Community Affairs Legislation Committee

Examination of Budget Estimates 2009-2010

Additional Information Received
CONSOLIDATED VOLUME 4

HEALTH AND AGEING PORTFOLIO

Whole of Portfolio, Outcomes 1 to 15

18 FEBRUARY 2010

ADDITIONAL INFORMATION RELATING TO THE EXAMINATION OF BUDGET EXPENDITURE FOR 2009-2010

Included in this volume are answers to written and oral questions taken on notice and tabled papers relating to the supplementary budget estimates hearing on 21 October 2009 and cross portfolio Indigenous matters hearing 23 October 2009

*** Please note that the tabling date of 25 February 2010 is the proposed tabling date**

HEALTH AND AGEING PORTFOLIO

Senator	Quest. No.	Whole of portfolio	Vol. 4 Page No.	Date tabled in the Senate or presented out of session*
Cormann	188	Health Reform Taskforce consultation staffing costs		04.02.10
Boyce	72	Program underspends		04.02.10
Boyce	76	Health and Hospital Commission report		04.02.10
Boyce	80	Staffing levels		04.02.10
Boyce	81	Changes in Actual Staffing Level (ASL)		04.02.10
Boyce	82	Reductions in staff numbers		04.02.10
Boyce	83	Redundancies		04.02.10
Boyce	86	Electoral data		04.02.10
Adams	126	Staffing levels		04.02.10
Adams	127	Actual Staffing Level (ASL)		04.02.10
Adams	129	Staff reductions		04.02.10
Adams	130	Redundancies		04.02.10
Adams	134	Electoral specific data		04.02.10
Adams	154	Award modernisation		04.02.10
Adams	155	Work Safe legislation		04.02.10
Adams	156	Salary increases		04.02.10
Adams	164	Health and Hospital Commission report		04.02.10
Boyce	218	FOI requests		04.02.10
Adams	267	Program underspends		04.02.10
Adams	165	"Listening Tour"		04.02.10
Adams	178	Health and Hospitals Fund		04.02.10
Adams	128	Staffing		04.02.10
Adams	70	Staffing		04.02.10
Boyce	73	Departmental reports and reviews		04.02.10
Boyce	74	Publication of reports		04.02.10
Boyce	75	Departmental reports		04.02.10
Boyce	77	Election commitments		04.02.10
Boyce	79	Staffing		04.02.10
Boyce	87	Consultations		04.02.10
Boyce	88	Health and Hospital Commission Report		04.02.10
Adams	135	Consultancies		04.02.10
Adams	137	Discretionary grants		04.02.10
Adams	138	Commissioned reports		04.02.10

Boyce	249	Commissioned reports	04.02.10
Adams	136	Advertising expenditure	04.02.10
Cormann	250	Health and Hospitals Fund (HHF)	04.02.10
Boyce	84	Electoral reports	04.02.10
Boyce	85	Electorate level reports	04.02.10
Adams	132	Electoral reports	04.02.10
Adams	133	Electorate level reports	04.02.10
Siewert	42	Social marketing campaigns	04.02.10

Outcome 1: Population Health

	T1 tabled by Senator Colbeck	Media transcript TAA Adelaide Leon Byner Morning Program 21.10.09 with Minister Burke re food labelling laws.. Australia to allow import of beef products from countries where there has been mad cow disease (BSE)	29.10.09
Barnett	37	Weighing it up – obesity in Australia	04.02.10
Ronaldson	15	Preventative health budget	04.02.10
Xenophon	19	Bowel cancer screening program	04.02.10
Adams	109	Bowel cancer screening program	04.02.10
Ronaldson	1, 3, 5, 6, 7	National Preventive Taskforce	04.02.10
Ronaldson	9	Australian National Preventative Health Agency	04.02.10
Ronaldson	10-12	Preventative health programs	04.02.10
Ronaldson	14	Preventative health	04.02.10
Boyce	78	National Preventive Health Agency	04.02.10
Siewert	44	Social marketing campaigns	04.02.10
Adams	110-111	Bowel cancer screening program	04.02.10
Siewert	262	Funding models	04.02.10
Boyce	263	Definitions of 'private patients' used in reports	04.02.10
Back	271	BSE and imported beef and beef products	04.02.10
Heffernan	272	BSE and imported beef and beef products	04.02.10
Xenophon	22	Ice users	04.02.10
Barnett	36	Obesity	04.02.10
Siewert	43	Alcopops	04.02.10
Boyce	91	Listing and evaluation fees	04.02.10
Adams	175	Weighing it up – obesity in Australia	04.02.10
Siewert	53	GE Foods	04.02.10
Ronaldson	4	National Preventative Health Taskforce	04.02.10
Ronaldson	8, 13	Australian National Preventive Health Agency (ANPHA)	04.02.10
Xenophon	21	'Don't Let Ice Destroy You' Campaign	04.02.10
Siewert	49	CDC Triffid flaxseed	04.02.10
Siewert	50	Importation of flaxseed	04.02.10
Siewert	51	CDC Triffid flaxseed	04.02.10
Siewert	52	Flaxseed safety	04.02.10
Siewert	54	GE flax contamination	04.02.10
Siewert	56	GE contamination	04.02.10
Siewert	48	CDC Triffid flaxseed	04.02.10

Siewert	55	CDD Triffid	04.02.10
Boyce	219	Head of the Office of Prescription Medicines, TGA	04.02.10
Back	16	Whooping cough immunisation	04.02.10
Back	17	Whooping cough vaccine	04.02.10
Back	18	Roll out of whooping cough vaccine	04.02.10
Ronaldson	2	National Preventative Health Taskforce	04.02.10
Xenophon	23	'Don't Let Ice Destroy You' Campaign	04.02.10
Boyce	220	Research Infrastructure Support Services Limited	04.02.10

Outcome 2: Access to Pharmaceutical Services

Adams	114	Indigenous Australians access to prescription medicines	04.02.10
Adams	187	Pharmaceutical Benefits Scheme (PBS) Medicines	04.02.10
Cormann	199	PBS Medicines	04.02.10
Birmingham	60	Life saving drugs program	04.02.10
Adams	186	Pharmaceutical Benefits Scheme	04.02.10
Cormann	198	4th Community Pharmacy Agreement	04.02.10
Adams	265	PBS medicines	04.02.10

Outcome 3: Access to Medical Services

		Letter from DoHA dated 27 Oct 09 amending evidence provided at hearing on 21 Oct 09 relating to disallowance motion	29.10.09
Fielding	38-41, 229	MRI	04.02.10
Adams	184	Cataract surgery	04.02.10
Adams	190	MBS	04.02.10
Williams	35	Diagnostic imaging	04.02.10
Siewert	57	PET – lung cancer	04.02.10
Siewert	58	Positron emission Tomography (PET) lung cancer	04.02.10
Boyce	93	Bulk billing	04.02.10
Boyce	94	Diagnostic imaging services	04.02.10
Adams	230	Maternity Services Advisory Group	04.02.10
Adams	185	IVF & ART funding	04.02.10
Adams	181	MBS quality framework	04.02.10
Adams	183	Cataracts	04.02.10
Boyce	92	Items removed from MBS	04.02.10
Siewert	103	Review of the MBS	04.02.10
Adams	182	Cataract surgery	04.02.10
Cormann	274	New MBS item number 42718	04.02.10
Adams	117	Cataracts	04.02.10
Scullion	254	Cataract operations	04.02.10

Outcome 4: Aged Care and Population Ageing

		30 June 2009 stocktake of aged care places	26.11.09
Williams	32	Respite care	04.02.10
Adams	143	Aged Care Assessment Teams (ACAT)	04.02.10
Adams	162	Home and Community Care (HACC) funding recipients	04.02.10
Adams	171	Community Aged Care Packages (CACP)	04.02.10
Fifield	214	Continence Aids Payment Scheme	04.02.10
Xenophon	20	Inquiry into aged care	04.02.10
Williams	25	Aged care facilities	04.02.10
Williams	26	Homes under construction	04.02.10
Williams	29	Community care packages	04.02.10
Siewert	47	Additional interest charged to residents	04.02.10
Adams	105	Aged care in WA	04.02.10
Adams	131	Election commitments	04.02.10
Adams	139	Aged care	04.02.10
Adams	140	Bed licences	04.02.10
Adams	141	Aged care	04.02.10
Adams	142	Aged care approvals round	04.02.10
Adams	146	Extended aged care at home dementia packages	04.02.10
Adams	147-150	Extended aged care at home dementia	04.02.10
Adams	151	Community aged care packages	04.02.10
Adams	152	Community care	04.02.10
Adams	157	Aged care in WA	04.02.10
Adams	158	Aged care facilities	04.02.10
Adams	159	Correspondence from facilities	04.02.10
Adams	160	Vacancy rates	04.02.10
Adams	161	Low care and high care places	04.02.10
Adams	163	Aged care	04.02.10
Adams	166, 167, 169	General purpose financial reports	04.02.10
Adams	170	Community care	04.02.10
Adams	172	Indexation of the conditional adjustment subsidy	04.02.10
Adams	173	Australian Government directory of services for older people	04.02.10
Adams	174	Senate inquiry into aged care	04.02.10
Adams	205, 206	Aged Care Funding Instrument (ACFI)	04.02.10
Adams	207	Aged care approvals round	04.02.10
Adams	209	Bed licences	04.02.10
Adams	211	Residential aged care	04.02.10
Siewert	212	CAP payments	04.02.10
Brown, Carol	213	Cradle Coast	04.02.10
Adams	215	Australian Government directory of Services for Older People	04.02.10
Adams	216	Bed licences	04.02.10
Adams	261	Oral health training in residential aged care homes	04.02.10
Fifield	275	Continence management	04.02.10
Williams	24	Aged care facilities	04.02.10
Williams	27	Aged care operators	04.02.10
Williams	33, 34	Aged Care Assessment Team (ACAT)	04.02.10

Outcome 5: Primary Care

Outcome 6: Rural Health

Outcome 7: Hearing Services

Outcome 8: Indigenous Health

Adams	112	Indigenous dental treatment	04.02.10
Adams	118	Trachoma in Katherine	04.02.10
Adams	119	Rheumatic fever strategy	04.02.10
Adams	120-121	Aboriginal Medical Services	04.02.10
Adams	122	NT Intervention follow-up	04.02.10
Adams	135	Linking Indigenous people to GPs	04.02.10
Adams	125	Closing the Gap	04.02.10
Adams	195	Opal fuel	04.02.10
Scullion	217	Rheumatic fever strategy	04.02.10
Payne	253	Blank Page Summit	04.02.10
Siewert	255	Petrol sniffing in Yalata	04.02.10
Siewert	256	Halls Creek and Opal fuel	04.02.10
Scullion	258	Opal fuel	04.02.10
Siewert	259	Chronic disease package	04.02.10
Moore	260	Audiological services	04.02.10
Scullion	268	Diabetes in Indigenous communities	04.02.10
Siewert	269	Petrol stations	04.02.10
Siewert	270	Closing the Gap	04.02.10
Scullion	279	Indigenous health	04.02.10

Outcome 9: Private Health

Cormann	221	PHIAC's involvement and decision making process in Medibank Private Limited conversion to for-profit	04.02.10
Cormann	266	Informed financial consent	04.02.10

Outcome 10: Health System Capacity and Quality

Adams		National Breast and Ovarian Cancer Centre	26.11.09
Adams	264	Breast cancer	26.11.09
Boyce	89-90	Better health grants	04.02.10
Boyce	238-241	National eHealth Transition Authority	04.02.10
Boyce	242	Nationally endorsed and released discharge summary	04.02.10
Boyce	243	Healthcare identifiers	04.02.10
Boyce	244	Budget for healthcare identifiers	04.02.10
Boyce	95-96	Kidney failure	04.02.10
Boyce	246	Electronic prescriptions	04.02.10
Boyce	245	Healthcare identifiers	04.02.10
Adams	145	Respecting Patient Choices Program	04.02.10
Adams	144	Palliative care	04.02.10

Outcome 11: Mental Health

Boyce	101	Stigma and mental health	04.02.10
Boyce	197	Rural and remote access to the MBS better access initiative	04.02.10
Wortley	196	Cyber bullying	04.02.10
Boyce	102	Kidsmatter primary initiative	04.02.10

Outcome 12: Health Workforce Capacity

Adams	191	10-year moratorium on international medical graduates	26.11.09
Back	247	Overseas trained doctors	04.02.10
Siewert	59	Chiropractors	04.02.10
Adams	192	Medical training	04.02.10
Adams	193	Medical Training Review Panel	04.02.10
Adams	194	General Practice Training program	04.02.10
Williams	30	Training staff in rural/remote areas	04.02.10
Williams	31	Attracting staff to rural/remote areas	04.02.10
Adams	189	Single provider numbers	04.02.10

Outcome 13: Acute Care

Adams	179	Imported plasma products	26.11.09
Adams	176	Blood fractionation	04.02.10
Adams	177	Contract between CSL and NBA	04.02.10
Boyce	276	Elective surgery	04.02.10
Boyce	277	Waiting times	04.02.10
Cormann	278	Hospitals	04.02.10
Adams	113	Indigenous dental service	04.02.10

Outcome 14: Biosecurity and Emergency Response

Back	251	Pandemic H1N1 vaccine	04.02.10
Scullion	273	Pandemic H1N1 vaccination program	04.02.10
Adams	116	Pandemic H1N1 vaccination program	04.02.10

Outcome 15: Sport Performance and Participation

		Letter dated11 Nov 09 amending evidence provided at hearing on 21 Oct 09 relating to Local Sporting Champions program	26.11.09
Fifield	200	Crawford Review	04.02.10
Fifield	201	Illicit drugs in sport	04.02.10
Fifield	202	Sport and recreation facilities	04.02.10

Fifield	226	Local sporting champions 2008-09	04.02.10
Fifield	225	Major international event performances 2009	04.02.10
Fifield	227, 228	Local sporting champions	04.02.10
Fifield	222	Medal predictions	25.02.10
Fifield	223	Olympic cycle comparisons	25.02.10
Fifield	224	Benchmarks	25.02.10

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-188

OUTCOME 0: Whole of Portfolio

Topic: HEALTH REFORM TASKFORCE CONSULTATION STAFFING COSTS

Hansard Page: CA 10

Senator Cormann asked:

What would be the cost of those 18 to 20 people (seconded into the task force from other areas of the department) for six months?

Answer:

The estimated net cost to the Department for consultation staff for six months to end December 2009 is $183,265. This figure takes into account the staff who were directly involved in managing the consultation events. As many of these staff were sourced from other areas of the Department and their positions were not backfilled, there was no additional net staffing cost associated with their secondment.

Further, many of the staff seconded to the Taskforce were there for less than the full period.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-072

OUTCOME 0: Whole of Portfolio

Topic: PROGRAM UNDERSPENDS

Written Question on Notice

Senator Boyce asked:

Can the Department provide a list of all programs which were underspent in 2008-09?

Answer:

The table below shows 2008-09 actual expenses compared to the Final Budget Outcome estimates as reported in the Department's 2008-09 Annual Report, where the variance is greater than the Department of Finance and Deregulation advised reportable threshold of $20 million.

Program name	**($'000)**
Program 2.2: Pharmaceuticals and Pharmaceutical Services	-59,946
Program 5.2: Primary Care Financing, Quality and Access	-20,375
Program 13.2: Medical Indemnity	-48,331
Program 14.1: Health Emergency Planning and Response	-43,033

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-076

OUTCOME 0: Whole of Portfolio

Topic: HEALTH AND HOSPTIAL COMMISSION REPORT

Written Question on Notice

Senator Boyce asked:

Given that the Health and Hospital Reform Commission provided an interim report early this year and a final report almost four months ago, what actions have been taken to implement any of its recommendations?

Answer:

The final report of the National Health and Hospitals Reform Commission provides 123 recommendations about long term, comprehensive health care reform.

Since the report's release on 27 July 2009, the Government has been consulting with the public and health sector professionals to ask their views.

This includes a public communication website www.yourhealth.gov.au, which has had more than 136,000 visitors since its launch.

The Government has also undertaken around 75 consultations in capital cities and regional areas across the country, with more than 5,000 health professionals attending.

The Prime Minister said on 27 July 2009 that following the conclusion of this extensive direct engagement with the sector based on the concrete recommendations put to the Government by the Commission, the Government will then convene a special Council of Australian Governments (COAG) meeting with the states and territories in late 2009, explicitly on health and hospitals reform.

This will be followed by a further COAG meeting in early 2010 where the Commonwealth will put to the states and territories a reform plan that they would either agree with or disagree with as a future direction for health and hospitals reform.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-080

OUTCOME 0: Whole of Portfolio

Topic: STAFFING LEVELS

Written Question on Notice

Senator Boyce asked:

a) What are the current staffing levels for SES and non-SES officers?

b) What is the breakdown by location?

Answer:

a) The department has a total of 133 SES and 4,811 non-SES officers as at 31 October 2009.

b) The table below provides the breakdown by location.

Location	**SES**	**Non-SES**	**Total Staff**
Australian Capital Territory	128	3,955	4,083
New South Wales	1	196	197
Victoria	1	200	201
Queensland	1	164	165
South Australia	1	97	98
Western Australia	1	98	99
Tasmania		44	44
Northern Territory		57	57
Total	**133**	**4,811**	**4,944**

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-081

OUTCOME 0: Whole of Portfolio

Topic: CHANGES IN ACTUAL STAFFING LEVEL (ASL)

Written Question on Notice

Senator Boyce asked:

c) What have been the changes in ASL since November 2007?

d) Why have these changes occurred?

e) What have been the budgetary implications?

Answer:

a) The ASL for financial year 2008-09 was 134 less than in financial year 2007-08 (4,363 and 4,497 respectively).

b) The reductions in the department's staffing levels in financial year 2008-09 are consistent with the level of resources provided by the Government.

c) The department has allocated the resources provided consistent with the Government's objectives.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-082

OUTCOME 0: Whole of Portfolio

Topic: REDUCTIONS IN STAFF NUMBERS

Written Question on Notice

Senator Boyce asked:

f) In the case of reductions in staff numbers, how have these reductions been absorbed by the Department?

g) What functions have been sacrificed and why?

h) Has there been a target for staff reductions to achieve savings?

i) What is that target and what strategy is being implemented to achieve this?

Answer:

a) The reduction of staff has occurred through natural attrition and the offering and acceptance of 29 voluntary redundancies.

b) No specific functions have been targeted.

c) No.

d) Not applicable.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-083

OUTCOME 0: Whole of Portfolio

Topic: REDUNDANCIES

Written Question on Notice

Senator Boyce asked:

j) Have any voluntary or involuntary redundancies been offered to staff?

k) If so, how have staff been identified for such offers?

l) Are there such plans in the future?

Answer:

a) In 2008-09 the department offered 29 voluntary redundancies.

b) As is normal practice, branches within the department review and reprioritise functions and activities, and as a result some functions and activities change or are no longer undertaken. In 2008-09 in accordance with usual practice, affected staff, in positions where functions or activities changed, were consulted to identify those who had an interest in a proposed voluntary retrenchment.

c) At this time the department does not have any plans to offer further voluntary redundancies.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-086

OUTCOME 0: Whole of Portfolio

Topic: ELECTORAL DATA

Written Question on Notice

Senator Boyce asked:

Has electoral specific data been used by the current Government in any grants scheme since November 2007?

Answer:

No. Grants in the Health and Ageing portfolio are not implemented or allocated differentially on the basis of Commonwealth electorates. Decisions and assessments for grant eligibility are determined on a needs basis and not by Commonwealth electorate boundaries. All grants are administered in accordance with the Commonwealth Grant Guidelines released by the Department of Finance and Deregulation in July 2009. The department's Annual Report and the Portfolio Budget Statements set out information about its grants for administered funds.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-126

OUTCOME 0: Whole of Portfolio

Topic: STAFFING LEVELS

Written Question on Notice

Senator Adams asked:

m) What are the current staffing levels for SES and non-SES officers?

n) What is the breakdown by location?

Answer:

b) The department has a total of 133 SES and 4,811 non-SES officers as at 31 October 2009.

b) The table below provides the breakdown by location.

Location	**SES**	**Non-SES**	**Total Staff**
Australian Capital Territory	128	3,955	4,083
New South Wales	1	196	197
Victoria	1	200	201
Queensland	1	164	165
South Australia	1	97	98
Western Australia	1	98	99
Tasmania		44	44
Northern Territory		57	57
Total	**133**	**4,811**	**4,944**

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-127

OUTCOME 0: Whole of Portfolio

Topic: AVERAGE STAFFING LEVEL (ASL)

Written Question on Notice

Senator Adams asked:

o) What have been the changes in ASL since November 2007?

p) Why have these changes occurred?

q) What have been the budgetary implications?

Answer:

d) The ASL for financial year 2008-09 was 134 less than in financial year 2007-08 (4,363 and 4,497 respectively).

e) The reductions in the department's staffing levels in financial year 2008-09 are consistent with the level of resources provided by the Government.

f) The department has allocated the resources provided consistent with the Government's objectives.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-129

OUTCOME 0: Whole of Portfolio

Topic: STAFF REDUCTIONS

Written Question on Notice

Senator Adams asked:

r) Has there been a target for staff reductions to achieve savings?

s) What is that target and what strategy is being implemented to achieve this?

Answer:

a) No.

b) Not applicable.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-130

OUTCOME 0: Whole of Portfolio

Topic: REDUNDANCIES

Written Question on Notice

Senator Adams asked:

t) Have any voluntary or involuntary redundancies been offered to staff?

u) If so, how have staff been identified for such offers?

v) Are there such plans in the future?

Answer:

d) In 2008-09 the department offered 29 voluntary redundancies.

e) As is normal practice, branches within the department review and reprioritise functions and activities, and as a result some functions and activities change or are no longer undertaken. In 2008-09 in accordance with usual practice, affected staff, in positions where functions or activities changed, were consulted to identify those who had an interest in a proposed voluntary retrenchment.

f) At this time the department does not have any plans to offer further voluntary redundancies.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-134

OUTCOME 0: Whole of Portfolio

Topic: ELECTORAL SPECIFIC DATA

Written Question on Notice

Senator Adams asked:

Has electoral specific data been used by the current Government in any grants scheme since November 2007?

Answer:

No. Grants in the Health and Ageing portfolio are not implemented or allocated differentially on the basis of Commonwealth electorates. Decisions and assessments for grant eligibility are determined on a needs basis and not by Commonwealth electorate boundaries. All grants are administered in accordance with the Commonwealth Grant Guidelines released by the Department of Finance and Deregulation in July 2009. The department's Annual Report and the Portfolio Budget Statements set out information about its grants for administered funds.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-154

OUTCOME 0: Whole of Portfolio

Topic: AWARD MODERNISATION

Written Question on Notice

Senator Adams asked:

a) What will be the cost of maintaining service delivery at current levels?
b) How has this assessment been made?
c) What corrective measures are planned to deal with these impacts?

Answer:

a – c)

Any Public Service Awards that apply to staff of the Department are not affected by the implementation of Awards Modernisation from 1 January 2010.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-155

OUTCOME 0: Whole of Portfolio

Topic: WORK SAFE LEGISLATION

Written Question on Notice

Senator Adams asked:

What financial provisions has the Department made for extra costs associated with the new Work Safe Legislation?

Answer:

The legislation has not yet been passed by Parliament and as such, the Department is unable to ascertain whether any additional costs will be incurred.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-156

OUTCOME 0: Whole of Portfolio

Topic: SALARY INCREASES

Written Question on Notice

Senator Adams asked:

Have there been any provisions made for wage and salary increases following the implementation of Award Modernisation from 1 January 2010?

Answer:

Any Public Service Awards that apply to staff of the Department are not affected by the implementation of Awards Modernisation from 1 January 2010.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-164

OUTCOME 0: Whole of Portfolio

Topic: HEALTH AND HOSPTIAL COMMISSION REPORT

Written Question on Notice

Senator Adams asked:

a) Has the Minister been briefed on the NHHRC final report?

b) Does the Department believe that the Minister's office have a sound understanding of these issues?

Answer:

a) Yes.

b) Yes.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-218

OUTCOME 0: Whole of Portfolio

Topic: FOI REQUESTS

Written Question on Notice

Senator Boyce asked:

a) Have those requests, the two that were considered an unreasonable diversion of resources, been narrowed by the people seeking the information?

b) Can you tell me what they related to?

c) If the question has been narrowed?

d) If they have since been finalised?

Answer:

a) No.

b) Both requests related to documents held by the Therapeutic Goods Administration - one request related to documents used by any party in particular Federal Court proceedings and the other related to certificates submitted under section 26B and 26C of the *Therapeutic Goods Act 1989*, since 1 August 2004.

c) No - neither applicant responded to the request to narrow their freedom of information application.

d) One applicant has received formal notification of a decision to refuse to process the request; the other application has not progressed given the lack of response from the applicant.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-267

OUTCOME 0: Whole of Portfolio

Topic: PROGRAM UNDERSPENDS

Hansard page CA22

Senator Adams asked:

a) Which programs administered by the department and its agencies are currently experiencing underspends?

b) In each instance can you please provide full details, including the amount of the underspend, the reasons they have occurred and whether the underspend will be used elsewhere within the department?

c) If so, where?

Answer:

a – c)

Actual expenditure is monitored against the budget estimates on a continuous basis. Identified potential underspends are agreed with the Department of Finance and Deregulation and estimates are adjusted accordingly. This constant adjustment of estimates ensures close alignment between program expenditure and financial allocations from Government.

Underspends that become apparent through the year will be reflected in revised estimates and published in the Health and Ageing 2009-10 Portfolio Additional Estimates Statements tabled with the 2009-10 Additional Estimates Bills or in the Health and Ageing 2010-11 Portfolio Budget Statements tabled with the 2010-11 Budget Bills.

In light of this approach and at this date, no programs are known to be tracking for an underspend this financial year. Actual annual underspends for 2009-10 will be available in August 2010.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-165

OUTCOME 0: Whole of Portfolio

Topic: 'LISTENING TOUR'

Written Question on Notice

Senator Adams asked:

c) Given that Minister Elliot has travelled to each state and territory since becoming Minister and provided that you are confident with the Minister's knowledge of the portfolio, what does the Department hope to achieve from the Government's 'listening tour' which followed the release of the National Health and Hospitals Reform Commission's A healthier future for all Australians report in June this year?

d) Does the Department believe that the current 'listening tour' is necessary in order to respond to the recommendations of the National Health and Hospitals Reform Commission's final report?

Answer:

a and b)

At the time the National Health and Hospitals Reform Commission Report was launched on 27 July, the Prime Minister said that the Government will use the recommendations of this report as a basis for direct consultation with the health sector and the Australian public between now and the end of the year. He indicated that he wanted to hear first-hand from those in the front-line of health and hospital care.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-178

OUTCOME 0: Whole of Portfolio

Topic: HEALTH AND HOSPITALS FUND

Written Question on Notice

Senator Adams asked:

On 14 October 2008, the Prime Minister announced that the Government had committed $5 billion to the Health and Hospitals Fund (HHF), one of three nation-building funds.

a) What is the expenditure to date out of the fund?

b) Itemise each project and the amount and location of the spend to date?

c) What is the amount of funding still available in the HHF?

Answer:

a) As at 21 October 2009, a total of $187.9 million in HHF funding has been spent. Of the $186 million allocated in 2008-09, $185 million was spent. $2.943 million has been spent to date in 2009-10.

b)

Project Name	**Location**	**Project Cost $m (GST excl)**	**Expenditure to 21 Oct 09 $m (GST excl)**
National Cancer Statement			
Parkville Comprehensive Cancer Centre	Parkville, VIC	426.1	9.2
Lifehouse at RPA (the Chris O'Brien Cancer Centre)	Camperdown, NSW	100.0	
Regional Cancer Centres	National	560.0	
Funding Digital Mammography for BreastScreen Australia	National	120.0	
Garvan St Vincent's Campus Cancer Centre	Darlinghurst, NSW	70.0	29.8
Hospital Infrastructure and other projects of national significance			
Australian Red Cross Blood Service: Victoria/Tasmania Principal Site Development	Melbourne, VIC	120.0	
A new facility for the Donor Tissue Bank of Victoria (Ensuring future access to human tissue in Australia)	South Bank, Melbourne, VIC	13.0	
Townsville Hospital Expansion	Townsville, QLD	250.0	24.0
Rockhampton Hospital Expansion	Rockhampton, QLD	76.0	19.0

Health and Medical Research Institute	Adelaide, SA	200.0	30.0
New rehabilitation unit at Fiona Stanley Hospital	Murdoch, WA	255.7	
Midland Health Campus	Midland, WA	180.1	
Kimberley Renal Services	Broome (serving the Kimberley Region), WA	8.6	
Replacement Paediatrics Unit Broome Hospital	Broome (serving the Kimberley Region), WA	7.9	
Hospital Emergency Department in Alice Springs	Alice Springs, NT	13.6	
Northern Territory Medical Program	Darwin, NT	27.8	
Royal Darwin Hospital - Short Term Patient Accommodation	Darwin, NT	18.6	
Acute Medical and Surgical Service Unit, Launceston General Hospital (LGH)	Launceston, TAS	40.0	10.0
Narrabri District Health Service	Narrabri, NSW	27.0	
Blacktown Hospital Clinical School, Research and Education Centre	Blacktown, NSW	17.6	
Nepean Health Services Redevelopment - Stage 3 (including Pialla)	Penrith, NSW	96.4	17.0
Oral Health Centre	Brisbane, Qld	104.0	
Primary care infrastructure in rural Australia (23 projects of $500,000 or less in various locations)	NSW, SA, QLD, WA, VIC, TAS	9.2	2.9
Translational Research and Workforce Training			
Ingham Health Research Institute Facilities	Liverpool, NSW	46.9	
Monash Health Research Precinct Translation Facility	Clayton, VIC	71.0	
The Melbourne Neuroscience Project	Parkville, VIC	39.8	
Children's Bioresource Centre	Parkville, VIC	4.7	
The Eccles Institute Building better mind and vision health outcomes: Stage 3 of the John Curtin School of Medical Research redevelopment	Canberra, ACT	60.0	16.5
Menzies Building - Stage 2	Hobart, TAS	44.7	
New research and training facility - Menzies School of Health Research (NT)	Darwin, NT	34.2	
Construction of Hunter Medical Research Institute building	Newcastle, NSW	35.0	
Northern Health Research and Education Precinct	Epping, VIC	14.0	
Translational Research Institute – at Princess Alexandra Hospital	Brisbane, QLD	40.0	18.5
Nepean Clinical School	Penrith, NSW	17.2	
Clinical medical education and best practice in Ambulatory Care for the Werribee region of Victoria and Auburn region of NSW	Werribee, VIC and Auburn, NSW	22.8	11.0
Total		**3,171.9**	**187.9**

c) In a media release dated 19 October 2009, the Future Fund advised that as at 30 September 2009, funds in the HHF stood at $4.878 billion. This consists of the balance of unexpended funds from the $3.2 billion announced in the 2009-10 Budget, the uncommitted $1.8 billion and returns on investment.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-128

OUTCOME 0: Whole of Portfolio

Topic: STAFFING

Written Question on Notice

Senator Adams asked:

w) In case of reductions in staff numbers, how have these reductions been absorbed by the Department?

x) What functions have been sacrificed and why?

Answer:

b) The reduction of staff has occurred through natural attrition and the offering and acceptance of 29 voluntary redundancies.

b) No specific functions have been targeted.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-070

OUTCOME 0: Whole of Portfolio

Topic: STAFFING

Written Question on Notice

Senator Adams asked:

y) What is the total expenditure on staffing for the Department and for all portfolio agencies?

z) What is the SES and non-SES breakdown?

Answer:

a) The total 2008-09 expenditure on staffing for the Department and for all portfolio agencies is disclosed in Table 1.

b) The 2008-09 SES and non-SES breakdown of total expenditure on staffing is also disclosed in Table 1.

Table 1

Health Portfolio Agency	Total Staff Expenditure 2008-09[1]	SES & Equivalent Staff Expenditure 2008-09[2]	Non SES Staff Expenditure 2008-09
FMA Agencies			
Department of Health and Ageing	$455,766,000	$29,516,992	$426,249,008
Australian Organ and Tissue Donation and Transplantation Authority	$800,338	$242,511	$557,827
Australian Radiation Protection and Nuclear Safety Agency	$14,383,206	$1,290,192	$13,093,014
Australian Sports Anti-Doping Authority	$6,846,000	$700,356	$6,145,644
Cancer Australia	$2,671,721	$626,683	$2,045,038
National Blood Authority	$6,162,000	$1,181,679	$4,980,321
National Health and Medical Research Council	$22,546,000	$2,269,614	$20,276,386
Private Health Insurance Ombudsman	$842,260	$222,792	$619,468
Professional Services Review	$2,728,120	$544,579	$2,183,541
CAC Agencies			
Aged Care Standards and Accreditation Agency	$24,788,679	$1,315,170	$23,473,509
Australian Institute of Health and Welfare	$21,833,484	$1,393,512	$20,439,972
Australian Sports Commission[3]	$66,051,133	$1,835,000	$64,216,133
Food Standards Australia New Zealand	$14,497,859	$1,286,553	$13,211,306
General Practice Education and Training	$3,111,544	$726,919	$2,384,625
National Breast and Ovarian Cancer Centre	$2,443,029	$243,074	$2,199,955
Private Health Insurance Administration Council	$2,990,266	$208,758	$2,781,508
Total	**$648,461,639**	**$43,604,384**	**$604,857,255**

Notes:

[1] Total staff expenditure amount excludes payments to Board of Directors for CAC Agencies.

[2] SES and Equivalent Staff expenditure includes Statutory Office Holders and Medical Officers 5 & 6.

[3] Australian Sports Foundation (ASF) amounts are included with Australian Sports Commission as they employ all ASF staff.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-073

OUTCOME 0: Whole of Portfolio

Topic: DEPARTMENTAL REPORTS AND REVIEWS

Written Question on Notice

Senator Boyce asked:

The Department has published 30 reports so far in 2009, as made available on the website. I am interested in how Departmental reports are commissioned.

a) How many reports has the Government commissioned within the Department each year over the past three years?

b) Can the Department please provide details of each report including date commissioned, date report handed to government, date of public release, Terms of Reference and committee members?

c) How much did each report cost?

d) How many departmental staff are involved in each report and at what level?

e) What is the current status of each report?

f) When is the Government intending to respond to these reports?

g) What outcomes have been implemented at this point from any of these reports/reviews?

h) What outcomes from these reports/reviews is the Department currently assessing or actively preparing to implement?

Answer:

a) The term ‘reports’ and/or ‘reviews’ is fairly broad and ambiguous. In answering this question the Department has provided information on reports from major policy reviews commissioned by the current Government. The Department has identified six reports in this category. This figure excludes internal reports and reviews which are undertaken as part of the day-to-day management of programs; reviews routinely undertaken as part of administrative processes; and report publications which are produced as part of the health and ageing portfolio's statutory obligations and program responsibilities.

Answers to questions b, c, d and e for each report are summarised below:

REVIEW OF MATERNITY SERVICES IN AUSTRALIA

b) **Date commissioned**: 10 September 2008
Date handed to Government: Early February 2009
Date of public release: 21 February 2009
Terms of reference: The Review considered issues relevant to maternity services, including antenatal services, birthing options, postnatal services up to six weeks after birth, and peer and social support for women in the perinatal period.
Committee members: The review was undertaken by the Department of Health and Ageing.

c) **Cost:** $497,539.00

d) **Staffing:** Average staffing level over the period of the Review was 7.75 ASL.
The levels range from GAPS to SES1.

e) **Status:** Completed.

NATIONAL PRIMARY HEALTH CARE STRATEGY

b) **Date commissioned:** 11 June 2008
Date handed to Government: 29 June 2009
Date of public release: 31 August 2009
Terms of reference:
The External Reference Group will work closely with the Government in the development of the Strategy, including:

- providing expert input on primary health care issues being considered as part of the development of the Strategy;
- reviewing and commenting on information relating to the Strategy prior to release for broader consultation; and
- assisting the Department in the analysis of, and responses to, the range of comments which may be received from broader consultation processes.

Committee members: Dr Tony Hobbs (Chair); Mr Peter Fazey ; Professor Mark Harris; Associate Professor Noel Hayman; Professor Claire Jackson; Ms Judy Liauw; Professor Lyn Littlefield OAM; Ms Anne Matyear; Mr Mitch Messer; Dr Rod Pearce; Dr Vasantha Preetham; Professor Hal Swerissen; and Dr Barbara Vernon

c) **Cost:** $1,277,032.00

d) **Staffing:** Average staffing level over the period of the Review was 9.05 ASL. The levels range from APS4 to SES1.

e) **Status:** Completed.

NATIONAL HEALTH AND HOSPITALS REFORM COMMISSION

b) **Date commissioned:** 25 February 2008
Date handed to Government: 27 July 2009
Date of public release: 27 July 2009
Terms of reference:

Australia's health system is in need of reform to meet a range of long-term challenges, including access to services, the growing burden of chronic disease, population ageing, costs and inefficiencies generated by blame and cost shifting, and the escalating costs of new health technologies.

The Commonwealth Government will establish a National Health and Hospitals Reform Commission to provide advice on performance benchmarks and practical reforms to the Australian health system which could be implemented in both the short and long term, to address these challenges.

1. By April 2008, the Commission will provide advice on the framework for the next Australian Health Care Agreements, including robust performance benchmarks in areas such as (but not restricted to) elective surgery, aged and transition care, and quality of health care.
2. By June 2009, the Commission will report on a long-term health reform plan to provide sustainable improvements in the performance of the health system addressing the need to:
 a. reduce inefficiencies generated by cost-shifting, blame-shifting and buck-passing;
 b. better integrate and coordinate care across all aspects of the health sector, particularly between primary care and hospital services around key measurable outputs for health;
 c. bring a greater focus on prevention to the health system;
 d. better integrate acute services and aged care services, and improve the transition between hospital and aged care;
 e. improve frontline care to better promote healthy lifestyles and prevent and intervene early in chronic illness;
 f. improve the provision of health services in rural areas;
 g. improve Indigenous health outcomes; and
 h. provide a well qualified and sustainable health workforce into the future.

The Commission's long-term health reform plan will maintain the principles of universality of Medicare and the Pharmaceutical Benefits Scheme, and public hospital care.

The Commission will report to the Commonwealth Minister for Health and Ageing, and, through her to the Prime Minister, and to the Council of Australian Governments and the Australian Health Ministers' Conference.

The Commonwealth, in consultation with the States and Territories from time to time, may provide additional terms of reference to the Commission.

The Commission will comprise a Chair, and between four to six part-time commissioners who will represent a wide range of experience and perspectives, but will not be representatives of any individual stakeholder groups.

The Commission will consult widely with consumers, health professionals, hospital administrators, State and Territory governments and other interested stakeholders.

The Commission will address overlap and duplication including in regulation between the Commonwealth and States. The Commission will provide the Commonwealth Minister for Health and Ageing with regular progress reports.

Committee members: Dr Christine Bennett (Chair); Professor Justin Beilby; Dr Stephen Duckett; The Hon Dr Geoff Gallop AC; Dr Mukesh Haikerwal; Associate Professor Sabina Knight; The Hon Rob Knowles AO; Ms Mary Ann O'Loughlin; Professor Ronald Penny AO; Dr Sharon Willcox

c) **Cost:** $6,856,605.87

d) **Staffing:** Average staffing level over the period of the Review was 9.952 ASL.
Levels range from APS4 to SES2.

e) **Status:** Completed.

NATIONAL PREVENTATIVE HEALTH STRATEGY

b) **Date commissioned:** 9 April 2008
Date handed to Government: 30 June 2009
Date of public release: 1 September 2009
Terms of reference:
The Preventative Health Taskforce will provide evidence-based advice to government and health providers – both public and private – on preventative health programs and strategies, and support the development of a National Preventative Health Strategy.
The Strategy will provide a blueprint for tackling the burden of chronic disease currently caused by obesity, tobacco, and excessive consumption of alcohol. It will be directed at primary prevention and will address all relevant arms of policy and all available points of leverage, in both the health and non-health sectors, in formulating its recommendations.
The Taskforce will also:

1. support the further development of the evidence base on preventative health, to inform what works and what doesn't;
2. provide advice for policy makers on what strategies work best at a population level, and on the best buys for government investment in primary prevention;
3. provide advice on the most effective strategies for targeting prevention in high risk sub-populations including Aboriginal and Torres Strait Islander peoples and people living in rural and remote locations;
4. provide guidance and support for clinicians, particularly in primary care settings to play a more effective role in preventative health care;
5. provide advice to Government on options for better integration of preventative health practice into the Medicare Schedule and other existing government programs; and
6. support the development of inter-governmental and public-private partnerships on preventative health.

Accountability and deliverables
The Taskforce will report to the Commonwealth Minister for Health and Ageing. The Taskforce will use a multidisciplinary approach, operate in a collaborative, open and consultative manner, and work in partnership with existing agencies and bodies working in associated areas.
The Taskforce will provide:

- advice on the framework for the Preventative Health Partnerships between the Commonwealth and the states and territories by July 2008;
- a three year work program by September 2008;
- a National Preventative Health Strategy by June 2009; and
- advice on such matters as may be referred to the Taskforce from time to time by the Commonwealth Minister of Health and Ageing.

The Taskforce shall be supported in its operations by the Commonwealth Department of Health and Ageing.

Committee members: Professor Rob Moodie (Chair); Professor Mike Daube; Professor Paul Zimmet AO; Ms Kate Carnell AO; Dr Lyn Roberts AM; Dr Shaun Larkin; Professor Leonie Segal; the Australian Health Ministers' Conference (AHMC) will be asked to nominate two government representatives with particular experience in Indigenous public health, rural and remote public health, and community

c) **Cost:** $1,254,243.

d) **Staffing:** Average staffing level over the period of the Review was 5.23ASL.
Levels range from APS 4 to EL2:

e) **Status:** Completed.

NEW DIRECTIONS FOR AUSTRALIAN SPORT – CRAWFORD REPORT

b) **Date commissioned:** 28 August 2008
Date handed to Government: 16 October 2009
Date of public release: 17 November 2009
Terms of reference:
An independent expert panel has been appointed to make recommendations on the specific structures, programs and reform required to ensure the continuing robustness of the Australian sport system.
The panel, in reporting on these terms of reference, will take into account the growing challenges to Australia in the global sporting environment in the post-Beijing environment, note scientific advances and international sporting trends, and make particular recommendations about the best way to retain our international standing.
They will pay particular attention to the most effective manner that sport and physical activity can play a strong

role in building a healthier Australia and forming part of the Commonwealth Government's preventative health agenda. They will also assess the structure and capability of the Australian sports system as a whole, to achieve competitive advantage in delivering nationally desirable sport outcomes from social and community level right through to the highest levels of elite performance. Recommendations will be particularly directed towards the following Terms of Reference:

1. Ensure Australia's continued elite sporting success
   - Identify any areas of duplication within Australia's sporting system and recommend ways to build a more efficient system.
   - Examine the relationship between the Australian Sports Commission, Australian Institute of Sport, State and Territory Institutes, academies of sport and regional institutes and how this relationship could deliver better athlete pathways.
   - Recommend opportunities to ensure maximum returns from talent identification programs.
2. Better place sport and physical activity as a key component of the Government's preventative health approach
   - Examine Government frameworks to ensure an on-going focus on grassroots and community sport and physical activity.
   - Examine Government programs to increase participation rates in sport and physical activity, including analysis of existing programs.
   - Identify and recommend opportunities to break down barriers to participation at junior, adult and senior ages with a view to making it simpler and easier for Australians to participate in the sport or physical activity of their choice, including for women, the disabled and Indigenous people.
   - Recommend strategies to increase the effectiveness of the promotion of sport by the Federal Government to better communicate positive health and activity messages to the broader community.
3. Strengthen pathways from junior sport to grassroots community sport right through to elite and professional sport
   - Examine the capacity of the system to ensure optimal and efficient delivery of the athlete and coach pathway for any given sport.
   - Recommend the most effective support and recognition for the coaches, officials, umpires, administrators and volunteers who keep our community clubs alive.
   - Examine how relationships between the Commonwealth Government and National Sporting Organisations, State Sporting Organisations and Australia's peak representative bodies at key multi-sports competitions may be strengthened to deliver better performance outcomes.
4. Maintain Australia's cutting edge approach to sports science, research and technology
   - Examine the capacity of the system to ensure provision of cutting edge technology, innovation, sport science, sports medicine, applied research to underpin sport performance and development, including ways to maintain Australia's position as leaders in anti-doping.
   - Examine the current partnerships in place within these fields and recommend any potential partnerships.
5. Identify opportunities to increase and diversify the funding base for sport through corporate sponsorship, media and any recommended reforms, such as enhancing the effectiveness of the Australian Sports Foundation.

Committee members: David Crawford; Mark Bouris**;** Sam Mostyn**;** Pamela Tye; and

Colin Carter

c) **Cost:** $1,050,904

d) **Staffing:** Average staffing level over the period of the Review was 5.07 ASL. The levels range from APS4 to EL2.

e) **Status:** Completed.

HEALTH TECHNOLOGY ASSESSMENT REVIEW

b) **Date commissioned:** 18 December 2008
Date handed to Government: The Report is not completed.
Date of public release: The Report is not completed.
Terms of reference:
The Health Technology Assessment (HTA) Review is to report on the following matters:

1. Simplification and better co-ordination between the Commonwealth HTA processes (as identified in the Review scope), which includes:
   a. consideration of a single entry point and tracking system for applications for market registration and

funding;
   b. making time to affordable access as short as possible for new technologies while maintaining or improving the rigour of evaluation processes; and
   c. examination of the feasibility of conducting concurrent assessments for market registration and funding and coverage purposes, noting current work in this area.
2. Improving role clarity and addressing duplication between processes, where it exists, including consideration of consolidating functions with the Australian HTA system.
3. Reviewing post marketing surveillance mechanisms to ensure the ongoing safety, and efficacy of medical devices.
4. Strengthening transparency and procedural fairness in the assessment, decision making and fee negotiation arrangements for processes (as outlined in the Review scope) through improved communication with stakeholders about process, methodologies, outcomes and performance against key indicators.
5. Enhanced arrangements for assessment of co-dependent and hybrid technologies

Committee members: The review is being undertaken by the Department of Health and Ageing.

c) **Cost:** As the report is not yet complete, costs cannot be provided at this time.

d) **Staffing:** As the report is not yet complete, staffing information cannot be provided at this time.

e) **Status:** Ongoing at 21 October 2009.

f) On 12 May 2009, the Australian Government responded to the report of the Review of Maternity Services in Australia. The Department has not been advised when the Australian Government intends to respond to the other reports.

g) The Australian Government has responded to the recommendations from the *Review of Maternity Services in Australia* report with the Budget package, *Providing More Choice in Maternity Care – Access to Medicare and PBS for Midwives.*

h) The Department is supporting the Australian Government in using the recommendations of the National Health and Hospitals Reform Commission report, together with the draft National Primary Health Care Strategy and the National Preventative Health Strategy as a basis for direct consultation with the health sector and the Australian public.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-074

OUTCOME 0: Whole of Portfolio

Topic: PUBLICATION OF REPORTS

Written Question on Notice

Senator Boyce asked:

Does the Department as a whole oversee the publication of each report, or is this something done entirely within each outcome, program or agency?

Answer:

The respective areas of the Department oversee the publication of reports generated by those areas. External review bodies oversee the publication of reports produced by them.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2008

Question: E09-075

OUTCOME 0: Whole of Portfolio

Topic: DEPARTMENTAL REPORTS

Written Question on Notice

Senator Boyce asked:

a) Does the Department actively follow up with the Government to receive a response to reports, or decisions on recommendations contained within reports?

b) Does it keep a list of reports where a government response is outstanding?

c) If so, can the Department provide the list of reports where a government response is outstanding for each year over the past three years, including the date at which each report was handed to government?

Answer:

a) No, the Government determines the handling of policy reports which it commissions.

b) No.

c) Not applicable.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-077

OUTCOME 0: Whole of Portfolio

Topic: ELECTION COMMITMENTS

Written Question on Notice

Senator Boyce asked:

a) Does the Department monitor the status of Government election commitments?

b) If so, what information does the Department provide the Government on these commitments?

Answer:

a) The Department uses standard program management practices to regularly monitor the implementation progress of all program activities.

b) The Department provides information on a regular basis to the Government about the progress of policies and programs it is responsible for implementing.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-079

OUTCOME 0: Whole of Portfolio

Topic: STAFFING

Written Question on Notice

Senator Boyce asked:

aa) What is the total expenditure on staffing for the Department and for all portfolio agencies?

bb) What is the SES and non-SES breakdown?

Answer:

c) The total 2008-09 expenditure on staffing for the Department and for all portfolio agencies is disclosed in Table 1.

d) The 2008-09 SES and non-SES breakdown of total expenditure on staffing is also disclosed in Table 1.

Table 1

Health Portfolio Agency	Total Staff Expenditure 2008-09[1]	SES & Equivalent Staff Expenditure 2008-09[2]	Non SES Staff Expenditure 2008-09
FMA Agencies			
Department of Health and Ageing	$455,766,000	$29,516,992	$426,249,008
Australian Organ and Tissue Donation and Transplantation Authority	$800,338	$242,511	$557,827
Australian Radiation Protection and Nuclear Safety Agency	$14,383,206	$1,290,192	$13,093,014
Australian Sports Anti-Doping Authority	$6,846,000	$700,356	$6,145,644
Cancer Australia	$2,671,721	$626,683	$2,045,038
National Blood Authority	$6,162,000	$1,181,679	$4,980,321
National Health and Medical Research Council	$22,546,000	$2,269,614	$20,276,386
Private Health Insurance Ombudsman	$842,260	$222,792	$619,468
Professional Services Review	$2,728,120	$544,579	$2,183,541
CAC Agencies			
Aged Care Standards and Accreditation Agency	$24,788,679	$1,315,170	$23,473,509
Australian Institute of Health and Welfare	$21,833,484	$1,393,512	$20,439,972
Australian Sports Commission[3]	$66,051,133	$1,835,000	$64,216,133
Food Standards Australia New Zealand	$14,497,859	$1,286,553	$13,211,306
General Practice Education and Training	$3,111,544	$726,919	$2,384,625
National Breast and Ovarian Cancer Centre	$2,443,029	$243,074	$2,199,955
Private Health Insurance Administration Council	$2,990,266	$208,758	$2,781,508
Total	**$648,461,639**	**$43,604,384**	**$604,857,255**

Notes:

[1] Total staff expenditure amount excludes payments to Board of Directors for CAC Agencies.

[2] SES and Equivalent Staff expenditure includes Statutory Office Holders and Medical Officers 5 & 6.

[3] Australian Sports Foundation (ASF) amounts are included with Australian Sports Commission as they employ all ASF staff.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-087

OUTCOME 0: Whole of Portfolio

Topic: CONSULTANCIES

Written Question on Notice

Senator Boyce asked:

cc) How much has the Department spent on consultancy services since November 2007?

dd) How can the Department justify this expenditure?

ee) Could the Department provide a complete list of current consultancy services?

ff) For each consultancy, please indicate the rationale for the project and its intended use?

gg) For each consultancy, please indicate why the Department or its agencies could not have undertaken the work themselves?

Answer:

a) As at 21 October 2009, the Department (including the National Industrial Chemicals Notification and Assessment Scheme, Office of Gene Technology Regulator, and Therapeutic Goods Administration) had spent $73,509,847.87 on consultancy services since 1 November 2007.

b) These consultancies are important and necessary investments in undertaking substantial policy development work critical to the implementation of the government's policy reform agenda and to support evidence-based policy development.

c) A list of current consultancies as at 21 October 2009 has been provided in Attachment A. 36 consultancies for Therapeutic Goods Administration have been omitted as a result of restrictions in reporting under the *Privacy Act 1988* and commercial confidentiality.

d) The rationale for the project and its intended use for each of the consultancies is addressed via the 'Consultancy Purpose' field in Attachment A.

e) The reason the Department or its agencies could not undertake each of the consultancies is addressed via the "Consultancy Reason" field in Attachment A. The reasons cited accord with definitions as specified in the Department's Annual Report.

Consultant	Consultancy Purpose	Consultancy Reason
Albert G Frauman Pty Ltd	External Evaluation of Submissions/Applications on behalf of National Drugs & Poisons Schedule Committee	Need for specialist skills
Allan Lindsay Black	Lectures on International Chemicals Regulation & Risk Management Decisions	Need for specialist skills
Allen & Clarke Policy & Regulation Specialists	Evaluation of the NT Emergency Response Child Health Check Initiative & Expanding Health Service Delivery Initiative	Need for specialist skills
Allen Consulting Group	To Develop a National Breastfeeding Strategy	Need for independent research
Allen Consulting Group	To Review the Training, Education & Accreditation Program (TEAP)	Need for independent research
Apis Group Pty Ltd	Analysis of the Data Collected through the Consultation Process of Health Reform Taskforce	Need for specialist skills
Apis Group Pty Ltd	Development of a Project Plan for the Health Reform Taskforce	Need for specialist skills
Ascent Consulting Pty Ltd	To Review the Cost Effectiveness of the Group Aboriginal Health Strategy for Central Highlands After Hours Medical Service Nurse Triage Services in Victoria	Need for specialist skills
Associate Professor Danny Liew	Professional Assessment of Data for the National Drugs Schedule Committee	Need for independent research
Australian Bureau of Statistics VIC	Conduct of the Patient Experience Survey for 2009-10	Need for independent research
Australian Government Actuary	Provision of Medical Indemnity Actuarial Advice	Need for specialist skills
Australian Government Solicitor	Provision of Legal Services	Skills currently unavailable in agency
Australian Government Solicitor	Provision of Legal Services	Skills currently unavailable in agency
Australian Government Solicitor	Provision of Legal Services	Skills currently unavailable in agency
Australian Government Solicitor	Provision of Legal Services	Skills currently unavailable in agency
Australian Government Solicitor	Provision of Legal Services	Skills currently unavailable in agency
Australian Government Solicitor	Provision of Legal Services	Skills currently unavailable in agency
Australian Government Solicitor	Provision of Legal Services	Skills currently unavailable in agency
Australian Government Solicitor	Provision of Legal Services	Skills currently unavailable in agency
Australian Government Solicitor	Provision of Legal Services	Skills currently unavailable in agency
Australian Healthcare & Hospitals Association	Support & Research on Hospitals of the Future	Need for independent research
Australian Healthcare Associates Pty Ltd	Evaluation of the Secure Aboriginal Medical Services Information System (SAMSIS)	Need for specialist skills
Australian Healthcare Associates Pty Ltd	Review of Arrangements for S100 Drugs/Programs	Need for independent research
Australian Hearing Services	Research to Establish a Profile of Noise Exposure for Younger People in the Community	Need for independent research
Australian Hearing Services	To Conduct Research into the Prevalence of Hearing Loss in Young People & their Risk Exposure to Noise	Need for independent research

Australian National University - University House	To Conduct Research into the Prevalence & Incidence of Violence in General Practice	Need for independent research
Banscott Health Consulting Pty Ltd	Advice Relating to the Business Objectives of the PACD	Need for specialist skills
Blue Moon Unit Trust	Concept Testing Research for a Sexual Health Campaign	Need for independent research
Blue Moon Unit Trust	Concept Testing Research for Stage 2 of Illicit Drug Use Targetting Young Methamphetamine Users Campaign	Need for specialist skills
Business Mapping Solutions Pty Ltd	Funds Administrator for the Gumbi Gumbi Aboriginal & Torres Strait Islanders Corporation	Need for specialist skills
Campbell Research & Consulting Pty Ltd	Evaluation of the Medication Review Accreditation Incentives Program	Need for independent research
Campbell Research & Consulting Pty Ltd	Evaluation of the Residential Medication Management Program	Need for independent research
Campbell Research & Consulting Pty Ltd	To Develop the National Maternity Services Plan	Need for specialist skills
Carroll Communications Pty Ltd	Illicit Drug Use Campaign	Need for specialist skills
CGF Phoenix Pty Ltd	Investigation of an Alleged Breach of the APS Code of Conduct	Skills currently unavailable in agency
Claire Caesar Consulting	Planning & Regulatory Reforms of Complementary Medicines Systems	Skills currently unavailable in agency
Clayton Utz	Provision of Legal Services	Skills currently unavailable in agency
Clayton Utz	Provision of Legal Services	Skills currently unavailable in agency
Clayton Utz	Provision of Legal Services	Skills currently unavailable in agency
Clayton Utz VIC	Provision of Legal Services	Skills currently unavailable in agency
Coote Practice Pty Ltd	Medical Expertise on the Application Assessment Panels for the General Practice Super Clinics	Need for specialist skills
Craze Lateral Solutions Pty Ltd	National Mental Health Consumer Representation Scoping Study	Need for independent research
Deakin University	To Provide Health Technology Assessment & Research Support Services	Need for independent research
Deloitte Growth Solutions Pty Limit	Provision of Funds Administrator Services to Ilpurla Aboriginal Corporation	Need for specialist skills
DLA Phillips Fox	Provision of Legal Services	Skills currently unavailable in agency
DLA Phillips Fox	Provision of Legal Services	Skills currently unavailable in agency
Donald James St John	Specialist Technical Adviser to the Tender Evaluation Committee - Bowel Cancer	Need for specialist skills
Edith Cowan University	Research to Establish the Effectiveness of a Health Based Fear Appeal to Prevent Hearing Loss	Need for specialist skills
Ernst & Young	Evaluation of the 2006-10 Better Arthritis & Osteoporosis Care Initiative	Need for specialist skills
Ernst & Young	Review & Implementation of Activity Based Funding	Need for specialist skills
Flinders University	Evaluation of the Benefits of Swimming Pools for the Ear Health of Indigenous Australians	Need for independent research
Gevers Goddard-Jones Pty Ltd	Evaluation of the NT ATSI Community Aged Care Workforce Development Initiatives	Need for independent research

Golder Associates Pty Ltd	Peer Review on National Health & Medical Research Review of Health Investigation Levels	Need for specialist skills
Griffith University	External Evaluation of Submissions for Pharmaceutical Benefits Advisory Committee	Need for specialist skills
Health Outcomes International Pty Ltd	Evaluation of the Diabetes Pilot Program Diabetes Medication Assistance Service	Need for specialist skills
Health Outcomes International Pty Ltd	Evaluation of the Dose Administration Aids & Patient Medication Profiling Programs	Need for independent research
Health Outcomes International Pty Ltd	Evaluation of the MRI Mobile Unit Trial	Need for independent research
Healthcare Management Advisors Pty Ltd	ATSI Health Profiling & Benchmarking	Need for specialist skills
Healthcare Management Advisors Pty Ltd	Evaluation of the Australian Better Health Initiative (ABHI)	Need for specialist skills
Healthconsult Pty Ltd	Review of the Supply, Demand & Use of Cord Blood In Australia	Skills currently unavailable in agency
Horizon Research	National Physical Activity Recommendations for Children Aged 0-5 Brochure & Poster - Concept	Need for independent research
Horizon Research	Qualitative Research for the Saving Lives in the Water DVD	Need for independent research
Ipsos Public Affairs Pty Ltd	Develop the Ready To Drink Module in the National Binge Drinking Campaign Evaluation	Need for independent research
Ipsos Public Affairs Pty Ltd	National Binge Drinking Campaign Evaluation	Need for independent research
Ipsos Public Affairs Pty Ltd	National Smoke-Free Pregnancy Project Evaluation	Need for independent research
J G Service Pty Ltd	Provision of Construction Advice to the GP Super Clinic Program	Skills currently unavailable in agency
Jing Jing Li	External Evaluation of Rescheduling Submissions & Substance Reviews	Need for specialist skills
John McEwen	External Evaluation of Rescheduling Submissions & Substance Reviews	Need for specialist skills
JTA International Pty Ltd	To Develop Dental Care Service Delivery Models for the NT	Skills currently unavailable in agency
KPMG	Evaluation of the Better Access to Psychiatrists, Psychologists & GPs	Need for independent research
KPMG	Financial Services Relating to the Continence Aids Assistance Scheme	Need for specialist skills
KPMG	Health Management Advisor Services to Dharah Gbinj Aboriginal Medical Services Aboriginal Corporation	Need for specialist skills
KPMG	Review of the Impact of the New Medicare Levy Surcharge Thresholds on Public Hospitals	Need for specialist skills
KPMG	To Conduct an Orgnisational Review of the 5 Link Services in WA	Need for specialist skills
KPMG	To Map Dementia Services Pathways at a National & State/Territory Level	Need for independent research
Leeden Associates Pty Ltd	Expert Advice on H1N1 Influenza 2009	Need for specialist skills
Little Oak Pty Ltd	Maintenance of the Primary & Ambulatory Care Division Network Information System	Need for specialist skills
Little Oak Pty Ltd	Provision of Technical Data Advice	Skills currently unavailable in agency
M Love & D Toole & J S Wilson	Investigation of an Alleged Breach of the APS Code of Conduct	Skills currently unavailable in agency

Mark Williams Management Pty Ltd	Expert Advice in Relation to the Community Service 5th Community Pharmacy Agreements	Need for specialist skills
Matthews Pegg Consulting Pty Ltd	To Develop a Consultation RIS for Proposed Changes to the Regulation of Disinfectants	Need for specialist skills
Menzies School of Health Research	Prevention of Hearing Loss Associated with Otitis Media with Perforation in Indigenous Children	Need for independent research
Meryl Annette Stanton	Expert Advice on Organisational Psychology	Skills currently unavailable in agency
Minter Ellison	Provision of Legal Services	Skills currently unavailable in agency
Minter Ellison	Provision of Legal Services	Skills currently unavailable in agency
Monash University	External Evaluation of Submissions for Pharmaceutical Benefits Advisory Committee	Need for specialist skills
Monash University	To Provide a Review Report by Collecting & Analysing Available Scientific Literature	Need for specialist skills
Morison Consulting Pty Ltd	Independent Audit Advice	Need for specialist skills
MSR Consulting Pty Ltd	Expert Opinion on the Analysis & Evaluation of Dermal Absorption Studies	Need for specialist skills
MSR Consulting Pty Ltd	Lectures/Training on Dermal Absorption & Toxicokinetics	Need for specialist skills
M-Tag Pty Ltd	Assessment & Research Related Services to MSAC	Need for specialist skills
National Association of Testing Authorities Australia	Better Access to Radiation Oncology - Trialing of the Radiation Oncology Practice Standards	Need for specialist skills
National Institute of Labour Studies Inc	Evaluation of the Better Access Initiative	Need for independent research
Oakton Services Pty Ltd	Provision of Expert Program Management Advice	Need for specialist skills
Ochre Health Pty Ltd	Provision of an Organisational Review of Ilpurla Aboriginal Corporation	Need for independent research
Oliver Winder Pty Ltd	Independent Audit Advice	Need for specialist skills
OOSW Consulting Pty Ltd	Stategic Management Advice for the 2009/10 Accommodation Project	Need for specialist skills
Open Mind Research Group Holdings	Illicit Drugs in Sport Communications Strategy	Need for specialist skills
Origin Communications Pty Ltd	Provide Advice on an Indigenous Communications Plan	Need for specialist skills
Resolution Consulting Services Pty Ltd	Financial Advice to Support the Implementation & Monitoring of the Royal Flying Doctor Service Funding Agreement	Need for specialist skills
Resolution Consulting Services Pty Ltd	To Finalise Work on Carers Australia Reporting Mechanism	Need for specialist skills
Robin Hill Health Pty Ltd	Independent Financial Advice to Support the Implementation of GP Super Clinics Initiative	Need for specialist skills
Robin Hill Health Pty Ltd	Technical Financial Advice Services	Need for specialist skills
Royal Australasian College of Surgeons	Assessment & Research Related Services to MSAC	Need for specialist skills
Royal Australasian College of Surgeons	To Provide Health Technology Assessment & Research Support Services	Need for independent research
SMS Consulting Group Ltd	Facilitation Services to the GP Super Clinics Program	Skills currently unavailable in agency
South Australian Centre for Economic Studies	Cost Benefit Analysis of Legislation to Mandate the Supply of Opal Fuel	Need for independent research
Stay Tuned Productions Pty Ltd	Organise & Facilitate 2 Series of Focus Groups for the Health Technology Assessment Review	Skills currently unavailable in agency

Synergy Business Solutions	Technical Financial Advisory & Operational Service	Skills currently unavailable in agency
Tarcus Pty Ltd	Provision of Change & Project Management Services	Need for specialist skills
The Adelaide Research & Innovation Investment Trust	Evaluation of the Demonstration Sites for Day Respite in Residential Aged Care Facilities	Need for independent research
The Adelaide Research & Innovation Investment Trust	External Evaluation of Rescheduling Submissions & Substance Reviews	Need for specialist skills
The Adelaide Research & Innovation Investment Trust	External Evaluation of Submissions for Pharmaceutical Benefits Advisory Committee	Need for specialist skills
The Adelaide Research & Innovation Investment Trust	External Evaluation of Submissions/Applications on behalf of National Drugs & Poisons Schedule Committee	Need for independent research
The Adelaide Research & Innovation Investment Trust	To Provide Health Technology Assessment & Research Support Services	Need for independent research
The Social Research Centre Pty Ltd	Evaluation of Stages 1 & 2 of the Illicit Drug Use: Targeting Young Methamphetamine Users Campaign	Need for independent research
The Social Research Centre Pty Ltd	Evaulation of the Australian Better Health Initiative (ABHI) Measure Up Campaign	Need for specialist skills
The University of Melbourne	Design, Modelling & Evaluation of the Chlamydia Pilot in General Practice	Need for specialist skills
The University of Melbourne	External Evaluation of Submissions for Pharmaceutical Benefits Advisory Committee	Need for specialist skills
The University of Sydney	Assessment & Research Related Services to MSAC	Need for specialist skills
The University of Sydney	To Provide Health Technology Assessment & Research Support Services	Need for specialist skills
The University of Wollongong	National Evaluation Project in Residential Aged Care	Need for independent research
The University of Wollongong	National Evaluation Project in Residential Aged Care	Need for independent research
Thomas Whayman & McCarthy	To Investigate an Alleged Breach of the APS Code of Conduct	Skills currently unavailable in agency
University of Melbourne	Evaluation of the Better Access Initiative	Need for independent research
University of Technology, Sydney	External Evaluation of Submissions for Pharmaceutical Benefits Advisory Committee	Need for specialist skills
University Physicians Inc	Health@Home Plus	Need for specialist skills
UNSW Global Pty Ltd	Location/Facility, Service Delivery Model Governance Structure for a Drug & Alcohol Services	Need for specialist skills
Urbis Pty Ltd	Evaluation of the National ATSI Nutrition Strategy & Action Plan (NATSINSAP)	Need for independent research
Urbis Pty Ltd	Evaluation of the National External Breast Prostheses Reimbursement Program	Need for independent research
Urbis Pty Ltd	Evaluation of the Quality Use of Medicines Maximised for ATSI People Program	Need for specialist skills
Urbis Pty Ltd	Stage 1 of Evaluation of the Asthma Pilot Program	Need for independent research
Victoria University	National Continence Management Strategy	Need for independent research
Woolcott Research Pty Ltd	Evaluation Research for the National STIs Program Campaign	Need for independent research
Woolcott Research Pty Ltd	Qualitative & Quantitative Research for Health System Reform from Community Input	Need for independent research
XIP Pty Ltd	Provide Pharmaceutical Patent Information & Associated Services	Need for specialist skills

XIP Pty Ltd	Provide Pharmaceutical Patent Information & Associated Services	Need for specialist skills

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-088

OUTCOME 0: Whole of Portfolio

Topic: HEALTH AND HOSPITAL COMMISSION REPORT

Written Question on Notice

Senator Boyce asked:

e) Why are there two meetings scheduled to discuss the Report of the National Health and Hospitals Reform Commission (NHHRC)?

f) What is the purpose of each meeting?

g) Will the Government be responding to the NHHRC prior to or at the December COAG meeting?

