Community Affairs Committee

Examination of Budget Estimates 2007-2008

Additional Information Received
CONSOLIDATED VOLUME 2

HEALTH AND AGEING PORTFOLIO

Outcomes 4 to 15

22 FEBRUARY 2008

ADDITIONAL INFORMATION RELATING TO THE EXAMINATION OF BUDGET EXPENDITURE FOR 2007-2008

Included in this volume are answers to written and oral questions taken on notice and tabled papers relating to the budget estimates hearings on 30 and 31 May 2007

*** Please note that 20 March 2008 is the proposed date for answers to be presented to the President of the Senate where this date is indicated**

HEALTH AND AGEING PORTFOLIO

Senator	Quest. No.	Outcome 4: Aged Care and Population Ageing	Vol. 2 Page No.	Date tabled in the Senate or presented out of session*
	T9 tabled at hearing	Probity review of the aged care approvals round (ACAR)		14.06.07
	T10 tabled at hearing	Media release The Hon Christopher Pyne, Minister for Ageing, 25 April 2007 re Broughton Hall Nursing Home		14.06.07
	T11 tabled at hearing	Instrument under Subsection 86-9(1) of the *Aged Care Act 1997*		14.06.07
McLucas	80, 88	Aged care		16.08.07
McLucas	91, 93	Community aged care packages		16.08.07
McLucas	94, 95, 97	ANAO report		16.08.07
McLucas	325, 78, 79, 85	Aged care		16.08.07
McLucas	96	ANAO report		16.08.07
McLucas	101	Closure of aged care facilities in southern Tasmania		16.08.07
McLucas	329	Conditional adjustment payment		16.08.07
McLucas	332	Allocation of places in South Coast Qld		16.08.07
McLucas	323	Multi purpose services		16.08.07
McLucas	334	Broughton Hall		16.08.07
Adams	317-322	Aged care		16.08.07
McLucas	328	Fire safety		16.08.07
McLucas	330, 331, 347	Complaints investigation scheme		16.08.07
McLucas	83, 87, 90	Aged care		16.08.07
McLucas	89	Respite care		16.08.07
McLucas	324	Aged care innovative pool		16.08.07
McLucas	335	Innovative pool		16.08.07
McLucas	81, 82, 84	Aged care		16.08.07
McLucas	92	Community aged care packages		16.08.07
McLucas	98	CAP financial reports		16.08.07
McLucas	326	Commonwealth Carelink		16.08.07
McLucas	327	Aged care information line		16.08.07
McLucas	86	Aged Care		16.08.07
		Aged care places June 2007 stocktake		20.09.07

Senator	Quest. No.	Outcome 5: Primary Care	Vol. 2 Page No.	Date tabled in the Senate or presented out of session*
McLucas	378	Dental allied health		16.08.07
McLucas	178	Practice nurses		16.08.07
McLucas	176	Autism and chronic disease management Medicare items		16.08.07
Crossin	288	Budget measures		26.10.07
McLucas	181	Round the clock Medicare: investing in after hours GP services		26.10.07
McLucas	182, 183	PIP		26.10.07
		Outcome 6: Rural Health		
Moore	379	Rural women's GP service		16.08.07
McLucas	185	Rural women's GP service		16.08.07
Moore	381	Medical Specialist Outreach Assistance Program (MSOAP)		13.09.07
McLucas	184	Rural Health Strategy		13.09.07
McLucas	186	Medical Specialist Outreach Assistance Program (MSOAP)		13.09.07
		Outcome 7: Hearing Services		
Crossin	374	Hearing services funding		16.08.07
		Outcome 8: Indigenous Health		
	T14 tabled at hearing	ATSI Medicare health checks resource kit		14.06.07
	DoHA letter	Letter from DoHA 18 June 07 clarifying evidence provided at the hearing on 31 May 07 relating to petrol sniffing		16.08.07
McLucas	189	Indigenous health service accreditation		16.08.07
McLucas	187, 188	Family centred primary health care		16.08.07
McLucas	190	CDEP		16.08.07
Crossin	273-275, 277-280	Primary Health Care Access Program (PHCAP)		16.08.07
Crossin	283	Alcohol abuse		16.08.07
Crossin	287, 287A	Rephasing of funds within the combating petrol sniffing program		16.08.07
Crossin	292	Health@Home Plus		16.08.07
Crossin	293	Central Australia eye health blitz		16.08.07
Siewert	294	Rollout of *Opal* fuel and diversionary activities in the East Kimberley		16.08.07
Siewert	295	22 new counsellors for Link Up services		16.08.07
McLucas	191, 272, 276, 281	Primary Health Care Access Program (PHCAP)		13.09.07
McLucas	282, 284	Alcohol abuse		13.09.07
Crossin	285, 286	Additional measures		13.09.07
Crossin	368	Budget measures		26.10.07

Outcome 9: Private Health

	DoHA letter	Letter from DoHA 20 June 07 clarifying evidence provided at the hearing on 31 May 07 relating to mailout on private health improvements	16.08.07
Humphries	51, 54-59	Private health insurance	16.08.07
Humphries	53, 61	Private health insurance	13.09.07
Humphries	52, 60	Private health insurance	26.10.07
McLucas	314, 315, 316	Lifetime health cover	26.10.07
McLucas	380	Private health insurance	26.10.07
Humphries	50	Private health insurance	26.10.07

Outcome 10: Health System Capacity and Quality

Stott Despoja	12	Policy/development	16.08.07
Stott Despoja	15, 18, 20, 21, 22, 23	eHealth	16.08.07
Stott Despoja	39	HealthConnect	16.08.07
Stott Despoja	1-3	eHealth	16.08.07
Stott Despoja	4	HealthConnect	16.08.07
Stott Despoja	5	eHealth	16.08.07
Stott Despoja	6-7	Policy development	16.08.07
Stott Despoja	8	eHealth	16.08.07
Stott Despoja	9-11	Policy development	16.08.07
Stott Despoja	14, 16, 19	eHealth	16.08.07
Stott Despoja	24	HealthConnect	16.08.07
Stott Despoja	25	Project management	16.08.07
Stott Despoja	26	National Health Information Group	16.08.07
Stott Despoja	27	eHealth	16.08.07
Stott Despoja	28-29	Project management	16.08.07
Stott Despoja	30-31	HealthConnect	16.08.07
Stott Despoja	32	eHealth	16.08.07
Stott Despoja	33	SA HealthConnect request for proposal	16.08.07
Stott Despoja	35-38, 40	eHealth	16.08.07
Stott Despoja	42-43	AHIC	16.08.07
Stott Despoja	44-46	eHealth	16.08.07
Stott Despoja	48	Personal information	16.08.07
Stott Despoja	49	Banks	16.08.07
McLucas	193-194	Broadband for Health Program	16.08.07
Polley	367	Heart, stroke and vascular disease	13.09.07
Stott Despoja	13	Policy/development	13.09.07
Stott Despoja	34	HealthConnect	13.09.07
McLucas	192	Broadband for health program	13.09.07
Stott Despoja	17	eHealth	20.09.07
Stott Despoja	41	Budget/costs/staff	20.09.07
Moore	366	Strengthening Cancer Care Initiative	20.09.07
Moore	365	Local Palliative Care Grants Program	26.10.07
Stott Despoja	47	eHealth	26.10.07
Moore	364	Strengthening cancer care initiative	20.03.08

		Cancer Australia agency	
	T15 tabled at hearing	Membership of the National Working Group for Gynaecological Cancers	14.06.07
		National Health and Medical Research Council agency	
Senator Patterson	T18 provided after hearing 05.06.07	Australian Health Ethics Committee, ART review public consultation copy of submissions 1 - 93	14.06.07
		Outcome 11: Mental Health	
	T12 tabled at hearing	Uptake of the Better Access Initiative MBS items by State/Territory	14.06.07
	DoHA letter	Letter from DoHA 19 June 07 clarifying evidence provided at the hearing on 31 May 07 relating to support for day-to-day living in the community initiative	16.08.07
Allison	383	Expanding suicide prevention programs	16.08.07
McLucas	220, 221, 223	Rural and remote areas	16.08.07
McLucas	222	Mental health workforce	16.08.07
McLucas	224-232	Day to day living	16.08.07
McLucas	243-244	Youth Mental Health Foundation - *headspace*	16.08.07
McLucas	248	ADHD – Royal Australasian College of Physicians Clinical Guidelines Review terms of reference	16.08.07
McLucas	250-252	Attention-Deficit Hyperactivity Disorder (ADHD)	16.08.07
Moore	305-308	Mental health	16.08.07
Allison	309	Suicide statistics and the quality of data being reported	16.08.07
Allison	310	Expanding suicide prevention programs	16.08.07
Allison	311	Mental health	16.08.07
Moore	312	Increased mental health services for drought-affected communities	16.08.07
Moore	377	Mental health	16.08.07
McLucas	246	Youth Mental Health Foundation - Headspace	13.09.07
McLucas	247	Attention-Deficit Hyperactivity Disorder (ADHD) – RoyalAustralasian College of Physicians Clinical Guidelines Review Working Group	13.09.07
McLucas	249	Attention-Deficit Hyperactivity Disorder (ADHD) – RoyalAustralasian College of Physicians Clinical Guidelines Review Working Group – process for identifying conflicts of interest	13.09.07
McLucas	253	ADHD	13.09.07
McLucas	198, 199	Early intervention – Professor Berly Raphael	13.09.07
McLucas	200-202	Suicide intervention	13.09.07
McLucas	203-205	Better Access program	13.09.07
McLucas	206-207	Better Access initiative	13.09.07
McLucas	211-216	Expanding suicide prevention programs	13.09.07
McLucas	217-219	Telephone counselling	13.09.07
McLucas	195	Mental health	13.09.07
Moore	303	Mental health	13.09.07
McLucas	245	Youth Mental Health Foundation - Headspace	20.09.07
Webber	349	Dr Darryl Efron	20.09.07
McLucas	150	Autism	26.10.07

Outcome 12: Health Workforce Capacity

Senator	Quest. No.	Topic	Date tabled in the Senate*
McLucas	260, 300	Workforce	16.08.07
McLucas	301	Dental training	16.08.07
Eggleston	126-129	Australian General Practice Training Program	16.08.07
McLucas	179-180	Practice nurses	16.08.07
McLucas	259	Workforce	16.08.07
McLucas	264	Nurse Scholarship Program (NSP)	16.08.07
McLucas	302	Overseas trained dentists	16.08.07
McLucas	256	Bonded medical places scheme 2007 intake and expenditure	16.08.07
McLucas	254	GP ratios	13.09.07
McLucas	258	Workforce	13.09.07
McLucas	257	Medical rural bonded scholarship scheme places 2007 intake and expenditure	13.09.07
McLucas	255	GP ratios	20.09.07
McLucas	262	Workforce	20.09.07
McLucas	267	Overseas trained specialists upskilling program	20.09.07
McLucas	269	Clinical training of doctors	20.09.07
McLucas	261	Workforce – Prevocational General Practice Placements Program	26.10.07
McLucas	263	Workforce	26.10.07
McLucas	265	Nurse Scholarship Program: National Re-entry Scheme	26.10.07
McLucas	266	Workforce	26.10.07
McLucas	299	Workforce shortage	26.10.07
McLucas	270	More doctors for outer metropolitan areas measure	20.03.08

Senator	**Quest. No.**	**Outcome 13: Acute Care**	**Date tabled in the Senate***
McLucas	169	Dental program	16.08.07
McLucas	170	Dental	16.08.07
McLucas	271	Pathways	16.08.07
McLucas	346	Cost reporting	16.08.07
McLucas	345	Dental health	13.09.07

PROBITY REVIEW OF THE AGED CARE APPROVALS ROUND (ACAR)

TERMS OF REFERENCE

The revised terms of reference of the review, as agreed by Minister Pyne in April 2007, follow. The additional terms are shown in **bolded text.**

The review is examining:

- probity and ethics guidelines and associated training;
- management of conflict of interest registers;
- confidentiality and security;
- the **transparency of the** decision making process;
- **the timeliness and efficiency of the process including links to grants of approved provider status**; and
- feedback to applicants.

The review will include, but not be limited to, examining material relating to the 2005 and 2006 Approvals Rounds. In addition, interviews will be conducted with staff from the Department of Health and Ageing's state and territory offices and central office, applicants for places, members of peak industry bodies and staff from the Minister's Office.

REFERENCE GROUP

A reference group has been established to provide guidance and support to the consultant undertaking the review. The membership of the reference group, as agreed by Minister Pyne in April 2007, follows.

- Mr Glenn Bunney, National President, Aged and Community Services Australia;
- Mr Brian Dorman, Federal President, Aged Care Association of Australia and Executive Chairman and CEO of the Regis Group;
- Dr John Donovan, Commissioner of Complaints, National Health & Medical Research Council;
- Ms Allison Rosevear, Assistant Secretary, Residential Program Management Branch, Ageing and Aged Care Division, Department if Health and Ageing (originally Stephen Dellar); and
- Mr Paul Taranto, Assistant State Manager, NSW Office, Department if Health and Ageing.

Secretariat Support is provided by the Department of Health and Ageing.

T10

THE HON CHRISTOPHER PYNE MP
Minister for Ageing
MEDIA RELEASE

25 April 2007 CP37/07

The Minister for Ageing, Christopher Pyne, has reaffirmed his decision to publicly release preliminary details of an audit of Broughton Hall nursing home in Melbourne following a gastroenteritis outbreak and five deaths.

“While the home has seven days to respond to the preliminary assessment by the Aged Care Standards and Accreditation Agency, which found 12 possible areas of non-compliance with the 44 accreditation standards, I had previously given an undertaken to residents and their families that I would release the major findings as soon as possible, and I believe I should honour that commitment,” Mr Pyne said.

“The agency will visit the home every day to monitor the standards of care until I receive the final Review Audit Report and its recommendations.”

Mr Pyne said he was pleased that the home is already taking steps to remedy some of the issues of concern.

“I fully acknowledge that determining the cause of death of the five Broughton Hall residents is a matter for the Victorian Coroner and that the Coroner has yet to issue any findings in this regard,” Mr Pyne said.

“My actions in releasing the preliminary audit findings reflect my deep concern for the residents and families of Broughton Hall and I am happy to be held accountable for my belief that the overriding issue at stake is their health safety and well-being.

“That has been, and will continue to be, the guiding principle of the Government’s policy on aged care,” Mr Pyne said.

T11

T11

INSTRUMENT UNDER SUBSECTION 86-9(1) OF THE *AGED CARE ACT 1997*

On 24 April 2007, I, Carolyn Smith, relying on my power as delegate of the Secretary under subsection 86-9(1) of the *Aged Care Act 1997* (the Act), make publicly available information about Benetas @ Broughton Hall Nursing Home and Broughton Hall Hostel (the Services), including information obtained during the review audit conducted by an assessment team appointed by the Aged Care Standards and Accreditation Agency Ltd (the Agency) from 17 to 23 April 2007. The information comprises:

- the names of the services; and
- information about the approved provider's performance in relation to responsibilities and standards under the Act.

The information about the approved provider's performance in relation to responsibilities and standards under the Act that I am making publicly available includes that, in relation to the Accreditation Standards, information from the Review Audit Major Findings- Assessment Information of the Agency's assessment team that the provider has not complied with a number of accreditation outcomes under the standards in relation to the Services.

....

Carolyn Smith
First Assistant Secretary
Office of Aged Care Quality and Compliance

PN....20011807..................

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30-31 May 2007

Question: E07-080

OUTCOME 4: Aged Care and Population Ageing

Topic: AGED CARE

Written Question on Notice

Senator McLucas asked:

Do veterans receive any specific consideration in the planning process for any services listed below? If so, what specific treatment?

a. residential aged care
b. Extended Aged Care at Home
c. Extended Aged Care at Home Dementia
d. Community Aged Care Package
e. Respite Care

Answer:

Yes. Veterans, including the spouse, widow or widower of a veteran are recognised under the aged care legislation (Aged Care Principles) as one of the identified special needs group. As such the care needs of all people with 'special needs', must be taken into account in the planning process for making places available for allocation.

Aged Care Planning Advisory Committees, in all states and territories provide advice to the delegate of the Secretary of the Department of Health and Ageing on the distribution of aged care places across the Aged Care Planning Regions within their respective state or territory. This includes advice on the number and locality of new places with a focus on people with 'special needs' including veterans.

All providers allocated places in the Aged Care Approvals Round must demonstrate a capacity to provide appropriate care to people from all special needs groups, including to veterans and the spouse, widow or widower of a veteran.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30-31 May 2007

Question: E07-088

OUTCOME 4: Aged Care and Population Ageing

Topic: AGED CARE

Written Question on Notice

Senator McLucas asked:

Does the Department ensure that aged care nurses, allied professionals and aged care providers are aware of the complex needs of veterans? If so how?’

Answer:

It is the responsibility of approved providers to ensure that the care needs of all care recipients, including veterans are met.

Approved providers of Australian Government subsidised aged care services must ensure that Accreditation Standards are met. Specifically, Standard 3.4 (Emotional Support) and 3.8 (Cultural and Spiritual Care) expect that the approved provider assesses and meets the emotional and psychological needs of all residents, including veterans.

Applicants for aged care places in the Aged Care Approvals Round must demonstrate that they can provide a high level of appropriate care to all care recipients, including people from special needs groups, such as veterans. There is a continuing expectation on the approved provider that the conditions of allocation are met.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30-31 May 2007

Question: E07-091

OUTCOME 4: Aged Care and Population Ageing

Topic: COMMUNITY AGED CARE PACKAGES

Written Question on Notice

Senator McLucas asked:

What were the CACP, Extended Aged Care at Home (EACH) and Extended Aged Care at Home Dementia (EACH-D) vacancy rates for 2002/03; 2003/04; 2004/05; 2005/06?

Answer:

The information requested is provided in the table below. The EACH Program commenced in 2003-04 and the EACH-D Program in 2005-06.

	CACP	**EACH**	**EACH-D**
2002-03	4.66%	..	..
2003-04	3.31%	22.74%	..
2004-05	4.15%	18.34%	..
2005-06	6.57%	16.72%	66.23%

NOTES ON OCCUPANCY IN CACPS, EACH AND EACH-D PACKAGES

EACH and EACH-D

Generally, new EACH and EACH D services take three or four quarters to build up their occupancy levels, but when they do reach what appears to be an optimal level, that level is high. The average occupancy of EACH services that have been operating for at least 12 months and have not had a new allocation of packages during that time is 94%. EACH-D services that have been operating for six months have an occupancy of 83% and the very few that have been operating for 12 months have occupancies of 90%.

Because the community based high care sector is still small but growing, new allocations of places will cause significant drops in average occupancy – but these drops appear to be short-lived.

The EACH and EACH-D occupancy data are quite sensitive to claiming practices and data entry practices. It is known, for example, that some services do not claim for several months and then submit a claim covering all of those months.

CACPs

CACP occupancy is currently 93.1% nationally. A good proportion of the vacancy is the effect of new services or increased allocations having an impact on the apparent average occupancy level. The number of CACPs has increased 36% over the last five years.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30-31 May 2007

Question: E07-093

OUTCOME 4: Aged Care and Population Ageing

Topic: COMMUNITY AGED CARE PACKAGES

Written Question on Notice

Senator McLucas asked:

What are the average hours of care delivered in each of the packages, CACP, Extended Aged Care at Home (EACH) and Extended Aged Care at Home Dementia (EACH-D) where applicable from 2002/03; 2003/04; 2004/05; 2005/06; 2006/07 to date?

Answer:

CACP care service hours information has been reported on a per care recipient basis since 2004-05 and EACH and EACH-D hours since 2005-06. Since not every care recipient received care for a full year, especially where new packages began operating part-way through a financial year, hours of care information is provided as a monthly average:

Average Hours per Client per month	CACP	EACH	EACH-D
2004-05	20.03	..	..
2005-06	19.88	53.28	39.35
2006-07	19.42	51.31	48.82

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30-31 May 2007

Question: E07-094

OUTCOME 4: Aged Care and Population Ageing

Topic: ANAO REPORT

Written Question on Notice

Senator McLucas asked:

The Australian National Audit Office Report on the "Administration of the Community Aged Care Packages Program" released on 24 May states that "The aged care legislation specifies minimum content for the annual report that the responsible minister must cause to be laid before each House of Parliament on the operation of the Aged Care Act 1997. Those matters that are directly relevant to CACPs include:

- the extent of unmet demand for places; and
- the extent to which providers are complying with their responsibilities under the Act.

How is the Department going to address improved reporting to Parliament about the extent of unmet need and provider responsibilities, as required by the legislation?

Answer:

The Department will provide additional information on CACPs in the Report on the Operation of the Aged Care Act 1997.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30-31 May 2007

Question: E07-095

OUTCOME 4: Aged Care and Population Ageing

Topic: ANAO REPORT

Written Question on Notice

Senator McLucas asked:

The Audit Report states that DOHAs ongoing management of CACPs would be strengthened by improvements in the following areas:

- greater consistency in the practices of DoHA's State and Territory offices with regards to their regional planning and assessment roles in the Aged Care Approvals Round, as well as in the areas of program management and approaches to monitoring outcomes:
- improved monitoring of service provider performance including their focus on special needs groups over time.

How is the Department planning to address these issues?

Answer:

The Department is preparing new national guidelines to support its state and territory offices in their regional planning and assessment roles as part of the Aged Care Allocation Round.

The Department is also developing new systems and procedures to monitor conditions of allocation of places including those in relation to people with special needs.

One element of the *Securing the future of aged care for Australians* package was funding of $26.8 million over four years to enhance the community care quality assurance framework, and provide for the development of best practice models and benchmarking in key areas of community care. The Department will consult with consumer and provider representatives on these developments.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30-31 May 2007

Question: E07-097

OUTCOME 4: Aged Care and Population Ageing

Topic: ANAO REPORT

Written Question on Notice

Senator McLucas asked:

Another concern the ANAO highlighted was: “While the legislation provides for ‘special needs groups’ to receive particular attention in allocation of places; how far providers continue to adhere to conditions of grants of places relating to special needs groups year-upon-year is not monitored in any ongoing way.

How will the Department ensure that special needs CACPs actually go to the special needs groups they were intended for on a year-upon-year basis?

Answer:

The Department is currently developing a new information system that will centrally record and track aged care places, including the conditions of allocation attached to individual places. This will improve the Department’s capacity to systematically monitor adherence to conditions of allocation.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 31 May 2007

Question: E07-325

OUTCOME 4: Aged Care and Population Ageing

Topic: AGED CARE

Hansard Page: CA 16

Senator McLucas asked:

I would like the data for the past two years on the numbers of people approved by ACATs for CACP, EACH, low care and high care by planning region (or ACAT region).

Answer:

The attached data are the number of people approved for care by Aged Care Assessment Teams (ACATs) for the years 2004-2005 and 2005-2006. Data provided may include a client in one or more of the care types provided.

Data by planning region is not available.

ACAT Name	ACAT State	2004-05						2005-06					
		Total People Approved	Community			Residential		Total People Approved	Community			Residential	
			CACP	EACH	EACH-D	HIGH	LOW		CACP	EACH	EACH-D	HIGH	LOW
Albury	NSW	910	263	17		294	585	873	331	22	1	273	516
Auburn	NSW	384	87	5		249	83	395	118	15	2	220	102
Bankstown	NSW	1243	551	50		569	558	1321	526	78	31	666	542
Bathurst	NSW	362	146	6		150	168	440	155	17		219	172
Bega Valley	NSW	255	100	13		92	136	259	98	22	11	101	141
Blacktown	NSW	832	297	14		375	282	1027	360	60	11	459	365
Blue Mountains	NSW	654	230	12		277	304	674	243	34	2	276	318
Camden/Cambelltown/Wollondilly	NSW	780	301	6		334	292	822	280	23	8	368	322
Camperdown	NSW	1259	537	105		589	330	1218	530	100	9	558	344
Canterbury	NSW	634	227	24		258	235	640	167	28	3	325	205
Central Coast	NSW	3302	1772	112		1227	1812	2967	1491	160	29	1164	1317
Clarence Valley	NSW	404	146	14		222	142	438	147	32	12	247	150
Coffs Harbour	NSW	1066	493	89		358	578	994	385	72	3	376	486
Concord	NSW	1458	586	61		719	476	1461	645	61	9	683	559
Cooma	NSW	208	100			62	119	381	211	12	1	120	234
Cootamundra	NSW	834	320	88	1	390	367	828	331	121	2	365	394
Dubbo	NSW	814	296	8		259	448	687	218	39	2	267	314
Eurobodalla	NSW	468	274	39		185	236	494	309	22	1	184	246
Far West	NSW	350	123	1		121	181	331	113	2		120	181
Goulburn	NSW	346	144	1		121	198	334	123	1		126	197
Hornsby/Ku-ring-gai	NSW	1908	589	37		856	868	1821	617	70	13	824	824
Hunter Rural	NSW	1277	494	19		438	755	1268	516	63	4	446	762
Hunter Urban	NSW	3296	1345	107		1238	1746	4003	1689	275	36	1416	2278
Kogarah	NSW	1646	449	5		827	674	1550	441	52		775	619
Lady Davidson	NSW	242	50	2		117	95	281	55	8	4	136	117
Liverpool/Fairfield	NSW	1197	443	59		611	308	1311	420	136	20	664	402
Lower Mid North Coast	NSW	1055	431	70		356	631	1091	459	48	3	335	696
Lower North Shore	NSW	1430	392	6		730	530	1282	351	35	7	668	476
Macleay-Hastings	NSW	1029	503	66		373	605	1241	664	78	24	433	804
Manly	NSW	1133	574	49		449	388	1163	626	70	11	424	396
Milton/Ulladulla	NSW	237	115	26		56	136	207	73	28	1	90	74
Mona Vale	NSW	827	384	37		391	263	903	453	70	5	394	294

Number of People Approved by ACAT Team

ACAT Name	ACAT State	2004-05 Total People Approved	2004-05 Community CACP	2004-05 Community EACH	2004-05 Community EACH-D	2004-05 Residential HIGH	2004-05 Residential LOW	2005-06 Total People Approved	2005-06 Community CACP	2005-06 Community EACH	2005-06 Community EACH-D	2005-06 Residential HIGH	2005-06 Residential LOW
Murrumbidgee	NSW	380	196	59		172	202	430	186	54	2	211	212
Narrabri	NSW	259	83	13		102	123	231	63	7	1	89	109
Northern Beaches	NSW							4	1			1	2
Northern Illawarra	NSW	1553	618	107		596	709	1427	469	95	13	573	517
Northern Tablelands	NSW	500	167	14		217	231	468	213	17	9	216	196
Orange	NSW	558	163	2		282	217	540	160	18	1	253	221
Parkes	NSW	178	32	1		92	63	184	30	5		92	81
Penrith	NSW	989	373	12		444	401	1071	382	68	7	493	439
Randwick/Botany	NSW	1210	560	3		564	389	1094	499	52	3	498	384
Richmond	NSW	838	277	41		360	314	871	288	49	1	407	306
Ryde	NSW	1026	274	34		517	419	958	310	73	10	473	396
Shoalhaven	NSW	674	276	16		254	333	692	275	13	5	249	356
Southcare	NSW	1354	378	2		622	653	1352	461	53	18	565	742
Tamworth	NSW	652	254	17		189	450	468	127	10	4	187	246
Tweed Valley	NSW	884	413	13		311	449	798	298	62	7	310	430
Waverley	NSW	1178	399	7		511	466	1148	412	53	6	496	436
Westmead	NSW	2284	957	59		926	928	2193	998	175	18	893	864
Wingecarribee	NSW	392	133	24		169	170	438	110	15		190	224
Young	NSW	114	32			56	44	140	53	1		51	68
Ballarat	VIC	1452	479	75	2	554	796	1515	441	74	23	634	775
Bendigo	VIC	1838	423	75	1	685	1041	1833	425	92	13	701	1020
Bundoora	VIC	1587	390	36		625	842	1276	347	86	20	542	527
Caulfield	VIC	2590	871	76	1	989	1135	2672	916	92	17	1033	1134
Eastern	VIC	3801	877	125	1	1252	2407	3974	823	190	91	1388	2468
Geelong	VIC	1997	697	35	1	767	854	1997	654	62	64	794	836
Gippsland	VIC	1786	627	86	1	598	972	1834	546	135	16	657	1018
Heidelberg	VIC	1143	399	28		496	506	1120	361	34	9	458	528
Kingston	VIC	2351	487	88		1009	1205	2248	470	95	28	910	1130
Mildura	VIC	417	114	15		132	235	405	120	29	2	131	209
Mt Eliza	VIC	2573	848	112		866	1349	2233	522	100	32	832	1087
Northwest	VIC	2152	698	99	2	726	1079	2271	669	159	52	797	1150

Outer East	VIC	2736	939	196	2	966	1539	2849	1015	192	64	986	1662
Shepparton	VIC	989	303	15		320	565	1110	387	98	4	392	565
St Georges	VIC	1881	476	60		776	895	2071	487	99	26	880	1008
Wangaratta	VIC	1053	422	25		271	655	1121	391	50	9	307	700
Warrnambool	VIC	1194	799	56	1	380	651	894	349	86	24	335	408
Western	VIC	2416	1077	133		988	1112	2532	1040	233	60	991	1236
Bayside	QLD	5150	883	176	1	2331	2679	5090	968	172	47	2387	2497
Cairns	QLD	966	345	40		418	448	949	393	78	1	366	416
Central West	QLD	58	22	11		26	18	82	46	1		35	18
Fraser Coast	QLD	1762	394	53		736	977	1507	344	67	13	680	741
Gold Coast	QLD	3734	1886	306		1532	2156	4022	2294	342	33	1509	2462
Mackay	QLD	625	156	8		248	360	665	123	41		271	400
Mount Isa	QLD	87	35	4		28	30	80	25	3		34	32
Pine Rivers	QLD	928	184	47		463	473	1594	376	72	18	788	838
Prince Charles Hospital	QLD	1438	273	66	1	741	655	1129	311	53	15	508	583
Rockhampton	QLD	987	256	61		428	509	994	257	73	32	453	516
Roma	QLD	1668	420	75		654	908	1514	373	65	1	657	734
Royal Brisbane Hospital	QLD	2276	336	52		956	1317	2209	384	78	13	925	1227
Sunshine Coast	QLD	2167	768	1		760	1362	2310	800	64	1	874	1346
Townsville	QLD	1783	763	80		691	793	1587	739	110	1	583	671
West Moreton	QLD	1087	302	61		474	590	1095	311	111	28	555	530
Adelaide Hills and Southern Fleurieu	SA	831	345	62		218	575	862	437	56	15	214	581
Barossa	SA	228	121	17		61	165	242	139	16	7	79	160
Eastern	SA	2791	612	103		1499	1039	372	59	25	1	197	136
Flinders Far North	SA	161	91	11		43	88	171	98	32	1	52	76
Kangaroo Island	SA	20	1			5	15	25				5	21
Lower Eyre Peninsula	SA	204	101			47	134	262	136		3	54	183
Lower North	SA	156	76	5		54	87	143	84	15	2	48	88
Lower South East	SA	242	85	9		74	146	315	120	19		106	177
Mid North	SA	174	105	31		77	79	192	111	21	6	67	97

Number of People Approved by ACAT Team

ACAT Name	ACAT State	2004-05						2005-06					
		Total People Approved	Community			Residential		Total People Approved	Community			Residential	
			CACP	EACH	EACH-D	HIGH	LOW		CACP	EACH	EACH-D	HIGH	LOW
Murray Mallee	SA	239	186	31	1	76	138	324	212	35	7	125	159
Northern	SA	1420	304	69		701	593	3694	852	222	36	1947	1504
Riverland	SA	384	158	10		117	193	371	144	2		123	162
Southern	SA	2958	1516	249		1182	1561	5567	2254	268	57	2312	3035
Unknown	SA							178	178				
Upper South East	SA	160	92	15		49	85	187	134	16		60	91
Western	SA	2774	1007	141		1180	1460	268	99	12	1	116	131
Whyalla	SA	156	80	4		47	99	159	78	16		56	107
Yorke Peninsula	SA	273	113	8		121	139	308	151	27	4	115	172
Albany	WA	351	99			122	179	274	51		3	119	132
Armadale/Kelmscott	WA	350	66	2		160	180	421	93	12	8	197	221
Bentley Geriatric	WA	1179	411	61	1	449	621	1187	420	85	54	454	616
Bunbury	WA	768	218	1		308	441	877	369	9	16	325	482
Fremantle	WA	1285	494	169	1	555	645	1542	702	234	41	616	771
Geraldton	WA	229	91			70	140	281	119			87	176
Kalgoorlie	WA	127	63	1		49	59	128	51			37	60
Kimberley	WA	106	58			40	30	89	54			29	24
Mandurah	WA	713	235	39		280	421	734	269	53	7	284	434
Narrogin	WA	73	25			23	40	109	28			48	55
Northam	WA	180	50	2		78	67	154	47		1	71	63
Osborne Park	WA	1682	890	160	1	604	977	2021	1152	240	47	720	1143
Pilbara	WA	37	18			17	8	39	22			14	7
Royal Perth	WA	1085	609	25	1	369	604	1152	668	48	26	424	621
Sir Charles Gairdner	WA	1668	594	169		762	731	1691	605	184	38	740	722
Swan District	WA	744	320	3	1	278	343	779	359	58	20	267	377
North	TAS	866	190	27		484	286	819	202	31	8	476	266
North West	TAS	500	125			200	254	596	165	2	4	260	260
South	TAS	1340	343	44		644	477	1270	262	47		669	433
Alice Springs	NT	250	179	34		70	35	296	213	41	1	99	49

Darwin Aged Care Assessment Team	NT	341	178	50		121	91		345	204	51	14	109	83
Katherine Aged &Disability Program	NT	74	54			22	15		85	68			22	22
ACT	ACT	4243	1835	284		711	1791		3315	1634	388	83	708	1500
Total		136897	48434	5784	21	54530	67234		137838	49230	8175	1638	55813	66945

The column "Total People Approved" is the number of people approved for care. The specific Care Type columns count the number of people approved for that specific care type. A person will only be counted once for each care type although they may have previous approvals for that type of care. However, people may be approved for more than one type of care (eg CACP and Low level residential). In this circumstance they would be included in the numbers for each care type for which they had an approval. Therefore the total for all care types is not the number of people approved for care.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30-31 May 2007

Question: E07-078

OUTCOME 4: Aged Care and Population Ageing

Topic: AGED CARE

Written Question on Notice

Senator McLucas asked:

What input does DVA provide to inform the aged care planning process. If so, what?

Answer:

The Department of Veterans' Affairs provides input to Aged Care Planning Advisory Committees, either as fully appointed Committee members or through oral and/or written submissions to the Committee meetings. The Committees provide advice to the delegate of the Secretary of the Department of Health and Ageing on the distribution of aged care places across the Aged Care Planning Regions within their respective state or territory. This includes advice on the number and locality of new places with a focus on people with 'special needs' including veterans.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30-31 May 2007

Question: E07-079

OUTCOME 4: Aged Care and Population Ageing

Topic: AGED CARE

Written Question on Notice

Senator McLucas asked:

In practice, what range of things does "special needs" status entitle a veteran to?

Answer:

The care needs of people defined as 'people with special needs' under the *Aged Care Act 1997* and the Aged Care Principles must be taken into account in both the planning process for making places available for allocation and the distribution of aged care places across the Aged Care Planning Regions within their respective state or territory.

All applicants for new aged care places in the Aged Care Approvals Round must demonstrate that they can provide a high level of appropriate care to all care recipients, including people from 'special needs' groups, such as veterans including the spouse, widow or widower of a veteran.

Places may be allocated with a condition specifying that a provider must give priority of access to a particular 'special needs' groups, such as veterans.

All providers allocated places in the Aged Care Approvals Round must demonstrate a capacity to provide appropriate care to people from all special needs groups, including to veterans and the spouse, widow or widower of a veteran.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30-31 May 2007

Question: E07-085

OUTCOME 4: Aged Care and Population Ageing

Topic: AGED CARE

Written Question on Notice

Senator McLucas asked:

When a veteran applies for an assessment through the Aged Care Assessment Teams, how is their veteran status identified/established/recorded?

Answer:

As part of the assessment process the status of a veteran is identified and recorded via the Aged Care Client Record, which is an approved form required under Part 2.3 of the *Aged Care Act 1997*.

Part 1, Question 13, asks the question: Does the client have any form of DVA entitlement? Options within this question are:

- Gold card
- White card
- Orange card or other DVA entitlement
- No DVA entitlement.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30-31 May 2007

Question: E07-096

OUTCOME 4: Aged Care and Population Ageing

Topic: ANAO REPORT

Written Question on Notice

Senator McLucas asked:

Recommendation 4 in the ANAO Report on page 28 states:

The ANAO recommends that DoHA increase the transparency of its decisions on the allocation of places to providers by requiring State and Territory offices to:

a) assemble in written form material that could be provided as debriefing to providers on the basis for allocation decisions made by DoHA on provider applications for places; and
b) seek comment from providers on the quality of supporting information provided in the running of the ACAR and on the quality of feedback on the allocation of places.

DoHA's response was: Agreed with qualification.
What is this qualification?

Answer:

The qualification was that the Department does not agree that written debrief material should be assembled for all applicants. Instead the Department will continue to provide written debrief information on request, as this is a more efficient use of staff resources.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30-31 May 2007

Question: E07-101

OUTCOME 4: Aged Care and Population Ageing

Topic: CLOSURE OF AGED CARE FACILITIES IN SOUTHERN TASMANIA

Written Question on Notice

Senator Brown asked:

Two aged care facilities located in Claremont in southern Tasmania have recently been forced to close because the current federal funding model no longer supports the operation of smaller scale facilities. However given regionally dispersed nature of Tasmania's population a number of smaller scale facilities such as those that have been closed operate in Tasmania.

a) What consideration has been given to the need for smaller scale aged care facilities in areas such as Tasmania where the population is regionally dispersed?
b) Has the Department given consideration to the detrimental effect that the current aged care funding model is having on smaller aged care facilities in such areas?
c) Does the government have any structure/measures in place to assist elderly people who are forced to move a considerable distance away from their home town and community in order to secure an aged-care place? If so, what are they? If not, why not?
d) Has the Department conducted a cost/benefit analysis of the difference between promoting efficiency in the provision of aged care services and the negative effects likely to be suffered by elderly residents who are forced to move away from home to secure an aged care place?
e) The specific closure of the two aged care facilities in southern Tasmania has only exacerbated the already long waiting lists for the region which is currently around 270. Does the Department have any figures on the duration of time elderly people are being forced to wait to secure an aged care bed in the region? Does the Department have any measures in lace aimed at reducing the duration of this waiting period? If so what are they? If not why not? Has there been an increase in the numbers of elderly people on such waiting lists following the closure of the two facilities in southern Tasmania?
f) Have there been any discussions with other smaller scale nursing homes as to whether they are likely to be forced to close because of the nature of the current funding model?
g) Can any assurance be made that such facilities will not be forced to close?
h) What measures, if any does the government have in place to ensure that the quality of aged care in areas with regionally dispersed population such as Tasmania is retained?

i) Does the department consider residents ease in retaining contact with their local community, family and friends as criteria assessing the viability and value of smaller aged care facilities? If not why not?
j) Is efficiency the only factor that should be considered when assessing the successful provision of aged care services? If not, why have smaller homes, such as those in southern Tasmania, who have met accreditation standards, been forced to close?

Answer:

Throughout Australia there are many small aged care homes operating successfully through good management practices. With the exception of the effect of a sanction imposed under the *Aged Care Act 1997* for serious breaches of aged care requirements, the Department does not force a home to close. Whether or not to close a home is a business decision for the provider.

In recognition of the value and importance of the role of small rural services in the provision of aged care, the Australian Government pays a viability supplement on top of standard residential and community care funding. The aim of this payment is to improve the capacity of small, rural services to offer quality care.

All Australian Government subsidised residential aged care is supported by a comprehensive and rigorous framework aimed at ensuring the provision of quality care and accommodation for all residents. The quality measures apply to all aged care services funded under the *Aged Care Act 1997*, regardless of location.

The Aged Care Complaints Investigation Scheme provides an avenue for anyone who has concerns about the care and services provided in an Australian Government subsidised aged care service to raise these concerns with the Department of Health and Ageing. The Scheme has the capacity to investigate concerns and to take action where an approved provider fails to meet their responsibilities under the *Aged Care Act 1997*.

Data on waiting times for aged care services is not gathered because such data is inherently inaccurate due to a number of factors including because a person may:

- not be actively seeking care despite having been assessed as eligible for care;
- have his or her name on more than one waiting list at any given time;
- have been assessed as eligible for more than one type of care and have accessed an alternative type of approved care;
- have repeat assessments and approvals due to a change in circumstances; or
- have moved to another Aged Care Assessment Team area and have been reassessed.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 31 May 2007

Question: E07-329

OUTCOME 4: Aged Care and Population Ageing

Topic: CONDITIONAL ADJUSTMENT PAYMENT

Hansard Page: CA 24

Senator McLucas asked:

When the CAP was introduced, the disparity between aged care nurses was $170 a week. Currently, a nurse who works in aged care gets paid an average $235 a week less than her similarly qualified colleague who works in acute care – is that right?

Answer:

The Department is unable to confirm the quoted wage rates without having knowledge of the source of this information. The quarterly publication *nurses' paycheck* provides comparisons of wage rates paid to nurses in the aged care sector with those paid in the public hospital sector on a state by state basis across a selection of enterprise agreements or awards. It does not provide an Australia wide comparison.

Nurses' wages in the aged care and acute care sectors are not directly comparable due to a number of factors including the differences in fringe benefits tax treatment and the impact of enterprise bargaining arrangements and Australian Workplace Agreements.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30-31 May 2007

Question: E07-332

OUTCOME 4: Aged Care and Population Ageing

Topic: ALLOCATION OF PLACES IN SOUTH COAST QUEENSLAND

Hansard Page: CA36

Senator McLucas asked:

a) Did they (the Queensland Office) make contact with the Gold Coast City Council and make an assessment of the planning instrument over that land?

b) Did they (the Queensland Office) realise that there was a particular planning instrument in place over the land that was being assessed?

Answer:

a) No. It is not usual practice to seek external confirmation of planning requirements or to assess Council planning instruments. It is the responsibility of the provider to obtain the appropriate planning approvals.

b) The department is aware that the land is currently 'multi-zoned' which includes low/medium residential purposes.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2007-2008, 31 May 2007

Question: E07-323

OUTCOME 4: Aged Care and Population Ageing

Topic: MULTI-PURPOSE SERVICES

Hansard Page: CA 5, 6

Senator McLucas asked:

New services and places did not come online as quickly as anticipated so there has been a variation in funding from $72.6 million to $69.5 million. Which ones did not come online?

Answer:

Two multi-purpose services have not come online in the timeframe originally expected. These are in Dunedoo and Tottenham, in New South Wales. These services are expected to become operational on 1 July 2007.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 31 May 2007

Question: E07-334

OUTCOME 4: Aged Care and Population Ageing

Topic: BROUGHTON HALL

Hansard Page: CA 52

Senator McLucas asked:

I understand that there is no requirement for the Minister to make contact with the facility, but can I find out if he did?

Answer:

The Minister did not make contact with the facility in relation to the release of information, however the Department notified the approved provider in advance of the release.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30–31 May 2007

Question: E07-317

OUTCOME 4: Aged Care and Population Ageing

Topic: AGED CARE

Written Question on Notice

Senator Adams asked:

What assessment has the Department made of the likely impact of the new complaints management process on aged care facilities and given that the old scheme was not considered to be procedurally fair to providers what processes is the Department engaging in to ensure the new scheme will be procedurally fair to both aged care provider staff and the complaint?

Answer:

The Department of Health and Ageing designed the new complaints handling arrangements for aged care facilities, after extensive consultation with the aged care sector. The proposed reforms were discussed at five Aged Care Advisory Committee meetings between March 2006 and April 2007.

This provided the sector with opportunities to raise potential implementation issues and to make suggestions regarding how they may be addressed.

Under the new complaints handling arrangements all relevant parties, including approved providers, are afforded natural justice and procedural fairness during the course of an investigation. This is expressly provided for in the new *Investigation Principles 2007* (the principles).

Under the new investigation arrangements:

- all relevant parties are involved throughout the investigation process;
- where a complaint is made about an approved provider, the approved provider has the opportunity to respond to the issue;
- there is ample opportunity for all parties to receive feedback;
- all parties are given the opportunity for their concerns to be heard including interview by the Department in the course of the investigation and opportunity to provide relevant evidence; and
- approved providers and care recipients, or their representatives, to whom the matter under investigation relates, have the opportunity to seek external independent examination by the Aged Care Commissioner of decisions made by the Department under the principles.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30–31 May 2007

Question: E07-318

OUTCOME 4: Aged Care and Population Ageing

Topic: AGED CARE

Written Question on Notice

Senator Adams asked:

I understand from industry sources that the Department has engaged many more staff to administer the scheme. Please advise the numbers nationally and how these additional staff will be utilized?

Answer:

There are 140 additional ASL nationally administering the Aged Care Complaints Investigation Scheme and in the Office of the Aged Care Commissioner.

