Community Affairs Committee

Examination of Budget Estimates 2006-2007

Additional Information Received

CONSOLIDATED VOLUME 5

HEALTH AND AGEING PORTFOLIO

Outcomes 4 to 15

FEBRUARY 2007

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

ADDITIONAL INFORMATION RELATING TO THE EXAMINATION OF BUDGET EXPENDITURE FOR 2006-2007

Included in this volume are answers to written and oral questions taken on notice and tabled papers relating to the supplementary budget estimates hearing on 1 November 2006

*** Please note that the tabling date of 1 March 2007 is the proposed tabling date for answers where this date is indicated**

HEALTH AND AGEING PORTFOLIO

Senator	Quest. No.	Outcome 4: Aged Care and Population Ageing	Vol. 5 Page No.	Date tabled in the Senate*
	DoHA letter	Letter dated 15 Dec 06 from DoHA correcting evidence given by Mr Broadhead at the hearing on 1 Nov 06	1	08.02.07
McLucas	48	COAG Younger People in Nursing Home Initiative	2	08.02.07
McLucas	56	The Way Forward	3	08.02.07
McLucas	23	Elizabeth House Private Nursing Home	4-5	08.02.07
McLucas	30	Agency annual report	6-7	08.02.07
McLucas	51-52	CVS: police checks	8-9	08.02.07
McLucas	54	RCS reviews	10	08.02.07
McLucas	60-61	Complaints resolution scheme	11-13	08.02.07
McLucas	172	General purpose financial returns (GPFRs)	14	08.02.07
McLucas	235	Unannounced support contact visits	15	08.02.07
McLucas	27	Hastings Regional Nursing Home	16-17	08.02.07
McLucas	21	Innovative pool program	18-19	08.02.07
McLucas	22	Time to post reports on web site	20-23	08.02.07
McLucas	24	Complaints to the Agency	24	08.02.07
McLucas	26	Staff turnover – agency head office	25	08.02.07
McLucas	31	Spot checks	26	08.02.07
McLucas	32	Notification of a proposed revocation of a provisional allocation of places: Glenburn Private Nursing Home	27	08.02.07
McLucas	34, 36	Aged care funding instrument	28-29	08.02.07
McLucas	40, 42	Community Aged Care Packages (CACP)	30-31	08.02.07
McLucas	46, 50	COAG YPINH initiative	32-33	08.02.07
McLucas	53	Resident Classification Scale (RCS) reviews	34	08.02.07
McLucas	55	Aged care home finder	35	08.02.07
McLucas	57	Respite	36	08.02.07
McLucas	58	Indigenous aged care places	37	08.02.07
McLucas	59	Elder abuse	38	08.02.07
McLucas	171	Wages	39	08.02.07
McLucas	173	Aged Care Planning Advisory Committees	40-50	08.02.07
McLucas	174	December stocktake population figures	51	08.02.07
McLucas	175	High care/low care figures	52	08.02.07
McLucas	29	Staff cuts in aged care facilities	53	08.02.07
McLucas	35, 38, 39	Aged care funding instrument	54-56	08.02.07
McLucas	47	COAG YPINH initiative	57	08.02.07
McLucas	236	Principal outcomes	58	08.02.07
McLucas	43	Community aged care packages	59	08.02.07

Australian Government

Department of Health and Ageing

Senator Gary Humphries
Chair
Senate Community Affairs Committee
Parliament House
CANBERRA A.C.T. 2600

Dear Senator

CORRECTION OF INFORMATION GIVEN TO SUPPLEMENTARY BUDGET ESTIMATES HEARING, 1 NOVEMBER 2006

I write to correct an answer I gave during the Community Affairs Committee's examination of Outcome 4 of the Department of Health and Ageing's Supplementary Budget Estimates, on 1 November 2006.

In response to a question from Senator McLucas, I mistakenly stated "The majority of people entering care are actually low care. About 60 per cent of people coming into care are low care."

Senator McLucas then asked (Proof Committee Hansard, page CA 53), "What is the split on entry [to residential aged care homes] then, of high care to low care?" I replied, "Roughly 60-40."

This answer is correct, however, Senator McLucas then asked, "Sixty low care and 40 high care?" to which I responded "Yes. I can get you the exact figures."

My second answer was not correct. Of all admissions to permanent residential aged care in 2005-06 (including first-ever admissions, re-admissions and admissions resulting from a transfer from another home), 60.9 per cent were for high care and 39.1 per cent were for low care. Please accept that there was no intention on my part to mislead the Committee, I simply mis-recalled the figures I had read in a brief prior to the hearing.

As I undertook in my response to Senator McLucas, these figures will be also be provided as the answer to question on notice no. E06-000175.

Yours sincerely

Peter Broadhead
Assistant Secretary
Ageing and Aged Care Division

15 December 2006

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Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2006-2007, 1 November 2006

Question: E06-048

OUTCOME 4: Aged Care and Population Ageing

Topic: COAG YOUNGER PEOPLE IN NURSING HOME INITIATIVE

Written Question on Notice

Senator McLucas asked:

What does the DoHA propose to do with those people with disabilities in community aged care who with increasing needs are at risk of entry into residential aged care?

Answer:

Those people with complex care needs who require increasing levels of care will undergo reassessment and will be referred to services that can provide a more appropriate level of care.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2006-2007, 1 November 2006

Question: E06-056

OUTCOME 4: Aged Care and Population Ageing

Topic: THE WAY FORWARD

Written Question on Notice

Senator McLucas asked:

In response to Senate Question Number 2440, tabled on 24 September 2006. Can the Department please provide those reports that are now finalised?

Answer:

A number of reports associated with research and development work are currently being prepared for release. Copies will be available on the department's website when released.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2006-2007, 1 November 2006

Question: E06-023

OUTCOME 4: Aged Care and Population Ageing

Topic: ELIZABETH HOUSE PRIVATE NURSING HOME

Written Question on Notice

Senator McLucas asked:

In the Senate on 18 October in response to a question about Elizabeth House Private Nursing Home, the Minister said: "The Department has issued a notice of non-compliance, giving the Approved Provider until 22 December to rectify its compliance issues. This is the first step towards the imposition of Sanctions, which may be imposed if the deadline is not met".

a) Can I please check whether this is indeed the correct process that the Minister told me in the Chamber?
b) Who conducted the review of Elizabeth House, the Agency or the Department, which recommended a reversal of the Assessment team's recommendation that Accreditation be revoked?
c) What Assessment methodology was used?
d) How many unannounced spot checks did Elizabeth House Private Nursing Home receive in the three year up to August 2006, when the facility failed 30 out of 44 Expected Outcomes?
e) How many unannounced spot checks did Plumpton Villa, which failed 25 out of 44 Quality Outcomes, receive in the lead up to the facility's most recent accreditation in June 2006?

Answer:

a) The process relating to the issue of a Notice of Non-Compliance as described by the Minister was correct and in accordance with Section 67-1 of the *Aged Care Act 1997*.
b) The Agency conducted the Review Audit of Elizabeth House Nursing Home. There was no reversal of the assessment team's recommendation. The Agency considered the audit report furnished by the assessment team, including its recommendation, as well as other information, in making the decision regarding the accreditation of Elizabeth House Private Nursing Home. The Agency in deciding to accredit a home takes into account a range of matters including the assessment team's report, submissions from the provider, and information from the Department, including the home's complaints and compliance history.
c) The assessment methodology used in the conduct of audits arranged by the Agency is described in the Agency's "Audit Handbook". This is published on the Agency's

web site. The considerations that are involved during an audit in order to make an assessment of a home's compliance are set out in the "Results and processes in relation to the expected outcomes of the Accreditation Standards", also available on the Agency's web site.

d) During the period August 2003 to 16 August 2006, the Agency conducted one site audit, three support contacts (two announced, one unannounced) and one review audit of the Elizabeth House Private Nursing Home.

e) During the period August 2003 until 14 June 2006, the Agency conducted two site audits and six support contacts, (five announced, one unannounced) and one review audit of Plumpton Villa.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2006-2007, 1 November 2006

Question: E06-030

OUTCOME 4: Aged Care and Population Ageing

Topic: AGENCY ANNUAL REPORT

Written Question on Notice

Senator McLucas asked:

The Agency's annual report notes that 13 review audits were conducted on aged care facilities at the request of DHA. Why were these review audits requested by the Department, what dates were they undertaken, what were the findings for each of these facilities and what are the names of the facilities?

Answer:

Review audits were requested by the Department on 13 occasions in 2005/2006 on the grounds that the Department was of a view that the homes in question may not be fully complying with the accreditation standards.

The dates of the Review Audits are listed with the names of the homes below. The reports of the findings of the review audits are published on the Agency web site (www.accreditation.org.au) or can be obtained on request from the Agency.

The summary of the homes and outcomes are:

State	Name of home	Date of audit	Decision(1)	Compliance(2)
ACT	Ginninderra Gardens Hostel	16-19 Jan 06	Vary period	28/44
ACT	Ginninderra Gardens NH	16-19 Jan 06	Vary period	24/44
NSW	Calvary Retirement Community Cessnock	27-31 Mar 06	Vary period	34/44
Qld	John Cani Estate Hostel	2-3 Nov 05	Vary period	33/44
Qld	Masonic Care Queensland Sandgate Hostel	15-17Nov 05	Vary period	42/44
Qld	Netherlands Retirement Village	4-7Apr 06	Vary period	21/44
Qld	501 Respite and Care Services	29-30 May 06	Not Revoke	44/44
Qld	Logan Nursing Home	29-31 May 06	Vary period	31/44
Tas	Strathaven Nursing Home	29-Aug-2Sep 05	Not Revoke	44/44
Tas	Strathaven Hostel	29-Aug-2 Sep 05	Not Revoke	44/44
Tas	Rosary Gardens Nursing Home	12-16 Sep 05	Not Revoke	44/44

State	Name of home	Date of audit	Decision(1)	Compliance(2)
Tas	Umina Park Home for the Aged	27-Feb-2 Mar 06	Vary period	42/44
Tas	Aldersgate Village	14-18 Mar 06	Vary period	25/44

(1) "Vary period" means that the Agency reduced the period of accreditation. "Not Revoke" means the Agency did not vary the homes period of accreditation.

(2) The number of the 44 accreditation outcomes complied with at the time of the review audit.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2006-2007, 1 November 2006

Question: E06-051

OUTCOME 4: Aged Care and Population Ageing

Topic: CVS: POLICE CHECKS

Written Question on Notice

Senator McLucas asked:

Has the Department made a decision about police checks on volunteers in aged care who are not part of the Community Visitors Scheme? If so, what is that decision?

Answer:

The requirement for police checks on volunteers is being considered by the Australian Government in the context of the development of the proposed legislative amendments to the *Aged Care Act 1997*.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2006-2007, 1 November 2006

Question: E06-052

OUTCOME 4: Aged Care and Population Ageing

Topic: CVS POLICE CHECKS

Written Question on Notice

Senator McLucas asked:

The aged care industry estimates it will cost $30 million to undertake the current program of Police Checks. Is this assessment correct? What is the Government's assessment and who will meet these costs?

Answer:

The Department of Health and Ageing is aware that many approved providers already undertake police checks in meeting their existing responsibility to ensure that staff employed within a service are suitable. As there is no authoritative data on the current extent of this practice, it is not possible to make an accurate assessment of the additional cost of this measure to the industry.

Approved providers of aged care services are already required to undertake police checks for staff who are key personnel of the organisation, as part of their responsibilities under the *Aged Care Act 1997* and therefore already have systems in place.

The cost of a police check may be borne by either the approved provider or by an applicant for positions in the sector as part of their employment arrangements.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2006-2007, 1 November 2006

Question: E06-054

OUTCOME 4: Aged Care and Population Ageing

Topic: RCS REVIEWS

Written Question on Notice

Senator McLucas asked:

What is the proportion of the residents of aged care facilities values of downgrades and upgrades?

Answer:

There were 648 upgrades (3.9%) and 6063 (36.8%) downgrades of the Resident Classification Scale ratings sampled in the financial year ending 30 June 2006.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2006-2007, 1 November 2006

Question: E06-060

OUTCOME 4: Aged Care and Population Ageing

Topic: COMPLAINTS RESOLUTION SCHEME

Written Question on Notice

Senator McLucas asked:

Question E06-074 from Budget Estimates stated that: "aged care consumers and their families have been consulted by the Commissioner for Complaints, in conjunction with the Department, as part of the review of the Complaints Resolution Scheme". Can the Department provide a copy of the review?

Answer:

Consultation with consumers and their families is conducted by the Commissioner for Complaints on an ongoing basis. The results of these consultations are summarised in the Annual Report of The Commissioner for Complaints. The Annual Report for the period 1 July 2005 to 30 June 2006 is available on the Commissioner's web site at: http://www.commissionerforcomplaints.net.au

The Commissioner provided Minister Santoro and the Department of Health and Ageing with his views on how the Complaints Resolution Scheme could be improved. His views took account of the issues raised by aged care consumers over time.

The documentation of the Commissioner's views are in the form of internal working documents which continue to be considered in the development of the revised complaint handling procedures, which are due to be implemented on 1 April 2007.

Given that these are working documents and still under active consideration, it would not be appropriate to release them to the Committee.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2006-2007, 1 November 2006

Question: E06-061

OUTCOME 4: Aged Care and Population Ageing

Topic: COMPLAINTS RESOLUTION SCHEME

Written Question on Notice

Senator McLucas asked:

There is a case where complainants (staff on behalf of residents) took legal action to override the Aged Care Complaints Commissioner and the Principles to have a complaint accepted. Schramm & Ors v Comm for Complaints & Anor [2005], last updated 2 March 2006.

The Federal Magistrates Court of Australia ordered that the decision of the Commissioner for Complaints, Aged Care Resolution Scheme dated 4 November 2004 was set aside. The Respondents were ordered to pay the Applicants' costs.

a) Can the Complaints Commissioner provide an update on this case?
b) Is the Complaints Resolution Scheme now dealing with this complaint?
c) How much has this case cost the Complaints Resolution Scheme?
d) Are there any other appeals against the decision "not to accept", and what is happening with these appeals?
e) Has an Aged Care Commissioner been appointed, and if so who is it?

Answer:

a) Following the Court's decision, delivered on 22 December 2005, a determination hearing was scheduled.

   The solicitor acting for the complainants sought and was granted an injunction restraining the holding of the determination hearing until further order of the Court.

   On 18 October 2006, the Court ordered that decisions of the Commissioner for Complaints regarding the conduct of the determination hearing be set aside:
   - to the extent that they prevent the Applicants' solicitor accompanying the complainants as an adviser before the determination hearing of the Complaints Resolution Committee; and
   - to the extent that the only persons who may attend a Determination hearing held under

the Complaints Resolution Scheme are parties to a complaint, their advisers and only such other persons as all the parties agree may be there present.

On 7 November 2006, the Court ordered the Respondents to pay 70 per cent of the Applicants' costs.

b) Yes.

c) The cost, as at 1 November 2006, is $102,465.55 (GST inclusive).

d) The Schramm case is the only case which has been appealed to the Federal Court.

In the period 1 July 2005 to 30 June 2006 there were, however, 25 internal appeals against the non-acceptance of a complaint in line with the process set out in the *Aged Care Principles 1997*. Of these 25 appeals, the Commissioner recommended that:

- 14 decisions be confirmed;
- 5 decisions be set aside; and
- 6 were varied.

e) No. An Aged Care Commissioner will be appointed as part of the implementation of new complaints handling arrangements from 1 April 2007.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2006-2007, 1 November 2006

Question: E06-172

OUTCOME 4: Aged Care and Population Ageing

Topic: GENERAL PURPOSE FINANCIAL RETURNS (GPFRs)

Hansard Page: CA 42

Senator McLucas asked:

What did the analysis of the 2004-05 year show in terms of wages growth across the whole sector?

Answer:

The General Purpose Financial Reports that are now required as part of the Conditional Adjustment Payment allow the Department to monitor the degree to which input costs and margins are changing across the sector. The Reports do not directly monitor wages costs.

A copy of a report on analysis undertaken by Bentleys MRI for the Department is attached.

