Community Affairs
Legislation Committee

Examination of Budget Estimates 2004-2005

Additional Information Received

VOLUME 4

Outcomes 2, 3, 4, 5, 6, 7, 8, 9

HEALTH AND AGEING PORTFOLIO

FEBRUARY 2005

Note: Where published reports, etc have been provided in response to questions, they have not been included in the Additional Information volume in order to conserve resources.

ADDITIONAL INFORMATION RELATING TO THE EXAMINATION OF BUDGET EXPENDITURE FOR 2004-2005

Included in this volume are answers to written and oral questions taken on notice and tabled papers relating to the budget estimates hearing on 2 and 3 June 2004

HEALTH AND AGEING PORTFOLIO

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MEDICARE OFFICE DETAILS		
State	**Branch Name**	**Town/Suburb**
ACT	Belconnen	Belconnen
ACT	Civic	Canberra
ACT	Tuggeranong	Greenway
ACT	Woden	Phillip
NSW	Albury	Albury
NSW	Armidale	Armidale
NSW	Ballina	Ballina
NSW	Bankstown	Bankstown
NSW	Batemans Bay	Batemans Bay
NSW	Bathurst	Bathurst
NSW	Bega	Bega
NSW	Blacktown	Blacktown
NSW	Bondi Junction	Bondi Junction
NSW	Bowral	Bowral
NSW	Broken Hill	Broken Hill
NSW	Brookvale	Brookvale
NSW	Burwood	Burwood
NSW	Camden	Camden
NSW	Campbelltown	Campbelltown
NSW	Casino	Casino
NSW	Castle Hill	Castle Hill
NSW	Cessnock	Cessnock
NSW	Charlestown	Charlestown
NSW	Chatswood	Chatswood
NSW	Coffs Harbour	Coffs Harbour
NSW	Cooma	Cooma
NSW	Cowra	Cowra
NSW	Dubbo	Dubbo
NSW	Eastwood	Eastwood
NSW	Engadine	Engadine
NSW	Erina	Erina
NSW	Fairfield	Fairfield
NSW	Gosford	Gosford
NSW	Goulburn	Goulburn
NSW	Grafton	Grafton
NSW	Griffith	Griffith
NSW	Gunnedah	Gunnedah
NSW	Hornsby	Hornsby
NSW	Hurstville	Hurstville

NSW	Inverell	Inverell
NSW	Katoomba	Katoomba
NSW	Kempsey	Kempsey
NSW	Kotara	Kotara
NSW	Lake Haven	Lake Haven
NSW	Lismore	Lismore
NSW	Lithgow	Lithgow
NSW	Liverpool	Liverpool
NSW	Macksville	Macksville
NSW	Maitland	Maitland
NSW	Martin Place	Sydney
NSW	Merimbula	Merimbula
NSW	Miranda	Miranda
NSW	Moree	Moree
NSW	Mudgee	Mudgee
NSW	Muswellbrook	Muswellbrook
NSW	Narooma	Narooma
NSW	Narrabri	Narrabri
NSW	Newcastle	Newcastle
NSW	North Ryde	North Ryde
NSW	North Sydney	North Sydney
NSW	Nowra	Nowra
NSW	Orange	Orange
NSW	Pagewood	Pagewood
NSW	Parkes	Parkes
NSW	Parramatta	Parramatta
NSW	Penrith	Penrith
NSW	Port Macquarie	Port Macquarie
NSW	Queanbeyan	Queanbeyan
NSW	Raymond Terrace	Raymond Terrace
NSW	Richmond	Richmond
NSW	Roselands	Roselands
NSW	Shellharbour	Barrack Heights
NSW	Singleton	Singleton
NSW	Spit Junction	Spit Junction
NSW	Springwood	Springwood
NSW	Tamworth	Tamworth
NSW	Taree	Taree
NSW	The Entrance	The Entrance
NSW	Toronto	Toronto
NSW	Town Hall	Sydney
NSW	Tweed Heads	Tweed Heads South
NSW	Ulladulla	Ulladulla

NSW	Wagga Wagga	Wagga Wagga
NSW	Wallsend	Wallsend
NSW	Warriewood	Warriewood
NSW	Wollongong	Wollongong
NSW	Woy Woy (Umina)	Woy Woy
NSW	Wynyard (Australia Square)	Wynyard / Sydney
NSW	Young	Young
NT	Alice Springs	Alice Spings
NT	Casuarina	Casuarina
NT	Darwin	Darwin
QLD	Aitkenvale	Aitkenvale
QLD	Ashmore	Ashmore
QLD	Atherton	Atherton
QLD	Ayr	Ayr
QLD	Beenleigh	Beenleigh
QLD	Bowen	Bowen
QLD	Broadbeach (Pacific-Fair)	Broadbeach
QLD	Brookside	Mitchelton
QLD	Bundaberg	Bundaberg
QLD	Cairns	Cairns
QLD	Caloundra	Caloundra
QLD	Capalaba	Capalaba
QLD	Carindale	Carindale
QLD	Chermside	Chermside
QLD	Cleveland	Cleveland
QLD	Clifford Gardens	Toowoomba
QLD	Dalby	Dalby
QLD	Garden City	Upper Mt Gravatt
QLD	Gladstone	Gladstone
QLD	Gympie	Gympie
QLD	Hervey Bay	Pialba
QLD	Indooroopilly	Indooroopilly
QLD	Ingham	Ingham
QLD	Innisfail	Innisfail
QLD	Ipswich	Ipswich
QLD	Kawana-Waters	Buddina
QLD	Kingaroy	Kingaroy
QLD	Kippa-Ring	Kippa-Ring
QLD	Mackay	Mackay
QLD	Maryborough	Maryborough
QLD	Morayfield	Morayfield
QLD	Mt Isa	Mount Isa
QLD	Mt Ommaney	Mount Ommaney

QLD	Nambour	Nambour
QLD	Nth Rockhampton	North Rockhampton
QLD	Rockhampton	Rockhampton
QLD	Smithfield	Smithfield
QLD	Southport	Southport
QLD	Strathpine	Strathpine
QLD	Toombul	Toombul
QLD	Toowoomba	Toowoomba
QLD	Townsville	Townsville
QLD	Warwick	Warwick
QLD	Wintergarden	Brisbane
QLD	Woodridge	Woodridge
SA	Berri	Berri
SA	Colonnades	Noarlunga Centre
SA	Currie Street	Adelaide
SA	Elizabeth	Elizabeth
SA	Gawler	Gawler
SA	Marion	Oaklands Park
SA	Modbury	Modbury
SA	Mt Gambier	Mt Gambier
SA	Port Augusta	Port Augusta
SA	Port Lincoln	Port Lincoln
SA	Port Pirie	Port Pirie
SA	West Lakes	West Lakes
SA	Whyalla Norrie	Whyalla Norrie
TAS	Burnie	Burnie
TAS	Devonport	Devonport
TAS	Glenorchy	Glenorchy
TAS	Hobart	Hobart
TAS	Kingston	Kingston
TAS	Launceston	Launceston
TAS	Rosny Park	Rosny Park
VIC	Airport West	Airport West
VIC	Altona Gate	Altona North
VIC	Ararat	Ararat
VIC	Bairnsdale	Bairnsdale
VIC	Ballarat	Ballarat
VIC	Bendigo	Bendigo
VIC	Bentleigh	Bentleigh
VIC	Bourke St	Melbourne
VIC	Box Hill	Box Hill
VIC	Broadmeadows	Broadmeadows
VIC	Camberwell	Camberwell

VIC	Centrepoint	Melbourne
VIC	Chadstone	Chadstone
VIC	Chirnside Park	Chirnside Park
VIC	Coburg	Coburg
VIC	Colac	Colac
VIC	Collins Street	Melbourne
VIC	Corio	Corio
VIC	Dandenong	Dandenong
VIC	Doncaster	Doncaster
VIC	Echuca	Echuca
VIC	Elsternwick	Elsternwick
VIC	Forest Hill	Forest Hill
VIC	Frankston	Frankston
VIC	Geelong	Geelong
VIC	Glen Waverley	Glen Waverley
VIC	Greensborough	Greensborough
VIC	Hamilton	Hamilton
VIC	Highpoint	Maribyrnong
VIC	Horsham	Horsham
VIC	Knox City	Wantirna South
VIC	Melton	Melton
VIC	Mildura	Mildura
VIC	Moonee Ponds	Moonee Ponds
VIC	Mornington	Mornington
VIC	Morwell	Morwell
VIC	Northcote	Northcote
VIC	Northland	Preston
VIC	Portland	Portland
VIC	Prahran	Prahran
VIC	Ringwood	Ringwood
VIC	Sale	Sale
VIC	Shepparton	Shepparton
VIC	Southland	Cheltenham
VIC	Swan Hill	Swan Hill
VIC	Traralgon	Traralgon
VIC	Wangaratta	Wangaratta
VIC	Warragul	Warragul
VIC	Warrnambool	Warrnambool
VIC	Waurn Ponds	Waurn Ponds
VIC	Waverley Gardens	Mulgrave
VIC	Werribee	Werribee
VIC	Wodonga	Wodonga
WA	Albany	Albany

WA	Armadale	Armadale
WA	Booragoon	Booragoon
WA	Bunbury	Bunbury
WA	Cannington	Cannington
WA	Fremantle	Fremantle
WA	Geraldton	Geraldton
WA	Hillarys	Hillarys
WA	Kalgoorlie	Kalgoorlie
WA	Karrinyup	Karrinyup
WA	Mandurah	Mandurah
WA	Midland	Midland
WA	Morley	Morley
WA	Rockingham	Rockingham
WA	Subiaco	Subiaco
WA	Wesley Centre	Perth

New Offices

VIC	Rosebud
VIC	Narre warren

Criteria for Establishing a Medicare Office

Factors to consider include:

1. The availability of other claims lodgement methods such as: Medicare Easyclaim and HIC Online.
2. The cost of establishing and maintaining new Medicare offices.
3. The proximity to other Medicare offices and the potential impact it might have on the workload of other Medicare offices.
4. The level of bulk billing in the area.
5. The volume of claims lodged by customer in the area and the nature and level of different types of billing by doctors in the area.
6. Suitable site for the Medicare office – considerations include transport and security of staff and customers.

COST OF ESTABLISHING A LARGE AND A MEDIUM MEDICARE OFFICE		
Costs are based on estimates for the establishment of Narre Warren (large site) and Rosebud (medium site)		
	Narre Warren	**Rosebud**
SETUP	$313,000	$155,000
ONGOING	$780,000	$335,000

TABLED BY DoHA 3/6/04

Question: What is the rate of caesarean delivery versus vaginal delivery by hospitals nationally?

Answer: We are not able to provide data by individual named hospital but what we can provide is as follows:

(a) For public hospitals, we can provide data by hospital but it cannot be identified by hospital or by State because of confidentiality arrangements with the States. We cannot provide the information by State as it could potentially identify individual hospitals. We can provide a rate nationally for public hospitals as follows:

Rate of delivery (%)

Public Hospitals	Vaginal	Caesarean	Total
National	76.3	23.7	100

Source: 2002-03 National hospital morbidity (Casemix) data. Above data include private patients treated in public hospitals.

(b) For private hospitals, we can provide data by hospital but they will not be identified by name. We can provide the information by State however, where the data could potentially identify individual hospitals in the Territories these have been included in larger States.

Rate of delivery (%)

Private Hospitals	Vaginal	Caesarean	Total
NSW (incl ACT)	66.0	34.0	100
VIC	66.6	33.4	100
QLD	60.1	39.9	100
SA (incl NT)	65.2	34.8	100
WA	58.6	41.4	100
TAS	73.5	26.5	100
National	**64.2**	**35.8**	**100**

Source: 2002-03 Private Hospitals Data Bureau.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2003-2004, 2-3 June 2004

Question: E04-181

OUTCOME 2: Access to Medicare

Topic: HIC ONLINE

Written Question on Notice

Senator McLucas asked:

(a) Please provide an update of the roll-out of HIC Online to doctors' offices – how many offices are currently connected to HIC Online?

(b) How many have been connected since the implementation of the HIC Online provision in Fairer Medicare?

(c) How many of these were in rural areas?

Answer:

(a) As at 25 June 2004, 460 doctors' practices (approx 1,220 doctors) were transmitting Medicare claims via HIC Online.

HIC Online is now available to 70% of the GP market and major software vendors have advised that their business strategies are in place to ensure widespread product availability over the next two to six months.

(b) The HIC Online grant provision, part of the Government's new Medicare initiatives, came into effect on 1 December 2003. From that date to 25 June 2004, 314 practices have commenced transmitting Medicare claims. A further 282 doctors' practices have completed all the necessary registration processes and are ready to transmit as soon as their software vendors provide their upgrades. 25 software vendors have an HIC–endorsed product.

(c) Of the 314 doctors' practices that have commenced transmitting Medicare claims via HIC Online since 1 December 2003, 93 are located in rural areas.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2004-2005, 2 & 3 June 2004

Question: E04-182

OUTCOME 2: Access to Medicare

Topic: PRACTICE INCENTIVES PROGRAM (PIP) - SECOND IT INCENTIVE GRANT

Written Question on Notice

Senator McLucas asked:

In June 2003 the Department gave all practices registered for the PIP a grant of $6,800. A further payment is to be made to practices by the end of this year, but only if they comply with certain criteria.

(a) What are these criteria that must be met?

(b) How easy will it be for doctors to comply?

(c) It has been suggested that practices will be required to appoint an IT coordinator-is this correct?

(d) What is the level of payment that will be made to GPs?

(e) When will this payment be made?

(f) Where is this funding in the Budget?

Answer:

(a), (b), (c), (d) and (e)

PIP practices received a payment in May 2003 to assist them in moving paper-based records to an electronic format. The nature and timing of further payments linked to practice use of IM/IT are currently under consideration. Practices will be advised when arrangements have been settled.

(f) Where is this funding in the Budget?

The funding is part of the PIP that is appropriated through Appropriation Bill Number 1, Outcome 2.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2004-2005, 2 & 3 June 2004

Question: E04-069

OUTCOME 2: Access to Medicare

Topic: CONGENITAL ADRENAL HYPERPLASIA

Written Question on Notice

Senator Harradine asked:

What is the Department's view on calls for the implementation of newborn neonatal screening for the inherited disease Congenital Adrenal Hyperplasia?

Answer:

The development and implementation of newborn screening programs is the responsibility of State and Territory Governments.

The Australian Health Ministers Advisory Council Advisory Group on Human Gene Patents and Genetic Testing is considering nationally consistent guidelines for newborn screening programs by State and Territory Governments, including a process for assessment of new tests.

The NHMRC has reviewed the issue of screening for CAH in newborns in their report "*Child Health Screening and Surveillance: A Critical Review of the Evidence*" (February 2002) and has found there is insufficient evidence on the benefits and harms of screening to make a recommendation for or against screening.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2004-2005, 2 & 3 June 2004

Question: E04-070

OUTCOME 2: Access to Medicare

Topic: CONGENITAL ADRENAL HYPERPLASIA (CAH)

Written Question on Notice

Senator Harradine asked:

Does the Department accept that Australian States and Territories fall well behind in international best practice guidelines for the diagnosis of CAH?

Answer:

No. International best practice for the diagnosis of CAH is unclear. Many countries have different approaches to newborn screening. For example, the UK policy position is that CAH should not be included with other newborn biochemical screening at this time, while in the United States, some States screen for CAH while others do not.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2004-2005, 2 & 3 June 2004

Question: E04-071

OUTCOME 2: Access to Medicare

Topic: CONGENITAL ADRENAL HYPERPLASIA (CAH)

Written Question on Notice

Senator Harradine asked:

Does the Department accept that newborn screening for CAH would identify both male and female infants, prevent incorrect sex assignment and decrease mortality and morbidity and that CAH meets all of the recommended criteria for newborn screening?

Answer:

The Department has not undertaken a thorough assessment of whether CAH meets all the recommended criteria for newborn screening because it is not responsible for newborn screening policy or programs. However, it appears that screening for CAH does not meet the World Health Organisation criteria for a screening program.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2004-2005, 2 & 3 June 2004

Question: E04-072

OUTCOME 2: Access to Medicare

Topic: CONGENITAL ADRENAL HYPERPLASIA (CAH)

Written Question on Notice

Senator Harradine asked:

Does the Department accept that CAH screening would require no major changes to hospital protocols and that the cost of the test (approximately $2.50 per baby) would be more than made up for through reduced intensive care, ambulance transport, doctors visits and reduced stress on the family unit?

Answer:

While hospital protocols are a matter for the State and Territory Governments, the Department considers it unlikely CAH screening would require major changes to hospital protocols.

The Department is not in a position to comment on the costs and benefits of the test because assessment of costs and benefits depends on the circumstances of particular States and Territories, and the priorities of their Governments.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2004-2005, 2 & 3 June 2004

Question: E04-091

OUTCOME 2: Access to Medicare

Topic: MEDICARE STATISTICS ON SEX CHANGES

Written Question on Notice

Senator Harradine asked:

(a) How much money has been paid through Medicare for male to female sex changes and female to male sex changes in the past five years? Please provide a breakdown per year of the number of people and the funds provided.

(b) What percentage of the total cost of gender reassignment operations does the Medicare rebate represent?

(c) What criteria must be met for the Health Insurance Commission to approve the rebate?

Answer:

(a) While gender reassignment surgery is not specifically covered under the Medicare arrangements, there are a number of procedures in the Medicare Benefits Schedule (MBS) which may be performed as part of a gender reassignment operation, if this is determined by the practitioner to be clinically relevant.

Male to Female

Medicare statistics show that there are a number of male patients who undergo vaginoplasties each year (indicating a male to female gender reassignment).

Table 1 shows the estimated cost to Medicare for male to female gender reassignment based on the number of vaginoplasties on males. The cost to Medicare has been estimated on the basis of clinical advice regarding the type and number of surgical procedures that would be necessary to effect a gender reassignment in these cases.

Table 1 – Estimated cost of procedures used in male to female gender reassignment

Year	*Cost*	*Number of Male - Vaginoplasties*
1998 - 1999	**$35,496**	33
1999 - 2000	**$37,976**	28
2000 - 2001	**$44,551**	27
2001 - 2002	**$45,283**	33
2002 - 2003	**$52,687**	38
2003 – 2004	**$54,744**	38*

**Extrapolated from available figures for 2003 – 2004*

Note: These figures do not include the cost of consultations, anaesthesia, drug or hormone therapy that patients receive in association with sex change operations. It is not possible to identify these costs.

Female to Male
Medicare benefits for female to male gender reassignment cannot be quantified as the items used cannot be separated from their use for other clinical reasons.

(b) It is not possible to determine this figure because costs associated with consultations, anaesthesia, drug or hormone therapy are not known.

(c) The service must be determined as being clinically relevant. Clinically relevant services are services that are generally accepted by the medical profession as being necessary for the appropriate treatment of the patient. The need for any service is essentially a matter for the professional clinical judgement of the practitioner concerned, acting in accordance with Commonwealth, State and Territory laws.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2004-2005, 2 & 3 June 2004

Question: E04-092

OUTCOME 2: Access to Medicare

Topic: NUCHAL TRANSLUCENCY TESTING

Written Question on Notice

Senator Harradine asked:

a) What is the status of the Medical Services Advisory Committee (MSAC) considerations on including the Nuchal Translucency Screening Test in the Medicare schedule?

b) Is the MSAC to recommend recognising the test as part of existing ultrasound testing in pregnancy? If so, who is the Government consulting about such a proposal?

Answer:

a) The MSAC concluded its review of Nuchal Translucency (NT) testing in 2002.

b) MSAC found NT testing to be safe and effective when provided by individuals with appropriate expertise but concluded that it would not be cost effective to provide this test at additional cost. MSAC recommended that consideration should be given to incorporating NT testing into existing services provided in early pregnancy. The Department has consulted with the relevant medical professional colleges.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2004-2005, 2 & 3 June 2004

Question: E04-093

OUTCOME 2: Access to Medicare

Topic: NUCHAL TRANSLUCENCY SCREENING (NTS)

Written Question on Notice

Senator Harradine asked:

a) What is the current Medicare rebate for ultrasound testing? What would be the rebate should NTS testing be included in existing ultrasound testing?

b) How many ultrasound practitioners are accredited for the measurement of Nuchal Translucency in Australia?

Answer:

a) A Medicare rebate is available for ultrasound testing in early pregnancy to assess a number of conditions. The rebate is $59.50 if the service is referred and $29.75 if self-referred. There would be no additional rebate, in accordance with the Medical Services Advisory Committee recommendation, should nuchal translucency testing be specifically included in existing ultrasound testing.

b) All sonographers must be accredited to perform any ultrasound service that attracts a Medicare rebate. While there is not a Commonwealth requirement for ultrasound practitioners to be specifically accredited for nuchal translucency testing, the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) provides a quality assurance program for sonographers and medical practitioners providing these services. RANZCOG advises that, as of May 2004, 438 ultrasound practitioners were credentialled for nuchal translucency testing.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2004-2005, 2 & 3 June 2004

Question: E04-094

OUTCOME 2: Access to Medicare

Topic: THE INCLUSION OF NUCHAL TRANSLUCENCY SCREENING (NTS) IN THE MEDICARE SCHEDULE

Written Question on Notice

Senator Harradine asked:

(a) Please provide names and positions of members of the Medical Services Advisory Committee (MSAC) and its supporting committees.

(b) Is Dr Lachlan de Crespigny still a member of the supporting committee?

(c) Has Dr de Crespigny been active in pushing for NTS to be placed on the Medicare schedule?

Answer:

(a) The names and specialisations of MSAC members are provided at Attachment A. Membership details relating to all other supporting committees (now referred to as advisory panels) can be obtained at www.msac.gov.au/msacapps.htm

(b) No. Supporting committees are formed by the MSAC Executive to inform assessments of specific applications and referrals to MSAC and operate only for the period of the assessment. Dr de Crespigny was a member of the supporting committee for MSAC Reference 04 – *Nuchal translucency measurement in the first trimester of pregnancy for screening of trisomy 21 and other autosomal trisomies*. The supporting committee ceased to function in May 2002.

(c) MSAC supporting committees/advisory panels are formed to provide a source of expert advice to the organisations conducting MSAC assessments. People are appointed to supporting committees/advisory panels on the basis of their knowledge and expertise in respect of the technology being assessed. They do not represent the views of nominating professional organisations. While individuals will bring to this process a range of experience and perspectives, they and MSAC itself are required ultimately to base assessments on evidence rather than opinion.

Attachment A

Current Membership of the Medical Services Advisory Committee (MSAC)

Member	Expertise or Affiliation
Dr Stephen Blamey (Chair)	general surgery
Associate Professor John Atherton	cardiology
Professor Bruce Barraclough	general surgery
Professor Syd Bell	pathology
Dr Michael Cleary	emergency medicine
Dr Paul Craft	clinical epidemiology and oncology
Dr Gerry FitzGerald	Australian Health Ministers' Advisory Council representative
Dr Kwun Fong	thoracic medicine
Professor Jane Hall	health economics
Dr Terri Jackson	health economics
Professor Brendon Kearney	health administration and planning
Associate Professor Richard King	internal medicine
Dr Ray Kirk	health research
Dr Michael Kitchener	nuclear medicine
Dr Ewa Piejko	general practice
Mrs Sheila Rimmer	consumer health issues
Professor Jeffrey Robinson	obstetrics and gynaecology
Professor John Simes	clinical epidemiology and clinical trials
Professor Bryant Stokes	neurological surgery
Professor Ken Thomson	radiology
Dr Douglas Travis	urology

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2004-2005, 2 & 3 June 2004

Question: E04-095

OUTCOME 2: Access to Medicare

Topic: THE INCLUSION OF NUCHAL TRANSLUCENCY TESTING IN THE MEDICARE SCHEDULE

Written Question on Notice

Senator Harradine asked:

(a) Is the department aware that Dr de Crespigny is the subject of an investigation by the Medical Practitioners Board of Victoria for carrying out an abortion procedure following ultrasound on a 32-week-old unborn baby with suspected dwarfism at the Royal Women's Hospital?

(b) Does the department continue to take advice from medical practitioners who are the subject of such investigations? When would the department cease to take advice from such practitioners?

Answer:

(a) No, the Department is not aware of any investigations involving Dr de Crespigny.

(b) If the Department is made aware of circumstances where an individual's professional conduct may give reasonable cause to question their capacity to provide sound advice, then the Department will take appropriate action.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2004-2005, 2 & 3 June 2004

Question: E04-050

OUTCOME 2: Access to Medicare

Topic: ILLICIT USE OF PARACETAMOL / POLYDRUG USE AND AVAILABILITY OF DIVERTED PHARMACEUTICALS

Written Question on Notice

Senator Denman asked:

(a) Does the Department have any figures on either a national or State by State basis which indicates the levels of illicit use of paracetamol?

(b) Can these figures be provided by age group and by any other demographic division?

Answer:

(a) No. Paracetamol is not an illicit substance.

(b) No.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2004-2005, 2 & 3 June 2004

Question: E04-051

OUTCOME 2: Access to Medicare

Topic: ILLICIT USE OF PARACETAMOL / POLYDRUG USE AND AVAILABILITY OF DIVERTED PHARMACEUTICALS

Written Question on Notice

Senator Denman asked:

(a) Is the Department aware of the *Drug Action 2004* Report in Northern Tasmania which found that young Launceston people were overdosing on paracetamol more than on any other illicit drug?

(b) Is the Department aware of any evidence to indicate that this problem occurs elsewhere in Australia either at this level or to any other substantial degree?

Answer:

(a) Yes.

(b) No.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2004-2005, 2 & 3 June 2004

Question: E04-052

OUTCOME 2: Access to Medicare

Topic: ILLICIT USE OF PARACETAMOL / POLYDRUG USE AND AVAILABILITY OF DIVERTED PHARMACEUTICALS

Written Question on Notice

Senator Denman asked:

(a) What current or planned Commonwealth initiatives or programmes address this illicit use of paracetamol and other substances which can be brought over the counter by people of any age?

(b) What funding is available to specifically address this or similar problems?

Answer:

(a) **Information for consumers and health practitioners about the safe use of paracetamol**

In 2003, the Therapeutic Goods Administration (TGA) launched a campaign about the safe and appropriate use of paracetamol, which accompanied the release of a draft report on the safety of non-prescription analgesics commissioned by the TGA.

As part of this campaign, fact sheets were made available to inform health practitioners and consumers about the safe use of paracetamol.

National Drug Strategy

The National Drug Strategy provides a framework for the coordinated and integrated approach to address drug use in the Australian community. The Strategy can be accessed at www.nationaldrugstrategy.gov.au.

The Australian Institute of Health and Welfare conducted the latest National Drug Strategy Household Survey in 2001, which was the most comprehensive survey concerning licit and illicit drug use ever undertaken in Australia. The data collected from this and previous surveys have contributed to the development of policies for Australia's response to drug-related issues. More information is available at www.aihw.gov.au.

Quality Use of Medicines
The National Strategy for Quality Use of Medicines (QUM) has been developed to address challenges and barriers to realising all the benefits of QUM and has a goal to make the best possible use of medicines to improve health outcomes for all Australians.

QUM means:
- selecting management options wisely;
- choosing suitable medicines if a medicine is considered necessary so that the best available option is selected taking into account among other things, risks and benefits; and
- using medicines safely and effectively to get the best possible results by, among other things, minimising misuse, over-use and under-use.

(b) No funding has been allocated to address the issue of paracetamol.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2004-2005, 2 & 3 June 2004

Question: E04-053

OUTCOME 2: Access to Medicare

Topic: ILLICIT USE OF PARACETAMOL / POLYDRUG USE AND AVAILABILITY OF DIVERTED PHARMACEUTICALS

Written Question on Notice

Senator Denman asked:

The *Drug Action 2004* Report in relation to drug use in Northern Tasmania found that the use of polydrug and the availability of diverted pharmaceuticals is rising at an alarming rate.

(a) Does the Department have any figures on either a national or State by State basis which indicates the use of polydrug?
(b) Are there figures for previous years which would indicate trends in use?
(c) Does the Department have any figures on either a national or State by State basis which indicates the level of diverted pharmaceuticals?
(d) Are there figures for previous years which would indicate trends in use?

Answer:

(a) The Australian Institute of Health and Welfare collects statistics on polydrug use through data collected by the National Drug Strategy Household Surveys. This data is presented on a national basis for males and females. More information is available at www.aihw.gov.au.

(b) see (a)

(c) No.

(d) No.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2004-2005, 2 & 3 June 2004

Question: E04-054

OUTCOME 2: Access to Medicare

Topic: ILLICIT USE OF PARACETAMOL / POLYDRUG USE AND AVAILABILITY OF DIVERTED PHARMACEUTICALS

Written Question on Notice

Senator Denman asked:

(a) What current or planned Commonwealth initiatives or programmes address these particular issues?

(b) What funding is available to specifically address these problems?

Answer:

(a) A working group convened by Senator the Hon Christopher Ellison, Minister for Justice and Customs, has taken up the issue of diversion in order to promote a national response to the diversion of legitimate pharmaceutical products to the illicit manufacture of amphetamine-type substances.

The National Drug Strategy provides a framework for the coordinated and integrated approach to address drug use in the Australian community. The Strategy can be accessed at www.nationaldrugstrategy.gov.au.

(b) Under the National Drug Strategy the expenditure in 2003-04 is in the order of $48 million.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2004-2005, 2 & 3 June 2004

Question: E04-066

OUTCOME 2: Access to Medicare

Topic: POSITRON EMISSION TOMOGRAPHY (PET)

Written Question on Notice

Senator Denman asked:

(a) Other than those who received assistance through the Isolated Patients Travel and Accommodation Assistance Scheme (IPTAAS), how many Tasmanians have travelled to (i) Victoria and (ii) other States and Territories for a PET scan in 2003-2004 to date?

(b) How many Tasmanians in 2003-2004 to date have travelled to (i) Victoria and (ii) other States and Territories for a PET scan under the IPTAAS?

Answer:

(a) There are no data available on the number of Tasmanian patients who travel interstate for a PET scan by their own means.

(b) From July 2003 to March 2004, 185 Tasmanian patients received assistance under the Patient Travel Assistance Scheme (PTAS) to travel interstate for a PET scan. For the same period, 130 Tasmanian patients received a Medicare eligible PET scan. 123 of these scans were performed in Victoria, and seven in New South Wales.

Note that there are prescribed clinical conditions which patients receiving PET scans must satisfy to be eligible for a Medicare rebate. Not all Tasmanian PET patients funded under the PTAS would comply with these conditions. The number of PET scans performed on Tasmanian patients receiving PTAS assistance is therefore likely to be greater than the number of Medicare-eligible scans performed on Tasmanian patients.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2004-2005, 2 & 3 June 2004

Question: E04-067

OUTCOME 2: Access to Medicare

Topic: POSITRON EMISSION TOMOGRAPHY (PET)

Written Question on Notice

Senator Denman asked:

Can the Department provide details, findings and recommendations of all research funded by the Commonwealth into the use of PET in cancer management?

Answer:

Four research projects on PET's use in cancer management have been funded by the Department of Health and Ageing and the National Health and Medical Research Council (NHMRC). Background information on these is given below. Two projects have been funded through grants under the Consultative Council on Diagnostic Imaging Research Program (CCDIRP) and one by the NHMRC. In addition, the PET Evaluation Program is currently underway. Final reports for the CCDIRP projects are attached. As noted below, the results of the NHMRC project are not yet known.

The results of the completed projects have not directly formed the basis of any recommendations, but have been considered along with other information in the development of Commonwealth policy.

1. PET Evaluation Program

The Commonwealth PET Review recommended data collection to enable PET's further evaluation by the Medical Services Advisory Committee (MSAC). All eight PET facilities receiving Commonwealth funding are bound by the terms of their eligibility/grant agreements to participate in the PET Evaluation Program. These facilities are:

New South Wales	Royal Prince Alfred Hospital
	Liverpool Hospital
Victoria	Peter MacCallum Cancer Institute
	Austin Health (formerly Austin and Repatriation Medical Centre)
	Medical Imaging Australia (Monash Medical Centre)
Queensland	Wesley Hospital
Western Australia	Sir Charles Gairdner Hospital
South Australia	Royal Adelaide Hospital

To date, each of the seven successful tenderers has received $150,000 for the costs of their participation. Austin Health's participation costs are included in its overall grant.

The Program is scheduled for completion in mid to late 2006. Its primary objective is to gather sufficient evidence on PET's clinical efficacy (measured by PET's impact on patient management) to enable MSAC to reach definitive conclusions and make firm recommendations about future PET funding arrangements. The Program comprises two elements:

- demographic data describing basic patient information; and
- clinical protocol data derived from detailed studies of particular clinical indications.

Demographic data have been collected since March 2003. Protocols for the following indications are being implemented: melanoma, lymphoma, sarcoma, glioma, solitary pulmonary nodules and colorectal, oesophageal, ovarian and head and neck cancers.

2. National Health and Medical Research Council Standard Project Grant: 'Economic evaluation of positron emission tomography in management of non-small cell lung cancer'. Grant to University of Sydney ($289,948).

The study will provide information on the impact on clinical decision making and net health care resource use of PET in non-small cell lung cancer (NSCLC). It will address the question of whether the addition of PET to the diagnostic work-up has a significant impact on proposed management of patients with a diagnosis of NSCLC after routine work-up. The results are not yet published.

3. Consultative Committee on Diagnostic Imaging Research Program: 'A cost consequence study of care following cancer staging with and without the use of F-18 FDG PET scanning.' Grant to Monash University ($79,212). Final report submitted June 2003 (Attachment A).

This project examined the costs and consequences of introducing PET imaging into the treatment protocols for four common cancer indications: non-small cell lung cancer, head and neck cancer, non-Hodgkin's lymphoma, and colorectal cancer.

The research question was whether the higher costs of PET scanning could be justified by the consequences in terms of longer survival, lower costs of other forms or care and/or the quality of life outcomes of avoiding intensive and distressing interventions which had little likelihood of success.

4. Consultative Committee on Diagnostic Imaging Research Program: 'Evaluation of the impact of F-18 FDG PET scanning and health outcomes of oncology patients'. Grant to Peter MacCallum Cancer Institute ($159,269). Report No.3 submitted November 2000 (Attachment B(i) and Final Report submitted June 2002 (Attachment B(ii)).

This project studied the Institute's use of PET in non-small cell lung cancer (several studies), colorectal cancer, cervical cancer and head and neck cancer. It also includes reports on the role of PET in lymphoma and malignant melanoma.

A cost consequence study of care following cancer staging with and without the use of F-18 FDG PET Scanning

Final Report to the

Consultative Committee on Diagnostic Imaging

Commonwealth Department of Health and Aging

Terri Jackson[a]

Rodney Hicks[b]

Michael Mac Manus[c]

30 June 2003

a Senior Research Fellow, Monash University Health Economics Unit, Melbourne
b Director, Peter MacCallum Cancer Centre Positron Emission Tomography Centre, Melbourne
c Radiation Oncologist, Peter MacCallum Cancer Centre, Melbourne

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

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2004-2005, 2 & 3 June 2004

Question: E04-068

OUTCOME 2: Access to Medicare

Topic: POSITRON EMISSION TOMOGRAPHY (PET)

Written Question on Notice

Senator Denman asked:

(a) Has consideration been given to providing access to the Medicare schedule to those patients seeking to use PET to:

    (i) assist in the detection or determination of the extent of breast cancer; and
    (ii) detect the onset of Alzheimer's disease?

(b) If not, why not?

(c) If so, what is the outcome of the consideration?

Answer:

The PET indications which have so far been assessed by the Medical Services Advisory Committee (MSAC), and subsequently recommended for interim funding, were determined by eminent PET providers sitting on the MSAC PET Supporting Committee. PET's use in breast cancer and Alzheimer's disease was considered by this Committee. The Committee had reservations about PET's potential value for these indications and was of the view that the indications which were ultimately identified should be given priority.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2004-2005, 2 & 3 June 2004

Question: E04-177

OUTCOME 2: Access to Medicare

Topic: ATTENDANCE ITEM RESTRUCTURE WORKING GROUP

Written Question on Notice

Senator McLucas asked:

a) How much has the Department spent on this process to date?

b) What is the likely overall cost?

c) When is the Department likely to be in a position to begin the process of implementing the recommendations made by the Working Group to date?

d) What is the process by which these recommendations are being considered by Government?

Answer:

a) The Department of Health and Ageing estimates that total expenditure to date is $241,000.

b) The Working Group is likely to continue its work for another 12 to 18 months, which would bring the estimated total cost up to around $300,000.

c) The Working Group is considering how a staged process of item restructure would be implemented and is continuing to work through the original terms of reference including looking at GP after hours services and attendance at aged care facilities. Implementation of any restructure would be subject to Government consideration and decision.

d) The Working Group is a technical advisory group whose findings will inform debate on Medicare financing of general practice. The Group's Report will be offered to the Minister for consideration.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2003-2004, 2-3 June 2004

Question: E04-263

OUTCOME 2: Access to Medicare

Topic: PRODUCTION OF BULK BILLING DATA

Hansard Page: CA 31-32-2.6

Senator McLucas asked:

(a) When was the system for producing electorate data developed?

(b) Were the December statistics actually compiled?

(c) Was the directive in writing and if so, can the Committee have a copy of the Minute?

Answer:

(a) The Department has been using the same methodology for producing electorate statistics based on patient enrolment postcode information for over 10 years. Since many postcodes overlap electoral boundaries, concordance files, showing the proportion of the population of each postal area in each electorate have been used to allocate Medicare data to electorate.

Each time electoral boundaries have changed it has been necessary to acquire or construct concordance files showing the proportion of the population of each postal area in each electorate.

(b) Yes. However, the Minister decided prior to their release that electorate bulk billing statistics would henceforth be made available on an annual basis. The annual bulk billing statistics had regard to the underlying data for all quarters of 2003, including the December quarter.

(c) The Minister determined in writing, in response to a Departmental Minute, that electorate data would be released annually on a calendar year basis. It is not normal practice to disclose specific details of policy advice to the Minister.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2004-2005, 2-3 June 2004

Question: E04-264

OUTCOME 2: Access to Medicare

Topic: MEDICARE DATA SETS

Hansard Page: CA 33-36-2.6

Senator McLucas asked:

(d) Do we have any data by geographical area about the number of children who are being bulk billed?

(e) Under what age ranges is the Medicare data aggregated?

(f) What is the age breakdown of all non-referred GP services where a $5 incentive payment has been claimed?

(g) Is it possible to provide the numerator for the disaggregated number of unreferred GP attendances?

Answer:

(c) Yes.

(b) Medicare statistics are generally compiled in 5 year age ranges (under 5, 5-9 etc). With effect from the March quarter 2004, the 15-19 age group has been split into 15 and 16-19. This enables statistics to be compiled for the under 16, 16-64 and 65+ age groups.

(c) For statistics on the under 16 and 65+ age groups, refer to page CA 69 of the Senate Legislation Community Affairs Hansard of 2 June 2004.

(d) In February and March 2004, the HIC processed claims for 6,274,177, $5 incentive items for services in the Medicare Benefits Schedule, other than diagnostic imaging and pathology. The relevant item number is 10990. Approximately 6.0 million of these items were associated with non-referred (GP) attendances, excluding practice nurse items.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2004-05, 2 & 3 June 2004

Question: E04-158

OUTCOME 2: Access to Medicare

Topic: FRAUD & OVERSERVICING

Hansard Page: CA 39-2.6

Senator Allisonasked:

Without identifying individuals:

(a) How many GPs have had their Medicare rebate claiming patterns investigated by the HIC for the financial year 2002-03 and the current year to date?

(b) Of those GPs who were investigated, how many have had their overservicing costs recovered by the HIC?

(c) What is the total amount that has been recovered for inappropriate payments during the financial year 2002-03 and the year to date?

Answer:

(a) For the financial year 2002-03, the Health Insurance Commission (HIC) conducted interventions in relation to 631 general practitioners following a review of their claiming patterns.

For the financial year 2003-04 (year to date as at 25 June 2004) HIC has conducted interventions in relation to 580 general practitioners following a review of their claiming patterns.

(b) For the financial year 2002-03 recoveries were received from 42 general practitioners who were interviewed (following a review of their claiming patterns) during this period.

For the financial year 2003-04 (year to date as at 25 June 2004) recoveries were received from 40 general practitioners who were interviewed (following a review of their claiming patterns) during this period.

Please note that further recoveries are anticipated in respect of general practitioners interviewed during the above periods on completion of external peer review processes.

(c) Total recoveries in 2002-03 relating to inappropriate payments to general practitioners were approximately $1.8 million.

Total recoveries in 2003-04 (year to date as at 25 June 2004) relating to inappropriate payments to general practitioners are approximately $1.8 million.

These recoveries amounts relate to interventions conducted both in the year of receipt and prior years. It should be noted that further recoveries in respect of 2002-03 and 2003-04 interventions will be receipted in further years.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2004-05, 2 & 3 June 2004

Question: E04-159

OUTCOME 2: Access to Medicare

Topic: FRAUD & OVERSERVICING

Hansard Page: CA 41-2.6

Senator Allison asked:

(d) How many cases of inappropriate claiming by GP's were referred to the Director of the Professional Services Review for the financial year 2002-03 and the current year to date?

(e) How many cases of suspected fraud were referred to the Director of Public Prosecutions in this same time period?

Answer:

(a) For the financial year 2002-03 the Health Insurance Commission (HIC) referred 47 cases of inappropriate claiming by general practitioners to the Director of the Professional Services Review.

For the financial year 2003-04 the HIC referred 31 cases of inappropriate claiming by general practitioners to the Director of the Professional Services Review.

(b) For the financial year 2002-03 the HIC referred 12 cases of suspected fraud by general practitioners to the Director of Public Prosecutions.

For the financial year 2003-04 the HIC referred 2 cases of suspected fraud by general practitioners to the Director of Public Prosecutions.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2004-05, 2 & 3 June 2004

Question: E04-160

OUTCOME 2: Access to Medicare

Topic: STAFFING IN MEDICARE OFFICES

Hansard Page: CA 47 & 69-2.6

Senator McLucas asked:

Of the 200 additional staff which have been recruited by the Health Insurance Commission (HIC) to deal with the extra workload that has been created by the registration of families for the Medicare Safety Net:

(a) How many are permanent employees?

(b) Where are they currently located?

(c) In what capacity are they working (ie supervisor, Customer Service Officer)

For the remaining non- permanent employees:

(d) Where are they currently located?

(e) In what capacity are they employed (ie supervisor, Customer Service Officer)

Answer:

(a) None of the additional staff, who have been recruited by the HIC to deal with the extra workload that has been created by the registration of families for the Medicare Safety Net, have been employed as permanent employees.

(b) Not applicable.

(c) Not applicable.

In regard to the non-permanent employees, the additional resources required to undertake the processing of Medicare Safety Net registrations was made up of 200 full-time equivalents. They included:

- part-time employees working longer hours;
- full-time employees working overtime;
- a night shift in processing centres staffed by temporary and agency staff; and
- agency and temporary contract staff working in Medicare offices.

(d) The non-permanent employees have been employed across HIC's 228 Medicare offices, as well as in State Headquarters and Medicare Processing Centres in all capital cities.

(e) The additional staff have been employed as Customer Service Officers.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2004-2005, 2 & 3 June 2004

Question: E04-348

OUTCOME 2: Access to Medicare

Topic: UNREFERRED GP ATTENDANCES

Hansard Page: CA 42-2.6

Senator McLucas asked:

Can I ask for the time period for, let us say, percentage of the total unreferred attendances by item number by quarter. A percentage of the total number of unreferred attendances by item number for quarters back to the beginning of this financial year?

Answer:

Percentages of GP consultations in 2003/04, grouped by consultation length, are shown in the table below.