Answer:

a, b and c)

On the release of the final report of the National Health and Hospitals Reform Commission (NHHRC), the Prime Minister stated:

'Following the conclusion of this extensive direct engagement with the sector based on the concrete recommendations put to the Government by the Commission, the Government will then convene a special COAG meeting with the States and Territories in late 2009, explicitly on health and hospitals reform.'

This meeting occurred on 7 December 2009: the Prime Minister and state and territory Leaders discussed options for reforming Australia's health and hospitals system to deliver a healthier future for all Australians. COAG agreed to commence work immediately on the development of a national health reform plan as a priority in 2010.

The Commonwealth will actively engage with the states on the range of reform proposals canvassed by the NHHRC and related proposals, and will put specific proposals to the states in the first half of 2010.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-135

OUTCOME 0: Whole of Portfolio

Topic: CONSULTANCIES

Written Question on Notice

Senator Adams asked:

hh) How much has the Department spent on consultancy services since November 2007?

ii) How can the Department justify this expenditure?

jj) Could the Department provide a complete list of current consultancy services. For each consultancy, please indicate the rationale for the project and its intended use. For each consultancy, please indicate why the Department or its agencies could not have undertaken the work themselves.

Answer:

f) As at 21 October 2009, the Department had spent $73,509,847.87 on consultancy services since 1 November 2007.

g) These consultancies are important and necessary investments in undertaking substantial policy development work critical to the implementation of the government's policy reform agenda and to support evidence-based policy development.

h) A list of current consultancies as at 21 October 2009 has been provided in Attachment A. Included is the rationale for the project and its intended use which has been addressed via the 'Consultancy Purpose' field.

Also provided is the reason the Department or its agencies could not have undertaken the work themselves which has been addressed via the 'Consultancy Reason' field.

The reasons cited accord with definitions as specified in the Department's Annual Report.

36 consultancies for Therapeutic Goods Administration have been omitted as a result of restrictions in reporting under the *Privacy Act 1988* and commercial confidentiality.

Consultant	Consultancy Purpose	Consultancy Reason
Albert G Frauman Pty Ltd	External Evaluation of Submissions/Applications on behalf of National Drugs & Poisons Schedule Committee	Need for specialist skills
Allan Lindsay Black	Lectures on International Chemicals Regulation & Risk Management Decisions	Need for specialist skills
Allen & Clarke Policy & Regulation Specialists	Evaluation of the NT Emergency Response Child Health Check Initiative & Expanding Health Service Delivery Initiative	Need for specialist skills
Allen Consulting Group	To Develop a National Breastfeeding Strategy	Need for independent research
Allen Consulting Group	To Review the Training, Education & Accreditation Program (TEAP)	Need for independent research
Apis Group Pty Ltd	Analysis of the Data Collected through the Consultation Process of Health Reform Taskforce	Need for specialist skills
Apis Group Pty Ltd	Development of a Project Plan for the Health Reform Taskforce	Need for specialist skills
Ascent Consulting Pty Ltd	To Review the Cost Effectiveness of the Group Aboriginal Health Strategy for Central Highlands After Hours Medical Service Nurse Triage Services in Victoria	Need for specialist skills
Associate Professor Danny Liew	Professional Assessment of Data for the National Drugs Schedule Committee	Need for independent research
Australian Bureau of Statistics VIC	Conduct of the Patient Experience Survey for 2009-10	Need for independent research
Australian Government Actuary	Provision of Medical Indemnity Actuarial Advice	Need for specialist skills
Australian Government Solicitor	Provision of Legal Services	Skills currently unavailable in agency
Australian Government Solicitor	Provision of Legal Services	Skills currently unavailable in agency
Australian Government Solicitor	Provision of Legal Services	Skills currently unavailable in agency
Australian Government Solicitor	Provision of Legal Services	Skills currently unavailable in agency
Australian Government Solicitor	Provision of Legal Services	Skills currently unavailable in agency
Australian Government Solicitor	Provision of Legal Services	Skills currently unavailable in agency
Australian Government Solicitor	Provision of Legal Services	Skills currently unavailable in agency
Australian Government Solicitor	Provision of Legal Services	Skills currently unavailable in agency
Australian Government Solicitor	Provision of Legal Services	Skills currently unavailable in agency
Australian Healthcare & Hospitals Association	Support & Research on Hospitals of the Future	Need for independent research
Australian Healthcare Associates Pty Ltd	Evaluation of the Secure Aboriginal Medical Services Information System (SAMSIS)	Need for specialist skills
Australian Healthcare Associates Pty Ltd	Review of Arrangements for S100 Drugs/Programs	Need for independent research
Australian Hearing Services	Research to Establish a Profile of Noise Exposure for Younger People in the Community	Need for independent research
Australian Hearing Services	To Conduct Research into the Prevalence of Hearing Loss in Young People & their Risk Exposure to Noise	Need for independent research

Australian National University - University House	To Conduct Research into the Prevalence & Incidence of Violence in General Practice	Need for independent research
Banscott Health Consulting Pty Ltd	Advice Relating to the Business Objectives of the PACD	Need for specialist skills
Blue Moon Unit Trust	Concept Testing Research for a Sexual Health Campaign	Need for independent research
Blue Moon Unit Trust	Concept Testing Research for Stage 2 of Illicit Drug Use Targetting Young Methamphetamine Users Campaign	Need for specialist skills
Business Mapping Solutions Pty Ltd	Funds Administrator for the Gumbi Gumbi Aboriginal & Torres Strait Islanders Corporation	Need for specialist skills
Campbell Research & Consulting Pty Ltd	Evaluation of the Medication Review Accreditation Incentives Program	Need for independent research
Campbell Research & Consulting Pty Ltd	Evaluation of the Residential Medication Management Program	Need for independent research
Campbell Research & Consulting Pty Ltd	To Develop the National Maternity Services Plan	Need for specialist skills
Carroll Communications Pty Ltd	Illicit Drug Use Campaign	Need for specialist skills
CGF Phoenix Pty Ltd	Investigation of an Alleged Breach of the APS Code of Conduct	Skills currently unavailable in agency
Claire Caesar Consulting	Planning & Regulatory Reforms of Complementary Medicines Systems	Skills currently unavailable in agency
Clayton Utz	Provision of Legal Services	Skills currently unavailable in agency
Clayton Utz	Provision of Legal Services	Skills currently unavailable in agency
Clayton Utz	Provision of Legal Services	Skills currently unavailable in agency
Clayton Utz VIC	Provision of Legal Services	Skills currently unavailable in agency
Coote Practice Pty Ltd	Medical Expertise on the Application Assessment Panels for the General Practice Super Clinics	Need for specialist skills
Craze Lateral Solutions Pty Ltd	National Mental Health Consumer Representation Scoping Study	Need for independent research
Deakin University	To Provide Health Technology Assessment & Research Support Services	Need for independent research
Deloitte Growth Solutions Pty Limit	Provision of Funds Administrator Services to Ilpurla Aboriginal Corporation	Need for specialist skills
DLA Phillips Fox	Provision of Legal Services	Skills currently unavailable in agency
DLA Phillips Fox	Provision of Legal Services	Skills currently unavailable in agency
Donald James St John	Specialist Technical Adviser to the Tender Evaluation Committee - Bowel Cancer	Need for specialist skills
Edith Cowan University	Research to Establish the Effectiveness of a Health Based Fear Appeal to Prevent Hearing Loss	Need for specialist skills
Ernst & Young	Evaluation of the 2006-10 Better Arthritis & Osteoporosis Care Initiative	Need for specialist skills
Ernst & Young	Review & Implementation of Activity Based Funding	Need for specialist skills
Flinders University	Evaluation of the Benefits of Swimming Pools for the Ear Health of Indigenous Australians	Need for independent research
Gevers Goddard-Jones Pty Ltd	Evaluation of the NT ATSI Community Aged Care Workforce Development Initiatives	Need for independent research

Golder Associates Pty Ltd	Peer Review on National Health & Medical Research Review of Health Investigation Levels	Need for specialist skills
Griffith University	External Evaluation of Submissions for Pharmaceutical Benefits Advisory Committee	Need for specialist skills
Health Outcomes International Pty Ltd	Evaluation of the Diabetes Pilot Program Diabetes Medication Assistance Service	Need for specialist skills
Health Outcomes International Pty Ltd	Evaluation of the Dose Administration Aids & Patient Medication Profiling Programs	Need for independent research
Health Outcomes International Pty Ltd	Evaluation of the MRI Mobile Unit Trial	Need for independent research
Healthcare Management Advisors Pty Ltd	ATSI Health Profiling & Benchmarking	Need for specialist skills
Healthcare Management Advisors Pty Ltd	Evaluation of the Australian Better Health Initiative (ABHI)	Need for specialist skills
Healthconsult Pty Ltd	Review of the Supply, Demand & Use of Cord Blood In Australia	Skills currently unavailable in agency
Horizon Research	National Physical Activity Recommendations for Children Aged 0-5 Brochure & Poster - Concept	Need for independent research
Horizon Research	Qualitative Research for the Saving Lives in the Water DVD	Need for independent research
Ipsos Public Affairs Pty Ltd	Develop the Ready To Drink Module in the National Binge Drinking Campaign Evaluation	Need for independent research
Ipsos Public Affairs Pty Ltd	National Binge Drinking Campaign Evaluation	Need for independent research
Ipsos Public Affairs Pty Ltd	National Smoke-Free Pregnancy Project Evaluation	Need for independent research
J G Service Pty Ltd	Provision of Construction Advice to the GP Super Clinic Program	Skills currently unavailable in agency
Jing Jing Li	External Evaluation of Rescheduling Submissions & Substance Reviews	Need for specialist skills
John McEwen	External Evaluation of Rescheduling Submissions & Substance Reviews	Need for specialist skills
JTA International Pty Ltd	To Develop Dental Care Service Delivery Models for the NT	Skills currently unavailable in agency
KPMG	Evaluation of the Better Access to Psychiatrists, Psychologists & GPs	Need for independent research
KPMG	Financial Services Relating to the Continence Aids Assistance Scheme	Need for specialist skills
KPMG	Health Management Advisor Services to Dharah Gbinj Aboriginal Medical Services Aboriginal Corporation	Need for specialist skills
KPMG	Review of the Impact of the New Medicare Levy Surcharge Thresholds on Public Hospitals	Need for specialist skills
KPMG	To Conduct an Orgnisational Review of the 5 Link Services in WA	Need for specialist skills
KPMG	To Map Dementia Services Pathways at a National & State/Territory Level	Need for independent research
Leeden Associates Pty Ltd	Expert Advice on H1N1 Influenza 2009	Need for specialist skills
Little Oak Pty Ltd	Maintenance of the Primary & Ambulatory Care Division Network Information System	Need for specialist skills
Little Oak Pty Ltd	Provision of Technical Data Advice	Skills currently unavailable in agency
M Love & D Toole & J S Wilson	Investigation of an Alleged Breach of the APS Code of Conduct	Skills currently unavailable in agency

Mark Williams Management Pty Ltd	Expert Advice in Relation to the Community Service 5th Community Pharmacy Agreements	Need for specialist skills
Matthews Pegg Consulting Pty Ltd	To Develop a Consultation RIS for Proposed Changes to the Regulation of Disinfectants	Need for specialist skills
Menzies School of Health Research	Prevention of Hearing Loss Associated with Otitis Media with Perforation in Indigenous Children	Need for independent research
Meryl Annette Stanton	Expert Advice on Organisational Psychology	Skills currently unavailable in agency
Minter Ellison	Provision of Legal Services	Skills currently unavailable in agency
Minter Ellison	Provision of Legal Services	Skills currently unavailable in agency
Monash University	External Evaluation of Submissions for Pharmaceutical Benefits Advisory Committee	Need for specialist skills
Monash University	To Provide a Review Report by Collecting & Analysing Available Scientific Literature	Need for specialist skills
Morison Consulting Pty Ltd	Independent Audit Advice	Need for specialist skills
MSR Consulting Pty Ltd	Expert Opinion on the Analysis & Evaluation of Dermal Absorption Studies	Need for specialist skills
MSR Consulting Pty Ltd	Lectures/Training on Dermal Absorption & Toxicokinetics	Need for specialist skills
M-Tag Pty Ltd	Assessment & Research Related Services to MSAC	Need for specialist skills
National Association of Testing Authorities Australia	Better Access to Radiation Oncology - Trialing of the Radiation Oncology Practice Standards	Need for specialist skills
National Institute of Labour Studies Inc	Evaluation of the Better Access Initiative	Need for independent research
Oakton Services Pty Ltd	Provision of Expert Program Management Advice	Need for specialist skills
Ochre Health Pty Ltd	Provision of an Organisational Review of Ilpurla Aboriginal Corporation	Need for independent research
Oliver Winder Pty Ltd	Independent Audit Advice	Need for specialist skills
OOSW Consulting Pty Ltd	Stategic Management Advice for the 2009/10 Accommodation Project	Need for specialist skills
Open Mind Research Group Holdings	Illicit Drugs in Sport Communications Strategy	Need for specialist skills
Origin Communications Pty Ltd	Provide Advice on an Indigenous Communications Plan	Need for specialist skills
Resolution Consulting Services Pty Ltd	Financial Advice to Support the Implementation & Monitoring of the Royal Flying Doctor Service Funding Agreement	Need for specialist skills
Resolution Consulting Services Pty Ltd	To Finalise Work on Carers Australia Reporting Mechanism	Need for specialist skills
Robin Hill Health Pty Ltd	Independent Financial Advice to Support the Implementation of GP Super Clinics Initiative	Need for specialist skills
Robin Hill Health Pty Ltd	Technical Financial Advice Services	Need for specialist skills
Royal Australasian College of Surgeons	Assessment & Research Related Services to MSAC	Need for specialist skills
Royal Australasian College of Surgeons	To Provide Health Technology Assessment & Research Support Services	Need for independent research
SMS Consulting Group Ltd	Facilitation Services to the GP Super Clinics Program	Skills currently unavailable in agency
South Australian Centre for Economic Studies	Cost Benefit Analysis of Legislation to Mandate the Supply of Opal Fuel	Need for independent research
Stay Tuned Productions Pty Ltd	Organise & Facilitate 2 Series of Focus Groups for the Health Technology Assessment Review	Skills currently unavailable in agency

Synergy Business Solutions	Technical Financial Advisory & Operational Service	Skills currently unavailable in agency
Tarcus Pty Ltd	Provision of Change & Project Management Services	Need for specialist skills
The Adelaide Research & Innovation Investment Trust	Evaluation of the Demonstration Sites for Day Respite in Residential Aged Care Facilities	Need for independent research
The Adelaide Research & Innovation Investment Trust	External Evaluation of Rescheduling Submissions & Substance Reviews	Need for specialist skills
The Adelaide Research & Innovation Investment Trust	External Evaluation of Submissions for Pharmaceutical Benefits Advisory Committee	Need for specialist skills
The Adelaide Research & Innovation Investment Trust	External Evaluation of Submissions/Applications on behalf of National Drugs & Poisons Schedule Committee	Need for independent research
The Adelaide Research & Innovation Investment Trust	To Provide Health Technology Assessment & Research Support Services	Need for independent research
The Social Research Centre Pty Ltd	Evaluation of Stages 1 & 2 of the Illicit Drug Use: Targeting Young Methamphetamine Users Campaign	Need for independent research
The Social Research Centre Pty Ltd	Evaulation of the Australian Better Health Initiative (ABHI) Measure Up Campaign	Need for specialist skills
The University of Melbourne	Design, Modelling & Evaluation of the Chlamydia Pilot in General Practice	Need for specialist skills
The University of Melbourne	External Evaluation of Submissions for Pharmaceutical Benefits Advisory Committee	Need for specialist skills
The University of Sydney	Assessment & Research Related Services to MSAC	Need for specialist skills
The University of Sydney	To Provide Health Technology Assessment & Research Support Services	Need for specialist skills
The University of Wollongong	National Evaluation Project in Residential Aged Care	Need for independent research
The University of Wollongong	National Evaluation Project in Residential Aged Care	Need for independent research
Thomas Whayman & McCarthy	To Investigate an Alleged Breach of the APS Code of Conduct	Skills currently unavailable in agency
University of Melbourne	Evaluation of the Better Access Initiative	Need for independent research
University of Technology, Sydney	External Evaluation of Submissions for Pharmaceutical Benefits Advisory Committee	Need for specialist skills
University Physicians Inc	Health@Home Plus	Need for specialist skills
UNSW Global Pty Ltd	Location/Facility, Service Delivery Model Governance Structure for a Drug & Alcohol Services	Need for specialist skills
Urbis Pty Ltd	Evaluation of the National ATSI Nutrition Strategy & Action Plan (NATSINSAP)	Need for independent research
Urbis Pty Ltd	Evaluation of the National External Breast Prostheses Reimbursement Program	Need for independent research
Urbis Pty Ltd	Evaluation of the Quality Use of Medicines Maximised for ATSI People Program	Need for specialist skills
Urbis Pty Ltd	Stage 1 of Evaluation of the Asthma Pilot Program	Need for independent research
Victoria University	National Continence Management Strategy	Need for independent research
Woolcott Research Pty Ltd	Evaluation Research for the National STIs Program Campaign	Need for independent research
Woolcott Research Pty Ltd	Qualitative & Quantitative Research for Health System Reform from Community Input	Need for independent research
XIP Pty Ltd	Provide Pharmaceutical Patent Information & Associated Services	Need for specialist skills

XIP Pty Ltd	Provide Pharmaceutical Patent Information & Associated Services	Need for specialist skills

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-137

OUTCOME 0: Whole of Portfolio

Topic: DISCRETIONARY GRANTS

Written Question on Notice

Senator Adams asked:

Could the Department provide a list of all discretionary grants, including ad hoc and one-off grants since November 2007? Please provide details of the recipients, the intended use of the grants and what locations have benefited from the grants.

Answer:

A list of all discretionary grants, including ad hoc, and one-off grants between 1 November 2007 and 31 December 2008 are available on the Department's Internet site. Included are the details of the recipients, the intended use of the grants, and the locations that have benefited from the grants. These discretionary grants may be viewed at: http://health.gov.au/internet/main/publishing.nsf/Content/divisions-portfoliostrategiesdivision-disgrants

Since 1 January 2009, all Departmental grants have been published on the Department's Internet site. The details of these grants have been published according to the requirements initially laid out in *Estimates Memorandum 2009/09* and, most recently, the Commonwealth Grant Guidelines (1 July 2009). The published details include the following fields:

- Portfolio;
- Agency;
- Program Title;
- Grant Recipient;
- Grant Purpose;
- Total Grant/Variation Value;
- Grant Contract Execution Date;
- Grant Term;
- Grant Funding Location;
- Grant Variation Flag; and
- Grant Start Date.

These grants may be viewed at:
http://health.gov.au/internet/main/publishing.nsf/Content/pfps-grantsreporting

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-138

OUTCOME 0: Whole of Portfolio

Topic: COMMISSIONED REPORTS

Written Question on Notice

Senator Adams asked:

a) How many reports have been commissioned by the Government in Health and Ageing since November 2007?

b) Please provide details of each report including date commissioned, date report handed to Government, date of public release, Terms of Reference and Committee members?

c) How much did each report cost?

d) How many departmental staff were involved in each report and at what level?

e) What is the current status of each report?

f) When is the government intending to respond to these reports?

Answer:

a – f)

Please refer to the answer provided to Senate Estimates Question on Notice E09-073.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-249

OUTCOME 0: Whole of Portfolio

Topic: COMMISSIONED REPORTS

Hansard Page: CA 8

Senator Boyce asked:

a) How many reports have been commissioned by the government within the Department of Health and Ageing since November 2007?

b) Provide details of when each report was commissioned, when it was handed to the government and the date of public release, the terms of reference and the committee members for each report?

c) Also, the cost of each report and whether departmental staff or external staff were involved in the development of the content of the report?

Answer:

a – c)

Please refer to the answer provided to Senate Estimates Question on Notice E09-073.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-136

OUTCOME 0: Whole of Portfolio

Topic: ADVERTISING EXPENDITURE

Written Question on Notice

Senator Adams asked:

a) How much has the Department spent on advertising and marketing since November 2007?

b) Could the Department provide a complete list of all current contracts? Please indicate the rationale for each service provided and its intended use.

Answer:

a) Attachment A outlines the totals spent on advertising campaigns from 1 July 2007 through 30 September 2009. All campaigns with expenditure in 2007-2008 were in train prior to the change of government in November 2007.

In relation to all other advertising and marketing expenditure undertaken across the Department, to collate and compile the requested information would involve a significant resource effort that the Department is not currently in a position to undertake.

b) Please refer to Attachment B.

Attachment A Advertising campaign expenditure summary

Note—

- all figures are GST exclusive
- N/A indicates campaign not active
- '$ -' indicates campaign active but no expenditure in that period

Campaign	**2007-08 expenditure**	**2008-09 expenditure**			**2009-10 expenditure YTD** (to 30 Sept 09)		
	Total[a]	*Consultants and services*	*Media placement*	**Total**	*Consultants and services*	*Media placement*	**Total**
Asthma Awareness	**$165,463**	N/A	N/A	**N/A**	N/A	N/A	**N/A**
Australian Better Health Initiative—Measure Up	**$731,007**	$3,202,888	$12,500,000	**$15,702,888**	$68,870	$ -	**$68,870**
Binge Drinking	**$149,307**	$3,024,662	$8,802,260	**$11,826,922**	$6,569	-$20,332	**-$13,763**[b]
Bringing Nurses Back into the Workforce	**N/A**	$79,000	$928,407	**$1,007,407**	N/A	N/A	**N/A**
Eye Health Awareness	**$15,715**	$611,564	$1,987,024	**$2,598,588**	$96,726	$ -	**$96,726**
National Human Papillomavirus	**$1,895,000**	N/A	N/A	**N/A**	N/A	N/A	**N/A**
Illicit Drug Use	**$ -**	$736,733	$5,622,373	**$6,359,106**	$501,783	$ -	**$501,783**
National Drugs	**$13,149,796**	N/A	N/A	**N/A**	N/A	N/A	**N/A**
Private Health Insurance Communications	**$10,623,902**	N/A	N/A	**N/A**	N/A	N/A	**N/A**
Sexually Transmissable Infections Prevention	**$145,668**	$995,517	$1,438,205	**$2,433,722**	$18,805	$22,034	**$40,839**
Skin Cancer Awareness	**$4,664,347**	$606,481	$4,505,829	**$5,112,310**	$ -	$ -	**$ -**
H1N1 Influenza (Human Swine Flu) Public Information	**N/A**	$302,118	$3,766,222	**$4,068,340**	$152,645	$ -	**$152,645**
Total	**$31,540,205**	$9,558,963	$39,550,320*	**$49,109,283**	$845,398	$1,702	**$847,100**

(a) includes media placement and consultants/services expenditure

(b) includes media placement credit from previous year's activity, thus is a credit figure not an expenditure figure so far

* This information was recently reported in Campaign Advertising by Australian Government Departments and Agencies – Full Year Report 2008-09 (September 2009), issued by the Department of Finance & Deregulation – differences may occur due to rounding.

Attachment B: E09-136 – Advertising Expenditure

Name of current contract	Rationale for each service provided	Intended use
IDENT Pty Ltd (Branding and Design)	Direct source – no reasonable alternative or substitute	Provision of branding design services
Blue Star Print		Printing of Office of the Gene Technology Regulator Annual Report 2008-09
The Crisis Support Services (CSS) LIFE Communications contract	The Crisis Support Services (CSS) LIFE Communications contract aims to promote the Living Is For Everyone (LIFE) suite of resources to stakeholders to contribute to more effective suicide prevention activity in Australia, comprising: • LIFE: A Framework for Prevention of Suicide in Australia • Research and Evidence in Suicide Prevention • LIFE Fact Sheets It also aims to improve the effectiveness of suicide and self-harm prevention activities in Australia by providing access to the latest information and shared learnings from the National Suicide Prevention Strategy (NSPS) and other projects in prevention, intervention and postvention.	The objectives of this project are to provide stakeholders with: access to the LIFE suite of resources; the latest information, activities and resources in suicide prevention; a vehicle to contribute their learnings and draw on each other's expertise; and to facilitate clear and effective communication channels across a broad range of suicide prevention stakeholders in Australia. In addition to the livingisforeveryone.com.au website which includes live chats, discussion forums, online alerts, research and literature, the project disseminates print and electronic resources and hosts workshops and trade displays.
The Better Access Consumer and Carer Brochure contract	The Better Access Consumer and Carer Brochure contract is intended to provide consumers and carers with accessible information regarding the mental health services available under the Better Access initiative. Additional brochures are available to providers on request	The Consumer and Carer Brochures were distributed to General Practitioners, Social Workers, Occupational Therapists, Psychologists, Psychiatrists and Stakeholder Organisations for distribution to consumers who have been assessed by a GP as having a mental disorder, and their carers, as required

Name of current contract	Rationale for each service provided	Intended use
The Community Broadcasting Association of Australia's national suicide prevention project	The Community Broadcasting Association of Australia's national suicide prevention project seeks to provide help-seeking and well-being messages to a wide and diverse network of communities nationally, reaching a large number of Indigenous communities, rural and remote communities, and culturally and linguistically diverse communities.	This project utilises both satellite and local radio broadcasting to provide delivery of suicide, mental health and well-being messages 24 hours a day through over 270 radio stations nationwide. The contract also enables community engagement in communities around Australia and the distribution of a monthly magazine and audio CD to promote suicide prevention, help-seeking behaviours and well-being to a large national audience.
National Mailing and Marketing 09-10	Building Healthy Communities provides a resource kit on request from rural communities to provide guidance and assistance to build community capacity for healthy living, through preventative health strategies.	
National Mailing and Marketing 09-10	Rural Health promotional materials on request used to promote Rural Health initiatives at rural health and other related events such as school visits.	
Talent2 Pty Ltd	Services for Recruitment of the Chief Executive Officer of the Australian National Preventive Health Agency. Some funds will be allocated to advertising the role in national newspapers.	Recruitment Services

Name of current contract	Rationale for each service provided	Intended use
Caroll Communications Pty Ltd	In June 2009, Carroll Communications was contracted to undertake stakeholder consultation and a literature review to assess the knowledge, attitudes, intentions and behaviours of Aboriginal and Torres Strait Islander women and women from culturally and linguistically diverse (CALD) backgrounds regarding cancer prevention and their screening behaviour.	The research will inform the Government's consideration of how to support and facilitate participation in the BreastScreen Australia, National Cervical Screening and National Bowel Cancer Screening Programs amongst these communities, who participate in screening at lower rates than the general population.
BMF Advertising Pty Ltd	The National Skin Cancer Awareness Campaign (NSCAC), to educate young Australians about the importance of protecting themselves from skin cancer, was first announced in the 2005 Budget as part of the Strengthening Cancer Care Initiative. BMF Advertising was appointed through a select tender process to develop creative advertising services in 2006. For Phase Two of the NSCAC, BMF was appointed as a direct source for the procurement of similar services.	Supply creative artwork and negotiate talent fees.

Name of current contract	Rationale for each service provided	Intended use
BMF Advertising Pty Limited	The *National Amphetamine-Type Stimulant (ATS) Strategy 2008-2011*, developed on behalf of the Ministerial Council on Drug Strategy (MCDS) consists of five priority areas for action which includes references to social marketing programs and targeted strategies to raise awareness of the risks associated with Amphetamine Type Stimulants. BMF Advertising was engaged in 2009 through a select tender process to develop creative advertising services.	To develop advertising materials, youth marketing elements and supporting collateral.
BMF Advertising Pty Limited	Since the World Health Organization declared a pandemic of novel H1N1 influenza virus on 11 June 2009, Australia's Health Management Plan for Pandemic Influenza has actively guided a coordinated and measured response to the potential threat the virus poses to the Australian community. BMF Advertising was engaged in 2006 through a select tender process to provide creative advertising services.	To develop advertising materials and supporting collateral.

Name of current contract	Rationale for each service provided	Intended use
Origin Communications	Since the World Health Organization declared a pandemic of novel H1N1 influenza virus on 11 June 2009, Australia's Health Management Plan for Pandemic Influenza has actively guided a coordinated and measured response to the potential threat the virus poses to the Australian community. Origin Communications was engaged in 2006 through a select tender process to provide Indigenous Communications services in case of a pandemic.	To create Indigenous specific advertising and supporting collateral.
303 Group	On 10 March 2008, the Prime Minister announced a new national strategy to address the binge drinking epidemic among young Australians. Binge drinking among young people is a community wide problem that demands a community wide response, including an emphasis on young people taking greater personal responsibility for their behaviour. The 303 Group was appointed in 2008, as part of a select tender process, to develop creative materials for the National Binge Drinking Campaign.	To develop advertising materials including TV, radio, print and online advertisements, and supporting collateral as required.

Name of current contract	Rationale for each service provided	Intended use
Haystac Positive Outcomes	On 10 March 2008, the Prime Minister announced a new national strategy to address the binge drinking epidemic among young Australians. Binge drinking among young people is a community wide problem that demands a community wide response, including an emphasis on young people taking greater personal responsibility for their behaviour. Haystac Positive Outcomes (formerly Haystac Public Affairs) was appointed in 2008 as part of a select tender process, to extend the messages of the campaign using public relations activities, sponsorship and editorial strategies.	To develop public relations activities for youth, parents and teachers.
Origin Communications	On 10 March 2008, the Prime Minister announced a new national strategy to address the binge drinking epidemic among young Australians. Binge drinking among young people is a community wide problem that demands a community wide response, including an emphasis on young people taking greater personal responsibility for their behaviour. Origin Communications was selected in 2008, as part of a direct request for tender process to undertake stakeholder consultations, adapt and develop creative and public relations materials to an Indigenous audience.	To create Indigenous specific advertising and supporting collateral.

Name of current contract	Rationale for each service provided	Intended use
The Campaign Palace	This campaign is part of the National Eye Health Initiative announced in the 2006-07 Budget, designed to educate Australians about the importance of protecting themselves against avoidable vision loss and blindness. The Campaign Palace was selected in 2009 through a select tender process to provide creative services for the campaign.	To develop advertising materials including print, radio and internet.
Haystac	This campaign is part of the National Eye Health Initiative announced in the 2006-07 Budget, designed to educate Australians about the importance of protecting themselves against avoidable vision loss and blindness. Haystac was appointed in 2009 as part of a select tender process to provide public relations services for the campaign.	To develop public relations activities to support the campaign.
Origin Communications	This campaign is part of the National Eye Health Initiative announced in the 2006-07 Budget, designed to educate Australians about the importance of protecting themselves against avoidable vision loss and blindness. Origin Communications was contracted under a select tender process in 2009 to provide Aboriginal and Torres Strait Islander (Indigenous) services for the campaign.	To create Indigenous specific advertising and supporting collateral.

Name of current contract	Rationale for each service provided	Intended use
John Walter Thompson Pty Ltd (trading as JWT)	In the 2007-08 Federal Budget the Australian Government allocated $9.8 million for a new National Sexually Transmissible Infections Prevention Program to raise awareness of sexually transmissible infections (STIs) and encourage safe sexual practices among target populations to contribute to a reduction in the prevalence of STIs. JWT was engaged in 2009 through a select tender process to provide creative services for the campaign.	To develop a range of advertising materials for the campaign including radio, print, online and outdoor advertising.
Horizon Communication Group	In the 2007-08 Federal Budget the Australian Government allocated $9.8 million for a new National Sexually Transmissible Infections Prevention Program to raise awareness of sexually transmissible infections (STIs) and encourage safe sexual practices among target populations to contribute to a reduction in the prevalence of STIs. Horizon was engaged in 2009 through a select tender process to provide youth marketing services for the campaign.	To develop a range of resources to extend campaign messages and engage youth, community organisations and stakeholders.

Name of current contract	Rationale for each service provided	Intended use
National Promotions	Commonwealth Respite and Carelink Centres (Centres) are funded by the Australian Government as a link to a wide range of community, aged care and support services available locally or anywhere in Australia. Centres provide information about services for older people, people with a disability, and those who provide care and services. Centres also assist carers with options to take a break through short-term and emergency respite services.	Promotional products for the Commonwealth Respite and Carelink Centres are produced under the Commonwealth Carelink Program (CCP). This aims to raise awareness of Centres as a first point of contact for access to information about services available in the local community. As well as being accessible through a 1800 number and web site, part of the Centres' role is to actively outreach in their communities and promote their services to potential members of identified target groups.
Paragon Printers	Commonwealth Respite and Carelink Centres (Centres) are funded by the Australian Government as a link to a wide range of community, aged care and support services available locally or anywhere in Australia. Centres provide information about services for older people, people with a disability, and those who provide care and services. Centres also assist carers with options to take a break through short-term and emergency respite services.	Publications and resources produced under the Carer Information and Support Program (CISP) aim to provide timely and high quality information to support carers, tailored to their specific needs. These resources include carer support and emergency care publications in 14 community languages.

Name of current contract	Rationale for each service provided	Intended use
Sensis	Commonwealth Respite and Carelink Centres (Centres) are funded by the Australian Government as a link to a wide range of community, aged care and support services available locally or anywhere in Australia. Centres provide information about services for older people, people with a disability, and those who provide care and services. Centres also assist carers with options to take a break through short-term and emergency respite services.	Sensis coordinates a schedule of entries in the national White Pages telephone directories. The directories are rolled out to each region in Australia over the course of a 12 month period. The aim is to provide contact details in a publicly recognisable information directory.
Paragon Printers	The outsourcing of the provision, and distribution of, 68,500 colour copies of the *Changes to Legislation Relating to Pathology and Diagnostic Imaging Brochure* was more timely and represented good value for money when placed in the hands of external providers.	Diagnostic Services Branch required 68,500 colour copies of the *Changes to Legislation Relating to Pathology and Diagnostic Imaging Brochure* printed and distributed to help inform stakeholders of new legislative arrangements for both pathology and diagnostic imaging.
Opticon - Step by step guide	Development of a step by step guide for the IT Implementation Kit to be provided in html and word format for distribution to the aged care sector.	To assist the aged care sector with IT implementation through a step by step guide
2B Advertising & Design - Graphic Design Service	Printing services for eConnect presentation folder and letterheads for distribution packs to the aged care sector.	To provide a recognisable eConnect brand for DoHA at an industry conference
Intandem Evan Evans - plastic bags	1,000 promotional plastic bags for distribution at industry conferences	To provide a recognisable eConnect brand for DoHA at an industry conference

Name of current contract	Rationale for each service provided	Intended use
Looking Glass Press	To develop coordinated artwork for Aged Care Approvals Round documents to ensure users can readily identify the correct documents.	Aged Care Approvals Round Essential Guide 2008-09 Artwork and design and preparation of finished art for brochure and CD face for 2008-09 Aged Care Approvals Round products
Paragon Printers	To print the guides that potential applicants to the 2008-09 Aged Care Approvals Round will use	Printing of 2008-09 Aged Care Approvals Round essential guide
Paragon Printers	To print brochures so that potential applicants to the 2009-10 Aged Care Approvals Round are aware of dates and locations of information sessions	Printing of 2008-09 Aged Care Approvals Round Information Sessions brochure
Bearcage	Development of an 8 min DVD compilation of 6 case studies collected from a variety of aged care settings across the nations.	The DVD will create a story surrounding the application of IT in the aged care sector
Microview Solutions	To reproduce sufficient number of the CD to cover potential applicants to the Aged Care Approvals Round	CD duplication for the **2009-10** Aged Care Approvals Round
Wide Media	To produce CD that have the same artwork as other Aged Care Approvals Round materials so the users can readily identify the current Round materials	Aged Care Approvals Round Artwork printed on CD and assembled

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-250

OUTCOME 0: Whole of Portfolio

Topic: HEALTH AND HOSPITALS FUND (HHF)

Hansard Page: CA 14

Senator Cormann asked:

a) Can you tell us what the expenditure of the fund has been to date and, perhaps on notice, itemise each project and amount and location of the spend to date?

b) What is the amount of funding still available?

Answer:

d) As at 21 October 2009, a total of $187.9 million in HHF funding has been spent. Of the $186 million allocated in 2008-09, $185 million was spent. $2.943 million has been spent to date in 2009-10.

Project Name	Location	Project Cost $m (GST excl)	2008-09 Allocation $m	Exp to 21.10.09 $m (GST excl)
National Cancer Statement				
Parkville Comprehensive Cancer Centre	Parkville, VIC	**426.1**	**9.2**	**9.2**
Lifehouse RPA (the new Sydney Cancer Centre)	Camperdown, NSW	**100.0**	**1.0**	
Regional Cancer Centres	National	**560.0**		
Funding Digital Mammography for BreastScreen Australia	National	**120.0**		
Garvan St Vincent's Campus Cancer Centre	Darlinghurst, NSW	**70.0**	**29.8**	**29.8**
Hospital Infrastructure and other projects of national significance				
Australian Red Cross Blood Service: Victoria/Tasmania Principal Site Development	Melbourne, VIC	**120.0**		
A new facility for the Donor Tissue Bank of Victoria (Ensuring future access to human tissue in Australia)	South Bank, Melbourne, VIC	**13.0**		
Townsville Hospital Expansion	Townsville, QLD	**250.0**	**24.0**	**24.0**
Rockhampton Hospital Expansion	Rockhampton, QLD	**76.0**	**19.0**	**19.0**
Health and Medical Research Institute	Adelaide, SA	**200.0**	**30.0**	**30.0**
New rehabilitation unit at Fiona Stanley Hospital	Murdoch, WA	**255.7**		
Midland Health Campus	Midland, WA	**180.1**		
Kimberley Renal Services	Broome (serving the Kimberley Region), WA	**8.6**		

Replacement Paediatrics Unit Broome Hospital	Broome (serving the Kimberley Region), WA	**7.9**		
Hospital Emergency Department in Alice Springs	Alice Springs, NT	**13.6**		
Northern Territory Medical Program	Darwin, NT	**27.8**		
Royal Darwin Hospital - Short Term Patient Accommodation	Darwin, NT	**18.6**		
Acute Medical and Surgical Service Unit, Launceston General Hospital (LGH)	Launceston, TAS	**40.0**	**10.0**	**10.0**
Narrabri District Health Service	Narrabri, NSW	**27.0**		
Blacktown Hospital Clinical School, Research and Education Centre	Blacktown, NSW	**17.6**		
Nepean Health Services Redevelopment - Stage 3 (including Pialla)	Penrith, NSW	**96.4**	**17.0**	**17.0**
Oral Health Centre	Brisbane, Qld	**104.0**		
Primary care infrastructure in rural Australia (23 projects of $500,000 or less in various locations)	NSW, SA, QLD, WA, VIC, TAS	**9.2**		**2.9**
Translational Research and Workforce Training				
Ingham Health Research Institute Facilities	Liverpool, NSW	**46.9**		
Monash Health Research Precinct Translation Facility	Clayton, VIC	**71.0**		
The Melbourne Neuroscience Project	Parkville, VIC	**39.8**		
Children's Bioresource Centre	Parkville, VIC	**4.7**		
The Eccles Institute Building better mind and vision health outcomes: Stage 3 of the John Curtin School of Medical Research redevelopment	Canberra, ACT	**60.0**	**16.5**	**16.5**
Menzies Building - Stage 2	Hobart, TAS	**44.7**		
New research and training facility - Menzies School of Health Research (NT)	Darwin, NT	**34.2**		
Construction of Hunter Medical Research Institute building	Newcastle, NSW	**35.0**		
Northern Health Research and Education Precinct	Epping, VIC	**14.0**		
Translational Research Institute – at Princess Alexandra Hospital	Brisbane, QLD	**40.0**	**18.5**	**18.5**
Nepean Clinical School	Penrith, NSW	**17.2**		
Clinical medical education and best practice in Ambulatory Care for the Werribee region of Victoria and Auburn region of NSW	Werribee, Vic and Auburn, NSW	**22.8**	**11.0**	**11.0**
Totals		**3171.9**	**186.0**	**187.9**

e) In a media release dated 19 October 2009, the Future Fund advised that as at 30 September 2009, funds in the HHF stood at $4.878 billion. This consists of the balance of unexpended funds from the $3.2 billion announced in the 2009-10 Budget, the uncommitted $1.8 billion and returns on investment.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-084

OUTCOME 0: Whole of Portfolio

Topic: ELECTORAL REPORTS

Written Question on Notice

Senator Boyce asked:

a) Are there plans to publish a full suite of electoral reports on the Department's website?

b) If not, why not?

c) If so, when?

d) What data will be included?

Answer:

a – d)

The department publishes comprehensive data on Medicare Benefits Scheme (MBS) bulk billing and safety net for each electorate, on its website. These can be found at www.health.gov.au/electoratereports Data on MBS bulk billing and safety net was most recently updated in November 2009. Further information is provided to the Minister from time to time.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-085

OUTCOME 0: Whole of Portfolio

Topic: ELECTORATE LEVEL REPORTS

Written Question on Notice

Senator Boyce asked:

a) Does the Department prepare electorate level reports for Ministers?
b) What data is included in these reports?
c) How often is this updated?
d) Why is this material not publicly available?
e) Can a copy of the latest reports be provided?

Answer:

a – e)

The department publishes comprehensive data on Medicare Benefits Scheme (MBS) bulk billing and safety net for each electorate, on its website. These can be found at www.health.gov.au/electoratereports Data on MBS bulk billing and safety net was most recently updated in November 2009. Further information is provided to the Minister from time to time.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-132

OUTCOME 0: Whole of Portfolio

Topic: ELECTORAL REPORTS

Written Question on Notice

Senator Adams asked:

a) Are there plans to publish a full suite of electoral reports on the Department's website?

b) If not, why not?

c) If so, when?

d) What data will be included?

Answer:

a – d)

The department publishes comprehensive data on Medicare Benefits Scheme (MBS) bulk billing and safety net for each electorate, on its website. These can be found at www.health.gov.au/electoratereports Data on MBS bulk billing and safety net was most recently updated in November 2009. Further information is provided to the Minister from time to time.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-133

OUTCOME 0: Whole of Portfolio

Topic: ELECTORATE LEVEL REPORTS

Written Question on Notice

Senator Adams asked:

f) Does the Department prepare electorate level reports for Ministers?

g) What data is included in these reports?

h) How often is this updated?

i) Why is this material not publicly available?

j) Can a copy of the latest reports be provided?

Answer:

a – e)

The department publishes comprehensive data on Medicare Benefits Scheme (MBS) bulk billing and safety net for each electorate, on its website. These can be found at www.health.gov.au/electoratereports Data on MBS bulk billing and safety net was most recently updated in November 2009. Further information is provided to the Minister from time to time.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-042

OUTCOME 0: Whole of Portfolio

Topic: SOCIAL MARKETING CAMPAIGNS

Written Question on Notice

Senator Siewert asked:

c) Please provide figures for the amount set aside for social marketing campaigns on obesity and smoking 2007-08, 2008-09, 2009-10.

d) Will this be in addition to the planned funding ($102 million over four years) in the current National Preventive Agency legislation?

Answer:

a) The amounts spent for social marketing campaigns on obesity (*Measure Up* campaign) were:
   - $731,007 in 2007-08;
   - $15,702,888 in 2008-09; and
   - As at 30 November 2009 $4,918,192 has been spent and $11,861,677 has been committed of the $14.2 million set aside for 2009-10. Activities which will use the remaining unspent and uncommitted funds are currently being planned and it is anticipated all of the budget will be expended by year's end.

   The amounts allocated for social marketing campaigns on smoking (tobacco) are:
   - 2007-08: $12,382 spent prior to National Tobacco Youth Campaign being terminated.
   - 2008-09: Nil.
   - 2009-10: $5 million has been allocated for a national tobacco social marketing campaign targeting youth as part of the Reinvigorating the National Tobacco Strategy measure. $550,000 has also been allocated for developmental research for the new $60.5 million national tobacco campaign funded through the National Partnership Agreement on Preventive Health which will start in 2010-11.

b) Funding allocated to the Australian National Preventive Health Agency builds on these allocations.

TABLED BY SENATOR COLBECK
DOHA ESTIMATES 21.10.09
T1

5AA ADELAIDE – LEON BYNER MORNING PROGRAM – 11.50 am – Wednesday 21.10.09

FEDERAL AGRICULTURE MINISTER, TONY BURKE

re food labelling laws...Australia to allow import of beef products from countries where there has been mad cow disease (BSE) ...

BYNER:

....there is no definitive test for a live cow that may or may not have this (BSE), you've got to wait till they're dead and by then it's too late -(greetings omitted) – ***why on earth did you approve this?***

BURKE:

It was the industry that came to us, the Cattle Council in particular and organisations representing farmers who said that the current policy was putting particular risk to Australian farmers, and that's because **the current policy that we've had, doesn't only apply to imports. It also applies to the domestic industry, you've got the same set of rules.** Now what that means and this part of it I'm grateful for the chance got is able to explain it, because it hasn't made a lot of the discussion so far. **If for example, there were a breakout of BSE in Tasmania, all Australian beef no matter where it came from, would have to be taken off the shelves in Australia**, because **we have a policy at the moment that says for any country, including our own, if you have an outbreak anywhere in that country, you can't take a regional approach, you can't take a science-based or health-based approach. The approach has to be nationwide and immediate and it's all off the shelves.** Now, what that would do would be the 40% of our beef that's consumed within Australia, would be off the domestic shelves straight away and you can imagine how many people would be willing to buy the 60% that we try to export if we weren't even willing to eat it in Australia.

BYNER:

I know that for a fact that ***the Cattle Council that you quote has asked your people to go and talk to Bill Heffernan. He says you didn't do that****, because there is information. The thing is if we banned since 2001 meat from those regions to come, and our Japanese and Korean customers are patting us on the back. So, now what we've really done, whichever way you want to reason this Minister, is* ***we have now increased the risk that this mad cow disease could cause us much duress in Australia?***

BURKE:

In terms of the export market if I can start with that, what you raise with conversations **with the Cattle Council saying that they told someone to talk to Bill Heffernan, but that's the first I've heard that so I can't really speak to that**. On the issue of the Korean and Japanese market, there was a time where many Australians believed that they were willing to hold out US beef in particular as long as we kept it banned. Those days are over now. In Japan they've been taking US beef since 2006, Korea's being taking it since 2008, so there was a time where I can understand why that argument was being made. It's an argument that no longer holds and let's make clear that if there were to be a fresh outbreak in that part of the world, **this policy allows us to take a regional approach. What changes is the automatic exclusion of an entire national boundary** because of that outbreak.

1

BYNER:

I've got an email here from somebody in the meat industry who says - the meat industry is about to be hit with imported beef from America, the dairy industry have collapsed in America and the meat is being exported worldwide, dairy cattle produce milk never meant to be steak, the quality will be poor, the low prices and oversupply into our country will put a huge pressure on our farmers, as if they haven't been through enough hard times already - you want to comment on that?

BURKE:

Yeah, I think that simple test of that Leon, is what's happening in markets that already take both Australian beef and beef from other countries, and essentially that's the regional approach I referred to that applies at the moment both every other country in the world except Australia and what's happening there is they're still buying our beef in much bigger numbers than they're buying the beef that you've just referred to. I mean **the Korean market for example, 65% of what they take is from Australia, 15% ...is from the United States**. Now, the cheap beef that you've just referred to is available to those markets and it's not being taken for the very simple reason that around the markets around the world, we've got the best quality beef and that's what people buy.

BYNER:

Now - are you going to make sure that the food- you and I talk about food labelling before, given all these things going on, the customer has got to know where this is from, what's in it , how far away are we from this good labelling laws, to give people informed choice?

BURKE:

This is something that I'm talking with Mark Butler about - when we've been continuing the talks today **because there's a new element of it that we now need to get fixed** and I'm glad you've raised it. **That is if you look at the fishing industry for anything that comes in a can, it's already labelled in terms of where it comes from, but if it's fresh, we have a special law at the fish shop that when you buy cold fish, fresh fish - it has to be labelled where it comes from. We don't have that for red meat at the moment and that's something that we do now have to look at**. I don't expect much will come in at all, but if it comes in, in a can in terms of red meat, well, it's already labelled, but the issue of making sure that **if any butcher were to have imported meat, making sure that the customer has that label, it's something that we do now need to work on, you're right.**

BYNER:

Tony, we'll keep in touch with you on this, *thanks for coming on.*

ENDS

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-037

OUTCOME 1: Population Health

Topic: WEIGHING IT UP - OBESITY IN AUSTRALIA

Written Question on Notice

Senator Barnett asked:

In light of the recommendations contained in the House of Representatives Health Committee report, "*Weighing in Up – Obesity in Australia*", tabled in early June 2009, can the department advise:

a) If it is in the process of providing a detailed response on each of the Committee's recommendations and can it provide an indication of when the response will be finalised?

b) If it is aware that given the majority of morbidly obese people are from low socioeconomic backgrounds and have low take up of private health insurance, bariatric surgery remains financially unviable for these people as less than 10% of procedures are preformed in public hospitals?

c) If it is aware there is a 2-3 year wait list for bariatric surgery at most public hospitals?

d) If it is aware of the benefits all forms of bariatric surgey – Gastric Bypass, Sleeve Gastrectomy and Lap Band have in reducing and in some cases eradicating Type 2 diabetes in patients who have undergone the surgery?

e) What is the Department's position on the procedures referred to above?

f) How are they currently funded?

Answer:

a) The Government is considering the House of Representatives *Weighing it Up* report in conjunction with the Preventative Health Strategy, the National Hospital and Health Reform Commission and the Draft Primary Care Strategy. All of the recommendations in each of these reports are being considered on their merit.

b) Decisions regarding the availability of specific medical procedures for the treatment of public patients appropriately rest with the public hospitals in which the patients are to be treated.

The Government has no control over what doctors charge for their services. The Medicare benefits arrangements were developed to provide a rebate (or part reimbursement) for costs incurred by patients when receiving private services. In consultation with the medical profession, the Government sets the Medicare fee at a rate that is considered fair, sustainable and reflective of the complexity and time involved in performing the service. When a doctor treats a patient privately and charges a fee above the Medicare rebate, the Government relies on the goodwill and cooperation of individual medical practitioners to ensure the patient receives adequate medical care without undue financial hardship. Medical practitioners are encouraged to consider a patient's personal circumstances when applying their fees.

c) Admitted patient data on a national basis indicates the median elective surgery waiting time for people requiring bariatric surgery (i.e. gastric reduction, laparoscopic gastric reduction or gastric bypass) in 2007-2008 was 97 days.

As mentioned above, decisions regarding the availability of specific medical procedures for the treatment of public patients appropriately rest with the public hospitals in which the patients are to be treated.

The Australian Government acknowledges that elective surgery waiting times need to be improved, and is committed to ensuring that real and sustained improvements are made in this important area. As part of this commitment, the Government is investing up to $600 million in the Elective Surgery Waiting List Reduction Plan (the Plan). This Plan is working to ensure that patients waiting for elective surgery are seen within clinically recommended times.

Stage One of the Plan provided $150 million in additional funding to states and territories to bring about an immediate reduction in elective surgery waiting lists. The aim of this additional funding was to clear approximately 25,000 procedures by the end of 2008. Stage one was a success with 41,584 procedures carried out nationally, far exceeding the target by 64 percent. Under Stage One, Tasmania has received $8.1 million. This has resulted in 1,606 additional procedures being performed in 2008. This exceeded the original target of 895 by an impressive 79.4%.

Stage Two of the plan, which commenced in 2008, provided $150 million to states and territories to build on the success of Stage One. The funding was used for system and infrastructure improvements which will help to improve elective surgery performance in the long-term.

Under Stage Two, Tasmania has received $3.1 million to purchase new equipment for a number of hospitals.

The third and final stage of the Plan begins later this year and will provide up to $300 million to reward those states and territories which meet specific targets in reducing waiting times and increase the number of surgeries performed. Tasmania will receive its share of Stage Three funding based on its performance in reaching these targets.

d) The Department is aware of recent literature which draws a relationship between bariatric surgery and a reduction in type 2 diabetes.

e) Medicare benefits are claimable only for clinically relevant services rendered by an appropriate health practitioner. Gastric reduction surgery, including laparoscopic adjustable gastric banding, is recognised as an effective current treatment for morbid obesity, as detailed in the National Health and Medical Research Council's "Clinical Practice Guidelines for the Management of Overweight and Obesity in Adults". It was supported by the Medical Services Advisory Committee which found in 2003 that laparoscopic adjustable gastric banding was safe, effective and cost effective.

The Department's position is that bariatric surgery, including the choice of method is a clinical decision and should be determined between an individual and their medical specialist to ensure that it is an appropriate and any operative risk is considered acceptable.

f) There are a number of procedures associated with gastric banding that attract Medicare benefits, either performed laparoscopically or by open surgery, when the procedure is performed on people who are considered morbidly obese, and who elect to be treated as private patients.

Medicare does not cover the cost of the gastric band itself, as the Medicare benefits arrangements were designed to subsidise the cost of medical services provided by qualified medical practitioners, not the products used in conjunction with those services. Some private health funds provide benefits for aids and appliances, such as gastric bands, but the funds are free to determine the nature of health-related goods that attract benefits and any restrictions or limitations on such benefits.

For procedures performed free of charge in public hospitals, the Commonwealth Government makes a contribution to states and territories through the National Health Care Agreement. This arrangement is separate from the Medicare rebate system, which reimburses private patients up to 75% of the schedule fee for the surgical procedure.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-015

OUTCOME 1: Population Health

Topic: PREVENTIVE HEALTH BUDGET

Written Question on Notice

Senator Ronaldson asked:

Will DoHA's annual $35 million advertising budget now be reduced because preventive health is now the responsibility of another agency?

Answer:

The Department of Health and Ageing does not have an annual advertising budget. Funds for social marketing activities are allocated to particular campaigns and for specified timeframes. These allocations usually occur as part of the budget process.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-019

OUTCOME 1: Population Health

Topic: Bowel Cancer Screening Program

Written Question on Notice

Senator Xenophon asked:

As part of the bowel cancer screening program, kits are sent by post to people when they turn 50, 55 and 65 years, however there is not free screening on the years in between.

a) What modelling was done into the cost/benefit analysis of distributing kits every five years instead of more frequently?

b) What was the cost difference of distributing kits every five years compared to every two years, for example?

c) Would frequent re-screening potentially be more cost effective than the current system, and could that help save lives?

d) What are the rates of success for early detection of bowel cancer?

Answer:

a) No modelling was undertaken on the cost/benefit of distributing the kits every five years instead of more frequently.

b) This has not been assessed.

c) The National Health & Medical Research Council '*Guidelines for the prevention, early detection and management of colorectal cancer (2005)*' recommends screening with faecal occult blood test (FOBT) in people aged over 50 years at least once every two years. Pilot studies undertaken in Australia from 2002 to 2004 indicated that biennial screening for people aged 50 to 74 years was cost effective. The previous Government implemented bowel cancer screening for people turning 55 and 65 years. The current Government extended this to include people turning 50 years as part of an election commitment. The progressive introduction age cohorts was in response to the need to build capacity in the health system to meet demand for follow up services generated from people with positive screening results, particularly colonoscopy and histopathology services.

d) International randomised controlled trials have demonstrated that screening using the FOBT can reduce mortality rates from bowel cancer by between 15 - 33%. It is too early to assess the mortality benefit from introducing the National Bowel Cancer Screening Program however the current cancer detection rates suggest the Program will be successful in reducing deaths from bowel cancer over time. In 2008, 6.6% of participants tested positive for traces of bleeding from the bowel. Of the FOBT positive results where follow-up outcomes had been reported by 31 January 2009, 53% had a finding of a suspected cancer, adenoma or polyp. Of these, the detection rate of adenomas was 13.9% and of cancers was 4.3%; and another 35% of detected polyps were awaiting final classification from histopathology at the time of reporting. an additional 23% had other diagnoses detected at colonoscopy (NBCSP Monitoring Report 2009).

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-109

OUTCOME 1: Population Health

Topic: BOWEL CANCER SCREENING PROGRAM

Written Question on Notice

Senator Adams asked:

a) The national bowel cancer screening program was put on hold during the year due to a problem with the test kits and their subsequent withdrawal from use in the program. When will the new/updated kits be ready?

b) When will the bowel cancer screening program resume?

c) Will this hiatus in the program cause a negative perception about the program and that it may not be progressed?

d) What marketing will be conducted when the program resumes?

e) Has the fact that the program has been on hold caused the Government to reconsider the program in any way?

f) Will the program 'hit the ground running' when it is re-introduced?

g) How many new bowel screening kits will be rolled out?

Answer:

a) The National Bowel Cancer Screening Program (the Program) commenced issuing replacement kits on 2 November 2009.

b) The Program resumed on 2 November 2009.

c) There is no evidence that the suspension of screening invitations has led to negative perceptions of the Program. This cannot be assessed until a substantial number of invitations and replacement kits have been sent and sufficient time has elapsed to determine uptake.

d) Advertisements to participants were placed in national primary and regional newspapers. Advice for General Practitioners (GPs) was provided by:
   - a letter from Dorevitch Pathology to every GP nominated by participants who received a negative result from the old kit;
   - Friday Facts, a newsletter sent by the Royal Australian College of General Practitioners each Friday to its members; and
   - Medical press, "6 minutes", the Australian Doctor and the Medical Observer.

e) No.

f) Yes.

g) Approximately 1.6 million replacement faecal occult blood test (FOBTs) will be issued from 2 November 2009 to 31 March 2011:
   - 384,837 to people who received a modified FOBT kit and received a negative or inconclusive result;
   - 164,000 to people who were eligible to receive an Invitation Package between 8 May and 30 June 2009 (the remaining 08-09 cohort) will also be offered screening. That is a total of 548,837 people who will be offered re-testing and first time screening; and
   - 1,000,000 to those people who are in the 1 July 2009 to 30 December 2010 cohort of people turning 50, 55, and 65 years of age, and are considered part of the remediation.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-001

OUTCOME 1: Population Health

Topic: NATIONAL PREVENTATIVE HEALTH TASKFORCE

Written Question on Notice

Senator Ronaldson asked:

What are the functional differences between the National Preventative Health Taskforce (NPHT) and COAG's National Partnership Agreement on Preventive Health (NPAPH), including the Australian National Preventive Health Agency (ANPHA)?

Answer:

The National Preventative Health Taskforce is a ministerially appointed advisory group established to provide evidence-based advice to governments and health providers.

The National Partnership Agreement on Preventive Health (NPAPH) is a cross-jurisdictional agreement through which funds will be provided for a range of programs targeting the significant lifestyle risk factors for chronic disease. The Australian National Preventive Health Agency is being funded through the NPAPH, with the function of:

- providing evidence-based policy advice to health and other ministers interested in preventive health;
- administering social marketing programs and other national preventive health programs which it may be tasked with by Health Ministers;
- overseeing surveillance and research activities of a national nature; and
- stakeholder consultation.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-003

OUTCOME 1: Population Health

Topic: NATIONAL PREVENTATIVE HEALTH TASKFORCE

Written Question on Notice

Senator Ronaldson asked:

Why was there a need for the NPHT to go through a process of community consultation that lasted through February 09, when COAG agreed to a similar program, including the creation of ANPHA, in November 2008?

Answer:

The development of a long term strategy requires analysis and discussion of a range of potential interventions to ensure the most effective recommendations are put forward.

The consultations undertaken by the National Preventative Health Taskforce (the Taskforce) between October 2008 and February 2009 ensured a broad range of options were canvassed and critiqued in the course of the development of the National Preventative Health Strategy (the Strategy).

The Taskforce provided early advice to the Australian Government during the development of the National Partnership Agreement on Preventive Health (Prevention NP). This allowed the Government to incorporate the evidence the Taskforce was building through its research and development process in the design of the Prevention NP.

Whilst there is some overlap between the Strategy and the Prevention NP (notably the ANPHA and the use of social marketing and settings-based approaches), the recommendations made by the Taskforce cover a broader range of interventions that could be used by Governments in tackling obesity, tobacco and alcohol as drivers of chronic disease, including fiscal, regulatory and environmental strategies.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-005

OUTCOME 1: Population Health

Topic: NATIONAL PREVENTATIVE HEALTH TASKFORCE CAMPAIGN

Written Question on Notice

Senator Ronaldson asked:

Was any consideration given to running a communications campaign instead of creating a new agency, and if not, why not?

