Government Council	Nurse salary and operational costs	73,000
	Marthakal Homelands Resource Centre	Capital works - building extensions	70,000
		Services – p/t GP and purchase of education materials and medical equipment	65,353
NT Wide	St John Ambulance Australia (NT) Inc	First aid training, including first aid kit for participants.	50,000
Pitjantijatjara	Ilpurla Aboriginal Corporation	Increase admin position from 0.5 to 1.0 FTE	18,958

	Imanpa Community Council Incorporated	Capital works – upgrade health professional accommodation	10,000
	Mutitjulu Health Service	Purchase of defibrillator and ambulance	40,655
		Capital works - construction of an ambulance enclosure	13,700
		Staff training initiatives	31,000
	Ngaanyatjarra Pitjantjatjara Yankunytjatjara (NPY) Women's Council Aboriginal Corporation	Purchase of air conditioners and administrative equipment; and Installation of air conditioners for clinic	53,545
	NT Dept of Health and Community Services	Purchase of a defibrillator for the Imanpa Clinic.	22,665
South East Arnhem	NT Dept of Health and Community Services	Services – staffing (chronic disease nurse and administration officer)	88,940
		STI Program	53,854
South East Top End	Angurugu Community Government Council	Services - 0.5 administration position	15,570
		Contribution to community store through SRA	70,000
		Development of Strategic Plan for Substance Use Program	15,000
State wide	Human Service Training Advisory Council	Development of a governance training literacy tool and numeracy & literacy kit for board members of ACCHOs	63,000
	The Synod of the Dioceses of the NT Inc	Support for Indigenous suicide prevention trainers across NT	150,000
Top End West	Katherine West Health Board	Purchase of video otoscope equipment.	56,700

		Department of Health and Community Services	Establish a new primary health care service (salaries and operational costs) in the Wadeye community	813,275
		Miwatj Health Aboriginal Corporation	Regional Planning and Development workshop.	2,000
	Warlpiri	Central Australian Aboriginal Congress Inc	Services – staffing (health service development officer, Aboriginal liaison officer, male health coordinator, remote area nurse)	306,698
		Mt Theo/Yuendumu Substance Misuse Aboriginal Corporation	Services – staffing (health worker for Substance Misuse Program) and vehicle lease for patient transport	56,857
			NT Total	**3,367,602**
QLD	Atherton	Aborigines and Islanders Alcohol Relief Service Limited (AIARS)	Services - 2 x female counsellors	61,833
		Mamu Health Service Limited	Services - 2 x gender specific health workers and receptionist	79,949
		Mulungu Aboriginal Corporation Medical Centre	Services – staffing (2 x AHW to conduct chronic disease activities, nurse practitioner for management of parasitic & infectious disease); operational and administrative activities; training in foot care & diabetes education for health workers; and equipment (medical)	293,909
	Bowen	Girudala Community Coop Society	Services - health worker	32,083
	Brisbane North	Access Arts	Project officer training and equipment (office)	9,360
		Gallang Place Aboriginal And Torres Strait Islander Corp	Senior Counsellor	38,500
		Meeanjin Treatment Association Incorporated	Staffing - administrative support position and cleaner	23,333
		QLD ATSI Corporation for Alcohol & Drug Dependence Services	Services - registered nurse; provision of security services and purchase of air conditioners	112,102
	Brisbane South & East	Aboriginal & Islander Community Health Service Brisbane	IT Support Worker	22,500
		Aboriginal & Torres Strait Islander Corporation for Health Education & Training (ATSICHET)	Capital works including installation of fire escape and wheelchair access	80,000
			Services – staffing (PHC trainer, QA manager/course development coordinator, and student support officer)	83,205
		Inala Wangarra Incorporated	P/t Indigenous men's health and sport development officer	50,000
		Linkup QLD Aboriginal Corporation	Purchase of equipment (IT and office)	67,011
		Meeanjin Treatment Association Incorporated	Capital works including clinic re-location and fit out	160,000
			Services - accountant	25,000
	Bundaberg	Bundaberg and Burnett Region Community Development and Employment Program	Services - 2 x support workers and necessary resources.	150,000

	(BBRCDEP)		
	Yaamba Aboriginal & Torres Strait Islander Corp for Men	Services – accountant , registered nurse salary (session) and administrative equipment	42,506
Cairns	Aborigines and Islanders Alcohol Relief Service Limited (AIARS)	HR Consultant	50,000
	Gindaja Substance Misuse Aboriginal Corporation	Services – staffing (accountant, cleaner, receptionist); and purchase of kitchen equipment	75,000
		Capital works - clinic	40,000
	Gurriny Yeelamuka (Good Healing) Health Services Aboriginal Corporation	Services – staffing (administrative assistant, driver for patient transport, health promotions officer, pharmacy assistant, program manager, upgrade manager position to CEO) and pharmacy locum service	178,382
	Mookai Rosie-Bi-Bayan Aboriginal and Torres Strait Islander Corporation	IT Network and administrative equipment	36,407
	Queensland Aboriginal and Torres Strait Islander Health Worker Education Program Aboriginal Corporation	Services – staffing (compliance officer, curriculum writer) and purchase of IT equipment	84,300
	Wuchopperen Health Service Limited	Services – Staffing (assistant finance officer, IT support worker), administrative salaries and operational expenses; and equipment (medical and IT)	142,374
		Consultant to develop coordinated SEWB program	10,000
		HR Consultant	50,000
Central Highlands	Central QLD Rural Division of GP	Psychologist	15,000
	Regional Planning Forum	Regional planning activities	2,500
Cook	Apunipima Cape York Health Council (ACYHC)	Transition team for reform in Cape York and operational costs	254,000
	Lockhart River	Capital works contribution - SRA	160,000
	Far North Queensland Division of General Practice	Establish a new primary health care service (salaries and operational costs) in the Cape York region	425,419
	Royal Flying Doctor Service	Establish a new primary health care service (salaries and operational costs) in the Cape York region and staffing (counsellor)	443,515
Far South West	Charleville and Western Areas Aboriginal & Torres Strait Islanders Corporation	Services – staffing (GP and administrative assistant)	45,000
	Cunnamulla Aboriginal Corporation for Health	Medical Practitioner	30,000
	OIPC	Youth substance use education and prevention activities	45,000

Gladstone	Nhulundu Wooribah Indigenous Health Organisation Inc	Services – GP salary; equipment - ECG machine, Spirometer, Hemocue and IT; relocation and operational costs	71,237
Gulf	Regional Planning Contractor	Regional Planning activities	80,000
Hinchinbrook	Ferdy's Haven Alcohol Rehabilitation Aboriginal Corporation	Services – staffing (accountant) and administrative equipment	31,888
	Palm Island Aboriginal Council	Health promotion activities	30,000
Ipswich & West Moreton	Kambu Medical Centre Ipswich Incorporated	Services – staffing (Drug and alcohol counsellor, health promotion worker, and p/t driver)	99,167
Johnstone	Mamu Health Service Limited	Purchase of IT equipment	10,000
Mackay	Aboriginal & Islander Community Health Service Mackay	Insurance upgrade, purchase of medical equipment, relocation and operational costs associated with move to new premises	92,397
Mt Isa	Wuchopperen Health Service Limited	Project Officer to assist with service transition	50,000
	Regional Planning Forum	Regional planning activities	6,000
	Yapatjarra Aboriginal and Torres Strait Islander Corporation	Capital works – security, upgrade of air conditioning unit and maintenance of medical centre building	65,915
North West Darling Downs	Darling Downs Shared Care Inc	Staffing (administrative assistant) and relocation and operational costs associated with move to new premises	86,000
Rockhampton	Bidgerdii Aboriginal and Torres Strait Islander Corporation	Staffing - GP salary	58,333
	Gumbi-Gumbi Aboriginal & Torres Strait Islanders Corporation	Services – staffing (drug and alcohol counsellor, accountant, trainee counsellor/therapy assistant); training and equipment (IT)	98,841
		Capital works – fit out of premises	41,200
	Milbi Incorporated	Services – staffing (administrative assistant, accountant, developmental officer)	53,198
Sarina	Mudth-Niyleta Aboriginal & Torres Strait Islander Corporation	Capital works - building extensions	150,000
		Purchase of equipment (medical and office)	40,000
South Burnett	Barambah Regional Medical Service	Staffing – AHW and expansion of female GP service	35,024
	Consultant	Regional planning activities	40,000
	Wunjuada Aboriginal Corporation for Alcoholism & Drug Dependence Service	Drug and alcohol community outreach program	35,000
		Staffing - Accountant	25,000
South Coast & Hinterland	Kalwun Health Service	Relocation/operational costs associated with move to new premises and purchase of medical equipment	29,895

		Krurungal Aboriginal and Torres Strait Islander Corporation for Welfare Rescue and Housing	Services – staffing (female drug and alcohol worker, accountant); purchase of clinical equipment; and relocation and operational costs associated with move to new premises	68,417
	State wide	Contractor	Implementation of recommendations from the National Sexual Health and Blood Borne Virus Strategy	50,000
		OIPC	Contribution to healing centre and health promotion activities - SRA	100,000

		Queensland Aboriginal and Islander Health Council	Staffing (finance officer); finance workshop for ACCHOs and regional planning activities	571,916
		Queensland Health	Development of a state wide monitoring and reporting tool for regional plans	25,000
	Sunshine Coast & Cooloola	North Coast Aboriginal Corporation for Community Health	Staffing (Indigenous project officer) and expansion of brokerage model	56,616
	Toowoomba	Darling Downs Shared Care Inc	Medical equipment	11,650
	Torres	Northern Peninsula Area Women's Health Shelter	Services (family planning educator) and vehicle lease	38,792
		Queensland Health	Services - AHW for chronic disease and mobile health team to provide outreach primary health care services	269,101
	Townsville	Congress Community Development & Education Unit Ltd	Staff training, purchase of accounting skills and administrative equipment	3,439
		Ferdy's Haven Alcohol Rehabilitation Aboriginal Corporation	Services – staffing (registered nurse & AHW including establishment costs) and salaries associated with expansion of 24/7 counselling service	280,152
		Townsville Aboriginal & Islander Health Services (TAIHS)	Business planning and staff training activities	40,000
			Continuation of Mum's & Bubs program	84,583
			QLD Total	**6,246,949**
SA	Eyre	Mid North Regional Health Service Inc	Capital works	26,000
		Port Lincoln Aboriginal Health Service	Services – staffing (clinical coordinator and driver); vehicle, equipment (IT and office)	106,334
	Hills Mallee Southern	Hills Mallee Southern Regional Health Service	Services - counselling and staffing (social worker)	24,229
	North	Flinders & Far North Division of General Practive	Staffing - Aboriginal Health Worker	63,051
	Northern & Far Western	Flinders & Far North Division of General Practive	IT, administrative equipment and vehicle leasing	17,832
		Nganampa Health Council Inc	GP salary	45,000
		Pika Wiya Health Service Inc	Patient transportation - vehicle	65,000
			Minor capital - upgrade security & conversion for podiatry area	35,000
		Umoona Tjutagku Health Service (UTHS)	Patient transportation	65,000
			Women's Substance Use Worker	35,000
	South East	Pangula Mannamurna	Medical equipment	47,886
	State wide	Aboriginal Health Council of South Australia	Staffing (project officer) and promotional material, IT support and training	87,500
			SA Total	**617,832**

TAS	Northern	Cape Barren Island Aboriginal Association Inc	Asset maintenance and educational & promotional resources	5,000
		Flinders Island Aboriginal Association Incorporated	Part time bookkeeper	9,360
		South East Tasmanian Aboriginal Corporation	Asset Maintenance	22,770
		Tasmanian Aboriginal Centre Incorporated	Substance use health promotion and research activities	30,000

	Northern Western	Mersey Leven Aboriginal Corporation	Services – staffing (administrative support, mental health worker); chronic disease education & prevention activities and educational resources	76,000
		Tasmanian Aboriginal Centre Incorporated	Aboriginal Health Workers	100,000
	Southern	South East Tasmanian Aboriginal Corporation	Services – staffing (practice manager, cleaner, medical receptionist); vehicle lease; educational resources and health forums	57,182
			TAS Total	**300,312**
VIC	Barwon South West	Kirrae Health Service Inc	Increased operational & overhead costs related to capital works activities	12,500
	Gippsland	Lake Tyers Health & Children Services Association Inc	Increased operational costs due to capital works activities	12,500
		Moogji Aboriginal Council East Gippsland Inc	Increased operational costs due to capital works activities and insurance requirements	25,000
	Grampians	Goolum Goolum Aboriginal Co-Operative	Increased operational & overhead costs related to capital works activities	12,500
	Loddon Mallee	Cummeragunja Housing and Development Aboriginal Corporation	Insurance requirements	12,500
		Mildura Aboriginal Corporation (MAC)	Capital works - office extension	80,000
		Murray Valley Aboriginal Corporation - Robinvale	Capital works - office extension	80,000
	Metropolitan	Ngwala Willumbong Cooperative Limited	Office equipment	55,596
		Victorian Aboriginal Health Service Co-operative Ltd	Business planning activities and purchase of medical and office equipment	210,000
		Yarra Valley Community Health Service	Staffing - project officer to assist in the transition to an ACCHO	57,404
			VIC Total	**558,000**
WA	Goldfields	Ngunytju Tjitji Pirni	Purchase of medical equipment	8,500
		Paupiyala Tjarutja Aboriginal Corporation	Purchase of medical equipment	105,199
	Great Southern	Great Southern Division of General Practice Ltd	Antenatal care program	68,036
			Relocation costs associated with move to new premises	50,000
	Kimberley	Derby Aboriginal Health Service Council (DAHS)	Increased operational costs related to capital works activities	150,000
		Jungarni-Jutiya Alcohol Action Council Aboriginal Council of Halls Creek	Replacement of air conditioners	20,909
		Kimberley Aboriginal Medical Service Council Inc	Capital works - Bidyadanga - house fit out and furnishings and installation of generator	38,751
			Services – staffing (sexual health worker, Indigenous health training coordinator); and regional workshop	175,240

		Child health promotion materials	20,441
		Regional mental health planning	60,000
	Milliya Rumurra Aboriginal Corporation	Best practice standards compliance project and purchase of vehicle	169,545
	Ngnowar-Aerwah Aboriginal Corporation	Mental health support program	40,000
	Palyalatju Maparnpa Corporation Health Committee	Operational and administrative expenses	127,500
	Western Australian Country Health Service	Maternal and child health services	70,807

		Yuri Yungi Medical Service Aboriginal Corporation	Purchase of IT equipment	19,085
	Midwest	Carnarvon Medical Service Aboriginal Corporation	Nurse – operational costs	5,000
		Geraldton Regional Aboriginal Medical Service	Services - antenatal service and purchase of medical equipment	66,000
			Increased operational costs due to capital works activities	25,000
	South East Metro	Canning Division of General Practice	Staffing - AHW and coordinator; staff training; and operational and administrative expenses	56,234
	South West Metro	Aboriginal Health Council of Western Australia (AHCWA)	Management support & sevelopment program, administrative program, sector workshop	396,026
		Marr Mooditj Foundation Incorporated	For the development of the WA Aboriginal & Torres Strait Islander Health Worker Association constitution.	10,000
		Peel Community Development Group Incorporated	Equipment and minor capital renovations	52,892
		Peel Development Commission	Staffing - administrative officer	27,141
		Peel/South West Division of General Practice Ltd	Aboriginal Health Link project	91,000
		South Coastal Women's Health Services Association Inc	Indigenous health access program	222,961
	State wide	National Heart Foundation of Australia Western Australia Division	Project officer to develop and implement health promotion and education material on heart disease and other related chronic disease for WA	16,250
		SIDS and Kids Western Australia Inc	Development and training resources for SIDS in WA	37,750
		Western Australian Network of Alcohol and Other Drug Agencies (WANADA)	Develop an alcohol and other drugs network for Aboriginal and Torres Strait Islander staff	10,000
	Wheatbelt	Western Australia Country Health Services	Establish a new primary health care service (salaries and operational costs) in the Wheatbelt region	$1,519,490
			WA Total	**3,658,757**
Grand Total				**19,745,505**

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2006-2007, 31 May-1 June 2006

Question: E06-188

OUTCOME 8: Indigenous Health

Topic: IMPROVED PRIMARY HEALTH CARE INITIATIVE (IPHCI)

Hansard Page: CA54

Senator Crossin asked:

(a) What percentage of administered on-costs would the Northern Territory be keeping in administering those funds? (the $11.583m in Wadeye)
(b) Can you tell me how much the state and territory governments are taking out for administrative on-costs for the Indigenous health initiative?

Answer:

(a) The Northern Territory Government is not keeping any administered on-costs from the primary health care funds for Wadeye.

(b) The Department is currently negotiating with the Western Australian Government over any administration cost relating to the primary health care funds for Wheatbelt region.

In Toomelah, New South Wales and Cape York, Queensland, services are provided by non-government organisations and not the State Governments.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2006-2007, 31 May-1 June 2006

Question: E06-190

OUTCOME 8: Indigenous Health

Topic: INDIGENOUS HEALTH

Hansard Page: CA56

Senator Crossin asked:

How many shared responsibility agreements with Indigenous communities have included any eye health measures?

Answer:

To date, the Department's engagement with Shared Responsibility Agreements (SRAs) has not included any specific eye health measures. However, SRAs negotiated with Aboriginal and Torres Strait Islander communities by other Australian Government Departments may include measures relating to eye health.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2006-2007, 31 May-1 June 2006

Question: E06-185

OUTCOME 8: Indigenous Health

Topic: Indigenous Health

Hansard Page: CA45

Senator Moore asked:

Can I have a list of all the state government expenditure in that trial?

Answer:

The Department of Health and Ageing has requested this information and will provide it once it is available.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2006-2007, 31 May-1 June 2006

Updated Question: E06-185

OUTCOME 8: Indigenous Health

Topic: INDIGENOUS HEALTH

Hansard Page: CA 45

Senator Moore asked:

Can I have a list of all the state government expenditure in that trial?

Answer:

The South Australian Government has provided the attached table of State Government indicative funding levels for Anangu Pitjantjatjara Yankunytjatjara (APY) Lands.

STATE GOVERNMENT FUNDING – APY LANDS - 2006-07*

PORTFOLIO	Recurrent	Capital
	$	$
Department for Families and Communities	3,404,000	
Department of Health	1,770,000	
Department of Justice	4,132,000	1,000,000
Primary Industries and Resources SA	250,000	
Department of Environment and Heritage	125,000	
Department of Administration and Information Services	330,000	750,000
Department of Further Education, Employment, Science and Technology	1,371,000	62,000
Department of Transport	38,000	
Department of Education and Children's Services	10,724,000	
Department of the Premier and Cabinet	3,747,000	522,000
Task force funding	5,140,000	
TOTAL	**31,031,000**	**2,334,000**

*These figures are indicative – they are based on budget information provided by agencies in 2004 for proposed expenditure in 2006-07.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2006-2007, 31 May-1 June 2006

Question: E06-057

OUTCOME 8: Indigenous Health

Topic: PETROL SNIFFING

Senator Evans asked:

How much in total is now allocated to the Petrol Sniffing Prevention Program for 2006-07 and the out-years, following the announcement of additional funding in the budget?

How will the communities to be included in the further roll-out announced in the budget be determined?

Will there be any additional petrol stations carrying *Opal* in Alice Springs?

Answer:

Funding breakdown for the Petrol Sniffing Prevention Program for 2006-07 to 2009-10 is as follows:

- 2006-07 $9.7 million
- 2007-08 $7.9 million
- 2008-09 $8.3 million
- 2009-10 $8.5 million

Individual communities will be included through the Department identifying a community that has a petrol sniffing problem (often through talking to local police) and then approaching them to ascertain if they wish to access *Opal* fuel, or alternatively (and more commonly) a community approaching us and requesting that they be permitted to join the Program. Approaches from communities can occur through their engagement with their Indigenous Coordination Centre, our State and Territory offices or an approach direct to central office in Canberra.

The two regions to be introduced under the new Budget measure will be selected following an examination of available data regarding the prevalence of petrol sniffing and consideration of the feasibility of blanket coverage. These areas will need to be negotiated with relevant Australian Government agencies, including the office of OIPC and with the relevant State or Territory Government to ensure their commitment to a proposed regional rollout.

A commitment of up to $12 million over the next four years has been announced to replace all regular unleaded fuel in Alice Springs with *Opal* fuel in all petrol stations in that area. This is in addition to the Program funding set out above.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2006-2007, 31 May-1 June 2006

Question: E06-191

OUTCOME 8: Indigenous Health

Topic: INDIGENOUS HEALTH

Hansard Page: CA 60 – 1 June

Senator McLucas asked:

What percentage of total DoHA spending on Indigenous health is the DoHA allocation of $16.3m to the shared responsibility agreements?

Answer:

The Department of Health and Ageing is required to allocate a minimum of $16.3 million over the next four years for Shared Responsibility Agreements. Funds set aside in 2006-07 represent 0.84% of the total amount of funds allocated by the department for spending on Indigenous health in 2006-07.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2006-2007, 31 May - 1 June 2006

Question: E06-205

OUTCOME 9: Private Health

Topic: PRIVATE HEALTH INSURANCE

Hansard Page: CA 110

Senator Moore asked:

Do you have any data about the average out-of-pocket cost for privately insured patients by episode and speciality?

Answer:

The Private Health Insurance Administration Council (PHIAC) is developing a collection of out-of-pocket data by speciality. At the present time, the collection is still undergoing quality control and testing. When PHIAC is satisfied that the information is as accurate as possible, we will publish the information.

PHIAC currently collects out-of-pocket data in total and publishes this information on a Quarterly basis in a publication called Quarterly Gap Payment and Medical Benefit Statistics. Copies of that publication, which is also available from PHIAC's web-site are enclosed.

http://www.phiac.gov.au/statistics/index.htm

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2006-2007, 31 May - 1 June 2006

Question: E06-136

OUTCOME 9: Private Health

Topic: MEDIBANK PRIVATE

Written Question on Notice

Senator McLucas asked:

With references to answers provided at the Estimates hearing on 31 May and in particular p. CA 119, please provide the following details with regard to the "privatisation team".

a. How many Medibank staff are involved in this 'team' since the announcement of the sale?
b. Who are they and what is their position?
c. Are any Board members involved?
d. Are there any external parties or people involved, for example PR firms?
e. Is this 'team' looking at ways to manage public perceptions about the sale of the fund, including member retention?
f. How many Medibank staff were involved in this 'team' before the announcement of the sale?
g. Who are they and what is their position?
h. Are any Board members involved?
i. Are there any external parties or people involved, for example PR firms?
j. Has Medibank undertaken its own polling of members or the broader community or is it planning to do any polling or market research to examine the possible negative impacts on its brand?

Answer:

a. Two staff members from the Corporate Strategy and Communication division have been working on issues to do with the sale of Medibank Private since the Australian Government's announcement of 26 April 2006. Since the appointment of the government business and legal advisors on 13 July 2006, up to another twelve Medibank Private staff have been involved in an internal project team.
b. In addition to a Privatisation Project Manager and Assistant Privatisation Project Manager, the project team consists of representatives from across other relevant areas of the business.
c. No.
d. Medibank Private has sought specialist legal advice from Minter Ellison Lawyers on sale related obligations.
e. No.
f. None.
g. Not applicable.

h. No.
i. No.
j. As part of Medibank Private's business as usual a brand value index assessment is undertaken each quarter.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2006-2007, 31 May - 1 June 2006

Question: E06-137

OUTCOME 9: Private Health

Topic: PRIVATE HEALTH INSURANCE CHANGES

Written Question on Notice

Senator McLucas asked:

With regard to Prive Health Insurance changes announced on 26 April the associated fact sheet announces that the "current boundary between ancillary and hospital insurance" will be effectively removed..

a) How does Medibank expect this will affect their business?
b) How will Medibank determine which services their cover under this broader cover measure?
c) How will Medibank seek to contain potential increases in costs due to broader scope of coverage and range of services covered?

Answer:

a) The legislation for this reform is still in the drafting process. Medibank Private is involved in industry consultation as part of this. Given there is no finalised legislation, it is too early to comment on any changes to services.

   Medibank Private would expect the introduction of substitutive and preventative hospital services to take costs out of the system and therefore take pressure off premium rises.

b) Given there is no finalised legislation, it is too early to comment on any changes to services.

c) Medibank Private is supportive of moves by Government to allow health funds to be able to offer members greater access to a broader range of health services, including preventative health care and services that substitute for acute hospital care.

   Medibank Private is working closely with the Government, and industry, to further strengthen the value and offering of private health insurance, including taking pressure off premium rises.

Given there is no finalised legislation, it is too early to hypothesise about containing potential increases due to a broader scope of coverage and range of services covered. However, Medibank Private would expect the introduction of substitutive and preventative hospital services to take costs out of the system and therefore take pressure off premium rises.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2006-2007, 31 May - 1 June 2006

Question: E06-138

OUTCOME 9: Private Health

Topic: POLICY CHANGE

Written Question on Notice

Senator McLucas asked:

The fact sheet attached to the policy says that this policy change "should have no impact on premiums".

a) Has Medibank done any work on the potential impact of these changes on the company's premiums?
b) Under what circumstances could Medibank expect this policy to have a downward effect on premiums?
c) Is it possible that increasing the scope of cover will see premiums rise?
d) How will Medibank manage this, what sort of strategies would be to control already rising health costs?
e) Does it see an opportunity to become a more direct purchaser/provider of health services?

Answer:

a) The legislation is still being drafted and therefore Medibank Private has done no financial modelling and is unable to comment on the potential impact the proposed changes may have on premiums. However, Medibank Private would expect the introduction of substitutive and preventative hospital services to take costs out of the system and therefore take pressure off premium rises.
b) Medibank Private would expect that this policy, through a greater potential to include preventative care, substitutive care and best practice clinical pathways, to not only improve quality of life, but to take pressure off costs through better contracting and process efficiencies and therefore put downward pressure on premium rises.
c) The legislation is still being drafted and therefore Medibank Private has done no financial modelling and is unable to comment on the potential impact the proposed changes may have on premiums. However, Medibank Private would expect the introduction of substitutive and preventative hospital services to take costs out of the system and therefore take pressure off premium rises.
d) Medibank Private has made a commitment to continue to put downward pressure on premium rises. There have already been a number of initiatives implemented to be able to deliver on this commitment – initiatives that will drive change, and lower the cost base. These include the Hospital Purchasing Strategy, wellbeing program and workplace health program. These would be expected to continue.

e) Medibank Private is currently a direct purchaser of health services through its hospital contracting, preferred provider ancillary network and gapcover scheme. Medibank Private anticipates these would continue as well as the opportunity to contract with 'out-of-hospital' services.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2006-2007, 31 May - 1 June 2006

Question: E06-139

OUTCOME 9: Private Health

Topic: ADVERTISING

Written Question on Notice

Senator McLucas asked:

How much does Medibank currently spend on advertising?

a) Can you tell me the costs for each type of media and what is the split in cost between production and placement costs?
b) What companies has Medibank engaged in the past to do this sort thing? Can you provide me with a list since 2000?

