Submission No. 142
AUTHORISED: 9/8/06
KS

Australian Government

Department of Health and Ageing

Mr James Catchpole
Secretary
Standing Committee on Health and Ageing
House of Representatives
Parliament House
PO Box 6021
Canberra ACT 2600

Dear Mr Catchpole

Inquiry into Health Funding – Responses to Questions on Notice

The Department of Health and Ageing has been pleased to assist the House of Representatives Standing Committee on Health and Ageing in its Inquiry into Health Funding.

Attached to this letter are the Department's responses to Questions on Notice from the Committee's Public Hearings held on 30 May 2005 and 28 November 2005 and from the Budget Briefing of 10 May 2006.

I regret the delay in completing the responses: it was due in part to the complexity of many of the questions, as well as the dynamic nature of the health and ageing portfolio.

I am informed that contact has been maintained with the Committee Secretariat throughout the process, including notification that the responses were being updated to reflect 2006-07 Budget measures.

I understand that the Questions on Notice will form part of the Department's submission and will be posted on the Committee's website.

Please do not hesitate to contact Mr Jamie Clout on (02) 6289 7931 if you have any queries regarding the Department's responses.

Yours sincerely

David Kalisch
Deputy Secretary
Australian Government Department of Health and Ageing
24 July 2006

QUESTIONS ON NOTICE FROM 30 MAY 2005 PUBLIC HEARING

HOUSE OF REPRESENTATIVES STANDING COMMITTEE ON HEALTH AND AGEING

INQUIRY INTO HEALTH FUNDING

INDEX TO QUESTIONS ON NOTICE

Question Number	Question on Notice
	Questions from public hearing – 30 May 2005
1	Copy of an Australian Health Care Agreement (including reporting schedule) ***(Hansard Reference: Page HE4)***
2	ACAT data on: 1. Length of time for service delivery, from time of assessment by ACAT to actual delivery 2. Number of persons who cannot get to stage of being assessed by ACAT because of large elderly population and lack of packages available ***(Hansard Reference: Page HE11)***
3	GDP data on: 1. Trends in the Australian percent of GDP expenditure on health from 1996 to most recently available figure 2. Data for the same period for other OECD countries 3. The public/private breakdown ***(Hansard Reference: Page HE12)***
4	Breakdown of price and volume data for PBS spending, including a breakdown of major therapeutic groups ***(Hansard Reference: Page HE12/13)***
5	Details of the penalties imposed on the states in 1996 under the former health care agreements in respect of cost-shifting ***(Hansard Reference: Page HE16)***
6	Examples of partnership arrangements undertaken by the Health Reform Agenda Working Group and within each example, identify the problems/ issues that have been addressed; outline the strategies that were put in place to address the problem; and provide information on the outcomes. ***(Hansard Reference: Page HE17)***
7	Detailed information on programs (eg coordinated care trials) that pool funds, particularly state, Commonwealth, and private. More detailed information on multipurpose services and an evaluation of these, if any. ***(Hansard Reference: Page HE19)***
	Written questions on notice forwarded to the Department
	General questions
8	What does the department see as the primary drivers of increasing health costs?
9	What long term approaches is the department adopting to cope with the increased costs of the health system?

	Accountability
10	As one means to improve accountability, the AMA in its submission has advocated national standards to broadly cover access, efficiency and quality of hospital services and encompass matters such as waiting times, cost of hospital services and outcome measures from public hospital treatments. • Do you consider national standards would have a positive impact upon accountability?
11	The Financial Review recently suggested Mr Podger has recommended options for competitive funding. • What does your department think of the concept of competitive funding in the health sector, whereby, public and private hospitals compete for federal government funds?
	Public hospitals
12	How can the public hospital system be improved, ie waiting lists shortened and yet costs be kept at a sustainable level?
13	What do you see as the major challenge facing the public hospital system in Australia today?
14	What do you think of the idea of GP clinics at emergency waiting rooms?
	State/Commonwealth funding
15	Do you have any comment on suggestions that an Australian Health Care Commission be established to manage pooled funds on behalf of the Commonwealth and State Governments?
16	How could funding arrangements be simplified between the different levels of government?
17	Your submission states that the 'Australian Government is taking a leading role in establishing a cost-shared Transition Care Program with the states and territories'. Could you provide more information on the Department's involvement in this program.
	Private health insurance
18	Is the department in negotiation with health care providers to reduce costs?
19	Has the department considered methods to encourage greater participation of younger Australians in private health insurance?
	General questions on health services
20	Your submission discusses the Health Reform Agenda Working Group, which is focussed on improving health outcomes for Australians, improving coordination and integration of services and developing the national infrastructure to support reform. • How successful has this working group been to date in achieving these goals?
21	The AMA's submission to the Committee states 'Health outcomes for Aboriginal Peoples and Torres Strait Islanders are a national disgrace'. • What role does the department play in providing health services to Aboriginal people? How would you respond to this claim by the AMA?
22	Do you believe enough is being done in the area of health prevention? If not, what more could be done?
23	What role does the Commonwealth have as a provider of mental health services?
24	The AMA submission claims that, "Mental health is a 'weak link' in the Australian health care system". What is your view of this? What are the problems with services to the mentally ill? What could be done to address any weakness in the

	system?
25	The Committee is being asked to consider 'how best to ensure that a strong private health sector can be sustained into the future, based on positive relationships between private health funds, private and public hospitals, medical practitioners, other health professionals and agencies in the various levels of government,'. • What suggestions can you make to this Committee?
	Aged Care
26	In its submission, the AMA suggests that aged care is one area of particular "disconnect" within Commonwealth/state relationships. The AMA also notes that the growth in national expenditure on high-level residential aged care has been modest. • What strategies could be put in place to reduce the number of patients in public hospitals waiting for nursing home places? • What role can the states and territories play in reducing this problem?
27	The Municipal Association of Victoria indicates in its submission that, in addition to programs funded by the State, there are 17 Commonwealth funded programs providing community based care services in Victoria, which has resulted in a fragmented service which is unevenly distributed and difficult to access. • What can be done to make it easier for the elderly, those with disabilities and those leaving hospitals to access community based care facilities? • How can governments make it easier for people to access the myriad of community based care options provided by different levels of government and different assessment processes? • Are there any good practice examples of such community care based facilities for the Committee to consider?
28	How successful has the Home and Community Care (HACC) Program been in providing services for the frail aged and younger people with disabilities? What more needs to be done to clarify Commonwealth and state responsibilities?
	Younger People in Nursing Homes
29	The issue of younger people with disabilities being forced into nursing homes because of a lack of alternative facilities has been raised in submissions. • What can be done to place such younger people with disabilities into appropriate facilities? How many people are in this situation?
	Phone or Internet Based Services
30	In the ACT, the ACT Government funds *Health First*, a 24 hour a day, 7 days a week, telephone and Internet based service that offers a confidential and consistent source of advice on healthcare so that people can manage many of their problems at home or know where to go for appropriate care. • Do you see benefit in similar services in other states and territories?

HOUSE OF REPRESENTATIVES STANDING COMMITTEE ON HEALTH AND AGEING

INQUIRY INTO HEALTH FUNDING
28 November 2005 public hearing

QUESTIONS ON NOTICE

Question No.	Question on Notice
	RRMA classifications, provider numbers and workforce shortages
1	Could you please provide information on RRMA classifications? How do these classifications operate?
2	In regards to the allocation of provider numbers who is eligible to receive provider numbers (for example, are all Australian Medical Graduates eligible? What are the restrictions in regards to overseas trained doctors?)
3	Would the allocation of additional provider numbers to GPs address areas of work force shortage?
4	Please provide information on when the review of RRMA classifications is likely to conclude and what changes might occur.
	General Practitioner training
5	Please provide information on how changes to GP training has impacted on doctor numbers and the quality of medical training.
	Outer metropolitan work force strategy
6	Please provide information on how effective the outer metropolitan work force strategy has been.
7	How many doctors have moved to outer metropolitan areas since the introduction of the program? Please provide figures on what proportion are actually practicing.
	Overseas recruitment of doctors
8	What role does the Commonwealth play in recruiting overseas-trained doctors, surgeons and other medical specialists/ practitioners.?
9	Is the Commonwealth in competition with the States in regards to recruiting overseas trained doctors?
10	What are the details of the scheme and how does it operate?
11	How many doctors has this scheme brought to Australia so far?

QUESTIONS ON NOTICE FROM 10 MAY 2006
PRIVATE BRIEFING

HOUSE OF REPRESENTATIVES STANDING COMMITTEE ON HEALTH AND AGEING

INQUIRY INTO HEALTH FUNDING

INDEX TO QUESTIONS ON NOTICE

Question Number	Question on Notice
	Questions from private briefing – 10 May 2006
1	In the area of Aged Care, what provisions have been put in place for wage increases within the aged care sector? Were there going to be any changes to the way COPO is calculated? ***(Hansard Reference: Page HA12, Ms HALL)***
2	(In relation to the pregnancy MBS item) What sorts of safeguards and checks will people have with the pregnancy MBS item if they are not happy with GP referrals, i.e., if someone is not happy with a GP referral to a particular counsellor, what do they do about it? ***(Hansard Reference: Page HA7, Ms KING)***
3	In the area of strengthening health for Aboriginal and Torres Strait Islander people, is there any provision for reducing substance abuse and petrol sniffing and dealing with alcohol problems? Is there any provision for medical detoxification units in the regions? Has any consideration been given to dealing with detoxification issues? Is there any funding available? ***(Hansard Reference: Page HA3, Mr ENTSCH)***
4	Are there opportunities for scholarships to help individuals meet the cost of transferring into geriatric services or to help them up skill from other areas within the medical profession? Some of them are carrying a HECS debt, which is fine, they are paying that off, but they are saying: "We want to go into another area which means we are going to increase our HECS debt. We're happy to pay off what we've got, but we don't want to pay any more". Is there any information/advice on this? ***(Hansard Reference: Page HA8, Mr ENTSCH)***
5	Is Kidney Health Australia considered in the Health and Ageing Budget context? Are there any initiatives specifically for Kidney Health Australia? ***(Hansard Reference: Page HA9, Mr SOMLYAY)***
6	Can you alert me to any programs where there were underspends last year (2005-06 to 2006-07)? ***(Hansard Reference: Page HA10, Ms KING)***

QON1

HOUSE OF REPRESENTATIVES STANDING COMMITTEE ON HEALTH AND AGEING

INQUIRY INTO HEALTH FUNDING

ANSWERS TO QUESTIONS ON NOTICE

QUESTION NUMBER: **1**
DATE ASKED: 30 May 2005

QUESTION:
Can the Department provide a copy of the current Australian Health Care Agreements?

ANSWER:
The answer to the question is as follows:

A generic copy of the current Australian Health Care Agreement 2003-08 between the Australian Government and the states and territories is attached (**Attachment 1a**).

Each agreement currently in effect is available from the Department's website http://www.health.gov.au/internet/wcms/Publishing.nsf/Content/health-ahca-agreement.htm

ATTACHMENT 1a
Generic Australian Health Care Agreement (AHCA)

Australian Health Care Agreement

between

the Commonwealth of Australia

and

the State of <State>

2003-2008

QON2

HOUSE OF REPRESENTATIVES STANDING COMMITTEE ON HEALTH AND AGEING

INQUIRY INTO HEALTH FUNDING

ANSWERS TO QUESTIONS ON NOTICE

QUESTION NUMBER: **2**
DATE ASKED: 30 May 2005

QUESTION:
Aged Care Assessment Team (ACAT) data on:
(1) Length of time for service delivery, from time of assessment by ACAT to actual delivery; and
(2) Number of persons who cannot get to stage of being assessed by ACAT because of large elderly population and lack of packages available.

ANSWER:
The answer to the question is as follows:

(1) The average length of time from assessment to actual delivery for Extended Aged Care at Home (EACH) packages is about 50 days.

(2) ACATs respond to referrals as they are made. This does not depend on the availability of places in packaged or residential care. Instead, ACATs respond by allocating the client to a priority category, based on their situation at the time of referral. The three priority categories are:

- **Within 48 hours** refers to a person who, based on the information available at referral, requires an immediate response ie. within 48 hours. This would include circumstances where a person's safety is at risk, or there is a high likelihood that the person will be hospitalised or required to leave their current residence.
- **Between 3 and 14 days** when information available at referral indicates that the person is not at immediate risk of harm. This would include progressive deterioration in the person's physical, mental or functioning status, or that the level of care currently available does not meet their needs.
- **More than 14 days** when available information indicates that the person has sufficient support at present but that an assessment is required in anticipation of future care requirements. This could include approval for residential respite services or recognition that a person is having increased difficulty in living independently and options for future care need to be discussed with the person and their carer or family.

The Aged Care Assessment Program is administered by state and territory governments.

The Council of Australian Governments (COAG) has agreed to initiatives which will strengthen the Aged Care Assessment Program (ACAP) through better performance management, to achieve more timely assessments. The Australian Government has committed $24.1 million over four years, from 2006-07, in order to achieve this objective. The full participation and cooperation of both levels of Government is necessary to ensure effective implementation of the specific initiatives and demonstrable improvement in the program by the COAG agreed timeframe of December 2007.