Answer:

A number of different strategies and initiatives were considered during the development of the National Partnership Agreement on Preventive Health. After extensive deliberation and consideration of the evidence, all jurisdictions agreed that a range of different interventions would be required to address the lifestyle risk factors of chronic disease.

The communications campaigns funded under the Partnership Agreement will support behavioural change through public education on the need for all Australians to adopt healthy lifestyles. The Australian National Preventative Health Agency (ANPHA) fills a different niche by bringing together the best expertise in the country to engage employers, businesses, other sectors and the wider community to inform preventive health policy advice to all Health Ministers. The ANPHA will also fill a gap in the national synthesis of preventive health research and surveillance.

Incorporating communications campaigns into the ANPHA's agenda will, however, ensure that they are evidence-based and developed from broad, informative research to support behavioural change.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-006

OUTCOME 1: Population Health

Topic: NATIONAL PREVENTATIVE HEALTH TASKFORCE'S RECOMMENDATIONS

Senator Ronaldson asked:

Why did the National Preventative Health Taskforce's (NPHT) recommendations include proposals to make employers responsible for the eating, drinking, smoking and exercise habits of their staff, what was the Minister' response to this proposal?

Answer:

The NPHT recommended that government fund a range of settings-based interventions aimed at supporting individuals to change behaviours known to cause chronic diseases. The Strategy identifies that workplaces, schools and communities are locations that provide opportunities for these interventions. It does not propose making employers responsible for the lifestyle habits of their employees.

The Government will consider the recommendations made in the Strategy in conjunction with the findings of the National Health and Hospitals Reform Commission Report and the draft National Primary Health Care Strategy.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-007

OUTCOME 1: Population Health

Topic: PREVENTATIVE HEALTH PROGRAMS

Written Question on Notice

Senator Ronaldson asked:

What specific failings or shortcoming were there in DoHA's and AIHW's existing approach to preventative health programs, monitoring and surveillance that necessitated the creation of ANPHA as a new independent agency?

Answer:

The decision to create a national preventive health agency was not based on failings of any existing bodies. Rather, it was based on a recognition of the new challenges arising from complex preventive health problems such as obesity and excessive alcohol consumption, which require intensive effort to address, across a range of sectors over longer periods.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-009

OUTCOME 1: Population Health

Topic: AUSTRALIAN NATIONAL PREVENTIVE HEALTH AGENCY (ANPHA)

Written Question on Notice

Senator Ronaldson asked:

Once the decision was taken to create the ANPHA as an independent agency, what measures did the Minister take to ensure smooth coordination of roles with DoHA and AIHW to prevent duplication of function and effort?

Answer:

Significant consultation was undertaken during the planning and design stages of the ANPHA's establishment, including with states and territories to ensure that there would be no duplication of its roles and efforts.

In contrast to DoHA, the ANPHA will work to all Health Ministers, ensuring a national approach to policy and program design in preventive health can be applied in all jurisdictions. In tasking the ANPHA through its strategic and operating plans (as required by the legislation) Health Ministers will ensure the ANPHA's activities do not duplicate roles and responsibilities of existing agencies.

As the role of the Australian Institute of Health and Welfare is to collect data and statistics, the ANPHA will complement this by advising on data collection needs, and analysing data sets with a specific focus on informing development of policies and programs in preventive health. Further, by aggregating, analysing and synthesising data from a variety of sources the ANPHA will add value to current monitoring and reporting arrangements.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-010

OUTCOME 1: Population Health

Topic: PREVENTATIVE HEALTH PROGRAMS

Written Question on Notice

Senator Ronaldson asked:

Where and from whom did the idea for the creation of a new preventative health agency first arise?

Answer:

The specific proposal to create a national preventative health agency was a recommendation of the Australia 2020 Summit, held shortly after the National Prevention Summit, in April 2008. The recommendation proposed that the Australian National Preventative Health Agency would be an "independent health body funded by taxes on products with high social cost, e.g. alcohol, cigarettes and junk food (like a national version of VicHealth). The body would commission research, design interventions based on evidence, develop and deliver preventative health policy, and implement marketing and public health campaigns".

The agency concept was then further developed in a paper commissioned by the National Hospitals and Health Reform Commission (NHHRC) titled "*A National Agency for Illness Prevention and Health Promotion*" prepared in August 2008, and included in the Commission's interim report, in February 2009. The idea was also proposed in the National Preventative Health Taskforce's report "Australia: the healthiest country by 2020: A Discussion Paper" released for public consultation in September 2008.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-011

OUTCOME 1: Population Health

Topic: PREVENTATIVE HEALTH PROGRAMS

Written Question on Notice

Senator Ronaldson asked:

Given that existing agencies have been producing preventative health data, why has ANPHA been tasked to monitor and report the same data?

Answer:

The Australian National Preventative Health Agency has not been tasked with producing preventive health data. It will add value to current monitoring and reporting arrangements by aggregating, analysing and synthesising data from a variety of sources – using multidisciplinary methods - to inform policy advice to health and other ministers interested in preventive health, and to ensure the right data is available to meet the specific needs of the issues it is tasked to address. It will also play a role in providing technical leadership for jurisdictional data collection, and collections by other agencies and researchers.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-012

OUTCOME 1: Population Health

Topic: PREVENTATIVE HEALTH PROGRAMS

Written Question on Notice

Senator Ronaldson asked:

Given that internationally acclaimed advertising campaigns such as 'every cigarette is doing you damage' were conceived and produced prior to the creation of ANPHA, why is there a need to create a new independent agency to promote preventative health awareness?

Answer:

The National Tobacco Campaign (NTC) is recognised as the leading example historically of successful Commonwealth/state and non-government organisation collaboration in preventive health campaigns. A large part of the success of this campaign arose from the national role played by the Centre for Behavioural Research in Cancer of the Anti-Cancer Council of Victoria. In fact, the NTC example of technical leadership being provided by an independent agency helped inform the design of the Australian National Preventive Health Agency (ANPHA).

The NTC experience, combined with the new challenges with lifestyle risk factors provided the imperative to adapt that model. The establishment of the ANPHA recognised the key independent coordination and leadership role as well as the gap identified by Council of Australian Governments of a dedicated focus on preventive health at the national level.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-014

OUTCOME 1: Population Health

Topic: PREVENTATIVE HEALTH

Senator Ronaldson asked:

Are there any objective benchmarks, metrics or deliverables that would allow us to assess the efficacy of this social marketing campaign, and if so, will that analysis be made public, and if so, in which form?

Answer:

Benchmark, tracking and post-campaign evaluation is undertaken as part of all government social marketing campaigns, measuring both the effectiveness of implementation of the social marketing strategy and achievement of objectives.

Evaluation reports are usually produced and published on the relevant campaign website (e.g. the evaluation report from phase one of the *Measure Up* campaign can be found at: http://www.measureup.gov.au/internet/abhi/publishing.nsf/Content/About+the+campaign-lp)

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-078

OUTCOME 1: Population Health

Topic: NATIONAL PREVENTIVE HEALTH AGENCY (NPHA)

Written Question on Notice

Senator Boyce asked:

a) Legislation to establish the National Preventive Health Agency has been introduced to the Parliament – what is the proposed structure of this agency?

b) How many additional staff will be recruited for this new body?

c) Could or will any of these staff be seconded from within the Department?

d) Will departmental staff numbers be cut as new agencies such as this take responsibility for various areas of health policy?

e) How will the make up and credentials of its board be decided?

f) Will stakeholders be consulted on those positions?

Answer

a) The Australian National Preventive Health Agency Bill 2009 (the Bill) provides for the Agency to be established as an independent statutory authority. The Agency will be a prescribed agency for the purposes of the *Financial Management and Accountability Act 1997* (FMA Act) and that Act will apply to the operation of the Agency. The Chief Executive Officer (CEO) and staff will together constitute a statutory agency for the purposes of the *Public Service Act 1999*.

b) The CEO will be responsible for determining the staffing profile of the Agency, taking into account its budget, the functions outlined in the Bill, and in accordance with triennial strategic and annual operational plans agreed with Health Ministers.

c) The Bill provides for staff to be seconded to the Agency from the Commonwealth, state or territory government authorities. The secondment of any staff to the Agency will be at the discretion of the CEO and the relevant authority.

d) No. The Agency is being established to cover new policy areas not currently covered by the Department. The Agency will fill a gap identified by Council of Australian Government by providing the supporting infrastructure required to bring together relevant stakeholders and assist all Health Ministers in tackling the complex challenges in addressing the lifestyle risk factors causing preventable chronic conditions.

e) As an FMA Act Agency, the Agency will not have a governing board. However, the Bill provides that the Agency CEO be supported by an Advisory Council consisting of up to three government (one Commonwealth, two state/ territory) and eight non-government representatives.

The Commonwealth Minister for Health and Ageing, in consultation with all Australian Health Ministers, is responsible for the appointment of the Advisory Council members. The Bill provides that the non-government representatives have expertise relating to preventive health.

f) The Commonwealth Minister for Health and Ageing is required to consult with the Australian Health Ministers' Conference before making appointments to the Agency's Advisory Council. In addition, other stakeholders may be consulted in order to identify the best possible candidates.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-044

OUTCOME 1: Population Health

Topic: SOCIAL MARKETING CAMPAIGNS

Senator Siewert asked:

Will the Preventive Agency be the primary source of funding for all social marketing campaigns?

Answer:

The Preventive Health Agency will be a key source of funding for social marketing campaigns.

A number of government and non-government groups and organisations will continue to play important roles in funding social marketing activities.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-110

OUTCOME 1: Population Health

Topic: BOWEL CANCER SCREENING PROGRAM

Written Question on Notice

Senator Adams asked:

What is the Government's intention for the future role of bowel cancer screening?

Answer:

In May 2008 the Government announced funding of $87.4 million over three years to extend the National Bowel Cancer Screening Program (the Program) to 50 year olds. As a result over two million people turning 50, 55 or 65 years of age between 1 January 2008 and 31 December 2010 will be offered free bowel cancer screening under phase 2 of the Program. The Program is being phased in gradually to ensure that health services, such as colonoscopy and treatment services, are able to meet any increased demand. Extending the Program to include 50 year olds is a first step toward screening all Australians over 50 years in the longer term.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-111

OUTCOME 1: Population Health

Topic: BOWEL CANCER SCREENING PROGRAM

Written Question on Notice

Senator Adams asked:

Will current participants be re-invited, following their first screening?

Answer:

No. Not in this phase of the program. People are offered screening when they turn 50, 55 and 65 years of age.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-262

OUTCOME 1: Population Health

Topic: FUNDING MODELS

Hansard Page: CA 16

Senator Siewert asked:

In terms of issues around needs based funding versus other forms of funding provision, have you looked at that in much detail?

Answer:

An example of relevant work in the area of needs-based funding is included in the following report:

Australian Institute of Health and Welfare 2008. *Aboriginal and Torres Strait Islander Health Performance Framework, 2008 report: Detailed analyses*. Cat. no. IHW 22. Canberra: AIHW. Published 19 January 2009; ISBN-13 978 1 74024 860 0; INTERNET ONLY.

Section 3.12 *Access to services by types of service compared with need* of the report contains detailed analyses underlying the summary data presented in the policy report Aboriginal and Torres Strait Islander Health Performance Framework 2008 report, produced by the Department of Health and Ageing. The Aboriginal and Torres Strait Islander Health Performance Framework (HPF) is designed to provide the basis to monitor the impact of the National Strategic Framework for Aboriginal and Torres Strait Islander Health (NSFATSH) and inform policy analyses, planning and program implementation. The HPF consists of 70 measures covering three tiers: health status and outcomes; determinants of health; and health and systems performance.

Section 3.12 covers access to services by types of service compared with need (for example, primary care, hospital, dental and allied health and post-acute care and palliative care).

Data are presented for Indigenous and non-Indigenous populations.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-263

OUTCOME 1: Population Health

Topic: DEFINITIONS OF 'PRIVATE PATIENTS' USED IN STATISTICAL REPORTS

Hansard Page: CA18

Senator Boyce asked:

What is the reason for the differing definitions of 'private patients' used by DoHA in its 'State of our public hospitals' report and by the AIHW?

Answer:

For the majority of patients across Australia, the distinction between 'public' and 'private' patient is clear, based on the patient's election to be treated as public or private. However complexities arise because there are a number of possible funding sources for a patient, which are treated differently by the Australian Institute of Health and Welfare (AIHW) and the Department of Health and Ageing when the data items are mapped to a 'public' or 'private' category.

The nationally-endorsed standards for collection of hospital data define two concepts which can be used in the determination of whether a patient is 'public' or 'private'. These concepts are the patient's reported 'patient election status' and the 'principal source of funding'.

While the first is a simple choice about the chargeable status elected by a patient on admission to hospital, the second concept – principal source of funding - has multiple options. The national standards require a patient to be reported against one of the following Principal funding sources:

- *Australian Health Care Agreements*
- *Private health insurance*
- *Self-funded*
- *Workers' compensation*
- *Motor vehicle third party personal claim*
- *Other compensation (e.g. public liability, common law, medical negligence)*
- *Department of Veterans' Affairs*
- *Department of Defence*
- *Correctional Facility*
- *Other hospital or public authority (contracted care)*
- *Reciprocal health care agreements (with other countries)*
- *Other*
- *No charge raised*

If the Patient election status is not reported, or is inconsistent with the reported funding source, this second category determines the reported patient status.

The AIHW and the Department each map the funding source categories in different ways: the AIHW maps all patients to either public or private, while the Department maps to three categories - *Public*, *Private* or *Other*. (Further detail on the mappings is provided below).

To some extent, the way the two concepts are mapped depends on the purpose of the analysis. For example, the Department's report (*The State of our Public Hospitals*) would be able to assist readers' understanding of what proportion of patients' hospital stays are funded through Medicare *versus* through other government sources (the most significant of which are the Departments of Veterans' Affairs and Defence) *versus* through private health insurance or out-of-pocket payments.

The AIHW's report (*Australian Hospital Statistics)* provides data on finer categories of patients (with much greater detail, in particular, regarding sources of funding for hospital stays). Thus readers of the report can map those detailed data to the categories that best fit their own purposes.

While the different purposes of reporting need to be acknowledged, there is nevertheless room for further consideration of whether consistency can be achieved to avoid confusion amongst readers. With this objective in mind, the AIHW will raise this matter with the National Health Information Standards and Statistics Committee, which is the standards-setting body under the Australian Health Ministers Advisory Council.

The detailed mapping methodologies used by AIHW and the Department are described below:

The AIHW primarily defines patients as either *Public* or *Private* according to the Patient election status and secondarily according to Principal funding source.

Where the Patient election status is not reported, then the *Public* patient category includes records for admitted patients whose funding source was reported as *Australian Health Care Agreements* or *Reciprocal health care agreements* because it is assumed these patients were not charged.

Where the Patient election status is *Private*, and the funding source is *Australian Health Care Agreements* or *Reciprocal health care agreements*, the patient is reported as *Public*, because it is assumed the stated funding source is more likely to be correct.

Where the Patient election status is not reported or *Public*, the patient is reported as *Private* if the funding source reported is *Private health insurance*, *Self-funded*, *Motor vehicle third party personal claim*, *Workers compensation*, *Other compensation*, *Department of Veterans' Affairs*, *Department of Defence* or *Correctional facility*, because it is assumed that the stated funding source is more likely to be correct.

In *The State of our public hospitals, June 2009 report*, the Department defines patients as *Public*, *Private* or *Other* as follows:

- *Public* patients are those who are eligible for Medicare and elect to receive services as a public patient in accordance with *the Australian Health Care Agreements.*
- *Private* patients were those who pay for their hospital expenses using private health insurance and/or their own funds.
- *Other* patients were those who do not meet the above definitions for classification as *Public* or *Private* patients. *Other* patients include those whose hospital expenses are paid for by the Department of Veterans' Affairs, the Department of Defence or compensation arrangements. This category also includes patients from correctional facilities. Any patient admission record with unknown funding source will also be included here unless the patient's election status is clearly identified as public or private.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-271

OUTCOME 1: Population Health

Topic: BOVINE SPONGIFORM ENCEPHALOPATHY (BSE) AND IMPORTED BEEF AND BEEF PRODUCTS

Senator Back asked:

I imagine there will be more than adequate funding following this decision to ensure into the long term that these funds and these resources will be available?

Answer:

Additional resources have been allocated to Food Standards Australia New Zealand to undertake country risk assessments and in-country inspections. The details will be included in the Portfolio Additional Estimates Statements which are due to be tabled in Parliament before the end of this year.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-272

OUTCOME 1: Population Health

Topic: BOVINE SPONGIFORM ENCEPHALOPATHY (BSE) AND IMPORTED BEEF AND BEEF PRODUCTS

Hansard Page: CA 50-51

Senator Heffernan asked:

Could we have the details of the actual protocols put forward to support this case?

Answer:

Food Standards Australia New Zealand (FSANZ) is currently developing the risk assessment methodology. The Australian BSE Food Safety Assessment Committee, chaired by FSANZ, will use this methodology to undertake a risk assessment and, where necessary, an in-country inspection of applicant countries to determine that beef and beef products do not represent a risk to the health of Australian consumers.

The risk assessment methodology and process for conducting the risk assessments are expected to be finalised by 1 March 2010.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-022

OUTCOME 1: Population Health

Topic: ICE USERS

Written Question on Notice

Senator Xenophon asked:

a) In contrast to the campaign, how much money was spent on helping to physically treat Ice users for their addiction?

b) In what way was the money spent? (i.e. Programs/rehab/etc)

Answer:

a) The Department is not able to provide an accurate estimate as many treatment services are provided by state and territory governments. However, under round three of the Non-Government Organisation Treatment Grants Program (NGOTGP) the Commonwealth Government is providing $134.4 million over three years (2008-2011) to 197 non-government treatment services nationwide to operate a range of alcohol and other drug treatment services. It is not possible to determine what proportion of this is spent on helping Ice users.

b) Treatment options available under the NGOTGP include counselling, outreach support, peer support, home detoxification, medicated and non-medicated detoxification, therapeutic communities and in/out patient rehabilitation. Particular emphasis is placed on services for women, youth, families with children, people with co-morbid mental health and drug and alcohol conditions, psycho-stimulant users and Aboriginal and Torres Strait Islander people.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-036

OUTCOME 1: Population Health

Topic: OBESITY

Written Question on Notice

Senator Barnett asked:

a) How many Australians are currently overweight, obese and morbidly obese?

b) How many of the morbidly obese are estimated to require or benefit from some form of bariatric surgery? Please provide details.

Answer:

a) Based on the Australian Bureau of Statistics 2007-08 National Health Survey 36.6% of Australians are overweight, 22.4% are obese (body mass index equal to or greater than 30 kgs/m^2) and 2.4% are morbidly obese (body mass index equal to or greater than 40kgs/m^2).

b) Bariatric surgery is an alternative form of treatment for those individuals who are morbidly obese and for whom non-surgical methods of weight loss have been unsuccessful. The Department is unaware of how many individuals require or would benefit from bariatric surgery as this type of intervention is determined between an individual and their medical specialist to ensure that it is an appropriate approach and any operative risk is considered acceptable. The Department can confirm that the following private services were funded by Medicare in 2008/09:

	2008-09
Item 30511*	14,139
Item 30512**	231
Total services	14,370

*MBS item 30511 - Gastric reduction or gastroplasty for morbid obesity, by any method
**MBS item 30512 – Gastric bypass for morbid obesity, by any method including anastomosis.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-043

OUTCOME 1: Population Health

Topic: ALCOPOPS

Written Question on Notice

Senator Siewert asked:

Please indicate which part of the Department - and under which program - is responsible for administering the $50 million funds set aside for community sponsorship programs negotiated as part of this year's alcopops legislation - Customs Tariff Amendment (2009 Measures No. 1) Bill 2009 [No. 2]?

Answer:

Most of the measures included under the $50 million agreement will be administered by the Drug Strategy Branch of the Mental Health and Chronic Disease Division under Outcome 1: Population Health.

It is proposed that $5 million allocated for the enhancement of telephone counselling services and alcohol referrals, and the possible expansion of existing social marketing campaigns will be administered by the Australian National Preventive Health Agency.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2008-2009, 21 October 2009

Question: E09-091

OUTCOME 1: Population Health

Topic: LISTING AND EVALUATION FEES

Written Question on Notice

Senator Boyce asked:

In April, the Therapeutic Goods Administration (TGA) proposed to raise the listing and evaluation fees it charges companies by up to 14.3 percent. These increases occurred on June 20 2009. In previous years, the fee schedule of the TGA has risen in line with inflation.

a) To the TGA's knowledge, has the increase resulted in increased prices for consumer medicines in Australia?

b) Have applications dropped since the new fees were implemented?

c) Please provide the number of applications made to the TGA, broken down by type, for each month in 2009?

d) What feedback does the TGA collect regarding the impact on businesses and consumers caused by fee increases?

Answer:

a) No.

b) Overall applications have not declined since the introduction of the increase in fees.

c) The number of applications made to the TGA, broken down by type, for each month in 2009 is at Attachment A.

d) The TGA meets two times each year with the Consumer Health Forum and with the peak industry bodies such as Medicines Australia, Australian Self Medication Industry, Complementary Health Council of Australia and Medical Technology Industry Association of Australia to discuss industry and consumer perspectives on its regulatory activities. In addition, a bilateral meeting is held with each industry body to discuss the fees and charges proposals prior to setting the fees and charges for the next financial year. As part of the approval process to increase fees and charges above the agreed indexation rate (4.3% for the 2009-10 financial year), a Cost Recovery Impact Statement is prepared which includes feedback from both industry sectors and general public.

ATTACHMENT A

THERAPEUTIC GOODS ADMINISTRATION

APPLICATIONS RECEIVED IN 2009

TYPE OF PRODUCT	Jan-09	Feb-09	Mar-09	Apr-09	May-09	Jun-09	Jul-09	Aug-09	Sep-09	Oct-09
Prescription Medicines *Fee increase FY 2009/10 of 6.6%*	99	108	117	65	72	97	72	65	56	56
Listed Non-Prescription Medicines *Fee increase FY 2009/10 of 14.3%*	230	256	364	289	297	369	391	381	352	318
Registered Non-Prescription Medicines *Fee increase FY 2009/10 of 13.3%*	53	51	51	69	66	72	62	64	70	76
Medical Devices *Fee increase FY 2009/10 of 4.3%*	316	306	478	246	341	340	329	303	417	308
TOTAL APPLICATIONS RECEIVED	698	721	1010	669	776	878	854	813	895	758

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-175

OUTCOME 1: Population Health

Topic: WEIGHING IT UP - OBESITY IN AUSTRALIA

Written Question on Notice

Senator Adams asked:

In light of the recommendations contained in the House of Representatives Health Committee report, "*Weighing in Up – Obesity in Australia*", tabled in early June 2009, can the department advise:

g) If it is in the process of providing a detailed response on each of the Committee's recommendations and can it provide an indication of when the response will be finalised?

h) If it is aware that given the majority of morbidly obese people are from low socioeconomic backgrounds and have low take up of private health insurance, bariatric surgery remains financially unviable for these people as less than 10% of procedures are preformed in public hospitals?

i) If it is aware there is a 2-3 year wait list for bariatric surgery at most public hospitals?

j) If it is aware of the benefits all forms of bariatric surgery – Gastric Bypass, Sleeve Gastrectomy and Lap Band have in reducing and in some cases eradicating Type 2 diabetes in patients who have undergone the surgery?

Answer:

a – d)

This question on notice has been addressed in E09-037.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-053

OUTCOME 1: Population Health

Topic: GE FOODS

Written Question on Notice

Senator Siewert asked:

GE foods that enter Australia without a formal safety assessment under the *Australia New Zealand Food Standards Code* are illegal, correct?

Answer:

Yes. Before any genetically modified food can enter the food supply in Australia, it must be approved in the *Australia New Zealand Food Standards Code*, under Standard 1.5.2 – Food produced using Gene Technology. Approval is contingent upon FSANZ finding no safety concerns following completion of a comprehensive safety assessment, carried out according to internationally accepted protocols. Any unapproved genetically modified food is technically non-compliant with the *Australia New Zealand Food Standards Code.*

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-004

OUTCOME 1: Population Health

Topic: NATIONAL PREVENTATIVE HEALTH TASKFORCE

Written Question on Notice

Senator Ronaldson asked:

Was this community consultation process open to all interested parties, or limited to specific participants on a 'by-invitation-only' basis?

Answer:

In developing the National Preventative Health Strategy, the National Preventative Health Taskforce (the Taskforce) released a discussion paper, *Australia: the healthiest country by 2020* and three associated technical papers on obesity, tobacco and alcohol in October 2008. These documents formed the base for conducting consultations and calling for public submissions. The Taskforce received over 400 submissions in response to its discussion paper, which was open to all interested parties.

In addition the Taskforce held 40 consultations with almost 1,000 stakeholders in capital cities and select regional centres between October 2008 and February 2009. Included in these consultations were ten thematic round tables on major preventive health issues. The Taskforce engaged the Public Health Association of Australia to coordinate and facilitate the consultations. Whilst attendance at the consultations was by invitation only, the Association worked closely with national and local organisations to make sure all appropriate stakeholders were identified and invited. This process ensured that a wide range of participants with diverse backgrounds and experience were involved bringing a wealth of insight to the issues the Taskforce sought to address in developing the Strategy.

All submissions received and details of the formal consultations undertaken are provided on the Taskforce's website at www.preventivehealth.org.au

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-008

OUTCOME 1: Population Health

Topic: AUSTRALIAN NATIONAL PREVENTIVE HEALTH AGENCY (ANPHA)

Written Question on Notice

Senator Ronaldson asked:

Was any consideration given to incorporating Australian National Preventive Health Agency (ANPHA) within the DoHA or the AIHW, rather than making it an independent agency?

Answer:

In light of early advice from the National Preventative Health Taskforce and the National Health and Hospitals Reform Commission, and following consultation with states and territories (as required in the National Partnership Agreement on Preventive Health), it was decided that the Agency should be established as an independent authority.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-013

OUTCOME 1: Population Health

Topic: ANPHA

Senator Ronaldson asked:

The ANPHA legislation includes $102 million over four years for something called 'social marketing'; how does this differ from advertising and public relations?

Answer:

Social marketing is “the application of commercial marketing technologies to the analysis, planning, execution, and evaluation of programs designed to influence the voluntary or involuntary behaviour of target audiences in order to improve the welfare of individuals and society” (Donovan and Henley, 2003)[1].

1 Donovan, R. & Henley, N (2003). *Social Marketing: principles and practice*. Melbourne: IP Communications.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-021

OUTCOME 1: Population Health

Topic: 'DON'T LET ICE DESTROY YOU' CAMPAIGN

Written Question on Notice

Senator Xenophon asked:

a) How much money was spent on the 'Don't Let Ice Destroy You' advertising campaign
b) How many calls were made to the 1800 helpline over the duration of the campaign?
c) What was the breakdown of the callers?
d) What sort of advice was provided to callers?
e) What follow-up of callers/users was conducted?
f) What coordination was there with state agencies in relation to ongoing treatment and assistance for users?
g) How was this campaign measured in terms of effectiveness?

Answer:

a) On 14 April 2007 the Government announced $17.9 million to be allocated from existing resources for this campaign across four years from 2008-09 to 2011-12. For 2008-09 $6.6 million was spent on campaign activities.

b) Stage one of the campaign used the 1800 campaign information line from 19 April 2009 to 30 June 2009. During this time a total of 407 calls were received.

c) Calls received to the 1800 campaign information line:
   - 170 (41.9%) requesting campaign resources and information;
   - 131 (32.4%) seeking help and support;
   - 15 (2.9%) to raise concerns; and
   - 91 (22.8%) for other enquiries on a wide variety of matters.

d) Callers requiring advice were linked to the appropriately qualified support services. The information provided to callers ranged from:
   1. Referring callers enquiring about drug information services, counselling and support services to the state and territory Alcohol and Drug Information Services (ADIS).
   2. Taking orders for hard copies of campaign information resources.

3. Providing callers from a non-English speaking background with the Translating and Interpreting Service details if assistance was required.

4. Referring callers requiring further information about the National Drugs Campaign or about drugs to the campaign youth site www.australia.gov.au/drugs or Australian Drug Information Network (ADIN) www.adin.com.au
5. Referring callers requiring information about illicit drug policy to the National Drug Strategy website www.nationaldrugstrategy.gov.au
6. Registering a list of callers and organisations wishing to be added to the campaign database.

e) All callers expressing concerns, requesting resources or other enquiries were directly handled by departmental staff. Callers requesting specific drug information, advice or support services did not have their details recorded by the helpline and were not contacted for follow-up due to the *Privacy Act 1988*. Callers requesting such information, advice or support were to be followed up by the support services to which they were referred.

f) Ongoing coordination is provided through a national free call telephone line and the National Drugs Campaign website to link target groups with more information and to directly connect them to the state and territory Alcohol and Drug Information Services.

The National Drugs Campaign website www.drugs.heath.gov.au also provides links to other organisations that provide telephone and web based counselling:

- Australian Drug Information Network
- beyondblue
- Counselling Online
- Headspace
- Indigenous Support (VIBE)
- Kids Helpline
- Lifeline
- Reach out!
- SANE Helpline

The Commonwealth Government provides funding under the Non-Government Organisation Treatment Grants Program (NGOTGP) to non-government organisations in each state and territory to provide community based alcohol and other drug treatment services. Treatment service provision is coordinated by the Ministerial Council on Drug Strategy and the Intergovernmental Committee on Drugs under the framework of the National Drug Strategy.

g) The campaign has been evaluated using national telephone surveys of 15-24 year olds as part of the ongoing evaluation of the National Drugs Campaign. Surveys covering the Ice campaign were conducted in October/November 2007 and July/August 2009.

The 2009 evaluation surveyed approximately 1400 respondents and measured reach of the campaign, message recall, perceived influence of the campaign, attitudes towards drugs (Ice, speed, ecstasy and cannabis), risk of accepting an offer of/and reported used of each of the drugs.

The 2009 evaluation report is currently being finalised.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-049

OUTCOME 1: Population Health

Topic: CDC TRIFFID FLAXSEED

Written Question on Notice

Senator Siewert asked:

Is FSANZ aware that the European Food Safety Authority (EFSA) has recommended that this marker gene not be used for commercial GE crop varieties?

Answer:

Yes. EFSA recommended in 2004 that its use be restricted to field trial purposes.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-050

OUTCOME 1: Population Health

Topic: IMPORTATION OF FLAXSEED

Written Question on Notice

Senator Siewert asked:

Is FSANZ aware that the EU has banned the import of several varieties of Canadian flaxseed to prevent this flax variety from entering the food supply?

Answer:

Yes, FSANZ is aware that this variety of flaxseed is not compliant with EU regulations for approved GM crops. However, the action taken by individual jurisdictions within the EU is country-specific.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-051

OUTCOME 1: Population Health

Topic: CDC TRIFFID FLAXSEED

Written Question on Notice

Senator Siewert asked:

a) Has FSANZ ascertained whether any products entering Australia are likely to be contaminated with the variety?

b) If so, please table the details.

c) Has FSANZ undertaken a risk assessment to determine if the flax is likely to have entered Australia?

Answer:

a) No. FSANZ is an independent statutory agency with bi-national responsibilities for developing food regulatory measures. The enforcement and implementation of food standards is the responsibility of the state and territory governments in Australia and the New Zealand Government for domestic produce and the Australian Quarantine and Inspection Service (AQIS) for imported products in Australia.

   FSANZ was advised by AQIS that four permits were issued in 2008 and 2009 to import flax from Canada. However, FSANZ has not determined whether any seed is contaminated with the CDC Triffid variety. The Australian states and territories have agreed on a compliance plan which addresses appropriate enforcement action when an unapproved GM food enters the food supply.

b) Not applicable.

c) No. This would be an enforcement issue which would need to be undertaken by the appropriate enforcement agencies. However, FSANZ has undertaken a review of previous risk assessments on the CDC flaxseed which is addressed in EO9-O52.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-052

OUTCOME 1: Population Health

Topic: FLAXSEED SAFETY

Written Question on Notice

Senator Siewert asked:

HAS FSANZ undertaken a formal assessment of the flax?

Answer:

No. FSANZ obtained and reviewed safety assessments undertaken by Health Canada and the United States Food and Drug Administration. These assessments provided FSANZ with sufficient information to allow an evaluation of the likely public health and safety risk, should Triffid Flaxseed be consumed. FSANZ concluded that this flaxseed would pose no food safety concerns.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-054

OUTCOME 1: Population Health

Topic: GE FLAX CONTAMINATION

Written Question on Notice

Senator Siewert asked:

a) HAS FSANZ notified AQIS of the potential for contamination and the need to monitor imported products for illegal GE flax contamination?

b) Has FSANZ notified AQIS to withdraw any GE flax contaminated products from the food supply?

Answer:

a) Yes.

b) No. FSANZ would advise AQIS of any public health and safety concerns and then it would be up to AQIS to decide on the appropriate compliance action. Decisions on compliance action are based on the quantities entering Australia, the likelihood of detection and the potential risk to public health and safety.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-056

OUTCOME 1: Population Health

Topic: GE CONTAMINATION

Written Question on Notice

Senator Siewert asked:

In recent years, there has been a number of incidences of illegal GE contamination that have affected global food supplies. These have included StarLink Corn, LL Rice and BT63 Rice. Other regulators, such as those in the EU and Japan, have taken swift action to protect consumers by testing and removing products from the food supply. Has FSANZ ever recommended that AQIS or the States take action to test and remove any illegal GE products from the food supply?

Answer:

No. FSANZ would advise AQIS of any public health and safety concerns and then it would be up to AQIS to decide on the appropriate compliance action. The first step is to ascertain whether the product is being imported into Australia and in what quantities. Decisions on compliance action are based on the quantities entering Australia, the likelihood of detection and the potential risk to public health and safety. The states and territories have agreed on a compliance plan which addresses appropriate enforcement action when an unapproved GM food enters the food supply.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-048

OUTCOME 1: Population Health

Topic: CDC TRIFFID FLAXSEED

Written Question on Notice

Senator Siewert asked:

a) Is FSANZ aware that cereals, bakery products, bakery mixtures and nut and seed products have been contaminated in 28 countries by an unapproved and untested GE flax variety (CDC Triffid) from Canada?

b) Is FSANZ aware that this flax variety contains a resistance gene for the medically important antibiotic ampicillin?

Answer:

a) FSANZ is aware that a number of countries in the European Union (EU) detected genetically modified flaxseed, called Triffid Flaxseed, in imports of grain destined for both animal feed and human consumption.

b) Yes. Antibiotic Resistance Marker Genes are in common use in research laboratories and have many applications in biotechnology in the development of new medical and agricultural products.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-055

OUTCOME 1: Population Health

Topic: CDC TRIFFID

Written Question on Notice

Senator Siewert asked:

Has FSANZ warned the States of the potential contamination by CDC Triffid?

Answer:

Yes. FSANZ sought and received information from the Australian Quarantine and Inspection Service that permits were granted in 2008 and 2009 to import flaxseed from Canada. On receiving this advice, FSANZ alerted Australian states and territories of the possible presence of CDC Triffid flax in imported product.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2008-2009, 21 October 2009

Question: E09-219

OUTCOME 1: Population Health

Topic: HEAD OF THE OFFICE OF PRESCRIPTION MEDICINES, THERAPEUTIC GOODS ADMINISTRATION

Hansard Page: CA 125

Senator Boyce asked:

a) Is it normal practice for a qualified medical practitioner to be in the role of Head of the Office of Prescription Medicines?

b) Has a non medical practitioner been appointed to the Head of the Office of Prescription Medicines before?

Answer:

a) No. Senior and middle management positions in the former National Biological Standards Laboratory and the Therapeutic Goods Branch, National Health Division, of the then Department of Health all required medical qualifications. However, the organisational structure, legislative basis and physical environment of the present Therapeutic Goods Administration has changed from that of its predecessors, and medical qualifications for all management positions are no longer mandatory.

b) No. The role of Head of an Office in the TGA is a management and leadership role, not a technical role. The Office of Prescription Medicines has five clinical evaluation units, each headed by a qualified medical practitioner responsible for exercising delegated powers under the Therapeutic Goods Act 1989 and providing technical and medical advice as required to the Office Head.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-016

OUTCOME 1: Population Health

Topic: WHOOPING COUGH IMMUNISATION

Written Question on Notice

Senator Back asked:

Communicable Diseases Network Australia has to date reported a record number of cases of Whooping Cough in Australia. Of the total 22,440 reported cases in Australia to date for 2009, more than half were adults. With only 9950 cases in persons under 20 and 5,218 over 50.

a) Was there a resolution by Federal, State and Territory Health Ministers this year that a National Immunisation Strategy needed to be implemented to combat the whooping cough epidemic?

b) What does this strategy consist of? (immunisation of adults and children)

c) Are there any other components to it – ie. A public awareness campaign?

d) Cost to Commonwealth/States or Territories?

e) Why was NSW chosen to lead this strategy?

f) What was the timeframe in which it was implemented?

g) Will the public awareness campaign launched there form the basis for the national roll-out?

h) How did they reach out to stakeholders?

i) Are you able to provide information from the last month on the take up of vaccines for this program by age group yet?

j) Is there a cost for the patient for the vaccine, aside from the cost of visiting the doctor?

Answer:

a) No. The Australian Health Minister's Conference (AHMC) of September 2009 noted the development of the National Immunisation Strategy (NIS) was progressing. However, the NIS will provide a framework for the Immunisation Program overall and is not intended to specifically address the current pertussis outbreak. The Commonwealth has however separately agreed to work with jurisdictions to consider an appropriate national approach to pertussis.

b) The NIS is being developed with states and territories to guide Australia's approach to the prevention, management and control of vaccine preventable diseases. The NIS will deal with such matters as the supply of efficacious and quality vaccines, surveillance and research in relation to vaccine preventable diseases, data systems, service delivery, workforce and governance. The national approach to pertussis is currently being developed through the National Immunisation Committee (NIC), which comprises jurisdictional, medical and health professional and consumer representatives.

c) The Commonwealth is actively working with states and territories to coordinate the development of a national approach to pertussis including promotional material aimed at reducing the incidence of pertussis by encouraging potential and new parents, grandparents and those in close contact with newborns to get a pertussis-containing vaccination, that is adult diptheria, tetanus and acellular pertussis (DTPa).

d) The estimated total funding under the National Immunisation Program (NIP) for the combination vaccines that include pertussis is $57,428,455 for 2009-10. These funds are for the diptheria, tetanus and acellular pertussis vaccine (DTPa) for all babies at two, four and six months of age with two boosters, one between three years and a half and four years of age and one, as the combined adult diptheria, tetanus and acellular pertussis vaccine (dTpa) between 11 and 17 years of age.

The jurisdictions of the Northern Territory, New South Wales, Australian Capital Territory, Victoria and Queensland are funding adult pertussis booster vaccination program initiatives. The cost of these adult pertussis booster initiatives is a matter for the jurisdictions.

e) NSW has not been chosen to lead a pertussis strategy. The Commonwealth is working with states and territories to coordinate the development of a national approach to pertussis, including the development of promotional material. Some states and territories have initiated their own public awareness campaigns.

f) Those states and territories funding adult pertussis boosters have all commenced the programs since January 2009.

g) State and territory materials will be considered where appropriate.

h) Some states and territories have produced resources and promotional materials to encourage uptake of pertussis vaccination for children, and where they exist, the adult booster programs.

i) Nationally, childhood immunisation coverage for the combined diptheria, tetanus and acellular pertussis vaccine (DTPa) as at 30 September 2009 for children between 12-<15 months of age was 92.41%, for children between 24-<27 months was 94.97% and for children between 60-<63 months of age was 82.93%. Adult vaccination data are not available.

j) A vaccine for whooping cough is offered free of charge under the National Immunisation Program schedule for children at two, four and six months of age. In addition, a free DTPa booster is offered between three years and a half and four years of age, and again between 11 and 17 years of age. People ineligible to receive the vaccine under the National Immunisation Program or state based programs may incur a cost for the vaccine.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-017

OUTCOME 1: Population Health

Topic: WHOOPING COUGH VACCINE

Written Question on Notice

Senator Back asked:

h) Is there eligibility criteria for this vaccination for adults? and

i) Is this vaccine available to all adults regardless of whether they have had a vaccination before?

j) If not, how do you respond to concerns that ageing Australians may be exposed to greater risk as the potency if the vaccine is diminished over time?

d) What is being done to address this?

e) Would you consider extending this program to ensure they are not left exposed?

Answer:

a and b)

The pertussis vaccine is available for adults on private prescription from GPs. Some states and territories are providing pertussis vaccines to eligible adults free of charge under time-limited jurisdiction based programs. The eligibility criteria vary across jurisdictions.

c) The *Australian Immunisation Handbook*, 9th Edition (2008), (the Handbook), recommends a single booster dose of adult formulation pertussis vaccine (dTpa) for:
   - adults planning a pregnancy, for both parents as soon as possible after delivery of an infant, and for grandparents and other carers of young children;
   - adults working with young children such as health and child care workers; and
   - any adult expressing an interest in receiving a booster dose of pertussis vaccine.

   In addition, the Handbook recommends the use of the adult diptheria-tetanus-pertussis (dTpa) vaccine for adults aged 50 who express an interest in receiving a booster dose of diptheria and tetanus. The adult formulation of the pertussis vaccine is readily available on private prescription and through some jurisdictional programs.

d) In response to the recent increase in the incidence of whooping cough and the risk this poses to children too young to be vaccinated, the Australian Technical Advisory Group on Immunisation (ATAGI) has recommended that the scheduled fourth dose of pertussis vaccine can be administered from the age of 3 and a half years, and that the adolescent booster dose can be given in the first year of high school, that is from 11 years of age. The Handbook indicates that this will better protect younger siblings, especially babies who have not received at least 2 doses of pertussis vaccine.

A Pertussis Working Party under the ATAGI was established in May 2009 to provide the Minister for Health and Ageing with advice on national pertussis vaccination policy. The Commonwealth is also working with states and territories to develop a national approach to pertussis including promotional materials.

e) The current aim of the program is to prevent pertussis in young children, particularly for those who are not fully vaccinated until six months of age. Although there has been an increase in notifications of pertussis for adults, the increase is partly due to a real increase in the number of cases and partly as a result of the increased testing and subsequent case detection due to a more sensitive testing method.

The table below shows that in the past two years the pertussis notification rate of children under 15 is more than twice that of people aged 15 years and over, indicating the importance of pertussis vaccination in children.

Pertussis notifications and notification rates, by age at diagnosis

	2004	2005	2006	2007	2008	2009*
Notifications in persons aged under 15 years	2,261	1,266	690	673	4,862	10,398
Age specific rate per 100,000 population, under 15 years	56.4	31.5	17.0	16.5	117.8	252.0
Notifications in persons aged 15 years and over	6,482	9,932	10,307	4,669	9,640	16,522
Age specific rate per 100,000 population, 15 years and over	40.2	60.7	61.9	27.5	55.7	95.5
Rate ratio (of <15 yrs compared with 15+ yrs)	1.4	0.5	0.3	0.6	2.1	2.6

*Note notifications for 2009 are as at 11 December 2009, rate is non-annualised
Source: NNDSS data extracted 11 December 2009 by diagnosis date and age at diagnosis

Currently there is little scientific evidence indicating that introducing an adult pertussis booster program would effectively prevent outbreaks of pertussis. The ATAGI at its meeting of June 2009 decided it would need to review all the available evidence prior to making any recommendations in regards to adult pertussis vaccination.

There is a legislative requirement (Section 9B of the *National Health Act 1953*) that for the Commonwealth to consider introducing a vaccine under the National Immunisation Program it has to be registered by the Therapeutic Goods Administration and the Pharmaceutical Benefits Advisory Committee (PBAC) has to make a recommendation that inclusion of the vaccine or extension of eligibility for the vaccine to the proposed cohort is cost effective.

All vaccines considered under the National Immunisation Program or the Pharmaceutical Benefits Scheme undergo a thorough and evidence based assessment process by the PBAC. The PBAC seeks the advice of ATAGI in undertaking its assessment of vaccines.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-018

OUTCOME 1: Population Health

Topic: ROLL OUT OF WHOOPING COUGH VACCINE

Written Question on Notice

Senator Back asked:

What is the timeframe for roll-out in other states and territories?

Answer:

It is at the discretion of other states and territories that do not have an adult booster program whether they choose to implement a jurisdiction based adult pertussis booster program and the timeframe for any such program.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-002

OUTCOME 1: Population Health

Topic: NATIONAL PREVENTATIVE HEALTH TASKFORCE (NPHT)

Written Question on Notice

Senator Ronaldson asked:

What is the estimated cost to the Australian taxpayer of the NPHT over its 3-year appointment, including the following:

a) All fees and per diem payments?

b) Travel and accommodation?

c) Administration, including graphic design, printing, publication costs, PR agency fees, advertising and website fees?

d) Hall and venue rental?

e) The papers commissioned by the NPHT to assist with the drafting of its strategy?

Answer:

a – e)

The NPHT has been allocated $3.805 million over four years from 2007-08 to 2010-11.

As at 31 October 2009, expenditure for the Taskforce totalled $1,434,135, including expenditure for the items listed above as detailed in Table 1.

Table 1: Taskforce expenditure 2007-08 to 2010-11: as at 31 October 2009

	2007-08 ($)	**2008-09 ($)**	**2009-10 ($)**	**2010-11 ($)**	**TOTAL ($)**
Expenditure (total)	**34,328**	**1,040,066**	**359,741**	**0**	**1,434,135**
Fees (sitting & out-of-session per diem fees)	16,706	311,052	53,506		**381,264**
Travel & accommodation	10,503	165,676	27,931		**204,110**
Administration (design, printing, publication costs, advertising and website fees)*	6,743	51,390	104,926		**163,059**
Hall and venue rental	377	69,388	922		**70,687**
Commissioned papers		78,609			**78,609**
Other **		363,950	172,455		**536,405**

* There was no expenditure for PR agency fees.

** Other includes: writers, Departmental support staff, conference fees, and staff travel.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-023

OUTCOME 1: Population Health

Topic: 'DON'T LET ICE DESTROY YOU' CAMPAIGN

Written Question on Notice

Senator Xenophon asked:

Research by the University of Western Australia studied feedback from thousands of teenagers exposed to the campaign, and found a three-fold increase in the percentage of teenagers who said they did not believe using ice was risky, and a four-fold increase in those who strongly approved of regular ice use. Half thought the campaign exaggerated the risks

a) What modelling was done to examine the effectiveness of graphic 'shock advertising' versus education or softer forms of advertising?

b) Has the department looked at best practice in other countries?

c) What research has been made into approaches in other countries?

Answer:

The Research by the University of Western Australia was conducted on the Montana Meth Project, an anti-meth advertising campaign in Montana in the United States (Attachment A), and is not directly relevant to the Australian campaign.

a) Fear appeals are defined as 'persuasive messages that arouse fear'2. The effects of fear appeals have been studied extensively3. The use of fear appeals or graphic advertising have been effective in reducing drink driving, smoking prevalence, in increasing support of childhood immunisation, and in increasing negative perceptions of drug use.

   The research shows fear appeals are effective when the threat of a portrayed consequence is seen by the target audience as likely and serious, and the behaviour required to reduce or avoid the risk of this consequence is seen as simple, achievable and effective.

---

2 Witte, K. and Allen, M. (2000). 'A meta-analysis of fear appeals: Implications for effective public health campaigns', *Health Education & Behavior*, 27, 591-615.

3 Soames, R.F. (1988), '***Effective and Ineffective Use of Fear in Health Promotion Campaigns'***, American Journal of Public ***Health***, Vol 78 No 2,163-167.
Taylor, W. The Grim Reaper (1988). The use of research in policy Development and public education. Report of the 3rd National Conference on AIDS, 1988.
Winn, W. (1991). The Grim Reaper: Australia's first mass media AIDS Education Campaign in AIDS prevention through health promotion: facing sensitive issues. WHO 1991.
Witte, K. and Allen, M. (2000). 'A meta-analysis of fear appeals: Implications for effective public health campaigns', *Health Education & Behavior*, 27, 591-615.

To be effective, graphic advertising must clearly establish the link of the threat demonstrated and the person's behaviours. The target audience must also feel that the negative consequence could happen to them if they undertake that behaviour. The desired behaviour also needs to be seen as achievable to the target audience and that it is something within their control.

In line with the above information, formative and concept testing research conducted before the release of the Campaign confirmed that a graphic portrayal of the consequences of ice use was the most effective strategy for an influential prevention message. Given the very graphic nature of recent tobacco campaigns (both Commonwealth and others) young people who were involved in the concept testing, believed that a campaign addressing the dangers of an illicit drug should be portrayed more strongly. Softer forms of advertising were rejected by the target audience as lacking impact and credibility.

In addition to graphic portrayals in the advertising, the website www.drugs.health.gov.au contains more information to educate young people about the consequences of all illicit drugs.

b) The Department conducted a thorough environmental analysis as part of the development of the Campaign. This included a review of best practice, both nationally and internationally, in conducting effective anti drug social marketing campaigns.

c) Evaluations of overseas campaigns have been analysed. Campaigns from countries such as the United Kingdom and the United States have been included in formative and concept testing research to explore their potential for impact with an Australian audience. Many young people are already aware of these campaigns (for example, through youtube) but none of the existing overseas campaigns tested well in terms of credibility and relevance for Australian youth.

THE UNIVERSITY OF WESTERN AUSTRALIA

University News

Success of graphic meth ads questioned by UWA study

Wednesday, 10 December 2008
Topics: Media Statements International Research

An independent review investigating the effectiveness of a publicly funded graphic anti-methamphetamine advertising campaign in the United States has found that the campaign has been associated with many negative outcomes, including increases in the acceptability of drug use.

The review was published in the December issue of the peer-reviewed journal *Prevention Science*.

David Erceg-Hurn, who is currently completing his PhD in Clinical Psychology at The University of Western Australia, closely scrutinised the research findings of the Montana Meth Project (MMP). The MMP is an organisation responsible for conducting an expensive anti-meth graphic advertising campaign in the American state of Montana.

The ad campaign aims to reduce meth use by showing the extreme consequences of using meth "just once." Meth users are shown committing violent crimes, leaving friends to die and engaging in prostitution to fund their meth habit.

The US ads are similar to graphic anti-ice ads launched in Australia by the Federal Government in 2007. Ice (also known as crystal methamphetamine) is a particularly addictive form of meth.

The negative outcomes identified in Mr Erceg-Hurn's review include: following six months exposure to the graphic ads, there was a threefold *increase* in the percentage of teenagers who reported that using meth is *not* a risky behaviour; teenagers were four times more likely to *strongly approve* of regular meth use; teenagers were more likely to report that taking heroin and cocaine is *not* risky; and up to 50% of teenagers reported that the graphic ads exaggerate the risks of using meth.

The review found that the MMP overlooked these unflattering results when promoting their research findings to policymakers and the media. Instead, the MMP focused on select positive findings. Mr Erceg-Hurn said that it is important for organisations that are considering funding the MMP's ad campaign to be made aware of all of the MMP's findings - positive and negative.

The MMP has received millions in government funding, and donations from several corporations and community organisations.

Mr Erceg-Hurn criticised claims by MMP that the ad campaign has been responsible for reducing meth use in Montana.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2008-2009, 21 October 2009

Question: E09-220

OUTCOME 1: Population Health

Topic: RESEARCH INFRASTRUCTURE SUPPORT SERVICES LIMITED

Hansard Page: CA 124-125

Senator Boyce asked:

a) What action, if any was taken by the TGA against Mr Slater and Ms MacLachlan following the Commonwealth consent to judgement on those charges of negligence and misfeasance?

   Ms Rita MacLachlan is listed as a member of the Research Infrastructure Support Services (RISS) Limited's expert advisory committee in the September 2008 annual report.

b) Was Ms MacLachlan an employee of the TGA at 30 September 2008?

c) Could you please advise what date she left the TGA's employment?

d) If an employee of the TGA wants to work on the board or as an outside expert for a company that has dealings with the TGA, do they have to seek approval from anyone?

e) Could you advise me if that procedure was followed in the case of Ms MacLachlan?

f) Was any comment sought from the TGA in relation to a $7.5 million grant over four years that was given to RISS in 2008, through the Department of Innovation, Industry, Science and Research's National Collaborative Research Infrastructure Strategy program?

g) What was Ms MacLachlan's role with the TGA at the time that grant was awarded to RISS?

Answer:

a) The question is predicated upon two unsubstantiated premises which need to be addressed before any answer can appropriately be provided.

   First, the Commonwealth did not consent to judgement on 'charges of negligence and misfeasance' in the Selim/Pan proceeding. Rather, the Commonwealth consented to judgement in those proceedings without admission by the Commonwealth, as an agreed compromise settlement in circumstances in which the matter was part-heard and the evidence for the defence incomplete. Counsel for the applicants, Justin Gleeson SC commented in court that while the settlement sum was large in objective terms it was 'nevertheless a modest amount by reference to the claimed damages in the proceedings'.

Second, the question contains an implicit premise that there is some action which it would be appropriate to take against former TGA officers Mr Slater and Ms MacLachlan 'following the Commonwealth consent to judgment'. That premise is unsupported by any express or implicit reasoning or finding of fact. As the case was settled before the evidence was concluded the trial judge was not called upon to make any findings of fact of any kind and he did not do so. Accordingly, there were no findings concerning the conduct of any of the TGA officers in the proceedings.

In any event it is inappropriate to respond to the question on the basis of public interest immunity, since current proceedings in the Federal Court (to which proceedings the named former TGA officers are also party) arising from the same events may be prejudiced by ventilating those issues elsewhere.

b) Yes.

c) 1 May 2009.

d) The Australian Public Service Commission and the Department of Health and Ageing require all employees (including those of the TGA) to notify their employer of any private interests that could present a real or apparent conflict with their official duties. It is the responsibility of employees to consider and declare those private interests or relationships that could or could be seen to impact upon the decisions they are taking or the advice they are giving. SES employees of the Department of Health and Ageing are required to identify and disclose any such interests in writing to the Secretary annually and as the need arises (for example where their circumstances change). In addition the APS Code of Conduct requires employees to take reasonable steps to avoid a conflict

e) Advice received by the TGA is that Ms MacLachlan joined the RISS advisory committee following her retirement from the Australian Public Service. It is TGA's understanding that RISS Limited reported the date which Mrs McLachlan joined the board incorrectly, and she was not a member of its advisory committee on 30 September 2008.

f) No.

g) Head of the Office of Devices, Blood and Tissues.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-114

OUTCOME 2: Access to Pharmaceutical Services

Topic: INDIGENOUS AUSTRALIANS ACCESS TO PRESCRIPTION MEDICINES

Written Question on Notice

Senator Adams asked:

a) Do Indigenous Australians have the same access to and level of usage of prescription medicines as other Australians?

b) Apart from Section 100 what steps have been taken to ensure that Indigenous Australians have timely access to the prescription medicines they need?

Answer:

a) Aboriginal and Torres Strait Islander people have lower usage levels of prescription medicines through the Pharmaceutical Benefits Scheme (PBS) when compared with non-Indigenous Australians. PBS expenditure for Aboriginal and Torres Strait Islander people is around half that of the non-Indigenous average. Aboriginal and Torres Strait Islander people have between two to three times higher levels of illness than non-Indigenous people.

   Aboriginal and Torres Strait Islander people use less PBS medicines per person compared with the non-Indigenous population for a range of reasons, including lower access to the medical practitioners who prescribe medicines, and financial, geographic and cultural barriers to filling their prescriptions.

b) Measures which aim to improve access to PBS medicines for Aboriginal and Torres Strait Islander people are outlined below.

   Arrangements under section 100 of the *National Health Act 1953*
   Special PBS supply arrangements for clients of approved remote area Aboriginal health services, established since 1999 under the provisions of section 100 of the *National Health Act 1953*, ensure that essential medicines are available at the point of medical consultation, and without charge, to clients of over 160 participating remote health services. These arrangements address the geographical, cultural and financial barriers to PBS access experienced by Aboriginal and Torres Strait Islander peoples living in remote communities.

Special PBS listings

The Expert Advisory Panel (the Panel) on Aboriginal and Torres Strait Islander Medicines assists with the listing of medicines on the PBS for the treatment of conditions which predominantly occur in Aboriginal or Torres Strait Islander populations. The Panel also provides advice to the Pharmaceutical Benefits Advisory Committee on these medicines, particularly in relation to clinical need. As at 1 November 2009, there are 20 items listed on the PBS to assist with the health needs of Aboriginal and Torres Strait Islander people, including medicines to treat fungal infections, nicotine replacement therapy, and treatments for conditions such as chronic ear infections that have a high prevalence in these communities. These arrangements help to make medicines required by this population more affordable and therefore address the greater burden of disease.

The QUMAX arrangements

The Quality Use of Medicines maximised for Aboriginal and Torres Strait Islander People (QUMAX) program is a two year trial funded under the Fourth Community Pharmacy Agreement until 30 June 2010, and is managed by the Pharmacy Guild of Australia in partnership with the National Aboriginal Community Controlled Health Organisation. QUMAX aims to improve the health outcomes of Aboriginal and Torres Strait Islander peoples who attend over 60 participating Aboriginal Community Controlled Health Services in rural and urban areas of Australia. It aims to do this by improving quality use of medicines and access to PBS medicines. Better access to medicines through QUMAX is facilitated by providing medicines to eligible patients at no charge and paying for transport of the PBS medicines to the patient and vice versa.

Indigenous Chronic Disease PBS Co-payment measure

As part of the 'Closing the Gap' Indigenous Chronic Disease Package announced in the 2009-10 Budget, the Government will subsidise the cost of PBS medicines for Aboriginal and Torres Strait Islander patients living with, or at risk of, chronic disease. Under this measure, eligible patients will receive their medicines free of charge if they are concessional patients, or at $5.30 for non-concessional patients (representing a saving of up to $27.60 per item dispensed). This will assist to address the financial barrier to accessing PBS medicines.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-187

OUTCOME 2: Access to Pharmaceutical Services

Topic: PHARMACEUTICAL BENEFITS SCHEME (PBS) MEDICINES

Written Question on Notice

Senator Adams asked:

The Productivity Commission review of Regulatory Burdens on Business has recommended the removal of the PBS authority system, which requires doctors to obtain telephone authority from Medicare Australia to prescribe certain PBS medicines. Doctors can spend between 4 and 10 minutes on the telephone waiting to obtain an authority from a Medicare Australia clerk. Requests are never rejected. This red tape, imposed by the Department of Health and Ageing means doctors have less time to care for patients.

c) What are the benefits of the PBS authority system?

d) What evidence do you have to demonstrate that the PBS authority system actually deters doctors from prescribing PBS medicines outside the PBS restrictions?

Answer:

a) The PBS authority system operates where the drugs are listed on the PBS for limited indications or for a specific place in therapy. By requiring prescribers to answer questions relating to the patient's medical condition and attest that the prescription is being written in accordance with PBS item restrictions, the Government seeks to limit use of subisided therapy to that where cost effectiveness has been demonstrated.

b) The action of a doctor needing to consider the restrictions and apply for an authority influences prescribing decisions. Through this consideration many will have determined that the PBS restrictions would not be met and therefore not ring for an authority. Claims that requests are never rejected are not correct. Of the 6.4 million requests for authority in 2008-09, a total of 178,517 were rejected. There are several reasons for rejection, one of which is where a prescriber, when asked questions relating to the patient's medical condition, re-considers the request and chooses not to proceed.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-199

OUTCOME 2: Access to Pharmaceutical Services

Topic: PBS MEDICINES

Hansard Page: CA 82

Senator Cormann asked:

Are you aware of any circumstances where a request has been rejected?

Answer:

Yes. In 2008–09 there were 178 517 requests rejected.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-060

OUTCOME 2: Access to Pharmaceutical Services

Topic: LIFE SAVING DRUGS PROGRAM

Written Question on Notice

Senator Birmingham asked:

e) What drugs have been recommended for listing on the Life Saving Drugs Program and the Pharmaceutical Benefits Scheme by the Pharmaceutical Benefits Advisory Committee since November 2007?

f) When was each recommendation made?

g) What does each of the drugs do?

h) What action or decision has been taken by the Government in response to each recommendation?

Answer:

a, b, c and d)

The scope of this request is considerable, encompassing several hundred medicines. Therefore I consider the provision of the level of detail requested would involve an unreasonable diversion of Department of Health and Ageing resources.

A number of factors may influence the time it takes to list a medicine on the Life Saving Drugs Program (or on the Pharmaceutical Benefits Scheme), including pricing negotiations with the manufacturer, finalisation of the conditions for inclusion, quality and availability checks and consideration by the Australian Government.

The Pharmaceutical Benefits Advisory Committee (PBAC) meets three times a year in March, July and November. The Public Summary Documents, which details the outcomes of the PBAC meetings, are available on the Department of Health and Ageing's website six weeks after each PBAC meeting at www.health.gov.au/internet/main/publishing.nsf/Content/public-summary-documents-by-meeting

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-186

OUTCOME 2: Access to Pharmaceutical Services

Topic: PHARMACEUTICAL BENEFITS SCHEME

Written Question on Notice

Senator Adams asked:

In relation to the delayed implementation of more efficient arrangements for chemotherapy drugs under the Pharmaceutical Benefits Scheme (originally announced in last year's budget) [Ref. BP2, p. 3.2]. What progress has been made to resolve concerns raised about this measure?

Answer:

The Government has proposed several changes to the measure, including:

- Ensuring patients do not pay more for their chemotherapy through the suppression of patient co-payments on repeat prescriptions.
- Ensuring prescribing workloads are not increased through increasing maximum quantities and allowable repeats for all applicable chemotherapy medicines to reflect current treatment practices; and the inclusion of certain medicines in streamlined authority arrangements to reduce the number of telephone approvals that prescribers must obtain from Medicare Australia.
- Introduction of proposed criteria to remove unsuitable medicines from the measure and the addition of unavoidable wastage factors for some medicines.

The delay enables continued discussions with all stakeholders on outstanding matters. Issues surrounding community pharmacy will be considered in the context of the next Community Pharmacy Agreement due to commence on 1 July 2010.

The Department continues discussions with Roche Products Pty Ltd, the manufacturer of HERCEPTIN®, to determine whether alternative vial sizes available in other countries could also be made available in Australia. The Department is also working with professional bodies to develop guidelines on the safe preparation of chemotherapy infusions.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-198

OUTCOME 2: Access to Pharmaceutical Services

Topic: 4th COMMUNITY PHARMACY AGREEMENT

Hansard Page: CA 80

Senator Cormann asked:

Given that we are looking at the Fifth Agreement, presumably there is a first, second, third and fourth. What was the experience of negotiations for the first, second, third and fourth community pharmacy agreements. How long do these negotiations usually take?

Answer:

The Fourth Community Pharmacy Agreement was negotiated, over a period of approximately nine months, from April 2005 through to November 2005. The Agreement was signed on 16 November 2005, and commenced on 1 December 2005.

The Third Community Pharmacy Agreement was negotiated over a period of approximately seven months, from November 1999 though to May 2000. The Third Agreement commenced on 1 July 2000.

The Department is unable to provide the requested information for the first and second Agreements as this would require the retrieval and search of files from over 15 years ago and the considerable work involved would require a significant diversion of resources from other Departmental operations.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-265

OUTCOME 2: Access to Pharmaceutical Services

Topic: PBS MEDICINES

Written Question on Notice

Senator Adams asked:

i) Has prescribing changed since streamlined authority arrangements were introduced for 200 PBS authority medicines that now don't require a doctor to obtain telephone authority from Medicare Australia?

j) Are there any plans to expand the current list of 200 authority PBS medicines?

k) What is your response to the Productivity Commission recommendations to remove the authority system altogether?