These staff are employed within the Office of Aged Care Quality and Compliance to investigate concerns about potential breaches of approved provider responsibilities under the *Aged Care Act 1997* and to provide support, and policy and procedural advice to investigation officers.

Staff are also employed within the Office of the Aged Care Commissioner to provide an independent avenue of review about decisions made by the Complaints Investigation Scheme. Officers will examine, as a result of a complaint or on their own initiative, the Department's processes for handling matters under the Investigation Principles and the conduct of the Aged Care Standards and Accreditation Agency relating to its responsibilities under the Accreditation Grant Principles.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30–31 May 2007

Question: E07-319

OUTCOME 4: Aged Care and Population Ageing

Topic: AGED CARE

Written Question on Notice

Senator Adams asked:

How will the employment of these additional staff actually reduce the burden of compliance on the staff of aged care facilities?

Answer:

The employment of additional staff within the Aged Care Complaints Investigation Scheme will allow the Department of Health and Ageing to investigate concerns in a timely and efficient manner and provide greater and more timely feedback to the parties. The focus will be on the Department to investigate rather than on the parties to reach agreement where this may not be possible. We anticipate this will place less burden on providers and complainants.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30 – 31 May 2007

Question: E07-320

OUTCOME 4: Aged Care and Population Ageing

Topic: AGED CARE

Written Question on Notice

Senator Adams asked:

The industry has complained for many years about the confusion and over regulation imposed by Department and Agency staff investigating the same matters. Will this new scheme rectify this confusion?

Answer:

The roles of the Department of Health and Ageing and the Aged Care Standards and Accreditation Agency Ltd are distinct but complementary. The Aged Care Complaints Investigation Scheme administered by the Department deals with complaints and information about specific aspects of care, services or issues impacting on specific care recipients which may represent a breach of an approved provider responsibility under the *Aged Care Act 1997*.

The Agency has primary responsibility for monitoring homes for compliance with the Accreditation Standards and focuses primarily on systems and procedures. The accreditation role of the Agency is both a regulatory role and one that supports and encourages continuous improvement and quality care. Where information obtained in the investigation process suggests a systemic problem exists in an aged care service, the issues will be referred to the Agency if they relate to the Accreditation Standards.

Monitoring undertaken by both the Department and the Agency should provide assurance to the public of the consistent delivery of quality care and assist in the early identification of non-compliance, particularly relating to resident health and safety.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30 – 31 May 2007

Question: E07-321

OUTCOME 4: Aged Care and Population Ageing

Topic: AGED CARE

Written Question on Notice

Senator Adams asked:

The new scheme provides for the lodgement of complaints about the Agency and Department staff performance of their function and processes. What number of complaints if any have been received to date?

Answer:

As at 20 June 2007, the Department of Health and Ageing has received three complaints about Aged Care Complaints Investigation Scheme processes. No complaints have been received by the Aged Care Commissioner in relation to the conduct of the Aged Care Standards Accreditation Agency or staff of the Department.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30 – 31 May 2007

Question: E07-322

OUTCOME 4: Aged Care and Population Ageing

Topic: AGED CARE

Written Question on Notice

Senator Adams asked:

The industry is to commence compulsory reporting allegations of abuse 1st July 2007 how will the Department treat allegations that appear vexatious or part of an industrial campaign? What does the Department expect an aged care provider to do with a staff member where an allegation has been made but no evidence exists regarding abuse?

Answer:

The *Aged Care Act 1997* (the Act) requires approved providers of residential aged care to report allegations or suspicions of sexual and serious physical assault to the Department of Health and Ageing and the police.

The police are responsible for any criminal investigation while the Department will ensure that the approved provider is meeting their responsibilities under the Act to ensure the health, safety and well-being of all residents. The provider must take appropriate action to ensure the protection of residents while an investigation by the police is underway.

The Department would also expect the approved provider to take reasonable measures to protect the identity of any staff member who makes a report and protect them from victimisation.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 31 May 2007

Question: E07-328

OUTCOME 4: Aged Care and Population Ageing

Topic: FIRE SAFETY

Hansard Page: CA 21

Senator McLucas asked:

Of the 131 non-compliant facilities, can you provide the committee, by state/territory, the time line that we expect these facilities to be fire safety compliant.

Answer:

The break-up of the 131 services which have not met the higher quality targets of the 1999 Certification Assessment Instrument is:

Period for completion of building works	**NSW**	**VIC**	**QLD**	**SA**	**WA**	**TAS**	**ACT**	**NT**	**TOTAL**
30 June 2007	23	8	55	5	4	1	1	5	102
31 December 2007	10		2						12
30 June 2008			5		1				6
31 December 2008	2		7	1				1	11
TOTALS	35	8	69	6	5	1	1	6	131

The above table is based on figures as at 25 May 2007.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 31 May 2007

Question: E07-330

OUTCOME 4: Aged Care and Population Ageing

Topic: COMPLAINTS INVESTIGATION SCHEME

Hansard Page: CA 31

Senator McLucas asked:

In terms of the Notices of Required Action, is it possible to give me a feel for what the Department has required people to do following those investigations?

Answer:

As at 28 May 2007, the Aged Care Complaints Investigation Scheme had issued 12 Notices of Required Action.

For these cases approved providers were required to:

- undertake a risk assessment for falls for all residents at the home;
- provide details of an alleged assault to the family of a care recipient;
- develop and implement clear guidelines around medication management in relation to residents who refuse medication;
- conduct a review in relation to the management of residents who display aggressive and threatening behaviours;
- ensure that medications were administered, signed and managed effectively and that pain assessments were to be conducted to meet the needs of relevant care recipients;
- ensure that a care recipient had access to the nurse call bell at all times and that staff respond to the call system in a timely manner;
- ensure that medication was managed safely and correctly in accordance with relevant State legislation;
- ensure that clinical best practice in relation to monitoring and tracking of insulin be adhered to and that formal guidelines be developed for use within the home;
- ensure that all staff were aware of the Outbreak Management Plan protocols;
- improve documentation of oral and fluid intake for residents;
- ensure that a care recipient received assistance with mobility and wheelchair use; and
- improve documentation relating to wound dressing.

It should be noted that as these details relate to only four weeks of operation, they may not reflect longer term trends.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 31 May 2007

Question: E07-331

OUTCOME 4: Aged Care and Population Ageing

Topic: COMPLAINTS INVESTIGATION SCHEME

Hansard Page: CA 32

Senator McLucas asked:

How many:

a) conciliated outcomes have you had?

b) were resolved quickly due to misunderstandings?

Answer:

As at 28 May 2007, the Aged Care Complaints Investigation Scheme had received 534 cases which were deemed to be in scope i.e. a potential breach of approved provider's responsibilities under the *Aged Care Act 1997*. The Department of Health and Ageing has issued 12 Notices of Required Action in relation to these cases. Data is not yet available on the means of resolution of other cases.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 31 May 2007

Question: E07-347

OUTCOME 4: Aged Care and Population Ageing

Topic: COMPLAINTS INVESTIGATION SCHEME

Hansard Page: CA 32

Senator McLucas asked:

How many complaints have been received about the office procedures to this point (about the way investigation proceeded)?

Answer:

As at 20 June 2007, the Department of Health and Ageing (the Department) has received three complaints about Aged Care Complaints Investigation Scheme processes. No complaints have been received by the Aged Care Commissioner in relation to the conduct of the Aged Care Standards Accreditation Agency or staff of the Department.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30-31 May 2007

Question: E07-083

OUTCOME 4: Aged Care and Population Ageing

Topic: AGED CARE

Written Question on Notice

Senator McLucas asked:

Does DOHA keep any data on how many veterans use each of the following services:
a. residential aged care
b. Extended Aged Care at Home
c. Extended Aged Care at Home Dementia
d. Community Aged Care Package

Answer:

a. The number of permanent residents of aged care homes identified by the Department of Veterans' Affairs as holders of veterans' Gold or White cards, including eligible war widows and widowers, in 2006 was 34,993. Respite residents are not asked to provide information about their veteran status.

b., c. and d.
e. Information is collected on the veteran status of Extended Aged Care at Home (EACH), Extended Aged Care at Home Dementia (EACH-D) and Community Aged Care Package (CACP) recipients through occasional censuses, the most recent of which was conducted in 2002. According to the results of the 2002 CACP census, 10% of CACP recipients were identified as holders of Gold or White cards. Including those recipients who were identified as veterans but whose card status was not known, or who had no card, 13.6% of CACP recipients were identified as veterans. There were few EACH packages operating in 2002. Of the 288 recipients identified in the 2002 EACH census, 15 (5.2%) were reported to hold either Gold or White cards. Another 11 persons (3.8%) were identified as veterans with no card.

The next census is planned to be conducted later this year.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30-31 May 2007

Question: E07-087

OUTCOME 4: Aged Care and Population Ageing

Topic: AGED CARE

Written Question on Notice

Senator McLucas asked:

Can you provide a breakdown of how many veterans applied for, and how many received, aged care residential places and CACPs, EACH and EACH-D in:
i) 2006
ii) 2005
iii) 2004
iv) 2003
v) 2002

Answer:

No central record is kept of applications for places made to individual aged care services.

The total number of permanent residents identified by the Department of Veterans' Affairs as holders of veterans' Gold or White cards, including eligible war widows and widowers, and who resided in aged care homes at any time in the calendar years concerned is shown below:

Year	Number
2006	34,993
2005	33,691
2004	32,345
2003	30,439
2002	28,745

Respite residents are not required to provide information about their veteran status.

Information is collected about the veteran status of people using CACP, EACH or EACH-D services through occasional censuses. The last such census was conducted in 2002 and at that time 2,510 CACP recipients were identified as holders of veterans' Gold or White cards. Including those recipients who were identified as veterans but whose card status was not known, who had an Orange card or who had no card, the total number of CACP recipients identified as veterans was 3,432.

Of the 288 recipients identified in the 2002 EACH census, 15 were reported to hold either Gold or White cards. Another 11 persons were identified as veterans with no card.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30-31 May 2007

Question: E07-090

OUTCOME 4: Aged Care and Population Ageing

Topic: AGED CARE

Written Question on Notice

Senator McLucas asked:

What is the average age of veterans versus non-veterans who access:
a. residential aged care
b. Extended Aged Care at Home
c. Extended Aged Care at Home Dementia
d. Community Aged Care Package

Answer:

a. The average age of people identified by the Department of Veterans' Affairs as holders of Gold or White veterans' cards, including eligible war widows and widowers, entering permanent residential aged care services in 2005-06 was 85. The average age of all others entering permanent residential aged care services during the same year was 82.

b., c. and d.

Information is collected about the veteran status of Extended Aged Care at Home (EACH), Extended Aged Care at Home Dementia (EACH-D) and Community Aged Care Package (CACP) recipients through occasional censuses.

The last such census was in 2002. The census report indicated that the average age of CACP recipients was 81 years. While it did not report the average age of veteran and non-veteran CACP recipients, it noted that three-quarters of the recipients who were veterans were aged 75 years and over. In the age groups analysed in the report, the highest proportion of care recipients eligible for a Department of Veterans' Affairs entitlement was between 80 and 84 years (21%).

As with CACP recipients, about one third of EACH recipients were aged 85 years or over. The total number of EACH recipients in 2002 was small and the 2002 EACH census report did not provide an average age or undertake a comparative analysis of the ages of veteran and non-veteran recipients of EACH packages.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30-31 May 2007

Question: E07-089

OUTCOME 4: Aged Care and Population Ageing

Topic: RESPITE CARE

Written Question on Notice

Senator McLucas asked:

How many respite care clients are veterans or their partners?

Answer:

Data on use of respite care by people in receipt of Veterans' Affairs pension are collected where the respite care is provided through a Commonwealth Carer Respite Centre.

Based on 2005-06 data obtained for Commonwealth Carer Respite Centres, 3,790 clients were in receipt of a Veterans' Affairs pension, representing 2,605 care recipients, and 1,185 carers. This may not represent the total number of veterans who receive respite through Commonwealth Carer Respite Centres, as some may choose not to provide information on whether they are in receipt of a Veterans' Affairs pension.

Residential respite care recipients are not required to provide information about their veteran status.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 31 May 2007

Question: E07-324

OUTCOME 4: Aged Care and Population Ageing

Topic: AGED CARE INNOVATIVE POOL

Hansard Page: CA 6

Senator McLucas asked:

There have been changes in the level of occupancy and lengths of stay and so on, so the revision is from $10 million to $8 million. Can you break that down for me. There are subsidies and there are – what other funds are in that?

Answer:

Innovative Pool funding is comprised entirely of aged care subsidies paid to approved providers. The estimates variation reflects a number of factors, including lower than expected levels of occupancy in some pilot projects and that no new pilot projects have been established in 2006-07. In respect of this last, Innovative Pool pilots are generally only established where there are specific questions which cannot be answered other than by conducting a pilot to enable data to be gathered and approaches to be explored and tested. There is no commitment to maintain a minimum number of pilots.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 31 May 2007

Question: E07-335

OUTCOME 4: Aged Care and Population Ageing

Topic: INNOVATIVE POOL

Hansard Page: CA 53

Senator McLucas asked:

Could you provide me with a list of all the funded projects under the Innovative Pool, including their status and total Commonwealth money for each of those programs.

Answer:

The Innovative Pool is currently exploring a number of flexible models of care:

- *Disability aged care* – Nine pilots were established to explore the provision of aged care services for people with disabilities who are ageing in state and territory government funded disability accommodation. Eight have now ended. Funding will continue to be provided for all those individuals who were receiving services as at 25 May 2006. This ensures that individuals will not suffer adverse effects from the completion of the pilot. The maximum annual aged care subsidy payable for these services is $5.0 million.
- *Younger people with disabilities in aged care homes* – Two pilots were established to explore the transfer of younger people with disabilities from aged care homes to state and territory government funded disability accommodation. The maximum annual aged care subsidy payable for these services is $0.4 million.
- *High needs pilots* – explore alternative approaches to the provision of care in areas where the provision of aged care services present a particular challenge. There are currently four services with the maximum annual aged care subsidy payable of $2.8 million.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30-31 May 2007

Question: E07-081

OUTCOME 4: ged Care and Population Ageing

Topic: AGED CARE

Written Question on Notice

Senator McLucas asked:

Do you have any breakdown of veterans' future demand for aged care services? If so, can you please provide this data?

Answer:

Overall future demand for aged care services is calculated on the basis of population projections made by the Australian Bureau of Statistics. The Australian Government aims to fund, by 2011, 113 aged care places for every 1,000 Australians aged 70 or older including veterans.

Veterans holding White or Gold cards, including war widows/widowers, aged 70 and over were estimated to form 11.8% of people aged 70 and over, at 30 June 2006.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30-31 May 2007

Question: E07-082

OUTCOME 4: Aged Care and Population Ageing

Topic: AGED CARE

Written Question on Notice

Senator McLucas asked:

Do you have any data on the health and mental health needs of veterans and non-veterans in aged care? If so, can you please provide this data?

Answer:

The Australian Institute of Health and Welfare (AIHW) is currently conducting research into veterans' receiving aged care, including their use of health services. This research is based upon an analysis of records provided by the Department of Health and Ageing and the Department of Veterans' Affairs. A recent report, *Veterans on Community Aged Care Packages: a comparative study*, is available from the AIHW website (http://www.aihw.gov.au/publications/index.cfm/criteria/veterans). This study is the first of a number of projects that will give an insight into the use of aged care and medical services by veterans and how these interact.

The Residential Classification Scale (RCS) is currently used to determine the level of Australian Government subsidy that applies to each resident of a Government funded aged care home. A significant component of the RCS focuses on the additional effort needed to help people who have problems with cognition or who need additional care around the management of problem behaviours.

The RCS appraises residents' care needs against questions relating to the following matters:

Q1 the degree of assistance that the care recipient needs to communicate;
Q2 the degree of assistance that the care recipient needs with regard to mobility;
Q3 the degree of assistance that the care recipient needs with eating and drinking;
Q4 the degree of assistance that the care recipient needs with personal hygiene;
Q5 the degree of assistance that the care recipient needs to use a toilet;
Q6 the degree of assistance that the care recipient needs with bladder management;
Q7 the degree of assistance that the care recipient needs with bowel management;
Q8 the care recipient's ability to understand and undertake general living activities;
Q9 the care recipient's problem wandering or intrusive behaviour;
Q10 the care recipient's verbally disruptive or noisy behaviour;
Q11 the care recipient's physically aggressive behaviour;
Q12 the care recipient's emotional dependence;
Q13 the care recipient's danger to self or others;

Q14 the care recipient's other behaviour requiring additional staff time and effort;
Q15 the care recipient's social and human needs;
Q16 activities concerning the care recipient which require staff to interact with the care recipient's family, friends and/or community groups;
Q17 medication provided to the care recipient;
Q18 technical and complex nursing procedures provided to the care recipient;
Q19 therapy provided to the care recipient; and
Q20 other services provided to the care recipient (may include podiatrist, dietitian etc)

Clients are appraised against each question according to a four point scale. Point A indicates not applicable or that no or minimal assistance is required. Point B indicates that the care recipient has some difficulty and/or requires some assistance. Point C indicates that the care recipient has major difficulty and/or requires major assistance. Point D indicates that the care recipient has extensive difficulty and/or requires major assistance.

The relative percentages of residents with veterans' Gold or White cards, including eligible war widows and widowers, appraised as being A, B, C or D against each of the twenty questions as at 30 April 2007, compared with those of residents who do not have these veterans' cards, are shown below:

QUESTION 1	Non Veterans	Veterans
A	3.6%	3.8%
B	8.5%	9.8%
C	76.8%	81.9%
D	11.1%	4.5%
QUESTION 2	Non Veterans	Veterans
A	14.3%	15.1%
B	32.2%	35.2%
C	19.0%	19.5%
D	34.6%	30.2%
QUESTION 3	Non Veterans	Veterans
A	18.1%	20.4%
B	46.5%	48.6%
C	16.8%	16.4%
D	18.6%	14.7%
QUESTION 4	Non Veterans	Veterans
A	4.7%	5.6%
B	10.6%	13.0%
C	10.9%	9.2%
D	73.9%	72.2%
QUESTION 5	Non Veterans	Veterans
A	28.4%	32.4%
B	13.1%	14.5%
C	13.3%	13.4%
D	45.2%	39.7%
QUESTION 6	Non Veterans	Veterans
A	29.0%	32.1%
B	14.7%	16.2%
C	26.2%	23.8%
D	30.1%	27.8%

QUESTION 7	Non Veterans	Veterans
A	9.5%	10.4%
B	2.8%	2.8%
C	75.4%	75.9%
D	12.3%	10.9%
QUESTION 8	Non Veterans	Veterans
A	8.9%	10.7%
B	29.0%	32.5%
C	35.3%	35.1%
D	26.8%	21.6%
QUESTION 9	Non Veterans	Veterans
A	67.5%	68.6%
B	6.1%	6.2%
C	6.8%	7.0%
D	19.6%	18.3%
QUESTION 10	Non Veterans	Veterans
A	45.1%	50.1%
B	10.3%	10.6%
C	13.5%	12.9%
D	31.1%	26.4%
QUESTION 11	Non Veterans	Veterans
A	73.2%	77.9%
B	8.4%	7.1%
C	6.5%	5.8%
D	11.8%	9.3%
QUESTION 12	Non Veterans	Veterans
A	31.9%	33.5%
B	9.7%	10.9%
C	16.8%	16.9%
D	41.5%	38.7%
QUESTION 13	Non Veterans	Veterans
A	32.3%	32.2%
B	12.0%	12.4%
C	12.7%	13.1%
D	43.0%	42.4%
QUESTION 14	Non Veterans	Veterans
A	15.4%	17.0%
B	7.5%	8.4%
C	15.1%	16.2%
D	61.9%	58.4%
QUESTION 15	Non Veterans	Veterans
A	1.1%	1.2%
B	11.4%	11.8%
C	75.7%	76.0%
D	11.8%	10.9%
QUESTION 16	Non Veterans	Veterans
A	3.9%	2.9%
B	33.8%	33.6%
C	52.5%	55.4%
D	9.8%	8.1%
QUESTION 17	Non Veterans	Veterans

A	3.4%	3.8%
B	18.5%	19.4%
C	68.2%	67.5%
D	9.9%	9.3%
QUESTION 18	Non Veterans	Veterans
A	18.1%	18.5%
B	26.8%	28.7%
C	17.5%	18.5%
D	37.6%	34.3%
QUESTION 19	Non Veterans	Veterans
A	13.8%	14.7%
B	8.0%	8.4%
C	23.8%	23.5%
D	54.4%	53.4%
QUESTION 20	Non Veterans	Veterans
A	81.6%	83.7%
B	7.3%	6.2%
C	3.3%	2.7%
D	7.8%	7.4%

The RCS will be replaced by the Aged Care Funding Instrument (ACFI) in March 2008.

The ACFI will include specific supplements for the care of residents with challenging behaviours and those with complex health care needs. It will provide an improved measure of the different care needs of residents including veterans.

Information on the ACFI describing the new funding model for residential aged care: can be found at the Department's web page http://www.health.gov.au/acfi

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30-31 May 2007

Question: 07-084

OUTCOME 4: Aged Care and Population Ageing

Topic: AGED CARE

Written Question on Notice

Senator McLucas asked:

Do you have the figures on how many veterans under 60 years are in residential aged care? Do you have any figures on how many of these have dementia?

Answer:

On 30 April 2007, the number of permanent aged care residents identified by the Department of Veterans' Affairs as holders of Gold or White veterans' cards, including eligible war widows and widowers, who were under 60, was 53.

Questions 8 to 13 of the Resident Classification Scale (RCS), against which all permanent residents' need for assistance is assessed, relate to cognition and behavioural issues. High scores against these questions may be associated with symptoms of dementia.

Thirty four out of 53 veterans (64%) scored 'C' or 'D' (high level needs) in three or more of the questions 8 to 13. Please note that the RCS is not a diagnostic tool and analysis of the RCS scores for these 53 residents is at best indicative of the extent to which they may suffer dementia, it is not definitive.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30-31 May 2007

Question: E07-092

OUTCOME 4: Aged Care and Population Ageing

Topic: COMMUNITY AGED CARE PACKAGES

Written Question on Notice

Senator McLucas asked:

What are the savings to the Government if there are no care recipients receiving these packages?

Answer:

Funding for Community Aged Care Packages (CACP), Extended Aged Care at Home (EACH) and Extended Aged Care at Home Dementia (EACHD) packages are processed through a special appropriation under section 96-10 of the *Aged Care Act 1997* (the Act). This means, in effect, that the money for a care package is only appropriated if someone is receiving care through the package according to the provisions of the Act. If the package is not used, the funding is not appropriated and hence there is no unspent appropriation.

The Department develops estimates of expenditure under the special appropriation and these are the basis of the budget and forward estimates. In developing these estimates, the Department takes account of growth in places and expected occupancy levels. So, estimated expenditure already takes account of the expected utilisation of care packages. These estimates may be revised during the year, in light of new information. A revision downwards in the estimate of expenditure from a special appropriation is not a saving as such, it is simply a revision to the expected level of expenditure.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30-31 May 2007

Question: E07-098

OUTCOME 4: Aged Care and Population Ageing

Topic: CAP FINANCIAL REPORTS

Written Question on Notice

Senator McLucas asked:

What is the most recent year the Department has the analysis reports on the CAP financial reports? What do they show about the financial health of the sector over time? Can the Department please provide all detailed reports available?

Answer:

The only year for which an analysis report has been completed is 2004-05. A copy of that report has previously been provided with the response to question E06-172 following the Supplementary Budget Estimates hearings in November 2006.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30-31 May 2007

Question: E07-326

OUTCOME 4: Aged Care and Population Ageing

Topic: COMMONWEALTH CARELINK

Written Question on Notice

Senator McLucas asked:

Can I have the estimates for 2008-09, 2009-10 and 2010-11 for Commonwealth Carelink?

Answer:

Information for the years beyond the Budget year is not published and the Department is not authorised to release that information. (See attached response from Senator Minchin to Senator Evans – Question on Notice No.1310 to 1328.)

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 31 May 2007

Question: E07-327

OUTCOME 4: Aged Care and Population Ageing

Topic: AGED CARE INFORMATION LINE

Hansard Page: CA 20

Senator McLucas asked:

Can I have the estimates for 2008-09, 2009-10 and 2010-11 for the Aged Care Information Line?

Answer:

Program funding for Program 4.3 – Ageing Information and Support (which includes funding for the Aged Care Information Line) is $38.262 million in 2007-08.

Information for the years beyond the Budget year is not published and the Department is not authorised to release that information. (See attached response from Senator Minchin to Senator Evans – Question on Notice No.1310 to 1328.)

Question: E07-086

OUTCOME 4: Aged Care and Population Ageing

Topic: AGED CARE

Written Question on Notice

Senator McLucas asked:

How is funding for aged care services allocated between DOHA and DVA. Does this use a set formula/ratio? Are any aged care funding or places quarantined for special needs groups through the mainstream planning process?

Answer:

Aged care subsidies are payable to people approved to receive aged care services and who are receiving aged care services from an approved provider.

Under section 96-10 of the *Aged Care Act 1997*, funding for veterans is provided through special appropriations in the *Veterans Entitlements Act 1986* and the *Military Rehabilitation and Compensation Act 2004*. Funding for other residents is provided through the special appropriation in section 96-10 of the *Aged Care Act 1997*.

Aged Care Planning Advisory Committees, in all states and territories, provide advice to the delegate of the Secretary of the Department of Health and Ageing on the distribution of aged care places across the Planning regions within their respective state or territory. The Committees use their local knowledge and information provided by Members of Parliament, local governments and community groups in forming their recommendations on the needs of each planning region, which are reflected in the *Regional Distribution of Aged Care Places.*

The identification of a geographical location, special needs group or key issue within the *Regional Distribution of Aged Care Places* indicates that the relevant Aged Care Planning Advisory Committee has recommended the identified element as having a particular focus for the state, territory or aged care planning region.

The Department allocates places with certain conditions of allocation, including giving priority to people from one or more of the special needs groups. These conditions do not preclude the places from being used from time to time for the care of people who are not members of the particular special needs group, but the expectation is that this would be the exception rather than the rule.

All providers allocated places in the Aged Care Approvals Round must demonstrate a capacity to provide appropriate care to people from all special needs groups.

Total Operational Places by State/Territory
as at 30 June 2007

State/ Territory	High Care	Low Care	Total Residential	Community Care	Transition Care	TOTAL
NSW	30,201	27,872	**58,073**	14,219	571	**72,863**
VIC	20,149	23,598	**43,747**	10,768	424	**54,939**
QLD	14,020	16,268	**30,288**	7,365	257	**37,910**
SA	8,146	8,206	**16,352**	3,748	147	**20,247**
WA	6,638	7,866	**14,504**	3,743	100	**18,347**
TAS	2,303	2,138	**4,441**	1,136	52	**5,629**
NT	319	234	**553**	731	8	**1,292**
ACT	668	968	**1,636**	606	35	**2,277**
Australia	**82,444**	**87,150**	**169,594**	**42,316**	**1,594**	**213,504**

Total Operational Ratio by State/Territory
as at 30 June 2007

State/ Territory	High Care	Low Care	Total Residential	Community Care	Transition Care	TOTAL
NSW	45.0	41.5	**86.4**	21.2	0.8	**108.5**
VIC	40.3	47.2	**87.4**	21.5	0.8	**109.8**
QLD	39.7	46.0	**85.7**	20.8	0.7	**107.3**
SA	46.5	46.9	**93.4**	21.4	0.8	**115.7**
WA	38.4	45.4	**83.8**	21.6	0.6	**106.0**
TAS	44.8	41.6	**86.4**	22.1	1.0	**109.6**
NT	56.0	41.1	**97.0**	128.3	1.4	**226.7**
ACT	29.6	42.9	**72.5**	26.8	1.6	**100.9**
Australia	**42.2**	**44.6**	**86.8**	**21.7**	**0.8**	**109.3**

Notes:

The tables above include 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 residential high care, residential low care and community care places. Community care includes Community Aged Care Packages (CACP), EACH and EACH Dementia places

*** The Ratios in the table immediately above are derived from the Australian Bureau of Statistics (ABS) 2006 Population Census projections for June 2007.**

Population projections from the <u>2006 Population Census</u> at Aged Care Planning Region level are not yet available from the ABS. Therefore projections based on the <u>2001 Population Census</u> are used for the regional ratios in the following tables at the aged care planning region level.

TOTAL OPERATIONAL PLACES AND RATIOS AT REGIONAL LEVEL

As at 30 June 2007		Total Operational Places					Total Operational Ratio*				
State/ Territory	**Aged Care Planning Region**	**HIGH**	**LOW**	**RESI**	**Community Care**	**TOTAL**	**HIGH**	**LOW**	**RESI**	**Community Care**	**TOTAL**
NSW	Central Coast	1,578	1,693	**3,271**	957	**4,228**	37.0	39.7	**76.7**	22.4	**99.1**
	Central West	785	933	**1,718**	370	**2,088**	42.3	50.3	**92.6**	19.9	**112.5**
	Far North Coast	1,365	1,665	**3,030**	762	**3,792**	36.4	44.4	**80.9**	20.3	**101.2**
	Hunter	2,612	2,818	**5,430**	1,297	**6,727**	40.6	43.8	**84.4**	20.1	**104.5**
	Illawarra	1,443	1,633	**3,076**	1,031	**4,107**	32.5	36.7	**69.2**	23.2	**92.4**
	Inner West	3,151	1,473	**4,624**	824	**5,448**	75.1	35.1	**110.3**	19.6	**129.9**
	Mid North Coast	1,401	1,833	**3,234**	929	**4,163**	32.9	43.1	**76.0**	21.8	**97.9**
	Nepean	1,228	734	**1,962**	440	**2,402**	57.3	34.2	**91.5**	20.5	**112.0**
	New England	746	872	**1,618**	418	**2,036**	38.8	45.4	**84.2**	21.7	**105.9**
	Northern Sydney	4,482	3,943	**8,425**	1,635	**10,060**	53.2	46.8	**100.0**	19.4	**119.4**
	Orana Far West	572	850	**1,422**	400	**1,822**	36.2	53.9	**90.1**	25.3	**115.4**
	Riverina/Murray	1,041	1,332	**2,373**	579	**2,952**	36.0	46.1	**82.1**	20.0	**102.1**
	South East Sydney	3,552	2,882	**6,434**	1,746	**8,180**	42.0	34.1	**76.2**	20.7	**96.8**
	South West Sydney	2,722	2,325	**5,047**	1,325	**6,372**	42.9	36.6	**79.5**	20.9	**100.4**
	Southern Highlands	710	1,104	**1,814**	456	**2,270**	30.5	47.4	**77.9**	19.6	**97.5**
	Western Sydney	2,813	1,782	**4,595**	1,050	**5,645**	51.4	32.6	**84.0**	19.2	**103.2**
	All State (Transition Care)					**571**					**0.8**

Note: The Ratios in this table are derived from the Australian Bureau of Statistics (ABS) 2001 Population Census projections for June 2007. Population Census projections for June 2007 based on the 2006 Population Census are not yet available from the ABS at the aged care planning region level.

ATTACHMENT B

TOTAL OPERATIONAL PLACES AND RATIOS AT REGIONAL LEVEL

As at 30 June 2007		Total Operational Places					Total Operational Ratio*				
State/ Territory	**Aged Care Planning Region**	**HIGH**	**LOW**	**RESI**	**Community Care**	**TOTAL**	**HIGH**	**LOW**	**RESI**	**Community Care**	**TOTAL**
VIC	Barwon-South Western	1,653	2,099	**3,752**	889	**4,641**	39.4	50.0	**89.4**	21.2	**110.5**
	Eastern Metro	3,795	4,913	**8,708**	2,131	**10,839**	37.3	48.3	**85.7**	21.0	**106.7**
	Gippsland	1,027	1,367	**2,394**	618	**3,012**	35.2	46.8	**82.0**	21.2	**103.1**
	Grampians	939	1,121	**2,060**	512	**2,572**	39.4	47.0	**86.4**	21.5	**107.9**
	Hume	1,145	1,447	**2,592**	620	**3,212**	40.8	51.6	**92.5**	22.1	**114.6**
	Loddon-Mallee	1,338	1,705	**3,043**	742	**3,785**	38.7	49.3	**88.1**	21.5	**109.6**
	Northern Metro	3,001	3,044	**6,045**	1,628	**7,673**	41.5	42.1	**83.5**	22.5	**106.0**
	Southern Metro	5,142	5,473	**10,615**	2,508	**13,123**	42.0	44.7	**86.7**	20.5	**107.1**
	Western Metro	2,109	2,429	**4,538**	1,120	**5,658**	39.3	45.3	**84.6**	20.9	**105.5**
	All State (Transition Care)					**424**					**0.8**

Note: The Ratios in this table are derived from the Australian Bureau of Statistics (ABS) 2001 Population Census projections for June 2007. Population Census projections for June 2007 based on the 2006 Population Census are not yet available from the ABS at the aged care planning region level.

TOTAL OPERATIONAL PLACES AND RATIOS AT REGIONAL LEVEL

As at 30 June 2007		Total Operational Places					Total Operational Ratio*				
State/ Territory	**Aged Care Planning Region**	**HIGH**	**LOW**	**RESI**	**Community Care**	**TOTAL**	**HIGH**	**LOW**	**RESI**	**Community Care**	**TOTAL**
QLD	Brisbane North	2,045	1,986	**4,031**	780	**4,811**	48.8	47.4	**96.2**	18.6	**114.9**
	Brisbane South	2,469	2,615	**5,084**	1,153	**6,237**	43.1	45.7	**88.8**	20.1	**108.9**
	Cabool	1,019	1,221	**2,240**	571	**2,811**	37.1	44.4	**81.5**	20.8	**102.2**
	Central West	68	54	**122**	64	**186**	69.1	54.9	**124.0**	65.0	**189.0**
	Darling Downs	1,011	1,128	**2,139**	437	**2,576**	43.6	48.7	**92.3**	18.9	**111.1**
	Far North	613	808	**1,421**	423	**1,844**	35.1	46.3	**81.4**	24.2	**105.6**
	Fitzroy	643	779	**1,422**	339	**1,761**	41.5	50.2	**91.7**	21.9	**113.6**
	Logan River Valley	505	694	**1,199**	317	**1,516**	31.3	43.0	**74.4**	19.7	**94.0**
	Mackay	364	421	**785**	201	**986**	38.6	44.7	**83.3**	21.3	**104.7**
	North West	49	80	**129**	101	**230**	30.5	49.8	**80.2**	62.8	**143.0**
	Northern	785	775	**1,560**	334	**1,894**	48.3	47.7	**96.0**	20.6	**116.6**
	South Coast	1,604	2,034	**3,638**	907	**4,545**	34.2	43.4	**77.6**	19.4	**97.0**
	South West	74	151	**225**	97	**322**	35.9	73.3	**109.2**	47.1	**156.3**
	Sunshine Coast	1,368	1,741	**3,109**	806	**3,915**	34.6	44.1	**78.7**	20.4	**99.1**
	West Moreton	491	675	**1,166**	263	**1,429**	36.5	50.2	**86.7**	19.5	**106.2**
	Wide Bay	912	1,106	**2,018**	572	**2,590**	34.6	41.9	**76.5**	21.7	**98.2**
	All State (Transition Care)					**257**					**0.7**

Note: The Ratios in this table are derived from the Australian Bureau of Statistics (ABS) 2001 Population Census projections for June 2007. Population Census projections for June 2007 based on the 2006 Population Census are not yet available from the ABS at the aged care planning region level.

ATTACHMENT B

TOTAL OPERATIONAL PLACES AND RATIOS AT REGIONAL LEVEL

As at 30 June 2007		Total Operational Places					Total Operational Ratio*				
State/ Territory	Aged Care Planning Region	HIGH	LOW	RESI	Community Care	TOTAL	HIGH	LOW	RESI	Community Care	TOTAL
SA	Eyre Peninsula	129	182	**311**	88	**399**	35.8	50.5	**86.3**	24.4	**110.8**
	Hills, Mallee & Southern	538	594	**1,132**	335	**1,467**	40.2	44.3	**84.5**	25.0	**109.5**
	Metropolitan East	2,234	1,876	**4,110**	591	**4,701**	62.7	52.7	**115.4**	16.6	**132.0**
	Metropolitan North	1,406	1,046	**2,452**	522	**2,974**	53.3	39.6	**92.9**	19.8	**112.7**
	Metropolitan South	1,671	1,663	**3,334**	849	**4,183**	42.1	41.9	**84.0**	21.4	**105.5**
	Metropolitan West	1,215	1,259	**2,474**	616	**3,090**	41.6	43.1	**84.6**	21.1	**105.7**
	Mid North	69	220	**289**	87	**376**	19.1	61.0	**80.1**	24.1	**104.2**
	Riverland	146	238	**384**	118	**502**	31.1	50.7	**81.9**	25.2	**107.0**
	South East	189	358	**547**	138	**685**	29.3	55.5	**84.8**	21.4	**106.2**
	Whyalla, Flinders & Far North	146	187	**333**	158	**491**	36.2	46.3	**82.5**	39.1	**121.7**
	Yorke, Lower North & Barossa	403	583	**986**	246	**1,232**	38.5	55.7	**94.2**	23.5	**117.7**
	All State (Transition Care)					**147**					**0.8**
WA	Goldfields	143	127	**270**	81	**351**	53.5	47.5	**101.0**	30.3	**131.3**
	Great Southern	293	372	**665**	190	**855**	39.1	49.6	**88.7**	25.3	**114.0**
	Kimberley	48	82	**130**	67	**197**	39.8	68.0	**107.9**	55.6	**163.5**
	Metropolitan East	1,098	1,301	**2,399**	488	**2,887**	41.5	49.2	**90.7**	18.5	**109.2**
	Metropolitan North	1,496	1,982	**3,478**	951	**4,429**	33.3	44.2	**77.5**	21.2	**98.7**
	Metropolitan South East	1,499	1,375	**2,874**	576	**3,450**	52.3	47.9	**100.2**	20.1	**120.3**
	Metropolitan South West	1,269	1,613	**2,882**	781	**3,663**	32.0	40.6	**72.6**	19.7	**92.3**
	Mid West	173	192	**365**	149	**514**	34.7	38.5	**73.3**	29.9	**103.2**
	Pilbara	27	38	**65**	50	**115**	37.6	52.9	**90.4**	69.5	**159.9**
	South West	431	604	**1,035**	282	**1,317**	34.4	48.3	**82.7**	22.5	**105.3**
	Wheatbelt	161	180	**341**	128	**469**	31.0	34.7	**65.7**	24.6	**90.3**
	All State (Transition Care)					**100**					**0.6**

Note: The Ratios in this table are derived from the Australian Bureau of Statistics (ABS) 2001 Population Census projections for June 2007. Population Census projections for June 2007 based on the 2006 Population Census are not yet available from the ABS at the aged care planning region level.

ATTACHMENT B

TOTAL OPERATIONAL PLACES AND RATIOS AT REGIONAL LEVEL

As at 30 June 2007		Total Operational Places					Total Operational Ratio*				
State/ Territory	**Aged Care Planning Region**	**HIGH**	**LOW**	**RESI**	**Community Care**	**TOTAL**	**HIGH**	**LOW**	**RESI**	**Community Care**	**TOTAL**
TAS	North Western	489	461	**950**	243	**1,193**	40.9	38.6	**79.4**	20.3	**99.8**
	Northern	731	573	**1,304**	348	**1,652**	48.9	38.4	**87.3**	23.3	**110.6**
	Southern	1,083	1,104	**2,187**	545	**2,732**	43.5	44.3	**87.9**	21.9	**109.7**
	All State (Transition Care)					**52**					**1.0**
NT	Alice Springs	110	56	**166**	201	**367**	111.1	56.6	**167.7**	203.0	**370.7**
	Barkly	17	2	**19**	42	**61**	140.5	16.5	**157.0**	347.1	**504.1**
	Darwin	159	129	**288**	332	**620**	43.8	35.5	**79.4**	91.5	**170.8**
	East Arnhem	5	6	**11**	72	**83**	31.3	37.5	**68.8**	450.0	**518.8**
	Katherine	28	41	**69**	84	**153**	66.8	97.9	**164.7**	200.5	**365.2**
	All State (Transition Care)					**8**					**1.4**
ACT	Australian Capital Territory	668	968	**1,636**	606	**2,242**	29.6	42.9	**72.5**	26.8	**99.3**
	All State (Transition Care)					**35**					**1.6**

Note: The Ratios in this table are derived from the Australian Bureau of Statistics (ABS) 2001 Population Census projections for June 2007. Population Census projections for June 2007 based on the 2006 Population Census are not yet available from the ABS at the aged care planning region level. As the ACT is also an aged care planning region, the Department has been able to use ABS data from the 2006 Census.

ATTACHMENT B

Total Operational Places by Service Type

as at 30 June 2007

Mainstream Operational Places

Residential and Community Care places under the *Aged Care Act 1997*

State/Territory	High Care	Low Care	Total Residential	Community Care	TOTAL
NSW	29,787	27,665	**57,452**	12,598	**70,050**
VIC	19,954	23,464	**43,418**	9,477	**52,895**
QLD	13,796	16,111	**29,907**	6,516	**36,423**
SA	7,971	8,043	**16,014**	3,292	**19,306**
WA	6,303	7,541	**13,844**	3,220	**17,064**
TAS	2,249	2,105	**4,354**	970	**5,324**
NT	271	174	**445**	569	**1,014**
ACT	668	968	**1,636**	489	**2,125**
Australia	**80,999**	**86,071**	**167,070**	**37,131**	**204,201**

Flexible Operational Places

National Aboriginal and Torres Strait Islander Aged Care Strategy Operational Places

Not allocated under the *Aged Care Act 1997*

State/Territory	High Care	Low Care	Total Residential	Community Care	TOTAL
NSW	6	15	**21**	19	**40**
VIC	15	10	**25**	69	**94**
QLD	49	30	**79**	4	**83**
SA	75	38	**113**	45	**158**
WA	14	-	**14**	2	**16**
TAS	-	-	**-**	46	**46**
NT	48	60	**108**	72	**180**
ACT	-	-	**-**	-	**-**
Australia	**207**	**153**	**360**	**257**	**617**

Multipurpose Services Operational Places

Allocated under the *Aged Care Act 1997*

State/Territory	High Care	Low Care	Total Residential	Community Care	TOTAL
NSW	408	192	**600**	69	**669**
VIC	180	124	**304**	14	**318**
QLD	175	127	**302**	102	**404**
SA	100	125	**225**	14	**239**
WA	305	310	**615**	153	**768**
TAS	54	33	**87**	7	**94**
NT	-	-	**-**	-	**-**
ACT	-	-	**-**	-	**-**
Australia	**1,222**	**911**	**2,133**	**359**	**2,492**

ATTACHMENT C

Total Operational Places by Service Type
as at 30 June 2007

Extended Aged Care at Home (EACH) and EACH Dementia Operational Places
Allocated under the *Aged Care Act 1997*

State/Territory	EACH	EACH Dementia
NSW	1,083	450
VIC	882	326
QLD	527	216
SA	286	111
WA	292	76
TAS	75	38
NT	70	20
ACT	87	30
Australia	**3,302**	**1,267**

EACH places are attributed as Community Care as from June 2004 and EACH Dementia places as from December 2005

Transition Care Operational Places
Allocated under the *Aged Care Act 1997*

State/Territory	TOTAL
NSW	571
VIC	424
QLD	257
SA	147
WA	100
TAS	52
NT	8
ACT	35
Australia	**1,594**

Innovative Care Operational Places
Allocated to WA Only under the *Aged Care Act 1997*

State/Territory	High Care	Low Care	Residential	Community	Total
WA	16	15	31	-	31
Australia	**16**	**15**	**31**	**-**	**31**

ATTACHMENT C

Offline Places by State/Territory

As at 30 June 2007

State/ Territory	High Care	Low Care	Total Residential	Community Care	TOTAL	% of Total
NSW	703	534	**1,237**	-	**1,237**	**38.8%**
VIC	564	505	**1,069**	-	**1,069**	**33.6%**
QLD	224	117	**341**	2	**343**	**10.8%**
SA	54	6	**60**	-	**60**	**1.9%**
WA	240	186	**426**	-	**426**	**13.4%**
TAS	-	41	**41**	-	**41**	**1.3%**
NT	-	-	**-**	-	**-**	**0.0%**
ACT	-	10	**10**	-	**10**	**0.3%**
Australia	**1,785**	**1,399**	**3,184**	**2**	**3,186**	**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.