Answer:

a) Other than the AC Nielsen figures set out below, further breakdown of costs cannot be disclosed, as Medibank Private would compromise its commercial position.

Metropolitan TV	$5.7 million
Regional TV	$0.8 million
Metropolitan Press	$0.8 million
Regional Press	$0.1 million
Magazines	$0.4 million
Radio	$1.3 million
Cinema	$0.2 million
Outdoor	$0.4 million
Direct Mail	$0.4 million

b) Medibank Private's agency of record is DNA Agency Network Limited, a subsidiary of

M&C Saatchi.

Medibank Private's major media buyer is MPG, a subsidiary of Mitchell & Partners.

Medibank Private utilises a range of smaller providers as required to support various tactical marketing activities.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 31 May & 1 June 2006

Questions: E06-146

OUTCOME 9: Private Health

Topic: PRIVATE HEALTH INSURANCE OMBUDSMAN (PHIO)

Written Question on Notice

Senator McLucas asked:

(a) What effect will the extended powers in the bill before parliament and the changes as announced by the Minister on 26 April 2006 have on PHIO's operations?

i. What impact will it have on staffing levels?

ii. How will the extension of powers to examine brokers and providers work?

iii. How will the ombudsman be empowered to deal with disputes?

(b) How was the PHIO involved with formulating this policy, for example, did you request these extra powers?

(c) Can you give us an example of the sorts of cases the ombudsman has had to deal with in the past which led to this policy?

(d) Does the PHIO envisage greater demand for your services?

(e) Are there sufficient resources to meet this extra demand?

(f) With regard to the PHIO's new website, how much will this cost and what will these changes mean in practice, ie how will it benefit consumers?

i. Will this job be tendered out?

ii. How much will this cost?

iii. What will the website feature once it's all finished?

iv. When will this new site be delivered?

(g)Finally, on complaints, has the PHIO received complaints about the sale of Medibank?

i. What is the number of complaints received regarding Medibank, the future sale, and its potential impact on premiums?

ii. How does it respond to these complaints?

iii. Does the ombudsman have any concerns about the possible negative impacts of the sale on consumers?

iv. Does the ombudsman have any concerns about the possible negative impacts of the sale on the structure of the industry and the potential to reduce the number of large funds in the market?

Answer:

a) The extended powers will expand the Ombudsman's jurisdiction to deal with complaints by and about a wider range of private health providers and professionals, as well as increase the use of the PHIO's mediation role in contract negotiations between health funds and providers. In addition, the new object provision of the legislation makes it clear that the focus of PHIO activities is on consumer protection.

i) It is expected the extended powers will require an increase in PHIO's current staffing levels of around one ASL during 2006-07.

ii) The PHIO's standard processes for dealing with complaints about health funds, doctors and hospitals will be extended to encompass brokers and ancillary providers. Complaints against health service providers and brokers can only be dealt with if the complaint is made by an insured person or a health fund, or if the complaint is also against a health fund. The complaint must be about or connected with a health insurance arrangement and should involve the interests of insured persons.

Where the complainant has not made a sufficient attempt to resolve their complaint with the service provider, the Ombudsman will refer them back to these parties in the first instance.

Where complaints are complex or where formal contact with the service provider has failed to resolve the problem, the Ombudsman will write to the service provider or broker seeking further information. The Ombudsman will then have the option of closing the complaint at that point, investigating it further or mediating between the parties to achieve a resolution of the complaint.

(iii)The extension of the Ombudsman's powers will apply to the following areas:

- expansion of persons/bodies about which the PHIO may conduct investigations of procedures and practices;
- expansion of information gathering powers to all subjects of complaints and investigations;
- expansion of reporting/recommendation powers; and
- introduction of compulsory mediation, where directed by the PHIO.

The extension of the Ombudsman's powers in these areas will give the Ombudsman greater powers to investigate and resolve disputes in relation to a wider range of providers and issues.

b) The current and previous Ombudsman have identified and reported on ways to improve the PHIO's ability to deal with complaints and assist consumers on a number of occasions in recent years. This has included drawing attention to gaps in the Ombudsman's jurisdiction which

constrain the Ombudsman from dealing with complaints about and from some health service providers and brokers.

The Ombudsman was closely involved in the consultation process in relation to the new powers.

c) From time to time, complainants have approached the Ombudsman with complaints that did not fall within the Ombudsman's jurisdiction. Examples include complaints about ancillary service providers and health insurance brokers.

In some cases, the Ombudsman was able to assist the complainant, with the co-operation of the service provider on an informal "goodwill" basis. On other occasions, the lack of formal jurisdictional power meant the Ombudsman was unable to deal with the matter. The extension of the PHIO's powers ensures the PHIO is now able to deal with these matters.

d) Yes. It is expected that the expansion powers in relation to who can complain to the Ombudsman and about whom they can complain will lead to an increase in complaints to the office.

e) Yes. The Government has provided additional funding of $200,000 per annum via PHIO's industry levy from 2006-07 to meet any increased demand and the cost of obtaining additional professional mediation services.

f) The Government has allocated one-off start-up funding of $1.4 million in 2006-07 to develop the new web site. Ongoing hosting and maintenance and operation of the web site will be funded via PHIO's industry levy from 2007-08. The cost of this will be $562,000 per annum from 2007-08.

The new web site will contribute to consumer empowerment and competitiveness within the private health insurance market by improving the quality and accessibility of consumer information on private health insurance products.

i) Yes. The Ombudsman has engaged a consultant to provide procurement advice and services for the selection of a provider to develop and implement the new web site. A formal Request for Tender was released on 24 July 2006. Tenders close on 18 August 2006.

ii) We are unable to provide this information as tenders for the development of the web site have not yet been received.

iii) The web site will provide general information on private health insurance and comparative information on the full range of health insurance products available to Australian consumers.

iv) The web site will be operational on 1 April 2007.

g) No.

i) None. Since the announcement of the sale of Medibank Private on 26 April 2006, the Ombudsman has received one enquiry about this issue.

ii) It would depend on the nature of the complaint or enquiry. As indicated above, the Ombudsman has not received any complaints about this issue to date.

iii) The Government has stated that one of its objectives for the sale of Medibank Private is to maintain service and quality levels for Medibank contributors, including in regional and rural Australia. The Ombudsman will be monitoring the sale process and any complaints to the office to help ensure this objective is met.

iv) No. The Ombudsman's key role is to protect the interests of people who are covered by private health insurance, regardless of the size of their fund. The level of service provided by a fund to its members does not necessarily equate to its size. The Government has stated that one of its objectives for the sale of Medibank is to contribute to an efficient, competitive and viable private health industry and the Ombudsman is supportive of this aim.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2006-2007, 31 May - 1 June 2006

Question: E06-229

OUTCOME 9: Private Health

Topic: MEDIBANK PRIVATE

Hansard Page: CA 119 – 31 May

Senator Moore asked:

What is the title of the team that liaises with DoFA?
Is it the same team that has been working to date as the scoping study has been being scoped?

Answer:

There is no title. Staff members from the Corporate Strategy and Communication division have been working on issues to do with the sale of Medibank Private.

The scoping study was completed last year and the staff working on this returned to their previous roles once the study was completed.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2006-2007, 31 May - 1 June 2006

Question: E06-230

OUTCOME 9: Private Health

Topic: MEDIBANK PRIVATE

Hansard Page: CA 120 – 31 May

Senator Moore asked:

Have you had complaints from your members, through your standard complaint process, about Medibank Private being sold? Can you give us numbers?

Answer:

Medibank Private received 954 enquiries regarding privatisation in the period between 1 March 2006 and 16 June 2006. Of these, less than 3% were classified as complaints by Medibank Private's Customer Service Officers.

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2006-2007, 31 May - 1 June 2006

Question: E06-231

OUTCOME 9: Private Health

Topic: MEDIBANK PRIVATE

Hansard Page: CA 120 – 31 May

Senator Moore asked:

Has Medibank itself done any kind of information-seeking from its members about how they feel about the sale?
Have you had or are planning any process to inform your members?

Answer:

Medibank Private is continuously seeking information from members, whether it be through comprehensive retail centre and customer contact line feedback, membership enquiries or customer surveys.

At the end of the financial year, Medibank Private sends out an annual tax statement. The accompanying letter will refer members to the customer contact line and Medibank Private web site for more information.

The line to be included in the letter is:

> "With the Federal Government's recent announcement to sell Medibank Private, we understand that some members may have questions. That is why we have set up a section of the web site with frequently updated information. So if you ever have any questions you can visit www.medibank.com.au/privatisation, or just call us on 132 331."

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2006-2007, 31 May - 1 June 2006

Question: E06-232

OUTCOME 9: Private Health

Topic: MEDIBANK PRIVATE

Hansard Page: CA 121 – 31 May

Senator Moore asked:

What is your current budget for advertising? Can I get the actual figures on notice?

What about PR? Does that come into the same budget as advertising? Do you have a separate line item for PR? And can I get information on that as well?

Answer:

ACNielsen currently tracks Medibank Private's advertising expenditure at $10.1 million. Further details of Medibank Private's marketing activity and associated costs are commercial in confidence and cannot be disclosed, as it would compromise its commercial position.

There is no separate line item for PR. However PR activities as a result of normal operations, such as product launches, program launches and sponsorships, are funded out of a combination of one or more operational marketing, corporate development and sponsorship expenditures.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2006-2007, 31 May - 1 June 2006

Question: E06-233

OUTCOME 9: Private Health

Topic: MEDIBANK PRIVATE

Hansard Page: CA 121 – 31 May

Senator Moore asked:

I know the decision is quite recent, but I am fascinated by there being no thought given to the impact on your membership base, specifically, of the public decision that now it is going to be sold. I would have thought that was a threshold issue, almost like any kind of major structural change. Is it that that has not been considered yet?
You are telling me it is part of the planning?

Answer:

The issues of the sale have been considered in the forward planning process. This includes ensuring that members and employees are communicated with, to reinforce that it is business as usual for the organisation.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2006-2007, 31 May - 1 June 2006

Question: E06-234

OUTCOME 9: Private Health

Topic: MEDIBANK PRIVATE

Hansard Page: CA 122 – 31 May

Senator Moore asked:

As a member of Medibank Private, when can I expect to get something from the organisation telling me what is happening with my private health insurance company?

Answer:

Medibank Private has provided information on the web site, in retail centres and through the customer contact line.

At the end of the financial year, Medibank Private sends out an annual tax statement. The accompanying letter will refer members to the customer contact line and Medibank Private web site for more information.

The line to be included in the letter is:

> "With the Federal Government's recent announcement to sell Medibank Private, we understand that some members may have questions. That is why we have set up a section of the web site with frequently updated information. So if you ever have any questions you can visit www.medibank.com.au/privatisation, or just call us on 132 331."

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2006-2007, 31 May - 1 June 2006

Question: E06-235

OUTCOME 9: Private Health

Topic: MEDIBANK PRIVATE

Hansard Page: CA 122 – 31 May

Senator Moore asked:

In terms of your brand and PR, Medibank Private is an established brand. Is there any process in place in terms of protecting your brand in the market?

Answer:

Medibank Private regards its entire marketing calendar of activity to be designed to develop and invest in its brand. Medibank Private has and will always continue a rigorous program of brand development and maintenance across all state markets, and this is scheduled to continue, irrespective of the sale process.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2006-2007, 31 May - 1 June 2006

Question: E06-117

OUTCOME 10: Health System Capacity and Quality

Topic: MENTORING SYSTEM IN REGIONAL AND RURAL HOSPITALS

Written Question on Notice

Senator McLucas asked:

The Question to Question on Notice 1299 says that State and Territory Health Departments were invited to submit proposals in late 2005, and following assessments, 20 grants totalling $4 million are being finalised.

a) Were submissions received from all states and Territories?
b) Have the grants been finalised and made?
c) Can we have a list of successful grants with funding levels?

Answer:

a) Submissions were received from all states and territories except the Australian Capital Territory.

b) No.

c) The grants have not yet been finalised.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2006-2007, 31 May - 1 June 2006

Question: E06-129

OUTCOME 10: Health System Capacity and Quality

Topic: ADDITIONAL EDUCATION PLACES FOR MENTAL HEALTH

Written Question on Notice

Senator McLucas asked:

a) Could we have a breakdown of how health funding will be spent on mental health nurses and clinical psychologists?

b) Why are new clinical psychology positions only provided in 2007 and 2008?

c) How will the full time and part time post graduate scholarships be divided between nurses and clinical psychologists?

Answer:

a) It is not possible at this time to provide a comprehensive breakdown of funding as it has not yet been determined.

b) 200 first year postgraduate places in clinical psychology will commence annually from the beginning of the 2007 academic year and represent an ongoing commitment thereafter.

c) This has not yet been determined.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2006-2007, 31 May - 1 June 2006

Question: E06-123

OUTCOME 10: Health System Capacity and Quality

Topic: AUSTRALIAN COMMISSION ON HEALTH AND SAFETY

Written Question on Notice

Senator McLucas asked:

a) What was the funding breakdown for the last 4 years for the Australian Council for Health Care Quality and Safety?

b) What funding will be provided by the States and Territories?

Answer:

(a & b)
The Australian Council for Safety and Quality in Health Care was funded by the Australian Government providing 50% and the states and territories providing 50% shared on the basis of population (AHMAC funding formula). The table below is the breakdown of funding received by the Council.

State/ year	Total
ACT	447,732
CTH	27,500,000
NSW	9,279,375
NT	279,555
QLD	5,150,845
SA	2,138,417
TAS	669,068
VIC	6,831,575
WA	2,702,414
Grand Total	54,998,981

Health Ministers have agreed that an amount equivalent to each jurisdiction's contribution for 2005-06 will be provided to fund the first year of operation of the Commission.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2006-2007, 31 May - 1 June 2006

Question: E06-116

OUTCOME 10: Health System Capacity and Quality

Topic: E-HEALTH

Written Question on Notice

Senator McLucas asked:

a) Please provide a full list of funds committed to HealthConnect since 2001.
b) Of the funds allocated in 2004 through to July 2007, how much has been spent?
c) How much in Health*Connect* funds have gone to NEHTA?
d) Have any 2006-07 Health*Connect* funds been earmarked for NEHTA?
e) Aside from the 2006-07 Budget commitment, what additional funds has the Department contributed to NEHTA?
f) Have other Commonwealth departments also contributed?
g) What have the States and Territories contributed?
h) What is the current purpose of the HealthConnect projects?

Answer:

a) Administered Funds Committed to an E-Health Information Network (2001 to 2002-03) and E-Health Implementation (2004 to 2006-07)

2001-02 $	**2002-03 $**	**2003-04 $**	**2005-06 $**	**2006-07 $**
8,300,000	7,500,000	2,500,000	24,777,000	22,370,000

b) E-Health Implementation: Administered Expenditure from 2004-05 to July 2007

2004-05 $	**2005-06 $** (as at 30 April 2006)	**2006-07 $**
24,777,007	10,072,554	N/A

c) In 2005-06, $5.516 million from eHealth Implementation Administered funds was made to the National E-Health Transition Authority (NEHTA).

Detail	Amount $
Base Level Funding	3,900,000
Shared Electronic Health Record (SEHR)	1,057,000
Australian Catalogue of Medicine (ACOM)	559,000
Total	5,516,000

d) Yes - $2.8 million based on the Australian Health Ministers' Advisory Council (AHMAC) cost sharing formula (which is a 50% contribution by the Commonwealth and 50% by the states and territories), plus $731,000 for SEHR and $559,000 for ACOM.

e) The Department has not identified any additional funds for NEHTA.

f) None known.

g) In 2005-06, funding of $3.9 million was contributed by the states and territories for NEHTA Limited, based on the AHMAC cost sharing formula outlined above.

h) Health*Connect* is part of a national electronic health strategy that encourages the use of information technology to improve the quality, safety and efficiency of health care services in Australia.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2006-2007, 31 May - 1 June 2006

Question: E06-113

OUTCOME 10: Health System Capacity and Quality

Topic: MORE DOCTORS FOR OUTER METROPOLITAN AREAS

Written Question on Notice & p.CA118 1 June 2006

Senator McLucas asked:

a) Please provide the actual expenditure for each financial year for the More Doctors in Outer Metropolitan Areas program since its introduction in 2002.

b) Please break this annual expenditure down by:

i. Training placements for GPs
ii. Training placements for specialists
iii. Relocation incentives for VR GPs to established practices
iv. Relocation incentives for VR GPs to new practices
v. location incentives for non-VR GPs to established practices
vi. Relocation incentives for non-VR GPs to new practices
vii. Relocation incentives for specialists to established practices
viii. Relocation incentives for specialists to new practices

c) How many doctors (and how many FTE doctors) have moved to outer areas as a result of:

i. Training placements for GPs
ii. Training placements for specialists
iii. Relocation incentives for VR GPs to established practices
iv. Relocation incentives for VR GPs to new practices
v. Relocation incentives for non-VR GPs to established practicesRelocation incentives for non-VR GPs to new practices
vii. Relocation incentives for specialists to established practices
viii. Relocation incentives for specialists to new practices

Answer:

a) The actual expenditure for each financial year for the More Doctors for Outer Metropolitan Areas Measure program since its introduction in 2002 is provided in the table below:

2002/03	2003/04	2004/05	2005/06	Total
5,100,000	8,500,000	8,000,000	Not available at this time	21,600,000

b) (i - viii)The breakdown of the annual expenditure is available for the outer metropolitan training placements for GP Registrars, and for the combined outer metropolitan relocation, retention and specialist trainees programs. This breakdown is provided in the table below:

	2002/03	2003/04	2004/05	2005/06	Total
GP Registrars	1,200,000	2,800,000	2,200,000	Not Available	6,200,000
Relocation, Retention and Specialist Trainees	3,900,000	5,700,000	5,900,000	Not available	15,300,000
	5,100,000	8,500,000	8,000,000*	-	21,600,000 *

c) The number of doctors (and how many FTE doctors) who have relocated as a result of the Measure is provided in the table below:

			Total	FTE
i	GP Training Placements		384	Not Available
ii	Specialist Training Placements		15	15

iii	Non VR'd GPs	Existing	36	30.97
iv		New	9	8.7
v	VR'd GPs	Existing	125	58.73
vi		New	51	43.5
vii	Specialists	Existing	3	1.5
viii		New	12	10
	Total iii to viii		236	153.4

These figures are for the years 2002/03 to 2004/05 inclusive. Figures for 2005/06 are not yet available.

* Non-vocationally recognised (non-VR'd) GPs are those medical practitioners who do not

satisfy the criteria for vocational registration under section 3F of the *Health Insurance Act 1973* (the Act), or registration as a recognised Fellow of the Royal Australian College of General Practitioners under section 3EA of the Act.

** Vocationally recognised (VR'd) GPs are those medical practitioners who are registered by Medicare Australia under Section 3F of the Act. It also means a medical practitioner who is vocationally registered or a recognised Fellow of the RACGP within the meaning of the Act and who is not subject to section 19AA of the Act.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2006-2007, 31 May - 1 June 2006

Question: E06-237

OUTCOME 10: Health System Capacity and Quality

Topic: E-HEALTH

Hansard Page: CA 104

Senator Carol Brown asked:

Please provide a full list of funds committed to HealthConnect since 2001.

Answer:

Administered Funds Committed to an E-Health Information Network (2001 to 2002-03) and E-Health Implementation (2004 to 2006-07) - Health*Connect*

2001-02 $	**2002-03 $**	**2003-04 $**	**2005-06 $**	**2006-07 $**
8,300,000	7,500,000	2,500,000	24,777,000	22,370,000

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2006-2007, 31 May - 1 June 2006

Question: E06-238

OUTCOME 10: Health System Capacity and Quality

Topic: NATIONAL E-HEALTH TRANSITION AUTHORITY (NEHTA)

Hansard Page: CA 105

Senator Moore asked:

Do you have, in table form, Mr Shepherd, that has both so that we can see what the total expected expenditure is and what the commonwealth allocation is?

Answer:

Funding Source	**2005-06 $m**	**2006-07 $m**	**2007-08** $m	**2008-09 $m**	**Total**
Base Funding					
Australian Government	3.9	2.8	2.4		9.1
Jurisdictions (combined)	3.9	2.8	2.4		9.1
Total Base Funding	**7.8**	**5.6**	**4.8**		**18.2**
COAG Funding					
Australian Government		26.3	18.9	19.4	64.6
Jurisdictions (combined)		26.3	18.9	19.4	64.6
Total COAG Funding		52.6	37.8	38.8	129.3
Total NEHTA Funding	**7.8**	**58.2**	**42.6**	**38.8**	**147.5**

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2006-2007, 31 May - 1 June 2006

Question: E06-239

OUTCOME 10: Health System Capacity and Quality

Topic: CANCER

Hansard Page: CA 15

Senator McLucas asked:

Could you find out when the request from the minister's office was provided to the department and when the draft answer was provided back to the ministers office for both of those questions

Answer:

Question number 1299 was provided to the Department in October 2006. The draft response was sent to the Minister's office within the requisite timeframe but given the considerable activity that was occurring with many of the Strengthening Cancer Care measures, the response was almost immediately out of date. Consequently there were a number of iterations before the final answer was provided.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2006-2007, 31 May - 1 June 2006

Question E06-240

OUTCOME 10: Health System Capacity and Quality

Topic: CANCER

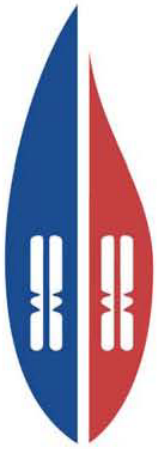
Hansard Page: CA 108

Senator McLucas asked:

No; that is what I am tracking. Is it possible to get a copy of that report?

Answer:

Yes. Copy attached.



NATIONAL
CANCER
CONTROL
INITIATIVE

'Handover' report to the Australian Government Department of Health and Ageing

May 2006

Introduction

This report fulfills the item in the NCCI contract that requires a 'handover report' for Cancer Australia to be submitted to the Department of Health and Ageing. In this report the main current activities of NCCI will be described, with emphasis on issues that need to be further developed by Cancer Australia or other groups.

The work of the National Cancer Control Initiative since its inception in 1997 has been described in two major reports, which have been produced as hard copy publications from NCCI, and are also available on the NCCI website. The first of these covers the period 1997-2002 {18317}, and the second covers the period 2003-2005 {22747}. In early 2005, an extensive independent review of NCCI activities was held which resulted in a report to the Minister of Health and Ageing, which should be available from the Department. The current report and these earlier reports taken together give a comprehensive description of NCCI's activities from 1997 to 2006. This report itself concentrates on projects active since September 2005.

The NCCI has produced a substantial number of reports on priority issues, which have been distributed in printed form and also through the NCCI website. These are listed in **Appendix 1.** These reports are public documents; they are indexed with national libraries and have ISBN numbers.

NCCI staff have contributed a large number of publications to the international peer-reviewed literature. While the recent publications are listed within this main report, **Appendix 2** gives a list of all publications produced by NCCI since 1997. These can be accessed through the usual library sources.

NCCI Website and access to NCCI materials

The NCCI website has been a valued resource, providing stakeholders with access to detailed information on the activities of the NCCI. The usage of the NCCI website has grown significantly over time since its launch in 2001. The NCCI website averaged over 67,000 hits per month in the last 12 month period. The active website will cease before May 31st, 2006.

Unfinished business

Arrangements have been made with The Cancer Council Victoria to continue the NCCI website for at least a year, as a portal linking to a brief review of recent projects, NCCI reports, and a list of NCCI publications in journals. The website will give the name and phone number of Mr Ian Kemp for enquiries to the Cancer Section of DoHA about NCCI and related issues. Access to NCCI materials in the future

should be secured by appropriate new arrangements through the Department of Health and Ageing or Cancer Australia. Copyright for these reports is attributed to The National Cancer Control Initiative, but under the terms of the contract the ultimate copyright holders are the Australian Government, and Ian Kemp has agreed to deal with requests for copyright clearance.

Management

NCCI Staff

All NCCI staff complete their contracts on May 31st or earlier. The professional staff of NCCI have major personal commitments to the alleviation of cancer, evidenced by their willingness to stay with the organisation through over two years of great uncertainty and cutbacks. They each have extensive and unique experience in their areas of work, and each professional member of staff has contributed to many aspects of the work carried out by NCCI.

Unfinished business

Several members of NCCI staff are willing to be contacted about further aspects of the areas of work developed by NCCI, and may be in a position to make further contributions, depending on their other responsibilities in the future. Contact details will be sent to the Department of Health and Ageing at a later date.

Management Committee

The Management Committee last met on 4 October 2005. The Management Committee has received the 2006 NCCI progress report which was sent to the Department of Health and Ageing for 15th March, and will receive this handover report. In the opinion of the Chair, Professor Michael Quinn, there is no reason to hold any further meetings of the Management Committee. The membership of the Committee at the last meeting was:

. • Director, The Cancer Council Victoria (Professor David Hill)
. • Chief Executive Officer, The Cancer Council Australia (Professor Alan Coates)
. • Chair, The Cancer Council Australia/Clinical Oncological Society of Australia Medical & Scientific Committee (Professor Ian Olver)
. • Representative of the Australian Cancer Network (Professor Bruce Barraclough)
. • One Ministerial nominee (Associate Professor Michael Quinn (Chair))
. • Two representatives of the Department of Health and Ageing
. • One nominee of the National Health & Medical Research Council (Professor Adele

Green)

- One person reflecting the interests of consumers (Vacant)
- Chief Executive Officer, National Breast Cancer Centre (Dr Helen Zorbas)
- Chair, National Cancer Strategies Group (Professor Robert Burton)
- Member with Primary Health Care Expertise (Associate Professor Patsy Yates)

Unfinished business

The Management Committee is aware of the closure of NCCI, but as members are appointed by the Minister, the Minister may wish to acknowledge the service of Management Committee members in an appropriate way.

Status of current NCCI projects, in relation to the 2006 business plan

1. Contribute to national leadership in cancer control

National cancer control programs

Work with others on national cancer policy and priorities, and towards establishment of of Cancer Australia,

Support work Cancer Australia, DoHA, National Cancer Strategies Cancer Group, The Cancer Council Australia, and other key stakeholders on Australia on cancer control developments. Provide input in regard to Cancer Australia developments and further development of the National Service Improvement Framework. Provide input into developments in cancer control at State and Territory level as required.