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28 June 2006

Dr David Cullen
Executive Director
Financial and Economic Modelling and Analysis Group
Ageing and Aged Care Division
Australian Department of Health and Ageing
GPO Box 9848
Canberra ACT 2601

Dear David

Re: Provision of Services to Analyse Financial Reports and Review Compliance for Conditional Adjustment Payment (CAP)

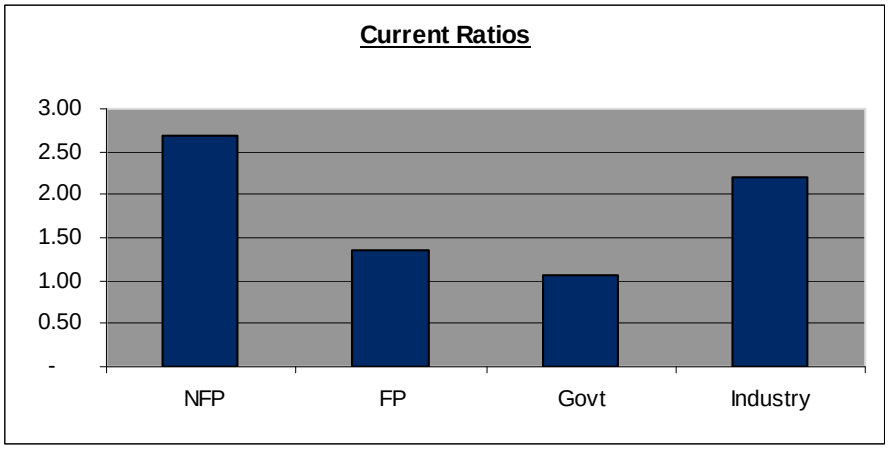
In accordance with our contract with the Department of Health & Ageing (the Department) in relation to the above project, we set out below our analysis of the statistic data presented from our review of the financial reports submitted by 1,231 providers throughout Australia. As requested, we have undertaken additional analysis of 103 individual facility reports submitted with GPFRs.

At the commencement of this assignment, we undertook a review of the financial templates provided by the Department to present financial ratio analysis to providers. A number of changes were made to the templates and financial models were developed to capture relevant data from the provider's General Purpose Financial Reports (GPFRs).

Aggregated industry data has been sent to all providers, along with an analysis of their own financial results. Copies of the Ratio Analysis and sample letters are provided at Appendix 1. The analysis below is separated into For Profit (FP), Not for Profit (NFP), Government (Govt) and Industry Averages. It should be noted that Government statistics have been removed from the Industry Averages results. The following outlines our observations:

1. Liquidity and Gearing Ratios

The following presents results of the analysis of provider current ratios:

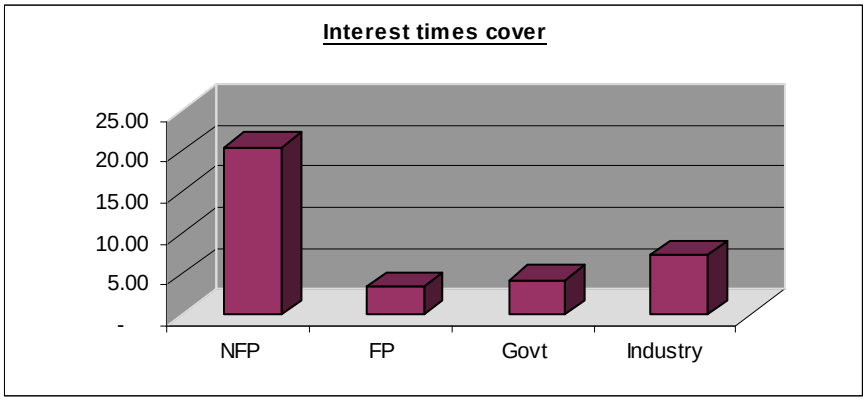


The current ratio for the year ended 30 June 2005 for the industry presents a positive result of 2.20 indicating that current assets exceed current liabilities more than 2 times. As anticipated the stronger ratio in the NFP group of 2.68 compares favourably to the FP group result of

1.37. The ratio for both groups in 2005 represents an improvement on the ratios in 2004, which suggests a strengthening in the liquidity of the sector.

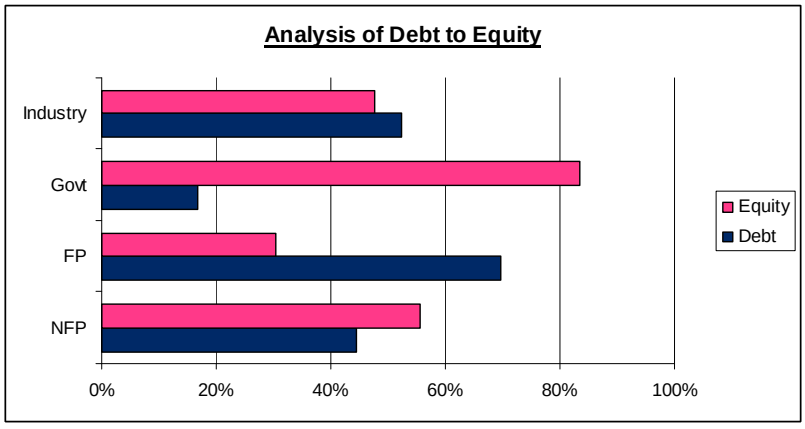
The result is impacted by the treatment of accommodation bonds, which are most often treated as a non-current liability by both the FP and NFP groups. The impact of the introduction of the International Financial Reporting Standards is likely to cause a reversal of this position as accommodation bonds are treated as "demand liabilities" which are classified as current.

A national survey on redevelopment in the sector undertaken by Bentleys MRI in 2002 revealed that almost 68% of NFP providers would be borrowing for the first time to finance their redevelopments. This is likely to have a major impact on their current ratios and capital costs in the future. Currently, the level of interest expense in the NFP group represents a significantly lighter burden when compared to the FP group, as illustrated in the Interest Time Cover analysis below.

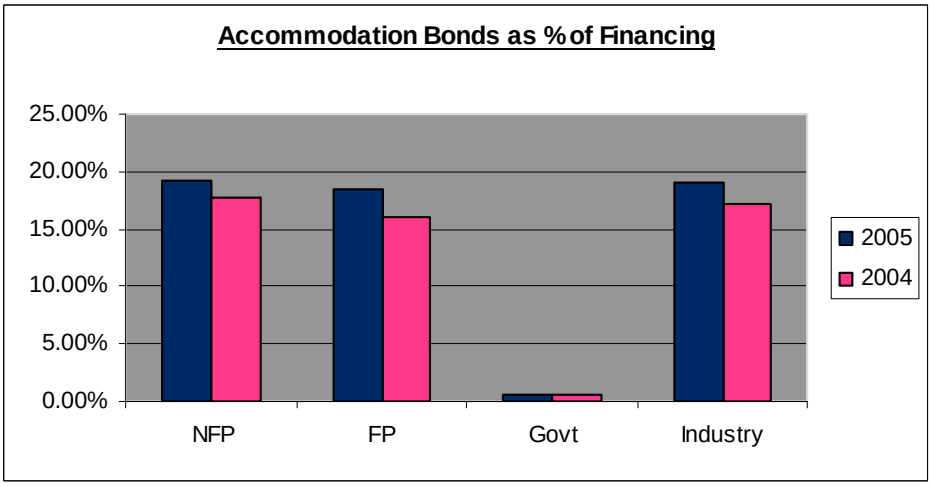


The comparative dependence on external debt to finance activities is reflected in the debt to equity ratios as follows:

	NFP	FP	Govt	Industry
Debt to Equity Ratio	0.8:1	2.3:1	0.2:1	1.1:1

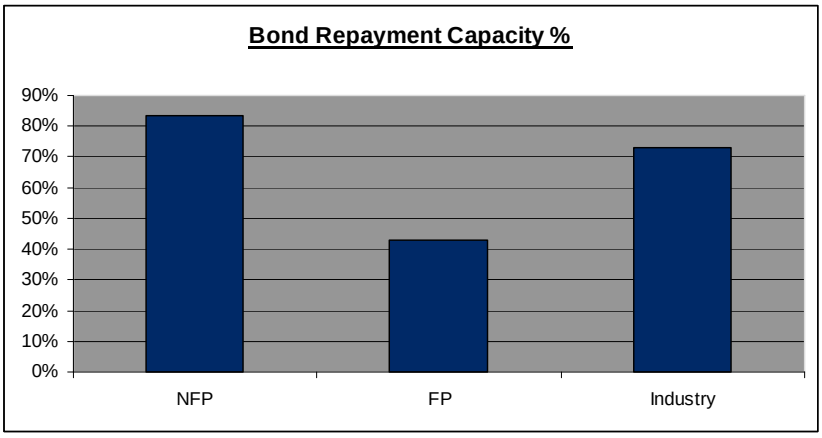


Further analysis on the components of debt reveals consistencies in the dependence on accommodation bonds. As anticipated, there has been an increase in the proportion of debt financing attributable to bonds from 2004 to 2005 as presented below:



This trend can be expected to continue as more low care, merged and extra service facilities are built and as providers become more commercial in their approach to bond levels. We are increasingly seeing growth in bond levels in the NFP sector and many organisations are now attracting bonds in excess of $500,000.

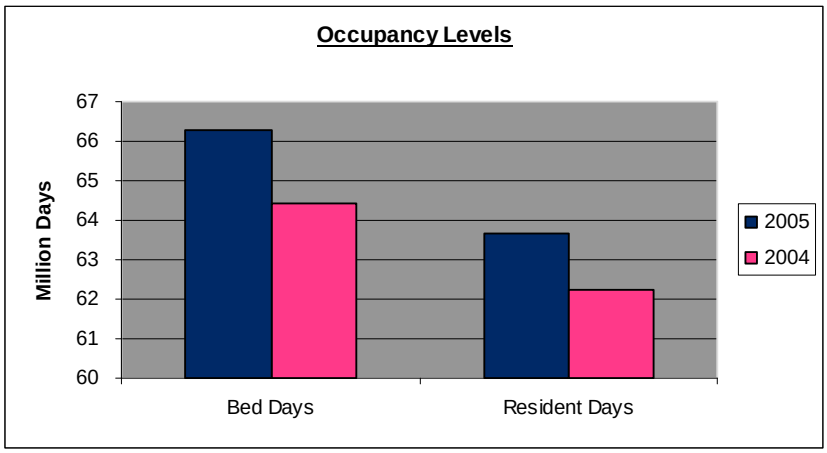
In these circumstances, the capacity of organisations to repay bonds on demand becomes increasingly important. Bond repayment capacity is a function of financing sources and liquidity levels as presented above. This results in a stronger position for the NFP groups as presented below.



We can expect that the gap between the FP and NFP groups to close over the coming years. Increased borrowings in the NFP sector will also see a reduction in the bond repayment capacity the industry as a whole as reserves are used for capital developments and borrowing levels rise.

Paramount to the success of a residential service is the maintenance of high occupancy levels. In recent years, we have seen anecdotal evidence of a softening in demand for low care residential services. Growth in community care services has started to impact on occupancy levels as has the increase in available beds.

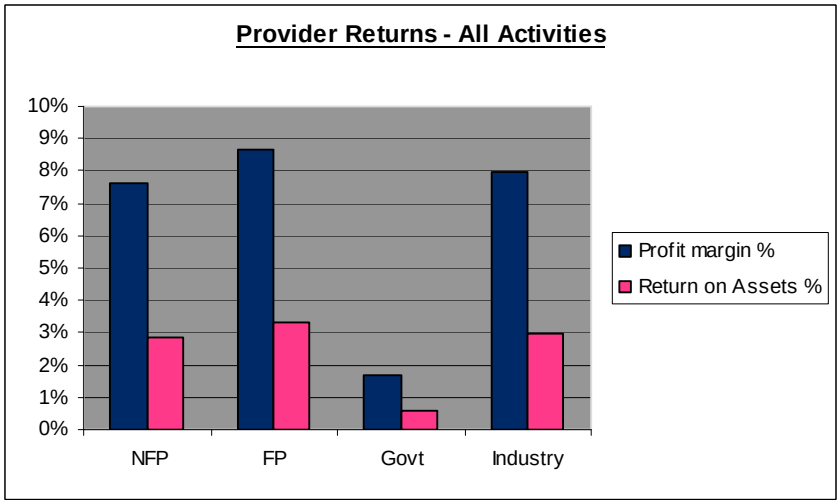
The analysis of occupancy levels below presents this trend. Further analysis will be undertaken to identify comparisons in high and low care and between States/Territories.



During 2005, Bentleys MRI undertook a research survey in Western Australia which identified a direct relationship between waiting lists and the services offered at residential aged care services. Whist waiting lists had continued to increase for high care services with single rooms, low care services and high care services with shared rooms were experiencing some of the lowest ever occupancy levels.

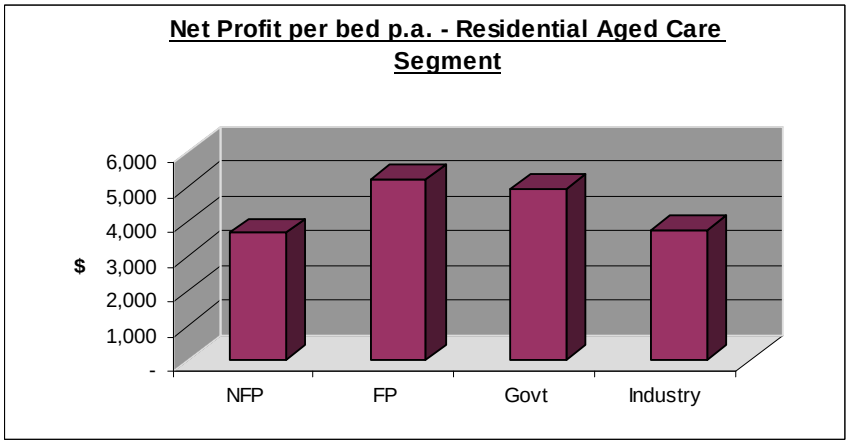
2. Financial Performance Ratios

The financial ratio analysis in relation to provider financial performance was constrained because of the limited information provided in general purpose financial reports. This condition was made worse because of the low number of providers that presented their segment information appropriately. However, the following analysis does present useful information on the profile of organisations participating in the industry.

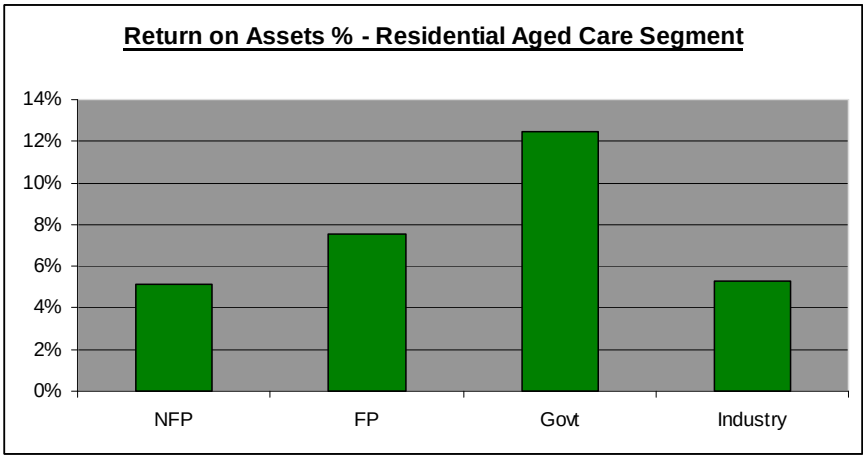


Provider return on assets reflected a marginal decline in 2005 compared to 2004. Industry averages for all activities remained constant whilst FP providers enjoyed a growth in returns compared to a decline in the NFP group.