ATTACHMENT D

Total Allocated Places by State/Territory

as at 30 June 2007

State/ Territory	High Care	Low Care	Total Residential	Community Care	Transition Care	TOTAL
NSW	32,848	33,742	**66,590**	14,243	703	**81,536**
VIC	23,037	26,574	**49,611**	10,858	502	**60,971**
QLD	15,809	18,274	**34,083**	7,399	351	**41,833**
SA	8,493	8,759	**17,252**	3,753	176	**21,181**
WA	7,720	9,032	**16,752**	3,800	160	**20,712**
TAS	2,507	2,423	**4,930**	1,153	57	**6,140**
NT	343	249	**592**	731	16	**1,339**
ACT	1,002	1,393	**2,395**	606	35	**3,036**
Australia	**91,759**	**100,446**	**192,205**	**42,543**	**2,000**	**236,748**

Total Allocated Ratio* by State/Territory

as at 30 June 2007

State/ Territory	High Care	Low Care	Total Residential	Community Care	Transition Care	TOTAL
NSW	48.9	50.2	**99.1**	21.2	1.0	**121.4**
VIC	46.0	53.1	**99.1**	21.7	1.0	**121.8**
QLD	44.7	51.7	**96.4**	20.9	1.0	**118.4**
SA	48.5	50.0	**98.6**	21.4	1.0	**121.0**
WA	44.6	52.2	**96.8**	22.0	0.9	**119.7**
TAS	48.8	47.2	**96.0**	22.4	1.1	**119.5**
NT	60.2	43.7	**103.9**	128.3	2.8	**235.0**
ACT	44.4	61.7	**106.1**	26.8	1.6	**134.5**
Australia	**47.0**	**51.4**	**98.4**	**21.8**	**1.0**	**121.2**

Notes:

The tables above include 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 residential high care, residential low care and community care places. Community care includes Community Aged Care Packages (CACP), EACH and EACH Dementia places

*** The Ratios in the table immediately above are derived from the Australian Bureau of Statistics (ABS) 2006 Population Census projections for June 2007.**

Population projections from the 2006 Population Census at Aged Care Planning Region level are not yet available from the ABS. Therefore projections based on the 2001 Population Census are used for the regional ratios in the following tables at the aged care planning region level.

TOTAL ALLOCATED PLACES AND RATIOS AT REGIONAL LEVEL

	As at 30 June 2007	Total Allocated Places					Total Allocated Ratio *				
State/ Territory	Aged Care Planning Region	HIGH	LOW	RESI	Community Care	TOTAL	HIGH	LOW	RESI	Community Care	TOTAL
NSW	Central Coast	1,663	2,014	**3,677**	957	**4,634**	39.0	47.2	**86.2**	22.4	**108.6**
	Central West	793	957	**1,750**	378	**2,128**	42.7	51.6	**94.3**	20.4	**114.7**
	Far North Coast	1,526	1,933	**3,459**	762	**4,221**	40.7	51.6	**92.3**	20.3	**112.7**
	Hunter	2,832	3,234	**6,066**	1,297	**7,363**	44.0	50.2	**94.2**	20.1	**114.4**
	Illawarra	1,815	2,483	**4,298**	1,031	**5,329**	40.8	55.9	**96.7**	23.2	**119.9**
	Inner West	3,297	1,685	**4,982**	824	**5,806**	78.6	40.2	**118.8**	19.6	**138.4**
	Mid North Coast	1,735	2,368	**4,103**	929	**5,032**	40.8	55.7	**96.5**	21.8	**118.3**
	Nepean	1,252	904	**2,156**	455	**2,611**	58.4	42.2	**100.6**	21.2	**121.8**
	New England	843	1,002	**1,845**	418	**2,263**	43.9	52.1	**96.0**	21.7	**117.7**
	Northern Sydney	4,639	4,280	**8,919**	1,635	**10,554**	55.1	50.8	**105.8**	19.4	**125.2**
	Orana Far West	594	898	**1,492**	401	**1,893**	37.6	56.9	**94.5**	25.4	**119.9**
	Riverina/Murray	1,248	1,498	**2,746**	579	**3,325**	43.2	51.8	**95.0**	20.0	**115.0**
	South East Sydney	3,898	3,755	**7,653**	1,746	**9,399**	46.1	44.4	**90.6**	20.7	**111.3**
	South West Sydney	2,890	3,137	**6,027**	1,325	**7,352**	45.5	49.4	**95.0**	20.9	**115.8**
	Southern Highlands	937	1,331	**2,268**	456	**2,724**	40.3	57.2	**97.4**	19.6	**117.0**
	Western Sydney	2,886	2,263	**5,149**	1,050	**6,199**	52.8	41.4	**94.1**	19.2	**113.3**
	All State (Transition Care)					**703**					**1.0**

Note: The Ratios in this table are derived from the Australian Bureau of Statistics (ABS) 2001 Population Census projections for June 2007. Population Census projections for June 2007 based on the 2006 Population Census are not yet available from the ABS at the aged care planning region level.

ATTACHMENT F

TOTAL ALLOCATED PLACES AND RATIOS AT REGIONAL LEVEL

As at 30 June 2007		Total Allocated Places					Total Allocated Ratio *				
State/ Territory	Aged Care Planning Region	HIGH	LOW	RESI	Community Care	TOTAL	HIGH	LOW	RESI	Community Care	TOTAL
VIC	Barwon-South Western	1,824	2,233	**4,057**	909	**4,966**	43.4	53.2	**96.6**	21.6	**118.3**
	Eastern Metro	4,379	5,465	**9,844**	2,131	**11,975**	43.1	53.8	**96.9**	21.0	**117.8**
	Gippsland	1,213	1,533	**2,746**	648	**3,394**	41.5	52.5	**94.0**	22.2	**116.2**
	Grampians	1,027	1,263	**2,290**	537	**2,827**	43.1	53.0	**96.1**	22.5	**118.6**
	Hume	1,259	1,537	**2,796**	620	**3,416**	44.9	54.8	**99.7**	22.1	**121.9**
	Loddon-Mallee	1,414	1,851	**3,265**	742	**4,007**	40.9	53.6	**94.5**	21.5	**116.0**
	Northern Metro	3,497	3,589	**7,086**	1,628	**8,714**	48.3	49.6	**97.9**	22.5	**120.4**
	Southern Metro	5,936	6,179	**12,115**	2,508	**14,623**	48.5	50.4	**98.9**	20.5	**119.4**
	Western Metro	2,488	2,924	**5,412**	1,135	**6,547**	46.4	54.5	**100.9**	21.2	**122.1**
	All State (Transition Care)					**502**					**1.0**

Note: The Ratios in this table are derived from the Australian Bureau of Statistics (ABS) 2001 Population Census projections for June 2007. Population Census projections for June 2007 based on the 2006 Population Census are not yet available from the ABS at the aged care planning region level.

TOTAL ALLOCATED PLACES AND RATIOS AT REGIONAL LEVEL

As at 30 June 2007		Total Allocated Places					Total Allocated Ratio *				
State/ Territory	Aged Care Planning Region	HIGH	LOW	RESI	Community Care	TOTAL	HIGH	LOW	RESI	Community Care	TOTAL
QLD	Brisbane North	2,191	2,075	**4,266**	780	**5,046**	52.3	49.5	**101.9**	18.6	**120.5**
	Brisbane South	2,789	2,822	**5,611**	1,168	**6,779**	48.7	49.3	**98.0**	20.4	**118.4**
	Cabool	1,189	1,428	**2,617**	571	**3,188**	43.2	51.9	**95.2**	20.8	**115.9**
	Central West	68	54	**122**	64	**186**	69.1	54.9	**124.0**	65.0	**189.0**
	Darling Downs	1,096	1,217	**2,313**	440	**2,753**	47.3	52.5	**99.8**	19.0	**118.8**
	Far North	666	850	**1,516**	432	**1,948**	38.2	48.7	**86.9**	24.7	**111.6**
	Fitzroy	666	796	**1,462**	339	**1,801**	43.0	51.3	**94.3**	21.9	**116.1**
	Logan River Valley	652	959	**1,611**	317	**1,928**	40.4	59.5	**99.9**	19.7	**119.6**
	Mackay	364	437	**801**	201	**1,002**	38.6	46.4	**85.0**	21.3	**106.4**
	North West	49	80	**129**	101	**230**	30.5	49.8	**80.2**	62.8	**143.0**
	Northern	807	783	**1,590**	334	**1,924**	49.7	48.2	**97.9**	20.6	**118.4**
	South Coast	1,971	2,416	**4,387**	909	**5,296**	42.1	51.6	**93.6**	19.4	**113.0**
	South West	74	155	**229**	97	**326**	35.9	75.2	**111.2**	47.1	**158.3**
	Sunshine Coast	1,553	2,124	**3,677**	811	**4,488**	39.3	53.8	**93.1**	20.5	**113.6**
	West Moreton	523	738	**1,261**	263	**1,524**	38.9	54.9	**93.7**	19.5	**113.3**
	Wide Bay	1,151	1,340	**2,491**	572	**3,063**	43.7	50.8	**94.5**	21.7	**116.2**
	All State (Transition Care)					**351**					**1.0**

Note: The Ratios in this table are derived from the Australian Bureau of Statistics (ABS) 2001 Population Census projections for June 2007. Population Census projections for June 2007 based on the 2006 Population Census are not yet available from the ABS at the aged care planning region level.

ATTACHMENT F

TOTAL ALLOCATED PLACES AND RATIOS AT REGIONAL LEVEL

As at 30 June 2007		Total Allocated Places					Total Allocated Ratio *				
State/ Territory	Aged Care Planning Region	HIGH	LOW	RESI	Community Care	TOTAL	HIGH	LOW	RESI	Community Care	TOTAL
SA	Eyre Peninsula	129	182	**311**	88	**399**	35.8	50.5	**86.3**	24.4	**110.8**
	Hills, Mallee & Southern	568	685	**1,253**	335	**1,588**	42.4	51.1	**93.5**	25.0	**118.5**
	Metropolitan East	2,254	1,882	**4,136**	591	**4,727**	63.3	52.9	**116.2**	16.6	**132.8**
	Metropolitan North	1,555	1,224	**2,779**	522	**3,301**	58.9	46.4	**105.3**	19.8	**125.1**
	Metropolitan South	1,799	1,879	**3,678**	849	**4,527**	45.4	47.4	**92.7**	21.4	**114.1**
	Metropolitan West	1,215	1,289	**2,504**	616	**3,120**	41.6	44.1	**85.7**	21.1	**106.7**
	Mid North	69	234	**303**	87	**390**	19.1	64.9	**84.0**	24.1	**108.1**
	Riverland	146	238	**384**	118	**502**	31.1	50.7	**81.9**	25.2	**107.0**
	South East	189	358	**547**	138	**685**	29.3	55.5	**84.8**	21.4	**106.2**
	Whyalla, Flinders & Far North	166	205	**371**	163	**534**	41.1	50.8	**91.9**	40.4	**132.3**
	Yorke, Lower North & Barossa	403	583	**986**	246	**1,232**	38.5	55.7	**94.2**	23.5	**117.7**
	All State (Transition Care)					**176**					**1.0**
WA	Goldfields	143	127	**270**	81	**351**	53.5	47.5	**101.0**	30.3	**131.3**
	Great Southern	293	385	**678**	190	**868**	39.1	51.3	**90.4**	25.3	**115.8**
	Kimberley	68	92	**160**	67	**227**	56.4	76.3	**132.8**	55.6	**188.4**
	Metropolitan East	1,246	1,456	**2,702**	508	**3,210**	47.1	55.1	**102.2**	19.2	**121.4**
	Metropolitan North	1,853	2,384	**4,237**	971	**5,208**	41.3	53.1	**94.4**	21.6	**116.1**
	Metropolitan South East	1,622	1,496	**3,118**	576	**3,694**	56.5	52.2	**108.7**	20.1	**128.8**
	Metropolitan South West	1,634	1,836	**3,470**	781	**4,251**	41.2	46.2	**87.4**	19.7	**107.1**
	Mid West	178	278	**456**	149	**605**	35.7	55.8	**91.5**	29.9	**121.5**
	Pilbara	27	53	**80**	50	**130**	37.6	73.7	**111.3**	69.5	**180.8**
	South West	495	725	**1,220**	282	**1,502**	39.6	57.9	**97.5**	22.5	**120.0**
	Wheatbelt	161	200	**361**	145	**506**	31.0	38.5	**69.5**	27.9	**97.4**
	All State (Transition Care)					**160**					**0.9**

Note: The Ratios in this table are derived from the Australian Bureau of Statistics (ABS) 2001 Population Census projections for June 2007. Population Census projections for June 2007 based on the 2006 Population Census are not yet available from the ABS at the aged care planning region level.

ATTACHMENT F

TOTAL ALLOCATED PLACES AND RATIOS AT REGIONAL LEVEL

State/ Territory	As at 30 June 2007 Aged Care Planning Region	Total Allocated Places HIGH	LOW	RESI	Community Care	TOTAL	Total Allocated Ratio * HIGH	LOW	RESI	Community Care	TOTAL
TAS	North Western	514	553	**1,067**	258	**1,325**	43.0	46.2	**89.2**	21.6	**110.8**
	Northern	784	625	**1,409**	348	**1,757**	52.5	41.8	**94.3**	23.3	**117.6**
	Southern	1,209	1,245	**2,454**	547	**3,001**	48.6	50.0	**98.6**	22.0	**120.6**
	All State (Transition Care)					**57**					**1.1**
NT	Alice Springs	110	56	**166**	201	**367**	111.1	56.6	**167.7**	203.0	**370.7**
	Barkly	17	2	**19**	42	**61**	140.5	16.5	**157.0**	347.1	**504.1**
	Darwin	179	144	**323**	332	**655**	49.3	39.7	**89.0**	91.5	**180.5**
	East Arnhem	9	6	**15**	72	**87**	56.3	37.5	**93.8**	450.0	**543.8**
	Katherine	28	41	**69**	84	**153**	66.8	97.9	**164.7**	200.5	**365.2**
	All State (Transition Care)					**16**					**2.8**
ACT	Australian Capital Territory	1,002	1,393	**2,395**	606	**3,001**	44.4	61.7	**106.1**	26.8	**132.9**
	All State (Transition Care)					**35**					**1.6**

Note: The Ratios in this table are derived from the Australian Bureau of Statistics (ABS) 2001 Population Census projections for June 2007. Population Census projections for June 2007 based on the 2006 Population Census are not yet available from the ABS at the aged care planning region level. As the ACT is also an aged care planning region, the Department has been able to use ABS data from the 2006 Census.

Total Allocated Places by Service Type
as at 30 June 2007

Mainstream Allocated Places
Residential and Community Care places under the *Aged Care Act 1997*

State/Territory	High Care	Low Care	Total Residential	Community Care	TOTAL
NSW	32,310	33,498	**65,808**	12,613	**78,421**
VIC	22,842	26,440	**49,282**	9,562	**58,844**
QLD	15,574	18,115	**33,689**	6,525	**40,214**
SA	8,318	8,596	**16,914**	3,292	**20,206**
WA	7,380	8,696	**16,076**	3,230	**19,306**
TAS	2,453	2,390	**4,843**	970	**5,813**
NT	291	189	**480**	569	**1,049**
ACT	1,002	1,393	**2,395**	489	**2,884**
Australia	**90,170**	**99,317**	**189,487**	**37,250**	**226,737**

Flexible Allocated Places

National Aboriginal and Torres Strait Islander Aged Care Strategy Allocated Places
Not allocated under the *Aged Care Act 1997*

State/Territory	High Care	Low Care	Total Residential	Community Care	TOTAL
NSW	6	15	**21**	19	**40**
VIC	15	10	**25**	69	**94**
QLD	49	30	**79**	4	**83**
SA	75	38	**113**	45	**158**
WA	14	-	**14**	2	**16**
TAS	-	-	**-**	46	**46**
NT	48	60	**108**	72	**180**
ACT	-	-	**-**	-	**-**
Australia	**207**	**153**	**360**	**257**	**617**

Multipurpose Service Allocated Places
Allocated under the *Aged Care Act 1997*

State/Territory	High Care	Low Care	Total Residential	Community Care	TOTAL
NSW	532	229	**761**	78	**839**
VIC	180	124	**304**	14	**318**
QLD	186	129	**315**	107	**422**
SA	100	125	**225**	14	**239**
WA	305	310	**615**	153	**768**
TAS	54	33	**87**	7	**94**
NT	4	-	**4**	-	**4**
ACT	-	-	**-**	-	**-**
Australia	**1,361**	**950**	**2,311**	**373**	**2,684**

Total Allocated Places by Service Type

as at 30 June 2007

Extended Aged Care at Home (EACH) and EACH Dementia Allocated Places
Allocated under the *Aged Care Act 1997*

State/Territory	EACH	EACH Dementia
NSW	1,083	450
VIC	882	331
QLD	532	231
SA	286	116
WA	299	116
TAS	90	40
NT	70	20
ACT	87	30
Australia	3,329	1,334

EACH places are attributed as Community Care as from June 2004 and EACH Dementia places as from December 2005.

Transition Care Allocated Places
Allocated under the *Aged Care Act 1997*

State/Territory	TOTAL
NSW	703
VIC	502
QLD	351
SA	176
WA	160
TAS	57
NT	16
ACT	35
Australia	2,000

Innovative Care (IC) Allocated Places
Allocated to WA Only under the *Aged Care Act 1997*

State/ Territory	High Care	Low Care	Total Residential	Community Care	TOTAL
WA	21	26	47	-	47
Australia	21	26	47	-	47

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30 May 2007

Question: E07-378

OUTCOME 5: Primary Care

Topic: DENTAL ALLIED HEALTH

Hansard Page: CA 81

Senator McLucas asked:

GPs Initiating Treatment – Number of GPs initiating treatment and number of patients being referred.

Answer:

The Department does not routinely extract Medicare data or report on the number of GPs referring patients for dental services.

Since the Medicare dental items commenced (1 July 2004 to 30 April 2007), a total of 5,730 patients have received dental services under this initiative.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30-31 May 2007

Question: E07 - 178

OUTCOME 5: Primary Care

Topic: PRACTICE NURSES

Written Question on Notice

Senator McLucas asked:

What proportion of general practices employs practice nurses?

Answer:

The Australian Government provides financial incentives through the Practice Incentives Program (PIP) that aim to encourage general practices to improve the quality of care provided to patients. There are two practice nurse initiatives available through the PIP to support general practices to employ practice nurses. These are the PIP rural practice nurse incentive and the PIP urban practice nurse incentive in urban areas of workforce shortage.

As at May 2007, there were around 2,160 general practices accessing the incentives, representing around 67% of eligible PIP practices.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30-31 May 2007

Question: E07-176

OUTCOME 5: Primary Care

Topic: AUTISM AND CHRONIC DISEASE MANAGEMENT MEDICARE ITEMS

Written Question on Notice

Senator McLucas asked:

a) Is Autism (or are any of the Autism Spectrum Disorders) classified as chronic diseases and therefore eligible to receive access to allied care through the allied health chronic disease program?

b) If not why not?

Answer:

The Chronic Disease Management (CDM) Medicare items provide Medicare rebates for GPs to manage the care of patients including the coordination of care from a multidisciplinary team. To be eligible for a GP Management Plan, a patient must have a chronic (or terminal) medical condition - one that has been or is likely to be present for six months or longer, including but not limited to asthma, cancer, cardiovascular illness, diabetes mellitus, musculoskeletal conditions and stroke. Patients who also have complex care needs are eligible for Team Care Arrangements including allied health services.

Autism Spectrum Disorders (ASD) are considered to be developmental disorders rather than medical conditions.

The type of treatment that is available under the Chronic Disease Management (CDM) care plans is not designed to specifically address the treatment needs of individuals with ASD. However, it is recognised that many patients with ASD may have co-morbidities.

If a child with autism also has a chronic medical condition and complex care needs and the GP prepares a GP Management Plan and Team Care Arrangements, a child can be referred by their GP to allied health professionals. Medicare benefits are available for a maximum of five allied health services (in total) for the patient per calendar year.

Whether a patient meets this criterion is essentially a matter for the GP and, other than the above reference, the MBS does not comprehensively list all possible medical 'conditions' that either are/are not regarded as chronic medical conditions for the purposes of the CDM items.

Where a patient's condition would not obviously come within the MBS definition, a GP may still consider that, notwithstanding the above, the patient's condition and circumstances are such that they require the preparation of a GP Management Plan, for example, because of non-compliance, inability to self-manage, functional disability etc.

In these cases, the GP should be satisfied that the GP's peers would regard the provision of a CDM service as appropriate for that patient, given the patient's needs and circumstances.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30-31 May 2007

Question: E07-288

OUTCOME 5: Primary Care

Topic: BUDGET MEASURES

Written Question on Notice

Senator Crossin asked:

For each of the 2006-07 Budget Measures in Indigenous health please specify
a) How much was expended in 2006-07 (please provide a departmental/administered funds breakdown)

Answer:

The Aboriginal and Torres Strait Islander Child Health Check was introduced in May 2006. From 1 July 2006 to 30 June 2007, 6,315 indigenous child health checks have been provided at a cost of $1,049,776 in administered funds. There are no targets for the Indigenous child health check.

Further information in relation to the 2006-07 Budget Measures in Indigenous health is provided in response E07 -368.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30-31 May 2007

Question: E07-181

OUTCOME 3: Access to Medical Services
5: Primary Care

Topic: ROUND THE CLOCK MEDICARE: INVESTING IN AFTER HOURS GP SERVICES

Written Question on Notice

Senator McLucas asked:

In answers to question on notice from the February Estimates round, it was revealed that the Government has under-spent on its Round the Clock Medicare package by $57.6 million as at June 2006.

Please provide a consolidated table of Round the Clock Medicare funding and expenditure to date (including YTD expenditure for 2006-07), broken down by component, showing how un-spent funds have been re-phased.

Answer:

As indicated in the answer to the February 2007 question on notice, the *Round the Clock Medicare: Investing in After-Hours GP Services* package has two components as follows:

- higher rebates for after-hours GP attendances; and
- three new types of grant funding to after-hours GP services:
  - Operating Subsidies;
  - Start Up Grants; and
  - Supplementary Grants.

Higher After-Hours Rebates

	2004-05	2005-06	2006-07
	$m	$m	$m
Original estimate*	42.1	83.8	91.7
Actual expenditure**	21.6	46.7	51.5

* Includes Medicare flow-ons

**For $10 loading only, does not include flow-ons which can not be tracked.

Medicare expenditure is demand driven. Funding for Medicare benefits is provided under the Medical Benefits special appropriation under the *Health Insurance Act 1973*.

As this is a special appropriation, funding is made available as required and therefore there is no need to seek rephases.

Grant funding

	2004-05	2005-06	2006-07 *
	$m	**$m**	**$m**
(A) Original estimates	2.00	10.50	16.00
(B) Net rephased amounts into 2007-08 and later years	-1.93	-8.27	-9.98
(C) Allocation post rephases (C=A+B)	**0.07**	**2.23**	**6.02**
(D) Expenditure	0.07	2.23	6.02^

* The 2006-07 amounts at B and C are subject to confirmation.

^ Amount as at 30 June 2007.

Rephased funds from 2004-05, 2005-06 and any subsequent rephasing will be available in future years to reflect the profile of funding needed by existing services, and supporting new services.

To date, in excess of 120 after-hours services have been funded throughout Australia under the first two rounds of the *Round the Clock Medicare* Program.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2007-2008, 30 - 31May 2007.

Question: E07-182

OUTCOME 5: Primary Care

Topic: PIP

Written Question on Notice

Senator McLucas asked:

How much has been spent in each of the last three financial years on the Practice Incentives Program? Please disaggregate by element (After hours care, cervical screening etc).

Answer:

The amount spent under each of the elements of the Practice Incentives Program (PIP) from 2004-05 to 2006-07 is provided in the attached tables.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2007-2008, 30 - 31May 2007

Question: E07-183

OUTCOME 5: Primary Care

Topic: PIP

Written Question on Notice

Senator McLucas asked:

Please provide consolidated table showing total expenditure per years for the last 3 years and original allocations.

Answer:

The allocation and expenditure of the Primary Care Practice Incentives Appropriation (formerly known as the Alternate Funding for General Practice Services Appropriation) from 2004-05 to 2006-07 is provided in the attached table.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30 May 2007

Question: E07-379

OUTCOME 6: Rural Health

Topic: RURAL WOMEN'S GP SERVICE

Hansard Page: CA 115

Senator Moore asked:

Please provide the name of the external consultant that conducted the lapsing program review of the Rural Women's GP Service.

Answer:

The name of the external consultant that undertook the economic component of the lapsing program review was Australian Healthcare Associated.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30 May 2007

Question: E07-185

OUTCOME 6: Rural Health

Topic: RURAL WOMEN'S GP SERVICE

Hansard Page: CA 113

Senator McLucas asked:

Please provide a list of locations of existing Rural Women's GP Services.

Answer:

The list of locations is eligible to receive the Rural Women's GP Service is provided at Attachment A.

ATTACHMENT A

List of locations eligible to receive the Rural Women's GP Service

Central Operations

Number	State	Location
1	NT	Alyangula
2	SA	Balaklava
3	NT	Batchelor
4	NT	Borroloola
5	SA	Burra
6	SA	Ceduna
7	SA	Coober Pedy
8	SA	Cowell
9	SA	Cummins
10	SA	Elliston
11	NT	Jabiru
12	SA	Karoonda
13	SA	Kimba
14	SA	Kingscote
15	SA	Kingston S.E.
16	NT	Lajamanu
17	SA	Lameroo
18	SA	Leigh Creek
19	SA	Lock
20	SA	Lucindale
21	SA	Marla/Mintabie Cluster
22	SA	Millicent
23	SA	Oak Valley
24	SA	Penola
25	SA	Pinnaroo
26	NT	Pt Keats
27	SA	Pt Pirie
28	SA	Pt Wakefield
29	SA	Robe
30	SA	Roxby Downs
31	SA	Streaky Bay
32	NT	Tennant Creek
33	NT	Timber Creek - Hub
34	SA	Tumby Bay
35	SA	Whyalla
36	SA	Woomera
37	SA	Wudinna

38	SA	Yalata
39	SA	Yorketown
40	NT	Yulara

South Eastern Section

Number	State	Location
1	NSW	Ashford
2	NSW	Balranald
3	TAS	Beaconsfield
4	NSW	Boggabri
5	NSW	Bombala
6	NSW	Bonalbo
7	NSW	Boorowa
8	TAS	Bothwell
9	NSW	Braidwood
10	NSW	Brewarrina
11	TAS	Campbell Town
12	VIC	Cann River
13	VIC	Casterton
14	VIC	Charlton
15	NSW	Cobar
16	NSW	Condobolin
17	NSW	Coonamble
18	VIC	Corryong
19	NSW	Delegate
20	TAS	Deloraine
21	NSW	Dunedoo/Coolah - Cluster
22	TAS	Dover
23	NSW	Dunedoo/Coolah Cluster
24	TAS	Fingal
25	TAS	Flinders Island
26	NSW	Gilgandra
27	NSW	Goodooga
28	VIC	Goroke
29	NSW	Gunnedah
30	NSW	Hay
31	NSW	Hillston
32	VIC	Hopetoun
33	NSW	Iluka
34	NSW	Ivanhoe
35	NSW	Khancoban

36	TAS	King Island
37	NSW	Lake Cargelligo
38	NSW	Lightning Ridge
39	NSW	Lockhart
40	VIC	Manangatang
41	NSW	Menindee
42	NSW	Merriwa
43	NSW	Narrabri
44	VIC	Nhill
45	TAS	Nubeena
46	NSW	Nundle
47	NSW	Nyngan
48	VIC	Omeo
49	VIC	Orbost
50	TAS	Orford
51	TAS	Ouse
52	VIC	Ouyen
53	NSW	Peak Hill
54	NSW	Pooncarie
55	TAS	Queenstown
56	VIC	Rainbow
57	VIC	Robinvale
58	TAS	Rosebery
59	VIC	Sea Lake
60	VIC	St Arnaud
61	TAS	St. Marys
62	TAS	Strahan
63	TAS	Swansea
64	VIC	Tallangatta
65	NSW	Temora
66	NSW	Tenterfield
67	TAS	Triabunna
68	NSW	Tullamore
69	NSW	Tumbarumba
70	NSW	Urana
71	NSW	Urbenville
72	NSW	Walgett
73	VIC	Warracknabeal
74	NSW	Warren
75	NSW	West Wyalong
76	NSW	Wilcannia

77	NSW	Yamba
78	VIC	Yarram
79	TAS	Zeehan

Queensland Section

Number	State	Location
1	QLD	Alpha
2	QLD	Agnes Water
3	QLD	Augathella
4	QLD	Aurukun
5	QLD	Bamaga
6	QLD	Barcaldine
7	QLD	Bedourie
8	QLD	Biloela
9	QLD	Birdsville
10	QLD	Blackall
11	QLD	Blackwater
12	QLD	Boulia
13	QLD	Bowen
14	QLD	Burketown / Dommadgee Cluster
15	QLD	Camooweal
16	QLD	Chillagoe
17	QLD	Clermont
18	QLD	Cloncurry
19	QLD	Coen
20	QLD	Collinsville
21	QLD	Cooktown - Hub
22	QLD	Croydon
23	QLD	Cunnamulla / Thargomindah Cluster
24	QLD	Dysart
25	QLD	Georgetown
26	QLD	Glenden
27	QLD	Hopevale - Spoke to Cooktown
28	QLD	Hughenden
29	QLD	Inglewood
30	QLD	Injinoo
31	QLD	Julia Creek
32	QLD	Jundah
33	QLD	Karumba
34	QLD	Kowanyama
35	QLD	Laura - Spoke to Cooktown

36	QLD	Lockhart River
37	QLD	Longreach
38	QLD	Miles
39	QLD	Miriam Vale
40	QLD	Mitchell
41	QLD	Moranbah
42	QLD	Mornington Island
43	QLD	Moura
44	QLD	Mt Surprise
45	QLD	Mundubbera
46	QLD	Napranum
47	QLD	New Mapoon
48	QLD	Normanton
49	QLD	Old Mapoon - Spoke to Weipa
50	QLD	Pormpuraaw
51	QLD	Quilpie
52	QLD	Richmond
53	QLD	Sapphire
54	QLD	Seisia
55	QLD	Tambo - Spoke to Cooktown
56	QLD	Tara
57	QLD	Taroom
58	QLD	Texas
59	QLD	Torres Strait Islands
60	QLD	Umagico
61	QLD	Weipa
62	QLD	Windorah
63	QLD	Winton
64	QLD	Wujal Wujal - Spoke to Cooktown
65	QLD	Yarrabah

Western Operations

Number	State	Location
1	WA	Beacon - Spoke from Mukinbudin
2	WA	Bencubbin - Spoke from Mukinbudin
3	WA	Beverley
4	WA	Boddington
5	WA	Boyup Brook
6	WA	Bruce Rock
7	WA	Carnarvon

8	WA	Corrigin
9	WA	Cunderdin
10	WA	Denham
11	WA	Dongara
12	WA	Fitzroy Crossing
13	WA	Gnowangerup
14	WA	Halls Creek
15	WA	Harvey
16	WA	Indian Ocean Territories
17	WA	Jerramungup/Bremer Bay Cluster
18	WA	Jurien
19	WA	Kalbarri
20	WA	Kellerberrin
21	WA	Kojonup
22	WA	Kondinin
23	WA	Koorda - Spoke from Mukinbudin
24	WA	Kununoppin
25	WA	Lake Grace/Newdegate Cluster
26	WA	Laverton
27	WA	Leinster
28	WA	Leonora
29	WA	Meriden
30	WA	Morawa
31	WA	Mt Magnet
32	WA	Mukinbudin - Hub
33	WA	Mullewa
34	WA	Narembeen
35	WA	Narrogin
36	WA	Newman
37	WA	Norseman
38	WA	Northampton
39	WA	Onslow
40	WA	Paraburdoo
41	WA	Pilbara WD
42	WA	Pingelly
43	WA	Quairading
44	WA	Ravensthorpe/Hopetoun Cluster
45	WA	Southern Cross/Westonia Cluster
46	WA	Three Springs
47	WA	Tom Price
48	WA	Wagin

49	WA	Wongan Hills
50	WA	Wyalkatchem
51	WA	Wyndham

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30 May 2007

Question: E07-381

OUTCOME 6: Rural Health

Topic: MEDICAL SPECIALIST OUTREACH ASSISTANCE PROGRAM (MSOAP)

Hansard Page: CA 116

Senator Moore asked:

Please provide a consolidated list of services that are funded under MSOAP, the kinds of specialist services that they offer and the locations.

Answer:

The consolidated list of services that are funded under MSOAP, the kinds of specialist services that they offer and the locations of the services to 31 December 2006, can be found at Attachment A. A breakdown of MSOAP services was also provided in response to Question on Notice E06-148 of the Supplementary Budget Estimates 2006-2007 held on 1 November 2006.

NSW Health	
Anaesthetic - upskilling (SimMan)	Macksville
Ophthalmology - Surgery	Griffith
Paediatrics - Developmental	Brewarrina
	Woodenbong
	Wentworth
	Broken Hill
	Casino
	Coraki
Paediatrics - Developmental	
	Goonellabah
	Muswellbrook
Paediatrics - Nephrology	
	Orange
Paediatrics - Neurology	
	Muswellbrook
	Orange
Paediatrics - Respiratory	
	Albury
Paediatrics - Urology	
	Orange
Paediatrics - Urology	
Physician - Cardiology	
	Tamworth
Physician - Endocrinology	
	Collarenebri
	Goodooga
	Lightning Ridge
	Walgett
	Balranald
	Dareton
	Ivanhoe
	White Cliffs
	Broken Hill
	Menindee
	Tibooburra
	Wilcannia
Physician - Gastroenterology	
	Moree
	Tamworth
Physician - Genetics	
	Merimbula
	Orange
	Lismore
	Wagga Wagga
	Wagga Wagga
	Tweed Heads

Physician - Geriatrics	
	Bega
	Griffith
Physician - Nephrology	
	Dubbo
	Wagga Wagga
Physician - Neurology	
	Kempsey
	Dubbo
	Lismore
	Griffith
	Wagga Wagga
Physician - Palliative	
	Port Macquarie
	Coffs Harbour
	Kempsey
	Dubbo
Physician - Palliative	
	Wagga Wagga
Physician - Rehabilitation	
	Dubbo
Physician - Respiratory	
	Jubal
	Tabulam
	Coffs Harbour
	Broken Hill
	Bonalbo
	Casino
	Kyogle
	Lismore
Physician - Sexual Health	
	Tamworth
Physician - Sexual Health	
	Dareton
	Broken Hill
	Wilcannia
Psychiatry - Child and Adolescent	
	Lismore
Psychiatry - General	
	Deniliquin
	Dubbo
	Griffith
	Wagga Wagga
Psychiatry - Geriatric	
	Port Macquarie
Psychiatry - Geriatric	
	Coffs Harbour
	Coffs Harbour
	Moruya

	Tumut
	Lismore
	Wagga Wagga
Psychiatry - Neurology	
	Albury
	Coffs Harbour
	Lismore
Surgery – Colorectal	
	Dubbo
Surgery - General	
	Corowa
Surgery - Oral and Maxillo facial	
	Tamworth
Surgery - Orthopaedic	
	Griffith
Surgery - Paediatric	
	Muswellbrook
NSW Rural Doctors Network Ltd	
Anaesthetic - upskilling (SimMan)	
	Kempsey
Dermatology	
	Batemans Bay
	Port Macquarie
	Taree
	Armidale
	Tamworth
	Albury
	Coffs Harbour
	Coffs Harbour
	Bega
	Cooma
	Broken Hill
Dermatology	
	Dubbo
	Griffith
O&G - Fertility	
O&G - General	
	Narrabri
	Young
	Inverell
O&G - Gynaecology	
	Finley
Ophthalmology - General	
	Moree
	Bega
	Hay
Paediatrics - Developmental	
	Broken Hill
Paediatrics - Endocrinology	

	Albury
Paediatrics - General	
	Gunnedah
	Corowa
	Deniliquin
Paediatrics - General	
	Bega
	Bombala
Paediatrics - Haematology	
	Wagga Wagga
Paediatrics - Neurology	
	Wagga Wagga
Physician - Addiction Medicine	
	Bourke
Physician - Cardiology	
	Walgett
	Bega
	Broken Hill
Physician - Cardiology	
	Dubbo
	Dubbo
Physician - Endocrinology	
	Port Macquarie
	Coffs Harbour
	Coffs Harbour
	Narooma
	Lithgow
	Griffith
Physician - Gastroenterology	
	Taree
Physician - Haematology	
	Moree
Physician - Haematology	
Physician - Nephrology	
	Moree
	Armidale
	Inverell
	Dareton
	Parkes
Physician - Neurology	
	Port Macquarie
	Armidale
	Coffs Harbour
	Coffs Harbour
	Bega
	Cooma
Physician - Neurology	
	Dubbo
Physician - Oncology	

	Finley
Physician - Palliative	
	Moruya
Physician - Respiratory	
	Walgett
	Dubbo
Physician - Rheumatology	
	Tamworth
	Moruya
	Pambula
Physician - Rheumatology	
	Orange
	Dubbo
	Wagga Wagga
Psychiatry - Adult	
	Coffs Harbour
	Coffs Harbour
	Grafton
	Wagga Wagga
Psychiatry - Child and Adolescent	
	Taree
Psychiatry - General	
	Warren
Psychiatry - General	
	Tamworth
	Tamworth
	Kempsey
	Muswellbrook
	Singleton
	Blayney
	Cowra
	Lithgow
	Cobar
	Forbes
	Griffith
	Leeton
Surgery - ENT	
	Crookwell
Surgery - General	
	Warialda
	Bingara
Surgery - Neuro	
	Gulgong
	Port Macquarie
	Tamworth
Surgery - Orthopaedic	
	Young
	Leeton

Surgery - Vascular	
	Batemans Bay
	Bega

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30-31 May 2007

Question: E07-184

OUTCOME 6: Rural Health

Topic: RURAL HEALTH STRATEGY

Written Question on Notice

Senator McLucas asked:

Please provide a consolidated list of funding and expenditure on all the programs included in the Rural Health Strategy, which includes:

- Expenditure to date, by financial year, against each program;
- Anticipated expenditure against each measure for the 2006-07 financial year;
- Anticipated expenditure against each measure for the 2007-08 financial year (incorporating the information provided by Departmental officers during the hearing).

Answer:

The consolidated list of expenditure on all the programs included in the Rural Health Strategy is provided at Attachment A.

RURAL HEALTH STRATEGY **ATTACHMENT A**

	Measure Title	2004-05 (Expenditure)	2005-06 (Expenditure)	2006-07 (Expenditure)	2007-08 (Estimated)
1	New General Practitioner Registrars	29.5	36.1	44.0	54.4
2	Rural Primary Health Program (RHS, MAHS and Projects)	53.0	54.8	55.7	56.6
3	Workforce Support for Rural General Practitioners	2.8	2.9	2.9	3.0
4	Rural Specialist Support Program (MSOAP)	16.1	17.6	17.7	17.7
5	Additional University Departments of Rural Health	5.3	5.3	5.4	5.5
6	Rural Clinical Schools	42.3	43.2	44.1	45.0
7	HECS Reimbursement (revised FEs)	2.1	2.4	2.8	8.9
8	Scholarships for Medical Students to Practice in Rural Areas (MRBS)	10.0	11.1	10.9	11.6
9	Enhanced Rural Australian Medical Undergraduate Scholarships (RAMUS)	2.1	2.2	2.2	2.3
10	Rural Private Access Program	6.7	13.2	11.3	11.4
11	Aged Care-Adjustment Grants for Small Rural Facilities (Viability and Capital Grants)	9.8	10.1	10.3	10.5
	TOTAL	***179.7***	***199.1***	***207.4***	***227.1***

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30-31 May 2007

Question: E07-186

OUTCOME 6: Rural Health

Topic: MEDICAL SPECIALIST OUTREACH ASSISTANCE PROGRAM (MSOAP)

Written Question on Notice

Senator McLucas asked:

Please provide a consolidated list of expenditure and funding on the MSOAP program to date, including:

a) Original budget allocations;
b) Additional funding provided since original budget allocations;
c) Expenditure for each financial year in which the program has been in operation, including YTD expenditure for 2006-07.

Answer:

a) Original budget allocations for the Medical Specialist Outreach Assistance Program:

1999-2000 $m	2000-01 $m	2001-02 $m	2002-03 $m	2003-04 $m	2004-05 $m	2005-06 $m	2006-07 $m	2007-08 $m
1.68	1.68	8.33	15.04	15.34	16.19	15.49	15.45	15.49

b) No additional funding has been provided since original budget allocations.

c) Expenditure for each financial year in which the program has been in operation:

1999-2000 $m	2000-01 $m	2001-02 $m	2002-03 $m	2003-04 $m	2004-05 $m	2005-06 $m	2006-07 $m
1.75	.688	9.57	13.14	10.04	13.77	15.4	15.4

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30 May 2007

Question: E07-374

OUTCOME 7: Hearing Services

Topic: HEARING SERVICES FUNDING

Hansard Page: CA 145

Senator Crossin asked:

How many children will benefit from the frequency modulated (FM) systems component of the Community Service Obligation?

Answer:

1,500 children are expected to benefit from the FM systems over a period of two years.

T14

Aboriginal and Torres Strait Islander Medicare Health checks resource kit accessible at:

http://www.health.gov.au/internet/wcms/publishing.nsf/Content/health-pacd-medicare-resource-kit

Department of Health and Ageing

Mr Elton Humphrey
Secretary
Senate Community Affairs Committee
Parliament House
CANBERRA ACT 2066

Dear Mr Humphrey

Request for Amendment to Evidence Provided at Budget Estimates Hearing, Date 31 May 2007: Outcome 8: Indigenous Health

I am writing to correct a statement that I made at the Budget Estimates Hearing of the Senate Community Affairs Committee on Thursday 31 May 2007.

Senator Siewert asked a series of questions related to petrol sniffing (Hansard page number CA101).

Ms Rachel Balmanno (Assistant Secretary, Health Strategies Branch) and I provided a response to the question.

Within context, I responded to a particular issue with accurate information available at that time. It has since been brought to my attention that the figures I provided in relation to the spike in premium fuel consumption of 40 per cent and 10 per cent need to be formally clarified.

In light of subsequent information provided to me, the response should now be amended as follows (changes are underlined):

"It spiked for a short time and went up to about 60 per cent but it has dropped down now to about 40 per cent, which is becoming more normal for Alice Springs."

Yours sincerely

Lesley Podesta
First Assistant Secretary
Office for Aboriginal and Torres Strait
Islander Health

June 2007

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30 - 31 May 2007

Question: E07-189

OUTCOME 8: Indigenous Health

Topic: INDIGENOUS HEALTH SERVICE ACCREDITATION

Written Question on Notice

Senator McLucas asked:

a) Who will conduct the accreditations?
b) How will standards/quality be measures be determined?
c) How frequently will accreditations be conducted?

Answer:

a) The organisations conducting assessments within the proposed single accreditation framework are yet to be determined. Further consideration will be given to this issue once development of the framework is complete. The Department anticipates using existing Australian healthcare accreditation infrastructure as appropriate.

Currently, Indigenous health services can seek accreditation from a range of healthcare and/or quality systems frameworks. Licensed assessors carry out the accreditation through a program of visits and evidence-based interviews. The assessors are themselves accredited to assess particular standards.

The proposed single accreditation framework for Indigenous health services will operate in the same manner.

The Department will investigate strategies to encourage Aboriginal and Torres Strait Islander people with an interest in this field to undertake training to be a health service accreditation assessor.

b) The standards for inclusion in the single accreditation framework are currently being scoped via three related projects:

1. The Department has initiated a research project with the Cooperative Research Centre for Aboriginal Health under existing industry partnership arrangements to undertake extensive consultations with the Indigenous health sector in order to identify the domains (and standards from existing frameworks) to be included within a single framework.

2. The Department is intending to appoint a Lead Agent from Australian healthcare accreditation providers to provide advice on licensing and assessment delivery arrangements for such a framework.

3. The Department is offering funding to the National Aboriginal Community Controlled Health Organisation (NACCHO) and its state/territory-based affiliates to provide advice on the level and type of support that would be required by Indigenous health organisations in order to achieve accreditation.

Once these standards and assessment processes are drafted, they will be put to the Australian Commission on Safety and Quality in Health Care (ACSQHC) for endorsement.

c) It is anticipated that the cycle of accreditation under the proposed single accreditation framework will be of three years' duration. This is in line with current healthcare accreditation processes.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30 - 31 May 2007

Question: E07-187

OUTCOME 8: Indigenous Health

Topic: FAMILY CENTRED PRIMARY HEALTH CARE

Written Question on Notice

Senator McLucas asked:

Please provide information on how this measure was costed – including assumptions used, unit costs, loadings for remote services etc

Answer:

The cost of delivering this measure is an estimate based on historical patterns within the program, taking into account factors of remoteness, timeframes and costs of capital infrastructure, travel and the like. The costings have been agreed with the Department of Finance and Administration but are subject to change.

Of the $38.2 million over 4 years allocated to the *A Better Future for Indigenous Australians – family centred primary health care* measure, $6.1 million in administered funding has been allocated over four years for training and skill enhancement for managers of Indigenous services, with a focus on health service management to deliver primary health care. The remainder of the administered funds is for the development or expansion of multidisciplinary teams to provide on-site and outreach primary health care to Aboriginal and Torres Strait Islander individuals, families and communities in at least six rural and remote areas.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30 - 31 May 2007

Question: E07-188

OUTCOME 8: Indigenous Health

Topic: FAMILY CENTRED PRIMARY CARE

Written Question on Notice

Senator McLucas asked:

How many Indigenous families and people are expected to benefit from this measure?