	September quarter 2003	**December quarter 2003**	**March quarter 2004**	**June quarter 2004**
Brief consultations	1.3%	1.3%	1.4%	1.8%
Standard consultations	85.5%	84.9%	84.7%	84.4%
Long consultations	11.9%	12.4%	12.5%	12.4%
Prolonged consultations	1.3%	1.4%	1.4%	1.4%

The consultation item groups shown in the table above account for over 95% of all unreferred GP attendances. The remainder of unreferred attendances include item groups such as the Enhanced Primary Care items, and Practice Incentive Program (PIP) incentive items.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2004-2005, 2 & 3 June 2004

Question: E04-349

OUTCOME 2: Access to Medicare

Topic: $5 BULK BILLING INCENTIVE

Hansard Page: CA 44-2.6

Senator McLucas asked:

If you could deconstruct the $15,500 into what was $5 payments and what else was going to add up to that total increase in doctor income?

Answer:

Since 1 February 2004, GPs could claim an extra $5 each time they bulk bill a service provided to a Commonwealth Concession Card holder or child under 16. From 1 May 2004, a bulk billing incentive of $7.50 has been available for services delivered in RRMAs 3-7, Hobart and surrounds. Additionally from 1 September 2004, GPs in outer-metropolitan areas with below average bulk billing rates and below average doctor-to-population ratios became eligible for the $7.50 bulk billing incentive.

The table below shows how much a full time equivalent GP could gain solely from the $5 and $7.50 bulk billing incentive items announced as part of *Strengthening Medicare*, based on a typical patient mix, and an average bulk billing rate for concession card holders and children.

Additional GP income from *Strengthening Medicare* bulk billing incentives[1].

Measure	**Per Full Time Equivalent GP in:**		
	RRMA 1	**RRMA 2**	**RRMAs 3-7**
More affordable health services – for children and Commonwealth Concession Card holders[3]	$17,780	$15,785[2]	$20,055

[1] The $15,500 amount was a national average based on a flat $5.00 incentive across all regions

[2] This figure is based on a $5 incentive payment. From 1 September 2004, GPs in outer metropolitan areas with below average bulk billing rates and below average doctor-to-population ratios are eligible for the $7.50 bulk billing incentive

[3] Table does not include the impact of *100% Medicare.*

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2004-2005, 2 & 3 June 2004

Question: E04-351

OUTCOME 2: Access to Medicare

Topic: UNREFERRED GP ATTENDANCES IN RESIDENTIAL AGED CARE FACILITIES

Hansard Page: CA 61-2.6

Senator Moore asked:

If we could find out from your research, on notice, what the average bulk-billing rate in aged care facilities is, just in terms of the basic information?

Answer:

The average bulk-billing rate for consultations in residential aged care facilities was 95.3% in 2003-04.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2004-2005, 2 & 3 June 2004

Question: E04-352

OUTCOME 2: Access to Medicare

Topic: COMPREHENSIVE MEDICAL ASSESSMENTS

Hansard Page: CA 61-2.6

Senator Moore asked:

How many assessments are expected to be conducted each year?

Answer:

Uptake of the Comprehensive Medical Assessment MBS items in residential aged care facilities is expected to grow to around 90,000 services annually by 2007-08.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2004-2005, 2 & 3 June 2004

Question: E04-346

OUTCOME 2: Access to Medicare

Topic: PRACTICE INCENTIVES PROGRAM (PIP) – PRACTICE NURSES AND/OR ALLIED HEALTH WORKERS FOR URBAN AREAS OF WORKFORCE SHORTAGE

Hansard Page: CA 62-2.6

Senator McLucas asked:

a) In what States are 432 practices located? Provide regional centre locations in QLD.

b) How many practices have taken up the opportunity to employ an allied health professional to that point in time?

c) Can you tell us what form of allied health professional the person is or is it just the general heading of 'allied health professional'

d) And also where they have been located?

e) How much has been spent out of that allocation to this point?

f) Can you provide to the committee, probably on notice, that ranked list? Is that possible?

Answer:

a) The 443 practices that responded to the offer to participate in the Practice Nurses and/or Allied Health Worker Incentive as at 30 April 2004 and received a payment in the PIP May quarterly payment are located as follows. Queensland data is not available on a regional basis.

State	***No. of Practices***	***%***
ACT	17	3.8
NSW	114	25.7
NT	7	1.6
QLD	56	12.6
SA	29	6.5
TAS	5	1.1
VIC	170	38.4
WA	45	10.2

	443	**100.0**

b) and d)

The actual number of the allied health professionals in unknown. Practices in urban areas of workforce shortage may utilise the services of a practice nurse in conjunction with, or instead of an allied health worker.

c) It is under the general heading of allied health professional.

e) $2,997,338 of the allocation has been paid to practices as at 31 May 2004.

f) A list of eligible urban areas of workforce shortage for the purposes of the PIP practice nurse grants is attached (Attachment A). This is a ranked list of areas that the 1100 PIP practices that received an offer to participate in the Practice Nurses and/or Allied Health Workers for Urban Areas of Workforce Shortage Incentive are located.

RANKED ORDER OF URBAN AREAS OF WORKFORCE SHORTAGE IN RRMAS 1-2 IN WHICH FIRST 1100 PRACTICES ARE LOCATED IN DESCENDING ORDER OF PRIORITY

state	area
QLD	SLA34654 Waterford West
QLD	SLA33466 Eagleby
QLD	SLA34608 Greenbank Boronia Heights
QLD	SLA34612 Kingston
QLD	SLA35973 Lawnton
NSW	SLA11720 Cessnock (C)
QLD	SLA34637 Slacks Creek
TAS	SLA60410 Brighton (M)
QLD	SLA32013 Caboolture (S) East
QLD	SLA33965 Ipswich (C) - East
VIC	SLA22752 Corio - Inner
QLD	SLA33476 Mt Warren Park
QLD	SLA36807 Thuringowa (C) - Pt A Bal
NT	SSD70510 Palmerston-East Arm
NSW	SLA16900 Shellharbour (C)
VIC	SLA22751 Bellarine - Inner
QLD	SLA36251 Alexandra Hills
TAS	SLA64811 Sorell (M) - Pt A
NSW	SLA16400 Port Stephens (A)
NSW	SLA18550 Wyong (A)
QLD	SLA32016 Deception Bay
NSW	SLA15050 Maitland (C)
QLD	SLA32023 Caboolture (S) Bal in BSD
QLD	SLA33496 Gold Coast (C) Bal in BSD
QLD	SLA36268 Thorneside
QLD	SLA30552 Beaudesert (S) - Pt A
QLD	SLA34623 Marsden
QLD	SLA34631 Rochedale South
QLD	SLA35961 Dakabin-Kallangur-M. Downs
QLD	SLA35988 Pine Rivers (S) Bal
QLD	SLA36264 Ormiston
QLD	SLA36265 Redland Bay
QLD	SLA36804 Kirwan
QLD	SLA32005 Burpengary-Narangba
QLD	SLA34634 Shailer Park
QLD	SLA36276 Wellington Point
NSW	SLA14650 Lake Macquarie (C)
NSW	SLA15902 Newcastle (C) - Remainder
VIC	SLA22171 Frankston (C) - East
VIC	SLA25341 Mornington P'sula (S) - East
QLD	SLA34605 Daisy Hill-Priestdale
QLD	SLA35958 Central Pine West
SA	SRS Northern Adelaide
NSW	SRS Outer South Western Sydney
VIC	SRS Outer Western Melbourne
VIC	SRS South Eastern Melbourne
ACT	SSD80540 Gungahlin-Hall

NSW	SLA16450 Queanbeyan (C)
VIC	SLA22754 Geelong West
VIC	SLA25344 Mornington P'sula (S) - South
QLD	SLA35974 Petrie
WA	SRS South East Metropolitan (Perth)
ACT	SSD80510 Belconnen
ACT	SSD80520 Weston Creek-Stromlo
ACT	SSD80525 Tuggeranong
NSW	SLA14400 Kiama (A)
VIC	SLA22174 Frankston (C) - West
QLD	SLA35957 Bray Park
WA	SRS East Metropolitan (Perth)
VIC	SRS North Western Melbourne
QLD	SLA36271 Thornlands
TAS	SLA61410 Clarence (C)
NSW	SRS North Western Sydney
QLD	SRS Southern Outer (Brisbane)
NT	SSD70505 Darwin City
QLD	SLA35971 Hills District
VIC	SRS Outer Eastern Melbourne
QLD	SRS Western Outer (Brisbane)
QLD	SLA36254 Birkdale
QLD	SRS Eastern Outer (Brisbane)
VIC	SLA22756 South Barwon - Inner
VIC	SLA25345 Mornington P'sula (S) - West

Legend:
SLA Statistical Local Area
SRS Statistical Region Sector
SSD Statistical Subdivision

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2004-2005, 2 & 3 June 2004

Question: E04-266

OUTCOME 2: Access to Medicare

Topic: IMPROVED MONITORING OF ENTITLEMENTS (IME)

Hansard Page: CA 74-2.6

Senator McLucas asked:

The review was done internally. Is that a public document?

Answer:

The Improved Monitoring of Entitlements review was completed in October 2003. The review report titled "Review of Improved Monitoring of PBS Entitlements (IME)" was prepared as a lapsing measure report in the context of the 2004-05 Budget process for the information of the Government. Accordingly, it is not available as a public document. The report indicates that the IME objectives remain relevant and appropriate and that savings will continue to accrue to the Pharmaceutical Benefits Scheme as a result of this measure.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2004-2005, 2 & 3 June 2004

Question: E04-267

OUTCOME 2: Access to Medicare

Topic: INCREASED USE OF PBS GENERICS

Hansard Page: CA 76-77-2.6

Senator McLucas asked:

(a) Can you tell me exactly what savings have been made to date against that provision? (Sustaining the Pharmaceutical Benefits Scheme – Facilitating the Use of Generic Medicines Budget Measure 2002-03)

(b) Could you give us a list of what drug groups are expected to come off patent in the next five years?

Answer:

(a) The savings attributed to Sustaining Pharmaceutical Benefits Scheme – Facilitating the Use of Generic Medicines Budget Measure 2002-03 is $14.9 million for the period February 2003 to December 2003.

(b) The Pharmaceutical Benefits Scheme (PBS) does not monitor patents on individual medicines. Patents are a matter between individual companies and IP Australia.

The Department, however, is aware that drugs in the following PBS drug groups are expected to come off patent over the next five years.

Drug Group – drugs for the treatment of:	**Patent expiry**
High cholesterol (statins)	2005 2006
High blood pressure	2004 2006 2008
Depression	2005 2007
Asthma	2006

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2004-2005, 2 & 3 June 2004

Question: E04-269

OUTCOME 2: Access to Medicare

Topic: TIERS IN IM/IT PROGRAM – Practice Incentives Program (PIP)

Hansard Page: CA 64-3.6

Senator McLucas asked:

I am wondering what triggers the payment if you collapse the reporting benchmarks?

Answer:

On 11 May 2004, the Minister announced measures to reduce the red tape burden on GPs with changes to PIP and Enhanced Primary Care items as the centrepiece of the strategy. This includes implementing the recommendations of the Red Tape Taskforce that is, updating the PIP IM/IT criteria by:

- replacing the current IM/IT tier one incentive payment with a direct and automatic link to accreditation;
- consolidating the other two IM/IT incentive tiers into one incentive; and
- introducing another IM/IT incentive to support the Government's e-health agenda.

These changes are planned for introduction from 1 November 2004 following further development and consultation with the profession.

The mechanism for triggering the payments will be developed in consultation with the profession.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2004-05, 2 & 3 June 2004

Question: E04-161

OUTCOME 2: Access to Medicare

Topic: PBS – PRESCRIPTION SHOPPING PROGRAM

Hansard Page: CA 72-2.6

Senator McLucas asked:

In regard to PBS prescriptions during the Prescription Shopping Program, has the HIC observed any actions that indicate an unusual level of inappropriate behaviour in the Northern Territory?

Answer:

As data for the Prescription Shopping project is currently available for only two quarters, it is too early in the operation of the project to identify any particular trends.

Differences across States or Territories, in terms of the characteristics of the patients identified under this project, would be best considered in view of at least 12 months data. As a result, to date, HIC has not observed any actions under the Prescription Shopping project that indicate differences in the population of identified patients across States and Territories.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2004-05, 2 & 3 June 2004

Question: E04-162

OUTCOME 2: Access to Medicare
Topic: PBS – PRESCRIPTION SHOPPING PROGRAM

Hansard Page: CA 74-2.6

Senator McLucas asked:

What are the different categories of medications that individuals identified under the Prescription Shopping Program, are utilising?

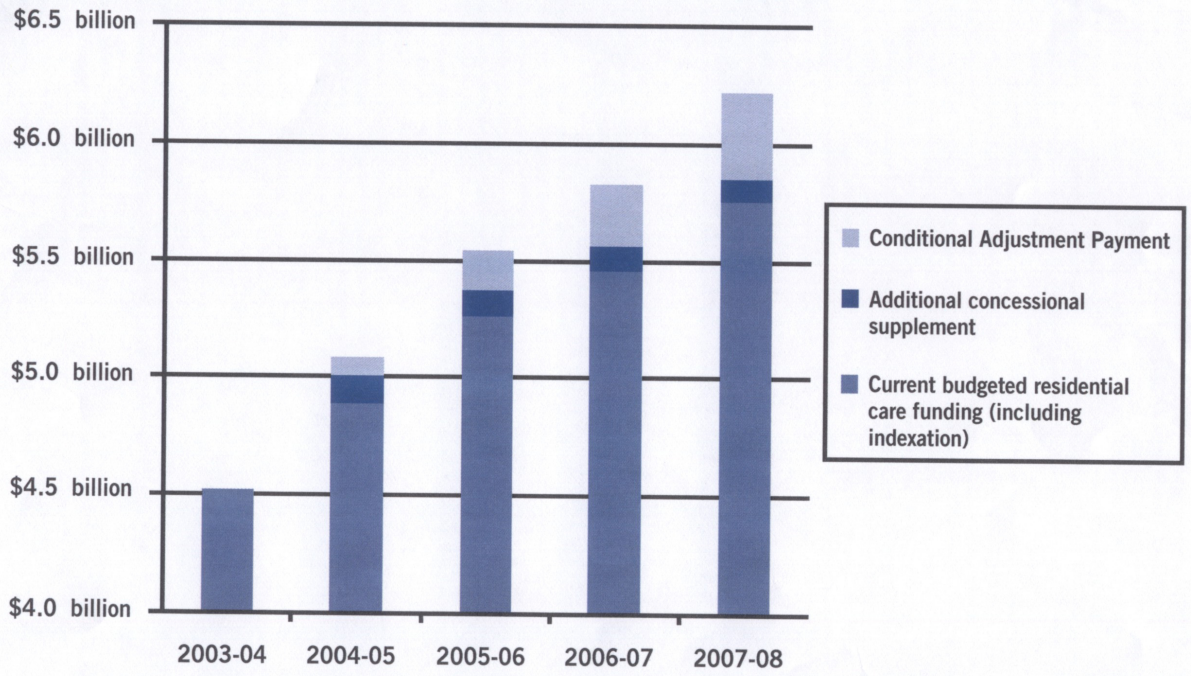
Answer:

The PBS medicines obtained by individuals identified under the Prescription Shopping project span all the therapeutic categories of pharmaceutical benefits.

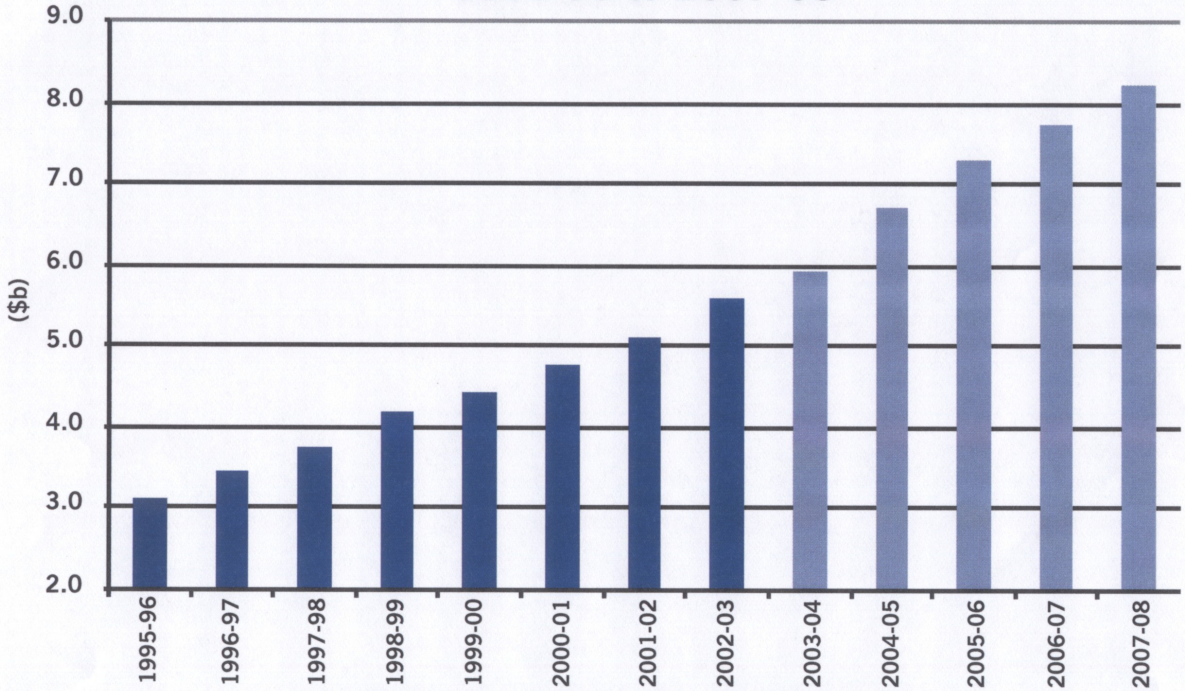
However, the pharmaceutical benefits within the "nervous system therapeutic" category (e.g. analgesics, antiepileptics, anti-Parkinson drugs, psycholeptics, psychoanaleptics, and other central nervous system drugs) tend to be the more predominant category of pharmaceutical benefits obtained by individuals identified under the project. This may reflect the fact that the nervous system drugs are currently a primary target of the project.

TABLED BY MINISTER CAMPBELL
02.06.04

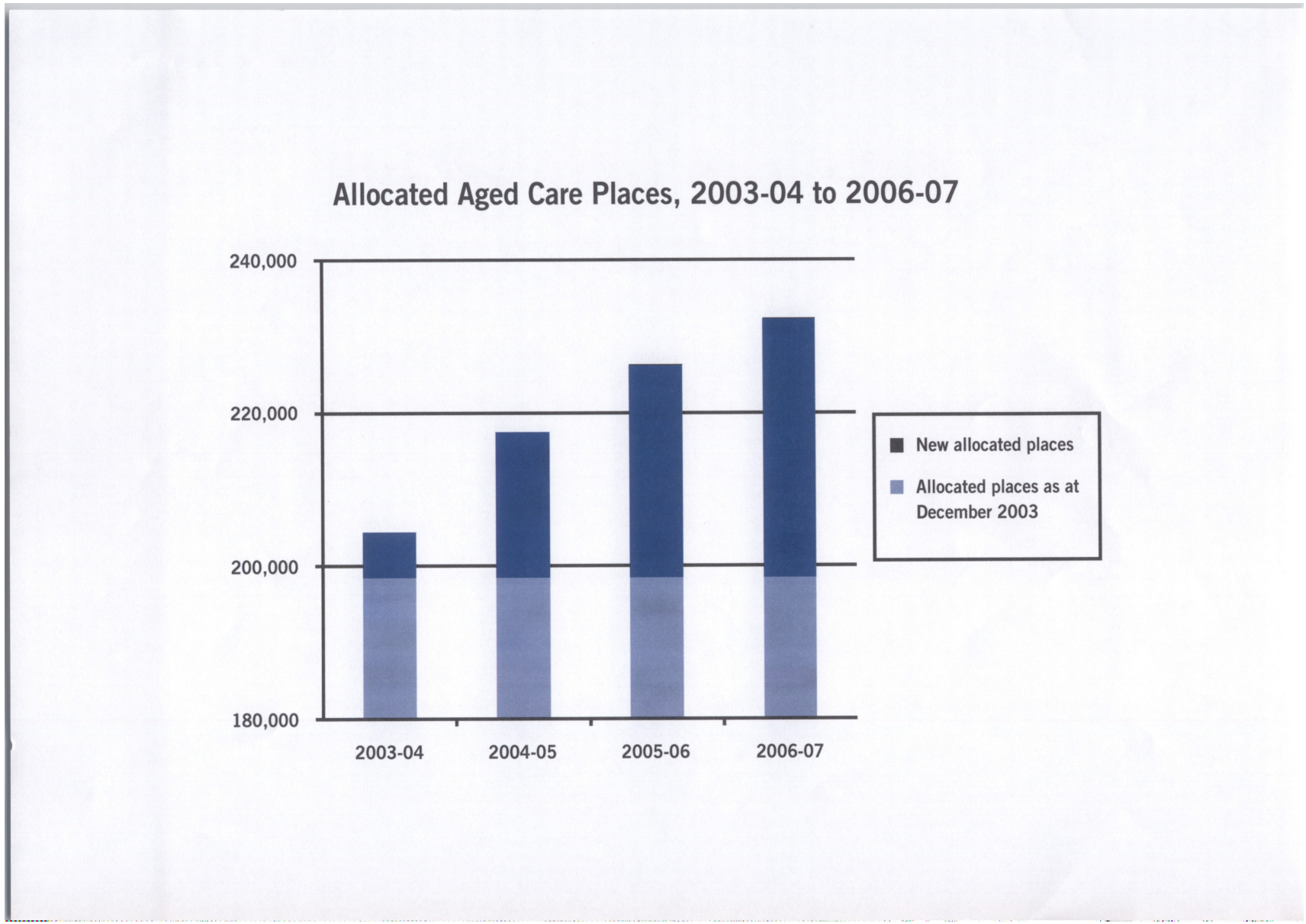
Australian Government support for Residential Aged Care, 2003-04 to 2007-08



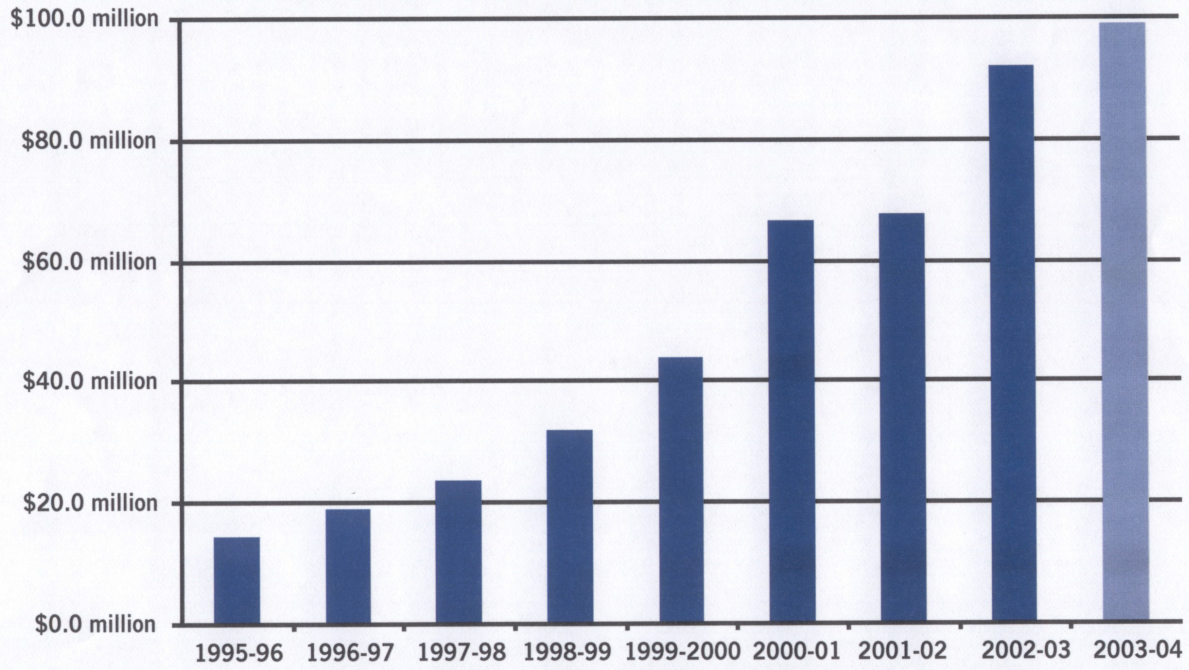
Australian Government expenditure on aged care - 1995-96 to 2007-08



Note: 1995-96 to 2002-03 (actual) and 2003-04 to 2007-08 (estimated)
2003-04 does not include one-off capital funding of $513.3 million

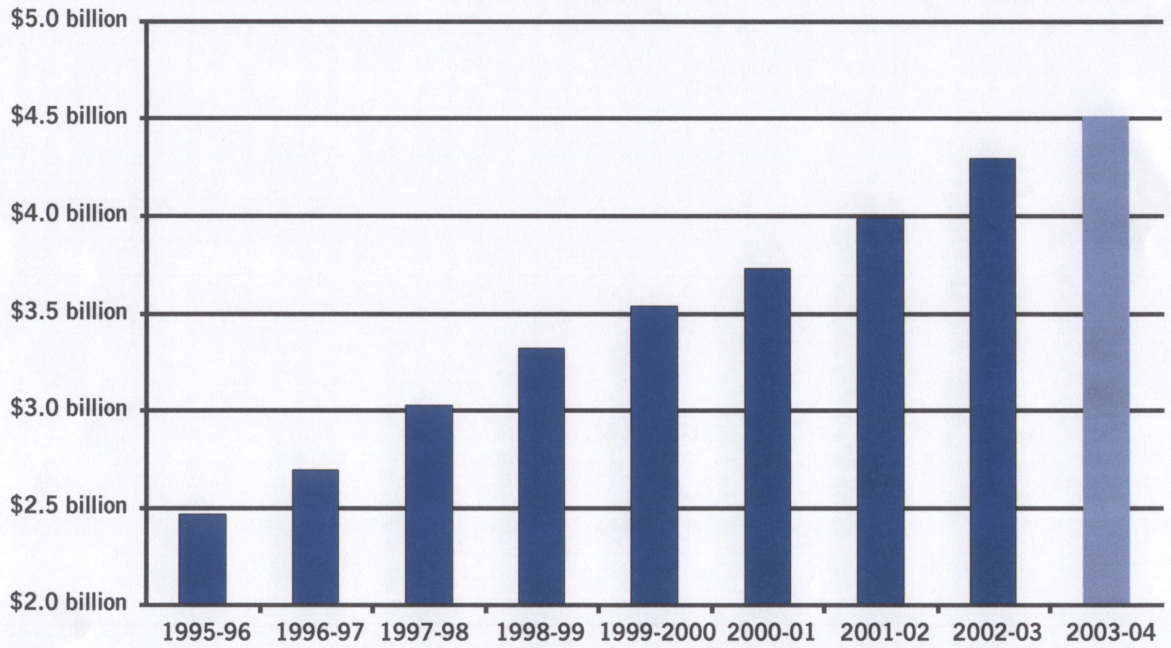

Allocated Aged Care Places, 2003-04 to 2006-07
240,000
220,000
200,000
180,000
2003-04
2004-05
2005-06
2006-07
New allocated places
Allocated places as at December 2003

Australian Government support for the National Respite Carers Program, 1995-96 to 2003-04



Note: 1995-96 to 2002-03 (actual) and 2003-04 (estimated)

Australian Government support for residential aged care, 1995-96 to 2003-04



Note: 1995-96 to 2002-03 (actual) and 2003-04 (estimated)

Total allocated aged care places, 1995-96 to 2002-03
200,000
190,000
180,000
170,000
160,000
150,000
140,000
1995-96
1996-97
1997-98
1998-99
1999-2000
2000-01
2001-02
2002-03

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2004-2005, 2 & 3 June 2004

Question: E04-096

OUTCOME 3: Enhanced Quality of Life for Older Australians

Topic: FUNDING OF AGED CARE PLACES

Written Question on Notice

Senator Harradine asked:

The Budget provided for an extra $2.2 billion over five years to increase the number of aged care places.

(a) How much of this money will go to Tasmania in each of these five years and how many aged care places will it provide for in each of these five years?

(b) What is the current unmet demand for aged care places in Tasmania?

(c) If there is a gap between the extra funding provided and the unmet demand, what does the Government suggest aged people who are unable to find a place should do?

Answer:

(a) The following sets the allocations for Tasmania for those measures in the Australian Government's *Investing in Australia's Aged Care: More Places, Better Care* which may be estimated at this time.

More Aged Care Places

In the 2004-05 Budget the Government increased the ratio of operational aged care places from 100 to 108 per thousand of the population 70 years and over.

The proposed allocations of new aged care places for Tasmania are set out below. The out-year figures are indicative only.

Distributed of aged care places to Tasmania

	2004-05	**2005-06**	**2006-07**	**TOTAL**
Residential Care Places	210	100	95	405
Community Care Places	65	115	50	230
Value in annual recurrent funding	$8.24m	$5.41m	$4.33m	$17.98m

The number of places to be released in 2007-08 and 2008-09 has not yet been determined.

Residential Care Subsidies

Additional payments for Tasmanian aged care providers over the period to 30 June 2008 arising from the one-off capital payment, the conditional adjustment payment and the increase in the concessional resident supplement is estimated at $49.2 million.

Other initiatives from the package cannot be separated out by State and Territory at this stage.

(b) and (c)

The allocations referred to in (a) taken together with the 1,061 aged care places allocated to Tasmania since 1999 will give Tasmania an additional 1,696 places by 2007. On present indications this number of places should be sufficient to meet the planning benchmark. The number of places is reviewed annually.

In response to Professor Hogan's *Review of Pricing Arrangements in Residential Aged Care* the Government revised the provision level from 100 operational places to 108 operational aged care places for every 1,000 people aged 70 years or over. This new ratio comprises 88 residential, (40 high care and 48 low care), and 20 community aged care places. The balance between residential and community care has been 're-weighted' to double the proportion of places offered in the community, (from 10 to 20 places), enabling more older Australians to receive care in their own homes for as long as possible.

Professor Hogan's modelling indicates that this expanded provision is sufficient to meet overall demand for aged care places in the medium term.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2004-2005, 2 & 3 June 2004

Question: E04-151

OUTCOME 3: Enhanced Quality of Life for Older Australians

Topic: ASSESSMENT OF AGED CARE FACILITIES

Written Question on Notice

Senator Allison asked:

(a) What flexibility will exist in the process for assessing the occupancy rate within a residential aged care facility which will be used to determine the number of $3500 grant per resident that the facility is eligible for?

(b) What processes has the Department put into place to allow facilities that feel they have been unfairly evaluated in relation to the determination of the number of residents they will receive the grants for to be reassessed?

Answer:

(a) The payment of $3,500 for each recipient of residential aged care will be calculated on the basis of whichever is the greater of the following:
- the number of care recipients in respect of whom the approved provider of the service was eligible for residential care subsidy on 31 March 2004; or
- the daily average number of care recipients in respect of whom the approved provider of the service was eligible for residential care subsidy during the payment period ending on 30 April 2004.

During 2004-05 a comparison will be made between the average daily occupancy during April 2004 with the number of residents as at 31 March 2004, allowing final entitlements to be calculated and paid to approved providers eligible to receive residential care subsidies under the *Aged Care Act 1997*.

(b) The number of residents in respect of whom a grant will be paid will be calculated on the basis of the monthly payment claims submitted by approved providers as part of the normal subsidy payment process. This process allows providers progressively to revise the number of residents in respect of whom a claim is made as the subsidy status of individual residents is clarified over time.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2004-2005, 2 & 3 June 2004

Question: E04-152

OUTCOME 3: Enhanced Quality of Life for Older Australians

Topic: REDUCING ADMINISTRATION BURDEN ON PROVIDERS

Written Question on Notice

Senator Allison asked:

The time spent on documentation by aged care providers to validate the Resident Classification Scale (RCS) continues to be a concern for providers. Hogan recommends reducing the RCS from the current 8 levels to 3. The Budget measures indicate that this will be done. Industry is still concerned about the level of paperwork. A review of the paperwork was commenced in 2002 and the RCS Industry Liaison Group (ILG) has been involved in this review. Apparently the RCS ILG was disbanded on the 31st of May.

There have been a number of projects involved in the Review – some of which have involved reports by consultants. These projects relate to a National Framework for Documenting Care in Residential Aged Care Services, A Reduced RCS Questions and the Use of Independent Assessors.

(a) Has the Department undertaken any investigations/modelling into how reducing the RCS from 8 to 3 levels, as recommended by the Hogan Report, will reduce the administrative burden on providers?

(b) If yes, what was the outcome of these?

(c) If not, why not?

(d) What work has the Department undertaken in investigating other measures which may be needed to reduce the administration burden?

Answer:

(a) A consultant has been engaged to identify and assess structural options for the three category funding model and the two supplements announced in the 2004-05 Budget. This work will build on the outcomes of the Reduced RCS project and the trial of independent assessors. A trial planned for 2005 will test the new model, including impact on providers. The new model will be implemented in conjunction with the introduction of an e-commerce platform for the residential aged care payment system.

The Government has provided $33 million (including $14.9 million capital funding) over four years to introduce, the e-commerce platform, which will reduce paperwork for providers and increase efficiency in the information exchange between the Government and aged care service providers.

(b) The consultancy is currently underway.

(c) Not applicable.

(d) The work completed in developing the National Framework for Documenting Care in Residential Aged Care Services, the draft Reduced RCS, and the findings of the Independent Assessor trial will all inform the development of the new funding model and have relevance to the nature and extent of care documentation required for accountability purposes.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2004-2005, 2 & 3 June 2004

Question: E04-153

OUTCOME 3: Enhancing Quality of Life for Older Australians

Topic: PAPERWORK REVIEW

Written Question on Notice

Senator Allison asked:

(a) What were the costs associated with the 3 projects overseen by the Resident Classification Scale (RCS) Industry Liaison Group (ILG) as part of the Paperwork Review?

(b) What plans does the department have to follow–up on the outcomes from these projects and the consultants reports associated with them?

(c) Now that the RCS ILG has been disbanded, what structure does the Department plan to use to ensure industry input into further discussion regarding the reducing of paperwork?

(d) How will the membership in this new structure be determined?

Answer:

(a) Approximately $827,000 has been expended on the three projects overseen by the RCS ILG, as part of the Paperwork Review.

(b) A consultancy has been engaged to integrate the outcomes of Paperwork Review projects into the new funding model.

(c) A consultative group, including members of the previous RCS Industry Liaison Group, has been established.

(d) By the Minister.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2004-2005, 2 & 3 June 2004

Question: E04-221

OUTCOME 3: Enhanced Quality of Life for Older Australians

Topic: AGED CARE PLACES

Written Question on Notice

Senator Forshaw asked:

On what basis did the Government decide to:

(a) keep the high care allocation to 40 per 100 – when anecdotal evidence tells us that there is unmet need at this level?

(b) not allocate a higher number of high care packages in the community (ie: Extending Aged Care at Home Packages)?

(c) reduce the low care allocation to 38 per 100 – when anecdotal evidence tells us that there is not much unmet need at this level?

Answer:

(a)-(c)
The factors that cause people to need residential or community care are varied and complex. They include health status, the availability of informal care, personal circumstances and personal preference.

The Review's modelling indicates that over the next decade the overall level of demand for aged care services will continue to grow in line with the 70+ population and that the demand for high care residential services will remain at about the current level.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2004-2005, 2 & 3 June 2004

Question: E04-222

OUTCOME 3: Enhanced Quality of Life for Older Australians

Topic: AGED CARE PLACES – PORTFOLIO BUDGET STATEMENT (PBS) SAVING FROM DEPARTMENT OF VETERANS' AFFAIRS

Written Question on Notice

Senator Forshaw asked:

Why does the PBS (page 138) indicate that there is a cost saving of $4.6m in 2006-07 and $7.9m in 2007-08 from the Department of Veterans' Affairs in relation to more aged care places?

Answer:

The decrease in the Department of Veterans' Affairs' appropriation is the effect of the change in the balance of care within the planning ratio.

The changes in the balance of care doubled the provision ratio for community care to 20 places for every 1,000 people aged at least seventy. This is in line with the clear preference of older Australians to remain at home as long as possible. The proportion of aged care places offered as low level residential care has been adjusted to 48 places for every 1,000 people aged at least seventy.

Community care places are funded solely through the Department of Health and Ageing, while residential care places are funded through both the Department of Health and Ageing and the Department of Veterans' Affairs.

The decrease in the Department of Veterans' Affairs' appropriation reflects the small decrease in the residential care provision ratio. This decrease is more than offset by the increase in the Department of Health and Ageing's appropriation.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2004-2005, 2 & 3 June 2004

Question: E04-223

OUTCOME 3: Enhanced Quality of Life for Older Australians

Topic: AGED CARE PLACES – RESPONSE TO HOGAN REVIEW – STRUCTURAL AND REGIONAL DISTORTIONS

Written Question on Notice

Senator Forshaw asked:

The Government's response to the Hogan Review says that it will set aged care places aside to meet structural and regional distortions:

a) what is the composition of these places?

b) what are the costings for these places?

Answer:

(a) In the 2004 Aged Care Approvals Round applicants will be able to apply for places for restructuring purposes, in any Region within a State or Territory, from the 8,860 residential aged care places that have been made available in the 2004 Aged Care Approvals Round.

(b) It is not possible to cost the value of restructuring allocations until the outcome of the 2004 Aged Care Approvals Round is known.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2004-2005, 2 & 3 June 2004

Question: E04-224

OUTCOME 3: Enhanced Quality of Life for Older Australians

Topic: AGED CARE PLACES - EXPENSES FOR SPECIAL APPROPRIATIONS OF OUTCOME 3

Written Question on Notice

Senator Forshaw asked:

What is the breakdown of the Estimated Expenses for Special Appropriations for Outcome 3 as outlined in the Portfolio Budget Statement 1.11, page 45? Specifically:

(a) How many places are to be provided by the $4.3b for residential aged care subsidies? Please provide a detailed breakdown of the various places and costs.

(b) How many places are to be provided under the $1427m (sic) for flexible care subsidies? Please provide a detailed breakdown.

(c) How many places are to be provided under the $327m for community care subsidies? Please provide a detailed breakdown.

Answer:

(a) Residential care subsidies – estimates (does not include 24,091 places funded by Department of Veterans' Affairs)

	Places	$m
RCS* high	84,774	3,151.5
RCS low	49,281	459.3
Respite	2,457	33.2
Supplements		681.2
Total	136,512	4,325.2

* Residential Classification Scale (RCS)

(b) Flexible care estimates

	Places	Estimates - $m
	4,595	142.7

(c) Community Care (CACP) estimates

	Places	Estimates - $m
CACP	30,548	327.4

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2004-2005, 2 & 3 June 2004

Question: E04-225

OUTCOME 3: Enhanced Quality of Life for Older Australians

Topic: AGED CARE BUDGET MEASURE - AGED CARE ASSESSMENT TEAMS (ACATs)

Written Question on Notice

Senator Forshaw asked:

(a) What were the criteria in determining the Government's allocation of $47.9 million to ACATs over 4 years? What is the breakdown?

(b) How many more ACAT assessments will this funding provide?

(c) Will waiting times for assessments be reduced? If so, by how much?

Answer:

(a) $21.7 million will be allocated directly to ACATs. This includes $14.3 million for more timely assessments and better case management by Teams and $7.4 million to strengthen the role of ACATs to provide greater support to older people. The remainder is for the implementation of common arrangements as set out in The Way Forward.

(b) The funding has been provided primarily for more timely assessments and better case management by ACATs.

(c) The additional funding will assist in some reduction in waiting times.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2004-2005, 2 & 3 June 2004

Question: E04-226

OUTCOME 3: Enhanced Quality of Life for Older Australians

Topic: AGED CARE BUDGET MEASURES - AGED CARE ASSESSMENT TEAMS (ACAT)

Written Question on Notice

Senator Forshaw asked:

The Government has agreed to the Hogan Review recommendation to remove the need for an ACAT assessment when a resident moves from low to high level care.

(a) How many assessments on average would no longer be required?

(b) Will this result in a cost-saving? If so, how much?

(c) Why does this measure include $200,000 in capital funding? What will this include?

Answer:

(a) The most recent data available (2001-02), indicates that around 20,000 assessments were undertaken by ACATs for residents in low level residential care. However, some of these were for people moving from one facility to another for whom assessment is still required.

(b) In 2004-05, $51.7 million has been allocated for ACATs. This is a 23.7 % increase since 2002-03 and includes the funds allocated under the new Budget measures. It also takes account of any cost savings resulting from low to high level assessments no longer being required. The additional funding was provided in recognition of the growing numbers of older people, to enhance the timeliness and quality of assessments and for the increased support role ACATs are providing to older people and their families.

(c) The $200,000 in capital is for the development of information technology to support electronic transfer of information between providers and funding bodies.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2004-2005, 2 & 3 June 2004

Question: E04-231

OUTCOME 3: Enhanced Quality of Life for Older Australians

Topic: AGED CARE BUDGET MEASURE - QUALITY COMMUNITY CARE

Written Question on Notice

Senator Forshaw asked:

Can we have a breakdown on the Aged Care Budget measure of $13.7m to develop a Quality Assurance framework for community care services?

Answer:

The amounts to be spent over four years are:

2004-05	$3.7 million
2005-06	$3.2 million
2006-07	$3.3 million
2007-08	$3.5 million

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2004-2005, 2 & 3 June 2004

Question: E04-232

OUTCOME 3: Enhanced Quality of Life for Older Australians

Topic: AGED CARE BUDGET MEASURE - QUALITY COMMUNITY CARE - QUALITY ASSURANCE FRAMEWORK

Written Question on Notice

Senator Forshaw asked:

What is the process for the development of the Quality Assurance framework?

Answer:

A quality reporting model has been developed in consultation with representatives from the aged care sector, peak consumer representative groups and peak service provider representative groups, with selected aged care providers for the Community Aged Care Package (CACP) program taking part in a trial. An external reference group will be established to ensure the above stakeholders are consulted on the implementation of quality reporting for the CACP, Extended Aged Care at Home and National Respite for Carers Programs.

Quality reporting is part of a broader accountability framework, which also includes:

- program level data collection and analysis;
- service level performance monitoring; and
- financial reporting and monitoring.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2004-2005, 2 & 3 June 2004

Question: E04-229

OUTCOME 3: Enhanced Quality of Life for Older Australians

Topic: AGED CARE BUDGET MEASURE - PRUDENTIAL ARRANGEMENTS

Written Question on Notice

Senator Forshaw asked:

What will the arrangements be in relation to the provider-funded guarantee fund as mentioned in the Government's response to the Hogan Review (page 4). In particular:

(a) Who will manage the fund?

(b) How will the Department ensure that providers are placing funds into it?

(c) How much will providers have to deposit into the fund?

Answer:

These arrangements will be developed in consultation with consumers and aged care providers.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2004-2005, 2 & 3 June 2004

Question: E04-230

OUTCOME 3: Enhanced Quality of Life for Older Australians

Topic: AGED CARE BUDGET MEASURE - FLEXIBLE SERVICES

Written Question on Notice

Senator Forshaw asked:

(a) How many Aboriginal and Torres Strait Islander Flexible Services are there?

(b) Can we have a breakdown of the $10.3 million funding?

(c) How much funding will they actually receive?

Answer:

(a) 29.