QON3

HOUSE OF REPRESENTATIVES STANDING COMMITTEE ON HEALTH AND AGEING

INQUIRY INTO HEALTH FUNDING

ANSWERS TO QUESTIONS ON NOTICE

QUESTION NUMBER: **3**
DATE ASKED: 30 May 2005

QUESTION:
GDP data on:
(1) Trends in the Australian percent of GDP expenditure on health from 1996 to most recently available figure.
(2) Data for the same period for other OECD countries.
(3) The public/private breakdown.

ANSWER:
The answer to the question is as follows:

Total health expenditure as a percentage of GDP from 1995-96 to 2003-04 for Australia is shown below.

Total health expenditure as per cent of GDP, Australia, 1995-96 to 2003-04

1995-96	1996-97	1997-98	1998-99	1999-00	2000-01	2001-02	2002-03	2003-04
8.4	8.6	8.6	8.7	8.9	9.2	9.4	9.6	9.7

Source: AIHW, Health Expenditure Australia 2003-04

(2) Statistics on total health expenditure as a percentage of GDP for all OECD countries for selected years are published by the AIHW in *Health Expenditure Australia 2003-04*. AIHW and OECD data for each year from 1995 to 2003 is shown below for ten OECD countries with similar socio-economic structures, health systems and standards of living:

Total health expenditure as per cent of GDP, selected OECD countries, 1995 to 2003

	1995	1996	1997	1998	1999	2000	2001	2002	2003
Australia	8.4	8.6	8.6	8.7	8.9	9.2	9.4	9.6	9.7
Canada	9.2	9.0	8.9	9.2	9.0	8.9	9.4	9.6	9.9
France	9.5	9.5	9.4	9.3	9.3	9.3	9.4	9.7	10.1
Germany	10.6	10.9	10.7	10.6	10.6	10.6	10.8	10.9	11.1
Japan	6.8	7.0	6.9	7.2	7.4	7.6	7.8	7.9	*na*
Netherlands	8.4	8.3	8.2	8.2	8.4	8.3	8.7	9.3	9.8
New Zealand	7.2	7.2	7.4	7.8	7.7	7.8	7.9	8.2	8.1
Sweden	8.1	8.4	8.2	8.3	8.4	8.4	8.8	9.2	9.4
United Kingdom	7.0	7.0	6.8	6.9	7.2	7.3	7.5	7.7	*na*
United States	13.3	13.2	13.0	13.0	13.0	13.1	13.8	14.6	15.0

Note:
For Australia and New Zealand, the reference year is the financial year (e.g. '2002' refers to the 2002-03 financial year).
For France, Germany, the Netherlands and Sweden, the reference year is the calendar year.
For Canada, Japan and the UK, the reference year is the twelve months from April to March (e.g. '2002' refers to April 2002 to March 2003).
For the US, the reference year is the twelve months from October to September (e.g. '2002' refers to October 2001 to September 2002).

Sources: OECD, OECD Health Data 2005, 1st edition and AIHW, Health Expenditure Australia 2003-04

(3) Statistics on public sector health expenditure as a percentage of total health expenditure for all OECD countries for selected years are published by the AIHW in *Health Expenditure Australia 2003-04*. AIHW and OECD data on the public and private shares of total health expenditure for each year from 1995 to 2003 is shown below for ten OECD countries with similar socio-economic structures, health systems and standards of living:

Public sector health expenditure as per cent of total health expenditure, selected OECD countries, 1995 to 2003

	1995	1996	1997	1998	1999	2000	2001	2002	2003
Australia	67.2	66.7	68.2	68.0	70.1	69.4	68.4	68.8	68.0
Canada	71.4	70.9	70.1	70.6	70.3	70.4	70.1	69.7	69.9
France	76.3	76.1	76.2	76.0	76.0	75.8	75.9	76.1	76.3
Germany	80.5	80.6	79.0	78.6	78.5	78.6	78.4	78.6	78.2
Japan	83.0	82.8	81.5	80.8	81.1	81.3	81.7	81.5	*na*
Netherlands	71.0	66.2	67.8	64.1	62.7	63.1	62.8	62.5	62.4
New Zealand	77.2	76.7	77.3	77.0	77.5	78.0	76.4	77.9	78.7
Sweden	86.6	86.9	85.8	85.8	85.7	84.9	84.9	85.3	85.2
United Kingdom	83.9	82.9	80.4	80.4	80.6	80.9	83.0	83.4	*na*
United States	45.3	45.7	45.2	44.3	44.1	44.2	44.8	44.9	44.4

Private sector health expenditure as per cent of total health expenditure, selected OECD countries, 1995 to 2003

	1995	1996	1997	1998	1999	2000	2001	2002	2003
Australia	32.8	33.3	31.8	32.0	29.9	30.6	31.6	31.2	32.0
Canada	28.6	29.1	29.9	29.4	29.7	29.6	29.9	30.3	30.1
France	23.7	23.9	23.8	24.0	24.0	24.2	24.1	23.9	23.7
Germany	19.5	19.4	21.0	21.4	21.5	21.4	21.6	21.4	21.8
Japan	17.0	17.2	18.5	19.2	18.9	18.7	18.3	18.5	*na*
Netherlands	29.0	33.8	32.2	35.9	37.3	36.9	37.2	37.5	37.6
New Zealand	22.8	23.3	22.7	23.0	22.5	22.0	23.6	22.1	21.3
Sweden	13.4	13.1	14.2	14.2	14.3	15.1	15.1	14.7	14.8
United Kingdom	16.1	17.1	19.6	19.6	19.4	19.1	17.0	16.6	*na*
United States	54.7	54.3	54.8	55.7	55.9	55.8	55.2	55.1	55.6

Note:
For Australia and New Zealand, the reference year is the financial year (e.g. '2002' refers to the 2002-03 financial year).
For France, Germany, the Netherlands and Sweden, the reference year is the calendar year.
For Canada, Japan and the UK, the reference year is the twelve months from April to March (e.g. '2002' refers to April 2002 to March 2003).
For the US, the reference year is the twelve months from October to September (e.g. '2002' refers to October 2001 to September 2002).

Sources: OECD, OECD Health Data 2005, 1st edition and AIHW, Health Expenditure Australia 2003-04

QON4

HOUSE OF REPRESENTATIVES STANDING COMMITTEE ON HEALTH AND AGEING

INQUIRY INTO HEALTH FUNDING

ANSWERS TO QUESTIONS ON NOTICE

QUESTION NUMBER: **4**
DATE ASKED: 30 May 2005

QUESTION:
Breakdown of price and volume data for PBS spending, including a breakdown of major therapeutic groups

ANSWER:
The answer to the question is as follows:

In nominal terms, the cost of the **Pharmaceutical Benefits Scheme (PBS)** to Government has increased by around 10% per annum between 1995-96 and 2004-05. Around 3.5% of the average annual increase in Government costs can be attributed to greater script volumes and the other 6.5% to increased costs.

The table below provides details regarding the growth in script volumes and costs to Government for the PBS and for drug groups that experienced significant growth between 1995-96 and 2004-05.

Pharmaceutical Benefits Scheme (PBS)				
			Increase over period	
	1995-96	**2004-05**	Absolute	Average annual
Government Cost	$2,207,446,127	$5,305,255,960	$3,097,809,833	
Script Volumes	124,888,282	170,279,502	45,391,220	
Average Cost (to Govt.)	$17.68	$31.16	$13.48	
Increase in Gov. Cost ($)				$344,201,093
Increase in Sc. Volumes (No.)				5,043,469
Increase in Av. Cost ($) (to Govt.)				$1.50
Growth in Gov. Cost (%)				10.2%
Growth in Sc. Volumes (%)				3.5%
Growth in Av. Cost (%)				6.5%

Serum lipid reducing agents (Drugs used for the treatment of high cholesterol)				
			Increase over period	
	1995-96	2004-05	Absolute	Average annual
Government Cost	$169,766,854	$918,740,374	$748,973,520	
as a percentage of the PBS	7.7%	17.3%		
Script Volumes	4,040,388	16,215,278	12,174,890	
Average Cost (to Govt.)	$42.02	$56.66	$14.64	
Increase in Gov. Cost ($)				$83,219,280
Increase in Sc. Volumes (No.)				1,352,766
Increase in Av. Cost ($) (to Govt.)				$1.63
Growth in Gov. Cost (%)				20.6%
Growth in Sc. Volumes (%)				16.7%
Growth in Av. Cost (%)				3.4%

Psycholeptics (Drugs used in the treatment of psychotic disorders)				
			Increase over period	
	1995-96	2004-05	Absolute	Average annual
Government Cost	$42,480,213	$272,719,845	$230,239,632	
as a percentage of the PBS	1.9%	5.1%		
Script Volumes	7,266,323	7,299,988	33,665	
Average Cost (to Govt.)	$5.85	$37.36	$31.51	
Increase in Gov. Cost ($)				$25,582,181
Increase in Sc. Volumes (No.)				3,741
Increase in Av. Cost ($) (to Govt.)				$3.50
Growth in Gov. Cost (%)				22.9%
Growth in Sc. Volumes (%)				0.1%
Growth in Av. Cost (%)				22.9%

Drugs for acid related disorders (Drugs used in the treatment of peptic ulcers)				
			Increase over period	
	1995-96	2004-05	Absolute	Average annual
Government Cost	$269,619,612	$504,362,281	$234,742,669	
as a percentage of the PBS	12.2%	9.5%		
Script Volumes	7,347,853	13,147,448	5,799,595	
Average Cost (to Govt.)	$36.69	$38.36	$1.67	
Increase in Gov. Cost ($)				$26,082,519
Increase in Sc. Volumes (No.)				644,399
Increase in Av. Cost ($) (to Govt.)				$0.19
Growth in Gov. Cost (%)				7.2%
Growth in Sc. Volumes (%)				6.7%
Growth in Av. Cost (%)				0.5%

Psychoanaleptics (Drugs used in the treatment of depressive disorders)				
			Increase over period	
	1995-96	2004-05	Absolute	Average annual
Government Cost	$143,264,175	$360,111,529	$216,847,354	
as a percentage of the PBS	6.5%	6.8%		
Script Volumes	5,404,551	12,595,291	7,190,740	
Average Cost (to Govt.)	$26.51	$28.59	$2.08	
Increase in Gov. Cost ($)				$24,094,150
Increase in Sc. Volumes (No.)				798,971
Increase in Av. Cost ($) (to Govt.)				$0.23
Growth in Gov. Cost (%)				10.8%
Growth in Sc. Volumes (%)				9.9%
Growth in Av. Cost (%)				0.8%

Agents acting on renin-angiotensin (Drugs used in the treatment of high blood pressure)				
			Increase over period	
	1995-96	2004-05	Absolute	Average annual
Government Cost	$222,537,697	$419,765,729	$197,228,031	
as a percentage of the PBS	10.1%	7.9%		
Script Volumes	8,270,940	19,901,853	11,630,913	
Average Cost (to Govt.)	$26.91	$21.09	-$5.81	
Increase in Gov. Cost ($)				$21,914,226
Increase in Sc. Volumes (No.)				1,292,324
Increase in Av. Cost ($) (to Govt.)				-$0.65
Growth in Gov. Cost (%)				7.3%
Growth in Sc. Volumes (%)				10.2%
Growth in Av. Cost (%)				-2.7%

Antineoplastic agents (Drugs used in the treatment of cancers)				
			Increase over period	
	1995-96	2004-05	Absolute	Average annual
Government Cost	$14,238,733	$199,821,921	$185,583,188	
as a percentage of the PBS	0.6%	3.8%		
Script Volumes	134,414	439,848	305,434	
Average Cost (to Govt.)	$105.93	$454.30	$348.37	
Increase in Gov. Cost ($)				$20,620,354
Increase in Sc. Volumes (No.)				33,937
Increase in Av. Cost ($) (to Govt.)				$38.71
Growth in Gov. Cost (%)				34.1%
Growth in Sc. Volumes (%)				14.1%
Growth in Av. Cost (%)				17.6%

Drugs for obstructive airway diseases				
			Increase over period	
	1995-96	2004-05	Absolute	Average annual
Government Cost	$197,401,580	$365,128,310	$167,726,729	
as a percentage of the PBS	8.9%	6.9%		
Script Volumes	9,486,217	9,409,505	-76,712	
Average Cost (to Govt.)	$20.81	$38.80	$17.99	
Increase in Gov. Cost ($)				$18,636,303
Increase in Sc. Volumes (No.)				-8,524
Increase in Av. Cost ($) (to Govt.)				$2.00
Growth in Gov. Cost (%)				7.1%
Growth in Sc. Volumes (%)				-0.1%
Growth in Av. Cost (%)				7.2%

Antithrombotic agents (Drugs used in the treatment of anti blood clotting)				
			Increase over period	
	1995-96	2004-05	Absolute	Average annual
Government Cost	$7,331,333	$177,220,579	$169,889,246	
as a percentage of the PBS	0.3%	3.3%		
Script Volumes	914,636	5,158,431	4,243,795	
Average Cost (to Govt.)	$8.02	$34.36	$26.34	
Increase in Gov. Cost ($)				$18,876,583
Increase in Sc. Volumes (No.)				471,533
Increase in Av. Cost ($) (to Govt.)				$2.93
Growth in Gov. Cost (%)				42.5%
Growth in Sc. Volumes (%)				21.2%
Growth in Av. Cost (%)				17.6%