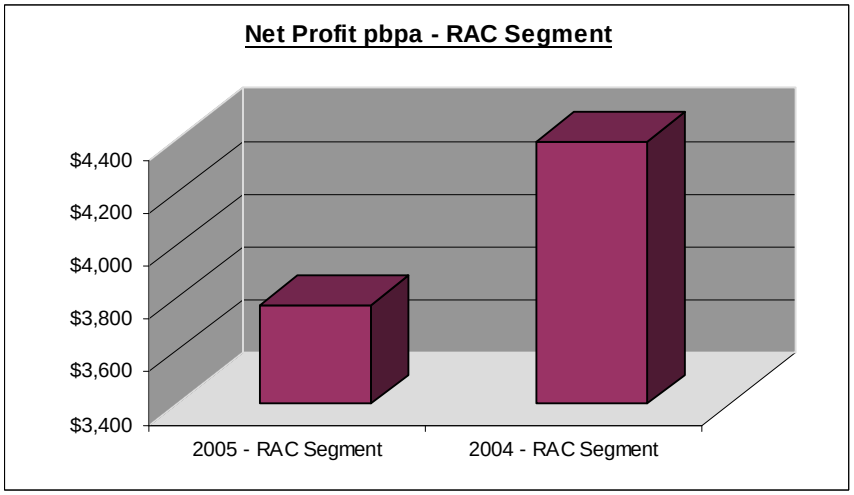
The analysis of segment information below also demonstrates the stronger returns from the FP group relating to residential care services. It should be noted that differing accounting treatment and segment reporting by Government providers limits the relevance of their results presented below.



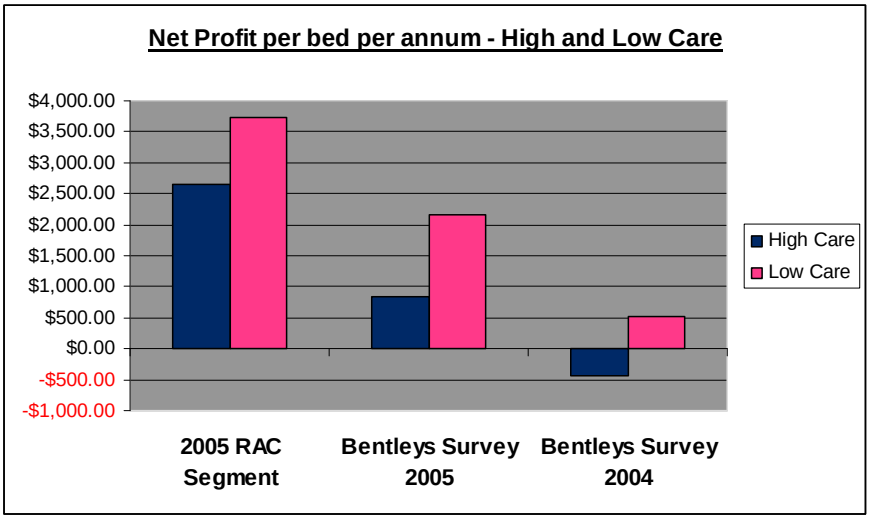
The segment information also reveals a more positive return on assets for the NFP and FP group compared to the return on all activities as illustrated below.



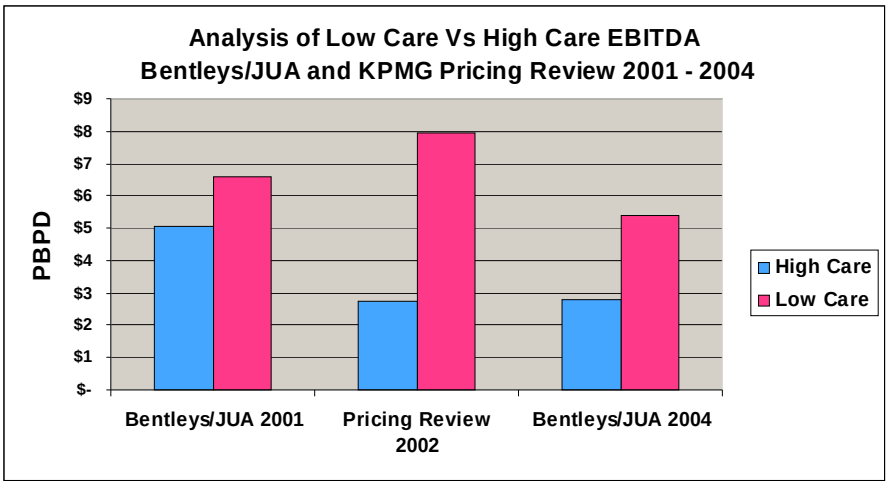
However, the segment results below indicate a reduction in profitability from 2004 to 2005. Further analysis reveals that only 42% of providers in the NFP group recorded an improvement in profitability whilst 64% of providers in the FP group recorded an increase. The results reflect the impact of the $3,500 per bed grant paid to providers late in the 2003/2004 financial year as part of the Commonwealth's forward plan for improved building standards for aged care homes. This was significantly more than the $1,000 per bed grant provided by the Commonwealth during the 2004/2005 financial year.



The results present a different trend to Bentleys/JUA National Aged Care survey which demonstrated improved results from 2004 to 2005 (excluding one-off grants). However, the trend in comparative returns in high care and low care is consistent as illustrated below.



It should be noted that the analysis between high and low care is based on the profile of the bed license (high or low care) rather than the profile of the resident (RCS Category) because the information was not available for this analysis. The disparity in returns between high and low care was also evident in the data used in the *Review of Residential Pricing Arrangements in Residential Aged Care*. The greater financial returns continue to occur in low care facilities, despite the growing demand for high care services.



As previously discussed, we would be happy to undertake further analysis at your direction. The source data extracted from provider financial statements has been summarised, de-identified and forwarded to your office.

Please do not hesitate to contact me should you wish to discuss any aspect of this report.

Yours sincerely

Cam Ansell
Director

Attachment 1 – Sample Letter and Financial Analysis Templates

Our Ref: cga/dha

Contact Person: Eric Davey

Contact Details: (08) 9480 2000 / edavey@bmrip.com.au

8 June 2006

Mailing Name
Address 1
Address 2

Dear Sir / Madam

Re: GENERAL PURPOSE FINANCIAL REPORT ANALYSIS

We refer to the Financial Report you have recently submitted to the Department of Health and Ageing (Department), pursuant to the Conditional Adjustment Payment (CAP) requirements of the *Residential Care Subsidy Principles 1997*.

We have used the information contained in your financial report to prepare the attached financial ratio analysis for you on behalf of the Department. The analysis has been prepared to assist in strengthening financial management practices within the aged care sector.

Please take the following factors into account when reviewing your summary:

- Your summary represents a guide for comparative analysis only. The diversity in provider structures, operating models, location and the interpretation of the data classification and disclosure requirements all have an influence on the analysis;

- Your summary may contain blank or incomplete information in one or more of the analysis areas. This will be because we were unable to extract the source information from your financial report necessary to complete these calculations. We may also have had to make a subjective judgement on the inclusion of parts of your source data, due to differing accounting disclosure interpretations; and

- We recommend that you read this summary in conjunction with the attached glossary of ratios. This glossary is provided to assist you understand the use of the ratios and the underlying calculation methodology.

The information submitted by your organisation is treated as highly confidential. The comparison between your organisation's financial results and the industry data is provided for your information purposes only and will not be disclosed to any other party.

If you require any further information on your summary analysis results, please contact Eric Davey or myself.

Yours sincerely

Cam Ansell
Director

APPENDIX 1

Financial Ratio Analysis

Bentleys mri
Thinking ahead

Organisation:

NAPS ID:
NAPS Group: **Not for Profit**

	Not For Profit + For Profit		Not for Profit Group 2004-2005	Aged Care Industry 2004-2005
	2004-2005	2003-2004		
Liquidity and Solvency				
Current ratio	22.07	27.24	2.68	2.20
Current Asset to Total Asset Analysis	62.31%	57.05%	22.19%	21.05%
Gearing Ratios				
Interest times cover	330.4	1115.7	20.50	7.30
Debt as % of total financing	28.55%	29.21%	37.39%	42.38%
Accommodation bonds as a % of total financing	14.72%	15.05%	19.28%	19.06%
Debt to Equity Ratio	0.5:1	0.5:1	0.8:1	1.1:1
Accommodation Bonds				
Accommodation bond asset cover	6.79	6.64	5.19	5.25
Bond repayment capacity %	407.49%	382.92%	83.36%	73.05%
Occupancy %	98.57%	98.70%	96.54%	96.06%
Financial Performance				
Net Profit - all activities	$6,043,187	$8,661,520	$820,598	$685,982
EBITDA - all activities	$8,817,647	$9,858,832	$1,498,767	$1,324,314
EBITDA per bed per annum - all activities	$16,032	$17,860	$10,539	$10,207
Profit margin % - all activities	19.47%	29.08%	7.60%	7.96%
Return on Assets % - all activities	5.42%	8.39%	2.86%	2.98%
Net Profit - Residential Aged Care segment			$666,424	$651,750
Net Profit per bed p.a. - Residential Aged Care segment			$3,680	$3,773
Return on Assets % - Residential Aged Care segment			5.17%	5.31%
Capital Investment				
Asset cover (times)	3.19	3.19	2.14	1.84
Net tangible assets per place	$202,817	$187,091	$197,144	$179,113
Average Useful Life Of Assets				
Buildings excluding land (years)	13		33	34
Staff Management				
Employee provision %	16.47%	23.50%	9.72%	9.27%
Employee expenses as a % of total expenses	54.06%	54.92%	57.15%	58.39%

The above report should be read in conjunction with the attached notes.

The aged care industry data does not include government providers

Financial Ratio Analysis

Bentleys mri
Thinking ahead

Organisation:

NAPS ID:
NAPS Group: **For Profit**

	Not For Profit + For Profit		For Profit Group 2004-2005	Aged Care Industry 2004-2005
	2004-2005	2003-2004		
Liquidity and Solvency				
Current ratio	1.46	1.44	1.37	2.20
Current Asset to Total Asset Analysis	36.48%	37.34%	17.87%	21.05%
Gearing Ratios				
Interest times cover	28.3	24.0	3.40	7.30
Debt as % of total financing	0.89%	4.58%	56.33%	42.38%
Accommodation bonds as a % of total financing			18.43%	19.06%
Debt to Equity Ratio	0.3:1	0.4:1	2.3:1	1.1:1
Accommodation Bonds				
Accommodation bond asset cover			5.43	5.25
Bond repayment capacity %			42.94%	73.05%
Occupancy %	99.78%	99.10%	94.64%	96.06%
Financial Performance				
Net Profit - all activities	$1,303,246	$2,355,137	$461,174	$685,982
EBITDA - all activities	$1,754,066	$2,849,619	$1,032,978	$1,324,314
EBITDA per bed per annum - all activities	$22,488	$36,534	$9,483	$10,207
Profit margin % - all activities	9.16%	16.61%	8.69%	7.96%
Return on Assets % - all activities	8.74%	16.78%	3.29%	2.98%
Net Profit - Residential Aged Care segment	$294,021	$120,977	$524,400	$651,750
Net Profit per bed p.a. - Residential Aged Care segment	$3,770	$1,551	$5,222	$3,773
Return on Assets % - Residential Aged Care segment			7.53%	5.31%
Capital Investment				
Asset cover (times)	3.86	3.27	1.27	1.84
Net tangible assets per place	$191,117	$179,913	$139,552	$179,113
Average Useful Life Of Assets				
Buildings excluding land (years)	20	20	40	34
Staff Management				
Employee provision %	11.79%	9.74%	8.34%	9.27%
Employee expenses as a % of total expenses	70.19%	71.83%	60.88%	58.39%

The above report should be read in conjunction with the attached notes.

The aged care industry data does not include government providers

Financial Ratio Analysis

Bentleys mri
Thinking ahead

Organisation:

NAPS ID:
NAPS Group: **Government**

	Organisation		Government Group 2004-2005	Aged Care Industry 2004-2005
	2004-2005	2003-2004		
Liquidity and Solvency				
Current ratio	2.65	2.25	1.05	2.20
Current Asset to Total Asset Analysis	23.64%	19.05%	9.37%	21.05%
Gearing Ratios				
Interest times cover	N/A	N/A	4.30	7.30
Debt as % of total financing	22.66%	23.09%	8.21%	42.38%
Accommodation bonds as a % of total financing	19.13%	19.31%	0.47%	19.06%
Debt to Equity Ratio	0.5:1	0.5:1	0.2:1	1.1:1
Accommodation Bonds				
Accommodation bond asset cover	5.23	5.18	211.69	5.25
Bond repayment capacity %	18.25%	44.75%	1067.96%	73.05%
Occupancy %	97.52%	81.35%	93.80%	96.06%
Financial Performance				
Net Profit - all activities	$358,632	$589,620	$1,048,814	$685,982
EBITDA - all activities	$626,457	$820,228	$5,751,300	$1,324,314
EBITDA per bed per annum - all activities	$26,102	$41,011	$74,328	$10,207
Profit margin % - all activities	7.56%	13.93%	1.68%	7.96%
Return on Assets % - all activities	4.29%	7.53%	0.58%	2.98%
Net Profit - Residential Aged Care segment	$43,455	$264,465	$357,242	$651,750
Net Profit per bed p.a. - Residential Aged Care segment	$1,811	$13,223	$4,955	$3,773
Return on Assets % - Residential Aged Care segment	1.23%	7.74%	12.44%	5.31%
Capital Investment				
Asset cover (times)	3.17	3.17	5.81	1.84
Net tangible assets per place	$348,414	$391,738	$2,323,527	$179,113
Average Useful Life Of Assets				
Buildings excluding land (years)	40	40	38	34
Staff Management				
Employee provision %	27.71%	28.08%	10.75%	9.27%
Employee expenses as a % of total expenses	70.35%	71.88%	61.15%	58.39%

The above report should be read in conjunction with the attached notes.

The aged care industry data does not include government providers

Financial report ratio analysis | Glossary of ratios

	Ratio	Calculation methodology	Description
LIQUIDITY AND SOLVENCY		Liquidity analysis provides an indication of an organisation's ability to pay their debts as and when they fall due.	
1	Current ratio	Current assets / Current liabilities less any current accommodation bond liability	Indicates ability to meet short term debt through current assets. A current ratio of more than 1 indicates that an organisation's current assets exceed its current liabilities.
2	Current assets to total assets	Current assets / Total assets	Provides analysis of the proportion of assets that are current.
GEARING		Gearing ratios review the extent your organisation uses differing forms of financing (such as accommodation bonds) and its ability to finance these liabilities.	
3	Interest times cover	Net profit before interest and tax (all activities) / interest expense	Shows the number of times that net profit will cover interest expense. Indicates an organisation's ability to service the interest on its debt.
4	Debt as a % of total financing	Total non current liabilities (including accommodation bond liabilities) / Total liabilities + total equity	Indicates the proportion of long term financing which is being supplied by debt and residents liabilities.
5	Accommodation bonds as a % of total financing	Total accommodation bond liability / Total liabilities + total equity	Identifies the proportion of long term financing which is being financed by resident liabilities.
6	Debt to equity ratio	Total liabilities / Total equity	Provides an analysis of the proportion of long term financing which is supplied by debt.
ACCOMMODATION BONDS		This section reviews your organisation's use of accommodation bonds and associated ability to repay these liabilities	
7	Accommodation bond asset cover	Total assets / Total accommodation bond liability	Provides an indication of the extent to which the accommodation bond liability is covered by assets
8	Bond repayment capacity %	Total financial assets / Total accommodation bond liability	Analysis of your ability to repay bonds in the short term.
9	Occupancy %	T Total resident days / Total bed days (from DoHA records)	Occupancy % is a core driver of your financial performance and your accommodation bond turnover.
FINANCIAL PERFORMANCE		Financial performance concentrates on the profitability of your activities (revenue and expenses).	
10	Net profit *(all activities)*	Net Profit **after** interest, tax, depreciation and amortisation	The excess of income over expenses. Provides an overall view on your organisation's profitability.
11	EBITDA *(all activities)*	Earning before interest, tax, depreciation and amortisation	Provides an overall view on profitability **before** the impact of expenses associated with differing

	Ratio	Calculation methodology	Description
			structures, investment and financing decisions.
12	EBITDA per bed per annum *(all activities)*	EBITDA / Number of places (from DoHA records)	Provides an indication of your profitability (before structuring, investment and financing decisions), comparative to your service size.
13	Profit margin % *(all activities)*	Net profit before interest and tax (but after depreciation) / Turnover (Revenue)	Shows your average profitability (before structuring, investment and financing decisions), generated on each $1 of revenue.
14	Return on assets % *(all activities)*	Net profit before tax / Total Assets	Indicates the productivity of assets employed in your organisation.
15	Net profit *(residential aged care segment)*	Net Profit **after** interest, tax, depreciation and amortisation	*See 10 above*
16	Net profit per bed per annum *(residential aged care segment)*	Net Profit **after** interest, tax, depreciation and amortisation / Number of places (from DoHA records)	Provides an indication of your net profitability, comparative to your size.
17	Return on assets % *(residential aged care segment)*	Net profit before tax / Total Assets	*See 14 above*
CAPITAL INVESTMENT		Capital investment (reflected through an organisation's asset position) provides longer term indicator of your organisation's financial stability.	
18	Asset cover (times)	Total assets less intangible assets / Total liabilities	Identifies the extent to which your tangible assets cover your total liabilities. A deficiency *may* indicate financial instability.
19	Net tangible assets per place	Total assets less intangible assets / Number of places (from DoHA records)	Provides an indication of the tangible asset stability of your organisation, comparative to your size.
AVERAGE USEFUL LIFE OF ASSETS		Building stock capital replacement (and associated quality considerations) is an important area to monitor within your organisation.	
20	Building (excluding land) in years	100% / Building depreciation %	Provides an indication of the anticipated useful life of your buildings.
STAFF MANAGEMENT		Employee expenses are usually the largest expense for a residential aged care provider.	
21	Employee provision %	Total provision for employee entitlements / Total employee expenses	Provides an indication as to how well you are managing your employee entitlement liabilities.
22	Employee expenses as a % of total expenses	Total employee expenses / Total expenses	Identifies the percentage of employee expenses as a proportion of total expenses.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2006-2007, 1 November 2006

Question: E06-235

OUTCOME 4: Aged Care and Population Ageing

Topic: UNANNOUNCED SUPPORT CONTACT VISITS

Hansard page: CA57

Senator McLucas asked:

How is the figure of 382 for July, August and September broken down?