Answer:

The measure will fund comprehensive primary health care to Aboriginal and Torres Strait Islander individuals, families and communities in six rural and remote areas.

At this stage, it is not possible to provide an estimate of how many Indigenous families and people will benefit from this measure, as this will depend on the location and area covered by the services funded, and these have not yet been determined.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30 - 31 May 2007

Question: E07-190

OUTCOME 8: Indigenous Health

Topic: CDEP

Written Question on Notice

Senator McLucas asked:

How does the Department work out where the jobs are that will be converted from CDEP?

Answer:

All primary health care and substance use organisations funded by the Office for Aboriginal and Torres Strait Islander Health were invited to lodge submissions for conversion of long term Community Development Employment Program (CDEP) subsidised positions. The Department assessed organisations' submissions against the following eligibility criteria:

- the position must be created through a CDEP Agreement on or before 9 May 2005 (i.e. 12 months prior to release of the 2006-07 Federal Budget on 9 May 2006);
- the position must be current and cross-checked with Department of Employment and Workplace Relations' CDEP records; and
- the position must be directly related to the provision of primary health care or substance use services or directly supporting provision of these services.

Positions that met the above criteria were approved for conversion from CDEP-subsidised positions to permanent fully waged positions funded through the Aboriginal and Torres Islander Health Program.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30-31 May 2007

Question: E07-273

OUTCOME 8: Indigenous Health

Topic: PRIMARY HEALTH CARE ACCESS PROGRAM (PHCAP)

Written Question on Notice

Senator Crossin asked:

a) Was it to provide equitable primary health care coverage across Australia?

b) Did that include the cities?

Answer:

a) Yes, PHCAP was introduced to improve the access of all Indigenous Australians to comprehensive primary health care services commensurate with health need.

b) Yes, PHCAP is a national initiative.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30 - 31 May 2007

Question: E07-274

OUTCOME 8: Indigenous Health

Topic: PRIMARY HEALTH CARE ACCESS PROGRAM (PHCAP)

Written Question on Notice

Senator Crossin asked:

Was there a formula per head of Aboriginal population? What is that formula?

Answer:

Please refer to E07-279 b).

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 31 May 2007

Question: E07-275

OUTCOME 8: Indigenous Health

Topic: PRIMARY HEALTH CARE ACCESS PROGRAM (PHCAP)

Written Question on Notice

Senator Crossin asked:

a) Does PHCAP still exist as part of government policy?

b) Has the objective of the program changed?

Answer:

a) Yes.

b) No.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 31 May 2007

Question: E07-277

OUTCOME 8: Indigenous Health

Topic: PRIMARY HEALTH CARE ACCESS PROGRAM (PHCAP)

Written Question on Notice

Senator Crossin asked:

Could you estimate the total expenditure from the PHCAP budget on planning studies over the life of PHCAP?

Answer:

From 1999 - 00, an estimated $3.52 million has been expended nationally on planning studies from PHCAP and other funding allocations within the Aboriginal and Torres Strait Islander Health program.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30 - 31 May 2007

Question: E07-278

OUTCOME 8: Indigenous Health

Topic: PRIMARY HEALTH CARE ACCESS PROGRAM (PHCAP)

Written Question on Notice

Senator Crossin asked:

Is there still a formula per head of Aboriginal population?

Answer:

Yes.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30 - 31 May 2007

Question: E07-279

OUTCOME 8: Indigenous Health

Topic: PRIMARY HEALTH CARE ACCESS PROGRAM (PHCAP)

Written Question on Notice

Senator Crossin asked:

a) Does PHCAP still operate in the cities? If so, which cities?

b) Is there a different formula in the cities? What is that formula?

Answer:

a) Yes, PHCAP is a national initiative and funds have been allocated to urban as well as rural and remote planning regions.

b) Yes, the PHCAP Benchmark formula takes into consideration the relevant Aboriginal and Torres Strait Islander population and is calculated as three times the average Medicare expenditure per capita nationally. The formula is adjusted for cost differentials in different parts of Australia and equates to two times the national average Medicare expenditure per capita in highly accessible areas (such as cities) to four times the national average Medicare expenditure per capita in very remote areas.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30-31 May 2007

Question: E07-280

OUTCOME 8: Indigenous Health

Topic: PRIMARY HEALTH CARE ACCESS PROGRAM (PHCAP)

Written Question on Notice

Senator Crossin asked:

How many zones were identified for it to be rolled out in and how many have been rolled out to date?

Answer:

As at 31 May 2007, Indigenous health organisations located in 52 of the 56 OATSIH Planning Regions have received PHCAP funds. However, a number of these organisations provide primary health care services beyond the boundaries of the planning regions in which they are located.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30 - 31 May 2007

Question: E07-283

OUTCOME 8: Indigenous Health

Topic: ALCOHOL ABUSE

Written Question on Notice

Senator Crossin asked:

How much has the Government committed to alcohol management plans in 2006-07? Please also provide a breakdown of this expenditure – what was it spent on?

Answer:

Alcohol Management Plans are the responsibility of the state, territory and local governments and are developed in cooperation with Indigenous communities.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30 - 31 May 2007

Question: E07-287

OUTCOME 8: Indigenous Health

Topic: REPHASING OF FUNDS WITHIN THE COMBATTING PETROL SNIFFING PROGRAM

Written Question on Notice

Senator Crossin asked:

On page 87 of the PAES can you please explain what you mean by the following items:

a) rephasing of funds within Combatting Petrol Sniffing Program

Answer:

a) The rephasing of funds within the Combatting Petrol Sniffing Program relates to the delay in take up of the *Opal* fuel subsidy in 2005-06. The rephased funds were used in 2006-07 to provide *Opal* fuel to service stations in Alice Springs.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30 - 31 May 2007

Question: E07-287A

OUTCOME 8: Indigenous Health

Topic: ADDITIONAL MEASURES

Written Question on Notice

Senator Crossin asked:

On Page 87 of the PAES can you please explain what you mean by the following items:

(a) "rephasing of funds within Combating Petrol Sniffing Program"

(b) "reprofiling of funds within the ATSI Health Services Program"

(c) "reprofiling of funds within the Primary Health Care Access Program"

Answer:

(a) The rephasing of funds within the Combating Petrol Sniffing Program relates to the delay in take up of the *Opal* fuel subsidy in 2005-06. The rephased funds were used in 2006-07 to provide *Opal* fuel to service stations in Alice Springs.

(b) The reprofiling of funds totalling $40.7 million ($27.9 million for the Aboriginal and Torres Strait Islander Health and $12.8 million for the Primary Health Care Access program) relates mainly to new capital works commitments made in 2005-06. Approximately $45 million was committed to new capital works projects in 2005-06, with the majority of the financial impact occurring in the forward years.
These capital works are essential to the delivery of Indigenous health services in rural and remote Australia. The majority of the reprofile relates to the new projects and slippages on projects committed in previous years. These slippages were mainly due to construction delays and difficulties associated with the competitive market for limited resources in the construction industry in remote areas.

(c) See response in (b).

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 31 May 2007

Question: E07-292

OUTCOME 8: Indigenous Health

Topic: HEALTH@HOME PLUS

Hansard Page: CA 98

Senator Crossin asked:

Is there some sort of paper or an explanation of this that you can provide?

Answer:

The home visiting program within *Health@Home Plus* will be based on the work of Professor David Olds and the Nurse Family Partnership program model and tools. This program has been the subject of several rigorous longitudinal studies that demonstrate significant social, economic and health benefits for participants in this program.

Details of the peer-reviewed journal articles outlining the results from three randomised controlled trials of the Nurse-Family Partnership model in Elmira, New York; Memphis, Tennessee; and Denver, Colorado; are attached.

Olds, D et al, (1997). 'Long Term Effects of Home Visitation on Maternal Life Course and Child Abuse and Neglect: 15 Year Follow-up of a Randomised Trial', in *JAMA*, Vol 278, No 8, pp. 637-643 (Attachment A)

Olds, D et al, (1998). 'Long Term Effects of Nurse Home Visitation on Children's Criminal and Antisocial Behaviour: 15 year Follow-up of a Randomised Trial,' in *JAMA*, October 14, Vol 280, No.14, pp. 1238-1244 (Attachment B)

Olds, D et al, (2004). 'Effects of Nurse Home Visiting on Maternal Life Course and Child Development: Age 6 Follow-up Results of a Randomised Trial,' in *Pediatrics*, Vol 114, No 6, pp. 1550-1559 (Attachment C)

Olds, D. (2006). 'The Nurse-Family Partnership: an Evidence-Based Preventive Intervention', *Infant Mental Health Journal*, Vol.27, No. 1, pp. 5-25 (Attachment D)

[Note: the attachments were tabled in the Senate on 16.08.07 and have not been included in the electronic/printed volume]

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2006-2007, 31 May 2007

Question: E07-293

OUTCOME 8: Indigenous Health

Topic: CENTRAL AUSTRALIA EYE HEALTH BLITZ

Hansard Page: CA99

Senator Crossin asked:

When you talk about 'Central Australia' this is taking in Warburton down to the Pit Lands in South Australia, or just to the Territory borders?

Answer:

The Central Australian eye health blitz surgical sessions are currently focusing on the communities in the Northern Territory as far north as the Barkly region. This initiative has not included the Pitjantjatjara Lands as patients from these communities are normally sent to Adelaide for surgery.

The regions covered in the first blitz during May included Yuendumu, Yuelamu, Papunya, Mt Kuebug, Haasts Bluff, Kintore, Willowra and Alice Springs. The target regions for the remaining surgical sessions in September and November 2007 will be determined by the waiting lists for eye surgery at Alice Springs Hospital.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2006-2007, 31 May 2007

Question: E07-294

OUTCOME 8: Indigenous Health

Topic: ROLLOUT OF *OPAL* FUEL AND DIVERSIONARY ACTIVITIES IN THE EAST KIMBERLEY

Hansard Page: CA103

Senator Siewert asked:

When do you expect that the rollout of *Opal* and diversionary programs will happen?

Answer:

Australian Government agencies have begun consultations with the Western Australian Government and key stakeholders in the East Kimberley. The rollout of *Opal* fuel is expected to commence prior to the next wet season with a view to coordinate other elements of the Eight Point Plan where possible.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2006-2007, 31 May 2007

Question: E07-295

OUTCOME 8: Indigenous Health

Topic: 22 NEW COUNSELLORS FOR LINK UP SERVICES

Hansard Page: CA 105

Senator Siewart asked:

Could you give us a list of the new counsellors? Was there a press release about this, or just a speech?

Answer:

The 22 new counsellors are located in the following services:

Western Australia
Great Southern Aboriginal Health Service, Albany - 1
Kimberley Stolen Generation Aboriginal Corporation, Broome - 1
Ngnowar Aerwah Aboriginal Corporation, Wyndham - 1
Wangka Maya Link Up, South Hedland - 1
Yorgum Aboriginal Corporation, Northbridge – 1

South Australia
Nunkuwarrin Yunti of South Australia, Adelaide – 2

Northern Territory
Central Australian Stolen Generations & Families Aboriginal Corporation, Alice Springs - 2
Karu Aboriginal Child Care Agency, Darwin - 2

Queensland
Link-Up Queensland Aboriginal Corporation – Head Office, Brisbane – 4 [throughout state]

New South Wales
Link-Up NSW Aboriginal Corporation, Lawson - 3 + 1 temp. (for ACT)

Victoria
Victorian Aboriginal Child Care Agency, Northcote - 2 + 1 temp (for TAS)

There was no media release on the announcement.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 31 May 2007

Question: E07-191

OUTCOME 8: Indigenous Health

Topic: Primary Health Care Access Program (PHCAP)

Written Question on Notice

Senator McLucas asked:

Please provide an updated list of PHCAP roll-out.

Answer:

The table below shows the distribution of new Primary Health Care Access Program (PHCAP) funding[1] of $28.388 million in 2006-07 by OATSIH Planning Region based on the location of the health service delivery organisation. It should be noted that this expenditure excludes capital works.

State / Territory	OATSIH Planning Region	Total 2006/2007 Expenditure ($m)
ACT	ACT	$0.300
ACT Total		**$0.300**
NSW	Greater Southern NSW	$0.313
	Hunter	$0.247
	Inner Greater Western NSW	$0.245
	New England	$0.479
	North Coast	$1.208
	North Sydney Central Coast	$0.130
	Outer Greater Western NSW	$0.957
	South East Sydney - Illawarra	$0.690
	Sydney South West	$0.366
	Sydney West	$0.061
NSW Total		**$4.697**
NT	Alice Springs	$0.592
	Arnhem	$0.273
	Barkly	$0.045
	Darwin Rural	$0.245
	Darwin Urban	$3.410#
	Katherine	$0.336
NT Total		**$4.901**

Includes organisations delivering services in Wadeye.

1 New PHCAP funding includes the *Improved Primary Health Care Initiative* 2005/06 Budget Measure and *Improving Indigenous Access to Health Care Services* 2006/07 Budget Measure.

State / Territory	OATSIH Planning Region	Total 2006/2007 Expenditure ($m)
QLD	Cape York	$0.759*
	Central QLD	$0.648
	Far North QLD	$5.052*
	Far South West QLD	$0.557
	North QLD	$0.542
	North West QLD	$0.147
	SE QLD Metro	$1.471*
	South West QLD	$0.351
	Torres LGA	$0.603
	Wide Bay/Sunshine	$0.516
QLD Total		**$10.645**
SA	Eyre Peninsula	$0.324
	Hills Mallee & Southern	$0.024
	Metropolitan SA North	$0.158
	Metropolitan SA South	$0.086
	Riverland	$0.076
	South East S.A	$0.014
	Whyalla, Flinders & Far North	$0.115
SA Total		**$0.796**
TAS	North - Tas	$0.068
	North West - Tas	$0.106
	South - Tas	$0.226
TAS Total		**$0.401**
VIC	East Metro Vic	$0.050
	Gippsland	$0.054
	Grampians	$0.031
	Hume	$0.081
	Loddon Mallee	$0.618
	Northern Metro Vic	$0.196
	Western Metro Vic	$0.070
VIC Total		**$1.099**
WA	Goldfields	$0.472
	Kimberley	$2.038
	Metropolitan WA	$0.855
	Midwest WA	$0.244
	Pilbara	$0.169
	South West WA	$0.197
	Wheatbelt	$1.573
WA Total		**$5.549**
Grand Total		**$28.388**

* Includes organisations delivering services in Cape York.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30 - 31 May 2007

Question: E07-272

OUTCOME 8: Indigenous Health

Topic: PRIMARY HEALTH CARE ACCESS PROGRAM

Written Question on Notice

Senator Crossin asked:

Can you provide a table of how much money it has received since 1999? Please include the amount allocated and expended for each year.

Answer:

The allocation and expense on Primary Health Care Access Program (PHCAP) since 1999 is as follows. It should be noted that these figures include capital works expenditure:

$ millions	1999-00 ($m)	2000-01 ($m)	2001-02 ($m)	2002-03 ($m)	2003-04 ($m)	2004-05 ($m)	2005-06 ($m)	2006-07 ($m)
Allocation excluding rephased amounts	4.2	12.8	18.9	29.1	47.7	61.7	68.4	72.4
Rephase						**12.6**	**11.5**[a]	**22.3**[a]
Total allocation	**4.2**	**12.8**	**18.9**	**29.1**	**47.7**	**74.3**	**79.9**	**97.7**
Expense	4.2	12.8	18.9	29.1	35.1	43.6	57.7	93.6
Rephased or reprofiled [b]					12.6	30.6	22.1	4.1
Total expensed and committed	**4.2**	**12.8**	**18.9**	**29.1**	**47.7**	**74.2**	**79.9**	**97.7**

[a] Balance of funds rephased/reprofiled to out years.

[b] Funds rephased/reprofiled to out years to meet Capital Works commitments for the construction/refurbishment of health clinics and staff housing in rural and remote areas, with some projects taking 3-5 years to complete.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30 - 31 May 2007

Question: E07-276

OUTCOME 8: Indigenous Health

Topic: PRIMARY HEALTH CARE ACCESS PROGRAM

Written Question on Notice

Senator Crossin asked:

a) What is the current level of expenditure on PHCAP services?

b) What is the current 2006-07 and 2007-08 allocation for PHCAP?

Answer:

a) In 2006-07 the Australian Government expensed the following for Primary Health Care Access Program (PHCAP):

Year	2006-07
Expensed - $ millions	93.6
Rephased - $ millions	4.1
Total - $ millions	97.7

b) The allocation for PHCAP for 2006-07 and 2007-08 is as follows:

Year	2006-07	2007-08
Allocation – $ millions	97.7	99.3

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30 - 31 May 2007

Question: E07-281

OUTCOME 8: Indigenous Health

Topic: Primary Health Care Access Program (PHCAP)

Written Question on Notice

Senator Crossin asked:

a) Which zones have been rolled out?
b) When were they rolled out?
c) How much funding did they each get in 2006-07?
d) How many Indigenous people was this intended to service?

Answer:

a) Refer to QoN E07-280.

b) Primary Health Care Access Program (PHCAP) funding has been allocated for the delivery of services across Australia as funds have become available. Additional PHCAP funding has been approved in several Federal Budgets since the initiative was introduced in the 1999-2000 Budget.

c) Refer to QoN E07-191

d) PHCAP is a national initiative and was introduced to improve the access of all Aboriginal and Torres Strait Islander people to comprehensive primary health care services.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2006-2007, 30-31 May 2007

Question: E07-282

OUTCOME 8: Indigenous Health

Topic: ALCOHOL ABUSE.

Written Question on Notice

Senator Crossin asked:

In November 2006 the Federal Government promised to crack down on liquor licensing laws in rural areas in Australia. It promised to spend another $200,000 on improving and managing alcohol related problems in Indigenous communities.

a) How much of that $200,000 has been spent?

b) What has it been spent on? Please provide a list of projects or activities including the cost of each project or activity.

Answer:

a) The Australian Government has spent $195,278 (GST inclusive) on a single project on improving and managing alcohol related problems in Indigenous communities.

b) The National Drug Research Institute (NDRI) is contracted to undertake a project to enhance the access of Indigenous Australians to quality treatment for alcohol-related problems. This project will consider how interventions known to be effective in mainstream populations can effectively be applied in Indigenous Australian contexts.

   The expected outcomes of the project will include:
   - a review of the range of interventions and their application among Indigenous people;
   - identification of factors that inhibit or facilitate the application of interventions;
   - identification of gaps in current knowledge, especially in relation to the process of implementation of effective interventions;
   - development of a comprehensive set of recommendations for enhancing the management of alcohol-related problems; and
   - development of a plan for implementation of the recommendations.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2006-2007, 31 May 2007

Question: E07-284

OUTCOME 8: Indigenous Health

Topic: ALCOHOL ABUSE

Written Question on Notice

Senator Crossin asked:
How much was spent by Government in total on addressing Indigenous alcohol abuse in 2006/07? Please provide a breakdown of expenditure.

Answer:

The Australian Government provides funding to address Indigenous alcohol abuse through the following initiatives:
a) The Aboriginal and Torres Strait Islander Health Substance Use Program;

In 2006/07 the Australian Government provided funding of $21.29 million to 70 services across Australia to address Indigenous alcohol abuse under the Aboriginal and Torres Strait Islander Substance Use Program. The primary drug of concern for services funded under the Substance Use Program is alcohol

A breakdown across national, state and territory expenditure is provided below.

Program	Jurisdiction	2006/07 Administered Expenditure ($)
Aboriginal and Torres Strait Islander Substance Use Program	National	156,036
	New South Wales	3,520,176
	Victoria	1,886,191
	Queensland	5,321,127
	South Australia	3,433,277
	Western Australia	2,262,459
	Tasmania	1,018,137
	Northern Territory	3,468,150
	ACT	225,550
TOTAL		**21,291,103**

b) The Council of Australian Governments' (COAG) measure for additional drug and alcohol treatment and rehabilitation services in regional and remote Indigenous communities;

In 2006/07 the total administered expenditure for the COAG measure for additional drug and alcohol treatment and rehabilitation services for regional and remote Indigenous communities was $1.69 million.

A breakdown across national, state and territory expenditure is provided below.

Program	Jurisdiction	2006/07 Administered Expenditure ($)
COAG Measure – additional drug and alcohol rehabilitation and treatment services	Queensland	496,000
	South Australia	250,000
	Northern Territory	38,000
	Western Australia	906,000
TOTAL		**1,690,000**

c) Outcome 1: Drug Strategy Branch within Population Health Division - including: *The National Illicit Drug Strategy Non Government Organisation Treatment Grants Programme*; *The National Illicit Drug Strategy Community Partnerships Initiative; The National Illicit Drug Strategy Capacity Building in Indigenous Communities*; and *A Better Future for Indigenous Australians – continuing the National Illicit Drug Strategy – Indigenous Communities Initiative*.

Money spent on addressing Indigenous alcohol abuse in 2006/07 by Outcome 1: Drug Strategy Branch:

A Better Future for Indigenous Australians – continuing the National Illicit Drug Strategy - Indigenous Communities Initiative

The 'Tough On Drugs' *Indigenous Communities Initiative* spent $2,447,352 for the 2006-07 financial year on Indigenous alcohol abuse.

National Illicit Drug Strategy - Capacity Building in Indigenous Communities – 2006-07

The *Capacity Building in Indigenous Communities Initiative* spent $ 799,854 for the 2006-07 financial year on Indigenous alcohol abuse.

National Illicit Drug Strategy - Non Government Organisations Treatment Grants Program (NGOTGP) – 2006-07

The *NGOTGP* spent $ 1,503,598 for the 2006-07 financial year. Many of the services funded under this Program provide both drug and alcohol treatment services across Australia

National Illicit Drug Strategy - Community Partnerships Initiative

The *Community Partnerships Initiative* spent $ 840,805 for the 2006-07 financial year. The projects funded under this Initiative aim to reduce drug use and drug-related harms including alcohol misuse through community projects.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30 - 31 May 2007

Question: E07-285

OUTCOME 8: Indigenous Health

Topic: ADDITIONAL MEASURES

Written Question on Notice

Senator Crossin asked:

Page 87 of the PAES 2006-07 refers to three additional measures:
1) Addressing violence and child abuse in Indigenous communities – drug and alcohol treatment and rehabilitation services for Indigenous Australians in remote and regional areas;
2) Addressing violence and child abuse in Indigenous communities – Indigenous Child Health Checks; and
3) Indigenous communities – reducing substance abuse (petrol sniffing) roll out of opal fuel in Alice Springs.

For each of those measures please answer:
a) How much has been expended to date in 2006-07? (Please provide a breakdown of departmental/administered funds)
b) What has been achieved on the ground to date?
c) What have been the outcomes to date?

Answer:

1. *Drug and Alcohol*
a)

2006-07	$ millions
Administered	1.690
Departmental	0.602

b) In South Australia negotiations have been conducted between the state government and non-government organisations towards auspice arrangements for the establishment of day centres in Port Augusta, Ceduna and Coober Pedy. Capital funds under the COAG measure have been allocated to the state government to support this process. In the Northern Territory, auspice arrangements are being developed with the Northern Territory Government and non-government agencies that can support new services in the region. The Western Australia Government is auspicing a number of new and extended services through the Drug and Alcohol Office (DAO). Capital funds under the COAG measure have been allocated to DAO to support this process.

c) To date, bilateral negotiations have been held with the Northern Territory, Queensland, South Australia, Western Australia and New South Wales Governments. Bilateral proposals for drug and alcohol treatment and rehabilitation services have been developed in the Northern Territory, South Australia and Western Australia. Queensland has developed a proposal to conduct a state-wide analysis to identify opportunities for investment of funds under the COAG Measure. In March 2007 the Minister for Ageing, The Hon Christopher Pyne, approved the proposals and associated funding for the Northern Territory (up to $15.9 million over four years), South Australia (up to $7.105 million over four years) and Western Australia (up to $8.4 million over four years). Queensland received in-principle approval of funding up to $10 million over three years following identification of priorities for investment. Negotiations are continuing with the remaining jurisdictions. Funding agreements are currently being developed between the state and territory governments, non-government organisations and the Australian Government in the Northern Territory, South Australia and Western Australia.

2. *Indigenous Child Health Checks*

a)

2006-07	$ millions
Administered -	0.182
Departmental	0.383

b) As at 31 May 2007 the Minster for Health and Ageing the Hon. Tony Abbott, has approved 11 sites, as suitable to participate in this measure. The following table presents Wave 1 and Wave 2 approved sites:

Priority	State/Territory	Recommended Region
Wave 1	Western Australia	Halls Creek
	South Australia	Yalata and Maralinga-Tjaruja Lands (Oak Valley)
	Queensland	Yarrabah
	New South Wales	Coonamble and Gulargambone
Wave 2	Western Australia	East Pilbara/Western Desert Communities include (Jigalong, Kunawarritji, Parnngurr, Punumu)
	New South Wales	Nyngan/Warren

Primary Health Care Services in Wave 1 sites have been invited to submit proposals, including budget for roll-out of this measure in their region. Funding commenced in 2006-07, and implementation of Wave 1 sites is expected to commence in 2007-08. Wave 2 sites will be approached to participate, if timing and available resourcing allows.

The Department has engaged a Workforce Support Provider who will assist Primary Health Care Services in each site with their recruitment, training and on-site support needs. This Workforce Support Provider is currently working with Wave 1 sites.

c) Implementation in each site has not yet commenced. Therefore reporting progress on program outcomes is premature.

3. *Roll out of Opal fuel in Alice Springs*
a) No Departmental funding was allocated for the *Rollout of Opal fuel in Alice Springs* in 2006-07. Resources used to administer the program in 2006-07 were funded through current Departmental appropriation. Administered funding of $11.4 million over three years was allocated in the 2006-07 Additional Estimates specifically for the rollout of *Opal* fuel into Alice Springs. Funding commences from 2007-08.

Rephased funds within the Combating Petrol Sniffing Program were used in 2006-07 to provide *Opal* fuel to service stations in Alice Springs.

b) All 11 service stations in Alice Springs have fully replaced regular unleaded petrol with *Opal* fuel.

c) Anecdotally there has been a reduction in petrol sniffing in Alice Springs since *Opal* fuel replaced regular unleaded petrol in March 2007.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30 - 31 May 2007

Question: E07-286

OUTCOME 8: Indigenous Health

Topic: ADDITIONAL MEASURES

Written Question on Notice

Senator Crossin asked:

It is noted that $602,000 was allocated to Departmental expenses for 2006-07 for the following measure: Addressing violence and child abuse in Indigenous communities – drug and alcohol treatment and rehabilitation services for Indigenous Australians in remote and regional areas.

a) What will this money be spent on?
b) How many new staff will this measure fund?
c) What team within the department will these staff sit in?
d) Will these staff be administering any other money?
e) Are these departmental resources only for administering the money outlined in the measure ($1.69 million in 2006-07)?

Answer:

a) The Departmental allocation for this measure includes the cost of Departmental ASL and additional travel required to administer and implement the measure.
b) While the measure provides funding for additional ASL, this does not readily translate to numbers of new staff. Departmental funding provided through the measure will allow for the staffing required to administer the program.
c) The staff managing the *Addressing violence and child abuse in Indigenous communities – drug and alcohol treatment and rehabilitation services for Indigenous Australians in remote and regional areas* measure sit in OATSIH Central Office and in State and Territory Offices.
d) No.
e) Yes.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30 - 31 May 2007

Question: E07-368

OUTCOME 8: Indigenous Health

Topic: BUDGET MEASURES

Written Question on Notice

Senator Crossin asked:

For each of the 2006-07 Budget Measures in Indigenous health please specify

a) How much was expended in 2006-07? (please provide a departmental/administered funds breakdown)

b) What has been achieved on the ground to date?

c) What have been the outcomes to date?

Answers:

a)

Measure	**Administered Expense ($ m)**	**Departmental Expense ($ m)**
Improving Indigenous Access to Health Care Services	$1.734	$1.517
Improving Indigenous Health Worker Employment	$3.480	$0.424
Improving the Capacity of Workers in Indigenous Communities	$1.330	$0.461
Strengthening Indigenous Communities – Reducing Substance Abuse (Petrol Sniffing)	$6.916*	$0.403

* For administrative efficiency, the administered funding of three specific petrol sniffing Budget Initiatives are managed as a consolidated budget rather than separate measures. In 2006-07 the three Budget Initiatives included 2005-06 Budget Measure *'Combating Petrol Sniffing'*, 2005-06 Additional Estimates *'Combating Petrol Sniffing'* and 2006-07 Budget Measure '*Strengthening Indigenous Communities – Reducing Substance Abuse (Petrol Sniffing)'*.

b) and c)

Improving Indigenous Access to Health Care Services 2006-07 Budget Measure

Urban Brokerage

Funding has been provided to establish five urban brokerage services, the first in 2006-07, with a staggered roll-out thereafter. Following a two staged competitive funding process for Site One, the Macarthur Division of General Practice Ltd in South West Sydney has been engaged and is in the process of recruiting staff. It commenced operations on 29 June 2007.

Rural and Remote Workforce Supply
Funding has been provided for the expansion of 10 multi-disciplinary teams to provide comprehensive primary health care services in rural and remote areas across Australia. The implementation timeline and funding commitment for expanded service delivery is over the four years of the budget measure to allow for completion of capital works to support expansion of service delivery in some areas.

Improving Indigenous Health Worker Employment 2006-07 Budget Measure
Forty-four (44) OATSIH-funded primary health care and substance use organisations have been provided with funds to convert 151 former Community Development Employment Project (CDEP) Program positions to permanent jobs.

Improving the Capacity of Workers in Indigenous Communities 2006-07 Budget Measure
Recipients of the five additional Puggy Hunter Memorial Scholarships for mental health for the 2007 academic year were advised that they were successful in December 2006.

In November 2006, OATSIH commissioned the development of a five-day in-service training program for Aboriginal health workers. The program, currently under development, targets clinic staff and will cover stabilisation and referral and interventions for drug and alcohol, suicide and grief and loss. Completion of the training program product as well as delivery, distribution and promotional mechanisms is expected in December 2007.

In February 2007 OATSIH commissioned the development of a culturally appropriate Mental Health First Aid Program training program and course materials, and the delivery of mental health first aid instructor training to Aboriginal health service staff nationally through a series of five day workshops. The Department will support 120 instructor scholarships. Pilot workshops were delivered in Orange NSW in March 2007, and in Cairns Queensland in May 2007, and eight more workshops are expected to be completed by March 2008.

The agreed sites for additional mental health worker positions are:

- Normanton (QLD);
- Kununurra and Derby (WA);
- Yalata and the APY Lands (SA);
- Tiwi Island, Galiwinku, Alice Springs Town Camps and Wadeye (NT); and
- Launceston (Tas).

The Tiwi Islands employed a mental health worker on 29 June 2007. The Department has approached potential auspice agencies regarding the positions at the remaining locations. As part of the COAG Mental Health Initiative's mental health workers reform package a number of the sites have been identified as being dependent on the provision of housing particularly in the rural and remote locations where current accommodation options are limited.

OATSIH has engaged professional services to develop a multi-media mental health resource package to support Aboriginal Health Workers, counsellors and other clinical staff in Aboriginal and Torres Strait Islander health services to effectively recognise, treat and educate on common mental health conditions and contributing lifestyle factors. The project is expected to be completed by March 2008.

OATSIH is finalising a tender process to develop a mental health textbook, which will support the mental health workforce to work with Aboriginal and Torres Strait Islander communities and individuals.

A procurement process is currently under consideration by OATSIH to commission services to develop and/or adapt culturally appropriate mental health assessment tools to assist health professionals undertaking mental health assessments for Aboriginal and Torres Strait Islander people.

An Expert Reference Group has been convened to advise on the above initiatives. The Expert Reference Group has met in March, May and August 2007.

Strengthening Indigenous Communities – Reducing Substance Abuse (Petrol Sniffing)
2006 - 07 Budget Measure
Achievements on the ground to date include all eleven service stations in Alice Springs having fully replaced regular unleaded petrol with *Opal* fuel. There are 103 participants receiving *Opal* fuel including 71 Communities/Supporting Organisations, 3 Pastoral properties and 29 Roadhouses/Service Stations.

The outcomes to date indicate a reduction in the incidence and impact of petrol sniffing particularly in the central desert region of Australia. The outcomes include a recent survey by the Nganampa Health Council which found an 80 per cent reduction in the prevalence of petrol sniffing across the APY Lands since the introduction of *Opal* fuel. The Central Australian Youth Link-Up Service reports a 90 to 95 per cent reduction in petrol sniffing in the Alice Springs and Western Desert communities since *Opal* fuel was introduced.

Department of Health and Ageing

Mr Elton Humphery
Secretary
Senate Community Affairs Committee
Parliament House
CANBERRA ACT 2066

Dear Mr Humphery

Request for Amendment to Evidence Provided at Budget Estimates Hearing, 31 May 2007 : Outcome 9

I am writing to correct a statement that I made at the Budget Estimates Hearings of the Senate Community Affairs Committee on 31 May 2007.

Senator McLucas asked the following question:

"Is it just a letter or has it got additional information in the envelope?"

My response was as follows:

"No, it is just a standard letter"

It has been brought to my notice that the mailout includes a pamphlet (attached) on private health improvements. The response should be amended as follows:

"It is just a standard letter but it includes a pamphlet on private health improvements"

Yours sincerely

Kerry Flanagan
First Assistant Secretary
Acute Care Division
June 2007

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30-31 May 2007

Question: E07-051

OUTCOME 9: Private Health

Topic: PRIVATE HEALTH INSURANCE

Written Question on Notice

Senator Humphries asked:

What is PHIAC doing to encourage Private Health Insurance and making it easier for new entrants to enter the market?

Answer:

Private Health Insurance Administration Council's (PHIAC's) responsibility is to ensure that health funds are solvent and protect the interests of consumers. It is not PHIAC's role to encourage or discourage new entrants into the private health insurance market. However, PHIAC does work closely with any applicants for registration to ensure that they understand the regulatory environment and to ensure that we deal with the application in an efficient and effective manner.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30-31 May 2007

Question: E07-054

OUTCOME 9: Private Health

Topic: PRIVATE HEALTH INSURANCE

Written Question on Notice

Senator Humphries asked:

What is PHIAC doing to encourage health funds to work with intermediaries in this country?

Answer:

Private Health Insurance Administration Council (PHIAC) is not undertaking any action to encourage or discourage health funds from working with intermediaries. It is up to individual organisations to decide for themselves whether or not there is a role for intermediaries in their business.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30-31 May 2007

Question: E07-055

OUTCOME 9: Private Health

Topic: PRIVATE HEALTH INSURANCE

Written Question on Notice

Senator Humphries asked:

What to your mind are the main barriers to increasing uptake of private health insurance in this country?

Answer:

Private Health Insurance Administration Council (PHIAC) views the cost of premiums as a possible barrier to entry. However health insurance premiums are directly related to the cost of provision of health services. An additional barrier is the out-of-pocket costs associated with medical services and prosthetics.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30-31 May 2007

Question: E07-056

OUTCOME 9: Private Health

Topic: PRIVATE HEALTH INSURANCE

Written Question on Notice

Senator Humphries asked:

What do you see as the main inefficiencies in the PHI industry today and what is PHIAC doing to reduce them?

Answer:

The private health insurance industry is reasonably efficient although there are always areas for improvement. Areas where insurers could increase efficiency is in the contractual arrangements with providers. However, this could be seen as moving towards the much criticised American managed-care model. Generally private health insurers in Australia are not interested in such a model of care. They are concerned to provide affordable premiums for funding arrangements that meet the consumer's needs while not intervening in clinical care decisions.

Management expenses for private health insurers are generally significantly below the level of management expenses in both life insurers or general insurance companies. Private Health Insurance Administration Council (PHIAC) monitors and reports on management expense levels in private health insurance in our annual report on the operations of the registered health benefits organisations.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30-31 May 2007

Question: E07-057

OUTCOME 9: Private Health

Topic: PRIVATE HEALTH INSURANCE

Written Question on Notice

Senator Humphries asked:

What powers does PHIAC have to scrutinise or inquire into the activities of private health insurance brokers and intermediaries?

Answer:

Private Health Insurance Administration Council (PHIAC) has no powers to scrutinise or enquire into the activities of private health insurance brokers and intermediaries. Where PHIAC becomes aware of complaints about brokers and intermediaries, PHIAC refers these complaints on to the Australian Competition and Consumer Commission.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30-31 May 2007

Question: E07-058

OUTCOME 9: Private Health

Topic: PRIVATE HEALTH INSURANCE

Written Question on Notice

Senator Humphries asked:

At any stage since 2001 has any action been taken by PHIAC to investigate or seek more information about the activities of a broker or intermediaries? If so, on how many occasions?

Answer:

Private Health Insurance Administration Council (PHIAC) has taken no action to investigate activities of a broker or intermediaries as we have no legislative power to investigate. PHIAC has sought more information about the behaviour of an intermediary from health funds that PHIAC regulates. This was to ascertain whether or not concerns raised with PHIAC were isolated to one organisation. PHIAC referred the issues raised to the Australian Competition and Consumer Commission and advised organisations with concerns to do the same.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30-31 May 2007

Question: E07-059

OUTCOME 9: Private Health

Topic: PRIVATE HEALTH INSURANCE

Written Question on Notice

Senator Humphries asked:

Has PHIAC ever received or investigated complaints about the activities of a broker or intermediary, or itself decided to investigate the activities of the broker or intermediary? If so, can brief details be provided?

Answer:

Private Health Insurance Administration Council (PHIAC) has received complaints about the activities of brokers and intermediaries. We have not investigated complaints ourselves as we have no legislative power to do so, but have inquired of other health funds whether they too had issues similar to the complaints PHIAC has received. Where other complaints or concerns existed, PHIAC suggested that the organisation refer the matter to the Australian Competition and Consumer Commission as the appropriate body to investigate those complaints.

PHIAC has received complaints about:

- the fees charged by an intermediary,
- implications in advertising by an intermediary that it will choose the best fund for the consumer, but statements to the fund by the intermediary implying referrals are based on brokerage fees paid.

These complaints were referred to the Australian Competition and Consumer Commission by PHIAC and by the funds concerned.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30-31 May 2007

Question: E07-053

OUTCOME 9: Private Health

Topic: PRIVATE HEALTH INSURANCE

Written Question on Notice

Senator Humphries asked:

Do you believe that intermediaries have a role in the Australian private health insurance sector and why?

Answer:

Private Health Insurance Administration Council (PHIAC) believes that intermediaries do have a role in the Australian private health insurance sector. Intermediaries are able to source information on different products for consumers and may be able to make recommendations on products for those consumers. They may be able to make choice for consumers easier in a complex market. However, currently there is no regulation of intermediaries in private health insurance and therefore there is no protection for consumers from inadequate or inappropriate advice and there is no requirement to identify the source and the amount of any fees paid to the broker by a health fund for that consumer's business. There is therefore a risk to consumers of inadequate or inappropriate advice and/or a recommendation based on a fee paid without any disclosure to the consumer to allow them to consider for themselves whether the advice is appropriate or not.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30-31 May 2007

Question: E07-061

OUTCOME 9: Private Health

Topic: PRIVATE HEALTH INSURANCE

Written Question on Notice

Senator Humphries asked:

Since the passage of the new Private Health Insurance Act in March 2007, what steps has PHIAC taken to clarify how it administers its responsibilities in relation to demutualisations of private health insurers?

Answer:

Private Health Insurance Administration Council (PHIAC) has reviewed the demutualisation requirements established under the *Private Health Insurance Act 2007*. PHIAC has sought appropriate legal advice on how we administer the process under the legislation and we are presently dealing with one application by an insurer to demutualise. PHIAC intends, after completion of the current application for demutualisation, to evaluate the process and develop and provide on our web site a set of guidelines for insurers which are considering demutualisation to ensure that they meet the requirements of the *Private Health Insurance Act 2007* as well as the compliance requirements of the Corporations Act.

PHIAC is ready to discuss with insurers that are considering the possibility of demutualisation, so that we can ensure that any consequent processes are efficient and effective in accordance with the legislation.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30-31 May 2007

Question: E07-052

OUTCOME 9: Private Health

Topic: PRIVATE HEALTH INSURANCE

Written Question on Notice

Senator Humphries asked:

Intermediaries - such as brokers - play a key role in both the finance and life insurance markets and indeed in the US and UK in health insurance. What is PHIAC doing to promote the intermediary sector of health insurance?

Answer:

Private Health Insurance Administration Council (PHIAC) currently has no legislative role in relation to the intermediary sector of health insurance and as the financial regulator should not encourage or discourage intermediaries. It is however, mindful that any views that it may express on related matters can be influential within the industry. As a point of policy, great care is taken by PHIAC to refrain from comment on matters not directly within its jurisdiction. Intermediaries in private health insurance are currently unregulated. PHIAC is aware that intermediaries are involved in private health insurance in Australia particularly in the corporate sector.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30-31 May 2007

Question: E07-060

OUTCOME 9: Private Health

Topic: PRIVATE HEALTH INSURANCE

Written Question on Notice

Senator Humphries asked:

Has there ever been discussion between PHIAC and brokers and intermediaries about industry codes of behaviour or conduct and how they might work? If so, when?

Answer:

Private Health Insurance Administration Council (PHIAC) was provided with a draft code of conduct by the Private Health Insurance Intermediaries Association (PHIIA) some years ago. There has been no discussion between PHIAC and intermediaries about a code of conduct since that time.

The Government recently has decided that private health insurers brokers and intermediaries will be subject to direct regulation by PHIAC. Consultation will occur with the industry to ensure the operation of broker and intermediary services are open and transparent, while keeping compliance costs reasonable.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 31 May 2007

Question: E07-314

OUTCOME 9: Private Health

Topic: LIFETIME HEALTH COVER

Hansard Page: CA 88

Senator McLucas asked:

(In relation to letter to uninsured people turning 31 about health insurance)…can we have a copy of the letter please?

Answer:

A copy of the letter is attached.

14 June 2007

Addressee
Address_1
Address_2
Address_3

Dear Addressee

You have an important decision to make before 1 July this year.

If you take out hospital insurance now – before 1 July following your 31st birthday – you will pay the lowest possible premium for your policy.

For every year you delay taking out private health insurance you will have to pay an additional 2% on the cost of your policy. For example, if you wait another 10 years to take out cover you will pay 20% more than if you acted now.

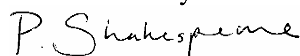
The additional amount is called a Lifetime Health Cover loading. The Lifetime Health Cover loading helps keep the system fair. This policy means those who take out private health insurance when they are younger, and keep it, pay less than those who join at a later age. Otherwise younger people would be subsidising the people who only get into the system when they get older. Simply put, this means that the earlier you start contributing to private health insurance, the less you pay each year.

So, if you act now, you will pay the lowest rate and avoid paying any penalties.

And, you'll receive all the benefits of private hospital cover. You'll be able to choose the doctor that treats you, the hospital you go to, and whether you're treated as a public or private patient. You will also benefit from the rebate on the cost of private health insurance – at least 30% for everyone and more for older Australians.

I have enclosed a brochure that explains recent improvements to private health insurance. You can also find more information about private health insurance on the new website, australia.gov.au/privatehealth, or by calling free call 1800 307 446.

Yours sincerely



Penny Shakespeare
Assistant Secretary
Private Health Insurance Branch

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 31 May 2007

Question: E07-315

OUTCOME 9: Private Health

Topic: PRIVATE HEALTH INSURANCE

Hansard Page: CA 90-92

Senator McLucas asked:

(a) What sorts of age cohorts do you have on which you keep data? Can you then provide us with – I do not think we have asked for this before – age cohorts of those who have private health insurance?
(b) So what is the number who just have ancillary [numbers or proportion]? Both if possible, please. What I am trying to find is if there is a trend occurring with that ancillary-only cohort.

Answer:

(a) The Private Health Insurance Administration Council (PHIAC) publishes a quarterly report, PHIAC A, which details the membership and benefits paid by private health insurers. Many of the statistics contained within this publication are provided according to the following age cohorts: 0-4, 5-9, 10-14, 15-19, 20-24, 25-29, 30-34, 35-39, 40-44, 45-49, 50-54, 55-59, 60-64, 65-69, 70-74, 75-79, 80-84, 85-89, 90-94, 95+.

According to information available from PHIAC, as at 31 March 2007, these are the number of persons in each age cohort covered by private health insurance.