Drugs for treatment of bone disease				
			Increase over period	
	1995-96	2004-05	Absolute	Average annual
Government Cost	$489,565	$153,758,487	$153,268,922	
as a percentage of the PBS	0.0%	2.9%		
Script Volumes	4,237	2,835,103	2,830,866	
Average Cost (to Govt.)	$115.55	$54.23	-$61.31	
Increase in Gov. Cost ($)				$17,029,880
Increase in Sc. Volumes (No.)				314,541
Increase in Av. Cost ($) (to Govt.)				-$6.81
Growth in Gov. Cost (%)				89.4%
Growth in Sc. Volumes (%)				106.0%
Growth in Av. Cost (%)				-8.1%

Antidiabetic therapy (Drugs used in the treatment of diabetes)				
			Increase over period	
	1995-96	2004-05	Absolute	Average annual
Government Cost	$72,281,500	$191,338,930	$119,057,431	
as a percentage of the PBS	3.3%	3.6%		
Script Volumes	2,271,266	5,245,377	2,974,111	
Average Cost (to Govt.)	$31.82	$36.48	$4.65	
Increase in Gov. Cost ($)				$13,228,603
Increase in Sc. Volumes (No.)				330,457
Increase in Av. Cost ($) (to Govt.)				$0.52
Growth in Gov. Cost (%)				11.4%
Growth in Sc. Volumes (%)				9.7%
Growth in Av. Cost (%)				1.5%

Analgesics (Drugs used in the treatment of pain)				
			Increase over period	
	1995-96	2004-05	Absolute	Average annual
Government Cost	$68,028,530	$153,387,586	$85,359,056	
as a percentage of the PBS	3.1%	2.9%		
Script Volumes	9,177,374	11,183,969	2,006,595	
Average Cost (to Govt.)	$7.41	$13.71	$6.30	
Increase in Gov. Cost ($)				$9,484,340
Increase in Sc. Volumes (No.)				222,955
Increase in Av. Cost ($) (to Govt.)				$0.70
Growth in Gov. Cost (%)				9.5%
Growth in Sc. Volumes (%)				2.2%
Growth in Av. Cost (%)				7.1%

HOUSE OF REPRESENTATIVES STANDING COMMITTEE ON HEALTH AND AGEING

INQUIRY INTO HEALTH FUNDING

ANSWERS TO QUESTIONS ON NOTICE

QUESTION NUMBER: **5**
DATE ASKED: 30 May 2005

QUESTION:

Please provide details of the penalties imposed on the states in 1996 under the former health care agreements in respect of cost-shifting.

The answer to the question is as follows:

In the 1996-97 and 1997-98 financial years, the Commonwealth imposed a cost-shifting penalty by withholding a total of $152.3 million from the Medicare Agreement Hospital Funding Grants, $75 million in 1996-97 and $77.3 million in 1997-98.

State	1996-97 $	1997-98 $
New South Wales	33,436,554	34,463,790
Victoria	23,966,606	24,702,907
Queensland	5,022,823	5,177,134
Western Australia	9,185,615	9,467,815
South Australia	3,388,402	3,492,500
Tasmania	0	0
Northern Territory	0	0
Australian Capital Territory	0	0
Total	75,000,000	77,304,146

HOUSE OF REPRESENTATIVES STANDING COMMITTEE ON HEALTH AND AGEING

INQUIRY INTO HEALTH FUNDING

ANSWERS TO QUESTIONS ON NOTICE

QUESTION NUMBER: **6**
DATE ASKED: 30 May 2005

QUESTION:
Examples of partnership arrangements undertaken by the Health Reform Agenda Working Group and within each example: identify the problems/issues that have been addressed; outline the strategies that were put in place to address the problem; and provide information on the outcomes.

ANSWER:
The answer to the question is as follows:

Collaboration between the Australian Government and states and territories has been occurring in many areas including the following:

- Improving Indigenous health: Remote Area Renal Services Project;
- Cancer funding reform; and
- Safety and Quality.

The Improving Indigenous Health: Remote Area Renal Services Project
The purpose of the project is to improve access, quality and timeliness of renal services for Aboriginal and Torres Strait Islander people living in remote areas.

Draft standards have been developed to guide the development and operation of remote area renal services for Aboriginal and Torres Strait Islander people living in remote areas. The standards include reference to the following:

- Pre-dialysis preparation/haemodialysis/peritoneal dialysis and post transplant;
- Infrastructure;
- Clinical processes;
- Workforce capability, sustainability, recruitment, training and retention;
- Client/family/community education and support; and
- Cultural security.

Cancer Funding Reform
The multijurisdictional Cancer Funding Reform Working Group (established under the Health Reform Agenda Working Group) is progressing a project that aims to analyse the extent to which current funding arrangements:

- contribute to the nature and distribution of cancer services; and
- inhibit the provision of best practice care.

The Working Group is also exploring ways in which funding arrangements could better support multidisciplinary care. Work on all these areas is still in the early stages.

Safety and Quality

The establishment of a new Australian Commission on Safety and Quality in Health Care was agreed to by Australian Health Ministers and commenced operation on 1 January 2006. Major priorities for the Commission are: improving the safety of hospitals, quality improvement in primary health care, greater engagement of the private sector, and national reporting on safety and quality. The Commission will work closely with the states and territories in addressing these priority areas.

The Commission succeeds the Australian Council for Safety and Quality in Health Care, which was established in January 2000 for a five-year term, and ceased on 31 December 2005. The council was successful in leading national efforts to improve the safety and quality of health care provision in Australia. It reported annually to all Health Ministers and was supported by all state and territory jurisdictions.

HOUSE OF REPRESENTATIVES STANDING COMMITTEE ON HEALTH AND AGEING

INQUIRY INTO HEALTH FUNDING

ANSWERS TO QUESTIONS ON NOTICE

QUESTION NUMBER: **7**
DATE ASKED: 30 May 2005

QUESTION:
(1) Detailed information on programs (eg coordinated care trials) that pool funds, particularly, state, Commonwealth and private.
(2) More detailed information on multi-purpose services and an evaluation of these, if any.

ANSWER:
The answer to the question is as follows:

(1) Examples of programs that pool funds:

(a) **After Hours Primary Medical Care Program**
GP Access After Hours is a regional project in the Hunter region of NSW as part of the After Hours Primary Medical Care (AHPMC) Program. The Hunter Urban Division of General Practice (HUDGP) manages the project with involvement from the Hunter New England Area Health Service (HNEAHS).

GP Access After Hours is primarily funded by the Australian Government with additional contributions from the State Government through the provision and maintenance of premises, infrastructure support and access to cash resources that would otherwise have been paid for the care of ambulatory patients. Until 30 June 2006, the Australian Government's contribution comprised a cash-out of MBS rebates with additional infrastructure funding for projected service costs through the AHPMC Program. From 1 July 2006, the infrastructure funding through the AHPMC Program will remain, however the cash-out will be discontinued and the project will receive MBS rebate income.

The GP Access After Hours involves:

- five GP clinics located at HNEAHS facilities at Newcastle Community Health Centre, Toronto Polyclinic, Belmont Hospital, Maitland Hospital and John Hunter Hospital (the latter three being co-located with emergency departments);
- a telephone triage and advice service;
- funded transport; and
- home visits from GPs.

(b) **Coordinated Care Trials**

The Coordinated Care Trials were time-limited research projects designed to test innovative approaches to providing care for people who are chronically ill or disadvantaged, and who experience difficulties obtaining the right combination of services at the right time.

The trials were a joint initiative between the Australian Government and relevant state and territory governments. Existing funding, both cash and in-kind, including MBS, PBS, hospital and community services from the Australian Government and the relevant state/territory governments, was pooled to purchase or to provide relevant services for trial participants.

The trials commenced operation in 2002-03. All trials concluded in 2005.

All five trials focussed on people with chronic and complex conditions, although three of the trials had a whole of population approach, focusing specifically on Aboriginal and Torres Strait Islander people.

The three trials focusing on Aboriginal and Torres Strait Islander people were:

- The Partnership for Aboriginal Care, covering the mid-north coast region of NSW;
- Sunrise Health Service, covering the Katherine East region of the NT; and
- South West Aboriginal Medical Service, covering the south-west region of WA.

The two trials with a mainstream population focus were:

- Teamcare Health II, sponsored by the Brisbane North Division of General Practice;
- Coordinated Healthcare, sponsored by Northern Health in Melbourne.

The Evaluation of the Coordinated Care Trials is near completion, with a final report expected in the latter half of 2006.

(c) **The Australian Council for Safety and Quality in Health Care (ACSQHC)**

At their meeting in July 2000, Health Ministers agreed to provide funding to the Australian Council for Safety and Quality in Health Care (ACSQHC) both direct and indirect to a maximum of $55 million over five years with the Australian Government providing 50% of $27.5 million and the states and territories providing $27.4 million shared on the basis of population. In July 2003, Health Ministers agreed to allow an extra year for ACSQHC to complete its work plan.

The Office of the Safety and Quality Council (within the Australian Government Department of Health and Ageing) managed ACSQHC finances and provided financial reports on a regular basis to the Council. All funds are held in a special account established under the *Financial Management and Accountability Act 1997* with receipts and payments reported formally in the annual report of the Australian Government Department of Health and Ageing.

ACSQHC has developed principles, processes and protocols (based on Australian Government guidelines) and agreed to by Health Ministers in 2001, to guide the procurement of work as part of implementing its national action plan, including the role of states and territories in leading bodies of work on behalf of the ACSQHC.

Applications for grants were sought by public advertisement for two programs – Safety Innovations in Practice Program and Medication Safety Innovation Awards. Apart from those two programs, the tasks of the ACSQHC generally are performed under consultancy contracts or funding agreements, with ACSQHC identifying needs and specifying the nature of work to be performed primarily through open or select tender processes.

The Australian Council for Safety and Quality in Health Care, ceased operation on 31 December 2005. The Council is succeeded by a new Australian Commission on Safety and Quality in Health Care. The Commission commenced operation on 1 January 2006. Major priorities for the Commission are; improving the safety and quality of hospitals and primary health care, and greater engagement of the private sector. One of their first tasks will be to improve national reporting on safety and quality. The Commission will work closely with the states and territories in addressing these priority areas and will be funded in the same manner as the Council. The Commission however will be an independent body and will manage its own funds.

(2) Multi-Purpose Services Program

The Multi-Purpose Services (MPS) Program is a joint Australian and state and territory Government initiative which aims to improve the health and aged care needs of people living in rural and remote areas. MPS are an innovative and flexible model of health service delivery, where the health services in a rural community come together under one management structure. This allows a more coordinated and cost-effective approach to health care resulting in more aged care services being made available to the community, such as residential and home and community care services, where previously they would not have been viable.

MPS receive Australian Government funding for flexible aged care places and state funding for a range of health services.

Currently there are 94 operational MPS nationally, a list of MPS is at **Attachment 7a**. A breakdown of numbers of MPS by State is as follows:

State	**Number of MPS**
NSW	34
VIC	7
QLD	16
SA	5
WA	29
TAS	3

Annual reporting requirements for MPS include the types of services provided during the reporting period; whether the MPS was able to meet the community's need for aged care and if not to what extent; an approximation of the number of Aboriginal and Torres Strait Islander people who accessed the MPS; influences on any changes to service provision; mechanisms available to the community to articulate their needs to the MPS; and quality improvement processes used. Data for the 2004-2005 financial year is currently being received and recorded by the Department of Health and Ageing.

With the implementation of the 2005-06 Respite Budget initiative on 1 January 2006, MPS will also be required to report on:

- whether respite services were provided; and
- the number of episodes of respite care provided for the reporting period.

In the May 2006 Federal Budget, the Australian Government is providing $150 million over four years to the states and territories to enhance the care provided to older people who remain in hospital for lengthy periods of time. This assistance is being provided under the Council of Australian Governments (COAG) initiative entitled Helping Public Patients in Hospital Waiting for Nursing Home Places, which is scheduled to commence from 1 July 2006.

The state and territory governments will be responsible for determining, within the parameters defined by COAG, how best to allocate the funds within their jurisdictions. In rural areas, programs will focus on improving the flexibility and capacity of rural hospitals to provide more age-friendly services. This may include the creation of new MPS or the expansion of existing MPS.

The Government announced a new measure over four years in the 2006 Budget to provide a viability supplement for community care programs at a cost of $19.4 million. The supplement is to be paid from 1 January 2007 to assist providers in rural and remote areas to meet generally higher costs and attract appropriate staff. Multi- Purpose Services (MPS) are among the programs to benefit from the supplement, along with CACP, EACH, EACHD, ATSI Flexible Care.