(b) and (c)

	2004-05 $m	**2005-06 $m**	**2006-07 $m**	**2007-08 $m**
Existing Funding	11.924	11.903	11.956	12.201
2004 Budget	1.5	2.7	2.9	3.1
TOTAL:	**13.4**	**14.6**	**14.9**	**15.3**

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2003-2004, 2 & 3 June 2004

Question: E04-227

OUTCOME 3: Enhanced Quality of Life for Older Australians

Topic: AGED CARE BUDGET MEASURE – RESIDENTIAL CLASSIFICATION SCALE (RCS) REVIEWS

Written Question on Notice

Senator Michael Forshaw asked:

(a) How many RCS Reviews, where an officer reviews the RCS levels of aged care resident/s, were conducted over the past 12 months?

(b) How many of those assessments led to an upgrade, or increase in RCS level and funding? Can this data be provided by State / Territory?

(c) How many of those assessments led to a downgrade, or decrease in RCS level and funding? Can this data be provided by State / Territory?

Answer:

(a) A total of 13,041 RCS Reviews were conducted over the 12 months ending 30 June 2004.

(b) Number of RCS Category Upgrades resulting from Reviews conducted over the 12 months ending 30 June 2004:

State/Territory	Number of Upgrades
NSW/ACT	196
VIC	84
QLD	104
SA/NT	61
WA	38
TAS	32
Total	**515**

(c) Number of RCS Category Downgrades resulting from Reviews conducted over the 12 months ending 30 June 2004:

State/Territory	Number of Downgrades
NSW/ACT	1824
VIC	1004
QLD	1045
SA/NT	486
WA	489
TAS	79
Total	**4927**

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2003 - 2004, 2 & 3 June 2004

Question: E04-228

OUTCOME 3: Enhanced Quality of Life for Older Australians

Topic: AGED CARE BUDGET MEASURE – RESIDENTIAL CLASSIFICATION SCALE (RCS) REVIEWS

Written Question on Notice

Senator Forshaw asked:

(a) Can the Department expand on the statement in the Portfolio Budget Statement 1.11, page 139 about strengthening the arrangements for classification reviews?

(b) What will this involve?

(c) What will be the total cost?

(d) Will it involve more RCS reviews?

(e) If so how many?

(f) What are the costs?

(g) Will it involve employing more Departmental officers?

(h) If so how many?

(i) What are the costs?

Answer:

(a) Additional resources will be utilised to identify inaccurate resident appraisals.

(b) An analysis of risk factors.

(c) Cannot be accurately determined at this stage.

(d) If required under the risk analysis.

(e) Cannot be accurately determined at this stage.

(f) Cannot be accurately determined at this stage.

(g) Yes.

(h) Recruitment is underway but final numbers cannot be accurately determined at this stage.

(i) Cannot be accurately determined at this stage.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2004-2005, 2 & 3 June 2004

Question: E04-233

OUTCOME 3: Enhanced Quality of Life for Older Australians

Topic: QUALITY ASSURANCE ACCREDITATION ELIGIBILITY

Written Question on Notice

Senator Forshaw asked:

Who will be eligible to undertake accreditation?

Answer:

All service providers that receive Australian Government funding for the Community Aged Care Package, Extended Aged Care at Home and National Respite for Carers Programs will be required to take part in the quality reporting initiative.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2004-2005, 2 & 3 June 2004

Question: E04-234

OUTCOME 3: Enhanced Quality of Life for Older Australians

Topic: QUALITY INVESTIGATORS

Written Question on Notice

Senator Forshaw asked:

(a) Who are the 'specialised investigators' mentioned in the Portfolio Budget Statement 1.11, page 144?

(b) Are they the same as the Accreditation Agency assessors?

Answer:

(a) The specialised investigators mentioned in the Portfolio Budget Statement 1.11 are officers of the Department of Health and Ageing who investigate potential breaches of Approved Provider responsibilities under the *Aged Care Act 1997* both in relation to the Accreditation Standards and other areas of Approved Provider responsibility outside the Accreditation Standards.

(b) The Department's compliance investigation officers are not the same as the Aged Care Standards and Accreditation Agency assessors. The 'ensuring quality care for aged care residents' measure under which the investigation officers operate, complements the activities of the Agency.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2004-2005, 2 & 3 June 2004

Question: E04-235

OUTCOME 3: Enhanced Quality of Life for Older Australians

Topic: VIABILITY SUPPLEMENT

Written Question on Notice

Senator Foreshaw asked:

Why does the Commissioner for Complaints not require any new funding?

Answer:

Funding for the Office of the Commissioner has been, and will continue to be, met from within existing Departmental funding.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2004-2005, 2 & 3 June 2004

Question: E04-236

OUTCOME 3: Enhanced Quality of Life for Older Australians

Topic: COMPLAINTS COMMISSIONER BREAKDOWN OF VIABILITY SUPPLEMENT

Written Question on Notice

Senator Forshaw asked:

What is the breakdown of the $14.8m for the Viability Supplement?

Answer:

The following table provides a breakdown of the Viability Supplement.

	04-05 $m	**05-06 $m**	**06-07 $m**	**07-08 $m**	**Total $m**
Existing Supplement	11.1	11.6	11.9	12.3	46.9
Additional Supplement	2.0	4.1	4.2	4.2	14.5
Total	**13.1**	**15.7**	**16.1**	**16.6**	**61.4**

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2004-2005, 2 & 3 June 2004

Question: E04-237

OUTCOME 3: Enhanced Quality of Life for Older Australians

Topic: TRANSITIONAL ASSISTANCE

Written Question on Notice

Senator Forshaw asked:

(a) What is meant by 'transitional assistance' in Aged Care Budget Fact Sheet No. 2?

(b) What is the estimated scope and scale of this need? That is, how many facilities are in need of this assistance, as identified by Government research?

(c) What are the criteria for awarding funding to this group of providers?

Answer:

(a) 'Transitional assistance' refers to the Conditional Adjustment Payment for which the Government has provided $877.8 million over four years from 1 July 2004. The need for and value of the conditional adjustment payment is subject to review in 2007-08. The Conditional Adjustment Payment will be made to all aged care homes that meet certain conditions (see part c).

(b) The *Review of Pricing Arrangements in Residential Aged Care* found that 'there is no category or classification where a provider is handicapped from achieving a relatively high performance' and that 'there is a strong pointer to the dominance of management themes to explain relatively weak standing (*Review of Pricing Arrangements in Residential Aged Care*, *Final Report*, page 56). Further details of the review's analysis of these matters are given in Chapter 3 and Appendix A of the Review's Report.

(c) The payment will be dependent on each provider giving its staff information and opportunities regarding workforce training, making audited financial statements publicly available each year, and taking part in a periodic work force census.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2004-2005, 2 & 3 June 2004

Question: E04-238

OUTCOME 3: Enhanced Quality of Life for Older Australians

Topic: RURAL AND REMOTE FACILITIES COMPARED TO MAJOR CENTRES

Senator Forshaw asked:

At what stage or year does the Government expect the management of rural and remote facilities to reach an equivalent standard comparable to those in capital cities or major centres?

Answer:

The Review of Pricing Arrangements in Residential Aged Care found examples of good management and poor management of residential aged care facilities in capital cities, other major centres, and in rural and remote areas.

The Government is encouraging improvement in the management of residential aged care facilities across Australia.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2004-2005, 2 & 3 June 2004

Question: E04-243

OUTCOME 3: Enhanced Quality of Life for Older Australians

Topic: GASTROENTERITIS IN AGED CARE FACILITIES

Written Question on Notice

Senator Forshaw asked:

When an infectious disease such as gastroenteritis occurs in an aged care facility, what is the standard infection control process? In particular:

(a) Is the facility quarantined? If so, what are the guidelines eg: family contact etc?

(b) Are staff levels increased to manage the extra workload?

(c) Does the Accreditation Agency or Department send officers into the facility to determine the health and safety of staff and residents?

Answer:

(a) Management of infectious diseases such as gastroenteritis is the responsibility of the relevant State or Territory Government Health Department and the Approved Provider. Decisions about quarantine, advice to relatives etc are made on a case by case basis by the relevant State or Territory Health Department.

The Australian Government Department of Health and Ageing has developed a set of guidelines titled *Infection control guidelines for the prevention of transmission of infectious diseases in the health care setting*. These guidelines can be found on the Department's website at www.icg.health.gov.au

(b) When an outbreak of an infectious disease occurs at an aged care home, the Approved Provider is required to maintain sufficient staff to continue to meet the individual care needs of residents which may involve additional staff.

(c) The Department and the Agency maintain close contact with the State or Territory Health Department during such outbreaks and either the Department or Agency (or both) will visit the home to ensure the continued care of residents, subject to any quarantine arrangements in place by the State or Territory Health Department.

One of the Expected Outcomes under the Accreditation Standards is Infection Control and this is monitored by the Agency on an ongoing basis in all aged care homes to ensure that homes have systems in place to deal with infection control.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2004-2005, 2 & 3 June 2004

Question: E04-244

OUTCOME 3: Enhanced Quality of Life for Older Australians

Topic: ANNUAL REPORT 2002-03

Written Question on Notice

Senator Forshaw asked:

Can we have a breakdown of the expenditure for the following, as outlined in the Department's Annual Report, page 126:

(a) Administered Item 1: Aged Care residential subsidies $3.7 billion Actual Expenses for 2002-03.

- Number of places.
- Residential Classification Scale (RCS) categories.
- Costs for each of the categories.
- Explanation for why there is an underspend of $45.7 million.

(b) Administered Item 1: Aged Care residential subsidies $3.8 billion Budget for 2003-04.

- Estimated number of places.
- Estimated RCS categories.
- Estimated costs for each of the categories

(c) Administered Item 2.

Answer:

(a) Administered Item 1: Aged Care residential subsidies $3.7 billion Actual Expenses for 2002-03.

- Number of operational residential care places at June 2003 – 148,547 (of which an estimated 22,300 are funded by DVA).

- RCS categories and costs – excludes expenditure by DVA and expenditure on supplements.

RCS 1	$965.8 million
RCS 2	$1,088.0 million
RCS 3	$524.2 million
RCS 4	$104.6 million
RCS 5	$192.6 million
RCS 6	$141.1 million
RCS 7	$132.1 million
RCS 8	Nil (no subsidy applies)

- Expenditure on residential care subsidies is demand driven based on operational places and the care requirements of residents. Demand was slightly higher than estimated, resulting in expenditure of $45.727 million greater than the estimate (or 1.26%)

(b) Administered Item 1: Aged Care residential subsidies $3.8 billion Budget for 2003-04.

- Number of operational residential care places at June 2004 – 153,963 (of which an estimated 23,100 are funded by DVA).

- RCS categories and costs – excludes estimated expenditure by DVA and estimated expenditure on supplements.

RCS 1	$986.0 million
RCS 2	$1,189.4 million
RCS 3	$603.3 million
RCS 4	$137.5 million
RCS 5	$176.1 million
RCS 6	$150.5 million
RCS 7	$149.9 million
RCS 8	Nil (no subsidy applies)

(c) Administered Item 2 – Community Care and Support for Carers

2002-03 – Actual spend

Special Appropriation:	
Community Aged Care Packages (CACP's)	$288.4 million
Appropriation Bill 1/3:	
Community Care Grants CACP	$1.8 million
Carers Support Strategy	$3.4 million
Day Therapy Centres	$31.0 million
HACC Planning and Development	$0.4 million
Housing and Care Linkages	$2.7 million
Safe at Home	$0.2 million
Respite for Carers	$104.1 million
Total	$143.6 million

Appropriation Bill 2/4

Home and Community Care (HACC)	$674.1 million

2003-04 Estimated spend

Special Appropriation:	
CACP's	$292.6 million
Appropriation Bill 1/3:	
Community Care Grants CACP	$2.3 million
Carers Support Strategy	$3.6 million
Day Therapy Centres	$32.0 million
HACC Planning and Development	$0.4 million
Housing and Care Linkages	$2.7 million
Safe at Home	$0.3 million
Respite for Carers	$112.4 million
Total	$153.7 million
Appropriation Bill 2/4:	
HACC	$732.4 million

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2004-2005, 2 & 3 June 2004

Question: E04-245

OUTCOME 3: Enhanced Quality of Life for Older Australians

Topic: AGED CARE FUNDING IN QUEENSLAND

Written Question on Notice

Senator Forshaw asked:

(a) How much funding (including residential aged care, Community Aged Care Packages (CACP's), Extended Aged Care at Home (EACH) and Home and Community Care (HACC)) is provided for aged care services (residential and community) in (i) North Queensland, and in (ii) South Queensland?

(b) How much funding (including residential aged care, CACPs, EACH and HACC) is provided for aged care services (residential and community) in the North and in the South of the Tropic of Capricorn?

(c) How many people are aged 65 years and over in the North and in the South of the Tropic of Capricorn?

Answer:

(a), (b) and (c)
The following table sets out Australian Government funding in 2002-03 for residential aged care, CACPs, EACH and HACC, and the population aged 65 years and over, for areas north and south of the Tropic of Capricorn in Queensland. As a result of the 2004-05 Budget, recurrent subsidies for residential aged care will increase by an additional 7 per cent by 2008 through a Conditional Adjustment Payment.

	North	South	Statewide (i)
Residential Care	$110,578,220	$ 660,100,179	-
Community Aged Care Packages	$7,383,869	$37,901,749	-
Extended Aged Care at Home	-	-	-
Home and Community Care (ii)	$33,299,326	$87,954,929	$10,120,727
Population 65 years and over (iii)	68,223	367,960	-

(i) Funding not attributable to a specific region
(ii) This is the Australian Government contribution to Home and Community Care funding—the North Queensland figure is based on the Northern, Peninsula and Central HACC regions. In Queensland, 64.64 % of HACC funding is provided by the Australian Government and the balance by the State Government, which administers the HACC program.
(iii) Based on ABS estimated resident population, 2002.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2004-2005, 2 & 3 June 2004

Question: E04-248

OUTCOME 3: Enhanced Quality of Life for Older Australians

Topic: COMMUNITY CARE REVIEW

Written Question on Notice

Senator Michael Forshaw asked:

What action has the Government taken regarding an integrated approach to community care since the National Reference Group for the Review of Community Care meeting in January 2004?

Answer:

The Way Forward was released on Monday 2 August 2004.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2004-2005, 2 & 3 June 2004

Question: E04-249

OUTCOME 3: Enhanced Quality of Life for Older Australians

Topic: MEWS AGED CARE FACILITY

Written Question on Notice

Senator Forshaw asked:

(a) Why is there no copy of the Review Audit on the Accreditation Agency website?

(b) Can a copy of the Review Audit be provided to the Committee?

Answer:

(a) The Review Audit Report for the Mews Aged Care Facility is now published on the Aged Care Standards and Accreditation Agency's (the Agency) website. The report had not been published at the time of the Budget Estimates question as the Agency does not publish Review Audits until avenues of appeal have been exhausted.

(b) The Review Audit report for The Mews Aged Care Facility is available on the Agency's website at www.accreditation.aust.com.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2004-2005, 2 & 3 June 2004

Question: E04-250

OUTCOME 3: Enhanced Quality of Life for Older Australians

Topic: MEWS AGED CARE FACILITY

Written Question on Notice

Senator Forshaw asked:

(a) What was the outcome of the Review Audit?

(b) Why were sanctions placed on the facility?

(c) Which standards did the facility fail to comply with?

(d) Did the Department lift Sanction 2? If not, why not?

Answer:

(c) The Review Audit report will be published on the Aged Care Standards and Accreditation Agency's website, when all avenues of appeal are completed. The final outcome is still under review.

(b) On 8 April 2004, the Aged Care Standards and Accreditation Agency conducted a support contact visit at The Mews Aged Care Facility and found that there was a serious risk to the health, safety and well-being of residents at the home.

The Department found that this non-compliance posed an immediate and severe risk to residents, and therefore imposed sanctions.

(c) The non-compliant outcomes that were the subject of the Notice of Decision to Impose Sanctions issued to the Approved Provider by the Department on 9 April 2004 were Expected Outcomes 2.5 Specialised Nursing Care Needs and 3.6 Privacy and Dignity under the Accreditation Standards.

(d) Yes.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2004-2005, 2 & 3 June 2004

Question: E04-251

OUTCOME 3: Enhanced Quality of Life for Older Australians

Topic: FIRE SAFETY

Written Question on Notice

Senator Forshaw asked:

(a) Did the Minister receive a letter from NSW Deputy State Coroner Carl Milovanovich regarding inadequate fire safety measures in nursing homes? If so, can a copy the letter be provided?

(b) Did the Minister reply? If not why not? If so, can a copy of the letter be provided?

Answer:

(a) Yes, copy of the letter provided at Attachment A.

(b) Yes, copy of the letter provided at Attachment B.

Attachment A

WESTMEAD CORONER'S COURT

NSW ATTORNEY GENERAL'S DEPARTMENT

Institute Rd, Westmead NSW 2145
Box 106, Westmead NSW 2145

Tel: (02) 9633 8000 - Fax: (02) 9633 8080

Office Hours: 9.30am - 1.00pm and 2.00pm - 4.00pm

The Honourable Tony Abbott MP
Minister for Health & Ageing
GPO Box 9848
CANBERRA ACT 2601

Our ref: 109/2003

Dear Mr. Abbott,

Inquest touching the death of Essie Lewis

An Inquest into the death of Essie Lewis was finalized at this Court on the 8th January, 2004 before Mr. Carl Milovanovich, Deputy State Coroner. Mrs. Lewis died from smoke inhalation following a fire in an aged care facility at Carramar on 29th January, 2003.

At the conclusion of the Inquest, the Coroner made the following recommendation under the provisions of Section 22A of the Coroner's Act, 1980:

I recommend to the (NSW) Minister for Local Government that:

1) ***Any aged care facility should be required, as a mandatory condition, to notify its Local Council, of any proposed changes in building appliances, fire fighting equipment, etc, that would have the effect, or may have the effect, of changing its current classification***

The Deputy State Coroner also directed that a copy of the brief of evidence and the transcript of the Inquest be forwarded for your information as there were issues raised in this case which are relevant to your portfolio as Minister for Health and Ageing. A copy of the transcript is enclosed herewith. A copy of the brief of evidence was forwarded to Quality Outcomes Branch of your Department on 22nd January, 2004.

Please contact me if you require any further information about this matter or if I can be of assistance in any other way.

Yours faithfully,

(Noel Drew)
Acting Executive Officer to the
Deputy State Coroner
WESTMEAD
12th March, 2004

Attachment B

The Hon Julie Bishop MP
Minister for Ageing

Mr Noel Drew
Acting Executive Officer to the Deputy State Coroner
NSW Coroner's Court
Box 106
WESTMEAD NSW 2145

Dear Mr Drew

I wish to acknowledge receipt of the transcript of evidence into the death of Mrs Essie Lewis and the inquiry into the fire at Heiden Park Lodge located at 16 Matthews Street, Carramar.

I note in the report that the recommendations made as a result of the fire are that:

- aged care facilities should be required, as a mandatory condition, to notify its local government body, that is its council, of any proposed changes in building appliances, fire fighting equipment, etc that would have the effect or may have the effect of changing its classification in order to get such approval.
- that the appropriate body responsible for fire safety compliance must be seen as the local government, who approve and classify buildings for occupation.

The Australian Government does not have a responsibility for the monitoring of fire safety however it is committed to ensuring that the safety and wellbeing of the elderly in residential aged care homes remains a priority. To this end, the Australian Government recently introduced a Fire Safety Declaration process aimed at ensuring that all residential aged care services comply with relevant State and local government fire safety legislation.

In addition the Australian Government will provide in excess of $513 million, equating to approximately $3,500 per aged care resident, to aged care providers in 2003-04. These funds are in recognition of the forward plan for improved safety and building standards for aged care homes required for 2008 certification, and in particular for improved fire safety. Approved providers will be expected to use these funds to ensure compliance with the ten-year forward plan for certification and account for how these funds are used through the fire safety declaration process.

I thank you for bringing this matter to my attention.

Yours sincerely

Julie Bishop

JULIE BISHOP

27 MAY 2004

Parliament House Canberra ACT 2600 • Telephone (02) 6277 7280 Facsimile (02) 6273 4138

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2004-2005, 2 & 3 June 2004

Question: E04-252

OUTCOME 3: Enhanced Quality of Life for Older Australians

Topic: FIRE SAFETY

Senator Forshaw asked:

What action has the Government taken to improve fire safety measures in aged care facilities?

Answer:

The Australian Government is committed to continuous improvement in the quality and safety of residential aged care homes.

This is achieved through the Certification Program and the Fire Safety Declaration Process which have been augmented through a one off capital payment of $513.3 million (or $3,500 per resident) under the Aged Care: Investing in Australia's Aged Care, More Places, Better Care Package.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2004-2005, 2 & 3 June 2004

Question: E04-275

OUTCOME 3: Enhanced Quality of Life for Older Australians

Topic: FIRE SAFETY STANDARDS

Hansard Page: CA 82-2.6

Senator Forshaw asked:

> …..funding of improved standards for accreditation. This is at page 136 of the PBS. It stated in the PBS that it is a one-off grant of $513.3 million in 2003-04 that is, in the current year. It is based upon an amount to be given to providers of $3,500 per aged care resident and is in recognition of the forward plan for improved safety and building standards and, in particular, the improved fire safety requirements.
>
> Do you know how many are working towards achieving the benchmark?
>
> Chair:
> I would be interested, if you are taking that on notice, to see how that compares with the Gregory report, where it was indicated that a large percentage of homes did not meet required fire safety standards.

Answer:

> The most recent measure of fire safety compliance derives from the Department's annual Fire Safety Declaration process. Approved providers were asked to declare for the period of 1 January 2003 to 31 December 2003 whether the residential aged care service had been compliant with all State, Territory and Local Government legislation relating to fire safety.
>
> A total of 2,949 residential aged care services were sent declarations with all services submitting returns. A total of 379 (12.8%) declarations indicated possible non-compliance with State, Territory and Local Government fire safety requirements.
>
> All non-compliant declarations have been referred to the relevant local Council (with the exception of the ACT, which have been forwarded to the ACT Fire Brigade) for their information and possible follow-up action. In addition, a copy of each of the non-compliant declarations has been provided to the Aged Care Standards and Accreditation Agency
>
> The introduction of the 1999 Certification Assessment Instrument placed a greater emphasis on residential aged care services achieving a higher standard of fire safety requirements. Issues such as those raised in the Gregory report are addressed within the Instrument and in accordance with the requirements of the Building Code of Australia.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2004-2005, 2 & 3 June 2004

Question: E04-276

OUTCOME 3: Enhanced Quality of Life for Older Australians

Topic: PAYMENT BY STUDENTS OF INDEXATION COMPONENT UNDER HIGHER EDUCATION LOANS PROGRAMME (HELP)

Hansard Page: CA 95-2.6

Senator Forshaw asked:

The last sentence of the last paragraph on page 137 of the Portfolio Budget Statement reads:

Payment by students of the indexation component under HELP is treated as interest revenue and impacts on the fiscal balance from 2005-06.

I am tempted to ask the minister with his expertise to explain it. I give in. Can you explain to me what that means?

Answer:

Responsibility for this matter resides with the Department of Education Science and Training.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2004-2005, 2 & 3 June 2004

Question: E04-279

OUTCOME 3: Enhanced Quality of Life for Older Australians

Topic: RECOMMENDATION 15 BREAKDOWN OF $33 MILLION

Hansard Page: CA 114-2.6

Senator Forshaw asked:

The difficulty here is in trying to relate the responses of the government, which refer to the amount in the official response, to what has been identified in the PBS. Can you give me a breakdown of the $33 million? What components will it be spent on?

Answer:

$33 million will be allocated over four years to develop and implement a new payments system designed to support the new funding model for aged care and to provide end to end e-Business services for the aged care sector.

	2004-05 $m	**2005-06** $m	**2006-07** $m	**2007-08** $m	**Total** $m
Total	**$7.1**	**$7.6**	**$13.2**	**$5.1**	**$33**
(including capital of)	$5.6	$4.7	$4.6	$0	$14.9

In 2004-05 the Department will:

- Implement core priority changes to the existing payment systems in line with the other payments related Budget measures scheduled for implementation in July 2004 and January 2005.
- Deliver the first stage of the new payment system, an e-Business capability designed to enable industry to make claims for payment electronically. Pilots are expected to commence late 2004 - early 2005 with a wider industry release to follow.
- Develop requirements for the new payment system to support new funding model.

In 2005-06 and 2006-07 the Department will develop and deliver the new e-enabled aged care payments system to support the new funding model for aged care.

The appropriation in 2007-08 relates to depreciation and ongoing system maintenance and support.

Question: E04-272

OUTCOME 3: Enhanced Quality of Life for Older Australians

Topic: HOGAN REVIEW - COSTS

Hansard Page: CA 79-2.6

Senator Forshaw asked:

I would like a detailed list of the amounts for each of those items – in other words, a summary of the amounts within $7.2 million that was spent on each of those elements and any other elements that you have not mentioned there, with the dollar amount for each one.

Answer:

Item		Amount
Emolument for Professor Hogan	$	127,833.40
Salaries of Taskforce (including overheads)	$	2,335,951.04
Consultancies	$	3,658,791.00
Consultations (including travel)	$	601,371.49
Printing and mailing	$	312,372.79
Other expenses	$	34,153.72
TOTAL	$	7,070,473.44

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2004-2005, 2 & 3 June 2004

Question: E04-273

OUTCOME 3: Enhanced Quality of Life for Older Australians

Topic: REMUNERATION FOR PROFESSOR HOGAN

Hansard Page: CA 80-2.6

Senator Forshaw:

Can you tell me how much the modest remuneration was for Professor Hogan?

Answer:

Professor Hogan was paid in line with the rates determined by the Remuneration Tribunal for part-time holders of public office in respect of whom a fee had not otherwise been specified by the Tribunal (Determination 2004/12 and its predecessors).

For this purpose Professor Hogan was classified as the Chair of a Category 3 Committee.

Professor Hogan was remunerated $127,833.40 for his work on the Review.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2004-2005, 2 & 3 June 2004

Question: E04-347

OUTCOME 3: Enhanced Quality of Life for Older Australians

Topic: HOGAN REVIEW - WORKING DOCUMENTS

Hansard Page: CA 80-2.6

Senator Forshaw asked:

Could the Committee be provided with copies of those other documents that you have referred to?

Mr Mersiades – We can provide copies of the short version ones that I mentioned dating from 29 January onwards. The November one, which I described as a collection of essays, is very much a deliberative document and does not represent the considered thoughts of the review. It was a point in time; it was not a milestone document in terms of being a draft. It more or less reflected the views of the staff drafting specific sections of the report, so it would be misleading to see that as any indication of the professor's thoughts.

Answer:

Reports provided.

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

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2004-2005, 2 & 3 June 2004

Question: E04-274

OUTCOME 3: Enhanced Quality of Life for Older Australians

Topic: FINAL REPORT – AMEND RECOMMENDATIONS

Hansard Page: CA 81-2.6

Senator Forshaw asked:

Is the Minister able to answer that in any more detail as to whether or not there was any request from the government to Professor Hogan to amend any of the recommendations in his report?

Answer:

The Department of Health and Ageing is unable to answer this question.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2004-2005, 2 & 3 June 2004

Question: E04-247

OUTCOME 3: Enhanced Quality of Life for Older Australians

Topic: HOGAN REVIEW - PRELIMINARY REVIEW

Written Question on Notice

Senator Forshaw asked:

Will the Government provide a copy of the Hogan Review document entitled 'Preliminary Views' dated 27 November 2003 in File No 2003/075991? If not why not?

Answer:

No.

The document does not purport to be Professor Hogan's considered views at the time he submitted the document and release of the document would be misleading as to Professor Hogan's considered views.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2004-2005, 2 & 3 June 2004

Question: E04-149

OUTCOME 3: Enhanced Quality of Life for Older Australians

Topic: IMPLEMENTATION OF RECOMMENDATIONS ARISING FROM HOGAN'S REPORT

Written Question on Notice

Senator Allison asked:

(a) In relation to the implementation of the recommendations arising from the Hogan Report, could the Department indicate what Framework or structures are proposed to enable appropriate consultation with industry representatives and consumer organisations?

(b) When will this framework/structure be put in place?

Answer:

The timing and form of the consultation arrangements are under consideration.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2004-2005, 2 & 3 June 2004

Question: E04-150

OUTCOME 3: Enhanced Quality of Life for Older Australians

Topic: IMPLEMENTATION OF RECOMMENDATIONS ARISING FROM HOGAN'S REPORT

Written Question on Notice

Senator Allison asked:

(a) What work has the Department undertaken in exploring the introduction of a star rating system for accommodation services as recommended in the Hogan Report?

(b) What will be the criteria used to determine star ratings?

(c) Who will undertake the ratings?

Answer:

(a) None.

(b) To be determined.

(c) To be determined.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2004-2005, 2 & 3 June 2004

Question: E04-277

OUTCOME 3: Enhanced Quality of Life for Older Australians

Topic: AGED CARE WORKFORCE BUDGET MEASURES

Hansard Page: CA 96-2.6

Senator Forshaw asked:

In relation to the following information provided: "For the WELL program, the English Literacy and program, there will be $5.383 million over the four years. For the undergraduate nursing places, it will be $32.847 million over four years; for the medication certification for enrolled nurses, $7.458 million over the four years; and the larger training initiative for care workers, $55.673 million over four years."

(a) Can you give me that on a year-by-year basis?

(b) Just on training, can you give us the breakdown of that figure in costs in respect of certificate III and certificate IV.

> **Ms Bailey**—We can give you some indicative costs, but they tend not to be a regulated cost. Different training providers charge different prices, and quantum impacts on the price. We can give you a generalised indicative cost.

Answer:

(a)
Care Worker Training - $55.7 million over four years

2004-05	2005-06	2006-07	2007-08
$7.9m	$15.6m	$15.9m	$16.3m

Enrolled Nurse Medication Management - $7.4 million over four years

2004-05	2005-06	2006-07	2007-08
$1m	$2.1m	$2.2m	$2.1m

The allocation of funding for the Workplace English Language and Literacy (WELL) program and the additional aged care undergraduate nursing places will be determined by the Department of Education, Science and Training in accordance with their own budget allocations.

(b)
The amount of funding that will be utilised to assist in the training of Certificate III and Certificate IV will be dependant upon the range and focus of submissions for the training projects.

Indicative costs of Certificate III and Certificate IV are in the range of $1,500 to $5,000 per place depending on the Registered Training Organisation and the location of the training delivery. Training delivery in rural and remote regions is generally more expensive than in metropolitan areas.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2004-2005, 2 & 3 June 2004

Question: E04-278

OUTCOME 3: Enhanced Quality of Life for Older Australians

Topic: CONCESSIONAL RESIDENT SUPPLEMENT

Hansard Page: CA 98-2.6

Senator Forshaw asked:

I do not think Professor Hogan looked at it in isolation either. He recommended that it be increased to $19 and indexed annually. He did not say 'in so many years time'. He said, 'Increase it to $19 and index it annually'. That was his recommendation at this point of time, and the Government has proposed an increase to $16.25.

(See Ms Halton answer CA99-2.6)
He recommended that amount, my understanding is, in the context of an overall requirement for capital in the sector. My understanding is that the minister has said very clearly that she did not believe it was necessary to increase it to that amount, given the aggregate of funding going into the sector from combination of measures.

Where is that on record? There is nothing on the record that I am aware of that says that the Government would not further increase the rate to what Professor Hogan recommended.

Answer:

In her booklet *Investing in Australia's Aged Care: More Places, Better Care* released on Budget night, the Minister for Ageing wrote (page 18):

> The *Review* estimated the capital requirement of the aged care sector at $9.2 billion over the next ten years. After updating this figure for the increased emphasis on community care, the Government estimates that the sector will require $10.3 billion to service this capital requirement and their existing debt levels over that period.
>
> Without additional assistance, public and private capital contributions (concessional resident supplement, accommodation bonds and charges) would have amounted to $9.1 billion, which would have left a shortfall of $1.3 billion over the next ten years or about $130 million per annum.
>
> This package will ensure that the shortfall is met entirely, with the vast proportion – nearly $1 billion – coming from the Government.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2004-2005, 2 & 3 June 2004

Question: E04-186

OUTCOME 3: Enhanced Quality of Life for Older Australians

Topic: AGENCY STAFFING LEVELS

Hansard Page: CA 114 – 2.6

Senator Forshaw asked:

Can you tell me what has happened with staffing levels in the Agency over the course of the last 12 months and what is going to happen in the next 12 months?

Answer:

The staff levels in the period 2003–04 were a combination of baseline staff of 150 plus staff employed on a term defined basis for the peak accreditation period, plus staff employed as external contractors during the peak accreditation period.

Baseline staff during 2004–05 will be 160. External contractors sufficient to meet the highs and lows of the accreditation workload will supplement them.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2003-2004, 2 & 3 June 2004

Question: E04-056

OUTCOME 3: Enhanced Quality of Life for Older Australians

Topic: RESPITE

Written Question on Notice

Senator Collins asked:

Australia wide, how many respite places are there?

(a) What is the level of Commonwealth Government funding to those respite beds in 2003-04.

(b) What is the level of funding allocated in the 2004-05 Budget?

Answer:

Current data indicates there were 1,442,091 respite bed days available nationally, as at 30 April 2004.

(a) Subsidies paid for respite bed days as at early June 2004 were about $76 million.

(b) Residential respite bed days are paid under special appropriation. There is no fixed allocation.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2004-2005, 2 & 3 June 2004

Question: E04-057

OUTCOME 3: Enhanced Quality of Life for Older Australians

Topic: RESPITE

Written Question on Notice

Senator Collins asked:

What level of funds have been provided by the Commonwealth Government to the:

(a) carer resource centres; and

(b) carer respite centres

during 2003-04, and what level has been budgeted for those centres in 2004-05.

Answer:

(a) Commonwealth Carer Resource Centres received Australian Government National Respite for Carers Program funding of $1.6 million in 2003-04.

(b) Commonwealth Carer Respite Centres received Australian Government National Respite for Carers Program funding of $43 million in 2003-04. They also received $3 million from the Australian Government National Palliative Care Program in 2003-04.

The commitment by the Australian Government to Commonwealth Carer Respite and Resource Centres in 2004-05 will be similar to that in 2003-04.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2004-2005, 2 & 3 June 2004

Question: E04-065

OUTCOME 3: Enhanced Quality of Life for Older Australians

Topic: RESPITE

Written Question on Notice

Senator Collins asked:

What kind of training and education initiatives are being provided in the carer resource centres?

(a) What has been the take up of these programs?

(b) In the 2003-04 year, what was the cost of these programs?

(c) What level of specific funding has been provided for these initiatives in 2004-05?

Answer:

Individual Commonwealth Carer Resource Centres determine the education and training activities they undertake.

(a) In the nine months from July 2003 to March 2004, approximately 5,000 carers participated in education and training activities.

(b) The centres are responsible for allocating and using their funding to support the full range of activities.

(c) The commitment by the Australian Government to Commonwealth Carer Respite and Resource Centres in 2004-05 will be similar to that in 2003-04.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2004-2005, 2 & 3 June 2004

Question: E04-240

OUTCOME 3: Enhanced Quality of Life for Older Australians

Topic: FUNDING FOR PROVISIONAL ALLOCATIONS

Written Question on Notice

Senator Forshaw asked:

The aged care planning ratio has been, until the recent announcement in the Budget, 100 places per 1,000 people aged 70 years+. Is this ratio outlined anywhere in the *Aged Care Act or Principles?*

Answer:

The aged care planing ratio is not outlined in the *Aged Care Act 1997* or *Principles under the Aged Care Act 1997.*

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2004-2005, 2 & 3 June 2004

Question: E04-241

OUTCOME 3: Enhanced Quality of Life for Older Australians

Topic: FUNDING OF PROVISIONAL ALLOCATIONS

Written Question on Notice

Senator Forshaw asked:

(a) If the Government decides to increase the ratio of aged places, is the funding subject to the Government's Annual Budget process?

(b) Is funding put aside when places are announced or when places are allocated?

(c) Where are the funds for allocated places held, and what happens to them if a facility doesn't build for several years.

Answer:

(a) Funding for aged care places is a special appropriation under the *Aged Care Act 1997* and is therefore not part of the annual appropriation Bills.

(b) & (c)
No. Estimates of expense under the *Aged Care Act 1997* are based on expected levels of operational places. Under the Act, a subsidy is not payable until a place becomes operational.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2004-2005, 2 & 3 June 2004

Question: E04-239

OUTCOME 3: Enhanced Quality of Life for Older Australians

Topic: AGED CARE APPROVAL ROUNDS - DECEMBER 2003 STOCKTAKE

Written Question on Notice

Senator Forshaw asked:

What are the statistics obtained in the December 2003 stocktake? Specifically:

(a) What is the ratio of allocated places (high and low residential places and Community Aged Care Package (CACP) places) by Aged Care Planning Region?

(b) What is the ratio of operational places (high and low residential places and CACP) by Aged Care Planning Region?

(c) What is the number of Extended Aged Care at Home (EACH) packages?

(d) How many places are more than 2 years old, by Aged Care Planning Region?

(e) How many allocations have been revoked in the last 12 months?

Answer:

(a) Attachment A provides allocated ratios by Aged Care Planning Region for high and low residential care places and CACPs as at 31 December 2003.

The ratios do not include the 5,889 residential places allocated through the 2003 Aged Care Approvals Round announced in February 2004. In addition the ratios do not include the 27,900 places announced in the June 2004-05 Budget.

(b) Attachment B provides operational ratios by Aged Care Planning Region for high and low residential care places and CACPs as at 31 December 2003. The ratios do not include the 27,900 places announced in the June 2004-05 Budget.

(c) There were 889 EACH packages allocated as at 31 December 2003

(d) Attachment C details provisionally allocated places more than two years old as at 31 December 2003.

The majority of delays in bringing new residential places into operation are due to issues over planning approvals or land availability and site suitability. An analysis of the reasons for the delays with provisional allocations more than two years old as at 31 December 2003 shows that 70% of provisionally allocated places have been affected by delays in gaining planning approval or land availability and site problems.

(e) Three providers had an allocation revoked in the 12 months to 31 December 2003.

Attachment A

Allocated Ratios by Aged Care Planning Region as at 31 December 2003

Aged Care Planning Region	High	Low	CACP	Total
New South Wales				
Central Coast	38.8	46.0	16.3	101.0
Central West	44.1	51.2	14.0	109.2
Far North Coast	38.5	45.9	15.5	99.9
Hunter	41.8	46.0	13.9	101.7
Illawarra	38.0	42.9	15.6	96.5
Inner West	82.7	39.5	17.3	139.5
Mid North Coast	35.5	46.9	15.2	97.6
Nepean	59.4	44.3	16.3	120.0
New England	40.7	48.8	17.8	107.3
Northern Sydney	56.9	49.1	12.4	118.4
Orana Far West	38.6	56.0	22.7	117.3
Riverina/Murray	38.2	46.8	15.7	100.7
South East Sydney	46.0	33.5	17.3	96.7
South West Sydney	49.6	39.3	15.6	104.5
Southern Highlands	37.1	50.7	14.4	102.2
Western Sydney	58.3	39.0	14.5	111.8
Victoria				
Barwon-South Western	42.1	50.8	16.9	109.8
Eastern Metro	43.1	50.1	13.7	106.9
Gippsland	40.0	49.7	15.5	105.2
Grampians	45.2	50.2	17.3	112.7
Hume	43.0	53.4	15.9	112.2
Loddon-Mallee	43.1	50.0	15.6	108.7
Northern Metro	43.3	48.8	17.2	109.3
Southern Metro	41.1	49.1	15.6	105.8
Western Metro	41.1	54.5	17.7	113.2
Queensland				
Brisbane North	53.4	49.9	13.1	116.4
Brisbane South	47.1	46.2	12.7	105.9
Cabool	38.1	48.1	11.4	97.6
Central West	58.7	45.6	71.7	176.0
Darling Downs	44.8	51.5	15.7	112.0
Far North	40.2	50.2	21.5	111.9
Fitzroy	45.7	56.7	19.6	121.9
Logan River Valley	32.7	45.4	15.4	93.5
Mackay	40.7	45.7	15.9	102.3
North West	37.7	62.6	45.8	146.1
Northern	51.0	52.6	14.6	118.3
South Coast	37.7	45.2	12.3	95.2
South West	36.4	72.2	47.7	156.3

Aged Care Planning Region	High	Low	CACP	Total
Queensland				
Sunshine Coast	36.3	48.0	12.7	97.1
West Moreton	39.3	59.4	12.3	111.1
Wide Bay	37.4	46.9	14.5	98.8
Western Australia				
Goldfields	62.3	60.5	27.1	149.8
Great Southern	41.2	55.7	17.9	114.7
Kimberley	68.9	93.2	50.7	212.8
Metropolitan East	49.6	60.6	16.7	126.9
Metropolitan North	35.6	49.2	13.8	98.6
Metropolitan South East	58.5	51.5	15.1	125.1
Metropolitan South West	36.5	47.5	13.1	97.1
Mid West	30.9	42.3	22.5	95.7
Pilbara	50.7	89.5	84.5	224.7
South West	39.1	53.0	16.8	108.9
Wheatbelt	29.7	41.4	16.4	87.6
South Australia				
Eyre Peninsula	27.7	58.3	20.7	106.7
Hills, Mallee & Southern	43.4	49.0	17.8	110.2
Metropolitan East	69.8	55.3	11.3	136.3
Metropolitan North	47.4	43.4	14.9	105.7
Metropolitan South	42.7	41.7	17.2	101.7
Metropolitan West	42.1	42.3	17.0	101.4
Mid North	19.0	59.6	19.6	98.3
Riverland	32.0	53.6	15.8	101.4
South East	31.4	58.9	15.5	105.8
Whyalla, Flinders & Far North	35.7	50.1	30.1	116.0
Yorke, Lower North & Barossa	40.1	59.1	19.2	118.3
Tasmania				
North Western	43.7	43.7	17.2	104.5
Northern	49.1	38.9	19.9	107.8
Southern	46.9	47.7	16.6	111.2
Australian Capital Territory				
Australian Capital Territory	36.2	46.8	18.7	101.7
Northern Territory				
Alice Springs	94.7	54.1	144.9	293.7
Barkly	122.3	14.4	273.4	410.1
Darwin	62.2	44.5	73.7	180.5
East Arnhem	36.5	43.8	525.5	605.8
Katherine	66.3	88.5	164.6	319.4

Note: Table include flexible care places: Extended Aged Care at Home (EACH), Multipurpose Services (MPS) and places under the National Aboriginal and Torres Strait Islander Aged Care Strategy (ATSI). Flexible care places are attributed as high care, low care and Community Aged Care Packages.