1.1 Work with others on national cancer policy and priorities, and towards establishment of Cancer Australia

Recent membership on key government and non-government committees

- ASAC Policy Review and New Technologies Working Group (M Elwood)
- ASAC Quality Improvement and Workforce Working Group (J StJohn)
- Australian Cancer Network Melanoma Guidelines editorial group (M Elwood)
- Australian Prostate Cancer Collaboration Education Committee: Program to Promote PSA Informed Choice Discussions in General Practice (B McAvoy, M Staples, J Fletcher)
- Australian Screening Advisory Committee (ASAC) (M Elwood, J StJohn, R Burton, B McAvoy (also representing RACGP))
- Bowel Cancer Screening Implementation Advisory Group for Victoria (J StJohn)

- Bowtel Cancer Screening Pilot Monitoring and Evaluation Task Group (M Elwood (chair), M Staples – now completed)
- Bowel Cancer Screening Pilot Quality Task Group (J StJohn (chair) – now completed)
- National Bowel Cancer Screening Implementation Advisory Group (J StJohn)
- Cancer Institute of NSW Education and Workforce Advisory Committee (B McAvoy)
- Cancer Institute of NSW Population Health and Screening Working Party (M Elwood, J StJohn)
- Cancer Screen NSW Advisory Committee (J StJohn)
- NSW Bowel Cancer Screening Implementation Advisory Committee (J StJohn, chair)
- Department of Veterans' Affairs: Expert Advisory Panel for the Cancer and Health Screening and Disease Prevention Program for F-111 Deseal/Reseal Personnel (M Elwood, chair)
- Department of Veterans' Affairs: Specialist Medical Review Council (J StJohn)
- Medical and Scientific Committee of The Cancer Council Australia (TCCA) and Clinical Oncological Society of Australia (COSA) (M Elwood)
- National Breast Cancer Centre and NCCI – Psychosocial Guidelines Implementation Steering Group (B McAvoy, J Fletcher)
- National Cancer Strategies Group (R Burton, M Elwood)
- National Health and Medical Research Council – Electromagnetic Energy Research Working Group (M Elwood)
- National Institute for Clinical Studies – Gaps report editorial group (M Elwood – work completed)
- National Public Health Partnership – National Strategies Coordination Reference Network (M Elwood – work completed)
- National Service Improvement Framework for Cancer, Expert Advisory Group (NSIF) (R Burton, M Elwood)
- The Cancer Council Australia Public Health Committee (M Staples)
- The Cancer Council Australia Public Health Committee General Practice Subcommittee (B McAvoy)
- The Cancer Council Victoria GP Working Group (B McAvoy, J Fletcher)
- The Cancer Council Victoria pharmaceutical policy working group (J Fletcher)

Active: To strengthen their input in these issues, staff at the NCCI monitor major international developments in cancer control and contribute an Australian perspective to international work. Robert Burton and Cleola Anderiesz have prepared an article *Cancer control in Australia 2005* for the WHO Cancer Section in Geneva. At the request of the editors, an article on the development of cancer control policy in Australia by Cleola Anderiesz, Mark Elwood and David Hill has been submitted to *Australian and New Zealand Health Policy*.

The development of cancer control programs in other countries is being kept under review, and comparisons made to Australian programs. Information on international cancer control programs is monitored through a regular review of published literature, Internet websites of international cancer agencies, research institutes, health organisations, cancer societies and government health departments, and by personal communication. This was greatly assisted by the participation of Mark Elwood, Robert Burton, and Brian McAvoy in the First International Cancer Control Congress, in October 2005 in Vancouver. As members of the organising Sub-Committee,

Mark Elwood and Robert Burton are continuing involvement in the follow-up to this congress and the planning of future meetings. NCCI is a member of the International Union Against Cancer (UICC), the leading voluntary international body with a role of developing and fostering cancer control worldwide. Robert Burton is the UICC Strategic Leader for capacity building, and is involved in the organisation of the 2006 meeting in Washington, DC. He continues to advise on cancer control in many countries on behalf of UICC and WHO.

Unfinished business

NCCI has been represented on a large number of government and non-government committees and national and state bodies. The contribution of NCCI staff to these groups has been strengthened by the NCCI's ability to review and monitor current professional and scientific developments in relevant areas and provide that information to these groups. In addition NCCI staff have on many occasions have developed strategic reports and summaries of scientific and professional information, undertaken consultations and scoping exercises, and have undertaking innovative research and development projects, at the request of these bodies. In some cases, for example, the National Cancer Strategies Group, no meetings have been held for a considerable time.

Some committees have appointed these members as representatives of NCCI, and others as independent members. Some committee appointments may continue on an individual basis; for others, arrangements will need to be made for this type of input to be provided in the future. The NCCI has no corporate capacity to make further arrangements for input into these groups, but arrangements may be made with individuals.

1. 2. Reducing the risk of cancer and finding cancer early

2. *2.1 Assessment of dermoscopy in the diagnosis of suspicious skin lesions in general practice*

Assessment of dermoscopy in the diagnosis of Continue trial to evaluate dermoscopy in general practice, in Perth. (most suspicious skin lesions in general practice. funding from NHMRC)

Active: Following the priority recommended in *Priorities for Action in Cancer Control* "Improving the efficiency of skin cancer control through a national program to increase the accuracy of general practitioner (GP) diagnosis of skin lesions that might be cancer", and the conclusions of the NCCI workshop on *'Efficient and Effective Melanoma Diagnosis',* funding was obtained from the NHMRC to conduct a 'Crossover trial of dermoscopy and short-term digital monitoring for the management of skin lesions in general practice'. The NCCI input to

this project has involved Mark Elwood, Brian McAvoy, Margaret Staples, Jane Fletcher, and Robert Burton. The project's chief investigators are Associate Professor Scott Menzies from the Sydney Melanoma Diagnostic Unit, Mark Elwood, Robert Burton and Brian McAvoy from NCCI, and Professor Jon Emery from the University of Western Australia. The primary aim of the study is to determine whether dermoscopy and short-term digital monitoring in a primary care setting significantly reduce the proportion of pigmented lesions excised or referred to a specialist. The secondary aim is to investigate whether dermoscopy or digital monitoring improve the confidence of GPs in their diagnosis and management of these lesions. The trial, which commenced in June 2005, is being run through the Primary Health Care Research and Evaluation Unit in the Department of General Practice at UWA. Eighty-nine GPs from the Perth metropolitan area who each have excised at least 10 pigmented lesions in the previous 12 months have been recruited. Participating GPs were given instructions in the correct management of pigmented skin lesions then given an on-line test to assess their diagnosis and proposed management of a series of skin lesions. Training in dermoscopy and digital monitoring was based on a written, self-instructional text and a CD ROM tutorial. At the completion of training there was a post-intervention test to reassess diagnostic accuracy. The trial has completed the run-in phase and over 120 patient lesions have been recruited for the trial proper. Pigmented lesions with a clinical diagnosis indicating that either biopsy or referral is warranted are eligible for the study. The management proposed following the clinical diagnosis will be compared with that proposed after the dermoscopic examination of the lesion. Clinicians will also record their confidence in the diagnosis before and after the dermoscopic examination and estimate the probability that the lesion is a melanoma. Suspicious lesions not warranting immediate excision will be monitored over 3 months for change. The trial has the power to assess a reduction of 20% in excision rates. Such a reduction would produce substantial savings in excision and pathology costs (up to $50 million per year if fully implemented) and would justify the introduction of dermoscopy as standard practice in primary care.

Unfinished business

The trial of dermoscopy in primary care was developed as a result of strategic considerations in regard to the management of skin cancer, pursued through the NCCI in workshops and widespread consultations involving the Department of Health and Ageing. The first choice of the NCCI was to develop this project as being closely aligned to policy development, with the actively involvement of the Department of Health and Ageing, so that the results of the study would be well understood and the study would be designed to address issues which would become relevant in policy development. If the results of this trial are supportive, there will be strong grounds to make dermoscopy standard practice in primary care in Australia, with implications in

terms of training, equipment, and compensation. The estimate of potential savings if unnecessary biopsies can be avoided by the methods assessed in this trial is up to $ 70 million per year. NCCI had planned that some of these policy issues would be explored while the clinical trial was in progress. However this did not occur, so it has been developed as an NHMRC project grant, of which the principal investigator is Associate Professor Scott Menzies. This project is continuing, and the NCCI staff who have made a major contribution to this study are continuing to work with Associate Professor Menzies in their individual capacities. The outcome of the project will be reported in the usual ways including reports in peer-reviewed journals. Cancer Australia should address the issue of the management of skin lesions in primary care, as it is a major aspect of cancer care in Australia, and should consult Associate Professor Menzies and the other investigators on that topic.

2.2 Supporting informed decision making about PSA testing for prostate cancer

Encourage informed decision making about PSA testing for prostate cancer	Continued development of workshops, information materials, and dissemination strategy, and related publications and reports. A proposal for a national program of train-the-trainer workshops has been submitted to DoHA. (funding from QCF, NSW CI, others)

Completed: The use of prostate specific antigen (PSA) testing as a screening test for early prostate cancer is controversial because of the absence of clear evidence for its effectiveness. Despite this, it is used extensively. Following a workshop held on 21 August 2003 by the NCCI in conjunction with the Australian Prostate Cancer Collaboration (APCC) to address key issues in regard to the decision making process regarding PSA testing, it was clear that there was a need to develop a GP education program. A working group was established, chaired by Dr Carole Pinnock, involving the Queensland Cancer Fund, The Cancer Council Victoria, The Cancer Council Tasmania, the Queensland Faculty of the Royal Australian College of General Practitioners, the Northern Section of the Urological Society of Australia, the Prostate Cancer Foundation of Australia and the NCCI. With financial support from the Queensland Cancer Fund, resource materials have been developed to support GPs in helping men (and their partners) reach informed decisions about PSA testing and digital rectal examination in the detection of early prostate cancer. These materials have been field tested in a series of GP workshops in Queensland and Victoria, and feedback from the participants has been used to refine the resources. Several workshops with Divisions of General Practice have been run in Queensland and Victoria. The GP/patient show card and GP reference card have been distributed to GPs in Australia with the June 2005 issue of the Australian Family Physician, funded by the National

Seniors Foundation, and with the agreement of the RACGP. These materials are available from the NCCI website http://www.ncci.org.au/services/prostate_GPresources.htm .

Active: This project has led to the development of a well-tested and valuable educational intervention, and there has been much experience in delivering this to a range of personnel in Australia. The activities involved in distributing and using this material are continuing through the various partners in the work. A proposal for NCCI to facilitate 'Train-the-Trainer' workshops for all States and Territories was submitted to the Australian Government Department of Health and Ageing (DoHA) in April 2005 and is still awaiting a response. Greater interest in these developments has been shown by some State bodies, and by overseas groups. An interactive workshop entitled
'Promoting shared decision making and informed choice for the early detection of prostate cancer – an evidence based workshop' was presented by Brian McAvoy, Jane Fletcher, and Margaret Staples at the *Improving the Management of Cancer Services* conference in Melbourne on 1 March 2006.
Unfinished business
The first of three Train-the-Trainer workshops for NSW, organized by NCCI and auspiced by the NSW Cancer Institute, was held on 28 March 2006, and two further workshops are planned. Negotiations have been commenced to develop online training through the RACGP's *GPlearning* program, funded by Andrology Australia. Discussions about further GP workshops have been held regarding Victoria, Queensland, South Australia, Western Australia and Tasmania. Although PSA screening is not endorsed by key authorities, it is widely used, and it is likely that a high proportion of men undergoing testing do so with inadequate information and in some cases no informed consent. Prostate cancer in general has been underfunded in terms of research and development relative to its importance. It will be important for future cancer plans to address this issue. Jane Fletcher and Brian McAvoy can provide further information.

2.3 Assess new developments in cancer screening

Assessment of issues in cancer screening	Continue assessment of new developments in cancer screening and work with the National Screening Advisory Committee and its New Technologies working group. Continuation of work on evaluation of screening for melanoma (funding from NHMRC).

General. Developments in cancer screening are being kept under review, and NCCI has recently contributed a discussion on this topic to The Cancer Council Victoria strategic planning process.

Screening for melanoma

Completed / Active: Two major projects are in progress, both based in Queensland. The pilot phase of the randomised trial of routine skin examination to reduce deaths from melanoma has provided much valuable information on the issues of skin examination in regard to melanoma, and several papers have been published in international journals, and other publications are in progress. The opportunity to complete the trial and show definitely whether routine skin examination is a lifesaving technique or a waste of resources has probably been lost because of the failure to give adequate priority to funding. No other trial has been undertaken anywhere in the world. In the absence of this trial, the case-control study of screening in Queensland, funded by NHMRC, is very important as it can provide some important information on the value of screening. It has completed data accrual and analysis is beginning. Mark Elwood is a principal investigator on both these studies, along with Professor Joanne Aitken and others at the Queensland Cancer Fund, and Professor Dallas English at the University of Melbourne.

Unfinished business

Through the case-control study and the pilot phase of the randomised trial, the investigators group has become recognized as a leading international group with expertise on the diagnostic and screening issues in melanoma. Because the randomised trial was not funded, there is no available high quality scientific evidence to answer the question of whether doctor or self-screening for melanoma is a valuable technique that would save many lives both in Australia and internationally, or is a major waste of resources. Estimates are that current skin screening activity paid for through Medicare is likely to amount to at least $50 million per year, and the annual increase in the Medicare cost of skin excisions is around $2 million per year, which is more than the cost of the previously proposed trial. The NHMRC guidelines for the management of melanoma are currently under revision, but guidance on screening will be difficult because of the absence of evidence for or against screening from any randomised trial. No such randomised trials of melanoma screening are in progress or, as far as we know, are planned anywhere else in the world, as the international opinion has been that Australia is the world leader in melanoma and has been expected to carry out the definitive trial. Most dermatological organisations and to an increasing extent general

cancer organisations support screening for melanoma either by self screening or by doctor screening, despite the absence of high quality evidence, on the assessment that the hazards are likely to be outweighed by the potential benefits. In the absence of a randomised trial, the results of the case-control study will be important and this is in the early stages of analysis. For further information on these studies, and access to the expertise built up, the appropriate contact persons are Associate Professor Joanne Aitken at the Queensland Cancer Fund, and Professor Mark Elwood.

2.4 Support the national implementation of bowel cancer screening

National bowel cancer screening program Support implementation of national program for bowel cancer screening.

Completed: The NCCI has been closely involved in the development of the national bowel cancer screening pilot program (the Pilot) for more than six years. This pilot has been led by the DoHA Screening Section. Mark Elwood chaired the Monitoring and Evaluation Task Group and was a member of the Implementation Committee; James St John chaired the Quality Task Group, was a member of the Policy Task Group and the Implementation Committee, and also was a member of the Steering Committee for the Victorian Pilot Site, and Margaret Staples was a member of the Monitoring and Evaluation Committee. The Pilot was conducted at three sites (Mackay, Qld; ten postcodes in Melbourne, and nine postcodes in Adelaide) between November 2002 and June 2004. The final report on the national bowel cancer screening pilot program was released at the end of 2005.

Active: In May 2005, funding was provided in the Federal Budget to allow bowel cancer screening, based on faecal occult blood testing, to be offered across Australia to all men and women turning 55 or 65 years of age. A total of 0.5 million people will be invited to enter the screening program each year, with review of its success in 2008. Planning for this expanded program has already commenced.

The NCCI is keeping aware of Australian and international developments, and has been asked by UK research groups to continue to contribute to international reviews of progress. James St John is a member of the implementation advisory committee for the national program and for Victoria and chairs the NSW Bowel Cancer Screening Implementation Advisory Committee. He is also a member of the Advisory Committee for the Review of Evidence on Accuracy of Faecal Occult Blood Tests, which is conducting reviews for the NHS in the UK. Mark Elwood has been invited to present on bowel cancer screening at international conferences in the USA and Canada later in 2006, and to join a group planning colorectal screening in British

Columbia. Mark Elwood and James St John are also advising TCCV and the NSW Cancer Institute on this topic.

Unfinished business

The national program of bowel cancer screening is now approaching implementation, although the proposed program for screening 55 and 65 year olds is only the beginning of a process to meet the needs, especially considering that colorectal screening for all Australians aged between 50 and 74 has been recommended by the NHMRC since 1999. In addition to the national program, state authorities and Cancer Councils may develop their own contribution to this issue. James St John is continuing to work on this issue with national implementation group and The Cancer Councils in Victoria and NSW, and he, Robert Burton and Mark Elwood will be willing to give further advice on this important topic.

2.5 The national sun behaviour survey 2003-4, risks and benefits of sun exposure, and development of a proposal for a national skin cancer awareness campaign

National skin cancer awareness program	Provide advice and support for the implementation of the national skin awareness and prevention program.

Completed: The National Sun Survey was completed over the summer of 2003 to 2004, on a national representative sample of subjects, using the technique developed by the Cancer Council Victoria based on Monday evening telephone interviews asking about behaviour during the previous weekend. Several reports have been produced, including the main report on *'Sun Protection and Sunburn Incidence of Australian Adults: Summer 2003-04*', which was released in February 2005. Less than 50% of people reported using common sun protection behaviours such as avoiding the sun during peak UV, using sunscreen, or wearing headwear or long sleeved tops. Two further reports on the sun protection behaviours of adolescents and children have also been completed.

In a related project, NCCI along with TCCV supported a 2004 workshop on the risks and benefits of sun exposure, to take into account the risks for skin cancer and the benefits of sun exposure in the production of vitamin D, and to consider emerging research on other cancers such as non-Hodgkin's lymphoma, and on autoimmune diseases. This workshop was chaired by Mark Elwood, and Margaret Staples and Faline Howes produced the report on the proceedings, which is available on the NCCI website. This meeting led to a joint position

statement from TCCA, the Australian and New Zealand Bone and Mineral Society, Osteoporosis Australia, and the Australasian College of Dermatologists. This was the first such multidisciplinary position statement produced in the world, and received considerable international interest.

Active: A discussion of the key results with the National Cancer Strategies Group (NCSG) has been recommended. Following the announcement in the Australian Government 2005-2006 budget that $5.5M over 2 years will be available for proceeding with the national skin cancer awareness campaign, NCCI has been liaising with the Skin Cancer Committee of TCCA to progress this endeavour. Margaret Staples and Brian McAvoy attended a meeting in 2006 organized by the DoHA to discuss strategies to implement the campaign and assess its impact on the population.

Unfinished business

The group with the greatest experience and an international reputation on all areas of behavioural change related to sun exposure is the SunSmart expert group within The Cancer Council Victoria, headed by Mr Craig Sinclair. That group should be approached for further input on this topic.

1. 3. Improving high quality and evidence-based cancer care
2. *3.1 Development of primary care strategy for cancer*

Continue developments in primary care aspects of cancer control.	Continue to develop and assess primary care aspects of cancer control developments, and provide primary care perspective to other projects, as appropriate. Proposals for investigation of GP's contacts with cancer patients, multidisciplinary care facilitation, and skin lesion management have been submitted to DoHA. This work can be activated if required, as resources permit. Completion of reports and publications.

Completed: This program addresses key issues in primary care which relate to many of the priority actions recommended in *Priorities for Action in Cancer Control*, including preventive activities, screening activities in primary care, assessment of symptoms and appropriate referral, and support of cancer patients in the community. Following an initial workshop, a scoping exercise to identify priorities, existing resources, and needs and gaps in support for primary care professionals on cancer issues was completed.

A report on Phases I and II of Primary Care Perspective on Cancer Report was submitted to DoHA in July 2004. This contained 5 proposals for ongoing work. NCCI is disappointed that no

response has been made to this report, which had more comprehensive input from stakeholders than any other report on this area. The proposals made were all for areas of work ready for development. The five proposals concern:

. • An investigation of GPs' contacts with cancer patients – this is a critical area with no active Australian work, although it is being developed in UK. The project would use two existing Australian databases, and links with the appropriate Australian and international investigators have already been set up.

• A demonstration project to develop facilitation of multidisciplinary care coordination across the continuum of cancer care – a priority area identified in Strengthening Cancer Care. This project was designed to build on the experience of the Border Coordinated Cancer Care project, described in this report.

• A review of different methods of diagnosing and managing skin lesions in primary care – this is a controversial area which has implications for standards and quality of care as well as Medicare costs. This project would complement the dermoscopy trial. Some work is being done in Queensland on this topic, but there is no information on what is happening in the rest of Australia.

. • The dissemination and implementation of educational materials to assist GPs in supporting men to make informed decisions about PSA testing. The NCCI work on this is described elsewhere in this report, but is only one component of a large issue. GP training and education is a priority area in *Strengthening Cancer Care*, and prostate cancer is a priority cancer. The issue continues to be raised in Parliament, and there is strong consumer demand for action.

. • The implementation of modules three (development and dissemination of consumer summary cards) and four (rural and remote strategy) of the psychosocial guidelines implementation strategy. This is yet another priority area in *Strengthening Cancer Care*. There is strong consumer and professional support for this.

Active: Following the scoping exercise, an audit of cancer education for GPs was undertaken. This involved a 20-item questionnaire administered by telephone. Services were contacted in every State and Territory with the exception of New South Wales where an independent audit of primary health care education had been undertaken recently. A total of 218 services and agencies were contacted, and 212 replied, giving a response rate of over 97%. The updated NCCI report on Phases I and II of the Primary Care Perspective on Cancer Project was submitted to the DoHA in February 2006. The NCCI Report on the Education and Training Audit (Adjunct to Phase II Scoping Exercise) is being finalised and prepared for submission to the DoHA. Three papers are being prepared for submission to peer reviewed journals on: the Scoping Exercise (Phase II), GPs and Cancer Control, and the Education and Training Audit.

There are two other developments generated by this project. A *General Practice Working Group* has been established within The Cancer Council Victoria, which includes Jane Fletcher and Brian McAvoy. The Cancer Council Australia Public Health Committee has established a *General Practice Sub-Committee*, co-chaired by Brian McAvoy.

Two new resources for GPs and primary care practitioners have been developed and have been posted under the *Information of Health Professionals* section of The Cancer Council Australia's website in March 2006. These are:

a. o *Fact sheets for health professionals and patients* – 21 concise one-page sheets covering lifestyle, early detection and diagnosis of cancer
b. o *Primary care cancer resources* – guidelines and advice on common cancers as well as issues associated with screening and psychosocial care. This will provide a 'one-stop-shop' for primary care cancer resources

Unfinished business

The NCCI development of a primary care perspective on cancer was a unique process, meeting a major gap in cancer strategy in Australia nationally. Brian McAvoy, as a senior professor and active practitioner in general practice and as deputy director of the NCCI has been in a unique position to develop a national consultative process and input into this program. This was done, and an active and interested national network of primary care practitioners was developed by NCCI, but the lack of support to move on to the next state of development and consultation has meant that much of this effort has been dissipated. Further input on this topic can be obtained from Brian McAvoy.

Analysis of the 2001 National Health Survey

Active: The NCCI has obtained permission to use the Confidential Unit Record File (CURF) from the 2001 National Health Survey, conducted by the Australian Bureau of Statistics. This contains data from 26,900 people from all States and Territories and across all age groups. An analysis is underway, led by Brian McAvoy and Jane Fletcher, to identify all participants reporting a diagnosis related to cancer, and compare the data with a similar UK National Health Survey conducted in 1999. This will provide an opportunity to assess some primary care aspects of cancer services. Further analyses are also underway to compare psychological distress and utilisation of GP services in patients with cancer, asthma, diabetes and heart disease. Further input on this topic can be obtained from Jane Fletcher.

3.2 Assist the Australian Cancer Network in production, revision, and dissemination of clinical practice guidelines

Assist ACN in production, revision, and dissemination Continue support of Australian Cancer Network in revision of melanoma of clinical practice guidelines clinical practice guidelines.

Revision of guidelines for melanoma

Active: At the request of the Australian Cancer Network, Mark Elwood and Margaret Staples have been preparing a draft of the guidelines for screening for melanoma, as part of the

revision of the evidence-based guidelines for clinical practice for melanoma, which were first produced in 1997. Work started in June 2005. However, the ACN's timetable for the guidelines revision has been extended, and the guidelines not be completed in the time available to NCCI.

Revision of the clinical guidelines for the prevention, early detection, and management of colorectal cancer

Completed: The Australian Cancer Network working group, under Professor Tom Reeve's guidance, has completed the revision of the 'Clinical practice guidelines for the prevention, early detection and management of colorectal cancer'. The guidelines were approved by the National Health and Medical Research Council in December 2005 and were printed and distributed in February 2006. The development and production of the guidelines represents the exceptional work of the multidisciplinary working parties, who oversaw the development of the guidelines, and the input and collaboration of a range of stakeholders across Australia. James St John was a member of the Principal Committee responsible for the revision of the guidelines and a member of the Working Party Executive. James St John and Cleola Anderiesz were closely involved in revision of individual chapters in the new document.

General Practitioner guidelines for lung cancer

Completed: The *Assessment and management of lung cancer: evidence based guidelines - A guide for general practitioners* was developed by the Australian Cancer Network, the NCCI and the GP summary guide Working Group. The guide was launched at the Clinical Oncological Society of Australia (COSA) Annual Scientific Meeting in Brisbane in November 2005. The NCCI was extensively involved in reviewing and editing the GP guide and oversaw the layout, design and publication of the guide. 35,000 copies of the GP guide were produced and the NCCI coordinated the dissemination to 34,000 GPs and physicians around Australia. The GP guide was distributed with the November edition of the *Australian Family Physician* and was also made available to health professionals during its launch at the COSA meeting.

Unfinished business

Information on all aspects of cancer clinical guidelines can be obtained from the Australian Cancer Network and its Chair, Professor Bruce Barraclough. Over the last few years, the NCCI has provided a very valuable service to the Australian Cancer Network in professional input, and also in technical support, with NCCI staff taking a major role in the literature search processes, in editing draft guidelines, and in consolidation of the input from consultative review of the guidelines.

This has been necessary because the ACN has had inadequate resources for this.

3.3 Psychological and other responses associated with chronic illness

Psychological aspects of chronic illnesses	Continued involvement as appropriate in multi-disciplinary group exploring ways to improve quality of life and health outcomes related to psychological aspects of chronic diseases (funding from Beyond Blue)

Active: The PANORAMIC consortium was formed at the end of 2003 with the aim of improving systems of care, quality of life and health outcomes of people with co-morbid physical disabilities such as cancer, diabetes and cardiovascular disease. It involves the National Heart Foundation, the Department of Psychology at Melbourne University, the Greater Green Triangle University Department of Rural Health, Flinders and Deakin Universities, Diabetes Australia, the Centre for International Mental Health, University of Melbourne, the Department of Diabetes and Endocrinology, Royal Melbourne Hospital, the Department of Cardiology, Austin and Repatriation Medical Centre and the NCCI. Beyond Blue, the national depression initiative, has awarded $250,000 over 3 years to the PANORAMIC Consortium to be part of a tripartite "cardiac consortium" focusing on risk factors and interventions in primary care. The Consortium has submitted an Expression of Interest to the NHMRC's General Practice Clinical Research Program.

Unfinished business

This work is continuing after the first, completed, phase, and further information can be obtained from Brian McAvoy.