Answer

	July	**August**	**September**	**Total**
Unannounced support contacts	115	113	154	382

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2006-2007, 1 November 2006

Question: E06-027

OUTCOME 4: Aged Care and Population Ageing

Topic: HASTINGS REGIONAL NURSING HOME

Written Question on Notice

Senator McLucas asked:

Hastings Regional Nursing Home had Sanctions applied on 10 March 2006 because the Approved Provider did not comply with all its responsibilities in relation to Accreditation Standards.

a) What didn't the Approved Provider comply with?
b) Has this facility now closed down, and if so when, why and how?
c) Does the Agency check whether staff entitlements have been paid, such as superannuation, during audit visits of aged care facilities?

Answer:

a) Sanctions were applied on 10 March 2006 by the Department of Health and Ageing in relation to the following non-compliant outcomes which were not remedied under a Notice of Non-Compliance:

- 1.2 Regulatory compliance;
- 2.1 Continuous improvement;
- 2.4 Clinical care;
- 2.10 Nutrition and hydration;
- 2.13 Behavioural management;
- 2.14 Mobility, dexterity and rehabilitation;
- 3.3 Education and staff development;
- 3.7 Leisure interests and activities;
- 4.2 Regulatory compliance.

The home had 15 other non-compliant outcomes identified by the Aged Care Standards and Accreditation Agency during a Review Audit. These were remedied following compliance action by the Department of Health and Ageing.

b) The facility closed on 19 June 2006 as a result of a commercial decision by the approved provider. The home was closed after all residents had been relocated to other homes in the area. The Department of Health and Ageing monitored the relocation of all residents in accordance with the provisions of the *Aged Care Act 1997*. The relocations were supervised by health professionals.

c) The Agency does not check whether staff entitlements have been paid during audit visits of aged care facilities. The Agency's responsibility extends to assessing standards for quality of care as set out in the Accreditation Standards of the Quality of Care Principles 1997.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2006-2007, 1 November 2006

Question: E06-021

OUTCOME 4: Aged Care and Population Ageing

Topic: INNOVATIVE POOL PROGRAM

Written Question on Notice

Senator McLucas asked:

a) What is happening to the Innovative Pool Program now that the original two year pilot has ended? What ongoing funding it [*sic*] to be provided to recipients of the Innovative Pool Program funding to sustain the living and care arrangements that have been established?

b) What is planned to deliver disability supports and services into nursing homes to improve the quality of life of YPINH who are aged over 50?

Answer:

a) Two Innovative Pool pilots were established to investigate the care and transition needs of younger people with disabilities in aged care homes who would be better placed in disability funded accommodation. The two Innovative Pool pilots are in South Australia and Victoria. Time limited funding is available to states and territories to help meet the cost of additional support needed by the young person to facilitate the smooth transition to state funded care.

Although the Australian Government was willing to establish more pilots, other states and territories did not take the opportunity to participate.

Providing for security and continuity of care for participants is an integral part of the planning processes and the pilot implementation agreements.

As part of the establishment of the pilots, state governments are committed to funding the ongoing disability care and accommodation needs of all those who have moved from aged care.

Neither pilot has yet ended. The South Australian pilot is scheduled to end in October 2007 and the Victorian pilot is due to end in April 2007.

b) States and territories have responsibility for providing disability support to people with disabilities.

Younger people with disabilities are only admitted to residential aged care facilities where there are no other care facilities or care services more appropriate to meet the person's needs. States and territories are free to provide additional services to people with disabilities who have had to resort to residential aged care. In some instances, states and territories do provide additional services.

Under the recent Council of Australian Governments initiative to reduce the number of younger people with disabilities in residential aged care facilities, states and territories are also free to use the additional joint funding provided by that initiative to provide additional services to younger people with disabilities who remain in residential aged care facilities, or who have no option but to go into residential aged care facilities.

While it is generally acknowledged that aged care homes rarely offer the most appropriate care and accommodation for younger people with disabilities, the Australian Government has accreditation and quality compliance systems in place to ensure all residents of aged care homes receive quality care.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2006-2007, 1 November 2006

Question: E06-022

OUTCOME 4: Aged Care and Population Ageing

Topic: TIME TO POST REPORTS ON WEB SITE

Written Question on Notice

Senator McLucas asked:

In an answer to a question (E06-217) from Budget Estimates Senator McLucas asked about how long it took to post a report on the Agency's website after an accreditation visit. In the answer the Agency stated that:

"The Accreditation Grant Principles 1999 provide that certain information including the executive summary of the audit report cannot be published until after the expiration of the period in which an application for reconsideration may be lodged. The information must be published within 28 days of that date."

We are looking for a more fulsome answer. Can ACSAA provide a schematic that indicates the timeframe from when an audit is undertaken and a posting on the website is made? Please include an explanation of all options the approved provider may pursue, and the time that takes, prior to final posting?

Answer:

Please see timeframe attached.

During 1 July 2006 to 30 September 2006, reports from accreditation site audits have been placed on the web site an average of 11 days from the first day when the report may be made public.

Accreditation process map for existing homes - No 1

The Aged Care Standards and Accreditation Agency Ltd

Refer to Accreditation Process Map 2 for request for reconsideration or review by AAT

	Application for accreditation due		25 weeks **(175 days)** prior to expiry date
1	Validate application *(Section 2.2-8)*	by day 7	Within 7 days of receiving the application for accreditation
2	Appoint assessment team *(Section 2.42)*	by day 28	Notify applicant in writing within 28 days of receiving the valid application
3	Complete desk audit *(Section 2.17, 2.18)*	by day 49	The assessment team provides a written report to the Agency within 49 days after receiving the valid application
4	Agency to decide whether to continue with application *(Section, 2.19)*	by day 56	Within 7 days of receiving the desk audit report
5	Agency to advise applicant of decision to continue with the application *(Section 2.19)*	by day 63	Within 7 days of making the decision on the desk audit report
6	Complete site audit, exit interview, statement of major findings *(Section 2.21-2.24)*	by day 119	Within 56 days of the Agency advice to applicant about the decision to continue with the application **Note: Site Audit cannot commence before day 75**
7	Complete assessment information and send to approved provider	by day 122	The assessment team provides a written report to the Agency within 3 working days and this is sent to the provider on receipt
8	Site audit report *(Section 2.25)*	by day 133	The assessment team provides a written report to the Agency within 14 days of the exit meeting
9	Response to major findings and assessment information *(Section 2.24 (5))*	by day 140	Approved provider submits a written response within 14 days of receipt of assessment information
10	Accreditation decision *(Section 2.28 and 2.31)*	by day 161	Within 28 days of receiving the site audit report, unless a later time has been agreed to with the applicant **Note: Decision cannot be made earlier than 2 months prior to expiry date (day 117)**
11	Inform applicant of decision to **accredit** (in writing) *(Section 2.29)*	by day 175	Within 14 days of making the decision Refer to Map no 2 for decision not to accredit
12	Publication of decision *(Section 9.1)*	by day 210	Within 28 days of end of the period in which a request for reconsideration or review of the decision may be made **(by day 210 for a decision to accredit if no request for reconsideration has been received.)**

Note: Sections refer to Accreditation Grant Principles 1999 (AGP)

Accreditation process map for existing homes - with reconsiderations - No 2

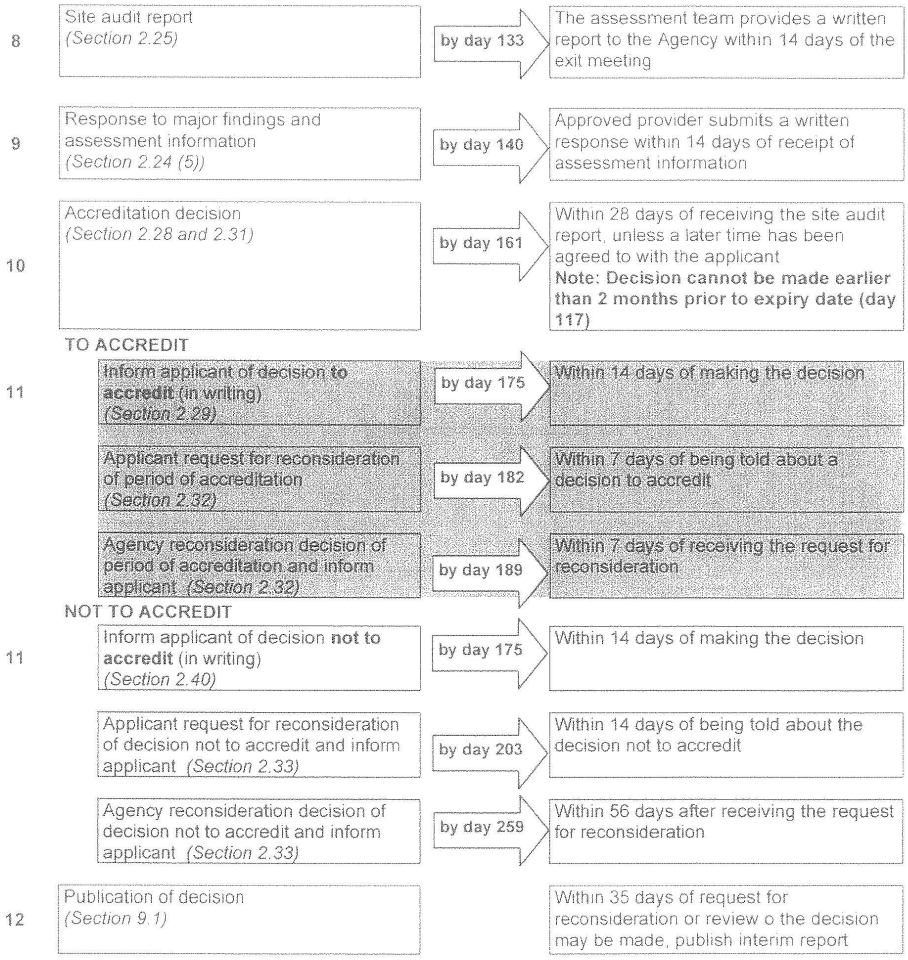
The Aged Care Standards and Accreditation Agency Ltd

Refer to Accreditation Process Map 1 for simplified version (without reconsideration/AAT)

	Application for accreditation due		25 weeks **(175 days)** prior to expiry date
1	Validate application *(Section 2.2-8)*	by day 7	Within 7 days of receiving the application for accreditation
2	Appoint assessment team *(Section 2.42)*	by day 28	Notify applicant in writing within 28 days of receiving the valid application
	Applicant request to reconsider exclusion of nominee in assessment team *(Section 2.44)*	by day 35	Within 7 days of receiving written notification of team **(decision within 7 days)**
	Agency reconsideration decision of exclusion of nominee and inform applicant (Section 2.44)		Within 7 days of receiving request
	Applicant objection to team *(Section 2.45)*	by day 42	Within 14 days of receiving written notification of team
	Agency decision of objection to team and inform applicant (Section 2.45)		Within 7 days of receiving objection
3	Complete desk audit *(Section 2.17, 2.18)*	by day 49	The assessment team provides a written report to the Agency within 49 days after receiving the valid application
4	Agency to decide whether to continue with application *(Section, 2.19)*	by day 56	Within 7 days of receiving the desk audit report
5	Agency to advise applicant of decision to continue with the application *(Section 2.19)*	by day 63	Within 7 days of making the decision on the desk audit report
	Applicant request to reconsider decision not to continue with the application *(Section 2.19)*		Within **7 days** of notification of desk audit decision
	Agency reconsideration decision of period of accreditation and inform applicant *(Section 2.19)*		Within **7 days** of receiving the request for reconsideration
6	Complete site audit, exit interview, statement of major findings *(Section 2.21-2.24)*	by day 119	Within 56 days of the Agency advice to applicant about the decision to continue with the application **Note: Site Audit cannot commence before day 75**
7	Complete assessment information and send to approved provider	by day 122	The assessment team provides a written report to the Agency within 3 working days and this is sent to the provider on receipt

Accreditation process map for existing homes - with reconsiderations - No 2

The Aged Care Standards and Accreditation Agency Ltd



Note: Sections refer to Accreditation Grant Principles 1999 (AGP)

Decisions reviewable by Administrative Appeals Tribunal (AAT) that relate to accreditation of existing homes. Refer to Section 7.1 of the *Accreditation Grant Principles 1999*.	**Section of AGP**
Decisions on reconsideration about the period for which the home is to be accredited	2.32
Refusal of an application on reconsideration	2.38
Refusal to include an applicant's nominated assessor in an assessment team	2.44
Refusal to accept an applicant's objection to a quality assessor	2.45

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2006-2007, 1 November 2006

Question: E06-024

OUTCOME 4: Aged Care and Population Ageing

Topic: COMPLAINTS TO THE AGENCY

Written Question on Notice

Senator McLucas asked:

In answer E06-076 from Budget Estimates the Agency said in response to a question about whether the Agency receives complaints about aged care facilities that: "The Agency receives information from a variety of sources. The Department of Health and Ageing routinely refers information to the Agency, including information lodged with the Complaints Resolution Scheme."

Please disaggregate the sources of complaints about aged care facilities to ACSAA by residents, residents' family/friends, residential aged care staff, community members, DOHA and other groups/entities in 2000, 2001, 2002, 2003, 2004, 2005 and 2006 to date.

Answer:

The information is dealt with on a facility basis and no aggregated records of sources (other than the number of referrals by type from the Department of Health and Ageing) are kept.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2006-2007, 1 November 2006

Question: E06-026

OUTCOME 4: Aged Care and Population Ageing

Topic: STAFF TURNOVER - AGENCY HEAD OFFICE

Written Question on Notice

Senator McLucas asked:

In Question E06-076 from Budget Estimates the Agency stated that there were 35.6 FTE staff at head office in Parramatta. Seven people (20%) resigned during the year.
a) What was the term of service of each of these employees?
b) What reasons did these people give for resigning in their exit interviews?

Answer:

a)
Two employees had more than five years' service.
One employee had between two-three years' service.
Four employees had less than two years service.

b)
One employee retired.
Four left for career progression.
Two provided no reason.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2006-2007, 1 November 2006

Question: E06-031

OUTCOME 4: Aged Care and Population Ageing

Topic: SPOT CHECKS

Written Question on Notice

Senator McLucas asked:

The Minister announced in the Budget that all residential aged care facilities would receive at least one unannounced spot check each year. $8.6 million over four years was allocated for this measure. How will this funding be allocated?