Attachment B

Operational Ratios by Aged Care Planning Region as at 31 December 2003

Aged Care Planning Region	High	Low	CACP	Places
New South Wales				
Central Coast	36.8	28.7	15.7	81.2
Central West	44.1	48.9	13.7	106.7
Far North Coast	35.2	39.5	14.8	89.5
Hunter	40.7	40.5	13.6	94.8
Illawarra	35.8	32.2	15.2	83.2
Inner West	77.0	34.1	16.8	127.9
Mid North Coast	30.6	38.5	14.6	83.7
Nepean	57.9	34.6	15.3	107.8
New England	40.7	45.3	17.1	103.1
Northern Sydney	54.5	46.1	11.8	112.3
Orana Far West	37.6	50.4	21.2	109.2
Riverina/Murray	36.6	44.2	15.2	96.0
South East Sydney	43.8	27.6	17.0	88.4
South West Sydney	47.9	31.1	15.1	94.2
Southern Highlands	31.4	40.0	13.6	85.0
Western Sydney	56.2	33.2	14.1	103.4
Victoria				
Barwon-South Western	38.6	42.9	16.	98.4
Eastern Metro	39.1	45.8	13.4	98.3
Gippsland	29.7	46.7	15.5	91.9
Grampians	41.8	48.1	16.4	106.3
Hume	35.8	47.2	15.7	98.8
Loddon-Mallee	40.7	46.3	14.8	101.8
Northern Metro	40.3	41.3	16.5	98.1
Southern Metro	37.0	43.0	15.2	95.3
Western Metro	36.3	46.2	16.6	99.0
Queensland				
Brisbane North	51.5	47.4	12.6	111.5
Brisbane South	44.9	44.3	12.2	101.4
Cabool	36.0	43.6	10.9	90.5
Central West	53.1	42.8	71.7	167.6
Darling Downs	43.6	49.6	15.7	109.0
Far North	38.7	48.9	19.4	107.0
Fitzroy	39.9	53.4	19.3	112.6
Logan River Valley	25.2	39.9	15.4	80.5
Mackay	40.7	45.7	15.2	101.7
North West	31.0	52.5	45.8	129.3
Northern	47.1	49.9	14.0	111.0
South Coast	33.1	41.7	11.8	86.6
Aged Care Planning Region	**High**	**Low**	**CACP**	**Places**

Queensland				
South West	36.4	72.2	47.7	156.3
Sunshine Coast	33.4	43.1	12.1	88.6
West Moreton	39.3	57.8	11.9	109.0
Wide Bay	35.6	44.0	14.5	94.2
Western Australia				
Goldfields	55.1	60.5	27.1	142.6
Great Southern	37.4	48.8	17.1	103.3
Kimberley	51.7	83.1	50.7	185.4
Metropolitan East	48.7	51.7	15.8	116.2
Metropolitan North	32.0	42.0	13.2	87.2
Metropolitan South East	55.5	47.0	14.1	116.6
Metropolitan South West	30.0	41.4	12.9	84.3
Mid West	30.2	41.4	22.2	93.8
Pilbara	50.7	33.8	84.5	168.9
South West	30.9	41.4	16.8	89.1
Wheatbelt	27.2	38.3	16.4	81.9
South Australia				
Eyre Peninsula	27.7	58.3	20.7	106.7
Hills, Mallee & Southern	38.9	41.7	17.8	98.3
Metropolitan East	69.3	54.7	11.3	135.2
Metropolitan North	36.5	37.6	14.4	88.5
Metropolitan South	41.5	37.6	15.5	94.5
Metropolitan West	41.7	37.3	17.0	96.0
Mid North	18.2	52.1	16.8	87.1
Riverland	30.9	51.4	15.8	98.0
South East	29.5	45.4	15.5	90.3
Whyalla, Flinders & Far North	34.4	50.1	24.8	109.3
Yorke, Lower North & Barossa	38.5	55.2	19.2	112.9
Tasmania				
North Western	43.7	41.3	17.2	102.1
Northern	48.8	35.0	19.3	103.1
Southern	46.8	39.5	15.8	102.2
Australian Capital Territory				
Australian Capital Territory	31.2	44.8	17.8	93.7
Northern Territory				
Alice Springs	94.7	54.1	144.9	293.7
Barkly	122.3	14.4	273.4	410.1
Darwin	55.1	38.3	69.1	162.4
East Arnhem	36.5	43.8	474.5	554.7
Katherine	66.3	88.5	164.6	319.4

Note: Table include flexible care places: Extended Aged Care at Home (EACH), Multipurpose Services (MPS) and places under the National Aboriginal and Torres Strait Islander Aged Care Strategy (ATSI). Flexible care places are attributed as high care, low care and Community Aged Care Packages.

Attachment C

Provisionally Allocated Places Over 2 Years Old as at 31 December 2003

Aged Care Planning Region	Places
New South Wales	
Central Coast	307
Central West	20
Far North Coast	90
Hunter	95
Illawarra	158
Inner West	134
Mid North Coast	149
Nepean	85
New England	33
Northern Sydney	15
Orana Far West	61
Riverina/Murray	58
South East Sydney	116
South West Sydney	146
Southern Highlands	230
Western Sydney	91
Victoria	
Barwon-South Western	62
Eastern Metro	201
Gippsland	20
Grampians	4
Hume	55
Loddon-Mallee	35
Northern Metro	196
Southern Metro	155
Western Metro	190
Queensland	
Brisbane North	20
Brisbane South	6
Cabool	55
Fitzroy	40
South Coast	15
Sunshine Coast	50
Wide Bay	20

State / Territory	Aged Care Planning Region	Places
Western Australia		
	Kimberley	10
	Metropolitan East	65
	Metropolitan North	90
	Metropolitan South East	53
	Metropolitan South West	83
	Pilbara	24
	South West	30
South Australia		
	Hills, Mallee & Southern	56
	Metropolitan North	35
	Metropolitan South	66
	Metropolitan West	68
	Mid North	20
	Riverland	10
	South East	48
	Yorke, Lower North & Barossa	9
Tasmania		
	Northern	15
	Southern	87
Northern Territory		
	Darwin	24

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2004-2005, 2 & 3 June 2004

Question: E04-242

OUTCOME 3: Enhanced Quality of Life for Older Australians

Topic: LICENSED AGED CARE BEDS

Written Question on Notice

Senator Forshaw asked:

(a) How many aged care beds are licensed and how many aged care beds are unlicensed?

(b) Can we have this data by Aged Care Planning Region?

Answer:

(a) The Department maintains statistics on aged care places allocated under the *Aged Care Act 1997* and places allocated under the National Aboriginal and Torres Strait Islander Aged Care Strategy. As at 31 December 2003 there were 198,498 aged care places. Statistics on unlicenced places are not kept by the Department.

(b) Attachment A lists the allocated aged care places by Aged Care Planning Region.

Attachment A

ALLOCATED PLACES AS AT 31 DECEMBER 2003		
State / Territory	Aged Care Planning Region	Total Allocated Places
NSW	Central Coast	4,073
	Central West	1,994
	Far North Coast	3,504
	Hunter	6,101
	Illawarra	3,874
	Inner West	5,681
	Mid North Coast	3,804
	Nepean	2,374
	New England	1,941
	Northern Sydney	9,882
	Orana Far West	1,695
	Riverina/Murray	2,938
	South East Sydney	7,934
	South West Sydney	5,418
	Southern Highlands	2,450
	Western Sydney	5,497
NEW SOUTH WALES TOTAL		69,160
VIC	Barwon-South Western	4,396
	Eastern Metro	10,023
	Gippsland	2,904
	Grampians	2,559
	Hume	2,934
	Loddon-Mallee	3,522
	Northern Metro	7,160
	Southern Metro	12,110
	Western Metro	5,325
VICTORIA TOTAL		50,933
QLD	Brisbane North	4,748
	Brisbane South	5,764
	Cabool	2,302
	Central West	189
	Darling Downs	2,450
	Far North	1,688
	Fitzroy	1,664
	Logan River Valley	1,259
	Mackay	825
	North West	217
	Northern	1,762
	South Coast	3,947
	South West	318
	Sunshine Coast	3,176
	West Moreton	1,342
	Wide Bay	2,298

QUEENSLAND TOTAL		33,949
WA	Goldfields	332
	Great Southern	783
	Kimberley	210
	Metropolitan East	2,990
	Metropolitan North	4,055
	Metropolitan South East	3,331
	Metropolitan South West	3,397
	Mid West	409
	Pilbara	133
	South West	1,202
	Wheatbelt	389
WESTERN AUSTRALIA TOTAL		17,231
SA	Eyre Peninsula	366
	Hills, Mallee & Southern	1,321
	Metropolitan East	4,757
	Metropolitan North	2,394
	Metropolitan South	3,875
	Metropolitan West	2,988
	Mid North	351
	Riverland	450
	South East	643
	Whyalla, Flinders & Far North	435
	Yorke, Lower North & Barossa	1,146
SOUTH AUSTRALIA TOTAL		18,726
TAS	North Western	1,135
	Northern	1,499
	Southern	2,640
TASMANIA TOTAL		5,274
ACT	Australian Capital Territory	2,071
AUSTRALIAN CAPITAL TERRITORY TOTAL		2,071
NT	Alice Springs	304
	Barkly	57
	Darwin	580
	East Arnhem	83
	Katherine	130
NORTHERN TERRITORY TOTAL		1,154
AUSTRALIAN TOTAL		198,498

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2004-2005, 2 & 3 June 2004

Question: E04-246

OUTCOME 3: Enhanced Quality of Life for Older Australians

Topic: IT PILOT

Written Question on Notice

Senator Forshaw asked:

(a) Did the Department undertake a small-scale trial this year to develop a computer system so that aged care providers can utilise electronic payments in future? If so, what did it involve, what costs were involved?

(b) Is the Department planning to undertake a pilot to further develop this information technology? If so, what are the estimated costs, what will it involve?

Answer:

(a) At aged care providers' request, the Department coordinated a trial to allow providers to use their own computer systems to generate paper-based claims for residential care subsidy. It did not involve the development of a computer system for electronic payments.

Forty-one aged care homes located in NSW, ACT and WA participated in the trial.

Departmental costs were not separately recorded as the small cost was absorbed within existing resources allocated for ongoing administration. The providers met their costs as did the software vendors who provided the software and support to the homes.

The trial confirmed the expected efficiencies for aged care homes but demonstrated the complexity of the claiming processes.

(b) The 2004-05 Budget makes provision for the development of a full e-Business capability for the sector. Information gathered in the trial will be used to inform further e-business developments.

Australian Government
Department of Health and Ageing

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

Dear Mr Humphrey

Request for Amendment to Evidence Provided at Budget Estimates Hearing, 3 June 2004: Outcome 4

I am writing to correct a statement that I made at the Budget Estimates 2004-2005 of the Senate Community Affairs Legislation Committee on 3 June 2004.

Below is an extract from the Hansard that contains the incorrect information referred to above.

"Ms L. Smith—Just confirming that number of GP registrar placements: there were 55 placements under the program in 2003. The 2004 data is not yet available. We will get that report pretty soon, I think. [3.47 p.m.]"

The figure given to the Committee was incorrect and in fact should be "54 placements under the program …".

Thank you for your time and assistance in making the appropriate changes to the Hansard.

Yours sincerely

Leonie Smith
Assistant Secretary
General Practice Programs Branch
July 2004

TABLED BY SENATOR HUMPHRIES 02.06.04

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Save Medicare

Medicare and bulk billing are in crisis but John Howard and his Government doesn't seem to care.

That's why Mark Latham and I want to hear about your experience with Medicare and bulk billing. Under Labor, Medicare worked. More than 80% of visits to the doctor cost patients nothing because the doctor bulk billed.

Under the Howard Government bulk billing rates have dropped over 12% meaning there are now 10 million fewer services each year being bulk billed by GPs. To make matters worse the amount you pay has skyrocketed by 55%.

These are damning statistics but they don't show the personal stories of people undergoing hardship because of the crisis in Medicare.

I have set up this Save Medicare page and the *Save Medicare Hotline* **(1800 006 269)** to give Australians the chance to tell the Howard Government their story about the Medicare crisis. If you have had a problem with Medicare or accessing bulk billing please use the form below to tell me your situation or phone **1800 006 269**.

Julia Gillard
Shadow Minister for Health

Medicare logo being used on ALP site.

Fields marked with an asterisk (*) need to be filled in.

Name: *

Address:

Email Address: *

Phone: *

Federal Electorate: If you don't know your Federal Electorate, visit our Electorate Search

Please tell me about your problems in using Medicare or with bulk billing

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2 June 2004

Ms Wynne Hannon
Department of Health and Aging

Dear Ms Hannon

Use of term medicare

1. I refer to your request for urgent advice in relation to the use of the terms 'medicare' and 'medicare plus'.

2. You have asked whether the use of these terms, and in a style used by the Commonwealth, in political statements by Members of Parliament or political parties could be unlawful in some way.

3. We do not think so.

Health Insurance Commission Act

4. Section 41C of the *Health Insurance Commission Act 1973* provides for offences in relation to the use of 'medicare' or a prescribed symbol. There is currently no prescription. However the name 'medicare' is given a broad definition in s.41C(5)

5. The offence in paragraph 41C(1)(a) is use in connection with 'a business, trade, profession or occupation'. In our view this is use in business or trade, or delivery of professional services or other services. It is a use which seeks to make a connection between medicare and goods or services provided. It is true that being a Member of Parliament is an occupation. But in our view use in a political statement is not a use caught by paragraph (a).

6. The offence in paragraph 41C(2)(c) is use 'by an association in connection with any activity of the association with the result of implying that the association is in any way connected with the Commonwealth or the Commission'. The use by Members of Parliament or political parties to make political statements would not fall within this offence.

Trade Marks Act

7. We understand that there may be relevant trade marks registered on behalf of the Commonwealth or a relevant agency.

8. However a trade mark is defined in s.17 of the *Trade Marks Act 1995* as a 'sign used, or intended to be used, to distinguish goods or services dealt with or provided

in the course of trade by a person from goods or services so dealt with or provided by any other person'. The principal infringement of a registered trade mark in the Act is the use as a trade mark of a sign that is substantially identical to, or deceptively similar to, the trade mark in relation to goods or services in respect of which the trade mark is registered (s.120). Use by Members of Parliament or political parties to make a political statement is not use as a trade mark, as that term is defined, nor is it use in relation to goods and services. At any rate there are a range of uses of a trade mark which are not infringements, within which use by Members of Parliament or political parties to make political statements may fall (s.122).

Copyright Act

9. We do not think that copyright could exist under the *Copyright Act 1968* in the terms 'medicare' or 'medicare plus'.

10. It is possible that there may be an argument that the word 'medicare' in the colour and design used by the Commonwealth is an artistic work for the purposes of the Copyright Act. We think this is probably not the case, but if it were so, unauthorised use of this artistic work would be a technical infringement of the Act. This would only move beyond a technical breach if the use was in fact misleading in some substantive way; this is unlikely to be the case in relation to a political statement.

Designs Act

11. The *Designs Act 2003* protects designs of products which, for the purposes of the Act, is a thing that is manufactured or hand made. This is therefore not relevant.

12. Therefore we are not aware of any Commonwealth law which would prevent a Member of Parliament or political party from using the terms medicare or medicare plus to make a political statement.

Misleading or deceptive

13. Such a use cannot be caught by s.52 of the *Trade Practices Act 1974* which provides that a corporation shall not, in trade or commerce, engage in conduct that is likely to mislead or deceive, and related provisions. The actions are not in trade or commerce. Nor could the use constitute common law wrong of deceit or passing off.

Australian Government Solicitor

Political communication

14. The High Court has held that the Constitution includes an implied freedom of political communication: *Lange v Australian Broadcasting Corporation* (1997) 189 CLR 520. Legislation will be read subject to that implied freedom. Legislation inconsistent with the freedom may be invalid. If there were any legislation which prevented the use by Members of Parliament of the terms in the context of political communication, it would need to be read in the context of this implied freedom

Yours sincerely

Robert Orr QC
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Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2004-2005, 2 & 3 June 2004

Question: E04-283

OUTCOME 4: Quality Health Care

Topic: STRENGTHENING MEDICARE – MEDIA PLACEMENT COSTS

Hansard Page: CA 11-13-2.6

Senator McLucas asked:

(a) Could you give me a separation of the $15.7 million (estimated media placement costs) in terms of television, print, radio and so on?

(b) What is the cost of the production of the booklet and the mail-out?

(c) What is the cost of the 1800 number?

Answer:

(a) Given that most paid media activity for the Strengthening Medicare Campaign was completed on 26 June 2004, we are awaiting final invoices in order to undertake a final reconciliation of total media placement costs. Once this task has been undertaken, the Department will provide these costs to the Committee.

(b) The cost of the production and mail-out to all Australian households of the *Strengthening Medicare* booklet, including creative production, printing and distribution, is $5,289,118.

(c) From the launch of the Strengthening Medicare Campaign on 23 May 2004 through to 26 June 2004, the cost of the Strengthening Medicare information line has been $184,000. This covers recruitment, salaries, training and related administrative costs. Final call costs are not yet available. Once these costs are available the Department will provide them to the Committee.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2004-2005, 2 & 3 June 2004

Question: E04-283

OUTCOME 4: Quality Health Care

Topic: STRENGTHENING MEDICARE – MEDIA PLACEMENT COSTS

Additional Information provided – Media Placement Costs (Question A)

Hansard Page: CA 11-13-2.6

Senator McLucas asked:

(d) Could you give me a separation of the $15.7 million (estimated media placement costs) in terms of television, print, radio and so on?

Answer:

(b) **Original answer provided:** Given that most paid media activity for the Strengthening Medicare Campaign was completed on 26 June 2004, we are awaiting final invoices in order to undertake a final reconciliation of total media placement costs. Once this task has been undertaken, the Department will provide these costs to the Committee.

Additional answer provided: the advertising cost breakdown is (a) television placements was $16.075 million, (b) radio placements was $68,336 and (c) newspaper placements was $825,951.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2004-2005, 2 & 3 June 2004

Question: E04-284

OUTCOME 4: Quality Health Care

Topic: STRENGTHENING MEDICARE – FOCUS GROUP REPORTS

Hansard Page: CA 16-2.6

Senator McLucas asked:

Could you provide us with the focus group reports?

Answer:

The focus group reports are part of the research conducted for the Campaign. As noted by Dr Wooding on Wednesday 2 June 2004, this information continues to be of value in developing future directions for both policy and communication about Medicare and therefore it is not considered appropriate to release this information.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2004-2005, 2 & 3 June 2004

Question: E04-285

OUTCOME 4: Quality Health Care

Topic: STRENGTHENING MEDICARE – MEDIA SPEND

Hansard Page: CA 17-2.6

Senator McLucas asked:

Could we get a breakdown of the media spend by type? I want to know the print, radio and television buys by location. Spending specifically requested for the *Torres News*, the *Weipa Bulletin*, the *Port Douglas* and *Mosman Gazette* and the *Cairns Post*.

Answer:

The Government Communications Unit of the Department of the Prime Minister and Cabinet has advised that it would not be appropriate to provide this level of detail in regard to media placement costs, as it would provide commercial information related to the Australian Government's Master Media Advertising Agency contract.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2004-2005, 2 & 3 June 2004

Question: E04-286

OUTCOME 4: Quality Health Care

Topic: STRENGTHENING MEDICARE – MEDIA SPEND

Hansard Page: CA 17-2.6

Senator McLucas asked:

Provide the cost of the research work on the development of the Campaign prior to action within the Campaign.

Answer:

Research to guide the development of campaign themes and materials was conducted by Worthington Di Marzio, at a cost of $38,830.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2004-2005, 2 & 3 June 2004

Question: E04-287

OUTCOME 4: Quality Health Care

Topic: STRENGTHENING MEDICARE – PROGRAM OF VISITS

Hansard Page: CA 18-2.6

Senator McLucas asked:

Do you have a program of the visits [related to the Medicare Campaign] already developed?
(a) How many locations are we proposing to go to?
(b) Can a list of locations be provided when finalised?
(c) How much [funding] is allocated to this part of the Campaign?

Answer:

(a)(b)&(c)

Strengthening Medicare information expos have been held in eight locations to date (Goulburn, Frankston, Broken Hill, Ballarat, Whyalla, Erina, Queanbeyan, Marion). Further locations are proposed for July 2004 but these are yet to be finalised, and are subject to the Minister's approval. A list of the program of regional expos completed, together with the associated costs, can be provided to the Committee once the program is completed.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2004-2005, 2 & 3 June 2004

Question: E04-288

OUTCOME 4: Quality Health Care

Topic: STRENGTHENING MEDICARE – EVALUATION

Hansard Page: CA 18-2.6

Senator McLucas asked:

(a) Can we have a copy of the evaluation when that occurs?

Answer:

An evaluation will be conducted on the Strengthening Medicare Campaign. A copy of the evaluation report may be made available to the Committee once it is considered to be no longer of immediate relevance to continuing policy and communication about Medicare, subject to the Minister's approval.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2004-2005, 2 & 3 June 2004

Question: E04-289

OUTCOME 4: Quality Health Care

Topic: STRENGTHENING MEDICARE – ADVERTISING AND PROMOTION FIGURES

Hansard Page: CA 20-21-2.6

Senator Humphries asked:

(a) Do we have figures for advertising and promotion of Department of Health themes and messages for previous years going back to the previous Government – from 1990 to 2004? To be provided in constant dollars, accompanied by an explanation of methodology?

Answer:

The Department is analysing advice provided by the Government Communications Unit, Department of the Prime Minister and Cabinet, which is drawn from the Central Advertising System. Using this information, and cross-checking against the Department's records, the Department will develop as comprehensive an answer as is possible for the Committee.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2004-2005, 2 & 3 June 2004

Question: E04-290

OUTCOME 4: Quality Health Care

Topic: STRENGTHENING MEDICARE – 'MEDICAREPLUS' IN BOOKLET

Hansard Page: CA 26-2.6

Senator McLucas asked:

How many times does the word 'MedicarePlus' appear in the green booklet?

Answer:

The word 'MedicarePlus' does not appear in the *Strengthening Medicare* booklet.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2004-2005, 2 & 3 June 2004

Question: E04-143

OUTCOME 4: Quality Health Care

Topic: MENTAL HEALTH

Written Question on Notice

Senator Allison asked:

(a) Could the Department indicate exactly how much money is being spent on mental health in Australia and how this is reflected as a percentage of the total health budget?

(b) How does this allocation compare to other national health priority areas that account for 25-30% of the disease burden?

(c) How does this compare to spending levels in other developed countries?

Answer:

(a) The *National Mental Health Report 2002* found that total spending on mental health services by third party funders in Australia in 1999-2000 was $2.6 billion. The Australian Government contributed $884 million (34.5%), States and Territories $1,558 million and private health insurance funds $120 million (4.7%).

The report estimated that of the 9.3% of Australia's gross domestic product spent on health care, approximately 6.6% of national total gross recurrent expenditure on health services was directed to the provision of specialised mental health services (page 17).

(b) The Australian Institute of Health and Welfare recently released *Health system expenditure on disease and injury in Australia 2000-01 (2004).* This follows the first detailed Australian study of expenditure across disease and injury groups published in 1998 using 1993-94 data. The report provides a systematic analysis of Australian health expenditure allocated by disease in 2000-01, accounting for around 86% of recurrent health expenditure or $49.2 billion in total.

The National Health Priority Areas are cardiovascular health, cancer control, injury prevention and control, mental health, musculoskeletal conditions, diabetes mellitus and asthma. Together, they account for $21.4 billion or 43.5% of allocated health system expenditure.

The report shows the allocated recurrent health expenditure on National Health Priority Areas for 2000-01 as follows:
\

Disease group	Total expenditure allocated ($ million)
All cardiovascular diseases	**5,393**
Ischaemic heart disease	1,488
Stroke	922
Other conditions	2,984
All musculoskeletal conditions	**4,725**
Arthritis	1,461
Other conditions	3,264
Injuries	**4,061**
Neoplasms	**2,764**
All mental disorders	**3,018**
Depression	1,042
Other conditions	1,976
Diabetes mellitus	**836**
Asthma	**615**
TOTAL	**21,412**

Between 1993-94 and 2000-01 the growth in inflation-adjusted expenditure allocated to disease was $13.2 billion, which represented a growth of 37%. Of the priority areas, only cardiovascular disease and mental disorders showed a below-average growth with only 26% and 32% growth respectively. The report, however, notes that the lower growth for mental disorders was due to the fact that these disease expenditure estimates do not include expenditure on community mental health services during a period when Australia was changing the focus in mental health from hospital care to community care. Growth was 43%, above-average, when this was factored in, with mental disorders expenditure increasing from 7.5% of allocated health expenditure in 1993-94 to 7.9% in 2000-01 (page 10).

(c) In 2003, the Australian Institute of Health and Welfare undertook an international comparison of data for those countries that have undertaken detailed disease costing studies for mental health expenditure. The countries included in *Australian expenditure on mental disorders in comparison with expenditure in other countries (2003)* were Canada, the Netherlands, the United States of America and Australia.

The report, which looked at 1993-94 data, states that when all health services are taken into account and a definition of mental disorders is applied that is consistent with other countries, approximately 9.6% of total health costs in Australia are directed to the care of people affected by mental health disorders (page 1). Although caution should be exercised in making comparisons due to differences in what is included in the 'mental disorders' categories, differences in health services used and differences in methods for allocating costs by disease, the summary concluded that:

> 'After adjustments to make the data as comparable as possible, we estimate that these four countries spend between 9.5 and 11.5% of their health expenditures on dementia, substance abuse disorders and other mental disorders.
> The amount spent on other mental disorders specifically, ranges from 6.2% for Australia to 6.6% for the Netherlands and 7.3% by the USA. Given the

uncertainties with these data, there is no evidence from this disease costs information that any of these four countries are under-spending or over-spending on mental disorders relative to each other.' (page vi)

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2004-2005, 2 & 3 June 2004

Question: E04-172

OUTCOME 4: Quality Health Care

Topic: GPET BOARD

Written Question on Notice

Senator McLucas asked:

The General Practice Reference Group has sought appointment of the board of General Practice Education and Training (GPET) for 1 year while consideration is given to new ownership and governance structures.

a) What arrangements are to be made with respect to the future structure and governance of GPET?

b) When will an external evaluation of the new GP vocational training arrangements take place?

Answer:

a) The Minister is currently considering nominees from a range of groups and individuals proposed for appointment to the GPET board. The length of individual appointments is also under consideration.

b) It is expected the evaluation will be completed by November 2004.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2004-2005, 2 & 3 June 2004

Question: E04-173

OUTCOME 4: Quality Health Care

Topic: 'OUT OF HOSPITAL OUT OF MIND' REPORT

Written Question on Notice

Senator McLucas asked:

When will the government respond to this report?

Answer:

The former Minister for Health, the Hon Kay Patterson wrote to the Chair of the Mental Health Council of Australia on 3 July 2003, following receipt of the Report.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2004-2005, 2 & 3 June 2004

Question: E04-174

OUTCOME 4: Quality Health Care

Topic: BETTER OUTCOMES IN MENTAL HEALTH

Written Question on Notice

Senator McLucas asked:

(a) Will the BOMH program be continued and expanded to meet the needs of GPs and patients?

(b) There are reports that with only 12 months to go and no surety of refunding, GPs are reluctant to undertake the training required under BOMH. What actions will be taken to better support this?

(c) Is there currently an evaluation of this program underway?

Answer:

(a) Continuation of the Better Outcomes in Mental Health Care Initiative, currently funded until June 2005, will be considered in the context of the 2005 Budget.

(b) Over 3500 GPs are now registered with the Health Insurance Commission for the Initiative. The number of Divisions of General Practice participating in the Initiative has increased from 33 in 2002-03 to over 105 in 2004-05. The General Practice Mental Health Standards Collaboration, the body responsible for accrediting GPs seeking registration for the Initiative, has reported that applications from GPs seeking accreditation remain constant.

(c) Yes.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2004-2005, 2 & 3 June 2004

Question: E04-297

OUTCOME 4: Quality Health Care

Topic: AGED CARE GP PANELS INITIATIVE

Hansard Page: CA 53-3.6

Senator Moore asked:

What is the evaluation process cost for the Aged Care GP Panels Initiative?

Answer:

The Initiative will be reviewed after twelve months of operation, and later evaluated as part of the standard budget process. These processes together are expected to cost approximately $200,000-$250,000, although precise costs have not yet been calculated.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2004-2005, 2 & 3 June 2004

Question: E04-268

OUTCOME 4: Quality Health Care

Topic: GENERAL PRACTICE PARTNERSHIP ADVISORY COUNCIL (GPPAC)

Hansard Page: CA 65-3.6

Senator McLucas asked:

(a) Who was on the Council?

Answer:

(a) Dr John Aloizos
Ms Margaret Brown
Dr Matthew Bryant
Dr Karda Cavanagh
Dr Bruce Chater
Dr John Davis
Dr Michael Jones
Prof Max Kamien
Dr Jill Maxwell
Mr Tony McCartney
Dr Peter McInerney
Dr Vasantha Preetham
Dr Gerald Segal
Dr Jeanette Tait
Dr Julie Thompson
Mr Tony Wade

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2004-2005, 2 & 3 June 2004

Question: E04-178

OUTCOME 4: Quality Health Care

Topic: GENERAL PRACTICE PARTNERSHIP ADVISORY COUNCIL (GPPAC)

Written Question on Notice

Senator McLucas asked:

(a) How will groups represented on GPPAC and not on the GPRG (NACCHO and consumer groups) now make their voice heard on these issues?
(b) What will happen to the work of GPPAC?

Specifically:

(c) What will happen to the work on implementing issues relating to the GP Strategy Review which recommended the establishment of the GPPAC in the first instance.
(d) What will happen to the $120,000 study on GPs working in Aboriginal health? Will this study now be published? If not, why not?
(e) Why has the GPPAC completed work on Quality Indicators and Clinical Practice Guidelines been shelved?
(f) How much did these reports cost?

Answer:

(a) NACCHO has two representatives on the National Aboriginal and Torres Strait Islander Health Council. NACCHO is also represented on a wide range of working groups and advisory committees across the Department.

NACCHO has been receiving funding to support a GP Network which facilitates exchange of information between GPs and GP registrars with Aboriginal patients.

The Department continues to fund the Consumers' Health Forum of Australia (CHF) under the Community Sector Support Program. The Department provides some additional assistance for support of approximately 200 CHF representatives on national committees and working parties.

(b) See (c)-(e) below.

(c) The GPPAC was established in 1998 to advise the then Minister for Health on implementation of recommendations contained in the General Practice Strategy Review. This work is now complete.

(d) This project was not yet complete when GPPAC was discontinued. It would be inappropriate for the Department or another consultative fora to publish work commissioned by GPPAC which was neither completed nor endorsed at the time of GPPAC's cessation.

The Department will draw upon the main findings of this research in implementing various aspects of the *Aboriginal and Torres Strait Islander Health Workforce National Strategic Framework*, as endorsed by the Australian Health Ministers' Advisory Council in May 2002.

(e) GPPAC's influence on the development and implementation of quality indicators for general practice can be seen in the Report on Government Services which includes measures very similar to those proposed by GPPAC.

Improving GP's use of clinical practice guidelines has been highlighted by the National Institute of Clinical Studies (NICS) on their work plan. NICS will continue to liaise with the Department as this work progresses.

(f) Quality Indicators - $100,000.
Clinical Practice Guidelines - $91,100.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2004-2005, 2 & 3 June 2004

Question: E04-075

OUTCOME 4: Quality Health Care

Topic: DOCTORS DELIBERATELY MISDIAGNOSING AUTISTIC DISORDERS

Written Question on Notice

Senator Harradine asked:

I refer to recent media reports about doctors admitting that they deliberately misdiagnose autistic disorders to help children get educational help or welfare that they would not otherwise be able to access.

(d) Does the fact that, for example, 58 per cent of Queensland paediatricians and child psychiatrists had deliberately exaggerated a child's symptoms to allow the child to receive educational or financial help and that more than a third had falsified Centrelink carer's allowance forms indicate that more funding and resources are needed for managing behaviourally disordered children?

(e) Is there a need for specialised teaching and assistance so that doctors don't have to go to the extreme of misdiagnosing autism when the child may not have an actual autistic disorder?

Answer:

(a) The Department is unable to address this question, as the issue of financial support for children with a disability is the responsibility of Centrelink.

(b) The provision of services for educational and disability programs are the responsibility of State and Territory Governments. It is therefore the discretion of the individual State or Territory Government as to whether additional services are required.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2004-2005, 2 & 3 June 2004

Question: E04-097

OUTCOME 4: Quality Health Care

Topic: RESPECTING PATIENTS CHOICES PROGRAM

Written Question on Notice

Senator Harradine asked:

I understand that the Department is supporting the "Respecting Patients Choices" program run at Melbourne's Austin Hospital. The program encourages patients to choose an advanced directive which would allow by neglect. The program encourages patients to complete a statement of choices, which they can do by ticking boxes. The second box states a patient refuses to be resuscitated. The first box states:

"If I reach a point where it is reasonably certain that I will not recover my ability to interact meaningfully with myself, my family, friends and environment, or I am in the terminal stage of an illness:"

"I want to stop or withhold treatments that might be used to prolong my life (such treatment may include tube feedings, intravenous fluid, respirator/ventilator, or antibiotics). I only want those treatments which provide me with comfort and dignity as part of a palliative care plan."

Many dementia patients in nursing homes would meet this description of being unable to "interact meaningfully with myself, my family, friends and environment" as would many people cared for in their own homes.

The prognosis "terminal stage of an illness" becomes a self-fulfilling prophecy if it means that the person is to be denied sustenance.

(a) Can you confirm that the Department is supporting or funding this project?

(b) What funding is provided for this program?

(c) Why is the Government funding this program?

(d) Is this or similar programs being run in other health facilities? If so, please give details of the facilities and the extent of government financial support in each case and in total.

(e) Doesn't this program put patients in danger of death by neglect?

(f) What ethical evaluation was undertaken before funding this project? Please provide a copy.

Answer:

(a) Yes.

(b) The Australian Government is providing $1,231,900 over two years (2003/04 – 2004/05) to Austin Health for the Respecting Patient Choices Program through the National Palliative Care Program.

(c) The National Palliative Care Strategy, endorsed by the Australian Health Ministers' Advisory Council in October 2000, respects the central importance of choice for people who are dying and their families – choice regarding the setting of care and the manner and type of care provided.

The Respecting Patient Choices Program aims to improve the quality and effectiveness of end of life care by providing patients with a mechanism for discussing and recording their choices about health care in an advance care plan.

Evaluation of the pilot program conducted at Austin Health in 2002 showed evidence that patients want to have discussions about their current health condition and future medical treatment options, and highlighted the benefits to patients and their families in having these discussions.

(d) No. However, the program will be implemented in several hospitals across Australia over the next 2-4 years. These sites and the funding allocation will be made publicly available once contracted.

(e) No.

It is recognised that when the time comes to make important end-of-life decisions many patients are incapable of participating in those decisions. The Respecting Patient Choices Program encourages and supports patients while they are capable to discuss and make choices about their treatment in advance, allowing their carers and health professionals to respect and act on their choices. The Program aims to alleviate concerns about end of life issues and have a positive effect on end-of-life care.

The Program does not support euthanasia.

(f) Ethics approval for the Respecting Patient Choices Program has been provided by the Human Research Ethics Committee at Austin Health. A copy of the approval is attached.

Human Research Ethics Committee

Research Support Unit
North Wing
Heidelberg Repatriation Campus

TO: **Dr William Silvester,**
Intensive Care
Austin Campus

FROM: Dr K (Humsha) Naidoo, Executive Secretary

PROJECT: Respecting Patient Choices (RPC): Investigating the Effect of Introducing a System of Advance Care Planning Regarding End-of-Life Care on Patients and their Next of Kin.

PROJECT NO: 01428

DATE: 26 November 2003

RE: Extension of Patient Choices Program to the community

Agenda Item 17.2

Dear Dr Silvester

I wish to inform you that at the meeting of the Human Research Ethics Committee held on 21 November 2003, the Secretary's provisional approval of the abovementioned correspondence was ratified by the committee.

DR K (HUMSHA) NAIDOO

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2004-2005, 2 & 3 June 2004

Question: E04-098

OUTCOME 4: Quality Health Care

Topic: CLINICAL GUIDELINES FOR TREATING HAEMOPHILIA PATIENTS WITH INHIBITORS

Written Question on Notice

Senator Harradine asked:

Has the Australian Haemophilia Centre Directors' Organisation developed national clinical guidelines for treating haemophilia patients with inhibitors (refer answer to question E03-069 June 2003). If so, has this had any impact on the policy for the provision of rFVIIa?

Answer:

No. However, the Australian Haemophilia Centre Directors' Organisation advised on 16 August 2004 that the guidelines would be completed later this year.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2004-2005, 2 & 3 June 2004

Question: E04-099

OUTCOME 4: Quality Health Care

Topic: JURISDICTIONAL BLOOD COMMITTEE

Written Question on Notice

Senator Harradine asked:

Following the release in May 2003 of the report of the working party regarding factor VIII and IX, a specially appointed Jurisdictional Blood Committee was established. What has been the work of this committee since its establishment? Is the Committee examining the possibility that policy guidelines restricting the use of recombinant products to a select few are discriminatory? Has the Committee made any progress towards allowing all haemophilia patients free access to recombinant factor?

Answer:

The Jurisdictional Blood Committee's role is set out in the National Blood Agreement. In brief it is to provide advice to Health Ministers and develop issues for consideration by Ministers across a broad range of blood issues. The Committee has provided a range of advice to Ministers and considered a number of issues relevant to the national blood sector.

No, the Committee is not examining the possibility that policy guidelines restricting the use of recombinant products to a select few are discriminatory.

The decision to permit access to recombinant clotting factors as a treatment of choice, where clinically appropriate, is one for Health Ministers.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2004-2005, 2 & 3 June 2004

Question: E04-100

OUTCOME 4: Quality Health Care

Topic: IMPLEMENTATION DATE FOR RECOMMENDATIONS OF AUSTRALIAN HEALTH MINISTERS ADVISORY COUNCIL (AHMAC)

Written Question on Notice

Senator Harradine asked:

The implementation date for the recommendations of the AHMAC was to have been January 1, 2004. What is the reason for the delay? Has a new implementation date been set?

Answer:

No date has been set for implementation of these recommendations.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2004-2005, 2 & 3 June 2004

Question: E04-179

OUTCOME 4: Quality Health Care

Topic: SHORTAGE OF INTRAGRAM P

Written Question on Notice

Senator McLucas asked:

(a) What actions has the National Blood Authority (NBA) taken to address the Intragram P shortage?

(b) How much longer is this shortage likely to continue?

(c) If additional plasma needs to be collected, who will pay for this?

(d) Was the NBA advised that there was the likelihood of a shortage of Intragram P? If yes, when was this advice received?

(e) What consultation did the NBA have with the Red Cross and the CSL Group (CSL) on this issue?

(f) Did the Red Cross and/or CSL advise the NBA of means to address this shortage?

(g) What guidelines have been put in place for use of this product so that no further shortages will occur?

Answer:

(a) The National Blood Authority (NBA) has weekly meetings with CSL and the Australian Red Cross Blood Service (ARCBS) to closely monitor usage and scheduled production of Intragam P. The NBA has also recommended increased plasma collections for 2004-05 to produce more Intragam P and has sourced an interim supply of an imported equivalent product.

(b) The increased plasma collections in 2004-05 will increase the amount of Intragam P available for use, but the growth in demand continues to be very rapid so some supply shortage is expected to continue.

(c) Governments pay for plasma collection through the National Blood Agreement.

(d) The NBA has received ongoing advice over the past 12 months regarding the pressure on supplies from increasing demand for Intragam P.

(e) The NBA has been in constant and regular contact with both CSL and the ARCBS on supplies of Intragam P.

(f) Yes.

(g) Intragam P is distributed through the ARCBS for clinical indications agreed by Australian Health Ministers' Advisory Council.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2004-2005, 2 & 3 June 2004

Question: E04-270

OUTCOME 4: Quality Health Care

Topic: DATA ON RURAL AND REMOTE AREAS

Hansard Page: CA 59-3.6

Senator McLucas asked:

(a) Is it possible to provide the numbers of doctors (both GPs and specialists) who were in rural and remote areas (RRMA 3-7) for 2000-01 and the following years?

Answer:

(a) A table showing the number of doctors follows:

Doctors in rural and remote areas (RRMA 3-7), 2000-01 to 2002-03

	Headcount	FTE	FWE
Specialists			
2000-01	2,562	1,305	1,606
2001-02	2,648	1,353	1,674
2002-03	2,736	1,388	1,728
General Practitioners			
2000-01	6,363	3,417	3,825
2001-02	6,588	3,555	4,005
2002-03	6,739	3,650	4,101

Notes:

Headcount

A count of all doctors who have provided at least one Medicare Service during the reference period. It should be borne in mind that the composition of the medical workforce accessing Medicare is complex. There are several thousand medical practitioners who each year provide only small numbers of services attracting Medicare benefits.

FTE (Full-Time Equivalent)

FTE is an alternative measure to head counts as it measures the number of doctors working full-time and the partial contribution of part-time doctors.

FTE is calculated by dividing each doctor's Medicare billing by the average billing of full-time doctors for the reference period. Where the doctor's Medicare billing is greater than or equal to the mean billing of full-time doctors, then the FTE is capped at one.

FWE (Full-Time Workload Equivalent)
FWE is a measure of service provision because it takes into account doctor's varying workloads. It is generally considered to provide a good overall indicator of medical workforce supply.

FWE is calculated by dividing each doctor's Medicare billing by the average billing of full-time doctors for the reference period. Where the doctor's Medicare billing is greater than or equal to the mean billing of full-time doctors, then the FTE is capped at one but the FWE is not.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2004-2005, 2 & 3 June 2004

Question: E04-271

OUTCOME 4: Quality Health Care

Topic: DATA ON RURAL AND REMOTE AREAS

Hansard Page: CA 60-3.6

Senator McLucas asked:

(a) Can you identify the number of rural and remote doctors that have physically left the area for the same periods?

Answer:

(a) It is not possible to provide a meaningful count of doctors that have physically left rural and remote areas. The medical workforce is highly mobile, and doctors frequently work from multiple practices that may span both urban and rural areas. This creates difficulty in counting 'arrivals' and 'departures' of doctors.

For example, one of the counting difficulties is that trainee doctors who undertake rotations in a variety of locations produce a series of statistical 'arrivals' and 'departures' for the regions they work in. However, these 'arrivals' and 'departures' are not informative.

Given the nature of the statistics, the most meaningful way to understand doctors' movements between years is to consider the overall changes in activity, as provided in the following table.

Full-Time Workload Equivalent (FWE*) general practitioners in rural and remote regions (RRMA 3-7), 2000-01 to 2002-03

Year	FWE
2000-01	3,825
2001-02	4,005
2002-03	4,101

*FWE is calculated by dividing each doctor's Medicare billing by the average billing of full-time doctor's for the reference period. FWE is a measure of service provision because it takes into account doctor's varying workloads. It is generally considered to provide a good overall indicator of medical workforce supply.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2004-2005, 2 & 3 June 2004

Question: E04-350

OUTCOME 4: Quality Health Care

Topic: AREAS OF CONSIDERATION

Hansard Page: CA 45-2.6

Senator McLucas asked:

Once the process has been identified, will you make public the principles by which areas can change their classification. I ask on notice that, as soon as they are available, they are made available to the committee so that we can have a look at them, given that it has been an issue for this committee for a long time.

Answer:

Information regarding *Areas of Consideration* is now available on the Internet. The web address is: www.health.gov.au/internet/wcms/publishing.nsf/Content/health-medicare-health_pro-gp-index.htm.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2004-2005, 2 & 3 June 2004

Question: E04-253

OUTCOME 5: Rural Health Care

Topic: RURAL HEALTH STRATEGY

Hansard Page: CA 57-58-3.6

Senator McLucas asked:

In the Portfolio Budget Statements there is an allocation of $830.2 million over four years, could you please provide a breakdown of those funds? Is it possible to give me a list of the former programs that that money used to fund? Can I have a break-up according to the program across the out years too?