3.4 Multidisciplinary care pilot study in a regional area (Albury-Wodonga)

Coordinated multidisciplinary cancer care	Continue involvement in this demonstration program of coordinated multidisciplinary cancer care in Albury-Wodonga. (funded by DoHA and State Governments of Victoria and New South Wales, independently of NCCI funding)

Active: The aim of the cancer coordination project is to improve linkages and better coordination of care amongst all health care professionals. Brian McAvoy is a member of the External Advisory Group. This flagship pilot for the National Service Improvement Framework for Cancer was launched in Albury-Wodonga in July 2004. Funded by the

DoHA with contributions from the Cancer Coordination Unit of the Victorian Department of Human Services and New South Wales Health through the Greater Murray Area Health Service, the program will run over 18 months. The project builds on the knowledge gained from the Hume Breast Services Enhancement Program, which over the past five years has been very successful in building multidisciplinary services through the engagement of GPs, specialist clinicians and psychosocial support professionals. The project is currently moving through its implementation stage. Two Cancer Care Coordinators have been appointed, and multidisciplinary care conferencing for gastro-intestinal cancers has begun. A database has been developed for logging of all activity and patient/carer connected data. This will assemble an indicative picture of cancer incidence, treatment provision, catchment area, patient movement into and out of the catchment area, support service utilisation, patient/carer support needs and perceived gaps in service provision and cross-border issues. A Progress Report was submitted to the DoHA in May 2005. The Border Coordinated Cancer Care project has now been completed, and the draft final report to the DoHA has been circulated to members of the External Advisory Group for comment.

Unfinished business

There is strong consumer and professional support for this area. A follow up demonstration project was one of five proposals submitted by NCCI to DoHA in July 2004. The project that has been completed is only a small contribution to the important general issue of improving coordinated care, particularly in rural and remote areas. Further input on this topic can be obtained from Dr Craig Underhill and Professor Brian McAvoy.

4. Implementation of lung cancer guidelines and assessment of impact

Implementation of lung cancer guidelines and assessment of impact.	A proposal for the next phase of this work has been submitted to DoHA. This work can be activated if required, as resources permit. Further reports and publications on completed work will be developed with other investigators.

Completed: The NCCI was requested by the NCSG to develop an implementation strategy for the lung cancer clinical practice guidelines and a proposal to evaluate the impact of these guidelines on clinical practice. The first phase of this work covering the period to June 30, 2005, was funded by DoHA. This project was undertaken in Queensland, in association with Associate Professor

Kwun Fong and his colleagues and with Associate Professor Joanne Aitken from The Queensland Cancer Registry.

The first phase of this work involved identifying key clinical indicators of guideline uptake, assessing current clinical practice in Queensland using the unique QILCOP (Queensland Integrated Lung Cancer Outcomes Project) database, and developing a proposal for an intervention model. Each of the 95 guideline recommendations in the *Clinical practice guidelines for the prevention, diagnosis and management of lung cancer* was assessed and assigned a priority rating based on the potential impact of lung cancer control in Australia, potential for change, potential numbers of lung cancer cases affected, evaluation potential, potential financial and labour costs and the level of evidence available to support the guideline. A list of 34 potential key clinical indicators was identified using this process. Following a meeting and input from the steering committee and other experts, the list of indicators was refined to 10 key clinical indicators covering the areas of initial presentation and referral, patient assessment before treatment, special investigations when applicable, primary treatment for small cell and non small cell lung cancer, and treatment of metastases and palliation.
Direct assessment or surrogate measures of QILCOP data, for the period 1 January 2000 to 31 December 2003, was compared to the 34 previously identified guideline recommendations to determine current clinical practice in Queensland for specialists participating in the QILCOP system. This represented data from approximately 2700 patients. Adherence to the guideline recommendations was high in 28 of the 34 guideline recommendations assessed. The QILCOP system is based on a multidisciplinary care model and as the evaluation of current clinical practice in the QILCOP system showed a high adherence to guideline recommendations an implementation strategy for a guideline-based multidisciplinary team model, which could apply nationally, was developed.

The report on the *Implementation of the Lung Cancer Guidelines,* identifying key clinical indicators of guideline uptake and assessing current clinical practice in Queensland using the unique QILCOP (Queensland Integrated Lung Cancer Outcomes Project) database was submitted to the DoHA in June 2005.

Active. A proposal for a nation-wide implementation strategy was submitted the DoHA in June 2005. The implementation strategy is centred on a guideline-based multidisciplinary team [MDT] care model that could apply nationally and aims to improve clinical care in accordance with the Australian Lung Cancer Guidelines. This proposal is to implement the model in a small number of selected test sites across the nation, and assess the acceptability, effectiveness and cost effectiveness of the strategy, and evaluate and assess what changes would be required to

establish this model in most facilities across the nation.

Unfinished business

Lung cancer has been greatly neglected in Australia. It is the cancer which causes the most deaths (more than breast cancer and prostate cancer combined) and it has the worst survival of any of the more common cancers, with five-year survival rates of only 11% in men and 14% in women. Moreover, it is one of the few cancers in which Australian survival figures are worse than those in some other comparable countries. The NCCI national workshop on improving the care of lung cancer was the first national approach to this issue, and the implementation program for the guidelines is the only strategic approach to improving the care of lung cancer patients which has national applicability. It is therefore disappointing that the proposals for active implementation of the guidelines, which are the logical next step to the preliminary work which has been done, have not yet received any support. The NCCI process has brought together many of the national leaders in the lung cancer area, and there is little doubt that further progress could be made with appropriate support. For further discussion on this issue, the principal investigator of the NCCI supported studies; Associate Professor Kwun Fong, should be approached.

5. Implementation of evidence-based guidelines for psychosocial care of cancer patients

Implementation of evidence-based guidelines for psychosocial care of cancer patients	A proposal for the next phase of this work has been submitted to DoHA. This work can be activated if required, as resources permit. Further reports and publications on completed work will be developed with other investigators.

Completed: A program for the phased implementation of the C*linical practice guidelines for the psychosocial care of adults with cancer* was developed jointly by NCCI and the National Breast Cancer Centre. The implementation plan is modular and includes interactive educational workshops, development and dissemination of health professional summary cards, consumer summary cards and a rural and remote strategy. An evaluation phase is built into the proposal. Funding for Module 1, a series of interactive educational workshops, and Module 2, the development and dissemination of the health professional summary card, was granted by DoHA in June 2004. Two teleconferences, chaired by Dr Jane Turner, were held to organise the interactive educational workshops and develop the health professional summary cards. A series of interactive educational workshops were conducted in October, November and December 2004, and a demonstration mini-workshop was undertaken as a breakfast session at the COSA conference in Canberra, 24 – 26 November 2004. Evaluation of these interactive educational workshops has been completed. The summary cards have been produced and were distributed in

the May 2005 edition of the Australian Family Physician and in the August edition of COSA's magazine, Marryalyan. The summary cards were also distributed through key professional organisations and were made available on the NCCI website, at http://www.ncci.org.au/services/psychgls_summarycard.htm A final report on the project's activities and evaluation of Modules 1 and 2 was submitted to the DoHA in October 2005.

Active: This is an area with strong consumer and professional support. A proposal for modules 3 and 4 of the implementation program has been submitted to the DoHA. Dissemination of the summary cards, and presentations on the project, are continuing.

Unfinished business

The psychosocial guidelines for the care of patients with cancer have been acknowledged as a uniquely valuable source of information both in Australia and internationally, as they represent the first effort at a comprehensive approach to this issue. The first and second phases of the implementation process have been very successful and extremely well received by participants. The NCCI staff input into this process has been extremely valuable. What has been achieved so far is only the first step in what needs to be an ongoing comprehensive approach to improving psychosocial aspects of care for cancer patients, and the proposals for phases 3 and 4 which have been already submitted to the Department of Health and Ageing would be appropriate next steps, along with such further developments. Further input on this issue should involve Dr Jane Turner. Jane Fletcher, the NCCI lead on this project, can give further information.

1. 6. Developments in cancer data and monitoring

2. *6.1 Developmental projects related to NCCI core clinical data set*

Support developmental projects related to NCCI core clinical data set, and contribute to developments in cancer registry and staging data	Maintain involvement in data sub-committee of NCSG, and Victorian Ministerial Task Force on Cancer data committee. Contribute to further developments of cancer registries, particularly to incorporate staging, as resources permit.

Completed: All but two items of the Clinical Cancer Core Data Set have been included in the National Health Data Dictionary (NHDD). The two items not included in the NHDD are: cause of death, which is being developed as a generic data element by the Australian Bureau of Statistics and the AIHW, and performance status score at diagnosis. The included items can be accessed through the AIHW website: http://meteor.aihw.gov.au/content/index.phtml/itemId/334019. Availability of the data set through the NHDD will make it more widely accessible to potential users. The full NCCI data dictionary, that includes the two data items excluded from the NHDD, is available from the NCCI website

http://www.ncci.org.au/pdf/Dictionary%20v5%20NCCI%20with%20cover.pdf. The NCSG was to consider further developments together with other information systems priorities. The Faculty of Radiation Oncology has recommended the NCCI data set as the standard for use in radiotherapy units.

Active: The NCCI data set is being used in many ways to improve clinical cancer data collection. For example, the active on-line registry (QILCOP) to monitor the management of lung cancer developed in Queensland by Associate Professor Kwun Fong and colleagues is based on the NCCI minimum data set. With funding from the Victorian Department of Health, the Victorian Cancer Outcomes Network is piloting the collection of the NCCI data set in four Victorian teaching hospitals and linking the data to cancer registry data. NCCI has been contributing to data developments in both New South Wales and Victoria.

Unfinished business

The national initiative taken by the NCCI in developing with extensive consultation a core clinical data set has resulted in the only agreed data set, with detailed descriptions, which has had national approval, is compatible with AIHW requirements, and is also compatible with the requirements of cancer registries as well as clinical facilities. The national initiative on this has been dissipated, as further developments through the National Cancer Strategies Group have not come together, and the main initiative for such data developments is now at state level, in for example Victoria and New South Wales, where there are considerable developments. NCCI still has frequent requests for information and advice on many aspects of data development, and one of the dangers of the lack of any national focus is that, as has happened in the past, many different data systems will be developed separately with the same objective but incompatible data formats and definitions. Margaret Staples has been the NCCI lead on the data area for many years and has unique experience in this topic, and could be approached for further information.

6.2 Review and development of clinical management surveys

Review of clinical management surveys (patterns of care surveys)	Complete publication on the impact of clinical management surveys. Work with NCSG and others to identify needs and opportunities for further surveys, if required.

Completed: Australia is one of the leading countries in the world for conducting substantial population-based clinical management surveys. At the request of the NCSG, a review of Australian clinical management surveys in cancer was completed and published on the NCCI

website in June 2004 and disseminated to groups such as the directors of State and the National Cancer Councils, Australian cancer registries, the Australian Cancer Network, NCSG, and authors of the surveys. Later, a questionnaire was sent to key investigators involved with the 29 published clinical management surveys, and 16 surveys that were planned or in progress to identify the impact of these surveys on aspects of clinical management and patient support. These questions are relevant to the need for further surveys and how they could best be done.

Active: The responses have been collated and an article encompassing the information provided in the report and supplemented by information gathered by the questionnaire has been submitted for publication. Some results were presented at the November 2005 meeting of COSA.

Unfinished business

One of the reasons the NCCI produced its report on clinical management surveys was because the National Cancer Strategies Group realized that surveys to show the current management for representative series of patients with major cancers were an important component of improving cancer care, and yet there had been no coordination between different groups doing quite similar work. The National Cancer Strategies Group was interested in developing a national strategy for such surveys and a funding mechanism, but this has not proceeded. There is currently to our knowledge no group taking a national view of the issues of monitoring routine cancer care.

6.3 Report on the incidence and trends of non-melanoma skin cancer

Further reports on aspects of non-melanoma skin cancer.	Complete publications from NCCI 2002 survey, including study of treatment patterns.

Completed: The main paper reporting the results from the 2002 National Non-melanoma Skin Cancer Survey and trends since 1985 was published in the Medical Journal of Australia in January 2006 (Staples et al., 2006. Med J Aust 184(1): 6-10)).

Active: A paper on the treatment of NMSC has been submitted for publication.

Unfinished business

The 2002 survey of non-melanoma skin cancer, which was funded mainly by the Cancer Councils with a substantial contribution from NCCI, has now been completed and has been published. One of the further objectives for this work was to develop an improved way of monitoring non-melanoma skin cancer in the future, perhaps avoiding the need for relatively expensive independent surveys like the 2002 survey, but because of restrictions on NCCI capacity this work was only partially developed. The issue of how best to

monitor and document the frequency of non-melanoma skin cancer in Australia still remains. Margaret Staples has unique experience in this topic and directed the 2002 survey and its analysis and could provide further information.

Publications and presentations (September 2005 to April 2006)

NCCI Reports:

. • Clinical Oncological Society of Australia, The Cancer Council Australia, National Cancer Control Initiative & National Aboriginal Community Controlled Health Organisation. 2005. *Services and treatment options for persons with cancer. Joint submission to Senate Inquiry into services and treatment options for persons with cancer.* Cancer Council Australia, Sydney.

. • The Cancer Council Victoria & National Cancer Control Initiative. 2005. *Cancer control in general practice - a summary report.* The Cancer Council Victoria; National Cancer Control Initiative, Melbourne.

. • National Cancer Control Initiative. 2005. *National Cancer Control Initiative 2003-2005 report.* National Cancer Control Initiative, Melbourne.

NCCI articles in peer-reviewed journals:

. • Aitken JF, Janda M, Elwood M, Youl PH, Ring IT & Lowe JB 2006. Clinical outcomes from skin screening clinics within a community-based melanoma screening program. *J Am Acad Dermatol* 54(1):105-114.

. • Aitken JF, Youl PH, Janda M, Lowe JB, Ring IT, & Elwood M. 2006. Increase in skin cancer screening during a community-based randomised intervention trial. *Int J Cancer* 118(4):1010-1016.

. • Janda M, Lowe JB, Elwood M, Ring IT, Youl PH & Aitken JF 2005. Do centralised skin screening clinics increase participation in melanoma screening (Australia)? *Cancer Causes Control* 17(2):161-168.

. • Karagas M, Zens MS, Stakel T, Swerdlow A, Rosso S, Osterlind A, Mack T, Kirkpatrick C, Holly E, Green A, Gallagher R, Elwood M & Armstrong B 2006. Pregnancy history and incidence of melanoma in women: a pooled analysis. *Cancer Causes Control* 17(1):11-19.

. • McAvoy BR & Coster GD 2005. General practice and the New Zealand health reforms--lessons for Australia? *Aust New Zealand Health Policy* 2:26

. • McAvoy BR, Steginga SK & Pinnock C 2006. The early detection of prostate cancer in general practice: supporting patient choice. *N Z Fam Phys* 33(1):49-57.

. • McPherson M, Elwood M, English DR, Baade PD, Youl PH, & Aitken JF. 2005. Presentation and detection of invasive melanoma in a high-risk population. *J Am Acad Dermatol* 54: 783792, 2006

. • Metcalfe R, Russell R, McAvoy B, Tse J, Sutherland G & Hoey L 2006. Promoting shared decision making and informed choice for the early detection of prostate cancer: Development and evaluation of a GP education program. *Cancer Forum* 30(1):38-42.

.• Sanders S, Del MC, Purdy S, Spinks A, Tait L & McAvoy B 2005. Evidence in practice--number

.8. What is the prognosis of optic neuritis? How often does it lead to multiple sclerosis? *Br J Gen Pract* 55(521):972-973.

. • Southey MC, Jenkins MA, Mead L, Whitty J, Trivett M, Tesoriero AA, Smith LD, Jennings K, Grubb G, Royce SG, Walsh MD, Barker MA, Young JP, Jass JR, St John DJ,

Macrae FA, Giles GG & Hopper JL 2005. Use of Molecular Tumor Characteristics to Prioritize Mismatch Repair Gene Testing in Early-Onset Colorectal Cancer. *J Clin Oncol* 23(27):6524-6532.
.• Staples MP, Elwood M, Burton RC, Williams JL, Marks R & Giles GG 2006. Non-melanoma skin cancer in Australia: the 2002 national survey and trends since 1985. *Med J Aust* 184(1):6-
.10.
. • Steginga SK, Pinnock C, Baade PD, Jackson C, Green A, Preston J, Heathcote P & McAvoy B 2005. An educational workshop on the early detection of prostate cancer. *Aust Fam Physician* 34(10):889-891.
. • Walker C, Weeks A, McAvoy B & Demetriou E 2005. Exploring the role of self-management programmes in caring for people from culturally and linguistically diverse backgrounds in Melbourne, Australia. *Health Expect* 8(4):315-323.

Guidelines

• Queensland Cancer Fund & National Cancer Control Initiative. 2005. The early detection of prostate cancer in general practice: supporting patient choice. Queensland Cancer Fund. Brisbane.

NCCI abstracts and conference or workshop presentations:

. • Bowman, R., Brady, J., Passmore, L., Fry, D., Anderiesz, C., Elwood, M., Armstrong, J., Abraham, R., Windsor, M., Pratt, G. & Fong, K. M. Queensland Integrated Lung Cancer Outcomes Project (QILCOP) and Australian lung cancer guidelines evaluation. *Asia Pac J Clin Oncol* 1(Suppl 1): A30. Clinical Oncological Society of Australia Annual Scientific Meeting. Brisbane. 15 - 18 November 2005.
. • Burton, R. Cancer prevention in Asia. 3rd Regional Conference of the Asia Pacific Organisation for Cancer Prevention. Rasht, Iran. 25 - 27 April 2005.
. • Burton, R. Cancer prevention in China. International Symposium on Bone and Soft Tissue Tumor. Tianjin, China. 23 - 24 September 2005.
. • Burton, R. Cancer control planning: A population approach. First International Cancer Control Congress. Vancouver, Canada. 23 - 26 October 2006.
. • Burton, R. Planning cancer and chronic disease control in Asia. Asian Pacific Organization for Cancer Prevention Regional Meeting. Nagoya, Japan. 20 - 21 January 2006.
. • Elwood, M. Strengths and limitations of scientific evidence in policy development. First International Cancer Control Congress. Vancouver, Canada. 23 - 26 October 2005.
. • Elwood, M. Screening and diagnosis of melanoma. Grand Rounds at Peter MacCallum Cancer Centre. Melbourne. 24 November 2005.
. • Elwood, M. The evaluation of screening for melanoma. Seminar, School of Population Health, University of Melbourne, December 2005.
. • Elwood, M., McAvoy, B., Staples, M., Fletcher, J., Menzies, S., Burton, R., Emery, J., Shahid, K. & Davies, S. Clinical trial of dermoscopy and digital monitoring in general practice. Clinical Oncological Society of Australia Annual Scientific Meeting. Brisbane. 15 - 18 November 2005.
. • Elwood, M. Cancer in Australia - can we do better? Enhancing cancer services in Southern Melbourne - Workshop of Southern Melbourne Integrated Cancer Services (SMICS) tumour groups. Melbourne. 8 March 2006.
. • Fletcher, J. & Hay, M. Quality of life, anxiety and depression in a sample of women with breast cancer related lymphoedema. *Asia Pac J Clin Oncol* 1(Suppl 1): A32. Clinical Oncological Society of Australia 32nd Annual Scientific Meeting. Brisbane. 15 - 18 November 2005.
. • Fletcher, J. The clinical practice guidelines for adults with caner: Implementation and beyond. 2nd Annual Oncology Social Work Australia Conference. Brisbane. 18 - 19

November 2005.

. • Fletcher, J., Davies, J. & McAvoy, B. A national audit of education and training activities for general practitioners in relation to cancer. RACGP Annual Scientific Meeting. Darwin. 29 September - 2 October 2005.

. • Fletcher, J., McAvoy, B. & Collins, L. Cancer, co-morbidity and psychosocial distress: results from the 2001 National Health Survey. *Asia Pac J Clin Oncol* 1(Suppl 1): A44. Clinical Oncological Society of Australia 32nd Annual Scientific Meeting. Brisbane. 15 - 18 November 2005.

. • Fletcher, J., McAvoy, B. & Davies, J. A national audit of cancer education and training activities for general practitioners. *Asia Pac J Clin Oncol* 1(Suppl 1): A44. Clinical Oncological Society of Australia 32nd Annual Scientific Meeting. Brisbane. 15 - 18 November 2005.

. • Fletcher, J., Turner, J., McAvoy, B. & Luxford, K. Improving psychosocial cancer care: the benefits of an interactive educational initiative. *Asia Pac J Clin Oncol* 1(Suppl 1): A25. Clinical Oncological Society of Australia 32nd Annual Scientific Meeting. Brisbane. 15 - 18 November 2005.

. • Fletcher, J., Turner, J., McAvoy, B. & Luxford, K. Supporting health professionals to improve the psychosocial care of adults with cancer: the development of an evidence-based summary guide. *Asia Pac J Clin Oncol* 1(Suppl 1): A50. Clinical Oncological Society of Australia 32nd Annual Scientific Meeting. Brisbane. 15 - 18 November 2005.

. • McAvoy, B. GP spectrum of cancer care. Grand Rounds at Peter MacCallum Cancer Centre. Melbourne. 24 November 2005.

. • McAvoy, B., Elwood, M. & Anderiesz, C. General practitioners and cancer control in Australia. First International Cancer Control Congress. Vancouver, Canada. 23 - 26 October 2005.

. • McAvoy, B., Fletcher, J., Staples, M., Steginga, S., Pinnock, C. & Russell, R. Promoting shared decision making and informed choice for the early detection of prostate cancer - An evidence based workshop. Improving the management of cancer services. Melbourne. 1 - 2 March 2006.

• McAvoy, B., Pinnock, C., Steginga, S., Metcalfe, R., Baade, P., Jackson, C., Green, A., Preston, J., Heathcote, P., Fletcher, J., Staples, M., Russell, R., Sutherland, G., Hoey, L. & Tse,

J. Promoting shared decision making and informed choice for the early detection of prostate cancer: development and evaluation of a GP program. *Asia Pac J Clin Oncol* 1(Suppl 1): A23. Clinical Oncological Society of Australia Annual Scientific Meeting. Brisbane. 15 - 18 November 2005.

. • St John, J. The National Bowel Cancer Screening Program. NSW Bowel Cancer Screening Implementation Advisory Group. Sydney. 22 December 2005.

. • Staples, M. & Fletcher, J. A national program to strengthen psychosocial care of adults with cancer. Grand Rounds at Peter MacCallum Cancer Centre. Melbourne. 24 November 2005.

. • Staples, M. How well do men report cancer in their relatives? Results from a case-control family study of prostate cancer. *Asia Pac J Clin Oncol* 1(Suppl 1): A8. Clinical Oncological Society of Australia Annual Scientific Meeting. Brisbane. 15 - 18 November 2005.

. • Staples, M., Howes, F., Elwood, M. & St John, J. The value of clinical management surveys of cancer in Australia. *Asia Pac J Clin Oncol* 1(Suppl 1): A11. Clinical Oncological Society of Australia Annual Scientific Meeting. Brisbane. 15 - 18 November 2005.

. • Youl, P., Baade, P., McPherson, M., Elwood, M., English, D. & Aitken, J. F. Increasing prevalence of clinical skin exams in Queensland: have skin clinics played a role? *Asia Pac J Clin Oncol* 1(Suppl 1): A4. Clinical Oncological Society of Australia Annual Scientific Meeting. Brisbane. 15 - 18 November 2005.

Other articles from NCCI work:

. • Delaney G, Jacob S & Barton M 2005. Estimation of an optimal external beam

radiotherapy utilization rate for head and neck carcinoma. *Cancer* 103(11):2216-2227.

- Delaney G, Jacob S & Barton M 2006. Estimating the optimal radiotherapy utilization for carcinoma of the central nervous system, thyroid carcinoma, and carcinoma of unknown primary origin from evidence-based clinical guidelines. *Cancer* 106(2):453-465.
- Featherstone C, Delaney G, Jacob S & Barton M 2005. Estimating the optimal utilization rates of radiotherapy for hematologic malignancies from a review of the evidence: part II-leukemia and myeloma. *Cancer* 103(2):393-401.

NCCI articles submitted or in press

In press

- Luxford K & Fletcher J. 2006. Leading the way - Best practice in psychosocial care for cancer patients. Cancer Forum
- Baade PD, English DR, Youl PH, McPherson M, Elwood JM, & Aitken JF. 2006. The relationship between melanoma thickness and time to diagnosis in a large population-based study. Arch Dermatol
- St John J 2006. Commentary - Prevention of colorectal cancer by colonoscopic surveillance in individuals with a family history of colorectal cancer: 16 year, prospective, follow-up study. Nat Clin Pract Oncol
- Jenkins MA, Baglietto L, Dowty JG, van Vliet C, Smith L, Southey MC, Mead LJ, Macrae FA, St John DJB, Jass JR, Giles GG, Hopper JL. Cancer risks for mismatch repair gene mutation carriers: a population-based early-onset case-family study. Clinical Gastroenterology and Hepatology.

NCCI Participation in conference and workshops

NCCI staff participated in the following conferences and workshops:

- September 2005, *RACGP Annual Scientific Meeting.* Darwin. Poster presented on behalf of NCCI.
- September 2005, *International Symposium on Bone and Soft Tissue Tumor*, Tianjin, China. Robert Burton presented.
- October 2005, *First International Cancer Control Congress*. Vancouver, Canada. Mark Elwood, Robert Burton, and Brian McAvoy presented.
- November 2005, *2nd Annual Oncology Social Work Australia Conference.* Brisbane. Jane Fletcher presented.
- November 2005, *Clinical Oncological Society of Australia Annual Scientific Meeting*. Brisbane. Mark Elwood, Brian McAvoy, Margaret Staples, and Jane Fletcher presented.
- November 2005, *Peter MacCallum Cancer Centre Grand Round.* Melbourne. Mark Elwood, Brian McAvoy, Margaret Staples and Jane Fletcher presented.
- December 2005, *NSW Bowel Cancer Screening Implementation Advisory Group*. Sydney. James St John presented.
- January 2006, *Asian Pacific Organisation for Cancer Prevention Regional Meeting*. Nagoya, Japan. Robert Burton presented.
- March 2006, *Improving the management of cancer services*. Melbourne. Brian McAvoy, Margaret Staples and Jane Fletcher conducted a workshop.

Appendix 1: NCCI reports, 1997 - 2006

2005

Clinical Oncological Society of Australia, The Cancer Council Australia, National Cancer Control Initiative & National Aboriginal Community Controlled Health Organisation. 2005. *Services and treatment options for persons with cancer. Joint submission to Senate Inquiry into services and treatment options for persons with cancer.* Cancer Council Australia, Sydney.

Condon JR, Barnes A, Armstrong BK, Selva-Nayagam S & Elwood M. 2005. *Stage at diagnosis and cancer survival of indigenous and non-indigenous people in the Northern Territory, 1991-2000.*
National Cancer Control Initiative, Melbourne.

National Cancer Control Initiative. 2005. *National Cancer Control Initiative 2003-2005 report.* National Cancer Control Initiative, Melbourne.