Answer:

a) The Department established a Streamlined Authorities Monitoring Group to monitor the first 12 months of implementation of the arrangements. The Group produced a report (available on the Department's website) which concluded that overall there had been no significant change to prescribing behaviour in the first year of implementation of the streamlined authorities arrangements. However, some medicines were identified as requiring continued monitoring. The Department has continued to monitor the arrangements and most recent data shows some increases in prescribing of a small number of drugs. The Department will continue to watch these medicines closely.

b) Some medicines are under consideration for adding to the streamlined authorities list and further medicines are expected to be added in the future. The Department has established an ongoing forum to raise issues and views on the streamlined authority arrangements. The forum includes representation from the AMA, Australian General Practice Network, Royal Australian College of General Practitioners, National Prescribing Service, Pharmaceutical Benefits Advisory Committee (PBAC) and the Department of Health and Ageing. This group may recommend additions to the streamlined authority list to the PBAC.

c) The authorities system provides a mechanism for restricting the prescription of medicines to conditions where cost-effectiveness has been established. The current criteria for streamlining authority medicines provide a reasonable balance between reducing administrative requirements and maintaining clinical effectiveness, patient safety and cost efficiency. That is, the criteria limit the listings to those medicines that treat chronic and stable conditions with stable dosage regimes and those that are less susceptible to risk of misuse or increased prescribing outside of restrictions.

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 Supplementary Budget Estimates Hearing, 21 October 2009 - Outcome 3

I am writing to amend the evidence that I gave at the Supplementary Budget Estimates Hearings of the Senate Community Affairs Committee on 21 October 2009.

The relevant transcript appears at page CA116 commencing with a question from Senator Cormann:

"What would be the effect to disallow the item in the Senate?"

My response was as follows:

"I think that it would revert back to the previous rebate."

After seeking further advice, I have been informed that the question turns on the wording of the disallowance motion. A disallowance motion could have the effect of either reverting to the previous rebate or of leaving no rebate in force. Therefore, I wish to change my evidence as follows:

> "It would either revert back to the previous rebate or remove the rebate, depending on the actual wording of the disallowance motion. Further legal advice would need to be obtained at the time."

I apologise for any inconvenience my previous response may have caused.

Yours sincerely,

Samantha Robertson
Assistant Secretary
Medicare Benefits Branch

27 October 2009

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-038

OUTCOME 3: Access to Medical Services

Topic: MRI

Written Question on Notice

Senator Fielding asked:

The granting of access to Medicare rebatable MRI is the equivalent of a public tender. In view of this, why is not a more rigorous process of considering public benefit applied?

Answer:

The granting of Medicare eligibility for MRI services in a responsible manner is a high priority for the Australian Government. Public benefit is an important consideration.

There have been several processes since 1998 to expand MRI Medicare eligibility nationally, which have increased MRI Medicare eligibility in a carefully managed way.

On 12 February 2008, the Government confirmed the 15 locations for the 2007-08 expansion of Medicare-eligible MRI services. Four of the locations were specific public hospitals. In relation to the other locations, the selection of suitable providers was undertaken by the Department of Health and Ageing through Invitation to Apply (ITA) processes.

For each ITA location, the Department issued an ITA document which identified the requirements in order for Medicare eligibility to be granted and sought applications from parties interested in providing a Medicare-eligible MRI service in the specific location. Applications received were evaluated by a Departmental evaluation committee against the evaluation criteria outlined in the ITA document. The Department appointed a probity adviser who monitored the operation of the evaluation process.

In the Budget delivered on 12 May 2009, the Government announced a detailed review, over the next two years, of possible long-term funding arrangements in diagnostic imaging. As part of this process, the arrangements for funding MRI will be examined, particularly restrictions around Medicare-eligible/ineligible units and the options in relation to lifting or reducing these restrictions. Consultation with stakeholders will form part of this review.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-039

OUTCOME 3: Access to Medical Services

Topic: MRI SCANNER IN WARRNAMBOOL

Written Question on Notice

Senator Fielding asked:

There is a clear need for an MRI scanner in Warrnambool. Why does the Government fail to consider the case at ministerial level? The solutions are available.

Answer:

The Government has considered the matter of Medicare eligibility for an MRI unit in Warrnambool.

On 17 July 2009, Minister Roxon's Adviser met with a delegation from Warrnambool to discuss this matter.

The Hon David Hawker MP, Member for Wannon, has also written on a number of occasions to Minister Roxon on this matter. The Parliamentary Secretary for Health has replied to Mr Hawker's correspondence on the Minister's behalf, and advised Mr Hawker that:

- there is no ongoing process for obtaining Medicare eligibility for an MRI unit;
- since 1999, there have been several expansion processes to increase the number of Medicare-eligible MRI units across Australia in a carefully managed way;
- there are no further expansions planned at this stage;
- in the May 2009 Budget, the Government announced a detailed review, over the next two years, of possible long-term funding arrangements in diagnostic imaging; and
- as part of this detailed review, the arrangements for funding MRI will be examined, particularly in relation to restrictions around Medicare-eligible/ineligible MRI units.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-040

OUTCOME 3: Access to Medical Services

Topic: MRI SCANNERS

Written Question on Notice

Senator Fielding asked:

On simple geographic access could anyone consider the current access to MRI scans equitable?

Answer:

While MRI is an expensive and sophisticated technology, the Australian Government appreciates that Australians value access to convenient and affordable MRI services.

As at November 2009, there are 124 Medicare-eligible MRI units operating across Australia, including in all capital cities and other locations.

There were 112 Medicare-eligible MRI units in November 2007, so there has been an increase of ten per cent over the past two years.

From the September quarter 2008 to the September quarter 2009, expenditure under Medicare on MRI scans increased by $6.8 million or more than 17 per cent. This growth in expenditure represented 19,716 additional MRI scans subsidised under Medicare over three months. This growth was due in part to the additional Medicare-eligible MRI units in operation.

In the Budget delivered on 12 May 2009, the Government announced a detailed review, over the next two years, of possible long-term funding arrangements in diagnostic imaging. As part of this process, the arrangements for funding MRI will be examined, particularly restrictions around Medicare-eligible/ineligible units and the options in relation to lifting or reducing these restrictions. Consultation with stakeholders will form part of this review.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-041

OUTCOME 3: Access to Medical Services

Topic: MRI IN WARRNAMBOOL

Written Question on Notice

Senator Fielding asked:

Does not the success of establishing specialist services in regional Australia, as the Warrnambool Base Hospital has done, deserve at least a hearing from the Minister?

Answer:

The Government has considered the matter of Medicare eligibility for an MRI unit in Warrnambool.

On 17 July 2009, Minister Roxon's Adviser met with a delegation from Warrnambool to discuss this matter.

The Hon David Hawker MP, Member for Wannon, has also written on a number of occasions to Minister Roxon on this matter. The Parliamentary Secretary for Health has replied to Mr Hawker's correspondence on the Minister's behalf, and advised Mr Hawker that:

- there is no ongoing process for obtaining Medicare eligibility for an MRI unit;
- since 1999, there have been several expansion processes to increase the number of Medicare-eligible MRI units across Australia in a carefully managed way;
- there are no further expansions planned at this stage;
- in the May 2009 Budget, the Government announced a detailed review, over the next two years, of possible long-term funding arrangements in diagnostic imaging; and
- as part of this detailed review, the arrangements for funding MRI will be examined, particularly in relation to restrictions around Medicare-eligible/ineligible MRI units.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-229

OUTCOME 3: Access to Medical Services

Topic: MAGNETIC RESONANCE IMAGING (MRI)

Hansard Page: CA 110-111

Senator Fielding asked:

a) Has the Minister's office had any contact with a delegation from Warrnambool over the issue of granting of a licence for an MRI unit at Warrnambool Hospital?

b) Why is there a restriction on providing a licence for an MRI unit at Warrnambool Hospital?

Answer:

a) Yes. Minister Roxon's Adviser met with a delegation from Warrnambool on 17 July 2009.

b) There are currently 124 Medicare-eligible MRI units operating across Australia, including 28 Medicare-eligible MRI units in Victoria.

There is no ongoing process for obtaining Medicare eligibility for an MRI unit and there are no future expansions planned at this stage.

In the Budget delivered on 12 May 2009, the Government announced a detailed review, over the next two years, of possible long-term funding arrangements in diagnostic imaging. As part of this process, the arrangements for funding MRI will be examined, particularly restrictions around Medicare-eligible/ineligible units and the options in relation to lifting or reducing these restrictions. Consultation with stakeholders will form part of this review.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-184

OUTCOME 3: Access to Medical Services

Topic: CATARACT SURGERY

Written Question on Notice

Senator Adams asked:

a) How many private opthalmologists are contracted to public hospitals on rates that are tied to MBS rebates?

b) Are these public hospital arrangements expected to be affected by the MBS funding cut for cataract surgery under the MBS?

Answer:

a) The Department does not have access to this information. Visiting Medical Officers (VMOs) are employed by state and territory governments who manage the public hospital system. The manner in which a VMO is employed, and the amount of remuneration paid to provide services in a public hospital is a matter for each state and territory.

b) The Department does not have access to this information.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-190

OUTCOME 3: Access to Medical Services

Topic: MBS SIMPLIFICATION REVIEW

Written Question on Notice

Senator Adams asked:

In relation to the MBS simplification process that was an election commitment by the ALP in 2007, the Minister's media release from December 2008 indicates that the MBS simplification review would be finalised in March 2009 and a new MBS schedule will be in force on 1 July 2009. The Minister's release also includes a specific commitment to recognise prevention work by GPs in the MBS. The Government said they would:

- Clarify and amend the item descriptors for level C and D items to provide better support for prevention and to remove any confusion over the use of these items.
- Streamline chronic disease management items by removing duplication in existing items.
- Rationalise the different health checks outlined in the MBS – moving to a structure based on the complexity of the check.
- Retain items for Residential Aged Care Facility visits and rationalise the items for all other out of surgery visits.
- Rationalise the items for after hours care (this will include a review of the item descriptors and the value of items).
- Rationalise the case conferencing items.Given that this was an election commitment in 2007, where is this review up to?

b) What progress has been made?

c) Are there changes to the MBS schedule in the 1 November regulations to reflect the outcome of this review?

d) What are the recommendations and outcomes of the review in respect of each of the areas listed above?

e) What are the timeframes for finalising this review and implementing its recommendations?

Answer:

a – e)

The Department of Health and Ageing has undertaken a review of the Medicare Benefits Schedule (MBS) primary care items in consultation with doctor groups and other stakeholders. A package of proposed reforms to the MBS was developed, aiming to streamline this part of the Schedule, remove red tape for doctors and encourage preventative health care activities.

The proposed reforms are currently being considered by the Government. The 1 November 2009 changes to the *Health Insurance (General Medical Services Table) Regulations 2009* do not reflect the outcome of this review.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-035

OUTCOME 3: Access to Medical Services

Topic: DIAGNOSTIC IMAGING

Written Question on Notice

Senator Williams asked:

a) When was the last time Medicare met increased costs for diagnostic imaging services?

b) Why has diagnostic imaging also not attracted an increase in Medicare rebates?

Answer:

a) The last increase to diagnostic imaging items on the MBS was November 2007 when there was a 2.03% fee increase for items 55113, 55114 and 55115, and a 2% fee increase for items 55116 and 55117. As a result of the last Federal Budget, the rebate for bulk billed services increased up to 10% of the schedule fee from 1 November 2009.

b) Notwithstanding the increases identified in part a) above, there was no standard indexation applied under the Memoranda of Understandings, which expired on 30 June 2008, with the diagnostic imaging industry. The Government conducted a review of future funding of diagnostic imaging services in 2008-09 and whilst introducing bulk billing incentives has commissioned a more extensive review of funding arrangements to be completed in 2010-11.

Senate Community Affairs Committee

ANSWERS TO SUPPLEMENTARY BUDGET ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21October 2009

Question: E09-057

OUTCOME 3: Access to Medical Services

Topic: PET - LUNG CANCER

Written Question on Notice

Senator Siewert asked:

In a reply to a question on notice from the previous estimates the Department stated that Australian Government representatives did not tell an International Health Technology Assessment conference in Poland in 2004 that PET scanning was effective in non small carcinoma of the lung and that there was local data demonstrating that PET also led to management change. I am aware of a publication from the INAHTA (International Network of Agencies for Health Technology Assessment) website, attributed to Dr Richard King and John Hastings representing the Australian Government, that appears to contradict the Departments claim. Can the Department clarify this anomaly?

Answer:

The 30 May 2004 presentation by Dr King and Mr Hastings did not claim that Position Emission Tomography (PET) was clinically effective in lung cancer but indicated that, while preliminary Australian data had shown that PET was effective in changing clinical management for non small cell carcinoma of the lung, demographic data still needed to be collected until 2006 when a full review of the local and international literature would take place.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21October 2009

Question: E09-058

OUTCOME 3: Access to Medical Services

Topic: POSITRON EMISSION TOMOGRAPHY (PET) - LUNG CANCER

Written Question on Notice

Senator Siewert asked:

a) The presentation in question dates to 30 May 2004. If the Department had decided that PET was effective and changed management in non small cell carcinoma lung, and therefore that did not need to be further researched with a specific clinical protocol as part of the PET data collection process, why did the Department continue to tell lung cancer sufferers that there was 'insufficient evidence' of PET's clinical effectiveness?

b) Why was the use of PET for non small cell carcinoma lung not put onto the general Medicare Benefits Schedule (MBS) before November 2005?

c) Was the decision that non small cell carcinoma lung did not require further data collection, in the form of a specific clinical protocol approved by Medical Services Advisory Committee (MSAC), taken in 2001 at a meeting between representatives of the Department, MSAC and the profession?

d) If the decision was made in 2001 that PET was effective and changed management in non small cell carcinoma lung, why wasn't that important information passed on to the public sooner?

Answer:

a) Information regarding the likely effectiveness of PET in changing the clinical management of non small cell carcinoma lung cancer was published in the MSAC Assessment Report of 2000 on PET (pages 15 and 24). However, the data on the change in management were from a single site, there was no evidence that the change in clinical management led to an improvement in the outcome for the patient, and thus the collection of further data was sought to confirm the wider application of this preliminary finding.

b) On 21 June 2001, the then Minister for Health and Aged Care signed Health Insurance Determination HS/2/01 under section 3C of the *Health Insurance Act 1973*, which enabled MBS funding, to support further data collection, for whole body FDG PET study, performed for the staging of proven non-small cell lung cancer, where curative surgery or radiotherapy is planned (item number 61529) for six PET facilities which were successful in the PET tender process. This item was then made available to all

eligible PET facilities under Health Insurance (PET) Determination HS/07/05 on 6 December 2005.

c) The Supporting Committee for evaluation of the role of PET in clinical indications recommended for review by the Commonwealth Review of Positron Emission Tomography met on 23 May 2001.

The minutes of this meeting record that on 2 February 2001 a meeting had been held with representatives of the Australian and New Zealand Association of Physicians in Nuclear Medicine (ANZAPNM), MSAC, the Department and PET providers to discuss PET data collection issues, at which:

"At the meeting indications for data collection in Australia were roughly prioritised on the basis of clinical need, the likelihood of obtaining good data in Australia, data already collected by PMCI and other Australian PET sites, and possible availability of overseas data. As noted above, ANZAPNM is now developing a formal proposal for the data collection to enable further development of the details. For example, while prima facie it is likely that the PMCI study has collected sufficient data already on non-small cell lung carcinoma, the PMCI data collection:

- *was at a single site whereas at the meeting it was agreed that collection of data from at least two sites should be sought for each indication to promote generalisability over potentially varying levels of expertise and practice; and*

- *was intended to specifically address the utility of FDG-18 NaI crystal PET, which again may turn out to be a confounding factor in the generalisability of the results.*"

d) The information was published in the MSAC Assessment Report of 2000 on Positron Emission Tomography (pages 15 and 24).

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-093

OUTCOME 3: Access to Medical Services

Topic: BULK BILLING

Written Question on Notice

Senator Boyce asked:

Figures released by the Minister in August show that a record 73.9 per cent of all Medicare services were bulk billed in 2008-09, an increase of 0.5 per cent on 2007-08. Did the Department factor in this increase into the data it included within the Portfolio Budget Statements showing that estimated Medicare expenditure was expected to remain steady (page 122)?

Answer:

No, as small incremental changes to bulk billing rates are not material to the global estimate of Medicare expenditure.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-094

OUTCOME 3: Access to Medical Services

Topic: DIAGNOSTIC IMAGING SERVICES

Written Question on Notice

Senator Boyce asked:

On November 1, the Government will introduce an incentive of 10 per cent of the Medicare Benefits Scheme (MBS) fee for each out of hospital diagnostic imaging service that is bulk billed to the patient. This will encourage practices to bulk bill diagnostic imaging services for patients.

a) How much will Medicare pay for an average bulk-billed diagnostic image service?

b) How many Australians does the Government estimate will bulk-bill these services in 2009-10, and how many were bulk-billed in 2008-09?

Answer:

a and b)

The Government does not release detailed estimates of future MBS expenditure and patient numbers. However, it is estimated that the average bulk billed rebate in 2009-10 is approximately $270 and approximately 10.2 million bulk billed diagnostic imaging services were performed in 2008-09.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-230

OUTCOME 3: Access to Medical Services

Topic: MATERNITY SERVICES ADVISORY GROUP

Hansard Page: CA 122

Senator Adams asked:

Can the membership list of the Maternity Services Advisory Group be provided?

Answer:

The members of the Advisory Group are listed below. Please note that members were nominated by their respective organisations.

Name of Member	**Organisation**
Prof John Horvath (Co-Chair)	Department of Health and Ageing (former Commonwealth Chief Medical Officer)
Ms Rosemary Bryant (Co-Chair)	Department of Health and Ageing (Commonwealth Chief Nurse and Midwifery Officer)
Ms Ann Kinnear	Australian Health Ministers Advisory Council
Dr Ted Weaver	Royal Australian and New Zealand College of Obstetricians and Gynaecologists
Dr Andrew Foote	National Association of Specialist Obstetricians and Gynaecologists
A/Prof Steven Katz	The Australian and New Zealand College of Anaesthetists
Dr Andrew Pesce	Australian Medical Association
Dr Ross Wilson	Royal Australian College of General Practitioners
Mr Steve Sant	Rural Doctors Association of Australia
Dr Marilyn Clarke	Australian Indigenous Doctors Association
Dr Barbara Vernon & Prof Sally Tracy	Australian College of Midwives
Ms Debra Cerasa	Royal College of Nursing Australia
Ms Gerardine (Ged) Kearney	Australian Nursing Federation
Ms Joanne Smethurst & Mr Bruce Teakle	Maternity Coalition
Ms Deborah Slater	Consumer Health Forum
Prof David Ellwood	Women's and Children's Hospitals Australasia
Mr John Amery	Australian Private Hospitals Association

Prof Jeffrey Robinson	Australian Healthcare and Hospitals Association
Prof Con Michael	Catholic Health Australia
Prof Dennis Pashen	Australian College of Rural and Remote Medicine
Dr Catherine Nagle	Perinatal Society of Australia and New Zealand
Prof Pat Brodie	Council of Deans of Nursing and Midwifery
Prof Julie Quinlivan	Medical Deans Australia and New Zealand
Ms Liz Wilkes	Australian Private Midwives Association

Senate Community Affairs Committee

ANSWERS TO QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 21 October 2009

Question no: E09-185

OUTCOME 3: Access to Medical Services

Topic: IVF & ART FUNDING

Written Question on Notice

Senator Adams asked:

In relation to claims that recent changes to the Government budget measure for IVF/ART MBS funding IVF/ART safety net caps still produce the same level of savings to the budget bottom line as the original budget measures. For each year of the forward estimates period, what is the difference between the annual estimate of the total financial impact of changes to IVF MBS items and IVF safety net caps as announced at Budget time and the annual estimate of the recently announced revised changes to IVF MBS items and IVF safety net caps?

Answer:

There are no changes to the annual estimates in the forward estimates for IVF MBS items and IVF safety net caps.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-181

OUTCOME 3: Access to Medical Services

Topic: MEDICARE BENEFITS SCHEDULE (MBS) QUALITY FRAMEWORK

Written Question on Notice

Senator Adams asked:

In relation to the Quality framework for reviewing services listed in the Medicare Benefits Schedule [Ref. BP2, p 287]:

a) What progress has been made on this activity?

b) What consultations have occurred?

c) What will the quality framework seek to achieve?

d) Will the review's terms of reference allow for findings and recommendations that relate to additional funding that may be required for medical services currently under-funded in the MBS (as opposed to focusing only on reductions in funding for particular services)?

e) On what basis will 'appropriate pricing' for MBS items be decided?

f) Which existing MBS items are planned for review in the first 12 months of this new review program?

g) How will this measure 'improve health outcomes for patients' as the description in the budget papers claims?

Answer:

a) A Task Group has been established to develop a strategic, systematic, evidence-based framework for listing new MBS items and review of existing items. Work on these frameworks has recently begun and will continue to be developed and refined throughout 2010 with expert and stakeholder involvement.

b) Formal consultation on the MBS Quality Framework imitative will commence in November and December 2009 with interested stakeholders. The department is keen to consult broadly and to ensure that all interested parties have an opportunity to have input into the process.

c) The central objective of the MBS Quality Framework is to strengthen the listing, pricing and review processes that underpin the MBS by ensuring that services are aligned with contemporary clinical evidence, represent best value for money and improve health outcomes for patients.

d) The reviews of existing items may provide recommendations for MBS rebates to be increased in some areas and decreased in others. This will be determined on a case by case basis in line with the evidence gathered during the review.

e) The process for considering price is being developed and will be informed by consultations.

f) There is no predetermined list of MBS items to be reviewed in the first 12 months. The review of existing MBS items will be informed by a strategic framework that includes criteria to help identify and prioritise review processes. Experts and stakeholders will input into the development of this framework.

g) The MBS Quality Framework will improve health outcomes for patients by ensuring that services listed on the MBS are effective and safe, aligned with best clinical practice and represent value for money.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-183

OUTCOME 3: Access to Medical Services

Topic: CATARACTS

Written Question on Notice

Senator Adams asked:

c) How many ophthalmologists did the Department consult to determine the average amount of time taken for a cataract procedure?

d) How many ophthalmologists did the Department consult to determine the revised MBS rebate for a cataract procedure?

Answer:

a and b)

The Department did not consult individual ophthalmologists regarding the average time taken for a cataract procedure, or regarding the revised rebates.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-092

OUTCOME 3: Access to Medical Services

Topic: ITEMS REMOVED FROM MEDICARE BENEFITS SCHEDULE (MBS)

Written Question on Notice

Senator Boyce asked:

The MBS online website advises that: Items 50124 and 50125 will be removed from the Schedule, with benefits payable under existing consultation items. Under the current Medicare benefits arrangements, there are some procedural services which are not specifically listed because they are regarded as forming part of a consultation, or attract benefits on an attendance basis. What is the estimated savings over the forward estimates from removing these items?

Answer:

The removal of items 50124 and 50125, which provide for joint injections, are part of a broader 2009-10 Budget measure. This measure, effective from 1 November 2009, will provide savings of $153.4 million over four years and helps to ensure the long-term affordability and sustainability of Medicare for both patients and the Government. The removal of the items also reflects the Government's commitment to simplifying and enhancing Medicare billing practices, and promoting appropriate clinical practice.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-103

OUTCOME 3: Access to Medical Services

Topic: REVIEW OF THE MEDICARE BENEFITS SCHEDULE (MBS)

Written Question on Notice

Senator Siewert asked:

a) In regards to the issue of the removal of item 50124 and 50125 from the MBS and given that the Minister has requested a departmental review of this Budget decision, will the Department confirm that the focus of the review is on Items 50124 and 50125 and not the planned major review of the MBS listing process scheduled for 2010?

b) What will be the completion date for the requested department review?

Answer:

a) The Minister has requested further advice regarding the removal of these items. The Department is currently involved in discussions with the Australian Rheumatology Association (ARA) and Arthritis Australia in order to examine relevant issues prior to providing this advice to the Minister.

b) There is no set completion date for this activity to occur. Timeframes will depend on the Department receiving sufficient evidence from the ARA regarding the complexities involved in certain joint injection procedures.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-182

OUTCOME 3: Access to Medical Services

Topic: CATARACT SURGERY

Written Question on Notice

Senator Adams asked:

In relation to the so-called 'ensuring the appropriate use of clinical procedures and adjusted to modern technologies' measure [Ref. BP2, p. 295], the Medicare Benefits Schedule (MBS) fee for cataract surgery will be cut by over 50%:

a) Given the real 32% MBS rebate cut in 1987, the 10% MBS fee cut in 1996 and the low level of MBS indexation over the entire period which will effectively result in an 80% total real cut in the government's MBS rebate for cataract surgery since 1992-93, what advances in technology and efficiency gains have occurred since the last cuts to MBS cataract rebates in 1996 to justify a further 50% fee reduction now?
b) What is the Department's estimate of increase in demand for public patient cataract surgery as a result of this measure?
c) What dialogue and communication occurred between the Commonwealth and state governments about this measure i) before it was announced in the budget ii) since the budget was released?

Answer:

a) The Medicare fee is determined with regard to the time involved in performing the service, and the complexity and professional difficulty involved. The fee for the cataract items were determined at a time when the procedure took longer. Improvements in technology, such as intraocular lenses and phacoemulsification machines have improved the techniques and equipment associated with performing cataract surgery.

   When the surgery was first performed, the procedure would take approximately 45 minutes, but now typically takes 20 minutes. The Fred Hollows Foundation states that cataracts can be removed in a straightforward 20 minute operation, done under local anesthetic. Similarly, the Australian Institute of Eye Surgery indicates that cataract surgery usually lasts less than 20 minutes, and is often performed using anesthetic eye drops without the need for injections. International data also mirrors the reduced time and complexity of cataract operations. For example, the National Health Service in the United Kingdom indicated that the surgery time takes around ten to twenty minutes, and the Swedish Eye Centre cites fifteen to thirty minutes.

Comparatively, reconstructive cranioplasty (repair of defect or deformity of the skull), covered under item 40600, takes longer, carries a high risk and attracts a fee of $882.25.

Regarding the previous reductions to cataract surgery fees, in 1987 two MBS items covered the cataract procedure; one for the extraction of a lens, and one for the insertion of a lens (items 42698 and 42701). In 1987 the fees for these items were reduced by approximately 30%, following an ophthalmology review that identified the time required to undertake these procedures had decreased significantly from the early 1970s. At the same time the Schedule fee for another lens extraction procedure was increased by almost 6%. The separate items for lens extraction and insertion of an artificial lens have been listed on the MBS since the inception of Medicare in 1984.

In 1996, a new item was introduced, (item 42702) which provides for the combined lens extraction and insertion of an artificial lens procedure. The Schedule fee for this item was set at $660.90. At the same time the fees for a number of procedural items in the MBS, including items 42698 and 42701, were reduced by approximately 10%, as the procedures were considered overpriced. Item 42702 has been indexed annually since listing in 1996, at the same level of indexation as other MBS items.

b) None.

c) i) The amendments to the cataract surgery items were announced as part of a Budget measure. Such measures are regarded as 'Budget-in-Confidence', hence no consultation is undertaken.
ii) An officer from the department has spoken with some officers from other state government departments regarding this measure since the budget was released including New South Wales, Queensland, Victoria and South Australia.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-274

OUTCOME 3: Access to Medical Services

Topic: NEW MBS ITEM NUMBER 42718

Hansard Page: CA 119-120

Senator Cormann asked:

How many services per annum do you anticipate will be claimed under MBS item 42718?

Answer:

The Secretary of the Department advised the Committee at Estimates on Wednesday, 21 October 2009 at approximately 9:30pm that the proportion of services anticipated to be covered by the new complex cataract item was around 10%. It appears that this was not picked up by Hansard, prior to its cutoff for the brief suspension.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-117

OUTCOME 3: Access to Medical Services

Topic: CATARACTS

Written Question on Notice

Senator Adams asked:

How many cataract operations will be cut to Indigenous Australians as a result of the government's decision to reduce funding for this service?

Answer:

Medicare data does not capture the number of cataract operations performed on Indigenous patients, however around 560 cataract procedures, or 0.4% of services, are performed in very remote areas.

The Commonwealth Government is continuing to provide funding for cataract surgery, including through the Medicare Benefits Schedule (MBS), supporting the Medical Specialist Outreach Assistance Program and through the Health Care Agreements with the states and territories.

In respect to Indigenous patients, $58.3 million is also being allocated under the *Improving Eye and Ear Health Services for Indigenous Australians for Better Education and Employment Outcome* for the Australian Government to continue to invest in three further intensive surgery weeks per year in Central Australia, for the next four years.

This will provide additional services in the management of eye and ear problems that will lead to better education and employment outcomes and assist in closing the gap. This measure includes:

- expansion of the Visiting Optometrist Scheme;
- increased services to address trachoma;
- training of health workers for hearing screening;
- maintenance and purchase of medical equipment for hearing screening;
- additional ear and eye surgery, particularly for remote Indigenous clients; and
- hearing health promotion.

Other tailored programs, such as the Central Australian Integrated Eye Health Program incorporates an integrated eye health service delivery model for Central Australia, with eye surgery intensives conducted to reduce the backlog of surgery on the Alice Springs Hospital

waiting list. Since 2006, $505,580 (GST inclusive) has been allocated to the Program, with an additional commitment of funds of $153,307 (GST inclusive) in 2009-10.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-254

OUTCOME 3: Access to Medical Services

Topic: CATARACT OPERATIONS

Written Question on Notice

Senator Scullion asked:

How many Indigenous Australians living in the intervention area will not have cataract operations as a consequence of the government's decision to reduce funding for this service?

Answer:

Medicare data does not capture the number of cataract operations performed on Indigenous patients, however around 560 cataract procedures, or 0.4% of services, are performed in very remote areas.

The Commonwealth Government is continuing to provide funding for cataract surgery, including through the Medicare Benefits Schedule (MBS), supporting the Medical Specialist Outreach Assistance Program and through the Health Care Agreements with the states and territories.

In respect to Indigenous patients, $58.3 million is also being allocated under the *Improving Eye and Ear Health Services for Indigenous Australians for Better Education and Employment Outcome* for the Australian Government to continue to invest in three further intensive surgery weeks per year in Central Australia, for the next four years.

This will provide additional services in the management of eye and ear problems that will lead to better education and employment outcomes and assist in closing the gap. This measure includes:

- expansion of the Visiting Optometrist Scheme;
- increased services to address trachoma;
- training of health workers for hearing screening;
- maintenance and purchase of medical equipment for hearing screening;
- additional ear and eye surgery, particularly for remote Indigenous clients; and
- hearing health promotion.

Other tailored programs, such as the Central Australian Integrated Eye Health Program incorporates an integrated eye health service delivery model for Central Australia, with eye surgery intensives conducted to reduce the backlog of surgery on the Alice Springs Hospital waiting list. Since 2006, $505,580 (GST inclusive) has been allocated to the Program, with an additional commitment of funds of $153,307 (GST inclusive) in 2009-10.

Australian Government

Department of Health and Ageing

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

Dear Mr Humphery

Provision of 30 June 2009 Stocktake of Aged Care Places
Outcome 4 – Aged Care and Population Ageing

At the Budget Estimates 2004-2005 Hearings of the Senate Community Affairs Legislation Committee, the Department undertook to forward to the Committee the figures for future Stocktakes of Aged Care Places following their completion.

The 30 June 2009 Stocktake of Aged Care Places tables are attached; an electronic copy of these attachments was emailed today to: community.affairs.sen@aph.gov.au

Yours sincerely

Peter Broadhead
Assistant Secretary
Residential Program Management Branch

October 2009

Total Operational Places by State/Territory

- 30 June 2009

State / Territory	Residential care			Community care			Total residential + community	Total transition care	Grand Total
	High care	Low care	Total residential	High care	Low care	Total community			
NSW	31,575	29,707	**61,282**	2,107	13,702	**15,809**	**77,091**	772	**77,863**
VIC	21,659	24,569	**46,228**	1,617	10,218	**11,835**	**58,063**	570	**58,633**
QLD	14,817	16,938	**31,755**	1,048	7,087	**8,135**	**39,890**	389	**40,279**
SA	8,983	8,045	**17,028**	529	3,556	**4,085**	**21,113**	193	**21,306**
WA	6,908	8,160	**15,068**	751	4,088	**4,839**	**19,907**	178	**20,085**
TAS	2,426	2,204	**4,630**	193	1,091	**1,284**	**5,914**	67	**5,981**
NT	345	275	**620**	113	661	**774**	**1,394**	22	**1,416**
ACT	805	963	**1,768**	156	514	**670**	**2,438**	37	**2,475**
Australia	**87,518**	**90,861**	**178,379**	**6,514**	**40,917**	**47,431**	**225,810**	**2,228**	**228,038**

Total Operational Ratios by State/Territory

- 30 June 2009

State / Territory	Residential care			Community care			Total residential + community (Planning ratio)	Total transition care	Grand Total
	High care	Low care	Total residential	High care	Low care	Total community			
NSW	45.0	42.3	**87.3**	3.0	19.5	**22.5**	**109.9**	1.1	**111.0**
VIC	41.2	46.8	**88.0**	3.1	19.4	**22.5**	**110.5**	1.1	**111.6**
QLD	39.5	45.1	**84.6**	2.8	18.9	**21.7**	**106.2**	1.0	**107.3**
SA	49.4	44.3	**93.7**	2.9	19.6	**22.5**	**116.2**	1.1	**117.3**
WA	37.3	44.0	**81.3**	4.1	22.1	**26.1**	**107.4**	1.0	**108.4**
TAS	45.2	41.1	**86.3**	3.6	20.3	**23.9**	**110.3**	1.2	**111.5**
NT	54.3	43.3	**97.6**	17.8	104.0	**121.8**	**219.4**	3.5	**222.9**
ACT	33.2	39.7	**72.9**	6.4	21.2	**27.6**	**100.6**	1.5	**102.1**
Australia	**42.6**	**44.2**	**86.9**	**3.2**	**19.9**	**23.1**	**110.0**	**1.1**	**111.0**

Notes:

Tables include flexible care places: Transition Care, Extended Aged Care at Home (EACH) and EACH Dementia, Multi-Purpose Services, Innovative Care and places under the National Aboriginal and Torres Strait Islander Flexible Program.

Multi-Purpose Services and Aboriginal and Torres Strait Islander places are notionally allocated as high care and low care residential care places and low care community care places.

Community care also includes Community Aged Care Packages (which are low care), EACH and EACH Dementia places (which are high care).

Total Operational Places and Ratios at Aged Care Planning Region - 30 June 2009

State / Territory	Aged care planning region	Total Operational Places							Total Operational Ratios						
		Residential care			Community care			Total residential + community	Residential care			Community care			Total residential + community (Planning Ratio)
		High care	Low care	Total residential	High care	Low care	Total community		High care	Low care	Total residential	High care	Low care	Total community	
NSW	Central Coast	1,610	1,820	**3,430**	123	870	**993**	**4,423**	38.5	43.5	**82.0**	2.9	20.8	**23.7**	**105.7**
	Central West	762	956	**1,718**	57	361	**418**	**2,136**	39.9	50.1	**90.0**	3.0	18.9	**21.9**	**112.0**
	Far North Coast	1,496	1,749	**3,245**	112	741	**853**	**4,098**	38.4	44.9	**83.3**	2.9	19.0	**21.9**	**105.2**
	Hunter	2,639	2,965	**5,604**	178	1,280	**1,458**	**7,062**	40.2	45.2	**85.4**	2.7	19.5	**22.2**	**107.6**
	Illawarra	1,675	1,986	**3,661**	142	909	**1,051**	**4,712**	36.1	42.8	**78.9**	3.1	19.6	**22.7**	**101.6**
	Inner West	3,067	1,451	**4,518**	100	804	**904**	**5,422**	74.8	35.4	**110.1**	2.4	19.6	**22.0**	**132.2**
	Mid North Coast	1,534	1,955	**3,489**	142	841	**983**	**4,472**	34.3	43.7	**78.0**	3.2	18.8	**22.0**	**100.0**
	Nepean	1,249	749	**1,998**	61	430	**491**	**2,489**	56.0	33.6	**89.6**	2.7	19.3	**22.0**	**111.6**
	New England	789	943	**1,732**	77	397	**474**	**2,206**	38.8	46.4	**85.2**	3.8	19.5	**23.3**	**108.6**
	Northern Sydney	4,563	3,776	**8,339**	253	1,632	**1,885**	**10,224**	53.1	44.0	**97.1**	2.9	19.0	**21.9**	**119.0**
	Orana Far West	670	878	**1,548**	60	371	**431**	**1,979**	39.9	52.3	**92.1**	3.6	22.1	**25.7**	**117.8**
	Riverina/Murray	1,123	1,412	**2,535**	88	557	**645**	**3,180**	37.1	46.6	**83.8**	2.9	18.4	**21.3**	**105.1**
	South East Sydney	3,688	3,062	**6,750**	272	1,685	**1,957**	**8,707**	43.0	35.7	**78.8**	3.2	19.7	**22.8**	**101.6**
	South West Sydney	2,941	2,644	**5,585**	196	1,254	**1,450**	**7,035**	45.6	41.0	**86.5**	3.0	19.4	**22.5**	**109.0**
	Southern Highlands	906	1,270	**2,176**	75	471	**546**	**2,722**	38.3	53.7	**92.0**	3.2	19.9	**23.1**	**115.1**
	Western Sydney	2,863	2,091	**4,954**	171	1,099	**1,270**	**6,224**	52.5	38.4	**90.9**	3.1	20.2	**23.3**	**114.2**
	All State (Transition Care)							**772**							

Total Operational Places and Ratios at Aged Care Planning Region - 30 June 2009

State / Territory	Aged care planning region	Total Operational Places							Total Operational Ratios						
		Residential care			Community care			Total residential + community	Residential care			Community care			Total residential + community (Planning Ratio)
		High care	Low care	Total residential	High care	Low care	Total community		High care	Low care	Total residential	High care	Low care	Total community	
VIC	Barwon-South Western	1,889	2,175	**4,064**	131	865	**996**	**5,060**	43.2	49.7	**92.9**	3.0	19.8	**22.8**	**115.7**
	Eastern Metro	4,002	5,001	**9,003**	321	2,005	**2,326**	**11,329**	37.8	47.2	**85.1**	3.0	18.9	**22.0**	**107.0**
	Gippsland	1,079	1,519	**2,598**	109	613	**722**	**3,320**	34.2	48.1	**82.3**	3.5	19.4	**22.9**	**105.2**
	Grampians	949	1,149	**2,098**	94	486	**580**	**2,678**	38.4	46.4	**84.8**	3.8	19.6	**23.4**	**108.2**
	Hume	1,214	1,468	**2,682**	105	553	**658**	**3,340**	40.9	49.4	**90.3**	3.5	18.6	**22.2**	**112.5**
	Loddon-Mallee	1,348	1,821	**3,169**	111	724	**835**	**4,004**	37.8	51.0	**88.8**	3.1	20.3	**23.4**	**112.2**
	Northern Metro	3,152	3,160	**6,312**	232	1,606	**1,838**	**8,150**	42.4	42.5	**84.9**	3.1	21.6	**24.7**	**109.6**
	Southern Metro	5,637	5,833	**11,470**	335	2,233	**2,568**	**14,038**	45.1	46.7	**91.8**	2.7	17.9	**20.6**	**112.4**
	Western Metro	2,389	2,443	**4,832**	179	1,133	**1,312**	**6,144**	43.6	44.6	**88.2**	3.3	20.7	**23.9**	**112.1**
	All State (Transition Care)							**570**							

Total Operational Places and Ratios at Aged Care Planning Region - 30 June 2009

State / Territory	Aged care planning region	Total Operational Places							Total Operational Ratios						
		Residential care			Community care			Total residential + community	Residential care			Community care			Total residential + community (Planning Ratio)
		High care	Low care	Total residential	High care	Low care	Total community		High care	Low care	Total residential	High care	Low care	Total community	
QLD	Brisbane North	1,939	1,946	**3,885**	130	760	**890**	**4,775**	48.3	48.5	**96.8**	3.2	18.9	**22.2**	**119.0**
	Brisbane South	2,583	2,802	**5,385**	148	1,090	**1,238**	**6,623**	44.5	48.3	**92.8**	2.6	18.8	**21.3**	**114.1**
	Cabool	1,179	1,386	**2,565**	73	543	**616**	**3,181**	38.3	45.0	**83.4**	2.4	17.6	**20.0**	**103.4**
	Central West	68	54	**122**	5	64	**69**	**191**	65.8	52.3	**118.1**	4.8	62.0	**66.8**	**184.9**
	Darling Downs	1,043	1,146	**2,189**	55	386	**441**	**2,630**	40.7	44.8	**85.5**	2.1	15.1	**17.2**	**102.7**
	Far North	607	795	**1,402**	50	457	**507**	**1,909**	32.8	43.0	**75.8**	2.7	24.7	**27.4**	**103.3**
	Fitzroy	683	789	**1,472**	65	314	**379**	**1,851**	42.5	49.1	**91.7**	4.0	19.6	**23.6**	**115.3**
	Logan River Valley	709	788	**1,497**	55	292	**347**	**1,844**	38.9	43.3	**82.2**	3.0	16.0	**19.1**	**101.3**
	Mackay	408	400	**808**	30	201	**231**	**1,039**	40.8	40.0	**80.9**	3.0	20.1	**23.1**	**104.0**
	North West	49	80	**129**	4	111	**115**	**244**	35.9	58.6	**94.5**	2.9	81.3	**84.2**	**178.8**
	Northern	837	783	**1,620**	48	306	**354**	**1,974**	47.4	44.3	**91.7**	2.7	17.3	**20.0**	**111.7**
	South Coast	1,730	2,113	**3,843**	135	857	**992**	**4,835**	35.0	42.7	**77.6**	2.7	17.3	**20.0**	**97.7**
	South West	74	151	**225**	5	97	**102**	**327**	33.7	68.8	**102.5**	2.3	44.2	**46.5**	**149.0**
	Sunshine Coast	1,440	1,837	**3,277**	100	800	**900**	**4,177**	34.4	43.8	**78.2**	2.4	19.1	**21.5**	**99.7**
	West Moreton	476	708	**1,184**	55	257	**312**	**1,496**	32.2	47.9	**80.1**	3.7	17.4	**21.1**	**101.3**
	Wide Bay	992	1,160	**2,152**	90	552	**642**	**2,794**	33.2	38.9	**72.1**	3.0	18.5	**21.5**	**93.6**
	All State (Transition Care)							**389**							

Total Operational Places and Ratios at Aged Care Planning Region - 30 June 2009

Total Operational Places

State / Territory	Aged care planning region	Residential care			Community care			Total residential + community
		High care	Low care	Total residential	High care	Low care	Total community	
SA	Eyre Peninsula	161	181	**342**	15	88	**103**	**445**
	Hills, Mallee & Southern	659	566	**1,225**	48	337	**385**	**1,610**
	Metropolitan East	1,777	1,659	**3,436**	69	524	**593**	**4,029**
	Metropolitan North	2,008	1,172	**3,180**	78	554	**632**	**3,812**
	Metropolitan South	1,989	1,665	**3,654**	124	812	**936**	**4,590**
	Metropolitan West	1,293	1,252	**2,545**	85	551	**636**	**3,181**
	Mid North	93	200	**293**	13	80	**93**	**386**
	Riverland	170	230	**400**	15	104	**119**	**519**
	South East	228	340	**568**	23	140	**163**	**731**
	Whyalla, Flinders & Far North	169	228	**397**	20	143	**163**	**560**
	Yorke, Lower North & Barossa	436	552	**988**	39	223	**262**	**1,250**
	All State (Transition Care)							**193**

Total Operational Ratios

State / Territory	Aged care planning region	Residential care			Community care			Total residential + community (Planning Ratio)
		High care	Low care	Total residential	High care	Low care	Total community	
SA	Eyre Peninsula	44.0	49.5	**93.4**	4.1	24.0	**28.1**	**121.6**
	Hills, Mallee & Southern	44.6	38.3	**83.0**	3.3	22.8	**26.1**	**109.0**
	Metropolitan East	61.3	57.2	**118.5**	2.4	18.1	**20.5**	**139.0**
	Metropolitan North	57.6	33.6	**91.2**	2.2	15.9	**18.1**	**109.3**
	Metropolitan South	50.7	42.5	**93.2**	3.2	20.7	**23.9**	**117.1**
	Metropolitan West	43.6	42.3	**85.9**	2.9	18.6	**21.5**	**107.4**
	Mid North	26.2	56.3	**82.4**	3.7	22.5	**26.2**	**108.6**
	Riverland	34.2	46.2	**80.4**	3.0	20.9	**23.9**	**104.3**
	South East	34.1	50.9	**85.0**	3.4	20.9	**24.4**	**109.3**
	Whyalla, Flinders & Far North	37.5	50.6	**88.0**	4.4	31.7	**36.1**	**124.2**
	Yorke, Lower North & Barossa	40.3	51.0	**91.3**	3.6	20.6	**24.2**	**115.5**
	All State (Transition Care)							

Total Operational Places and Ratios at Aged Care Planning Region - 30 June 2009

State / Territory	Aged care planning region	Total Operational Places							Total Operational Ratios						
		Residential care			Community care			Total residential + community	Residential care			Community care			Total residential + community (Planning Ratio)
		High care	Low care	Total residential	High care	Low care	Total community		High care	Low care	Total residential	High care	Low care	Total community	
WA	Goldfields	136	127	**263**	8	67	**75**	**338**	51.0	47.7	**98.7**	3.0	25.1	**28.1**	**126.8**
	Great Southern	214	300	**514**	30	136	**166**	**680**	34.3	48.0	**82.3**	4.8	21.8	**26.6**	**108.9**
	Kimberley	68	98	**166**	7	78	**85**	**251**	69.4	100.0	**169.4**	7.1	79.6	**86.7**	**256.1**
	Metropolitan East	1,044	1,324	**2,368**	169	518	**687**	**3,055**	38.6	49.0	**87.6**	6.3	19.2	**25.4**	**113.0**
	Metropolitan North	1,611	2,229	**3,840**	185	1,032	**1,217**	**5,057**	33.2	45.9	**79.1**	3.8	21.3	**25.1**	**104.2**
	Metropolitan South East	1,548	1,448	**2,996**	144	585	**729**	**3,725**	51.5	48.2	**99.7**	4.8	19.5	**24.3**	**124.0**
	Metropolitan South West	1,386	1,589	**2,975**	140	991	**1,131**	**4,106**	32.1	36.8	**69.0**	3.2	23.0	**26.2**	**95.2**
	Mid West	160	178	**338**	7	172	**179**	**517**	31.3	34.8	**66.1**	1.4	33.7	**35.0**	**101.2**
	Pilbara	54	11	**65**	0	50	**50**	**115**	85.3	17.4	**102.7**	0.0	79.0	**79.0**	**181.7**
	South West	447	604	**1,051**	42	279	**321**	**1,372**	32.4	43.8	**76.2**	3.0	20.2	**23.3**	**99.5**
	Wheatbelt	240	252	**492**	19	180	**199**	**691**	33.9	35.6	**69.5**	2.7	25.4	**28.1**	**97.6**
	All State (Transition Care)							**178**							
TAS	North Western	499	521	**1,020**	33	236	**269**	**1,289**	39.8	41.6	**81.4**	2.6	18.8	**21.5**	**102.8**
	Northern	798	607	**1,405**	46	341	**387**	**1,792**	51.5	39.2	**90.6**	3.0	22.0	**25.0**	**115.6**
	Southern	1,129	1,076	**2,205**	114	514	**628**	**2,833**	44.1	42.0	**86.1**	4.5	20.1	**24.5**	**110.7**
	All State (Transition Care)							**67**							

Total Operational Places and Ratios at Aged Care Planning Region - 30 June 2009														
Total Operational Places								**Total Operational Ratios**						
State / Territory	**Aged care planning region**	**Residential care**			**Community care**			**Total residential + community**	**Residential care**			**Community care**			**Total residential + community (Planning Ratio)**
		High care	**Low care**	**Total residential**	**High care**	**Low care**	**Total community**		**High care**	**Low care**	**Total residential**	**High care**	**Low care**	**Total community**	
NT	Alice Springs	110	56	**166**	20	187	**207**	**373**	93.9	47.8	**141.8**	17.1	159.7	**176.8**	**318.5**
	Barkly	17	2	**19**	0	42	**42**	**61**	95.5	11.2	**106.7**	0.0	236.0	**236.0**	**342.7**
	Darwin	181	152	**333**	93	272	**365**	**698**	41.6	34.9	**76.6**	21.4	62.5	**83.9**	**160.5**
	East Arnhem	9	6	**15**	0	74	**74**	**89**	50.0	33.3	**83.3**	0.0	411.1	**411.1**	**494.4**
	Katherine	28	59	**87**	0	86	**86**	**173**	58.9	124.2	**183.2**	0.0	181.1	**181.1**	**364.2**
	All State (Transition Care)							**22**							
ACT	ACT	805	963	**1,768**	156	514	**670**	**2,438**	33.2	39.7	**72.9**	6.4	21.2	**27.6**	**100.6**
	All State (Transition Care)							**37**							

Total Operational Places by Service Type
- 30 June 2009

Mainstream Operational Places

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

State / Territory	High care	Low care	Total residential	Community care*	Total
NSW	30,990	29,407	**60,397**	13,567	**73,964**
VIC	21,440	24,432	**45,872**	10,135	**56,007**
QLD	14,582	16,779	**31,361**	6,972	**38,333**
SA	8,591	7,797	**16,388**	3,464	**19,852**
WA	6,574	7,849	**14,423**	3,927	**18,350**
TAS	2,366	2,170	**4,536**	1,029	**5,565**
NT	291	189	**480**	587	**1,067**
ACT	805	963	**1,768**	514	**2,282**
Australia	**85,639**	**89,586**	**175,225**	**40,195**	**215,420**

*These are Community Aged Care Packages which are counted as low care community care places.

Flexible Operational Places

National Aboriginal and Torres Strait Islander Aged Care Program Places

Not allocated under the *Aged Care Act 1997*

State / Territory	High care	Low care	Total residential	Community care*	Total
NSW	6	15	**21**	14	**35**
VIC	15	10	**25**	69	**94**
QLD	49	30	**79**	8	**87**
SA	81	38	**119**	45	**164**
WA	14	0	**14**	2	**16**
TAS	0	0	**0**	49	**49**
NT	50	86	**136**	72	**208**
ACT	0	0	**0**	0	**0**
Australia	**215**	**179**	**394**	**259**	**653**

*These are counted as low care community care places.

Multi-Purpose Service (MPS) Operational Places

Allocated under the *Aged Care Act 1997*

State / Territory	High care	Low care	Total residential	Community care*	Total
NSW	579	227	**806**	96	**902**
VIC	195	124	**319**	14	**333**
QLD	186	129	**315**	107	**422**
SA	311	210	**521**	14	**535**
WA	308	311	**619**	159	**778**
TAS	60	27	**87**	13	**100**
NT	4	0	**4**	2	**6**
ACT	0	0	**0**	0	**0**
Australia	**1,643**	**1,028**	**2,671**	**405**	**3,076**

*These are counted as low care community care places.

Total Operational Places by Service Type
- 30 June 2009

Extended Aged Care at Home (EACH) and EACH Dementia Operational Places

Allocated under the *Aged Care Act 1997*

State / Territory	EACH*	EACH Dementia*
NSW	1,432	675
VIC	1,120	497
QLD	697	351
SA	355	174
WA	557	194
TAS	123	70
NT	83	30
ACT	111	45
Australia	**4,478**	**2,036**

* EACH and EACH Dementia places are counted as high care community care places.

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

Transition Care (TC) Operational Places

Allocated under the *Aged Care Act 1997*

State / Territory	Total
NSW	772
VIC	570
QLD	389
SA	193
WA	178
TAS	67
NT	22
ACT	37
Australia	**2,228**

Innovative Care (IC) Operational Places

Allocated under the *Aged Care Act 1997*

State / Territory	High care	Low care	Total residential	Community care*	Total
NSW	0	58	**58**	25	**83**
VIC	9	3	**12**	0	**12**
QLD	0	0	**0**	0	**0**
SA	0	0	**0**	33	**33**
WA	12	0	**12**	0	**12**
TAS	0	7	**7**	0	**7**
NT	0	0	**0**	0	**0**
ACT	0	0	**0**	0	**0**
Australia	**21**	**68**	**89**	**58**	**147**

*These are counted as low care community care places.

Total Allocated Places by State/Territory

- 30 June 2009

State / Territory	Residential care			Community care			Total residential + community	Total transition care	Grand Total
	High care	Low care	Total residential	High care	Low care	Total community			
NSW	36,172	34,451	70,623	2,487	14,346	**16,833**	**87,456**	934	**88,390**
VIC	25,072	27,109	52,181	1,925	10,665	**12,590**	**64,771**	674	**65,445**
QLD	17,840	19,281	37,121	1,496	8,058	**9,554**	**46,675**	480	**47,155**
SA	9,515	8,486	18,001	593	3,657	**4,250**	**22,251**	231	**22,482**
WA	8,486	9,123	17,609	1,010	4,223	**5,233**	**22,842**	227	**23,069**
TAS	2,579	2,510	5,089	238	1,163	**1,401**	**6,490**	82	**6,572**
NT	378	307	685	138	715	**853**	**1,538**	29	**1,567**
ACT	1,146	1,311	2,457	196	604	**800**	**3,257**	41	**3,298**
Australia	**101,188**	**102,578**	**203,766**	**8,083**	**43,431**	**51,514**	**255,280**	**2,698**	**257,978**

Total Allocated Ratios by State/Territory

- 30 June 2009

State / Territory	Residential care			Community care			Total residential + community (Planning Ratio)	Total transition care	Grand Total
	High care	Low care	Total residential	High care	Low care	Total community			
NSW	51.6	49.1	**100.7**	3.5	20.4	**24.0**	**124.6**	1.3	**126.0**
VIC	47.7	51.6	**99.3**	3.7	20.3	**24.0**	**123.3**	1.3	**124.6**
QLD	47.5	51.3	**98.8**	4.0	21.5	**25.4**	**124.3**	1.3	**125.6**
SA	52.4	46.7	**99.1**	3.3	20.1	**23.4**	**122.5**	1.3	**123.8**
WA	45.8	49.2	**95.0**	5.5	22.8	**28.2**	**123.3**	1.2	**124.5**
TAS	48.1	46.8	**94.9**	4.4	21.7	**26.1**	**121.0**	1.5	**122.5**
NT	59.5	48.3	**107.8**	21.7	112.5	**134.2**	**242.1**	4.6	**246.6**
ACT	47.3	54.1	**101.4**	8.1	24.9	**33.0**	**134.4**	1.7	**136.1**
Australia	**49.3**	**49.9**	**99.2**	**3.9**	**21.1**	**25.1**	**124.3**	**1.3**	**125.6**

Notes:

Tables include flexible care places: Transition Care, Extended Aged Care at Home (EACH) and EACH Dementia, Multi-Purpose Services, Innovative Care and places under the National Aboriginal and Torres Strait Islander Flexible Program.

Multi-Purpose Services and Aboriginal and Torres Strait Islander places are notionally allocated as high care and low care residential care places and low care community care places.

Community care also includes Community Aged Care Packages (which are low care), EACH and EACH Dementia places (which are high care).

Total Allocated Places and Ratios at Aged Care Planning Region - 30 June 2009

State / Territory	Aged care planning region	Total Allocated Places							Total Allocated Ratios						
		Residential care			Community care			Total residential + community	Residential care			Community care			Total residential + community (Planning Ratio)
		High care	Low care	Total residential	High care	Low care	Total community		High care	Low care	Total residential	High care	Low care	Total community	
NSW	Central Coast	1,878	2,067	**3,945**	153	870	**1,023**	**4,968**	44.9	49.4	**94.3**	3.7	20.8	**24.5**	**118.8**
	Central West	824	973	**1,797**	79	392	**471**	**2,268**	43.2	51.0	**94.2**	4.1	20.5	**24.7**	**118.9**
	Far North Coast	1,752	2,012	**3,764**	120	766	**886**	**4,650**	45.0	51.7	**96.6**	3.1	19.7	**22.7**	**119.4**
	Hunter	3,074	3,330	**6,404**	231	1,335	**1,566**	**7,970**	46.9	50.8	**97.6**	3.5	20.3	**23.9**	**121.5**
	Illawarra	2,117	2,420	**4,537**	157	909	**1,066**	**5,603**	45.6	52.2	**97.8**	3.4	19.6	**23.0**	**120.8**
	Inner West	3,175	1,581	**4,756**	140	839	**979**	**5,735**	77.4	38.5	**115.9**	3.4	20.4	**23.9**	**139.8**
	Mid North Coast	1,859	2,449	**4,308**	172	891	**1,063**	**5,371**	41.6	54.8	**96.3**	3.8	19.9	**23.8**	**120.1**
	Nepean	1,291	779	**2,070**	86	445	**531**	**2,601**	57.9	34.9	**92.8**	3.9	20.0	**23.8**	**116.6**
	New England	868	1,051	**1,919**	85	416	**501**	**2,420**	42.7	51.7	**94.4**	4.2	20.5	**24.7**	**119.1**
	Northern Sydney	4,843	4,227	**9,070**	281	1,732	**2,013**	**11,083**	56.4	49.2	**105.6**	3.3	20.2	**23.4**	**129.0**
	Orana Far West	708	902	**1,610**	67	380	**447**	**2,057**	42.1	53.7	**95.8**	4.0	22.6	**26.6**	**122.4**
	Riverina/Murray	1,396	1,564	**2,960**	105	599	**704**	**3,664**	46.1	51.7	**97.8**	3.5	19.8	**23.3**	**121.1**
	South East Sydney	4,608	3,938	**8,546**	309	1,765	**2,074**	**10,620**	53.8	46.0	**99.7**	3.6	20.6	**24.2**	**123.9**
	South West Sydney	3,473	3,245	**6,718**	223	1,334	**1,557**	**8,275**	53.8	50.3	**104.1**	3.5	20.7	**24.1**	**128.2**
	Southern Highlands	1,111	1,365	**2,476**	85	486	**571**	**3,047**	47.0	57.7	**104.7**	3.6	20.5	**24.1**	**128.8**
	Western Sydney	3,195	2,548	**5,743**	194	1,187	**1,381**	**7,124**	58.6	46.8	**105.4**	3.6	21.8	**25.3**	**130.7**
	All State (Transition Care)							**934**							

Total Allocated Places and Ratios at Aged Care Planning Region - 30 June 2009

State / Territory	Aged care planning region	Total Allocated Places							Total Allocated Ratios						
		Residential care			Community care			Total residential + community	Residential care			Community care			Total residential + community (Planning Ratio)
		High care	Low care	Total residential	High care	Low care	Total community		High care	Low care	Total residential	High care	Low care	Total community	
VIC	Barwon-South Western	2,094	2,285	**4,379**	165	895	**1,060**	**5,439**	47.9	52.3	**100.1**	3.8	20.5	**24.2**	**124.4**
	Eastern Metro	4,776	5,607	**10,383**	348	2,090	**2,438**	**12,821**	45.1	53.0	**98.1**	3.3	19.7	**23.0**	**121.1**
	Gippsland	1,331	1,600	**2,931**	137	643	**780**	**3,711**	42.2	50.7	**92.9**	4.3	20.4	**24.7**	**117.6**
	Grampians	1,069	1,308	**2,377**	113	506	**619**	**2,996**	43.2	52.9	**96.1**	4.6	20.5	**25.0**	**121.1**
	Hume	1,393	1,583	**2,976**	132	583	**715**	**3,691**	46.9	53.3	**100.2**	4.4	19.6	**24.1**	**124.3**
	Loddon-Mallee	1,517	1,906	**3,423**	150	759	**909**	**4,332**	42.5	53.4	**95.9**	4.2	21.3	**25.5**	**121.4**
	Northern Metro	3,636	3,601	**7,237**	276	1,682	**1,958**	**9,195**	48.9	48.4	**97.3**	3.7	22.6	**26.3**	**123.7**
	Southern Metro	6,492	6,275	**12,767**	388	2,303	**2,691**	**15,458**	52.0	50.2	**102.2**	3.1	18.4	**21.5**	**123.7**
	Western Metro	2,764	2,944	**5,708**	216	1,204	**1,420**	**7,128**	50.4	53.7	**104.2**	3.9	22.0	**25.9**	**130.1**
	All State (Transition Care)							**674**							

Total Allocated Places and Ratios at Aged Care Planning Region - 30 June 2009

State / Territory	Aged care planning region	Total Allocated Places							Total Allocated Ratios						
		Residential care			Community care			Total residential + community	Residential care			Community care			Total residential + community (Planning Ratio)
		High care	Low care	Total residential	High care	Low care	Total community		High care	Low care	Total residential	High care	Low care	Total community	
QLD	Brisbane North	2,241	2,030	**4,271**	145	820	**965**	**5,236**	55.9	50.6	**106.5**	3.6	20.4	**24.1**	**130.5**
	Brisbane South	3,059	3,046	**6,105**	173	1,150	**1,323**	**7,428**	52.7	52.5	**105.2**	3.0	19.8	**22.8**	**128.0**
	Cabool	1,198	1,522	**2,720**	73	661	**734**	**3,454**	38.9	49.5	**88.4**	2.4	21.5	**23.9**	**112.3**
	Central West	68	54	**122**	9	64	**73**	**195**	65.8	52.3	**118.1**	8.7	62.0	**70.7**	**188.8**
	Darling Downs	1,156	1,220	**2,376**	95	446	**541**	**2,917**	45.1	47.6	**92.8**	3.7	17.4	**21.1**	**113.9**
	Far North	826	930	**1,756**	60	507	**567**	**2,323**	44.7	50.3	**95.0**	3.2	27.4	**30.7**	**125.6**
	Fitzroy	733	834	**1,567**	80	379	**459**	**2,026**	45.6	51.9	**97.6**	5.0	23.6	**28.6**	**126.2**
	Logan River Valley	965	1,035	**2,000**	75	362	**437**	**2,437**	53.0	56.8	**109.8**	4.1	19.9	**24.0**	**133.8**
	Mackay	437	435	**872**	40	201	**241**	**1,113**	43.7	43.5	**87.3**	4.0	20.1	**24.1**	**111.4**
	North West	49	80	**129**	4	126	**130**	**259**	35.9	58.6	**94.5**	2.9	92.3	**95.2**	**189.7**
	Northern	914	833	**1,747**	58	326	**384**	**2,131**	51.7	47.2	**98.9**	3.3	18.5	**21.7**	**120.6**
	South Coast	2,298	2,635	**4,933**	230	982	**1,212**	**6,145**	46.4	53.2	**99.7**	4.6	19.8	**24.5**	**124.2**
	South West	92	159	**251**	5	105	**110**	**361**	41.9	72.4	**114.4**	2.3	47.8	**50.1**	**164.5**
	Sunshine Coast	1,945	2,358	**4,303**	284	880	**1,164**	**5,467**	46.4	56.3	**102.7**	6.8	21.0	**27.8**	**130.5**
	West Moreton	603	725	**1,328**	55	427	**482**	**1,810**	40.8	49.1	**89.9**	3.7	28.9	**32.6**	**122.5**
	Wide Bay	1,256	1,385	**2,641**	110	622	**732**	**3,373**	42.1	46.4	**88.5**	3.7	20.8	**24.5**	**113.0**
	All State (Transition Care)							**480**							

Total Allocated Places and Ratios at Aged Care Planning Region - 30 June 2009

State / Territory	Aged care planning region	Total Allocated Places							Total Allocated Ratios						
		Residential care			Community care			Total residential + community	Residential care			Community care			Total residential + community (Planning Ratio)
		High care	Low care	Total residential	High care	Low care	Total community		High care	Low care	Total residential	High care	Low care	Total community	
SA	Eyre Peninsula	161	181	**342**	15	88	**103**	**445**	44.0	49.5	**93.4**	4.1	24.0	**28.1**	**121.6**
	Hills, Mallee & Southern	674	637	**1,311**	65	347	**412**	**1,723**	45.6	43.1	**88.8**	4.4	23.5	**27.9**	**116.7**
	Metropolitan East	1,841	1,659	**3,500**	71	524	**595**	**4,095**	63.5	57.2	**120.7**	2.4	18.1	**20.5**	**141.3**
	Metropolitan North	2,161	1,359	**3,520**	98	615	**713**	**4,233**	61.9	39.0	**100.9**	2.8	17.6	**20.4**	**121.3**
	Metropolitan South	2,089	1,786	**3,875**	142	832	**974**	**4,849**	53.3	45.6	**98.9**	3.6	21.2	**24.9**	**123.7**
	Metropolitan West	1,341	1,281	**2,622**	87	551	**638**	**3,260**	45.3	43.2	**88.5**	2.9	18.6	**21.5**	**110.0**
	Mid North	93	204	**297**	13	80	**93**	**390**	26.2	57.4	**83.6**	3.7	22.5	**26.2**	**109.7**
	Riverland	220	232	**452**	20	114	**134**	**586**	44.2	46.6	**90.8**	4.0	22.9	**26.9**	**117.7**
	South East	280	356	**636**	23	140	**163**	**799**	41.9	53.2	**95.1**	3.4	20.9	**24.4**	**119.5**
	Whyalla, Flinders & Far North	219	238	**457**	20	143	**163**	**620**	48.6	52.8	**101.4**	4.4	31.7	**36.1**	**137.5**
	Yorke, Lower North & Barossa	436	553	**989**	39	223	**262**	**1,251**	40.3	51.1	**91.4**	3.6	20.6	**24.2**	**115.6**
	All State (Transition Care)							**231**							

Total Allocated Places and Ratios at Aged Care Planning Region - 30 June 2009

State / Territory	Aged care planning region	Total Allocated Places							Total Allocated Ratios						
		Residential care			Community care			Total residential + community	Residential care			Community care			Total residential + community (Planning Ratio)
		High care	Low care	Total residential	High care	Low care	Total community		High care	Low care	Total residential	High care	Low care	Total community	
WA	Goldfields	140	127	**267**	22	67	**89**	**356**	52.5	47.7	**100.2**	8.3	25.1	**33.4**	**133.6**
	Great Southern	214	334	**548**	40	146	**186**	**734**	34.3	53.5	**87.8**	6.4	23.4	**29.8**	**117.6**
	Kimberley	68	98	**166**	7	78	**85**	**251**	69.4	100.0	**169.4**	7.1	79.6	**86.7**	**256.1**
	Metropolitan East	1,461	1,570	**3,031**	212	546	**758**	**3,789**	54.0	58.1	**112.1**	7.8	20.2	**28.0**	**140.2**
	Metropolitan North	2,021	2,420	**4,441**	223	1,047	**1,270**	**5,711**	41.6	49.9	**91.5**	4.6	21.6	**26.2**	**117.7**
	Metropolitan South East	1,767	1,544	**3,311**	172	588	**760**	**4,071**	58.8	51.4	**110.2**	5.7	19.6	**25.3**	**135.5**
	Metropolitan South West	1,760	1,825	**3,585**	215	1,055	**1,270**	**4,855**	40.8	42.3	**83.1**	5.0	24.5	**29.4**	**112.6**
	Mid West	160	198	**358**	17	172	**189**	**547**	31.3	38.7	**70.1**	3.3	33.7	**37.0**	**107.0**
	Pilbara	54	26	**80**	4	55	**59**	**139**	85.3	41.1	**126.4**	6.3	86.9	**93.2**	**219.6**
	South West	576	725	**1,301**	69	279	**348**	**1,649**	41.8	52.6	**94.3**	5.0	20.2	**25.2**	**119.6**
	Wheatbelt	265	256	**521**	29	190	**219**	**740**	37.4	36.2	**73.6**	4.1	26.8	**30.9**	**104.5**
	All State (Transition Care)							**227**							
TAS	North Western	514	555	**1,069**	33	253	**286**	**1,355**	41.0	44.3	**85.3**	2.6	20.2	**22.8**	**108.1**
	Northern	831	643	**1,474**	63	362	**425**	**1,899**	53.6	41.5	**95.1**	4.1	23.4	**27.4**	**122.5**
	Southern	1,234	1,312	**2,546**	142	548	**690**	**3,236**	48.2	51.3	**99.5**	5.5	21.4	**27.0**	**126.4**
	All State (Transition Care)							**82**							

Total Allocated Places and Ratios at Aged Care Planning Region - 30 June 2009

State / Territory	Aged care planning region	Total Allocated Places							Total Allocated Ratios						
		Residential care			Community care			Total residential + community	Residential care			Community care			Total residential + community (Planning Ratio)
		High care	Low care	Total residential	High care	Low care	Total community		High care	Low care	Total residential	High care	Low care	Total community	
NT	Alice Springs	110	56	**166**	23	204	**227**	**393**	93.9	47.8	**141.8**	19.6	174.2	**193.9**	**335.6**
	Barkly	17	2	**19**	0	42	**42**	**61**	95.5	11.2	**106.7**	0.0	236.0	**236.0**	**342.7**
	Darwin	214	184	**398**	100	287	**387**	**785**	49.2	42.3	**91.5**	23.0	66.0	**89.0**	**180.5**
	East Arnhem	9	6	**15**	0	90	**90**	**105**	50.0	33.3	**83.3**	0.0	500.0	**500.0**	**583.3**
	Katherine	28	59	**87**	15	92	**107**	**194**	58.9	124.2	**183.2**	31.6	193.7	**225.3**	**408.4**
	All State (Transition Care)							**29**							
ACT	ACT	1,146	1,311	**2,457**	196	604	**800**	**3,257**	47.3	54.1	**101.4**	8.1	24.9	**33.0**	**134.4**
	All State (Transition Care)							**41**							

Total Allocated Places by Service Type
- 30 June 2009

Mainstream Allocated Places

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

State / Territory	High care	Low care	Total residential	Community care*	Total
NSW	35,528	34,148	**69,676**	14,204	**83,880**
VIC	24,833	26,962	**51,795**	10,582	**62,377**
QLD	17,583	19,118	**36,701**	7,935	**44,636**
SA	9,123	8,238	**17,361**	3,565	**20,926**
WA	8,152	8,812	**16,964**	4,062	**21,026**
TAS	2,519	2,476	**4,995**	1,101	**6,096**
NT	324	221	**545**	641	**1,186**
ACT	1,146	1,311	**2,457**	604	**3,061**
Australia	**99,208**	**101,286**	**200,494**	**42,694**	**243,188**

*These are Community Aged Care Packages which are counted as low care community care places.