Answer:

Regional Health Strategy funding by measure ($'000) in 2003-04

New General Practitioner Registrars	40,420
Enhanced Rural Assistance to Medical Undergraduate Students Scholarships	2,085
HECS Reimbursement Scheme	3,765
Bonded Scholarships for Medical Students to Practice in Rural Areas	7,421
Medical Training – University Departments of Rural Health	14,517
Medical Training – Rural Medical Training Clinical Schools	41,003
Medical Specialist Outreach Assistance	15,941
Workforce Support for Rural General Practitioners	2,674
More Allied Health Services	15,188
Regional Health Services Expansion	27,417
Rural Chronic Disease Initiative	5,455
*Enhanced Rural and Remote Pharmacy Package	2,800
Bush Nursing, Small Community and Regional Private Hospitals	10,592
Aged Care – Adjustment Grants for Small Rural Facilities	9,766
Communications Strategy (Departmental funding)	522
Total	**199,566**

* This measure also forms part of the five-year Third Community Pharmacy Agreement, which lapses in 2004-05. Continued funding for this measure, following evaluation, will be considered in Budget 2005-06.

Rural Health Strategy funding (2004-05 to 2007-08)

The funding for the Rural Health Strategy 2004-05 to 2007-08, approved in Budget 2004-05, is $830.2 million over the four years. This represents continuing funding at the 2003-04 level (above), with indexing in the out years contributing to the overall total. The Rural Health Strategy continues funding for a flexible package of health and aged care services and workforce measures. These measures are:

New General Practitioner Registrars
Enhanced Rural Assistance to Medical Undergraduate Students Scholarships
HECS Reimbursement Scheme
Bonded Scholarships for Medical Students to Practice in Rural Areas
Medical Training - University Departments of Rural Health
Medical Training - Rural Medical Training Clinical Schools
Rural Specialist Support Program (previously Medical Specialist Outreach Assistance)
Workforce Support for Rural General Practitioners
Rural Primary Health Program (previously More Allied Health Services and Regional Health Services)
Rural Primary Health Program – Primary Health Projects (previously Rural Chronic Disease Initiative)
*Enhanced Rural and Remote Pharmacy Package
Rural Private Access Program (previously Bush Nursing, Small Community and Regional Private Hospitals)
Aged Care - Adjustment Grants for Small Rural Facilities
Communications Strategy (Departmental funding)

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2004-2005, 2 & 3 June 2004

Question: E04-073

OUTCOME 6: Hearing Services

Topic: HEARING IMPAIRMENT AS A NATIONAL HEALTH PRIORITY

Written Question on Notice

Senator Harradine asked:

In view of the fact that four million Australians have a hearing impairment or a disorder of the ear and that the Government has indicated that it supports "appropriate public awareness strategies on deafness and hearing loss", why is hearing loss and other disorders of the ear not a National Health Priority?

Answer:

The number of National Health Priority Areas is limited to ensure that effective action is taken on each. The next review of the National Health Priority Areas will occur in 2005. The Portfolio Minister has arranged for this issue to be brought to the attention of the Secretariat of the National Health Priority Action Council for consideration in the context of the next review.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2004-2005, 3-4 June 2004

Question: E04-294

OUTCOME 6: HEARING SERVICES

Topic: Hearing Services – Indigenous Hearing Health

Hansard Page: CA 117-3.6
90

Senator Crossin asked:

In relation to otitis media specifically and the recommendations of the 2002 report on Commonwealth funded hearing services to Aboriginal and Torres Strait Islander people, have the six Workforce recommendations been progressed?

Answer:

The six workforce strategies (recommendations) contained in the Report on Commonwealth Funded Hearing Services to Aboriginal and Torres Strait Islander People (2002) were incorporated into the Work Plan for Future Actions in Ear and Hearing Health (2003). The Work Plan was jointly developed by the Office for Aboriginal and Torres Strait Islander Health (OATSIH) and Office of Hearing Services following the release of the report.

In the Government's response outlined in the Work Plan, the six workforce recommendations are covered under two of the guiding policy principles (2 & 5).

Policy Principle 2: Promote skills development in the primary health care workforce in the clinical management of otitis media.

Progress under this guiding policy principle includes:

- OATSIH contracts Australian Hearing to provide hearing training to at least two health workers from each of the 111 participating Aboriginal Community Controlled Health Services, in all States and Territories (except in the Northern Territory).

- OATSIH signed an 18 month contract in February 2004 with Central Australian Aboriginal Congress for the delivery of hearing training to Aboriginal Health Workers in Central Australia. Negotiations are currently being finalised with Northern Territory Department of Health and Community Services on a similar approach to hearing training in the Top End of the Northern Territory.

- OATSIH is engaged in a regional level project to measure the uptake of the Recommendations for Clinical Care Guidelines on the Management of Otitis Media.

- OATSIH is facilitating the development of Aboriginal and Torres Strait Islander Health Worker Competencies and an Industry Training Package under the Aboriginal and Torres Strait Islander Health Workforce National Strategic Framework. Specialist streams, such as ear and hearing health, will be developed through this process and will underpin the ongoing refinement of Aboriginal and Torres Strait Islander Health Worker training in the area of hearing health.

Policy Principle 5: Enhance and harness the role Aboriginal Health Workers play in the delivery of ear health services and health promotion in Aboriginal Community Controlled Health Services.

Progress under this guiding policy principle includes:

- A national hearing health seminar was held in June 2004. The 'Berrimpa' – Connecting People, Programs and Multidisciplinary Practice for Aboriginal and Torres Strait Islander Hearing Health seminar provided the opportunity to re-energise the role of Aboriginal and Torres Strait Islander Health Workers and other practitioners in providing hearing health services.

- In February 2004, the Minister for Health and Ageing, the Hon Tony Abbott MP announced $50,000 to fund Central Australian Aboriginal Congress to develop a business case for implementation of a regional centre of excellence in ear, language development and hearing health. OATSIH is facilitating negotiations with other relevant agencies including the Australian Government Departments of Education, Science and Training, Family and Community Services and the Northern Territory Department of Health and Community Services in this work.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2004-2005, 2 & 3 June 2004

Question: E04-295

OUTCOME 6: Hearing Services

Topic: HEARING SERVICES – INDIGENOUS HEARING HEALTH

Hansard Page: CA 118-3.6

Senator Crossin asked:

What is the progress on implementing recommendations 6 & 7 of the report?

Answer:

The six workforce strategies (recommendations) contained in the Report on Commonwealth Funded Hearing Services to Aboriginal and Torres Strait Islander Peoples (2002) were incorporated into the Work Plan for Future Actions in Ear and Hearing Health (2003). The Work Plan was jointly developed by the Office for Aboriginal and Torres Strait Islander Health and Office of Hearing Services following the release of the report.

Workforce issues are addressed in the Work Plan in Policy Principles 2 & 5.

Policy Principle 2:	Promote skills development in the primary health care workforce in the clinical management of otitis media.
Policy Principle 5:	Enhance and harness the role Aboriginal health workers play in the delivery of ear health services and health promotion in Aboriginal community controlled health services.

Information on progress against these policy principles was provided in the answer to Question E04-294.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2004-2005, 2 & 3 June 2004

Question: E04-296

OUTCOME 6: Hearing Services

Topic: HEARING SERVICES – INDIGENOUS HEARING HEALTH

Hansard Page: CA 117-3.6

Senator Crossin asked:

How much money is allocated for training for the Aboriginal health workers?

Answer:

The Commonwealth contracts Australian Hearing to provide hearing training to at least two health workers from each of the 112 participating Aboriginal community controlled health services in all States and Territories (except in the Northern Territory). Funding of $304,925 has been allocated for this purpose in 2003-04.

Funding of $119,801 has been allocated to Central Australian Aboriginal Congress to deliver training to Aboriginal health workers in the Central Australian region for the 2003-04 and 2004-05 financial years.

Negotiations are currently underway for the delivery of training for Aboriginal health workers in the Top End of the Northern Territory. Funding in the order of $100,000 will be provided in 2004-05 to the Northern Territory Department of Health and Community Services for this purpose.

Therefore in total $424,726 was allocated in 2003-04 to provide hearing training for health workers in Indigenous communities.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2004-2005, 2 & 3 June 2004

Question: E04-154

OUTCOME 6: Hearing Services

Topic: HEARING SERVICES FOR ADULT CLIENTS

Written Question on Notice

Senator Allison asked:

(a) What data does the Department have on the number of people over the age of 21 who are not able to access the Australian Hearing Voucher System and are not able to pay for maintenance and upgrades of their hearing devices?

(b) Are there any plans to review the needs of those over the age of 21 who are not able to access the Voucher System? Or to reassess the eligibility criteria for accessing the Voucher System?

Answer:

(a) The Department does not have data on people who are not eligible for the Australian Government Hearing Services Program.

(b) The Department continually reviews the provision of hearing services under the Australian Government Hearing Services program.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2004-2005, 2 & 3 June 2004

Question: E04-155

OUTCOME 6: Hearing Services

Topic: HEARING SERVICES FOR ADULT CLIENTS

Written Question on Notice

Senator Allison asked:

(a) What follow-up work has the Department undertaken in regard to exploring the options proposed by the report which resulted from the Feasibility Study into the possibility of putting the Commonwealth funded Community Service Obligation (CSO) part of Australian Hearing out to commercial operation?

(b) When is it anticipated that work will be undertaken to explore these options?

Answer:

(a) The Government has noted the Feasibility Study report and does not propose any changes to the delivery of Government funded CSO arrangements at the present time.

(b) No further work is planned.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2004-2005, 2 & 3 June 2004

Question: E04-156

OUTCOME 6: Hearing Services

Topic: HEARING SERVICES FOR ADULT CLIENTS

Written Question on Notice

Senator Allison asked:

(a) Could the Department indicate what proportion of the total number of clients accessing Hearing Australia services are from an Indigenous background?

(b) How does this proportion compare with the data that the Department has on the level of hearing related problems within the Indigenous population as compared to the rest of the Australian population?

(c) What proportion of the funding to Australian Hearing is allocated for addressing hearing problems within the Indigenous population?

Answer:

(a) In 2002-03, 5% of the total number of clients with special needs (including children) accessing Australian Hearing services were from an Indigenous background.

(b) The true prevalence of hearing loss in the Indigenous population is unclear because of the difficulty associated with collecting accurate data.

With regard to the rest of the Australian population, The Australian Institute of Health and Welfare in its biennial report to Parliament, *Australia's Health 2000*, estimates that approximately 17% of the Australian population had a hearing loss of sufficient level to cause problems in conversations with more than one person.

(c) In 2002-03, Australian Hearing spent approximately 3% of the total allocation for the provision of hearing services to clients with special needs for addressing hearing problems within the Indigenous population.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2004-2005, 2 & 3 June 2004

Question: E04-292

OUTCOME 6: Hearing Services

Topic: HEARING SERVICES – GROWTH IN SERVICES AND COST INCREASES

Hansard Page: CA 109-3.6

Senator Crossin asked:

Can you disaggregate growth in services and an allowance for cost increases for the 2004-05 and 2005-06 periods?

Answer:

The estimates for expenditure on vouchers under the Australian Government Hearing Services Program from 2004-05 to 2005-06 are as follows:

Year	**2004-05**	**2005-06**
Baseline (incl. price changes)	169.41	185.75
Growth in services	12.75	14.0
Total $'m	**182.16**	**199.75**

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2004-2005, 2 & 3 June 2004

Question: E04-293

OUTCOME 6: Hearing Services

Topic: HEARING SERVICES RECEIVED BY INDIGENOUS ADULTS

Hansard Page: CA 113-3.6

Senator Crossin asked:

How many Indigenous adults received services under the Program last year (2002-2003)?

Answer:

The number of self identified Indigenous adults who received services under the Program in 2002-03 was 275. Of these, 182 were special needs clients using Australian Hearing and 93 self identified under the voucher program.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2003-2004, 2 & 3 June 2004

Question: E04-197

OUTCOME 7: Aboriginal and Torres Strait Islander Health

Topic: HEARING PROGRAM

Hansard Page: CA 76-3.6

Senator Allison asked:

(a) Is it possible to tell the committee how much unmet need there is, despite these 30 [hearing health] workers and those that are provided in the state-run clinics?

(b) Has there been an estimate made of the adequacy of those services?

(c) If not, what is the extent of the shortfall?

Answer:

(a) The Office for Aboriginal and Torres Strait Islander Health (OATSIH) is committed to protecting the investment in the 30 Child Health Sites and is aware that many Services, beyond the 30 Child Health Sites, provide primary health care intervention for ear disease and hearing screening.

OATSIH supports this through the provision of primary health care funding, the provision and ongoing maintenance of audiological equipment and the training of two Aboriginal and Torres Strait Islander health workers from each of the 112 eligible Aboriginal community controlled health services.

Data from Service Activity Reporting (SAR) indicates that in 2000-01:

- hearing screening was being delivered in 73% of all Aboriginal community controlled health services;
- audiology services were accessible through 50% of all Aboriginal community controlled health services; and
- ear, nose and throat specialist services were accessible through 27% of all Aboriginal community controlled health services.

(b) In August 2000, the (then) Department of Health and Aged Care initiated a review of the hearing health services delivered to Aboriginal and Torres Strait Islander peoples by the Australian Government. The review found that there was a significant increase in the number of children screened by Aboriginal and Torres Strait Islander Health Workers.

However, the target group of children aged 0-5 years had not been sufficiently reached due to the technical difficulties of screening this age group, and particularly the 0-3 years age group, resulting in a greater focus on older school-aged children. In order to address this, the Review recommended that ear health be positioned within a broader approach to family, maternal and child health.

To this end, re-orientation of the Hearing Program is being facilitated primarily through the current OATSIH focus on strengthening Child and Maternal Health in Aboriginal and Torres Strait Islander primary health care services.

(c) Not applicable.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2004-2005, 2 & 3 June 2004

Question: E04-198

OUTCOME 7: Aboriginal and Torres Strait Islander Health

Topic: INSTITUTIONAL RACISM IN RELATION TO INDIGENOUS HEALTH CARE: MEDICAL JOURNAL OF AUSTRALIA ARTICLE

Hansard Page: CA 79-3.6

Senator Allison asked:

(a) A paper that appeared in the *Medical Journal of Australia* quite recently, and it was also the subject of an ABC radio program, made the accusation that health care provision for Indigenous people included institutional racism. Have you had a chance to look at that article and can you advise the committee whether or not you think that is accurate?

(b) A case study of a service in Western Australia had overspent its budget by 10 per cent because of an enormous increase in the number of people seeking services and, ultimately, it was closed down… was cited [in the article]. Do you know of any instances of that?

(c) Is that commonplace?

(d) Are we scrutinising services to such an extent that we remove programs that are successful?

Answer:

(a) The article referred to was published in the *Medical Journal of Australia* on Monday 17 May 2004, and is titled "Indigenous racism in Australian healthcare: a plea for decency".

The Australian Government agrees with the authors that Indigenous health disadvantage is multi-causal and requires action that addresses the broad social determinants of health.

The article's approach to improving the health of Indigenous Australians is mirrored in the *National Strategic Framework for Aboriginal and Torres Strait Islander Health* which provides a clear national focus for improving the health status of Aboriginal and Torres Strait Islander people.

The National Strategic Framework acknowledges a number of reasons for the poor performance of the Australian health system in meeting the needs of Aboriginal and Torres Strait Islander people and identifies strategies for overcoming barriers such as health service provider attitudes and practice, communication issues, poor cultural understanding and racism.

The approach adopted by the Australian Government, and endorsed by all State and Territory Governments in the National Strategic Framework, is to maximise access by Aboriginal and Torres Strait Islander people to health services, particularly primary health care services, by:

- improving access to, and the responsiveness of the mainstream health financing and service delivery system; and
- ensuring access is improved through complementary expansion of Indigenous-specific health and substance use services that are community controlled and/or managed.

(b) The service referred to in the article is Derbarl Yerrigan Health Service (DYHS) in Perth. The service had a 2003-04 budget of $9.5 million, of which $3.6 million was provided by Australian Government Department of Health and Ageing program funding.

The service has had a very turbulent history over the past three years requiring considerable intervention and support from the Department. The Department has worked consistently with DYHS since 2000 when the service found itself in serious financial difficulty and advised the Department's Office for Aboriginal and Torres Strait Islander Health (OATSIH) that it had serious cash flow problems.

In the first instance these problems arose because DYHS had expanded very quickly and had opened an additional three sites (Midland, Mirrabooka and Cannington) in the absence of any agreement from this Department for additional funds to meet the costs of these additional services and it was therefore operating well beyond its level of income. An independent analysis of the organisation's financial situation conducted in November 2000 found that if the organisation maintained its existing level of expenditure, there would be an end of year deficit of $3.6 million.

In December 2001 a funds administrator was appointed under section 10 of the Funding Agreement. The Board of DYHS and the State Health Department were in full support of the Commonwealth's decision to exercise this right under the Funding Agreement. The funds administration period ceased on 30 September 2002 as both the Commonwealth and State Governments were satisfied at that time that the organisation had made sufficient financial and management reforms.

A second period of funds administration commenced in June 2003. This decision was made when the Department became aware of problems in relation to the organisation's governance and 'factional' differences between elected members of the Board that were placing the sound management of the organisation at risk.

At no time during this period has there been a decrease in Departmental funding to DYHS. DYHS has recently received additional funding to enhance services through the Primary Health Care Access Program.

There have been instances where an organisation has experienced difficulties such that funding to that organisation has been discontinued. In general, this is a last resort, and when it occurs, an alternative arrangement is made with another organisation (or organisations) to continue the provision of services. An example of this is when following the Tiwi Health Board in the Northern Territory going into insolvency administration, the continuation of services was achieved by transfer of responsibility for the services to the Northern Territory Department of Health and Community Services.

(c) No, cessation of funding to an organisation is not commonplace.

(d) No.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2004-2005, 2 & 3 June 2004

Question: E04-199

OUTCOME 7: Aboriginal and Torres Strait Islander Health

Topic: ORAL HEALTH

Hansard Page: CA 80-3.6

Senator Allison asked:

How many Indigenous Australians are undertaking training in dental health?

Answer:

According to the most recent data available, six Indigenous students were enrolled in dental health courses in 2003.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2004-2005, 2 & 3 June 2004

Question: E04-200OUTCOME 7: Aboriginal and Torres Strait Islander Health

Topic: PRIMARY HEALTH CARE ACCESS PROGRAM (PHCAP)

Hansard Page: CA 83-86-3.6

Senator Crossin asked:

(a) Can you provide me with a disaggregation of the PHCAP funding for 2004-05 by state and territory and provide a breakdown of what will have been funded that was not previously there i.e. the new growth money?
(b) Do you have an update of the table of expenditures on PHCAP by state and territory for 2003-04?
(c) What is the forward estimate for 2005-06?
(d) How many of PHCAP zones would you say are rolled out around the country?
(e) Are any of them fully rolled out at this stage?

Answer:

(a) The estimated PHCAP funding by jurisdiction for 2004-05 (as at June 2004) is provided in the following table:

State	**Estimated 2004-05 PHCAP Funding as at 30 June 2004**
Queensland	$10,723,090
Northern Territory	$16,986,939
New South Wales	$8,270,818
Western Australia	$8,850,811
South Australia	$5,209,390
Victoria	$2,231,280
Tasmania	$455,600
ACT	$26,000
Total	**$52,753,928**

Subject to appropriation, it is anticipated that the administered funding available for 2004-05 will also include some rephased funding from 2003-04 attached to capital works projects, as well as the additional $8 million approved in the 2004-05 Federal Budget.

PHCAP funds not yet allocated will be allocated in the remainder of 2004 towards initiatives to improve access to primary health care for Aboriginal and Torres Strait Islander people.

It is not possible to provide information on all of what will be funded in 2004-05 until allocations are finalised. This work is still being undertaken. In aggregate, decisions taken in 2003-04 provided funds for over 100 new service delivery positions, including some 24 additional GPs, 22 additional nurses and more than 65 additional Aboriginal and Torres Strait Islander health workers. Full year funding for these positions will be provided in 2004-05. Funds were also allocated in 2003-04 for more than 40 capital projects to increase or upgrade facilities. These do not include allocations yet to be made in 2004-05.

(b) A complete table of final expenditure for 2003-04 for PHCAP cannot be provided until an end of year reconciliation is complete. This process is currently being undertaken and the results will be provided within a month of the completion of the 2003-04 financial year.

(c) The forward estimate for 2005-06 PHCAP administered funds (as at 22 June 2004) is $63.721 million. This does not include any funds that may be rephased from 2003-04.

(d) As at 30 June 2004, funding under the PHCAP program for additional service provision and/or enhanced facilities has been approved in localities within 59 Office for Aboriginal and Torres Strait Islander Health (OATSIH) planning regions. Distribution of the OATSIH planning regions receiving PHCAP funding by jurisdiction is provided in the table following:

State	**Number of OATSIH Planning Regions***	**Number of OATSIH Planning Regions for which some PHCAP Funding has been approved****
Queensland	39	17
Northern Territory	21	11
New South Wales	17	8
Western Australia	12	7
South Australia	8	8
Victoria	6	5
Tasmania	3	2
ACT	1	1
Total	**107**	**59**

* An OATSIH planning region is a term used across the OATSIH program to identify specific geographic areas within each jurisdiction.

** Statewide initiatives have also been approved in Queensland, Northern Territory, Victoria and South Australia.

(e) No.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2004-2005, 2 & 3 June 2004

Question: E04-201

OUTCOME 7: Aboriginal and Torres Strait Islander Health

Topic: PRIMARY HEALTH CARE REVIEW

Hansard Page: CA 87-3.6

Senator Crossin asked:

(a) What was the total cost of conducting the Primary Health Care Review?
(b) What consultancies were involved in the review?
(c) What was the work undertaken by each consultancy?
(d) What was the cost of each consultancy?

Answer:

(a) The work of the Primary Health Care Review is still being completed. The reports of independent consultants to the Review are being prepared for publication. Administered funds expenditure is expected to be approximately $495,000 including publication costs. In addition, there has been the use of staff time for the Department of Health and Ageing and other Australian Government departments participating in the Inter-Departmental Committee (Departments of the Treasury; Prime Minister and Cabinet; Finance and Administration; Immigration and Multicultural and Indigenous Affairs; and Aboriginal and Torres Strait Islander Services).

(b) - (d)

- ***National Strategies for Improving Indigenous Health and Health Care*** **by Associate Professor Judith Dwyer, Kate Silburn and Gai Wilson, La Trobe University.** This report provides an overall assessment of the Aboriginal and Torres Strait Islander Health Program. This report draws on the work of the other consultants, departmental and service data, information from previous reviews and research findings. It presents an assessment of the level and impact of current funding and health care provision for Indigenous Australians; a strategy for improving the effectiveness of health care for Indigenous people; and advice regarding outcome indicators against which the effectiveness of Australian Government investment in Indigenous health care could be monitored.

  Cost: Judith Dwyer - La Trobe University - $111,177 (GST inclusive)

- ***Investment Analysis of the Aboriginal and Torres Strait Islander Primary Health Care Program in the Northern Territory*** **by Carol Beaver, Centre for Chronic Disease, University of Queensland and Dr Yuejen Zhao, Health Gains Planning Unit, Department of Health and Community Services, Northern Territory.**
  This report assesses the impact of investment in current services provision for Indigenous Australians using a select number of specific diseases (5 chronic diseases affecting adults and 4 diseases affecting children). It also examines the impact of changing investment levels for primary health care, both in terms of changing levels as well as changing the mix of services provided.

  Cost: Northern Territory Government for the Cost Effectiveness Modelling of Primary Health Care undertaken by Carol Beaver and Yuejen Zhao - $24,000 (GST inclusive)

- ***Costings Models for Aboriginal and Torres Strait Islander Health Services*** **by Econtech Pty Ltd.**
  This report examines funding requirements for health care for Aboriginal and Torres Strait Islander people using two approaches - a relative needs (or population benchmark approach) and a supply side or resource requirement approach.

  Cost: Econtech Pty Ltd - $61,160 (GST inclusive)

- ***Capacity Development in Aboriginal and Torres Strait Islander Health Service Delivery – Case Studies*** **by Associate Professor Cindy Shannon and Dr Helen Longbottom, Shannon Consulting Services Trust.**
  This report analyses a number of health services (high, medium and low capacity) with the aim of examining changes over time, identifying factors that improve capacity, and barriers to change. A range of case study sites were selected from different locations, with differing populations, different models of service delivery and at different stages of development.

  Cost: Associate Professor Cindy Shannon - Shannon Consulting Services Trust - $47,882 (GST inclusive)

- ***Cancer, Health Services & Indigenous Australians*** **by Dr John Condon, Co-operative Research Centre for Aboriginal and Tropical Health, Menzies School of Health Research.**
  This report examines the performance of the Australian health system in relation to cancer control for Indigenous Australians in the Northern Territory as one way of providing an insight into the relationship between health care (including primary health care) and a range of issues including survival rates for Aboriginal and Torres Strait Islander Australians.

  Cost: Dr John Condon - Menzies School of Health Research - $14,300 (GST inclusive)

- ***Maternal and Child Health Care Services: Actions in the Primary Health Care Setting to Improve the Health of Aboriginal and Torres Strait Islander Women of Childbearing Age, Infants and Young Children*** **by Dr Sandra Eades, Menzies School of Health Research.**
  Dr Sandra Eades explored the contribution that an organised approach to maternal and child health primary health care has and can make to improved health outcomes for Aboriginal and Torres Strait Islander Australians. The paper looks at evidence from the literature and case studies as well as current national activity in maternal and child primary health care.

  Cost: Dr Sandra Eades - Menzies School of Health Research - $27,500 (GST inclusive)

- ***Substance Misuse and Primary Health Care among Indigenous Australians*** **by Associate Professor Dennis Gray, National Drug Research Institute, Curtin University of Technology; Associate Professor Sherry Saggers, Centre for Social Research, Edith Cowan University; Professor David Atkinson, Rural Clinical School, University of Western Australia and Phillipa Strempel, Curtin University of Technology**.
  This report examines the evidence in relation to a number of substance use issues including patterns of use, health effects, causes of higher levels of use and the range of substance misuse interventions. The report also provides advice on future directions.

  Cost: Associate Professor Dennis Gray - Curtin University of Technology – $10, 867.74 (GST inclusive)

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2004-2005, 2 & 3 June 2004

Question: E04-202

OUTCOME 7: Aboriginal and Torres Strait Islander Health

Topic: MEDIA RELEASE: 'MORE MONEY FOR INDIGENOUS HEALTH'

Hansard Page: CA 89-3.6

Senator Crossin asked:

(a) On 25 February this year the minister announced that a number of areas would receive a one-off injection of new funds. Do you have a comprehensive list of those areas and how much each received?

(b) Can you tell me on what basis each of these areas was provided with this one-off funding? e.g. Did they apply for these funds? Did someone make an assessment that Amoonguna, for example, needed $6,094? How was that amount arrived at and the AMSs identified?

Answer:

(a) A comprehensive list of Aboriginal Community Controlled Health Services (ACCHS) that received funds under the Patient Information and Recall Systems (PIRS) funding program as announced by the Minister on 25 February 2004 is at Attachment A.

(b) The PIRS funds are provided against applications submitted by individual ACCHS in response to a call for submissions. The call for submissions for the 2003-04 PIRS funding round was announced on 16 September 2003. The applications are assessed on the basis of highest level of demonstrated need, value for money and technical feasibility. Applications are short-listed according to priority and funded according to the availability of funds for the particular funding round.

The funding for Amoonguna was provided in response to an application authored by the ACCHS working in conjunction with a Department of Health and Ageing Project Manager. The amount sought by the ACCHS and provided under the PIRS program was $6,094 (ex-GST) and was intended to enable the service to acquire an additional Personal Computer, an additional clinical software license and to purchase some related equipment for a new consultation area.

ATTACHMENT A

OFFICE FOR ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH
DEPARTMENT OF HEALTH AND AGEING

LIST OF ABORIGINAL COMMUNITY CONTROLLED HEALTH SERVICES ALLOCATED FUNDING UNDER THE PATIENT INFORMATION AND RECALL SYSTEM (PIRS) PROGRAM AS ANNOUNCED BY THE MINISTER OF 25TH FEBRUARY, 2004

Jurisdiction/Service	Purpose	Amount $ (ex-GST)
Northern Territory		
Miwatj Health Aboriginal Corporation	Implement an ISDN-based Wide Area Network	30,361
Amoonguna Community Incorporated	To provide a new personal computer, software licence and ancilliary equipment	6,094
Areyonga Clinic	To provide a new personal computer and upgrade existing equipment	5,631
Anyinginyi Congress Aboriginal Corporation	To provide a new computer workstation	4,000
Central Australian Aboriginal Congress	Upgrade existing PIR system	10,986
Mutitjulu Community Health Service	To provide a new computer workstation, laser printer, telephone, furniture and software support contract and to fund staff training in PIR system	61,350
Nganmarriyanga Community Incorporated	Upgrade existing PIR system	27,255
Northern Territory Total		145,677
Queensland		
Aboriginal and Islander Community Health Service Brisbane Limited	Expand existing system at main facility and four outstation clinics	102,642
Wuchopperen Medical Service	Initial license fees and support contracts for Project Ferret software	24,998
Cunnamulla Aboriginal Corporation for Health	Upgrade existing system workstations, establish Microsoft Exchange Server and establish internet site	40,539
Nhulundu Wooribah Indigenous Health Service (Gehgre)	Implement a 4-user PIR system based on Communicare software	53,993

Goondir Aboriginal and Torres Strait Islander Corporation for Health Services	Multi-site systems upgrade including refurbishment of equipment and staff training	123,630
Yulu-Burri-Ba Aboriginal Corporation for Community Health	Support for existing PIR system, equipment upgrading and staff training	23,935
Aboriginal and Islander Community Health Service Brisbane Limited	Staff training and equipment upgrade	26,119
Queensland (continued)		
Bidgerdii Aboriginal & Torres Strait Islander Corporation for Community Health	Staff training and equipment upgrade	26,119
Queensland Total		423,709
Australian Capital Territory		
Winnunga Nimmityjah Health Service (ACT) Incorporated	Staff training and acquisition of additional PIR system equipment	58,328
Victoria		
Gippsland and East Gippsland Aboriginal Cooperative Limited	Acquire additional system workstation and software license	4,851
Murray Valley Aboriginal Cooperative	Upgrade server and workstations, acquire software licenses, acquire new network hub	40,000
Ramahyuck District Aboriginal Corporation	Acquire new server, 3 new workstations and additional software licenses	50,000
Gunditjmara Aboriginal Cooperative	Implement new PIR system (software only)	52,212
Gippland and East Gippsland Aboriginal Cooperative Limited	Ongoing staff training and annual support and maintenance fees	19,324
Ramahyuck District Aboriginal Corporation	Staff training	13,598
Rumbalara Aboriginal Cooperative	Upgrade server	20,000
Rumbalara Aboriginal Cooperative	Staff training and systems support	35,000
Victoria Total		234,985
Tasmania		
Tasmania Aboriginal Centre Incorporated	Enable ADSL connections between three sites	25,200

South Australia		
Nunkuwarrin Yunti Incorporated	Implement a PIR system including provision of hardware, software, licenses and staff training	100,253
Nganampa Health Council Incorporated	Employ software consultant for 160 hours	16,000
Tullawon Health Service Incorporated	Provide for software development and review and staff training	8,800
Port Lincoln Aboriginal Health Service	Staff Training	18,375
Ceduna-Koonibba Aboriginal Health Service	Trial of hand-held computers, staff training and systems support	37,406
South Australia Total		180,834
Western Australia		
Ngaanyatjarra Health Service	Acquire 15 laptop computers and upgrade existing system server	35,000
South-West Aboriginal Medical Service	Staff training and systems support in relation to Coordinated Care Trial over two years	84,750
Western Australia (continued)		
Ngunytju Tjitji Pirni	Acquire additional software licenses and staff training	14,000
Kimberley Aboriginal Medical Service Council	Expansion of computer network, acquire 2 desktop PCs, acquire additional Citrix networking software licenses, acquire and ISDN router and 6 pharmaceutical label printers	63,152
Medisys Australia Pty. Limited	Staff training services to be provided to Nangganawili, and TjunTjuntjara	44,262
Yura Yungi Medical Service	Upgrade workstations and acquire additional software licenses	20,500
Western Australia Total		261,664
Total Australia		**$1,330,397**

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2004-2005, 2 & 3 June 2004

Question: E04-203

OUTCOME 7: Aboriginal and Torres Strait Islander Health

Topic: COAG TRIAL – APY LANDS

Hansard Page: CA 90-92-3.6

Senator Crossin asked:

(a) How long has the Department been the lead agency for the COAG trial on the APY Lands?
(b) Please provide a copy of the draft Shared Responsibility Agreement.
(c) When was the Secretaries Group formed?
(d) On what dates has the Secretaries Group met?
(e) Please provide the committee with a copy of the Mai Wiru regional stores policy.

Answer:

(a) On 20 August 2002, the Department of Health and Ageing was endorsed as the lead agency for the Council of Australian Governments trial on the Anangu Pitjantjatjara Yankunytjatjara Lands at a meeting of the Secretaries Group on Indigenous Issues.

(b) A copy of the draft Shared Responsibility Agreement is at Attachment A.

(c) On 9 April 2002, a meeting of Secretaries of Departments concerned with Indigenous issues and the Chief Executive Officer of the Office for Aboriginal and Torres Strait Islander Health endorsed the concept of a Secretaries Group to oversee the development of whole of government activity on Indigenous issues.

(d) The Secretaries Group has met on the following dates:
- 2002: 9 April; 11 June; 20 August; 3 September; 1 October; 5 November; 3 December;
- 2003: 4 February; 4 March; 1 April; 6 May; 1 July; 5 August; 2 September; 7 October; 2 December;
- 2004: 3 February; 2 March; 6 April; 4 May; 1 June.

(e) A copy of the Mai Wiru regional stores policy is at Attachment B.

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

SHARED RESPONSIBILITY AGREEMENT

Between

Anangu Pitjantjatjara

through the Pitjantjatjara Yankunytjatjara Land Council

the

Commonwealth of Australia

through the Department of Health and Ageing

the

State of South Australia

through the Department for Aboriginal Affairs and Reconciliation

and the

Aboriginal and Torres Strait Islander Commission

through the Nulla Wimila Kutju Regional Council

December 2003

A COUNCIL OF AUSTRALIAN GOVERNMENTS' INITIATIVE

OVERVIEW

This is a *Shared Responsibility Agreement* (the Agreement) between Anangu Pitjantjatjara, the Australian Government and the South Australian Government (the Governments) and the Aboriginal and Torres Strait Islander Commission (ATSIC).

In this Agreement, the above entities are collectively referred to as 'the partners'.

The Agreement is made in a spirit of partnership, and:

- recognises and respects each of the partner's rights and responsibilities; and
- provides a basis for cooperation and partnership between Anangu Pitjantjatjara, the Governments and ATSIC.

OBJECTIVES

In making the Agreement Anangu Pitjantjatjara, the Governments and ATSIC have agreed to work together to:

- establish partnerships and share responsibility for achieving measurable and sustainable improvements for Indigenous people living in the Anangu Pitjantjatjara Yankunytjatjara Lands ('the Region');
- support and strengthen local governance;
- support and strengthen decision making and accountability of all four partners; and
- learn from a shared approach - identify what works and what doesn't and apply lessons to future approaches both at the community level and more broadly.

ARRANGEMENTS

For the purposes of the Agreement:

- at the Regional level - the Pitjantjatjara Yankunytjatjara Land Council is acknowledged as the peak regional body and primary point of Indigenous community contact;
- the Nulla Wimila Kutju Regional Council is acknowledged as the primary point of ATSIC contact;
- The Australian Government will be represented through the Department of Health and Ageing (the 'lead agency'); and
- The South Australian Government will be represented through the Department for Aboriginal Affairs and Reconciliation (DAARE).

The partners recognise the need to ensure that the views of the wider APY community as expressed in particular through Community Councils, Anangu service organisations and other Indigenous peak bodies within the Region are taken into account.

REGIONAL PRIORITIES

Following from community consultations across the Region the partners agree that the key regional priorities for the Agreement fall into the following broad categories:

Improving the health and well being of Anangu by:

- implementing responses by all of the partners to the problem of substance misuse, and
- improving availability and affordability of healthy food supplies.

Improving educational attainment, training opportunities, employment opportunities and career pathways, especially for younger Anangu.

Improving access for Anangu to a wide range of social and community services by developing the infrastructure for regional delivery of basic services such as banking and financial facilities, postal and telecommunications services, and a range of Commonwealth government services eg Centrelink, Medicare easy claim, Job Network.

Improving physical infrastructure, especially the quality, reliability and affordability of essential services, the maintenance and upgrade of roads, air and other public transport and appropriately designed, constructed and maintained community housing.

Supporting and strengthening existing regional governance structures.

The partners recognise that priorities identified under the Agreement may change over time.

PROGRESSING PRIORITIES AND OUTCOMES

Within the Regional Priorities detailed above, specific priorities and agreed outcomes will be progressed through the APY Lands Council of Australian Governments' (COAG) Steering Committee which is made up of representatives of all the partners as follows:

Secretary, Commonwealth Department of Health and Ageing;
CEO, South Australian Department for Aboriginal Affairs and Reconciliation;
Chair and Director of Pitjantjatjara Yankunytjatjara Land Council;
SA ATSIC Commissioner, and SA State Manager of ATSIS.

This Committee has been established to provide the overall direction for the APY Lands COAG 'Shared Responsibility' initiative. In particular, the Steering Committee will:

- Guide the development of the Shared Responsibility Agreement between the four partners and monitor the performance under this Agreement;

- Assist APY communities in achieving improved outcomes for the priorities that are identified by Anangu through extensive community consultations and negotiations;

- Develop and oversee the implementation of an appropriate evaluation strategy to be agreed by the four partners;

- Build on, and work in close cooperation with, the existing APY Lands Inter- Government Inter-Agency Collaboration Committee (APYLIICC, known as Tier 1) with regard to its terms of reference and in particular to build effective working relationships between Anangu and Governments;

- Provide guidance to, and seek input from, APYLIICC in relation to community priorities agreed through the COAG initiative.

Steering Committee members or their representatives will participate in Tier 1.

ATTACHMENTS TO THE AGREEMENT

Specific priorities and agreed outcomes will be detailed in the project attachments to this Agreement. These will be agreed from time to time as projects and outcomes are negotiated and endorsed by the partners. The attachments will:

- contain information about how the partners agree to implement and manage their respective responsibilities;
- detail agreed performance indicators, benchmarks and (need for) baseline data; and
- establish specific feedback and monitoring mechanisms.

These may be added to or changed at any time to reflect agreed new or revised priorities and outcomes.

PERFORMANCE MEASUREMENT AND EVALUATION

The partners agree to monitor and evaluate progress against agreed benchmarks and milestones as well as agree to make performance information available for national evaluations.

ACCESS TO DATA

Data collected during, or as part of, an activity carried out under the Agreement will be made available to each of the partners.

DISPUTE SETTLING ARRANGEMENTS

As part of the Agreement the partners will agree on a simple process for settling any disagreements/disputes or misunderstandings that may arise.

REVIEW OF PROGRESS

The partners will review progress with activities undertaken as part of this Agreement after six months and again at regular intervals as agreed by the partners and endorsed by the APY Lands COAG Steering Committee.

DURATION AND VARIATION OF AGREEMENT

The Agreement will come into effect from the date of signing by all partners and shall continue in force until they agree to terminate the Agreement or prepare another Agreement document that replaces this one.

The partners may agree in writing at any time to change the contents of the Agreement.

If any partner wishes to withdraw from the Agreement at least 3 months notice must be given to the other partners.

This Agreement was made on the day of 2003.

Signed for and on behalf of
the PITJANTJATJARA YANKUNYTJATJARA LAND COUNCIL by

)

_ _

Mr Gary Lewis
Chairperson
Pitjantjatjara Yankunytjatjara Land Council

Signed for and on behalf of
the COMMONWEALTH OF AUSTRALIA by

)

_ _

Tony Abbott MP

Minister

Health and Ageing

Signed for and on behalf of
The GOVERNMENT OF SOUTH AUSTRALIA by

)

_ _

Terry Roberts
Minister
Aboriginal Affairs and Reconciliation

Signed for and on behalf of
The ABORIGINAL AND TORRES STRAIT ISLANDER COMMISSION by

)

_ _

Mr Lionel Quartermaine
Chairperson (A/g)

Aboriginal and Torres Strait Islander Commission

)

_ _

Mr Klynton Wanganeen

SA Zone Commissioner

Aboriginal and Torres Strait Islander Commission

)

– –

Mr Alwyn McKenzie
Chairperson

Nulla Wimila Kutju Regional Council

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2003-2004, 2 & 3 June 2004

Question: E04-204

OUTCOME 7: Aboriginal and Torres Strait Islander Health

Topic: DIMIA BUDGET FIGURES (*Budget 2004-05*)

Hansard Page: CA 95-3.6

Senator Crossin asked:

Referring to the 2004-05 PBS, on pages 221 to 222, Table C7.2, $281.183 million is provided for Aboriginal and Torres Strait Islander health. In a document that was produced by DIMIA that outlined expenditure on health services in Indigenous communities in PHCAP, the amount given was $293.956 million. Can you explain the difference for me?

Answer:

The Department of Immigration and Multicultural and Indigenous Affairs (DIMIA) prepared an Indigenous Budget Package, which included details of what the Department of Health and Ageing will spend on Indigenous health in 2004-05. The difference between the two figures can be explained by two factors:

(1) The DIMIA publication includes both administered and departmental funds while the $281.183 million outlined in the Department of Health and Ageing's 2004-05 Portfolio Budget Statements relates solely to administered funds.

(2) The figure of $293.956 million quoted by the Senator in the DIMIA document, is the result of the addition of two figures, those for Health Services and the Primary Health Care Access Program. The $281.183 million figure in the Department of Health and Ageing's 2004-05 Portfolio Budget Statements relates not only to those two programs but also includes funding for the ATSIC/Army Community Assistance Program and Fringe Benefits Tax Supplementation.

A reconciliation of the two figures is provided in the attached table.

Description	**DIMIA's 2004/05 Indigenous Budget Package** (incl Administered and Departmental funds)	**Health and Ageing PBS figures** (Administered funds only)
Health Services in Aboriginal and Torres Strait Islander Communities	220,855,031	207,656,000
Aboriginal and Torres Strait Islander Primary Health Care Access Program	73,101,271	61,620,000
	293,956,302	
Improving living conditions in remote communities – ATSIC/Army Community Assistance Program	4,463,665	4,277,000
Fringe Benefits Tax Supplementation for Aboriginal and Torres Strait Islander Health	7,630,000	7,630,000
		281,183,000

Total from DIMIA figures referred to in the question

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2004-2005, 2 & 3 June 2004

Question: E04-205

OUTCOME 7: Aboriginal and Torres Strait Islander Health

Topic: SPECIFIC ALLOCATIONS FOR 2004-05

Hansard Page: CA 96-101-3.6

Senator Crossin asked:

(a) What is the allocation for primary health care services: (i) in total; and (ii) for each such service in particular for 2004-05?
(b) What is the allocation for substance use specific services: (i) in total; and (ii) for each such service in particular for 2004-05?
(c) What is the allocation for emotional and social wellbeing services: (i) in total; and (ii) for each such service in particular for 2004-05?
(d) What is the allocation for administration of the Patient Information and Recall System program for 2004-05?
(e) Can you give me a breakdown of the state and territory Bringing Them Home counsellor positions and the amount allocated to them?
(f) What funds will be allocated to the Indigenous substance abuse programs in 2004-05?
(g) What funds will be allocated to the 17 new clinic redevelopments or improvements and 15 new health staff houses and duplexes in remote areas and where will the new staff houses and duplexes be located? i.e. provide a list of capital works, the locations and the amounts.
(h) What amount of funds will be allocated in 2004-05 to the National Indigenous Australians' Sexual Health Strategy?

Answer:

Specific program funding allocations for the 2004-05 financial year are determined using financial information from 2003-04. As confirmed at the Budget Estimates hearings on 3 June 2004, information relating to expenditures in 2003-04 will be provided to the Committee within one month of the end of the 2003-04 financial year. All figures provided below are indicative figures only. These figures are subject to change, pending the financial outcome for 2003-04.