Answer:

Before the budget announcement the Agency was funded to conduct an average of 1.25 visits per home each year. The additional funding provides for the Agency to increase accreditation activity to an average of 1.75 visits per home each year, including one unannounced visit per home each year.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2006-2007, 1 November 2006

Question: E06-032

OUTCOME 4: Aged Care and Population Ageing

Topic: NOTIFICATION OF A PROPOSED REVOCATION OF A PROVISIONAL ALLOCATION OF PLACES: GLENBURN PRIVATE NURSING HOME

Written Question on Notice

Senator McLucas asked:

a) Has the Department revoked the provisional allocation of 30 low care places made to Cambrai Pty Ltd in respect of Glenburn Private Nursing Home – as outlined in a Notice of Proposed Revocation letter on 29 August 2006? If so, on what basis was this decision made?
b) In the same letter from the Department it states: "On 28 September 2004 you received notification from the Department that the provisional allocation period had been extended, in accordance with section 15-7 of the Act and was now due to expire on 10 January 2007". How can the Department revoke the provisional allocation, even though the Department had given an extension to 10 January 2007?

Answer:

a) This is protected information under the *Aged Care Act 1997*.
b) Details of the particular case are protected information under the *Aged Care Act 1997*. Section 15-4 of the *Aged Care Act 1997* provides that the Secretary may revoke a provisional allocation if the Secretary is satisfied that a condition to which the provisional allocation is subject has not been met. This can occur anytime within a provisional allocation period.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2006-2007, 1 November 2006

Question: E06-034

OUTCOME 4: Aged Care and Population Ageing

Topic: AGED CARE FUNDING INSTRUMENT

Written Question on Notice

Senator McLucas asked:

a) How has the impact of the proposed ACFI subsidy levels been tested to ascertain the financial impact on current approved services and providers?
b) When will the results of any such tests be made available to the industry?
c) How will the Government assist those approved services facing financial difficulty (from the ACFI) to adjust their client mix?

Answer:

a) Minister Santoro commissioned an independent review by Access Economics of the financial impact of the Aged Care Funding Instrument (ACFI) on aged care services.
b) Access Economics presented their findings to the ACFI Reference Group on 15 November 2006.
c) In its 2004 aged care Budget package, *Investing in Australia's Aged Care – More Places, Better Care,* the Australian Government announced that existing residents will remain in their current classification until they require a higher level of care. This 'grandparenting' effectively means that subsidies will not fall for any existing residents, and will increase for others, during the transition to the ACFI. As a result, services will not experience any immediate downturn in revenue with the introduction of the ACFI and most will see some increase in revenue.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2006-2007, 1 November 2006

Question: E06-036

OUTCOME 4: Aged Care and Population Ageing

Topic: AGED CARE FUNDING INSTRUMENT

Written Question on Notice

Senator McLucas asked:

How does the new funding instrument move subsidy funding from low level care to high level care whilst maintaining provider financial viability and access within the same total available resources?

Answer:

In its 2004 aged care Budget package, *Investing in Australia's Aged Care – More Places, Better Care,* the Australian Government, in addition to announcing it would reduce the number of funding classifications from the current eight to three, also introduced two new supplements. One supplement is for residents with dementia exhibiting challenging behaviours and the other for residents with other complex care needs including palliative. The supplements were to be funded from existing resources, which included an additional $877.8 million over four years for the Conditional Adjustment Payment. The Australian Government also announced that existing residents will remain in their current classification until they require a higher level of care. This 'grandparenting' effectively means that subsidies will not fall for any existing residents, and some may increase, during the transition to the Aged Care Funding Instrument.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2006-2007, 1 November 2006

Question: E06-040

OUTCOME 4: Aged Care and Population Ageing

Topic: COMMUNITY AGED CARE PACKAGES

Written Question on Notice

Senator McLucas asked:

Re answer to Question E06-083 from Budget Estimates, why does the Department not keep waiting times for Community Aged Care Packages?

Answer:

Data on waiting times is not gathered because such data is inherently unlikely to be accurate due to a number of factors including because the person:

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

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2006-2007, 1 November 2006

Question: E06-042

OUTCOME 4: Aged Care and Population Ageing

Topic: COMMUNITY AGED CARE PACKAGES (CACP)

Written Question on Notice

Senator McLucas asked:

What were the numbers of people approved for CACP, Low Care and High Care for 2005/06?

Answer:

Jurisdiction	CACP	Low-level Residential	High-level residential
New South Wales	15,624	17,760	16,303
Victoria	9,515	16,565	11,849
Queensland (Quarters 2-4)	5,111	8,713	7,082
Western Australia	5,134	5,672	4,268
Tasmania	617	958	1,405
Northern Territory	412	126	208
ACT	1,558	1,563	725
Total	37,971	51,357	41,840

Note:

1. The data is incomplete because
   a) South Australia did not report approvals items; and
   b) for the first Quarter of 2005-2006 Queensland did not record approvals items.

2. The data includes multiple approvals for the same person for different levels of care within a year and multiple approvals (eg, CACP and low-level care) made at the same assessment.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2006-2007, 1 November 2006

Question: E06-046

OUTCOME 4: Aged Care and Population Ageing

Topic: COAG YPINH INITIATIVE

Written Question on Notice

Senator McLucas asked:

What part is DoHA playing in a formal sense in the effort to keep/get YPINH out? What formal connection does it have with the COAG YPINH initiative through either FACSIA or the States directly?

Answer:

The Department of Families, Community Services and Indigenous Affairs is responsible for implementing the initiative on behalf of the Australian Government. The Department of Health and Ageing is represented on an Inter-Departmental Committee established to coordinate Australian Government agencies involvement in the initiative.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2006-2007, 1 November 2006

Question: E06-050

OUTCOME 4: Aged Care and Population Ageing

Topic: COAG YPINH INITIATIVE

Written Question on Notice

Senator McLucas asked:

Given that the COAG YPINH project is mainly targeted at the under 50's (which comprises les [*sic*] that [*sic*] 1/6th of the total inappropriately placed group of YPINH under 65), and that it is going to take five years to address their needs, what is proposed to be done with: those people in aged care aged between 50-65 who may not get any support through this program; those that will enter aged care in 2007-11 for whom no provision has been made in the COAG program?

Answer:

The Council of Australian Governments initiative initially targets people under 50 years of age in aged care homes. Other people with disabilities who are inappropriately accommodated in aged care homes (including those who enter after the start date of this initiative) are also eligible under the program, as well as people at risk of being placed inappropriately in aged care.

Under the Commonwealth State/Territory Disability Agreement, the states and territories have agreed that they have 'responsibility for the planning, policy setting and management of specialist disability services except employment services'.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2006-2007, 1 November 2006

Question: E06-053

OUTCOME 4: Aged Care and Population Ageing

Topic: RESIDENT CLASSIFICATION SCALE (RCS) REVIEWS

Written Question on Notice

Senator McLucas asked:

Please provide RCS review figures for 2005/06.

Answer:

A total of 16,474 RCS reviews were conducted nationally in the financial year ending 30 June 2006.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2006-2007, 1 November 2006

Question: E06-055

OUTCOME 4: Aged Care and Population Ageing

Topic: AGED CARE HOME FINDER

Written Question on Notice

Senator McLucas asked:

Will the Aged Care Home Finder Website contain reports from the Aged Care Standards and Accreditation Agency where a facility has failed one or more quality outcome? Will the website contain reports from spot checks?

Answer:

The Aged Care Home Finder component of the Aged Care Australia website will not contain any accreditation reports. The Aged Care Home Finder will indicate whether a home is currently accredited or not and provide users who are viewing the details of a particular home with a direct link to the reports that are currently available for that home on the Aged Care Standards and Accreditation Agency web site (www.accreditation.org.au).

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2006-2007, 1 November 2006

Question: E06-057

OUTCOME 4: Aged Care and Population Ageing

Topic: RESPITE

Written Question on Notice

Senator McLucas asked:

Correspondence has been received regarding concerns over the use of the "financial year" for assessment of respite care approval (63 days) by ACATs, and the use of "calendar year" for payment of Carer Allowance (can have respite for up to 63 days before losing payments).

a) Is the Department aware of this inconsistency in systems and the impact this has on older people and their families?
b) Does the Department have any plans to amend this anomaly?

Answer:

a) The Department of Health and Ageing is aware that the difference in the reporting years has occasionally created difficulties for carers. However, both the Department of Health and Ageing and Centrelink have taken measures to ensure that individuals are not disadvantaged by the differences in the legislation.

b) The Department of Health and Ageing has provisions under the *Aged Care Act 1997* for care recipients to seek assessments by an Aged Care Assessment Team and approval for an unlimited number of 21-day extensions. Similarly, Centrelink guidelines for Carer Allowance have been intentionally amended to permit the extension of the 63-day respite limit if the different annual periods used by the aged care home and Centrelink cause hardship. Access to carer payments can be reviewed as required until a new allocation of temporary cessation of care days becomes available on 1 January of a new year.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2006-2007, 1 November 2006

Question: E06-058

OUTCOME 4: Aged Care and Population Ageing

Topic: INDIGENOUS AGED CARE PLACES

Written Question on Notice

Senator McLucas asked:

Answer to question E06-081 re the additional Aboriginal and Torres Strait [sic] states that the "Strategy for allocation of places is under development in the Department for consideration by the Minister in the near future". Has this been undertaken and how will the places be allocated and where?

Answer:

Yes. In October 2006 the Minister approved the strategy for allocation of places. Proposals for new places which strengthen the viability of services are being sought from aged care providers contracted under the Aboriginal and Torres Strait Islander flexible aged care program. The locations will be determined as part of the assessment of proposals.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2006-2007, 1 November 2006

Question: E06-059

OUTCOME 4: Aged Care and Population Ageing

Topic: ELDER ABUSE

Written Question on Notice

Senator McLucas asked:

Is the Department monitoring reports of abuse in aged care facilities, and if so, how many cases have been reported to the Department since July.

Answer:

Yes. As at 30 November 2006, the Department has received, since July 2006, 23 allegations of abuse in aged care facilities, of which four have resulted in charges being laid.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2006-2007, 1 November 2006

Question: E06-171

OUTCOME 4: Aged Care and Population Ageing

Topic: WAGES

Hansard Page: CA 42

Senator McLucas asked:

Do you do any collection of information about movement in wages? And what about personal care workers?

Answer:

The Department of Health and Ageing monitors a number of the various state industrial awards which provide rates of pay for personal care workers in those states. This excludes Victoria which no longer has a state based industrial relations system and the territories which are also covered by the federal system.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2006-2007, 1 November 2006

Question: E06-173

OUTCOME 4: Aged Care and Population Ageing

Topic: AGED CARE PLANNING ADVISORY COMMITTEES

Hansard Page: CA 49

Senator McLucas asked:

Can we get on notice the names of those who are on the Committees? I do accept that it might be a bit tricky to go back over time to get the membership of those committees, but, without pushing too hard, if you could go back into what is very readily available, that would be very helpful.

Answer:

The readily available details of the membership of individual State and Territory Aged Care Planning Advisory Committees, appointed in 2001-2003, 2003-2005 and 2005-2007, are at Attachment A.

Attachment A

Aged Care Planning Advisory Committees – 2005 to 2007

Name of Member	*Term of appointment*
New South Wales	
Kathleen Brewster	4 April 2005 to 3 April 2007
Michelle Chandler	4 April 2005 to 3 April 2007
Nancy Deloi Bosler	4 April 2005 to 3 April 2007
Robyn Draper	4 April 2005 to 3 April 2007
Madelon Heuke	4 April 2005 to 3 April 2007
Catherine Katz	8 March 2006 to 3 April 2007
Claudia Kennedy	4 April 2005 to 3 April 2007
Elena Manning	4 April 2005 to November 2006
Jocelyn Oatley	4 April 2005 to 3 April 2007
Jill Pretty	4 April 2005 to 3 April 2007
Paul Taranto	4 April 2005 to 3 April 2007
John Wall	4 April 2005 to 3 April 2007
Victoria	
Mary Barry	4 April 2005 to 3 April 2007
Mathew Evans	4 April 2005 to March 2006
Meigan Lefebure	4 April 2005 to 3 April 2007
Jill Linklater	4 April 2005 to 3 April 2007
Lynette Moore	4 April 2005 to 3 April 2007
Ljubica Petrov	4 April 2005 to 3 April 2007
Robyn Pritchard	4 April 2005 to 3 April 2007
Chris Puckey	4 April 2005 to March 2006
Viv Sherpherdson	27 March 2006 to 3 April 2007
Denise Stead	27 March 2006 to 3 April 2007
Margaret Summers	27 March 2006 to 3 April 2007
Rosemary Thompson	4 April 2005 to 3 April 2007
Dean Varndell	4 April 2005 to March 2006
John Wise	4 April 2005 to 3 April 2007

Queensland	
Rob Coutts	4 April 2005 to 3 April 2007
Margaret Donaldson	4 April 2005 to 3 April 2007
Mike Edwards	27 March 2006 to 3 April 2007
Greg Joyner	4 April 2005 to 3 April 2007
Graham Kraak	4 April 2005 to 3 April 2007
Christine Minetti	4 April 2005 to 3 April 2007
Wendy Moyle	4 April 2005 to 3 April 2007
Terrie Nicholson	4 April 2005 to 3 April 2007
Ian Reed	4 April 2005 to March 2006
Josephine Smyth	4 April 2005 to 3 April 2007
Western Australia	
Helen Atrill	4 April 2005 to 3 April 2007
Maria Bunn	4 April 2005 to 3 April 2007
Sandy Collard	4 April 2005 to 3 April 2007
Stephen French	4 April 2005 to 3 April 2007
Michelle Mackenzie	4 April 2005 to 3 April 2007
Joan Malpass	4 April 2005 to 3 April 2007
Gail Milner	4 April 2005 to 3 April 2007
Robert Mitchell	4 April 2005 to 3 April 2007
Frank Schaper	4 April 2005 to 3 April 2007
Pauline Stuart	4 April 2005 to 3 April 2007
South Australia	
Gill Douglas	4 April 2005 to 3 April 2007
David Kemp	4 April 2005 to 3 April 2007
Heather Lane	4 April 2005 to 3 April 2007
John McKellar	4 April 2005 to 3 April 2007
Val Pylypenko	4 April 2005 to 3 April 2007
Judith Smith	4 April 2005 to 3 April 2007
Dana Vukovich	4 April 2005 to 3 April 2007
Ian Yates	4 April 2005 to 3 April 2007

Tasmania	
Helen Campbell	4 April 2005 to 3 April 2007
Mollie Campbell-Smith	4 April 2005 to 3 April 2007
Janet Carty	12 April 2006 to 3 April 2007
Rodney Greene	4 April 2005 to 3 April 2007
Marguerite Lester	4 April 2005 to 3 April 2007
Kenneth Lowrie	4 April 2005 to 3 April 2007
Jennifer Norton	4 April 2005 to December 2005
Kevin O'Loughlin	4 April 2005 to December 2005
Anthony Speed	4 April 2005 to 3 April 2007
Robyn Thomson	4 April 2005 to 3 April 2007
Lisa Wardlaw-Kelly	4 April 2005 to 3 April 2007
Australian Capital Territory	
Ann Atkinson	4 April 2005 to 3 April 2007
Dr Joan Buchanan	4 April 2005 to 3 April 2007
Kim Daniells	23 October 2006 to 3 April 2007
Paul Flint	4 April 2005 to 3 April 2007
Jane Gallagher	4 April 2005 to August 2006
Gerald Garrity	4 April 2005 to 3 April 2007
Michael Kenna	4 April 2005 to 3 April 2007
Jann Lennard	4 April 2005 to 3 April 2007
Michelle McGrath	4 April 2005 to 3 April 2007
Ross McKay	4 April 2005 to 3 April 2007
Gaynor McNess	4 April 2005 to 3 April 2007
Joyce Rajasekaram	4 April 2005 to 3 April 2007
Northern Territory	
Phylis Barrand	4 April 2005 to 3 April 2007
Raelen Beale	4 April 2005 to 3 April 2007
Kath Brewer	4 April 2005 to 3 April 2007
Sue Filipovitch	4 April 2005 to 3 April 2007
Brian Kennedy	4 April 2005 to 3 April 2007
Kate Lee	4 April 2005 to 3 April 2007
Jill MacAndrew	4 April 2005 to 3 April 2007
Lee Oliver	4 April 2005 to 3 April 2007
Carol Perry	4 April 2005 to 3 April 2007