ATTACHMENT 7a
MULTI-PURPOSE SERVICES BY STATE

NSW (34)
Baradine
Urana
Urbenville
Braidwood
Delegate
Dorrigo
Tumbarumba
Warren
Culcairn
Trangie
Trundle
Lake Cargelligo
Oberon
Grenfell
Coolamon
Jerilderie
Lord Howe Island
Boggabri
Vegetable Creek / (Emmaville)
Gilgandra
Collarenebri
Gulargambone
Blayney
Denman
Brewarrina
Rylstone
Coolah
Barraba
Lightning Ridge
Kyogle
Nimbin
Henty
Bourke
Tullamore

VIC (7)
Corryong
Orbost
Apollo
Timboon
Mallee Track
Robinvale
Alpine / (Tawonga, Myrtleford, Bright)

QLD (16)
Clermont
Cooktown
Dirranbandi
Quilpie
Mundubbera
Inglewood
Mossman
Texas
Woorabinda
Theodore
Alpha
Bauhinia Shire (Springsure)
Blackall
Barcaldine
Winton
Collinsville

SA (5)
Midwest / (Wudinna, Elliston, Streaky Bay)
Ceduna / Oak Valley
Kangaroo Island
Eastern Eyre
Murray Mallee (Lameroo, Pinnaroo, Karoonda)

WA (29)
Dalwallinu
Boyup Brook
Northampton/Kalbarri
Katanning
Leonora/Laverton
Murchison
Eastern Wheatbelt
York
Denmark
Kondinin
Lake Grace
Ravensthorpe
Norseman
Cunderdin
Augusta
North Midlands
Beverley
Dongara/Mingenew/Eneabba
Pemberton
Mortlock
Moora
Quairaiding
Bruce Rock
Dumbleyung
Corrigin
Nannup
Morawa/Perenjori
Mullewa
Plantaganet

TAS (3)
Beaconsfield
Campbell Town
Tasman

HOUSE OF REPRESENTATIVES STANDING COMMITTEE ON HEALTH AND AGEING

INQUIRY INTO HEALTH FUNDING

ANSWERS TO QUESTIONS ON NOTICE

QUESTION NUMBER: **8**
DATE ASKED: 30 May 2005

QUESTION:
What does the Department see as the primary drivers of increasing health costs?

ANSWER:
The answer to the question is as follows:

According to the Australian Institute of Health and Welfare's *Health Expenditure Australia 2003-04* growth in nominal health expenditure over the past decade was due to inflation (39.4%), population growth (12.6%), and increases in real expenditure per person (35.0%).

The Department believes that much of this growth is due to technological advances that improve the quality and effectiveness of the health care available in Australia but tend to increase costs. Other contributing factors are increasing incomes, population growth, growing consumer expectations, and the impact of an ageing population.

Between 1993-94 and 2002-03, the main types of health spending that have contributed the most to growth in costs are hospitals (28.1%), pharmaceuticals (24.5%) and medical services (12.3%). High-level residential care and dental services contributed 5.1% and 5.3% of growth. Further information on health expenditure can be found in the Australian Institute of Health and Welfare's *Health Expenditure Australia 2003-04*.

HOUSE OF REPRESENTATIVES STANDING COMMITTEE ON HEALTH AND AGEING

INQUIRY INTO HEALTH FUNDING

ANSWERS TO QUESTIONS ON NOTICE

QUESTION NUMBER: **9**
DATE ASKED: 30 May 2005

QUESTION:
What long-term approaches is the Department adopting to cope with the increased costs of the health system?

ANSWER:
The answer to the question is as follows:

The Department is implementing a number of different approaches to manage the costs of the health system, including:

- Clinical and cost-effectiveness assessments for pharmaceuticals, medical services and vaccines.
  - The Pharmaceutical Benefits Advisory Committee requires evidence of the costs and effects of new products in relation to existing treatment prior to listing on the Pharmaceutical Benefits Scheme (PBS) or funding under the National Immunisation Program.
  - The Medical Services Advisory Committee evaluates the safety, efficacy and cost effectiveness of new medical technologies and procedures prior to recommending their inclusion in the Medicare Benefits Schedule (MBS).
  - Existing items on the PBS and MBS are reviewed regularly to ensure they provide value for money
- Risk-sharing arrangements
  - Risk-sharing arrangements such as price/volume agreements and rebates are negotiated taking into account the estimates of utilisation and the area/s of uncertainty to be monitored.
- Brand premium policy
  - This policy allows pharmaceutical suppliers to set additional patient-paid charges above the agreed benchmark (usually a modest amount) on multi-branded and therapeutically interchangeable brands listed on the PBS, provided one brand is available at the subsidised price.
- Pathology Agreements
  - The latest Memorandum of Understanding (MoU) between the Australian Government and the pathology industry commits more than $8 billion for pathology outlays under Medicare from 2004-05 to 2008-09. This provides for a growth rate of about 5 per cent a year over the five year term. Almost 85 per cent of pathology tests ordered by

doctors under Medicare are bulk-billed. The MoU is designed to maintain this rate and keep out-of-pocket costs for patients down.

There are other approaches which focus on shared responsibility for achieving optimal health outcomes:

- Patient co-payments for pharmaceuticals
  - Consumers share the cost of PBS medicines at $4.70 for concession card holders and $29.50 for general consumers.
- Educating consumers and professionals about health and health products and services
  - The Quality Use of Medicines strategy promotes the concept that members of the "medication team", made up of doctors, pharmacists, nurses and consumers, each have a role to play in ensuring that medicines are used wisely.
- Australian Better Health Initiative
  This initiative, agreed by the Council of Australian Governments in February 2006, has total funding of $500 million, with $250 million provided by the Australian Government and $250 million supplied by the states and territories.

  This new national program will promote good health and reduce the burden of chronic disease. The initiative includes the following main elements:
  - Promoting healthy lifestyles
  - Early detection of lifestyle risks and chronic disease
  - More support for healthy lifestyle changes
  - Encouraging patients to manage their chronic disease
  - Improving primary care integration and coordination of cancer care

HOUSE OF REPRESENTATIVES STANDING COMMITTEE ON HEALTH AND AGEING

INQUIRY INTO HEALTH FUNDING

ANSWERS TO QUESTIONS ON NOTICE

QUESTION NUMBER: **10**
DATE ASKED: 30 May 2005

QUESTION:
As one means to improve accountability, the AMA in its submission has advocated national standards to broadly cover access, efficiency and quality of hospital services and encompass matters such as waiting times, cost of hospital services and outcome measures from public hospital treatments.

– Do you consider national standards would have a positive impact upon accountability?

ANSWER:
The answer to the question is as follows:

The 1998-2003 Australian Health Care Agreements required states and territories to report against a range of national benchmarks on matters such as access and waiting times. Despite this, performance against national benchmarks declined in nearly every state and territory over the five years of the agreements.

The Australian Government has adopted a different approach to improving accountability in the current Australian Health Care Agreements (2003-08). Under the compliance provisions of the agreements, state and territory government stand to lose 4% of their annual Health Care Grant payments if they fail to report data against the performance indicators contained in the Agreements. Data must be provided within the agreed format and by the due date to ensure that each state continues to be eligible to receive its compliance payment.

The agreements also oblige the states and territories to work collaboratively with the Australian Government to improve performance reporting during the life of the agreements, including by agreeing on a range of new indicators and introducing new national data sets.

Data received from the states and territories is published annually in *The State of our Public Hospitals Report.* The purpose of the report is to:

- Increase community understanding about the performance of the hospital sector, which includes explanations for the general reader about the meaning of common hospital statistical measures also reported by other agencies;
- Show how both performance and the hospital sector is changing over time; and
- Stimulate improvement in service performance and health outcomes by comparing the performance of each state and territory, according to performance indicators established under the Australian Health Care Agreements.

The report provides some common statistical measures of access, efficiency and quality also reported by the Australian Institute of Health and Welfare (*Australian Hospital Statistics*) and the Productivity Commission (*Report on Government Services*). There are minor differences in the figures reported in each of these documents due to different timing of data supplies from state and territories and different reporting methods used by each agency.

The State of our Public Hospitals Report uses data supplied by the states and territories in accordance with reporting timeframes and indicator measures established under the Australian Health Care Agreements and applies data definitions agreed to through national governance arrangements overseen by the National Health Information Group.

There are a number of impediments to imposing national benchmarks at a hospital level, including availability of data, inconsistency of recording and reporting systems and the need to carefully design benchmarks to guard against possible perverse outcomes.

HOUSE OF REPRESENTATIVES STANDING COMMITTEE ON HEALTH AND AGEING

INQUIRY INTO HEALTH FUNDING

ANSWERS TO QUESTION ON NOTICE

QUESTION NUMBER: **11**
DATE ASKED: 30 May 2005

QUESTION:
The Financial Review recently suggested Mr Podger has recommended options for competitive funding. What does your department think of the concept of competitive funding in the health sector, whereby, public and private hospitals compete for federal government funds?

ANSWER:
The answer to the question is as follows:

Freedom of consumer choice is a key guiding principle of the Australian Government's health policies. Fundamental to this is the premise that all eligible Australians are to be given the choice to receive free hospital treatment, as public patients.

The Government recognises that both the public and private sectors have a valuable role in the health system as a whole, and provides significant funding for both sectors. Public hospitals are supported through the Australian Health Care Agreements (AHCAs) with states and territories. Private hospitals are supported through the Medicare Benefits Scheme, the Pharmaceutical Benefits Scheme and the Private Health Insurance rebate.

Under the current AHCAs, states and territories are responsible for determining how best to deliver hospital services. This can include the engagement of private hospitals to treat public patients – a practice that is permitted under the AHCAs. The Government supports this arrangement as the resources of the private sector can be used to relieve pressure on public hospitals thus enabling all Australians access to high quality care in a timely and affordable manner. The sole proviso is that states and territories meet their obligations to provide free public patient treatment to Australians who elect to be so treated.

HOUSE OF REPRESENTATIVES STANDING COMMITTEE ON HEALTH AND AGEING

INQUIRY INTO HEALTH FUNDING

ANSWERS TO QUESTIONS ON NOTICE

QUESTION NUMBER: **12**
DATE ASKED: 30 May 2005

QUESTION:
How can the public hospital system be improved, i.e. waiting lists shortened and yet costs be kept at a sustainable level?

ANSWER:
The answer to the question is as follows:

Australia's public hospitals provide high quality, effective treatment to around four million admitted patients and four million emergency patients each year. More than 38 million outpatient services are also provided. There is, however, the capacity for every organisation and system to improve. Through the Australian Health Care Agreements (AHCAs), the Australian Government provides each state and territory with substantial funding to help them meet the costs of providing free public hospital services to everyone who chooses to be treated as a public patient.

There is variation in performance across the states and territories with regards to such things as elective surgery waiting times, recurrent hospital expenditure per person, the number of admissions and the number of public hospital beds.

Each state and territory is accountable for the performance of its own public hospitals and for making decisions about allocating funding to get the best health outcomes for its community. For example, while some may choose to invest in arrangements to reduce the length of public hospital waiting lists, others may feel a better return on investment is to look at improvements in safety and quality, emergency department waiting times or new technology.

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INQUIRY INTO HEALTH FUNDING

ANSWERS TO QUESTIONS ON NOTICE

QUESTION NUMBER: **13**
DATE ASKED: 30 May 2005

QUESTION:
What do you see as the major challenge facing the public hospital system in Australia today?

ANSWER:
The answer to the questions is as follows:

The major challenges facing the public hospital system in Australia include:

- providing safe, high quality and affordable services in line with community expectations;
- meeting the demand for hospital services which will continue to accelerate as the population grows and ages;
- funding technological and medical advances;
- maintaining an expert workforce in the face of international shortage of skilled health professionals; and
- recognising the interdependence of the public and private sector in providing the full range of hospital-based services.

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INQUIRY INTO HEALTH FUNDING

ANSWERS TO QUESTIONS ON NOTICE

QUESTION NUMBER: **14**
DATE ASKED: 30 May 2005

QUESTION:
What do you think of the idea of GP clinics at emergency waiting rooms?

ANSWER:
The answer to the question is as follows:

GP clinics operating in close proximity to emergency departments is one of a number of general practice models that can be supported under current arrangements, subject to the requirements of the *Health Insurance Act 1973* and the *Australian Health Care Agreements.*

After hours GP services which are located in or near public hospitals are being supported through a number of Australian Government programs including the After Hours Primary Medical Care Program, GP Services – improving after hours access 2004-05 Budget initiative and the Round the Clock Medicare – Investing in After Hours GP Services Program. In addition, a recently announced COAG initiative also offers support for potentially similar models for delivering primary care in rural and remote areas.

HOUSE OF REPRESENTATIVES STANDING COMMITTEE ON HEALTH AND AGEING

INQUIRY INTO HEALTH FUNDING

ANSWERS TO QUESTIONS ON NOTICE

QUESTION NUMBER: **15**
DATE ASKED: 30 May 2005

QUESTION:
Do you have any comment on suggestions that an Australian Health Care Commission be established to manage pooled funds on behalf of the Commonwealth and State Governments?

ANSWER:
The answer to the question is as follows:

The Government's strong position is that existing reform processes should be allowed to progress and the establishment of a new commission with decision-making power, but not politically accountable directly to the people, would add unnecessary levels of administration and cost.