Flexible Allocated Places

National Aboriginal and Torres Strait Islander Aged Care Program Places

Not allocated under the *Aged Care Act 1997*

State / Territory	High care	Low care	Total residential	Community care*	Total
NSW	6	15	**21**	14	**35**
VIC	35	20	**55**	69	**124**
QLD	49	30	**79**	8	**87**
SA	81	38	**119**	45	**164**
WA	14	0	**14**	2	**16**
TAS	0	0	**0**	49	**49**
NT	50	86	**136**	72	**208**
ACT	0	0	**0**	0	**0**
Australia	**235**	**189**	**424**	**259**	**683**

*These are counted as low care community care places.

Multi-Purpose Service (MPS) Allocated Places

Allocated under the *Aged Care Act 1997*

State / Territory	High care	Low care	Total residential	Community care*	Total
NSW	638	230	**868**	103	**971**
VIC	195	124	**319**	14	**333**
QLD	208	133	**341**	115	**456**
SA	311	210	**521**	14	**535**
WA	308	311	**619**	159	**778**
TAS	60	27	**87**	13	**100**
NT	4	0	**4**	2	**6**
ACT	0	0	**0**	0	**0**
Australia	**1,724**	**1,035**	**2,759**	**420**	**3,179**

*These are counted as low care community care places.

Total Allocated Places by Service Type
- 30 June 2009

Extended Aged Care at Home (EACH) and EACH Dementia Allocated Places

Allocated under the *Aged Care Act 1997*

State / Territory	EACH*	EACH Dementia*
NSW	1,700	787
VIC	1,356	569
QLD	973	523
SA	399	194
WA	689	321
TAS	152	86
NT	100	38
ACT	146	50
Australia	**5,515**	**2,568**

* EACH and EACH Dementia places are counted as high care community care places.

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

Transition Care (TC) Allocated Places

Allocated under the *Aged Care Act 1997*

State / Territory	Total
NSW	934
VIC	674
QLD	480
SA	231
WA	227
TAS	82
NT	29
ACT	41
Australia	**2,698**

Innovative Care (IC) Allocated Places

Allocated under the *Aged Care Act 1997*

State / Territory	High care	Low care	Total residential	Community care*	Total
NSW	0	58	**58**	25	**83**
VIC	9	3	**12**	0	**12**
QLD	0	0	**0**	0	**0**
SA	0	0	**0**	33	**33**
WA	12	0	**12**	0	**12**
TAS	0	7	**7**	0	**7**
NT	0	0	**0**	0	**0**
ACT	0	0	**0**	0	**0**
Australia	**21**	**68**	**89**	**58**	**147**

*These are counted as low care community care places.

Comparison of Allocated and Operational Places and Ratios for Stocktakes June 2006 to June 2009

30 June 2006

State/ Territory	Allocated Places and Ratios								**Operational Places and Ratios**							
	Residential		Community		Transition care		Total		**Residential**		**Community**		Transition care		**Total**	
	Places	*Ratio*	Places	*Ratio*	Places	*Ratio*	Places	*Ratio*	**Places**	***Ratio***	**Places**	***Ratio***	Places	*Ratio*	**Places**	***Ratio***
NSW	65,408	*97.1*	13,120	*19.5*	550	*0.8*	79,078	*117.4*	56,690	*84.1*	12,935	*19.2*	304	*0.5*	**69,929**	***103.8***
Vic	48,675	*98.0*	9,997	*20.1*	376	*0.8*	59,048	*118.8*	42,759	*86.0*	9,957	*20.0*	42	*0.1*	**52,758**	***106.2***
Qld	33,106	*96.1*	6,554	*19.0*	273	*0.8*	39,933	*116.0*	29,453	*85.5*	6,510	*18.9*	84	*0.2*	**36,047**	***104.7***
SA	16,959	*97.4*	3,472	*19.9*	121	*0.7*	20,552	*118.0*	15,994	*91.8*	3,472	*19.9*	90	*0.5*	**19,556**	***112.3***
WA	16,165	*95.6*	3,485	*20.6*	100	*0.6*	19,750	*116.8*	14,318	*84.7*	3,347	*19.8*	50	*0.3*	**17,715**	***104.7***
Tas	4,832	*95.3*	1,078	*21.3*	52	*1.0*	5,962	*117.6*	4,440	*87.6*	1,043	*20.6*	15	*0.3*	**5,498**	***108.5***
NT	564	*109.6*	695	*135.1*	-	-	1,259	*244.8*	534	*103.8*	695	*135.1*	-	-	**1,229**	***238.9***
ACT	2,226	*99.9*	541	*24.3*	35	*1.6*	2,802	*125.7*	1,594	*71.5*	533	*23.9*	10	*0.4*	**2,137**	***95.9***
Australia	187,935	*97.0*	38,942	*20.1*	1,507	*0.8*	228,384	*117.9*	**165,782**	***85.6***	**38,492**	***19.9***	**595**	***0.3***	**204,869**	***105.8***

30 June 2007

State/ Territory	Allocated Places and Ratios								**Operational Places and Ratios**							
	Residential		Community		Transition care		Total		**Residential**		**Community**		Transition care		**Total**	
	Places	*Ratio*	Places	*Ratio*	Places	*Ratio*	Places	*Ratio*	**Places**	***Ratio***	**Places**	***Ratio***	Places	*Ratio*	**Places**	***Ratio***
NSW	66,590	*99.1*	14,243	*21.2*	703	*1.0*	81,536	*121.4*	58,073	*86.4*	14,219	*21.2*	571	*0.8*	**72,863**	***108.5***
Vic	49,611	*99.1*	10,858	*21.7*	502	*1.0*	60,971	*121.8*	43,747	*87.4*	10,768	*21.5*	424	*0.8*	**54,939**	***109.8***
Qld	34,083	*96.4*	7,399	*20.9*	351	*1.0*	41,833	*118.4*	30,288	*85.7*	7,365	*20.8*	257	*0.7*	**37,910**	***107.3***
SA	17,252	*98.6*	3,753	*21.4*	176	*1.0*	21,181	*121.0*	16,352	*93.4*	3,748	*21.4*	147	*0.8*	**20,247**	***115.7***
WA	16,752	*96.8*	3,800	*22.0*	160	*0.9*	20,712	*119.7*	14,504	*83.8*	3,743	*21.6*	100	*0.6*	**18,347**	***106.0***
Tas	4,930	*96.0*	1,153	*22.4*	57	*1.1*	6,140	*119.5*	4,441	*86.4*	1,136	*22.1*	52	*1.0*	**5,629**	***109.6***
NT	592	*103.9*	731	*128.3*	16	*2.8*	1,339	*235.0*	553	*97.0*	731	*128.3*	8	*1.4*	**1,292**	***226.7***
ACT	2,395	*106.1*	606	*26.8*	35	*1.6*	3,036	*134.5*	1,636	*72.5*	606	*26.8*	35	*1.6*	**2,277**	***100.9***
Australia	192,205	*98.4*	42,543	*21.8*	2,000	*1.0*	236,748	*121.2*	**169,594**	***86.8***	**42,316**	***21.7***	**1,594**	***0.8***	**213,504**	***109.3***

Comparison of Allocated and Operational Places and Ratios for Stocktakes June 2006 to June 2009

30 June 2008

State/ Territory	Allocated Places and Ratios								**Operational Places and Ratios**							
	Residential		Community		Transition care		Total		**Residential**		**Community**		Transition care		**Total**	
	Places	*Ratio*	Places	*Ratio*	Places	*Ratio*	Places	*Ratio*	**Places**	***Ratio***	**Places**	***Ratio***	Places	*Ratio*	**Places**	***Ratio***
NSW	68,568	*99.9*	15,696	*22.9*	772	*1.1*	85,036	*124.0*	59,798	*87.2*	15,663	*22.8*	674	*1.0*	**76,135**	***111.0***
Vic	50,981	*99.5*	11,821	*23.1*	570	*1.1*	63,372	*123.6*	45,114	*88.0*	11,806	*23.0*	502	*1.0*	**57,422**	***112.0***
Qld	35,668	*98.0*	8,131	*22.3*	389	*1.1*	44,188	*121.4*	31,067	*85.4*	8,066	*22.2*	343	*0.9*	**39,476**	***108.5***
SA	17,940	*100.9*	4,097	*23.1*	193	*1.1*	22,230	*125.1*	16,924	*95.2*	4,077	*22.9*	176	*1.0*	**21,177**	***119.1***
WA	17,315	*97.0*	4,197	*23.5*	178	*1.0*	21,690	*121.5*	14,895	*83.4*	4,177	*23.4*	160	*0.9*	**19,232**	***107.7***
Tas	4,876	*93.1*	1,259	*24.0*	67	*1.3*	6,202	*118.4*	4,501	*85.9*	1,243	*23.7*	57	*1.1*	**5,801**	***110.7***
NT	677	*111.4*	774	*127.4*	22	*3.6*	1,473	*242.4*	577	*95.0*	774	*127.4*	16	*2.6*	**1,367**	***225.0***
ACT	2,473	*105.9*	670	*28.7*	37	*1.6*	3,180	*136.2*	1,793	*76.8*	669	*28.6*	35	*1.5*	**2,497**	***106.9***
Australia	198,498	*99.2*	46,645	*23.3*	2,228	*1.1*	247,371	*123.6*	**174,669**	***87.3***	**46,475**	***23.2***	**1,963**	***1.0***	**223,107**	***111.5***

30 June 2009

State/ Territory	Allocated Places and Ratios								**Operational Places and Ratios**							
	Residential		Community		Transition care		Total		**Residential**		**Community**		Transition care		**Total**	
	Places	*Ratio*	Places	*Ratio*	Places	*Ratio*	Places	*Ratio*	**Places**	***Ratio***	**Places**	***Ratio***	Places	*Ratio*	**Places**	***Ratio***
NSW	70,623	*100.7*	16,833	*24.0*	934	*1.3*	88,390	*126.0*	61,282	*87.3*	15,809	*22.5*	772	*1.1*	**77,863**	***111.0***
Vic	52,181	*99.3*	12,590	*24.0*	674	*1.3*	65,445	*124.6*	46,228	*88.0*	11,835	*22.5*	570	*1.1*	**58,633**	***111.6***
Qld	37,121	*98.8*	9,554	*25.4*	480	*1.3*	47,155	*125.6*	31,755	*84.6*	8,135	*21.7*	389	*1.0*	**40,279**	***107.3***
SA	18,001	*99.1*	4,250	*23.4*	231	*1.3*	22,482	*123.8*	17,028	*93.7*	4,085	*22.5*	193	*1.1*	**21,306**	***117.3***
WA	17,609	*95.0*	5,233	*28.2*	227	*1.2*	23,069	*124.5*	15,068	*81.3*	4,839	*26.1*	178	*1.0*	**20,085**	***108.4***
Tas	5,089	*94.9*	1,401	*26.1*	82	*1.5*	6,572	*122.5*	4,630	*86.3*	1,284	*23.9*	67	*1.2*	**5,981**	***111.5***
NT	685	*107.8*	853	*134.2*	29	*4.6*	1,567	*246.6*	620	*97.6*	774	*121.8*	22	*3.5*	**1,416**	***222.9***
ACT	2,457	*101.4*	800	*33.0*	41	*1.7*	3,298	*136.1*	1,768	*72.9*	670	*27.6*	37	*1.5*	**2,475**	***102.1***
Australia	203,766	*99.2*	51,514	*25.1*	2,698	*1.3*	257,978	*125.6*	**178,379**	***86.9***	**47,431**	***23.1***	**2,228**	***1.1***	**228,038**	***111.0***

Total Offline Places by State/Territory

- 30 June 2009

State / Territory	High care	Low care	Total residential	Total community	Total residential + community	% of Total
NSW	756	837	1,593	0	1,593	34.8%
VIC	580	1,057	1,637	0	1,637	35.7%
QLD	391	113	504	0	504	11.0%
SA	111	9	120	0	120	2.6%
WA	345	247	592	0	592	12.9%
TAS	0	136	136	0	136	3.0%
NT	0	0	0	0	0	0.0%
ACT	0	0	0	0	0	0.0%
Australia	**2,183**	**2,399**	**4,582**	**0**	**4,582**	**100.0%**

Notes:

Tables include flexible care places: Transition Care, Extended Aged Care at Home (EACH) and EACH Dementia, Multi-Purpose Services, Innovative Care and places under the National Aboriginal and Torres Strait Islander Flexible Program.

Multi-Purpose Services and Aboriginal and Torres Strait Islander places are notionally allocated as high care and low care residential care places and low care community care places.

Community care also includes Community Aged Care Packages (which are low care), EACH and EACH Dementia places (which are high care).

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-032

OUTCOME 4: Aged Care and Population Ageing

Topic: RESPITE CARE

Written Question on Notice

Senator Williams asked:

If someone is in respite care in a nursing home and they have to spend a few days in hospital, the bed funding for that person ceases until they return, but no-one else can use that bed. One aged facility tells me it costs them about $100 a day.

a) Are nursing homes funded for patients in respite care?

b) If the patient has to be taken to hospital for say three days, does the nursing home continue to be funded for that bed during that person's time in hospital?

c) If not, why not?

d) Does the department see it as an anomaly in funding?

Answer:

a) Yes.

b) No.

c) A Service will not be paid for any form of leave for a respite care recipient, including all leave where the recipient enters hospital. The service may offer the bed to another person for those days while the recipient is in hospital.

d) No. As the facility does not have a recipient in care, there should be no additional expenses while that recipient is in hospital.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-143

OUTCOME 4: Aged Care and Population Ageing

Topic: AGED CARE ASSESSMENT TEAMS (ACAT)

Written Question on Notice

Senator Adams asked:

What is the average waiting time for an ACAT assessment?

Answer:

For the period 1 July 2007 – 30 June 2008, the average time from when a person's referral is accepted by the Aged Care Assessment Team (ACAT), and when the ACAT has the first face to face contact with the person, for Australia as a whole was 22.2 days.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-162

OUTCOME 4: Aged Care and Population Ageing

Topic: HOME AND COMMUNITY CARE (HACC) FUNDING RECIPIENTS

Written Question on Notice

Senator Adams asked:

When will the government provide a full list of HACC funding recipients?

Answer:

State and territory governments provide an update of HACC project information to the Australian Government each financial year, including service provider contact details. However, in order to make this list publicly available, each state and territory would need to agree to the release of the information, taking into account any jurisdictional-specific privacy requirements within service provider contracts.

This request should be directed to state and territory governments for consideration in their capacity as contract managers with HACC service providers.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-171

OUTCOME 4: Aged Care and Population Ageing

Topic: COMMUNITY AGED CARE PACKAGES (CACP)

Written Question on Notice

Senator Adams asked:

a) Is the Department aware of instances where families of CACP recipients have had responsibility for case management?

b) If so, how many?

Answer:

a) No. CACP providers remain responsible and accountable for all care and services delivered under a CACP at all times, including with respect to case management.

   Notwithstanding this, it is possible for care recipients and/or their representative(s) to take an active role in the administration of care delivered under their package, at the agreement of the CACP provider. The Department is aware of organisations trialling models of consumer directed care.

b) Not applicable.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-214

OUTCOME 4: Aged Care and Population Ageing

Topic: CONTINENCE AIDS PAYMENT SCHEME

Hansard Page: CA 41

Senator Fifield asked:

People can get four free deliveries a year, and they will not be able to in the future/

a) What is the cost of these deliveries each year?

b) Whether they are delivered by postage or freight, what is the cost to the Commonwealth? It will not give us a perfect indication of how much additional money clients will be up for, but it will give us some sort of indication.

Answer:

a) The cost of deliveries for the 2008-09 financial year was $2,567,837.00.

b) Delivery costs (freight and/or postage) for the 2008-09 financial year were $2,567,837.00.

Postage costs – including letters to clients and distribution of the product is included in administrative costs.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-020

OUTCOME 4: Aged Care and Population Ageing

Topic: INQUIRY INTO AGED CARE

Written Question on Notice

Senator Xenophon asked:

What plans does the government have in response to Senate Finance and Public Administration Committee inquiry earlier this year, to conduct benchmarking to better understand the relationship between subsidy allocation and indexation in aged care?

Answer:

The Government is currently considering the Inquiry's recommendations and will respond in due course.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-025

OUTCOME 4: Aged Care and Population Ageing

Topic: AGED CARE FACILITIES

Written Question on Notice

Senator Williams asked:

a) How many aged care facilities opened in the 12 months to the end of June?

b) How many beds were provided?

Answer:

a and b)

In the period 1 July 2008 to 30 June 2009 a total of 32 residential aged care services commenced operation. A total of 2,695 residential aged care places were provided as a result.

Please note this last figure does not include new places provided through the expansion of existing homes.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-026

OUTCOME 4: Aged Care and Population Ageing

Topic: HOMES UNDER CONSTRUCTION

Written Question on Notice

Senator Williams asked:

How many aged care facilities are under construction?

Answer:

The Department's annual Survey of Aged Care Homes collects, *inter alia*, data on new building work, rebuilding work and upgrading work that has been completed during the year or is in progress at the end of the year. Information on planned building work is also collected.

The 2008-09 survey had a 96.1% response rate with 2,682 of 2,791 aged care homes submitting a response. Responses are weighted to estimate figures for the entire residential aged care sector.

Based on analysis of the 2008-09 survey data, the Department estimates that 675 aged care homes were either undertaking or had completed some form of building work during 2008-09. Table 1 provides further information. In addition, an estimated 89 aged care homes had undertaken significant preparatory planning activity for new building work to commence in the future.

Table 1: Estimated number of aged care homes undertaking building work, 2008-09

	Homes that completed building work	Homes with building work in progress
New building work [(a)]	87	686
Rebuilding work [(b)]	22	33
Upgrading work [(c)]	367	190
Any building work [(d)]	**469**	**282**

Notes to Table

(a) New building work is defined as the construction of a completely new service, and does not include extensions to an existing building.

(b) A rebuild is the demolition of an entire service and its reconstruction on the same site.

(c) An upgrade is the renovation or refurbishment of an existing service, including extensions to an existing building or reconstruction of part of a building.

(d) The total numbers of homes undertaking building work is not the sum of the number of homes with building work completed or in progress as homes can be undertaking both rebuilding and upgrading work.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-029

OUTCOME 4: Aged Care and Population Ageing

Topic: COMMUNITY CARE PACKAGES

Written Question on Notice

Senator Williams asked:

a) Regarding Community Care Packages - equity and access - kilometres become a high cost when providing services to clients rurally. At present Community Care is paying for 18500 kilometres per month to service 135 current clients. Why is there no reimbursement for these kilometres?

b) Is there a review of viability supplement as there is no difference in daily subsidy between Metro and Country/rural clients?

Answer:

a) When applying for Community Care places through an Aged Care Approvals Round, approved providers nominate the aged care planning region and local government areas in which they plan to deliver services. Approved providers would be aware of the costs of providing services in the region/s they have nominated and should have factored them into their bids.

b) The community care viability supplement for providers in rural and remote areas, introduced in 2007, does effectively enable a higher subsidy in rural areas. Eligibility and the amount of supplement are determined by the remoteness of the location as defined by the Accessibility - Remoteness Index of Australia score of a care recipient's location. Community care service providers receive a daily supplement for each care recipient living in an eligible location.

There is no specific review of the viability supplement underway.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-047

OUTCOME 4: Aged Care and Population Ageing

Topic: ADDITIONAL INTEREST CHARGED TO RESIDENTS

Written Question on Notice

Senator Siewert asked:

a) Is the department aware of some providers charging additional interest charges for any arrears in interest payments?

b) Does the department know how many residents have had to leave residential care because they couldn't afford to pay the interest on their assessed bond?

Answer:

a) The *Aged Care Act 1997* and Principles include a specific formula for calculating interest payments in relation to accommodation bonds. This formula is based on simple interest for a defined period of time and does not provide for compound interest to be charged.

b) There is a range of protections in place to ensure that residents are not denied care because of their inability to pay. These include hardship provisions to assist residents facing genuine hardship in paying their fees, together with other protections to ensure residents are not asked to pay a bond they cannot afford and that they are left with at least a certain level of assets after paying a bond. There are also strong security of tenure provisions.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-105

OUTCOME 4: Aged Care and Population Ageing

Topic: AGED CARE IN WA

Written Question on Notice

Senator Adams asked:

How does the Department of Health and Ageing propose to address the serious capital funding shortfall where land and building costs far exceed capital funding allowances made through accommodation bonds, charges and zero interest loans that simply do match reality in WA?

Answer:

The Australian Bureau of Statistics compiles statistics on building activity in aged care - *Building Activity, Australia* (ABS Cat no. 8752.0). These statistics provide an independent measure of the willingness of aged care providers to invest in the residential aged care industry under the current funding arrangements.

The following data details the value of building work commenced in the residential aged care sector in Western Australia annually since 2001-02

2001-02	*2002-03*	*2003-04*	*2004-05*	*2005-06*	*2006-07*	*2007-08*	*2008-09*
$30.133m	$60.156m	$86.325m	$31.995m	$92.518m	$101.669m	$99.818m	$99.769m

The data indicates that the level of building commencements in the residential aged care sector in Western Australia continues to be at or above historical levels.

Question: E09-131

OUTCOME 4: Aged Care and Population Ageing

Topic: ELECTION COMMITMENTS

Written Question on Notice

Senator Adams asked:

a) What is the status of each election commitment within the Ageing portfolio?

b) Which election commitments are experiencing slippages?

c) Why?

d) Where relevant, what are the revised implementation dates?

e) What are the implications of this slippage?

Answer:

a) There were nine election commitments relating to ageing and aged care:
   1. New Directions for Older Australians – Improving the transition between hospital and aged care (implemented)
   2. New Directions for Older Australians – Review of the aged care planning ratios (work in progress)
   3. New Directions for Older Australians – Making the bed allocation process more efficient (work in progress)
   4. New Directions for Older Australians – Low interest loans for new residential aged care beds in areas of need (implemented)
   5. National Elderly Commissioner – Ambassador for Ageing (implemented)
   6. Ministerial Council on Ageing (implemented)
   7. Cabanda High Care Development (implemented)
   8. Disability and Carers (work in progress)
   9. Increasing the number of nurses and personal care workers in aged care (implemented)

b) Not applicable.

c) Not applicable.

d) Not applicable.

e) Not applicable.

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-139

OUTCOME 4: Aged Care and Population Ageing

Topic: AGED CARE

Written Question on Notice

Senator Adams asked:

Smaller rural communities across Australia have a lower income generation capacity than city counterparts and the demands placed on providers of Aged Care Services in the rural and remote Australia are unique. How is it with a Budget outlay nearing $11 billion for Aged Care that there is only $30 million provision for regional and remote viability supplements?

Answer:

The viability supplement is paid under the *Aged Care Act 1997* (the Act) to eligible providers of residential and community care in rural and remote areas to address some of the additional costs of delivering care in those locations.

In the 2009 Budget, the Rudd Government provided an additional $14.8 million to increase the rates of the Commonwealth viability supplement paid to rural and remote residential care providers, commencing from 1 January 2010, by more than 40 per cent.

The Commonwealth also pays several other supplements under the Act to address issues of financial incapacity, including the accommodation supplement, which is payable in respect of residents with lower levels of assets, and the hardship supplement, which is payable in respect of residents who are experiencing difficulties in paying their aged care fees.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-140

OUTCOME 4: Aged Care and Population Ageing

Topic: BED LICENCES

Written Question on Notice

Senator Adams asked:

a) How many bed licences have been handed back since 1 March 2009?

b) Can you please provide a breakdown by planning region of where these bed licences have been handed back?

c) When a bed licence is handed back, does that bed licence become available to other aged care providers from within the same aged care planning region?

Answer:

a) From 1 March to 21 October 2009, 21 operational residential places were relinquished and 103 provisionally allocated residential places surrendered.

b) The 21 operational residential places relinquished were in the Australian Capital Territory (which is itself an aged care planning region). The 103 provisionally allocated residential places surrendered were as follows:
   - 20 from the Northern Sydney planning region in NSW;
   - 73 from the Illawarra planning region in NSW; and
   - 10 from the Southern Metro planning region in Victoria.

c) When residential aged care places are returned they are taken into consideration in determining the number of new places to be released by aged care planning regions in future Aged Care Approvals Rounds.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-141

OUTCOME 4: Aged Care and Population Ageing

Topic: AGED CARE

Written Question on Notice

Senator Adams asked:

Does the Department believe that the current financial constraints are restricting providers' ability to expand infrastructure and increase their capacity to meet the needs of an ageing population?

Answer:

The Department's annual Survey of Aged Care Homes collects, *inter alia*, data on building work that has been completed during the year or is in progress at the end of the year. Information on the number of aged care places covered by this building work is also collected.

The 2008-09 survey had a 96.1% response rate with 2,682 of 2,791 aged care homes submitting a response. Responses are weighted to estimate figures for the entire residential aged care sector.

The following table provides the Department's estimates for the number of aged care places covered by building work completed by the residential aged care sector between 2002-03 and 2008-09.

2002-03	*2003-04*	*2004-05*	*2005-06*	*2006-07*	*2007-08*	*2008-09*
5,113	3,301	5,703	5,322	4,938	6,835	7,085

The data show that the number of aged care places covered by the building work completed by the aged care sector in the last two years was significantly higher than in the previous five years.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-142

OUTCOME 4: Aged Care and Population Ageing

Topic: AGED CARE APPROVALS ROUND

Written Question on Notice

Senator Adams asked:

Does the Department have confidence that the Aged Care Approvals are meeting the aged care needs of the future?

Answer:

In 2009, the Australian National Audit Office conducted a performance audit of the Planning and Allocating Aged Care Places and Capital Grants (Audit Report No.40 2008–09). The report found that, 'the planning and allocation of aged care places is a mature process and, overall, [the Department of Health and Ageing] has adopted an appropriate approach to its planning, implementation and reporting against government targets. It has effectively managed the planning and allocation of aged care places and capital grants, in accordance with the *Aged Care Act 1997*.'

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-146

OUTCOME 4: Aged Care and Population Ageing

Topic: EXTENDED AGED CARE AT HOME DEMENTIA (EACH D) PACKAGES

Written Question on Notice

Senator Adams asked:

What was the total number of Australians assessed to be in need of an EACH D package in 2008-09?

Answer:

In 2008-09, Aged Care Assessment Teams approved 915 people to receive an EACH D package.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-147

OUTCOME 4: Aged Care and Population Ageing

Topic: EXTENDED AGED CARE AT HOME DEMENTIA (EACH D)

Written Question on Notice

Senator Adams asked:

a) Can the Department provide the total number of EACH D packages delivered to regional and rural Australia in 2008-09?

b) Did the total number of EACH D packages meet the needs of regional and rural Australia?

Answer:

a) In June 2009, the total number of operational EACH D packages delivered by services operating outside major cities was 635.

b) In June 2009, there were 0.9 operational EACH D packages for every 1000 people aged at least 70 living outside major cities, which was broadly comparable with the national figure of 1.0 operational EACH D packages for every 1000 people aged at least 70.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-148

OUTCOME 4: Aged Care and Population Ageing

Topic: EXTENDED AGED CARE AT HOME DEMENTIA (EACH D)

Written Question on Notice

Senator Adams asked:

If no EACH D package is available for a person assessed as being in need of such a package, what care options are then available?

Answer:

New arrangements introduced on 1 January 2009, enable a person approved to receive an EACHD to also be eligible to receive Extended Aged Care at Home or Community Aged Care Packages. The person may also access Home and Community Care services.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-149

OUTCOME 4: Aged Care and Population Ageing

Topic: EXTENDED AGED CARE AT HOME DEMENTIA (EACH D)

Written Question on Notice

Senator Adams asked:

a) Is the Department aware of any persons assessed as needing an EACH D package that have been allocated a package providing lesser care due to an inadequate number of EACH D packages?

b) If so, how many?

Answer:

a) The Department is not aware of individual cases where people assessed as eligible for high care are accessing a lower level of care package; however this is possible under the new arrangements introduced on 1 January 2009. Under the new arrangements a person approved to receive EACH D will also be eligible to access Extended Aged Care at Home (EACH) and Community Aged Care Packages. The changes to eligibility for EACH D and EACH approval mean that approvals in a community setting will now align with approvals in a residential care setting.

b) Because a care recipient may be approved for multiple types and levels of care, it is not possible to determine the number of clients as per request.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-150

OUTCOME 4: Aged Care and Population Ageing

Topic: EXTENDED AGED CARE AT HOME DEMENTIA (EACH D)

Written Question on Notice

Senator Adams asked:

How much funding was allocated to the delivery of EACH D packages in the 2008-09 Budget

Answer:

Funding for EACH D packages is appropriated from the Commonwealth's Consolidated Revenue Fund by the standing appropriation of the *Aged Care Act 1997* (the *Act*) (s.96-10).

In 2008-09, some $83.606 million was appropriated by the *Act* for EACH D packages.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-151

OUTCOME 4: Aged Care and Population Ageing

Topic: COMMUNITY AGED CARE PACKAGES (CACP)

Written Question on Notice

Senator Adams asked:

a) How much funding was allocated to CACP in the 2008-09 Budget?

b) How much money has the Government saved by delivering CACPs to those assessed as needing an EACH D package?

Answer:

a) Funding for Community Aged Care Packages is appropriated from the Commonwealth's Consolidated Revenue Fund by the standing appropriation of the *Aged Care Act 1997* (s.96-10).

In 2008-09, some $479.718 million was appropriated by the *Aged Care Act 1997* for Community Aged Care Packages.

b) Under the *Approval of Care Recipients Principles 1997*, an Aged Care Assessment Team can only approve a person for a Community Aged Care Package if, *inter alia*, the person is able to remain living at home with the assistance of the Community Aged Care Package.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-152

OUTCOME 4: Aged Care and Population Ageing

Topic: COMMUNITY CARE

Written Question on Notice

Senator Adams asked:

a) What is the average number of hours of assistance provided through a Community Aged Care Packages (CACP), Extended Aged Care at Home (EACH) and Extended Aged Care at Home Dementia (EACH D) package respectively?

b) Has the average number of hours increased or decreased over the past five years?

c) What reasons can the Department provide for the decrease?

d) Does the Department believe that the decrease in the average number of hours is at least partly due to the failure of the indexation to reflect the true costs of delivering care at home?

Answer:

a) The amount of assistance provided to care recipients can vary considerably depending on their care needs. Also, not all services are measured in terms of hours of assistance such as meal delivery and formal linen services.

The amount of assistance provided per week in the CACP, EACH and EACHD programs are ascertained through conducting a census of community care providers. There have been two community care censuses. These were conducted in:

- 2002, the results of which can be found at http://www.aihw.gov.au/publications/index.cfm/title/10003 and http://www.aihw.gov.au/publications/index.cfm/title/9852 ; and
- 2008, the results of which are not yet finalised.

b) The results from the 2008 census of community care providers are not yet final. This question can not be answered until this occurs.

c) See answer to question b).

d) See answer to question b).

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-157

OUTCOME 4: Aged Care and Population Ageing

Topic: AGED CARE IN WA

Written Question on Notice

Senator Adams asked:

How is the Aged Care Industry going to be sustainable with forward estimates showing indexation at only 1.9%?

Answer:

Analysis by the Department of Health and Ageing shows that, taking into account improvements in productivity and controlling for changes in the frailty of people receiving care, growth in revenue per resident per day has outstripped growth in the costs of delivering care over the last ten years.

The Department's analysis was provided in its Supplementary Submission to the Senate Finance and Public Administration Committee's Inquiry into residential and community aged care in Australia, which can be found at:
http://www.aph.gov.au/Senate/committee/fapa_ctte/aged_care/submissions/sub114a.pdf

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October & 23 October 2009

Question: E09-158

OUTCOME 4: Aged Care and Population Ageing

Topic: AGED CARE FACILITIES

Written Question on Notice

Senator Adams asked:

a) How many aged care facilities have closed in 2009?

b) Can you provide the location of each of these closures.

Answer:

a and b)

From 1 January 2009 to 31 October 2009, 37 residential aged care services closed. The distribution of these by state is shown in the table below.

State/Territory	Residential services
NSW	14
Vic	10
Qld	2
WA	2
SA	6
Tas	2
ACT	0
NT	1
Total	**37**

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-159

OUTCOME 4: Aged Care and Population Ageing

Topic: CORRESPONDENCE FROM FACILITIES

Written Question on Notice

Senator Adams asked:

a) Has the Department received correspondence from providers expressing a view that without reform their facility risks closure?

b) If so, how many?

Answer:

a) The Department receives a significant amount of correspondence from aged care providers each year. It is not possible to determine whether any of that correspondence has expressed the view that without reform a provider's facility risks closure without re-examining all of that correspondence, which is held on paper files in the Central and state/territory offices of the Department as well in the Department's file archives.

b) See a) above.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-160

OUTCOME 4: Aged Care and Population Ageing

Topic: VACANCY RATES

Written Question on Notice

Senator Adams asked:

a) What is the current national vacancy rate for both high and low care beds?

b) Could you please provide a break down of vacancy rates by aged care planning region?

Answer:

a) It is not possible to calculate separate vacancy rates for high and low level residential aged care places because of the policy of ageing-in-place, which allows a resident to continue to receive subsidised care in that place even if their care needs increased to high level care.

   In June 2009, the average national vacancy rate for all residential aged care places was 7.4 per cent.

b) Vacancy rates in June 2009 for each aged care planning region are provided in Table 1.

Table 1: Vacancy rates by Aged Care Planning Region, 2008-09

STATE	REGION	VACANCY RATE
NSW	Central Coast	6.41%
	Central West	5.11%
	Far North Coast	7.84%
	Hunter	3.57%
	Illawarra	10.03%
	Inner West	9.01%
	Mid North Coast	8.52%
	Nepean	3.98%
	New England	6.06%
	Northern Sydney	6.75%
	Orana Far West	5.89%
	Riverina/Murray	5.77%
	South East Sydney	9.06%
	South West Sydney	8.13%
	Southern Highlands	13.45%
	Western Sydney	9.07%
VIC	Barwon-South Western	7.32%
	Eastern Metro	8.66%
	Gippsland	6.41%
	Grampians	6.06%
	Hume	3.23%
	Loddon-Mallee	5.31%
	Northern Metro	8.86%
	Southern Metro	9.73%
	Western Metro	10.69%
QLD	Brisbane North	7.95%
	Brisbane South	7.20%
	Cabool	6.67%
	Central West	35.00%
	Darling Downs	6.39%
	Far North	5.97%
	Fitzroy	11.35%
	Logan River Valley	7.08%
	Mackay	1.25%
	North West	22.60%
	Northern	11.39%
	South Coast	12.67%
	South West	11.47%
	Sunshine Coast	7.82%
	West Moreton	8.59%
	Wide Bay	6.26%
SA	Eyre Peninsula	2.61%
	Hills, Mallee & Southern	3.46%
	Metropolitan East	4.01%
	Metropolitan North	4.85%
	Metropolitan South	3.69%
	Metropolitan West	2.15%
	Mid North	6.51%
	Riverland	3.13%
	South East	4.14%
	Whyalla, Flinders & Far North	2.09%
	Yorke, Lower North & Barossa	4.41%
WA	Goldfields	8.29%
	Great Southern	9.04%
	Kimberley	20.84%
	Metropolitan East	5.36%
	Metropolitan North	6.61%
	Metropolitan South East	6.33%
	Metropolitan South West	4.56%
	Mid West	1.87%
	Pilbara	5.54%
	South West	6.28%
	Wheatbelt	7.86%
TAS	North Western	13.11%
	Northern	7.29%
	Southern	5.68%
NT	Alice Springs	8.13%
	Barkly	2.98%
	Darwin	19.86%
	Katherine	9.65%
ACT	ACT	6.15%

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-161

OUTCOME 4: Aged Care and Population Ageing

Topic: LOW CARE AND HIGH CARE PLACES

Written Question on Notice

Senator Adams asked:

How many older Australians are waiting for access to low care and high care places in rural and regional aged care facilities?

Answer:

It is not possible for the Department to determine how many people are waiting for an aged care place at any given time.

The Department collects information on how many people receive approval to enter residential care from an Aged Care Assessment Teams (ACAT). However, some people decide not to enter care after seeking an ACAT assessment, and many people take time to visit different aged care homes and arrange their affairs before moving into their preferred aged care home.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-163

OUTCOME 4: Aged Care and Population Ageing

Topic: AGED CARE

Written Question on Notice

Senator Adams asked:

a) What does the Department identify as the most challenging issues facing aged care?

b) Does the Department regularly brief the Minister on the identified challenging issues?

Answer:

a) The Department notes that the National Health and Hospitals Reform Commission identified three key challenges for the future of aged care:
   - the ageing population;
   - their increasingly complex care needs; and
   - creating more choices in aged care to meet this need.

b) The Department of Health and Ageing regularly briefs the Minister for Ageing on the issues raised and faced by care recipients and aged care providers.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-166

OUTCOME 4: Aged Care and Population Ageing

Topic: GENERAL PURPOSE FINANCIAL REPORTS

Written Question on Notice

Senator Adams asked:

a) In a letter from Minister Elliot to Minister Ludwig – dated 17 September 2009 – Minister Elliot advised that the 2007-08 General Purpose Financial Reports of aged care providers was incomplete due to a number of providers seeking extensions to submit their reports. How many aged care providers has the Government granted extensions to?

b) On what grounds were providers granted extensions?

c) How long were the extensions for?

Answer:

a) 120 approved providers were granted extensions with respect to the submission of their 2007-08 general purpose financial reports.

b) Extensions were granted where approved providers demonstrated reasonable grounds for a delay in the completion of their financial reports, such as a particular difficulty in finalising their accounts or an unanticipated and unavoidable delay with their auditor.

c) Most of the extensions were for 1-2 months. Five providers were given extensions for three months, five for four months, four for six months, six for seven months and two for more than seven months.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-167

OUTCOME 4: Aged Care and Population Ageing

Topic: GENERAL PURPOSE FINANCIAL REPORTS

Written Question on Notice

Senator Adams asked:

How many providers are yet to submit their records for the 2007-08 round?

Answer:

Of those providers who were required to complete general purpose financial reports for 2007-08, two providers have yet to complete their reports.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-169

OUTCOME 4: Aged Care and Population Ageing

Topic: GENERAL PURPOSE FINANCIAL REPORTS

Written Question on Notice

Senator Adams asked:

a) From existing data, is the Department aware of the number of aged care providers currently operating in the red?

b) If so, how many?

Answer:

a) The Department of Health and Ageing has constructed a useable dataset of detailed financial information for aged care providers for 2006-07, based on information extracted from the General Purpose Financial Reports that were submitted by approved providers of residential aged care as part of the eligibility requirements for the Conditional Adjustment Payment.

   The data set is available on the Department of Health and Ageing's website at http://www.health.gov.au/internet/main/publishing.nsf/Content/ageing-resid-care-fin-data.htm

   The Department notes that, while the General Purpose Financial Reports are required to be prepared to accounting standards and formally audited, the quality and comprehensiveness of the financial information they contain varies from provider to provider. It cautions that the dataset should be used with caution as:

   1) It is evident that there is considerable variation in the interpretation of accounting standards. For instance, there is variation in the way capital grants and one-off payments are treated.
   2) The Department's interpretation of the accounting data provided in the General Purpose Financial Reports has not been verified with the accountants of aged care providers.

b) See a) above.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-170

OUTCOME 4: Aged Care and Population Ageing

Topic: COMMUNITY CARE

Written Question on Notice

Senator Adams asked:

a) Can the Department confirm that a working group of the Ageing Consultative Committee is currently investigating mechanisms to increase levels of consumer involvement for Community Care recipients?

b) When is the Committee expected to report back on the issue?

Answer:

a) On 10 October 2008, the Ageing Consultative Committee established a sub-group to further develop options to pilot individualised budgets for community care packages and respite care.

b) The Ageing Consultative Committee considered and endorsed the report of the Working Group on 25 June 2009.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-172

OUTCOME 4: Aged Care and Population Ageing

Topic: INDEXATION OF THE CONDITIONAL ADJUSTMENT SUBSIDY

Written Question on Notice

Senator Adams asked:

What is the NET EFFECT of cutting the indexation of the conditional adjustment subsidy (taking into consideration the pension increase etc) over:

a) one year?

b) two years?

c) three years?

d) four years?

e) What does the departmental modelling show?

f) Will providers be better or worse off in real terms in four years time with cutting indexation of the conditional adjustment subsidy?

Answer:

a – f)

The Conditional Adjustment Payment (CAP) is an additional primary supplement paid under the *Aged Care Act 1997* to eligible aged care providers. The level of the CAP payable in respect of a care recipient is equal to 8.75 per cent of the basic subsidy payable in respect of that care recipient.

As the levels of the basic subsidy are increased through indexation on 1 July each year, the level of the CAP payable in respect of a care recipient is also increased through indexation each year.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-173

OUTCOME 4: Aged Care and Population Ageing

Topic: AUSTRALIAN GOVERNMENT DIRECTORY OF SERVICES FOR OLDER PEOPLE

Written Question on Notice

Senator Adams asked:

When will the government update the Australian Government Directory of Services for Older People as the 2007 version is way out of date?

Answer:

The new edition of the *Australian Government Directory of Services for Older People* is being finalised.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-174

OUTCOME 4: Aged Care and Population Ageing

Topic: SENATE INQUIRY INTO AGED CARE

Written Question on Notice

Senator Adams asked:

When will the government respond to the Senate Inquiry into Residential and Community Aged Care in Australia?

Answer:

The Government is currently considering the Inquiry's recommendations and will respond in due course.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-205

OUTCOME 4: Aged Care and Population Ageing

Topic: AGED CARE FUNDING INSTRUMENT (ACFI)

Hansard Page: CA 23

Senator Adams asked:

Has the department received correspondence from providers regarding the inadequacy of ACFI?

Answer:

The Department of Health and Ageing has received a range of correspondence about the ACFI since its introduction on 20 March 2008. The vast majority has been seeking clarification about how the ACFI should be implemented.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-206

OUTCOME 4: Aged Care and Population Ageing

Topic: AGED CARE FUNDING INSTRUMENT (ACFI)

Written Question on Notice

Senator Adams asked:

As far as the department goes, how much has it spent on managing the ACFI process, from your point of view?

Answer:

The Department of Health and Ageing has budgeted $8.1 million for the management of the processes associated with the ACFI in 2009-10. These processes include:

- developing and maintaining the ACFI, including preparing information products; answering questions from approved providers, and addressing issues raised by the aged care industry;
- supporting the Aged Care Funding Instrument Reference Group and the Aged Care Funding Instrument Technical Reference Group, each of which consists of representatives of consumers and aged care organisations; and
- managing the validation and review process associated with ACFI.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-207

OUTCOME 4: Aged Care and Population Ageing

Topic: AGED CARE APPROVALS ROUND

Hansard Page: CA 25

Senator Adams asked:

The aged care planning regions where bed shortages exist and the total bed shortage in each region - that is overall. Could you take that on notice so that we are aware of where there are bed shortages at the present time against the benchmark.

Answer:

The number of operational subsidised aged care places made available by the Commonwealth across Australia is governed by a set of national target provision ratios, which ensure growth in the number of places is in line with growth in the population of older people in Australia.

The current national target provision ratio is for there to be 113 operational subsidised aged care places across Australia for every 1000 people aged at least 70. This target is due to be met by 2011.

There are no specified target provision ratios for each state and territory, or for regions within states and territories.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Questions: E09-209

OUTCOME 4: Aged Care and Population Ageing

Topic: BED LICENCES

Hansard Page: CA 32

Senator Adams asked:

How many bed licences have been handed back since 1 March 2009?

Answer:

From 1 March to 21 October 2009, 21 operational residential places were relinquished and 103 provisionally allocated residential places surrendered.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-211

OUTCOME 4: Aged Care and Population Ageing

Topic: RESIDENTIAL AGED CARE

Hansard Page: CA 34

Senator Adams asked:

I want to find out what was spent in the 2007 year and then 2008 on residential aged care.

Answer:

Total Australian Government funding on residential aged care subsidies was:

- $5.656 billion in 2006-07;
- $6.003 billion in 2007-08, and
- $6.474 billion in 2008-09.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-212

OUTCOME 4: Aged Care and Population Ageing

Topic: CAP PAYMENTS

Hansard Page: CA 34

Senator Siewert asked:

a) Is the review of the CAP payments likely to be released?

b) If so, when?

Answer:

a and b)

A decision has not been made on the release of the report of the Review of the Conditional Adjustment Payment.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-213

OUTCOME 4: Aged Care and Population Ageing

Topic: CRADLE COAST

Hansard Page: CA 38

Senator Brown asked:

a) Will there be discussions with the Cradle Coast project consortium?

b) I am trying to work out how the ACST, the peak body in Tasmania, might fit into the consortium. Have they got a representative on the committee?

Answer:

a) The Department of Health and Ageing is involved in continuing discussions with the Cradle Coast project consortium.

b) Aged and Community Services Tasmania is a member of the steering committee for the Cradle Coast project.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-215

OUTCOME 4: Aged Care and Population Ageing

Topic: AUSTRALIAN GOVERNMENT DIRECTORY OF SERVICES FOR OLDER PEOPLE

Hansard Page: CA 42

Senator Adams asked:

When is the government going to update the Government Directory of Services for Older People? This was last done in 2007 and it is quite out of date.

Answer:

The new edition of the *Australian Government Directory of Services for Older People* is being finalised.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Questions: E09-216

OUTCOME 4: Aged Care and Population Ageing

Topic: BED LICENCES

Hansard Page: CA 42

Senator Adams asked:

When I was asking bout the bed licences before, I asked just about operational places. I would like to know the total of bed licences handed back since 1 March 2009, and that includes all bed licences, not just operational places.

Answer:

From 1 March to 21 October 2009, 21 operational residential places were relinquished and 103 provisionally allocated residential places surrendered.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-261

OUTCOME 4: Aged Care and Population Ageing

Topic: ORAL HEALTH TRAINING IN RESIDENTIAL AGED CARE HOMES

Hansard Page: CA 42

Senator Adams asked:

Could you please provide information on the oral health project in South Australia on which the Department is basing its oral health training program for aged care workers in aged care homes?

Answer:

Under the Encouraging Best Practice in Residential Aged Care program, the Department of Health and Ageing funded the South Australian Dental Service $1.3 million to lead the Better Oral Health in Residential Care project. This two-year project which ended in November 2009 was trialled in seven aged care homes in South Australia, NSW and Victoria. Through a train-the-trainer program, registered nurses were trained so that they in turn could train aged care workers in daily oral hygiene.

An important component of the project was the team approach, recognising that best outcomes for residents' oral health are achieved when staff and health professionals work together. General practitioners, registered nurses, nurses, care workers and dental professionals had responsibility for one or more of the four key processes:

- Oral Health Assessment
- Oral Health Care Plan
- Daily Oral Hygiene
- Dental Treatment

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-275

OUTCOME 4: Aged Care and Population Ageing

Topic: CONTINENCE MANAGEMENT

Hansard Page: CA 39

Senator Fifield asked:

Would you be able to table or provide a copy of the letter that has gone out to current clients.

Answer:

A copy of the letter sent to current clients is provided at Attachment A.

Australian Government

Department of Health and Ageing

Dear CAAS Client

As you are a Continence Aids Assistance Scheme (CAAS) client, I am writing to you to let you know about some changes that will occur from 1 July 2010.

You are currently receiving a subsidy of up to $489.95 in 2009-2010 for continence products ordered through Intouch, the Australian Government's administrator of the CAAS. The subsidy aims to assist you to meet some of the costs of your continence products.

As announced in the Federal Budget 2009, the Continence Aids Payment Scheme will replace the CAAS from 1 July 2010. Under the new Scheme eligible clients will receive a direct payment into a nominated bank account by Medicare Australia. The payment amount will be in line with the current value available under the CAAS and it will continue to be indexed annually.

As an existing client you will have the opportunity to transfer to the new Scheme without the need to reapply. Medicare Australia will be writing to you in the coming months to obtain additional information necessary to become a client under the new Scheme.

Your details will be provided to Medicare Australia, in accordance with the CAAS Application Guidelines, to enable them to write to you and to assist with your transfer to the new Scheme.

In the meantime, the Department will be arranging a number of information sessions for clients, health professionals and suppliers about the changes.

The new scheme will allow you to use your payment to access the continence supplier and products of your choice, including your local pharmacy. It is not a reimbursement scheme so you will not need to produce receipts for your purchases.

For those of you who require specific continence products, like catheters, information will be made available to help you obtain details about accessing these types of products through suppliers or manufacturers. Information will also be available to assist people in rural and remote areas.

I want to reassure you that you do not need to do anything at this point. As a current CAAS client you will be transferred to the new Scheme provided you meet Medicare's request for the additional information.

Intouch will continue to administer the CAAS in the same way until 30 June 2010, which means that you can access your subsidy for continence products until the new payment scheme commences.

Further information about the Continence Aids Payment Scheme and changes to the CAAS (including information session times), will be made available on the Department's Bladder Bowel Website at www.bladderbowel.gov.au
If you have a specific enquiry you can email continence@health.gov.au

If you do not have internet access, you can contact the Department of Health and Ageing on 1800 807 487 (free call) to request further information.

Yours sincerely

Melinda Bromley
Assistant Secretary
Office for an Ageing Australia
Department of Health and Ageing
15 September 2009

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-024

OUTCOME 4: Aged Care and Population Ageing

Topic: AGED CARE FACILITIES

Written Question on Notice

Senator Williams asked:

At our last Estimates round, I think a figure was given that 48 aged care facilities had ceased to operate in the 12 months to the end of February.

a) Do you have an update on that figure?

b) Could you give me a state breakdown of where these are?

c) What were the reasons given for these facilities closing?

d) Effectively how many beds were closed?

e) How many residents did this affect?

f) Were new places found for all of these residents?

g) Do you know how many of these residents were moved to nursing homes that were a greater distance from their home base?

Answer:

a) From 1 March 2009 to 31 October 2009, 32 residential aged care services ceased to operate.

b)

State/Territory	Residential services
NSW	11
Vic	10
Qld	2
WA	1
SA	6
Tas	2
ACT	0
NT	0
Total	**32**

c) The majority of services listed above (17) closed due to the age or design of the building structure, many of which have consolidated the associated residential aged care places into new services or extensions to existing services.

Other reasons for services ceasing to exist were: Converting to Multipurpose Services (4); services co-locating on one site (4); approved provider reviewing its strategic direction (2); building lease ending (2); non-compliance action (2); and approved provider retiring (1).

d) The services had collectively operated 1,298 residential aged care places; 470 have been moved to other services. A further 709 places are temporarily off-line while providers consider their strategic business plans. The remaining 164 places were revoked following a decision by the Department of Health and Ageing to revoke the approved provider status of the approved provider.

e) 1,066 residents were in care at the time the services closed.

f) Before closing a residential aged care service, all approved providers are responsible for ensuring suitable alternative accommodation is arranged for existing residents that meets their assessed long term needs and is affordable. Suitable alternative accommodation also depends on the resident and/or family/guardian preferences.

g) The Department is unable to answer this question as it is unclear what is meant by home base.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-027

OUTCOME 4: Aged Care and Population Ageing

Topic: AGED CARE OPERATORS

Written Question on Notice

Senator Williams asked:

a) I have a figure that says the average annual return for aged care operators is 1.1 percent – does that align with your figures?

b) That is an extremely low margin – does it not worry you about their viability?

Answer:

a) No. The Department's analysis of the 2006-07 general purpose financial reports of aged care providers indicates that the average return across all residential aged care providers is about three per cent.

b) Given wide variations in efficiency in the residential aged care industry, the average across all providers is not an adequate measure of the capacity to make a return in the residential aged care sector. It is widely accepted that a better measure is the returns earned by providers in the top quartile, as this provides a better indication of whether or not funding levels are sufficient to allow efficient providers to make a reasonable return on their investment.

   The Department's analysis of the 2006-07 general purpose financial reports of aged care providers indicates that the average return across all residential aged care providers in the top quartile was about ten per cent.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-033

OUTCOME 4: Aged Care and Population Ageing

Topic: AGED CARE ASSESSMENT TEAM (ACAT)

Written Question on Notice

Senator Williams asked:

a) Could you explain the role of ACAT and what it does?
b) Before a resident goes into a nursing home, they are assessed by ACAT as high or low care are they not?
c) Could you tell me what form the assessment takes - where is it held, how long does it take, what sort of questions they are asked etc?
d) Is a family member present?
e) What guidelines are then used to determine whether the patient is low or high care?
f) And depending on what classification they fall under, there is a different Government subsidy paid to the nursing home. Is that correct?
g) What is that subsidy?

Answer:

a) ACATs assess the care needs of frail older people and assist them to gain access to the most appropriate types of care. ACATs also provide information about, and refer clients to, broader community services that do not require a formal approval such as the Home and Community Care Program.

b) Yes.

c) ACATs conduct a comprehensive and multi-disciplinary assessment of the person's restorative, physical, medical, psychological, cultural and social care needs. They provide a choice of appropriate services to meet the person's care needs and preferences.

   Assessments are conducted face to face and the visit can take place wherever the client is located at the time of assessment. Assessments are normally conducted in the client's home, a residential facility or hospital setting. In some remote areas it may be necessary to conduct a telephone assessment or utilise telehealth, in consultation with a local health professional.

The duration of the assessment process depends on the needs of the person being assessed, and the assessment may occur over one or more visits.

To establish a person's functional capacity and overall care needs, the assessor asks relevant questions or uses assessment tools. The ACAT also considers the person's accommodation arrangements, carer and family support, financial circumstances, access to transport and community support systems.

d) Wherever possible, and with the client's consent, the ACAT involves the person's carer, family members, service provider and General Practitioner (or other medical practitioner) in the assessment and care planning process.

e) The decision to approve a person for a high or low level of care is made according to the criteria and conditions specified in the *Aged Care Act 1997* and the accompanying *Aged Care Principles*.

f) Yes. The level of basic care subsidy payable in respect of a care recipient is determined by the Department of Health and Ageing at one of 65 levels depending on the level of the care recipient's ACAT approval and the provider's appraisal of the care recipient needs against the Aged Care funding instrument.

g) The current subsidy rates for residents classified under the *Aged Care Classification Instrument* are as set out in the *Aged Care (Residential Care Subsidy – Basic Subsidy Amount) Determination 2009 (No. 1)*, which can be found in the Federal Register of Legislative Instruments (F2009L02377) at www.comlaw.gov.au

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-034

OUTCOME 4: Aged Care and Population Ageing

Topic: AGED CARE ASSESSMENT TEAM (ACAT)

Written Question on Notice

Senator Williams asked:

a) I understand one of the problems facing aged care facilities is that some patients are assessed by ACAT as low-care, but when they move into the facility they actually have high care needs under the Aged Care Funding Instrument (ACFI). That means the aged care operator is left to make-up the shortfall. Do you have figures say for the last 12 months as to how many examples of this there have been?

b) How long does it take for the ACAT team to return to reassess the patient?

c) In the intervening period, the nursing home is left to foot the difference in cost?

d) If the patient is reassessed by ACAT as high care, is the nursing home reimbursed for the days they were out of pocket because the first assessment was wrong?

e) If not, why not?

f) This is impacting on the bottom line of operators – has the Department been approached by the industry to rectify this formula?

Answer:

a) When an ACAT approves a person for residential care they also either limit the person's approval to low level care (approval for low care) or do not limit the person's approval to low level care (approval for high care).

Once a care recipient has entered an aged care home for permanent care, often some time after they received their approval for subsidised care from an ACAT, the aged care provider appraises the care recipient's needs against the Aged Care Funding Instrument (ACFI).

When the ACAT has limited a care recipient's approval for care to low level care and the approved provider has appraised the care recipient's care needs as high level care then the Department classifies the resident into the interim Low Category. This applies until either; a new ACAT assessment occurs, the resident "ages in place" (i.e. a voluntary reappraisal or a major change in classification is lodged and accepted), or a Commonwealth Nursing Officer (CNO) classifies the resident at an ACFI level equivalent to a high level of care following a review.

A voluntary reappraisal of a residents' care needs can be undertaken; at any time from 12 months after the existing appraisal, after a 'major change' in care needs, or within 2 months after a resident transfers.

In 2008-09, some 6,600 out of a total of 52,940 first permanent admissions to residential aged care were classified into the Interim Low Category.

This number is expected to reduce significantly once the changes to the definition of High Care under the ACFI come into effect from 1 January 2010.

b) The average time from when a person's referral to be assessed in a residential setting is accepted by the ACAT and when the ACAT has the first face to face contact with a person, for Australia as a whole, is 16 days.

c) The *Aged Care Act 1997* (The Act) does not allow the Department to classify a newly entering resident as requiring high level care until an ACAT has approved the resident for high level care. The Act also does not allow ACATs to backdate an approval for care.

It is not legally possible to pay a provider high care subsidies in respect of a newly entering resident who is not approved for high level care until either; a new ACAT assessment has been completed, the resident "ages in place", or a CNO classifies the resident at an ACFI level equivalent to a high level of care following a review.

d) An ACAT reassessment leading to a change in a care recipient's approved level of care does not mean the first assessment was wrong but rather can refect a range of factors, including a deterioration or improvement in the person's health during the intervening period.

e) See d) above.

f) There has been an ongoing dialogue with the industry on this issue since the commencement of the Act.