(a)(i) As at 2 July 2004, the indicative amount allocated for primary health care services in 2004-05 is $196 million. This includes indicative amounts for Fringe Benefits Tax (FBT) supplementation to services, as well as initiatives related to primary care in areas such as eye health, nutrition, immunisation, chronic disease and management support to services, but excludes indicative amounts for patient information and recall systems, workforce strategies, capital works, substance use services, and the sexual

health, social and emotional wellbeing and Bringing Them Home programs identified elsewhere in this answer.

(a)(ii) Specific allocations for each organisation funded to provide primary health care services are still being finalised and will be provided to the Committee within one month of the end of the 2003-04 financial year.

(b)(i) As at 2 July 2004, the total indicative allocation for substance use specific services in 2004-05 is $17,716,169.

(b)(ii) As at 2 July 2004, indicative allocations for each substance use specific service in 2004-05 are:

OATSIH funded Substance Use Services	State	Budget for 04-05
Aboriginal Medical Service Co-operative Limited	NSW	69,708
Benelong's Haven Limited	NSW	597,924
Bundjalung Tribal Society	NSW	347,686
Illawarra Aboriginal Medical Service Aboriginal Corporation	NSW	177,899
Katungul Aboriginal Corporation Community & Medical Services	NSW	190,310
Marrin Weejali Aboriginal Corporation	NSW	202,501
Oolong Aboriginal Corporation Incorporated	NSW	189,514
Orana Haven Aboriginal Corporation	NSW	343,778
Roy Thorne Substance Misuse Rehabilitation Centre Incorporated	NSW	454,692
South Coast Medical Service Aboriginal Corporation	NSW	431,766
Weigelli Centre Aboriginal Corporation	NSW	388,240
New South Wales Total		**3,394,018**
Aboriginal and Islander Alcohol Awareness and Family Recovery Incorporated	NT	75,480
Angurugu Community Government Council	NT	183,371
Anyinginyi Congress Aboriginal Corporation	NT	411,080
Central Australian Aboriginal Alcohol Programs Unit	NT	602,567
Council for Aboriginal Alcohol Program Services Incorporated	NT	865,289
Ilpurla Aboriginal Corporation	NT	119,714
Intjartnama Aboriginal Corporation	NT	235,722
Kalano Community Association Incorporated	NT	228,782
Miwatj Health Aboriginal Corporation	NT	54,279
Mt Theo/Yuendumu Substance Misuse Aboriginal Corporation	NT	235,686
Ngkarte Mikwekenhe Community Incorporated	NT	47,805
Wurli-Wurlinjang Aboriginal Corporation	NT	199,163
Northern Territory Total		**3,258,938**
Aborigines and Islanders Alcohol Relief Service Ltd	QLD	671,889
Congress Community Development and Education Unit Limited	QLD	308,412
Ferdys Haven Rehabilitation Aboriginal Corporation	QLD	226,603
Gindaja Substance Misuse Aboriginal Corporation	QLD	272,633
Gumbi Gumbi Aboriginal and Torres Strait Islanders Corporation	QLD	130,844
KASH Aboriginal Corporation	QLD	458,646
Krurungal Aboriginal and Torres Strait Islander Corporation for Welfare Resource and Housing	QLD	57,165
Meeanjin Treatment Association Incorporated	QLD	93,501
Milbi Incorporated	QLD	82,206

Queensland Aboriginal & Torres Strait Islanders Corporation for Alcohol & Drug Dependence Serices	QLD	829,110
Wunjuada Aboriginal Corporation for Alcoholism and Drug Dependence Service	QLD	145,862
Yaamba Aboriginal and Torres Strait Islander Corporation for Men	QLD	126,272
Queensland Total		**3,403,143**
Aboriginal Drug & Alcohol Council of SA Incorporated	SA	299,088
Aboriginal Sobriety Group of SA Incorporated	SA	1,049,281
Ceduna/Koonibba Aboriginal Health Service Incorporated	SA	232,433
Dunjiba Community Council Incorporated	SA	134,048
Kalparrin Incorporated	SA	719,799
Nganampa Health Council Incorporated	SA	133,747
Port Lincoln Aboriginal Health Service Incorp	SA	116,739
The Corporation of the City of Port Augusta	SA	344,169
Tullawon Health Service Incorporated	SA	97,585
Umoona Tjutagku Health Service Incorporated	SA	112,253
South Australian Total		**3,239,142**
Tasmanian Aboriginal Centre Incorporated	TAS	1,069,023
Tasmanian Total		**1,069,023**
Goolum Goolum Aboriginal Co-operative	VIC	66,246
Gunditjmara Aboriginal Co-operative	VIC	71,322
Mildura Aboriginal Corporation - Mildura	VIC	244,742
Murray Valley Aboriginal Co-operative - Robinvale	VIC	71,819
Ngwala Willumbong Co-operative Limited	VIC	608,397
Ramahyuck District Aboriginal Corporation	VIC	68,128
Rumbalara Aboriginal Co-operative	VIC	24,939
Victorian Aboriginal Health Service Co-operative Limited	VIC	55,103
Victorian Total		**1,210,696**
Bay of Isles Aboriginal Community (Incorporated)	WA	182,930
Bloodwood Tree Association	WA	147,580
Geraldton Regional Aboriginal Medical Service	WA	45,103
Jungarni - Jutiya Alcohol Action council Aboriginal Corporation of Halls Creek	WA	280,234
Kununurra Waringarri Aboriginal Corporation	WA	345,306
Milliya Rumurra Aboriginal Corporation	WA	308,802
Nangganawili Aboriignal Community Controlled health and Medical Services Aboriginal Corporation	WA	62,410
Ninga Mia Village Aboriginal Corporation	WA	92,367
Noongar Alcohol and Substance Abuse Service Incorporated	WA	676,477
Western Australia Total		**2,141,209**

(c) (i) Funding for Emotional and Social Wellbeing Services is represented by combining the recurrent service funding of two national programs. These two programs are:

- The Bringing Them Home Program $11,579,919
- The Mental Health Program $5,500,390

Recurrent service funding for these two programs totals $17,080,309 in the 2004-05 financial year.

Indexation will be applied to recurrent services.

(ii) Indicative allocations for each emotional and social wellbeing service funded under the Bringing Them Home Program and the Mental Health Program in 2004-05 as at 2 July 2004 are:

Organisation	State	Budget for 04/05
Regional Centres		
Darwin RC (Danila Dilba)	NT	343,620
Central Australian Aboriginal Congress	NT	177,757
Alice Springs RC (NPY)	NAT/NT	153,135
Armidale RC	NSW	221,917
Sydney RC (Redfern AMS)	NSW	225,295
Brisbane RC (ATSICHET)	QLD	227,138
Cairns RC (FNQ Consortium)	QLD	338,209
Adelaide RC (Nunkuwarrin Yunti)	SA	336,861
Melbourne RC (VACCHO)	VIC	145,439
Tasmania RC (TAC)	TAS	146,613
Kimberley Aboriginal Medical Services Council Inc.	WA	338,210
Perth Regional Centre (IPS)	WA	350,000
Total		**3,004,194**

Mental Health Services		
Wuchopperen	QLD	315,829
Gallang Place A&TSI Corp	QLD	184,927
Access Arts Inc	QLD	40,852
Townsville A&I health Service	QLD	87,934
Nunkuwarrin Yunti	SA	256,186
Aboriginal Drug & Alcohol Council of SA	SA	53,516
Mildura Aboriginal Corporation	VIC	45,311
Rumbalara Aboriginal Co-op Ltd	VIC	189,750
Ramahyuck district Aboriginal Corporation	VIC	76,711
Central Gippsland Aboriginal Health	VIC	68,025
Bunurong Health Service	VIC	57,406
Victorian AHS Co-op Koori Kids Network	VIC	185,358
Yarra Valley Community Health Service	VIC	41,194
Biripi Aboriginal Corp	NSW	137,131
Daruk Aboriginal Community Controlled Health Service	NSW	139,150
Durri Aboriginal Corp	NSW	111,517
Illawarra AMS	NSW	57,435
Marr Mooditj Foundation Inc	WA	101,704
Kimberly AMS Council	WA	346,260
Ord Valley AHS Aboriginal Corporation	WA	
Derby AHS Council Aboriginal Council	WA	
Total		**2,496,196**

PROGRAM TOTAL		**5,500,390**

(d) The indicative allocation for administration of the Patient Information and Recall System Program for 2004-05 as at 2 July 2004 is $2,120,000.

(e) The breakdown of Bringing Them Home Counsellors by State and Territory is shown below. For the 2004-05 financial year, funding for Bringing Them Home Counsellors

has been standardised at $90,190 per position. The one exception is the Counsellor at Ceduna, South Australia, which is funded for $101,058, reflecting the large region serviced, and the associated higher travel costs.

State/Territory	Number of Counsellors	Funding
New South Wales	19	$1,713,606
Victoria	13.5	$1,217,565
Queensland	19	$1,713,605
South Australia	13	$1,183,218
Western Australia	19	$1,713,605
Tasmania	2	$180,380
Northern Territory	17	$1,533,227
Australian Capital Territory	4	$360,760
TOTAL	**106.5**	**$9,615,966**

Indexation will be applied to recurrent services.

(f) As at 2 July 2004, an indicative figure of $21,418,980 will be allocated to the Indigenous substance abuse programs in 2004-05.

(g) There are currently (as at 30 June 2004) 129 Capital Works projects with a value of $125 million that are being funded through the Office for Aboriginal and Torres Strait Islander Health (OATSIH). A list of these projects is attached below.

Capital works projects commence once an offer of funding is made and accepted by an organisation. Actual construction generally commences some time later following consultation with stakeholders, and completion of the detailed design and documentation including ensuring design compliance with local council building codes. Tenders are then called for construction, which only commences once a successful tenderer has been selected and a contract for the works agreed.

OATSIH manages the projects from the time the offer of funds is made, through the design and development phase, the construction and practical completion until the defects liability period has expired (usually 12 months after construction is completed).

The 17 clinic redevelopments or improvements and approximately 15 new staff houses approved in 2003-04 for construction in 2004-05 have been marked with an asterix. The actual construction period of the projects can vary however, depending on a range of factors including location, availability of experienced builders and materials and the weather.

Organisation Name	***Project Type***	***Project Location***	***Approved budget (excl GST)***

NSW			
Aboriginal Medical Service Co-operative Ltd (Redfern)	Clinic	Redfern	$ 2,105,000
Pius X Aboriginal Corporation	Clinic	Moree	$ 1,203,523
Bourke Aboriginal Community Controlled Health Service	Clinic	Bourke	$ 938,432
Durri Aboriginal Corporation Medical Services	Clinic	Kempsey	$ 1,181,818
Bulgarr Ngaru Medical Aboriginal Corporation	Clinic	Grafton	$ 1,127,273
Armidale & District Services Inc.	Clinic	Armidale	$ 1,953,800
Condobolin Aboriginal Health Service Incorporated	Clinic	Condobolin	$ 990,000
Benelong's Haven Ltd	Substance Misuse Facility	Kempsey	$ 125,000
* Awabakal Newcastle Aboriginal Co-operative Limited	Clinic	Newcastle	$ 310,800
* Coomealla Health Aboriginal Corporation	Clinic	Dareton	$ 1,711,146
* Orana Haven Aboriginal Corporation	Clinic	Brewarrina	$ 1,120,000
* Roy Thorne Substance Rehabilitation Centre Incorporated	Substance Misuse Facility	Moree	$ 2,154,000
* Marrin Weejali Aboriginal Corporation	Clinic	Emerton	$ 1,697,500
			$ 16,618,292
Queensland			
Queensland Health Department	Doctors Housing	Cape York	$ 240,000
Cherbourg Community Council	Clinic	Murgon	$ 1,056,335
Cunnamulla Aboriginal Corporation for Health	Doctors Housing	Cunnamulla	$ 280,000
Northern Peninsula Area Women's Services (Bamaga – NPAWS)	Clinic	Bamaga	$ 1,027,500
Queensland Health Department	Doctors Housing	Badu Island	$ 260,000
Townsville Aboriginal and Islander Health Service Ltd (TAIHS)	Clinic	Townsville	$ 2,805,000
Wu Chopperen Medical Service Ltd	Clinic	Cairns	$ 800,992
Aborigines and Islanders Alcohol Relief Service Ltd - Douglas House	Substance Misuse Facility	Cairns	$ 2,301,870
Mackay Aboriginal Health Service	Clinic	Mackay	$ 2,414,675
Congress Community Development and Education Unit Ltd (CCDEU – Townsville)	Substance Misuse Facility	Townsville	$ 481,818
Mookai Rosie-Bi-Bayan Aboriginal and Torres Strait Islander Corporation	Clinic	Earlville	$ 1,540,000
Aboriginal and IslanderCommunity Health Services Brisbane Limited	Clinic	Woolloongabba	$ 200,000
Ferdy's Haven Rehabilitation Aboriginal Corporation	Clinic	Palm Island	$ 421,000
Gumbi Gumbi Aboriginal and Torres Strait Islanders Corporation	Clinic	Rockhampton	$ 465,000
Karboyick Larkinjar Aboriginal Corporation for Health (Normanton)	Clinic	Normanton	$ 130,000
Queensland Health Department	Nurses Housing	Thursday Island	$ 500,000
Wunjuada Aboriginal Corporation for Alcohol and Drug Dependence	Substance Misuse Facility	Cherbourg	$ 90,000
Yaamba Aboriginal and Torres Strait Islander Corporation for Men	Clinic	Bundaberg	$ 200,000
* Charleville and Western Areas Aboriginal and Torres Strait Islanders Corporation	Clinic	Roma	$ 400,000
* Goondir Aboriginal Corporation for Health Services	Clinic	St George	$ 1,100,000
* Woorabinda Aboriginal Council	Nurses Housing (3)	Woorabinda	$ 671,000
* Mornington Island Shire Council	Nurses Housing (1+)	Mornington Island	$ 449,000
* Mamu Medical Service Limited	Clinic – Feasibility Study	Ravenshoe	$ 40,715
* Goondir Aboriginal Corporation for Health Services	Clinic	Dalby	$ 3,079,000
* Kambu Medical Centre Ipswich Incorporated (Ipswich/A&IHS)	Clinic	Ipswich	$ 3,056,911
			$ 24,010,816
Northern Territory			
Aboriginal and Torres Strait Islander Commission	Doctors Housing	Eastern Arrente Region	$ 267,750
Aboriginal and Torres Strait Islander Commission	Nurses Housing	Bonya	$ 920,658
Aboriginal and Torres Strait Islander Commission	Nurses Housing	Willowra and Yuelumu	$ 1,111,219
Central Australian Aboriginal Alcohol Programs Unit (CAAPU)	Substance Misuse Facility	Alice Springs	$ 2,942,366

Kalano Community Association Incorporated	Clinic	SW Katherine Region	$	2,355,000
Mutitjulu Community Health Service Aboriginal Corporation	Doctors Housing	Uluru	$	360,000
Northern Territory Department of Health and Community Services	Clinic	Various locations	$	2,448,000
UmbaKumba Community Council Incorporated	Nurses Housing	Umbakumba	$	307,273
Pintubi Homelands Health Service	Clinic	Kintore	$	1,500,000
Gapuwiyak Community Incorporated	Doctors Housing	Nhulunbuy Region	$	685,000
Urapuntja Health Service Aboriginal Corporation	Doctors Housing	Alice Springs	$	260,259
Anyinginyi Congress Aboriginal Corporation	Clinic	Tennant Creek	$	1,501,000
Ngaanyatjarra Pitjantjatjara Yankunytatjara Women's Council Aboriginal Corporation	Nurses Housing	AP Lands	$	759,816
Marthakal Homelands Resource Centre Association Incorporated	Nurses Housing	Elcho Island	$	340,000
Thangenharenge Aboriginal Corporation (Anmatjerre)	Nurses Housing	Anmatjerre	$	316,381
Nyrippi Community Council Incorporated (Walpiri Housing)	Doctors Housing	Warlpiri Region	$	370,477
Anyinginyi Congress Aboriginal Corporation	Nurses Housing	Northern Barkley	$	281,386
Tiwi Health Pty Ltd T/A Tiwi Health Board Trust	Clinic	Bathurst Island	$	100,000
Urapuntja Health Service Aboriginal Corporation	Clinic	Urapuntja	$	509,091
Council for Aboriginal Alcohol Program Services Incorporated	Substance Misuse Facility	Darwin	$	364,091
Central Australian Aboriginal Congress Incorporated	Clinic	Alice Springs	$	470,455
Ampilawatja Health Centre Aboriginal Corporation	Clinic	Ampilawatja	$	478,863
Miwatj Health Aboriginal Corporation	Nurses Housing	Nhulunbuy	$	900,000
Ltyentye Apurte Community Government Council	Nurses Housing	Santa Teresa	$	321,818
Yuendumu Community Government Council - Willowra Housing	Doctors Housing	Yuendumu	$	524,160
Laramba Community Council	Doctors Housing	Laramba	$	524,160
Papunya Community Council Inc	Doctors Housing	Papunya	$	291,200
Ikuntji Community Council Incorporated	Doctors Housing	Ikuntja	$	524,160
Katherine West Health Board - Minyerri House	Doctors Housing	Minyerri	$	963,000
Malabam (Maningrida) Health Board Aboriginal Corporation	Nurses Housing	Maningrida	$	462,000
Anmatjere Community Government Council	Doctors Housing	Ti Tree	$	566,092
Northern Territory Department of Health and Community Services	Clinic	Bathurst Island	$	3,770,690
Angurugu Community Government Council	Nurses Housing	Alyangula	$	410,000
Demed Association Incorporated Homeland Resource Centre	Clinic	Oenpelli	$	827,000
Ngaanyatjarra Health Service Aboriginal Corporation	Clinic – Feasibility Study	Kiwirrkurra	$	30,000
Ngkarte Mikwekenhe Community Incorporated	Clinic –Feasibility Study	Alice Springs	$	30,000
Ilpurla Aboriginal Corporation	Substance Misuse - Feasibility Study	Ilpurla Outstation	$	33,360
Northern Territory Department of Health and Community Services	Doctors Housing	Various locations	$	4,715,000
Milingimbi & Outstations Progress Resource Association	Doctors Housing	Milingimbi	$	500,000
* Ngaanyatjarra Health Service Aboriginal Corporation	Clinic	Alice Springs	$	1,280,890
* Laynhapuy Homelands Association Incorporated	Clinic	Nhulunbuy Region	$	2,850,000
* Gulf Health Service Incorporated	Nurses Housing (3)	Borroloola	$	1,035,857
* Mungoorbada Aboriginal Corporation	Nurses Housing (2)	Katherine	$	1,328,564
* Ramingining Homelands Resource Centre Aboriginal Corporation	Clinic	Winnellie	$	1,325,000
* Mt Theo/Yuendumu Substance Misuse Aboriginal Corporation	Clinic	Mt Theo	$	1,650,000
* Marngarr Community Government Council	Clinic	Nhulunbuy Region	$	1,500,000
			$	**45,012,036**

South Australia				
South Australia Dept of Human Services	Clinic	Ceduna	$	575,455
South Australia Dept of Human Services - Umoona Tjutagka Health Service	Substance Misuse Facility	Coober Pedy	$	57,273
Yalata Maralinga Health Service Inc	Nurses Housing	Yalata	$	473,000
Nganampa Health Council	Doctors Housing	AP Lands	$	2,000,000
Yalata Maralinga Health Service Inc	Clinic	Yalata	$	1,545,455
Ceduna Konibba Aboriginal Health Service	Doctors Housing	Ceduna	$	665,350
Nganampa Health Council	Nurses Housing	AP Lands	$	518,182
Port Lincoln Aboriginal Health Service Incorporated	Substance Misuse Facility	Pt Lincoln	$	177,080
Nunkuwarrin Yunti Incorporated	Clinic	Adelainde	$	527,750
Nganampa Health Council	Clinic – Feasibility Study	AP Lands	$	90,000
Nganampa Health Council	Clinic	Nyapari	$	371,000
Nganampa Health Council	Admin Building	Umuwa	$	576,000
Nganampa Health Council	Clinic	Watarru	$	371,000
Nganampa Health Council	Clinic	Yunyarinyi	$	371,000
Goreta Aboriginal Corporation	Clinic	Point Pearce	$	344,850
* Pika Wiya Health Service Incorporated	Clinic	Copley and Neppabunna	$	415,000
* Mid Murray Council	Clinic	Swan Reach	$	356,700
			$	**9,435,095**
Western Australia				
Derby Aboriginal Health Service Council Aboriginal Corporation	Clinic	Stanley Street, Derby	$	310,000
Noongar Alcohol And Substance Abuse Service Incorporated	Substance Misuse Facility	Perth	$	2,699,964
Bega Garnbirringu Health Service	Doctors Housing	Kalgoorlie	$	440,000
Burringurrah Community Aboriginal Corporation	Clinic	Burringurrah	$	920,883
Puntukurnu Aboriginal Medical Service Aboriginal Corporation	Clinic	Kunawarritji	$	400,000
Wheatbelt Aboriginal Corporation	Clinic	Perth	$	250,475
Geraldton Regional Aboriginal Medical Service	Clinic	Geraldton	$	2,106,950
Derby Aboriginal Health Service Council Aboriginal Corporation	Clinic	Derby	$	4,824,090
Mawarnkarra Health Service Aboriginal Corporation	Clinic	Roebourne	$	3,340,440
Wirraka Maya Health Service Aboriginal Corporation (Pt Hedland)	Clinic – Feasibility Study	Port Hedland	$	60,000
Yura Yungi Medical Service Aboriginal Corporation	Doctors Housing	Halls Creek	$	320,000
Ngangganawili Aboriginal Community Controlled Health and Medical Services Aboriginal Corporation	Nurses Housing	Wiluna	$	559,738
Ngunytju Tjitji Pirni	Clinic	Kalgoorlie	$	130,000
Wirraka Maya Health Service Aboriginal Corporation	Clinic	Sth Hedland	$	1,014,050
Yura Yungi Medical Service Aboriginal Corporation	Nurses Housing	Halls Creek	$	332,800
* Ngangganawili Aboriginal Community Controlled Health and Medical Services Aboriginal Corporation	Clinic	Wiluna	$	1,720,000
* Mawarnkarra Health Service Aboriginal Corporation	Nurses Housing (2)	Roebourne	$	90,000
* Mercy Community Services Incorporated	Nurses Housing (3+)	Wembley	$	1,180,000
* Nindilingarri Cultural Health Services	Clinic	Fitzroy crossing	$	2,826,632
			$	**23,526,022**
Victoria				
Victoria Aboriginal Health Service Co-Op Ltd.	Clinic	Fitzroy	$	159,000
Lake Tyres Aboriginal Health and Childrens Services	Clinic	Lake Tyres	$	1,011,755
Moogji Aboriginal Council East Gippsland Incorporated	Clinic	Orbost	$	1,039,000
Goolum Goolum Aboriginal Co-op	Clinic	Horsham	$	2,150,000
Wathaurong Aboriginal Cooperative	Clinic	Nth Geelong	$	1,000,000
			$	**5,359,755**

Tasmania			
Tasmanian Aboriginal Centre Incorporated	Clinic	Hobart	$ 350,000
South East Tasmainia Aboriginal Corporation	Clinic	Cygnet	$ 49,000
Flinders Island Aboriginal Association Inc	Clinic	Flinders Island	$ 60,000
Cape Barren Islanders Community Association	Nurses Housing	Cape Barren Island	$ 256,882
			$ 715,882
ACT			
Winnunga Nimmityjah Aboriginal Health Service	Clinic	Canberra	$ 462,000
			$ 462,000

	Projects		**Funding**
TOTALS			
NSW	13		**$ 16,618,292**
Queensland	24		**$ 24,010,816**
Northern Territory	46		**$ 45,012,036**
South Australia	17		**$ 9,435,095**
Western Australia	19		**$ 23,526,022**
Victoria	5		**$ 5,359,755**
Tasmania	4		**$ 715,882**
ACT	1		**$ 462,000**
Total	**129**		**$ 125,139,898**

(h) As at 2 July 2004, the indicative total amount to be allocated to the National Indigenous Australians' Sexual Health Strategy in 2004-05 is $9,634,920.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2003-2004, 2 & 3 June 2004

Question: E04-206

OUTCOME 7: Aboriginal and Torres Strait Islander Health

Topic: SPECIFIC EXPENDITURE FOR 2003-04

Hansard Page: CA 97-3.6

Senator Crossin asked:

As at 30 June 2004:
(a) What was the expenditure for primary health care services?
(b) What was the expenditure for substance use specific services?
(c) What was the expenditure for emotional and social wellbeing services?

Answer:

As confirmed at the Budget Estimates hearings on 3 June 2004, information relating to expenditures in 2003-04 will be provided to the Committee within one month of the end of the 2003-04 financial year.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2004-2005, 2 & 3 June 2004

Question: E04-207

OUTCOME 7: Aboriginal and Torres Strait Islander Health

Topic: WINNUNGA NIMMITYJAH ABORIGINAL HEALTH SERVICE

Hansard Page: CA 102-3.6

Senator Crossin asked:

(a) I understand a key recommendation of that health service's current and former strategic plan is the appointment of a practice manager. Is that correct?

(b) Is a dietitian employed by the Winnunga Nimmityjah Health Service?

(c) If so, what is the amount of funding provided by the Department for the employment of the dietitian?

Answer:

(a) Yes.

(b) No.

(c) Not applicable.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2004-2005, 2 & 3 June 2004

Question: E04-208

OUTCOME 7: Aboriginal and Torres Strait Islander Health

Topic: EYE HEALTH REVIEW

Hansard Page: CA 106-3.6

Senator Crossin asked:

(a) How much in total has the eye health review cost to date?

(b) Please provide a breakdown of the consultant's fee.

Answer:

(a) The Centre for Remote Health was paid a total of $248,515.00 (GST inclusive) to undertake the consultancy.

(b) The contract to undertake the review was held between the Department of Health and Ageing and the Centre for Remote Health, located in Alice Springs. The Centre for Remote Health appointed the consultancy team and negotiated individual consultant fees. The Department does not have a breakdown of these fees.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2004-2005, 2 & 3 June 2004

Question: E04-210

OUTCOME 7: Aboriginal and Torres Strait Islander Health

Topic: TRACHOMA

Hansard Page: CA 107-3.6

Senator Crossin asked:

Please provide a copy of the Department's report to the World Health Organisation (WHO) that mapped the distribution of trachoma.

Answer:

A copy of the Department's report to the WHO is attached.

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

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2004-2005, 2 & 3 June 2004

Question: E04-211OUTCOME 7: Aboriginal and Torres Strait Islander Health

Topic: COAG TRIAL – CAPE YORK

Hansard Page: CA 109-3.6

Senator McLucas asked:

Can the Department provide an update on the COAG Trial in Cape York, with particular reference to the implications of the changed arrangements for ATSIC?

Answer:

The COAG trial in Cape York will continue under the changed arrangements for ATSIC, as will all COAG trials. The trials will continue to model and test new ways of working with communities and across governments, building on progress already made in the trial sites.

The roles of sponsor Secretaries and lead agencies in the COAG trial sites will also continue. In the case of Cape York COAG trial, the lead agency is the Department of Employment and Workplace Relations (DEWR).

Local lead agency staff (ie DEWR) will remain working on the ground, with other Australian Government agencies, and with direct links with their home agency. Lead agency staff will become part of the Indigenous Coordination Centres (ICCs). They may physically co-locate with the new ICCs where this is sensible; where it is not possible they will be considered as out-posted staff of ICCs.

ICC Managers will be responsible for COAG trials within their areas and report directly to the relevant sponsor Secretary about these matters. In effect there would be joint reporting – to the relevant COAG trial Secretary and to the Office of Indigenous Policy Coordination (OIPC) through normal OIPC arrangements.

The Indigenous Communities Coordination Taskforce, now located in the OIPC, has provided a progress report on each COAG trial site in response to a Question on Notice taken by the Department of Immigration and Multicultural and Indigenous Affairs.

The Department of Health and Ageing will continue to work with DEWR, the lead agency for Cape York COAG, and other government agencies, in meeting COAG trial aims.

The Department of Health and Ageing continues to focus on the Cape York Whole-of-Health Project. This project is now moving to implementation of strategies that address community identified health needs/priorities and continues to work with stakeholders to develop the appropriate service delivery models.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2004-2005, 2 & 3 June 2004

Question: E04-101

OUTCOME 7: Aboriginal and Torres Strait Islander Health

Topic: NGUKURR ALLEGATIONS

Written Question on Notice

Senator Harradine asked:

(a) Is the department aware of a report in The Bulletin of 28 April 2004 where it is alleged that in Ngukurr in the Northern Territory "…some 20 schoolgirls were allegedly taken from class to the local clinic, where the head nurse conducted 'school screenings' – checking for pregnancy and sexually transmitted diseases, and to discuss birth control? It is claimed that some of those girls were given Implanon…"and that a teacher"…did not believe the government-run clinic had gained parental or guardian consent for the implants.

(b) Are you also aware that the Katherine Regional Aboriginal Legal Aid Service is investigating claims from older Ngukurr women that they have been sterilised against their will?

(c) Does the Department provide any funding to this particular clinic in Ngukurr?

(d) Has the department investigated these claims? If so, please provide a copy of the report of those investigations.

Answer:

(a) The Department of Health and Ageing is aware of the article in *The Bulletin* of 28 April 2004, entitled 'Dropping the Baby'.

(b) No.

(c) The Department of Health and Ageing does not provide any funding to the Ngukurr Clinic. The Ngukurr Clinic is funded and staffed by the Northern Territory Department of Health and Community Services.

(d) The Department of Health and Ageing has not investigated the claims outlined in the article.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2004-2005, 2 & 3 June 2004

Question: E04-157

OUTCOME 8: Choice Through Private Health

Topic: MENTAL HEALTH

Written Question on Notice

Senator Allison asked:

How has the Department of Health and Ageing endorsed a 'rule change' in the portability conditions of a product of one private health insurance company that appears to discriminate against those with a psychiatric disability?

Answer:

All health funds must comply with the *National Health Act 1953* and their own rules. The rules describe in some detail the funds' products. One health fund sought a change to its rules to apply a "benefit limitation period" of 12 months to psychiatric and rehabilitation services, to people transferring from other funds. This means that, for the first 12 months after joining the fund, benefits are paid for these services at the Government-determined default rate, rather than the full contract rate. This rule change took effect on 12 January 2004.

The rule change, being consistent with the current provisions of the *National Health Act 1953* (the Act), did not fall within the grounds on which a rule change may be disallowed.

See also the answer to Senate Estimates Question on Notice E04-262, for a list of funds with benefit limitation periods on some or all of their products, and the services to which those benefit limitation periods apply.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2004-2005, 2 & 3 June 2004

Question: E04-180

OUTCOME 8: Choice Through Private Health

Topic: CHANGES TO PHI PORTABILITY

Written Question on Notice

Senator McLucas asked:

Does the Department see any inconsistency between the approval for Australian Unity to limit for 12 months full benefits for members who have transferred from another fund and who wish to claim for psychiatric and rehabilitation and the portability rules?

Answer:

No. See answer to E04 – 157.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2004-2005, 2 & 3 June 2004

Question: E04-257

OUTCOME 8: Choice through Private Health Insurance

Topic: MEDIBANK PRIVATE'S PREMIUM INCREASES

Hansard Page: CA 9-2.6

Senator Knowles asked:

What is the trend line with your premium increases in the last, say, five years compared to the industry average?

Do you have a yearly breakdown on that?

Answer:

Medibank Private and Private Health Insurance Funds Premium Increases 2000-2004

Year	2000	2001	2002	2003	2004
PHI Industry	1.8%	0.0%	6.9%	7.4%	7.6%
Medibank Private (MPL)	0.0%	0.0%	8.9%	4.9%	8.9%
Other Funds (minus MPL)	2.4%	0.0%	6.0%	8.4%	7%
Difference between MPL & Other Funds	-2.4%	0.0%	+2.9%	-3.5%	+1.9%
Cumulative Difference	2.4%	2.4%	0.5%	4%	2.1%
Compound Cumulative Difference*	2.4%	2.4%	-0.4%	3.4%	1.5%

*year on year increases

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2004-2005, 2 & 3 June 2004

Question: E04-258

OUTCOME 8: Choice through Private Health Insurance

Topic: TERMINATION OF MEDIBANK PRIVATE'S REQUEST FOR PROPOSAL TENDERING PROCESS FOR HOSPITAL PURCHASING STRATEGY

Hansard Page: CA 5-2.6

Senator McLucas asked:

What will the cost be to Medibank Private, do you think?

Answer:

The cost to Medibank Private of the deferral of the Request for Proposal tendering process was approximately $110,000. The costs were incurred in the development of historic data, information on hospitals involved in the Request for Proposal and the costs associated with undertaking the process itself prior to cessation. It should be noted that this information is used by Medibank Private in its day-to-day contracting with Private Hospitals and the funds used in developing this information were not wasted as the information obtained remains useful and the knowledge gained from the process steps undertaken will be meaningful in the future.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2004-2005, 2 & 3 June 2004

Question: E04-259

OUTCOME 8: Choice Through Private Health

Topic: FUNDING FOR POLICY ADVICE

Hansard Page: CA 121-3.6

Senator McLucas asked:

Funding for policy advice in the Portfolio Budget Statement on page 234 provides $4.9 million for this output, which is considerably less than the actual cost from last financial year of $7.7 million. Can you give the Committee an explanation of why that has occurred.

Answer:

Measures announced in the context of the 2003-04 Budget and the 2003-04 Additional Estimates have resulted in a decrease in overall departmental outputs for Outcome 8 from $20.8 million in 2003-04 to $13.2 million in 2004-05.

The main measure was the removal of the private health insurance safety net for out-of-hospital medicare expenses which impacted 2004-05 by $7.1 million (reduction).

The allocation of this decrease against the three output groups has resulted in a proportional reduction for Output Group 1 (Policy Advice) in 2004-05 of $2.8 million.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2004-2005, 2 & 3 June 2004

Question: E04-260

OUTCOME 8: Choice Through Private Health

Topic: OUTREACH SERVICES TO PATIENTS IN AGED CARE FACILITIES

Hansard Page: CA 123-124-3.6

Senator McLucas asked:

a) How will the trials operate? Have the trials been constructed yet?

b) What I am looking for is: what the trials will involve - what we are looking at; what will the cost be; and where the funding is?

c) It [PBS, page 226] said that six trials were to be established by June 2005. I was going to ask where those trials were going to occur?

Answer:

a) Following the success of private sector based Hospital in the Home services (outreach services) a number of hospitals, residential aged care facilities and private health funds expressed an interest in providing Hospital in the Home services to residents of aged care facilities.

   Currently when residents of aged care facilities require hospital treatment they must physically move to a hospital to receive the relevant treatment. The proposed trials will test the efficacy of extending Hospital in the Home to privately insured acutely ill residents of aged care facilities. These residents will be admitted patients of a hospital who can receive all or part of their treatment or care that otherwise would be provided in the hospital in their aged care facility.

   Under the outreach legislation, hospitals wishing to participate in the trials have to be approved by the Minister for Health and Ageing or his delegate. They will also need to satisfy guidelines that are based on the existing Hospital in the Home Guidelines, taking account of the requirements of the *Aged Care Act 1997*.

   An expanded Private Sector Outreach Working Party (which currently assesses all outreach applications) will consider each trial application to ensure it complies with the guidelines and if satisfied, will recommend to the Minister that the trial be approved. The Working Party will be comprised of representatives from private hospitals, private health funds, health professionals, age care health professionals, aged care homes and consumers.

The trials have not yet started.

b) No Australian Government funding is required for the actual running of the trials. Private Health Insurance funds will pay for approved hospital services delivered in the residential aged care home as they would if the resident was admitted within the four walls of the hospital.

However, an evaluation framework for the proposed trials is currently being developed by PriceWaterhouseCoopers following an open tender process. The cost of this work ($45,669) is being met by the Department. Further evaluation work will also be funded by the Department.

c) It is not yet known where the trials will occur. The Department will seek Expressions of Interest from interested parties from a broad range of facilities in different States and Territories.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2004-2005, 2 & 3 June 2004

Question: E04-261

OUTCOME 8: Choice through Private Health

Topic: DATA ON PRIVATE HEALTH INSURANCE COMPILED BY ELECTORATE

Hansard Page: CA 125-6-3.6

Senator McLucas asked:

(a) In 2000, data was compiled by electorate for the number of people covered by private health insurance for the months of June, July and September. It was provided to this committee in response to a question asked in November 2000. Has any further private health insurance membership data by electorate been collated since that time?

(b) When you find out what the most recent set is, if it (sic) [is] after September 2000, could we have that data, in the series it has been collected in?

(c) We would like to know what the cost to the department was of doing that work in 2000. (Later agreed that if data produced more recently, okay to give the cost for the more recent data – CA 126)

(d) I suppose the question I am trying to ask is: did we have to buy a piece of software?

(e) If you are currently compiling data by electorate of private health insurance membership, that would be useful as well - if that information is being compiled.

Answer:

(a) Yes. Work was undertaken in October 2003 after the receipt of 2002-03 postcode-based private health insurance rebate data from the Health Insurance Commission (HIC). Annual data is provided as part of the Department of Health and Ageing's service provider agreement with the HIC.

(b) The latest data the Department has is for 2002-03. The attached table provides that data requested for 2002-03. It is important to consider the caveats which apply to this data:

- Data is based on mapping HIC postcode data to electorates; in 25% of cases postcodes cover more than one electorate. The error introduced by this mapping is usually small but may be significant for some electorates. Caution should be used in making comparisons over time as changes in demographics, postcode boundaries and electorate boundaries affect the mapping.
- HIC data does not include policies where the rebate was claimed through the tax system (7% of rebates) however the data provided is evenly extrapolated to allow for this.

- There is a possibility of double counting in the data if funds are slow to deregister members after they change to another fund.
- The postcode recorded by the HIC is the postcode originally registered for the member and is not updated should a member move residence.

(c) The cost to the Department of producing electorate statistics on private health insurance membership is broadly in line with the standard costs given in the answer to E04-187 in February 2004 on the production of Medicare Benefits Schedule quarterly statistics. The private health insurance information took four person days to produce at an estimated cost of $2,000.

(d) No additional software was purchased.

(e) No data on private health insurance membership by electorate is currently being compiled.

Private Health Insurance, Hospital Cover, 2002-03
Estimated number of people with hospital cover
and participation rate, by Federal Electorate
Data extrapolated to include the portion of the
rebate claimed through the tax system (7%).
Note the caveats at the end of the table.

State	Electorate	Total	Rate
ACT	Canberra	82,974	52.6%
	Fraser	77,832	48.0%
ACT Total		160,806	50.2%
NSW	Banks	62,688	50.7%
	Barton	64,728	48.3%
	Bennelong	79,798	60.7%
	Berowra	94,116	71.5%
	Blaxland	46,574	33.3%
	Bradfield	107,968	77.6%
	Calare	45,848	35.7%
	Charlton	56,311	45.9%
	Chifley	39,244	25.8%
	Cook	77,493	65.0%
	Cowper	35,854	29.5%
	Cunningham	59,049	48.7%
	Dobell	56,795	43.0%
	Eden-Monaro	43,533	34.8%
	Farrer	58,128	46.6%
	Fowler	37,450	25.3%
	Gilmore	48,617	40.1%
	Grayndler	52,165	37.2%
	Greenway	66,510	45.5%
	Gwydir	46,223	36.4%
	Hughes	79,583	59.7%
	Hume	50,650	40.0%
	Hunter	52,852	41.4%
	Kingsford-Smith	68,444	46.7%
	Lindsay	55,449	42.0%
	Lowe	72,520	52.3%
	Lyne	42,903	33.7%
	Macarthur	57,619	41.0%
	Mackellar	83,663	64.9%
	Macquarie	57,828	42.7%
	Mitchell	89,107	67.5%
	New England	44,335	36.1%
	Newcastle	56,471	44.4%
	North Sydney	91,916	64.8%
	Page	39,760	31.9%
	Parkes	49,828	40.6%
	Parramatta	69,410	47.4%
	Paterson	49,195	40.5%
	Prospect	54,231	37.7%
	Reid	39,750	28.6%
	Richmond	43,590	35.0%

	Riverina	59,190	44.5%
	Robertson	62,743	48.3%
	Shortland	51,528	41.6%
	Sydney	65,187	40.9%
	Throsby	48,906	38.3%
	Warringah	88,053	65.9%
	Watson	50,078	36.0%
	Wentworth	85,663	60.7%
	Werriwa	43,320	29.6%
NSW Total		2,982,864	44.9%
NT	Lingiari	24,998	22.7%
	Solomon	39,742	41.4%
NT Total		64,740	31.4%
QLD	Blair	48,922	39.9%
	Bowman	56,449	41.7%
	Brisbane	64,964	45.9%
	Capricornia	67,375	52.5%
	Dawson	64,586	45.5%
	Dickson	62,840	46.0%
	Fadden	59,024	42.9%
	Fairfax	44,658	33.1%
	Fisher	54,246	41.4%
	Forde	41,475	27.4%
	Griffith	66,727	49.2%
	Groom	74,353	58.6%
	Herbert	64,975	45.1%
	Hinkler	54,794	42.7%
	Kennedy	54,215	37.1%
	Leichhardt	49,373	31.5%
	Lilley	59,152	46.9%
	Longman	38,268	28.2%
	Maranoa	65,387	52.1%
	McPherson	70,863	46.6%
	Moncrieff	66,759	43.6%
	Moreton	60,375	46.1%
	Oxley	41,079	28.3%
	Petrie	50,074	38.2%
	Rankin	46,703	30.6%
	Ryan	82,244	60.5%
	Wide Bay	42,292	34.3%
QLD Total		1,552,171	41.8%
SA	Adelaide	63,468	50.0%
	Barker	44,471	35.4%
	Bonython	38,830	27.7%
	Boothby	74,467	60.5%
	Grey	41,645	32.2%
	Hindmarsh	65,090	56.2%
	Kingston	48,699	37.7%
	Makin	62,046	48.7%
	Mayo	71,996	57.9%
	Port Adelaide	52,893	43.2%
	Sturt	72,562	58.6%
	Wakefield	49,170	39.1%
SA Total		685,336	45.3%

TAS	Bass	39,127	41.9%
	Braddon	27,090	28.3%
	Denison	51,778	56.3%
	Franklin	54,435	57.6%
	Lyons	35,640	39.0%
TAS Total		208,070	44.5%
VIC	Aston	72,641	52.7%
	Ballarat	60,327	49.2%
	Batman	45,660	34.1%
	Bendigo	50,747	41.2%
	Bruce	58,328	45.5%
	Burke	54,676	39.5%
	Calwell	53,494	29.7%
	Casey	61,999	48.1%
	Chisholm	67,154	51.4%
	Corangamite	79,490	64.4%
	Corio	75,504	59.7%
	Deakin	67,249	55.5%
	Dunkley	54,115	42.6%
	Flinders	52,664	39.7%
	Gellibrand	35,491	27.0%
	Gippsland	31,202	26.5%
	Goldstein	86,010	63.6%
	Higgins	78,164	58.4%
	Holt	46,245	31.2%
	Hotham	51,969	39.5%
	Indi	41,966	34.6%
	Isaacs	52,131	39.0%
	Jagajaga	73,106	56.8%
	Kooyong	83,427	62.9%
	La Trobe	64,066	44.6%
	Lalor	43,484	30.2%
	Mallee	46,905	39.4%
	Maribyrnong	45,558	37.2%
	McEwen	57,493	42.5%
	McMillan	39,368	31.5%
	Melbourne	54,325	34.1%
	Melbourne Ports	66,199	47.1%
	Menzies	77,041	63.3%
	Murray	51,217	40.7%
	Scullin	52,473	38.0%
	Wannon	41,603	36.1%
	Wills	55,749	41.6%
VIC Total		2,129,239	43.5%
WA	Brand	46,053	35.8%
	Canning	47,649	37.2%
	Cowan	58,658	44.0%
	Curtin	81,531	64.0%
	Forrest	52,943	39.9%
	Fremantle	65,161	50.4%
	Hasluck	55,194	42.1%
	Kalgoorlie	51,100	32.5%
	Moore	66,994	54.3%
	O'Connor	59,780	46.7%

	Pearce	53,089	40.5%
	Perth	58,111	46.8%
	Stirling	68,957	53.2%
	Swan	53,114	41.5%
	Tangney	88,860	68.8%
WA Total		907,194	46.3%
Australian Total		8,690,419	44.1%

1) Data is based on mapping HIC postcode data to electorates; in 25% of cases postcodes cover more than one electorate.
2) HIC data does not include policies where the rebate was claimed through the tax system (7% of rebates).
3) There is a possibility of double counting in the data, if funds are slow to deregister members after they change to another fund.
4) The postcode recorded by the HIC is the postcode reported originally and is not updated.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2004-2005, 2 & 3 June 2004

Question: E04-262

OUTCOME 8: Choice Through Private Health

Topic: BENEFIT LIMITATION PERIODS

Hansard Page: CA 126-3.6

Senator McLucas asked:

(a) Could I have a list of the funds and the limitations?