HOUSE OF REPRESENTATIVES STANDING COMMITTEE ON HEALTH AND AGEING

INQUIRY INTO HEALTH FUNDING

ANSWERS TO QUESTIONS ON NOTICE

QUESTION NUMBER: **16**
DATE ASKED: 30 May 2005

QUESTION:
How could funding arrangements be simplified between the different levels of government?

ANSWER:
The answer to the question is as follows:

The Australian Government works in partnership with state and territory governments to deliver health care in a system with a range of funding and regulatory mechanisms. Both levels of government work to ensure that a coordinated system of health care is available to all Australians.

This cooperation is formalised through a range of funding agreements with associated performance reporting requirements and in joint ventures such as the Australian Commission for Safety and Quality in Health Care and through the work program of all Health Ministers including the National Health Reform Agenda. Other examples of joint initiatives are the Australian Health Care Agreements, Public Health Outcome Funding Agreements, Australian Immunisation Agreements, Home and Community Care Program, Multipurpose Services and Indigenous Programs. The department's submission has more information on these initiatives.

Other examples of programs which pool funds, including coordinated care trials and multipurpose services are in the response to question on notice number 7.

At its meeting of 3 June 2005, the Council of Australian Governments (COAG) discussed areas where the health system can be improved by clarifying roles and responsibilities and by reducing duplication and gaps in services, including:

- simplifying access to care services for the elderly, people with disabilities and people leaving hospital;
- helping public patients in hospital waiting for nursing home places;
- helping younger people with disabilities in nursing homes;
- improving the supply, flexibility and responsiveness of the health workforce;
- increasing the health system's focus on prevention and health promotion;
- accelerating work on a national electronic health records system;
- improving the integration of the health care system;
- continuing work on a National Health Call Centre Network; and
- addressing specific challenges of service delivery in rural and remote Australia.

COAG agreed that Senior Officials would consider these ways to improve Australia's health system and report back to it with a plan of action to progress these reforms. On 10 February 2006, COAG release a Communiqué outlining its response to the Senior Officials' report and detailing a $1.1billion reform package to achieve better health for all Australians. The package aims to:

- establish a new approach to promotion, prevention and early intervention;
- better manage rural health service delivery in communities with populations of less than 7000;
- provide better care for older people in hospitals; and
- provide better care for younger people with disabilities in nursing homes.

Funding of $660 million will be provided by the Commonwealth and $480 million by the states and territories.

COAG also requested that Senior Officials progress further work on health workforce and mental health issues, and report back to it in mid-2006.

HOUSE OF REPRESENTATIVES STANDING COMMITTEE ON HEALTH AND AGEING

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ANSWERS TO QUESTIONS ON NOTICE

QUESTION NUMBER: **17**
DATE ASKED: 30 May 2005

QUESTION:
Your submission states that the 'Australian Government is taking a leading role in establishing a cost-shared Transition Care Program with the states and territories'. Could you provide more information on the Department's involvement in this program?

ANSWER:
The answer to the question is as follows:

Transition care has been developed as a jointly funded program between the Australian Government and all states and territories through the Transition Care Task Group which is chaired by an officer of the Department of Health and Ageing and includes representatives from each state and territory health department and two clinicians.

The Australian Government's commitment to the Transition Care Program will expand to 2,000 places by 2006-07. With an average estimated period of care of eight weeks, this means that, when fully established, the program will assist up to 13,000 older Australians each year.

The Australian Government, in consultation with the Task Group, has established the program, including:

- developing program guidelines which include a quality improvement framework;
- establishing a program management dataset and an evaluation framework;
- establishing a payment mechanism through the mainstream aged care payment system; and
- providing transition care training for Aged Care Assessment Teams.

Since 2004-05, a total of 1,507 flexible care places have been allocated for transition care. Transition care services are becoming operational as local services become ready to provide care. As at June 2006, services are operational in Western Australia, South Australia, New South Wales, Queensland and the Australian Capital Territory.

More details about the Transition Care Program are provided in the response to Question on Notice #26.

HOUSE OF REPRESENTATIVES STANDING COMMITTEE ON HEALTH AND AGEING

INQUIRY INTO HEALTH FUNDING

ANSWERS TO QUESTIONS ON NOTICE

QUESTION NUMBER: **18**
DATE ASKED: 30 May 2005

QUESTION:
Is the department in negotiation with health care providers to reduce costs?

ANSWER:
The answer to the question is as follows:

The Department is responsible for the implementation of a range of policies aimed at assisting health funds to control expenditure, for example the arrangements for clinical assessment and benefit negotiations for prostheses. The Department does not however, get involved in the commercial operations of health care providers.

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INQUIRY INTO HEALTH FUNDING

ANSWERS TO QUESTIONS ON NOTICE

QUESTION NUMBER: **19**
DATE ASKED: 30 May 2005

QUESTION:
Has the department considered methods to encourage greater participation of younger Australians in private health insurance?

ANSWER:
The answer to the question is as follows:

Yes. The introduction of Lifetime Health Cover in 2000 prompted a substantial increase in the participation of younger age groups.

The Independent Review of Lifetime Health Cover that was tabled in both houses of Parliament in December 2003 found that Lifetime Health Cover was successful in providing a major boost to membership numbers and a significant improvement in the membership profile. The review also concluded that the incentives contained in Lifetime Health Cover are encouraging people to take out cover early in life and maintain it.

One of the initiatives announced in April 2006 is that Medicare Australia will write to those people about to be affected by Lifetime Health Cover loadings so that they can avoid incurring a loading.

New broader health cover will allow health funds to develop products that may attract younger Australians.

The department continues to monitor the uptake of private health insurance.

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ANSWERS TO QUESTIONS ON NOTICE

QUESTION NUMBER: **20**
DATE ASKED: 30 May 2005

QUESTION:
Your submission discusses the Health Reform Agenda Working Group, which is focused on improving health outcomes for Australians, improving coordination and integration of services and developing the national infrastructure to support reform.

How successful has this working group been to date in achieving these goals?

ANSWER:

The Health Reform Agenda Working Group was a useful forum for state and territory and Australian Government officials to discuss health priorities and reform opportunities in the health care system. Some of the health reform priorities considered included safety and quality, access to services in rural and remote areas, and mental health. These considerations have helped in the development of new initiatives. In the Australian Health Ministers' Advisory Council (AHMAC) meeting in March 2006, it was decided that the Working Group's role has now finished, although other officials' groups will continue to consider health policy issues.

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ANSWERS TO QUESTIONS ON NOTICE

QUESTION NUMBER: **21**
DATE ASKED: 30 May 2005

QUESTION:
The AMA's submission to the Committee states 'Health outcomes for Aboriginal Peoples and Torres Strait Islanders are a national disgrace'.

(1) What role does the department play in providing health services to Aboriginal people?
(2) How would you respond to this claim by the AMA?

ANSWER:
The answer to the question is as follows:

(1) The Department plays a significant role in funding primary health care service delivery through its Indigenous-specific and mainstream health programs. This is complemented by State and Territory Governments who also provide primary health care services to Aboriginal and Torres Strait Islander peoples.

The 2004 review of Aboriginal and Torres Strait Islander Primary Health Care commissioned by this Government concluded that good progress has been made in recent years in developing primary health care delivery systems and the required infrastructure, but more needs to be done. That is why the Government is committing substantial additional resources to improve the number and accessibility of primary health care services to Indigenous people in Australia. The 2006-07 Budget provided an additional $136.7 million for health measures for Aboriginal and Torres Strait Islander people. Of these additional funds, $101.6 million was appropriated to the Health portfolio for four new measures: reducing substance abuse; improving the capacity of workers in Indigenous communities to recognise mental illness; improving access to mainstream health services; and improving Indigenous health worker employment.

Since 1996, Australian Government funding for Indigenous-specific primary health care and substance use services has increased by over $260 million, a real increase of 160 per cent. Total program funding of $485.8 million has been allocated in the 2006-07 Budget for Indigenous health programs across the Health and Ageing portfolio.

(2) The Department agrees that Aboriginal and Torres Strait Islander peoples have much poorer health than other Australians and that the causes are complex.

There have, however, been real, measurable improvements in some areas of the health of Aboriginal and Torres Strait Islander peoples in recent years. These improvements include:

- a 25 per cent decrease in mortality for both males and females in Western Australia between 1991 and 2002,
- during the same period there were downward trends in crude death rates in South Australia (males, females and persons) and in the Northern Territory (females and persons), however these were not statistically significant.
- a significant decrease in infant mortality in Western Australia, Northern Territory and South Australia over the same period, and
- a significant decrease in mortality from circulatory disease in Western Australia and South Australia.

As Indigenous health status is multi-causal, all Health Ministers have committed to the *National Strategic Framework for Aboriginal and Torres Strait Islander Health*. The National Strategic Framework provides a clear national focus for improving the health status of Aboriginal and Torres Strait Islander people that the Australian Government, all states and territories and the community sector are committed to achieving collaboratively over the next ten years. All Health Ministers signed the National Strategic Framework in July 2003.

The National Strategic Framework recognises a competent health workforce with appropriate clinical, management, community development and cultural skills as a key result area. This includes supporting appropriate training, supply, recruitment and retention strategies, and increasing the number of Aboriginal and Torres Strait Islander people working across all health professions.

Wider strategies that impact on health, such as education, employment and the health of people in custodial settings form a key focus of the National Strategic Framework. Our aim is to develop partnerships with, and obtain commitment from other sectors whose activities impact on health. This is consistent with the Australian Government's Indigenous affairs arrangements.

The Australian Government is committed to improving the health of Aboriginal and Torres Strait Islander people by working with Indigenous communities and governments to build a strong comprehensive primary health care system. This includes community engagement in the management and delivery of Indigenous specific health services and programs, coupled with improving access to mainstream health services.

Child and maternal health, including low birth weight, are being addressed within the Government's Aboriginal and Torres Strait Islander health programs. The impact of good antenatal care is demonstrated by the Townsville Aboriginal and Islanders Health Services (TAIHS) - Mums and Babies program and the Nganampa Health Council Child and Maternal Health program. The data from these programs has shown an increase in antenatal care visits for pregnant women resulting in a reduction in low birth weight babies, pre-term births and peri-natal deaths.

The 2005-06 Budget included new funding of $102 million over four years for the *Healthy for Life Program*. This program supports action to improve the health of mothers, infants and children, and improve the management of chronic diseases such as diabetes, renal and cardiovascular disease. It is an innovative approach to break the cycle of poor health for Aboriginal and Torres Strait Islander peoples by both delivering a healthy start to life for Indigenous children and finding and treating those adults with chronic conditions to prevent complications and premature death. The first round of 27 successful sites approved for funding under the *Healthy for Life Program* were announced by the Minister for Health and Ageing in December 2005, and a second round of sites will be announced in June 2006.

The Australian Government expects to see improved access to early and regular ante natal care, improved birth weights in infants, fewer unplanned visits to the doctor and admission to hospitals for infants, young children and people with chronic conditions and their complications. Improved child health sets the scene for enhanced development and learning opportunities. Healthier adults will mean that they are better able to contribute to family, economic and cultural life.

The Australian Government is continuing to take action to improve the way mainstream programs work. Access to Medicare and the Pharmaceutical Benefits Scheme has improved, with Medicare and PBS expenditure on Aboriginal and Torres Strait Islander peoples increasing by nearly 80% since 1995-96. A new Medicare-funded health check for Aboriginal and Torres Strait Islander children was listed on the Medicare Benefits Schedule on 1 May 2006, and which complements the Indigenous adult health check MBS item which commenced on 1 May 2004.

Workforce supply, training and financing are key issues in Indigenous health. The new Healthy for Life program includes additional scholarships to increase the number of Indigenous Australians trained as health professionals. Sixty nine full time-equivalent Puggy Hunter Memorial Scholarships were approved in 2006.

The 2006-07 Budget committed $20.8 million over five years to provide training to workers in Indigenous health services to identify and respond to mental illness and related substance abuse in community members. This initiative also includes 25 new scholarships for Indigenous students under the Puggy Hunter Memorial Scholarship Scheme specifically to undertake studies in mental health, and funding for 10 additional mental health worker positions. To assist Indigenous health services to attract and retain Indigenous staff, the Government has committed $20.5 million over four years to provide full wages for 130 positions in these services. These measures will help build the skills base in Indigenous communities to improve the performance of local health services and also provide opportunities for employment and careers for local people

To increase access to primary health care for Aboriginal and Torres Strait Islander people, the Government is providing $39.5 million over four years to establish five health brokerage services to link Indigenous Australians with culturally appropriate mainstream health services. The five services will link up to 15,000 Indigenous people to GPs and other health professionals in urban and regional areas. This initiative also includes the recruitment of up to 40 additional GPs, nurses and allied health professionals in rural and remote areas.

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ANSWERS TO QUESTIONS ON NOTICE

QUESTION NUMBER: **22**
DATE ASKED: 30 May 2005

QUESTION:
Do you believe enough is being done in the area of health prevention? If not, what more could be done?

ANSWER:
The answer to the question is as follows:

The Australian Government provides over 55% of total public health funding. This investment has grown in recent years as a result of increased activity in areas such as biosecurity and immunisation. The Department administers a number of new preventive health measures announced by the Australian Government in the 2005-06 Budget including:
- bowel cancer screening ($43.4 million over three years);
- smoking cessation (youth campaign $24.9 million over four years and quitting smoking during pregnancy $4.3 million over three years); and
- skin cancer prevention ($5.5 million over two years).