More recently, since the implementation of the ACFI on 20 March 2008, the major issue of concern has been changes to the definition of High Care introduced with the new funding tool, rather than arrangements for ACAT approvals. An unintended outcome of the introduction of the ACFI has been that some residents who would have been appraised as requiring low level care under the previous arrangements are now being appraised as requiring high level care, which has increased the level of misalignment with ACAT assessments. In the 2009 Budget, the Government announced action to address this design anomaly, by modifying the definition of high and low care.

Extensive consultations have been held with consumers, providers and health professionals through the ACFI Technical Reference Group, the ACFI Reference Group and the Ageing Consultative Committee.

Under this approach, the categorisation of residents into high or low care will be much the same as it was before the ACFI was introduced. Amendments to relevant regulations were implemented on 1 January 2010.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-045

OUTCOME 4: Aged Care and Population Ageing

Topic: RURAL AND REMOTE AGED CARE

Written Question on Notice

Senator Siewert asked:

$14 million was earmarked for rural and remote aged care. How many new beds have been created with this funding?

Answer:

In the 2009-10 Budget, the Australian Government provided $14.8 million over two years to increase the viability supplement paid to eligible aged care providers in regional, rural and remote areas.

As a result, the average viability supplement will increase by more than 40 per cent in real terms over two years – ie, an increase from $3.43 per person per day in 2008-09 to an estimated $5.12 in 2010-11. The increased supplement will be paid for more than 15,000 residents in over 400 eligible services across Australia.

The viability supplement is paid to eligible residential care providers and for care provided in a residential setting in Multi-purpose Services and Aboriginal and Torres Strait Islander Flexible Aged Care Service will increase from 1 January 2010. The increase will apply to those services eligible to receive viability supplement through the 2005 viability supplement scheme.

The viability supplement does not of itself fund the creation of new places.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-046

OUTCOME 4: Aged Care and Population Ageing

Topic: AGED CARE BONDS

Written Question on Notice

Senator Siewert asked:

a) Does the department keep figures of how many providers are charging the maximum permissible interest rate for the assessed aged care bonds for residents entering care?

b) If the department does have these figures is it possible to obtain a copy of them?

c) Does the department keep track of how long these providers are charging the maximum permissible interest rate for the assessed aged care bonds for residents entering care?

d) If the department does have these figures is it possible to obtain a copy of them?

Answer:

a) No.

b) Not applicable.

c) No.

d) Not applicable.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-104

OUTCOME 4: Aged Care and Population Ageing

Topic: AGED CARE APPROVALS ROUND (ACAR)

Written Question on Notice

Senator Adams asked:

Given that only 519 of the 1208 residential care places offered in WA through the 2008 ACAR were taken up (and there is already evidence that some of these places are likely to be returned due to inadequate funding levels), and during 2008 some 110 provisional bed licenses were handed back, what strategies is the Department of Health and Ageing going to use to ensure that the necessary number of beds are going to be actually available to the WA community in 2010-11?

Answer:

As at 30 June 2009, there were nearly 2,000 residential places allocated in Western Australia that were not yet operational. These places will assist in meeting the needs of older Western Australian's in the future as they become operational. Also, in the 2008-09 ACAR two capital grants totaling $10.6 million were allocated to approved providers in Western Australia.

In the 2008-09 Budget the Rudd Government provided $300 million over two years for the zero real interest loans initiative. The objective of the initiative is to encourage providers of residential aged care, through low cost finance, to establish residential aged care service in areas where they were previously less likely to invest.

Under round one of the zero real interest loans initiative aged care service providers in Western Australia have been offered $46.6 million in loans for 347 new beds and 28 community care packages.

In addition, the 2009-10 ACAR will incorporate Stage 2 of the zero real interest loan initiative. The majority of aged care planning regions (that is, not including two metropolitan planning regions) in Western Australia will be targeted in this initiative and in some instances providers will be able to apply for a zero real interest loan, places and a capital grant.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-106

OUTCOME 4: Aged Care and Population Ageing

Topic: RESIDENTIAL CARE PLACE IN WESTERN AUSTRALIA

Written Question on Notice

Senator Adams asked:

Is the Minister aware that the average cost of providing a residential care place in WA is now $250,000, based on the previous 4 projects completed in Perth Metro?

Answer:

No.

The Department's annual Survey of Aged Care Homes asks the industry to report, *inter alia*, data on new building work, rebuilding work and upgrading work that has been completed during the year or is in progress at the end of the year. Information on planned building work is also collected.

The 2008-09 survey had a 96.1% response rate with 2,682 of 2,791 aged care homes submitting a response. Responses are weighted to estimate figures for the entire residential aged care sector.

Based on analysis of the 2008-09 survey data, the Department estimates that the average cost of constructing an aged care home in Western Australia (WA) in 2008-09 was $209,951 per bed.

The survey found that six aged care homes were constructed in WA in 2008-09, all located in the Perth metropolitan region. The reported cost per place for the six homes varied between $52,600 and $243,350.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-107

OUTCOME 4: Aged Care and Population Ageing

Topic: RESIDENTIAL CARE BEDS IN WA

Written Question on Notice

Senator Adams asked:

Would the Minister for Ageing please identify the number of residential care beds WA should currently have, and how many the state currently has against existing planning ratios?

Answer:

The national benchmark for Australian Government subsidised residential aged care places is 88 places per 1,000 people aged 70 years and over. There is no specific state or territory benchmark for residential care places.

As at the 30 June 2009 stocktake of aged care places, Western Australia had 15,068 operational and 17,609 allocated residential aged care places. This produced an operational residential ratio of 81.3 and an allocated residential ratio of 95.0. The national operational residential ratio is 86.9 with an allocated residential ratio of 99.2

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-108

OUTCOME 4: Aged Care and Population Ageing

Topic: AGED CARE IN WA

Written Question on Notice

Senator Adams asked:

a) Is the Minister for Ageing aware that a senior's village of 300 independent living units and an integrated aged care facility on-site in Perth's SE has some 9 community care providers delivering various forms of community packages to residents, with at least one carer travelling some 65kms from her base to service just 2 clients in the Suburb?

b) How is this cost efficient?

Answer:

a) No.

b) When applying for Community Care places through an Aged Care Approvals Round, approved providers nominate the aged care planning region and local government areas in which they plan to deliver services. Approved providers would be aware of the costs of providing services in the region/s they have nominated and should have factored them into their bids.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-153

OUTCOME 4: Aged Care and Population Ageing

Topic: AWARD MODERNISATION

Written Question on Notice

Senator Adams asked:

a) What impact will the Award Modernisation process have on the delivery of aged care services across Australia in terms of the cost and delivery of services?

b) What state/areas will be adversely impacted by the Government's Award Modernisation changes?

c) Can the Department guarantee that no aged care facility will be worse off as a result of the Award Modernisation changes?

Answer:

1.

2. a) The Australian Industrial Relations Commission released two new modern awards for the aged care industry on 3 April 2009.

3.

4. The Commission recently announced that it will utilise a full five-year transition period to modern awards, which was supported by the Australian Government. Throughout the award modernisation process, the Commission has considered the actual cost impact and the overall economic impact of the move to modern awards.

b) The majority of aged care facilities in most states appear to be covered by collective agreements. Collective agreements will continue to operate after the introduction of the modernised awards. There is a further safeguard provided for employees following award modernisation via the take-home pay orders.

c) It is not the department’s role to issue guarantees.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-168

OUTCOME 4: Aged Care and Population Ageing

Topic: GENERAL PURPOSE FINANCIAL REPORTS

Written Question on Notice

Senator Adams asked:

When will the de-identified database of the 2007-08 audited General Purpose Financial Reports be completed?

Answer:

The de-identified database of the 2007-08 audited General Purpose Financial Reports is available on the Department of Health and Ageing's website www.health.gov.au

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-203

OUTCOME 4: Aged Care and Population Ageing

Topic: REGIONAL BREAKDOWN OF PLACES

Hansard Page: CA 20

Senator Siewert asked:

It is EO 276. You made the total places available, the total applications received and the total places sought. I am wondering if it is possible to get a further breakdown of the use for residential places and community packages.

Answer:

Attachment A provides a further breakdown of the information provided in response to Budget Estimates Question on Notice E09-276. Please note that E09-276 contained some factual errors, these have been corrected in Attachment A. This attachment sets out the total number of residential and community aged care places made available, the total number of applications received for both care types and the total number of places sought by care type.

ATTACHMENT A

National response to 2008-09 Aged Care Approvals Round

	Residential aged care places			Community aged care places			Total of all places		
State/territory	**No of places advertised**	**No of applications received**	**No of places sought**	**No of places advertised**	**No of applications received**	**No of places sought**	**No of places advertised**	**No of applications received**	**No of places sought**
New South Wales	2,106	95	3,810	888	629	11,695	2,994	724	15,505
Victoria	1,486	111	5,488	610	376	7,219	2,096	487	12,707
Queensland	2,416	75	3,687	610	320	5,956	3,026	395	9,643
Western Australia	1,208	11	536	336	122	2,016	1,544	133	2,552
South Australia	123	24	526	165	123	1,642	288	147	2,168
Tasmania	131	3	91	75	79	738	206	82	829
ACT	169	3	134	45	24	360	214	27	494
Northern Territory	24	0	0	55	13	92	79	13	92
Totals	**7,663**	**322**	**14,272**	**2,784**	**1,686**	**29,718**	**10,447**	**2,008**	**43,990**

New South Wales - response to 2008-09 Aged Care Approvals Round

	Residential aged care places			Community aged care places			Total of all places		
	No of places advertised	**No of applications received**	**No of places sought**	**No of places advertised**	**No of applications received**	**No of places sought**	**No of places advertised**	**No of applications received**	**No of places sought**
Central Coast	110	4	216	20	25	308	130	29	524
Central West	110	5	200	20	13	175	130	18	375
Far North Coast	116	6	177	33	21	386	149	27	563
Hunter	220	16	511	98	73	1,843	318	89	2,354
Illawarra	140	6	208	15	23	185	155	29	393
Inner West	0	1	4	75	34	598	75	35	602
Mid North Coast	150	2	80	55	50	966	205	52	1,046
Nepean	220	2	172	30	27	290	250	29	462
New England	30	2	11	5	10	84	35	12	95
Northern Sydney	0	6	112	128	60	1,476	128	66	1,588
Orana Far West	50	3	15	7	6	69	57	9	84
Riverina/Murray	30	5	56	42	36	390	72	41	446
South East Sydney	280	13	788	117	83	1,799	397	96	2,587
South West Sydney	270	8	478	107	82	1,602	377	90	2,080
Southern Highlands	60	8	189	25	28	255	85	36	444
Western Sydney	320	8	593	111	58	1,269	431	66	1,862
Totals	**2,106**	**95**	**3,810**	**888**	**629**	**11,695**	**2,994**	**724**	**15,505**

Victoria - response to 2008-09 Aged Care Approvals Round

	Residential aged care places			Community aged care places			Total of all places		
	No of places advertised	**No of applications received**	**No of places sought**	**No of places advertised**	**No of applications received**	**No of places sought**	**No of places advertised**	**No of applications received**	**No of places sought**
Barwon-South Western	90	10	**397**	57	38	573	147	48	970
Eastern Metro	350	36	**1,796**	100	55	1,139	450	91	2,935
Gippsland	120	3	**87**	35	18	289	155	21	376
Grampians	90	3	**190**	20	20	207	110	23	397
Hume	30	6	**129**	47	31	419	77	37	548
Loddon-Mallee	120	10	**509**	58	30	435	178	40	944
Northern Metro	190	14	**665**	88	67	1,384	278	81	2,049
Southern Metro	200	21	**1,308**	118	66	1,567	318	87	2,875
Western Metro	170	8	**407**	87	51	1,206	257	59	1,613
At the state level	126*						126*		
Totals	**1,486**	**111**	**5,488**	**610**	**376**	**7,219**	**2,096**	**487**	**12,707**

*A ‘pool’ of 126 aged care places was made available at the state level for distribution to all aged care planning regions in Victoria focusing on places for restructuring purposes.

Queensland - response to 2008-09 Aged Care Approvals Round

	Residential aged care places			Community aged care places			Total of all places		
	No of places advertised	**No of applications received**	**No of places sought**	**No of places advertised**	**No of applications received**	**No of places sought**	**No of places advertised**	**No of applications received**	**No of places sought**
Brisbane North	60	8	243	60	39	690	120	47	933
Brisbane South	230	18	919	90	55	1,090	320	73	2,009
Cabool	80	1	217	40	14	407	120	15	624
Central West	0*	0	0	0	0	0	0*	0	0
Darling Downs	60	5	45	65	15	375	125	20	420
Far North	80	3	200	20	13	174	100	16	374
Fitzroy	100	2	41	20	8	80	120	10	121
Logan River Valley	150	5	274	40	21	415	190	26	689
Mackay	130	3	141	5	5	70	135	8	211
Northern	100	3	114	20	18	155	120	21	269
North West	0*	2	16	0	0	0	0*	2	16
South Coast	400	10	409	100	56	1,326	500	66	1,735
South West	0*	0	0	0	0	0	0*	0	0
Sunshine Coast	480	7	455	60	44	699	540	51	1,154
West Moreton	190	3	274	30	9	185	220	12	459
Wide Bay	200	5	339	30	23	290	230	28	629
At the state level	156*			30*			186*		
Totals	**2,416**	**75**	**3,687**	**610**	**320**	**5,956**	**3,026**	**395**	**9,643**

*A ‘pool’ of 186 aged care places was made available to all aged care planning regions in Queensland with a focus on special needs groups; this pool was also made available to potential applicants in the Central West, North West and South West aged care planning regions of Queensland which, while being above the benchmark ratio for both residential and community service provision, given the size of the regions, may have been subject to applications to address availability at the local level.

Western Australia - response to 2008-09 Aged Care Approvals Round

	Residential aged care places			Community aged care places			Total of all places		
	No of places advertised	**No of applications received**	**No of places sought**	**No of places advertised**	**No of applications received**	**No of places sought**	**No of places advertised**	**No of applications received**	**No of places sought**
Goldfields Great Southern Kimberley Mid West Pilbara Wheatbelt	120	1	19	65	17	123	185	18	142
Metro East	140	3	143	40	7	205	180	10	348
Metro North	260	3	200	60	39	694	320	42	894
Metro South East	110	2	122	15	8	70	125	10	192
Metro South West	320	1	35	66	28	607	386	29	642
South West	70	1	17	10	4	32	80	5	49
At the state level	188*	-	-	80*	9	285	268*	9	285
Totals	**1,208**	**11**	**536**	**336**	**112**	**2,016**	**1,544**	**123**	**2,552**

*A ‘pool’ of 268 aged care places was made available for distribution at the state level to aged care planning regions in Western Australia largely to address the needs of people from special needs groups.

South Australia - response to 2008-09 Aged Care Approvals Round

	Residential aged care places			Community aged care places			Total of all places		
	No of places advertised	**No of applications received**	**No of places sought**	**No of places advertised**	**No of applications received**	**No of places sought**	**No of places advertised**	**No of applications received**	**No of places sought**
Eyre Peninsula	0	0	0	0	1	5	0	1	5
Hills, Mallee and Southern	0	0	0	22	24	155	22	24	155
Metro East	0	0	0	0	0	0	0	0	0
Metro North	35	7	175	78	36	886	113	43	1,061
Metro South	0	1	20	35	41	447	35	42	467
Metro West	88	12	291	0	2	25	88	14	316
Mid North	0	1	0	0	0	0	0	1	0
Riverland	0	0	0	20	9	55	20	9	55
South East	0	0	0	0	0	0	0	0	0
Whyalla, Flinders and Far North	0	0	0	0	2	10	0	2	10
Yorke, Lower North and Barossa	0	3	40	0	6	39	0	9	79
At the state level	0	0	0	10*	2	20	10*	2	20
Totals	**123**	**24**	**526**	**165**	**123**	**1,642**	**288**	**147**	**2,168**

* A ‘pool’ of 10 aged care places was made available at the state level for allocation to all metropolitan aged care planning regions in South Australia with a specific focus on the provision of care for people from Aboriginal and Torres Strait Islander communities

Tasmania - response to 2008-09 Aged Care Approvals Round

	Residential aged care places			Community aged care places			Total of all places		
	No of places advertised	No of applications received	No of places sought	No of places advertised	No of applications received	No of places sought	No of places advertised	No of applications received	No of places sought
Northern	10	1	2	23	34	250	33	35	252
North Western	60	---	--	8	7	49	68	7	49
Southern	61	2	89	44	38	439	105	40	528
Totals	**131**	**3**	**91**	**75**	**79**	**738**	**206**	**82**	**829**

Australian Capital Territory - response to 2008-09 Aged Care Approvals Round

	Residential aged care places			Community aged care places			Total of all places		
	No of places advertised	No of applications received	No of places sought	No of places advertised	No of applications received	No of places sought	No of places advertised	No of applications received	No of places sought
Totals	**169**	**3**	**134**	**45**	**24**	**360**	**214**	**27**	**494**

Northern Territory - response to 2008-09 Aged Care Approvals Round

	Residential aged care places			Community aged care places			Total of all places		
	No of places advertised	**No of applications received**	**No of places sought**	**No of places advertised**	**No of applications received**	**No of places sought**	**No of places advertised**	**No of applications received**	**No of places sought**
Alice Springs	0	0	0	14	3	20	14	3	20
Barkly	0	0	0	0	0	0	0	0	0
Darwin	0	0	0	14	3	35	14	3	35
East Arnhem	0	0	0	6	2	16	6	2	16
Katherine	0	0	0	6	5	21	6	5	21
At the territory level	24*	0	0	15*			39*		
Totals	**24**	**0**	**0**	**55**	**13**	**92**	**79**	**13**	**92**

* A ‘pool’ of 39 aged care places was made available at the territory level for distribution to all aged care planning regions in Northern Territory.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-208

OUTCOME 4: Aged Care and Population Ageing

Topic: BED LICENCES

Hansard Page: CA 32

Senator Adams asked:

Can you provide a breakdown of the number of licences in each aged-care planning region for the previous three aged-care approvals rounds that have not yet become operational?

Answer:

The number of residential aged care places allocated in the 2008-09, 2007 and 2006 Aged Care Approvals Rounds by aged care planning regions, that are not operational, as at 30 June 2009, is provided in Attachment A.

Attachment A

Residential Provisional Allocations from 2006 to 2008-09 Aged Care Approvals Round as at 30 June 2009		
State/ Territory	**Aged care planning region**	**Number of residential provisional allocations**
Qld	Brisbane North	112
	Brisbane South	564
	Cabool	135
	Darling Downs	127
	Far North	215
	Fitzroy	83
	Logan River Valley	339
	Mackay	64
	Northern	107
	South Coast	786
	South West	4
	Sunshine Coast	715
	West Moreton	101
	Wide Bay	305
NSW	Central Coast	394
	Central West	58
	Far North Coast	309
	Hunter	426
	Illawarra	512
	Inner West	14
	Mid North Coast	263
	Nepean	72
	New England	79
	Northern Sydney	105
	Orana Far West	15
	Riverina/Murray	163
	South East Sydney	890
	South West Sydney	707
	Southern Highlands	144
	Western Sydney	594
Vic	Barwon-South Western	277
	Eastern Metro	720
	Gippsland	175
	Grampians	109
	Hume	184
	Loddon-Mallee	224
	Northern Metro	307
	Southern Metro	583
	Western Metro	472
	Hills, Mallee & Southern	76

SA	Metropolitan North	211
	Metropolitan South	198
	Metropolitan West	68
	Mid North	4
	Riverland	52
	Yorke, Lower North & Barossa	1
WA	Great Southern	25
	Metropolitan East	352
	Metropolitan North	326
	Metropolitan South East	213
	Metropolitan South West	363
	South West	125
	Wheatbelt	4
Tas	North Western	15
	Northern	59
	Southern	149
NT	Darwin	65
ACT	ACT	346

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-210

OUTCOME 4: Aged Care and Population Ageing

Topic: BED APPROVALS

Hansard Page: CA 33

Senator Boyce asked:

Could you give me a list of all bed approvals that are more than five years outstanding and, hence, becoming operational?

Answer:

The list of residential provisional allocations more than five years old, as at 30 June 2009 is provided in the table below.

List of Provisionally Allocated Residential Places More Than Five Years Old as at 30 June 2009

State/territory	Provisionally allocated places more than 5 years old
Queensland	136
NSW	405
Victoria	194
Tasmania	25
Western Australia	88
ACT	32

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-231

OUTCOME 5: Primary Care

Topic: BALLAN GP SUPER CLINIC

Hansard Page: CA 136

Senator Boyce asked:

Could you take that on notice to tell me what extra infrastructure was provided with the $900,000?

Answer:

In addition to Commonwealth funding of $1.4 million, the Ballan community provided private donations of $900,000 towards the establishment of the Ballan GP Super Clinic.

The private investment supported the acquisition and refurbishment of an historic house facing onto the main street, along with associated stamp duty and legal expenses. Acquisition of the building has enabled the relocation of community health services and existing physiotherapy from the Bush Nursing Hospital to the house, freeing floor space that will allow refurbishment of the Board Room area and the administrative area in the Bush Nursing Hospital (CEO's office, Director of Nursing's office, reception and administration). There are no additional services associated with the acquisition.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-280

OUTCOME 5: Primary Care

Topic: GP SUPER CLINICS

Hansard Page: CA 137

Senator Boyce asked:

See what other information you can give me. [Senator refers to applicants for the Bundaberg GP Super Clinic.]

Answer:

Nil. The Department of Health and Ageing does not provide information on the number of applications that have been received, or details of the applicants involved, in any competitive Invitation to Apply process including those to establish GP Super Clinics.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-098

OUTCOME 5: Primary Care

Topic: PRACTICE INCENTIVES PROGRAM EHEALTH INCENTIVE

Written Question on Notice

Senator Boyce asked:

During the last Estimates Hearing, I placed a question on notice where I asked if the Department could tell me, state by state, where the practices which have signed up for the PIP eHealth Incentive are. The Department stated that this information will not be available until mid-August 2009. Can the Department now disclose where those practices are?

Answer:

The following information indicates the number of general practices in each state or territory that were eligible for a payment through the Practice Incentives Program eHealth Incentive in August 2009:

State	NSW	VIC	QLD	SA	WA	TAS	NT	ACT	Total
Number of practices	1,113	843	701	241	301	83	11	53	3,346

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-099

OUTCOME 5: Primary Care

Topic: PRACTICE INCENTIVES PROGRAM EHEALTH INCENTIVE

Written Question on Notice

Senator Boyce asked:

a) Can the Department explain the types of information which will be provided to practitioners through the eHealth incentive?

b) How will they increase the quality of service that the practitioner gives to the patient?

Answer:

a and b)

As part of the eligibility requirements of the Practice Incentives Program (PIP) eHealth Incentive, general practices must provide practitioners from the practice with access to a range of key electronic clinical resources. These include resources to improve the quality of prescribing (e.g. Australian Medicines Handbook), support quality care (e.g. Royal Australian College of General Practitioners Guidelines for Preventive Activities in General Practice) and enhance health outcomes (e.g. The Australian Immunisation Handbook).

Encouraging practices to use electronic resources aims to support clinical decision-making by ensuring that practitioners have access to the most up-to-date information available, at the point of consultation.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-100

OUTCOME 5: Primary Care

Topic: PRACTICE INCENTIVES PROGRAM EHEALTH INCENTIVE

Written Question on Notice

Senator Boyce asked:

One of the requirements of a practice participating in the PIP eHealth Incentive is that the practice has a secure messaging capability. There were some delays to the system because of a confusion as to what this meant. The Department is now requiring practices to confirm that their software vendor has agreed to participate in the development and implementation of the secure messaging standard when it is finalised.

a) Can the Department explain this a bit further?
b) What kind of agreement was required by the software vendors?
c) How is the Department ensuring that the information stays secure?
d) Has any software vendors refused to agree to the requirement?
e) When does the Department estimate that the development and implementation of the secure messaging standard will be finalised?

Answers:

a) Practice eligibility for the Practice Incentives Program (PIP) eHealth Incentive requires confirmation that the practice has a secure messaging capability using a product that is provided by an eligible supplier. An eligible supplier is defined as one who has agreed to participate in the consultative process by completing a Statement of Commitment. Practices are advised that, to determine their eligibility for the eHealth Incentive, they need to check the National E-Health Transition Authority (NEHTA) website to see if their supplier is listed.

b) In order to be listed as eligible, suppliers were required to submit a Statement of Commitment to NEHTA. This Statement of Commitment represents a commitment by the supplier to:
    - participate in the consultation process that will ultimately lead to secure messaging specifications and compliance timelines agreed between NEHTA and industry; or
    - participate in the consultation process through the supplier's representative organisation such as the Medical Software Industry Association (MSIA); and
    - comply with the specifications and implementation timelines mutually and progressively agreed by NEHTA and industry.

NEHTA invited medical software industry suppliers to participate in a consultation program to develop secure messaging specifications and compliance requirements. The group, called the Practice Incentives Program Secure Messaging Working Group is also known as the ePIP Working Group. Consultation activities with this group included a series of nine workshops run by NEHTA.

c) The PIP eHealth Incentive was developed in consultation with NEHTA, and aligns with the directions set out in the Australian Government's National eHealth Strategy. The eHealth Incentive guidelines state that the use of Public Key Infrastructure (PKI) certificates is essential to ensure secure information exchange and that in order to meet the eligibility requirements, practices should use PKI certificates when sending or receiving information via the practice's messaging system. Given the sensitive nature of health information and following the National eAuthentication Framework (published by AGIMO), PKI has been endorsed by NEHTA as the standard to keep information secure. PKI on SmartCard follows international standards as being the best method of protecting information privacy.

d) All vendors who have agreed to the requirement to submit a Statement of Commitment are listed on the NEHTA website. There are currently 47 eligible suppliers listed, this list is available at www.nehta.gov.au/pip-vendors The Department is not aware of any vendors who have refused to meet the requirement.

e) On 29 September 2009, the MSIA and representative vendors of the ePIP Working Group endorsed the following NEHTA Secure Messaging specifications for submission to Standards Australia:
   - Secure Message Delivery (SMD);
   - Web Service Profile (WSP);
   - XML Secured Payload Profile (XSP); and
   - Endpoint Location Service (ELS).

   The specifications will now go through the regulated standards development process under the guidance of Standards Australia.

Senate Community Affairs Committee

ANSWERS TO QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-180

OUTCOME 5: Primary Care

Topic: IMPROVING MATERNITY SERVICES PACKAGE

Written Question on Notice

Senator Adams asked:

In relation to the decision to give 'eligible midwives' and 'eligible nurse practitioners' access to the MBS and the PBS [Ref. Improving Maternity Services Package, BP2, p.284]:

a) What progress has been made in developing regulations to underpin the eligibility and collaborative care arrangements that will be required?

b) Given that this measure has been costed in the budget papers, for services expected to be provided by i) midwives and ii) nurse practitioners, what are the expected MBS fees for each type of services that have been factored into the budget costing?

c) Given that this measure has been costed in the budget papers, for services expected to be provided by i) midwives and ii) nurse practitioners, what is the estimated additional number of MBS services that are expected to be claimed as a result of these referrals and have therefore been factored into the budget costing?

d) Given that this measure has been costed in the budget papers, for each type of services referred by i) midwives and ii) nurse practitioners, what is the estimated additional number of MBS services that are expected to be claimed as a result of these referrals and have therefore been factored into the budget costing?

e) Given that this measure has been costed in the budget papers, what is the estimated additional number of prescriptions and the estimated additional PBS benefits to be paid annually as a result of prescribing by i) eligible midwives and ii) eligible nurse practitioners?

Answer:

a) The Department is consulting with key stakeholders and technical experts (midwifery, nursing, medical, academic and consumer), through advisory groups and technical workshops (Maternity Services Advisory Group, Nurse Practitioner Advisory Group, PBS Midwife Technical Advisory Group, Maternity Technical Advisory Group, Advance Practice Advisory Group and Nurse Practitioner Technical Advisory Group). The primary focus of these advisory groups and technical workshops is to provide advice to the Minister for Health and Ageing about how eligibility, collaborative arrangements, Medicare Benefits Schedule (MBS) arrangements and Pharmaceutical Benefits Scheme (PBS) arrangements can be given effect.

As at 23 November, meetings held to date are:

- The Maternity Services Advisory Group - 12 August 2009, with another scheduled for 26 November 2009;
- The Nurse Practitioner Advisory Group - 28 August 2009, with another scheduled for 24 November 2009;
- The PBS Midwife Technical Advisory Group - 24 September and 20 October 2009;
- The Maternity Technical Advisory Group - 12 October and 4 November 2009;
- Advance Practice Advisory Group - 12 October and 4 November 2009; and
- The Nurse Practitioner Technical Advisory Group - 13 October 2009 and 13 November 2009.

b, c and d)

The items will be funded under the MBS special appropriation on a demand driven basis. The Department does not have set targets for these services. Estimates used for costing the midwives and nurse practitioner items were part of Cabinet consideration in the Budget context and therefore cannot be made available by the Department.

e) The items will be funded under the PBS special appropriation on a demand driven basis. The Department does not have set targets for these services. Estimates used for costing the midwives and nurse practitioner items were part of Cabinet consideration in the Budget context and therefore cannot be made available by the Department.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-232

OUTCOME 5: Primary Care

Topic: GP SUPER CLINICS

Hansard Page: CA 136

Senator Boyce asked:

Could you tell us or tell me where and what services they (*the five 'partially operational' GP Super Clinics*) do provide and when they would be fully operational?

Answer:

The following report reflects the situation as at 16 November 2009. As 'fully operational' is not a formal milestone under the funding agreement, we have provided timeframes for 'practical completion', which requires building works to be complete and services to have commenced. These are approximate time frames as timely completion of construction is heavily dependent on external factors, including local council building planning and approval processes, availability of construction workforce, materials and weather conditions.

GP Super Clinic early services are being provided as follows:

GP Super Clinic location	**Description of early services**	**Anticipated completion date**
Blue Mountains (NSW)	A new GP and a practice nurse are providing additional services at the Blackheath Clinic.	New facility (Springwood hub) - Late 2010
Devonport (TAS)	Asthma, chronic disease management clinic, and phasing-in of diabetes chronic disease management clinic being provided from existing facilities.	New facility – Mid 2010
North Central Coast (NSW)	GPs, practice nurses, physio, podiatrist and audiometrist being provided at temporary refurbished site.	New facility - Early 2012
Southern Lake Macquarie (NSW)	New services provided –physio/rehabilitation centre including hydrotherapy, and increased pathology collection.	New facility - Late 2010
Palmerston (NT)	After hour services commenced as Phase 1 of implementing the GP Super Clinic on 15 December 2008.	New facility - Late 2010

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-097

OUTCOME 5: Primary Care

Topic: PRACTICE INCENTIVES PROGRAM (PIP)

Written Question on Notice

Senator Boyce asked:

The Government has stated that the PIP was developed to provide incentives that would discourage GPs from providing quick consultations resulting in unnecessary prescribing, tests and referrals. How is the reduction of quick consultations actually being measured?

Answer:

The original PIP documentation stated that: *"The PIP aims to compensate for the limitations of fee-for-service arrangements. Under these arrangements, practices that provide numerous quick consultations receive higher rewards than those that take the time to look after the ongoing health care needs of their patients. High throughput of patients is also associated with unnecessary prescribing, tests and referrals."*

The PIP provides incentive payments to encourage practices to improve the quality of care provided to patients. For example, the diabetes incentive payment rewards GPs for completing a number of activities, such as measuring blood pressure, conducting a comprehensive eye examination, and testing for microalbuminuria to ensure patients with diabetes receive best practice care. It is not possible to complete the activities required for some PIP incentives in a short consultation.

Other PIP incentives aim to encourage practices to improve the quality of care provided to patients in those areas that are not reimbursed through fee-for-service arrangements, such as the supervision of medical students and the use of e-health technologies.

The Government closely monitors the number of general practices receiving payments for each of the PIP incentives, to identify changes in behaviour and improvements in the quality of care being provided to patients.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-028

OUTCOME 6: Rural Health

Topic: ISOLATED PATIENTS AND ASSISTED TRAVEL SCHEME

Written Question on Notice

Senator Williams asked:

My office has written on two occasions to the Minister for Health and Ageing regarding the Isolated Patients Travel and Accommodation Assistance Scheme (IPTAAS) inquiry that concluded in September 2007. There were 16 recommendations that came from the IPTAAS Inquiry. Could you please advise specifically which if any of the recommendations have been implemented by the Federal Government?

Answer:

State and territory governments are responsible for administering patient assisted travel schemes (PATS). The Commonwealth Government has no funding or policy responsibility for PATS.

Accordingly, very few of the Senate Inquiry recommendations fall within Australian Government responsibility.

In relation to Recommendation one of the Senate Community Affairs Committee report, as part of the New National Healthcare Agreement, states and territories have committed to providing and funding PATS and ensuring patients are aware of how to access the schemes.

In addition, in relation to Recommendation 14, as part of the 2009-10 Federal Budget, the Commonwealth Government committed $560 million from its Health and Hospital Fund for the construction of a network of around ten best practice regional cancer centres, including associated accommodation facilities, to help improve access and support for cancer patients in rural and regional Australia.

The Commonwealth Government is continuing to work with states and territories to improve the system so that patients can travel to attend essential medical and specialist services.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-234

OUTCOME 6: Rural Health

Topic: COMMONWEALTH FUNDING FOR RURAL PROGRAMS

Hansard Page: CA 91

Senator Williams asked:

a) What is the funding provided from every Commonwealth specific targeted rural program where the Commonwealth is responsible for the delivery and the funding?

b) Can you provide a briefing on programs that are specifically targeted for rural and remote Australia?

Answer:

a) Total spending by the Commonwealth Government on targeted rural and remote health programs is $1,049.7 million over four years (2009-10 to 2012-13).

b) The following is a list of Commonwealth specific targeted rural programs.

Current Program Name: Regional Health Services
Funding 2009-10: $49,229,000
Program Description

- The Regional Health Services (RHS) program aims to improve the health and wellbeing of people in rural Australia by increasing the access to a broad range of primary health services for the prevention and treatment of illness in communities of less than 5,000 people.
- The RHS program supports supplementary non-medical primary health care services including: community nursing; dietetics, podiatry, physiotherapy, speech therapy and occupational therapy; mental health and counselling services; social work; health promotion and education activities; youth, drug and alcohol services; family and child health services; and Indigenous health services.
- Services are delivered by existing community primary health care providers and include state/NT government health services; Aboriginal Health Services; local government; non-government organisations; and Divisions of General Practice. The actual services delivered depend on the identified needs of the communities covered.
- As part of the 2009-10 Federal Budget, the RHS will be consolidated to form the new Rural Primary Health Services (RPHS) Program as from 1 January 2010.

Current Program Name: More Allied Health Services
Funding 2009-10: $16,980,000
Program Description

- The More Allied Health Services (MAHS) program aims to increase access to a range of allied health services to rural communities.
- MAHS addresses unmet need through Divisions of General Practice identifying and purchasing approved allied health services that are deemed to be most needed in their local community. General practitioners refer patients to allied health professionals based on patient need.
- MAHS provides funding for clinical care by allied health workers in rural and remote communities including services by physiotherapists, podiatrists, social workers, psychologists, Aboriginal mental health workers, Aboriginal health workers, diabetes educators, dieticians and other primary health care providers.
- As part of the 2009-10 Federal Budget, the MAHS will be consolidated to form the new Rural Primary Health Services (RPHS) Program from 1 January 2010.

Current Program Name: Multipurpose Centres
Funding 2009-10: $1,990,000
Program Description

- The Multi Purpose Centres (MPC) program aims to assist rural and remote communities to gain access to, and coordinate appropriate health and community services.
- The program is targeted at rural communities that are not able to sustain existing services, or establish new services on a stand alone basis, in recognition of the need to coordinate health and community services to rural and remote communities in a more flexible and effective way.
- As part of the 2009-10 Federal Budget, MPCs will be consolidated to form the new Rural Primary Health Services (RPHS) Program from 1 January 2010.

Current Program Name: Building Healthy Communities & National Rural Primary Health Projects (health only)
Funding 2009-10: $7,864,000
Program Description

- The Primary Health Projects Sub-Program was part of the Rural Primary Health Program. The Primary Health Projects Sub-Program takes a preventative approach to:
  - help people living in rural and remote areas of Australia to change their lifestyle, through the provision of information, activities, encouragement and support;
  - develop community connections in ways that encourage people to take action to improve their own health and health services; and
  - improve the management of chronic disease.
- Particular targets for the projects were the principal chronic disease risk factors of:
  - injury;
  - smoking;
  - harmful alcohol consumption;
  - obesity; and
  - low levels of physical activity.
- There were two types of Primary Health Project:
  - National Rural Primary Health projects; and
  - Building Healthy Communities in Remote Australia (BHC) Initiative.

- As part of the 2009-10 Federal Budget BHC will be consolidated to form the new Rural Primary Health Services (RPHS) Program, from 1 January 2010.

Current Program Name: Medical Specialist Outreach Assistance Program
Funding 2009-10: $19,228,000
Program Description

- The Medical Specialist Outreach Assistance Program (MSOAP), introduced in 2000, aims to improve access for people living in rural and remote areas to medical specialist services. MSOAP addresses some of the financial disincentives incurred by specialists providing outreach services and complements specialist outreach services provided by state and Northern Territory governments.

- The program's objectives are to:
  - increase visiting specialist services in areas of identified need;
  - support medical specialists to provide outreach medical services in regional, rural and remote areas;
  - facilitate visiting specialist and local health professional relationships and communication about ongoing patient care; and
  - increase and maintain the skills of regional, rural and remote health professionals in accordance with local need.

- Support for specialists in the form of assistance with travel costs, accommodation, venue hire and some administration associated with outreach visits, removes some of the disincentives of providing outreach in rural and remote locations.

- In 2008-09, 1,430 MSOAP outreach services were funded nationally, noting that a service is defined as a specialist providing outreach to an outreach location.

Current Program Name: Medical Specialist Outreach Assistance Program Indigenous Chronic Disease (MSOAP ICD)
Funding 2009-10: $1,397,000
Program Description

- As part of the Australian Government's commitment to the National Partnership Agreement on *Closing the Gap in Indigenous Health*, funding over four years from 2009-10 has been allocated to expand the MSOAP to focus on diabetes, cardiovascular disease, chronic respiratory disease, chronic renal disease and/or cancer in identified indigenous communities

- This measure introduces Multidisciplinary Service Teams (MDTS) (general practitioners, medical specialists and allied health professionals), to better manage the complex and chronic health conditions experienced by Indigenous Australians in rural and remote areas. The composition of the teams will vary depending on the health and treatment needs of the people in communities.

- The MSOAP-ICD measure intends to primarily focus service delivery in Australian Standard Geographical Classification (ASGC) – Remoteness Areas - remote and very remote; however, Indigenous communities situated in Inner Regional and Outer Regional locations will be considered where a service may enhance access to health services for resident and surrounding Indigenous communities.

- MSOAP Advisory Forums in each state and the Northern Territory will work with Indigenous Health Partnership forums to identify and prioritise community needs. Services through this Program will commence in late 2009-10.

Current Program Name: Medical Specialist Outreach Assistance Program Maternity Services (MSOAP)
Funding 2009-10: $0 - Program commences from 1 July 2010.
Program Description

- Funding over four years was allocated in the 2009-10 Budget to expand MSOAP to provide outreach maternity services in rural and remote Australia.
- This measure will foster a collaborative team approach to maternity services with registered midwives, registered maternal and child health nurses and allied health professionals working in conjunction with obstetricians. Local health professionals will also be involved and opportunities for upskilling from visiting team members will be provided.
- MSOAP Advisory Forums in each state and the Northern Territory are responsible for identifying and prioritising service needs. These forums comprise a broad range of stakeholders with relevant knowledge and expertise. It is expected that in implementing this measure the forum will be expanded where necessary to include appropriate representation from specialist maternity service providers/organisations.

Current Program Name: Visiting Optometrist Scheme
Funding 2009-10: $2,873,000
Program Description

- The Visiting Optometrists Scheme (VOS) aims to improve the access of people living and working in rural and remote communities to optometric services. This is achieved by addressing some of the financial disincentives incurred by participating optometrists providing outreach services.
- In the 2007-08 Budget, the Australian Government announced additional funding to the VOS bringing total funding to $11.9 million over four years (2007-08 to 2010-11).
- Funding may cover optometrists' travel, accommodation and meals, facility fees and administrative support at outreach location, external locum support at the home practice, and the lease and transport of equipment. In addition, an absence from practice allowance may be payable to compensate optometrists for 'loss of business opportunity' due to the time spent travelling to and from an outreach location to deliver VOS supported services.

Current Program Name: VOS Expansion - Eyes and Ears Budget Measure
Funding 2009-10: $753,000
Program Description

- The *Improving Eye and Ear Health Services for Indigenous Australians for Better Education and Employment Outcomes* measure under the *Closing the Gap* package includes funding of nearly $6.5 million (GST exclusive) over four years to expand the VOS. This additional funding will increase the frequency of visits to Indigenous communities currently receiving outreach services by participating optometrists, as well as to establish new services to remote and very remote Indigenous communities with the greatest identified need.
- The Department will utilise existing VOS reference groups in each state and the Northern Territory, and the VOS national advisory committee, to determine a national priority list of rural and remote Indigenous communities in need of optometric services.

Current Program Name: Royal Flying Doctor Service
Funding 2009-10: $62,744,866
Program Description

- The Australian Government funds the Royal Flying Doctor Service (RFDS) to provide "traditional" services (health care clinics, primary aero-medical evacuations, medical chests and remote consultations) in rural and remote Australia.

Current Program Name: Rural Women's GP Service
Funding 2009-10: $3,220,000
Program Description

- The Rural Women's GP Service (RWGPS) aims to improve access to primary health care services for women in rural and remote Australia, who currently have little or no access to a female GP, by facilitating the travel of female GPs to these communities. The RWGPS is open to all members of the community, including men and children.
- Funding is provided to support the travel of female GPs to eligible locations to provide primary care clinics. RWGPS funds are used to pay for items such as female GP salaries, travel, medical consumables and host facility fees. In addition to direct funding, the RFDS also bills Medicare for consultations. The RWGPS is a free service to patients.
- The RWGPS is administered through a funding agreement with the Australian Council of the RFDS of Australia and the Service is provided by each of the four RFDS Operational Sections.

Current Program Name: National Rural and Remote Health Infrastructure Program
Funding 2009-10: $9,697,000
Program Description

- As part of the 2008-09 Federal Budget, the Australian Government announced the establishment of the National Rural and Remote Health Infrastructure Program (NRRHIP), a new competitive grant program that will improve access to health services by funding projects in rural and remote communities where a lack of infrastructure is a barrier to the establishment of new health services, or the enhancement of existing health services.
- NRRHIP is an amalgamation of the former Rural Medical Infrastructure Fund (RMIF) and the former Rural Private Access (RPA) program.
- NRRHIP will direct more than $46 million over four years to the provision of essential health infrastructure (capital works and/or purchase of equipment), which will, in turn, support the development of innovative models of health service delivery for rural and remote communities. Funding is also provided to small rural private hospitals for strategic service planning.
- A total of $500,000 (GST exclusive) per application is available under the NRRHIP to eligible applicants willing to provide health services to rural and remote communities that have populations of up to 20,000. The amount for each funding stream of an application is capped as follows:
  - $500,000 (GST exclusive) for capital works / refurbishment;
  - $250,000 (GST exclusive) for equipment; and/or
  - $50,000 (GST exclusive) for strategic service planning for rural private hospitals.
- Applicants eligible for funding under the NRRHIP are:

  - Local government organisations (shire councils, district councils, regional councils);
  - Divisions of General Practice;

  - Indigenous Community Councils (or incorporated Aboriginal Corporations registered under The *Corporations (Aboriginal and Torres Strait Islander) Act 2006* (CATSI Act);
  - private practitioners, where funding will be used for training facilities for medical students/registrars;
  - allied health professionals, who are providing privately insurable health services; dentists in private practice; and
  - small rural private hospitals eligible for funding under the former Bush Nursing, Small Community and Regional Private Hospitals program, as well as private hospitals eligible under the RPA program.

- Divisions of General Practice and local government organisations may also apply for NRRHIP funding for facilities which are located on public hospital or health campus grounds.

Current Program Name: National Rural Health Alliance
Funding 2009-10: $916,206
Program Description

- The National Rural Health Alliance (NRHA) is funded by the Australian Government, to operate a Secretariat to facilitate a range of information management and coordination functions in order to resource and inform governments, key stakeholders and Australians living in rural areas, on rural health matters.

- The NRHA undertakes a range of activities as the non-government peak body representing rural health organisations. It is comprised of 28 Member Bodies, representing health consumers, health professionals and health service providers.

Current Program Name: Services for Australian Rural and Remote Allied Health
Funding 2009-10: $285,005
Program Description

- Services for Australian Rural and Remote Allied Health (SARRAH) is funded by the Australian Government, to represent rural and remote allied health professionals. SARRAH's membership consists of individual allied health professionals across rural and remote Australia.

Current Program Name: Rural Doctors Association of Australia
Funding 2009-10: $364,162
Program Description

- RDAA is funded to undertake a range of activities to support medical practitioners working in rural and remote communities, with a particular focus on:
  - ensuring that the interests and viewpoints of medical practitioners either practising or intending to practise in rural and remote communities are represented;
  - communicating government policies to its members; and
  - presenting to the Department, analysis and research on Commonwealth Government policies and input to the development of future policies.

Current Program Name: Council of Remote Area Nurses of Australia
Funding 2009-10: $1,221,529

Program Description

- This funding supports Council of Remote Area Nurses of Australia (CRANA) operational activity, provides remote specific professional development and supports programs for remote area nurses. The Department funds CRANA to support these goals through funding three components: the Secretariat, the First Line Emergency Care Program and a Health Research Education Officer position.

Current Program Name: National Rural Health Students Network
Funding 2009-10: $885,400
Program Description

- The National Rural Health Students' Network (NRHSN) is funded by the Australian Government to represent 29 Rural Health Clubs with over 8000 members located at universities throughout Australia. The NRHSN is a multidisciplinary Network representing medical, nursing and allied health students aiming to increase the health workforce and health outcomes for rural and remote Australians.

Current Program Name: Health Consumers of Rural and Remote Australia
Funding 2009-10: $54,806
Program Description

- The Health Consumers of Rural and Remote Australia (HCRRA) is funded by the Australian Government to improve rural health outcomes by involving consumers in planning, implementation, management and evaluation of health services throughout rural and remote Australia.

Current Program Name: National Rural and Remote Health Stakeholder Support Scheme
Funding 2009-10: $0 - Program commences from 1 July 2010
Program Description

- As a result of the review of Commonwealth funded rural health programs, the Government agreed to establish a *National Rural and Remote Health Stakeholder Support Scheme*, effective from 1 July 2010. This initiative will develop a consistent approach to the funding provided to six peak rural and remote health stakeholder organisations to help support their core secretariat functions and to enable them to contribute to the development of better policy and programs to address rural and remote health issues.

- The organisations affected by this initiative are:
  - National Rural Health Alliance;
  - Services for Rural and Remote Allied Health;
  - Rural Doctors Association of Australia;
  - Health Consumers of Rural and Remote Australia;
  - Council of Remote Area Nurses of Australia; and
  - National Rural Health Students Network.

- A single set of criteria and guidelines will be developed for the *National Rural and Remote Health Stakeholder Support Scheme* that clearly articulate the basis on which these organisations are funded and the expected outcomes. It will also reduce the administrative burden on stakeholder organisations by introducing streamlined reporting and accountability requirements for the funding.

Current Program Name: Rural Retention Program
Funding 2009-10: $24,613,000
Program Description

- The Rural Retention Program is an initiative that recognises long-serving general practitioners in rural and remote communities that may experience significant difficulties in retaining general practitioners.

- The Program is designed to recognise long-serving doctors in these locations and provide incentive payments to them in order to encourage them to stay longer. Communities in which these doctors work will benefit through improved access to general practice services and continuity of health care.

- Eligibility and payment amounts are based on:
  - the length of service of individual doctors;
  - the remoteness of the area they are practising in; and
  - the level of services they provide.

Current Program Name: Registrars Rural Incentive Payment Scheme (RRIPS)
Funding 2009-10: $17,351,000
Program Description

- This program encourages general practice registrars to take up the Rural Pathway. RRIPS offers structured financial incentives to those registrars who commit to the Rural Pathway. Medicare Australia administers the incentive payments.

Current Program Name: HECS Reimbursement Scheme
Funding 2009-10: $5,451,000
Program Description

- The HECS Reimbursement Scheme aims to promote careers in rural medicine and increase the number of doctors in rural and regional Australia in the longer term. The Scheme commenced in 2000-01.

- Through the Scheme, communities will gain improved access to health services as more doctors move to work in rural areas. Participants, who undertake training or provide medical services in designated rural and remote areas of Australia, will have one fifth of their HECS medical fees reimbursed for each year of service.

- The scheme applies to Australian medical graduates who choose to undertake postgraduate training, or provide medical services in designated rural and remote areas.

Current Program Name: Workforce Support for Rural GPs
Funding 2009-10: $3,032,000
Program Description

- The Workforce Support for Rural GPs (WSRGP) program provides funding to support newly arrived and existing general practice workforce (including registrars and medical students) in rural areas. The aim of the WSRGP is to develop the capacity of the general practitioner workforce in rural and remote areas, and the accessibility of the general practitioner workforces to rural and remote communities.

Current Program Name: Rural and Remote General Practice Program
Funding 2009-10: $18,262,000
Program Description

- The Rural and Remote General Practice Program provides funding to Rural Workforce Agencies in each state and the Northern Territory to provide a range of activities and support to improve the recruitment and retention of GPs to rural and remote areas. This includes helping communities to recruit GPs, finding appropriate placements for doctors who want to relocate to rural Australia, assisting with the costs of relocation, supporting

their families with fitting into a new community and helping doctors to access the necessary infrastructure, support and training.

Current Program Name: Training for Rural & Remote Procedural GPs Program
Funding 2009-10: $18,000,000
Program Description

- This program provides financial assistance for procedural GPs in rural and remote areas to access relevant activities in order to assist them in maintaining or updating their skills.
- The program has two components:
  - a grant for the cost of up to ten days training, including the cost of locum relief to a maximum of $20,000 per GP; and
  - a grant for the cost of up to 3 days training, to a maximum of $6,000 per GP per financial year.
- The Australian College of Rural and Remote Medicine, the Royal Australian College of General Practitioners and Medicare Australia jointly administer the program.

Current Program Name: Recruitment, Support, Coordination & Assistance for Overseas Trained Doctors
Funding 2009-10: $17,009,000
Program Description

- This is a package of measures to attract and assist Overseas Trained Doctors (OTDs) in their efforts to work in Australia as medical practitioners. Key features include:

Section 19AB

- Section 19AB of the Act (also known as the ten year moratorium), restricts access to Medicare provider numbers and requires OTDs to work in a district of workforce shortage for a minimum period of ten years in order to access the Medicare benefits arrangements.
- In 2010-11 a scaling incentive will be applied to the ten year moratorium where the moratorium will be scaled so that former overseas medical students and OTDs who choose to practice in rural and remote areas will be able to discharge their return of service obligation in a shorter period of time.
- The Health Insurance Amendment (New Zealand Overseas Trained Doctors) Bill 2009 will affect those OTDs who first arrived in Australia on a temporary visa, obtained medical registration and who subsequently achieved permanent residency status. The amendment proposes that the ten year moratorium will be counted from the time the medical practitioner is first registered as a medical practitioner in Australia, rather than when they became a permanent resident, and will cease after ten years, provided the medical practitioner has gained permanent residency or citizenship during that period.

International recruitment strategies

- Contracted medical recruitment agencies assist employers/sponsors of medical practitioners to find appropriately qualified OTDs to fill their eligible vacancies. They also assist OTDs with arranging immigration, medical registration, specialist recognition where appropriate, and access to Medicare rebates. In late 2008, Rural Health Workforce Australia (RHWA) agreed to take on the management of this program. This transition process was completed on 1 December 2008. As of this date, Rural Health Workforce Australia responsible for the administration of the International Recruitment Strategy on behalf of the Department of Health and Ageing.

Improved training arrangements and additional support program

- The Department provides funds for training and mentoring under the Five Year OTD and Rural Locum Relief Additional Assistance Programs to encourage doctors working in rural and remote locations to achieve Fellowship of the Royal Australian College of General Practitioners. Since 2005, at least 200 doctors have gained Fellowship under this program.

Assistance for OTDs and employers in arranging placements

- The DoctorConnect website (www.doctorconnect.gov.au) provides advice and assistance for OTDs seeking to enter the Australian medical workforce. The website also provides information for Australian employers wishing to recruit an OTD. The DoctorVacancy website (www.doctorvacancy.com.au) provides a medical practitioner job vacancy listing facility to complement the DoctorConnect website and provide a listing of available employment opportunities throughout Australia.

Current Program Name: Specialist Obstetricians Locum Scheme
Funding 2009-10: $1,965,000
Program Description

- The Specialist Obstetricians Locum Scheme (SOLS) supports the access of rural women to quality local obstetric care by providing the rural specialist obstetrician workforce with locum support. The scheme also aims to sustain safety and quality in rural practice by facilitating access to personal leave or professional development or breaks from on-call commitments for rural obstetricians. Additional funding was provided through the 2008 Federal Budget to expand the scheme. SOLS is managed by the RDAA, the Royal Australian and New Zealand College of Obstetricians and Gynaecologists and Rural Health Workforce Australia (represented by the NSW Rural Doctors Network).

Current Program Name: Rural Other Medical Practitioners Program
Funding 2009-10: $69,500,000
Program Description

- This program encourages non-vocationally recognised medical practitioners to provide general practice services in eligible rural locations by providing access to the higher A1 Medicare rebate.

Current Program Name: University Departments of Rural Health
Funding 2009-10: $20,558,000
Program Description

- The University Departments of Rural Health program encourages students of medicine, nursing and other health professions to pursue a career in rural practice by providing opportunities for students to practise their clinical skills in a rural environment. It also supports health professionals currently practising in rural settings.

Current Program Name: John Flynn Placement Program
Funding 2009-10: $3,064,000
Program Description

- Under this program, working closely with a rural doctor mentor and the placement community, medical students develop an overview of the challenges and rewards associated with rural medical practice and non-metropolitan health care services. An amount of $500 per week is paid to cover food and living expenses while on placement. Costs of travel and accommodation are organised and paid for by the Australian College of Rural and Remote Medicine, which is the national management agency for the program.

Current Program Name: Dental Training Expanding Rural Placements Program
Funding 2009-10: $1,918,000
Program Description

- This program supports clinical placements for metropolitan dentistry students in established rural training settings. Funding through this measure includes capital funding, student support, new teaching appointments and administration costs.

Current Program Name: Rural Undergraduate Support and Coordination Program
Funding 2009-10: $5,883,000
Program Description

- This program funds participating Australian medical schools to perform three key functions:
  - promoting the selection of rural applicants;
  - developing support systems for medical students with an interest in rural medicine; and
  - providing short-term rural placements for all Australian medical students

Current Program Name: Rural Health Education Foundation
Funding 2009-10: $742,000
Program Description

- The Department has provided funding to Rural Health Education Foundation (RHEF) since 2004. RHEF provides access to continuing professional development and medical education broadcasts to health professionals in rural and remote Australia.

Current Program Name: Support Scheme for Rural Specialists
Funding 2009-10: $1,200,000
Program Description

- This program improves access to Continuing Professional Development (CPD) activities for rural and remote based specialists. The scheme aims to ameliorate factors that contribute to medical specialists moving away from rural based practice, including isolation and difficulties in accessing CPD available to specialists in large centres.

Current Program Name: Rural Advanced Specialist Training Scheme
Funding 2009-10: $490,000
Program Description

- This program provides funding to specialist colleges for specialist training initiatives in rural Australia. Under this program, funding has been provided to anaesthetists, dermatologists, obstetricians and gynaecologists, physicians, psychiatrists and surgeons for a range of projects to support advanced trainee specialists in rural areas. Projects have included mentoring, workshops, training activities using modern communications technology and other outreach programs.

Current Program Name: Rural Health, Support, Education and Training Program
Funding 2009-10: $700,000
Program Description

- The Rural Health, Support, Education and Training Program contributes towards the recruitment and retention of rural health workers. It does this by funding initiatives that provide health workers with appropriate support, education or training to improve the health status of rural and remote communities.

Current Program Name: Rural Practice Nurse Incentive
Funding 2009-10: $29,800,000

Program Description

- The Rural Practice Nurse Incentive payments aim to encourage general practices to employ a practice nurse and/or an Aboriginal health worker. Practices in rural and remote areas can access funding of up to $35,000 per annum to support the employment of practice nurses.

Current Program Name: Procedural General Practitioner Payment
Funding 2009-10 : $10,000,000
Program Description

- The Procedural GP Payments aim to encourage GPs in rural and remote areas to maintain local access to surgical, anaesthetic and obstetric services. A procedural GP provides non-referred services, normally in a hospital theatre, maternity care setting or appropriately equipped facility that are typically the province of a specific referral based specialty in urban areas. There are four levels of payments available through the Practice Incentives Program procedural GP payment, ranging from $1,000 to $17,000 per year, depending on the activities provided by the practice.
-

Current Program Name: Domestic Violence Incentive
Funding 2009-10: $4,000,000
Program Description

- The Domestic Violence Incentive aims to encourage general practices in rural and remote areas to act as a referral point for women experiencing domestic violence.
- Practices in rural and remote areas can access funding of up to $4,000 per annum to have available for a minimum number of sessions an appropriately trained and qualified nurse or Aboriginal health worker to act as a referral point to domestic violence support services for women experiencing domestic violence.
- A key eligibility requirement of the Domestic Violence Incentive is that practices must have an appropriately trained practice nurse or Aboriginal health worker. The relevant training is provided by Lifeline Australia.

Current Program Name: Rural Pharmacy Maintenance Allowance (RPMA)
Funding 2009-10: $71,400,000 is allocated to RPMA for the life of the Fourth Community Pharmacy Agreement until 30 June 2010
Program Description

- The Rural Pharmacy Maintenance Allowance Program aims:
  - to retain Australia's rural and remote pharmacy network; and
  - to provide income support to pharmacies in rural and remote areas in recognition of the additional financial and personal cost of operating in these areas.

Current Program Name: Rural Pharmacy Start-Up Allowance
Funding 2009-10: $1,500,000 is allocated to the Start-Up allowance for the life of the Fourth Community Pharmacy Agreement until 30 June 2010
Program Descriptio

- The Start-Up Allowance aims:
  - to encourage pharmacies to open in more remote locations that currently do not have a pharmacy and there is evidence that a pharmacy can be viable and would be supported by the community;
  - the scheme provides a subsidy of $100,000, paid over two years; and
  - the pharmacy premises must be established in either a Pharmacy ARIA category 6 ("Very Remote") or 5 ("Remote") to be eligible for the allowance.

Current Program Name: Rural Pharmacy Succession Allowance
Funding 2009-10: $2,100,000 is allocated to the Start-Up allowance for the life of the Fourth Community Pharmacy Agreement until 2010

Program Description

- The Succession allowance aims:
  - to encourage the purchase of existing rural pharmacies that would otherwise close down.
  - the allowance of $60,000, over two years, is available where the existing owner wishes to retire or move, and has been unable to sell for two years or more despite genuine attempts to do so.
  - for eligibility, the pharmacy premises must be located in a Pharmacy ARIA category 6 ("Very Remote"), 5 ("Remote"), or 4 ("Moderately Accessible").

Current Program Name: Rural Pharmacy Pre-Registration Allowance
Funding 2009-10: $10,400,000 is allocated to the Start-Up allowance for the life of the Fourth Community Pharmacy Agreement until 30 June 2010

Program Description

- The Pre-Registration Allowance Program aims:
  - to increase the rural pharmacy workforce by encouraging the placement of new graduates in rural and remote pharmacies.
  - the Pre-Registration Incentive Allowance pays up to $10,000 per pharmacy per annum for a 12 month placement (minimum $5,000 for a 6 month placement) to offset the costs of employing and training a pharmacy graduate during their pre-registration year.

Current Program Name: Rural Pharmacy Workforce Program.
Funding 2009-10: $25,300,000 is allocated to the Rural Pharmacy Workforce Program for the life of the Fourth Community Pharmacy Agreement until 30 June 2010

Program Description

- The Rural Pharmacy Workforce Program (RPWP) aims:
  - to maintain and improve access to quality community pharmacy services in rural and remote communities, and
  - to strengthen and support the rural and remote pharmacy workforce in Australia.
- The RPWP consists of various initiatives designed to:
  - recruit, train and retain pharmacists for rural and remote areas including undergraduate and postgraduate scholarships;
  - an emergency locum scheme;
  - student placement allowance scheme;
  - specific scholarships for indigenous students;
  - small project funding;
  - rural commissioned research projects;
  - placement of pharmacist academics in rural areas;
  - a national rural pharmacy promotion campaign; and
  - a rural pharmacy newsletter.

Current Program Name: Multi Purpose Services
Funding 2009-10: $101,721,000
Program Description

- The Multi Purpose Services (MPS) program aims to provide a flexible and integrated approach to health and aged care service delivery to small rural communities. Funding for MPS is provided by both the Australian Government and the relevant state government.

Current Program Name: Mental Health Services in Rural and Remote Areas Program
Funding 2009-10: $15,403,000
Program Description

- The Commonwealth is providing funding of up to $91 million from 2006-07 to 2012-13 under the Mental Health Services in Rural and Remote Areas (MHSRRA) Program. The MHSRRA Program funds Divisions of General Practice, Aboriginal Medical Services and the Royal Flying Doctor Service for the delivery of mental health services by appropriately trained mental health care workers, including psychologists, social workers, occupational therapists, mental health nurses, Aboriginal health workers and Aboriginal mental health workers.

- The MHSRRA Program provides funding for mental health professionals in communities that would otherwise have little or no access to mental health services. The program is designed to address inequities in access to the Medicare Benefits Schedule (MBS) by targeting areas where access to MBS subsidised mental health services is low. The MHSRRA Program also addresses workforce shortage issues by providing flexible employment models suited to local needs and conditions. This includes flexibility to accommodate geographically, culturally and linguistically diverse populations, such as indigenous communities, in rural and remote areas of Australia.

Current Program Name: Mental Health Support for Drought Affected Communities
Funding 2009-10: $5,197,000
Program Description

- The *Mental Health Support for Drought Affected Communities* Initiative provides funding over three years (2007-2010) to build the capacity of drought affected communities to respond to the psychological impact of drought. The majority of the funding has been allocated to 42 eligible Divisions of General Practice to provide community outreach and crisis counselling for distressed individuals, families and communities. Funding has also been allocated to *beyondblue* and the Australian General Practice Network for community awareness activities, education and training for health workers and community leaders.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-236

OUTCOME 6: Rural Health

Topic: MEDICAL SPECIALIST OUTREACH ASSISTANCE PROGRAM

Hansard Page: CA 93

Senator Adams asked:

Has the level of service from the Medical Specialist Outreach Program (MSOAP)increased, in relation to people accessing the service, since 2008-09?

Answer:

The Department will not be in a position to answer this question until 2009-10 service data is received and validated. Fundholders provide the Department with MSOAP service data every six months. The first service data report for services delivered in the period 1 July 2009 to 31 December 2009 is due for submission to the Department in February 2010.

In 2008-09, patient numbers for the MSOAP came to a total of 171,291. It should be noted that that this figure does not necessarily reflect the number of people who accessed MSOAP services, as numbers may include individual patients who made multiple visits to a service provider.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-237

OUTCOME 6: Rural Health

Topic: NATIONAL RURAL AND REMOTE HEALTH INFRASTRUCTURE PROGRAM (NRRHIP)

Hansard Page: CA 94

Senator McEwan asked:

Were there any repeat applicants (from previous rounds) in round 3 of the National Rural and Remote Health Infrastructure Program?