Aged Care Planning Advisory Committees – 2003 to 2005

Name of Member	*Term of appointment*
New South Wales	
Monica Bhatia	April 2003 to 31 December 2004
Kath Brewster	April 2003 to 31 December 2004
Henny Cahill	April 2003 to 31 December 2004
Alberto Castillo	April 2003 to 29 February 2004
Alberto Castillo	15 March 2004 to 30 June 2004
Jill Elias	April 2003 to 31 December 2004
Roberta Flint	April 2003 to 31 December 2004
Christine Foran	April 2003 to 31 December 2004
Jo Kuila	April 2003 to 31 December 2004
Jill Pretty	April 2003 to 29 February 2004
Jill Pretty	15 March 2004 to 30 June 2004
Sheila Rimmer	April 2003 to 31 December 2004
Paul Taranto	April 2003 to 31 December 2004
Victoria	
Mary Barry	April 2003 to 29 February 2004
Mary Barry	15 March 2004 to 30 June 2004
Kerry Devenish	April 2003 to April 2004
Penny Houghton	April 2003 to 31 December 2004
Michelle Moon	April 2003 to 31 December 2004
Lynette Moore	April 2003 to 29 February 2004
Lynette Moore	15 March 2004 to 30 June 2004
Chris Puckey	April 2003 to 31 December 2004
Jenny Semple	April 2003 to 31 December 2004
Linda Sparrow	April 2003 to 31 December 2004
Margaret Summers	28 April 2004 to 30 June 2004
Raelene Thompson	April 2003 to 31 December 2004
Bronwyn Williams	April 2003 to 31 December 2004
Derryn Wilson	April 2003 to 31 December 2004

Queensland	
Laurie Barnett	April 2003 to 29 February 2004
Laurie Barnett	15 March 2004 to 30 June 2004
Venessa Curnow	April 2003 to 31 December 2004
Dawn Gorle	April 2003 to 31 December 2004
Mariya Ignatievsky	April 2003 to late 2003
Greg Joyner	April 2003 to 31 December 2004
Graham Kraak	28 April 2004 to 31 December 2004
J Gary McNab	April 2003 to 31 December 2004
Sue Meehan	April 2003 to 31 December 2004
Jo Root	April 2003 to 31 December 2004
Nathan Williamson	April 2003 to 31 December 2004
Kelly Yip	April 2003 to 31 December 2004
Western Australia	
Judith Adams	April 2003 to 29 February 2004
Susan Allica	April 2003 to 31 December 2004
Helen Attrill	April 2003 to 31 December 2004
Maria Bunn	April 2003 to 29 February 2004
Maria Bunn	15 March 2004 to 30 June 2004
Stephen French	April 2003 to 31 December 2004
Ken Marston	April 2003 to 31 December 2004
Councillor Ian Mickel	April 2003 to 31 December 2004
Gail Milner	April 2003 to 31 December 2004
Michael O'Kane	20 May 2004 to 30 June 2004
Tina Pickett	April 2003 to 31 December 2004
Frank Schaper	April 2003 to 29 February 2004
Frank Schaper	15 March 2004 to 30 June 2004
Marilyn West	April 2003 to 31 December 2004
Robert Willday	20 May 2004 to 30 June 2004
South Australia	
Terry Healey	April 2003 to 31 December 2004
Professor Graeme Hugo	April 2003 to 31 December 2004
David Kemp	April 2003 to 31 December 2004
Carol Mohan	April 2003 to 29 February 2004
Carol Mohan	15 March 2004 to 30 June 2004
Chris Overland	April 2003 to 29 February 2004
Chris Overland	15 March 2004 to 30 June 2004

Judith Smith	April 2003 to 31 December 2004
Marj Tripp	April 2003 to 29 February 2004
Marj Tripp	15 March 2004 to 30 June 2004
Dana Vukovich	April 2003 to 31 December 2004
Ian Yates	April 2003 to 29 February 2004
Ian Yates	15 March 2004 to 30 June 2004

Tasmania	
Elizabeth Barron	April 2003 to 31 December 2004
Hilary Brown	April 2003 to 31 December 2004
Mollie Campbell-Smith	April 2003 to 31 December 2004
Rebecca Essex	April 2003 to 31 December 2004
William Flassman	April 2003 to 29 February 2004
William Flassman	15 March 2004 to 30 June 2004
Ian Kennett	April 2003 to 31 December 2004
Martin Morrissey	April 2003 to 31 December 2004
Julian Northmore	April 2003 to 31 December 2004
Kevin O'Loughlin	April 2003 to 31 December 2004
Angela Reddy	April 2003 to 31 December 2004
Anthony Speed	April 2003 to 31 December 2004

Australian Capital Territory	
Helen Bedford	April 2003 to March 2004
Alba Bono	April 2003 to 29 February 2004
Alba Bono	15 March 2004 to 30 June 2004
Dr Joan Buchanan	April 2003 to 31 December 2004
Dorothy Dashwood	April 2003 to 29 February 2004
Dorothy Dashwood	15 March 2004 to 30 June 2004
Jane Gallagher	April 2003 to 29 February 2004
Jane Gallagher	15 March 2004 to 30 June 2004
Michelle McGrath	April 2003 to 31 December 2004
Margaret Morton	April 2003 to 31 December 2004
Jim Purcell	April 2003 to 29 February 2004
Jim Purcell	15 March 2004 to 30 June 2004
Paul Sadler	April 2003 to 29 February 2004
Paul Sadler	15 March 2004 to 30 June 2004
Joan Scott	28 April 2004 to 31 December 2004
Len Waugh	April 2003 to 31 December 2004

Northern Territory	
Damian Conley	April 2003 to 31 December 2004
Sue Filipovich	April 2003 to 31 December 2004
Leigh Hillman	April 2003 to 2003
Sharijn King	April 2003 to 29 February 2004
Kate Lee	April 2003 to 29 February 2004
Kate Lee	15 March 2004 to 30 June 2004
Lee Oliver	April 2003 to 31 December 2004
Leonie Simmonds	April 2003 to 31 December 2004

Aged Care Planning Advisory Committees – 2001 to 2003

Name of Member	*Term of appointment*
New South Wales	
Alberto Castillo	26 March 2001 to 28 February 2003
John Cowper	26 March 2001 to 28 February 2003
Dr Hugh Fairfull-Smith	26 March 2001 to 28 February 2003
Alix Goodwin	26 March 2001 to 28 February 2003
Heather Johnson	26 March 2001 to 28 February 2003
Deborah Kuhn	26 March 2001 to 28 February 2003
Susanne Macri	26 March 2001 to 28 February 2003
Gary Morris	26 March 2001 to 28 February 2003
Jill Pretty	26 March 2001 to 28 February 2003
Paul Taranto	26 March 2001 to 28 February 2003
Simon Watts	26 March 2001 to 28 February 2003
Victoria	
Mary Barry	26 March 2001 to 28 February 2003
Fay Carter	26 March 2001 to 28 February 2003
Jane Herington	26 March 2001 to 28 February 2003
Sandra Hills	26 March 2001 to 28 February 2003
Helen Kurincic	26 March 2001 to 28 February 2003
Dr John Leaper	26 March 2001 to 28 February 2003
Lynette Moore	26 March 2001 to 28 February 2003
Lesley Podesta	26 March 2001 to 28 February 2003
Patricia Reeve	26 March 2001 to 28 February 2003
Maureen Walker	26 March 2001 to 28 February 2003
Derryn Wilson	26 March 2001 to 28 February 2003
Queensland	
Laurie Barnett	26 March 2001 to 28 February 2003
Margaret Brown	26 March 2001 to 28 February 2003
Athena Ermides	26 March 2001 to 28 February 2003
Mariya Ignatievsky	26 March 2001 to 28 February 2003
Roger Kelly	26 March 2001 to 28 February 2003
Jo Root	26 March 2001 to 28 February 2003
Judith Skinner	26 March 2001 to 28 February 2003
Ross Smith	26 March 2001 to 28 February 2003
Jim Toohey	26 March 2001 to 28 February 2003
Bev Watkinson	26 March 2001 to 28 February 2003

Western Australia	
Judith Adams	26 March 2001 to 28 February 2003
Maria Bunn	26 March 2001 to 28 February 2003
Di Fergusson-Stewart	26 March 2001 to 28 February 2003
Stephen French	26 March 2001 to 28 February 2003
Pauline Iles	26 March 2001 to 28 February 2003
Stephen Loo	26 March 2001 to 28 February 2003
Gail Milner	26 March 2001 to 28 February 2003
Councillor Clive Robartson	26 March 2001 to 28 February 2003
Frank Schaper	26 March 2001 to 28 February 2003
Simone Tedman	26 March 2001 to 28 February 2003
Marilyn West	26 March 2001 to 28 February 2003
South Australia	
Kate Fotiadis	26 March 2001 to 28 February 2003
David Kemp	26 March 2001 to 28 February 2003
Yvonne McLaren	26 March 2001 to 28 February 2003
Carol Mohan	26 March 2001 to 28 February 2003
Jim Raggat	26 March 2001 to 28 February 2003
Lee Sando	26 March 2001 to 28 February 2003
Peter Sparrow	26 March 2001 to 28 February 2003
Heather Steven	26 March 2001 to 28 February 2003
Dr Tom Stubbs	26 March 2001 to 28 February 2003
Marj Tripp	26 March 2001 to 28 February 2003
Ian Yates	26 March 2001 to 28 February 2003
Tasmania	
Greg Burgess	26 March 2001 to 28 February 2003
George Debnam	26 March 2001 to 28 February 2003
Grant Doyle	26 March 2001 to 28 February 2003
William Flassman	26 March 2001 to 28 February 2003
Gaylene Johnson	26 March 2001 to 28 February 2003
Marlene Johnson	26 March 2001 to 28 February 2003
Tommy Maddox	26 March 2001 to 28 February 2003
Kevin O'Loughlin	26 March 2001 to 28 February 2003
Angela Reddy	26 March 2001 to 28 February 2003
Mark Stemm	26 March 2001 to 28 February 2003
Faye Tatnell	26 March 2001 to 28 February 2003
Peter Tucker	26 March 2001 to April 2001

Australian Capital Territory	
Chris Healy	August 2001 to 28 February 2003
Glenda Humes	26 March 2001 to 28 February 2003
Dr David Jarvis	26 March 2001 to 28 February 2003
Wendy McIntyre	26 March 2001 to 28 February 2003
Margaret Morton	26 March 2001 to 28 February 2003
Jim Purcell	26 March 2001 to 28 February 2003
Paul Sadler	26 March 2001 to 28 February 2003
Karen Sorenson	26 March 2001 to 28 February 2003
Margaret Summers	26 March 2001 to August 2001
Vaitylingam Thamotharalingam	26 March 2001 to 28 February 2003
Len Waugh	26 March 2001 to 28 February 2003
Northern Territory	
Damian Conley	26 March 2001 to 28 February 2003
Sharon Davis	26 March 2001 to 28 February 2003
Sue Filipovich	26 March 2001 to 28 February 2003
Peggy Havnen	26 March 2001 to 28 February 2003
Leigh Hillman	26 March 2001 to 28 February 2003
Sharijn King	26 March 2001 to 28 February 2003
Kate Lee	26 March 2001 to 28 February 2003
Lee Oliver	26 March 2001 to 28 February 2003
Leslie Penhall	26 March 2001 to 28 February 2003
Marguerite Rooke	26 March 2001 to 28 February 2003
Anastasia Wilson	26 March 2001 to 28 February 2003

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2006-2007, 1 November 2006

Question: E06-174

OUTCOME 4: Aged Care and Population Ageing

Topic: DECEMBER STOCKTAKE POPULATION FIGURES

Hansard Page: CA 52

Senator McLucas asked:

I might get from you, on notice, the same thing for the December stock-take figures as well.

Answer:

Residential Operational Ratios and
Estimated Population of People Aged 70 years or Over

	June 2004	**June 2005**	**June 2006**
Operational Ratio	84.0	85.1	85.6
Est. Pop. People Aged 70 +	1,858,346	1,892,756	1,936,548

	Dec 2004	**Dec 2005**	**Dec 2006**
Operational Ratio	85.5	86.3	Not available until March 2007
Est. Pop. People Aged 70 +	1,858,346	1,892,756	1,936,548

The June ratios are generally more reliable as the population estimates provided by the Australian Bureau of Statistics represent the population at June each year. The December ratios, although taking into account updated Stocktake figures for operational places, do not take into account the population growth during the six months from June to December.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2006-2007, 1 November 2006

Question: E06-175

OUTCOME 4: Aged Care and Population Ageing

Topic: HIGH CARE/LOW CARE FIGURES

Hansard Page: CA 53

Senator McLucas asked:

What is the split on entry, then, of high care to low care?

Answer:

Of all admissions to permanent residential aged care in 2005-06 (including first ever admissions, re-admissions and transfers from another home), 60.9 per cent were for high care and 39.1 per cent were for low care.

Of first ever admissions to permanent residential aged care in 2005-06, 52.3 per cent were for high care and 47.7 per cent were for low care.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2006-2007, 1 November 2006

Question: E06-029

OUTCOME 4: Aged Care and Population Ageing

Topic: STAFF CUTS IN AGED CARE FACILITIES

Written Question on Notice

Senator McLucas asked:

a) Has the Agency undertaken any unannounced spot checks on: Mirridong Nursing Home, Kelaston Nursing Home, Narracan Gardens Aged Care Facility, Balmoral Grove Private Nursing Home and Ronnoco Private Nursing Home since July 2006? If so when and what was the outcome of those visits?
b) How does the Agency ensure that there are adequate staffing levels in these facilities and that residents are receiving proper care?

Answer:

a) Yes. Unannounced visits have been conducted at all facilities since 1 July 2006. Information regarding support contacts is protected information under division 86 of the *Aged Care Act 1997*.

b) Expected outcomes 1.3, 2.3, 3.3 and 4.3 require that "management and staff have appropriate knowledge and skills to perform their roles effectively." Expected outcome 1.6 requires homes to ensure that "there are appropriately skilled and qualified staff sufficient to ensure that services are delivered in accordance with these standards and the residential care service's philosophy and objectives."

The Agency assesses home's performance against the Accreditation Standards using prescribed audit methodologies as set out in the Agency's "Audit handbook for assessors" including interviewing residents, relatives, management and staff, and observing staff practices and their interactions with residents. The Agency's "Results and processes" handbook provides guidance to assessors in considering relevant results and processes in assessing home's performance against the Accreditation Standards.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2006-2007, 1 November 2006

Question: E06-035

OUTCOME 4: Aged Care and Population Ageing

Topic: AGED CARE FUNDING INSTRUMENT

Written Question on Notice

Senator McLucas asked:

a) What support does Government plan to give the industry to introduce the new scheme?
b) Will aged care providers be expected to meet all the business process and information technology changes from their internal resources?

Answer:

a) The Australian Government will be offering a comprehensive national training package to all Australian Government subsidised aged care homes free of charge.

b) Yes, aged care providers will be expected to meet the business process and information technology changes from their internal resources.

As explained in the answer to E06-034, the Australian Government has committed that existing residents will remain in their current classification until they require a higher level of care. As a result, funding to aged care facilities will increase with the introduction of the Aged Care Funding Instrument (ACFI), as no existing resident will receive a lower care subsidy but existing residents who would receive a significantly higher subsidy under the ACFI will do so. The additional funding flowing to the sector as a result of the effects of 'grandparenting' of care subsidies may be used to meet the costs of business process and information technology changes.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2006-2007, 1 November 2006

Question: E06-038

OUTCOME 4: Aged Care and Population Ageing

Topic: AGED CARE FUNDING INSTRUMENT

Written Question on Notice

Senator McLucas asked:

One of the industry's primary objectives from the new instrument was to overcome the excessive documentation created by the current validation system. What assessment of reduction in documentation has been undertaken? What does it show? Please provide the Committee with the assessment?

Answer:

The Aged Care Funding Instrument (ACFI) design is based primarily on assessment of core dependency and breaks the nexus between ongoing care documentation and classification. It therefore addresses a significant cause of the funding paperwork problem. The national trial of the ACFI found that it took aged care staff, on average, less than one hour to complete the ACFI. The report on the national trial of the ACFI is not yet publicly available.

This contrasts with the Resident Classification Scale (RCS), in which managing RCS documentation for each resident has become a major continuing task. The Australian Catholic University recently estimated in a study titled *At What Cost?*, commissioned by Aged Care Association Australia, that the total wage cost of RCS related paperwork is over $142 million per annum. This study also reported staff hours involved in RCS-only activities. These findings equated to an average of 13 hours per new resident and an average of 34 hours for an RCS annual reappraisal.