The Department also administers a wide range of existing preventive health measures, including: the National Immunisation Program; the National Illicit Drug Strategy; and cervical and breast cancer screening programs.

In the 2006-07 Federal Budget, the Australian Government, in order to increasing awareness and understanding of the harms associated with alcohol, provided $25.2 million over 4 years to update the Australian Alcohol Guidelines and conduct a national alcohol education and information campaign.

Additional funding in the 2006-07 Federal Budget was provided to the National Illicit Drugs Strategy and include:
- Establishment of a National Cannabis Control and Prevention Centre ($14 million over 4 years);
- Combating emerging trends in illicit drug use, including funding for Phase 3 of the National Drugs Campaign ($34.4 million over 4 years);
- Establishment of counsellors network for University Campuses ($19.8 million over 4 years);
- Alerting the Community to the links between drug use and mental health ($21.6 million over 4 years);
- Improved services for people with drug and alcohol problems and mental illness ($73.9 million over 5 years).

Under the Public Health Outcome Funding Agreements (PHOFAs) with each jurisdiction, the Australian Government provides broadbanded funding to a total of $812 million (adjusted annually for indexation) over five years (2004-05 to 2008-09) for public health programs. The public health outcome areas targeted under the PHOFAs include: HIV/AIDS and related sexually transmissible and blood borne diseases, breast and cervical cancer screening, and health risk factors including alcohol and tobacco programs, women's health and sexual and reproductive health.

The Australian Government works with other governments, experts and key stakeholders to consider opportunities for future action. The Department continues to support the work of the National Obesity Taskforce by providing the Secretariat function and developing initiatives against the Taskforce's national action plan *Healthy Weight 2008: Australia's Future – the National Action Agenda for Children and Young People and their Families*. The plan is guiding the work of different levels of government. Australian Government activity includes the Prime Minister's Building a Healthy Active Australia Initiative. The initiative provides $116 million over four years (2004-08), comprising:

- Healthy eating and regular physical activity – information for Australian families ($11 million);
- Active after school communities programme ($90 million);
- Healthy school communities ($15 million); and
- Active school curriculum initiative.

The Australian Government is making an unprecedented investment in immunisation. In 1996, Australian Government expenditure on vaccines was $13 million a year. Vaccine expenses for 2004-05 are expected to be $285 million, a twenty-two fold increase. From 1 November 2005, the National Immunisation Program has included varicella vaccine and the replacement of oral polio vaccine with injectable inactivated polio vaccine.

The Australian Government also makes a significant investment in medicines that prevent the onset of chronic diseases or assist in their management. For example, in the financial year 2004-05, Pharmaceutical Benefits Schedule (PBS) expenditure on cholesterol-lowering drugs, treatments for diabetes and blood pressure medication exceeded $1.1 billion.

	Year Ending Jun 05	
Anatomical Therapeutic Chemical Group	**Script volume**	**Cost $**
SERUM LIPID REDUCING AGENTS	16,215,278	918,740,374
ANTIDIABETIC THERAPY (INSULINS AND ANALOGUES AND ORAL BLOOD GLUCOSE LOWERING DRUGS)	5,245,377	191,338,930
ANTIHYPERTENSIVES	726,247	10,131,964
TOTAL	**22,186,902**	**1,120,211,268**

HOUSE OF REPRESENTATIVES STANDING COMMITTEE ON HEALTH AND AGEING

INQUIRY INTO HEALTH FUNDING

ANSWERS TO QUESTIONS ON NOTICE

QUESTION NUMBER: **23**
DATE ASKED: 30 May 2005

QUESTION:
What role does the Commonwealth have as a provider of mental health services?

ANSWER:
The answer to the question is as follows:

Under Australia's system of federation, the provision and regulation of public mental health services is the responsibility of state and territory governments. Although the Australian Government does not directly manage public mental health services, it has a role in mental health reform leadership and funding to assist mental health reform. It has supported the improvement of state and territory services under the *National Mental Health Strategy*.

A range of mainstream programs and services are also provided by the Australian Government, which provide essential support for people with a mental illness. These include primary care services through general practitioners, and medical and pharmaceutical benefits funding. Support is also provided through social and community services, income support, disability programs and housing assistance programs.

Between 1995-96 and 2002-03, the Australian Government's expenditure on mental health care activities for which it has responsibility increased from $792 million to $1.208 billion, an increase of 52% in real terms. This ongoing commitment to mental health will be greatly increased with the announcement in the Federal Government Budget 2006-2007 of additional funding of $1.9 billion over the period of 2006-2007 to 2010-2011.

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INQUIRY INTO HEALTH FUNDING

ANSWERS TO QUESTIONS ON NOTICE

QUESTION NUMBER: **24**
DATE ASKED: 30 May 2005

QUESTION:
The AMA submission claims that, "Mental health is a 'weak link' in the Australian health care system". What is your view of this? What are the problems with services to the mentally ill? What could be done to address any weakness in the system?

ANSWER:
The answer to the question is as follows:

The Australian Government is committed to improving the efficiency and effectiveness of mental health services in Australia.

While much has been achieved in mental health service reform since the introduction of the National Mental Health Strategy in 1992, the Australian Government acknowledges that there is still work to be done to further improve the outcomes for consumers. Future efforts should be directed towards further consolidating and strengthening mental health care reform to address the four priority themes in the National Mental Health Plan which are focusing on prevention and mental health promotion; improving service responsiveness; strengthening quality; and, fostering research, innovation and sustainability.

The 2006 Federal Budget included an additional $1.9 billion to improve services for people with a mental illness, their families and carers. This represents the Australian Government's commitment to the COAG Mental Health Reform package. The areas for which the Australian Government is responsible are comprehensively addressed by increasing access to primary health care, increasing the mental health workforce, and providing more respite places, and treatment for people with both mental health and drug or alcohol problems.

The Australian Government is continuing to work with state and territory governments and key stakeholder groups to implement these measures. Details on how organisations can link with or access services under these measures will be available early in the 2006-07 financial year.

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INQUIRY INTO HEALTH FUNDING

ANSWERS TO QUESTIONS ON NOTICE

QUESTION NUMBER: **25**
DATE ASKED: 30 May 2005

QUESTION:
The Committee is being asked to consider 'how best to ensure that a strong private health sector can be sustained into the future, based on positive relationships between private health funds, private and public hospitals, medical practitioners, other health professionals and agencies in the various levels of government'.

What suggestions can you make to this Committee?

ANSWER:
The answer to the question is as follows:

The department's submission which addressed this term of reference highlighted a number of initiatives that have already been introduced by the Australian Government to ensure that a strong private sector can be sustained into the future (eg. gap cover schemes).

Since presenting its submission, the department has undertaken three projects that have further informed policy development. These projects are the:

- Private Health Insurance Modelling Project;
- Review of Reinsurance; and
- Review of Basic and Second Tier Default Benefits and Gap Cover.

As a result of this work, the Australian Government subsequently announced significant changes to private health insurance arrangements on 26 April 2006. These initiatives should add choice, certainty and value in private health care, and ensure that the private health sector continues its vital partnership with the public sector.

From April 2007 under the new arrangements:

- Health funds will be able to offer products that cover services that do not require admission to hospital but are part of, prevent or substitute for hospital care. In doing this funds will have the opportunity to negotiate with a range of professional bodies that will perform chronic care management for conditions, such as diabetes and asthma. Better aligning insurance products with current clinical practice and consumer expectations will ensure stronger relationships within the health sector;

- Broader health cover will be underpinned by changes to the reinsurance arrangements, which will also benefit single parent families by recognising them as 1 single equivalent unit;
- Those people about to be affected by Lifetime Health Cover (LHC) loadings (30 year olds, new migrants, and new Medicare card holders) will be notified of their upcoming LHC deadline with a letter from Medicare Australia;
- Insurers will be required to provide standard product information to help people compare policies and to understand their entitlements under their policies. This will help not only when shopping around for cover, but when people actually need to use their cover;
- The Private Health Insurance Ombudsman will also develop a comparative product website to help consumers make the best choices for their family's needs;
- The Government will sell Medibank Private;
- An information campaign will enhance fund members' understanding of what their private health insurance entitles them to;
- The focus of regulation will move from being fund based to product based. Doing this will result in the removal of redundant and duplicate provisions, freeing funds to operate more efficiently while still protecting the public's interest; and
- The Government is also continuing to work with the AMA, insurers and hospitals to improve rates of Informed Financial Consent for private medical and hospital services.

From July 2008:

- Uniform safety and quality criteria will be introduced so that in the future all privately insured services will be provided by an accredited facility and/or suitable qualified provider. This will ensure the quality of privately insured services provided within the sector.

Consultation forums are occurring during June and July 2006 with the private health sector, ensuring that the new arrangements effectively engage all groups within the sector.

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ANSWERS TO QUESTIONS ON NOTICE

QUESTION NUMBER: **26**
DATE ASKED: 30 May 2005

QUESTION:
In its submission, the AMA suggests that aged care is one area of particular "disconnect" within Commonwealth/state relationships. The AMA also notes that the growth in national expenditure on high-level residential aged care has been modest.

- What strategies could be put in place to reduce the number of patients in public hospitals waiting for nursing home places?
- What role can the states and territories play in reducing this problem?

ANSWER:
The answer to the question is as follows:

The Australian Government is working with states and territories to improve care for older people.

At the 10 February 2006, Council of Australian Governments (COAG) meeting, all governments agreed that from July 2006 a new program will commence to improve care for older patients in public hospitals to avoid lengthy stays, re-admissions and to improve care for older people living long term in smaller rural hospitals. The Australian Government will provide $150 million over four years to the states and territories to develop programs which will:

- reduce avoidable admissions to hospitals and residential aged care;
- improve hospital inpatient services and facilities for long stay, older patients;
- assist older people to access suitable long term care; and
- where agreed, in rural areas establish or expand new multi-purpose services to provide improved care to older people in small rural communities.

This is in addition to the Transition Care Program which helps older people return home after a hospital stay rather than enter residential care. This Program is targeted to those older people who are eligible for residential care but who, with further therapeutic care, may be able to regain functioning and independence and hence return home. Transition care also allows older people and their families time to determine whether they can return home with additional support from community care services or need to consider the level of care provided by an aged care home. Transition care can be provided in either a residential or community setting.

Joint work is also underway through the Pathways Home program to improve transitions between the hospital sector and aged care sector. The Australian Government is providing $253 million to the states and territories under the Pathways Home Program, as part of the 2003-08 Australian Health Care Agreements. This funding assists the move nationally towards a greater focus on step-down and rehabilitative care to support people, particularly older people, to return home in a timely and appropriate manner following a hospital admission.

Previously, the Australian Government, in conjunction with states and territories, put in place a range of strategies to improve the care of older people, including those in hospitals. These are outlined in the *National Action Plan for Improving the Care of Older People Across the Acute-Aged Care Continuum, 2004-2008*. This Action Plan (at **Attachment 26a**) was endorsed by all Health Ministers in July 2004.

ATTACHMENT 26a

National Action Plan for improving the care of older people across the acute-aged care continuum, 2004-08

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ANSWERS TO QUESTIONS ON NOTICE

QUESTION NUMBER: **27**
DATE ASKED: 30 May 2005

QUESTION:
The Municipal Association of Victoria indicates in its submission that, in addition to programs funded by the State, there are 17 Commonwealth funded programs providing community based care services in Victoria, which has resulted in a fragmented service which is unevenly distributed and difficult to access.

- What can be done to make it easier for the elderly, those with disabilities and those leaving hospitals to access community based care facilities?
- How can governments make it easier for people to access the myriad of community based care options provided by different levels of government and different assessment processes?
- Are there any good practice examples of such community care based facilities for the Committee to consider?

ANSWER:
The answer to the question is as follows:

A New Strategy for Community Care – The Way Forward (**Attachment 27a**), outlines the actions the Australian Government will progress to reshape and improve the community care system, including the adoption of common arrangements. As part of the 2004-05 Federal Budget an amount of $26.1 million was committed over four years to implement the key action areas outlined as part of the Government's way forward for community care. Progress has been made in a number of areas resulting in streamlined administrative and service delivery arrangements. As a result there are now 54 co-located and integrated Commonwealth Carer Respite and Carelink Centres across Australia. These provide carers and those needing information on local community services easier access to the support they need. A further two Commonwealth Carer Respite Centres are providing respite assistance to isolated Aboriginal communities in the Northern Territory.

At its February 2006, meeting, the Council of Australian Governments (COAG) announced the Better Health Plan For All Australians Action Plan. As part of this plan, by December 2007, governments will provide more timely and consistent assessments for frail older people requiring care services and their carers by improving and strengthening the Aged Care Assessment Program and will simplify entry points and improve eligibility and assessment processes for the Home and Community Care (HACC) Program.

Easy to identify ‘entry points’ into HACC will make it easier for people to find and access the services they require. The entry points will determine eligibility, undertake an assessment to identify the need for service and then refer to appropriate services. Entry points will also be able to refer frail older Australians who have more complex needs to Aged Care Assessment Teams, so that a more comprehensive assessment can be undertaken. Access will also be made easier by developing nationally consistent eligibility and assessment processes.