The Cancer Council Victoria & National Cancer Control Initiative. 2005. *Cancer control in general practice - a summary report.* The Cancer Council Victoria; National Cancer Control Initiative, Melbourne.

2004

National Cancer Control Initiative. 2004. *Sun and health.* National Cancer Control Initiative, Melbourne.

National Cancer Control Initiative. 2004. *NCCI clinical cancer core data set and data dictionary.* National Cancer Control Initiative, Melbourne.

NCCI Cancer Research Review Working Group. 2004. *Cancer research in Australia - a survey of cancer researchers.* National Cancer Control Initiative, Melbourne.

Threlfall T, Wittorff J, Boutdara P, Fritschi L, Heyworth J, Katris P & Sheiner H. 2004. *Collection of population-based cancer staging information in Western Australia - a feasibility study.*
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Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2006-2007, 31 May - 1 June 2006

Question: E06-195

OUTCOME 10: Health System Capacity and Quality

Topic: NATIONAL BREAST CANCER CENTRE

Hansard Page: CA 93 – 1 June

Senator Ferris asked:

What is the amount of government funding that has been given this year to the National Breast Cancer Centre?

Answer:

In 2005-06 the National Breast Cancer Centre received $2.85 million from the Commonwealth Government.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2006-2007, 31 May - 1 June 2006

Question: E06-127

OUTCOME 11: Mental Health

Topic: SUPPORT FOR DAY-TO-DAY LIVING IN THE COMMUNITY

Written Question on Notice

Senator McLucas asked:

a) How will this program operate?

b) What types of NGOs will be eligible for funding?

c) What additional capacity do these organisations have to provide additional places?

d) The funding provided is about $1,500 / place / year. How do you know this is adequate funding for the provision of these services?

e) Which mentally ill patients will be eligible for these places?

f) How many patients are there who would potentially fit this category?

g) How can you match up location of NGOs with capacity with location of mentally ill patients needing services?

h) How will this program be evaluated?

Answer:

a) Non-government organisations (NGOs) will be funded via a competitive application process to provide living skills programs to people with a high level of disability associated with their mental illness.

b) This measure will build the capacity of existing NGOs that provide these services. Consideration will also be given to funding new NGO services.

c) A study will be undertaken to establish the current and additional capacity of NGOs to provide these services.

d) Funding is based on estimated costs and caseloads of current mental health NGO programs (derived from the annual National Survey of Mental Health Services).

e) People with a high level of psychiatric disability associated with their mental illness will be eligible for this service.

f) Approximately 70,000 adult Australians will be eligible for this service.

g) To receive funding under this measure there will be a competitive funding process. Part of the assessment criteria will include a capacity to provide services in locations of need.

h) The program will be evaluated on an on-going basis through NGO reporting against milestones and deliverables required under their agreements with the Australian Government, and through an external evaluation.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2006-2007, 31 May - 1 June 2006

Question: E06-128

OUTCOME 11: Mental Health

Topic: NEW EARLY INTERVENTION SERVICES

Written Question on Notice

Senator McLucas asked:

a) What are these new mental health services for children and young people?
b) Who will develop these resources and provide training?
c) What is the definition of complex as in "complex mental health conditions"?
d) What services are available to help the parents of children who have risk factors for mental health problems (anxiety, behavioural problems, failing to cope in transition to school or high school) but who do not have complex mental health conditions?

Answer:

a) The new services are those being provided through the following Australian Government COAG Mental Health measures:
   - Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Scheme
   - New Funding for Mental Health Nurses
   - Funding for Telephone Counselling, Self Help and Web-based Support Programmes
   - Support for day-to-day Living in the Community
   - Improving the Capacity of Health Workers in Indigenous Communities
   - Helping Young People Stay in Education
   - New Personal Helpers and Mentors
   - More Respite Care Places to Help Families and Carers
   - Community Based Programmes to Help Families Coping With Mental Illness
   - Improved Services for People With Drug And Alcohol Problems And Mental Illness
   - Mental Health Services in Rural And Remote Areas.

b) Organisations will be selected to develop resources and provide training through an open procurement process.

c) A complex mental health condition is defined in this context as a severe mental disorder that has a significant impact on the social and educational functioning of a young person.

d) Parents are able to access a range of services for children who may be at risk of developing a mental health problem, but who have not yet developed a complex mental health condition. These services include:
- general practice
- psychological services
- psychiatric services
- State/Territory services, such as Community Health Services, Parenting Centres and Child and Adolescent Mental Health Services.

In addition, the Australian Government has implemented the MindMatters initiatives for secondary schools and is just starting the KidsMatter initiative in Primary Schools. MindMatters and KidsMatter focus on creating a positive school environment to promote children's mental health and wellbeing and to provide children with the skills and resources for successful schooling, social relationships and community participation. MindMatters and KidsMatter also provides training and resources to school staff to enable them to identify and support children and young people at risk of developing a mental health problem.

The Australian Government funded the Youth Mental Health Foundation which will improve access to services for young people with mental health problems, including those with associated drug and alcohol problems.

The Australian Government is also providing $39.6 million over the five years to June 2009 to assist *beyondblue*- The National Depression Initiative, for issues of depression, anxiety and related substance misuse disorders. One of *beyondblue's* five priority areas is developing prevention and early intervention programs. In May 2006, *beyondblue* released a DVD "Tackling Depression in Schools" which provides information about depression aimed at helping students, teachers and parents manage and prevent the illness in the school community.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2006-2007, 31 May - 1 June 2006

Question: E06-126

OUTCOME 11: Mental Health

Topic: TELEPHONE COUNSELLING, SELF-HELP AND WEB-BASED SUPPORT

Written Questions on Notice

Senator McLucas asked:

a) How much federal health funding has *Lifeline* received since its inception??
b) What proportion is this of the total *Lifeline* budget?
c) How much federal health funding has *Kids Help Line* received since its inception?
d) What proportion is this of the total *Kids Help Line* budget?
e) How will these services link in with the mental health service to be provided as part of the National Health Call Centre Network?
f) What outputs / outcomes will be reported?
g) How will the success of this funding be evaluated?
h) What web-based support programs will be supported?
i) Given previous funding support to *depressioNet*, why is there no inclusion of this initiative which is well established?
j) Will initiatives like *depressioNet* be linked into this new system?

Answers:

a) The department has provided *Lifeline* with $20 million since 1997.
b) The department is unaware of *Lifeline's* total budget or the proportion of that budget that departmental funding would represent.
c) The department has provided *Kids Help Line* with $8.7 million since 1997.
d) The department is unaware of *Kids Help Line's* total budget or the proportion of that budget that departmental funding would represent.
e) These services will complement but not duplicate the mental health service to be provided as part of the National Health Call Centre Network. Both *Lifeline* and *Kids Help Line* provide crisis counselling services rather than clinical advice.
f) The intended outcome is improved access to information on mental health and crisis counselling services. The outputs will include mental health information for the community and calls answered by telephone counselling services.
g) This measure will be evaluated on its ability to improve access to telephone counselling services, crisis advice and referral, and on the delivery of new online self-help programs and web based counselling services.

h) The department envisages that online services that may be supported could include evidence-based counselling, support and referral and access to self help on-line interactive tools for people to better self manage their illness.

i) *depressioNet* will be at liberty to apply for funding through a competitive application process, as well as any other similar organisation.

j) Any organisation with the capacity to deliver the required services may apply for funding through the competitive application process.

Question from Senator Polley
Senate Estimates, Outcome 12
1 June 2006

Question:

What localities in Tasmania are considered to be Districts of Workforce Shortage?

Response:

- Large sectors of Tasmania are considered to be 'districts of workforce of workforce shortage' for the purposes of employing overseas trained doctors who wish to access Medicare benefits. Information on the localities currently considered to be districts of workforce shortage appears at Attachment A.

- A 'doctor to population ratio' is frequently used to help determine whether a locality is within a district of workforce shortage. This ratio is based on recent Medicare billing statistics for Statistical Local Areas (SLAs) or collections of contiguous SLAs. This ratio takes into account Medicare billing by part time medical practitioners. More details on how the doctor to population ratio is calculated is at Attachment B.

Division: HSID
Cleared by: Alison Larkins
Contact Officer: Jenny Chynoweth
Phone: (w) (h) (mob)
Date: 1 June 2006

Outcome: 12

Question from Senator Polley
Senate Estimates Outcome 12
1 June 2006

Attachment A

Tasmania – Districts of Workforce Shortage

SLA 2004	DWS	Selected Towns and Localities
Break O'Day (M)	N	St Helens, Stieglitz, Scamander
Brighton (M)	Y	Bridgewater, Gagebrook, Pontville
Burnie (C) - Pt A	Y	Burnie, Wivenhoe
Central Coast (M) - Pt A	N	Ulverstone , Penguin
Central Highlands (M)	Y	Bothwell
Circular Head (M)	Y	Smithton, Stanley
Clarence (C)	Y	Risdon Vale, Rose Bay, Richmond
Derwent Valley (M) - Pt A	N	New Norfolk
Derwent Valley (M) - Pt B	Y	Maydena
Devonport (C)	N	Devonport
Dorset (M)	Y	Scottsdale, Bridport
George Town (M) - Pt A	N	George Town
Glamorgan/Spring Bay (M)	Y	Bicheno, Swansea
Glenorchy (C)	N	Glenorchy, Claremont, Derwent Park
Hobart (C) - Remainder	N	Battery Point, Glebe, Sandy Bay
Huon Valley (M)	Y	Huonville, Dover
Kentish (M)	Y	Sheffield, Railton
King Island (M)	Y	Currie
Kingborough (M) - Pt A	Y	Kingston, Snug, Kettering
Latrobe (M) - Pt A	N	Latrobe, Port Sorell
Launceston (C) - Pt B	N	Launceston, Mowbray, Ravenswood
Launceston (C) - Pt C	Y	Lilydale
Meander Valley (M) - Pt A	Y	Prospect, Deloraine
Northern Midlands (M) - Pt A	N	Longford, Perth, Evandale
Northern Midlands (M) - Pt B	Y	Campbell Town, Ross
Sorell (M) - Pt A	Y	Sorell, Carlton
Southern Midlands (M)	Y	Bagdad, Oatlands
Tasman (M)	Y	Nubeena, Eaglehawk Neck
Waratah/Wynyard (M) - Pt A	N	Somerset, Wynyard
Waratah/Wynyard (M) - Pt B	Y	Waratah
West Coast (M)	N	Queenstown, Rosebery, Zeehan
West Tamar (M) - Pt A	Y	Beaconsfield, Beauty Point, Riverside

Unpublished DoHA statistics as at December 2005.

Attachment B

Details on the calculation of 'district of workforce shortage'

A district of workforce shortage is one in which the community is considered to have less access to medical services than that experienced by the population in general, either because of the remote nature of the community or because of the lack of services or a combination of the two factors.

A 'doctor to population ratio' is frequently used to help determine whether a locality is within a 'district of workforce shortage'. This ratio is based on recent Medicare billing statistics for Statistical Local Areas (SLAs). Where SLAs form natural groupings across a locality, the SLAs are grouped together to form catchments of contiguous SLAs.

The doctor to population ratio is determined using Australian Bureau of Statistics Estimated Resident Population (ERP) and Australian Standard Geographic Classification (ASGC) Statistical Local Areas (SLA). The ratio is currently based on 2004 SLAs and the June 30 2004 Estimated Resident Population. The ratio of population to Full-time Equivalent GPs for an SLA or group of SLAs is compared to the national average.

In using the Medicare billing statistics, the Department of Health and Ageing uses a full time equivalent measure, which takes into account Medicare billing in the area irrespective of whether or not local doctors are working in a part time or a full time capacity. The Medicare billing statistics and the doctor to population ratios are updated on a quarterly basis.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2006-2007, 31 May - 1 June 2006

Question: E06-130

OUTCOME 13: Acute Care

Topic: ORGAN DONATION

Written Question on Notice

Senator McLucas asked:

In January 2004, the Minister for Health was asked about the fall in organ donation rates in 2003 over 2002. He said about the fact that it is not known whether the information on the Australian Organ Donor Register is valid:

"I don't know if that is a problem with RTAs or a problem with the Australian Donor Register. I will gladly seek information from the HIC to see where the problem is."

a) Was this problem fixed?

Answer:

a) The January 2004 comment by Minister Abbott related to the currency of contact details for individuals on the Australian Organ Donor Register (AODR) at that time. This issue was addressed in the July 2005 upgrade of the AODR from an 'intent' register to a 'consent' register.

From 1 July 2005, the AODR was upgraded to a register of legally valid consent, which is a more definitive indication of an individual's agreement to organ and tissue donation. It also included procedures for validating and updating contact details for AODR registration. After submitting a signed AODR consent form, each registrant is sent an AODR donor card to verify the contact details stored on the AODR. In addition, registrants are asked to provide their Medicare card number upon registration to maintain the currency of the AODR whenever Medicare details are updated.

At 31 May 2006 there were 759,218 legally valid consent registrations on the AODR and 95% of these registrants have provided their Medicare card number.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2006-2007, 31 May - 1 June 2006

Question: E06-173

OUTCOME 13: Acute Care

Topic: ORGAN DONATION AND TRANSPLANTATION SERVICES

Hansard Page: CA 13 – 1 June

Senator Carol Brown asked:

How many potential donors in the hospital system do not proceed to make donations because of family reasons?

Answer:

There is currently no nationally consistent methodology for collecting and auditing data on potential organ donors (where brain death and medical suitability for donation are confirmed) and the rate of family objection to donation (either due to clarification of known donor objection, unknown intent or overridden intent).

The state and territory organ donation coordination agencies currently estimate that between 18% to 48% of potential donations may not proceed due to family reasons (either due to clarification of known donor objection, unknown donor intent or overridden intent). This is one of the data development issues to be considered by the Expert Clinical Taskforce to be established under the 2006 Budget measure on organ and tissue donation.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2006-2007, 31 May - 1 June 2006

Question: E06-175

OUTCOME 13: Acute Care

Topic: ORGAN DONATION AND TRANSPLANTATION SERVICES

Hansard Page: CA 14 – 1 June

Senator Carol Brown asked:

Can you please provide information on the number of people who have died over the last five years while on transplantation waiting lists.

Answer:

The following table represents the total number of people who have died on the transplant waiting list over the last five years and were listed as still requiring an organ and/or tissue at the time of death.

	2001		2002		2003		2004		2005	
	People on the list	**People who died on the list**	**People on the list**	**People who died on the list**	**People on the list**	**People who died on the list**	**People on the list**	**People who died on the list**	**People on the list**	**People who died on the list**
Kidney	1595	37	1490	55	1488	50	1399	47	1407	43
Heart	67	18	70	10	65	6	45	13	52	20
Liver	125	15	78	22	110	16	104	13	125	37
Pancreas	59	2	38	3	37	0	37	0	38	1
Lung	124	12	112	24	124	14	78	20	94	27

Notes:

1. *Patients requiring multiple organs are included in totals for both organ types.*
2. *Patient death dates have not been validated or cross-checked.*
3. *Patients that are withdrawn from the list before they die, because they are un-transplantable, are not recorded as deaths on the waiting list.*

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2006-2007, 31 May - 1 June 2006

Question: E06-091

OUTCOME 13: Acute Care

Topic: CONTRACT WITH PR FIRM

Written Question on Notice

Senator McLucas asked:

a) Has Philip Flood expressed an opinion about the PR activity around the Review he is conducting?
b) Did he ask for this activity to cease?
c) What is the Budget for the Flood review?
d) Where did the money for the Royce PR contract come from?
e) Did it come from the allocation to the Review?
f) How much money is included in the Review funds for overseas travel?
g) Who is paying for Philip Flood's overseas travel? What is the cost of this travel? Where did he go, who did he meet with?
h) When is the Review due to Report?
i) Is it on track to report in this time frame?

Answer:

a) Mr Flood has not sought, or received, public relations support for the Review of Australia's Plasma Fractionation Arrangements. On his appointment as chair of the review, Mr Flood advised that he would not respond to media inquiries prior to release of the review report and he proposed that any inquiries should be handled by the Department of Health and Ageing or the Minister for Health and Ageing's office. In the conduct of the review, Mr Flood has endorsed the release of public information about the review process, to ensure that the general public and key stakeholders are aware of the review and have the opportunity to contribute to the review process. This has involved public advertisements and stakeholder letters about the submission and consultation process and development of material on the review process for the department's website. Royce (Vic) Pty Ltd was engaged by the department to assist in developing this public information communication strategy.
b) No.
c) The review will cost $3.0 million over 2005-06 and 2006-07.
d) The money for the Royce (Vic) Pty Ltd contract has come from the budget allocation for the review.
e) Yes.
f) Approximately $148,500.

g) The funds are from the review budget. The estimated cost for Mr Flood's overseas

travel is $17,000. The final cost will not be known until the trip has been acquitted which will occur in July. Mr Flood will meet with Baxter Healthcare Corporation (plasma fractionators) in Los Angeles; Talecris (plasma fractionators) in Raleigh-Durham; and the Office of US Special Trade Representative, the Centre for Biologics Evaluation and Research of the Food and Drug Administration, and the Department of Health and Human Services in Washington DC.

h) The review is due to report on 1 January 2007.

i) Yes.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2006-2007, 31 May - 1 June 2006

Question: E06-170

OUTCOME 13: Acute Care

Topic: ORGAN DONATION AND TRANSPLANTATION SERVICES

Hansard Page: CA 12

Senator Carol Brown asked:

Can the Department provide advice on the base funding for the organ and tissue donation sector over three financial years 2007-08 to 2009-10?

Answer:

The base funding for the organ and tissue donation sector for the years 2007-08, 2008-09 and 2009-10 is as follows:

2007-08 $12.098 million
2008-09 $12.286 million
2009-10 $12.482 million

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2006-2007, 31 May - 1 June 2006

Question: E06-171

OUTCOME 13: Acute Care

Topic: ORGAN DONATION AND TRANSPLANTATION SERVICES

Hansard Page: CA 12

Senator Carol Brown asked:

a) Can you provide advice on base funding provided by the department for organ and tissue donation over the last 10 years, prior to the 2006-07 Budget measure?
b) With that information, could you take on notice what education and awareness campaigns the department has funded in that time frame?

Answer:

a) The table below provides data on the base funding provided by the department for the organ and tissue donation sector over the last ten financial years:

Year	$'m
1996-97	1.521
1997-98	1.404
1998-99	1.759
1999-00	2.156
2000-01	3.157
2001-02	7.703
2002-03	8.669
2003-04	10.361
2004-05	10.722
2005-06*	11.676
Total	**59.128**

*Estimated expenditure

b) In 2004-05, the department funded a community awareness campaign on the Australian Organ Donor Register which included an all-household mailout.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2006-2007, 31 May - 1 June 2006

Question: E06-176

OUTCOME 13: Acute Care

Topic: ORGAN DONATION AND TRANSPLANTATION SERVICES

Hansard Page: CA 14

Senator Carol Brown asked:

Do you keep figures on live donors?
I would appreciate it if you could give me the last five years.

Answer:

Yes.

Number of Living Donor Organ Transplants from 2000 – 2006

Organ	**2001**	**2002**	**2003**	**2004**	**2005**	**Total**
Kidney	213	230	218	243	246	**1,150**
Liver	0	1	1*	1	0	**3**
Total	**213**	**231**	**219***	**244**	**246**	**1,153**

Notes:

* A domino whole liver transplant. Domino transplants are when the organ from a patient undergoing an organ transplant is transplanted into another recipient.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2006-2007, 31 May - 1 June 2006

Question: E06-180

OUTCOME 13: Acute Care

Topic: PLASMA

Hansard Page: CA 23

Senator Forshaw asked:

a) I would like to know what advice was given to Mr Flood about the meetings between Royce Pty Ltd, the Department and key stakeholders?
b) Was he informed before they were held?
c) Did he (Philip Flood) express any view about the procedure?

Answer:

a) During early January 2006, the department engaged in preliminary discussions with Mr Flood regarding his role as proposed Chair of the Review of Australia's Plasma Fractionation Arrangements. On 12 January 2006, Mr Flood was informed of the engagement of Royce (Vic) Pty Ltd, and that Royce (Vic) Pty Ltd was developing a communications strategy for the review. Mr Flood was invited to meet with Royce (Vic) Pty Ltd prior to the announcement of the review.

b) On 7 February 2006, Mr Flood met with Royce (Vic) Pty Ltd and was provided with information about the proposed communications strategy for the review, including introductory meetings between the department, Royce (Vic) Pty Ltd and the following organisations:
    - Therapeutic Goods Authority;
    - National Blood Authority;
    - Department of Foreign Affairs and Trade; and
    - Australian Red Cross Blood Service.

    He was also informed that the department and Royce (Vic) Pty Ltd would have an introductory meeting with CSL Ltd on 8 February 2006.

c) Mr Flood did not express a view about the meetings between the department, Royce (Vic) Pty Ltd and key stakeholders.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2006-2007, 31 May - 1 June 2006

Question: E06-181

OUTCOME 13: Acute Care

Topic: PLASMA

Hansard Page: CA 23

Senator Forshaw asked:

Could you please provide details about overseas travel undertaken by the Review Committee and departmental personnel for the Review of Australia's Plasma Fractionation Arrangements?

Answer:

Two overseas trips were undertaken for the Plasma Fractionation Review in order to meet with key industry stakeholders, regulators of plasma products and government agencies responsible for plasma products financing and policy.

Two members of the review secretariat and one representative from the TGA visited Europe from 5-11 June 2006 and held meetings with industry and government representatives in the Czech Republic, Austria, the Netherlands, Norway, Germany, the United Kingdom, Ireland and France.

Three members of the review committee, Mr Philip Flood AO, Mr Peter Wills AC and Professor Kevin Rickard AM, and one member of the review secretariat visited the US from 1-9 July 2006 and held meetings with plasma fractionators, US Food and Drug Administration and the Office of US Special Trade Representative. In addition, the member from the review secretariat met with the Canadian Blood Service, regulator and public health agencies prior to joining the US trip.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Response by National Blood Authority

Budget Estimates 2006-07, 31 May – 1 June 2006

Question: E06-134

OUTCOME 13: Acute Care

Topic: BLOOD PLASMA, DEFINED BLOOD PRODUCTS

Written Question on Notice

Senator McLucas asked:

a) What is the NBA position on self sufficiency for blood plasma and plasma fractionation products?

b) Is this position laid out anywhere in NBA papers? Can we have copies?

c) How does the NBA decide how much plasma to authorise the Red Cross to collect?

d) Is it correct that it is within the authority of the NBA to authorise Red Cross to collect more plasma than is currently the case?

e) If not, what are the limitations?

f) Is it correct that if there was more plasma collected there would be less need to import at least some blood products?

g) Why has the NBA adopted an approach that will see Australia dependent on imports for almost a quarter of blood plasma requirements by 2006-07?

h) How far ahead does the NBA provide advice to the Red Cross about projected plasma needs?

i) How are Defined Blood Products defined?

j) How many Defined Blood Products are there?

k) What role does the NBA play in:
    i. Deciding what is a Defined Blood Product?
    ii. Deciding when other blood plasma products should be imported?
    iii. Determining the conditions around the importation and approval of blood plasma products?

Answer:

a) The National Blood Authority (NBA) does not have a position on self sufficiency for blood plasma and plasma fractionation products as the primary role of the NBA is to purchase blood and blood products to meet the needs of Australia's health system in accordance with the National Supply Plan and Budget approved by Australian Health Ministers each year.

   The NBA follows policy made by Australian Governments. On 7 April 2006 the Australian Health Ministers' Conference (AHMC) released a Policy Statement on National Self-Sufficiency in the Supply of Blood and Blood Products.

b) A copy of the Policy Statement on National Self-Sufficiency in the Supply of Blood and Blood Products is reprinted below.

   AHMC Policy Statement on National Self-Sufficiency in the Supply of Blood and Blood Products

   The Australian Health Ministers' Conference (AHMC) has determined that a clear statement is needed on the governments' current position on self-sufficiency in the blood sector. Self-sufficiency means Australia striving to source blood components and plasma from within Australia to meet appropriate clinical demand.

   This statement has been developed in response to a number of questions about whether recent government decisions to import certain blood products are consistent with the national policy aim relating to promoting national self-sufficiency in the blood supply.

   All Australian, State and Territory governments are signatories to the National Blood Agreement 2003, which sets out, among other things, the policy objectives and aims for Australia's national blood sector.

   The primary policy objectives in the National Blood Agreement are to:
   provide an adequate, safe, secure and affordable supply of blood products, blood related products and blood related services; and
   promote safe, high quality management and use of blood products, blood related products and blood related services in Australia.
   Underpinning these primary policy objectives are a number of secondary policy aims, including promoting national self-sufficiency. This policy aim has not changed.

   However, importation of blood products does occur in a narrow range of circumstances where there is an inability to meet clinical needs through the domestic supply, and where supply chain risks must be addressed. This happens within a framework that:

   - *ensures adequacy of supply to Australian patients in need*
   - *minimises the supply security and product safety risks to patients*
   - *ensures affordability of products to the Australian health sector; and*
   - *recognises the practicalities of production and distribution*

   Australia is self-sufficient in fresh blood components/products except for a few rare blood types, and is largely self-sufficient in plasma products. However, it is necessary to import products such as IVIg where demand exceeds what is produced domestically and recombinant products, which are not produced in Australia.

The Australian Red Cross Blood Service is funded by all Governments to collect fresh blood and blood plasma for use in Australia. All blood and blood products are provided free of charge to patients.

Imported products are subject to the same safety and regulatory standards as domestic products prior to approval by the Therapeutic Goods Administration for release in Australia.

c) The NBA works in conjunction with jurisdictions to establish clinical demand for blood and blood products in Australia, and then develops a draft national supply plan in conjunction with jurisdictions to meet that clinical demand. The National Supply Plan and Budget approved by the AHMC under the National Blood Agreement specifies the volume of plasma to be collected by the Australian Red Cross Blood Service and provided to CSL Limited for fractionation.

d) No, it is not correct. The National Supply Plan and Budget agreed by the AHMC annually is the authority for approval of the volume of plasma to be collected by the Australian Red Cross Blood Service and provided to CSL Limited for fractionation

e) See the answer to question d).

f) Yes, it is correct.

g) In arranging the import of certain blood plasma products the NBA has implemented government policy decisions which are made by the AHMC for the blood sector in Australia under the auspices of the agreed National Supply Plan and Budget.

h) In preparing the National Supply Plan and Budget the NBA provides formal advice to the Australian Red Cross Blood Service in November before the supply year (for example, in November 2005 for the 2006-07 supply year), and informal advice from August of the previous year; and then regularly, including to the end of the supply year.

i) The term *Defined Blood Products* is a general term which has been used historically to refer to products in the National Supply Plan which are not currently produced in Australia and which therefore must be sourced from overseas.

j) There are ten defined blood products.

k) i. The National Supply Plan and Budget agreed by the AHMC for the blood sector in Australia contains an agreed National Products List which in turn determines on a year-by-year basis which products are defined blood products.