Table 1: Coverage of Hospital Insurance Tables by age cohort, March Quarter 2007

Age Cohort	Persons
0-4	503,517
5-9	529,389
10-14	579,354
15-19	623,223
20-24	480,551
25-29	401,797
30-34	574,202
35-39	678,091
40-44	695,537
45-49	756,080
50-54	745,314
55-59	720,191
60-64	577,288
65-69	402,445
70-74	292,250
75-79	244,699
80-84	152,866
85-89	73,648
90-94	30,239
95+	7,786
Total	**9,068,467**

Table 2: Coverage of Ancillary Insurance Tables by age cohort, March Quarter 2007

Age Cohort	Persons
0-4	509,728
5-9	562,525
10-14	628,553
15-19	664,834
20-24	521,439
25-29	459,974
30-34	601,618
35-39	691,001
40-44	707,999
45-49	762,721
50-54	734,604
55-59	679,926
60-64	523,092
65-69	339,779
70-74	228,375
75-79	175,793
80-84	103,818
85-89	47,498
90-94	18,318
95+	4,671
Total	**8,966,266**

NOTE:
'Coverage of Hospital Insurance Tables by age cohort' includes hospital only policies and also hospital and ancillary policies combined
'Coverage of Ancillary Insurance Tables by age cohort' includes ancillary only policies and also hospital and ancillary policies combined

Ancillary only coverage by age cohort is not available and it is not possible to make an accurate estimate based on the available information.

(b) According to information available from PHIAC, as at 31 March 2007, 1.37 million people (15.3% of the population) had ancillary only cover. There has been an upward trend in ancillary only coverage since 30 September 2001, when there were 1.12 million people covered (14.1% of the population).

Further details concerning these statistics are available on the internet at: http://www.phiac.gov.au/statistics/trends/index.htm

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 31 May 2007

Question: E07-316

OUTCOME 9: Private Health

Topic: LIFETIME HEALTH COVER

Hansard Page: CA 92

Senator McLucas asked:

(a) (Is there) an increasing number of complaints going to the (Private Health Insurance) Ombudsman from people who are required to pay the Lifetime Health Cover loading?

(b) Is it trending up or down?

(c) Does the Ombudsman collect any data on the age and income level of the complainants?

(d) Are the complaints from people who are entitled to an exemption or try to make a case with the private health insurer but have that rejected?

Answer:

(a) No. The following table summarises the number of complaints recorded by the Private Health Insurance Ombudsman (PHIO) in relation to the Lifetime Health Cover loading over the past two years.

	Number of Lifetime Health Cover complaints received by PHIO							
Quarter ending	30/6/05	30/9/05	31/12/05	31/3/06	30/6/06	30/9/06	31/12/06	31/03/07
	26	21	30	21	23	23	7	14

(b) The number of complaints has been lower in the most recent two quarters (ending 31/12/06 and 31/03/07) compared to the previous six quarters.

(c) The PHIO does not collect data on the age and income level of the complainants, unless it is specifically relevant to the subject of the complaint.

(d) The PHIO does not collect data on complaints that it may have received in relation to applications for exemptions under these arrangements. Most complaints from consumers involved them making a case that the loading should not apply to them for other reasons, such as that they were not aware of the rules around Lifetime Health Cover.

When Lifetime Health Cover was introduced on 1 July 2000 there were transitional provisions allowing people to obtain an exemption to the Lifetime Health Cover loading provided they met specific conditions. This acknowledged that an individual's financial or other circumstances might have precluded them from taking out private health insurance. These provisions allowed people who met the hardship criteria as at 1 July 2000 to submit applications for an exemption to the general rules.

The closing date for applications under the hardship provisions was 1 July 2002. There is no discretionary power under which the government or private health insurers may extend this deadline. Under the *Private Health Insurance Act 2007*, the exemption provisions no longer apply.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 31 May 2007

Question: E07-380

OUTCOME 9: Private Health

Topic: PRIVATE HEALTH INSURANCE

Hansard Page: CA 88

Senator McLucas asked:

Has the Department of Health and Ageing done any analysis on whether the fact that the threshold has not changed encourages or discourages people from taking out private health insurance?

Answer:

The thresholds for the Medicare Levy Surcharge are established under taxation legislation, and are therefore a matter for the Treasury.

However, the Department continually monitors the effectiveness and impact of government policies affecting private health insurance, including the Medicare Levy Surcharge. According to the Health Insurance Survey conducted by Ipsos/TQA Research in 2005, the Medicare Levy Surcharge, along with other government incentives, has been a key factor in encouraging people to take out private health insurance.

The findings of this survey were that 53% of respondents in upper income brackets agreed that the surcharge influenced them to take out private health insurance in the last two years. The survey also reported that a high proportion of young singles (20%) and young couples (36%) agreed that they were motivated by the surcharge to take out private health insurance in the last few years.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30-31 May 2007

Question: E07-050

OUTCOME 9: Private Health

Topic: PRIVATE HEALTH INSURANCE

Written Question on Notice

Senator Humphries asked:

What can be done to make the Private Health Insurance market more competitive?

Answer:

Private Health Insurance Administration Council's (PHIAC) view is that the market is competitive given the regulatory environment. Consumers' rights to transfer between funds without re-serving waiting periods (the portability requirements) mean that any organisation which becomes too expensive risks the transfer of their members to other competing funds. There are also a number of funds operating within each state market which allows consumers choice of fund. The Ombudsman's private health web site also provides considerable information to consumers about health insurance products which should further enhance consumer choice.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30-31 May 2007

Question: E07- 012

OUTCOME 10: Health System Capacity and Quality

Topic: POLICY/DEVELOPMENT

Written Question on Notice

Senator Stott Despoja asked:

Will the UHI Initiative require its own enabling legislation? Is so, has work commenced on draft legislation? Will an exposure draft be made available for public comment?

Answer:

The Department of Health and Ageing in consultation with relevant stakeholders, including National E-Health Transition Authority (NEHTA), is currently assessing what legal support, such as enabling legislation, may be required to support the development and implementation of the Unique Health Identifier (UHI) Initiative.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30-31 May 2007

Question: E07-015

OUTCOME 10: Health System Capacity and Quality

Topic: eHEALTH

Written Question on Notice

Senator Stott Despoja asked:

NEHTA states 14 submissions were received. Were any of these submissions joint submissions? What is the explanation for the low numbers of submissions?

Answer:

The National E-Health Transition Authority (NEHTA) managed the submissions process. The Department of Health and Ageing is unable to comment on this process.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30-31 May 2007

Question: E07-018

OUTCOME 10: Health System Capacity and Quality

Topic: eHEALTH

Written Question on Notice

Senator Stott Despoja asked:

The Access Card is going to allocate an identifier for use in the access of Health Services - how then can it be that this doesn't intersect with the identifier NEHTA plans to allocate for use in the Health Sector?

Answer:

The Access Card and the Individual Health Identifier (IHI) will not be linked as they have different purposes for use.

The Access Card will provide access to Australian Government health benefits, veterans' and social services for eligible people.

The purpose of the IHI is to enable the unique identification of a consumer who interacts with any part of the health sector, including Australian Government, state, or private providers.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30-31 May 2007

Question: E07-020

OUTCOME 10: Health System Capacity and Quality

Topic: eHEALTH

Written Question on Notice

Senator Stott Despoja asked:

NEHTA's planned secondary uses consultancy for 2007 will identify principles for assessing secondary uses in both the UHI and Shared EHR and develop a secondary uses framework. What reason might there be for the actual data record as distinct from the UHI number to be the subject of secondary use?

Answer:

It would be inappropriate to pre-empt the scope or outcomes of this work. According to the National E-Health Transition Authority (NEHTA) work plan this is due to be delivered in July 2008.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30-31 May 2007

Question: E07-021

OUTCOME 10: Health System Capacity and Quality

Topic: eHEALTH

Written Question on Notice

Senator Stott Despoja asked:

Will the use of the actual UHI identifier for secondary record linkage be controlled? For example, presently secondary linkage of identifiers must specifically be authorised from ethics bodies. Will this be a requirement of the secondary use of the UHI identifier?

Answer:

All governments are working together with the National E-Health Transition Authority (NEHTA) to address the policy issues for the use of the Unique Healthcare Identifiers (UHI) including secondary use issues.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30-31 May 2007

Question: E07-022

OUTCOME 10: Health System Capacity and Quality

Topic: eHEALTH

Written Question on Notice

Senator Stott Despoja asked:

In the privacy blueprint NEHTA writes that informing consumers about any privacy breaches is consistent with NEHTA's position, however it is not covered in the privacy blueprint. Why has this been left out of the privacy blueprint? Why won't individuals be compensated where their health information is compromised?

Answer:

The Australian Government in conjunction with all states and territories is developing a National Health Information Regulatory Framework. This framework will provide a comprehensive regulatory framework to address health information collection and handling, complaints resolution and enforcement measures nationally, and to give legal authority and support for national eHealth initiatives such as the Unique Healthcare Identifier (UHI) and Share Electronic Health Record (SEHR) programs.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30-31 May 2007

Question: E07-023

OUTCOME 10: Health System Capacity and Quality

Topic: eHEALTH

Written Question on Notice

Senator Stott Despoja asked:

NEHTA committed in early-2006 to a preliminary Privacy Impact Assessment. What work, if any, is being done on a full Privacy Impact Assessment? What additional privacy risks have been identified since the completion of the preliminary PIA?

Answer:

The Department is aware that the National E-Health Transition Authority (NEHTA) has commissioned independent preliminary Privacy Impact Assessments (PIA's). NEHTA proposes that the results of the preliminary PIAs will provide a basis for NEHTA's Privacy Blueprint documents. As stated by NEHTA, full PIAs will be conducted by independent privacy consultants once the project specifications have been finalised.

A privacy blueprint for the Unique Healthcare Identifiers was released on 18 December 2006 for public consultation and NEHTA has received 14 submissions discussing the blueprint. Work to progress the full PIA is an integral part of the NEHTA work plan.

A draft privacy blueprint for the Shared Electronic Health Record is currently being developed.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30-31 May 2007

Question: E07-039

OUTCOME 10: Health System Capacity and Quality

Topic: HEALTHCONNECT

Written Question on Notice

Senator Stott Despoja asked:

How much funding is available to the States to implement the eHealth project?

Answer:

The Commonwealth works with the States. The States and Territories are independent jurisdictions able to raise and allocate funding accordingly to providers within their health systems.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30-31 May 2007

Question: E07-001

OUTCOME 10: Health System Capacity and Quality

Topic: eHEALTH

Written Question on Notice

Senator Stott Despoja asked:

Given Australia has been working on a variety of Shared Electronic Health Record (SEHR) proposals since a House of Representative Report in 1997 why has it taken a decade to get to the stage of developing a business case for eHealth which is yet to be completed or released?

Answer:

Over the last decade, a number of business cases for the development of a SEHR have been drafted. While some jurisdictions (for example – NT) have implemented SEHR, progress has not been consistent across Australia, partly due to plans being overtaken by the evolution of the SEHR concept and advancements in eHealth technology.

Part of the National E-Health Transition Authority's (NEHTA) current work plan is to finalise a Business Case for the development and implementation of a national SEHR.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30-31 May 2007

Question: E07-002

OUTCOME 10: Health System Capacity and Quality

Topic: eHEALTH

Written Question on Notice

Senator Stott Despoja asked:

Will the business case for the National Shared Electronic Health Record be ready for Council of Australian Governments (COAG) in 2007?

Answer:

It is our understanding that the National E-Health Transition Authority (NEHTA) proposes that the business case for the Shared Electronic Health Record will be provided to the Australian Health Ministers' Conference in late 2007 and to the Council of Australian Governments (COAG) early 2008.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30-31 May 2007

Question: E07-003

OUTCOME 10: Health System Capacity and Quality

Topic: eHEALTH

Written Question on Notice

Senator Stott Despoja asked:

Has Cabinet approved an e-health initiative agenda? If so, what state is the agenda at? When will the agenda be made public?

Answer:

Current funded eHealth initiatives are: Health*Connect,* Broadband for Health, Managed Health Network Grants, and the National E-Health Transition Authority. In addition, the Council of Australian Governments has provided funding to accelerate work on a national electronic health records system including the development of Unique Healthcare Identifiers and to standardise Clinical Terminologies.

All elements have been publicly announced.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30-31 May 2007

Question: E07-004

OUTCOME 10: Health System Capacity and Quality

Topic: HEALTHCONNECT

Written Question on Notice

Senator Stott Despoja asked:

Is the Health*Connect* program proceeding? At what stage is the Health*Connect* program: testing / pilot / implementation?

Answer:

The Health*Connect* program is proceeding. The Health*Connect* program, via funding to states and territories, is funding initiatives to progress eHealth. Funding agreements are currently in place with the Northern Territory, South Australia and Tasmania. Funding applications for 2007-08 funding (from all states and territories) are currently being assessed.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30-31 May 2007

Question: E07-005

OUTCOME 10: Health System Capacity and Quality

Topic: eHEALTH

Written Question on Notice

Senator Stott Despoja asked:

Has the complete scope of the NEHTA UHI Initiative and residual Health Connect Program been worked out yet? For example: Have the issues of informed consent versus implied consent been resolved? Have the issues of capacity been resolved?

Answer:

As directed by COAG in February 2006, National E-Health Transition Authority (NEHTA) is responsible for the development and implementation of the Unique Health Identifier (UHI) initiative.

The UHI initiative is not part of the Health*Connect* Program.

The issues of consent and capacity are currently being considered by all governments through the Australian Health Ministers' Advisory Council.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30-31 May 2007

Question: E07-006

OUTCOME 10: Health System Capacity and Quality

Topic: POLICY/DEVELOPMENT

Written Question on Notice

Senator Stott Despoja asked:

What new contracts are being finalised in relation to the HealthConnect projects?

Answer:

All states and territories have submitted a funding proposal for 2007-08.

The 2007-08 proposals are currently being evaluated by the Department and it is expected the agreements will be negotiated and finalised early in the 2007-08 financial year.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30-31 May 2007

Question: E07- 007

OUTCOME 10: Health System Capacity and Quality

Topic: POLICY/DEVELOPMENT

Written Question on Notice

Senator Stott Despoja asked:

How will the NEHTA UHI Initiative ensure that individuals cannot be re-identified from their records?

Answer:

National E-health Transition Authority (NEHTA) is responsible for the development and implementation of the Unique Health Identifier (UHI) initiative. Information on NEHTA's progress and approach to developing the UHI service, including how individual privacy will be protected, is on the NEHTA website. Ongoing privacy impact assessment and consultation is being undertaken.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30-31 May 2007

Question: E07-008

OUTCOME 10: Health System Capacity and Quality

Topic: eHEALTH

Written Question on Notice

Senator Stott Despoja asked:

How will the identifier assigned in the NEHTA UHI Initiatives be managed?

Answer:

As per the decision of the Council of Australian Governments in February 2006, the National E-Health Transition Authority (NEHTA) will manage the development of the Unique Healthcare Identifiers (UHI). Details of the ongoing operation and governance of the identifiers are currently being developed.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30-31 May 2007

Question: E07- 009

OUTCOME 10: Health System Capacity and Quality

Topic: POLICY/DEVELOPMENT

Written Question on Notice

Senator Stott Despoja asked:

How does the NEHTA UHI Initiative intend to address the various privacy regimes in each jurisdiction which afford differing levels of privacy protection to consumers?

Answer:

National E-health Transition Authority (NEHTA) is responsible for the development and implementation of the UHI initiative. Information on NEHTA's progress and approach to developing the Unique Health Identifier (UHI) service, including how individual privacy will be protected is on the NEHTA website. Ongoing privacy impact assessment and consultation is being undertaken.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30-31 May 2007

Question: E07- 010

OUTCOME 10: Health System Capacity and Quality

Topic: POLICY/DEVELOPMENT

Written Question on Notice

Senator Stott Despoja asked:

At what stage, is the draft national health privacy code? Is the draft code impacting negatively on the NEHTA UHI initiative or HealthConnect projects?

Answer:

The content of the draft code has been developed, however, it has not been formally endorsed at ministerial level and an implementation mechanism has not been agreed. The National E-health Transition Authority (NEHTA), Unique Health Identifier initiative and HealthConnect projects are progressing within existing privacy legislation and/or frameworks.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30-31 May 2007

Question: E07-011

OUTCOME 10: Health System Capacity and Quality

Topic: POLICY/DEVELOPMENT

Written Question on Notice

Senator Stott Despoja asked:

How much progress has been made with developing Federal health IT standards? Will Australia's eight state and territory health systems be forced to adopt federal health IT standards?

Answer:

The National E-Health Transition Authority (NEHTA) is developing specifications for national standards in the areas of data, terminology, secure messaging, message formats, identity management and shared electronic health records.

In March 2007 NEHTA confirmed Health Level 7 as the national standard for the electronic messaging of health information across Australia. This standard would apply to messages sent electronically such as hospital discharge summaries, referrals, prescriptions, specialist letters and reports including pathology and radiology. Work on other standards is on track.

State and territory governments are closely involved in NEHTA governance and activity. It is expected all jurisdictions will adopt these standards.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30-31 May 2007

Question: E07-014

OUTCOME 10: Health System Capacity and Quality

Topic: eHEALTH

Written Question on Notice

Senator Stott Despoja asked:

Where are the actual submissions which resulted in the Privacy Blueprint? Why has NEHTA not published them on their website?

Answer:

The submissions on the Privacy Blueprint are with the National E-Health Transition Authority (NEHTA). NEHTA is responsible for managing their own website.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30-31 May 2007

Question: E07-016

OUTCOME 10: Health System Capacity and Quality

Topic: eHEALTH

Written Question on Notice

Senator Stott Despoja asked:

As for the privacy blueprint itself, it states that NEHTA will identify additional avenues and means of communication throughout 2007-08 to ensure wide coverage key stakeholders for future consultation activities. Who are the key stakeholders? What is NEHTA's communications budget for its e-health initiatives?

Answer:

It is understood that the National E-Health Transition Authority (NEHTA) has an ongoing consultation strategy and seeks input from key stakeholders. Identification of these stakeholders is a matter for NEHTA. Details of the NEHTA communication budget are an operational matter appropriately managed by NEHTA.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30-31 May 2007

Question: E07-019

OUTCOME 10: Health System Capacity and Quality

Topic: eHEALTH

Written Question on Notice

Senator Stott Despoja asked:

On the 30th January 2007, The Australian newspaper published a long article entitled "Doing the numbers on e-Health" by Karen Dearne. In the article we are told that it is NEHTA's preference to change the law so they can mine the most reliable of the Medicare client databases for names and addresses to populate their identify database. In light of this comment, are the two proposals not connected? Don't you consider the public may not support a proposal to covertly, and without consent, mine a Medicare database for details provided by citizens in good faith and for an unrelated purpose?

Answer:

The National E-Health Transition Authority (NEHTA) has identified the Consumer Directory Maintenance System (CDMS) as the most reliable source of information on the identity of the majority of people who use health services in Australia. Consequently NEHTA views the use of the CDMS as the most cost effective means to fulfil the task, allocated by COAG, of developing Individual Healthcare Identifier's. Information on NEHTA's progress and approach to developing the Unique Health Identifier (UHI) service, including how individual privacy will be safeguarded, is on the NEHTA website. Public consultation on the privacy framework to support the UHI service has been conducted and ongoing privacy impact assessment is being undertaken.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30-31 May 2007

Question: E07-024

OUTCOME 10: Health System Capacity and Quality

Topic: HEALTHCONNECT

Written Question on Notice

Senator Stott Despoja asked:

Will the Department commit to a Privacy Impact Assessment process for its Health*Connect* Program? Will individual states and territories, as custodians of Australians health information, be expected to conduct their own Privacy Impact Assessment prior to involving themselves in the NEHTA initiative or any Health*Connect* projects?

Answer:

The Privacy Impact Assessment to be conducted by the National E-Health Transition Authority (NEHTA) will impact on all eHealth activities including the Health*Connect* Program.

States and territories have their own governance arrangements for Privacy Impact Assessment.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30-31 May 2007

Question: E07-025

OUTCOME 10: Health System Capacity and Quality

Topic: PROJECT MANAGEMENT

Written Question on Notice

Senator Stott Despoja asked:

Have any contracts been prepared or signed in relation to the $128 million nationwide eHealth Record Program since the departure of former chair, Professor Andrew Coates? If so, what contracts?

Answer:

The Department has entered into contracts with the following organisations under the 2004-05 $128 million eHealth Budget Measure:

- Northern Territory Department of Health and Community Services;
- South Australian Department of Health;
- Tasmanian Department of Health and Human Services;
- Western Australian Department of Health;
- Victorian Department of Human Services;
- New South Wales Health Department;
- Australian Capital Territory Health;
- Queensland Health;
- National E-Health Transition Authority, and
- Standards Australia.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30-31 May 2007

Question: E07-026

Outcome 10: Health System Capacity and Quality

Topic: NATIONAL HEALTH INFORMATION GROUP

Written Question on Notice

Senator Stott Despoja asked:

What was the reason for disbanding the Committees of the National Health Information Group?

Answer:

The National Health Information Group has not been disbanded, it has been renamed the National Health Information Management Principle Committee (NHIMPC). The committees under the NHIMPC continue to operate.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30-31 May 2007

Question: E07-027

OUTCOME 10: Health System Capacity and Quality

Topic: eHEALTH

Written Question on Notice

Senator Stott Despoja asked:

What are NEHTA's responsibilities in relation to Health*Connect*, if any?

Answer:

National E-Health Transition Authority (NEHTA) is responsible for setting standards to support Health*Connect* and other eHealth implementation in all states and territories.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30-31 May 2007

Question: E07-028

OUTCOME 10: Health System Capacity and Quality

Topic: PROJECT MANAGEMENT

Written Question on Notice

Senator Stott Despoja asked:

Can you provide a Project description of NEHTA's baseline work program?

Answer:

National E-Health Transition Authority's (NEHTA's) baseline work program includes:

- Clinical Data Standards;
- Identification Standards;
- Patient Index (NHI);
- Provider Index;
- Product/Service Directories;
- Consent Models;
- Secure Messaging and Information Transfer;
- User Authentication and Access Control;
- Technical Integration Standards;
- Supply Chain;
- EMR/EHR Standards;
- Knowledge Centre; and
- Health Informatics Industry Reform.

Details of each of these initiatives are available from NEHTA or via their website www.nehta.gov.au

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30-31 May 2007

Question: E07-029

OUTCOME 10: Health System Capacity and Quality

Topic: PROJECT MANAGEMENT

Written Question on Notice

Senator Stott Despoja asked:

Why is NEHTA's baseline work program receiving funds that were earmarked for the Health*Connect* program? Is this new money for NEHTA?

Answer:

The Health*Connect* budget funds were for the implementation of a national health information network. It was determined that the most effective means of advancing the Health*Connect* program was to invest a proportion of the funds into the baseline work program of the National E-Health Transition Authority (NEHTA).

This is drawn from existing funds.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30-31 May 2007

Question: E07-030

OUTCOME 10: Health System Capacity and Quality

Topic: HEALTHCONNECT

Written Question on Notice

Senator Stott Despoja asked:

What have you identified as the key project risks in relation to the implementation of Health*Connec*t? What contingencies/plans, if any, do you have in place to manage those risks?

Answer:

The Australian Government has identified two key project risks for Health*Connect.* These are the states and territories ability to deliver projects according to specified timeframes and sustainability of the program beyond 2007-08.

The Australian Government has in place a number of risk management arrangements which are utilised through the funding agreements with states and territories for the development and implementation of Health*Connect* activities and initiatives.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30-31 May 2007

Question: E07-031

OUTCOME 10: Health System Capacity and Quality

Topic: HEALTHCONNECT

Written Question on Notice

Senator Stott Despoja asked:

Has the project's benefits been re-evaluated since the trials in Tasmania, Northern Territory and South Australia?

Answer:

Through Australian Government funding arrangements, states and territories are required to provide regular reports on the progress, achievements and challenges in developing and implementing the various projects funded under the Health*Connect* program. These reports are considered and analysed by the Department on a regular basis and assist in evaluating any future requests for funding.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30-31 May 2007

Question: E07-032

OUTCOME 10: Health System Capacity and Quality

Topic: eHEALTH

Written Question on Notice

Senator Stott Despoja asked:

Why has NEHTA, despite invitations, refused to join IT14 (the peak SA Health Informatics Committee)? Why is NEHTA not represented on any of the working sub-committees of IT14 which set Australian Health Informatics standards for messaging and data representation, including HER(sic)?

Answer:

The Department of Health and Ageing is not able to respond to these questions. These are operational matters appropriately managed by the National E-Health Transition Authority (NEHTA).

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30-31 May 2007

Question: E07-033

OUTCOME 10: Health System Capacity and Quality

Topic: SA HEALTHCONNECT REQUEST FOR PROPOSAL

Written Question on Notice

Senator Stott Despoja asked:

I understand that SA Health*Connect* has made available a Request for Proposal (RFP) or functional specification on which the tender for the SA Health*Connect* program is based on 22 May of this year. Curiously the document refers: "throughout to The National Health*Connect* number and not the NHI/UHI Initiative (or NHI/UHI number). And at 1.5 (intended audience) the document will be revised following feedback from stakeholders and will form the basis of a more detailed requirements document and information technology procurement which tends to indicate the document is a draft." In light of the above, what involvement did NEHTA have in assisting SA Health*Connect* with the RFP. Does it concern NEHTA that this document appears to be out of date?

Answer:

As the RFP was prepared and submitted by the SA Health Department, the content of the document is a matter for the SA Government. The Australian Government is not in a position to comment on tender documents submitted by other governments.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30-31 May 2007

Question: E07-035

OUTCOME 10: Health System Capacity and Quality

Topic: eHEALTH

Written Question on Notice

Senator Stott Despoja asked:

On the 30th January 2007, the Australian published a long article entitled "Doing the numbers on e-health" by Karen Dearne. From the article, NEHTA thinks its can provide a health identifier for $15 million a year over three years ($45million). Given the Access Card Project is costed at over $1.1 billion over four years how does NEHTA expect to stay to budget?

Answer:

Unique Health Identifier and Access Card have been created for two very different purposes (refer E07-017). It is not appropriate to compare the two projects in terms of possible expenditure.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30-31 May 2007

Question: E07-036

OUTCOME 10: Health System Capacity and Quality

Topic: eHEALTH

Written Question on Notice

Senator Stott Despoja asked:

Why are there no 'independent directors' on the NEHTA Board given that NEHTA is a Public Company limited by Guarantee?

Answer:

Under the National E-Health Transition Authority (NEHTA) constitution, the NEHTA board will consist of nine directors. To be eligible to be elected as a director, each individual must hold the position of Chief Executive or Senior Executive of their state or territory Department of Health. There is no requirement for NEHTA to appoint independent directors.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30-31 May 2007

Question: E07-037

OUTCOME 10: Health System Capacity and Quality

Topic: eHEALTH

Written Question on Notice

Senator Stott Despoja asked:

Is the present governance of NEHTA with a CEO level board and advisory committees whose membership is not made public the right way to manage a critical national effort such as the National E-Health Agenda?

Answer:

All Health Ministers, at the Australian Health Ministers' Conference of 28 January 2005, agreed to establish the National E-Health Transition Authority (NEHTA) as a not-for-profit company limited by guarantee, and governed by all state and territory governments and the Australian Government. Health Ministers endorsed the establishment of a Governing Board, comprising the Chief Executive or a Senior Executive from each of the nine jurisdictions' Health Departments. Details of the governing board were released to the public in a Communiqué from all Health Ministers on 28 January 2005.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30-31 May 2007

Question: E07-038

OUTCOME 10: Health System Capacity and Quality

Topic: eHEALTH

Written Question on Notice

Senator Stott Despoja asked:

Why has NEHTA waited nearly three years to advertise a dedicated Privacy Officer? What will the privacy officer's roles and responsibilities be?

Answer:

These are operational matters appropriately managed by the National E-Health Transition Authority (NEHTA).

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30-31 May 2007

Question: E07-040

OUTCOME 10: Health System Capacity and Quality

Topic: eHEALTH

Written Question on Notice

Senator Stott Despoja asked:

Given the vast majority of patient care is delivered in the private sector just what incentives (from government) will be required to get the private sector on board?

Answer:

The Australian Government is committed to maintaining its leadership role in the development of eHealth across all sectors of health care provision – public and private.

General Practitioners (GPs), as private healthcare providers, deliver a high percentage of healthcare services in Australia. Through the Practice Incentive Program, the Australian Government has helped GPs use eHealth systems by providing funding for computing and electronic information exchange systems.

In addition, private healthcare providers have also had the opportunity to access Australian Government funding through the Broadband for Health and Managed Health Network Grants.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30-31 May 2007

Question: E07-042

Outcome 10: Health System Capacity and Quality

Topic: AUSTRALIAN HEALTH INFORMATION COMMISSION (AHIC)

Written Questions on Notice

Senator Stott Despoja asked:

What is the policy rationale for reinstituting the Australian Health Information Commission (AHIC)?

Answer:

The Australian Health Information Council, currently in its second term of operation, experienced a delay in the rescheduling of council meetings due to the resignation of the previous Chair, Professor A Coats. Following the appointment of the current Chair, Professor J Angus, a full work program has recommenced.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30-31 May 2007

Question: E07-043

Outcome 10: Health System Capacity and Quality

Topic: AUSTRALIAN HEALTH INFORMATION COMMISSION (AHIC)

Written Question on Notice

Senator Stott Despoja asked:

What process did the Department follow in its appointment of members to the new AHIC? Were probity checks performed? Were usual recruitment practices followed?

Answer:

Members of the Australian Health Information Commission (AHIC) are appointed by the Australian Health Ministers' Advisory Council in accordance with the committee's processes. AHIC as an Australian Health Ministers' Advisory Council (AHMAC) sub-committee sought AHMAC approval and endorsement for members for the second term of operation.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30-31 May 2007

Question: E07-044

OUTCOME 10: Health System Capacity and Quality

Topic: eHEALTH

Written Question on Notice

Senator Stott Despoja asked:

Will there be full public disclosure of the membership, skills and interests of all those who are involved in NEHTA advisory committees?

Answer:

This question is a matter which should be referred to the National E-Health Transition Authority (NEHTA).

The Australian Government's role is as a part-owner of NEHTA and the Government has one seat on a Board of nine. As such the Government cannot act alone to commit NEHTA to specific policies.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30-31 May 2007

Question: E07-045

OUTCOME 10: Health System Capacity and Quality

Topic: eHEALTH

Written Question on Notice

Senator Stott Despoja asked:

On Friday, May 04, 2007, The Directors of the National E-Health Transition Authority (NEHTA) advised that they are seeking to complete an independent review of NEHTA as required under NEHTA's constitution. Who will be conducting the independent review? Will the report be provided to the Government? Will it be made public? What is the timeframe for reporting?

Answer:

The successful tenderer is yet to be announced.

The outcomes of the Independent Review will be presented to the Australian Health Ministers' Advisory Council and the Australian Health Ministers' Conference.

Recommendations from the review are anticipated later this year.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30-31 May 2007

Question: E07-046

OUTCOME 10: Health System Capacity and Quality

Topic: eHEALTH

Written Question on Notice

Senator Stott Despoja asked:

Why has there been no review commissioned by, funded by, and reported to the Commonwealth Department of Health? Having NEHTA commission the itself [sic], and then to have its officers manage the review, is this not a clear example of NEHTA officers being in a situation of a major conflict of interest?

Answer:

The Department of Health and Ageing has contributed to the development of the terms of reference for the Independent Review of the National E-Health Transition Authority (NEHTA) and will work closely with the successful tenderer and will be consulted during the course of the review.

The Department of Health and Ageing, along with other state and territory governments, will critically assess the results of the Independent Review once they are available and provide advice to the board from a jurisdictional perspective.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30-31 May 2007

Question: E07-048

OUTCOME 10: Health System Capacity and Quality

Topic: PERSONAL INFORMATION

Written Question on Notice

Senator Stott Despoja asked:

Are there standards for merging databases of patient's personal information? Can those standards be imposed on providers?

Answer:

The National E-Health Transition Authority's (NEHTA) work on clinical information, terminology and interoperability are all directed to the objective of ensuring that clinical information can be passed (where appropriate and authorised) from one clinical information system to another in a manner that ensures that the content and meaning are maintained.

Mechanisms to encourage the uptake of standards by providers are under consideration.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30-31 May 2007

Question: E07-049

OUTCOME 10: Health System Capacity and Quality

Topic: BANKS

Written Question on Notice

Senator Stott Despoja asked:

Since the banks are moving to two-factor authentication, how should health care providers authenticate themselves?

Answer:

One of the National E-Health Transition Authority's (NEHTA) work items is the development of a user authentication framework. This work will provide the answer to this question once complete. Further information and contact details may be found on the NEHTA website at www.nehta.gov.au under the "Identity Management" work program.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30-31 May 2007

Question: E07-193

OUTCOME 10: Health System Capacity and Quality

Topic: BROADBAND FOR HEALTH PROGRAM

Written Question on Notice

Senator McLucas asked:

Does the Broadband for Health program provide assistance to any health services apart from pharmacies and general practices?

Answer:

Under the Broadband for Health program an eligible health service includes general practices, Aboriginal Community Controlled Health Services, Royal Flying Doctor Service Sites and community pharmacies.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30-31 May 2007

Question: E07-194

OUTCOME 10: Health System Capacity and Quality

Topic: BROADBAND FOR HEALTH PROGRAM

Written Question on Notice

Senator McLucas asked:

Has any funding under the Broadband for Health program been provided to Breastscreen services?

Answer:

No funding has been provided to Breastscreen services under the Broadband for Health program.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 31 May 2007

Question: E07-367

OUTCOME 10: Health System Capacity and Quality

Topic: HEART, STROKE AND VASCULAR DISEASE

Hansard Page: CA 124

Senator Polley asked:

a) What is the allocation of funds?
b) How much of that money goes into early detection and prevention programs?
c) When you provide that information about the allocation of funds would it be possible to get that broken down by state?

Answer:

a) Cardiovascular Health specific programs are funded under the National Diabetes Strategy (BRE 036) Annual Base Funding. A breakdown of funding provided to Cardiovascular Health specific programs in 2006-07 and so far that committed for 2007-08, 2008-09 and 2009-10 is provided below.

	2006-07	**2007-08**	**2008-09**	**2009-10**
COMMITTED	$587,114	$20,000	$0	$0

In addition, the Australian Government is also providing significant funding for projects to inform, encourage and support people to control their own health by addressing obesity and lifestyle risk factors for chronic diseases, including cardiovascular disease.

b) The funding provided for specific cardiovascular health programs under the National Diabetes Strategy goes into treatment (eg. Public Access Defibrillation) and monitoring (eg the National Centre for Monitoring Heart, Stroke and Vascular Disease) programs. No funding is provided for the early detection and prevention of cardiovascular disease specifically.

As stated above, the Australian Government is providing significant funding for non-specific programs addressing chronic disease risk factors.

In addition the Australian Government currently supports specialised services through the Enhanced Primary Care items including the one-off preventive health check for people between the ages of 45 and 49 years (inclusive) who are at risk of developing a chronic disease, the annual voluntary health assessments for older Australians (75 years and over) and the Aboriginal and Torres Strait Islander Adult Health Check. These checks would aid in the early detection of cardiovascular disease.

c) The cardiovascular specific programs and the non-specific programs addressing chronic disease risk factors are national programs. The funding therefore cannot be broken down to state level.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30-31 May 2007

Question: E07-013

OUTCOME 10: Health System Capacity and Quality

Topic: POLICY/DEVELOPMENT

Written Question on Notice

Senator Stott Despoja asked:

NEHTA, in a media release in April 2007, confirms Health Level 7 (HL7) as the national standard for the electronic messaging of health information across Australia. I note NEHTA is neither a government entity nor is it actually funded to make any product procurement.

a) Under what authority is NEHTA able to declare that HL 7 is to become the national standard?
b) Is it not the role of Standards Australia to declare standards?
c) Is HL7 to become an Australian Standard?
d) What consultation process with industry, and medical practitioners was conducted in order to arrive at HL7? Were any alternative standards considered? What costs will the health sector have to bear in order to comply with Health Level 7?
e) What Standards are NEHTA working on and what is within the purview of Standards Australia? Has NEHTA abandoned the standards process altogether? Should Australia have both NEHTA and Standards Australia involved in e-Health Standards setting or should this role be clearly placed in one place of the other?

Answer:

a) The National E-Health Transition Authority (NEHTA) was established by all Australian governments to provide direction on eHealth infrastructure matters such as requirements for secure messaging.
b) Standards Australia develops voluntary consensus based standards for others to enforce through contractual arrangements or the like if they chose.
c) Standards Australia has developed and published Australian implementations of the HL7 standards in a number of clinical areas.
d) It is understod that NEHTA consulted with jurisdictions, organisations and individuals associated with Standards Australia's IT-014 (Health Informatics) Committee. Standards considered included HL7 version two, HL7 version three and Clinical Document Architecture release two, the European standard EN 13606 and also the open *EHR* approach. Costs will not be significant as they will be incurred as part of routine replacement and updating of software.
e) NEHTA is working on standards relating to data, data structures, terminology, messaging, identification, user authentication, Shared Electronic Health Record (SEHR) and supply chain. They have a close working relationship with Standards Australia. Full details would need to be provided by NEHTA.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30-31 May 2007

Question: E07-034

OUTCOME 10: Health System Capacity and Quality

Topic: HEALTHCONNECT

Written Question on Notice

Senator Stott Despoja asked:

How much of the $128 million e-Health record budget has been spent? What is the breakdown in expenses?

Answer:

Funding has been appropriated across the 2004-05 to 2007-08 as indicated:

2004-05 ($m)	2005-06 ($m)	2006-07 ($m)	2007-08 ($m)	TOTAL ($m)	
21.7	20.7	20.4	21.1	83.9	Administered funding
10.9	11.1	11.1	11.3	44.4	Departmental funding
32.6	31.8	31.5	32.4	128.3	

The allocation of funds across Departmental and Administered funding was done in accordance with the accrual budgeting principles at that time.

The Department expended all funding for 2004-05 and 2005-06.

In 2006-07 the full allocation of Departmental funding was expensed. Administered funding of approximately $11.6 million was expensed with the Department seeking a rephase of $8.4 million in Administered funds to 2007-08.

The Department is currently finalising negotiations for funding from the 2007-08 allocation.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30-31 May 2007

Question: E07-192

OUTCOME 10: Health System Capacity and Quality

Topic: BROADBAND FOR HEALTH PROGRAM

Written Question on Notice

Senator McLucas asked:

Please provide a consolidated list of original allocations to the Broadband for Health program and expenditure for each financial year to date.

Answer:

Year	Allocated	Expenditure
2004-05	$19.9 million	$2 million
2005-06	$31.3 million	$28.7 million
2006-07	$25.2 million*	$19 million

* Previously $10.2 million. An additional $15 million was allocated to the program from the Senior Minister's Review (SMR).

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30-31 May 2007

Question: E07-017

OUTCOME 10: Health System Capacity and Quality

Topic: EHEALTH

Written Question on Notice

Senator Stott Despoja asked:

Section 3.2 "Overlap of UHI with other initiatives" discusses the connection to the Australian Government's Health and Social Services Access Card. NEHTA states that there is a mistaken belief that there was or should be a formal relationship between the two initiatives. Can you please explain why NEHTA considers this belief is mistaken? Has NEHTA had any discussions with the Office of Access Card? Clearly they are parallel projects being run out of the same department, what guarantees will there be that the businesses will not be restructured within the department to implement the Access Card and UHI?

Answer:

There is no link between the Access Card and the Unique Health Identifier (UHI).

The purpose of the Access Card is to provide access to Australian Government health benefits, veterans' and social services for eligible people. This work is being undertaken by the Department of Human Services.

The purpose of the UHI is to uniquely identify the people who receive healthcare, the people who provide healthcare and the places where healthcare is provided and is being managed through the Department of Health and Ageing.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30-31 May 2007

Question: E07 - 041

OUTCOME 10: Health System Capacity and Quality

Topic: BUDGET/COSTS/STAFF

Written Question on Notice

Senator Stott Despoja asked:

Do we have the doctors, nurses and pharmacists who are sufficiently well trained and skilled in IT to make the transition to the e-health way of doing things?

Answer:

Currently universities set their own medical curriculum and they are required to meet the program specifications of the Australian Medical Council (AMC), the national standards advisory body for basic medical education. Currently the AMC accredits undergraduate, international, vocational specialist and general practitioners. The prevocational training years (Post graduate Years one and two) are accredited at the state and territory level by registration boards for interns and Postgraduate Medical Education Councils for PGY2.

As with all vocations a level of aptitude in information technologies is essential to the successful completion of a medical education. The extent of the information technology training will depend on the individual university, the AMC and post-graduate training environment in which a medical practitioner is employed.

The content of university courses for health professionals is a matter for universities, as self-accrediting bodies, in conjunction with state registration boards as the accreditation bodies for health professionals. Courses in recent years are known to be making increasing use of IT, thus building the IT skills of graduates. The content of Continuing Professional Development (CPD) for current professionals is a matter for professional bodies.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 31 May 2007

Question: E07-366

OUTCOME 10: Health System Capacity and Quality

Topic: STRENGTHENING CANCER CARE INITIATIVE

Hansard Page: CA119

Senator Moore asked:

Was all of the allocated funding for the Establishment of Cancer Australia expensed in 2004-05 and 2005-06?

Answer:

Establishment of Cancer Australia

No. The need for broad consultation about the establishment of the new agency and the complexity of the governance arrangements for the new body, meant not all funds were expensed.

$470,000 not expensed in 2004-05 was rephased to 2005-06. $3,345 million not expensed in 2005-06 was rephased across 2006-07, 2007-08 and 2008-09.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2007-2008, 31 May 2007

Question: E07-365

OUTCOME 10: Health System Capacity and Quality

Topic: LOCAL PALLIATIVE CARE GRANTS PROGRAM

Hansard Page: CA112

Senator Moore asked:

For a snapshot of the Local Palliative Care Grants Programs including:

a) What was the total allocation of money for the last round of grants
b) Over what period of time will the current grants be running
c) At what level is the delegate who approves the grant recipients

Answer:

a) The total funding allocated for round four of the Local Palliative Care Grants Program is $4 million.

b) Organisations that receive funding will implement their projects from September 2007 to March 2009.

c) The grants are approved in accordance with the Financial Management and Accountability Act 1997 by the Assistant Secretary, Chronic Disease and Palliative Care Branch following a thorough examination of applications against selection criteria.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30-31 May 2007

Question: E07-047

OUTCOME 10: Health System Capacity and Quality

Topic: eHEALTH

Written Question on Notice

Senator Stott Despoja asked:

When will the average person begin to see changes, such as a working SEHR system in doctors' offices?

Answer:

eHealth initiatives are already impacting on the way that the general public receives health care. Shared Electronic Health Records (SEHR) are currently in operation in New South Wales, Northern Territory, Tasmania and South Australia covering public and private sector health settings.

- In NSW 12,812 consumers are registered to have a SEHR in place including public hospitals and general practice.
- In the Northern Territory approximately 11,500 consumers are registered for a SEHR.
- One thousand consumers including 500 veterans are connected to a SEHR in Brisbane north involving general practices, community nurses and public and private hospitals.
- Prescriptions are being transferred electronically in an aged care setting in Darwin and electronic medication management is being used.
- In Tasmania an electronic Patient Discharge Medication Record that is produced at the point of hospital discharge is sent electronically to general practitioners.
- In South Australia over 100,000 hospital discharge summaries have been sent to date to GPs and GPs are also sharing patient care plans.
- In the Eastern Goldfields area of Western Australia, GPs are making electronic referrals to specialists and allied health professionals and specialists are providing reports to the referring GPs electronically.
- Electronic hospital discharge summaries are being sent to GPs in both the Eastern Goldfields and Northern Territory.

All these activities are components of a working SEHR system. Australian Government funded initiatives and programs will continue to provide opportunity and encourage the uptake of eHealth by healthcare professionals working in all area of the health system. The impact of the adoption of eHealth systems will grow as NEHTA continues to release key standards.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2006 - 2007, 31 May 2007

Question: E07-364

OUTCOME 10: Health System Capacity and Quality

Topic: STRENGTHENING CANCER CARE INITIATIVE

Hansard Page: CA111

Senator Moore asked:

Please provide year to date figures for 2006-07, for all of the Strengthening Cancer Care initiatives.

Answer:

QUITTING SMOKING WHEN PREGNANT (Outcome 1)

FUNDING: $4.3 million over three years from 2005-06 ($3.3 million administered).

Expenditure 2006-07: $770,448

This measure has been extended from a three year program to a four year program. This measure slipped because of delays by the National Advisory Group on Smoking and Pregnancy in determining specific areas for investment and making recommendations to the Minister on project funding. The measure will be fully expended within the revised timeframe.

SKIN CANCER AWARENESS CAMPAIGN (Outcome 1)

FUNDING: $7 million* over two years from 2005-06 ($6.6 million administered).
*Of which, an additional $1.5million was made available for the campaign in 2006-07.

Expenditure 2006-07: $6,389,086

Funds were fully expensed within 2006-07 financial year.

BOWEL CANCER SCREENING (Outcome 1)

FUNDING: $43.4 million over three years from 2005-06 for the phasing in of a national bowel cancer screening program. This funding includes $7.8 million pilot announced in the 2004-05 Budget for the Bowel Cancer Screening Pilot program ($28.4 million administered not including the $7.8 million pilot).

Expenditure 2006-07: $14,799,000 (Departmental and Administered)

Unexpended funds of $2.25 million across the life of the Program have accrued in the 2006-07 financial year. This $2.25 million is due to the achievement of better than expected prices on some Program.