(b) Did you take on whether or not it was discriminatory? (Australian Unity rule change to apply a benefit limitation period for psychiatric and rehabilitation claims to members transferring from other funds)

Answer:

(a) The attached table sets out the names of the funds offering products with benefit limitation periods and the type of service(s) to which the benefit limitation periods apply. These benefit limitation periods may apply to one or more products and apply for a period (specified in the fund's rules) of between one and three years. Most apply to new members (ie new to health insurance) and some to people transferring from other funds.

(b) Until 30 June 2004 the Department was required to assess all rule changes against subsection 78(4) of the *National Health Act 1953* (the Act). The Australian Unity rule change, being consistent with the provisions of the Act in that period, did not fall within the grounds on which a rule change may be disallowed.

FUND		TYPE OF SERVICE						
	Assisted Reproduction Services	Pregnancy Related Services	Sterilisation and Reversal	Cardiothoracic	Psychiatric Services	Rehabilitation	Plastic & Cosmetic Surgery	Hip Replacement
Australian Unity		√			√	√		
BUPA	√	√		√	√	√		√
DRUIDS VIC	√		√				√	√
FEDERATION	√	√	√	√	√	√	√	√
GMHBA	√				√	√	√	√
HBF	√	√						√
HEALTH CARE							√	
HIF OF WA	√		√		√			√
HEALTHGUARD	√	√	√		√		√	√
HCF/IOR					√			√
LATROBE	√				√	√		√
MEDIBANK PRIVATE			√		√	√		
MBF	√				√			√
MILDURA HOSPITAL	√	√						
NIB					√	√		
ST LUKES	√		√				√	

Source: Rules Application Processing System database as at 30 June 2004

FUNDS THAT OFFER PRODUCTS WITH BENEFIT LIMITATION PERIODS	TYPE OF SERVICE								
	Cataract Surgery	Knee Replacement	Surgical removal of teeth	Invertility investigation or treatment	Joint Replacement	Renal Transplant	Dialysis for Chronic Renal Failure	Bone marrow transplant	Lithotripsy
Australian Unity									
BUPA	√								
DRUIDS VIC									
FEDERATION									
GMHBA									√
HBF									
HEALTH CARE									
HIF OF WA			√	√	√				
HEALTHGUARD									
HCF/IOR		√				√	√		
LATROBE									
MEDIBANK PRIVATE				√					
MBF	√	√					√	√	
MILDURA HOSPITAL									
NIB									
ST LUKES									

Source: Rules Application Processing System database as at 30 June 2004

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2004-2005, 2 & 3 June 2004

Question: E04-039

OUTCOME 9: Health Investment

Topic: NALTREXONE IMPLANTS

Written Question on Notice

Senator Denman asked:

During the February estimates, Ms Hefford provided some information on naltrexone slow release implants.

(a) Have the trials she referred to now been completed?

(b) If so, what are the results?

(c) If not, when is it estimated that the trials will be completed?

Answers:

(a) No.

(b) See (a) above.

(c) 31 December 2005.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2004-2005, 2 & 3 June 2004

Question: E04-040

OUTCOME 9: Health Investment

Topic: NALTREXONE IMPLANTS

Written Question on Notice

Senator Denman asked:

Through which program and what amount of funding, if any, has the Commonwealth Government provided for these trials?

Answer:

The trial is being funded through the National Health and Medical Research Council's Project Grant Scheme. Total funding is $404,675 over two years.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2004-2005, 2 & 3 June 2004

Question: E04-041

OUTCOME 9: Health Investment

Topic: NALTREXONE IMPLANTS

Written Question on Notice

Senator Denman asked:

Were these trials approved by research ethics committees set up in line with NHMRC guidelines? If so, can details be provided? If not, can the reasons why be provided?

Answer:

(i) Yes.

(ii) Yes, a research ethics committee approved these trials in accordance with the National Health and Medical Research Council's (NHMRC) *National Statement on Ethical Conduct in Research Involving Humans*. The NHMRC only requires the Administering Institution to provide advice that appropriate ethics clearances have been obtained which is in accordance with the National Statement and is a condition of NHMRC funding.

(iii) See answer to (ii) above.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2004-2005, 2 & 3 June 2004

Question: E04-102

OUTCOME 9: Health Investment

Topic: EMBRYO RESEARCH

Written Question on Notice

Senator Harradine asked:

I note that the Reproductive Technology Accreditation Committee of the Fertility Society of Australia has amended its code of practice for centres using assisted reproductive technologies to reflect the requirements of the *Research Involving Human Embryos Act 2002* and the *Prohibition of Human Cloning Act 2002*. Please provide details of how the code of practice has changed and how and why it differs from the previous code of practice.

Answer:

It is the understanding of the National Health and Medical Research Council Secretariat that, as at 3 August 2004, no changes have been made to the Reproductive Technology Accreditation Committee Code of Practice, which is available on the FSA website, since it was revised in April 2002.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2004-2005, 2 & 3 June 2004

Question: E04-106

OUTCOME 9: Health Investment

Topic: EMBRYO RESEARCH

Written Question on Notice

Senator Harradine asked:

Please provide details of how it is proposed that Human Research Ethics Committees participate in the monitoring inspection process on a trial basis.

Answer:

Inspectors will conduct inspections of all Licence Holders to monitor compliance with Licence conditions and the *Research Involving Human Embryos Act 2002* (RIHEA).

When planning inspections, Inspectors will contact the Human Research Ethics Committee (HREC) that assessed the Licence Holder's application to advise the HREC that the National Health and Medical Research Council (NHMRC) will be conducting an inspection of the particular licence. Inspectors will also advise the HREC that they are welcome to participate in the inspection as an observer only and pending approval / agreement with the Licence Holder. Permission must be sought from the Licence Holder as only Inspectors appointed under section 33 of the RIHEA are authorised to enter Licence Holder Premises under the legislation for the purposes of monitoring compliance.

The NHMRC believes it is important to ensure relevant HRECs are kept informed of inspections to be undertaken. Relevant HRECs will also be provided with written findings of relevant Licence Holder Inspections in a letter and will be encouraged to contact the NHMRC Monitoring and Compliance Section should they have any concerns regarding Inspection findings and outcomes.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2004-2005, 2 & 3 June 2004

Question: E04-107

OUTCOME 9: Health Investment

Topic: EMBRYO RESEARCH

Written Question on Notice

Senator Harradine asked:

What is the process proposed for the planned review of the *Research Involving Human Embryos Act*? What work has been undertaken so far?

Answer:

The Minister is currently considering the process for the appointment of the Review Committee and the development of its terms of reference in consultation with the Prime Minister and other relevant Ministers. The Review Committee will comprise individuals with recognised ability in the fields of science, law, ethics and/or community representation.

The review will be independent. It will involve extensive consultation with Australian Governments and the wider community.

An Australian Government Steering Group has been convened in order to oversee the establishment of the review and to facilitate consultation with other jurisdictions. This steering group will be disbanded when the review is established.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2004-2005, 2 & 3 June 2004

Question: E04-116

OUTCOME 9: Health Investment

Topic: 'EXCESS ART EMBRYO' DEFINITION

Written Question on Notice

Senator Harradine asked:

(a) Why is the definition of "excess ART embryo" different in the *Research Involving Human Embryos Act* to the *Prohibition of Human Cloning Act*?

(b) What are the legal implications of the difference between the two definitions? Does the additional word "treatment" in the *Research Involving Human Embryos Act* mean that there is a practical difference between the definitions?

Answer:

Legal advice indicates that there is no practical difference between the two definitions as they appear in the *Prohibition of Human Cloning Act 2002* and the *Research Involving Human Embryos Act*.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2004-2005, 2 & 3 June 2004

Question: E04-104

OUTCOME 9: Health Investment

Topic: LICENSING COMMITTEE

Written Question on Notice

Senator Harradine asked:

Minutes for the meeting of the NHMRC Licensing Committee on 18 and 19 December note that the Secretariat would obtain a copy of the National Stem Cell Conference papers. Please provide a copy of the papers.

Answer:

The abstracts made available to participants of the 1st National Stem Cell Centre Scientific Conference, 2003 were obtained and provided to members of the Licensing Committee. A copy of the documents is attached.

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

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2004-2005, 2 & 3 June 2004

Question: E04-105

OUTCOME 9: Health Investment

Topic: LICENSING COMMITTEE

Written Question on Notice

Senator Harradine asked:

Please provide a copy of the final or most up-to-date draft format for reporting required by condition 6001 of the Standard Conditions for Using Excess ART Embryos.

Answer:

A copy of the final format for the *Report on the Use of Excess ART Embryos*, as required by condition 3001 of the Standard Conditions for Using Excess ART Embryos, is attached. This document is available on the NHMRC website at www.nhmrc.gov.au/embryo/

Australian Government
National Health and Medical Research Council

Report on the Use of Excess ART Embryos

Licence Number: (*insert licence number*)

Licence Holder: (*insert licence holder as detailed on the licence*)

Activity Title: (*insert activity title as detailed on the licence*)

Period of Report: (*insert the period covered by this report*)

Period the licence is in force: (*insert the period for which the licence has been provided)*

---

1. **Excess ART embryos**:

   Complete the attached spreadsheet in respect of all excess ART embryos for which proper consent has been obtained in respect of the authorised activity (one line per embryo)

2. **Progress toward achievement of the outcomes detailed in the Application for Licence that resulted in this licence**:

Provide an outline of the activity undertaken and outcomes achieved during the reporting period (approximately 500 words)
(text box can be expanded as required)

3. Summary of activity planned for the next reporting period:

Provide a brief description of the activity planned for the next reporting period (approximately 200 words)

(text box can be expanded as required)

Use of Excess ART Embryos

Licence Number:	
Licence Holder:	
Activity Title:	
Period of Report:	
Total Number of Embryos Authorised for Use:	
Total Number of Embryos with Proper Consent:	

List all embryos for which proper consent has been obtained in respect of the authorised activity (one line per embryo):

Count	Embryo ID number	Date proper consent notified to NHMRC Licensing Committee	Site of authorised activity	Date Thawed	OUTCOME (Select one Outcome from picklist)	COMMENTS
					1: Remains in Storage 2: Used for Authorised Activity 3: Did not Survive Thawing 4: Did not grow to the stage/condition required for authorised use 5:Other Outcome - Please Describe	
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						
13						
14						

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2004-2005, 2 & 3 June 2004

Question: E04-108

OUTCOME 9: Health Investment

Topic: NHMRC LICENSING COMMITTEE

Written Question on Notice

Senator Harradine asked:

Please provide a copy of the draft or finalised criteria to assist the NHMRC Licensing Committee to determine whether an application meets the requirements of section 21(4)(b) of the *Research Involving Human Embryos Act*.

Answer:

This document is still in development. It will be made publicly available (including on the NHMRC website) when it has been finalised by the NHMRC Licensing Committee.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2004-2005, 2 & 3 June 2004

Question: E04-109

OUTCOME 9: Health Investment

Topic: LICENSING COMMITTEE KIT

Written Question on Notice

Senator Harradine asked:

Please provide a copy of the revised, reformatted and expanded information kit of the NHMRC Licensing Committee when completed.

Answer:

A copy of the final document will be provided when it has been completed.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2004-2005, 2 & 3 June 2004

Question: E04-103

OUTCOME 9: Health Investment

Topic: LICENSING COMMITTEE

Written Question on Notice

Senator Harradine asked:

In the NHMRC Licensing Committee minutes for 29 and 30 September 2003, you refer to the secretariat seeking a legal opinion on the use of excess ART embryos for training purposes. Please provide a copy of the legal opinion.

Answer:

The minutes of the Licensing Committee meeting of 29 and 30 September 2003 did indicate that the secretariat was "asked to seek a legal opinion on the use of excess ART embryos for training purposes."

The issue to be resolved was whether Parliament intended that training be included as a use of excess ART embryos that could be licensed under the *Research Involving Human Embryos Act 2002*. The Revised Explanatory Memorandum to the Research Involving Embryos Bill 2002 states that one example of where there is a requirement to be licensed is using excess embryos in training people in ART techniques.

Legal advice was obtained as to whether explanatory memoranda could be relied upon as an aid to the interpretation of legislation. Advice received indicated that the Revised Explanatory Memorandum to the Research Involving Embryos Bill 2002 could be utilised to confirm the literal meaning of the term "use" in section 20(1) of the *Research Involving Human Embryos Act 2002.*

Subsequently, the Licensing Committee agreed that each application for a licence to use excess ART embryos will be considered by the Committee on a case by case basis in accordance with the requirements of the Act.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2004-2005, 2 & 3 June 2004

Question: E04-110

OUTCOME 9: Health Investment

Topic: LICENSING COMMITTEE

Written Question on Notice

Senator Harradine asked:

Please provide a copy of the letters of advice to proposed license holders including the paragraph outlining what the license holder can expect of the inspectors appointed by the licensing committee.

Answer:

A copy of the letter is attached.

Australian Government
National Health and Medical Research Council

Contact for this correspondence:
Name: Rhonda Stilling
E-mail: rhonda.stilling@nhmrc.gov.au
Telephone: (02) 6289 9402
Facsimile: (02) 6289 9836
In reply please quote:

Dear

EMBRYO RESEARCH LICENSING COMMITTEE OF THE NHMRC (NHMRC LICENSING COMMITTEE) – APPLICATION NUMBER *(insert number)*

The NHMRC Licensing Committee has completed its consideration of your application (*insert number and title of application)* and intends to issue a licence as detailed at Attachment 1.

It is essential to note that the conditions of this proposed licence are in addition to all of the statutory provisions of the *Research Involving Human Embryos Act 2002* and the *Prohibition of Human Cloning Act 2002*. You should ensure that you are familiar with the provisions of this legislation. It can be accessed on the NHMRC web site at www.nhmrc.gov.au/embryo.

When considering an application for a licence authorising the use of excess ART embryos, the NHMRC Licensing Committee must make its decision in accordance with Section 21 of the *Research Involving Human Embryos Act 2002*, as detailed at Attachment 2. The proposed licence is the result of the Committee's consideration of all information provided by the applicant and the requirements of Section 21 of Act.

Please consider the proposed licence carefully to determine whether the details are correct and acceptable to you as the intended licence holder. Should all details be correct, and you are prepared to accept the proposed conditions as well as those contained in the *Research Involving Human Embryos Act 2002,* you will need to advise the NHMRC Licensing Committee in writing of your decision by *(insert date)*. The licence will then be issued.

Should you have any concerns or queries about aspects of the proposed licence these should be documented and forwarded to the NHMRC Licensing Committee for consideration by *(insert date)*. The Committee and its Secretariat will then work with you in an effort to resolve the issues raised.

Under no circumstances should you contact a member of the NHMRC Licensing Committee. All communication with the NHMRC Licensing Committee must be made through the Committee Secretariat at:

NHMRC Licensing Committee Secretariat
MDP 109
GPO Box 9848
CANBERRA ACT 2601

Telephone: 02 6289 9889
Facsimilie: 02 6289 9836
Email: embryo.research@nhmrc.gov.au

The activity set out in this proposed licence may not commence until the NHMRC Licensing Committee has issued the licence and the pre-commencement conditions prescribed by Section 24 of the *Research Involving Human Embryos Act 2002* have been met.

You should also be aware that Section 29 of the *Research Involving Human Embryos Act 2002* requires the NHMRC Licensing Committee to maintain a public database containing the following information in relation to each licence (including a licence as varied):

a) the name of the person to whom the licence was issued;
b) a short statement about the nature of the uses of excess ART embryos that are authorised by the licence;
c) any conditions to which the licence is subject;
d) the number of excess ART embryos in respect of which use is authorised by the licence;
e) the date on which the licence was issued; and
f) the period throughout which the licence is to remain in force.

Thus, once issued, summary information and a copy of your licence will be placed on the embryo research page of the NHMRC website at www.nhmrc.gov.au/embryo/artembry.htm. Each licence is drafted in consultation with the applicant to ensure that private information and confidential commercial information is protected when the licence is made available to the public.

You should also note that, in accordance with Section 22 of the *Research Involving Human Embryos Act 2002*, the NHMRC is required to notify the (*insert name of HREC*) and *(insert name of relevant State body*) when a licence has been issued to you. A copy of this letter has therefore been forwarded to these organisations.

Inspectors appointed under Section 33 of the *Research Involving Human Embryos Act 2002* will monitor compliance with the conditions attached to licences issued by the NHMRC Licensing Committee and the requirements specified by the *Research Involving Human Embryos Act 2002* and the *Prohibition of Human Cloning Act 2002.* Where a licence holder requires further information about the legislation or compliance with specific conditions of

the licence, Inspectors are available to conduct information exchange visits. A copy of two Monitoring and Compliance fact sheets are enclosed at Attachment 3 for your information.

It is essential that the advice contained in this letter and its attachments remains confidential until a licence has been issued. Failure to maintain confidentiality could compromise the ability of the NHMRC Licensing Committee to properly perform its function under the *Research Involving Human Embryos Act 2002.*

You may appeal to the Administrative Appeals Tribunal for review of decisions of the NHMRC Licensing Committee. Information about your review rights is enclosed at Attachment 4.

Should you have any queries please contact the NHMRC Licensing Committee Secretariat as detailed on page one of this letter.

Yours sincerely

Dr Clive Morris

Executive Director

Compliance and Evaluation Branch

[Date]

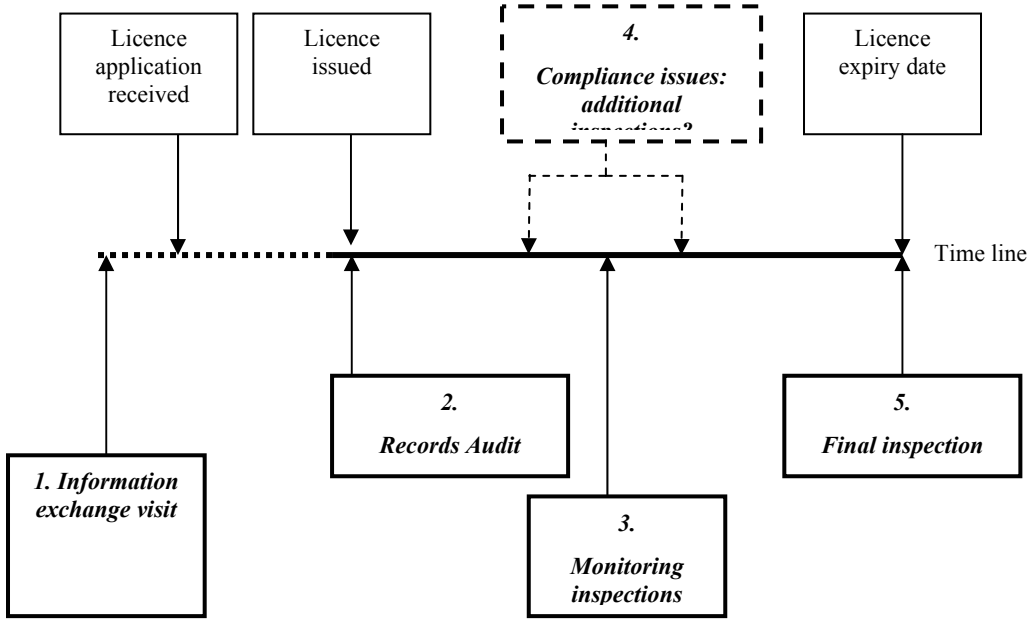
cc. (*insert details for HREC and relevant State body*)

NHMRC MONITORING AND COMPLIANCE
FACT SHEET 1
OVERVIEW OF THE MONITORING AND COMPLIANCE ACTIVITIES CONDUCTED BY INSPECTORS

This fact sheet provides a general overview of the monitoring and compliance activities that Inspectors will conduct in relation to Licences issued by the NHMRC Licensing Committee to authorise the use of excess ART embryos.

The monitoring and compliance activities are designed to provide guidance on compliance with Licence conditions, the *Research Involving Human Embryos Act 2002* and the *Prohibition of Human Cloning Act 2002*. The *NHMRC Monitoring and Compliance Fact Sheet 2: Monitoring and Compliance Information* provides more detail about individual monitoring and compliance activities.

Overview of the monitoring and compliance activities conducted by Inspectors



1. Information Exchange Visit

Information Exchange Visits are designed to strengthen cooperative compliance of organisations and persons affected by the legislation through an increased awareness of legislative requirements.

2. Records Audit Inspection

Records Audit Inspections are conducted by Inspectors to provide assistance to Licence Holders in meeting their conditions of Licence. A Records Audit Inspection includes a detailed examination of records and systems (eg. embryo tracking system, procedures to ensure correct embryo thawed) relevant to the licensed activities. Records Audit Inspections are conducted within a few weeks of the issuing of the Licence by the NHMRC Licensing Committee.

3. Monitoring Inspections

Monitoring inspections of Licence Holders are conducted by Inspectors to ensure that compliance with legislative requirements and Licence conditions is maintained. Monitoring Inspections provide another opportunity for information exchange with the Licence Holder.

Monitoring inspections of Licence Holders will be conducted at least annually for the duration of the Licence. Where a Licence is issued for a period of less than 12 months, at least one monitoring inspection will be conducted. Where necessary, further monitoring inspections may be required to address compliance issues.

4. Compliance Issues

Compliance issues identified during the course of a Records Audit Inspection or Monitoring Inspection will be reported to the NHMRC Licensing Committee and may result in further Information Exchange Visits and/or follow-up inspections of the Licence Holder.

5. Final Inspection

Final Inspections are conducted on, or immediately preceding the Licence expiry date. Inspectors will provide advice and assistance to Licence Holders in the preparation of their final report on their licensed activities.

Do you need further information?

Further information is available from the NHMRC Monitoring and Compliance Section:

MDP109 GPO Box 9848
Canberra ACT 2601
Telephone: 1800 020 103
Facsimile: 02 6289 9836
monitoring@nhmrc.gov.au
http://www.nhmrc.gov.au/embryo/monitor

NHMRC MONITORING AND COMPLIANCE
FACT SHEET 2
MONITORING AND COMPLIANCE INFORMATION

This fact sheet:

- provides further detail to the overview provided in *NHMRC Monitoring and Compliance Fact Sheet 1: Overview of the Monitoring and Compliance Activities Conducted by Inspectors*;
- is designed to promote a better understanding of the monitoring and compliance activities that Inspectors will conduct in relation to Licences issued by the NHMRC Licensing Committee to authorise the use of excess ART embryos; and
- provides guidance on compliance with Licence with Licence conditions, the *Research Involving Human Embryos Act 2002* and the *Prohibition of Human Cloning Act 2002*.

1 INFORMATION EXCHANGE VISITS

1.1 What is an Information Exchange Visit?

Information Exchange Visits are provided to organisations and individuals affected by the legislation (including Licence Holders) and have the following objectives:

- to promote increased awareness of the *Research Involving Human Embryos Act 2002* and the *Prohibition of Human Cloning Act 2002*;
- to foster two-way communication between those affected by the legislation and the NHMRC Monitoring and Compliance Section;
- to encourage information sharing; and
- to provide guidance on ensuring compliance.

1.2 What is the purpose of an Information Exchange Visit?

Inspectors will conduct Information Exchange Visits to:

- provide organisations and individuals affected by the legislation with an opportunity to have their information requirements met and any specific concerns/issues they may have addressed;
- increase awareness of legislative requirements; and
- foster a cooperative compliance relationship.

1.3 What is the format of an Information Exchange Visit?

The content and format of each Information Exchange Visit is tailored to the specific needs of each organisation, including organisations that may be applying for, or preparing a Licence application to submit to the NHMRC Licensing Committee for the use of excess ART embryos.

Prior to the Information Exchange Visit the organisation is provided with an Information Request Form on which the organisation specifies the following information:

- the specific information needs of the organisation;
- individuals or groups of staff (eg. research, administrative, management) that would like a separate face to face meeting; and
- preferred delivery method(s).

The information provided by the organisation on the Information Request Form is used to design an Information Exchange Visit that meets the information needs of the organisation. The delivery method can include the following:

- PowerPoint presentation of information requested by the organisation; and/or
- meeting with individual staff; and/or
- meeting with groups of staff.

2 RECORDS AUDITS INSPECTION

2.1 What is the purpose of Records Audit Inspection?

Records Audit Inspections of Licence Holders are conducted by Inspectors to:

- ensure record keeping and documentation systems meet Licence conditions and legislative requirements;
- provide guidance for compliance with Licence conditions and the *Research Involving Human Embryos Act 2002* and the *Prohibition of Human Cloning Act 2002*; and
- provide advice to, and exchange information with, the Licence Holder as necessary.

2.2 When will Records Audit Inspection be conducted?

A Records Audit Inspection will be conducted within a few weeks of the issuing of the Licence by the NHMRC Licensing Committee.

3 MONITORING INSPECTIONS

3.1 What is the purpose of Monitoring Inspections?

Inspectors will conduct Monitoring Inspections of Licence Holders in order to:

- provide advice to the Licence Holder;
- provide guidance to ensure compliance with Licence conditions, the *Research Involving Human Embryos Act 2002* and the *Prohibition of Human Cloning Act 2002*;
- review the licensed activities; and

- assess the level of compliance of the Licence Holder with Licence conditions and legislative requirements.

3.2 How often will Monitoring Inspections be conducted?

Monitoring Inspections of Licence Holders will be conducted at least annually for the duration of the Licence. Where a Licence period is less than 12 months, at least one Monitoring Inspection will be conducted. Should compliance issues come to light Monitoring Inspections may be conducted more frequently.

4 MAINTAINING COMPLIANCE AND LICENCE HOLDERS

4.1 What is a compliance issue?

A compliance issue arises when a Licence Holder has difficulty in meeting Licence conditions or legislative requirements. Compliance issues may be reported by the Licence Holder or identified during a Records Audit Inspection or Monitoring Inspections of Licence Holders.

4.2 How will compliance issues be resolved?

Compliance issues will be reported to the Chair of the NHMRC Licensing Committee and will be dealt with on a case by case basis.

The resolution of a compliance issue may result in any one or more of the following actions:

- further Information Exchange Visits;
- follow-up inspections; or
- variation, suspension or cancellation of the Licence

5 FINAL INSPECTIONS

5.1 What is the purpose of Final Inspections?

Inspectors will conduct Final Inspections of Licence Holders in order to:

- provide advice on the preparation of the final report on the licensed activities;
- provide advice on processes to ensure that activities involving excess ART embryos will not be conducted after the Licence expiry date unless authorised by a valid Licence; and
- ensure Licence Holders have achieved all legislative requirements and Licence conditions on completion of the licensed activities.

5.2 When will Final Inspections be conducted?

Final Inspections of Licence Holders will be conducted on, or immediately proceeding, the Licence expiry date.

6 INSPECTIONS AND AUDITS – GENERAL INFORMATION

6.1 Will Licence Holders be notified of Audits and Inspections before they take place?

The Licence Holder will be contacted by an Inspector prior to the Records Audit Inspection, Monitoring Inspection or Final Inspection to arrange a mutually agreeable date and time. The Human Research Ethics Committee (HREC) that assessed the Licence application will also be informed of the impending audit or inspection.

6.2 How will Audits and Inspections be conducted?

Audits and Inspections will involve the following activities:

6.2.1 Presentation of Inspector identity card

When the Inspectors arrive at the premises they will identify themselves by presenting their Inspector identity card, which includes the Inspector's photograph and signature. This is to assure Licence Holders that the holder of the card has been appointed in accordance with Section 33(1) of the *Research Involving Human Embryos Act 2002* Act by the Chair of the NHMRC Licensing Committee.

6.2.2 Introductory meeting

Prior to conducting the audit or inspection an introductory meeting will be held with the Licence Holder. The purpose of this meeting is to:

- explain the audit or inspection process;
- provide Licence Holders with an opportunity to ask questions, seek clarification and receive any appropriate advice or assistance they may require; and
- take on notice any questions that the Inspectors are unable to answer at the time.

6.2.3 Documentation inspection

During this phase of the audit or inspection the Inspectors will examine the records, documentation and embryo tracking systems relevant to the excess ART embryos that have been authorised for use in the licensed activities, including:

- documentary evidence that each embryo used in the licensed activity has been declared to be excess to the needs of the woman for whom it was created and her spouse at the time the embryo was created;
- documentary evidence that proper consent for the licensed use of the excess ART embryos is obtained from each responsible person in relation to each excess ART embryo;
- records (including laboratory books) relating to all outcomes of the licensed activity for each individual excess ART embryo removed from cryostorage; and
- other records/documentation considered relevant to the Licence.

6.2.4 Premises inspection

During this phase of the audit or inspection the Inspectors will inspect the premises, paying particular attention to:

- the tracking system to uniquely identify each excess ART embryo at all times;
- procedures for ensuring that the correct embryo is thawed;
- that all activities involving human embryos are either licensed or exempt from licensing;
- that only persons authorised by the Licence are involved in the licensed activity; and
- compliance with all Licence conditions, the *Research Involving Human Embryos Act 2002* and the *Prohibition of Human Cloning Act 2002*.

6.2.5 Debrief meeting

At the conclusion of the audit or inspection, the Inspectors will conduct a debrief meeting with the Licence Holder to discuss the findings of the audit or inspection. Any comments that the Licence Holder has in relation to the findings of the Monitoring Inspection will be included in the Monitoring Inspection Report to the Chair of the NHMRC Licensing Committee. Licence Holders will receive a letter advising them of the outcomes of the monitoring and compliance activity after it has been endorsed by the Chair of the NHMRC Licensing Committee. A copy of this letter will be sent to the relevant HREC and State or Territory agency.

Do you need further information?

Should an organisation have any queries regarding monitoring and compliance matters or the *Research Involving Human Embryos Act 2002* and the *Prohibition of Human Cloning Act 2002*, the NHMRC Monitoring and Compliance Section can be contacted directly for advice at:

MDP109 GPO Box 9848
Canberra ACT 2601
Telephone: 1800 020 103
Facsimile: 02 6289 9836
monitoring@nhmrc.gov.au
http://www.nhmrc.gov.au/embryo/monitor

Section 21 Determination of application by Committee

(1) This section applies if a person has made an application under Section 20 for a licence.

(2) The NHMRC Licensing Committee must decide, in accordance with this section, whether or not to issue a licence.

(3) The NHMRC Licensing Committee must not issue the licence unless it is satisfied of the following:

(a) that appropriate protocols are in place:

(i) to enable proper consent to be obtained before an excess ART embryo is used under the licence (see paragraph 24 (1)(a)); and

(ii) to enable compliance with any restrictions on such consent;

(b) if the use of an excess ART embryo proposed in the application may damage or destroy the embryo – that appropriate protocols are in place to enable compliance with the condition that such use is authorised only in respect of an embryo created before 5 April 2002 (see subsection 24(3));

(c) that the activity or project proposed in the application has been assessed and approved by a HREC that is constituted in accordance with, and acting in compliance with, the NHMRC *National Statement on Ethical Conduct in Research Involving Humans (*1999), as in force from time to time.

(4) In deciding whether to issue the licence, the NHMRC Licensing Committee must have regard to the following:

(a) restricting the number of excess ART embryos to that likely to be necessary to achieve the goals of the activity or project proposed in the application;

(b) the likelihood of significant advance in knowledge or improvement in technologies for treatment as a result of the use of excess ART embryos proposed in the application, which could not reasonably be achieved by other means;

(c) any relevant guidelines, or relevant parts of guidelines, issued by the NHMRC under *the National Health and Medical Research Council Act 1992* and prescribed by the regulations for the purposes of this paragraph;

(d) the HREC assessment of the application mentioned in paragraph (3)(c);

(e) such additional matters (if any) as are prescribed by the regulations.

REVIEW OF DECISIONS OF THE NHMRC LICENSING COMMITTEE BY THE ADMINISTRATIVE APPEALS TRIBUNAL

WHICH DECISIONS ARE REVIEWABLE?

Decisions of the NHMRC Licensing Committee that are reviewable by the Administrative Appeals Tribunal include:

(a) a decision under s.21 of the *Research Involving Human Embryos Act 2002* (the Act) not to issue a licence;

(b) a decision in respect of the period throughout which the licence is to be in force under s.23 of the Act;

(c) a decision to specify a licence condition under s.24(4) of the Act;

(d) a decision to vary or refuse to vary a licence under s.25 of the Act;

(e) a decision to suspend or revoke a licence under s.26 of the Act.

WHO CAN APPLY?

An application for review of a decision of the NHMRC Licensing may be made:

(a) in relation to a decision under s.21 of the Act not to issue a licence – by the applicant for the licence;

(b) in relation to a decision in respect of the period throughout which the licence is to be in force under s.23 of the Act – by the licence holder;

(c) in relation to a decision to specify a licence condition under s.24(4) of the Act – by the licence holder;

(d) in relation to a decision to vary or refuse to vary a licence under s.25 of the Act – by the licence holder; or

(e) in relation to a decision to suspend or revoke a licence under s.26 of the Act – the person who was the licence holder immediately before the suspension or revocation.

TIME LIMITS

There are time limits on lodging applications to the Tribunal. Applications to the Administrative Appeals Tribunal for review of reviewable decisions of the NHMRC Licensing Committee should be made within 28 days from the date the decision is received.

FEES

In most cases an application fee of $574 is required to accompany an application for review. The application fee may be waived by the Tribunal or refunded in certain circumstances.

FURTHER INFORMATION

Contact details for the Administrative Appeals Tribunal can be found in your local telephone directory. The address for all correspondence is:

Deputy Registrar
Administrative Appeals Tribunal
GPO Box 9955
in your Capital City

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2004-2005, 2 & 3 June 2004

Question: E04-111

OUTCOME 9: Health Investment

Topic: LICENSING COMMITTEE

Written Question on Notice

Senator Harradine asked:

Please provide a copy of the document referred to in the Licensing Committee minutes of 18 and 19 December, item 12.3, describing how to obtain consent for the use of excess human embryos and the letter to state authorities as well as how the model differs from the current practice, when available.

Answer:

The NHMRC Licensing Committee worked with the NHMRC's Australian Health Ethics Committee to produce advice on the legislative requirements for obtaining proper consent for research on excess ART embryos. A companion document outlining the operational stages of consent required before embryos can be used for activities licensed under the *Research Involving Human Embryos Act 2002* has also been produced. The documents are available on the NHMRC website at www.nhmrc.gov.au/embryo/inform.htm

A copy of these documents and the letter to State authorities is attached.

Australian Government
National Health and Medical Research Council

Contact for this correspondence:
Name: Rhonda Stilling
E-mail: rhonda.stilling@nhmrc.gov.au
Telephone: (02) 6289 9402
Facsimile: (02) 6289 9836
In reply please quote:

Dear

EMBRYO RESEARCH LICENSING COMMITTEE OF THE NHMRC

OBTAINING PROPER CONSENT

The *Research Involving Human Embryos Act 2002* requires that any licence issued by the Committee must be subject to the condition that, before an excess assisted reproductive technology (ART) embryo is used, each responsible person must have given proper consent. The Act also requires that all applications for a licence to use excess ART embryos are assessed and approved by a properly constituted Human Research Ethics Committee (HREC) prior to being considered by the NHMRC Licensing Committee.

The NHMRC Licensing Committee has therefore worked with the Australian Health Ethics Committee (AHEC) to produce advice on the legislative requirement for obtaining proper consent. A document entitled 'Research Involving Human Embryos Act 2002: Advice from Australian Health Ethics Committee and the Licensing Committee of the NHMRC on the Legislative Requirements for Obtaining Proper Consent for Research on Excess ART Embryos' is now available for use by licence applicants and HRECs.

To assist applicants and HRECs to understand the operational stages of consent required before embryos can be used for activities licensed under the *Research Involving Human Embryos Act 2002,* the Licensing Committee has also developed a document entitled 'Obtaining Consent: Stages where declarations or consent forms are required'.

The NHMRC Licensing Committee has asked that both these advisory documents be made available to your organisation in the interest of ensuring that arrangements put in place by relevant groups under your jurisdiction comply with statutory requirements. I have enclosed a copy of each document, which can also be obtained from the Embryo Research page of the NHMRC website at www.nhmrc.gov.au/embryo.

Should you require any further information or assistance at any time the NHMRC Licensing Committee Secretariat is available to assist. The Secretariat can be contacted at:

NHMRC Licensing Committee Secretariat
MDP 109
GPO Box 9848
CANBERRA ACT 2601

Telephone: 02 6289 9889
Facsimilie: 02 6289 9836
Email: embryo.research@nhmrc.gov.au

I will keep you informed of other relevant procedural and policy advice as it is developed by the NHMRC Licensing Committee.

Yours sincerely

Dr Clive Morris
Executive Director
Centre for Compliance and Evaluation
April 2004

Obtaining Consent: Stages where declarations or consent forms are required

This document outlines the operational stages of consent that are required before embryos can be used for activities licensed under the *Research Involving Human Embryos Act 2002* (RIHEA).

The advice in this document is intended to supplement the advice provided by the NHMRC Licensing Committee and the Australian Health Ethics Committee in late 2003, which links the requirements of the NHMRC *Ethical guidelines on assisted reproductive technology (1996)*, the *National Statement on Ethical Conduct in Research Involving Humans (1999)* and the RIHEA. This advice is available on the NHMRC web-site (www.nhmrc.gov.au/embryo/inform.htm).

Consent for the purposes of the RIHEA is a two-stage process. First, couples must declare in writing that the embryos are excess to their requirements and second "proper consent" is obtained for use of excess embryos in a licensed research project. This is explained in more detail below.

Stage 1: Declaration that embryos are "excess ART embryos"

This occurs when a couple determines that they no longer require embryos, which have been created for them for the purposes of their ART treatment. A written declaration is required at this point. The declaration that the embryos are no longer required for achieving pregnancy must be made irrespective of the intended outcomes for the embryos. This declaration meets the requirements of the definition of *excess ART embryo* in the RIHEA.

Outcomes for excess ART embryos

The couple for whom the embryos were created may be asked to indicate, at the time that they declare their embryos to be excess ART embryos, what they wish to happen to the embryos. This indication enables the clinic to provide the couple with further information as required. The options are:

- Allowing embryos to succumb, in which case no further consent is required;
- Donating embryos to another couple, in which case clinics will follow their normal procedures; or
- Donating embryos to activities licensed under the RIHEA.

Stage 2: Proper Consent for use in specific activities licensed under the RIHEA

If embryos have been declared to be excess ART embryos (Stage 1) and a couple are considering donating their excess ART embryos to research, then they will need to give "proper consent" as defined in the RIHEA. This involves being provided with sufficient information, including an oral explanation, at a level appropriate to their ability to understand it, for them to be able to make an informed decision before signing the consent form.

Restrictions on consent and responsible persons

- It should be noted that the RIHEA requires "proper consent" to be obtained from all "responsible persons". In addition to the woman (and her spouse) for whom the embryo was created, responsible person includes each person who donated gametes and his or her spouse at the time.
- It should also be noted that the RIHEA requires a licence holder to have in place protocols that allow compliance with any restrictions that responsible persons may place on proper consent.

"Advance directives" and commencement of ART programs

- When a woman or couple commence ART treatment, they are asked to give consent to that treatment. In some jurisdictions, this consent includes an "advance directive" relating to future use of the embryos.
- In relation to the RIHEA, such advance directives do not constitute proper consent (the two stage process outlined above) and proper consent to the use of an excess ART embryo would still need to be obtained after the ART embryo has been declared excess.

Research Involving Human Embryos Act 2002: Advice[1] from Australian Health Ethics Committee and the Licensing Committee of the NHMRC on the Legislative Requirements for Obtaining Proper Consent for Research on Excess ART Embryos

The *Research Involving Human Embryos Act 2002* (*RIHE Act*) requires each licence to be subject to the condition that, before an excess ART embryo is used as authorised by the licence, each responsible person in relation to the excess ART embryo must have given proper consent to that use (Section 24). This interim document is intended to make licence applicants and HREC members aware of what constitutes proper consent in regard to this legislation[2].

This advice is given to guide HRECs only in relation to consent to uses of embryos that have been declared, by the persons responsible, to be excess to their needs. The advice is not given for use in relation to consent to any other decisions about embryos or research in assisted reproductive technology.

Preamble

The *RIHE Act* (Section 8) defines proper consent, in relation to the use of an excess ART embryo, as consent obtained in accordance with the *NHMRC Ethical Guidelines on Assisted Reproductive Technology 1996* (herein the *Guidelines*). The *RIHE Act* (Section 21) also determines that the NHMRC Licensing Committee must not issue a licence unless satisfied that the activity or project proposed in the application has been assessed and approved by a HREC that is constituted in accordance with, and acting in compliance with the *NHMRC National Statement on Ethical Conduct in Research Involving Humans* (1999) (herein the *National Statement*).

It is essential that applicants and HRECs have a thorough knowledge of these documents. It should be noted that provisions of the *RIHE Act* and any regulations made under it, take precedence over any guidelines issued by the NHMRC and its committees.

The decision to make their excess ART embryos available for research is a difficult one for many people. There are differences of opinion in our community regarding the moral status of the human embryo. It is important that licence applicants are sensitive in their approach to obtaining consent. It should also be noted that the relationship between people and embryos for which they are responsible can change over time.

The procedures outlined in this document must not be initiated until all persons responsible have agreed in writing that the embryos are excess. Consent for the specified research project must not be sought until embryos are declared to be excess.

Licence applicants report in writing that an HREC has assessed and approved the activity or project to which the licence relates so as to show compliance with the conditions specified in Section 24 of the *RIHE Act*.

[1] This advice is based on the current NHMRC *Ethical guidelines on assisted reproductive technology 1996* and legislation as at September 2003.
[2] HRECs should follow this advice pending the completion of the revised reproductive technology guidelines.

It is the responsibility of the HREC to ensure that the activity or project has been designed so that proper consent will have been obtained before an excess ART embryo is used. A HREC must also ensure that no member of the committee adjudicates on research in which that member has any conflict of interest (see *National Statement* 2.20).

In reviewing and approving the proposed process for obtaining proper consent, the following points should be taken into consideration.