The NBA's role *(as set out in the National Blood Agreement and National Blood Authority Act 2003)* is to prepare the draft National Supply Plan and Budget in consultation with jurisdictions and suppliers, and to provide advice to the Jurisdictional Blood Committee (JBC) and AHMC in the approval process. The NBA may also be called upon to provide advice for the purposes of policy decision making by AHMC supported by JBC outside the annual supply plan and budget process.

ii. See the answers to Questions g) and k).

iii. The Therapeutic Goods Administration is responsible for determining the conditions for the supply and use in Australia of all blood plasma products.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Response by the National Blood Authority

Budget Estimates 2006-07, 31 May – 1 June 2006

Question: E06-182

OUTCOME 13: Acute Care

Topic: IMPORTATION OF BLOOD PLASMA PRODUCTS

Written Question on Notice

Senator Forshaw asked:

a) What blood plasma products are currently regularly imported into Australia?

b) What blood plasma products have been imported into Australia over the past four years?

c) Provide the commercial name, the name of the manufacturer and the country of origin.

Answer:

(a, b & c)

The table below contains details of imported blood plasma products which are included in current National Blood Authority supply arrangements. The same products, with the exception of Octagam® which has been supplied in Australia since early 2005, have supplied in Australia over the past four years.

Commercial name	Manufacturer (Supplier)	Country of Origin
Factor Eight Inhibitor Bypass Agent (FEIBA®)	Baxter AG (Baxter Healthcare Pty Ltd)	Austria
Ceprotin®	Baxter AG (Baxter Healthcare Pty Ltd)	Austria
Factor VII concentrate®	Baxter AG (Baxter Healthcare Pty Ltd)	Austria
LFB Hemoleven®	LFB (CSL Limited)	France
Factor XI	Bio Products Laboratory (CSL Limited)	United Kingdom
Fibrogammin P®	ZLB Behring AG (CSL Limited)	Germany
WinRho®	Cangene (CSL Limited)	Canada
Octagam®	Octapharma AG (Octapharma Aust Pty Ltd)	Austria, France and Sweden
Sandoglobulin NF®	ZLB Behring AG (CSL Limited)	Switzerland

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2006-2007, 31 May - 1 June 2006

Question: E06-003

OUTCOME 13: Acute Care

Topic: DBP PROJECT

Written Question on Notice

Senator Carol Brown asked:

The Department's 2002-03 Annual Report shows a $25,000 consultancy contract with PSI Consulting for "Probity advice to Blood and Organ Donation Taskforce for DBP project".

a) What is the DBP project?
b) Why was probity advice needed?
c) Can you please provide a copy of the probity report.

Answer:

Please refer to E06-092.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2006-2007, 31 May - 1 June 2006

Question: E06-092

OUTCOME 13: Acute Care

Topic: CONSULTANCY CONTRACTS ON BLOOD PRODUCTS

Written Question on Notice

Senator McLucas asked:

The Department's 2002-03 Annual Report lists the following consultancy contracts:

1. $100,000 – PSI Consulting
   Independent quality assurance, audit and probity advice and services in relation to future plasma fractionation and diagnostic products arrangements

2. $20,988 – Acumen Alliance ACT Pty Ltd
   Business advice for the procurement process for Defined Blood Products

3. $25,000 - PSI Consulting
   Probity advice to Blood and Organ Donation Taskforce for DBP project

For each of these:
a) What the study was about?
b) Why the study was needed?
c) Why was probity advice needed?
d) When was the study requested?
e) Which part of the Department requested this?
f) When was the study completed?
g) Can we have a copy of the study?

Answer:
1. $100,000 – PSI Consulting
   a), b) & c)
   This consultancy was managed by the former Blood Products Unit of the Department of Health and Ageing, prior to the establishment of the current national blood arrangements and the National Blood Authority in July 2003. In line with usual practice, this consultancy was to provide independent quality assurance, audit and probity advice and services to the steering committee for the future plasma fractionation and diagnostic products arrangements. The advice was in relation to policy development and implementation processes for the purchase of plasma fractionation services from CSL Limited, and diagnostic reagent products for Australia's blood supply.
   d) The consultancy contract commenced on 7 June 2002.
   e) As above.
   f) The consultancy contract concluded on 30 June 2003.
   g) The final report from this consultancy is attached.

2. $20,988 – Acumen Alliance ACT Pty Ltd

a) & b)This consultancy was to provide advice and analysis of commercial and business aspects of the tender selection process for the defined blood products request for tender (RFT) 90/0203.

c) The consultancy contract was not for probity advice.

d) The consultancy contract commenced on 10 January 2003.

e) This work was undertaken by the former Blood and Organ Donation Taskforce of the department prior to the establishment of the National Blood Authority in July 2003.

f) The consultancy contract concluded on 31 May 2003.

g) The deliverable from this consultancy was a spreadsheet model used by the tender evaluation committee for the defined blood products RFT 90/0203 for comparative assessment of product volume, mix and prices of specific tenders. In line with the Senate motion of 30 October 2003, the Minister has confirmed that this material is commercial-in-confidence and should not be released to the Senate. The spreadsheet contains information relating to the price structures of specific tenders and its disclosure could significantly disadvantage contractors or advantage competitors in future procurement processes for such products.

3. $25,000 - PSI Consulting

a), b) & c)

This consultancy was to provide independent certified assurance of the probity of the procurement and tender evaluation processes for the defined blood products RFT 90/0203, in line with usual practice. This work was undertaken by the former Blood and Organ Donation Taskforce prior to the establishment of the National Blood Authority in July 2003.

d) The consultancy contract was a variation to the PSI contract detailed in part 1 of this question. This variation commenced on 4 December 2002.

e) As above.

f) The consultancy contract concluded on 30 June 2003.

g) This consultancy was a variation of the consultancy contract as detailed in part 1 of this question and therefore the final report from this consultancy is the same as that provided in part 1. The final report of this consultancy is attached.

[Note: the attachments were tabled in the Senate on 19.10.06 and have not been included in the electronic/printed volume]

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2006-2007, 31 May - 1 June 2006

Question: E06-241

OUTCOME 13: Acute Care

Topic: PSI CONSULTING

Written Question on Notice

Senator McLucas asked:

The Department's 2002-03 Annual Report shows a $25,000 consultancy contract with PSI Consulting for "Probity advice to Blood and Organ Donation Taskforce for DBP project".

d) Why was probity advice needed?
e) Can you please provide a copy of the probity report.

Answer

Please refer to E06-092.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2006-2007, 31 May - 1 June 2006

Question: E06-167

OUTCOME 13: Acute Care

Topic: ACUTE CARE DIVISION - EXTRA FUNDING FOR STAFFING

Hansard Page: CA 11

Senator Moore asked:

In terms of the money that has been allocated to your division under these programs, are you getting extra funding for staffing?

Answer:

Yes. In Outcome 13 there is an additional $496,000 in 2006-07 for extra staffing.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2006-2007, 31 May - 1 June 2006

Question: E06-010

OUTCOME 14: Health & Medical Research

Topic: THE HUMAN GENETICS ADVISORY COMMITTEE

Written Question on Notice

Senator Stott-Despoja asked:

The HGAC has established Working Groups to "respond to relevant recommendations in Essentially Yours and develop the committee's response to current issues". Please provide details on the progress of each of these groups.

Answer:

All Working Groups are reviewing progress with relevant recommendations from *Essentially Yours*. In addition:

The Health Delivery, Technical and Research Working Group's activities include:

- investigating the feasibility of a national genetics service, including workforce, training, education assessment and funding issues;
- a review of human tissue collections and genetic registers; and
- seeking advice from the National Association of Testing Authorities on regulation and standards for DNA parentage testing.

The Communication and Education Working Group's activities include:

- discussions with the Committee of Deans of Australian Medical Schools and the Australian Council of Deans of Nursing and Midwifery regarding an integrated approach to training in human genetics for undergraduates;
- consideration of broader educational issues across community and post graduate medical education; and
- the development of a communication strategy to ensure engagement of the public on genetic issues.

The Industry and Commercialisation Working Group and the Ethical, Legal and Social Issues Working Group are in the early stages of jointly considering the issues around the collection and use of genetic information in employment.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2006-2007, 31 May - 1 June 2006

Question: E06-011

OUTCOME 14: Health & Medical Research

Topic: THE HUMAN GENETICS ADVISORY COMMITTEE

Written Question on Notice

Senator Stott-Despoja asked:

Which of the Essentially Yours recommendations will the HGAC be responding to and what will happen to these responses?

Answer:

The HGAC will address all recommendations assigned to it through the December 2005 Australian Government response to *Essentially Yours: The Protection of Human Genetic Information in Australia*. The HGAC will then provide advice through the National Health and Medical Research Council to the Minister for Health and Ageing.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2006-2007, 31 May - 1 June 2006

Question: E06-012

OUTCOME 14: Health & Medical Research

Topic: THE HUMAN GENETICS ADVISORY COMMITTEE

Written Question on Notice

Senator Stott-Despoja asked:

The communiqué from the HGAC's second meeting reveals plans for a meeting of stakeholders to initiate community consultation. Who are these stakeholders? At what stage of development are the community consultations?

Answer:

The HGAC hosted a Consultative Workshop in Melbourne on 8 June 2006. Stakeholders who attended represented a range of peak bodies, parents, patients, families, consumer groups and religious organisations, as well as professional bodies and organisations with an interest in human genetics and public health.

The HGAC is considering the views of stakeholders and plans to develop a consultative mechanism to assist it in responding to current and emerging issues in human genetics.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2006-2007, 31 May - 1 June 2006

Question: E06-013

OUTCOME 14: Health & Medical Research

Topic: THE HUMAN GENETICS ADVISORY COMMITTEE

Written Question on Notice

Senator Stott-Despoja asked:

Provide details of the progress of the Ethical, Legal and Social Issues Working Group in investigating the issue of genetic testing of employees.

Answer:

The Ethical, Legal and Social Issues Working Group and the Industry and Commercialisation Working Group are in the early stages of jointly considering the issues around the collection and use of genetic information in employment.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2006-2007, 31 May - 1 June 2006

Question: E06-014

OUTCOME 14: Health & Medical Research

Topic: THE HUMAN GENETICS ADVISORY COMMITTEE

Written Question on Notice

Senator Stott-Despoja asked:

Has the HGAC provided any advice to the Minister yet and if so, on what issues?

Answer:

To date, the HGAC has not provided advice to the Minister.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2006-2007, 31 May - 1 June 2006

Question: E06-147

OUTCOME 14: Health & Medical Research

Topic: NHMRC Funding

Written Question on Notice

Senator McLucas asked:

With reference to the additional funding announced for health and medical research as outlined in Budget Paper 2 p.265, totalling $500 million over 4 years, can you provide the following:

(a) Does this funding go into the Medical Research Endowment Account (MREA)?

(b) What proportion of this funding does not go into MREA?

(c) Where does this go?

(d) The PBS (p.172) refers to a share of MREA appropriations going to "people support activities". What does this mean?

Answer:

(a) (b) and (c) The entire $500 million will go into the MREA in yearly amounts of $21 million, $87 million, $158 million and $234 million from 2006-07 to 2009-10.

(d) The PBS (p.172) indicates that 20% of MREA appropriation is allocated to people support activities. These activities relate to the funding of scholarships, fellowships and career development awards which aim to provide funding to support the people required to complete health and medical research in Australia.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2006-2007, 31 May - 1 June 2006

Question: E06-149

OUTCOME 14: Health & Medical Research

Topic: NHMRC FUNDING

Written Question on Notice

Senator McLucas asked:

With reference to a time series of NHMRC funding which is available on the NHMRC web site, titled: NHMRC Funding at a Glance – 10 Year Time Series:

(e) Can the Department explain the variation between monies appropriated and those actually expended?

(f) The fact sheet also provides an explanation for this difference. Can the Department explain what proportion of grants or applications are delayed by each of the reasons set out in the fact sheet? (Refer to attachment after the fact sheet – in bold and underlined.)

(g) What impact do ethical issues have on the timeliness of applications being processed and monies being expended?

(h) Why has the difference between monies appropriated and money actually spent grown in the last 3 years, relative to previous years?

(i) Specifically, how many funding applications would this involve?

(j) Do these delays apply to applicants seeking extensions or continuing funding, or does it just apply to new funding?

(k) Can the Department guarantee that new funding made available in this Budget won't be subject to similar delays, as the 20 per cent of money appropriated was subject to delays in 2003-04?

(l) How will the Department ensure this money is delivered when it is budgeted for?

(m) How much of the current NHMRC funding remains underspent in this financial year?

(n) How many applicants does this effect?

(o) How many re-extensions of current programs does this effect? What are these research programs?

Answer:

(a) There are a number of factors that contribute to the appropriation and expenditure amounts not matching, including:
- the duration of grants range from one to five calendar years and money is held to meet future obligations of existing grants;
- the expenditure amount only includes funds remitted during a given financial year; and
- grants awarded may not be taken up or may be delayed for a variety of reasons (eg inability to obtain ethical clearances, staff recruitment, patient recruitment for clinical trials, leave taken by a chief investigator, change of administering institution).

(b) The NHMRC does not obtain data relating to the proportion of grants or applications that are delayed by each of the reasons set out in the fact sheet.

(c) Under the Deed of Agreement between the Commonwealth of Australia and the grant Administering Institutions, funds will not be remitted to an Administering Institution until such time as the necessary approvals have been obtained. These include Human Research Ethics Committee approval, Animal Ethics Committee approval, Institutional Biosafety Committee approval, and Commonwealth and State authority authorisation for the importation of experimental organisms.

For the vast majority of NHMRC awards, Administering Institutions have six months after the intended grant commencement date to obtain these approvals. This may result in a six-month delay in expending funds.

(d) In 2002-03, 87.2% of the appropriation was expended; in 2003-04, 81.2% of the appropriation was expended; and in 2004-05, 91.2% of the appropriation was expended. There has, therefore, been a decrease in the difference between monies appropriated and monies actually spent in the last three years.

(e) It is not possible to answer this question as there is no standard size or duration of a grant.

(f) As per (b) above.

(g) The appropriation to the MREA in 2005-06 was $430.45 million and the NHMRC has budgeted to expend $430 million.

(h) The NHMRC plans the expenditure from the MREA well in advance and, as the new triennium commences (1 July 2006), will be developing a Strategic Plan and associated budget in the coming months. This Strategic Plan will be tabled in Parliament by 30 December 2006.

(i) As per (g) above.

(j) As per (e) above.

(k) Not applicable. No NHMRC grants are extended without being assessed against all other applications received in a particular application round.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2006-2007, 31 May - 1 June 2006

Question: E06-015

OUTCOME 14: Health and Medical Research

Topic: FUNDING FOR ADULT STEM CELL CENTRE AT GRIFFITH UNIVERSITY

Written Question on Notice

Senator Stott Despoja asked:

a) Provide details about the bid process. Was it competitive? How many other researchers bid?
b) Was the grant process stimulated by Professor Mackay-Sim applying for this grant?
c) Would the Minister welcome other Australian adult stem cell scientists putting forward a funding bid for their work?
d) Who was consulted in the bid process?
e) Were other scientific groups evaluated as competitors or benchmark?

Answer:

a) The selection of the institutions for funding was a decision of Government in the Budget context.
b) Many research institutions put in funding proposals each year.
c) Yes.
d) The selection of the institutions for funding was a decision of Government in the Budget context.
e) The selection of the institutions for funding was a decision of Government in the Budget context.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2006-2007, 31 May - 1 June 2006

Question: E06-016

OUTCOME 14: Health and Medical Research

Topic: FUNDING FOR ADULT STEM CELL CENTRE AT GRIFFITH UNIVERSITY

Written Question on Notice

Senator Stott Despoja asked:

a) Which Commonwealth Department will Professor Mackay-Sim report to in regard to the grant?
b) Will the same strict and regular reporting rules and governance apply to the National Adult Stem Cell Research Centre (NASCRC) as it does the Australian Stem Cell Centre (ASSC)?
c) What milestones must the NASCRC achieve to qualify for the annual sum of funding? Or will it be applied without caveats?
d) What governance structures will be in place to administer and report of the new Centre?
e) Is the grant a "one-off"?

Answer:

a) The National Adult Stem Cell Research Centre (NASCRC) will report to the Department of Health and Ageing in respect of the 2006-07 grant for infrastructure and operational costs.
b) The Department is currently negotiating a Funding Agreement with Griffith University for the funding identified in the Budget to establish the NASCRC. Reporting requirements will form part of the Agreement.
c) Milestones agreed between the parties will be reflected within the Funding Agreement.
d) The governance structures for the NASCRC are a matter for Griffith University.
e) Funding has been provided for the establishment and operational costs of the NASCRC. The funding is $2 million in 2005-06 for infrastructure and $20 million over four years, for the operational costs of the NASCRC from 2006-07.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2006-2007, 31 May - 1 June 2006

Question: E06-017

OUTCOME 14: Health and Medical Research

Topic: FUNDING FOR ADULT STEM CELL CENTRE AT GRIFFITH UNIVERSITY

Written Question on Notice

Senator Stott Despoja asked:

a) What return on investment does the Minister expect from the work of the NASCRC?
b) Is the Centre expected to be self-sustaining at the end of the grant period?

Answer:

a) The purpose of providing funding to the National Adult Stem Cell Research Centre (NASCRC) is to increase Australia's medical research capacity in the area of adult stem cell research.

b) Funding provided to Griffith University for the NASCRC is $2 million capital in 2005-06 and $20 million over four years for operational costs commencing in 2006-07. As with any university, Griffith University is able to seek additional funding from other sources.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2006-2007, 31 May - 1 June 2006

Question: E06-018

OUTCOME 14: Health and Medical Research

Topic: FUNDING FOR ADULT STEM CELL CENTRE AT GRIFFITH UNIVERSITY

Written Question on Notice

Senator Stott Despoja asked:

c) What evidence was used to ascertain that Professor Mackay-Sim is a "world leading adult stem cell scientist"?

d) What independent scientific review was done on his work in the due diligence process applied to determining the recipients of funds?

Answer:

a) The decision to grant funds to the Griffith University for the establishment of the National Adult Stem Cell Research Centre was a decision of Government in the Budget context.

b) The decision to provide funds to the Griffith University for the establishment of the National Adult Stem Cell Research Centre was a decision of Government in the Budget context.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2006-2007, 31 May - 1 June 2006

Question: E06-019

OUTCOME 14: Health and Medical Research

Topic: FUNDING FOR ADULT STEM CELL CENTRE AT GRIFFITH UNIVERSITY

Written Question on Notice

Senator Stott Despoja asked:

a) Why was this particular neurological stem cell work funded to this extent over the work of other scientists such as Perry Bartlett, Doug Hilton, Paul Simmons and David Haylock?
b) What are the expected outcomes of Professor Mackay-Sim's work in terms of commercial projections and work?
c) Which other stem cell scientists supported the Griffith University bid?
d) Will the Centre accept applications from [sic] funding from other scientists around the country or is the funding for the exclusive use of Professor Mackay-Sim?

Answer:

a) The decision to provide funds to the Griffith University for the establishment of the National Adult Stem Cell Research Centre (NASCRC) was a decision of Government in the Budget context.
b) The funding agreement between the university, which is still being negotiated will include milestones, deliverables and outcomes.
c) The decision to provide funds to the Griffith University for the establishment of the NASCRC was a decision of Government in the Budget context.
d) The funds announced in the Budget are for the NASCRC, which is part of the Griffith University. The operation of the centre, including funding, are matters for the university.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2006-2007, 31 May - 1 June 2006

Question: E06-020

OUTCOME 14: Health and Medical Research

Topic: FUNDING FOR ADULT STEM CELL CENTRE AT GRIFFITH UNIVERSITY

Written Question on Notice

Senator Stott Despoja asked:

a) As a National Centre, is there an expectation it will represent all adult stem cell research in Australia?
b) Provide details of how Professor Mackay-Sim will expand his work with the help of this grant?

Answer:

a) It is expected that the National Adult Stem Cell Research Centre (NASCRC) will work cooperatively and collaboratively with other research institutions undertaking stem cell research in Australia. This includes the Australian Stem Cell Centre.

b) The funding is to establish the NASCRC and to contribute to operational costs, expanding capacity and capability for adult stem cell research.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2006-2007, 31 May - 1 June 2006

Question: E06-021

OUTCOME 14: Health and Medical Research

Topic: FUNDING FOR ADULT STEM CELL CENTRE AT GRIFFITH UNIVERSITY

Written Question on Notice

Senator Stott Despoja asked:

a) What infrastructure is in place at the Griffith University to date?
b) How will the $2 million tagged for infrastructure be spent?
c) Will there be duplication of resources with the ASCC's extensive infrastructure, developed over the past 4 years through the National Research Facilities Program?
d) Will the new centre collaborate on infrastructure with the ASCC laboratories in Melbourne and the ASCC laboratories in Brisbane?

Answer:

a) Griffith University currently houses research laboratories, animal facilities and administration areas within its existing facilities. These facilities are being replaced with a new Eskitis Institute for Cell and Molecular Therapies (EICMT) building. The EICMT building will house the National Adult Stem Cell Research Centre (NASCRC) and funding under this measure is for the sole use of the NASCRC within the larger EICMT facility.
b) The $2 million for infrastructure will be used for the construction and fit out of research laboratories and facilities for the NASCRC within the new EICMT building.
c) The NASCRC will complement the facilities of the Australian Stem Cell Centre (ASCC).
d) The NASCRC will collaborate with the ASCC in relation to research on adult stem cells.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2006-2007, 31 May - 1 June 2006

Question: E06-022

OUTCOME 14: Health and Medical Research

Topic: FUNDING FOR ADULT STEM CELL CENTRE AT GRIFFITH UNIVERSITY

Written Question on Notice

Senator Stott Despoja asked:

a) The National Adult Stem Cell is similar sounding to the Australian Stem Cell Centre. Has the Minister considered that this may cause confusion overseas?
b) Is the name of the new centre a direct infringement of the ASCC trademark?

Answer:

a) The name, the National Adult Stem Cell Research Centre (NASCRC), is a matter for the Griffith University.
b) The name, the NASCRC, is a matter for the Griffith University.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2006-2007, 31 May - 1 June 2006

Question: E06-023

OUTCOME 14: Health and Medical Research

Topic: FUNDING FOR ADULT STEM CELL CENTRE AT GRIFFITH UNIVERSITY

Written Question on Notice

Senator Stott Despoja asked:

Australia is well regarded internationally because of its cohesive, unified approach to stem cell research under the ASCC. Is this an attempt to directly undermine and damage the reputation of the ASCC?

Answer:

The research of NASCRC will complement and enhance the work of the ASCC.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2006-2007, 31 May - 1 June 2006

Question: E06-024

OUTCOME 14: Health and Medical Research

Topic: FUNDING FOR ADULT STEM CELL CENTRE AT GRIFFITH UNIVERSITY

Written Question on Notice

Senator Stott-Despoja asked:

a) What educational opportunities will be offered by the centre, for example, scholarships?
b) What other education functions will the centre offer?

Answer:

(a & b)
The educational opportunities and functions to be offered by the centre are a matter for Griffith University.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2006-2007, 31 May - 1 June 2006

Question: E06-131

OUTCOME 14: Health and Medical Research

Topic: FUNDING FOR ADULT STEM CELL CENTRE AT GRIFFITH UNIVERSITY

Written Question on Notice

Senator McLucas asked:

a) What requirement is the Eskitis Centre required to meet as a consequence of funding in terms of:
   i) Key objectives
   ii) Education and Training
   iii) Partnerships
   iv) Commercial enterprises
b) Who will own the intellectual property that this funding generates?
c) How will the effectiveness of this funding be evaluated?
d) How are the requirements which will be held against the Eskitis Centre in respect of this funding be different from those of the Australian Stem Cell Centre?
e) Why are there different requirements for government research funds?
f) Who will head up this new Adult Stem Cell Research Centre?
g) Who decides on the Head? (the Government or Griffith University?)
h) How will the Head be chosen?
i) Will this be an open selection process?
j) When will this decision be made?

Answer:

a) (i)-(iv) Funding is not being provided to the Eskitis Institute for Cell and Molecular Therapies (EICMT).
a) Any intellectual property generated under a funding agreement would be vested in the recipient. The Commonwealth will seek a world-wide, exclusive licence to use, copy or modify materials resulting from the funding under this measure.
b) The Funding Agreement between the Commonwealth and the University will include outcomes and deliverables. There will be regular reporting provided pursuant to the Agreement.
c) Funding is not being provided under this measure to the EICMT.
d) The requirements for recipients of Government funds reflect the purpose for which the funding is given.
e) The NASCRC is part of Griffith University, which will determine who is Head of the Centre. .
f) Appointments to positions within the University are a matter for the University.
g) This is a matter for Griffith University.
h) This is a matter for Griffith University.
i) This is a matter for Griffith University.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2006-2007, 31 May - 1 June 2006

Question: E06-148

OUTCOME 14: Health and Medical Research

Topic: FUNDING FOR ADULT STEM CELL CENTRE AT GRIFFITH UNIVERSITY

Written Question on Notice

Senator McLucas asked:

With reference to Budget Paper 2 p.269 titled Medical Research Facilities - grants for development and expansion.

a) How were these facilities chosen for funding?
b) On what basis were funding amounts allocated?
c) Did these decisions come from Pre-Budget submissions?
d) When were these decisions made?
e) When will these organisations get their funding given its being budgeted for the 2005-06 - this - financial year?
f) Where are each of these research centres is located?

Answer:

a) The selection of the 18 facilities for funding was a decision of Government in the Budget context.
b) The allocation of funds to the 18 facilities was a decision of Government in the Budget context.
c) The selection of the 18 facilities for funding was a decision of Government in the Budget context.
d) The decision to fund the 18 facilities was a decision of Government in the Budget context.
e) The Department has negotiated and finalised Funding Deeds for all 18 facilities. They will receive funding prior to 30 June 2006.

f) A table of the facilities and their locations is below.