SYDNEY CHILDREN'S HOSPITAL – MEDICARE BENEFITS ELIGIBILITY FOR MAGNETIC RESONANCE IMAGING (MRI) (Outcome 3)

FUNDING: $5.1 million over four years from 2005-06 (all administered).

The Department is unable to identify the actual MRI MBS expenditure for the Sydney Children's Hospital as the relevant Medicare Australia identifier (LSPN) includes another MRI unit at the same hospital. However, the total 2006-07 MRI MBS expenditure for the two units was $1,854,794.

This measure is progressing according to plan and it is expected that the funds will be expensed within the timeframe of the measure.

RADIATION THERAPY INTERNSHIPS AND UNDERGRADUATE PLACES (Outcome 3)

FUNDING: $14.9 million over five years from 2004-05 (administered: $6.3 million for Department of Health and Ageing, $4.4 million for Department of Education, Employment and Workplace Relations).

Expenditure 2006-07: $1,202,000 (Department of Health and Ageing)

As part of this initiative, 100 additional radiation therapist training places are to be provided over five years at a cost of $6.0 million. This element is managed by the Department of Education, Employment and Workplace Relations.

This measure has slipped because of delays in approval and recruitment for positions. The funds were moved across 2005-06 and 2006-07 years. The measure is expected to be expended within the original timeframe.

THE NATIONAL BREAST CANCER CENTRE (Outcome 10)

FUNDING: $4 million over five years from 2004-05 ($3.9 million administered).

Expenditure 2006-07: $800,000

Expenditure for this measure is in line with the appropriated funds.

BREAST CANCER NETWORK AUSTRALIA (Outcome 10)

FUNDING: $1 million over four years from 2005-06 ($800,000 administered).

Expenditure 2006-07: $204,000

Expenditure for this measure is in line with the appropriated funds.

LOCAL PALLIATIVE CARE GRANTS PROGRAMS (Outcome 10)

FUNDING**:** $23.1 million over four years from 2005-06 ($20.9 administered).

Expenditure 2006-07: $4,742,925

Expenditure for this measure is in line with the appropriated funds.

NATIONAL RESEARCH CENTRE FOR ASBESTOS RELATED DISEASE (AND GRANTS) (Outcome 14)

ORIGINAL FUNDING**:** $5.5 million over four years from 2005-06 (including departmental). An additional $0.7 million was announced in 2006-07.

Expenditure 2006-07: $121,819

There was initial slippage in this measure due to a delay in the establishment of the centre. However, grant applications for $5,761,355 over three years have now been executed and the measure is expected to be expended within the original timeframe.

From 1 July 2006 the following initiatives were the responsibility of Cancer Australia:

ESTABLISHMENT OF CANCER AUSTRALIA

ORIGINAL FUNDING: $13.7 million over five years from 2004-05 ($13 million administered).

Expenditure 2006-07: $670,033

Expenditure for this measure is in line with the appropriated funds.

BUILDING CANCER SUPPORT NETWORKS

ORIGINAL FUNDING: $3.1 million over five years from 2004-05 ($2.6 million administered).

Expenditure 2006-07: $598,315

This measure is progressing according to plan and it is expected that the funds will be fully expensed within the timeframe of the measure.

CANCER RESEARCH

ORIGINAL FUNDING: $17.6 million over four years from 2005-06 ($16.5 million administered).

The original administered allocation of $4 million in 2005-06 has been rephased as follows: $1 million in 2006-07, $1.5 million in 2007-08, and $1.5 million in 2008-09.

Expenditure 2006-07: $3,735

This measure has slipped due to delays in the establishment of Cancer Australia, the lead time required to develop the funding framework, and the timing of the NHMRC's national project grant process. This revised measure is expected to be fully expended within the original timeframe.

INFRASTRUCTURE SUPPORT FOR CANCER CLINICAL TRIALS

ORIGINAL FUNDING**:** $21.7 million over four years from 2005-06 ($20.6 million administered).

Expenditure 2006-07: $307,409

This measure has slipped due to delays in the establishment of Cancer Australia, and the lead time required to consult and to develop the program framework. This measure is expected to be fully expended within the original timeframe.

MENTORS FOR REGIONAL HOSPITALS AND CANCER PROFESSIONALS

ORIGINAL FUNDING: $14.1 million over four years from 2005-06 ($12.4 million administered).

$1.5 million was rephased from 2006-07 to 2007-08.

Expenditure 2006-07: $1,181,942

This measure is progressing according to plan and it is expected that the funds will be fully expensed within the timeframe of the measure.

PROFESSIONAL DEVELOPMENT PACKAGES FOR CANCER PROFESSIONALS

ORIGINAL FUNDING: $3.3 million in 2005-06 ($2.5 million administered).

$1.9 million was rephased from 2005-06 to 2006-07 and 2007-08.

Expenditure 2006-07: $1,000,000

Expenditure for this measure is in line with the appropriated funds.

DEVELOPING TRAINING COURSES FOR CANCER NURSES

ORIGINAL FUNDING**:** $4.1 million over four years from 2005-06 ($3.6 million).

Expenditure 2006-07: $994,000

Expenditure for this measure is in line with the appropriated funds.

National Working Group for Gynaecological Cancers

Member	Area of Expertise
Mrs Stephanie Alvarez	Consumer
Prof Sanchia Aranda	Cancer Australia Advisory Council
Prof David Bowtell	Lab research
Dr Marion Carey	Epidemiology / Prevention
Dr Robyn Cheuk	Radiation oncology
Dr Katherine Clark	Palliative care
Prof David Currow	Cancer Australia
A/Prof Margaret LJ Davy AM	Oncologist
Prof Michael Friedlander	Clinical trials
Ms Helen Green	Nursing
Prof Ian G Hammond	Oncologist
Ms Margaret Heffernan OAM	Consumer
Dr Monika Janda	Psycho-oncology
Ms Andriana Koukari	Screening
Ms Tish Lancaster	Nursing
Ms Joy McLaughlin	Dept of Health and Ageing
Mrs Lesley McQuire	Consumer
Prof Michael A Quinn	Lab research
Dr Katharine Salmon	Primary care
A/Prof Penelope M Webb	Lab research
Dr Helen Zorbas	National Breast Cancer Centre

T18

Australian Health Ethics Committee, ART review public consultation
copy of submissions 1 – 93

[Note: the submissions were tabled in the Senate on 14.06.07 and have not been included in the electronic/printed volume]

T12

UPTAKE OF THE BETTER ACCESS INITIATIVE MBS ITEMS BY STATE/TERRITORY

		November 2006 – April 2007								
Item No.	**Item description**	**Nationally # claims**	**NSW # claims**	**Vic # claims**	**Qld # claims**	**SA # claims**	**WA # claims**	**Tas # claims**	**ACT # claims**	**NT # claims**
2710	GP Mental Health Care Plan	210,784	74,359	63,003	36,122	11,656	17,708	4,337	2,847	752
2712	GP Mental Health Care Review	19,049	6,955	6,175	2,969	818	1,607	319	157	49
2713	GP Mental Health Care Consultation	137,333	47,365	37,349	24,210	10,713	12,654	2,705	1,549	788
80000 – 80020*	Clinical psychologist items	103,372	32,873	31,273	9,629	4,972	19,605	3,331	1,483	206
80100 – 80120*	Psychologist items	233,866	73,789	85,590	47,425	9,104	9,781	4,779	2,794	604
80125 – 80145*	Occupational Therapists	1,150	268	278	207	162	150	77	8	0
80150 – 80170*	Social Workers	8,454	3,284	2,094	1,675	642	658	58	42	1
291 and 293^	Assessment & Management Plan, Psychiatrist	3,475	1,388	721	717	370	119	90	28	42
296 - 299	Initial Consult, Psychiatrist	31,815	10,807	8,149	6,517	2,736	2,416	581	475	134
	Total	749,298	251,088	234,632	129,471	41,173	64,698	16,277	9,383	2,576

Source: Medicare Australia website, Medicare Statistics, 25 May 2007

*Note: These allied health items are only available to patients who are referred by:

- a medical practitioner who is managing the patient under a GP Mental Health Care Plan (item 2710) and/or a psychiatrist assessment and management plan (item 291); or
- a psychiatrist; or
- a paediatrician.

^Note: MBS items 291 and 293 existed prior to the introduction of the Better Access initiative, but the rebates for these items were increased significantly on 1 November 2006 under the Better Access initiative.

Australian Government

Department of Health and Ageing

Mr Elton Humphery
Secretary
Senate Community Affairs Committee
Parliament House
CANBERRA ACT 2066

Dear Mr Humphery

Request for Amendment to Evidence Provided at Community Affairs Hearing 62, date 31 May 2007 : Outcome 11 Mental Health

I am writing to correct a statement that was made at the Budget Estimates 62 of the Senate Community Affairs Committee on Thursday 31 May 2007.

Senator Moore asked the following question:

"And the support for day-to-day living in the community initiative, $46 million?"

The response was as follows:

"And next financial year, $8.679 million."

It has been brought to my notice that this statement is incorrect. The response should now be amended as follows (changes are underlined):

"And the next financial year, $8.662 million"

Yours sincerely

Rosemary Calder
First Assistant Secretary
Mental Health & Workforce Division
4 June 2007

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30-31 May 2007

Question: E07-383

OUTCOME 11: Mental Health

Topic: EXPANDING SUICIDE PREVENTION PROGRAMS

Hansard page: CA83 31/5

Senator Allison asked:

Is it possible to provide the committee with a kind of mud map of the country to show where the applications have come from so far in terms of whether their reach is going to be across the country or not?

Answer:

The National Suicide Prevention Strategy (NSPS) promotes suicide prevention activities across the Australian population, as well as for specific groups at risk of suicide and self harm, including Aboriginal and Torres Strait Islander peoples. The NSPS supports national and community-centred suicide prevention activities.

Fourteen community-centred suicide prevention projects have been funded since 1 July 2006 to respond to specific Aboriginal and Torres Strait Islander regional community needs. The listing at Attachment A details each project and its geographical reach. A mud map of the country showing the reach of these projects is not available.

Aboriginal and Torres Strait Islander Suicide Prevention Projects

New South Wales

Organisation: South Coast Medical Service Aboriginal Corporation
Project title: Koori Kids Wellbeing Program Shoalhaven
Description: This project aims to implement an educational program designed for young Aboriginal children (3–13yrs) and provide support for children with existing emotional and behavioural problems.
Project reach: Shoalhaven area of southern NSW.

Organisation: Men's Health Information and Resource Centre, University of Western Sydney
Project title: Networks of Support: building individual, family resilience and community capacity in Western Sydney
Description: A project to facilitate men, both young and old to gain access to appropriate mental health information and services and in particular to support those from the Aboriginal community.
Project reach: Mt Druitt/Emerton areas of Blacktown, Western Sydney.

Organisation: Lifeline Newcastle and Hunter
Project title: Comprehensive Suicide Prevention Service
Description: A regionally targeted project that aims to develop a comprehensive Suicide Prevention Service to educate, advise and support those high risk groups within the community.
Project reach: Newcastle, Lake Macquarie, the Hunter, New England and Mid Coast areas.

Organisation: Murrumbidgee Division of General Practice Ltd
Project title: Life Matters for Koori Youth in the Western Riverina
Description: This project between the Murrumbidgee Division of General Practice and the Griffith Aboriginal Medical Service aims to address Indigenous youth intentional self harming and suicidal behaviour.
Project reach: Western Riverina, South Western NSW.

Northern Territory

Organisation: Waltja Tjutangku Palyapayi Aboriginal Corporation
Project title: We Know Our Strength
Description: This project aims to support three remote Aboriginal communities to identify and reinforce their resilience, capacity, knowledge and strengths, and also to provide them with comprehensive information about suicide prevention.
Project reach: The remote Central Australian communities of Titjikala, Santa Teresa and Mt Liegig.

Organisation: Ngaanyatjarra Pitjantjatjara Yankunytjatjara Women's Council Aboriginal Corporation
Project title: Speaking Up About Mental Health
Description: This project will enable the development of a series of radio conversations around mental health issues.
Project reach: The cross-border region of WA, SA and NT - Anangu Pitjantjatjara Yankunytjatjara (SA) lands, southern NT and the Ngaanyatjarra Shire (WA).

Organisation: Mount Theo/Yuendumu Substance Misuse Program
Project title: Jaru Pirrijirdi (Strong Voices) Project
Description: An integrated after-care and community development project to promote mental health and wellbeing, protect against substance misuse and support Aboriginal young people to build resilience.
Project reach: Yuendumu, Willowra and Nyirrpi communities in Central Australia.

Organisation: Tiwi Islands Youth Diversion/Development Unit
Project title: Youth Diversion/Development program
Description: This project will support a range of interventions and support services designed to promote social wellbeing and youth development.
Project reach: Tiwi Islands, north of Darwin.

Queensland

Organisation: Centre for Rural and Remote Mental Health Queensland Ltd
Project title: Learning from the experts: Building bridges to implement successful life promotion and suicide prevention expertise across Aboriginal communities
Description: A suicide prevention and education project focussing on Aboriginal communities.
Project reach: Hopevale and Kowanyama (Cape York) and South West Queensland.

Organisation: Wesley Mission Brisbane
Project title: Ngali Jarjum Byun - "we, children, today…" Cross-cultural awareness and life skills program
Description: Aimed at young people aged 13-17 who are engaging in self-harming behaviours or who have expressed suicidal ideations, this project aims to implement a preventative and early intervention program.
Project reach: Gold Coast and Beenleigh area, South East Queensland.

Organisation: Queensland Police-Citizens Youth Welfare Association
Project title: Something Better
Description: The 'Something Better' project aims to assist and support young Aboriginal people that are at risk of suicide by providing them with exposure to sporting activities outside of their community.
Project reach: The community of Wujal Wujal in Cape York.

South Australia

Organisation: Centacare Catholic Family Services - Port Pirie Diocese
Project title: Sustainable Personal Development for Aboriginal Men
Description: This project aims to build resilience and community capacity within Aboriginal communities for men aged 15 to 45.
Project reach: Port Pirie, Port Augusta, Port Lincoln and Ceduna.

Western Australia

Organisation: Centrecare Incorporated
Project title: Mirritjunka wanti: Millen Street Project
Description: This project is designed to increase involvement of local Aboriginal young people and their families in "no more deaths for Aboriginal youth" by developing relevant and culturally secure resources to raise awareness.
Project reach: Kalgoorlie-Boulder, Esperance and Goldfields regions.

Organisation: Women's Health Care Association
Project title: Nangar Warloo 'The Sun is Returning'
Description: This project will address issues of prevention and postvention – interventions after a suicide in support for bereaved family and friends – of suicide and self harm within the Indigenous community by extending the existing Aboriginal Grandparents Family Support Program – the Nangar Warloo.
Project reach: Perth.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30-31 May 2007

Question: E07-220

OUTCOME 11: Mental Health

Topic: RURAL AND REMOTE AREAS

Written Question on Notice

Senator McLucas asked:

Does the department have up-to-date data on how many mental health nurses are currently employed in rural and remote areas? If so please supply this data.

Answer:

The Australian Institute of Health and Welfare reported that there were 13,277 nurses working within the mental health sector in 2004 (*Nursing and Midwifery Labour Force 2004,* 2006).

This data does not break down the percentage or number of nurses working within the mental health sector in rural and remote settings.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30-31 May 2007

Question: E07-221

OUTCOME 11: Mental Health

Topic: RURAL AND REMOTE AREAS

Written Question on Notice

Senator McLucas asked:

Does the department have up-to-date information on how many more mental health nurses are needed to address the crisis in mental health?

Answer:

The Department is aware of current supply issues facing the mental health workforce.

The Australian Government is strengthening the mental health nursing workforce through:

- the *Additional Education Places, Scholarships and Clinical Training in Mental Health* initiative, which will provide up to 75 scholarships worth $10,000 per year for postgraduate study in mental health nursing and clinical psychology;
- the *Credentialing for Practice Program* (CPP), managed by the Australian College of Mental Health Nurses (ACMHN), which aims to increase the number of credentialed mental health nurses within Australia; and
- the *COAG National Action Plan on Mental Health 2006-2001, Increasing Workforce Capacity* funding will increase the supply and quality of the mental health workforce with an additional 420 mental health nursing places each year being funded.

The *Mental Health Nurse Incentive Program* is also working to strengthen this workforce through:

- expanding the roles and responsibilities for community based mental health nurses in Australia, creating an alternative career pathway for mental health nurses within the community; and
- allowing an 18 month ‘grace’ period for nurses under the initiative to obtain qualifications necessary for national credentialing. Under these arrangements, eligible organisations will be able to engage the following individuals:

- mental health nurses currently credentialed with the ACMHN and/or;
- registered nurses with current registration who have obtained, or are working towards obtaining, specialist qualifications in mental health, such as a Graduate Diploma in Mental Health Nursing or a Masters in Mental Health Nursing, and three years recent experience in mental health nursing.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30-31 May 2007

Question: E07-223

OUTCOME 11: Mental Health

Topic: RURAL AND REMOTE AREAS

Written Question on Notice

Senator McLucas asked:

In terms of accountability, what measurement tools will the department be implementing to gauge "improved access"?

Answer:

The data and information will be collected from participants using standard measurement tools to inform service delivery and mapping, and to meet the Council of Australian Governments (COAG) *National Action Plan on Mental Health 2006-11 Framework for Monitoring Implementation Progress of Australian Government Funded Initiatives* (the Framework) reporting requirements. Key information requirements for the Framework are:

- what services;
- by whom;
- to whom;
- at what cost; and
- with what effect.

An external evaluation will also be undertaken.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30-31 May 2007

Question: E07-222

OUTCOME 11: Mental Health

Topic: MENTAL HEALTH WORKFORCE

Written Question on Notice

Senator McLucas asked:

What benchmarks has the Department set in terms of numbers of specialist and nursing staff per head of population?

Answer:

The Australian Government has not set benchmarks but instead is advised by expert bodies as part of its decision making process. In the case of specialists, until last year this has been through the Australian Medical Workforce Advisory Committee (AMWAC) and is now through the Health Workforce Principal Committee (HWPC) and the work of its committees.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30-31 May 2007

Question: E07-224

OUTCOME 11: Mental Health

Topic: DAY TO DAY LIVING

Written Question on Notice

Senator McLucas asked:

What methodology has the department used to conclude that $40 million over five years will fund the 7,000 places identified as being service by this Programme?

Answer:

Those figures are considered advice to government as part of the Budget process and are not able to be released.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30-31 May 2007

Question: E07-225

OUTCOME 11: Mental Health

Topic: DAY TO DAY LIVING

Written Question on Notice

Senator McLucas asked:

At a raw calculation, you're looking at about $5000 per person to assist Programme recipients in cooking and social outings – can you provide the research and data which was used to calculate the costs of providing these services?

Answer:

Those figures are considered advice to government as part of the Budget process and are not able to be released.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30-31 May 2007

Question: E07-226

OUTCOME 11: Mental Health

Topic: DAY TO DAY LIVING

Written Question on Notice

Senator McLucas asked:

Who will be responsible for conducting these activities – departmental staff, contractors or outsourced personnel?

Answer:

The *Support for Day to Day Living in the Community* Program will be delivered through Non-Government Organisations and Indigenous specific primary health care organisations, with proven experience in providing community based services to people with severe and persistent mental illness.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30-31 May 2007

Question: E07-227

OUTCOME 11: Mental Health

Topic: DAY TO DAY LIVING

Written Question on Notice

Senator McLucas asked:

Has the department allocated specific amounts to each aspect of the Programme; that is, a set amount for social outings and a set amount for cooking and so on?

Answer:

No, Non-Government Organisations and Indigenous specific primary health care organisations will be offered a set amount per place for the provision of the *Support for Day to Day Living in the Community* Program to participants. The program provides two levels of support; a drop-in level and a medium support level. It also provides funding to facilitate the participant's involvement in community social activities.

The drop-in level provides peer support and activities within an informal environment which develops social skills and community participation. The medium support level includes these activities as well as providing structured and socially based activity programs. A component of the program's funding is allocated for discretionary funding to facilitate participant's involvement in community social activities.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30-31 May 2007

Question: E07-228

OUTCOME 11: Mental Health

Topic: DAY TO DAY LIVING

Written Question on Notice

Senator McLucas asked:

What is the process for accountability with this Programme? Is it just having 7,000 people pass through the doors, or are there specific and measurable criteria which the department is using to benchmark the success of this initiative?

Answer:

Service providers will be required to provide standard progress reports involving qualitative and quantitative measures. Key measures will include:

1. number of hours of client participation
2. number of clients accessing services
3. the number of new clients accepted against referral sources
4. number of clients
    - i. who have been functionally assessed;
    - ii. who have demonstrated an improvement in areas assessed;
    - iii. for whom an individual management plan has:
        - a) been developed for the first time; and
        - b) been reviewed;
    - iv. who left the program and their reason for leaving

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30-31 May 2007

Question: E07-229

OUTCOME 11: Mental Health

Topic: DAY TO DAY LIVING

Written Question on Notice

Senator McLucas asked:

How will the funding allocations across states and territories be determined?

Answer:

There is no set funding for each state and territory. Funding allocations have been informed by the Australian Health Ministers' Advisory Council (AHMAC) formula, anticipated needs of each of the 49 pre-identified geographical area and the capacity of the organisation to service the number of places.

Negotiations are continuing with successful applicants for funding under the program. The total funding for each state and territory under the *Support for Day to Day Living in the Community* Program to 30 June 2009 is subject to the successful outcomes of these negotiations.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30-31 May 2007

Question: E07-230

OUTCOME 11: Mental Health

Topic: DAY TO DAY LIVING

Written Question on Notice

Senator McLucas asked:

What is the yearly cap on this Programme? Are there 7,000 additional places across a five year period; and if so, will the department cap the number of places available per year?

Answer:

Funding allocations for the Support for Day to Day Living Program over the five year funding period.

	2006-07	**2007-08**	**2008-09**	**2009-10**	**2010-11**	**Total**
$m	3.875	8.662	9.215	9.391	9.845	40.988

The measure aims to provide a minimum of 7,000 places over the five year period.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30-31 May 2007

Question: E07-231

OUTCOME 11: Mental Health

Topic: DAY TO DAY LIVING

Written Question on Notice

Senator McLucas asked:

How do people with a mental illness apply for this funding?

Answer:

Funding is not provided to people with a mental illness directly. Funding is being provided to Non-Government Organisations and Indigenous-specific primary health care organisations.

Individuals with a mental illness can access the programmes delivered by the Non-Government Organisations and Indigenous-specific primary health care organisations in their local communities through a number of pathways including:

- Self referral;
- GP referral;
- Mental Health Services;
- Psychiatrist or Psychologist;
- Social Welfare Services;
- Personal Helpers and Mentors program; and
- Other human/community service agencies.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30-31 May 2007

Question: E07-232

OUTCOME 11: Mental Health

Topic: DAY TO DAY LIVING

Written Question on Notice

Senator McLucas asked:

Where is this Programme going to be advertised?

Answer:

Advertisements inviting applications for funding for the period to 30 June 2009 appeared in the following national newspapers on Saturday 17 and 24 February 2007:

The Australian
The Canberra Times
The Sydney Morning Herald
The Age
Brisbane Courier Mail
Adelaide Advertiser
The West Australian
Hobart Mercury
NT News
Herald Sun
The Daily Telegraph

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30-31 May 2007

Question: E07-243

OUTCOME 11: Mental Health

Topic: YOUTH MENTAL HEALTH FOUNDATION - HEADSPACE

Written Questions on Notice

Senator Jan McLucas asked:

What is the progress of the Youth Mental Health Foundation?

Answer:

Ten large and 21 small grants have been awarded from round one of the Youth Services Development Fund. This is to enable organisations to create new models for delivering mental health services to young people. Models include production of education and training resources as well as strategies that have an emphasis on improving early help seeking behaviors by young people with mental health and substance use problems.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30-31 May 2007

Question: E07-244

OUTCOME 11: Mental Health

Topic: YOUTH MENTAL HEALTH FOUNDATION - HEADSPACE

Written Questions on Notice

Senator McLucas asked:

What is governance structure in place in the Foundation? Has this changed since the original tender was let to run the Foundation? If so, how?

Answer:

The Foundation is guided by an Advisory Board providing advice to the Foundation Executive Committee, which manages the day to day operations through a Chief Executive Officer. This reflects the governance structure of *headspace* as outlined in the Funding Agreement and has not changed since the original tender was let.

Question: E07-248

OUTCOME 11: Mental Health

Topic: ADHD – ROYAL AUSTRALASIAN COLLEGE OF PHYSICIANS CLINICAL GUIDELINES REVIEW TERMS OF REFERENCE

Written Question on Notice

Senator Jan McLucas asked:

What is the review's remit – can it recommend anything beyond diagnosis and prescribing guidelines (ie education, other social supports needed etc)?

Answer:

The terms of reference for the Royal Australasian College of Physicians review of the ADHD Clinical Practice Guidelines are as follows:

To revise the 1997 National Health and Medical Research Council (NHMRC) Guidelines on Attention Deficit Hyperactivity Disorder (ADHD), incorporating literature published since, to inform health professionals, educators, researchers, policymakers, carers, consumers and interested community members.

Specifically, the revision of the 1997 NHMRC Guidelines on ADHD should:

1. Define and describe the current conceptualisation of ADHD.
2. Address aspects of ADHD that have generated community and professional interest over the past decade, including:
   - Neurobiology
   - Aetiology – genetics, environmental factors
   - Comorbid conditions
   - Symptom patterns and management at different developmental stages, including preschoolers, adolescents, adults
   - Issues specific to particular populations eg Indigenous Australians and people from Culturally and Linguistically Diverse (CALD) backgrounds
   - Role of newer medications eg. long-acting stimulant preparations, nonstimulants
   - Long-term outcomes
   - Quality of life – patient, family
   - Complementary and alternative therapies
   - Diagnostic practices (differential diagnosis)
   - Access to services

3. Synthesise and interpret the current state of knowledge on ADHD for different stakeholders.
4. Update the list of available resources to assist clinicians, educators, carers and consumers in the evaluation and management of ADHD.
5. Advise on national data collection in the management of ADHD.
6. Advise on targets for further research into the causes, management and outcomes of ADHD.
7. Provide recommendations for policy and practice for different stakeholders.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30-31 May 2007

Question: E07-250

OUTCOME 11: Mental Health

Topic: ATTENTION-DEFICIT HYPERACTIVITY DISORDER (ADHD)

Written Question on Notice

Senator McLucas asked:

Specifically, do any provide advice, or conduct research on behalf of, or receive any direct or
indirect benefit from ADHD drug manufacturers, either personally or professionally?

Answer:

The declarations of potential conflicts of interest of the committee will be published with the completed guidelines.

Discussion of potential conflicts of interest at this time would require the identification of individual members and several members have indicated they are concerned that public discussion of the membership at this stage of the review process may detract from the capacity of the committee to produce the best possible review. They have accordingly indicated that they do not wish to participate in the review should this discussion occur at this time. The Department is concerned that should members withdraw, the review of the guidelines will be seriously compromised through the loss of expertise.

It is important that reviews of this kind are undertaken by clinicians, researchers and other experts who are recognised for their expertise. It is common practice for these experts to provide their expertise to a range of committees including government and industry committees. It would be difficult to find anyone in the field who has not had some engagement with research and development relating to ADHD.

There are serious concerns that should members of the current committee withdraw their assistance it will not be possible to reconvene another group with such a high standard of academic and clinical expertise. There would then be a real possibility that the review of the guidelines could not be completed. While it is recognised that the membership of the committee is a matter of public interest, it is also true that a failure to complete the current review would be detrimental to the public interest.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30-31 May 2007

Question: E07-251

OUTCOME 11: Mental Health

Topic: ADHD

Written Question on Notice

Senator McLucas asked:

Do any guidelines for conflict of interest exist for NHMRC committees that draw up clinical guidelines? If so please provide a copy.

Answer:

The National Health and Medical Research Council (NHMRC) has comprehensive policies and procedures for managing conflicts of interests for all of its committee members. The policy is contained in the NHMRC's document titled *The Members' Handbook (the Handbook).* A relevant excerpt from a chapter on Members' Responsibilities regarding Disclosure of Interest and Confidentiality from the *Handbook* is at Attachment A.

The ADHD guidelines are being developed under the externally developed guidelines which includes clear NHMRC guidance about managing conflict of interest issues. These are found in the NHMRC publication titled *NHMRC standards and procedures for externally developed guidelines*. The revised publication is shortly to be uploaded onto the NHMRC website and will include the information at Attachment B.

The NHMRC acknowledges the importance of including clear guidance for the NHMRC external guideline developers about managing conflict of interest issues in its publication *NHMRC standards and procedures for externally developed guidelines* at: http://www.nhmrc.gov.au/publications/_files/nh56.pdf which provides support to external guideline developers. The revised publication is shortly to be uploaded onto the NHMRC website and will include the information at Attachment B.

ATTACHMENT A

The following is an excerpt from the Members' Handbook, updated in August 2006:

4.1 Members' Responsibilities regarding Disclosure of Interest and Confidentiality

Prior to their appointment, members are required to sign two forms:

- a Disclosure of Interest (Attachment A); and

- a Deed of Confidentiality (Attachment B).

Introduction

Members of the Council of the NHMRC, Principal Committees and Working Committees provide high quality, expert and independent advice that enable the NHMRC to discharge its functions. Members are drawn from a wide cross-section of the community and from different areas of expertise and experience.

Members are appointed for their expertise and experience across a diverse range of professions and fields. Members may therefore experience actual, apparent or potential conflicts between their responsibilities in activities for the NHMRC and their personal interests or other professional responsibilities. They may also be privy to information of the NHMRC that is confidential and must not be disclosed.

These guidelines are designed to guide members and the NHMRC Secretariat in the exercise of their responsibilities in order to ensure all conflicts of interest are addressed in a rigorous and transparent way that accords with the requirements of the *National Health and Medical Research Council Act 1992* (the Act).

Scope

These guidelines apply to:

- members of Council and its Principal Committees appointed by the Minister;
- members of committees appointed by the CEO; and
- all other persons appointed or engaged to assist the work of committees (be they called working groups, steering committees, expert groups, and the like).

These guidelines may not apply in the following circumstances:

- Consultants appointed under section 46 (as in these cases, consultants are engaged using the standard contract which includes specific provisions for conflict of interest and confidentiality).

- Situations where the CEO establishes a committee under subsection 39(1) and decides that different guidelines are appropriate. In these cases, it is the responsibility of the CEO to determine the procedure to be followed by the committee and would include the NHMRC Members Handbook Last updated – August 2006 Page 4.1–2
disclosure of member's interests in matters being considered by the committee (see section 39(3)).

- In regard to the Embryo Research Licensing Committee, established as a Principal Committee under the *Research Involving Human Embryos Act 2002,* section 13(4) of that Act provides that the regulations may make provision for and in relation to the disclosure of a member's interests in matters being considered by the NHMRC Licensing Committee.

Note: The CEO may choose to adopt these guidelines when determining the procedures to be followed by the Licensing Committee. However if regulations are in force under the *Research Involving Human Embryos Act* that make provision for disclosure of interests of Licensing Committee members, these regulations will override any determination made under the *NHMRC Act.*

Conflict of Interest

A conflict of interest arises in any situation in which a member or related person has an interest which influences, or may appear to influence, the proper performance of the members' responsibilities to the NHMRC. The appearance of a conflict of interest is as important as any actual conflict of interest.

Who is a member? A member is any person who is or has been appointed to membership of the Council, a Principal Committee, a working party or committee or who is or has been engaged to advise or assist the Council or any working party or committee.

Who is a related person? A related person is the partner or spouse of the member, a member of the member's family or a close friend of the member.

What is an interest? The *NHMRC Act* refers to an 'interest' but does not define what this means, and therefore a fairly broad reading of that term is warranted. It is difficult if not impossible to define exhaustively all situations in which there is an interest that may conflict with the responsibilities of a member. Further, the appearance of a conflict of interest is as important to the NHMRC as any actual conflict of interest.

There are generally three types of interest (which in many cases overlap) and they provide a useful guide for consideration of members. The appearance of any of the following situations will therefore be considered to involve an interest that may conflict with a member's responsibilities.

i. Direct pecuniary interest

A direct pecuniary interest arises wherever there is a potential for a member or related person to directly gain financially from the results of NHMRC discussions or decision-making processes to which the member contributes. This may include situations such as:

- a directorship of or shareholdings in a company that may benefit from a decision of the NHMRC to which the member contributes;
- a financial investment in an organisation, such a trust, that may benefit from a decision of the NHMRC to which the member contributes;

- a consultancy or a grant involving financial gain to the member's employer (eg a hospital or higher education institution) in circumstances where the member will benefit financially from their involvement; or
- a relationship based on a common interest such as professional or institutional allegiance, sporting, social or cultural associations who may benefit from a decision of the NHMRC to which the member contributes.

ii. Indirect pecuniary interest

An indirect pecuniary interest arises from members' employment or professional interests or from their personal relationships. They include:

- situations of members holding a formal position of authority in a non-commercial organisation such as an educational institution. For example if a university Deputy Vice-Chancellor (Research) was a member of a Working Committee, he or she would have an indirect pecuniary interest in any project, grant or consultancy for which a member of that university had applied, and a head of department would have a similar interest wherever departmental members are involved; or
- an application for a consultancy or grant by a member's partner or relative, a close personal friend or a close professional colleague.

iii. Non-pecuniary interest

Actual or potential non-pecuniary interests arise where a member simultaneously has an appointment to, or employment or consultancy or other involvement with, another organisation or body that is in some way involved with the NHMRC. The interest may arise if the interests of NHMRC and the other body or organisation are in conflict, or if access to information arising from NHMRC involvement could be used to unfair advantage if divulged to the other organisation or body.

Such an interest also arises where a member has a relationship, whether professional – as with a colleague in an employment context or a professional association – or personal, with a person who may benefit from a decision of the NHMRC to which the member contributes.

Managing a conflict of interest

A conflict of interest, or the appearance of a conflict, is likely to undermine the credibility of a project, process or decision. More importantly, that may in turn undermine the status and damage the reputation of the NHMRC. Managing conflicts of interest in a vigorous, consistent and transparent fashion is essential. The two primary mechanisms used to manage situations of conflict are *disclosure* and *exclusion*.

Disclosure of interests upon appointment

Before starting to hold office, members and other persons engaged under the *NHMRC Act* are to provide written statements of any interest the member/person may have in matters to be considered or activities undertaken by the relevant as follows:

- The CEO must give to the Minister a written statement of interests the member has that may relate to the functions of the CEO.

- A member of Council or a committee must give to the CEO a written statement of interests the member has that may relate to any activity of the Council or Committee.

- Members of the NHMRC Licensing Committee. Under the *Research Involving Human Embryos Act 2002*, before appointing a member to the Licensing Committee, the Minister must be satisfied on receipt of a written declaration by the member proposed to be appointed that the member proposed does not have a direct or indirect pecuniary interest in a body that undertakes the use of excess ART embryos, being an interest of a kind that could conflict with the proper performance of the members functions (s16(3)(c) *Research Involving Human Embryos Act 2002*). The NHMRC Licensing Committee is a Principal Committee under the *NHMRC Act* (other than for purposes of a few specified *NHMRC Act* provisions dealing with Principal Committees). The provisions of the *Research Involving Human Embryos Act 2002* also set out that regulations may make provision for the disclosure of member's interest in matters being considered by the NHMRC Licensing Committee. If regulations are made in regards to conflict of interest they will override any guidelines that the Council may determine (sections 13(4) and 13(5) of the *Research Involving Human Embryos Act 2002* refers).

Disclosure of interests during tenure

The responsibility to identify and report an interest that is in potential conflict or actual conflict with their responsibilities, or has the appearance of such a conflict, is always that of the member.

Members during their tenure (or persons during their engagement) who identify an interest (most typically when they become aware that an issue is about to be considered) must as soon possible disclose the nature of the interest.

- members of Committee as soon as possible after any other facts come to their knowledge, disclose to the Chair of the committee the nature of the interest. If the member is the Chair, then the CEO is to be informed;

- if a disclosure is made, a member must not be present when the Council or Committee considers the matter or take part in any decision making;

- however if the Chair (or CEO) otherwise determines, the above does not apply.

Procedure at Meetings

Chairs of meetings must provide the opportunity for members to declare an interest in any activity of, or matters being considered by, the Council, Principal Committees or Working Committees. This should be a standing agenda item for all committee meetings and any supporting committees. At the commencement of each meeting, the Chairperson should invite members to declare or discuss any relevant matter.

In all cases, the member's disclosure must be recorded in the minutes of the meeting or if given outside the meeting, be recorded in the minutes of the next meeting after disclosure.

Exclusion

If the Chairperson of the Council has declared an interest, he or she must not be present when the Council considers the matter, or take part in any decision of the Council in relation to the matter, unless the CEO otherwise determines.

If a member of the Council has declared an interest, he or she must not be present when the Council considers the matter, or take part in any decision of the Council in relation to the matter, unless the Chairperson of the Council otherwise determines.

If a member of the Principal Committee, working party or committee has declared an interest, he or she must not be present when the Principal Committee, working party or committee considers the matter, or take part in any decision of the Principal Committee, working party or committee in relation to the matter, unless the Chairperson of the Principal Committee, working party or committee otherwise determines.

Legislative requirements and policy

These guidelines cannot cover all cases of where a conflict of interest may occur. Members may find themselves in situations that are not clear-cut where there is a genuine doubt as to whether a conflict of interest exists. Where there is doubt, that is sufficient reason for members to declare their interest.

There are legislative requirements in the *NHMRC Act* for members to disclose interests in matters being considered (see section 42A).

Section 44B(3) requires the Minister or the CEO (whoever made the appointment) to terminate the appointment of an appointed member for failure to comply, without reasonable excuse, with the disclosure of interests' requirements of the *NHMRC Act* or

ATTACHMENT B

NHMRC requirement for declaring Conflict of Interest – currently being included in the publication: ***NHMRC standards and procedures for externally developed guidelines***

"13. Declaring Conflicts of Interest

Guideline developers should ensure against actual and potential conflicts of interest when employing Advisory or Working Committees to oversee the guidelines development by requiring that members declare any conflicts of interest to the guideline developers upon the guidelines being accepted onto the NHMRC's work plan and at the beginning of all meetings and teleconferences regarding the guideline's development.

This involves the members warranting that, to the best of their knowledge after making diligent inquiry, at the date of commencement and at each subsequent meeting and teleconference no conflict of interest with the topic exists or is likely to arise in respect to developing the guidelines.

If, during the development of the guidelines a conflict of interest arises, or appears likely to arise in respect of the guideline's development, the member must agree to:

(a) notify the guideline developer immediately in writing of that conflict or apparent conflict and the steps the member proposes to take to resolve or otherwise deal with the conflict or apparent conflict;

(b) make full disclosure of all relevant information relating to the conflict or apparent conflict; and

(c) take such steps as have been proposed by the developer, or at the discretion of the NHMRC, to resolve or otherwise deal with the conflict.

If the member does not notify the developer or is unable or unwilling to resolve or deal with the conflict as required, the developer may cease the members involvement in the guideline's development."

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30-31 May 2007

Question: E07-252

OUTCOME 11: Mental Health

Topic: ADHD

Written Question on Notice

Senator McLucas asked:

Why were there originally delays in funding NHMRC research on clinical guidelines?

Answer:

The National Health and Medical Research Council (NHMRC) has not received any funding with regards to the current review of the ADHD Clinical Practice Guidelines. A contract has been developed to assist the Royal Australasian College of Physicians (RACP) to conduct this work.

Since the 1997 Guidelines were rescinded the NHMRC consulted with several possible groups with a view to having the guidelines reviewed. The RACP accepted this task in 2006 and secured funding from the Australian Government to proceed after the negotiation and development of a contract for services.

Work commenced immediately once funding was provided. There was not an unusual delay in this process.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 31 May 2007

Question: E07-305

OUTCOME 11: Mental Health

Topic: MENTAL HEALTH

Hansard Page: CA 60

Senator Moore asked:

If you can tell us what is involved in that that would be useful.

Answer:

Mr Smyth referred to a minor payment of $8,787, which had been made to the Royal Australian and New Zealand College of Psychiatrists to develop an information and orientation resource about the Better Access initiative for psychiatrists. This payment was made in November 2006.

The Royal Australian and New Zealand College of Psychiatrists is the lead organisation in the coalition of the four groups (The Royal Australian and New Zealand College of Psychiatrists, the Royal Australian College of General Practitioners, the Australia Psychological Society and the Australian College of Mental Health Nurses), referred to as the Mental Health Professionals Association (MHPA).

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30 May 2007

Question: E07-306

OUTCOME 11: Mental Health

Topic: MENTAL HEALTH

Hansard Page: CA 76

Senator Webber asked:

That feeds into my concern about new clients accessing new services, because a lot of these people were cut out of the old system because of the cost. So to access it there was great celebration, but then the fee goes up and it is becoming cost prohibitive again. (Mr Kalisch—We can certainly take up that specific question with the Australian Psychological Society as well. As Professor Calder says, it has not really been directly raised with us. So we can directly ask them the question.)

Answer:

The Department has discussed the concerns raised by Senator Webber with the Australian Psychological Society (APS).

The APS has advised that it does not collect data on the fees charged by APS members or other psychologists, and has not received complaints from members of the public about increases in fees charged by psychologists since the introduction of the Better Access initiative.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 31 May 2007

Question: E07-307

OUTCOME 11: Mental Health

Topic: MENTAL HEALTH

Hansard Page: CA 77

Senator Allison asked:

I am sure it does. The question is whether we are seeing a downgrading of the standards for clinical psychologists or not; that is what I am driving at.

Answer:

The standards for professional recognition as a clinical psychologist are set by the psychology profession, represented nationally by the Australian Psychological Society (APS). The APS has advised the Department that there have been no changes to the requirements for eligibility for membership of the Australian Psychological Society's College of Clinical Psychologists in response to the introduction of the Better Access initiative.

Under the Better Access initiative to be eligible to provide Psychological Therapy services clinical psychologists must be eligible for membership of the APS's College of Clinical Psychologists, and registered with the Psychologists Registration Board in the state or territory in which they are practising (clinical psychologists whose state/territory registration includes any limitation are not eligible to register with Medicare Australia to provide Psychological Therapy services under this initiative).

The APS is responsible for advising Medicare Australia whether clinical psychologists are eligible for membership of the APS's College of Clinical Psychologists. This means ensuring clinical psychologists have specific training, qualifications, clinical supervision and practice experience that is required for College membership. It also includes endorsement by two psychologists who are familiar with the psychologist's professional work and who are either members of the APS College of Clinical Psychologists or psychologists whose eligibility for College membership can be demonstrated.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 31 May 2007

Question: E07-308

OUTCOME 11: Mental Health

Topic: MENTAL HEALTH

Hansard Page: CA 78

Senator Moore asked:

It is generally in terms of the provision of services in that area, the involvement specifically with consumers in the Indigenous area and whether there is any special allocation within any of the programs you worked through earlier to ensure that Indigenous issues are picked up. I know there is in the suicide strategy. That one jumps to mind because there is a particular component, but for the other ones-with rural and remote, with the Better Access to psychiatrists, with the education components in terms of getting professionals into the field, all of those-could you give us a briefing paper on the Indigenous components? Would that be better than taking the time now?

Answer:

The programs and services being delivered under the measures the Department is implementing are accessible by a broad range of population groups, including Aboriginal and Torres Strait Islander peoples. In addition, the Department has considered how all measures will impact Aboriginal and Torres Strait Islander peoples through a number of ways. For instance:

- The Indigenous Strategies Working Group (ISWG) has recently broadened their terms of reference to enable them to provide advice on planning and implementation of the measures the Department is responsible for.
- The Chairperson of the ISWG is a member of the Department's Stakeholder Reference Group and represents the views of Indigenous people.
- In planning for implementation, all program areas have considered how each measure will best meet the needs of Indigenous people, and this has involved a range of consultation mechanisms.

Requested information is presented in table format at Attachment A.

Attachment A

Measure	***Aboriginal and Torres Strait Islander Element***
Improving the capacity of Health Workers in Indigenous communities	The full $20.8 million provided under this measure specifically targets Aboriginal and Torres Strait Islander people and communities.
New funding for mental health nurses measure	The measure does not specifically target Aboriginal and Torres Strait Islander people, however, those living in rural and remote areas will benefit from this measure. There is no funding for specific population groups in this measure.
Mental Health Services in Rural and Remote Areas	The measure does not specifically target Aboriginal and Torres Strait Islander people, however, services will be provided under the measure in some Aboriginal and Torres Strait Islander communities.
Additional Education Places, Scholarships and Clinical Training	The measure does not specifically target Aboriginal and Torres Strait Islander people, however the Mental Health Postgraduate Scholarship states a preference for people of rural or Aboriginal and Torres Strait Islander background. There is no funding allocated for specific population groups in this measure.
Mental Health in Tertiary Curricula	Funding agreements are in place with several health profession accreditation bodies to review undergraduate course accreditation requirements to include a minimum mental health component. All agreements require the accreditation bodies to ensure that the culturally appropriate management of Aboriginal and Torres Strait Islander clients is addressed through these projects. There is no funding allocated for specific population groups in this measure.
Improved Services for People with Drug and Alcohol Problems and Mental Illness	This measure does not specifically target Aboriginal and Torres Strait Islander people. The Department encourages Non-government Alcohol and other Drug Treatment services, including Aboriginal and Torres Strait Islander Alcohol and Other Drug Treatment organisations to apply for funding. The Department is working with the Office of Aboriginal and Torres Strait Islander Health to disseminate information to Aboriginal and Torres Strait Islander Alcohol and Other Drug Treatment organisations through Indigenous Coordination Centres (ICCs). Advertisements will be run in news papers, including the Koori Times in June/July 2007.