The Australian Government is currently renegotiating HACC Agreements with states and territories to provide an improved framework and streamlined arrangements to better support the delivery of HACC services to the community.

There are a number of models of innovative service delivery which the committee might like to look at. In order to identify suitable services, Departmental officers could meet with Committee members to discuss their specific areas of interest and possible geographical areas if visits are intended.

ATTACHMENT 27a
A New Strategy for Community Care -- The Way Forward

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INQUIRY INTO HEALTH FUNDING

ANSWERS TO QUESTIONS ON NOTICE

QUESTION NUMBER: **28**
DATE ASKED: 30 May 2005

QUESTION:

How successful has the Home and Community Care (HACC) Program been in providing services for the frail aged and younger people with disabilities? What more needs to be done to clarify Commonwealth and state responsibilities?

ANSWER:

The answer to the question is as follows:

The HACC Program has been successful in providing services to frail older people and younger people with disabilities to assist in preventing avoidable or premature admission to residential care. During 2004-05, approximately 3,250 organisations provided HACC funded services to over 707,000 clients across Australia, a seven per cent increase compared with the number of clients who accessed the program in the previous year.

Commonwealth and state responsibilities for HACC are set out in the HACC Agreements between the Australian Government and each state and territory. Ways of improving the operation of the program, and changes to these responsibilities, are being explored. Australian Government and state and territory officials are undertaking a review of the current Agreement.

At its February 2006, meeting, the Council of Australian Governments (COAG) announced the Better Health Plan For All Australians Action Plan. As part of this plan, by December 2007, governments will provide more timely and consistent assessments for frail older people requiring care services and their carers by improving and strengthening the Aged Care Assessment Program and will simplify entry points and improve eligibility and assessment processes for the Home and Community Care (HACC) Program.

Easy to identify ‘entry points’ into HACC will make it easier for people to find and access the services they require. The entry points will determine eligibility, undertake an assessment to identify the need for service and then refer to appropriate services. Entry points will also be able to refer frail older Australians who have more complex needs to Aged Care Assessment Teams, so that a more comprehensive assessment can be undertaken. Access will also be made easier by developing nationally consistent eligibility and assessment processes.

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ANSWERS TO QUESTIONS ON NOTICE

QUESTION NUMBER: **29**
DATE ASKED: 30 May 2005

QUESTION:
The issue of younger people with disabilities being forced into nursing homes because of a lack of alternative facilities has been raised in submissions.

- What can be done to place such younger people with disabilities into appropriate facilities? How many people are in this situation?

ANSWER:
The answer to the question is as follows:

At the February 2006, Council of Australian Governments (COAG) meeting, a program to start to reduce the number of younger people with disabilities living in aged care homes was announced.

The new five year program will begin in July 2006, with funding of up to $122 million from the Australian Government and up to $122 million from the states and territories over the five years.

Under the program, younger people with disabilities currently in aged care homes will be offered a care needs assessment, and where appropriate, an alternative accommodation and care option. The program, which will be implemented in close consultation with younger people, their families and carers, will initially target people aged under 50 years in aged care homes. Other people with disabilities inappropriately accommodated in aged care homes will also be eligible under the program, as well as people at risk of being placed inappropriately in aged care. People will only be moved from their existing care facility if they wish to move.

The states and territories will have primary responsibility for delivering the new program. The Australian Government's involvement is through the Families, Community Services and Indigenous Affairs portfolio.

There are currently around 6,500 permanent residents of aged care homes aged under 65 years. About 1,000 of these are aged under 50 years.

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ANSWERS TO QUESTIONS ON NOTICE

QUESTION NUMBER: **30**
DATE ASKED: 30 May 2005

QUESTION:
In the ACT, the ACT Government funds *Health First*, a 24 hour a day, 7 days a week, telephone and Internet based service that offers a confidential and consistent source of advice on healthcare so that people can manage many of their problems at home or know where to go for appropriate care. Do you see benefit in similar services in other states and territories?

ANSWER:
The answer to the question is as follows:

The Australian Government sees value and benefit in health call centres and has been working with states and territories to develop a consistent national approach in this area. On 10 February 2006 the Council of Australian Governments (COAG) agreed to establish a National Health Call Centre Network (NHCCN) as part of the $1.1 billion national health reform package – *Better health for all Australians*.

The NHCCN is expected to cost approximately $176 million over five years 2005-06 to 2009-10. The Australian Government will contribute approximately $96 million and states and territories will contribute the balance of approximately $80 million. The NHCCN is expected to take first calls by July 2007, with national coverage to be achieved within four years.

Additionally, COAG agreed that a further $20 million, to be funded equally by the Australian Government and State and Territory Governments, will be targeted to enhance the capacity of the network to support mental health.

QON1

HOUSE OF REPRESENTATIVES STANDING COMMITTEE ON HEALTH AND AGEING

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ANSWERS TO QUESTIONS ON NOTICE

QUESTION NUMBER: **1**
DATE ASKED: 28 November 2005

QUESTION:
Could you please provide information on RRMA classifications? How do these classifications operate?

ANSWER:
The answer to the question is as follows:

The RRMA classification was developed in 1994 as a general purpose tool to define rural and remote Australia.

Using 1991 population Census data and 1991 Statistical Local Area (SLA) Boundaries, RRMA creates three zones (metropolitan, rural and remote). Localities are allocated to zones based on distance and population density. Within zones, areas are then allocated to one of the seven RRMA classes based on their population size (Table 1 below).

Table 1: RRMA Classifications

Zone	Class	Population size	Abbreviation
Metropolitan Zone	Capital Cities Other Metropolitan Centres	All Capital Cities ≥ 100,000	RRMA 1 RRMA 2
Rural Zone	Large Rural Centres Small Rural Centres Other Rural Areas	25,000 – 99,999 10,000 – 24,999 < 10,000	RRMA 3 RRMA 4 RRMA 5
Remote Zone	Remote Centres Other Remote Areas	≥ 5,000 < 5,000	RRMA 6 RRMA 7

QON2

HOUSE OF REPRESENTATIVES STANDING COMMITTEE ON HEALTH AND AGEING

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ANSWERS TO QUESTIONS ON NOTICE

QUESTION NUMBER: **2**
DATE ASKED: 28 November 2005

QUESTION:
In regards to the allocation of provider numbers who is eligible to receive provider numbers (for example, are all Australian Medical Graduates eligible?) What are the restrictions in regards to overseas trained doctors?

ANSWER:
The answer to the question is as follows:

Medicare provider number arrangements restrict doctors who do not hold Fellowship of a recognised medical college from accessing Medicare benefits unless they are enrolled in a specialist training program or an approved workforce program. These arrangements aim to ensure that doctors are appropriately skilled before entering unsupervised medical practice.

Medicare provider number arrangements also restrict overseas trained doctors from accessing a Medicare provider number unless they are working in a district of workforce shortage. These arrangements aim to improve the distribution of the medical workforce.

QON3

HOUSE OF REPRESENTATIVES STANDING COMMITTEE ON HEALTH AND AGEING

INQUIRY INTO HEALTH FUNDING

ANSWERS TO QUESTIONS ON NOTICE

QUESTION NUMBER: **3**
DATE ASKED: 28 November 2005

QUESTION:
Would the allocation of additional provider numbers to GPs address areas of workforce shortage?

ANSWER:
The answer to the question is as follows:

No.

There are no limits on the number of provider numbers allocated to Australian trained doctors who are working in general practice. Overseas trained doctors are generally only granted provider numbers to work in 'districts of workforce shortage' for a period of five to ten years.

In most circumstances, a provider number will be granted to an appropriately qualified overseas trained doctor wishing to work in a locality that has been classified, at that point in time, as a 'district of workforce shortage'.

QON4

HOUSE OF REPRESENTATIVES STANDING COMMITTEE ON HEALTH AND AGEING

INQUIRY INTO HEALTH FUNDING

ANSWERS TO QUESTIONS ON NOTICE

QUESTION NUMBER: **4**
DATE ASKED: 28 November 2005

QUESTION
Please provide information on when the review of RRMA classifications is likely to conclude and what changes might occur?

ANSWER:
The answer to the question is as follows:

The review of the Rural, Remote and Metropolitan Areas (RRMA) classification system is currently on-going and no date has been set for completion. As the review has not been completed, it is premature to speculate on any changes that may arise.

At this stage, the Government is not convinced that an alternative system would be a clear improvement.

QON5

HOUSE OF REPRESENTATIVES STANDING COMMITTEE ON HEALTH AND AGEING

INQUIRY INTO HEALTH FUNDING

ANSWERS TO QUESTIONS ON NOTICE

QUESTION NUMBER: **5**
DATE ASKED: 28 November 2005

QUESTION:
Please provide information on how changes to GP training has impacted on doctor numbers and the quality of medical training?

ANSWER:
The answer to the question is as follows:

In 2003, when the regionalised GP training arrangements were fully implemented, 450 training places were available on the Australian General Practice Training Program. All training places were filled in 2003.

In 2004, the Government increased the number of training places available from 450 to 600. While not all training places have been taken up since that time, registrar uptake of training places for the years 2004 to 2006 has remained relatively steady, ranging between 89% and 93% of full capacity.

In relation to the quality of training, a registrar survey commissioned by General Practice Education and Training Ltd (GPET) in 2005 indicated that 83% of registrars were satisfied or very satisfied with the quality of training.

The standards for GP vocational education and training are set by the Royal Australian College of General Practitioners, and regional training providers are required to deliver training in accordance with those standards.

HOUSE OF REPRESENTATIVES STANDING COMMITTEE ON HEALTH AND AGEING

INQUIRY INTO HEALTH FUNDING

ANSWERS TO QUESTIONS ON NOTICE

QUESTION NUMBER: **6 and 7**
DATE ASKED: 28 November 2005

QUESTION:
Outer metropolitan work force strategy
Q6: Please provide information on how effective the outer metropolitan work force strategy has been.
Q7: How many doctors have moved to outer metropolitan areas since the introduction of the program? Please provide figures on what proportion are actually practicing.

ANSWER:
The answers to the questions are as follows:

Q6: The More Doctors for Outer Metropolitan Areas Measure has been very effective, well exceeding its target of adding 150 doctors to outer metropolitan areas of workforce shortage across Australia.

Q7: By 31 March 2006, 250 doctors were working in outer metropolitan areas as a result of the Outer Metropolitan Relocation Incentives Scheme. These included 32 who had significantly increased their hours in outer metropolitan areas, and 218 who had actually relocated their practice to an outer metropolitan area. In addition, as at 30 June 2005, 357 general practice registrars have undertaken six month placements in outer metropolitan areas as a part of the Outer Metropolitan GP Registrars Program.

HOUSE OF REPRESENTATIVES STANDING COMMITTEE ON HEALTH AND AGEING

INQUIRY INTO HEALTH FUNDING

ANSWERS TO QUESTIONS ON NOTICE

QUESTION NUMBER: **8-11**
DATE ASKED: 28 November 2005

QUESTIONS:
Overseas recruitment of doctors
Q8: What role does the Commonwealth play in recruiting overseas-trained doctors, surgeons and other medical specialists/ practitioners?
Q9: Is the Commonwealth in competition with the States in regards to recruiting overseas-trained doctors?
Q10: What are the details of the scheme and how does it operate?
Q11: How many doctors has this scheme brought to Australia so far?

ANSWERS:
The answers to the questions are as follows:

Q8: As part of its Strengthening Medicare package, the Australian Government announced five measures to increase the number of appropriately qualified overseas trained doctors working in Australia. These measures include:

- international recruitment strategies;
- opportunities for doctors to stay longer or obtain permanent residency through changes to immigration arrangements;
- improved training arrangements and additional support programs;
- reduced "red tape" in approval processes; and
- assistance for employers and overseas trained doctors in arranging placements.

Employers/sponsors of general practitioners and other medical specialists provide details of eligible vacancies or employment opportunities to one or more of the sixteen recruitment agencies that have a contract with the Department.

The overseas trained doctors recruitment program provides an international recruitment process managed by the Australian Government which complements existing State and private sector recruitment arrangements.

Q9: No, the Commonwealth is not in competition with the States in regards to recruiting overseas trained doctors.

The recruitment activity being undertaken through the Australian Government recruitment program requires the medical practitioner to be providing services in approved districts of workforce shortage and have a minimum Medicare billing component. This recruitment activity assists states and territories to fill vacancies. The state and territory governments are still able to, and should be encouraged to, undertake recruitment to fill shortages within their state or territory.

Q10: The Australian Government currently has contracted sixteen medical recruitment agencies to recruit appropriately qualified overseas trained doctors to fill medical vacancies in districts of workforce shortage.

The Department will meet the cost of recruitment fees for eligible vacancies filled by these agencies. To be eligible, vacancies or employment opportunities must be in approved districts of workforce shortage and have a minimum Medicare billing component. Additionally, only overseas trained doctors who have not worked in the Australian medical workforce within the last 12 months will be eligible to fill these vacancies.