Name of facility	Location of facility
Brain and Mind Research Institute	**University of Sydney, Camperdown, NSW**
Centenary Institute	**Royal Prince Alfred Hospital, Camperdown, NSW**
Children's Cancer Institute Australia	**Sydney Children's Hospital, Randwick, NSW**
Gallipoli Research Foundation	**Greenslopes Private Hospital, Greenslopes, Qld**
Garvan Institute	**Darlinghurst, NSW**
Heart Research Institute	**Camperdown, NSW**
Howard Florey Institute	**University of Melbourne, Parkville, Vic**
Hunter Medical Research Institute	**John Hunter Hospital, New Lambton, NSW**
Macfarlane Burnet Institute	**Melbourne, Vic**
Marshall Centre for Infectious Diseases (now UWA Centre of Excellence for Infectious Diseases)	**University of Western Australia, Crawley, Western Australia**
Murdoch Children's Research Institute	**Royal Children's Hospital, Parkville, Vic**
National Adult Stem Cell Research Centre	**Griffith University, Nathan, Qld**
Olivia Newton-John Cancer Centre	**Heidelberg, Vic**
Queensland Brain Institute	**University of Queensland, St Lucia, Qld**
Sydney Melanoma Unit	**Royal Prince Alfred Hospital, Camperdown, NSW**
Westmead Millenium Institute	**Westmead Hospital, Westmead, NSW**
Woolcock Institute	**Royal Prince Alfred Hospital, Camperdown, NSW**
Victor Chang Cardiac Research Institute	**Darlinghurst, NSW**

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2006-2007, 31 May - 1 June 2006

Question: E06-119

OUTCOME 14: Health and Medical Research

Topic: NEW CANCER RESEARCH GRANTS

Hansard Page: CA 92

Senator McLucas asked:

The answer to QoN 1299 said that grant information on new cancer grants for 2006 would not be available until mid-April.

a) Could we now have the figures for the number of new grants for cancer research and the funding level (including out years)?
b) Ask for a list of the number of new cancer grants and spending for each calendar year from 2000.

We had earlier asked about how we could identify the $4 million increase in cancer research funding that was an election commitment and the answer (QoN 1299) seems to be that the NHMRC is looking at priority areas.

c) Why are priorities being reconsidered when they were laid out in the Government's election policy (viz. improving screening programs, early detection of breast and ovarian cancer, emerging new treatments for bowel and prostate cancers, better coordination of care)?
d) Why is the NHMRC doing this when the Government's policy made it clear that it was up to Cancer Australia to submit a National cancer Research Plan for endorsement by the government?
e) What is happening here? What mechanism do you have to demonstrate that $4 million more has gone (or will go) into cancer research?

Answer:

a) The NHMRC has allocated $91.32 million in funding for 192 new grants commencing in 2006, for cancer related research.

b) The number of new grants for cancer research during the period 2000 to 2006 is as follows:

	Year	Number of New Awards	Total Funding Expenditure
	2000	97	$29.86 million
	2001	164	$56.47 million
	2002	154	$89.90 million
	2003	144	$112.29 million
	2004	165	$72.90 million
	2005	192	$97.16 million
	2006	192	$91.32 million

The total spending for each calendar year from 2000 is outlined on the attached spreadsheet.

c) The priorities for the Cancer Research component of the Government's Strengthening Cancer Care initiative are not being reconsidered.

d) Cancer Australia is responsible for developing a National Cancer Research Plan for the Cancer Research element of Strengthening Cancer Care initiative. The Cancer Research measure was allocated $17.6 million over four years commencing in 2005-06. Funding for the 2005-06 financial year has been re-phased to enable Cancer Australia to develop and implement the National Cancer Research Plan.

e) See (d) above.

Attachment

NHMRC Funded Cancer Research per Calendar Year 2000 - 2006

Year Funding Commenced	2000 $	2001 $	2002 $	2003 $	2004 $	2005 $	2006 $	2007 $	2008 $	2009 $	2010 $	Total $
2000	8,771,559	8,753,063	8,465,829	1,965,179	1,596,133	242,716	66,000	-	-	-	-	**29,860,478**
2001		17,415,874	15,913,085	13,949,276	5,433,534	3,458,362	170,837	66,000	49,500	-	-	**56,456,468**
2002			22,137,074	23,382,651	20,527,869	11,346,121	10,026,326	2,139,875	338,248	-	-	**89,898,164**
2003				22,716,666	25,478,307	25,873,252	17,956,354	15,430,476	4,450,408	375,000	-	**112,280,463**
2004					17,448,166	19,883,262	18,527,253	8,632,011	6,912,199	1,494,023	-	**72,896,913**
2005						26,541,789	25,404,485	23,706,293	11,719,746	9,791,450	-	**97,163,763**
2006							26,349,454	25,361,306	23,342,951	8,988,600	7,273,163	**91,315,474**

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2006-2007, 31 May - 1 June 2006

Question: E06-196

OUTCOME 14: Health & Medical Research

Topic: ESKITIS INSTITUTE FOR CELL AND MOLECULAR THERAPIES

Hansard Page: CA 94

Senator McLucas asked:

Have the Eskitis Institute for Cell and Molecular Therapies, a group of researchers, previously submitted applications for support or funding to the NHMRC?
Could you also advise us what sorts of applications they were, and whether or not they have been successful.

Answer:

Researchers associated with the Eskitis Institute for Cell and Molecular Therapies have submitted three applications for National Health and Medical Research Council (NHMRC) Project Grants, through its Administering Institution, Griffith University.

Professor Alan Mackay-Sim applied for research support in 2005 and was granted a NHMRC Project Grant for research into Adult Stem Cell Therapy for Parkinson's Disease. Griffith University will receive a total $516,000 funding over three years commencing in 2006 for this grant.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2006-2007, 31 May - 1 June 2006

Question: E06-194

OUTCOME 14: Health and Medical Research

Topic: OVARIAN CANCER RESEARCH

Hansard Page: CA 130 – 1 June

Senator Adams asked:

My questions are on the NHMRC funded research into ovarian cancer. The Senate Community Affairs References Committee had a gynaecologist round table four or five weeks ago. We asked a question on notice about whether we could have a summary of expenditure on ovarian cancer. The Department has given it to us, but the problem is quite a large amount of the data on the list is for breast cancer and other cancers.

(p) Could you please provide us with revised data showing the actual funding attributed to ovarian cancer research?

(q) Could the Department please advise why breast cancer funding data has been included with the ovarian cancer research data when the associations between breast cancer and ovarian cancer are minimal?

(r) Could the Department please advise the Committee of the number of submissions on ovarian cancer or other gynaecological cancer research initiatives, and what percentage were rejected by NHMRC and other funding groups?

(s) The allocation of $189.4 million to 2008-09 does not adequately represent the needs of the gynaecological cancer sector and it is considered totally unacceptable. Would you be able to look at that?

Answer:

(a) The earlier advice included funding attributed to ovarian cancer research - $14 million since 2000. Subsequent approvals of research awards have increased this figure to $21 million. In 2004, NHMRC also approved a further $42 million worth of research awards that related to cancer but could not be ascribed to a specific cancer type.

(b) Breast cancer funding data was not included in the earlier advice.

(c) Below are percentage success rates for applications received by the NHMRC for research into ovarian cancer and into gynaecological cancer.

	Ovarian Cancer			Gynaecological Cancer*		
Funding Year	Apps	Awards	% awarded**	Apps	Awards	% awarded**
2000	6	6	100%	25	13	52%
2001	5	3	60%	21	9	43%
2002	6	5	83%	24	10	42%
2003	10	8	80%	37	13	35%
2004	10	4	40%	34	8	24%
2005	8	3	38%	35	9	26%
2006	17	12	71%	41	19	46%
Total	**62**	**41**	**66%**	**217**	**81**	**37%**

*Includes applications for ovarian cancer.
**Average success rate for Project Grant applications (all areas of research) 2003 23%, 2004 23%, 2005 22%, 2006 21%.

(d) Through the Strengthening Cancer Care initiative, the Commonwealth Government has committed a further $189.4 million over the five years to 30 June 2009 for enhanced prevention and early detection, support for people living with cancer, research, professional development, and better coordination of the cancer effort. Under this initiative, additional funding of $17.6 million is being provided over three years for dedicated research into cancer. One of the initial priorities for this cancer research measure will be the early detection of ovarian and breast cancers. The Government's new national cancer agency, Cancer Australia, will be responsible for this measure. This measure complements the considerable research into gynecological cancers that is being undertaken through the NHMRC.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2006-2007, 31 May - 1 June 2006

Question: E06-120

OUTCOME 14: Health and Medical Research

Topic: NATIONAL RESEARCH CENTRE FOR ASBESTOS RELATED DISEASES

Written Question on Notice

Senator McLucas asked:

Answer to QoN 1299 said that the National Asbestos Research Working Group would meet on April 5 to assess and rank applications for individual research grants.

a) Please provide details of funding grants and levels

The Administering institutions for these projects will then be invited to apply to host the virtual National Research Centre.

b) Has this been done?

c) OR When will this be done?

d) When is it proposed that the centre will finally be underway? Answer to QoN 1299 says funding recommendations will be submitted for approval in May 2006.

e) Is the $5 million commitment to this initiative to cover both research and the operations of the National Research Centre?

Answer:

a) Funding and grant levels will be announced following approval by the Minister.

b) & c) Only one institution was nominated by the short-listed applicants, and this institution was invited to submit a proposal to host the virtual National Research Centre.

d) Funding recommendations have been made to the Minister. An announcement is expected in the near future.

e) The $5 million commitment to this initiative is expected to cover both research and the operations of the National Research Centre.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2005-2006, 16 February 2006

Question: E06-064

OUTCOME 14: Health and Medical Research

Topic: LICENSING COMMITTEE

Written Question on Notice

Senator Fielding asked:

a) The Licensing Committee has provided minutes of its meetings to the Community Affairs Committee. Please provide copies of minutes for any further meetings.

Answer:

a) Endorsed minutes of the Licensing Committee meeting of 26 May 2006 are attached.

NHMRC LICENSING COMMITTEE

DRAFT MINUTES OF THE MEETING OF 26TH MAY 2006

THE BRASSEY HOTEL, CANBERRA

8.30am to 3.00pm Friday 26th May 2006

Attendance

Members	**Secretariat**
Professor Jock Findlay (Chairperson)	Dr Harry Rothenfluh
Professor Don Chalmers	Dr Mike Gear
Dr Helen Szoke	Dr Alison Mackerras
Dr Graham Kay	Ms Erica Sherburn
Dr Julia Nicholls	Ms Dianne Bennett
Associate Professor Christopher Newell	Mr Christopher Hennessey-Milne

Legal Services Branch	**Observers**
Mr Neil Dwyer <u>for relevant items 5-8</u>	Professor Ron Trent (Chairperson, Human Genetics Advisory Committee)
Claire Fraser	Dr Greg Ash
Ms Michelle Kirby	Mrs Cathy Clutton (AHEC Secretariat)
	Mr Nigel Harding

Item 1: Opening

The meeting commenced at 8.30am on Friday 26 May 2006.

Item 1.1: Apologies

Professor Bryan Campbell submitted an apology for the meeting. Mrs Cathy Clutton attended in order to brief members on AHEC activities.

Item 1.2: Confidentiality and Conflict of Interest

Members were reminded of their obligations in respect of confidentiality and conflict of interest declarations.

Item 1.3: Confirmation of Agenda

The timing of the agenda items was confirmed. Members were invited to identify any non-starred item that required discussion.

Item 1.4: Chairperson's Report

Members were informed of the outcomes of the 24-25 May 2006 Council meeting.

Item 1.5: Out of Session Activities

Members noted that no out-of-session decisions had been made by the Committee since the 16-17 March 2006 meeting.

Item 1.6: Committee Membership

Members were advised that the process for appointing all positions on the Committee for the next triennium (1 July 2006 to 30 June 2009) was expected to be completed before 30 June 2006, except for the cross member with the Australian Health Ethics Committee (AHEC). The process for filling this position will be initiated once the AHEC membership has been announced.

Item 2: Minutes and Actions Arising from Previous Meeting

Members endorsed the draft minutes of the 16-17 March 2006 meeting subject to minor editorial corrections, and noted the table outlining the progress of the actions arising from that meeting.

Item 3: NHMRC Activities

Item 3.1: Council Activities

Members noted the report provided by the Council Secretariat.

Item 3.2: Report by AHEC Representative

Members noted matters considered by AHEC since the Licensing Committee meeting of 16-17 March 2006.

Item 3.3: Interaction with GTRAP

Members noted issues under consideration by GTRAP.

Action Arising:

Members are to receive a confidential copy of the recent draft GTRAP cellular therapy guidelines for the conduct of clinical trials.

Item 3.4: ..... Secretariat Activities

Members were provided with a verbal report on Secretariat staff movements. Members:

- thanked departing Secretariat staff, Ms Michelle Bausch and Ms Julie Martin, for their contributions to the Secretariat; and
- noted the appointment of Ms Erica Sherburn as an NHMRC Inspector by the Chairperson of the Licensing Committee and congratulated her on the appointment.

Item 3.4:1: New Contact Details of Secretariat Staff

Members noted the information provided.

Item 3.5: NHMRC Governance Arrangements

The Committee was briefed on the progress of the new governance arrangements of the NHMRC.

Action Arising:

Secretariat to advise the NHMRC Centre for Corporate Operations that the Chairperson, Professor Findlay, will be overseas for all of July 2006. The Secretariat will pursue an arrangement for an Acting Chairperson for that period.

Item 3.6: Biannual Report to Parliament

Members noted that the Biannual Report of the NHMRC Licensing Committee for the period 1 October 2005 to 31 March 2006 will be tabled in Parliament before 30 June 2006.

Item 4: Budget

Secretariat updated members on the Licensing Committee budget.

Item 5: Use of Non-cryopreserved Excess ART Embryos in Licensed Activities

Members discussed the issue of whether licences can be issued for the use of fresh excess ART embryos.

Decisions:

The Committee resolved the following:

- The *Research Involving Human Embryos Act 2002* does not expressly prohibit the use of fresh embryos in a licensed activity.

- The *Ethical Guidelines on the Use of Assisted Reproductive Technology in Clinical Practice and Research 2004* (the ART Guidelines) recommend a cooling off period of not normally less than two weeks after consent for the use of the excess ART embryos has been given.

- An embryo cannot be declared to be excess to the needs of a couple for whom it was created until after it exists.

- An embryo that is created for an IVF cycle involving preimplantation genetic diagnosis (PGD) cannot be declared to be excess to the needs of a couple for whom it was created until after the PGD results are known.

- The Licensing Committee concluded that the current ART Guidelines are inconsistent with the issue of licences for the use of fresh excess ART embryos due the significantly reduced cooling-off period.

Item 6: Justification for the Use of Viable Excess ART Embryos in Training Licences

Members discussed the Committee's guidelines for the use of viable excess ART embryos in training licences.

Actions Arising:

- Secretariat will review the guidelines on the use of viable embryos for training and submit for Licensing Committee consideration and approval.

Item 7: Review Advice on Whether an Embryo Is Live or Dead

Members discussed this issue in the light of recent developments concerning reproductive science.

Actions Arising:

- The Licensing Committee will re-examine their advice once more information becomes available.

- In the interim the Secretariat will place a disclaimer on the NHMRC website with the following wording:

Disclaimer: The information on this webpage is for guidance only. It is not intended to be taken as legal advice. If you are in any doubt about provisions of, or consequences arising from the operation of, the legislation or the issuing of licences, you should seek your own independent legal advice.

Item 8: Licence Considerations

Item 8.1: Applications

Item 8.1.1: Licence Application 309710

Members discussed this application.

Decisions:

- The Committee could not issue a licence for the use of fresh embryos because the requirement to significantly shorten the cooling-off period is not permitted under the *Ethical guidelines on the use of assisted reproductive technology in clinical practice and research (2004)*.

- Members noted that Licence 309710 could be issued for the use of frozen embryos, subject to the requested information being provided by the licence holder.

Action Arising:

Secretariat to notify the applicant in writing of the Committee's decisions.

Item: 8.2 Variations

Item 8.2.1: Summary of All Variations

Members noted the information provided on this item.

Action Arising:

Future summary tables to categorise all licence variations by type of variation and licence number.

Item 8.2.2: Licence 309709 – Request for Extension of Licence Period

Members discussed the variation application.

Decision:

Members considered that the request was reasonable because the licence holder had made significant progress towards achieving the goals of the licensed activity. The licence holder's preliminary experiments had taken longer than anticipated but will minimise the number of embryos required in the overall project. Members approved a 12 month extension to Licence 309709.

Action Arising:

Secretariat to notify the licence holder in writing of the approval of the licence extension.

Item 8.2.3: Licence 309707 – Addition of Authorised Persons

Members noted the variation application.

Decision:

As a consequence of two members of the licence holder's research team departing, new authorised persons are required to continue the project. Members approved the variation to the licence.

Action Arising:

Secretariat to notify the licence holder in writing of the Committee's approval of the variation.

Item 8.3: Consent

Item 8.3.1: Advice Received to Date

Members noted the information provided.

Item 8.3.2 Consent Checklist

Members noted the information provided.

Action Arising:

Secretariat to make editorial corrections and update version on the NHMRC website.

Item 8.4: Expiry of Licences

Members discussed the information provided on this item.

Decision:

Members agreed to the wording of the new Standard Condition 3001 (the current version of which is found on the NHMRC website). Members approved the report templates.

Action Arising:

Secretariat to seek comment from the licence holders and then vary the licences.

Item 9: Compliance

Item 9.1: Report on Monitoring Inspections

Members noted that two monitoring inspections had been conducted since the 16-17 March 2006 Committee meeting.

Item 9.1.1: Report on the Monitoring Inspection of Monash University Licence 309707

This monitoring inspection was conducted on 21 April 2006.

Decision:

The Committee was satisfied with the outcomes.

Action Arising:

A summary of the monitoring inspection is to be included in the next Licensing Committee Report to Parliament for the period 1 April 2006 to 30 September 2006.

Item 9.1.2: Report on the Monitoring Inspection of Sydney IVF Licence 309703

This monitoring inspection was conducted on 3-4 May 2006.

Decision:

The Committee was satisfied with the outcomes.

Action Arising:

A summary of the monitoring inspection is to be included in the next Licensing Committee Report to Parliament for the period 1 April 2006 to 30 September 2006.

Item 9.2: Licence Holder Reports to Licensing Committee

Members noted that all licence holders had provided reports on the use of excess ART embryos for the reporting period 1 October 2005 to 31 March 2006. All of these reports were received by the Licensing Committee Secretariat on or before the due date specified in the Standard Licence Conditions.

Item 9.3: Update on Compliance Communication Arrangements with States & Territories

Members noted the information provided.

Item 10: Review of Legislation

Members discussed and noted progress of this item.

Item 11: Licensing Committee Projects

Members discussed and noted the progress on the projects.

Item 12: Communications Activities

Item 12.1: Information Exchange Visits

Members noted the report on the Information Exchange Visits to Griffith University and the University of Queensland on 2 May 2006.

Item 12.2: Communications Working Group Update

Members noted the information provided.

Item 12.3: Consumer Issues

Members discussed and noted the information provided on this item.

Item 12.4: Information Kit

Members noted that the Information Kit will be finalised before the August 2006 meeting.

Action Arising:

Secretariat to publish Information Kit on the NHMRC website and in hard copy.

Item 12.5: "Human Embryo – a biological definition" Discussion Paper

Members noted the information provided on this item.

Action Arising:

Secretariat to prepare the paper and submit for publication to a peer-reviewed scientific journal.

Item 12.6: Consumer Issues Workshop

Members noted that the workshop was successfully conducted. Members thanked the Secretariat for their work in organising the workshop.

Action Arising:

Secretariat to progress communication with relevant consumer groups and inform the Minister for Ageing of outcomes of the consumer issues workshop.

Item 12.7: Licensing Committee Bulletin

Members noted the information provided.

Decision:

Members agreed to defer publication of the next edition of the Bulletin until July 2006.

Item 13: Submission to the Review of the National Statement on Ethical Conduct in Human Research

Members noted the information provided on this item.

Item 14: Other Business

Members discussed the arrangements for the next meeting being held in Brisbane on 24 - 25 August 2006.

Actions Arising:

- Secretariat to invite a Q-Gen representative to attend the August meeting and give a presentation on good manufacturing practice as it is applied to laboratories used for the derivation and culture of human embryonic stem cells.

- Secretariat to invite Brisbane based members of the Research Committee and the Human Genetics Advisory Committee to a meeting.

Item 14.1: Update – AHEC's National Ethics Application Form (NEAF)

Members noted the information provided.

The meeting concluded at 3.00pm on Friday 26 May 2006.

Statement in response to media comments by Dr George Merridew - *Health System 'won't cope' in terror attack* (Article: Australian, Monday 15 May 2006, page 4)

"Australians should be reassured that there is work going on constantly in this country to prepare our hospitals and our health response in the case of a major crisis. Our public hospitals are always busy, but with the work that has already been done, particularly in light of the Bali experience, and the planning that is occurring to prepare our system for an emergency situation we will deal with emergencies that may arise. For example, Australia's strategy to deal with a bird flu pandemic has been developed and is constantly being updated to prepare us for such an outbreak in humans.

As Chief Medical Officer for South Australia I am constantly working with the other states and the Commonwealth to ensure that we are prepared.

The development of the AUSBURN plan has meant that we can all collaborate in the care of burns victims, with each State developing its own response in the event of being confronted by a number of major burns victims. The role of specialist burns surgeons supervising the care of such victims in the first instance through their plastic surgeon and general surgeon colleagues will be pivotal."

Professor Chris Baggoley,
Chief Medical Officer
Department of Human Services
South Australia

25 May 2006

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Budget Estimates 2005-2006, 1 June 2006

Question: E06-253

OUTCOME 15: Biosecurity and Emergency Response

Topic: TOTAL EXISTING NUMBER OF GPS INVOLVED IN ASPREN

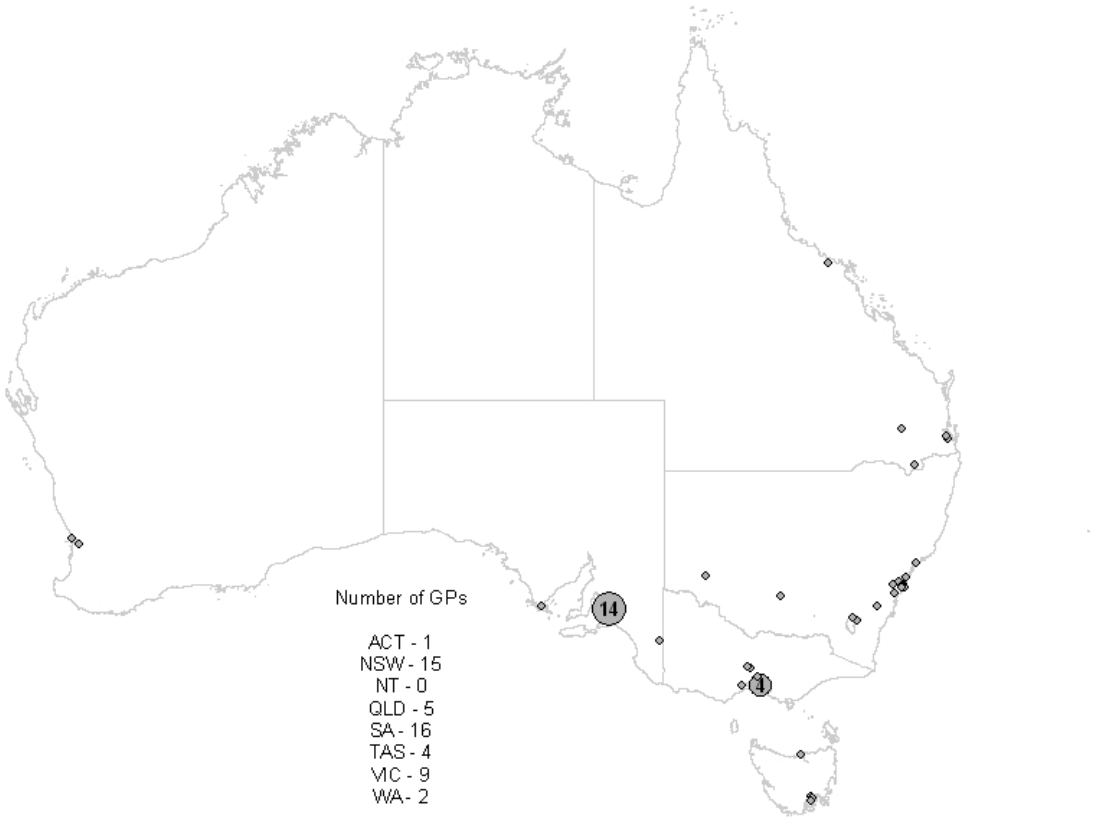
Hansard Page: CA 99

Senator McLucas asked:

Have we mapped them? Could we get a map of the total when you have mapped the total number?

Answer:

See map 1 (attached).


Number of GPs
ACT - 1
NSW - 15
NT - 0
QLD - 5
SA - 16
TAS - 4
VIC - 9
WA - 2
14
4

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2006-2007, 31 May - 1 June 2006

Question: E06-133

OUTCOME 15: Biosecurity and Emergency Response

Topic: GUIDELINES FOR PRESCRIBING ANTI-VIRALS

Written Question on Notice

Senator McLucas asked:

If this winter is a bad flu season, what will be done to ensure that:
- anti-viral drugs are available to those that need them;
- anti-viral drugs are prescribed and taken appropriately.

Answer:

The supply of pharmaceuticals to Australian consumers is the responsibility of the pharmaceutical industry.

The manufacturer of Tamiflu (Roche) has ensured that sufficient stock is available now in Australia to meet the expected demand in this winter flu season. Roche will continue to ship Tamiflu to Australia from the manufacturing facility to ensure that there is an adequate supply of Tamiflu during the 2006 winter flu season.

The Australian Government has provided significant funding since 1998 for the National Prescribing Service (NPS) Limited to implement programs to improve Quality Use of Medicine (QUM).

QUM means:
- selecting management options wisely;
- choosing suitable medicines if one is considered necessary; and
- using medicines safely and effectively.

In 2006-07, funding of $18.45 million is being provided to the NPS under core program funding to guide prescribing, dispensing and administering behaviors among relevant health professionals.

This funding enables education activities for prescribers and pharmacists though printed information, educational visits by NPS facilitators, prescribing feedback and analysis, case studies, clinical audits and a phone line for health professionals - the Therapeutics Advice and Information Service.

Funding of $4.98 million is being provided to the NPS in 2006-07 to conduct consumer education activities. Consumer education includes national awareness campaigns (including “Common colds need common sense”) and population level activities. Population level activities target seniors, culturally and linguistically diverse communities and Indigenous Australians. A phone line for consumers - Medicines Line - is also available.

In relation to influenza, the Influenza Specialist Group (ISG) has been established by the healthcare professions with the objective of reducing the burden of influenza in Australia. One of the current activities of the ISG is establish standardised, evidence-based, recommendations for prescribing anti-viral drugs. When these recommendations have been completed and endorsed, they will be published in professional medical journals.

In addition, the various medical and pharmacy professional organisations maintain effective and comprehensive professional development programs for their members which focus on appropriate medicine prescribing and consumption practice.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2006-2007, 31 May - 1 June 2006

Question: E06-095

OUTCOME 15: Biosecurity and Emergency Response

Topic: COMMUNITY ACQUIRED MULI-RESISTANT ORGANISMS

Written Question on Notice

Senator McLucas asked:

a) A teleconference on this issue was held in May 2005 – what has been done since?
b) In May 2005, the Public Health Laboratory Network discussed making community acquired MRSA a National Notifiable Infection. Has this been done?
c) If not why not?
d) Does the Department/Federal Government regularly collect data on community acquired MRSA?
e) If not, whose responsibility is this?
f) Giving the increase in community acquired MRSA infections and deaths, what is being done at the Federal level about this?
g) What guidelines are in place/are being developed to address this issue in the community?
h) Has the Department received recommendations on addressing community acquired MRSA from:
    a. The Expert Group on Antimicrobial Resistance (EAGAR)
    b. The Public Health Laboratory Network (PHLN)
    c. Other professional bodies?
i) Can we have copies of these recommendations?
j) What has been the response to date from the Department to these recommendations?
k) What has been budgeted for EAGAR over the past four years and for the next four years?