Better access to psychiatrists, psychologists and GPs through the MBS	The measure does not specifically target Aboriginal and Torres Strait Islander people, however they will benefit. There is no funding allocated for specific population groups in this measure.
Telephone counselling, self-help and web-based support programmes	The measure does not specifically target Aboriginal and Torres Strait people, however they are able to access the programs being delivered under this measure. There is no funding allocated for specific population groups in this measure.
Mental Health Support for Drought-Affected Communities	The measure does not specifically target Aboriginal and Torres Strait people, however they will able to access the programs if they live in one of the 39 Divisions to be funded.
Alerting the Community to Links Between Illicit Drugs and Mental Illness	In addition to the use of mainstream communications channels, the measure will include a targeted Indigenous strategy to ensure key messages are communicated in a culturally appropriate and relevant way amongst Indigenous communities. Funding for the purposes of targeting Indigenous groups will be allocated within the budget following finalisation of the strategic approach.
Support for day-to-day living in the community	It is expected that services funded under this measure will be open to all members of the community with severe and persistent mental illness, including Aboriginal and Torres Strait Islander people. In addition, each organisation funded will be required to identify areas of need and groups in the organisation's locality who do not have adequate access to structured social activity programs and take steps to reduce barriers to these groups accessing the programs being provided under this measure. These groups may include Aboriginal and Torres Strait Islander peoples, people from culturally and linguistically diverse backgrounds or other groups as identified by the Participant. In addition, the Department is currently consulting with the Indigenous Strategies Working Group on any additional mechanisms that may be appropriate to ensure the measure provides services to Indigenous Australians.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 31 May 2007

Question: E07-309

OUTCOME 11: Mental Health

Topic: SUICIDE STATISTICS AND THE QUALITY OF DATA BEING REPORTED

Hansard Page: CA 82

Senator Lyn Allison asked:

When is the task force expected to complete its work?

Answer:

The Australian Bureau of Statistics (ABS) published an information paper on 11 April 2007 regarding external causes of death (*Information Paper*, *External Causes of Death, Data Quality, 2005* (cat. no. 3317.0.55.001).

This paper has been written as a response to concerns raised by users of ABS Causes of Death data, particularly users of suicide data. The information paper attempts to explain some issues that users of ABS data should take into account when comparing ABS data to other data, provides some guidance in interpreting cause of death data and also provides information on ABS processes.

A Suicide Coding Review Working Group will undertake a review of current ABS and other Australian organisation's suicide coding practices. The review will include the ABS's interpretation of ICD10 suicide coding rules, coroner practices and constraints with regard to making a finding of suicide and how this relates to a statistical definition of suicide, and revision of suicide coding practices.

The Suicide Coding Review Working Group may make recommendations for consideration by the ABS with regard to these issues. However, the final responsibility and accountability for practices and data quality rests with the ABS. It is anticipated that the Working Group will undertake the review over a period of three to six months, and it should be completed by November/December 2007.

The Department of Health and Ageing will continue to work with both the Australian Bureau of Statistics and Australian Institute of Health and Welfare regarding data quality issues.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30-31 May 2007

Question: E07-310

OUTCOME 11: Mental Health

Topic: EXPANDING SUICIDE PREVENTION PROGRAMS

Written Question on Notice

Senator Allison asked:

Are there any Indigenous specific programs under this outcome?

Answer:

The National Suicide Prevention Strategy (NSPS) promotes suicide prevention activities across the Australian population, as well as for specific groups at risk of suicide and self harm, including Aboriginal and Torres Strait Islander peoples. The NSPS aims to reduce the incidence of suicide across the Australian population by supporting national and community suicide prevention activities.

The NSPS utilises advisory committees who provide regular input to and advice on the direction of Indigenous suicide prevention activities. These formal advisory committees include: the Indigenous Strategies Working Group, the National Advisory Council on Suicide Prevention and the Community and Expert Advisory Forum. Each of these advisory committees has Indigenous Australian representatives.

A range of suicide prevention projects were funded under the NSPS in late 2006. These projects provide support to people and groups at high risk of suicide, including Aboriginal and Torres Strait Islander people. A list of the projects specifically supporting Aboriginal and Torres Strait Islander people is attached.

In addition to the community based projects, there are several national activities that specifically support Aboriginal and Torres Strait Islander suicide prevention, including:

- A cultural adaptation of the Mental Health First Aid Manual is under development. The Manual aims to develop, in consultation with Aboriginal and Torres Strait Islander people, a culturally sensitive mental health literacy program, including early intervention for suicide prevention.

- An Aboriginal Suicide Prevention Capacity Building Forum was held in Alice Springs from 12-14 June 2007. The aims of this Forum were for participants to experience greater networking and information sharing amongst community-based organisations that are part of the NSPS or have a focus on suicide prevention.
- InVibe Magazine (aimed at Indigenous youth in juvenile justice and/or custodial settings, drop in centres and youth at risk organisations) is being funded to include culturally appropriate information about mental health, suicide prevention and well being.
- A culturally and clinically appropriate adaptation of the "What is…" range of metal health brochures is being developed.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 31 May 2007

Question: E07-311

OUTCOME 11: Mental Health

Topic: MENTAL HEALTH

Hansard Page: CA 84

Senator Allison asked:

Can a list be provided of those invited?

Answer:

Attendees	
Name	**Position and Organisation**
Sharon Appleyard	Assistant Secretary, Rural Health Branch Australian Government Department of Health and Ageing
Jan Bennett	Principal Adviser, Mental Health and Workforce Division Australian Government Department of Health and Ageing
Michael Bishop	President Services for Australian Rural and Remote Allied Health
Jennifer Bowers	Chief Executive Officer Centre for Rural and Remote Mental Health Queensland
Bill Buckingham	Consultant
Rosemary Calder	First Assistant Secretary, Mental Health and Workforce Division Australian Government Department of Health and Ageing
David Campbell	President Australian College of Rural and Remote Medicine
Kirsty Cheyne-Macpherson	Director, Mental Health Reform Branch Australian Government Department of Health and Ageing
Helen Connor	Executive Director Australian Mental Health Consumer Network

Attendees	
Name	**Position and Organisation**
Frank Deane	Professor Illawarra Institute for Mental Health
Mark Diamond	General Manager, Mental Health, Population and Public Health South Australian Department of Health
Ivan Frkovic	Manager, COAG Mental Health Implementation Team Queensland Health
Kate Gilbert	Director, Policy and Analysis Branch, Office of Aboriginal and Torres Strait Islander Health Australian Government Department of Health and Ageing
Des Graham	Director, Mental Health Services Tasmanian Department of Health and Human Services
Aaron Groves	Director of Mental Health Queensland Health
Bronwyn Hendry	Director, Mental Health Northern Territory Department of Health and Community Services
Ernest Hunter	Professor Queensland Health
Brian Jenner	Group Manager Ambulatory Care Latrobe Regional Hospital
Brian Kelly	Director NSW Centre for Rural and Remote Mental Health
Michelle Kennedy	Assistant Director, Mental Health Reform Branch Australian Government Department of Health and Ageing
Tim Lenten	Senior Lecturer, Mental Health Centre for Rural Mental Health
Bo Li	Senior Policy Adviser Australian Association of Occupational Therapists
Geri Malone	Executive Director Association for Australian Rural Nurses and Midwives

Attendees	
Name	**Position and Organisation**
Rod Mann	Service Planning and Development Unit Victorian Department of Human Services
Lee Martinez	Program Manager Mental Health South Australian Department of Health
Richard Menasse	Area Director, Mental Health West Australian Department of Health
Ian Munt	Rural Special Interest Group Royal Australian and New Zealand College of Psychiatrists
Carolyn Ngan	Senior Project Officer Mental Health West Australian Department of Health
Janine O'Dwyer	Assistant Director, Mental Health Reform Branch Australian Government Department of Health and Ageing
David Perkins	Director, Centre for Equity and Primary Health Research in the Illawarra and Shoalhaven
Jane Pirkis	Principal Research Fellow, Program Evaluation Unit, School of Population Health, University of Melbourne
Sebastian Rosenberg	Chief Operating Officer Mental Health Council of Australia
Kim Ryan	Executive Officer Australian College of Mental Health Nurses
Angelina Salamone	National Manager Educational Services Royal Australian College of General Practitioners
Steve Sant	Chief Executive Officer Rural Doctors' Association of Australia
Nathan Smyth	Assistant Secretary, Mental Health Reform Branch Australian Government Department of Health and Ageing
Elizabeth Sommerville	Mental Health Advisory Group Australian Association of Social Workers
Jackie Stephenson	National Health Program Manager Royal Flying Doctor Service of Australia
David Stokes	d) Manager Professional Issues

Attendees	
Name	**Position and Organisation**
	Australian Psychological Society
Allison Tryon	Acting Section Manager Personal Helpers and Mentors Program, Department of Families, Community Services and Indigenous Affairs
Andrew Waters	Manager Policy and Communications National Rural Health Alliance
Harvey Whiteford	Principal Medical Adviser (Mental Health), Mental Health Reform Branch Australian Government Department of Health and Ageing
Marshall Watson	Board Member Australian Indigenous Doctors' Association
Leanne Wells	Manager Policy and Development/Principal Adviser Mental Health Australian General Practice Network
Renee Williams	North East Victoria Division of General Practice
Robert Williams	Manager Mental Health Services Royal Flying Doctor Service of Australia

Invitees unable to attend	
Name	**Position and Organisation**
John Brayley	Director, Mental Health Department of Health South Australia
Kate Carnell	Chief Executive Officer Australian General Practice Network
Henry Councillor	Chairperson National Aboriginal Community Controlled Health Organisation
Karen Francis	President Australian Rural Nurses and Midwives
Julian Freidin	President Royal Australian and New Zealand College of Psychiatrists
Sally Goold	Executive Director Congress of Aboriginal and Torres Strait Islander Nurses

Invitees unable to attend	
Name	**Position and Organisation**
Fiona Judd	Director Centre for Rural Mental Health
David Kavanagh	University of Queensland
Lyn Littlefield	Executive Director Australian Psychological Society
Ross Maxwell	Rural Doctors' Association of Australia
David McGrath	Mental Health and Drug and Alcohol Programs NSW Health
Joy McLaughlan	Assistant Secretary, Policy and Analysis Branch, Office of Aboriginal and Torres Strait Islander Health Australian Government Department of Health and Ageing
Helen McMurtrie	Administrative Officer Australian Association of Occupational Therapists
John Mendoza	Chief Executive Officer Mental Health Council of Australia
Nigel Milan	National Executive Director Royal Flying Doctor Service Australia
Morton Rawlin	Director of Education Royal Australian College of General Practitioners
Peter Richardson	Executive Officer Australian Association of Social Workers
Mark Rooney	Executive Director, Office of Mental Health Department of Health West Australia
Ruth Vine	Director of Mental Health Department of Human Services Victoria
John Wakerman	Chairperson National Rural Health Alliance
Mark Wenitong	President Australian Indigenous Doctors' Association

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 31 May 2007

Question: E07 - 312

OUTCOME 11: Mental Health

Topic: INCREASED MENTAL HEALTH SERVICES FOR DROUGHT-AFFECTED COMMUNITIES

Hansard Page: CA 56

Senator Moore asked:

Would psychologists, occupational therapists and Indigenous health workers who have qualifications in counselling qualify for employment under this measure?

Answer:

This will be determined following further consultations with key stakeholders and taking account of workforce considerations.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30-31 May 2007

Question: E07-377

OUTCOME 11: Mental Health

Topic: MENTAL HEALTH

Hansard Page: CA 60

Senator Moore asked:

So where has the $2.705 million that has already been spent gone to.

Answer:

The table below provides information on expenditure for 2006-07 financial year by broad category of activity (as described below).

Category of Activity	**Amount (rounded)**
Launch	$10,200
Phase 1 information and awareness raising	$106,000
Multidisciplinary education and training	$678,200
Credentialing of professionals	$509,800
Quality Assurance/Improvement	$388,000
Allied mental health	$99,000
Rural initiatives	$859,600
Sponsorship	$39,400
Stakeholder Consultation	$6,000
Total	**$2,696,200**

Launch of the initiative
Funding to support the 9 October 2006 launch of the Better Access initiative and *Mental Health in Rural Remote Areas* initiative, including production of associated fact sheets and media kits.

Phase 1 information and awareness raising
Funding provided to professional organisations to produce initial resources to raise awareness and inform stakeholders about the Better Access initiative.

Multidisciplinary education and training
Development of a national multidisciplinary training package and a series of national information and orientation sessions that support GPs, psychiatrists, psychologists and other allied mental health professionals to access education and training regarding the multidisciplinary team-based approach to mental health care under the Better Access initiative.

Credentialing of professionals
Start-up funding to support the credentialing of clinical psychologists eligible to access new Medicare items under the Better Access initiative and to support the expansion of the Australian College of Mental Health Nurses Credentialing for Practice Program.

Quality Assurance and Improvement
Initiatives that support the provision of high quality education and training and professional practice for GPs, psychiatrists, psychologists and other allied mental health professionals, the largest component of which is for the development, monitoring and promotion of quality standards for GP education and training in primary mental health care.

Allied mental health
Support for allied mental health professionals to access advice on the requirements of the Australian Government Better Access initiative, and other primary mental health care initiatives, and to improve liaison and advice about issues of concern to allied mental health professionals.

Rural initiatives
Activities to raise awareness of the Better Access initiative (including a television broadcast and DVD) and to place a mental health academic (in the main psychologists) in each University Department of Rural Health to promote and support mental health in rural and remote Australia.

Sponsorship
Sponsorship of conferences/symposiums to raise awareness and support information dissemination amongst mental health professionals.

Stakeholder Consultation
Workshops and consultation with stakeholders that have occurred since the launch of the initiative.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30-31 May 2007

Question: E07-246

OUTCOME 11: Mental Health

Topic: YOUTH MENTAL HEALTH FOUNDATION - HEADSPACE

Written Questions on Notice

Senator Jan McLucas asked:

What processes are in place by the Foundation to engage with national and state youth groups to encourage their participation in the *headspace* initiative? What groups are involved?

Answer:

headspace has developed a national Youth Participation Strategy. They are currently in the process of engaging a project officer to co-ordinate both Youth and Carer participation strategies for *headspace*.

headspace youth services will bring together local GPs, mental health, drug and alcohol and vocational support services to provide holistic care to young people with mental health and drug and alcohol problems.

headspace are required to link with Australian Government youth mental health initiatives, including MindMatters, KidsMatters and the COAG *New Early Intervention Services for Parents, Children and Young People* Measure.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30-31 May 2007

Question: E07-247

OUTCOME 11: Mental Health

Topic: ATTENTION-DEFICIT HYPERACTIVITY DISORDER (ADHD) – ROYAL AUSTRALASIAN COLLEGE OF PHYSICIANS CLINICAL GUIDELINES REVIEW WORKING GROUP

Written Question on Notice

Senator McLucas asked:

Who is on the Royal College of Physicians committee for drawing up guidelines for ADHD?

Answer:

The membership of the committee will be published with the completed guidelines.

Several members have indicated they are concerned that public discussion of the membership at this stage of the review process may detract from the capacity of the committee to produce the best possible review. They have accordingly indicated that they do not wish to participate in the review should this discussion occur at this time. The Department is concerned that should members withdraw, the review of the guidelines will be seriously compromised through the loss of expertise.

It is important that reviews of this kind are undertaken by clinicians, researchers and other experts who are recognised for their expertise. It is common practice for these experts to provide their expertise to a range of committees including government and industry committees. It would be difficult to find anyone in the field who has not had some engagement with research and development relating to ADHD.

There are serious concerns that should members of the current committee withdraw their assistance it will not be possible to reconvene another group with such a high standard of academic and clinical expertise. There would then be a real possibility that the review of the guidelines could not be completed. While it is recognised that the membership of the committee is a matter of public interest, it is also true that a failure to complete the current review would be detrimental to the public interest.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30-31 May 2007

Question: E07-249

OUTCOME 11: Mental Health

Topic: ADHD – ROYAL AUSTRALASIAN COLLEGE OF PHYSICIANS CLINICAL GUIDELINES REVIEW – PROCESS FOR IDENTIFYING CONFLICTS OF INTEREST

Written Question on Notice

Senator McLucas asked:

What if any process was in place for identifying potential conflicts of interest of committee members?

Answer:

Under the Contract for Service with the Royal Australasian College of Physicians (RACP) the review of the ADHD Clinical Practice Guidelines is required to adhere to the National Health and Medical Research Council (NHMRC) *Standards and procedures for externally developed guidelines*. These standards include processes for identifying and managing potential conflicts of interest of committee members.

In addition, the RACP *Guidelines for ethical relationships between physicians and industry* includes specific guidelines for identifying and managing dualities and conflicts of interest. These include processes for the declaration of conflicts of interest, the consideration of these declarations by the committee and where necessary the management of conflicts of interest.

Management of this process is the responsibility of the RACP.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30-31 May 2007

Question: E07-253

OUTCOME 11: Mental Health

Topic: ADHD

Written Question on Notice

Senator McLucas asked:

When did the NHMRC actually receive that funding (not when it was agreed upon – when did they actually receive it?)

Answer:

The National Health and Medical Research Council (NHMRC) has not received any funding with regards to the current review of the ADHD Clinical Practice Guidelines.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30-31 May 2007

Question: E07-198

OUTCOME 11: Mental Health

Topic: EARLY INTERVENTION - PROFESSOR BEVERLY RAPHAEL

Written Question on Notice

Senator McLucas asked:

Has the department reached an agreement with Professor Beverly Raphael to scope need around a possible trauma, loss and grief network?

Answer:

Yes, the Department has a funding agreement with Professor Beverly Raphael.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30-31 May 2007

Question: E07-199

OUTCOME 11: Mental Health

Topic: EARLY INTERVENTION – PROFESSOR BEVERLY RAPHAEL

Written Question on Notice

Senator Jan McLucas asked:

a) How much funding is allocated to this agreement?
b) What will it provide?

Answer:

a) $75,000 was allocated for this agreement.
b) The project involved consultation with Australian experts and provided research for the possible establishment of an Australian Trauma, Loss and Grief Network. A survey involving experts from across Australia and a focus group informed recommendations. A final report from the consultation has been received and is currently being reviewed by the Department.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30-31 May 2007

Question: E07-200

OUTCOME 11: Mental Health

Topic: SUICIDE PREVENTION

Written Question on Notice

Senator McLucas asked:

What is the progress of the two research projects under this initiative?

Answer:

The Department is supporting two research activities, which focus on self harm. These studies will provide a greater understanding of factors that lead to deliberate self-injury and suicide in the community including potential opportunities for intervention. The resulting increased knowledge base will provide a firm basis for the development of appropriately targeted and effective prevention, early intervention and clinical management programs.

Both research projects are commencing in June 2007 and will be completed in June 2008.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30-31 May 2007

Question: E07-201

OUTCOME 11: Mental Health

Topic: SUICIDE PREVENTION

Written Question on Notice

Senator McLucas asked:

How much funding was allocated to each project?

Answer:

Case control studies of suicide and attempted suicide

The total amount of funding that the Department will contribute to the University of Sydney for this study is $200,000 (GST excl).

Epidemiological study of deliberate self injury in the Australian community

The total amount of funding that the Department will contribute to the University of Queensland for this study is $449,105 (GST excl).

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30-31 May 2007

Question: E07-202

OUTCOME 11: Mental Health

Topic: SUICIDE PREVENTION

Written Question on Notice

Senator McLucas asked:

Did this project consider any at-risk groups specifically?

Answer:

Case control studies of suicide and attempted suicide

Yes. The target population for this study is young adults aged 18-34 years from lower socio-economic groups and regional and remote areas in New South Wales.

Epidemiological study of deliberate self injury in the Australian community

This study will target people of all ages in the Australian population. A significant component of this research includes determining the prevalence and nature of deliberate self-injury among Aboriginal and Torres Strait Islander people and rural and remote populations. These particular groups are at higher risk of deliberate self-injury and suicide.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30-31 May 2007

Question: E07-203

OUTCOME 11: Mental Health

Topic: Better Access Program

Written Question on Notice

Senator McLucas asked:

Please provide data on take-up of the new MBS items by RRMA, or urban/rural area.

Answer:

Statistics on uptake of individual Medicare items, including the Better Access mental health care items, are not published by RRMA classification.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30-31 May 2007

Question: E07-204

OUTCOME 11: Mental health

Topic: BETTER ACCESS PROGRAM

Written Question on Notice

Senator McLucas asked:

If not possible by RRMA, what measurement tools does the department have to compare take-up in rural versus metro areas?

Answer:

The Department monitors the uptake of the Better Access Medicare items from a range of aspects including location of service, however this information is not publicly available.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30-31 May 2007

Question: E07-205

OUTCOME 11: Mental Health

Topic: BETTER ACCESS

Written Question on Notice

Senator McLucas asked:

Under the provisions of this package, a GP can refer a patient to a psychologist – but what does the GP do if there is no psychologist available?

Answer:

The *Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule* (Better Access) initiative enables patients to be referred to psychologists and other allied mental health providers, but is not predicated on the basis that all patients will be referred to such providers.

Under Better Access patients with an assessed mental disorder are able to access Medicare items for psychological therapy (provided by clinical psychologists) and focussed psychological strategies services (provided by appropriately registered general psychologists, occupational therapists and social workers) where the patient is being managed by a GP under a GP Mental Health Care Plan and/or a psychiatrist assessment and management plan; or is referred by a psychiatrist or a paediatrician.

Focussed psychological strategies services may also be provided by a medical practitioner who is registered with Medicare Australia as having satisfied the requirements for higher level mental health skills for the provision of the service. These GP Medicare items were introduced as a component of the *Better Outcomes in Mental Health Care Program* (BOiMHC), which existed prior to the introduction of the Better Access Medicare items on 1 November 2006.

GPs can also choose to refer a patient to a private psychiatrist for Medicare rebateable services or to state/territory managed specialised mental health services. Where appropriate, patients may also be managed in general practice using the GP Mental Health Care Plan, care plan review and consultation items.

In addition to the Better Access Medicare items, other initiatives are supporting improved access to allied mental health services including psychologist services. Through the BOiMHC program Divisions of General Practice act as fund holders for the Access to Allied Psychological Services component, which funds focussed psychological strategies for patients referred by general practitioners.

Under the COAG *Mental Health Services in Rural and Remote areas* initiative funding will be provided for more allied and mental health nursing services in rural and remote communities, including those provided by social workers, psychologists, mental health nurses, occupational therapists, Aboriginal health workers and Aboriginal mental health workers.

Other programs that support mental health care in rural and remote areas include *More Access to Allied Health Services* and the *Medical Specialist Outreach Assistance Program.*

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30-31 May 2007

Question: E07-206

OUTCOME 11: Mental Health

Topic: BETTER ACCESS INITIATIVE

Written Question on Notice

Senator McLucas asked:

Does the department have data on waiting times between a GP referral for specialist mental health treatment and the actual appointment? If not, what system is in place that ensures this initiative is ensuring people with a mental health problem are seen in a timely fashion?

Answer:

The Department does not collect data on waiting times from GP referral to first appointment, for psychological therapy or focussed psychological strategies services under the Better Access initiative.

The Better Access initiative has increased community access to mental health care for people experiencing mental disorders, with almost 750,000 mental health services having been claimed under new Medicare items from November 2006 to April 2007.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30-31 May 2007

Question: E07-207

OUTCOME 11: Mental Health

Topic: BETTER ACCESS INITIATIVE

Written Question on Notice

Senator McLucas asked:

What is the Government currently doing to ensure the availability of psychologists? For example, in many country areas there are stories of people waiting between six weeks and three months for an appointment with a psychologist.

Answer:

The implementation of the Better Access initiative has helped promote increased psychologist availability, with growing registered provider numbers since the inception of the measure. In the first seven months (November 2006 to May 2007) of the initiative 1,654 clinical psychologists have registered to provide 'Psychological Therapy' items; and 7,761 general psychologists have registered to provide Focused Psychological Strategies items.

As with the health workforce generally, there are problems with both the supply and distribution of the mental health workforce, including psychologists, and this impacts on waiting times.

The Australian Government is increasing access to clinical psychologists through the Mental Health Postgraduate Scholarship Scheme (MHPSS) and the *Additional education places, scholarships and clinical training in mental health initiative*.

The MHPSS is part of the *Better Mental Health Services for Australia - Additional Education Places, Scholarships and Clinical Training in Mental Health* Council of Australian Governments (COAG) Mental Health package announced in the May 2006 Budget. A total of 75 full time equivalent scholarships, covering mental health nursing and clinical psychology, worth $10,000 per annum for full time study are being offered this year (part time students will receive $5,000 pa).

The *Additional education places, scholarships and clinical training in mental health initiative* provided $103.5 million over five years to support additional higher education places in clinical psychology and mental health nursing. This measure is now in place, and will provide 210 additional clinical psychology places each year. It is anticipated that the cumulative effect of this measure will provide an additional 1,200 clinical psychologists by the end of 2011.

The Better Access initiative Medicare items are complemented by a range of separate Australian Government initiatives which fall under various initiatives. The *Mental Health Services in Rural and Remote areas* initiative, will provide more allied and mental health nursing services in rural and remote communities including those provided by social workers, psychologists, mental health nurses, occupational therapists, Aboriginal health workers and Aboriginal mental health workers.

The Australian Government is also supporting improved access to allied mental health services, through the Access to Allied Psychological Services component of Better Outcomes in Mental Health Care Program, including services for people living in rural and remote areas.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30-31 May 2007

Question: E07-211

OUTCOME 11: Mental Health

Topic: EXPANDING SUICIDE PREVENTION PROGRAMS

Written Question on Notice

Senator McLucas asked:

Is the Department/Minister aware of reports and evidence suggesting that data on suicide provided by the Bureau of Statistics is not completely accurate? In terms of your suicide strategy, what methods of data collection is the Government using?

Answer:

The *External Causes of Death Statistics 2005* was released by the Australian Bureau of Statistics (ABS) in March 2007.

The Department is aware that there have been suggestions and evidence that data on suicide provided by the ABS is not accurate.

An information paper was released by the ABS on 11 April 2007 regarding external causes of death (Information Paper, External Causes of Death, Data Quality, 2005 (cat. no. 3317.0.55.001)). This paper has been written as a response to concerns raised by users of ABS Causes of Death data, particularly users of suicide data. The Information Paper attempts to explain some issues that users of ABS data should take into account when comparing ABS data to other data, provides some guidance in interpreting cause of death data and also provides information on ABS processes.

The ABS suggest that it is more useful to look at long term trends rather than focus on changes from year to year. Fluctuations in data from year to year occur for a number of reasons including the extent to which deaths are registered in the years they occurred, delays in finalising coronial processes and the differences in coronial reporting from one jurisdiction to another, and actual fluctuations in number of deaths from external causes.

The ABS is undertaking a number of initiatives to address the data quality issues in relation to causes of death. This involves a collaborative effort with the Registrar of Births, Deaths and Marriages, coroners and the National Coronial Information System (NCIS), and includes a review of mortality processing and coding practices, increasing the availability of metadata, and a review of outputs including release dates.

The department has had discussions with both the Australia Bureau of Statistics and Australian Institute of Health and Welfare regarding data quality issues and a number of projects are being considered that both address the issue of improving the quality of the data and to determine what data is missing.

The Australian Government relies upon data on suicide statistics provided by the ABS and does not currently use other methods of data collection.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30-31 May 2007

Question: E07-212

OUTCOME 11: Mental Health

Topic: EXPANDING SUICIDE PREVENTION PROGRAMS

Written Question on Notice

Senator McLucas asked:

According to the ABS, suicide rates in Australia are declining – is this the Government's view or will you investigate other methods of collecting more accurate data?

Answer:

According to the Australian Bureau of Statistics (ABS), there were 2,101 suicides registered in 2005, representing an age standardised death rate of 10.3 per 100,000.

The figures are very similar to those of 2004, continuing a lower trend, and well below the figures of 1997, when there were 14.7 deaths per 100,000 and the highest recorded number of suicides with 2,720 suicide deaths registered.

Based on these statistics, it can be concluded that suicide rates in Australia have steadily declined in the last ten years since 1997. However, caution is needed in the interpretation of the data due to issues of data quality.

The Department has had discussions with both the ABS and Australian Institute of Health and Welfare regarding data quality issues and a number of projects are being considered that both address the issue of improving the quality of the data and to determine what data is missing.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30-31 May 2007

Question: E07-213

OUTCOME 11 : Mental Health

Topic: EXPANDING SUICIDE PREVENTION PROGRAMS

Written Question on Notice

Senator McLucas asked:

What rate or level of suicide is this Programme aimed at reducing current levels to?

Answer:

The National Suicide Prevention Strategy is not aimed at reducing the current suicide rates or levels to a specific target.

The Australian Bureau of Statistics (ABS) suggest that it is more useful to look at long term trends rather than focus on changes from year to year. Fluctuations in data from year to year occur for a number of reasons including the extent to which deaths are registered in the years they occurred, delays in finalising coronial processes and the differences in coronial reporting from one jurisdiction to another, and actual fluctuations in number of deaths from external causes.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30-31 May 2007

Question: E07-214

OUTCOME 11 : Mental Health

Topic: Expanding Suicide Prevention Programs

Written Question on Notice

Senator McLucas asked:

What is the accountability framework for this program? What measures are in place – e.g. a drop in ABS suicide data; a total reduction in suicides; or are there benchmarks by age-group or geographic location or by type of employment?

Answer:

The performance indicator listed for the National Suicide Prevention Strategy in the Portfolio Budget Statement for 2006-07 is as follows:

- Number and evaluation of national and community-based projects funded under National Suicide Prevention Strategy - Seventy per cent of community projects evaluated with positive outcomes.

An evaluation framework for the National Suicide Prevention Strategy is currently being developed to define how appropriateness, effectiveness and efficiency of the Strategy will be measured. The evaluation framework, which will be consistent with the COAG Mental Health Monitoring Framework, will address a range of requirements including:

- approach or clear map for the conduct of evaluations, either on an individual program basis or cluster of programs;
- methods to be used for evaluation;
- information relevant to programs that may be subject to evaluation under the framework;
- timing for undertaking evaluations; and
- standards for assessing the quality of evaluation activities.

The evaluation framework is to be completed in July 2007.

There is a requirement for all community-based suicide prevention projects to work in conjunction with an external evaluator to ensure that performance indicators (specified in the funding agreements) are collected and collated. These performance indicators are based on the COAG Mental Health Monitoring Framework.

The Australian Bureau of Statistics suggest that it is more useful to look at long term trends rather than focus on changes from year to year. Fluctuations in data from year to year occur for a number of reasons including the extent to which deaths are registered in the years they occurred, delays in finalising coronial processes and the differences in coronial reporting from one jurisdiction to another, and actual fluctuations in number of deaths from external causes.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30-31 May 2007

Question: E07-215

OUTCOME 11: Mental Health

Topic: EXPANDING SUICIDE PREVENTION PROGRAMS

Written Question on Notice

Senator McLucas asked:

Indigenous suicide, by contrast to the rest of Australia, is increasing dramatically. What programmes have been initiated specifically addressing Aboriginal and Torres Strait Islander suicide?

Answer:

The *National Suicide Prevention Strategy* (administered by Outcome 11 – Mental Health) includes a focus on Indigenous Suicide Prevention.

A round of suicide prevention projects was funded in October 2006. These projects provide support to people and groups at high risk of suicide, including Aboriginal and Torres Strait Islander people. To this end, currently 12 (out of 46) community-based suicide prevention projects have been funded, which respond to specific Indigenous regional needs, at a value of $4.4 million over three years. Details of the 12 projects are at Attachment A.

Additional Indigenous suicide prevention projects that commenced in 2006-07 include:

Mount Theo/Yuendumu Substance Misuse Program
Funding of $625,000 over three years is being provided under a Shared Responsibility Agreement to promote mental health and wellbeing, protect against substance misuse and support Aboriginal young people to build resilience.

Tiwi Islands

Funding of $60,000 in 2006-07 is being provided under a Shared Responsibility Agreement to support the Tiwi Islands Youth Diversion/Development Unit to offer a range of interventions and support services designed to promote social wellbeing and youth development in communities on the Tiwi Islands. These initiatives will promote enhanced community engagement and individual participation in a range of activities, including education, life and job skills training, family mediation and counselling, substance abuse awareness, the transmission of Tiwi cultural knowledge and skills, community service activities and sport/recreation.

InVibe Magazine

Funding of $112,780 is being provided over three years for five issues of the InVibe magazine. The magazine is targeted at Indigenous youth in juvenile justice and/or custodial settings, drop in centres and youth at risk organisations. Funding is being provided to ensure that the magazine includes culturally appropriate information about mental health, suicide prevention and well being.

Redevelopment of Indigenous Suicide Prevention Resources

Funding of $55,000 is being provided for the development of culturally and clinically appropriate Indigenous suicide prevention resources. Resources will be based on the recently revised "What is…" brochures. This project will commence in June 2007 and is expected to be completed in December 2007.

Mental Health First Aid

A cultural adaptation of the Mental Health First Aid Manual is being developed. This manual aims to develop, in consultation with Aboriginal and Torres Strait Islander people, a culturally sensitive mental health literacy program, including early intervention for suicide prevention.

Aboriginal Suicide Prevention Capacity Building Forum

An Aboriginal Suicide Prevention Capacity Building Forum was held in Alice Springs from 12-14 June 2007. The aims of this Forum are for participants to experience greater networking and information sharing amongst community-based organisations that are part of the National Suicide Prevention Strategy or have a focus on suicide prevention. This will assist to build the capacity of these organisations to implement suicide prevention projects effectively.

Attachment A

Twelve community-based Indigenous suicide prevention projects

South Coast Medical Service Aboriginal Corporation (NSW)
Funding amount: $620,000
Koori Kids Wellbeing Program Shoalhaven
This project aims to implement an educational program designed for young Aboriginal children, (3–13yrs) in Southern NSW and provide support for children with existing emotional and behavioural problems.

Men's Health Information and Resource Centre, University of Western Sydney (NSW)
Funding amount: $460,000
Networks of Support: building individual, family resilience and community capacity in Western Sydney
A project to facilitate men, both young and old within the Mt. Druitt area of NSW, to gain access to appropriate mental health information and services and in particular to support those from the Aboriginal community.

Lifeline Newcastle and Hunter (NSW)
Funding amount: $720,000
Comprehensive Suicide Prevention Service (CSPS)
A regionally targeted project that aims to develop a comprehensive Suicide Prevention Service to educate, advise and support those high risk groups within the community.

Murrumbidgee Division of General Practice Ltd (NSW)
Funding amount: $43,000
Life Matters for Koori Youth in the Western Riverina
This project between the Murrumbidgee Division of General Practice and the Griffith Aboriginal Medical Service aims to address Indigenous youth intentional self harming and suicidal behaviour within communities of the Western Riverina NSW.

Waltja Tjutangku Palyapayi Aboriginal Corporation (NT)
Funding amount: $480,000
We Know Our Strength
This project aims to support three remote Central Australian Aboriginal communities to identify and reinforce their resilience, capacity, knowledge and strengths, and also to provide them with comprehensive information about suicide prevention.

Ngaanyatjarra Pitjantjatjara Yankunytjatjara Women's Council Aboriginal Corporation (NT)
Funding amount: $32,000
Speaking Up About Mental Health
This project will enable the development of a series of radio conversations around mental health issues- to be broadcast through the Anangu Pitjantjatjara Yankunytjatjara (SA) lands, southern NT and the Ngaanyatjarra Shire (WA).

Centre for Rural and Remote Mental Health Queensland Ltd (Qld)
Funding amount: $1,500,000
Learning from the experts: Building bridges to implement successful life promotion and suicide prevention expertise across Aboriginal communities.
A suicide prevention and education project targeting Aboriginal communities in Far North and South West Queensland.

Wesley Mission Brisbane (Qld)
Funding amount: $33,000
Ngali Jarjum Byun - "we, children, today…" Cross-cultural awareness and life skills program
Aimed at young people aged 13-17 in the Gold Coast and Beenleigh area, who are engaging in self-harming behaviours or who have expressed suicidal ideations, this project aims to implement a preventative and early intervention program.

Queensland Police-Citizens Youth Welfare Association (Qld)
Funding amount: $49,000
Something Better
The 'Something Better' project aims to assist and support young Indigenous people in the Aboriginal community of Wujal Wujal Queensland, that are at risk of suicide by providing them with exposure to sporting activities outside of their community.

Centacare Catholic Family Services - Port Pirie Diocese (SA)
Funding amount: $350,000
Sustainable Personal Development for Aboriginal Men
This project aims to build resilience and community capacity within Aboriginal communities for men aged 15 to 45.

Centrecare Incorporated (Goldfields–Esperance, WA)
Funding Amount: $50,000
Mirritjunka wanti: Millen Street Project
This project is designed to increase involvement of local Aboriginal young people and their families in "no more deaths for Aboriginal youth" by developing relevant and culturally secure resources to raise awareness.

Women's Health Care Association (WA)
Funding Amount: $50,000
Nangar Warloo 'The Sun is Returning'
This project will address issues of prevention and postvention – *interventions after a suicide in support for bereaved family and friends* – of suicide and self harm within the Indigenous community by extending the existing Aboriginal Grandparents Family Support Program – the Nangar Warloo (The Sun is Returning).

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30-31 May 2007

Question: E07-216

OUTCOME 11: Mental Health

Topic: EXPANDING SUICIDE PREVENTION PROGRAMS

Written Question on Notice

Senator McLucas asked:

Given that internet and fixed line phone access is not available in many remote and indigenous communities, what anti-suicide measures are specially in place that are not reliant on technology to deliver them?

Answer:

A range of initiatives are being implemented to provide mental health and suicide prevention programs in rural and remote parts of Australia.

Under the National Suicide Prevention Strategy community projects, more than $8 million in funding is being provided over the next three years for 17 projects that specifically target suicide prevention in rural and remote communities. Twelve community-based suicide prevention projects have been funded which respond to specific Indigenous regional needs, at a value of $4.4 million over three years.

To raise awareness and understanding about the warning signs of suicide, 'Helping Someone at Risk of Suicide' is a brochure that has been developed specifically to target people in rural areas. The brochure is being distributed by the Australian Government Drought Buses, the Australian General Practice Network, the National Rural Health Alliance and the Rural Financial Counselling Service.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30-31 May 2007

Question: E07-217

OUTCOME 11: Mental Health

Topic: TELEPHONE COUNSELLING

Written Question on Notice

Senator McLucas asked:

What is the accountability framework for this Programme?

Answer:

To ensure that key accountability mechanisms of the COAG measures are in place, a Monitoring Subgroup of the COAG Implementation IDC has been convened. This comprises representatives of four portfolio areas responsible for implementation of the Australian Government initiatives. The monitoring subgroup has developed an Australian Government Monitoring Framework to enable internal monitoring of activity at the Australian Government level.

In terms of this specific Program, the accountability framework, which is being developed, is based on individual contractual requirements, progress reporting and key information requirements. These information requirements will be included in the Monitoring Framework for the Australian Government COAG Initiatives and will report on four key areas:

- Information about level and type of services provided;
- Information about providers of services;
- Information about client recipients of services; and
- Information about funding allocations expenditure.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30-31 May 2007

Question: E07-218

OUTCOME 11: Mental Health

Topic: TELEPHONE COUNSELLING

Written Question on Notice

Senator Jan McLucas asked:

What are the performance measures, eg number of internet 'hits' or incoming telephone calls?

Answer:

Performance measures are being developed in cooperation with states and territories to monitor the implementation and outcomes of the COAG Mental Health Initiatives funded under the 2006-07 Budget. Specifically under this initiative, key information requirements are also being developed. These information requirements will be included in the Monitoring Framework for the Australian Government COAG Initiatives and will report on four key areas:

- Information about level and type of services provided, including number of programs developed, number of internet 'hits' or number of calls made to telephone services;
- Information about providers of services;
- Information about client recipients of services, including area of residence, age and sex and clinical problem and severity; and
- Information about funding allocations expenditure by service type.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30-31 May 2007

Question: E07-219

OUTCOME 11: Mental Health

Topic: TELEPHONE COUNSELLING

Written Question on Notice

Senator McLucas asked:

With communications services in regional areas known to be problematic, has the department come to an arrangement with Telstra to ensure that areas identified as 'at risk' (indigenous communities, farming communities affected by the drought etc) receive priority repair and maintenance service similar to that which Telstra provide to customers with a life-threatening condition?

Answer:

The Department of Health and Ageing has no arrangement with Telstra for communities to have priority repair. This provider does not have an arrangement in place to provide priority service to those affected by mental illness.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30-31 May 2007

Question: E07-195

OUTCOME 11: Mental Health

Topic: FUNDING AND EXPENDITURE

Written Question on Notice

Senator McLucas asked:

Please provide a consolidated list of funding and expenditure on the measures of the COAG mental health package which DOHA is responsible for, which includes:

a) original budget allocations for each measure
b) additional allocations that have been made to any measures since the original allocations were made (such as the addition of the drought initiative to the Rural and Remote Areas measure in this year's budget), and the adjusted allocations for these measures as a result of additional allocations
c) anticipated expenditure against each measure for the 2006-07 financial year
d) anticipated expenditure against each measure for the 2007-08 financial year (incorporating the information provided by Departmental officers during the hearing)
e) where there are differences, explanations as to why there are differences between anticipated expenditure and original allocations
f) where there are anticipated under-spends, an explanation of where the unspent funding will be rephrased to (financial year and measure if different)

Answer:

Requested financial information on measures the Department of Health and Ageing has responsibility for implementing is presented in table format at Attachment A.

Given the number of elements of the *Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule* measure, detailed information is provided at Attachment B rather than included in the table at Attachment A.

BUDGET ESTIMATES - COAG MENTAL HEALTH - E07 195

Attachment A

COAG Mental Health Measure	**Budget Allocations $m 2006/07 to 2010/11**	**Additional Allocations $m 2006/07 to 2010/11**	**Expenditure 2006-07**	**Anticipated Expend 2007-08**	**Original Allocation - Actual Expend - Comment**	**Under-spends - rephase - year and/or measure**
Expanding **Suicide Prevention** programmes (*Note, this only represents the funding provided to expand the National Suicide Prevention Strategy program, and does not reflect the total funding under the Strategy)*	62.375	Nil	$10,281,000	$10,850,000	0	There are no significant underspends anticipated for the 2006-2007 financial year.
Improving the capacity of Health Workers in **Indigenous Communities**	20.8	Nil	$1,330,298	$5,835,000	$1,516,000 in the 2006-07 financial year.	Underspend of $185,701 for the 2006-2007 financial year.
Telephone counselling, self-help and web-based support programmes	56.93	Nil	$7,021,000	$11,938,000	0	There are no significant underspends anticipated for the 2006-2007 financial year.

Alerting the community to links between **Iliicit Drugs and Mental** illness	18.6 (over 4 years)	Nil	$405,697	$8,117,000	Tender processes to contract specialist communication production services will now occur in 2007/08 due to the complexity of the campaign and the number of stakeholders involved in the consultation process.	Underspends in 2006-2007 will be rephased to 2007-2008 under the same budget measure.There are no significant underspends anticipated for the 2006-2007 financial year.
Mental Health in **Tertiary Curricula**	5.595	Nil	$1,256,000	$1,161,000	0	There are no significant underspends anticipated for the 2006-2007 financial year.
Improved services for people with **drug and alcohol problems** and mental illness	79.9	Nil	$0	$16,304,000	0	There are no significant underspends anticipated for the 2006-2007 financial year.
Increased funding for the **Mental Health Council of Australia**	1.04	Nil	$200,000	$204,200 (includes indexation)	0	There are no significant underspends anticipated for the 2006-2007 financial year.
New early intervention services for **Parents, Children and Young** people	28.135	Nil	$1,897,000	$2,546,000	0	There are no significant underspends anticipated for the 2006-2007 financial year.
Mental Health services in **rural and remote** areas	51.679	20.6 *(Note, this is a reallocation from the education and training component of the Better Access measure)*	$5,354,000	$14,363,000	0	There are no significant underspends anticipated for the 2006-2007 financial year.