The key features of the contracts which the Government has with recruitment agencies are:

- recruiters are paid a fee only if and when they have successfully placed a doctor;
- a doctor must be placed in a district of workforce shortage approved by the Australian Government; and
- contracted recruitment agencies are prohibited from undertaking marketing activities or approaching doctors in developing countries.

Q11: Overseas trained doctors recruited under the Strengthening Medicare initiative must work in a district of workforce shortage and undertake a minimum Medicare billing component as part of their employment. These requirements may be met in either public hospitals or private practice.

As at 1 May 2006, 306 overseas trained doctors have been placed in rural, remote and other areas of workforce shortage by Australian Government contracted recruitment agencies with a further 147 contracted to commence work in Australia in the near future.

Of the 306 doctors working in Australia as a result of these new international recruitment arrangements, 233 are working as general practitioners and 73 are working as specialists in areas such as, surgery, radiology, psychiatry, pathology, orthopaedics, obstetrics and gynaecology and anaesthetics.

QON1

HOUSE OF REPRESENTATIVES STANDING COMMITTEE ON HEALTH AND AGEING

INQUIRY INTO HEALTH FUNDING

ANSWERS TO QUESTIONS ON NOTICE

QUESTION NUMBER: **1**
DATE ASKED: 10 May 2006

QUESTION:
In the area of aged care, what provisions have been put in place for wage increases within the aged care sector? Were there going to be any changes to the way COPO is calculated?

ANSWER:
The answer to the question is as follows:

The Australian Government does not specifically set wages for staff in the aged care sector. This is primarily a matter for negotiation between employees and employers in workplace agreements.

There has been no change to existing arrangements for indexation of Commonwealth Own Purpose Outlays. For the last ten years or so, annual indexation of aged care subsidies has been based in part on movements in the Safety Net Adjustment to wages made by the Industrial Relations Commission. While the role of the Industrial Relations Commission in making Safety Net Adjustments has ceased under the Australian Government's changes to workplace relations the wage component of Wage Cost Indices continues to reflect the most recent Safety Net Adjustment from the AIRC (June 2005). Indexation in 2005-06 was 1.9% and in 2006-07 it is 2.0%.

The Government will notify aged care providers in June of the new subsidy rates to apply in the coming financial year. This should make no difference to financial planning by providers this year as compared with previous years, when new rates have also been advised in June.

The Government has recently advised that the Fair Pay Commission (FPC) determinations will replace the Industrial Relations Commission (IRC) in making Safety Net Adjustments once the FPC determinations are available.

QON2

HOUSE OF REPRESENTATIVES STANDING COMMITTEE ON HEALTH AND AGEING

INQUIRY INTO HEALTH FUNDING

ANSWERS TO QUESTIONS ON NOTICE

QUESTION NUMBER: **2**
DATE ASKED: 10 May 2006

QUESTION:
(In relation to the pregnancy MBS item) What sorts of safeguards and checks will people have with the pregnancy MBS item if they are not happy with GP referrals, i.e., if someone is not happy with a GP referral to a particular counsellor, what do they do about it?

ANSWER:
The answer to the question is as follows:

As with all other referral arrangements under Medicare, patients who are not happy with a referral to a particular allied health professional for non-directive pregnancy counselling will be able to discuss with their GP a new referral to a different eligible provider.
Patients will also be able to contact the National Pregnancy Support Telephone Hotline, 24 hours a day, 7 days a week, and receive non-directive counselling from professional counsellors.

HOUSE OF REPRESENTATIVES STANDING COMMITTEE ON HEALTH AND AGEING

INQUIRY INTO HEALTH FUNDING

ANSWERS TO QUESTIONS ON NOTICE

QUESTION NUMBER: **3**
DATE ASKED: 10 May 2006

QUESTION:
In the area of strengthening health for Aboriginal and Torres Strait Islander people, is there any provision for reducing substance abuse and petrol sniffing and dealing with alcohol problems? Is there any provision for medical detoxification units in the regions? Has any consideration been given to dealing with detoxification issues? Is there any funding available?

ANSWER:
The answer to the question is as follows:

Outcome 8 - Indigenous Health:

The 2006-07 Budget provided:

- $20.1 million over four years for reducing petrol sniffing through the Reducing Substance Use (Petrol Sniffing) measure; and
- $20.8 million over five years for improving the detection, early intervention and effective management of people with mental illness and associated substance abuse issues through the Improving the Capacity of Workers in Indigenous Communities measure.

There is no funding specifically for medical detoxification units.

The issue of substance detoxification has been given extensive consideration in the area of strengthening the health of Aboriginal and Torres Strait Islander people.

- Treatment and respite facilities are one of the components of the 8 point plan to reduce petrol sniffing in the designated central desert region of Central Australia. Under this component the Australian Government is working with the West Australian, South Australian and Northern Territory Governments to improve treatment options for petrol sniffers at the primary, secondary and tertiary levels. The options being considered include substance detoxification services.

- The Department has agreed to provide $673,000 to the Northern Territory for capital works in relation to a new adult treatment and rehabilitation service at Aranda House in Alice Springs.
- The Department has committed $3.65 million for capital works for two outstations in Central Australia to improve quality of the treatment and rehabilitation services provided by these outstations.
- The Office for Aboriginal and Torres Strait Islander Health Substance Use Program provides $18.316 million annually to support 64 Aboriginal and Torres Strait Islander substance use services. Of the 64 substance uses services mentioned above: 41 are specific Aboriginal and Torres Strait Islander substance use services. Of these 28 are residential, 13 are non-residential. The remaining 23 are funded as part of Indigenous primary health care services. The Substance Use Program funds services in every jurisdiction.
- A further $2.271 million was allocated from the Substance Use Program in 2005-06 for a number of strategic national projects supporting service delivery.

Outcome 1 – Population Health

The 2003-04 Budget provided:

- The "Tough on Drugs" Indigenous Community Initiative, worth $10.5 million over four years.
- Funding to assist Indigenous communities to develop local solutions to critical issues that contribute to violence, such as alcohol and drug abuse.

Projects funded under this initiative address key areas for action identified in the National Drug Strategy Complementary Action Plan endorsed by the Ministerial Council on Drug Strategy. For example projects funded include those that address volatile substances and the development of the Indigenous Alcohol Treatment Guidelines.

At this point the Indigenous Communities Initiative does not provide funds to deal with detoxification issues, however this does not mean funding will not be made available in the future.

HOUSE OF REPRESENTATIVES STANDING COMMITTEE ON HEALTH AND AGEING

INQUIRY INTO HEALTH FUNDING

ANSWERS TO QUESTIONS ON NOTICE

QUESTION NUMBER: **4**
DATE ASKED: 10 May 2006

QUESTION:
Are there opportunities for scholarships to help individuals meet the cost of transferring into geriatric services or to help them up skill from other areas within the medical profession? Some of them are carrying a HECS debt, which is fine, they are paying that off, but they are saying: "We want to go into another area which means we are going to increase our HECS debt. We're happy to pay off what we've got, but we don't want to pay any more". Is there any information/advice on this?

ANSWER:
The answer to the question is as follows:

The 2006-07 Budget includes $36.0 million over 4 years to continue the Aged Care Nursing Scholarship program which aims to encourage people to take up aged care nursing and to improve retention of aged care workers by enhancing career pathways. The measure provides for 250 aged care nursing scholarships each year (valued at $10,000 per annum, up to a maximum of $30,000 per scholarship) with preference given to people in rural and regional areas.

Over 1,000 aged care nursing scholarships have been taken up since 2003.

The aim of the scholarship is to help defray the costs of studying aged care nursing and recipients are at liberty to use the scholarship to pay off any associated HECS debt.

Doctors who have finished their undergraduate degree in medicine and are going on to vocational training do not acquire further HECS debt.

HOUSE OF REPRESENTATIVES STANDING COMMITTEE ON HEALTH AND AGEING

INQUIRY INTO HEALTH FUNDING

ANSWERS TO QUESTIONS ON NOTICE

QUESTION NUMBER: **5**
DATE ASKED: 10 May 2006

QUESTION:
Is Kidney Health Australia considered in the Health and Ageing Budget context? Are there any initiatives specifically for Kidney Health Australia?

ANSWER:
The answer to the question is as follows:

There is no direct funding for Kidney Health Australia in this Budget. Measures in the 2006-07 Budget which address kidney health issues include:

Australian Better Health Initiative

The Government will provide $250 million over five years from 2005-06 towards this shared initiative announced as part of the Council of Australian Government (COAG) $1.1 billion health action plan in February this year. The initiative will include the following elements:

Promoting healthy lifestyles – including rolling health promotion campaigns, national school canteen guidelines and school and local community-based programs.

Early detection of lifestyle risks and chronic disease – a new Medicare item will encourage doctors in general practice and community health centres to conduct health checks on patients about 45 years of age with identifiable health risk factors.

More support for healthy lifestyle changes – increased counseling and education on how to implement and sustain healthy lifestyle changes by various providers including GPs, nurses and allied health professionals, state health services, and non-government organizations.

Encouraging patients to manage their chronic disease – new self management program will assist people affected by chronic disease, and education and resources will support health professionals advising patients on self management.

The Government is also maintaining funding for the *Lifescripts* initiative to provide GPs with practical tools and skills to help patients address lifestyle risk factors.

More Australian-trained doctors and nurses

The Commonwealth Government will invest almost $250 million over four years to train more doctors and nurses, as part of its contribution to the COAG Health Workforce package, as announced on 8 April 2006.

Funding research for future health

The Government has committed an additional $500 million over four years to increase funding for health and medical research grants provided through the National Health and Medical Research Council.

HOUSE OF REPRESENTATIVES STANDING COMMITTEE ON HEALTH AND AGEING

INQUIRY INTO HEALTH FUNDING

ANSWERS TO QUESTIONS ON NOTICE

QUESTION NUMBER: **6**
DATE ASKED: 10 May 2006

QUESTION:
Ms King asked:

Can you alert me to any programs where there were underspends last year (2005-06 to 2006-07)?

Mr Clout- We expect about $200 million worth of underspends at this point in 2005-06, which have now been rephased into later years.

CHAIR- Can we take that on notice?

Mr Clout- Yes, I can provide you with that.

ANSWER:
The answer to the question is as follows:

Program name	2005-06	2006-07	2007-08	2008-09	2009-10
	(Amounts in $m)				
Obesity Campaign - School Based Grants	-5.463	5.463	-	-	-
Skin Cancer Awareness Campaign	-0.164	0.164	-	-	-
Bowel Cancer Screening Program	-1.470	1.470	-	-	-
Broadbanded funding - Nat Public Health	-0.220	0.220	-	-	-
NIDS Diversification Exist Needle - Syringe	-0.069	0.069	-	-	-
NIDS - IDRS Expert Committees ANCD (PHD)	-0.820	0.820	-	-	-
NIDS - Research Fund	-0.409	0.409	-	-	-
NIDS - Indigenous Communities	-1.200	1.200	-	-	-
Quitting Smoking during Pregnancy	-1.592	1.592	-	-	-
IPH Drug Strategy	-0.415	0.415	-	-	-
NIDS - Illicit Drug Diversion Grants States	-6.000	4.000	2.000	-	-
NIDS - National Tobacco Campaign - campaign funding	-0.284	0.284	-	-	-
National Immunisation Strategy	-3.000	3.000	-	-	-
Prevention Falls in Older People	-0.551	0.551	-	-	-
Community Pharmacy Agreement	-102.000	12.000	35.000	30.000	25.000

PBS - Improved Concessional Validation	-4.500	4.500	-	-	-
Fairer Medicare - GP take up of HIC online	-2.167	2.167	-	-	-
Better Skills for Better Care	-0.050	0.050	-	-	-
Aged Care Program Support	-0.046	0.046	-	-	-
Aust Aged Care - Implement and Communication	-2.953	1.000	1.500	0.453	-
Reforms in Community Care	-4.785	4.785	-	-	-
Dementia A National Health Priority	-5.300	2.000	2.000	1.300	-
Dementia Training	-0.600	0.200	0.200	0.200	-
Rural and Remote Building Fund	-10.000	4.000	4.000	2.000	-
Targeted Capital Assistance	-2.000	1.000	1.000	-	-
Women's Safety Agenda	-0.400	0.152	0.564	-0.316	-
GPITS Primary Care Financing	-1.500	1.000	0.250	0.250	-
After Hours Primary Medical Care	-6.000	6.000	-	-	-
Medicare Round the clock After Hour Grants	-7.700	2.500	5.200	-	-
Combatting Petrol Sniffing	-2.350	2.350	-	-	-
Healthy for Life	-3.000	3.000	-	-	-
Primary Health Care Access Program	-9.338	9.338	-	-	-
Cancer Australia	-3.345	2.662	0.410	0.273	-
Asthma Management Strategy	-1.400	1.400	-	-	-
Training Courses for Cancer Nurses	-1.332	0.484	0.527	0.321	-
Professional Dev for Cancer Professionals	-1.937	1.000	0.937	-	-
Strengthening Palliative Care Services	0.000	-0.250	0.700	-0.450	-
Cancer Research	-4.000	1.000	1.500	1.500	-
Pandemic Vaccine Accelerated Development	-1.479	1.479	-	-	-