Answer:

In total there were 238 applications received under round three of the NRRHIP. Of those, 48 were repeat applicants from rounds one and two.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-235

OUTCOME 6: Rural Health

Topic: RURAL HEALTH PROGRAM FUNDING

Hansard Page: CA 35

Senator Williams asked:

How much is spent per capita on rural and remote area health compared to urban areas – specifically, details of funding provided from every Commonwealth specific targeted rural program delivered by Deptartment of Health and Ageing.

Answer:

Eligibility for targeted Commonwealth rural health programs under the rural health program structure given policy authority in the 2009-10 budget excludes services delivered in Australian Standardised Geographic Classification Remoteness Area (ASGC–RA) 1 – Major Cities. Expenditure per capita in ASGC–RAs 2-5 (Inner Regional to Very Remote) on Commonwealth targeted rural health programs is $156 over four years from 2009-10 in addition to nation-wide health program expenditure (see note below). Details of targeted Commonwealth rural health programs are provided in response to Question E09000234.

Note: The 2009-10 Commonwealth Budget included a new program structure for rural health. For the four year budget and forward estimates period to 2012-13 the total budget for programs in the new rural health structure is $1,049.7m. 2008 ABS data shows the combined population of ASGC–RAs 2-5 is 6,738,845 giving the per capita figure above.

Note: The combined Medical Benefits Schedule (MBS) and Pharmaceutical Benefits Schedule (PBS) expenditure for 2008-09 is:

- Major cities and metropolitan $1,005 per capita (RRMA categories 1-2); and
- Rural and remote $901 per capita (RRMA categories 3-7).

The $156 per capita referred to above is in addition to the combined spending on MBS and PBS per capita.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 23 October 2009

Question: E09-252

OUTCOME 8: Indigenous Health

Topic: KATUNGUL ABORIGINAL MEDICAL SERVICE

Hansard Page: CA 4-5

Senator Payne asked:

From correspondence from Minister Macklin, I have an indication that these matters would also be referred to the Minister for Health and Ageing, Ms Roxon. Are you in a position, since you are from the relevant department, to indicate when I might expect a response from the Minister for Health and Ageing to the material referred to her by the Minister for Families, Housing, Community Services and Indigenous Affairs, Ms Macklin?

Answer:

A response on Minister Roxon's behalf was provided by The Hon Mark Butler MP, Parliamentary Secretary for Health on 18 September 2009. A copy is attached for reference.

The Hon Mark Butler MP
Parliamentary Secretary for Health

Senator Marise Payne
PO Box 1420
PARRAMATTA NSW 2150

Dear Senator Payne

I refer to your representations of 29 April 2009 to the Minister for Families, Housing, Community Services and Indigenous Affairs, the Hon Jenny Macklin MP, on behalf of Katungul Aboriginal Corporation Community and Medical Services, and representatives of the Wallaga Lake Aboriginal Community, regarding possible asbestos contamination in residential areas of Wallaga Lakes. Your letter has been referred to the Minister of Health and Ageing, the Hon Nicola Roxon MP. As Parliamentary Secretary for Health, the Minister has asked me to respond on her behalf. I apologise for the delay in responding.

I note that Minister Macklin has already provided you with a response which details the actions undertaken by the New South Wales Government and the Eurobodalla Shire Council in relation to this issue.

A risk assessment for the asbestos-containing material present at the Wallaga Lake Koori Village (the Village) was prepared for NSW Health by Pickford & Rhyder Consulting Pty Ltd. The final risk assessment report states that the asbestos-containing material present at the Village is in the form of bonded asbestos-cement.

Airborne sampling was undertaken at various locations throughout the Village, including the child care centre, to determine if there was a health risk in respect to airborne asbestos fibres. The results of all airborne asbestos fibre sampling were found to be less than the detection limit of the method, indicating that there is no measurable risk to health from airborne asbestos fibres.

Results of asbestos analysis of soil samples has indicated that no respirable or free asbestos fibres were detected in the soil. This result is significant as it indicates that the asbestos fibres are only present in the bonded asbestos-cement fragments and have not been separated from the fragments to become a health risk.

The report concludes that the health risk from asbestos of those people living and working at the Wallaga Lake Koori Village site is comparable to and cannot be differentiated from living in a suburban environment, and that no person would be exposed to measurable amounts of airborne asbestos fibres.

I trust that the above information is of assistance.

Yours sincerely

MARK BUTLER

18 SEP 2009

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 23 October 2009

Question: E09-257

OUTCOME 8: Indigenous Health

Topic: OPAL FUEL AND PETROL SNIFFING

Hansard Page: CA 49

Senator Adams asked:

Would you be able to supply the committee with a list of those communities you are consulting with?

Answer:

No. For privacy reasons this detail is not made public.

Consultations with relevant stakeholders, communities and fuel distributors are currently underway in the Goldfields region for the proposed roll-out of Opal fuel.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 23 October 2009

Question: E09-123

OUTCOME 8: Indigenous Health

Topic: ABORIGINAL MEDICAL SERVICES

Written Question on Notice

Senator Adams asked:

How many of the targeted 1,190 workers in Aboriginal Medical Services have been trained in identifying and responding to the early signs of mental illness and substance abuse so far?

Answer:

In 2008 ORYGEN Research Centre, University of Melbourne developed a culturally appropriate version of its Mental Health First Aid instructor training program for OATSIH-funded and other health services. During the term of its contract with the Department, ORYGEN trained 199 Aboriginal and Torres Strait Islander people as Aboriginal Mental Health First Aid (AMHFA) instructors (exceeding the original target of 120). As of November 2008, the 199 Aboriginal AMHFA Instructors had run 155, 14-hour AMHFA courses reaching 1115 people. The Department cannot specify how many of the participants were workers in Aboriginal Medical Services, as that level of detailed information was not collected.

In 2009-10, a number of Registered Training Organisations (RTOs) are being funded to deliver AMHFA training (14 hour course) and mental health worker training (five day course) nationally and the numbers of workers in Indigenous health, substance use and Social and Emotional Wellbeing services will be collected by the RTOs.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 23 October 2009

Question: E09-061

OUTCOME 8: Indigenous Health

Topic: ABORIGINAL MEDICAL SERVICES

Senator Payne asked:

In answer to a question on notice at Budget Estimates about the average response time from submission of a funding application by an Aboriginal Medical Service to notification, the department said:

'The response time depends on the criteria for assessing the application, what further information may be required, when it is received and in some cases when funding becomes available.'

a) With these variables in mind, what is the average response time from submission of a funding application to notification being delivered to the Aboriginal Medical Service?

b) If the department is unable to provide this information, why not?

Answer:

a and b)

This response should be read in conjunction with responses to Questions on Notice E09-062 and E09-063.

The majority of funding to Aboriginal or Torres Strait Islander community controlled health and substance use services is ongoing recurrent funds. These funds are allocated annually to the organisations together with an annual indexation increase without the need for a submission.

Response times for applications for funding against new Budget measures varies for each measure according to the complexity of project, the need for follow-up, the need for site visits and consideration by the respective state/territory Indigenous Health Partnership Forum.

In 2008-09 the Office for Aboriginal and Torres Strait Islander Health conducted six funding rounds for programs related to Budget measures. The average time taken from receipt of funding application to notification of outcome was 92 calendar days. Details of the rounds are as follows:

Program	Average number of calendar days from receipt of funding application to notification of outcome.
Bringing them Home Counsellors	24
COAG Substance Use	49
New Directions	73
Healthy for Life	96
Accreditation Support Grants	105
Australian Nurse Family Partnership Program	114

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 23 October 2009

Question: E09-062

OUTCOME 8: Indigenous Health

Topic: ABORIGINAL MEDICAL SERVICES

Written Question on Notice

Senator Payne asked:

'How many projects put forward for funding by Aboriginal Medical Services are currently waiting for approval?' and 'Can the department provide details about when each of these project funding requests was submitted?' The department replied:

'OATSIH invites applications for funding and also receives ad hoc requests for funding from organisations. aWhen OATSIH invites applications for funding, a systematic process is followed according to the specific criteria applicable...Unsolicited requests for funding are given careful consideration based on merit, in accordance with government priorities and availability of funds. Organisations are advised of the outcome at completion of assessment.'

None of this information answers the two original questions. Can the department now provide this information, and if not why not? (The questions relate to the effectiveness of the agency in carrying out its core business, and its service standards, and should not be difficult to answer.)

Answer:

This response should be read in conjunction with responses to Questions on Notice E09-061 and E09-063.

The Office for Aboriginal and Torres Strait Islander Health (OATSIH) currently has 67 applications for funding from Aboriginal and Torres Strait Islander community controlled health organisations awaiting approval.

Of the 67 requests:

- 18 are unsolicited (or ad hoc) requests for funding all of which have been received since August 2009.
    - six are for capacity building and development projects e.g. governance training and were received in September 2009;
    - one relates to funding for Men's Health and was received in October 2009; and

- 11 relate to miscellaneous requests for funding (for motor vehicles, IT enhancements, equipment upgrades etc.), the earliest of which was received in August 2009.

- 49 have been received in response to funding rounds, of which 84% have been received since September 2009. A breakdown is provided below for your information:

  - one x COAG 2007 Substance Use received September 2009;
  - four x New Directions received July and October 2009;
  - three x Healthy for Life received October and November 2009;
  - 34 x Accreditation Support Grants received September 2009; and
  - seven x Social and Emotional Wellbeing (SEWB) Support and Training Services received April 2009; this funding round was the result of a policy/program change. The Department is engaged in non-binding, pre-contractual negotiations with each of the organisations. In the meantime, funding has been provided to all of the organisations in line with previous contractual arrangements to ensure that services continue to be provided and that the organisations' clients are not disadvantaged.

The time taken from receipt of request for funding to decision is affected by a number of factors, including, but not limited to: poor or incomplete applications; feedback from the respective Indigenous Health Partnership Forum; site visits, assessment of infrastructure to deliver the program and confirming the availability and/or capacity to attract the workforce.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 23 October 2009

Question: E09-063

OUTCOME 8: Indigenous Health

Topic: OATSIH's FUNDING POLICY

Written Question on Notice

Senator Payne asked:

a) In answer to question on notice at Budget Estimates about whether the department could provide a copy of OATSIH's funding policy for Aboriginal or Torres Strait Islander community controlled health and substance use services, the department provided two paragraphs of information, none of which referred specifically to a funding policy. Is it correct then that OATSIH does not in fact have a formal funding policy for Aboriginal or Torres Strait Islander community controlled health and substance use services?

b) If it does, why did the department not supply it, and can it do so now?

Answer:

a and b)

The majority of funding to Aboriginal or Torres Strait Islander community controlled health and substance use services is ongoing recurrent funds. These funds are allocated annually to the organisations together with an annual indexation increase, without the need for a submission. This was the basis for the provision of core funds when the program was transferred to the Department of Health and Ageing in 1996 and has remained unchanged.

New funding for organisations becomes available through new Budget measures. These measures are appropriated for a specific purpose and this sets the parameters for how the funding may be used (e.g. to support child and maternal health programs, fund Indigenous outreach workers etc.).

Funding through these Budget measures has been allocated in accordance with the Commonwealth procurement or grant guidelines. Any organisation that fits the requirements for the funding is eligible to apply. Guidelines that outline the purpose and criteria for each funding process are made publicly available on the Department of Health and Ageing 'Tenders and Grants' internet page.

The allocation of funding under these new Budget measures also takes into account where ever possible the level of relative need and health priorities of Aboriginal and Torres Strait Islander people. These regional priorities are determined in consultation

with the Indigenous Health Partnership Forums which include representation by the Commonwealth and state and territory governments and state affiliates of the National Aboriginal Community Controlled Health Organisation.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 23 October 2009

Question: E09-064

OUTCOME 8: Indigenous Health

Topic: DECLINED FUNDING OFFERS

Written Question on Notice

Senator Payne asked:

a) In answer to a question on notice at Budget Estimates about the discontinuation of funding for Aboriginal and Torres Strait Islander community controlled health and substance use services, the department said that the Armidale and District Services group had declined to accept an offer of funding because they did not agree with the Commonwealth's conditions of funding. On what dates were the offer and refusal made?

b) What were the conditions with which they disagreed?

c) Were these new conditions that had not previously been part of their funding arrangements?

Answer:

a) The Department offered a funding agreement to Armidale Aboriginal Health Service Incorporated (AAHSI) on 25 October 2007. The then Minister for Health and Ageing, the Hon Tony Abbott received a letter dated 5 November 2007 from AAHSI stating that the organisation would not accept funding under the Department's conditions and would operate without Commonwealth funding. The NSW State Office of the Department received a letter dated 20 November 2007 from AAHSI noting that the Board had passed a resolution to not accept the funding offer without further negotiation.

b) AAHSI disagreed with the Department's intention to appoint a funds administrator/health management advisor to support the organisation.

c) There is an existing clause in the Department's Funding Agreement that allows the Department to appoint a funds administrator/health management advisor. In the letter of offer to AAHSI the Department advised of its concerns about the service and its intention to invoke this clause during the period of the Agreement.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 23 October 2009

Question: E09-065

OUTCOME 8: Indigenous Health

Topic: FUNDING FOR ABORIGINAL AND TORRES STRAIT ISLANDER COMMUNITY CONTROLLED HEALTH

Written Question on Notice

Senator Payne asked:

In answer to a question on notice at Budget Estimates, the department said that funding for Aboriginal and Torres Strait Islander community controlled health and substance use services increased from $290.722 million in 2007-08 to $328.625 million in 2008-09. How was this increase in funding spent?

Answer:

The increase of $37.903 million in funding was provided to organisations for providing comprehensive primary health care services. $36.853 million was allocated to Aboriginal and Torres Strait Islander community controlled organisations for various primary health care programs including Child and Maternal Health, Chronic Disease, Substance Use and Closing the Gap in the NT. $1.049 million was allocated to Aboriginal and Torres Strait Islander community controlled health services for social and emotional wellbeing services, the majority of which was for additional Bringing them Home counsellors.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 23 October 2009

Question: E09-066

OUTCOME 8: Indigenous Health

Topic: ABORIGINAL AND TORRES STRAIT ISLANDER COMMUNITY CONTROLLED HEALTH

Written Question on Notice

Senator Payne asked:

a) Did any of the Aboriginal and Torres Strait Islander community controlled health and substance use services that were already on recurrent funding agreements with OATSIH receive increases in funding as a result of the overall increase?

b) If so, how many, and which ones?

c) Were any new Aboriginal and Torres Strait Islander community controlled health and substance use services brought on to recurrent funding agreements with OATSIH as a result of the overall increase?

d) If so, how many, and which ones?

Answer:

a) Yes.

b) 169 Aboriginal and Torres Strait Islander community controlled health organisations that were already on recurrent funding agreements with OATSIH received increases in funding for primary health care, substance use and social and emotional wellbeing services as a result of the overall increase. They are:

Aboriginal & Torres Strait Islander Community Health Service Brisbane Limited
Aboriginal Alcohol & Drug Service (AADS)
Aboriginal and Islander Alcohol Awareness and Family Recovery Incorporated
Aboriginal and Torres Strait Islanders Community Health Service (Mackay) Limited
Aboriginal Drug & Alcohol Council of SA Incorporated
Aboriginal Medical Service Co-operative Limited
Aboriginal Medical Service Western Sydney Co-operative Ltd
Aboriginal Sobriety Group Incorporated
Aborigines and Islanders Alcohol Relief Service Limited
Albury Wodonga Aboriginal Health Service Incorporated
Ampilatwatja Health Centre Aboriginal Corporation

Anyinginyi Health Aboriginal Corporation
Australian First Nations Academy for Cultural Family Therapy and Counselling Ltd.
Awabakal Newcastle Aboriginal Co-operative Limited
Ballarat and District Aboriginal Co-operative
Barambah Regional Medical Service (Aboriginal Corporation)
Barkly Region Alcohol & Drug Abuse Advisory Group Incorporated
Bega Garnbirringu Health Service
Bendigo & District Aboriginal Co-Operative
Benelong's Haven Limited
Bidgerdii Aboriginal and Torres Strait Islanders Corporation Community Health Service
Biripi Aboriginal Corporation Medical Centre
Bourke Aboriginal Health Service
Broome Regional Aboriginal Medical Service
Bulgarr Ngaru Medical Aboriginal Corporation
Cape Barren Island Aboriginal Association Inc.
Carnarvon Medical Service Aboriginal Corporation
Central Australian Aboriginal Alcohol Programs Unit
Central Australian Aboriginal Congress Incorporated
Central Australian Stolen Generation & Families Aboriginal Corporation
Charleville and Western Areas Aboriginal and Torres Strait Islanders Corporation
Condobolin Aboriginal Health Service Incorporated
Congress Community Development and Education Unit Limited
Coomealla Health Aboriginal Corporation
Council for Aboriginal Alcohol Program Services Incorporated
Cummeragunja Housing and Development Aboriginal Corporation
Cunnamulla Aboriginal Corporation for Health
Dandenong and District Aborigines Co-operative Limited - Bunurong Health Service
Danila Dilba Health Service
Darling Downs Shared Care Incorporated (T/A Carbal Medical Centre)
Demed Association Incorporated Homeland Resource Centre
Derbarl Yerrigan Health Service Incorporated
Derby Aboriginal Health Service Council Aboriginal Corporation
Dharah Gibinj Aboriginal Medical Service Aboriginal Corporation
Djarragun College Limited
Durri Aboriginal Corporation Medical Services
Ferdy's Haven Alcohol Rehabilitation Aboriginal Corporation
Flinders Island Aboriginal Association Incorporated
Gallang Place Aboriginal and Torres Strait Islander Corporation
Geraldton Regional Aboriginal Medical Service
Gindaja Treatment and Healing Indigenous Corporation
Gippsland and East Gippsland Aboriginal Co-operative Limited
Goldfields/Esperance Federation of Aboriginal Health Incorporated
Goolburri Health Advancement Aboriginal Corporation
Goolum Goolum Aboriginal Co-operative
Goondir Aboriginal and Torres Strait Islanders Corporation for Health Services
Goori House Addiction Treatment Centre
Griffith Aboriginal Community Medical Service Incorporated

Gumbi Gumbi Aboriginal and Torres Strait Islanders Corporation
Gunditjmara Aboriginal Co-operative
Gurriny Yealamucka (Good Healing) Health Services Aboriginal Corporation
Illawarra Aboriginal Medical Service Aboriginal Corporation
Ilpurla Aboriginal Corporation
Jungarni - Jutiya Alcohol Action Council Aboriginal Corporation
Jurrugk Aboriginal Health Service Aboriginal Corporation
Kalano Community Association Incorporated
Kalparrin Community Incorporated
Kalwun Health Service
Kambu Medical Centre Ipswich Incorporated
KASH Aboriginal Corporation
Katherine West Health Board Aboriginal Corporation
Katungul Aboriginal Corporation Community & Medical Services
Kimberley Aboriginal Medical Services Council Incorporated
Kimberley Stolen Generation Committee Aboriginal Corporation
Kirrae Health Service Incorporated
Krurungal - Aboriginal and Torres Strait Islander Corporation for Welfare Resource and Housing
Lake Tyers Health & Children Services Association Incorporated
Laynhapuy Homelands Association Incorporated
Link-Up (Queensland) Aboriginal Corporation
Maamba Aboriginal Corporation
Maari Ma Health Aboriginal Corporation
Malabam Health Board Aboriginal Corporation
Mamu Health Service Limited
Marrin Weejali Aboriginal Corporation
Marthakal Homeland and Resource Centre Association
Mawarnkarra Health Service Aboriginal Corporation
Mersey Leven Aboriginal Corporation
Milbi Incorporated
Mildura Aboriginal Corporation Inc - Mildura
Milliya Rumurra Aboriginal Corporation
Miwatj Health Aboriginal Corporation
Moogji Aboriginal Council East Gippsland Incorporated
Mookai Rosie-Bi-Bayan Aboriginal and Torres Strait Islander Corporation
Mudth-Niyleta Aboriginal and Torres Strait Islander Corporation
Mulungu Aboriginal Corporation Medical Centre
Mungabareena Aboriginal Corporation
Murray Valley Aboriginal Co-operative - Robinvale
Namatjira Haven Ltd
Ngaanyatjarra Health Service (Aboriginal Corporation)
Ngaanyatjarra Pitjantjatjara Yankunytjatjara (NPY) Women's Council Aboriginal Corporation
Ngaimpe Aboriginal Corporation (The Glen)
Nganampa Health Council Incorporated
Ngangganawili Aboriginal Community Controlled Health and Medical Services Aboriginal Corporation
Ngkarte Mikwekenhe Community Incorporated
Ngnowar-Aerwah Aboriginal Corporation

Ngwala Willumbong Co-operative Limited
Nhulundu Wooribah Indigenous Health Organisation Incorporated
Nindilingarri Cultural Health Services
Njernda Aboriginal Corporation
Nooda Ngulegoo Aboriginal Corporation
Northern Peninsula Area Women's Shelter Aboriginal and Torres Strait Islander Corporation
NT Stolen Generations Aboriginal Corporation
Nunkuwarrin Yunti Incorporated
Oak Valley (Maralinga) Incorporated
Orana Haven Aboriginal Corporation
Ord Valley Aboriginal Health Service Aboriginal Corporation
Palmerston Association Incorporated
Palyalatju Maparnpa Aboriginal Corporation Health Committee
Pangula Mannamurna Incorporated
Paupiyala Tjarutja Aboriginal Corporation
Pintupi Homelands Health Service
Pitjantjatjara Yankunytjatjara Media Incorporated
Pius X Aboriginal Corporation
Pormpur Paanth Aboriginal Corporation
Port Lincoln Aboriginal Health Service Incorporated
Puntukurnu Aboriginal Medical Service Aboriginal Corporation
Queensland Aboriginal & Torres Strait Islanders Corporation for Alcohol & Drug Dependence Services
Ramahyuck and District Aboriginal Corporation
Ramingining Homelands Resource Centre Aboriginal Corporation
Rekindling The Spirit Limited
Riverina Medical and Dental Aboriginal Corporation
Roy Thorne Substance Misuse Rehabilitation Centre Incorporated
Rumbalara Aboriginal Co-operative
South Coast Medical Service Aboriginal Corporation
South Coast Womens Health & Welfare Aboriginal Corporation
South East Tasmanian Aboriginal Corporation
South West Aboriginal Medical Service Aboriginal Corporation
Sunrise Health Service Aboriginal Corporation
Tasmanian Aboriginal Centre Incorporated
Tasmanian Aboriginal Child Care Association
Tharawal Aboriginal Corporation
The Oolong Aboriginal Corporation
Thubbo Aboriginal Medical Co-operative Ltd
Townsville Aboriginal and Islander Health Service Limited
Tullawon Health Service Incorporated
Umoona Tjutagku Health Service Incorporated.
Urapuntja Health Service Aboriginal Corporation
Victorian Aboriginal Health Service Co-operative Limited
Walgett Aboriginal Medical Services Co-operative Limited
Walhallow Aboriginal Corporation
Warlpiri Youth Development Aboriginal Corporation
Wathaurong Aboriginal Co-operative
Weigelli Centre Aboriginal Corporation

Wellington Aboriginal Corporation Health Service
Western Australian Network of Alcohol and Other Drug Agencies (WANADA)
Western Desert Nganampa Walytja Palyantjaku Tjutaku
Western Suburbs Indigenous Gathering Place Association Inc.
Winda Mara Aboriginal Corporation
Winnunga Nimmityjah Aboriginal Health Clinic/Health Service (ACT) Incorporated
Wirraka Maya Health Services Aboriginal Corporation
Women's Karadi Aboriginal Corporation
Wuchopperen Health Service Limited
Wunjuada Aboriginal Corporation for Alcoholism and Drug Dependence Service
Wurli Wurlinjang Aboriginal Corporation
Yaamba Aboriginal and Torres Strait Islander Corporation for Men
Yerin Aboriginal Health Services Incorporated
Yorgum Aboriginal Corporation
Yulu-Burri-Ba Aboriginal Corporation for Community Health
Yura Yungi Medical Service Aboriginal Corporation

c) No.

d) Three Aboriginal and Torres Strait Islander community controlled health and substance use organisations that were previously funded through auspicing arrangements moved to direct funding agreements with OATSIH during 2008-09.

Galambila Aboriginal Health Service Incorporated
Mount Isa Aboriginal Community Controlled Health Services Ltd
Orange Aboriginal Health Service Incorporated

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 23 October 2009

Question: E09-067

OUTCOME 8: Indigenous Health

Topic: ABORIGINAL AND TORRES STRAIT ISLANDER COMMUNITY CONTROLLED HEALTH

Written Question on Notice

Senator Payne asked:

a) Of the 172 Aboriginal and Torres Strait Islander community controlled health and substance use services that received funding from OATSIH in 2008-09, how many received recurrent funding, and how many received other types of funding?

b) Can the department provide a list of organisations and the type of funding each received?

Answer:

(a)(i) Of the 172 Aboriginal and Torres Strait Islander community controlled health organisations that received funding from OATSIH in 2008-09, all 172 received recurrent funding.

(a)(ii) Of the 172 Aboriginal and Torres Strait Islander community controlled health organisations that received recurrent funding from OATSIH in 2008-09, 71 also received one-off funding.

(b)(i) List of organisations that received recurrent funding and the type of funding each received:

Aboriginal & Torres Strait Islander Community Health Service Brisbane Limited
Aboriginal and Torres Strait Islanders Community Health Service (Mackay) Limited
Aboriginal Medical Service Co-operative Limited
Aboriginal Medical Service Western Sydney Co-operative Ltd
Albury Wodonga Aboriginal Health Service Incorporated
Ampilatwatja Health Centre Aboriginal Corporation
Awabakal Newcastle Aboriginal Co-operative Limited
Ballarat and District Aboriginal Co-operative
Barambah Regional Medical Service (Aboriginal Corporation)
Bega Garnbirringu Health Service
Bendigo & District Aboriginal Co-Operative
Bidgerdii Aboriginal and Torres Strait Islanders Corporation Community Health

Service
Biripi Aboriginal Corporation Medical Centre
Bourke Aboriginal Health Service
Broome Regional Aboriginal Medical Service
Bulgarr Ngaru Medical Aboriginal Corporation
Cape Barren Island Aboriginal Association Inc.
Carnarvon Medical Service Aboriginal Corporation
Central Australian Aboriginal Congress Incorporated
Charleville and Western Areas Aboriginal and Torres Strait Islanders Corporation
Condobolin Aboriginal Health Service Incorporated
Coomealla Health Aboriginal Corporation
Cummeragunja Housing and Development Aboriginal Corporation
Cunnamulla Aboriginal Corporation for Health
Dandenong and District Aborigines Co-operative Limited - Bunurong Health Service
Danila Dilba Health Service
Darling Downs Shared Care Incorporated (T/A Carbal Medical Centre)
Demed Association Incorporated Homeland Resource Centre
Derbarl Yerrigan Health Service Incorporated
Derby Aboriginal Health Service Council Aboriginal Corporation
Dharah Gibinj Aboriginal Medical Service Aboriginal Corporation
Durri Aboriginal Corporation Medical Services
Flinders Island Aboriginal Association Incorporated
Galambila Aboriginal Health Service Incorporated
Goolburri Health Advancement Aboriginal Corporation
Goondir Aboriginal and Torres Strait Islanders Corporation for Health Services
Griffith Aboriginal Community Medical Service Incorporated
Gurriny Yealamucka (Good Healing) Health Services Aboriginal Corporation
Illawarra Aboriginal Medical Service Aboriginal Corporation
Jurrugk Aboriginal Health Service Aboriginal Corporation
Kalwun Health Service
Kambu Medical Centre Ipswich Incorporated
Katherine West Health Board Aboriginal Corporation
Katungul Aboriginal Corporation Community & Medical Services
Kimberley Aboriginal Medical Services Council Incorporated
Kirrae Health Service Incorporated
Laynhapuy Homelands Association Incorporated
Maari Ma Health Aboriginal Corporation
Malabam Health Board Aboriginal Corporation
Mamu Health Service Limited
Marthakal Homeland and Resource Centre Association
Mersey Leven Aboriginal Corporation
Miwatj Health Aboriginal Corporation
Mookai Rosie-Bi-Bayan Aboriginal and Torres Strait Islander Corporation
Mount Isa Aboriginal Community Controlled Health Services Ltd
Mudth-Niyleta Aboriginal and Torres Strait Islander Corporation

Mulungu Aboriginal Corporation Medical Centre
Mungabareena Aboriginal Corporation
Ngaanyatjarra Health Service (Aboriginal Corporation)
Ngaanyatjarra Pitjantjatjara Yankunytjatjara (NPY) Women's Council Aboriginal Corporation
Nhulundu Wooribah Indigenous Health Organisation Incorporated
Nindilingarri Cultural Health Services
Njernda Aboriginal Corporation
Northern Peninsula Area Women's Shelter Aboriginal and Torres Strait Islander Corporation
Nunkuwarrin Yunti Incorporated
Oak Valley (Maralinga) Incorporated
Orange Aboriginal Health Service Incorporated
Ord Valley Aboriginal Health Service Aboriginal Corporation
Palyalatju Maparnpa Aboriginal Corporation Health Committee
Pangula Mannamurna Incorporated
Paupiyala Tjarutja Aboriginal Corporation
Pintupi Homelands Health Service
Pitjantjatjara Yankunytjatjara Media Incorporated
Pius X Aboriginal Corporation
Puntukurnu Aboriginal Medical Service Aboriginal Corporation
Ramingining Homelands Resource Centre Aboriginal Corporation
Riverina Medical and Dental Aboriginal Corporation
South Coast Womens Health & Welfare Aboriginal Corporation
South East Tasmanian Aboriginal Corporation
South West Aboriginal Medical Service Aboriginal Corporation
Sunrise Health Service Aboriginal Corporation
Tasmanian Aboriginal Child Care Association
Tharawal Aboriginal Corporation
Thubbo Aboriginal Medical Co-operative Ltd
Townsville Aboriginal and Islander Health Service Limited
Urapuntja Health Service Aboriginal Corporation
Walgett Aboriginal Medical Services Co-operative Limited
Walhallow Aboriginal Corporation
Wathaurong Aboriginal Co-operative
Wellington Aboriginal Corporation Health Service
Western Desert Nganampa Walytja Palyantjaku Tjutaku
Western Suburbs Indigenous Gathering Place Association Inc.
Winda Mara Aboriginal Corporation
Women's Karadi Aboriginal Corporation
Wuchopperen Health Service Limited
Yerin Aboriginal Health Services Incorporated
Yulu-Burri-Ba Aboriginal Corporation for Community Health
Yura Yungi Medical Service Aboriginal Corporation
Anyinginyi Health Aboriginal Corporation
Djarragun College Limited
Geraldton Regional Aboriginal Medical Service

Gippsland and East Gippsland Aboriginal Co-operative Limited
Goolum Goolum Aboriginal Co-operative
Gunditjmara Aboriginal Co-operative
Lake Tyers Health & Children Services Association Incorporated
Mawarnkarra Health Service Aboriginal Corporation
Mildura Aboriginal Corporation Inc - Mildura
Moogji Aboriginal Council East Gippsland Incorporated
Murray Valley Aboriginal Co-operative - Robinvale
Nganampa Health Council Incorporated
Ngangganawili Aboriginal Community Controlled Health and Medical Services Aboriginal Corporation
Pormpur Paanth Aboriginal Corporation
Port Lincoln Aboriginal Health Service Incorporated
Ramahyuck and District Aboriginal Corporation
Rumbalara Aboriginal Co-operative
Tasmanian Aboriginal Centre Incorporated
Tullawon Health Service Incorporated
Umoona Tjutagku Health Service Incorporated.
Victorian Aboriginal Health Service Co-operative Limited
Winnunga Nimmityjah Aboriginal Health Clinic/Health Service (ACT) Incorporated
Wurli Wurlinjang Aboriginal Corporation
Australian First Nations Academy for Cultural Family Therapy and Counselling Ltd.
Central Australian Stolen Generation & Families Aboriginal Corporation
Gallang Place Aboriginal and Torres Strait Islander Corporation
Goldfields/Esperance Federation of Aboriginal Health Incorporated
Kimberley Stolen Generation Committee Aboriginal Corporation
Link-Up (Queensland) Aboriginal Corporation
NT Stolen Generations Aboriginal Corporation
Rekindling The Spirit Limited
Wirraka Maya Health Services Aboriginal Corporation
Yorgum Aboriginal Corporation
Aboriginal Alcohol & Drug Service (AADS)
Aboriginal and Islander Alcohol Awareness and Family Recovery Incorporated
Aboriginal Drug & Alcohol Council of SA Incorporated
Aboriginal Sobriety Group Incorporated
Aborigines and Islanders Alcohol Relief Service Limited
Barkly Region Alcohol & Drug Abuse Advisory Group Incorporated
Benelong's Haven Limited
Central Australian Aboriginal Alcohol Programs Unit
Congress Community Development and Education Unit Limited
Council for Aboriginal Alcohol Program Services Incorporated
Ferdy's Haven Alcohol Rehabilitation Aboriginal Corporation
Gindaja Treatment and Healing Indigenous Corporation
Goori House Addiction Treatment Centre
Gumbi Gumbi Aboriginal and Torres Strait Islanders Corporation

Ilpurla Aboriginal Corporation
Jungarni - Jutiya Alcohol Action Council Aboriginal Corporation
Kalano Community Association Incorporated
Kalparrin Community Incorporated
KASH Aboriginal Corporation
Krurungal - Aboriginal and Torres Strait Islander Corporation for Welfare Resource and Housing
Maamba Aboriginal Corporation
Marrin Weejali Aboriginal Corporation
Milbi Incorporated
Milliya Rumurra Aboriginal Corporation
Namatjira Haven Ltd
Ngaimpe Aboriginal Corporation (The Glen)
Ngkarte Mikwekenhe Community Incorporated
Ngnowar-Aerwah Aboriginal Corporation
Ngwala Willumbong Co-operative Limited
Nooda Ngulegoo Aboriginal Corporation
Orana Haven Aboriginal Corporation
Palmerston Association Incorporated
Queensland Aboriginal & Torres Strait Islanders Corporation for Alcohol & Drug Dependence Services
Roy Thorne Substance Misuse Rehabilitation Centre Incorporated
The Oolong Aboriginal Corporation
Warlpiri Youth Development Aboriginal Corporation
Weigelli Centre Aboriginal Corporation
Western Australian Network of Alcohol and Other Drug Agencies (WANADA)
Wunjuada Aboriginal Corporation for Alcoholism and Drug Dependence Service
Yaamba Aboriginal and Torres Strait Islander Corporation for Men

(b)(ii) List of organisations that received one-off funding and the type of funding each received:

Aboriginal & Torres Strait Islander Community Health Service Brisbane Limited
Albury Wodonga Aboriginal Health Service Incorporated
Ampilatwatja Health Centre Aboriginal Corporation
Barambah Regional Medical Service (Aboriginal Corporation)
Bega Garnbirringu Health Service
Bendigo & District Aboriginal Co-Operative
Bidgerdii Aboriginal and Torres Strait Islanders Corporation Community Health Service
Biripi Aboriginal Corporation Medical Centre
Bourke Aboriginal Health Service
Broome Regional Aboriginal Medical Service
Bulgarr Ngaru Medical Aboriginal Corporation
Carnarvon Medical Service Aboriginal Corporation
Central Australian Aboriginal Congress Incorporated
Cummeragunja Housing and Development Aboriginal Corporation
Danila Dilba Health Service

Derby Aboriginal Health Service Council Aboriginal Corporation Durri Aboriginal Corporation Medical Services Galambila Aboriginal Health Service Incorporated Goondir Aboriginal and Torres Strait Islanders Corporation for Health Services Griffith Aboriginal Community Medical Service Incorporated Kalwun Health Service Kambu Medical Centre Ipswich Incorporated Katungul Aboriginal Corporation Community & Medical Services Laynhapuy Homelands Association Incorporated Maari Ma Health Aboriginal Corporation Malabam Health Board Aboriginal Corporation Mamu Health Service Limited Marthakal Homeland and Resource Centre Association Miwatj Health Aboriginal Corporation Mount Isa Aboriginal Community Controlled Health Services Ltd Mulungu Aboriginal Corporation Medical Centre Ngaanyatjarra Health Service (Aboriginal Corporation) Ngaanyatjarra Pitjantjatjara Yankunytjatjara (NPY) Women's Council Aboriginal Corporation Njernda Aboriginal Corporation Orange Aboriginal Health Service Incorporated Ord Valley Aboriginal Health Service Aboriginal Corporation Pintupi Homelands Health Service Riverina Medical and Dental Aboriginal Corporation South Coast Medical Service Aboriginal Corporation South West Aboriginal Medical Service Aboriginal Corporation Tharawal Aboriginal Corporation Wellington Aboriginal Corporation Health Service Western Suburbs Indigenous Gathering Place Association Inc. Yulu-Burri-Ba Aboriginal Corporation for Community Health Yura Yungi Medical Service Aboriginal Corporation
Anyinginyi Health Aboriginal Corporation Djarragun College Limited Geraldton Regional Aboriginal Medical Service Goolum Goolum Aboriginal Co-operative Lake Tyers Health & Children Services Association Incorporated Murray Valley Aboriginal Co-operative - Robinvale Ngangganawili Aboriginal Community Controlled Health and Medical Services Aboriginal Corporation Pormpur Paanth Aboriginal Corporation Ramahyuck and District Aboriginal Corporation Rumbalara Aboriginal Co-operative Winnunga Nimmityjah Aboriginal Health Clinic/Health Service (ACT) Incorporated Wurli Wurlinjang Aboriginal Corporation
Central Australian Stolen Generation & Families Aboriginal Corporation Kimberley Stolen Generation Committee Aboriginal Corporation Link-Up (Queensland) Aboriginal Corporation

Rekindling The Spirit Limited
Yorgum Aboriginal Corporation
Barkly Region Alcohol & Drug Abuse Advisory Group Incorporated
Council for Aboriginal Alcohol Program Services Incorporated
Marrin Weejali Aboriginal Corporation
Milbi Incorporated
Milliya Rumurra Aboriginal Corporation
Namatjira Haven Ltd
Ngaimpe Aboriginal Corporation (The Glen)
Warlpiri Youth Development Aboriginal Corporation
Weigelli Centre Aboriginal Corporation

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 23 October 2009

Question: E09-068

OUTCOME 8: Indigenous Health

Topic: FUNDING FROM OATSIH

Written Question on Notice

Senator Payne asked:

How many Aboriginal and Torres Strait Islander community controlled health and substance use services receive funding from OATSIH, in this financial year and for the previous five financial years?

Answer:

The following number of Aboriginal and Torres Strait Islander community controlled health, substance use and social and emotional wellbeing organisations received funding from OATSIH, in this financial year (as at 30 September 2009) and for the previous five financial years.

Financial Year	No of Organisations	Comment
2009-10	170	A
2008-09	172	B
2007-08	184	C
2006-07	176	
2005-06	198	
2004-05	189	

A) The 2009-10 figure is as at 30 September 2009. The reduction in the number of funded organisations relates to a change in funding policy for Social and Emotional Wellbeing Regional Centres (SEWB-RC) which resulted in one organisation no longer being eligible for funding. The balance relates to one organisation that was funded directly during 2008-09 but moved to being funded through an auspicing arrangement in 2009-10.

B) The reduction in the number of Aboriginal and Torres Strait Islander community controlled health, substance use and social and emotional wellbeing organisations funded during 2008-09 when compared with those funded during 2007-08 was largely due to local government reforms in the Northern Territory and regionalisation of health services in South Australia.

The Northern Territory Government reformed the NT system of Local Government during 2008-09, replacing 56 Local Government Councils with eight Shires, and four Municipal Councils on 1 July 2008. Up until this date the Office for Aboriginal and Torres Strait Islander Health was funding eight Aboriginal Community controlled health organisations through Local Government Councils to deliver health, substance use and social and emotional wellbeing services. As a result of the reforms, new auspice arrangements were found for each of the eight services, with four incorporated into existing Aboriginal Medical Services, three transferring to the NT Department of Health and Families, and one transferring to a new Shire Council.

Similarly, as a result of restructuring within Country Health South Australia (CHSA), the OATSIH transitioned to a single funding agreement with CHSA instead of several agreements with individual service providers.

It should be noted that the reduction in the number of funded organisations is merely an administrative change and has not resulted in a reduction in service provision.

C) The reduction in the number of Aboriginal and Torres Strait Islander community controlled health, substance use and social and emotional wellbeing organisations funded during 2006-07 is as a result of reclassification of *organisation types* in the OATSIH's payments administration system relating to what constitutes an Aboriginal and Torres Strait Islander community controlled health service. This was undertaken to bring the system classification in to line with the National Aboriginal Community Controlled Health Organisation definition of community controlled organisations.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 23 October 2009

Question: E09-069

OUTCOME 8: Indigenous Health

Topic: CLOSING THE GAP FUNDING

Written Question on Notice

Senator Payne asked:

How much of the $1.6 billion in additional funding for Indigenous health in the COAG National Partnership Agreement on Closing the Gap will go to Aboriginal or Torres Strait Islander community controlled health and substance use services?

Answer:

The Commonwealth is contributing $805.5 million over four years to the National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes. State and territory governments are contributing up to $771.5 million and the Commonwealth is not able to respond on the breakdown of this jurisdictional funding.

From the Commonwealth's contribution, Aboriginal and Torres Strait Islander Community Controlled Health Services are able to access funding specific for Indigenous health care services. They will also be able to access additional funding through participating in new and enhanced incentive and program support arrangements. It is not possible however to quantify the amount of additional funding that will go to Aboriginal Community Controlled Health Organisations (ACCHOs) as this will ultimately depend on the outcome of grants processes, and the level of activity generated payments for MBS and Practice Incentive Payments (PIP) payments.

Almost $70 million over the next four years is available for the ACCHO sector to fund:

- more than 80 new Indigenous Outreach Worker positions (plus on the job training and support) to help Indigenous people access the health care services they need;
- around 75 additional health professionals and practice managers;
- staff housing and clinical upgrades in rural and remote areas to support deployment of additional health professionals; and
- an additional 38 General Practitioners registrar training posts and 50 nursing clinical placements offered each year in Indigenous health services.

Many ACCHOs will also be able to access funds available through:

- Medicare from the increased take up of health checks and chronic disease care coordination items through Section 19(2) arrangements;
- the new PIP Indigenous Health Incentive;
- chronic disease self-management programs and funding for new healthy lifestyle workers; and
- programs to reduce smoking rates, including a new tobacco workforce and local community campaigns.

ACCHOs will also have access to national workforce training and professional development programs; improved access to affordable specialist, allied health care and medicines for Indigenous patients with a chronic disease; program resources and education materials; and local communication campaigns. Campaign activities will mainly be directed through local Indigenous organisations, including Indigenous health services.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 23 October 2009

Question: E09-071

OUTCOME 8: Indigenous Health

Topic: ABORIGINAL HEALTH AND MEDICAL RESEARCH COUNCIL

Written Question on Notice

Senator Payne asked:

a) Have any concerns been raised about the operation or management of the Aboriginal Health and Medical Research Council of NSW (AH&MRC)?

b) If so, can you provide details about the nature of these concerns, when they were raised, whether the department shares these views, and what if any action is being taken on these matters?

Answer:

a) Yes

b) Two member services of the AH&MRC raised concerns with the Department about:

(i) governance and staff remuneration at the AH&MRC;
(ii) the de-funding by NSW Health of the AH&MRC's Collaborative Centre for Aboriginal Health;
(iii) breaches of the *Corporations Act 2001* in respect to financial reports as reported by the Australian Securities and Investments Commission (ASIC) at the 2008 AH&MRC Annual General Meeting ; and
(iv) governance issues within the AH&MRC, particularly those in relation to the AH&MRC Constitution.

The Department's response to these issues follows:

(i) Internal governance and staff remuneration are the responsibility of the organisation and if members are unhappy with these matters they should them up with the AH&MRC.
(ii) This was a decision of the NSW Department of Health and any concerns should be taken up with that agency.
(iii) The organisation has assured the Department they are now compliant with the *Corporations Act 2001* to the satisfaction of ASIC. The Department will confirm that this is still the case when it conducts its audit of the AH&MRC in early 2010.
(iv) Constitutional issues are the jurisdiction of the incorporating entity. If members are not happy with changes to the AH&MRC Constitution they should address these concerns to ASIC.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 23 October 2009

Question: E09-112

OUTCOME 8: Indigenous Health

Topic: INDIGENOUS DENTAL TREATMENT

Written Question on Notice

Senator Adams asked:

a) As a result of the intervention how many Indigenous Australians in the Northern Territory have been identified as in need of dental treatment?

b) How many have received that treatment?

Answer:

a) 3,218 children were given dental referrals from the NT intervention Child Health Checks.

b) By 30 June 2009 38% or 1,226 children that were referred following a Child Health Check have been seen at least once by a dentist. However, in the two years to 30 June 2009, a total of 5,106 dental services have been provided to 3,363 children as a result of the health care follow up to the NT intervention.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 23 October 2009

Question: E09-115

OUTCOME 8: Indigenous Health

Topic: INDIGENOUS COMMUNITIES WITH TYPE 2 DIABETES

Written Question on Notice

Senator Adams asked:

a) Name the top ten Indigenous communities with the highest level of diabetes type 2 in Australia?
b) What programs and services are currently being conducted in those communities to reduce the incidence of diabetes and manage the impact of it?

Answer:

a) There is no available data about rates of Type 2 Diabetes in specific Indigenous communities across Australia.

b) See answer to part a).

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 23 October 2009

Question: E09-118

OUTCOME 8: Indigenous Health

Topic: TRACHOMA IN KATHERINE

Written Question on Notice

Senator Adams asked:

a) 23% of Indigenous children in Katherine have trachoma according to eye specialist Hugh Taylor. What is being done in Katherine to tackle this?

b) Why won't the government tackle this terrible problem?

Answer:

a) The Australian Government currently provides funding to the Northern Territory Government to assist in the implementation of trachoma screening and control programs through the NT Government's Healthy School Aged Kids Program and in collaboration with primary health care staff from the Aboriginal Community Controlled Health Services. As part of this program seven Katherine communities were screened for trachoma in 2008.

b) On 26 February 2009 the Prime Minister announced a funding commitment of $58.3 million to tackle eye and ear diseases in Indigenous communities. The *Improving Eye and Ear Health Services for Indigenous Australians for Better Education and Employment Outcomes* measure continues the Australian Government's approach to improving health outcomes for Indigenous Australians by improving the screening, early detection, treatment and management of hearing and eye health conditions.

Trachoma control programs and population health programs in general are principally delivered by state and territory health departments. As part of this measure $16 million has been committed to strengthening trachoma control and surveillance programs in Indigenous communities in the Northern Territory, Western Australia, South Australia and other states if trachoma is identified.

In late October 2009 the Department invited the three jurisdictions with endemic trachoma, including Northern Territory Department of Health and Families to provide a funding submission for expanded trachoma control activity in areas identified as experiencing endemic trachoma. These submissions will inform future trachoma based funding agreements with these jurisdictions. Expanded trachoma control activities under these new funding agreements are expected to commence in early 2010, these are expected to include increased screening and treatment programs in areas such as Katherine.

The Department is working with key stakeholders regarding the development and implementation of trachoma control programs in areas identified as experiencing endemic trachoma. The approach will include supporting better uptake of the elements of the WHO's SAFE strategy (Surgery, Antibiotics, Facial cleanliness, Environmental control).

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, October 2009

Question: E09-119

OUTCOME 8: Indigenous Health

Topic: RHEUMATIC FEVER STRATEGY

Written Question on Notice

Senator Adams asked:

Why is the government moving so slowly to reduce the incidence of rheumatic heart disease among Indigenous Australians?

Answer:

The Australian Government has committed $11.2 million over five years from 2007-08 to support the Northern Territory, Western Australian and Queensland governments in their work to reduce the prevalence and incidence rates of Rheumatic Fever.

The Commonwealth executed a funding agreement in October 2008 with the Northern Territory for continuation of the existing register and control program in that jurisdiction, with a focus on providing proper diagnosis and improving access to necessary antibiotics. This project is on track.

Funding agreements were also signed with the Queensland and Western Australian health departments in February and March 2009 respectively to establish register and control programs in their respective jurisdictions. Whilst some initial delays were experienced in Queensland and Western Australia, primarily due to difficulties within these jurisdictions in recruiting suitably qualified staff to work in more remote areas, these projects are now progressing well.

A funding agreement for the establishment of the National Coordination Unit with the Menzies School of Health Research was executed in May 2009. The National Coordination Unit will coordinate efforts to tackle Acute Rheumatic Fever and Rheumatic Heart Disease across the Northern Territory, Western Australia and Queensland. A significant component of its work will be the development of education, training and self-management resources for health professionals, health care workers and patients, to assist with the detection and treatment of Acute Rheumatic Fever and Rheumatic Heart Disease.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 23 October 2009

Question: E09-120

OUTCOME 8: Indigenous Health

Topic: ABORIGINAL MEDICAL SERVICES

Written Question on Notice

Senator Adams asked:

Are there any Aboriginal Medical Services that currently do not have a GP on staff?

Answer:

Out of 155 Australian Government funded Aboriginal and Torres Strait Islander primary health care services in 2007-08, 108 services had a doctor on staff (paid by the service) as at 30 June 2008. An additional 17 services had visiting doctors, and two services had vacant doctor positions as at 30 June 2008.

Of the 28 services with no doctors (paid by the service, visiting or vacant), at least 14 provided specific services such as health promotion/education, counselling, dental services, women's health or sexual health, and, therefore, may not require a doctor.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 23 October 2009

Question: E09-121

OUTCOME 8: Indigenous Health

Topic: ABORIGINAL MEDICAL SERVICES

Written Question on Notice

Senator Adams asked:

Will all Aboriginal Medical Services meet Australian health care accreditation standards by 30 June 2011?

Answer:

No.

Aboriginal community controlled health organisations (ACCHOs) are being offered support under the Establishing Quality Health Standards program to achieve accreditation by June 2011.

To date, some 90% of ACCHOs have indicated their intention to complete or be well progressed in the process of accreditation by June 2011.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 23 October 2009

Question: E09-122

OUTCOME 8: Indigenous Health

Topic: NT INTERVENTION FOLLOW UP

Written Question on Notice

Senator Adams asked:

How many follow-up medical services arising from health checks provided under the NT Intervention are yet to be made?

Answer:

There were 6,516 children with at least one referral made for primary health care and/or specialist services from the Child Health Checks (CHC). The Department has been provided data on follow-up services for three quarters of these children.

There are 3,718 children with outstanding CHC referrals as at the 30 June 2009. Three quarters of these are for dental (1,992) and audiology (750) services. The remainder are mostly for primary health care (226), paediatrician (195) and ear, nose and throat (178).

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 23 October 2009

Question: E09-124

OUTCOME 8: Indigenous Health

Topic: LINKING INDIGENOUS PEOPLE TO GPS

Written Question on Notice

Senator Adams asked:

a) How many of the proposed five brokerage services linking Indigenous people to GPs have been established?

b) What are the results?

Answer:

a) The Department has funded three brokerage services. No further services are being funded under this measure.

b) The three established brokerage services are fully operational.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 23 October 2009

Question: E09-125

OUTCOME 8: Indigenous Health

Topic: CLOSING THE GAP

Written Question on Notice

Senator Adams asked:

What action has been taken to date to support the objectives in the National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes?

Answer:

The National Partnership Agreement (NPA) on Closing the Gap in Indigenous Health Outcomes took effect on 1 July 2009. The first few months have focussed on implementation planning, developing essential infrastructure and stakeholder consultation, with the majority of service delivery to commence between May and July 2010.

Commonwealth activities to date are in accordance with the Implementation Plan endorsed by Health Ministers, and include:

1) Preventive Health (Tackling Smoking)

- Completion of a literature review as the first step in the national tobacco formative research project, and appointment of a consultant to commence the formative social marketing campaigns research.

2) Patient Experiences (Primary health care services that can deliver)

- The number of MBS follow up items for Practice Nurses and Aboriginal Health Workers has been increased from five to ten follow up services per client, per annum, following an Indigenous health check.
- Release of Requests for Tender to develop the monitoring and evaluation framework and establishment of sentinel sites.

3) Sustainability (Fixing the gaps and improving the patient journey)

- Funding agreements for Indigenous Health Project Officers in Divisions of General Practice have been distributed.
- Scoping exercise for orientation, education and training needs for Indigenous Outreach Workers and Healthy Lifestyle Workers in progress.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 23 October 2009

Question: E09-195

OUTCOME 8: Indigenous Health

Topic: OPAL FUEL

Written Question on Notice

Senator Adams asked:

a) How many communities that want Opal fuel have not got it?

b) How many remote communities do not have Opal fuel?

c) When will the Rabbit Flat Roadhouse replace conventional sniffable fuel with Opal unsniffable fuel?

Answer:

a) All communities that have requested Opal fuel are receiving the product if the appropriate fuel distribution networks and community infrastructure are in place to allow for Opal fuel's supply. Only one community - Yalata in South Australia - has requested Opal fuel, and does not currently have access, but installation is in progress.

b) The supply of Opal fuel is targeted to communities and fuel retailers in and surrounding regions where petrol sniffing is prevalent. Without defining a particular remote region of Australia, it is difficult to provide an accurate figure of how many remote communities or fuel retail sites do not supply Opal fuel.

c) The proprietor of the Rabbit Flat Roadhouse has, to date, not been willing to supply Opal fuel. The proprietor has recently indicated that the site will cease operations at the end of 2010.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 23 October 2009

Question: E09-217

OUTCOME 8: Indigenous Health

Topic: RHEUMATIC FEVER STRATEGY

Hansard Page: CA 39

Senator Scullion asked:

a) [I]s there any follow-up [of people identified as having rheumatic heart disease through the strategy]? What I am looking for is what level of medical intervention they would all be receiving. Would you be able to, on notice, confirm that the treatment you have described, or whatever treatment, is actually being provided to all those people [identified with rheumatic heart disease]?

b) Post that identification and notification process, how many would have received assistance?

c) Of course, there are issues with mobility and traceability. Perhaps you could provide me with some of the tracking and tracing processes, given the mobility of that demographic.

Answer:

a) Yes, the Northern Territory (NT) Rheumatic Heart Disease (RHD) Program maintains a recall system using patient information obtained by various means such as the RHD Program register, electronic patient information systems and information from master charts which is a paper based recall system used in remote communities.

The level of medical intervention is a clinical decision based on the clinical diagnosis. The NT government has developed clinical guidelines for treatment, *NT Rheumatic Heart Disease Program – Priority Guidelines* and these have been adapted from the National Heart Foundation guidelines, *"Diagnosis and management of acute rheumatic heart disease and rheumatic heart disease in Australia"* (www.heartfoundation.org.au).

As outlined in the National Heart Foundation guidelines, prevention of further episodes of rheumatic fever is a priority and secondary prophylaxis requires a control strategy with regular Benzathine Pencillin G, usually given monthly. The appropriate duration of secondary prophylaxis can be ten years or more and this is a clinical decision determined by age of patient, time since their last episode of rheumatic fever, and potential harm from recurrent rheumatic fever.

The Department is funding the Queensland and Western Australian governments to develop registers and control programs. As such, data from these states are currently not accurate or complete.

b) From January to June 2009, the NT RHD register reported that 1,075 people needed secondary prophylaxis and of these 986 people had been recorded as having at least one injection (92%). The NT government suggest the coverage rate when averaged out for these 986 people is 66%, with patients having received almost five out of seven injections for the reporting period.

c) Due to the mobility of Aboriginal and Torres Strait Islanders in the NT, the RHD Register records the two main communities where people may reside or visit regularly to allow them to be traced. The Department is advised that if a person has missed their secondary prophylaxis injection, it is normal practice that RHD Program staff contact the clinic where that individual last received their injection. The Department understands that if this is not successful then program staff use the knowledge of clinical staff including nurses and Aboriginal Health Workers and other related networks in order to try and trace people.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 23 October 2009

Question: E09-253

OUTCOME 8: Indigenous Health

Topic: BLANK PAGE SUMMIT

Hansard Page: CA 31

Senator Payne asked:

a) What was the cost of attendance of any representative of the department?

b) Did the federal officials attending have to pay the cost of registration, which I understand was about $2,450?

Answer:

a) The cost was $4242.27, including registration.

b) Yes.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 23 October 2009

Question: E09-255

OUTCOME 8: Indigenous Health

Topic: PETROL SNIFFING IN YALATA

Hansard Page: CA 48

Senator Siewert asked:

a) Where are we up to with rolling out the program at Yalata?

b) Is it expected that it will be in place by June 2010?

Answer:

a) The Yalata Community is approved to receive Opal fuel but does not currently have a working fuel pump. The Department of Health and Ageing together with the South Australian Government are providing funding and support to obtain a stand alone fuel unit to supply Opal fuel to the community. A working group consisting of the Department of Health and Ageing, the South Australian Government, Yalata Community, Yalata Community's accountants and chaired by the Ceduna Indigenous Co-ordination Centre is overseeing the project's implementation.

   The Yalata Council has selected a site on the outskirts of the community to establish the facility. This site is located near the main highway and was selected in anticipation that it will attract business from passing tourists.

   Quotes for the installation of the fuel tank system are being finalised and a supplier will be selected in consultation with the community council. Applications for the required licences and approvals are being sought concurrently.

   It is essential that a business plan is put in place to ensure the community has capacity for the ongoing upkeep of the fuel system and the revenue it generates.

b) It is anticipated that the project will be completed by the end of June 2010. This is dependent on the appropriate approvals and licences being received and the work to ensure appropriate infrastructure is undertaken to required standards and regulations. In addition, the project is to be in line with Yalata Community's requirements.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 23 October 2009

Question: E09-256

OUTCOME 8: Indigenous Health

Topic: HALLS CREEK AND OPAL FUEL

Hansard Page: CA 48

Senator Siewert asked:

At this stage are all the fuel outlets in Halls Creek supplying Opal fuel?

Answer:

At this stage there are no fuel outlets in Halls Creek supplying Opal fuel. Poinciana Roadhouse, which has been registered to supply Opal fuel since December 2007, has ceased fuel operations in early 2008 due to renovations. These renovations have now been completed however Poinciana Roadhouse has not resumed fuel operations. There is a Shell Coles Express site which cannot be supplied with Opal fuel until an agreement is reached with Shell Australia. Shell Australia has indicated that it is uneconomical for them to deliver Opal fuel to the northern parts of Australia until a storage facility is established in Darwin. The Department of Health and Ageing is exploring options for the establishment of such facility. There is also a BP service station that will not agree to supply Opal fuel until all sites in Halls Creek also agree to convert.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 23 October 2009

Question: E09-258

OUTCOME 8: Indigenous Health

Topic: OPAL FUEL

Hansard Page: CA 49

Senator Scullion asked:

When was the last communication with Tilmouth Well Roadhouse?

Answer:

On 18 May 2009, a joint letter from the Minister for Health and Ageing, the Hon Nicola Roxon MP, and the Minister for Families, Housing, Community Services and Indigenous Affairs, the Hon Jenny Macklin MP, was sent to the Manager of the Tilmouth Well Roadhouse. The letter urged them to reconsider their decision not to stock Opal fuel.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 23 October 2009

Question: E09-259

OUTCOME 8: Indigenous Health

Topic: CHRONIC DISEASE PACKAGE

Hansard Page: CA 52

Senator Siewert asked:

What percentage of funds is going to the grants program, for example? If you could please give us a breakdown.

Answer:

In 2009-10, 49% of funding provided under the Commonwealth's Indigenous Chronic Disease Package is estimated to be available for grants. An exact breakdown cannot be provided at this stage as details are still being finalised.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 23 October 2009

Question: E09-260

OUTCOME 8: Indigenous Health

Topic: AUDIOLOGICAL SERVICES

Hansard Page: CA 53

Senator Moore asked:

Can you provide numbers as well as percentages for the answer you gave about the percentage of different categories of hearing loss - if we could get numbers as well as percentage that would be useful.

Answer:

Results

- Of the 3,165 children for whom data from an audiology check were processed:
  - 54% or 1,718 children had either bilateral or unilateral hearing loss; and
  - 21% or 670 children had mild hearing loss in the better ear, 11% or 343 children had moderate hearing loss and 0.4% or 16 children had severe or profound hearing loss;

- Of the 1,718 children who had hearing loss 91% or 1,564 children had conductive hearing loss, 3% or 50 children had sensorineural hearing loss and 3% or 52 children had mixed hearing loss.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 23 October 2009

Question: E09-268

OUTCOME 8: Indigenous Health

Topic: DIABETES IN INDIGENOUS COMMUNITIES

Hansard Page: CA 41

Senator Scullion asked:

I would like a list of the 10 communities in the intervention area that have highest level of diabetes type 2?

Answer:

There are no Northern Territory intervention specific or other data sources of Indigenous people with Type 2 Diabetes that the Department can use to obtain comparable data at community level of diabetes prevalence.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 23 October 2009

Question: E09-269

OUTCOME 8: Indigenous Health

Topic: PETROL STATIONS

Hansard Page: CA 53

Senator Siewert asked:

I do not have the detail of the location of other petrol stations. They are in that same region, but in the Kimberley. How many petrol stations are in Halls Creek itself?

Answer:

There are three service stations in Halls Creek: Poinciana Roadhouse, Shell Coles Express and BP Service Station. None of these service stations supply Opal fuel at the moment.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 23 October 2009

Question: E09-270

OUTCOME 8: Indigenous Health

Topic: CLOSING THE GAP

Written Question on Notice

Senator Siewert asked:

What percentage of the Closing the Gap funding reaches Aboriginal and other community organisations which provide critical care services?

Answer:

Critical Care is defined as the direct delivery by a physician(s) of medical care for a critically ill or critically injured patient. A critical illness or injury acutely impairs one or more vital organ systems such that there is a high probability of imminent or life threatening deterioration in the patient's condition. Critical care services therefore include the treatment of vital organ failure and/or the prevention of further life threatening deterioration in a patient's condition and are hospital based.

The Closing the Gap funding is not aimed at critical care services but rather the prevention, detection and management of chronic disease before it reaches the critical phase.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 23 October 2009

Question: E09-279

OUTCOME 8: Indigenous Health

Topic: INDIGENOUS HEALTH

Hansard Page: CA 38

Senator Scullion asked:

I am looking forward to that, Mr Thomann. As I said, perhaps you can deal with those areas in your answers to question on notice. We would like to know what plans you have. I know that the committee would be very interested to know about the physical mechanisms in terms of blockages – whether it is infrastructure, mobility or personnel. We were not sure about that, and I am sure you will have those in your plans. That will be very useful to us if you can have that on notice.

Answer:

The plan

The Commonwealth Government has a National Partnership Agreement (NPA) with the Northern Territory (NT) Government; *Closing the Gap in the Northern Territory National Partnership Agreement*. Within this agreement is Schedule F: Follow Up Care – Dental. The Commonwealth is responsible for funding provision of follow-up dental services. The Commonwealth will provide $10.703 million over three years for dental follow up services and related policy and data activities. $6.421 million will be provided to the NT Government and $3.211 million will be provided to Aboriginal Medical Services.

As part of its responsibilities under this NPA the NT Government provided the Commonwealth with an Action Plan. The Plan outlines the delivery of follow up dental services to Indigenous children under 16 years, who have been referred from or are eligible for a child health check, from prescribed communities and town camps. These services will be funded from 2009-10 to 2011-12. The Action Plan was endorsed by the Department on 19 August 2009.

The NT Government will also provide a transition plan to the Commonwealth by 31 May 2012 outlining how they will provide a sustainable and high level of dental service provision to the target group beyond 2011-12.

Blockages
Recruiting, training and deploying sufficient workforce has been a challenge. Strategies employed have made much use of short-term, visiting dental staff recruited from across Australia. These systems have taken time to develop and their success needs to be seen in light of general health workforce shortages affecting many aspects of health care in Australia. The Remote Area Health Corps is specifically designed to meet this need in the NT.