Better access to psychiatrists, psychologists and GPs through the MBS	538	-30.7	*Attachment B refers*	*Attachment B refers*	*Attachment B refers*	*Attachment B refers*
Additional education places, scholarships and clinical training in mental health	103.5 (total) of which 31.5 sits with DoHA comprised of: 18.0 Psychiatrist Training - 11.6 Scholarships, - 1.9 Medical Support . The remainder sits with DEST. The following information reports on DoHA's component only.	Nil	$3,124,513	$6,302,000	A number of components have phased implementation, with some funding agreements/contracts yet to be put in place	There are no significant underspends anticipated for the 2006-2007 financial year.
Support for **Day-to-Day** living in the community	45.963	Nil	$5,384,000	$9,629,000	0	There are no significant underspends anticipated for the 2006-2007 financial year.
New funding for **Mental Health Nurses**	191.6	Nil	$2,063,000 (Departmental only)	$24,041,000	0	There are no significant underspends anticipated for the 2006-2007 financial year.
Mental Health Support for **Drought-affected Communities**	Nil	10.1 over 2 years *(Note, this is a reallocation from the education and training component of the Better Access measure)*	$0	$5,000,000	0	N/A as no funding provided in 2006/2007

Attachment B

Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule

In relation to the *Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule* measure:

a) The 2006-07 Budget allocated $538 million to the Better Access initiative over the five year period to 2010-11. This consists of four main funding elements:
   - ***Medicare Benefits Schedule (MBS)* -** The largest of these elements, at *$410.7 million***,** covers the estimated costs associated with the new MBS items for general practitioners, psychiatrists, clinical psychologists and other allied mental health professionals. Medicare rebates for these items are funded within the Medicare Benefits special appropriation on a demand-driven basis.
   - ***Pharmaceutical Benefits Scheme (PBS)*** - As a proportion of the new MBS items will result in prescriptions for patients who are newly diagnosed with a mental disorder as a result of the Better Access initiative, *$31.8 million* was allocated for the impact of these new items on the PBS.
   - ***Department of Health and Ageing and Medicare Australia* -** To enable management and administration of the initiative, *$10.8 million* was allocated to the Department and Medicare Australia.
   - ***Mental Health Education and Training* -** To ensure that the primary and specialist mental health workforces are equipped to recognise and treat mental illness **$***84.7 million* was allocated for mental health education and training.

2006-07 Budget - Better Access education and training component

2006-07	2007-08
$10.7 m	$16.6 m

Note: The 2006-07 PBS includes a line for Outcome 5 that shows the funding for education and training over four years, to 2009-10 (i.e. total of $64 million).

b) The 2007-08 Budget included $30.7 million to improve the delivery of mental health support and services to drought-affected rural and remote communities. This funding was reallocated from the education and training component of the Better Access initiative, to help promote better access to psychological services for all Australians, including those in rural and remote areas. The objectives of the education and training measure can be met with the remaining $54 million in funding.

   The $30.7 million includes $10.1 million over two years for the *Mental Health Support for Drought-Affected Communities* measure. The remaining $20.6 million will be allocated to boost the existing *Mental Health Services in Rural and Remote Areas* initiative. This initiative now carries funding of $72.3 million over four years (up from the $51.7 million initially allocated to the measure in the 2006-07 Budget).

2007-08 Budget - Better Access education and training component (adjusted allocation)

2006-07	2007-08
$2.7 m	$8.6 m

c) It is anticipated that $2.705 million will be spent in 2006-07 for the education and training component of the Better Access initiative.

Actual expenditure on Medicare benefits for Better Access items for the period 1 November 2006 to 30 April 2007 (most recent figures available) was $79.7 million (this includes benefits paid for psychiatry items 291 and 293, which existed prior to the Better Access initiative but rebates for these items were increased significantly with the introduction of the Better Access initiative on 1 November 2006).

The Medicare items associated with the Better Access initiative are demand-driven services that are funded within the Medicare special appropriation. Anticipated expenditure for these services and their impact on the PBS is not published on an individual item basis. Expenditure on Medicare rebates does not compare directly to the Better Access Budget allocation for these services, as the Budget allocation represents the net additional cost of the Medicare items, taking into account the effect of offsetting savings and flow-on costs associated with the items.

d) It is anticipated that $8.6 million will be spent in 2007-08 for the education and training component of the Better Access initiative.

Anticipated expenditure for Better Access Medicare items is not published on an individual item basis (refer to answer c) above).

e) $84.7 million was initially allocated to the education and training component of the Better Access initiative. An education and training framework to guide implementation of activities under this component has now been developed in consultation with the professions and was approved on 15 February 2007 by the then Parliamentary Secretary to the Minister for Health and Ageing, the Hon Christopher Pyne MP. The Department is confident that an amount of $54 million over four years will be sufficient to implement this framework. This will in no way compromise the ability of the Better Access measure to provide patient access to mental health services.

f) $8 million from the 2006-07 Better Access budget has been re-phased across the next four years from 2007-08 to the *Increased mental health services for drought affected communities* measure, as that is when the new measure to assist people in drought affected areas commences.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 31 May 2007

Question: E07-303

OUTCOME 11: Mental Health

Topic: FUNDING AND EXPENDITURE

Hansard Page: CA 54

Senator Moore asked:

We will go through these because I think it would be useful to have explanations across a few of them. Do you have a graph or some other format you can give me all this information in?

Answer:

Yes, the requested financial information on measures the Department of Health and Ageing has responsibility for implementing is presented in table format at Attachment A.

BUDGET ESTIMATES - COAG MENTAL HEALTH - E07 195

Attachment A

COAG Mental Health Measure	Budget Allocations $m 2006/07 to 2010/11	Additional Allocations $m 2006/07 to 2010/11	Expenditure 2006-07	Anticipated Expend 2007-08	Original Allocation - Actual Expend - Comment	Under-spends - rephase - year and/or measure
Expanding **Suicide Prevention** programmes *(Note, this only represents the funding provided to expand the National Suicide Prevention Strategy program, and does not reflect the total funding under the Strategy)*	62.375	Nil	$10,281,000	$10,850,000	0	There are no significant underspends anticipated for the 2006-2007 financial year.
Improving the capacity of Health Workers in **Indigenous Communities**	20.8	Nil	$1,330,298	$5,835,000	$1,516,000 in the 2006-07 financial year.	Underspend of $185,701 for the 2006-2007 financial year.
Telephone counselling, self-help and web-based support programmes	56.93	Nil	$7,021,000	$11,938,000	0	There are no significant underspends anticipated for the 2006-2007 financial year.
Alerting the community to links between **Illicit Drugs and Mental** illness	18.6 (over 4 years)	Nil	$405,697	$8,117,000	Tender processes to contract specialist communication production services will now occur in 2007/08 due to the complexity of the campaign and the number of stakeholders involved in the consultation process.	Underspends in 2006-2007 will be rephased to 2007-2008 under the same budget measure.There are no significant underspends anticipated for the 2006-2007 financial year.
Mental Health in **Tertiary Curricula**	5.595	Nil	$1,256,000	$1,161,000	0	There are no significant underspends anticipated for the 2006-2007 financial year.

Improved services for people with **drug and alcohol problems** and mental illness	79.9	Nil	$0	$16,304,000	0	There are no significant underspends anticipated for the 2006-2007 financial year.
Increased funding for the **Mental Health Council of Australia**	1.04	Nil	$200,000	$204,200 (includes indexation)	0	There are no significant underspends anticipated for the 2006-2007 financial year.
New early intervention services for **Parents, Children and Young** people	28.135	Nil	$1,897,000	$2,546,000	0	There are no significant underspends anticipated for the 2006-2007 financial year.
Mental Health services in **rural and remote** areas	51.679	20.6 *(Note, this is a reallocation from the education and training component of the Better Access measure)*	$5,354,000	$14,363,000	0	There are no significant underspends anticipated for the 2006-2007 financial year.
Better access to psychiatrists, psychologists and GPs through the MBS	538	-30.7	*Attachment B refers*	*Attachment B refers*	*Attachment B refers*	*Attachment B refers*
Additional education places, scholarships and clinical training in mental health	103.5 (total) of which 31.5 sits with DoHA comprised of: 18.0 Psychiatrist Training - 11.6 Scholarships, - 1.9 Medical Support . The remainder sits with DEST. The following information reports on DoHA's component only.	Nil	$3,124,513	$6,302,000	A number of components have phased implementation, with some funding agreements/contracts yet to be put in place	There are no significant underspends anticipated for the 2006-2007 financial year.

Support for **Day-to-Day** living in the community	45.963	Nil	$5,384,000	$9,629,000	0	There are no significant underspends anticipated for the 2006-2007 financial year.
New funding for **Mental Health Nurses**	191.6	Nil	$2,063,000 (Departmental only)	$24,041,000	0	There are no significant underspends anticipated for the 2006-2007 financial year.
Mental Health Support for **Drought-affected Communities**	Nil	10.1 over 2 years *(Note, this is a reallocation from the education and training component of the Better Access measure)*	$0	$5,000,000	0	N/A as no funding provided in 2006/2007

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30-31 May 2007

Question: E07-245

OUTCOME 11

Topic: YOUTH MENTAL HEALTH FOUNDATION - HEADSPACE

Written Question on Notice

Senator McLucas asked:

How much of the Foundation's funds have been spent on supporting youth services external to headspace and how much on internal infrastructure within headspace?

Answer:

- The 2005-06 Youth Mental Health Budget Initiative provided $69m to June 2009 to help young people with mental health problems.

- The cornerstone of this initiative is the establishment of headspace: the National Youth Mental Health Foundation which will receive $51.8 million to June 2009. This includes $34.2million for the establishment of Communities of Youth Services (CYSs), which will bring together local youth mental health, drug and alcohol, primary care and education, training and support agencies to work together to provide improved services to young people.

- **headspace** committed $17.44 million in 2006-07 for its four key program areas: grants for external youth services ($12.13 million); establishing a centre of excellence ($1.28 million); a community awareness program ($1.88 million); and education and training for service providers ($2.15 million). It committed $1.91million for core Foundation costs in 2006-07. The audit report of **headspace** funds for the 2006-07 financial year will clarify the actual expenditure for this period.

- A further $15 million under the initiative has been allocated for distribution, by the Australian Government, to Divisions of General Practice where there is a headspace funded Communities of Youth Service to extend access to allied health services for young people with mental health and associated drug & alcohol problems, evaluation and related activities.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30-31 May 2007

Question: E07-349

OUTCOME 11: Mental Health

Topic: DR DARYL EFRON

Written Question on Notice

Senator Webber asked:

Given that Dr Daryl Efron's alleged conflict of interest in advising the Government and the manufacturers of ADHD drugs Ritalin (Novartis) and Strattera (Eli Lily) is the reason he resigned as Chair of the NHMRC ADHD Guidelines Committee:

(a) Has Dr Efron been allowed to remain on the committee? If so why?
(b) Who are the other members of the committee?
(c) Do any other members of the committee have any similar conflicts of interest? Specifically do any provide advice, or conduct research on behalf of, or receive any direct or indirect benefit from ADHD drug manufacture funding either personally or professionally?

Answer:

The membership of the committee will be published with the completed guidelines.

Several members have indicated they are concerned that public discussion of the membership at this stage of the review process may detract from the capacity of the committee to produce the best possible review. They have accordingly indicated that they do not wish to participate in the review should this discussion occur at this time. The Department is concerned that should members withdraw, the review of the guidelines will be seriously compromised through the loss of expertise.

It is important that reviews of this kind are undertaken by clinicians, researchers and other experts who are recognised for their expertise. It is common practice for these experts to provide their expertise to a range of committees including government and industry committees. It would be difficult to find anyone in the field who has not had some engagement with research and development relating to ADHD.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30-31 May 2007

Question: E07-150

OUTCOME 11: Mental Health

Topic: AUTISM

Written Question on Notice

Senator McLucas asked:

What actions have been taken in response to the report on autism commissioned by the Department, A review of the research to identify the most effective models of practice in early intervention of children with autism spectrum disorders (published July 2006)?

Answer:

Since the autism report, *A review of the research to identify the most effective models of practice in early intervention of children with autism spectrum disorders*, was submitted to the department the report has been made available on the Department's website at http://www.health.gov.au/internet/wcms/publishing.nsf/Content/mental-child-aut as well as in hardcopy. The booklet *Early Intervention for Children with Autism Spectrum Disorders: Guidelines for Best Practice* has also been made available electronically on the above mentioned website address as well as in hard copy. The resources are now available to parents of children with Autism Spectrum Disorders, the general public and state and territory governments to better inform them on effective models in early intervention for autism spectrum disorders.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30-31 May 2007

Question: E07-260

OUTCOME 12: Health Workforce Capacity

Topic: WORKFORCE

Written Question on Notice

Senator McLucas asked:

In 2007, how many of the "Rural Pathway" places in the GP program were filled? What percentage is this of the total number of training places?

Answer:

Each year 600 training places are available under the Australian General Practice Training (AGPT) program. In 2007 there were 619 acceptances for GP registrar positions under the program. This translated into 247 places in the "Rural Pathway" program representing about 40% of the total number of training places available in 2007.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30 May 2007

Question: E07-300

OUTCOME 12: Health Workforce Capacity

Topic: WORKFORCE

Hansard Page: CA 135

Senator McLucas asked:

Raw data for the number of specialists by specialty by state.

Answer:

The Department does not compile these statistics.

However, the information can be obtained from the Australian Institute of Health and Welfare (AIHW) *Medical labour force 2004* report, published in December 2006.
This information can be located at:
http://www.aihw.gov.au/publications/hwl/mlf04/mlf04-x05.xls

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30-31 May 2007

Question: E07-301

OUTCOME 12: Health Workforce Capacity

Topic: DENTAL TRAINING

Hansard Page: CA 138

Written Question on Notice

Senator McLucas asked:

The number of dental training places has increased from 221 in 1995 to 312 in 2005, to a planned 516 in 2010. Is this DEST data and is it correct?

Answer:

Department of Education, Science and Training (DEST) maintains data on the allocation of dental training places. DEST advises that the data on the allocation of training places in 1995 and 2005 is correct however the projected figure (516 training places in 2010) is not DEST data.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30-31 May 2007

Question: E07-126

OUTCOME 12: Health Workforce Capacity

Topic: AUSTRALIAN GENERAL PRACTICE TRAINING PROGRAM

Written Question on Notice

Senator Eggleston asked:

Whether it believes the model of general practice training developed by WAGPET reflects the original policy aims of regionalising general practice training and providing for some local control.

Answer:

Yes. The Australian Government funds GPET to provide regional training within an allocated budget. All Regional Training Providers (RTPs) determine their own model within the standards required by the Professional Colleges. WAGPET is one of 21 RTPs funded under the program.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30-31 May 2007

Question: E07-127

OUTCOME 12: Health Workforce Capacity

Topic: AUSTRALIAN GENERAL PRACTICE TRAINING PROGRAM

Written Question on Notice

Senator Eggleston asked:

Whether it believes the process by which GPET allocates funds across states and regions is soundly based and whether this process results in a defensible and equitable distribution of funds.

Answer:

Yes. GPET's allocation of funds is based on a model that takes into account the relative costs in each region, actual training activities that will be undertaken, the geography and peculiarities of the region and the potential economies of scale.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30-31 May 2007

Question: E07-128

OUTCOME 12

Topic: Australian General Practice Training Program

Written Question on Notice

Senator Eggleston asked:

What measures could be implemented to give regional training organisations such as WAGPET longer term certainty in funding than the present drawn out, debilitating annual negotiations?

Answer:

Contract arrangements between GPET and individual regional training providers is a matter for GPET. However, the Commonwealth has entered into a 3 year funding agreement with GPET and we are advised that current contracts between GPET and regional training providers are also negotiated for three years and not on an annual basis.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30-31 May 2007

Question: E07-129

OUTCOME 12: Health Workforce Capacity

Topic: AUSTRALIAN GENERAL PRACTICE TRAINING PROGRAM

Written Question on Notice

Senator Eggleston asked:

What measures could be implemented so that regional training organisations such as WAGPET have adequate scope to develop training arrangements that appropriately reflect local circumstances and needs?

Answer:

Under the Australian General Practice Training Program (AGPT) program, training for general practice is based on a regionalised model to allow training arrangements that appropriately reflect local circumstances and needs. This is delivered through 21 regional training providers. The program is required to be delivered to professional standards stipulated by the Royal Australian College of General Practitioners and Australian College of Rural and Remote Medicine

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30-31 May 2007

Question: E07-179

OUTCOME 12: Health Workforce Capacity

Topic: PRACTICE NURSES

Written Question on Notice

Senator McLucas asked:

How many practice nurses in total are currently working in general practices?

Answer:

As at 31 December 2006, it is estimated that 5,980 nurses are working in general practices across Australia. This is based on estimates made by Divisions of General Practice.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30-31 May 2007

Question: E07-180

OUTCOME 12: Health Workforce Capacity

Topic: PRACTICE NURSES

Written Question on Notice

Senator McLucas asked:

What is the current ratio of FTE practice nurses to FTE GPs? Please disaggregate by state/territories.

Answer:

Because practice nurses do not bill Medicare directly, it is not possible to estimate the number of full time equivalent practice nurses in the same way the full time equivalent number of GPs is estimated through Medicare billing.

The number of practice nurses (headcount) is estimated to be 5,980 as at December 2006 and the number (headcount) of GPs is estimated to be 25,146 in 2005-06[1]. The full time equivalent number of GPs is estimated to be 14,789[1].

[1]Department of Health and Ageing website: http://www.health.gov.au/internet/wcms/publishing.nsf/Content/health-pcd-statistics-gpnos.htm

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30-31 May 2007

Question: E07-259

OUTCOME 12: Health Workforce Capacity

Topic: WORKFORCE

Written Question on Notice

Senator McLucas asked:

In 2007, how many of the "General Pathway" places in the GP training program were filled? What percentage is this of the total number of training places available?

Answer:

In 2007 the Australian General Practice Training program was 90% subscribed with 582 registrars starting with the program. This translated into 335 places in the "General Pathway" representing 52% of the total number of training places available.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30-31 May 2007

Question: E07-264

OUTCOME 12: Health Workforce Capacity

Topic: NURSE SCHOLARSHIP PROGRAM (NSP)

Written Question on notice

Senator McLucas asked:

How many scholarships were awarded in 2007 under the Australian Rural and Remote Nurse Scholarship Program? What is the total expenditure to date on this program by financial year?

Answer:

The Nurse Scholarship Program (NSP), formerly called the Australian Rural and Remote Nurses Scholarship Program, is made up of three scholarship schemes: the Rural and Remote Undergraduate Scheme, the Continuing Professional Education Scheme for Rural and Remote Nurses and the National Nurse Re-entry Scheme.

In 2007 to date no new scholarships have been awarded under the NSP. The selection process for the first round of scholarships for the Continuing Professional Education Scheme for Rural and Remote Nurses and the National Nurse Re-entry Scheme are currently underway. The Rural and Remote Undergraduate Scheme is now open for applications and will close on Friday, 13 July 2007. More than 3,500 scholarships have been awarded since the Program inception in 1998.

The total expenditure to date on the NSP by financial year including scholarship payments, support measures (mentor program), administration costs and marketing is as follows:

Financial year	Expenditure in $ (GST excl)
1998/99	$600,000
1999/2000	$600,000
2000/2001	$600,000
2001/2002	$3,302,270
2002/2003	$5,645,000
2003/2004	$8,080,000
2004/2005	$6,852,000
2005/2006	$6,853,050
2006/2007*	$7,477,437
2007/2008*	$6,849,579

*expected

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30 May 2007

Question: E07-302

OUTCOME 12: Health Workforce Capacity

Topic: OVERSEAS TRAINED DENTISTS

Hansard Page: CA 139

Senator McLucus asked:

Overseas trained dentists practising in Australia: how many do we have?

Answer:

The Department has recently received a snapshot of data from the Australian Dental Association which it intends using to further its knowledge of the number of dental professionals.

At present the data that has been provided is insufficient to enable us to comment on the number of overseas trained dentists practising in Australia.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30-31 May 2007

Question: E07-256

OUTCOME 12: Health Workforce Capacity

Topic: BONDED MEDICAL PLACES SCHEME 2007 INTAKE AND EXPENDITURE

Written Question on Notice

Senator McLucas asked:

In 2007, how many students have taken up medical school places under the Bonded medical places scheme? What is the total expenditure on this program to date by financial year?

Answer:

A total of 1,260 students are undertaking medical school studies in 2007 under the Bonded Medical Places Scheme.

The Bonded Medical Places Scheme only provides a university place at medical school and students pay their HECS.

The cost of the university place is met by Department of Education, Science and Training, the Department of Health and Ageing does not have expenditure under this program.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30-31 May 2007

Question: E07-254

OUTCOME 12: Health Workforce Capacity

Topic: GP RATIOS

Written Question on Notice

Senator McLucas asked:

Please provide a list of GP: population ratios by state/territory.

Answer:

The population to full-time equivalent (FTE) GP ratio uses published Estimated Resident Population (ABS Catalogue No. 3218.0) figures for the population component.

In using the Medicare billing statistics for the GP component, the Department of Health and Ageing uses an FTE 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.

Ratio of Population to FTE General Practitioners by State and financial year

Year	NSW	VIC	QLD	SA	WA	TAS	NT	ACT	Australia
2005-06	1,355	1,395	1,376	1,289	1,576	1,368	2,214	1,691	1,393

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30-31 May 2007

Question: E07-258

OUTCOME 12: Health Workforce Capacity

Topic: WORKFORCE

Written Question on Notice

Senator McLucas asked:

What is the total expenditure to date in 2007 on the Rural Australia medical undergraduate scheme? How many students have received funding under this scheme in 2007?

Answer:

From 1 January 2007 to 30 June 2007 expenditure on RAMUS is $1,785,644.

In the same period 550 students have received funding under the scheme, of these 153 were newly awarded scholarships in 2007.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30-31 May 2007

Question: E07-255

OUTCOME 12: Health Workforce Capacity

Topic: GP RATIOS

Written Question on Notice

Senator McLucas asked:

Please provide a list of GP: population ratios by federal electorate – an update on data previously provided for 2004.

Answer:

Federal electorate level data on the GP to population ratio is not used for the determination of district of workforce shortage status and as such is not part of the range of data used by the Department on a routine basis. The relevant GP to population ratio data level for the determination of district of workforce shortage is usually at the statistical local area (SLA) level, or aggregate thereof. SLAs are not a subordinate unit of electorates and therefore any extrapolation will be imprecise. SLA level GP to population ratio data is not released by the Department.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30-31 May 2007

Question: E07-262

OUTCOME 12: Health Workforce Capacity

Topic: WORKFORCE

Written Question on Notice

Senator McLucas asked:

What is the total expenditure to date on the GPs re-entry program by financial year? How many GPs have re-entered the workforce as a result of participating in this program?

Answer:

Expenditure to date:

2004-05	$23,749
2005-06	$44,492
2006-07	$95,000

As of 31 March 2007, 40 GPs have re-entered the workforce as a result of participating in this program.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30-31 May 2007

Question: E07-267

OUTCOME 12: Health Workforce Capacity

Topic: OVERSEAS TRAINED SPECIALISTS UPSKILLING PROGRAM

Written Question on Notice

Senator McLucas asked:

How many overseas trained specialists have gained college Fellowships through participating in the Overseas Trained Specialist Upskilling program?
What is the total expenditure to date on this program by financial year?

Answer:

The Upskilling Program aims to provide support and training for up to 24 months for overseas trained specialists seeking to achieve Fellowship of a specialist medical college in Australia. It also aims to support the permanent entry and retention of overseas trained specialists in Australia, in the areas they are most needed, so that they can contribute on a long term basis to the community and the medical workforce.

Funding has been provided to state and territory health departments to establish Upskilling posts to enable candidates to receive required training and supervision. Funding has also been provided to medical colleges to develop resources and support for candidates to reach Fellowship of the relevant specialist medical college.

From 2004, state and territory health departments have been funded a total of $4,337,298.00 to support 117 candidates to receive additional training and supervision required for the attainment of specialist college Fellowship. Approximately 40% are still undertaking the program and 31 have achieved Fellowship of their respective specialist college.

Funds of $2,895,975.00 have been provided to specialist medical colleges to June 2007 to develop resources and mentoring and support schemes for overseas trained specialists to attain Fellowship. These programs are ongoing until 2008 and it is estimated that 200 overseas trained specialists will participate in these programs.

Year	State & Territory Health Dept	Specialist Colleges
2004-2005	$ 846,727.00	Nil
2005-2006	$1,982,267.00	$1,840,550.00
2006-2007	$1,508,304.00	$1,055,425.00
Sub Total	**$4,337,298.00**	**$2,895,975.00**
Overall Total	**$7,233,273.00**	

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30-31 May 2007

Question: E07-269

OUTCOME 12: Health Workforce Capacity

Topic: CLINICAL TRAINING OF DOCTORS

Written Question on Notice

Senator McLucas asked:

1) Please provide information on DOHA appropriations directed to clinical training of doctors, including:
a) any identified clinical training component in the AHCAs or any other SPPs
b) direct to private trainers including colleges
c) direct to private hospitals
d) any other funding provided which supports doctors' clinical training.
In the answer please include:
- expenditure information for 2005-06, anticipated expenditure for 2006-07, and budgeted expenditure for 2007-08;
- the outcome against which each item of funding is appropriated;
- where applicable, the budget measure against which the expenditure is counted.

Answer:

1) For the purposes of this response, clinical training is defined as situations where there are interactions between a student or trainee and a patient (real or simulated) with oversight or feedback by a supervisor in an environment other than a class room. A broader definition of clinical training could include such things as locum support programs and population health training. While there are no system wide estimates of the costs of clinical training2, the Department of Health and Ageing does contribute to the clinical training of doctors in various ways as shown below:

2 *The Blame Game: Report on the inquiry into health funding* 2006:93

a) There is no identified clinical training component of the funding in the Australian Health Care Agreements (AHCAS). DoHA contributes to the states and territories' funding of hospital based training through the (AHCAs). Responsibilities of the states and territories under clause 10 (c) of the AHCAs include the requirement to "continue to provide support for medical specialist training positions." The AHCAs are high level funding policy documents and as such are not prescriptive, except for the need to provide free public hospital services for patients. States and territories determine the number of training places to be provided and the level of funding to be allocated within individual hospital budgets for this purpose.

b) There are DoHA programs that include some degree of support for clinical training through Specialist Colleges – mainly in rural areas. These include programs such as the Australian Specialist Training Posts in Rural Areas (ASTPRA) and Rural Advanced Specialist Training Support (RASTS). This list is not exhaustive.

c) There are no DoHA appropriations that currently provide funding directly to private hospitals for clinical training. However, Outcome 12.2 *Medical Specialist Training – Broad Range of Settings* may include payments to private hospitals for this purpose into the future.

d) DoHA runs many programs that provide a level of support for clinical training to occur while not necessarily providing funding for this explicit purpose. This includes:
   - General Practice Education and Training (GPET);
   - Rural Clinical Schools; and
   - University Departments of Rural Health (UDRH).

   Whilst it is difficult to quantify the percentage of these appropriations that are specifically directed to clinical training, they would predominantly support this activity. Therefore, funding information has not been provided.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30-31 May 2007

Question: E07-261

OUTCOME 12: Health Workforce Capacity

Topic: WORKFORCE – PREVOCATIONAL GENERAL PRACTICE PLACEMENTS PROGRAM

Written Question on Notice

Senator McLucas asked:

How many of the general practice placements in the Prevocational General Practice Placements Program (PGPPP) have been taken up so far this year? What is the total expenditure on this program to date (since 2003) by financial year?

Answer:

Between 1 July 2006 and 1 June 2007, 183 (12 week equivalent) general practice placements have been finalised or are underway.

The following figures reflect administered expenditure. Departmental expenditure or Medicare Billing is not included.

FINANCIAL YEAR	EXPENDITURE ($M)	COMMENT
2004-2005	4.523	Placements commenced January 2005
2005-2006	15.975	
2006-2007	11.827	

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30-31 May 2007

Question: E07-263

Outcome 12: Health Workforce Capacity

Topic: WORKFORCE

Written Question on Notice

Senator McLucas asked:

What is the total expenditure to date on the Specialist Re-Entry Program by financial year? How many specialists have re-entered the workforce as a result of participating in this program?

Answer:

In the period since June 2004 when the program commenced, nineteen specialists have completed individual re-entry programs, while a further four specialists are currently participating in a re-entry program.

Total expenditure to date:

2003-04	**2004-05**	**2005-06**	**2006-07**
$106,818.68	$281,442.42	$174,163.75	$127,703.86

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30-31 May 2007

Question: E07-265

OUTCOME 12: Health Workforce Capacity

Topic: NURSE SCHOLARSHIP PROGRAM: NATIONAL NURSE RE-ENTRY SCHEME

Written Question on Notice

Senator McLucas asked:

What is the total expenditure to date on the National Nurse Re-entry Scheme? How many nurses have re-entered the workforce as a result of participating in this scheme?

Answer:

The Nurse Scholarship Program (NSP) is an Australian Government initiative which provides scholarships and support mechanisms for undergraduate students or nurses wishing to undertake continuing professional education or re-enter the workforce. Most of the scholarships target people from rural or remote regions of Australia. The program is made up of three scholarship schemes: the Rural and Remote Undergraduate Scheme, the Continuing Professional Education Scheme for Rural and Remote Nurses and the National Nurse Re-entry Scheme.

The National Nurse Re-entry Scheme was implemented in 2005-06 and the first scholarships were awarded in April 2006. Prior to this, re-entry scholarships were awarded under the Australian Rural and Remote Nurse Scholarship Scheme: Re-entry and Upskilling Scheme and the Metropolitan Nurse Re-entry Scheme. To date, 840 re-entry scholarships have been awarded under these three schemes. Of these, 428 scholars have completed their re-entry course and 222 are still studying. The remainder have either not taken up the scholarship, withdrawn, failed or otherwise terminated their re-entry program. The total expenditure to date on the three re-entry schemes is $2,143,608 (GST excl).

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30-31 May 2007

Question: E07-266

OUTCOME 12: Health Workforce Capacity

Topic: WORKFORCE

Written Question on Notice

Senator McLucas asked:

How many doctors have entered the Australian medical workforce as a result of the Identification, Assessment and Counselling Permanent Resident Overseas Trained Doctors Not Currently in the Australian Medical Workforce Program? What is the total expenditure to date on this program by financial year?

Answer:

As a result of this program, as at 31 May 2007, 71 Overseas Trained Doctors have passed the Australian Medical Council (AMC) clinical examination and have therefore qualified for entry into the Australian medical workforce. Additionally, 78 Overseas Trained Doctors have passed the AMC multiple choice questionnaire and are now preparing for the clinical examination.

Total expenditure to date by financial year:		$
2003/2004	Management & administration	465,947
2004/2005	Management, administration & Scholarship funding - 450 @ $10,000 each	5,316,217
2005/2006	Management & administration	241,070
2006/2007	Management & administration	395,237
TOTAL EXPENDITURE 2003/04 to 2006/07		6,418,471

The program has been extended to operate to the end of the 2007/2008 financial year. 202 of the 450 scholarships remain available for allocation.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30-31 May 2007

Question: E07-299

OUTCOME 12: Health Workforce Capacity

Topic: WORKFORCE SHORTAGE

Hansard Page: CA 130

Senator McLucas asked:

Areas of workforce shortage for the past quarter, the past 12 months and the past 3 or 5 years

Answer:

Background

A doctor to population ratio is frequently used to help determine whether a locality is within an area of workforce shortage (AOWS). Medicare billing statistics are used for the determination of the doctor component of the ratio. These statistics use 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. For the population component of the ratio, the Australian Bureau of Statistics Estimated Resident Population (ABS Catalogue No. 3218.0) population figures at the Statistical Local Area (SLA) level are used.

The Medicare billing statistics and the doctor to population ratios are updated on a quarterly basis. SLAs are used to define areas because SLAs are the smallest geographic unit for which annual population figures are available.

In general, a doctor to population ratio at the SLA or aggregate of SLA level determines whether an area is an AOWS, when compared to the national average. Areas with a doctor to population ratio greater than the national average are considered to be AOWS.

Response

Over 1,400 individual SLAs are grouped into 767 areas, of which 660 comprise single SLAs. Therefore over 50% of SLAs are combined with at least one other SLA in the derivation of AOWS.

Given that the doctor to population ratio is compared with the national average ratio, it follows that at least half of the areas will be AOWS. In addition, all remote areas are automatically classified as AOWS, regardless of their doctor to population ratio.

Given the volume of information, an analysis of change in eligibility for AOWS status in Australia is best represented as follows:

March quarter 2007 (latest available quarter)

*Table 1: AOWS eligibility status March quarter 2007**

March quarter 2007	**Area %** (km^2)	**SLA %**	**Population %**
*Not AOWS**	26%	34%	41%
AOWS#	74%	66%	59%

June quarter 2006 to March quarter 2007 – the past 12 months

*Table 2: AOWS eligibility status June quarter 2006 to March quarter 2007**

Over 12 month period	**Area %** (km^2)	**SLA %**	**Population %**
*Not AOWS**	21%	30%	38%
AOWS#	69%	61%	52%
AOWS change+	10%	9%	10%

Past 3 to 5 years

Information is not readily available for the past 3 to 5 years. There have been a number of breaks in the series as a result of SLA boundary updates, making comparison over time more difficult.

December quarter 2005 to March quarter 2007 – the past 18 months

*Table 3: AOWS eligibility status December quarter 2005 to March quarter 2007**

Over 18 month period	**Area %** (km^2)	**SLA %**	**Population %**
*Not AOWS**	19%	29%	35%
AOWS#	62%	57%	51%
AOWS change+	19%	14%	14%

* Areas, SLAs, Population not AOWS for the period indicated
\# Areas, SLAs, Population remaining AOWS for the period indicated
\+ Areas, SLAs, Population that have changed AOWS status for the period indicated

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30-31 May 2007

Question: E07-270

OUTCOME 12: Health Workforce Capacity

Topic: MORE DOCTORS FOR OUTER METROPOLITAN AREAS MEASURE

Written Question on Notice

Senator McLucas asked:

Please provide a consolidated table of funding and expenditure on the More Doctors for Outer Metro Areas program, which includes:

a) Original budget allocations, if possible broken down by each element of the program (the Relocation Incentive Grants, Outer Metropolitan GP Registrars Program, Outer Metropolitan Specialists Program, and Outer Metropolitan Other Medical Practitioners Program).
b) Additional allocations that have been made to the program since the original allocations were made (including funding in the 2006-07 Budget).
c) Actual expenditure for each of the program in its first four years, if possible broken down by each element of the program.
d) Anticipated expenditure for 2006-07 financial year.
e) Where there are differences between original allocations and actual/expenditure (or anticipated expenditure for 2006-07), an explanation of where any unspent funding was re-phased to.

Answer:

a) The More Doctors for Outer Metropolitan Areas Measure comprises four programs, namely the:

- Outer Metropolitan Relocation Incentive Grant Program;
- Outer Metropolitan Other Medical Practitioners Program;
- Outer Metropolitan Registrars Program; and
- Outer Metropolitan Specialist Trainee Program.

Funding for the Outer Metropolitan Registrars Program is provided through Outcome 5 (previously Outcome 4), while the other three components are in part funded through Outcome 12 (previously Outcome 9) and 3 (previously Outcome 2).

A large proportion of the program budget is for Outcome 3 which is associated with the Medicare billing of doctors under the Outer Metropolitan Specialist Trainee Program and the Outer Metropolitan Other Medical Practitioners Program. The actual budget and expenditure amount for these Medicare billings is not readily identifiable at the individual program level.

Program	**Outcome – Administered Funding**
Relocation Incentive Grant Program	12
Outer Metropolitan Specialists Trainee Program	12 and 3
Outer Metropolitan GP Registrars Program	5
Outer Metropolitan Other Medical Practitioners Program	3

The More Doctors for Outer Metropolitan Areas Measure was provided funding of $80 million over fours years from 2002-03 to 2005-06. The totals of the **administered funding**, as appropriated at that time, are provided below:

	2002-03	**2003-04**	**2004-05**	**2005-06**	**Total**
Total Administered (Financial Year)	$9.9m	$15.7m	$22.8m	$22.8m	**$71.2m**

This was subsequently reduced through Budget processes in later years in response to underspends in the Outer Metropolitan Specialist Trainee Program component of the Measure to provide funding for Practice Nurses and Medical Rural Proceduralists. The breakdown of the final budget is provided below:

	2002-03	**2003-04**	**2004-05**	**2005-06**	**Total**
Total adjusted Administered (Financial Year)	$9.9m	$7.03m	$12.4m	$13.87m	**$43.2m**

The 2002-03 to 2005-06 Budget for the More Doctors for Outer Metropolitan Areas Measure at the individual program or outcome level is not available.

b) Under the 2006-07 Budget, the measure was provided a further $64.5million to attract up to a further 265 general practitioners and specialists and up to 50 specialist training placements to meet ongoing needs in outer metropolitan areas. The breakdown of the funding is as follows:

Outcome	**2006-07 ($m)**	**2007-08 ($m)**	**2008-09 ($m)**	**2009-10 ($m)**	**Total ($m)**
12	6.8	7.39	7.56	8.25	**30.0**
5	1.742	1.242	1.242	1.242	**5.468**
3	4.218	4.508	5.218	5.998	**19.942**
[3] **Total 'Administered'**	**12.76**	**13.14**	**14.02**	**15.49**	**55.41**
Total Financial Year (Departmental & Administered)	**15.**	**15.4**	**16.3**	**17.8**	**64.5**

[3] A large proportion of the program budget is for Outcome 3 (previously Outcome 2) which is associated with the Medicare billing of doctors under the Outer Metropolitan Specialist Trainee Program and the Outer Metropolitan Other Medical Practitioners Program. The actual budget and expenditure amount for these Medicare billings is not readily identifiable at the individual program level.

c) The table below provides actual **administered** expenditure by financial year for Outcomes 5 and 12:

	2002-03	2003-04	2004-05	2005-06	Total
[1] Total (Outcomes 5 and 12)	$436,205	$2.01m	$3.16m	$3.85m	**$9.46m**

The allocation of **Departmental** resourcing against outcomes and outputs for staffing remains notional. Expenditure-to-date figures by Budget measure is not published.

d) The expenditure in 2006-07 for the measure is as follows:

Outcome	Actual Expenditure 2006-07 ($m)
12	**4.598**
5	**1.395**
[1] **Administered**	**5.993**

The allocation of Departmental resourcing against outcomes and outputs for staffing remains notional. Expenditure-to-date figures by Budget measure is not published.

All Departmental resources provided for Outcome 5 and 12 in 2006-07 are expected to be fully expended.

e) In 2002-03 $1.495 million was re-phased from Outcome 5 (previously 4) Administered funds to 2003-04.

In 2004-05 $500,000 was re-phased from Outcome 5 Administered funds to 2005-06.

A further $243,000 was re-phased from Outcome 12 (previously 9) Administered funds to 2005-06.

[1] A large proportion of the program budget is for Outcome 3 (previously Outcome 2) which is associated with the Medicare billing of doctors under the Outer Metropolitan Specialist Trainee Program and the Outer Metropolitan Other Medical Practitioners Program. The actual budget and expenditure amount for these Medicare billings is not readily identifiable at the individual program level.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30-31 May 2007

Question: E07-169

OUTCOME 13: Acute Care

Topic: DENTAL PROGRAM

Written Question on Notice

Senator McLucas asked:

With reference to the department's response to QON E07-103 that the National Oral Health Plan is taken into account when developing oral health policy - please indicate which aspects of the plan were taken into account when the Government expanded its chronic disease / dental care program, as announced in the Budget?

Answer:

The National Oral Health Plan is taken into account when developing policy within the Commonwealth's area of responsibility. The appropriate section of the plan for people with chronic conditions and complex care needs where a person's oral health is impacting on or is likely to impact on his or her general health, is Action Area Five: People with Special Needs.

The plan's definition of "special needs" contains a number of sub-groups, including people with physical chronic conditions and those whose health creates special circumstances surrounding their oral care. The outcomes in this action area call for targeted programs for specific and/or high needs groups.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30-31 May 2007

Question: E07-170

OUTCOME 13: Acute Care

Topic: DENTAL

Written Question on Notice

Senator McLucas asked:

We understand that the National Oral Health Plan Monitoring Group recently submitted its annual report to the Health Minister's Advisory Council. Can we have a copy of the report?

Answer:

Australian Health Minister's Advisory Council (AHMAC) endorsed the report on the implementation of the National Oral Health Plan 2004-2014 on 13 June 2007 and approved the provision of the report to the Australian Health Ministers' Conference (AHMC) at their 24 July 2007 meeting. Whether the report is released publicly is a matter for AHMC. If AHMC decides to release the report, a copy will be provided to the committee secretariat.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30-31 May 2007

Question: E07-271

OUTCOME 13: Acute Care

Topic: PATHWAYS

Written Question on Notice

Senator McLucas asked:

a) Was all money allocated to the Pathways Home Program in the current round of AHCAs spent?
b) If not please provide information on re-directions/re-phasing.

Answer:

The total amount of funding provided under the Pathways Home Program is $252.8 million.

At the end of 2006-07, the total amount of funding provided to the states and territories under the Pathways Home Program will be $217.8 million, with $17.6 million provided in 2003-04, $86.5 million provided in 2004-05, $55.1 million being provided in 2005-06 and $58.6 million being provided in 2006-07.

The funding in question is for the five year period 2003-2008 and the remaining funds are expected to be paid to states and territories by the end of June 2008.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30 May 2007

Question: E07-346

OUTCOME 13: Acute Care

Topic: COST REPORTING

Hansard Page: CA 51

Senator Mc Lucas asked:

In what other areas of health does the Institute report on cost as a barrier to service?

Answer:

The Australian Institute of Health and Welfare (AIHW) has reported on cost as a barrier to service in the following recent reports:

- *Aboriginal and Torres Strait Islander health performance framework 2006 report: detailed analyses, June 2007* (internet only*). S*ection 3.10 reports on Access to services by type of service compared to need: Table 3.10.10 provides information on the proportion of cases where cost is a reason for not visiting the doctor, dentist, other health professional or hospital; Table 3.10.11 provides information on co-payments for visiting doctors; Table 3.10.12 provides information on the extent to which cost prohibits Indigenous people from taking out private health insurance. The report also has a general section on affordability of care for Indigenous people.

- *Therapy and equipment needs of people with cerebral palsy and like disabilities in Australia, 2006*, reported on costs as a barrier to people receiving therapy and equipment (pp. 96–98).

- *Current and future demand for specialist disability services*, *2007*, reported on the effect of cost on unmet demand for accommodation and respite services (p75).

- *National evaluation of the Aged Care Innovative Pool Disability Aged Care Interface Pilot: final report, 2006* reported on cost as barrier to receipt of community services by people with long-term disability (p44), and on p216 and throughout on the impact of cost of fee-for-service private allied health care for people on disability support pension, combined with waiting times in public health system for preventative/maintenance allied health intervention and barriers to accessing these services through Home and Community Care Program for people with a disability who are ageing in Commonwealth-State Disability Agreement (CSTDA)-funded accomodation.

- *National evaluation of the Aged Care Innovative Pool Dementia Pilot: final report, 2006* includes some information on the extent to which Home and Community Care clients do not transfer to a care program which would better meet their needs because of cost (p291).

- *Community Aged Care Packages in Australia 2004-05: a statistical overview. Aged care statistics series no. 23*. Provides a discussion of care recipients in financial hardship (p26).

- *Veterans on Community Aged Care Packages: a comparative study. Aged care series no. 9***.** on p.iv and p.21 contains some brief information on whether cost may be a reason for lower utilisation of Community Aged Care Packages by veterans.

- *Crisis or commotion: an objective look at the evidence on caregiving in families,* article by an AIHW staff member in *Family Matters*, the journal of the Australian Institute of Family Studies (issue in print, 20 June 2007) includes some information on cost of alternative forms of care provision as a reason for people taking on a role as primary carer.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 30 May 2007

Question: E07-345

OUTCOME 13: Acute Care

Topic: DENTAL HEALTH

Hansard Page: CA 51

Senator Mc Lucas asked:

Do you have any further information in relation to children's attendance for dental treatment, including whether cost is an inhibitor of children attending, and if so, to what degree?

Answer:

The following information on estimated percentages of children in the Australian population for whom cost was a barrier to dental care was provided by the Australian Institute of Health and Welfare's (AIHW's) Dental Statistics Research Unit (DSRU). The estimates are based on the responses to questions asked of parents/guardians regarding 1,291 children aged 5-14 years who were sampled as a supplement to the 2004–06 National Survey of Adult Oral Health.

Estimates of the proportion of children whose parents avoided or delayed visiting a dental professional because of cost in the preceding 12 months
Age Group: 5-14 years: 8.4 %
Age Group: 5-9 years: 6.9%
Age Group: 10-14 years: 9.9%

Estimates of the proportion of children where parents considered that cost prevented them from having recommended dental treatment in the preceding two years
Age Group: 5-14 years: 4.4%
Age Group: 5-9 years: 2.3%
Age Group: 10-14 years: 6.1%
(The survey respondents for this question were limited to children who attended for dental care in the 2 years prior to interview)

The DSRU advises that these figures (which show lower percentages than for adults in the same survey) are consistent with other patterns that are observed in oral health and access to care in the Australian population. In particular:

a) dental care for children of this age often is less expensive than for older people;
b) many children receive such care from state/territory school dental services at reduced or no cost, out-of-pocket, to parents; and
c) many parents report placing priority on their children's dental care, foregoing dental treatment themselves in favour of their children.