An earlier study, *People before Paper* (2003), commissioned by Aged and Community Services Australia, found that the RCS was taking nine percent of care staff time, including 16 per cent of nursing staff time.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2006-2007, 1 November 2006

Question: E06-039

OUTCOME 4: Aged Care and Population Ageing

Topic: AGED CARE FUNDING INSTRUMENT

Written Question on Notice

Senator McLucas asked:

The Productivity Commission report on government red tape recommended a number of reforms for the aged care industry. What plans does the Government have to improve the red tape issues for aged care particularly those areas the PC reported on?

Answer:

The Australian Government's response to the Report of the Taskforce on Reducing Regulatory Burden on Business is available from the Treasury web site at www.treasury.gov.au

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2006-2007, 1 November 2006

Question: E06-047

OUTCOME 4: Aged Care and Population Ageing

Topic: COAG YPINH INITIATIVE

Written Question on Notice

Senator McLucas asked:

How is the Department of Health and Ageing going to assist the broader COAG YPINH initiative in its own area of direct policy/program responsibility?

Answer:

The Department of Families, Community Services and Indigenous Affairs is responsible for implementing the initiative on behalf of the Australian Government. The Department of Health and Ageing participates in an Inter-Departmental Committee and has provided information on the numbers and locations of people aged under 65 currently residing in residential aged care facilities, to facilitate states and territories approaching younger people to ascertain whether they wish to participate in the initiative. The department has also developed a draft protocol to ensure that state and territory authorities responsible for disability support services have the opportunity to respond when a younger person seeks assessment with a view to entering residential aged care.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2006-2007, 1 November 2006

Question: E06-236

OUTCOME 4: Aged Care and Population Ageing

Topic: PRINCIPAL OUTCOMES

Hansard Page: CA 60

Senator McLucas asked:

Is it possible, though, for you to identify not the names of them but the number of principal outcomes that each module is addressing?

Answer:

A number of assessment modules are still under development. Once all 12 are finalised, the modules will be published on the Agency's web site. The set will cover the range of key systems and processes in facilities that are related to expected outcomes.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2006-2007, 1 November 2006

Question: E06-043

OUTCOME 4: Aged Care and Population Ageing

Topic: COMMUNITY AGED CARE PACKAGES

Written Question on Notice

Senator McLucas asked:

How many people in receipt of an EACH-Dementia package live alone?

Answer:

The Department of Health and Ageing does not have data about the current living arrangements of people receiving Extended Aged Care at Home (EACH) Dementia Packages. However, the Department of Health and Ageing does hold data on the living arrangements of EACH Dementia recipients at the time of their assessment by an Aged Care Assessment Team.

Of the 587 people admitted or readmitted to an EACH Dementia Package during 2005-06 and the first quarter of 2006-07, 95 were living alone at the time of their ACAT assessment. The living arrangements of these care recipients may have changed since their assessment.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2006-2007, 1 November 2006

Question: E06-176

OUTCOME 4: Aged Care and Population Ageing

Topic: OCCUPANCY RATES BY PLANNING REGIONS

Hansard Page: CA54

Senator McLucas asked:

Is it possible to get a vacancy rate by planning region tabled? Can that be constructed?

Answer:

The table below shows average vacancy rates for residential aged care by Aged Care Planning Region for the whole of 2005-06.

Offline places, which are not available to be occupied, are counted as vacant in these figures. As a result these figures overestimate vacancies as a proportion of places actually available for use. At the 30 June 2006 stocktake, for example, approximately 1.3% of all non-provisional places at that date, nationally, were offline.

NSW	Central Coast	3.6%
	Central West	4.1%
	Far North Coast	3.8%
	Hunter	2.1%
	Illawarra	5.3%
	Inner West	7.2%
	Mid North Coast	3.3%
	Nepean	2.3%
	New England	3.7%
	Northern Sydney	6.1%
	Orana Far West	3.4%
	Riverina/Murray	2.8%
	South East Sydney	4.4%
	South West Sydney	6.1%
	Southern Highlands	6.3%
	Western Sydney	4.0%
	New South Wales	4.6%

Vic	Barwon-South Western	6.0%
	Eastern Metro	6.7%
	Gippsland	5.2%
	Grampians	3.6%
	Hume	4.1%
	Loddon-Mallee	4.3%
	Northern Metro	8.5%
	Southern Metro	8.1%
	Western Metro	10.1%
	Victoria	7.1%
Qld	Brisbane North	5.1%
	Brisbane South	3.1%
	Cabool	2.7%
	Central West	16.3%
	Darling Downs	3.5%
	Far North	6.3%
	Fitzroy	2.8%
	Logan River Valley	4.6%
	Mackay	0.8%
	North West	15.0%
	Northern	3.6%
	South Coast	4.5%
	South West	9.0%
	Sunshine Coast	4.9%
	West Moreton	5.2%
	Wide Bay	2.5%
	Queensland	4.0%
SA	Eyre Peninsula	4.7%
	Hills, Mallee & Southern	2.8%
	Metropolitan East	2.5%
	Metropolitan North	3.9%
	Metropolitan South	1.7%
	Metropolitan West	1.1%
	Mid North	2.7%
	Riverland	1.5%
	South East	5.5%
	Whyalla, Flinders & Far North	2.0%
	Yorke, Lower North & Barossa	2.7%
	South Australia	2.5%

WA	Goldfields	7.1%
	Great Southern	4.0%
	Kimberley	15.0%
	Metropolitan East	6.0%
	Metropolitan North	2.5%
	Metropolitan South East	5.0%
	Metropolitan South West	7.6%
	Mid West	0.9%
	Pilbara	5.9%
	South West	4.7%
	Wheatbelt	5.5%
	Western Australia	5.1%
Tas	North Western	2.1%
	Northern	2.8%
	Southern	5.6%
	Tasmania	4.0%
NT	Alice Springs	4.5%
	Barkly	4.3%
	Darwin	4.9%
	Katherine	6.3%
	Northern Territory	4.9%
ACT	ACT	2.1%
	Australian Capital Territory	2.1%
Australia		4.9%

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2006-2007, 1 November 2006

Question: E06-049

OUTCOME 4: Aged Care and Population Ageing

Topic: COAG YOUNGER PEOPLE IN NURSING HOME INITIATIVE

Written Question on Notice

Senator McLucas asked:

Some HACC Linkages programs are refusing to take people with degenerative conditions into their programs because of the risk of them getting 'stuck' in their programs – what steps has DoHA taken to negotiate directly with State disability services departments to arrange referral protocols for this group?

Answer:

The purpose of Linkages, a formalised packaged care arrangement under the Home and Community Care (HACC) Program in Victoria, is to support individuals with more complex needs who are at risk of premature or inappropriate admission to residential aged care, and who can and want to be supported in the community. A copy of the chapter of the Victorian HACC Program Manual which provides information on the scope and application of Linkages is attached.

Provision of HACC services are not determined by the type of disability – services are provided to individuals on the basis of their functional disability, as determined through an assessment and prioritisation of need process. Decisions not to provide services may be based on the provider assessment that the level of care required is greater than the package can accommodate. Therefore, depending on the level of disability, HACC may not be the most appropriate program for the individual. There are a range of Commonwealth and State funded packaged care and residential care programs that may be more suitable for those individuals that have care needs greater than what can be provided through the HACC program.

Neither DoHA or the Victorian Department of Human Services (DHS) are aware of any Linkage service provider refusing access to people with degenerative conditions because of the risk of them getting 'stuck' in their program. Any specific examples can be referred to DoHA or to DHS (who have responsibility for the day to day management of the HACC program in Victoria) for follow up.

DHS have advised that 21 of the 23 Linkages service providers in Victoria are also service providers under Disability Services programs, therefore, where an individual is assessed as not suitable for HACC Linkages, the providers are aware of processes for accessing appropriate alternative programs.

7.12 Linkages

7.12.1 Introduction

Linkages is a case management service which has brokerage funds to purchase additional services for people whose needs cannot be met entirely by the usual level of HACC services. This constitutes a package of care for each consumer.

Linkages supports individuals with complex care needs to live independently in the community by providing individually tailored packages of care.

Linkages is intended to meet the needs of people who might otherwise require admission to a low-care residential service. Linkages Packages are not generally able to meet levels of need equivalent to high-care residential services.

The terms 'case management' and 'case manager', as used by Linkages, should be distinguished from the HACC activity Assessment and Care Management, as described in Sub-Section 7.3.

In essence, Linkages packages provide case management and brokerage services to consumers assessed as having more complex care needs than can be met through the normal suite of HACC services, or who would gain particular benefit from case management.

7.12.2 Scope of the Service

A Linkages service will undertake a comprehensive assessment of the consumer's needs, and will then develop a care plan. The care plan will usually involve HACC agencies, private providers, other health and community support services, family and/or neighbours.

The purpose is to plan and coordinate services around the individual in a flexible and consumer-focused way. Particular emphasis is placed on the integration of community services and health services, whether home-based or community-based, and whether private or publicly funded. Linkages providers should work closely with other health and community service organisations including Aged Care Assessment Services, community support services and other HACC agencies.

The Linkages case management process involves five core activities:

. •screening for eligibility
. •assessment
. •care planning and service coordination
. •monitoring and service adjustment
. •case closure.

Linkages providers are responsible for ensuring each task is undertaken. There must be clearly stated and established procedures for performance of these activities. In some cases the consumer and/or their carer may take responsibility for aspects of case management.

7.12.3 Targeting Linkages Packages

Linkages packages should be appropriately targeted. All people referred to the service who fall within the HACC target group, and who have complex needs, should be assessed on the basis of relative need.

The Linkages target group comprises people with some or all of the following characteristics:

- have complex care needs, that is a range of interacting physical/medical, social and emotional needs and require assistance to organise community care
- have needs which are subject to rapid change and therefore require frequent monitoring
- find it difficult to get services through the normal HACC Program system which are sufficiently flexible in terms of the type, duration or time of assistance to meet their complex care needs
- have care needs which require the integration of formal and informal support
- require advocacy and monitoring
- have carers whose quality of life is significantly compromised by their caring role and who request assistance or
- in addition to complex care needs, have special needs not met by available services due to their ethnic or Aboriginal background or their geographic isolation.

Anyone who becomes a Linkages consumer should:

- have a definite desire and commitment to remain living in the community and
- require case management, and where appropriate brokerage, in order to remain living independently in the community.

Consumers who meet these criteria but whose needs can be appropriately met by existing HACC services should not be offered a Linkages package. The Linkages target group is not everyone who is 'at risk'. Some quite dependent people can be adequately supported by 'mainstream' HACC services without specialised case management.

An existing Linkages consumer should not be denied case management merely because a person with higher levels of need is referred to the project.

Assessment by an Aged Care Assessment Service is not required in order to receive a Linkages package, but is required for a Commonwealth-funded Community Aged Care Package (CACP).

7.12.4 Assessment

The primary feature of a Linkages assessment is its focus on the consumer and their carer as equal partners in the assessment process. The assessment should be comprehensive, taking a holistic approach which considers relevant social, personal and environmental issues in order to provide a flexible, consumer-focused package.

Refer to Sub-Section 7.3 Assessment and Care Management for further information.

7.12.4 Case Planning

As an outcome of the assessment process, the case manager is responsible for establishing and documenting each consumer's case plan. The case plan should be recorded in a format accessible to the consumer (such as on tape for people who are print handicapped). The plan will have been developed in consultation with and agreed by the consumer, the carer and service providers.

The case plan should demonstrate a creative and flexible approach, which is not limited by standard patterns of service delivery. The plan should detail the services to be provided from both the HACC and non-HACC sources.

Specifically the plan should set out:

. • the rights, roles and responsibilities of the consumer and the organisation(s) providing service
. • the process for monitoring and reviewing the case plan and the consumer's role in the review
. • all fees to be paid by the consumer and arrangements for fee payment.

Refer to Section 9 HACC Fees Policy for further details on fee setting and collecting.

7.12.6 Monitoring

Each Linkages consumer should have a case manager who is responsible for monitoring the effectiveness of the case plan. Each consumer's situation should be monitored in a way that ensures that changes in the consumer's needs are identified and addressed in consultation with existing or additional service providers.

Monitoring may be done directly by the case manager through personal contact with the consumer and/or carer. It may also be done through an agreed feedback process involving service delivery staff. The case manager should exercise judgement in determining the most effective monitoring arrangement. Regular reviews should occur, and their timing should be documented in the case plan.

Changes in the consumer's circumstances and care arrangements should be documented in the case plan by the case manager and distributed to other service providers, the consumer and carer.

7.12.7 Exit from Linkages

Consumers will leave Linkages packages for a variety of reasons including changes in living arrangements, entry to residential care and death. A case manager should seek alternative care arrangements for a consumer if:

. • the consumer's situation improves and linkages package are no longer required
. • the consumer can no longer be cared for in the community with available resources or has requested alternative care
. • the funded agency can no longer ensure appropriate care in accordance with this Manual. it is not always possible to keep every consumer at home on a long term basis, and in these instances a linkages package is not intended to be used as an inappropriate substitute for residential care.

The role of the case manager in case closure should mirror the approach taken in other case management activities. The case manager exercises judgement, in conjunction with the consumer and carer.

Case closure may involve counselling, meeting with the consumer and their family or informal carers, consultation with an Aged Care Assessment Service and liaison with residential care providers and other appropriate services.

Case managers should be aware of the significant benefit to consumers and carers that the security of continuity of services can bring. A consumer should not be denied case

management services because a person with higher needs is referred to the project. However, no guarantee can be given to consumers and carers that they are entitled to receive Linkages packages permanently.

7.12.8 Core Hours and Maintenance of Effort

Providers of Linkages packages should negotiate agreements with other HACC agencies which ensure that a person already receiving HACC services continues to receive at least the same level of service when they move to Linkages. This is referred to as 'maintenance of effort.'

If a new Linkages consumer has not previously been in receipt of HACC services, the Linkages coordinator should negotiate levels of core HACC services as part of the care plan.

The role of Linkages is to purchase additional services that supplement existing HACC service delivery levels, not replace them.

Linkages coordinators should negotiate with the council or other mainstream providers to set an agreed level of core hours for HACC activities. All Linkages consumers are entitled to receive the core hours of service, if appropriate, whether or not they were receiving HACC services prior to becoming a Linkages consumer. Region-wide arrangements have been negotiated among all HACC agencies in some regions.

General HACC funds and consumer fees fund core hours of service. Once the consumer has used up his or her allocation of core hours for the period, Linkages funds are used to purchase additional hours as needed.

7.12.9 Brokerage Funds

Brokerage funds are used to purchase services and equipment, which will make a critical difference to maintaining the Linkages consumer at home.

The funds should be used to:

- provide services, items or equipment that are consistent with the aims and objectives of HACC
- purchase high quality services, items or equipment with due regard to their cost effectiveness.

Brokerage funds should not be used to purchase equipment where the purchase of the equipment should be the role of other funded agencies or programs. If no other agency or program is responsible for purchasing equipment for the consumer, Linkages brokerage funds can be used on the basis that the equipment remains the property of the Linkages service and is returned to the Linkages service when the consumer is no longer using the service.

When a Linkages agency purchases services from another HACC agency, such as a council, the price should be equivalent to the current HACC unit price or funding rate set by the Department.

Sub-Contracting Services

The Linkages agency may arrange service delivery by contracting another agency or an individual to provide the service. A written statement that clearly outlines the criteria for distinguishing a contractor from an employee should be drawn up by the Linkages agency. The statement should establish that the contractor (either an individual or an agency) is being engaged to provide a service, as defined by the terms of the contract. This will ensure that the contractor is not a de facto employee of the Linkages agency and that the Linkages agency meets its legal obligations, while providing a high quality and flexible service.

The written contract should address the following:

- agreed levels of services
- full cost of services to be purchased

. • nature of service to be provided
. • accounting and invoicing procedures
. • insurance cover to be provided
. • data collection requirements
. • period and date of contract review
. • breach of contract
. • handling of disputes.

The Linkages agency is required to give first priority to other HACC-funded agencies as contractors. The Linkages agency should therefore identify all HACC providers in the area and be aware of the exact nature of the service they provide, as well as their cost, quality and flexibility. Regardless of the method of service delivery, overall responsibility for consumer outcomes, particularly quality assurance and consumer rights, rests with the Linkages package provider.