Provision of all services requires adequate service delivery infrastructure including staff accommodation, clinic space and specialised equipment such as dental facilities. These take time to build and need to be integrated with the long term requirements for such facilities. Mobile facilities have been used where possible in the interim.

Service delivery
In the two years to 30 June 2009, 5,106 dental services have been provided to 3,363 children. A total of 3,218 children were referred for dental follow-up services. By 30 June 2009, 1,226 of these particular children had been seen. In the remaining period of funding to 2011-12, dental services will be made available to the remaining 1,992 children who have an outstanding dental referral from their child health check.

A longer term measure of success will be the successful transition from the provision of these dental follow-up services to a sustained level of ongoing dental service provision to the target group beyond 2011-12 by the NT Government.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-221

OUTCOME 9: Private Health

Topic: PHIAC'S INVOLVEMENT AND DECISION MAKING PROCESS IN MEDIBANK PRIVATE LIMITED'S CONVERSION TO FOR-PROFIT

Hansard Page: CA78

Senator Cormann asked:

a) In your call for submissions what is it that you asked for, roughly, in broad terms?

b) Did the eight people who wrote to you all exclusively write, 'we should get some money out of this,' or did they raise other issues?

Answer:

a) PHIAC asked for submissions on whether the conversion would, in substance, involve the demutualisation of Medibank Private Limited (MPL).

b) The eight people who made submissions raised issues including:
   i. Seeking the distribution of monies from the demutualisation;
   ii. MPL is a mutual organisation;
   iii. Demutualisation would reduce health fund protection and increase premiums;
   iv. MPL "morally" belongs to members; and
   v. MPL should obtain at least a 75% vote of members in favour of conversion.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-266

OUTCOME 9: Private Health

Topic: INFORMED FINANCIAL CONSENT

Hansard Page: CA74

Senator Cormann asked:

a) Can you talk us through the preparatory work that has been performed by the Department of Health and Ageing in relation to implementing the policy to mandate for full informed financial consent?

b) What is the public interest ground on which you cannot give me any more information?

Answer:

a) – b) Disclosure of the advice would interfere with the ability of government to freely deliberate within government on policy options and would disclose legal advice provided to the Commonwealth which is subject to legal professional privilege. Other documents were prepared for consideration by the Cabinet. In accordance with long-standing practice, the request is therefore subject to a claim of public interest immunity.

9106

NATIONAL BREAST AND OVARIAN CANCER CENTRE

11 November 2009

Mr Elton Humphrey
Committee Secretary
Senate Standing Committee on Community Affairs
PO Box 6100
Parliament House
CANBERRA ACT 2600

Dear Mr Humphrey

At the Senate Estimates hearing on 21 October 2009 National Breast and Ovarian Cancer Centre spoke of their recent projects including a new audio resource. The Committee expressed interest in receiving copies of this resource *When the women you love has early breast cancer.*

The CD features personal stories, insight and wisdom from women diagnosed with breast cancer and the men who supported them, as well as advice and practical tips on navigating the breast cancer journey from leading clinical experts.

The CD explores the importance of open communication and listening, and the impact of a breast cancer diagnosis on sexuality, relationships and mental health. It is narrated by actor and author William McInnes, whose wife was diagnosed with breast cancer in 2004.

The resource helps men to understand they are not alone, that many others have been through this journey and that help is available.

Please find enclosed 13 copies.

Should you have any questions about our work or any matters in relation to breast or ovarian cancer, please do not hesitate to contact A/Professor Christine Giles on 02 9357 9404 or christine.giles@nbocc.org.au.

Yours sincerely

Dr Helen Zorbas
Chief Executive Officer

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-264

OUTCOME 10: Health System Capacity and Quality

Topic: BREAST CANCER

Hansard Page: CA 106

Senator Adams asked:

Launch of CD for men who support women going through the breast cancer diagnosis, *When the woman you love has early breast cancer*.

Answer:

13 copies of the CD have been mailed to the Senate Standing Committee on Community Affairs.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-089

OUTCOME 10: Health System Capacity and Quality

Topic: BETTER HEALTH GRANTS

Written Question on Notice

Senator Boyce asked:

a) What processes did the Department go through to determine which projects received funding?

b) Was there a tender process to determine the institutions undertaking the research, and what criteria did the Department use to choose each institution?

c) Have the projects been given a deadline for reporting?

d) Has funding been committed for the implementation of any of the recommendations made by these studies?

e) Did the Department investigate whether any similar studies to those chosen under the program had already been completed overseas?

Answer:

a and b)

Under the National Health and Medical Research Council (NHMRC) Partnerships for Better Health initiative, Partnership Projects applications were subjected to an open, transparent and contestable competitive process that was advertised in accordance with the requirements of the *National Health and Medical Research Council Act 1992* and conducted in accordance with advice from Research Committee and the Council of the NHMRC. Partnership Projects applicants were advised of the selection criteria against which all applications were assessed through the Funding Policy for the scheme available at http://www.nhmrc.gov.au/grants/partnerships/projects.htm

The Partnership Projects Grant Review Panel (PPGRP), comprised of researchers and health policy and health practice experts, was established to assess the applications. The PPGRP:

- shortlisted applications against the selection criteria;
- sought external assessments from experts in the specific field of research for each shortlisted application;
- external assessors assessed the applications against the selection criteria;
- PPGRP spokespersons provided full assessment reports;
- external and spokesperson assessments were de-identified, and
- applicants were provided with the opportunity to provide a written response to the assessments.

The PPGRP then convened to consider the shortlisted applications against the selection criteria in light of the expert external assessments, the applicants' responses and their own

assessments. Applications were scored and ranked. The PPGRP then recommended funding for applications based on its judgement about the overall merits of each application against the selection criteria of the call.

At all stages of the assessment process, NHMRC ensured that panel members and external assessors with high conflicts of interest were excluded from the assessment process.

A de-identified, ranked list of applications (with brief summaries of the proposed project) was provided to Research Committee (RC) on 8-9 September 2009.

With RC endorsement, the de-identified, ranked list was then provided to the council of NHMRC on 1-2 September 2009.

NHMRC was able to provide recommendations for funding to the Minister for Health and Ageing for 28 grants totaling just over $22.1 million.

b) Funding of NHMRC grants is provided through the Medical Research Endowment Account (MREA) which is appropriated by the Commonwealth Parliament for this purpose. A consequence of this is that the NHMRC is required, by law, to ensure that the research funds are used in a manner that is efficient, effective and ethical.

   To meet this requirement, NHMRC will only release funds to institutions that are registered with the NHMRC as Administering Institutions. In order to be registered as such an institution, stringent requirements must be met including proof of appropriate levels of infrastructure and support to ensure that the research can be properly supported and of the financial viability of the institution, to ensure that the particular research being funded will not stall or lapse and the potential benefit from it be lost.

c) All NHMRC grants are offered in accordance with the Deed of Agreement between NHMRC and the Administering Institution. Under the Deed of Agreements, annual progress and financial reports are required by 31 March of each year. At the completion of the grant, a final report and financial acquittal is required by 30 June of the following year.

d) NHMRC Partnership Projects funding is provided to facilitate the conduct of research into health policy and practice. NHMRC funding is not committed for the implementation of any of the final recommendations made by these studies.

e) NHMRC awards grants on the basis of scientific quality as judged by peer-review across the entire spectrum of health, medical and public health research. Partnership Projects is designed to support connections, within the Australian context, that will improve the translation of research evidence into health policy and practice, with the aim of improving Australian health services and processes.

   As part of the assessment criteria NHMRC panel members are directed to assess applications against the advertised selection criteria. The selection criteria for the call for Partnership Projects included asking if the *aims and concepts of the project are innovative,* whether the *project is likely to yield new methods and techniques for addressing issues*; and what was the *capacity of the partner organisation(s) to use the findings to influence policy decision making and health system performance.*

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-090

OUTCOME 10: Health System Capacity and Quality

Topic: BETTER HEALTH GRANTS

Written Question on Notice

Senator Boyce asked:

I refer to the project 'Reducing Impulsive Behaviour in Repeat Violent Offenders' which is receiving $1.3 million in Better Health Grants and studying whether SSRIs can reduce compulsive behaviour. The study is being undertaken by the Curtin University of Technology. Why is this study being conducted?

Answer:

The proposal was recommended for funding by the Partnership Projects Grant Review Panel based on the overall merits of the application against the selection criteria.

The proposal directly addresses a national health priority area, Injury Prevention and Control. It does not research whether SSRIs can reduce compulsive behaviour - that has already been found to be the case. This project asks whether this proven therapy could be practiced by corrective services in Australia to reduce impulsive behaviour in repeat violent offenders and thereby reduce recidivism and violence in the community.

A particular strength of this application was that the policy partners included the NSW Justice Health, the state-wide area health service responsible for providing health care for prisoners, and the NSW Department of Corrective Services. These agencies are well placed to use the findings to influence policy decision making and health system performance, the primary aim of this scheme.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Questions E09-238

OUTCOME 10: Health System Capacity and Quality

Topic: NATIONAL eHEALTH TRANSITION AUTHORITY CLINICAL TERMINOLOGY v2.2

Hansard Page: CA 98

Senator Boyce asked:

[Version 1 stated 99 percent, Senator asked if version 2.2 increased the percentage] Is it more than 99 per cent now?

Answer:

Version 2.2 of the Australian Medicines Terminology contains 99% of those TGA Registrable items that are known to be marketed for use in the Australian health care system.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Questions E09-239

OUTCOME 10: Health System Capacity and Quality

Topic: NATIONAL eHEALTH TRANSITION AUTHORITY CLINICAL TERMINOLOGY v2.2

Hansard Page: CA 98

Senator Boyce asked:

Explanation of difference between v1 and v2?

Answer:

The Australian Medicines Terminology (AMT) is continuously updated and releases are issued on a consistent basis. These updates would include additional data that are registered on the Australian Register of Therapeutic Goods (ARTG) and additional items identified by stakeholders. Version 1.0 of the AMT contained 3,501 products. Version 2.2 contained 10,163 products. Version 1 was targeted at PBS products only, whereas version 2.2 contains Pharmaceutical Benefits Scheme (PBS) and ARTG products.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Questions E09-240

OUTCOME 10: Health System Capacity and Quality

Topic: NATIONAL eHEALTH TRANSITION AUTHORITY (NEHTA) CLINICAL TERMINOLOGY v2.2

Hansard Page: CA 98

Senator Boyce asked:

Who is using this clinical terminology?

Answer:

A significant number of organisations have accessed the Australian Medicines Terminology product from the NEHTA website. NEHTA has issued over 200 licenses to organisations who have subscribed to Clinical Terminology.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Questions E09-241

OUTCOME 10: Health System Capacity and Quality

Topic: NATIONAL eHEALTH TRANSITION AUTHORITY (NEHTA) Clinical Terminology v2.2

Hansard Page: CA 99

Senator Boyce asked:

Could you tell me on notice how many organisations have accessed it or are currently using it - whatever useful information you can give me about the actual use of the clinical terminology?

Answer:

A significant number of organisations have accessed the Australian Medicines Terminology (AMT) product from the NEHTA website. NEHTA has issued over 200 licenses to organisations who have subscribed to Clinical Terminology.

There are over 40 downloads of each AMT monthly release and 80 downloads of the Systematised Nomenclature of Medicine Clinical Terminology (SNOMED CT) International release.

NEHTA is actively engaged with a number of organisations to assist them in their uptake of AMT and SNOMED CT-AU. Some examples of vendor organisations actively working with AMT and/or SNOMED CT include Cerner, ISoft, MIMS, FDB, the Pharmaceutical Benefits Scheme and Best Practice.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-242

OUTCOME 10: Health System Capacity and Quality

Topic: NATIONALLY ENDORSED AND RELEASED DISCHARGE SUMMARY

Hansard Page: CA 99

Senator Boyce asked:

Who is using that?

Answer:

The Discharge Summary package of specifications was released on 14 August 2009 with the Clinical Document Architecture implementation guide released on 18 November 2009 and currently being taken through the Standards Australia process. Jurisdictions and vendors are determining their use and take up of the specifications.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-243

OUTCOME 10: Health System Capacity and Quality

Topic: HEALTHCARE IDENTIFIERS

Hansard Page: CA 100

Senator Boyce asked:

Where would you expect it to be rolled out first?

Answer:

National eHealth Transition Authority is currently working with the states and territories to plan and scope rollouts of identifiers into public health systems.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-244

OUTCOME 10: Health System Capacity and Quality

Topic: BUDGET FOR HEALTHCARE IDENTIFIERS

Hansard Page: CA 101

Senator Boyce asked:

This authority was established in 2004 and the budget has been more than $200 million over that length of time is that the correct figure?

Answer:

National eHealth Transition Authority (NEHTA) was established in 2005 and the budget for the Health Identifiers Program has totalled $98 million.

Announcements for funding to cover the full range of NEHTA functions have been as follows:

Australian Health Minister's Conference, 28 January 2005 - $18.2 million (over three years); Council of Australian Governments, 10 February 2006 - $130.2 million (over four years); and Council of Australian Governments, 29 November 2008 - $218 million (over three years).

Announcements total $366.2 million over seven years (2005-06 – 2011-12).

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-095

OUTCOME 10: Health System Capacity and Quality

Topic: KIDNEY FAILURE

Written Question on Notice

Senator Boyce asked:

Figures released in September by the Australian and NZ Dialysis & Transplant Registry show that there has been a 7.1 per cent increase in kidney failure and acceptance into end-stage treatment programs. This equates to 7 new patients a day.

a) Is the Department aware that kidney failure is increasing, and is the Department doing anything to accommodate the increase and the extra need for treatment?

b) The report noted that there was a 6.3% increase in the number of people who went into dialysis each year, and this represents an estimated average annual cost of $65k per patient. Does the Department agree with these estimated costs?

Answer:

a) The Department is aware that kidney failure is increasing.

The Australian Government recognises the importance of monitoring kidney disease and has directed more than $1 million to the Australian Institute of Health and Welfare (AIHW) to establish the National Centre for Monitoring Kidney Disease. This Centre provides key information about the extent and impact of kidney disease across Australia.

The Government has also funded a range of measures to foster research and provide high quality services. For example:

- The Government provides significant funds for renal disease prevention, management and treatment through its primary care funding (eg. Medicare Benefits Schedule and the Pharmaceutical Benefits Scheme (PBS)) and through funding to state and territory governments under the National Health Care Agreement.
- In 2009, the National Health and Medical Research Council has allocated $16.6 million for 107 grants towards kidney disease research;
- In 2007-08, through the PBS and the Repatriation Pharmaceutical Benefits Scheme, the Government spent more than $30 million to help people with the cost of medications needed to treat chronic kidney disease.

- The Government has allocated $8.6 million to improve access to dialysis services in the Kimberley region of Western Australia, and $5.3 million to improve access to dialysis services for remote communities in the Northern Territory.

- $7 million was provided to build a renal dialysis unit at the North Lakes Health Precinct in Queensland. The Unit is now completed and services will begin later this year.
- The Australian Government has also directed $151.1 million over four years (2008-09 to 2011-12) to implement a world's best practice national reform package for organ and tissue donation for transplantation. Transplantation is considered the preferred option for kidney replacement therapy by patients and healthcare professionals.

b) The Department is currently using the data provided in the AIHW report "*Health expenditure on chronic kidney disease in Australia 2004-05" (published September 2009)* which reported the following:

Type of dialysis	**Average expenditure per patient per year ($)**
Haemodialysis in hospital or satellite centre	$75,660
Haemodialysis at home	$64,330
Continuous ambulatory peritoneal dialysis	$50,362
Automated peritoneal dialysis	$50,362

Sources: Victorian Department of Human Services 2004; National Hospital Cost Data Collection cost report round 9 (2004–05) and ANZDATA Registry data

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, October 2009

Question: E09-096

OUTCOME 10: Health System Capacity and Quality

Topic: KIDNEY FAILURE

Written Question on Notice

Senator Boyce asked:

Given that kidney failure is often caused by other diseases such as diabetes, what is the Department doing to increase the awareness and management of the diseases which lead to kidney failure?

Answer:

The Government recognises the impact of chronic kidney disease in Australia and the need for effective prevention and treatment.

As part of the 2009 Budget, it was announced that, in partnership with the states and territories, the Australian Government will invest $872.1 million over six years in preventing lifestyle risks that cause chronic disease including chronic kidney disease.

The Council of Australian Governments, jurisdictions and the Commonwealth combined, have committed $200 million ($103.4 million being the Commonwealth contribution) in 2007 to tackle type 2 diabetes. As part of this initiative, General Practitioners (GP) can now, under Medicare, undertake a diabetes risk evaluation and provide risk modification advice for people in the 40 to 49-year age group who are at high risk of the disease and refer them to a subsidised lifestyle modification program.

In July, the Government announced funding for 82 organisations for one-off grants of between $20,000 and $200,000 (GST excl) that will deliver specific chronic disease self-management and lifestyle risk modification strategies in communities and regions throughout Australia. Chronic Disease Self Management strategies can improve patient quality of life, reduce GP visits, reduce hospital admissions and shorten hospital stays. Lifestyle risk modification strategies aim to support primary health professionals through targeted information and training to deliver healthy lifestyle advice to people at risk of, or with chronic diseases.

The Government is committed to working to reverse the growing trend of diabetes and other chronic diseases and commissioned the development of the Draft National Primary Health Care Strategy and the Preventative Health Strategy. These documents provide advice on primary and preventative health programs and strategies, focusing on the burden of chronic diseases such as diabetes currently caused by obesity, tobacco and excessive alcohol consumption and are being used as the basis for consultations with health professionals and the community. This consultation will inform the Government's response to these issues in the context of the broader health reform agenda.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-246

OUTCOME 10: Health System Capacity and Quality

Topic: TRIAL EXCHANGE OF ELECTRONIC PRESCRIPTIONS BETWEEN GPS AND COMMUNITY PHARMACIES

Hansard Page: CA 101

Senator Boyce asked:

a) How would that trial be conducted?

b) Who would be involved?

c) Would real data be used?

d) What are the protocols around advising people that real data is being used or would this simply be organisation to organisation?

e) Would individuals be aware that their prescriptions are being handled in this way?

Answer:

a – e)

National eHealth Transition Authority (NEHTA) released draft specifications for the transfer of prescriptions between GPs and Community Pharmacies on 30 October 2009. These specifications have been released for industry comment and, in line with usual practice, NEHTA will work with industry to finalise the specifications.

NEHTA has advised that collaboration with the two existing electronic transfer of prescription services is underway to both review the NEHTA specifications and identify implementation opportunities.

If either or both of these services adopted the NEHTA specifications, they would be early adopters of these specifications in a controlled environment using their existing protocols and practices.

The implementation of any new or upgraded system requires a period of testing prior to operational use, however real prescription information would be used once testing has proved the system to be safe and secure.

For the patient, there would be no change in how they receive the prescription or the medications. A paper prescription would still be provided with the addition of a bar code printed on the prescription and the process for the patient would be exactly as it is for a non e-prescription.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-245

OUTCOME 10: Health System Capacity and Quality

Topic: HEALTHCARE IDENTIFIERS

Hansard Page: CA101

Senator Boyce asked:

Do you have a schedule of who will be rolling this out when?

Answer:

The National eHealth Transition Authority (NEHTA) is currently working with the states and territories to plan and scope rollouts of identifiers into public health systems. NEHTA is also working with the primary care sector and primary care software vendors to develop an implementation pathway.

The legislative framework to enable the secure use of Healthcare Identifiers is currently being developed and public consultation on draft legislation occurs during December 2009. Legislation is expected to be introduced to Parliament in the Autumn 2010 sitting to enable the Healthcare Identifier service to begin operation in mid 2010.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-145

OUTCOME 10: Health System Capacity and Quality

Topic: RESPECTING PATIENT CHOICES PROGRAM

Written Question on Notice

Senator Adams asked:

a) How much funding is proposed to be committed to the Respecting Patient Choices program in the future, from which source or sources of funds?

b) What evaluation has been undertaken into the Respecting Patient Choices program?

c) What are the results and recommendations of any such evaluation of the Respecting Patient Choices program?

d) What consultation has occurred, and with whom, about the Respecting Patient Choices program?

e) What support, or concern, has there been from the aged care community about the Respecting Patient Choices program?

f) Have any policy decisions been made about the future of the Respecting Patient Choices program, as one - but only one - option for advance care planning?

Answer:

a) Respecting Patient Choices is currently funded until June 2010. Future funding decisions will be subject to Government consideration.

b) An evaluation of the Respecting Patient Choices Palliative Care Model is due to be completed in May 2010. Formative evaluations of the introduction of the Respecting Patient Choices model in residential aged care facilities and hospitals were conducted in 2005 and 2006.

c) Evaluation of the introduction of the Respecting Patient Choices model to residential aged care facilities and hospitals found that it was successful.

d) The Respecting Patient Choices project has a national reference group which includes government representatives, client and industry group representatives, and union representatives.

e) No representations have been received from the aged care community about the Respecting Patient Choices project.

f) No.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-144

OUTCOME 10: Health System Capacity and Quality

Topic: PALLIATIVE CARE

Written Question on Notice

Senator Adams asked:

How much funding has the Respecting Patient Choices program, funded under the National Palliative Care Program, received to date?

Answer:

Respecting Patient Choices has received $2,905,479.50 (GST inclusive) to date. The funding agreement is for the period January 2007 to June 2010.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-101

OUTCOME 11: Mental Health

Topic: STIGMA AND MENTAL HEALTH

Written Question on Notice

Senator Boyce asked:

During last Estimates, I raised the issue that the major problem in the mental health area was stigma. The Department stated that it was very involved with the non-government organisation (NGO) sector to address this issue and was funding programs with the NGOs. Are those programs entirely funded by the Government, or in partnership with the NGOs?

Answer:

- The Department provides funds to a number of NGOs to conduct mental health and suicide prevention initiatives and projects that have a strong focus on reducing the stigma associated with mental illness.
- The Mindframe National Media Initiative is the Australian Government's national strategy to encourage the promotion of responsible and accurate reporting and portrayal of mental illness and suicide in the media in order to reduce harm and copycat behaviour, and reduce the stigma experienced by people who experience a mental illness.
- The Department funds the Hunter Institute of Mental Health to conduct five of the Mindframe education and training projects. The Hunter Institute is a business unit of the Hunter New England Area Health Service whose aim is to promote mental health and to improve the outcomes for people with mental illnesses. The Australian Government is the sole provider of funding for Mindframe projects.
- Also funded under the Mindframe National Media Initiative, SANE Australia aims to reduce stigma by improving community understanding of mental illness through its publications and resources, ongoing work with the media through the SANE Media Centre and the StigmaWatch program.
- SANE Australia are funded by the Australian Government to conduct these stigma-reduction activities, however SANE Australia also conduct other activities which are funded through donations and other grants.

- An important part of the Australian Government's efforts to increase community awareness and understanding of mental health issues has been through *beyondblue* and its sustained and comprehensive media campaigns relating to high-prevalence disorders such as depression and anxiety. While the Australian Government provides significant funding for these activities, state and territory governments also provide funding through a cost shared arrangement. *beyondblue* also receive funding from a number of other sources.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-197

OUTCOME 11: Mental Health

Topic: RURAL AND REMOTE ACCESS TO THE MBS BETTER ACCESS INITIATIVE

Hansard Page: CA 61

Senator Boyce asked:

How many individuals within far northern Queensland, particularly the Normanton area in the Gulf of Carpentaria, have accessed mental health services under the Better Access Initiative? That is the figures for the inland area of far northern Queensland not for the coastal area.

Answer:

In the period from 1 November 2006 to 31 October 2009, around 1,200 mental health services have been provided in the inland area of the Normanton and far north Queensland area of the Gulf of Carpentaria under the Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule (Better Access) initiative. Data is not readily available on the number of individuals who have accessed these mental health services.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-196

OUTCOME 11: Mental Health

Topic: CYBER BULLYING

Hansard Page: CA 59

Senator Wortley asked:

Can you tell me whether there has been an increase in the use by youth of headspace, particularly the sections dealing with depression in relation to cyber bullying?

Answer:

headspace services became operational beginning with the establishment of ten youth friendly sites in 2007, growing to 30 sites in 2008. During the start up phase, from establishment to November 2009, *headspace* has provided services to almost 18,000 young people.

While *headspace* records clinical information on the causes behind a presenting problem or diagnosis, specific data on young people presenting to *headspace* because of cyber bullying is not available as this is not currently a reportable data element of the project.

Approximately 10% of Australian students in years 4-9 have experienced cyber bullying *(McGrath, 2009)*. The recently released report *State of Australia's Young People (2009)* indicates that more than a quarter of Year 8 students know someone who has been cyber bullied. Other research indicates that 31% of 14-17 year olds and 21% of 10-13 year olds have experienced cyber bullying *(Microsoft Australia, 2008)*. There is also clear evidence to show that cyber bullying and traditional bullying are closely related, 83% of students who bully offline also bully online *(Cross, Shaw, Hearn et al, 2009*).

In August 2008, *headspace* convened an online forum on Cyber bullying. The forum had a total of 91 posts, 1407 views and 45 users. This segment of the *headspace* website has subsequently been accessed 23,092 times.

As a result of the obvious interest in this topic, *headspace* recently initiated a 12 month cyber bullying campaign in partnership with S-press magazine*. This awareness campaign aims to address and combat the growing incidence of online bullying. It targets school age young people directly and provides information on ways to combat cyber bullying and how to report cyber bullying.

[*S-press is Australia's largest free publication for teenagers with 95,000 copies distributed to 99 per cent of high schools. It covers every aspect of teen life from news, sport, education and careers, to social events, entertainment and fashion.]

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-102

OUTCOME 11: Mental Health

Topic: KIDSMATTER PRIMARY INITIATIVE

Written Question on Notice

Senator Boyce asked:

The Minister announced on 5 October 2009 that the Government was committing $12.2 million to the KidsMatter Primary initiative, which aims to promote mental health, prevent mental health illness and initiate early intervention in primary schools. The Government will also commit $6.5 million over three years to develop a similar project for the early childhood sector.

a) Which studies have the Department used to determine the age at which mental health problems can be detected?

b) What kinds of mental health problems are specifically targeted by the KidsMatter project?

c) How will the KidsMatter projects detect mental health problems - is it through monitoring the children, or are the children required to volunteer to testing?

d) The project will be implemented in 400 schools nationwide. Can the Department provide a list of the schools where the project will be implemented?

e) Are there any plans to implement similar projects such as KidsMatter in High Schools in Australia?

Answer:

a) KidsMatter Primary and KidsMatter Early Childhood are being conducted in partnership with beyondblue: the national depression initiative, the Australian Psychological Society, Principals Australia and Early Childhood Australia.

Child and infant mental health is recognised as a field of inquiry in the international research literature and has received increased attention in recent decades. There is a growing body of international and Australian research supporting the existence and identification of mental health difficulties in early childhood (usually defined as birth – eight years old) and primary school aged children.

There is strong data available about the detection of mental health problems in primary school aged children, however, there is less data available for early childhood. In the absence of epidemiological data for the early childhood period, estimates can be made

based on the results of individual studies. Some of the recent studies referenced in KidsMatter (see attached references) include:

Australian studies

An Australian study of children aged one and a half to three years showed externalising (e.g. aggression and defiance) and internalising (e.g. anxiety and social withdrawal) problems out of the normal range in between 4 and 14% of children (Bayer et al., 2008). The Child and Adolescent component of the National Survey of Mental Health and Wellbeing, an epidemiological study of the prevalence of mental health problems in Australian children focused on children aged 4 to 17 years, found 14% of children scored in the clinical range for mental health problems (Sawyer et al., 2000).

International studies

International research in this area is showing that mental health difficulties in the years before school is similar in terms of diagnostic classification, prevalence and comorbidity to those seen in later childhood (Sterba et al. 2007; Egger & Angold 2006; Egger & Angold 2004). In Copenhagen, where there is a longitudinal study of young children taking place, children aged one and half years old were found to have mental health difficulties according to internationally recognised classification systems (ICD-10 and DC 0-3) (Skovgaard et al., 2007). The Briggs-Gowan research group from the U.S.A. has shown that clinically significant levels of depression and anxiety symptoms using parent reports can be detected in toddlers (24-36 months) and ranged between 2% and 24% (Briggs-Gowan et al., 2001; Carter et al., 2004).

b) The KidsMatter initiatives aim to promote the positive mental health of all children through supporting teachers, early childhood staff, parents and carers to work together to assist children to develop age appropriate social and emotional skills. The development of these skills equips children to develop resilience and protects children against the development of mental health problems. KidsMatter also aims to support teachers, early childhood staff, parents and carers to identify early signs and symptoms of mental health difficulties in children and provide support to these children and their families. This support may be provided in the classroom or service as well as by assisting families to access appropriate professional help. In this way, KidsMatter targets all mental health problems experienced by children. No problem is specifically targeted.

c) KidsMatter supports teachers, early childhood staff, parents and carers to recognise early signs and symptoms of potential mental health problems in children. KidsMatter does not screen or test children.

Teachers and early childhood staff are supported with professional learning and evidence based resources and are encouraged to have protocols and processes in place within the school or early childhood service regarding identification and referral to appropriate services where required.

d) Primary schools currently participating formally in KidsMatter Primary are listed on the website at www.kidsmatter.edu.au As new schools commence implementation of KidsMatter Primary they will be included in this information.

e) MindMatters is the Commonwealth's framework for improving the mental health outcomes of secondary school students. Using a range of resources MindMatters aims to increase the capacity of Australian secondary schools for mental health promotion, prevention and early intervention. It includes the delivery of professional development to

teachers and other key school personnel and the provision of materials and a website to support a whole school approach. MindMatters has been implemented in Australian secondary schools since 2000 and is delivered by Principals Australia. Further information is available at www.mindmatters.edu.au

References

Bayer, J.K., Hiscock, H., Ukoumunne, O.C., Price, A., & Wake, M. 2008, Early childhood aetiology of mental health problems: a longitudinal population-based study. *The Journal of Child Psychology and Psychiatry and Allied Disciplines*, vol. 49, pp 1166-1174.

Briggs-Gowan, M.J., Carter, A.S., Skuban, E.M., & Howitz, S.M. 2001, Prevalence of social-emotional and behavioral problems in a community sample of 1- and 2- year-old children. *Journal of the American Academy of Child and Adolescent Psychiatry*, vol. 40, pp 811-819.

Carter, A.S., Briggs-Gowan, M.J., & Ornstein Davis, N. 2004, Assessment of young children's social-emotional development and psychopathology: Recent advances and recommendations for practice. *Journal of Child Psychology and Psychiatry and Allied Disciplines*, vol. 45, pp 109-134.

Egger H.L., & Angold, A. 2006, Common emotional and behavioral disorders in preschool children: presentation, nosology, and epidemiology. *Journal of Child Psychology and Psychiatry and Allied Disciplines*, vol. 47, pp 313–337.

Egger, H.L., & Angold, A. 2004, The preschool age psychiatric assessment (PAPA): A structured parent interview for diagnosing psychiatric disorders in preschool children. In R. DelCarmen-Wiggins & A. Carter (Eds.), *Handbook of infant, toddler, and preschool mental health assessment.* (pp. 223-243). New York: Oxford University Press.

Sawyer MG, Arney FM, Baghurst PA, Clark JJ, Graetz BW, Kosky RJ, et al., 2001,The mental health of young people in Australia: Key findings from the Child and Adolescent Component of the National Survey of Mental Health and Well-Being. Australian and New Zealand Journal of Psychiatry, vol. 35, pp 806–814.

Skovgaard, A.M., Houmann, T., Christiansen, E., Landorph, S., Jorgensen, T., Olsen, E.M., Heering, K., Kaas-Nielsen, S., Samberg, V., and Lichtenberg, A. 2007, The prevalence of mental health problems in children $1^1/_2$ years of age – the Copenhagen Child Cohort 2000. *Journal of Child Psychology and Psychiatry and Allied Disciplines*, vol. 48, pp 62-70.

Sterba, S., Egger, H.L., & Angold, A. 2007, Diagnostic specificity and nonspecificity in the dimensions of preschool psychopathology. *Journal of Child Psychology and Psychiatry and Allied Disciplines*, vol. 48, pp 1005-1013.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-191

OUTCOME 12: Health Workforce Capacity

Topic: 10-YEAR MORATORIUM ON INTERNATIONAL MEDICAL GRADUATES

Written Question on Notice

Senator Adams asked:

In relation to the 10-year moratorium on international medical graduates (which the Department has been reviewing internally recently):

a) Has the Department conducted a review into the impact of the 10 year moratorium on international medical graduates?

b) What are the findings and recommendations of that review?

c) What is the process and timeframe for progressing the recommendations in the review?

Answer:

a) On 30 April 2008, the Audit of Health Workforce in Rural and Regional Australia report was released. This included the role of overseas trained doctors (OTDs) or international medical graduates in the provision of health services.

b) As a result of the audit, Minister Roxon asked the Department to review the Commonwealth funded rural health programs and the geographic classification systems that determine the eligibility for rural health program funding.

In response to the audit and reviews, under the 2009 Budget the Australian Government announced the Rural Health Workforce Strategy:

- a $134.4 million package to improve rural and remote workforce shortages and better target existing incentives through the provision of additional financial and non-financial support for rural doctors;
- a new structure for rural and remote health programs, including program consolidation, to be introduced in conjunction with the Budget measures; and
- the progressive introduction of the Australian Standard Geographical Classification - Remoteness Areas (ASGC-RA) system to replace the outdated Rural, Remote and Metropolitan Areas (RRMA) classification system as the basis of funding rural health programs.

c) A key measure under the Rural Health Workforce Strategy will see the ten year moratorium period for OTDs scaled so that the greater benefits are targeted to the most remote areas. Scaling will commence from 1 July 2010, enabling OTDs to reduce their restriction period depending on the location in which they choose to practice, which is indicated in the table below.

ASGC-RA Classification	**ASGC-RA 1 (Major Cities)**	**ASGC-RA 2 (Inner Regional)**	**ASGC-RA 3 (Outer Regional)**	**ASGC-RA 4 (Remote)**	**ASGC-RA 5 (Very Remote)**
Period of restriction	10 years	9 years	7 years	6 years	5 years

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-247

OUTCOME 12: Health Workforce Capacity

Topic: OVERSEAS TRAINED DOCTORS

Hansard Page: CA 93

Senator Back asked:

Can you advise the length of time that doctors coming into Australia spend in rural communities before they are able to go to the major regional or metropolitan areas.

Answer:

In order to access Medicare benefits arrangements, an overseas trained doctor (OTD) subject to Section 19AB of the *Health Insurance Act 1973* (the Act) must work in a location that is deemed to be a district of workforce shortage (DWS). This can include outer metropolitan areas and does not restrict doctors solely to rural and remote areas. A location is deemed to be a DWS if it falls below the national average for the provision of medical services.

Currently, section 19AB of the Act applies to OTDs and former overseas medical students (FOMS) who gained their first medical registration or became a permanent resident or citizen on or after 1 January 1997. OTDs and FOMSs who are subject to section 19AB are generally required to work in a DWS for a minimum period of ten years from the date of their first medical registration, or from the date the doctor became a permanent resident. This requirement is referred to as the ten year moratorium.

Commencing from 1 July 2010, scaling will be applied to the ten year moratorium. From this date, an OTD's period of restriction will be scaled down in accordance with the remoteness of their practice locality, as indicated in the table below.

ASGC-RA* Classification	**ASGC-RA 1 (Major Cities)**	**ASGC-RA 2 (Inner Regional)**	**ASGC-RA 3 (Outer Regional)**	**ASGC-RA 4 (Remote)**	**ASGC-RA 5 (Very Remote)**
Period of restriction	10 years	9 years	7 years	6 years	5 years

* Australian Standard Geographical Classification – Remoteness Structure (ASGC-RA)

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-059

OUTCOME 12: Health Workforce Capacity

Topic: CHIROPRACTORS

Written Question on Notice

Senator Siewert asked:

a) Why does the government permit chiropractors to trade directly with private patients but not public patients?

b) Do governments apply the same requirements on any other similarly registered and licensed health care profession?

c) If yes, what profession/s and on what basis?

d) If no, why only the chiropractic profession?

Answer:

a) The Commonwealth Government does not restrict where chiropractors practise or who they provide services to. States and territories are responsible for employing public sector health workers.

b) Not applicable, as above.

c) Not applicable, as above.

d) Not applicable, as above.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-192

OUTCOME 12: Health Workforce Capacity

Topic: MEDICAL TRAINING

Written Question on Notice

Senator Adams asked:

In relation to post-university medical training for the increasing cohort of medical students graduating from Australian universities which, as a result of Federal Government initiatives, will increase to 3,500 graduates p.a. by 2012. What process has the Commonwealth Government got in place to regularly monitor the availability of intern and prevocational positions in each state and territory?

Answer:

The state and territory government health departments' report the number of commencing medical intern training places annually to the Commonwealth and this data is provided in the Medical Training Review Panel (MTRP) Report which is produced annually.

The MTRP Report provides a picture of medical education and training in Australia and includes a chapter on prevocational training containing data for the number of postgraduate year 1 commencements (also known as intern year) as well as postgraduate year 2 places.

The provision of medical intern training places is the responsibility of each state and territory government and interns are employed by public hospitals. The Commonwealth is continuing to liaise with the states and territories regarding work they are doing to increase capacity for medical intern training places to meet growing demand.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-193

OUTCOME 12: Health Workforce Capacity

Topic: MEDICAL TRAINING REVIEW PANEL

Written Question on Notice

Senator Adams asked:

a) Has the Department conducted a review of the Medical Training Review Panel?

b) What are the findings and recommendations of that review?

c) What is the process and timeframe for progressing the recommendations in the review?

Answer:

a) Yes, the Department conducted a review in 2008.

b) The review's overall key findings are that the Medical Training Review Panel is valued and strongly supported, and that its work should continue along existing lines with some expansion around current data collection and interpretation functions and consideration of emerging issues. The review also recommended expansion of the membership, streamlining of appointment processes, greater consultation and interaction with various bodies and groups, and more frequent meetings.

c) These recommendations are currently being considered.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-194

OUTCOME 12: Health Workforce Capacity

Topic: GENERAL PRACTICE TRAINING PROGRAM

Written Question on Notice

Senator Adams asked:

a) Can the Department provide an update on applications for this year's general practice training program?

b) Did the demand for general practice training places for next year exceed the number of funded places available?

c) If yes, by how much?

Answer:

a) As of 30 October 2009, General Practice Education and Training Limited has received 1,004 applications for entry to the Australian General Practice Training program in 2010.

b) As the selection process is still underway it is not possible to determine whether demand for places will exceed the number of funded places available.

c) Not applicable.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-030

OUTCOME 12: Health Workforce Capacity

Topic: TRAINING STAFF IN RURAL/REMOTE AREAS

Written Question on Notice

Senator Williams asked:

Are you aware of the difference in the cost of training and up-skilling staff in rural/remote areas compared to metro areas and what is being done to address this?

Answer:

Rural Health Multidisciplinary Training Program
The Government's continued support for the national network of 17 rural clinical schools and 11 university departments of rural health is making a major contribution towards increasing access to training and reducing the cost of rural education for students and health professionals. These initiatives are supported through the Government's Rural Health Multidisciplinary Training Program, which will provide funding in excess of $116 million in 2009-10 to support training, research and professional development activities at a broad range of rural sites throughout Australia. This overarching program provides resources to participating universities in recognition of the substantial additional cost of delivering high quality educational experiences in rural and remote settings. A recent evaluation of the initiatives funded through this measure found that the funding provided by the Australian Government is generating positive results for the rural health workforce by reducing professional isolation and contributing to both recruitment and retention.

The Nurse Scholarship Program
The Nurse Scholarship Program provides financial support for nurses in rural and remote areas wishing to undertake undergraduate education, continuing professional education as well as assisting nurses in rural and remote areas who are re-entering the workforce. This program is administered by the Royal College of Nursing, Australia.

General Practice Vocational Training
GP training is provided through 20 regional training providers who operate in vastly different geographical environments. There is a difference between the cost of general practice vocational training in rural and urban areas.

- Some of the additional costs associated with rural training include:
  - travel costs associated with the regular meetings between GP registrar and medical educators; and

– establishment of information technology and online learning systems to support the delivery of training within regional and rural areas.

- Registrars on the Australian General Practice Training program rural pathway are eligible for incentives under the General Practice Rural Incentives Program for training undertaken in rural and remote locations.
- Registrars on the general pathway are also eligible for incentives for training undertaken in locations designated as Outer Metropolitan.
- Registrars on the Remote Vocational Training Scheme (RVTS) have access to locum support when they are required to leave their practice to attend face-to-face training. The cost of this support is met by RVTS Limited.

Specialist Training Program

The Department recognises that there are additional costs associated with the establishment of specialist training positions in regional and rural Australia. Funding for the Specialist Training Program includes an additional loading of $20,000 on top of the $100,000 salary contribution available per Full Time Equivalent training post, for training posts in regional and rural areas.

The same provision applies to the funding available for pathology training posts under the "Supporting Best Practice in Pathology and Diagnostic Imaging" measure announced in the 2009–10 Budget. In this measure the Royal College of Pathologists of Australasia will be required to ensure that up to 20 of the total of 53 training posts attracting Commonwealth funding will be located in rural areas. Each of these 20 rural positions will attract a $20,000 rural loading.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-031

OUTCOME 12: Health Workforce Capacity

Topic: ATTRACTING STAFF TO RURAL/REMOTE AREAS

Written Question on Notice

Senator Williams asked:

a) Are you aware of the difficulty of attracting and retention of care workers, registered nurses and enrolled nurses in rural/remote areas?

b) What is being done about this difficulty?

Answer:

a) The Department of Health and Ageing is aware of the difficulty of attracting and retaining care workers, registered nurses and enrolled nurses to some rural/remote areas.

c) The Department of Health and Ageing's Nurse Scholarship Program provides financial support for nurses in rural and remote areas wishing to undertake undergraduate education, continuing professional education as well as assisting nurses in rural and remote areas who are re-entering the workforce. This program is administered by the Royal College of Nursing, Australia.

The Department also funds CRANA*plus* in Alice Springs which is the only organisation that has remote health as its sole focus. The objectives of CRANA*plus* include improving the training, preparedness and support of the remote health workforce and increasing the recruitment and retention of remote health professionals. CRANA*plus* provides training and support for the remote and isolated health workforce including nurses, aboriginal health workers, medical practitioners, allied health professionals and health service managers.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-189

OUTCOME 12: Health Workforce Capacity

Topic: SINGLE PROVIDER NUMBERS

Written Question on Notice

Senator Adams asked:

The Productivity Commission Review of Regulatory Burdens on Business has yet again recommended that the Government introduce a single provider number under Medicare for each medical practitioner rather than the current arrangements where practitioners are required to have a different provider number for each location that they practice in. What progress has the Department made in implementing this recommendation?

Answer:

The Department is aware of this recommendation.

Adoption of a single provider number would need to be considered in the context of any national eHealth reform agenda.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-179

OUTCOME 13: Acute Care

Topic: IMPORTED PLASMA PRODUCTS

Written Question on Notice

Senator Adams asked:

Octapharma Australia Pty Ltd currently has a number of products seeking funding under Schedule 4 of the National Blood Agreement (for products without an equivalent available). These products have all been approved by the Therapeutic Goods Administration but so far, none of these products have been granted funding. What is the reason for the delay?

Answer:

All suppliers to the national supply plan were advised on 7 May 2009 that the Jurisdictional Blood Committee (JBC) has agreed that all Schedule 4 applications should be set aside for a period while the process is reviewed, to allow JBC members an opportunity to consider properly the operational components of the Schedule 4 assessment process.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-176

OUTCOME 13: Acute Care

Topic: BLOOD FRACTIONATION

Written Question on Notice

Senator Adams asked:

In this Committee's hearing of 3 June this year, I asked Dr Turner of the National Blood Authority (NBA) if any companies, other than CSL Ltd, had applied to operate or set up a new business in blood fractionation. Dr Turner's answer was in the negative but she subsequently corrected that response in a letter to the Secretary of the Committee. And I am happy with that. In the meantime, Senator Moore as chair received a letter from Octapharma Australia, a major supplier of plasma products, world-wide, indicating to correct the record that that company had in fact submitted a formal proposal to the Howard Government in May 2007 to build a $400 million plasma fractionation facility in Australia to compete with CSL.

The letter indicated that the offer was later submitted to the Rudd government, together with a business case, in March 2008, and that the proposal was considered by the Jurisdictional Blood Committee, comprising Commonwealth and state and territory members. The letter then indicates that the company had received no response to that 2008 offer and also indicates that despite winning TGA licences for a number of its new plasma products, none of these products have been granted funding approval.

I understand that the NBA is currently negotiating a new five year contract with CSL to operate from 1 January next year. This is not a competitive matter. There are no other bidders. CSL once again is being given a contract. Now I understand that the Australian Health Ministers' Conference in July 2007 agreed that the NBA should not have to guarantee CSL exclusive rights to fractionate Australian plasma. But that seems to be what is happening, and I would like to know why?

I fully understand the position of the then government when CSL Ltd was formed out of the old Commonwealth Serum Laboratories that exclusivity – a monopoly right over Australian donated blood – was sensible in the national interest. And CSL has done a good job and prospered – prospered to the extent that it is today the largest blood fractionator in the world. So it doesn't need support anymore – the national interest now would seem to dictate that there is competition and transparency in this as in all public sector contracts so that government and the taxpayers can see whether or not we are getting a good deal from this monopoly supplier.

My question is: whatever the reasons were for the special relationship with CSL, those reasons no longer exist. When will we see a fair and competitive market for blood fractionation and plasma products in Australia?

Answer:

CSL is subject to restrictions which are imposed through the *Commonwealth Serum Laboratories Act 1961*. These restrictions impose certain limits on CSL's operations in Australia to ensure that the company acts in the national interest. The safeguards represented by this legislation serve to protect public health and safety.

The Octapharma proposal was predicated on a decision by all Australian governments to allocate a proportion of publicly funded donated plasma to source their operations. The consideration of future access arrangements to Australia's plasma for the purposes of fractionation is a matter for all Governments. Any request for access to Australian plasma would need to be considered by the Australian Health Ministers' Conference, as the relevant ministerial council under the National Blood Agreement.

There are no impediments from a health perspective to Octapharma establishing a plasma fractionation facility in Australia assuming they meet manufacturing licence requirements from the Therapeutic Goods Administration.

Octapharma has a number of blood products included on the Australian Register of Therapeutic Goods (ARTG) and is able to enter into the tender process for imported products, as can any manufacturer with products registered on the ARTG. Under the national blood arrangements Octapharma is currently the successful tenderer and supplier of imported intravenous immunoglobulin. The value of this contract in 2007-2008 was $29.3 million.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-177

OUTCOME 13: Acute Care

Topic: CONTRACT BETWEEN CSL AND NBA

Written Question on Notice

Senator Adams asked:

a) With regard to a new supply contract under negotiation between CSL and the NBA, at what stage are the CSL/NBA negotiations and has CSL sought and/or has the NBA given a guarantee of exclusive rights to fractionate Australian plasma?

b) Recommendation 2b of the Australian Health Ministers' Conference of July 2007 stated 'options to secure the long-term viability of the supply of products fractionated from Australian plasma should continue to be monitored and explored with reference to national and international industry developments.' Regarding Recommendation 2b, and assuming that options to secure that long-term viability of supply have been 'monitored and explored', what options have been identified and what happens next?

Answer:

a) The Plasma Products Agreement (PPA) is a five-year agreement between the National Blood Authority (NBA) on behalf of all Australian governments, and CSL Limited. The PPA is due to expire on 31 December 2009 and the NBA is currently in negotiations with CSL Limited to develop a new contract to enable the continued fractionation of Australian plasma into a range of Therapeutic Goods Administration registered blood products for use within Australia.

   CSL Limited has the only fractionation facility in Australia for the manufacture of blood products. The NBA follows government policy in entering into contracting arrangements, which includes a requirement to manufacture all blood products made from Australian plasma, on-shore.

   Negotiations with CSL Limited to agree the new contract to operate from 1 January 2010 are complex and ongoing. Disclosure of commercial details of the negotiations at this time would be inappropriate as this may prejudice the ability of the parties to reach a satisfactory negotiated outcome across all relevant issues.

b) The NBA is currently in negotiations with CSL to develop a new contract which will result in the continuation of supply of a range of blood products fractionated from Australian plasma. This contract, and all other procurement and contracting arrangements, continue to give due consideration to government policy in relation to long term viability and national and international industry developments.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-276

OUTCOME 13: Acute Care

Topic: ELECTIVE SURGERY

Hansard Page: CA 45

Senator Boyce asked:

Could we have a list of the expenditure in each state and the number of elective surgery procedures undertaken in each state, on notice, thank you?

Answer:

Expenditure on Stage One of the Elective Surgery Waiting list Reduction Plan and number of procedures undertaken.

State	Funding from the Commonwealth in 2008 ($m)	Target additional procedures to be undertaken in 2008	Additional procedures actually provided in 2008
NSW	43.3	8,743	12,153
VIC	34.2	5,908	13,478
Qld	27.6	4,000	5,928
WA	15.4	2,720	3,727
SA	13.6	2,262	3,196
TAS	8.1	895	1,606
ACT	2.5	250	858
NT	5.3	500	638
AUST	**150**	**25,278**	**41,584**

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-277

OUTCOME 13: Acute Care

Topic: WAITING TIMES

Senator Boyce asked:

Are the clinical recommendations about waiting times nationally consistent?

Answer:

In general terms, yes. The three categories used to classify patients waiting for elective surgery in all jurisdictions relate to the degree of urgency of treatment and are generally accepted as being:

- Category 1 - "urgent"
- Category 2 - "semi-urgent"
- Category 3 - "non-urgent"

In practice the three categories have been expanded and further defined as:

- Category 1 - admission within 30 days desirable for a condition that has the potential to deteriorate quickly to the point that it may become an emergency.
- Category 2 - admission within 90 days desirable for a condition causing some pain, dysfunction or disability but which is not likely to deteriorate quickly, or become an emergency.
- Category 3 - admission at some time in the future for a condition causing minimal or no pain, dysfunction or disability, which is unlikely to deteriorate quickly, and which does not have the potential to become an emergency.

All states and territories use similar, although not identically worded, categories for elective surgery waiting times. There are also some variations between jurisdictions to meet their own particular needs or practices, for example:

- Some jurisdictions further specify that Category 3 patients should be admitted within 365 days (or 12 months).
- Some jurisdictions set benchmarks for the number of patients treated within the specified time for each category, ie 100% for category 1, 80% for category 2 and 90% for category3.
- New South Wales has a fourth category, "Not Ready For Care" for patients who are not clinically ready for surgery or who have deferred admission for personal reasons.

These categories are nationally endorsed and form part of the Elective Surgery Waiting

List Times National Minimum Data Set.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-278

OUTCOME 13: Acute Care

Topic: HOSPITALS

Hansard Page: CA 73

Senator Cormann asked:

I would like to get an indication, on notice, of some of the circumstances in which action has been taken by the Commonwealth towards state and territory governments.

Answer:

The Commonwealth has not taken action against a state or territory in relation to public hospitals waiving out-of-pocket charges for private patients. Where a patient elects to receive treatment on a private patient basis, the Healthcare Agreements allow the patient to be charged an amount for public hospital services as determined by the state or territory.

The Commonwealth has taken action against a state where it was notified and provided with sufficient evidence, for instance, by ensuring the reimbursement of the out-of-pocket costs of a patient who had not made an informed choice to be seen as a private patient in a practitioner's private room, while the patient was an admitted public patient.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-113

OUTCOME 13: Acute Care

Topic: INDIGENOUS DENTAL SERVICE

Written Question on Notice

Senator Adams asked:

a) Has the mobile Indigenous dental service Budget measure provided any services yet?

b) If so, how many and in what locations?

Answer:

a) No services have been provided yet. The implementation plan for this measure involves program development in 2009-10, including a consultancy to identify a number of possible projects suitable for implementing and testing models of dental service delivery to Indigenous populations in rural and regional areas of Australia. Service delivery under this measure is expected to commence in 2010-11.

b) Given the answer to a) above, this question is not applicable.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-251

OUTCOME 14: Biosecurity and Emergency Response

Topic: PANDEMIC H1N1 VACCINE

Hansard Page: CA 52

Senator Back asked:

Could you take on notice what the state by state distribution of the vaccination has been?

Answer:

The state by state distribution of vaccine, as at 27 November 2009 is provided in the table below.

Jurisdiction	Total Dose Allocation
NSW	3,906,780
QLD	1,608,420
SA	684,040
WA	890,680
VIC	1,512,680
TAS	164,740
NT	77,820
ACT	72,100
Commonwealth (Dept of Defence and DFAT)	35,600
Total	8,952,860

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 23 October 2009

Question: E09-273

OUTCOME 14: Biosecurity and Emergency Response

Topic: PANDEMIC (H1N1) VACCINATION PROGRAM

Hansard Page: CA 40

Senator Scullion asked:

How many Indigenous Australians have been immunised against swine flu in the Northern Territory?

Answer:

There is limited data available on vaccination uptake at both national and jurisdictional levels. However, as at 3 December 2009, more than 5.3 million doses of Panvax vaccine had been distributed nation wide, with more than 64,000 doses delivered to the Northern Territory.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 23 October 2009

Question: E09-116

OUTCOME 14: Biosecurity and Emergency Response

Topic: PANDEMIC (H1N1) VACCINATION PROGRAM

Written Question on Notice

Senator Adams asked:

a) How many Indigenous Australians have been immunised against swine flu?

b) How many Indigenous Australians have been immunised against swine flu in the Northern Territory?

Answer:

a and b)

There is limited data available on vaccination uptake at both national and jurisdictional levels. However, as at 3 December 2009, more than 5.3 million doses of Panvax vaccine had been distributed nation wide, with more than 64,000 doses delivered to the Northern Territory.

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 the Supplementary Budget Estimates Hearing on 21 October 2009 Hearing
Outcome 15

I am writing to correct a statement that I made at the Supplementary Budget Estimates of the Senate Community Affairs Committee on 21 October 2009.

Senator Fifield asked the following questions regarding the Local Sporting Champions program (CA 68):

Senator FIFIELD—Is it only members of the House who have that opportunity, is it?

Ms Flanagan—That is right. And the Senate, I am sorry.

Senator FIFIELD—I thought it might have just been members of the House and I thought that would be outrageous discrimination. It is good to hear that is not the case. How is it determined when a senator has input as opposed to a member of the House?

Ms Flanagan—There is no difference in criteria.

The information provided by the Australian Sports Commission in response to Senator Fifiled's query requires clarification, specifically in regard to how Senators can be involved in the Local Sporting Champions program. Therefore, additional information regarding the program is provided below.

The Local Sporting Champions was officially launched by Minister Ellis in November 2008. The program provides financial assistance to young sportsmen and women required to travel greater than 250km to participate in state or national sporting competitions. The grants can contribute to the cost of travel, accommodation, uniforms or equipment.

Grants of $500 per individual and $3,000 per team are available to young people between the ages of 12 and 18 years to compete in national sporting organisation endorsed state or national sporting competitions or national school sport competitions which involve travel greater than 250km return.

The Australian Sports Commission is responsible for administering the allocated $1.6 million annually for the Local Sporting Champions program. However, Federal Members of Parliament (MP) are responsible for the selection of successful Local Sporting Champions grant applicants.

Funding has been split 50-50 between metropolitan and non-metropolitan electorates. This equates to $9,000 in grants available for metropolitan electorates per annum, and $12,500 in grants available for non-metropolitan electorates per annum.

The program relies on MPs to form assessment panels within their electorate to assess applications and nominate grant recipients. The Commission has provided each MPs office with guidance material to assist with the formation of this group and to ensure its effectiveness.

At the conclusion of each round, Members are required to declare that the successful nominations are the result of collective agreement from the independent assessment panel and are void of any conflict of interest.

Senators do not have their own program, however, there are two ways in which a Senator may become involved in the approval process of grant applications; they may be invited by an MP to sit on the independent assessment panel or they can support individual and/or team applications at the request of the applicant.

I trust that the above information is of use and clarifies the role that MPs and Senators play in the Local Sporting Champions program.

Yours sincerely

Judy Flanagan
Director
Community Sport
Australian Sports Commission

11 November 2009

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-200

OUTCOME 15: Sport

Topic: CRAWFORD REVIEW

Hansard Page: CA 65

Senator Fifield asked:

Are you able to advise the date on which the review was completed? Could you tell us when the minister received a copy?

Answer:

The Independent Sport Panel (Crawford Review) completed its report to the Minister on Thursday, 15 October 2009. The Minister received a copy of the Report on Friday, 16 October 2009.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-201

OUTCOME 15: Sport

Topic: ILLICIT DRUGS IN SPORT

Hansard Page: CA 66

Senator Fifield asked:

How many national sporting organisations would meet those requirements [eligibility for out-of-competition testing]?

Answer:

The eligibility requirements for the Illicit Drugs in Sports Grants Program have not been finalised.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-202

OUTCOME 15: Sport

Topic: SPORT AND RECREATION FACILITIES

Hansard Page: CA 67

Senator Fifield asked:

Could you take me through the nature of the project [more detail] at the Helensburgh club. And also the nature of the project [more detail] at the Ingle Farm Soccer Club.

Answer:

Helensburgh Netball Club
The Australian Government made a commitment in the context of the 2007 election to provide $50,000 to the Helensburgh Netball Club for the upgrade of netball courts. The project plan provided to the Department includes:

- Construction of two new asphalt netball courts;
- Re-surfacing of two existing netball courts;
- Construction of new fencing; and
- Completion of flooring in the clubhouse

Ingle Farm Amateur Soccer Club
The Australian Government made a commitment in the context of the 2007 election to provide $50,000 to the Ingle Farm Amateur Soccer Club for the upgrade of lighting at the Club's sports field.

The Department is seeking a project plan and budget from the Club for this project.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-226

OUTCOME 15: Sport

Topic: LOCAL SPORTING CHAMPIONS 2008-09

Hansard Page: CA 68

Senator Fifield asked:

a) Moving to the Local Sporting Champions program now, of the $1.6 million allocated to the program, how much has been allocated to individuals and how much to teams?

b) Could you also check how many individual grants were allocated in 2008-09? You have given me the dollar figure for 2008-09. Could you take on notice the number for individual grants and team grants?

c) Has every Member of Parliament participated in this program? My understanding is that local members have the opportunity to choose who the recipients will be. Have all local members in the relevant electorates taken up that opportunity?

Answer:

a) Of the $1.6 million annual budget for the Local Sporting Champions program, $931,500 has been allocated for individual grants and $639,000 has been allocated for team grants.

b) The total number of Local Sporting Champions grants allocated for payment during the 2008-09 financial year was 908 ($606 500). 847 grants were paid to individuals ($423 500) and 61 grants were paid to teams ($183 000).

c) To date, eight electorates have not provided recommendations concerning Local Sporing Champions nominations. The Australian Sports Commission is in the process of meeting with all electoral offices to discuss their involvement in the program for 2009-10 and beyond.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-225

OUTCOME 15: Sport

Topic: MAJOR INTERNATIONAL EVENT PERFORMANCES 2009

Hansard Page: CA 64

Senator Fifield asked:

a) This may be something that you can tell me now or again you may need to take it on notice. I would be interested in how each sport performed at the major international events in 2009, where they ranked and how many medals they won. As you say, that is part of what goes into helping determine the estimate for the 2012 games. Let us say the previous 12 months or going back a little further. That is Olympic sports at international events—the ones I mentioned [swimming, athletics, cycling, sailing, canoeing and rowing].

b) Also, just to assist us, what major international events are going forward for the remainder of 2009, 2010 and 2011?

Answer:

a) <u>2009 Results (Benchmark Events)</u>

Sport	**Event**	**Gold**	**Silver**	**Bronze**	**Total**
Swimming	World Championship	2	3	8	13
Athletics	World Championship	2		2	4
Cycling	World Championship	2	3		5
Sailing	World Championship	1	1		2
Canoe/Kayak	World Championship	1		1	2
Rowing	World Championship		2		2

b) Major Events

There are no benchmark events for the remainder of 2009.

Sport	**2010**	**2011**
Swimming	Commonwealth Games (India)	World Championship (China)
Athletics	Commonwealth Games (India)	World Championship (Korea)
Cycling	World Championship (Denmark/Australia), Commonwealth Games (India)	World Championship (Netherlands/Denmark)
Sailing	World Championship (multiple venues)	World Championship (Perth)
Canoe/Kayak	World Championship (Slovenia/Poland)	World Championship (Slovakia/France)
Rowing	World Championship (New Zealand)	World Championship (Slovenia)

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-227

OUTCOME 15: Sport

Topic: LOCAL SPORTING CHAMPIONS – INPUT FROM SENATORS

Hansard Page: CA 68

Senator Fifield asked:

I thought that it might be done on a geographic basis that is how you might determine who the member of the House is who has input. But given senators cover the same territory as members of the House in a particular state how do you determine when a senator's input is sought?

Answer:

There are two ways in which a Senator may become involved in the approval process of grant applications; they may be invited by a Member of Parliament to sit on the independent assessment panel or they can support individual and/or team applications at the request of the applicant.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-228

OUTCOME 15: Sport

Topic: LOCAL SPORTING CHAMPIONS – MP/SENATOR INVOLVEMENT

Hansard Page: CA 68

Senator Fifield asked:

d) Could you also advise how many members of the House of Representatives have taken part in this program, and also how many members of the Senate have done so?

e) Could you indicate whether there are cases where a member of the House in a particular electorate and a Senator have both had input in that same area?

f) Could you indicate in each case where a Senator has had the input, and why that was the case?

Answer:

a – c)

142 Members of Parliament and their electorate offices have engaged in the Local Sporting Champions program. Senators are not responsible for the selection of applicants, so no senators have taken direct part in this program.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-222

OUTCOME 15: Sport

Topic: MEDAL PREDICTIONS

Hansard Page: CA 61-62

Question on Notice

Senator Fifield asked:

a) What are the benchmarks that have been set for the Commonwealth Games, including the associated Paralympics events? In other words, what are our goals? How many gold medals do we want to win? How many medals do we want to win in total?

b) Could you do that for the Commonwealth Games, the 2012 Olympic Games as well as the Paralympics? Let us do the winter as well.

Answer:

The Australian Government does not set medal targets for national sporting organisations at international events. Peak bodies such as the Australian Olympic Committee, the Australian Paralympic Committee and the Australian Commonwealth Games Association do from time to time make statements as to their expectations for future events.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-223

OUTCOME 15: Sport

Topic: OLYMPIC CYCLE COMPARISONS

Hansard Page: CA 63

Senator Fifield asked:

Is it possible, or meaningful for that matter, to compare where we are at this stage in the Olympic cycle with where we have been say in the previous two Olympic cycles? Is that something that is possible to measure or useful to look at? Do we do that? Do we say, 'Yes, we are doing better overall than the various meets at this stage of the Olympic cycle compared to this point in the previous Olympic cycle or the one before that'?

Answer:

The Australian Sports Commission does not undertake such analysis or research because such analyses do not provide any guide to future successes.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2009-2010, 21 October 2009

Question: E09-224

OUTCOME 15: Sport

Topic: BENCHMARKS

Hansard Page: CA 64

Senator Fifield asked:

I have some further questions in relation to benchmarks. As I say, you may need to take these on notice because it may involve consultation with the relevant national bodies. I would be interested in the medal aspirations—if I can go that far—for swimming, athletics, cycling, sailing, canoeing and rowing for the 2012 Olympics. How many medals does each of those sports expect/hope to win at those games?

Answer:

The Australian Government does not set medal targets for sporting events. Peak bodies and national sporting organisations may from time to time make statements as to their expectations for future events, however, estimates are likely to change over time having regard to both Australian and International development. Performance and estimates are also refined as the relevant event draws nearer.