Principles of Ethical Conduct

The *National Statement* clearly defines its primary purpose as the protection of the welfare and rights of participants in research. The values and principles that researchers are required to demonstrate and follow towards participants include integrity, respect for persons, beneficence and justice (see *National Statement* 1.1-1.21). The definition of participants in the *National Statement* includes those upon whom the research impacts. This translates into the need to obtain consent from persons responsible for the embryos, before any research activity is undertaken..

Proper consent means consent that is:

- informed;
- given by a person competent to do so;
- voluntary; and
- specific.

1. Informed

1.1 Persons responsible for the embryos should be provided with information, at their level of comprehension, about the purpose, methods and possible outcomes of research, including the likelihood and form of publication of research results (*National Statement* 1.7). This should be done as an oral explanation, supported by written information in plain language which is provided in sufficient time for it to be taken away, read and considered, prior to the giving of consent. This explanation should be given with sensitivity to the individual needs of the patient (*Guidelines* 3.1.2*)*.

1.2 Where persons responsible are not fluent in English, it is recommended that an independent interpreter be used to convey information and answer questions. Written information must be translated into the language of the responsible persons (*National Statement* 2.26; *Guidelines* 3.1.2). Similarly, where persons responsible have other communication needs, appropriate facilities should be provided.

1.3 Informed decision-making is required for all persons responsible, including the spouses or partners of donors of gametes and embryos at the time of donation. (*Guidelines* 3.2.5, 6.4). Licence applicants should be aware that in some cases, more than two adults will need to give consent for the use of any given embryo. These parties should be contacted at the time at which the future of the embryos is being decided and given the relevant information as outlined in this document.

1.4 The researcher is required to disclose to the HREC any financial interest in the research and the HREC must consider the extent to which disclosure of relevant financial aspects of research should be made to the persons responsible (*National Statement* 2.21). As persons responsible must be given all information which may be of significance (*Guidelines* 3.1), HRECs would normally decide to disclose all financial aspects to participants. For example, where researchers plan to request altruistic donation of embryos with the intention of gaining commercial profit, this must be made clear to the donors before consent is obtained.

1.5 Persons responsible should be provided with the name or position and contact details of the person nominated by the relevant HREC to receive complaints along with procedures for raising concerns or obtaining additional information on the research (*National Statement*, 2.42).

1.6 Persons responsible must be informed that records may be viewed by NHMRC inspectors to meet the requirements of the *RIHE Act*.

2. Competence to make a choice

2.1 Persons responsible from whom consent is obtained must be competent to make a choice. Where a person responsible does not have the capacity to make a choice, the choice may be made by a person with lawful authority to decide for that participant. (*National Statement* 1.7).

2.2 Persons responsible are free to refuse to give consent to the use of an embryo without giving any explanation or justification for the refusal (*National Statement* 1.8).

2.3 Subject to prevailing state/territory legislation, where disputes arise between responsible persons about the use of an embryo, the embryo should be kept and not allowed to succumb until the dispute has been resolved and a decision taken about the embryo (*Guidelines* 3.2.8*)*.

2.4 Should a person with responsibility to make decisions about an embryo die, the surviving person(s) responsible should make the relevant decisions about the use of the embryo, taking into consideration any advance directive from the deceased and subject to prevailing state/territory legislation.

2.5 Subject to prevailing state/territory legislation, should all responsible persons die, any advance directive from the deceased responsible persons should be considered. If there is no advance directive, or if an advance directive exists but has not been endorsed, or the advance directive cannot be complied with, the embryo should be allowed to succumb. (*Guidelines* 3.2.9).

3. Voluntary

3.1 Consent of persons responsible must be voluntary and not subject to any coercion, inducement or influence, such as financial or other rewards, that could impair its voluntary character. (*National Statement* 1.10)

3.2 In particular it is important that researchers be aware of the possibility of even unwitting coercion, for example where a doctor-patient relationship exists and the doctor is also the researcher (*National Statement* 7.1). For this reason, it is recommended that the person who approaches the persons responsible for the embryos to be used, be independent of their clinical care.

3.3 Any concealment of the purposes of a study from the persons responsible is not considered ethical and prevents informed and voluntary consent (*National Statement* 17.1).

4. Specific

4.1 Persons responsible should be provided with information about the intended use of the embryo. The consent form must specify the purpose for which that embryo or embryos may be used (*Guidelines*, 3.2.5). Consent must be given for a specific purpose, for example, for destructive research (detail type of research and the rationale for the research). In the case of destructive embryo research, it must be made clear to the persons responsible for the embryo that the fate of individual embryos may not be able to be reported. The specific scope of the research and the consent sought must be made clear. For example, if stem cells were to be harvested from a given embryo, the persons responsible would be consulted about that use of the embryo, but, for the purpose of giving the proper consent required under the RIHE Act, would not need to be consulted about the subsequent use of those stem cells.

5. Withdrawal of consent

5.1 A person responsible must be free at any time to withdraw consent to further involvement in the research (*National Statement* 1.12). In the case of destructive embryo research, persons responsible for the embryo need to be aware that withdrawal is not possible after the embryo has been destroyed. In view of this, it is recommended that the consent of persons responsible to a use which will damage or destroy an embryo must not be acted upon until a suitable fixed period of time for re-consideration has been allowed, normally at least 2 weeks after their consent to such research. This 'cooling-off' period before consent becomes effective must be explained to the persons responsible when consent is obtained.

6. Consent forms

6.1 Consent should be given in writing *(Guidelines* 3.2.2*)*.

6.2 The entire consent process, including forms and protocols, should be reviewed and approved by an HREC.

6.3 For clarity, terminology on the consent form should match definitions in the *RIHE Act*.

6.4 All of the documentation to be used in obtaining consent should be included in the application to the HREC (National Statement 2.24) as well as in the application for a licence to the NHMRC Licensing Committee.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2004-2005, 2 & 3 June 2004

Question: E04-112

OUTCOME 9: Health Investment

Topic: LICENSING COMMITTEE

Written Question on Notice

Senator Harradine asked:

Please provide minutes of any further meetings of the NHMRC Licensing Committee since December 18 and 19, 2003 and the minutes of the June 8 and 9, 2004 meeting when available.

Answer:

The minutes of the NHMRC Licensing Committee meeting of 16 March 2004 are attached.

The minutes of the meeting of 8-9 June 2004 will be provided when available.

Australian Government
National Health and Medical Research Council

NHMRC LICENSING COMMITTEE

Minutes of the Meeting of 16 March 2004
Canberra

8.00am to 5.00pm Tuesday 16th March 2004

ATTENDANCE

Members:
Professor Jock Findlay (Chairperson)
Dr Megan Best
Professor Don Chalmers
Dr Peter Illingworth
Dr Graham Kay
Dr Julia Nicholls
Ms Helen Szoke

Apologies:
Dr Kerry Breen
A/Pr Christopher Newell

Secretariat:
Dr Clive Morris
Mr Phillip Hoskin
Ms Rhonda Stilling
Dr Alison Mackerras
Ms Amy Hendry
Dr Harry Rothenfluh
Ms Jennifer Simpson
Ms Carmel Boyd

Legal Services Branch:
Mr Mark Gladman

Item 1: Opening

The meeting commenced at 8.10am.

Item 1.1: Apologies

Members noted apologies for the meeting.

Item 1.2: Confidentiality and Conflict of Interest

Members were reminded of their obligations in respect of confidentiality and conflict of interest.

Item 1.3: Chairman's Report

The Chairman informed members that:

- NHMRC Management Committee had met in the first week in February;
- He and Ms Szoke attended a session for trainees in the Certificate for Reproductive Endocrinology and Infertility on the 13th March 2004; and

A copy of the Licensing Committee Chairs' Report to Council for its meeting of

18-19 March 2004 was distributed to the members at the meeting.

Item 2: Appointment of Deputy Chair

Professor Don Chalmers was appointed as Deputy Chair of the Licensing Committee.

***Decision**:* Appoint Professor Don Chalmers as Deputy Chair of the Licensing Committee.

Item 3: Minutes of Meeting of 18th and 19th December 2003

The Minutes of the meeting of 18 and 19 December 2003 were endorsed with three editorial amendments.

Item 3.1: Action Arising

The schedule detailing progress on action arising from the meeting of 18-19 December 2003 was noted.

Item 3.2: Outcomes of Discussion with Reproductive Technology Accreditation Committee (RTAC)

The Committee discussed the desirability of strengthening its relationship with RTAC and agreed to commence the development of an agreement about information exchange between the NHMRC Licensing Committee and RTAC, through the Fertility Society of Australia (FSA). This will ensure that the two Committee's have timely information about issues of particular relevance to both parties. Members agreed that the arrangements would be such as to protect confidential information.

The Secretariat was asked to draft, in consultation with Legal Services Branch, an information exchange document for consideration at the June 2004 meeting of the NHMRC Licensing Committee.

In the interim, all policy advice endorsed by the NHMRC Licensing Committee will be forwarded to FSA/RTAC for information.

Item 4: NHMRC Activities

Item 4.1: Council Activities

Council Secretariat briefed members on recent activities of Council including:

- the Joint meeting of Council and all Principal Committees to be held on 17 March 2004;
- the development of an NHMRC submission to the Australian Law Reform Commission's inquiry into Gene Patenting and Human Health;
- the outcomes of the meeting of Management Committee of the 2 February 2004;

- the Aboriginal and Torres Strait Islander Forum update, noting that the ATSI forum has requested that the Licensing Committee speak to the forum about the work of the NHMRC Licensing Committee.

It was agreed that a Working Committee comprised of Professor Findlay and Drs Best and Nicholls will represent the NHMRC Licensing Committee in future work associated with the NHMRC submission to the Australian Law Reform Commission's inquiry into Gene Patenting and Human Health.

Decisions:

Working Committee comprised of Professor Findlay and Drs Best and Nicholls to represent the NHMRC Licensing Committee in future work associated with the NHMRC submission to the Australian Law Reform Commission's inquiry into Gene Patenting and Human Health.

Item 4.2: Business Plan

Members noted that business plans for the NHMRC's Principal Committees will be a major item for discussion at the joint Council and Principal Committee meeting to be held on the 17th March 2004. The Committee will respond to decisions taken at the joint meeting and consider a further draft of its Business Plan at its June 2004 meeting.

Decisions:

Committee to discuss its Business Plans at the joint Council and Principal Committee meeting on the 17th March 2004, and make amendments as necessary.

Item 4.3: Report by Australian Health Ethics Committee (AHEC) Representative

Members noted the AHEC Chair's Report to Council.

The Committee expressed a particular interest in the review of the Ethical Guidelines on Assisted Reproductive Technology 1996 and noted that the draft guidelines will be made available to the NHMRC Licensing Committee for consideration. The draft Guidelines are expected to be available for the June 2004 meeting of the NHMRC Licensing Committee.

Decision:

NHMRC Licensing Committee to consider the redrafted *Ethical Guidelines on Assisted Reproductive Technology* at its June 2004 meeting.

Item 4.4: Privacy Working Group

Ms Szoke, who represents the NHMRC Licensing Committee on the NHMRC's Privacy Working Group, updated members on the work of the Group. The Committee noted the report.

Item 5: Consent

The Committee requested minor modifications to the "Obtaining Consent: Stages where declarations or consent forms are required" document and once these had been made endorsed the document for use and distribution, including via the NHMRC website.

Decision:

Secretariat to place the endorsed document entitled "Obtaining Consent: Stages where declarations or consent forms are required" on the NHMRC web site as well as making it available to applicants.

Send letter introducing document to relevant State Authorities.

Item 6: Likelihood of Significant Advance

Members discussed the draft document and suggested amendments. Secretariat was asked to distribute an amended draft to the Committee for out of session endorsement. Following endorsement this document will be placed on the NHMRC website.

Decision:

Secretariat to include amendments and seek out of session endorsement.

Secretariat to then place the endorsed document on the NHMRC website.

Item 7: Status of Licences

The Committee noted that Secretariat has obtained advice from the Department's General Counsel on the licence documents for five licences that the Committee has agreed to issue. The Minister has been informed of the Committee's intention to now issue these five licences.

Item 8: Update of Information

The Committee noted the timeframe for the consultant to revise, reformat and expand the Information Kit.

Item 9: Communication

The Committee considered the draft framework for a communication plan prepared by the Working Committee, and agreed that this will now be expanded.

Secretariat will take this work forward in consultation with the Working Committee and report back to the Licensing Committee at its June meeting.

It was further agreed that a bulletin, targeted in particular to consumer groups, will be prepared. The bulletin will be disseminated via the NHMRC website and forwarded as hard copy to consumer groups.

Decision:

Secretariat to expand the communication plan in consultation with the Working Committee.

A bulletin, targeted in particular to consumer groups, will be prepared. The bulletin will be disseminated via the NHMRC website and forwarded as hard copy to consumer groups.

Item 10.1: Monitoring and Compliance Information Pack

Members were informed of the Monitoring and Compliance draft Information Pack that will be sent out with the licence to Licence Holders. The six draft fact sheets and the pre-inspection checklist, were considered. It was agreed that the Information Pack would be reduced from six to two fact sheets and a minor change made to the pre-inspection checklist.

A member raised the issue of Inspectors being asked to sign confidentiality agreements prior to performing monitoring inspections. Discussion centred on Section 30 of the RIHE Act 2002 and more broadly the provisions of the Public Service Act 1999 (Cth). It was noted that Inspectors are public servants and, as such, are required to maintain confidentiality of all information received in the course of their duties. As such, members agreed that Inspectors should not sign such agreements when performing duties and functions under the Act, including during Inspections. It was also agreed that the information manual currently being developed would make reference to this issue. In addition, members requested that Inspectors raise the issue of confidentiality during the introductory meeting with Licence Holders.

Decision:

Secretariat to reduce the Information Pack from six to two fact sheets and amend the pre-inspection checklist.

Information manual to make reference to the treatment of confidential information.

Inspectors to raise the issue of confidentiality during the introductory meeting with Licence Holders.

Item 10.2: Frequency of Visits

Members noted information provided about the frequency and type of monitoring and compliance activities that the Monitoring and Compliance Section propose to undertake in relation to licence holders. The Committee will be briefed after each visit.

Item 10.3: Development of Bilateral Agreements with Vic Dept of Health

Members noted action taken since the December meeting regarding the development of compliance and communication arrangements with the Victorian Department of Human Services.

Item 10.4: Development of MOU with Infertility Treatment Authority (ITA) regarding non-compliance referrals

Two members declared a possible conflict of interest. This was dealt with in accordance with NHMRC procedures.

The Committee discussed the desirability of exchange of information with the ITA regarding monitoring of compliance with the legislation. Members agreed to commence drafting an MOU between the NHMRC Licensing Committee and ITA. This will ensure that these two groups have timely information about non-compliance.

The Secretariat was asked to draft, in consultation with Legal Services Branch, a MOU for consideration at the June 2004 meeting of the NHMRC Licensing Committee. Secretariat will also clarify whether the agreement should be with ITA or the Victorian Department of Human Services.

Decision:

Secretariat to draft, in consultation with Legal Services Branch, a MOU between NHMRC and the ITA for consideration at the June 2004 meeting of the NHMRC Licensing Committee.

Item 10.5: Animal Cloning

Members were advised of the intention of the Monitoring and Compliance Section to include organisations undertaking animal cloning research in their information exchange activity.

The Committee requested that the Secretariat contact the NHMRC's Animal Welfare Committee to seek an opportunity for input to the revision of the Australian Code of Practice for the Care and Use of Animals for Scientific Purposes. The Committee can then ensure that, where relevant, the revised code includes reference to the Prohibition of Human Cloning Act 2002.

Decision:

Secretariat contact the NHMRC's Animal Welfare Committee to seek an opportunity for input to the revision of the Australian Code of Practice for the Care and Use of Animals for Scientific Purposes.

Item 10.6: Update on Clonaid and Reproductive Medicine Albury

Members noted a report from the Chief Inspector on two separate investigations that are taking place into activities of Clonaid and Reproductive Medicine Albury.

Item 11: Consideration of Application

The Committee noted the spreadsheet outlining progress on the consideration of applications.

Members were asked to declare any potential conflict of interest with applications under consideration. All declared conflicts of interest were dealt with in accordance with NHMRC procedures.

Item 11.1: Timelines

The Committee discussed proposed timeframes for consideration of applications for a licence to use excess ART embryos. Secretariat was asked to streamline the process wherever possible, while ensuring that the Committee's obligation to undertake a thorough assessment of each application in accordance with the requirements of the legislation is not compromised.

It was agreed that a statement would be placed on the NHMRC website indicating that, for applications to be considered at a particular meeting on the Committee's published meeting schedule, the application must be received by Secretariat at least 10 weeks prior to that meeting date. The statement should be in general terms, recognising that more complex applications may take additional time and drawing applicants' attention to the need for comprehensive coverage of the information requirements established by the Committee.

Item 11.2: Application – 309709

The Committee approved in principle the issue of a licence to the applicant, subject to satisfactory finalisation of licence conditions. For the purpose of licence conditions, the Committee determined that the applicant may thaw up to 200 embryos in connection with this project. When the stated goal of 6 characterised embryonic stem cell lines is achieved the applicant is not permitted to thaw any more embryos.

With respect to the requirements of Section 21 of the Research Involving Human Embryos Act 2002, subject to the above, the Committee:
decided to issue a licence (21(2));
was satisfied that appropriate protocols are in place to obtain proper consent (21(3)(a)(i)) and ensure compliance with any restrictions on that consent (21(3)(a)(ii));
noted that only embryos created before 5 April 2002 will be used (2(3)(b));
was satisfied that the activity had been considered and approved by an HREC in accordance with 21(3)(c);
had regard to restricting the number of embryos (21(4)(a))
had regard to the likelihood of the activity being a significant advance in knowledge or improvement in technologies (21(4)(b));
had regard to the relevant guidelines and the HREC assessment of the proposed activity (21(4)(c) and 21(4)(d)).

Decision:

Finalise licence conditions and issue licence 309709.

Item 11.3: Application - 309707

The Committee noted the information provided by the applicant in response to the Secretariat's recent letter. The Committee's consideration of this information raised a number of further issues that will now be raised with the applicant. The Secretariat and the Working Committee for the application will work with the applicant to resolve these issues and will report back to the June 2004 meeting of the NHMRC Licensing Committee.

Decision:
Secretariat to seek further information from the applicant for consideration by the Working Committee.

The Secretariat and the working group for the application will continue the assessment process and report to the June 2004 meeting of the NHMRC Licensing Committee.

Decision:

Working Committee to progress consideration of the application and report to the June 2004 meeting of the NHMRC Licensing Committee.

Item 11.5: Application - 309700, 309705

The Committee noted that decisions made at Agenda Items 5 and 6 with respect to consent and the number of embryos used for training purposes will allow the Secretariat to write to the applicant again about this application. The Secretariat and the Working Committee for the application will continue the assessment process and report to the June 2003 meeting of the NHMRC Licensing Committee.

Decision:
Secretariat to write to the applicant.
Working Committee to continue the assessment process and report to the June 2004 meeting of the NHMRC Licensing Committee.

Item 12: Information Items

Item 12.1: Progress on Development of Database

Progress with the development of the database was noted.

Item 12.2: Review of Legislation

Members noted the update on arrangements for the review of the legislation and requested that this matter be included on the agenda for the June meeting.

Item 12.3: Articles

Members noted the articles provided.

Item 13: Other Business

No other business was discussed.

Item 13.1: Meeting Schedule

The next meeting will be held in Sydney on 8th and 9th June 2004.

Conclusion of Meeting

The meeting concluded at 4.15pm on Tuesday 16th March 2003.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2004-2005, 2 & 3 June 2004

Question: E04-112

OUTCOME 9: Health Investment

Topic: LICENSING COMMITTEE

SUPPLEMENTARY INFORMATION TO ANSWER PROVIDED EARLIER

Written Question on Notice

Senator Harradine asked:

Please provide minutes of any further meetings of the NHMRC Licensing Committee since December 18 and 19, 2003 and the minutes of the June 8 and 9, 2004 meeting when available.

Answer:

The minutes of the NHMRC Licensing Committee meeting of 8-9 June 2004 are attached.

Australian Government
National Health and Medical Research Council

NHMRC LICENSING COMMITTEE

Minutes of the Meeting of 8 and 9 June 2004
Sydney

10.00am to 5.00pm Tuesday 8 June 2004
9.00am to 2.30pm Wednesday 9 June 2004

ATTENDANCE

Members:

Professor Jock Findlay (Chairperson)
Dr Megan Best
Dr Kerry Breen (8 June only)
Dr Graham Kay
A/Pr Christopher Newell
Dr Julia Nicholls
Dr Helen Szoke

Apologies:

Dr Peter Illingworth
Professor Don Chalmers

Secretariat:

Dr Clive Morris
Mr Tony Rolfe
Dr Alison Mackerras
Ms Rhonda Stilling
Mr Phillip Hoskin
Ms Jennifer Simpson
Ms Carmel Boyd

Legal Services Branch:
Mr Mark Gladman

Observers:
Prof Bryan Campbell

Invited Speakers:

A/Professor Bernadette Tobin
Professor Ronald Trent

Item 1: Opening

The meeting commenced at 10.00am on Tuesday 8 June 2004.

Item 1.1: Apologies

Members noted apologies for the meeting.

Item 1.2: Confidentiality and Conflict of Interest

Members were reminded of their obligations in respect of confidentiality and conflict of interest.

Item 1.3: Confirmation of Agenda

Members agreed to the timing of agenda items and noted that A/Professor Tobin and Professor Trent would address the meeting at agenda items 4.4 and 4.5 respectively.

Item 1.4: Chairman's Report

Members were informed that:

- Council met on 18 and 19 March 2004;
- NHMRC Management Committee met at the end of April and by teleconference in late May;
- Professor Findlay attended a meeting of the NHMRC's Research Committee early in May to inform Members about the role of the Licensing Committee; and
- On 24 May Professor Findlay met with Minister Bishop to inform her about the work of the Committee to date.

A copy of the Licensing Committee Chair's Report to Council for its meeting of 18 June 2004 was tabled at the meeting.

Item 2: Minutes of 16 March 2004 meeting

Members endorsed the minutes of the March meeting.

Item 2.1: Action Arising

The schedule detailing progress on action arising from the meeting of 16 March 2004 was noted.

Item 3: Out of Session Items

Item 3.1: Biannual Report

Members noted progress and that a copy of the report will be forwarded to each Member once tabled in Parliament.

Item 3.2: Issue of Licences

Members discussed the process used to resolve urgent matters out of session.

The Committee reaffirmed the agreed process for consideration of matters out of session, indicated a preference for dealing with complex matters by teleconference and requested that Secretariat contact Members by telephone to inform them when an out of session item is to be forwarded by email.

Item 4: NHMRC Activities

Item 4.1: Council Activities

Members noted the report provided by the Council Secretariat.

Item 4.2: Business Plan

Secretariat informed Members about the development of the Performance Management Framework, its relationship to Council's Strategic Plan and flow-on to the Business Plans of each Principal Committee. Further information will be provided at the September meeting of the Licensing Committee.

Item 4.3: Report by Australian Health Ethics Committee (AHEC) Representative

Dr Breen informed Members about work undertaken by AHEC since the March meeting of the Licensing Committee. Members also noted the AHEC Chair's Report to Council.

Item 4.4: Report from CREGART

The Committee was provided with a copy of the draft revised *Ethical guidelines on assisted reproductive technology in clinical practice and research.* Dr Kerry Breen and Associate Professor Bernadette Tobin, co-chairs of the Committee for the Review of Ethical Guidelines for Assisted Reproductive Technology (CREGART), answered Members' questions and noted comments on the draft.

Item 4.5: GTRAP

Professor Ron Trent, Chair of Research Committee's Gene and related Therapies Research Advisory Panel (GTRAP), outlined the purpose of the GTRAP. Of particular interest to the Licensing Committee was GTRAP's human stem cell research expert group. The Committee agreed that it could look to this expert group within GTRAP for additional expert advice.

Item 4.6: Privacy Working Group

The Committee's representative on the NHMRC's Privacy Working Group, Dr Szoke, updated Members on the work of the Group.

Item 4.7: Budget Outcome

Members were advised of the process and timeframe for allocation of funding for the review of the *Prohibition of Human Cloning Act 2002* and the *Research Involving Human Embryos Act 2002*. The Committee agreed to develop a submission to the review.

Decision:
Chair to work with secretariat to develop a draft submission to the review of the legislation for discussion at a future meeting.

Item 5: Variation of Licences

Item 5.1: Variation Process

The Committee noted the need for procedural fairness and approved, subject to suggested amendments, the draft process for variation, suspension, revocation and surrender of a licence.

Members agreed to advise the Minister of variations to licences.

The Committee agreed in principle to vary the Standard Conditions for Using Excess ART Embryos by adding a condition regarding surrender of a licence should the Licence Holder no longer be able to uphold its responsibilities under the licence. This condition will be drafted by the Secretariat in consultation with the Department's Legal Services Branch.

Decision:

Secretariat and Legal Services Branch to draft a condition regarding surrender of a licence for inclusion in the Standard Conditions.

Item 5.2: Licence Variations

The Committee agreed to vary condition 9302 of Licences 309701, 309702A, 309702B and 309703 to reflect the requested changes to persons authorised to use excess ART embryos.

The Working Party will meet with the Licence Holder to discuss the remaining variations requested.

The Working Party will then make a recommendation to the full committee out of session via a teleconference.

Decision:

Vary condition 9302 of licences 309702A, 309702B and 309703 to reflect the requested changes to persons authorised to use excess ART embryos.

Working Party to meet with the Licence Holder and will make a recommendation out of session via teleconference.

Item 6: Likelihood of Significant Advance

Members discussed the draft document and suggested amendments. Secretariat was asked to distribute an amended draft to the Committee for additional comments out of session.

A further draft will then be presented for endorsement at the September meeting. Following endorsement the document will be placed on the NHMRC website.

Decision:

Secretariat to provide revised draft to Members out of session for comments and present a further draft for endorsement at the September meeting.
Secretariat to then place the endorsed document on the NHMRC website.

Item 7: Good Manufacturing Practice

The Committee discussed the issue of Good Manufacturing Practice (GMP) and how it could impact on decisions made by the Committee. It agreed to seek advice from the NHMRC's Gene and related Therapies Research Advisory Panel.

Decision:

Seek advice from the NHMRC's Gene and Related Therapies Research Advisory Panel.

Item 8: Update of Information Kit

The Committee noted progress with the update and revision of the information kit and that a draft will be forwarded to Members for consideration out of session.

Decision:

Secretariat to forward a copy of draft information kit to Members for consideration out of session.

Item 9: Communications and Media Management

The Committee endorsed the draft bulletin and requested that it be distributed in hard copy to each organisation included on the mailing list, as well as posted on the website. Members agreed to forward to secretariat any further additions to the mailing list.

The Committee noted the agreed procedure for dealing with media issues. It was agreed that the Chair should be copied into all correspondence regarding the Licensing Committee.

Item 10: Monitoring

Item 10.1: Information Exchange Visits since the last Licensing Committee meeting.

The Chief Inspector briefed the Committee on activities undertaken since the March 2004 meeting.

Item 10.2:.....Compliance and communication arrangements with NSW, Victoria and SA (including MOU with ITA)

The Committee noted action taken on the development of communication arrangements with NSW, Victoria and South Australia since the March 2004 meeting.

Item 10.3: Inspection of Licences 309701, 309702A, 309702B and 309703

Members were informed of the first inspections for licences **309701, 309702A, 309702B and 309703** and noted the outcomes of those inspections The inspection report has been forwarded to the Chair.

Item 10.4: Inspection of Licence 307904

Members were informed of the first inspection for licence **309704**. The inspection report will be forwarded to the Chair shortly.

Item 10.5: Monitoring and Compliance Standard Operating Procedures (SOP's)

Members noted that the Information Exchange and Inspection SOP's are now available for the Committee to review.

Item 10.6: Update on ClonAid and Reproductive Medicine Albury

Members noted the update from the Chief Inspector on the conclusion of the investigations into activities of ClonAid and Reproductive Medicine Albury. The investigation reports will be forwarded to the Chair.

Item 11. Consideration of Applications

When considering applications to use excess ART embryos to establish new embryonic stem cell lines the Committee developed a draft set of criteria for use in determining when an embryonic stem cell line has become 'established'. Secretariat was asked to seek feedback on these draft criteria from a range of experts in the field of embryonic stem cell research.

Decision:

Seek feedback on the draft criteria for use in determining when an embryonic stem cell line has become 'established' from a range of experts in the field of embryonic stem cell research.

dealt with in accordance with NHMRC procedures.

Item 11.1: Application - 309707

Following consideration of the Working Party's report on progress with consideration of the application, Members agreed that the Working Party should visit the applicant to clarify remaining issues.

Decision:

Working Party to visit the applicant of 309707 to clarify remaining issues.

Item 11.2: Application – 309708

With respect to the requirements of Section 21 of the Research Involving Human Embryos Act 2002 the Committee:

- decided to issue a licence (21(2));
- was satisfied that appropriate protocols are in place to obtain proper consent (21(3)(a)(i)) and ensure compliance with any restrictions on that consent (21(3)(a)(ii));
- noted that only embryos created before 5 April 2002 will be used (2(3)(b));
- was satisfied that the activity had been considered and approved by an HREC in accordance with 21(3)(c);
- had regard to restricting the number of embryos (21(4)(a))
- had regard to the likelihood of the activity being a significant advance in knowledge or improvement in technologies (21(4)(b));
- had regard to the relevant guidelines and the HREC assessment of the proposed activity (21(4)(c) and 21(4)(d)).

The Committee agreed in principle to issue a licence subject to the preparation of appropriate licence conditions. The Committee requested that the Secretariat draft the licence conditions and agreed that the application should be reconsidered at its next meeting.

Decision:

The Committee agreed in principle to issue a licence for application 309708 subject to the preparation of appropriate licence conditions.

Secretariat to draft the licence conditions and agreed that the application should be reconsidered at its next meeting.

Item 11.3: Application - 309700, 309705

The Committee noted that the applicant had not yet replied to a request for further information. It was agreed that the applicant should be advised that if a response is not received by 1 August 2004 the Committee will make a decision based on the information it has before it at the time.

Decision:

Secretariat to advise the applicant of 309700 and 309705 that if a response is not received by 1 August 2004, the Committee will make a decision based on the information it has before it at the time.

Item 12: Information Items

Item 12.1: Progress on Development of Database

Progress on the development of the database was noted.

Item 12.2: Review of Legislation

Members noted the update on arrangements for the review of the legislation. Refer to item 4.7.

Item 12.3: NHMRC Annual Report

Members noted that the report was provided to Minister Abbott for tabling on 31 April.

Item 12.4: Interaction with RTAC

Secretariat updated the Committee on communications with RTAC. Secretariat has agreed to meet with the Chairman of RTAC and other relevant participants in mid July 2004.

Item 12.5: Liaison with NHMRC ATSI Forum

Members noted the report provided on the recent presentation to the NHMRC ATSI forum by the Secretariat.

Item 13: Other Business

No other business was discussed.

Item 13.1: Licensing Committee Meetings for 2005

Members agreed that the Licensing Committee meetings for 2005 will be held on:

- 1 and 2 March;
- 31 May and 1 June;
- 31 August and 1 September; and
- 30 November and 1 December

The next meeting will be held in Canberra on 9 and 10 September 2004.

Conclusion of Meeting

The meeting concluded at 2.30pm on Wednesday 9 June 2004.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2004-2005, 2 & 3 June 2004

Question: E04-114

OUTCOME 9: Health Investment

Topic: LICENSING COMMITTEE

Written Question on Notice

Senator Harradine asked:

How many applications are currently before the NHMRC Licensing Committee for approval?

Answer:

The NHMRC Licensing Committee is currently considering four applications for a licence to use excess ART (assisted reproductive technology) embryos.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2004-2005, 2 & 3 June 2004

Question: E04-113

OUTCOME 9: Health Investment

Topic: MINISTER'S INVOLVEMENT ON HUMAN CLONING ISSUES

Written Question on Notice

Senator Harradine asked:

I note that in answer to question E04-058 you said that you had not consulted Minister Andrews as this was precluded by the announcement of a Cabinet reshuffle on 29 September 2003.

(a) Was this draft briefing to obtain Minister Andrews' agreement to a position to put to the Prime Minister for his consideration? What was the nature of the draft briefing?

(b) If Minister Andrews was not available to receive the briefing, did a brief go to the new Minister for Ageing, Ms Julie Bishop, for her to approve a position to put to the Prime Minister for his consideration? If not, was any Minister briefed by the Department and if so, who?

(c) Given that Professor Pettigrew, represented Australia and made statements to the United Nations regarding Australia's position on 23 September 2002 and on 30 September 2003 - before the Cabinet reshuffle - wouldn't it have been appropriate to brief Minister Andrews before the Australia's position had been put to the UN?

(d) Was the proposed brief to Minister Andrews merely to inform him of the position taken by Australia, or to seek his agreement to a position or an approach to the development of Australia's position?

Answer:

(a) The Prime Minister's letter of 19 September 2003, which was copied to Minister Andrews, outlined the Australian position.

(b) Minister Abbott was provided with briefing notes on 3 October 2003.

(c) The Prime Minister's letter of 19 September 2003 which outlined the Australian position was copied to Minister Andrews.

(d) The proposed brief was to brief the Minister on the Australian position.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2004-2005, 2 & 3 June 2004

Question: E04-115

OUTCOME 9: Health Investment

Topic: IDC DISCUSSIONS

Written Question on Notice

Senator Harradine asked:

In answer to question E04-062 you referred to a copy of a report being attached. That report appears to be a one page document giving some details about the NHMRC - not a document which sets out the outcome of discussions at the IDC meetings. Please provide a copy of the report.
Answer:

A copy of the report is again attached.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2004-2005, 2 & 3 June 2004

Question: E04-118

OUTCOME 9: Health Investment

Topic: COAG Agreement

Written Question on Notice

Senator Harradine asked:

(a) Why did the Council of Australian Governments (COAG) agreement between the states and territories on Research Involving Human Embryos and Prohibition of Human Cloning, dated 31 March 2004, use the definition of "excess ART embryo" in the *Prohibition of Human Cloning Act* and not the definition from the *Research Involving Human Embryos Act?*

(b) Why was the COAG agreement, dated 31 March 2004, necessary?

(c) The Agreement records that it was signed by Jim Bacon as Premier of Tasmania, but by 31 March 2004 Tasmania's Premier was Paul Lennon. Who signed the agreement for Tasmania?

Answer:

(a) Advice indicates that there is no legal difference between the definition of excess assisted reproductive technology (ART) embryos in the *Prohibition of Human Cloning Act 2002* and the *Research Involving Human Embryos Act 2002*.

(b) The Inter-Governmental Agreement, which was signed by the Prime Minister on 31 March 2004, was prepared in order to facilitate the Council of Australian Governments (COAG) agreement of 5 April 2002. COAG agreed that the Commonwealth, States and Territories would introduce nationally consistent legislation banning human cloning and other unacceptable practices and establish a national regulatory framework for the use of excess ART embryos.

(c) This question has been referred to the Department of Prime Minister and Cabinet.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2004-2005, 2 & 3 June 2004

Question: E04-183

OUTCOME 9: Health Investment

Topic: HEALTH*CONNECT* AND MEDI*CONNECT*

Written Question on Notice

Senator McLucas asked:

Planned roll-outs of a combined Health*Connect* / Medi*Connect* system in Tasmania and South Australia as early as July are described as having 'stunned' stakeholders.

(a) What is the timeframe for the roll-out of a combined Health*Connect* / Medi*Connect* system?

(b) Is there a current combined Health*Connect* / Medi*Connect* system currently operating? Ask for details - how many doctors, pharmacists, patients, hospitals.

(c) What funding has been provided to the GP Computing Group to assist with this

(d) What funding for IT has been cut from the budget of the Divisions?

Answer:

(a) The Department is currently developing a detailed implementation and strategic plan for Health*Connect*. It is expected that a combined Health*Connect* / Medi*Connect* system will be implemented during 2004-05, initially in South Australia and Tasmania.

(b) The Health*Connect* Trial in Southern Tasmania incorporates some Medi*Connect* functionality–namely, pharmacists are able to downland prescription details from a Health*Connect* record and record details of medicines dispensed on the Health*Connect* record. As of June 2004, there are currently 116 GP practices, 8 pharmacies, 1 public hospital and 920 consumers participating. The trial will finish in November 2004 and a detailed evaluation report will be published. The next overlapping phase will be State implementations of Health*Connect* / Medi*Connect* in Tasmania and South Australia, which will commence from July 2004.

(c) The General Practice Computing Group (GPCG) has been funded since 1998-99 to advance information management / information technology initiatives in General Practice. No specific funding has been provided to the GPCG to assist with the roll-out of Health*Connect* / Medi*Connect*.

(d) Specific time-limited funding for Divisions to undertake information management / information technology activity, including establishing information technology in general practices and developing the capacity of general practices to better manage information, ceased on 31 December 2001.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2004-2005, 2 & 3 June 2004

Question: E04-184

OUTCOME 9: Health Investment

Topic: NATIONAL HEALTH INFORMATION MANAGEMENT AND INFORMATION AND COMMUNICATIONS TECHNOLOGY GOVERNANCE ARRANGEMENTS

Written Question on Notice

Senator McLucas asked:

A report on e-health done for the Government by Boston Consulting Group (BCG) says that important national projects are scattered and vastly under-funded, with projects typically small and managed by part-time committees.

What actions are proposed to address the issues raised by the BCG's report National Health Information Management and ICT Strategy?

Answer:

The BCG was engaged by the Victorian Department of Human Services in December 2003 on behalf of the National Health Information Group (NHIG) to review the scope, funding and timetabling of Government information management and information and communications technology (IM&ICT) projects and activities, and to provide advice on priority areas for national action in health IM&ICT.

The BCG Report was considered by the Australian Health Ministers' Conference on 23 April 2004. Ministers noted independent advice from the BCG on priority areas of national action, and the need for improved cooperation to take advantage of the significant opportunity that exists to create an interconnected system. Health Ministers provided in-principle endorsement of the need for national capacity to drive forward critical health IM&ICT priorities, and requested further advice on the possible shape of national capacity, including the option of establishing a new national entity dedicated to national IM&ICT reform.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2004-2005, 2 & 3 June 2004

Question: E04-185

OUTCOME 9: Health Investment

Topic: IT ISSUES

Written Question on Notice

Senator McLucas asked:

The head of the Department's IT has said that the budget would flesh out Government plans for Health*Connect* roll-outs in South Australia and Tasmania.

(a) Where are those plans in the budget?

(b) Of the funding provided for the combined Health*Connect* and Medi*Connect* programs, how much is new money, what is generated from savings - and how are these savings (PBS page 252) achieved?

Answer:

(a) The budget papers indicate the Australian Government is providing $128.3 million over the next four years towards the implementation of Health*Connect*. Specifically this is expected to include a phased implementation of Health*Connect* including the establishment of at least two whole-of-State reference implementation sites (PBS page 247). The detailed implementation plans are under development and, as in previous years, will be published on the Health*Connect* website when available.

(b) No new money is provided. Funding is from forward estimates for the Medi*Connect* lapsing program, formerly known as the Better Medication Management System (BMMS). The savings of $15.1 million over four years are administered savings of the Medi*Connect* lapsing program. It is also estimated the Health*Connect* measure will achieve savings in the Pharmaceuticals Benefits Scheme of $27.1 million over four years, through reducing prescribing anomalies. Over and beyond those figures, Health*Connect* will provide a wider contribution to health and wellbeing, and the wider economy, both in terms of reduced morbidity and mortality arising as a result of adverse medication events.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2004-2005, 2 & 3 June 2004

Question: E04-254

OUTCOME 9: Health Investment

Topic: MORE DOCTORS IN OUTER METROPOLITAN AREAS

Hansard Page: CA 60-63-3.6

Senator McLucas asked:

a) Can you turn the amount of 160 doctors that have taken up a relocation assistance grant into full-time equivalent doctors?

b) Were all of those doctors GPs, or were some specialists included in that 160? Can you give me the separation between those two groups?

c) How do you monitor doctors who start under the program working part-time and then wish to extend their hours, do you have a contract? Can you provide me with what is in the contract?

d) Can you provide me with the criteria by which you decide which outer metropolitan areas actually meet the area of need criteria, or is that something you can tell me about straightaway?

Answer:

a) The 161 doctors approved under the Measure correspond to approximately 110 doctors working full time (38 hours per week).

b) The 161 doctors approved under the measure consist of 10 specialists, 114 vocationally recognised GPs and 37 non-vocationally recognised GPs.

c) Doctors in receipt of an outer metropolitan relocation grant sign a deed of agreement with the Commonwealth. This agreement specifies:

- number of hours per week to be worked;
- length of the contract (number of years); and
- practice location.

The Department of Health and Ageing uses Medicare billing data and Health Insurance Commission information related to Medicare provider numbers to monitor compliance with the agreement. If a doctor increases the number of hours worked in the approved location he/she may be eligible for a pro rata increase in their relocation incentive grant.

d) For the purposes of the Measure, an 'outer metropolitan district of workforce shortage' is a statistical local area (SLA), part of an SLA, or a set of SLAs, located in an outer metropolitan area which exhibits a medical workforce shortage. Workforce shortage is generally assessed by comparing the full-time equivalent doctor to population ratio in a given SLA against the program benchmark ratio of 1:1404.

The outer metropolitan zone is defined as that part of a capital city statistical division which lies outside the Australian Bureau of Statistics defined urban centre for the 1991 census. The defined urban centre broadly corresponds to the central built up area at that time. This allows for the outer metropolitan area to include areas that have grown in population in the last ten years as well as urban fringe and semi-rural localities.

In addition, some inner metropolitan areas where there are shortages of doctors can be declared to be 'areas of consideration' and become eligible for programs and incentives under the Measure. 'Areas of consideration' were introduced to allow the Measure to respond to the needs of inner metropolitan communities that are close to the outer metropolitan boundary and also have shortages of doctors.

Areas of consideration have been determined on the basis that the area is experiencing a workforce shortage and meets one or more of the following requirements:

- is generally continuous with the existing outer metropolitan area;
- forms a band adjacent to the inner boundary of an outer metropolitan area;
- is situated within a growth corridor; or
- exhibits an 'island effect'(an area that is surrounded by designated outer metropolitan areas).

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2004-2005, 2 & 3 June 2004

Question: E04-255

OUTCOME 9: Health Investment

Topic: BONDED MEDICAL STUDENTS

Hansard Page: CA 69-3.6

Senator McLucas asked:

Outside the 234 new places, when exactly did JCU take up 10 extras?

Answer:

Under the new Medicare arrangements, the Australian Government is making available an additional 234 publicly funded medical school places in 2004 and 246 new places each year from 2005. The 12 additional places from 2005 will be at James Cook University.

In June 2003, it was agreed that James Cook University would be temporarily allocated an additional 10 places for 2004. These 10 places, together with 40 places temporarily allocated to the University of Queensland, will be transferred to Griffith University once it begins operation, which is expected to occur in 2005. Students in these temporarily allocated places will complete the whole of their medical education at James Cook University and the University of Queensland.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2004-2005, 2 & 3 June 2004

Question: E04-256

OUTCOME 9: Health Investment

Topic: OVERSEAS TRAINED DOCTORS

Hansard Page: CA 71-3.6

Senator McLucas asked:

I understand that Indigenous health workers are also on the skilled migration list. Is that correct?

I would be interested to know what opportunity we have to attract Indigenous health workers from overseas to Australia, if in fact that is true.

Answer:

Aboriginal and Torres Strait Islander health workers are on the skilled migration list.

There is limited opportunity to attract Aboriginal and Torres Strait Islander health workers from overseas to Australia. The Department of Health and Ageing, in conjunction with the Department of Immigration and Multicultural and Indigenous Affairs, is considering the continued inclusion of this category on the Skilled Occupation List.