Answer:

a) This issue was discussed at the 30 May 2005 teleconference of the Public Health Laboratory Network (PHLN). PHLN comprises representatives of Australia's public health laboratories.

On 21 June 2005, the Chief Medical Officer met with members of the Expert Advisory Group on Antimicrobial Resistance (an expert Committee of the National Health and Medical Research Council), and other experts in the field of antimicrobial resistance to discuss the issue further.

On 29 June 2005, the Communicable Disease Network Australia (CDNA), considered the feasibility of making community acquired MRSA a notifiable disease.
CDNA is a committee of experts in communicable disease from the Commonwealth, State and Territory governments and academia, which at that time reported to the

National Public Health Partnership. At that time, CDNA was of the opinion that there were issues on the reliability of the data, such that there were difficulties in adequately interpreting the data. CDNA recommended that community acquired MRSA should not become a nationally notifiable disease.

On 31 May 2006, the Commonwealth Department of Health and Ageing submitted a paper to the CDNA on the issue of community acquired MRSA. The paper was discussed on 7 June 2006. The CDNA is in the process of considering the issue and has been asked to report back to the Department on:

- the relative importance of community acquired infections with antimicrobial resistant organisms particularly, methicillin resistant *Staphylococcus aureus* infections; and
- any recommended surveillance and/or response actions required.

The Department of Health and Ageing will consider CDNA's recommendations when received.

b) No. See response to (a) above.

c) The relevant expert body, the CDNA, considered the issue on 29 June 2005 and at that time was of the opinion that there were issues on the reliability of the data, such that there were difficulties in adequately interpreting the data. CDNA recommended that community acquired MRSA should thus not become a nationally notifiable disease.

d) No.

e) Agreement has not been reached between jurisdictions on the desirability or appropriate approaches of systematic data collection on community acquired MRSA. In general, States and Territories have the primary responsibility for collection of data on communicable disease. The CDNA is currently considering the desirability of, and most appropriate method of surveillance.

f) The Commonwealth Department of Health and Ageing has sought the advice of the CDNA on the extent of the problem and appropriate responses. The CDNA is currently considering the issue. The Department of Health and Ageing will consider CDNA's recommendations when received.

g) There are currently no national guidelines in place. The Department is not aware of any guidelines for community acquired MRSA produced by the States and Territories.

h) (a) EAGAR presented a paper to the Chief Medical Officer on 21 June 2005 to raise awareness of community acquired MRSA.

(b) The PHLN has not made specific recommendations to the Department on community acquired MRSA.

(c) In June 2005, the CDNA considered that community acquired MRSA should not be made a nationally notifiable disease. The CDNA is currently considering the issue again.

i) N/A.

j) The Department has been working with the appropriate expert body, the CDNA, to consider the issue.

k)

2003-03	2003-04	2004-05	2005-06
$50,000	$50,000	$30,000	$30,000

Department of Health and Ageing financial support for EAGAR for future years has not yet been determined.

COMMUNITY-ACQUIRED MRSA
The Significant Emerging Community Infection

Definition of caMRSA

Community-acquired MRSA (caMRSA) is a general term describing strains of MRSA that have emerged and spread in the community, rather than in hospital. Specific community-acquired clones have now been identified which are clearly different from classical multi-resistant hospital-acquired clones (Appendix 1). This briefing paper relates to those clones. For case finding, a range of definitions have been used [Salgardo et al 2003]. The CDC has published a case definition recently [CDC, 2004]:

> "A case of CA-MRSA was defined as illness compatible with staphylococcal disease, in which MRSA was cultured from the site of infection….in an outpatient setting or <48 hours after hospital admission, and with none of the following health-care associated risk factors: hospitalization, surgery, dialysis, or residence in a long-term care facility <1 year before the onset of illness; permanent indwelling catheter or percutaneous medical device; or a previous positive MRSA culture."

Clinical Features of caMRSA in Australia

- The clinical picture of caMRSA infections mirrors that of methicillin-susceptible strains in the community. The full range from minor skin and wound infections, through to pneumonia, osteomyelitis, septicaemia and endocarditis have been documented.
- When compared to classical hospital-acquired MRSA, caMRSA is more common in Aboriginal people [Macguire et al, 1998].
- Some caMRSA clones have acquired the Panton-Valentine Leukocidin toxin (PVL), associated with more severe illness, especially necrotising pneumonia.
- There are more and more reports of serious disease and death attributable to caMRSA from across Australia.

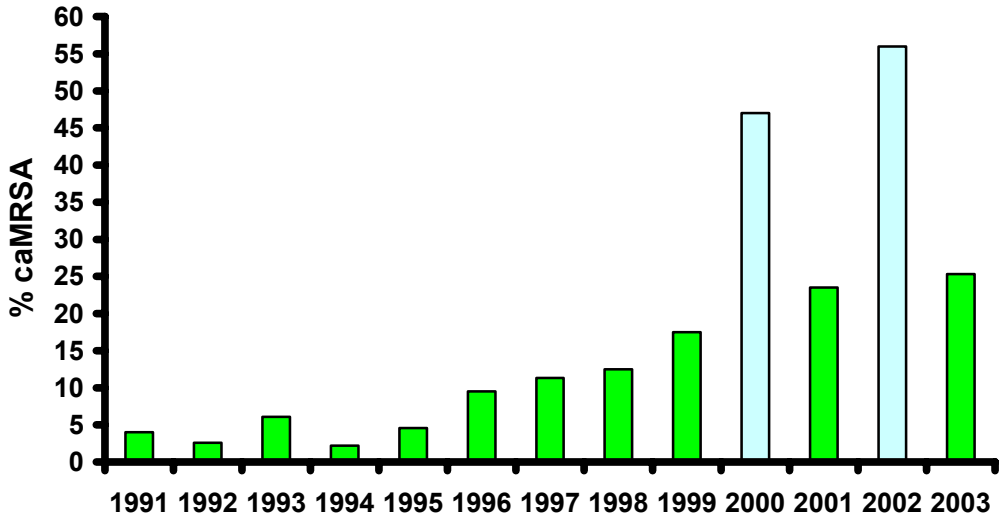
History of caMRSA in Australia

As far as can be determined Australia has been reporting caMRSA for the longest period of time of any country, with the possible exception of Denmark where there was a problem many years ago, controlled until very recently (Appendix 2). The first recorded instances in Australia were from the Kimberley region of Western Australia in 1989 [Udo et al]. Since that time there have been a number of important events

- Steady evolution in caMRSA in Western Australia with replacement of one major clone by another and the emergence of newer clones
- The introduction of the Western Samoan Phage Pattern (WSPP) clone from the Pacific Islands and/or New Zealand. These are prominent in Polynesian communities in eastern Australian [Collignon et al, 1998].
- The notable emergence of the Queensland strain which is PVL-positive.
- Community-acquired strains have become an increasing proportion of all the MRSA seen in Australia's teaching hospitals over the last decade, as evidenced by the surveillance studies conducted by the Australian Group on Antimicrobial Resistance. Only clinical isolates are included in this surveillance; colonising isolates are excluded. In routine surveillance years where all *S. aureus* strains are included from both inpatients and outpatients, now occurring 2nd yearly, caMRSA now make up 25% of all MRSA seen (December 2003). In recent even years (2000 and 2002), where *S. aureus* strains are collected only from bone fide outpatients, caMRSA now makes up more that 50% of all MRSA.

It is clear the caMRSA in now emerging as a significant public health threat and is worsening with time.

Figure 1 – Percentage of all MRSA that are community-acquired – AGAR surveillance

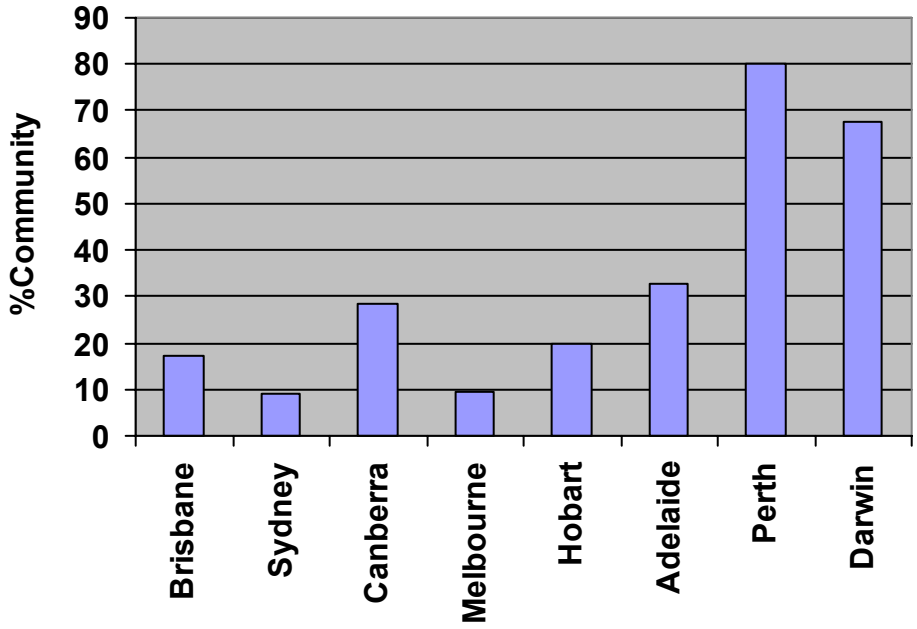


The Current Epidemiology of caMRSA in Australia

The following is the present state of the epidemiological knowledge of caMRSA in Australia:

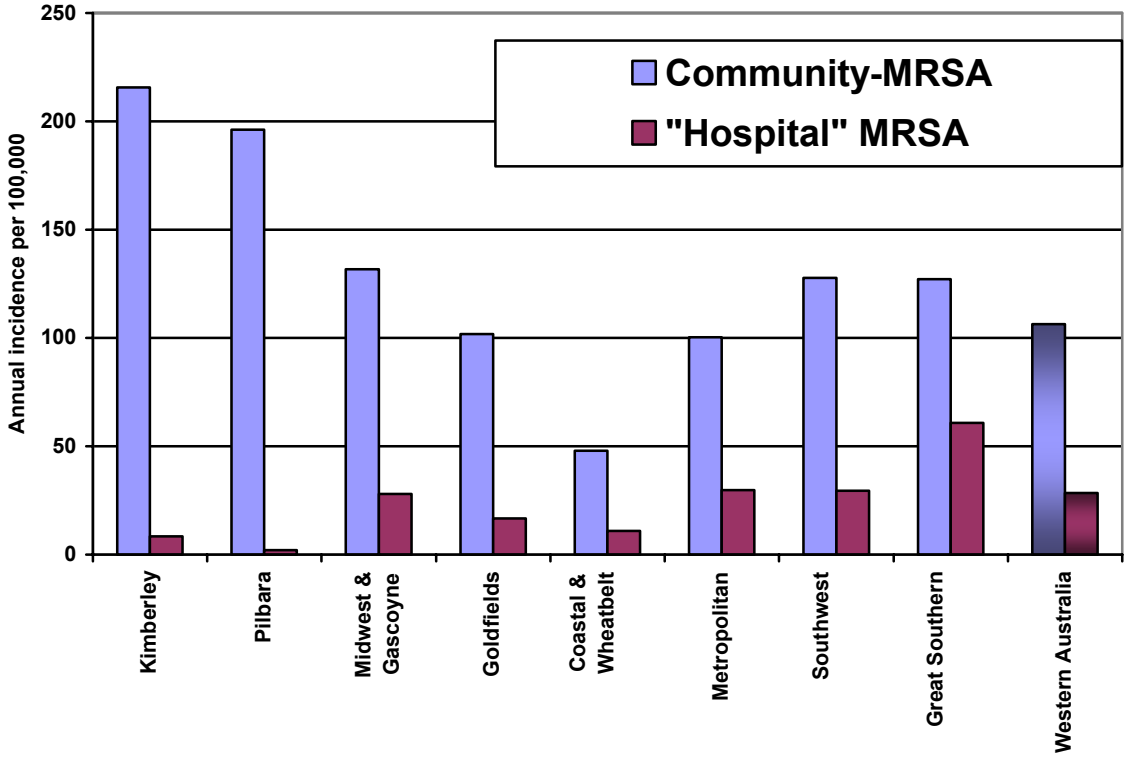
- They are not hospital strains that have brought into the community after people have been hospitalised. Classical hospital strains are found in the community, almost always in people who have been hospitalised previously, but are not readily transmitted in the community and appear to be less common in the community now than caMRSA.
- They have emerged on multiple occasions and in multiple places, both in Australia and internationally
- Some strains have been imported into Australia and spread subsequently
- In contrast to classical hospital-acquired MRSA, they are non-multi-resistant, i.e. they are resistant to ß-lactams and mostly susceptible to other antibiotic classes. In Australia, some strains harbour resistance to macrolides (erythromycin) and/or fusidic acid. A worrying trend in WA is the acquisition of further resistance genes make them multi-resistant and therefore even more difficult to treat.
- There are 5 major clones in Australia (See Appendix 1):
    - Three "WA" (Western Australian) types predominant in Western Australia, SA and NT.
    - A "WSPP" (Western Samoan Phage Pattern) type, prominent on the eastern seaboard, especially in people of Polynesian origin
    - A "Queensland" type, first noted in southern Queensland but now documented as a problem in NSW and SA.
- Hospital outbreaks of caMRSA have been recorded in Australia [O'Brien et al, 1999]. As most hospital outbreaks are not reported, it is difficult to know how frequently caMRSA causes them. What is important is that the growing reservoir of caMRSA is being constantly fed into the hospital system, where opportunities for amplification and spread are even greater, as well as significantly increasing the overall community pool after discharge

Figure 2 – Percentage of MRSA that were community-acquired in AGAR 2003 Survey



Aboriginality remains an important risk factor for caMRSA colonisation and infection. Clinically significant infections caused by the Queensland strain are now being seen in NSW and South Australia. There is some evidence that caMRSA is as important in nursing homes as classical hospital-acquired multi-resistant strains.
Because MRSA is notifiable in WA, data are available on incidence rates by health region (Figure 3). The data below are for financial year 2003-2004.

Figure 3 – Incidence of caMRSA in the Health Regions of WA, July 2003-June 2004



Benchmarking with Other Countries

caMRSA is now be reported as a significant problem in the US and is being reported with increasing frequency from many other areas of the world. The US has probably reached a similar stage in caMRSA evolution. They have noted a particular problem in paediatric patients [Herold et al, 1998; CDC, 1999]. They have also identified a range of other risk groups including Native Americans, homeless youth, men who have sex with men, jail inmates, military recruits, children in child care centres and competitive athletes [Deresinksi, 2005].
caMRSA is now seen with some frequency in Canada and New Zealand. It is being reported from many other areas of the world including some European and Asian countries.

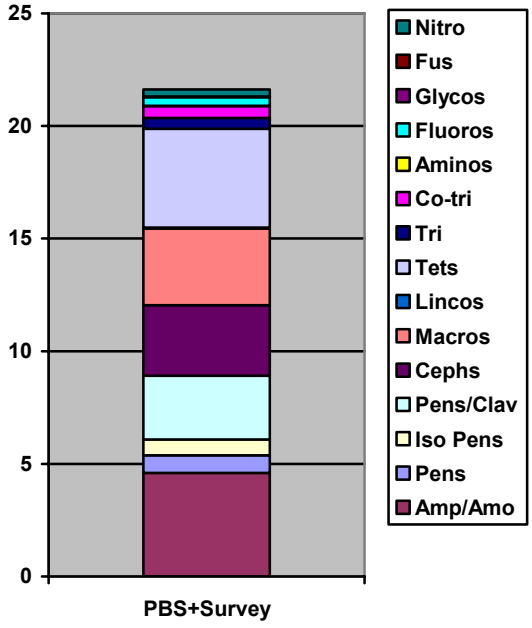
Treatment Issues for caMRSA

Although caMRSA are susceptible to range of other antibiotic classes, in practice it turns out that treatment options are somewhat limited. For minor infections agents such as macrolides and co-trimoxazole are most often recommended. Clindamycin can also be used, while tetracycline is active in vitro, but not relied upon in vivo. Neither is suitable for children (the former due to lack of a paediatric formulation now). For strains that are macrolide resistant (most common in WA 1 MRSA), clindamycin is a controversial alternative due to inducible resistance, and reported failures in more serious infection. Fluoroquinolones are not recommended as single agents as resistance appears to emerge readily.
For serious infection requiring hospitalisation, vancomycin is still the drug of choice, with rifampicin plus fusidic acid the standard approach to follow-on oral therapy except in special conditions such as endocarditis. A proportion of WA 1 strains are resistant to fusidic acid.

Possible Drivers for Increasing caMRSA Prevalence

There are virtually no published data on what drives caMRSA prevalence. At the level of the individual, one can speculate that frequent exposure to antibiotics and skin disease act as risk factors for colonisation. This is a plausible explanation for higher rates of colonisation and disease in Aboriginals. At the level of the population, Australia still has fairly high rates of community antibiotic use, and the majority of agents used (>50% in defined daily dose terms) will select for resistance (penicillins and cephalosporins).

Figure 4 – Australian Statistics on Medicines data for Antibiotics 2000, Defined daily Doses



Current Knowledge Gaps

- **Prevalence**: We have a very incomplete understanding of the prevalence of caMRSA in the community. There have been no published community studies assessing rates of colonisation.
- **Incidence**: Incidence rates of infection are known in WA where the isolation of MRSA is Notifiable and the great majority of strains are sent for typing. There are no data for the rest of the country.
- **Risk factors**: Nothing is known in Australia about risk factors for colonisation or infection
- **Outcome data**: There are no comprehensive data on morbidity or mortality compared to methicillin-susceptible *S. aureus*. Information of treatment outcomes and optimum outpatient treatment is lacking

Possible Interventions to Decrease caMRSA Prevalence

As it is naturally adapted to the human host, eradication is not an option, rather strategies to minimise spread are required.
Until we have data on risk factors for colonisation and infection, it is difficult to predict what interventions are likely to be the most beneficial.
What is needed is a credible and affordable surveillance system (including notification) for not just hospital isolates (as in AGAR surveillance), but true disease surveillance with outcome estimates.
Reducing selective pressure through significant reduction in community antibiotic exposure would also seem reasonable. At least 50% of all community antibiotic use in Australia is considered unnecessary.

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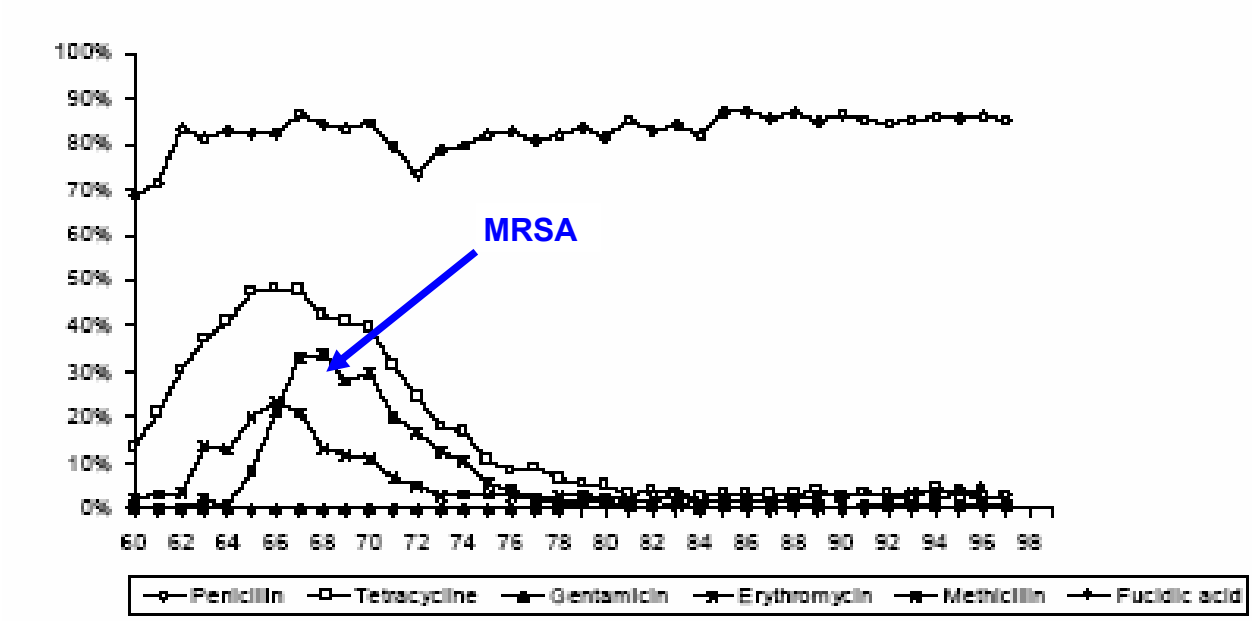
Appendix 1

Prevalence of different clones of caMRSA in the last AGAR survey 2003

CLONE	ALTERNATIVE NAME	% all caMRSA
ST1-MRSA-IV	WA-1 MRSA	43
ST129-MRSA-IV	WA-2 MRSA	13
ST30-MRSA-IV	WSSP MRSA	11
ST93-MRSA-IV	Queensland MRSA	11
ST5-MRSA-IV	WA-3 MRSA	10
ST45-MRSA-V	WA-4 MRSA	3
ST75-MRSA-IV	WA-8 MRSA	2
ST5-MRSA-V	WA-11 MRSA	2
ST8-MRSA-V	–	1.5
ST8-MRSA-IV	WA-12 MRSA	0.8
STnovel-MRSA-IV	–	0.8
STnovel-MRSA-IV	–	0.8
STnovel-MRSA-novel	-	0.8
Total		**N=133**

Appendix 2

Susceptibilties of blood culture isolates of S. aureus in Denmark (1960-1998), N>25,000
(from DANMAP 1998)



Reduction in MRSA rates was attributed to government education about prudent antibiotic use and a subsequent reduction in use of broad-spectrum agents including tetracyclines and streptomycin

Recent resurgence of MRSA in Denmark (mostly community-acquired)
(From DANMAP 2003)

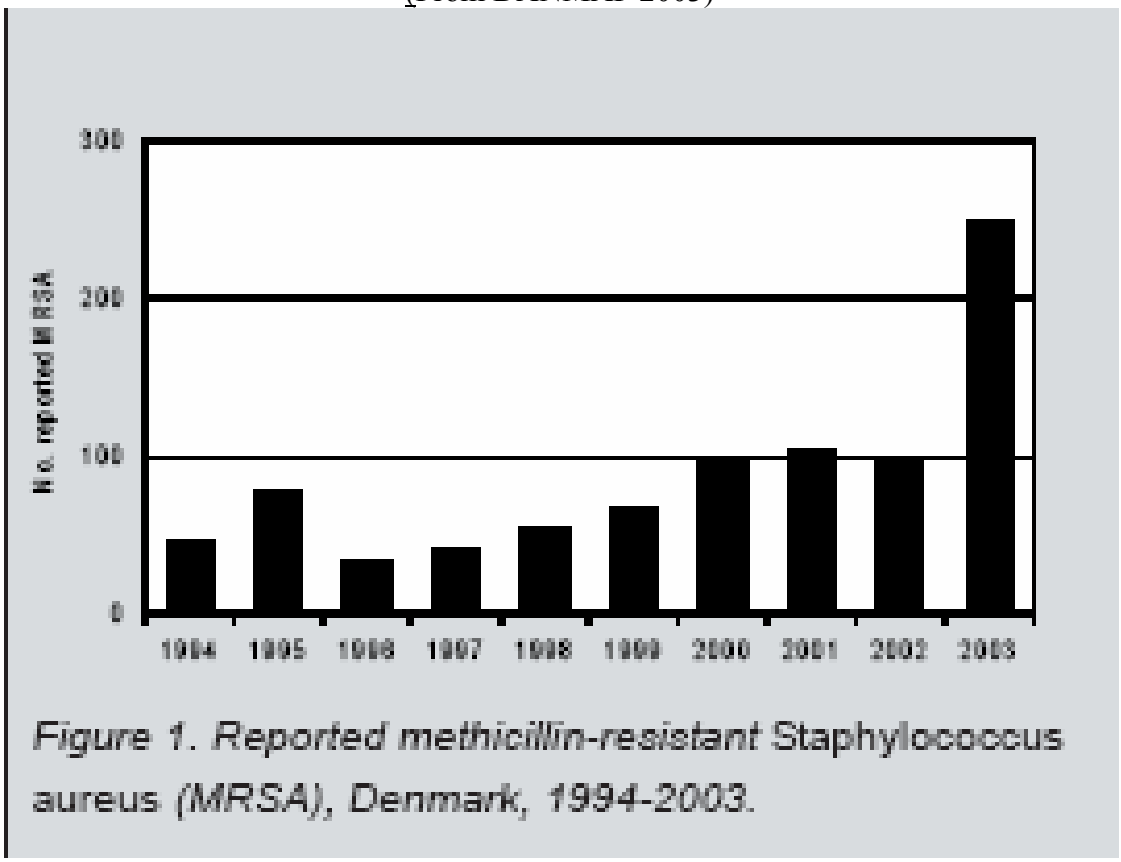


Figure 1. Reported methicillin-resistant Staphylococcus aureus *(MRSA), Denmark, 1994-2003.*

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2006-2007, 31 May - 1 June 2006

Question: E06-132

OUTCOME 15: Biosecurity & Emergency Response

Topic: OFFICE OF HEALTH PROTECTION (OHP)

Written Question on Notice

Senator McLucas asked:

a) How many staff does this Office currently have?

b) How is this projected to grow over the next 4 years?

Answer to Q06-074 states that it is envisioned that the Office will have 150 FTE staff by 30 June 2006. The PBS states that the average staffing level for 2006-07 will be 137.

c) Which is correct?

Answer:

a) 144 actual staff as at 30 June 2006. This includes part-time staff.

b) Over the second half of 2005-06 OHP has been in the process of staffing up to the allocated levels. OHP is expected to maintain its current allocation of 137 Average Staffing Level during 2006-07. This allocation will reduce by 5.5 ASL at the completion of Exercise Cumpston in 2006-07.

c) Both figures are correct. The 137 ASL reported in the 2006-07 PBS is an average figure for the 12 months to 30 June 2007. The FTE figure of 150 relates to staff positions and allows for absences on long-term leave, or temporary transfer and recruitment lags.