See Sub-Section 8.7.1 on Sub-Contracting for further information.

Direct Employment of Staff

A Linkages agency can directly employ staff to provide services to its consumers.

7.12.10 Comparison with CACPs

Community Aged Care Packages (CACPs) are not funded by HACC. CACP guidelines do not apply to Linkages. In comparison to Linkages packages, CACPs may offer a narrower range of service.

Key differences are:

. • Linkages agencies can purchase nursing with their brokerage funds. CACPs cannot purchase nursing, according to commonwealth guidelines. however CACP recipients assessed as needing nursing can be referred to a HACC nursing service
. • an ACAS assessment is mandatory for receipt of a CACP, but not for Linkages.

The value of a package under each program is approximately the same. A person receiving a CACP is not eligible for a linkages package. HACCfunded agencies including linkages providers have no 'maintenance of effort' obligation towards agencies providing CACPs or consumers in receipt of a CACP.

Refer to Section 2 for more information about CACPs, and to the Commonwealth website: www.health.gov.au

7.12.11 Staffing

The key staffing positions for Linkages packages are:

. • a coordinator responsible for service coordination, service development, financial management, and in some instances care management
. • case managers who work out of the Linkages agency or a mainstream HACC agency and who provide case management for an average of 25 to 30 people at any time
. • administrative support staff who assist in ensuring the smooth operation of the service
. • Linkages coordinator.
. A. Linkages Coordinator

The Coordinator's position is complex and demands highly developed skills and knowledge in managing staff and resources. It requires a sound knowledge of the needs of older people and people with disabilities and their carers, and an ability to work effectively within the relevant service networks that support these groups. A professionally qualified worker, with several years experience in a relevant field, should hold the position.

B. Case Managers

The case manager requires a detailed knowledge of the ageing process and the needs of younger people with disabilities, as well as the special needs of specific consumer groups such as people from culturally and linguistically diverse backgrounds and people from Aboriginal and Torres Strait Islander communities. Linkages case managers should have professional qualifications in a health and community services discipline and previous direct experience in working with people in the HACC target group.

7.12.12 Consumer Fees

Services are required to assess, set and collect fees in accordance with the Victorian HACC Fees Policy.

Fees charged by Linkages packages must be negotiated with the consumer, be affordable and take into account the total cost of fees for all services provided as part of a consumer's case plan and other associated costs of care. No one can be refused a service based on inability to pay.

The allocation of fees collected from Linkages consumers should be negotiated between each Linkages agency and the relevant Departmental regional office.

Refer Section 9 HACC Fees Policy for further information.

It is recommended that Linkages agencies establish a single system of fee collection, so that the consumer receives a single bill for all services provided. The system should enable recovery of fees by providers of core services, such as councils. Fees collected for services funded by Linkages must be accounted for separately from that due for core HACC services.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2006-2007, 1 November 2006

Question: E06-041

OUTCOME 4: Aged Care and Population Ageing

Topic: COMMUNITY AGED CARE PACKAGES

Written Question on Notice

Senator McLucas asked:

How does the Department measure unmet need in community care?

Answer:

The Department distributes the available places on a needs based approach. Each year the Minister for Ageing creates new aged care places (residential, community or flexible) for each state and territory for the following financial year, having regard to the national benchmark ratio of 108 places per 1,000 people aged 70 and over. Of the 108 places, 20 are allocated for community based care. In response to unmet need, this proportion has doubled since 2004. Prior to 1996, this type of care was not included in the national benchmark ratio.

The Aged Care Planning Advisory Committees in each state and territory then provide advice to the Department on the distribution of the new places in each state and territory. The Committees do this after taking into account the views of the local and regional communities – usually received by way of submissions to the Committees and quantitative data supplied by the Department (on population projections and aged care place numbers at a local level).

The Committees may recommend a focus on particular geographic localities within a planning region and for special needs groups. The advice is taken into account by the delegate of the Secretary of the Department before decisions on the regional distribution of places is made.

Australian Government

Department of Health and Ageing

SECRETARY

Senator McLucas
Parliament House
CANBERRA ACT 2600

Dear Senator McLucas

I refer to your question at the Supplementary Budget Estimates hearing on 1 November 2006 in relation to Blackburn aged-care facility in Melbourne (see Hansard extract below).

> I turn to the Blackburn aged-care facility in Melbourne, which I understand is now closed .... That was a very difficult circumstance. We had the oldest person in Australia in that facility. The local member, Mr Barresi, became involved in the transfer of that elderly lady. You will recall that the operators were very well regarded people. It was an internal dispute between the operators and the owner of the building. It was a very distressing time for those residents and they were eventually moved. Mr Barresi, I understand, offered to provide a limousine to transfer one of the residents to her new place of living, and that was refused by the family. But during that conversation, Mr Barresi indicated that the Darts, the very good providers who were operating Blackburn, would be all right because they have an application in for more beds. How would Mr Barresi know that? ..... I think an investigation into what has occurred is required, given the very strict protection of that information that should happen.

The Department's Audit and Fraud Control Branch has investigated the allegation and found that there was no evidence pointing to a breach by departmental officers of the protection of information provisions in the *Aged Care Act 1997* (the Act). The investigators noted that an application for allocated places may be accompanied by supporting material in the form of business references for example. Therefore there is potential that people and organisations other than the applicant may be aware of the fact that a person has lodged, or intends to lodge, an application. Those persons or organisations are not bound by the protection of information provisions in the Act.

Yours sincerely

Jane Halton

3 February 2007

cc Mr Elton Humphery
Secretary, Senate Committee on Community Affairs

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Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2006-2007, 1 November 2006

Question: E06-025

OUTCOME 4: Aged Care and Population Ageing

Topic: OUT OF HOURS VISITS

Written Question on Notice

Senator McLucas asked:

The Agency stated that it makes out of hours visits to aged care facilities. What proportion of the Agency's visits are out of hours, and what times are considered out of hours?

Answer:

The Agency does not keep records of the number of 'out of hours' visits.

The Accountability Principles 1998 define business hours as "the hours between 9am and 5pm on a business day".

The Agency therefore considers "out of hours" to be any time that is not between 9am and 5pm on a business day.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2006-2007, 1 November 2006

Question: E06-028

OUTCOME 4: Aged Care and Population Ageing

Topic: INAPPROPRIATE USE OF ANTIPSYCHOTIC MEDICATIONS

Written Question on Notice

Senator McLucas asked:

A report in InSite newspaper October/November 2006 said that "nursing home residents are being inappropriately prescribed antipsychotic medication, with fears that the trend is linked to cost cutting."

a) How does the Agency assess whether residents of aged care facilities are being inappropriately prescribed antipsychotic medication?
b) Has the Agency noted an increasing trend in the prescription of antipsychotic medication to residents?
c) If the Agency does find that a facility is inappropriately prescribing antipsychotic medication what action would the Agency undertake to rectify this?

Answer:

a) The Agency does not determine if medications are appropriately prescribed. Inappropriate prescribing of medication by medical practitioners is a matter for the relevant State or Territory regulatory authority, i.e. the Medical Board. The Agency assesses homes' systems for ensuring "residents' medication is managed safely and correctly" (2.7 Medication management). This involves identifying whether the medication has been prescribed by a person lawfully authorised to do so, if the resident or resident's representative has been consulted and if the home recommends reviews of residents' medications including psychotropic medications as appropriate.

   Assessment teams also review the home's use of medications as part of its overall behavioural management of individual residents, that is, if current strategies for individual residents, including the use of psychotropic medications are ensuring "the needs of residents with challenging behaviours are managed effectively (2.13 Behavioural management).

Behavioural management and medication management approaches are also considered in determining if "management of the residential care service is actively working to provide a safe and comfortable environment consistent with residents' care needs" (4.4 Living environment) which includes assessment as to whether residents are still free to move, if the behavioural management approaches ensure the environment is calm, and if residents are placing themselves or others, at risk.

In assessing expected outcomes, the Agency considers what outcomes are being achieved and may form a view as to what are the contributing factors to non-compliance.

Where problems are identified they are usually resolved within a short time frame fixed by the Agency.

b) No. This is not monitored under the Standards as this is a matter between the individual resident and his or her medical practitioner.

Initiatives implemented by the Government, which aim to foster and support appropriate medication management, include:

- *The Australian Medicines Handbook: Aged Care* – aimed specifically at GPs to assist them with appropriate prescribing for older people;
- *Guidelines for Medication Management in Residential Aged Care Facilities* (November 2002) produced by the Australian Pharmaceutical Advisory Council;
- *Medical Care of Older Persons in Residential Aged Care Facilities (4th Edition, April 2006);* and
- funding for medication review and case conferencing services for aged care residents and older people in the community.

Additionally under the 2005 Budget initiative *Helping Australians with dementia and their carers – making dementia a National Health Priority* the Government is providing $320.6 million over four years to support consumers and carers and to provide training to the aged care workforce.

c) See answer to (a) above.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2006-2007, 1 November 2006

Question: E06-033

OUTCOME 4: Aged Care and Population Ageing

Topic: AGED CARE FUNDING INSTRUMENT

Written Question on Notice

Senator McLucas asked:

Is the time frame for the introduction of the new Aged Care Funding Instrument still 1 July 2007?

Answer:

The Australian Government has announced that the ACFI will be introduced on 20 March 2008.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2006-2007, 1 November 2006

Question: E06-037

OUTCOME 4: Aged Care and Population Ageing

Topic: AGED CARE FUNDING INSTRUMENT

Written Question on Notice

Senator McLucas asked:

Is it correct that many of the business rules relating to the new scheme still remain to be decided? If so is a 1 July 2007 start date realistic?

Answer:

The Australian Government has announced that the ACFI will be introduced on 20 March 2008.

Outcome 5

Practice and General Practitioner (GP) Payments made through the Primary Care Practice Incentives Appropriation.

PRACTICE INCENTIVES PROGRAM (PIP)

The PIP provides a number of incentives that aim to support general practices to improve the quality of care provided to patients. Practices must be accredited or registered for accreditation against the *RACGP Standards for general practices* to participate in the Program.

Element	Aspect or Activity
1. IM/IT	**Tier 1 - Basic:** The practice maintains electronic patient records, which include clinical data on allergies/sensitivities for the majority of active patients; and The practice implements appropriate information security measures (e.g. virus protection, firewall, backup and recovery, access control and practice procedures/processes to support/maintain appropriate information security). The practice also uses appropriate security (e.g. encryption systems) when patient information and/or clinical data are transferred electronically. **Tier 2 - Enhanced:** The practice qualifies for Tier 1; and The practice uses electronic patient records to record and store clinical information on the majority of active patients, including current and past major diagnoses and current medications.
2. After hours care *Practices may qualify for any or all tiers.*	**Tier 1:** The practice ensures that patients have access to 24-hour care including access to out of hours visits where necessary and appropriate. **Tier 2:** ***Practices with less than 2,000 SWPEs*:*** The practice qualifies for Tier 1 and the practice GPs provide at least 10 hours per week of the practice's after hours cover (on average). ***Practices with 2,000 SWPEs or more:*** The practice qualifies for Tier 1 and the practice GPs provide at least 15 hours per week of the practice's after hours cover (on average). **Tier 3:** The practice GPs provide 24-hour cover (seven days a week) for practice patients.
3. Teaching	The practice teaches university medical students.
4. Quality Prescribing	The practice participates in 3 recognised educational activities (one of which is a clinical audit) per full time GP (on average).
5. Rural Loading	A rural loading ranging from 15% to 50% depending on the remoteness of the practice location, paid on incentive payments to rural and remote practices.
6. Diabetes	**Sign-on Payment:** One-off payment to practices that join the incentive and undertake to use a patient register and a recall/reminder system for patients with diabetes. **Outcomes Payment:** Payment to practices where at least 2% of practice patients are diagnosed with diabetes and 20% or more of these patients have completed a cycle of care. **Service Incentive Payment:** Payment to General Practitioners for completing a cycle of care for a patient with diabetes.
7. Asthma	**Sign-on Payment:** One-off payment to practices that join the incentive. **Service Incentive Payment:** Payment to General Practitioners for completing an Asthma Cycle of Care for patients with moderate to severe asthma.
8. Cervical Screening	**Sign-on Payment:** One-off payment to practices that join the incentive. **Outcomes Payment:** Payment to practices for screening 50% of women aged between 20 and 69 years in a 30 month reference period.

Element	Aspect or Activity
	Service Incentive Payment: Payment to General Practitioners for screening women between 20 and 69 years who have not had a cervical smear within the last four years.
9. **Mental Health**	**Sign-on Payment:** One-off payment to General Practitioners in PIP or accredited practices who undergo Level 1 training and register for the incentive. **Service Incentive Payment:** Payment to General Practitioners for completing a 3 Step Mental Health Process.
10. **Practice Nurses**	**Practices in urban areas of workforce shortage:** Payment to PIP practices in areas of workforce shortage that employ or retain the services of a Practice Nurse and/or Allied Health Worker. **Practices in rural and remote areas:** Payment to rural and remote practices that employ or retain the services of a practice nurse and/or an Aboriginal Health Worker.
11. Procedural GP Payment. *A GP can only qualify for one tier/procedural payment.* *Available to practices in rural and remote areas.*	**Tier 1:** A GP in a rural or remote practice provides any service that meets the definition of a procedural GP. **Tier 2**: A GP meets the Tier 1 requirement and provides after-hours procedural services on a regular or rostered basis (15 hours per week on average). **Tier 3:** A GP meets the Tier 2 requirements and provides surgical &/or anaesthetic &/or obstetric services totaling more than 50 eligible procedures per year. **Tier 4:** A GP meets the Tier 2 requirements and delivers more than 20 babies a year or meets the obstetric needs of the community.

* Standardised Whole Patient Equivalent (SWPE) is used to measure practice size and adds a weighting factor for age and gender to each patient. The average load for a full time General Practitioner is 1,000 SWPEs per year.

GENERAL PRACTICE IMMUNISATION INCENTIVES SCHEME (GPII)

The General Practice Immunisation Incentives (GPII) Scheme provides practices and GPs with financial incentives to monitor, promote and provide immunisation services to children under the age of seven years.

Element
Service Incentive Payment (SIP): A monthly payment made to GPs who notify the Australian Childhood Immunisation Register (ACIR) of a vaccination that completes an immunisation schedule according to the National Immunisation Program (NIP).
Outcomes Payment: A quarterly payment to practices that achieve 90% or greater full immunisation for children less than seven years of age.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2006-2007, 1 November 2006

Question: E06-152

OUTCOME 5: Primary Care

Topic: RURAL PROCEDURAL GPs

Written Question on Notice

Senator McLucas asked:

How many procedural GPs get a PIP payment?

Answer:

In August 2006, there were 747 GPs accessing Practice Incentives Program (PIP) procedural payments.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2006-2007, 1 November 2006

Question: E06-001

OUTCOME 5: Primary Care

Topic: PREGNANCY COUNSELLING – PRIVACY CONCERNS

Written Question on Notice

Senator Stott Despoja asked:

a) Following the revised wording of the pregnancy counselling Medicare item number that now allows the item number to be accessed by women who are "concerned about a pregnancy or a pregnancy that occurred in the preceding 12 months', how does the Department define the term 'concerned'?
b) Does it only include women considering a termination?
c) If not, what other situations faced by a pregnant woman will fall under the item number?
d) Can the Department confirm that women using this item number will be able to be identified by anyone with access to their file, including Medicare and those in their GP's surgery?
e) Is the Department planning on implementing safeguards to prevent breaches in privacy?
f) If so, how will the Department ensure that a woman's privacy will not be compromised?
g) How is the term concerned different from the previous term "uncertain"?
h) Which women will now be able to access the item number who would not have been able to if the original wording was maintained?

Answers:

a) The intention of the item is to support women who are concerned about any aspect of their pregnancy where non-directive counselling might be useful. This might include (but not be limited to) women who have concerns regarding the impact of the pregnancy on their own health; the impact on their relationship; lifestyle changes that may need to be adopted in light of the pregnancy; issues to do with emotional preparedness for parenting; dealing with general anxiety about the birth itself; strategies for handling post-partum depression; or dealing with the impact that the arrival of a new baby may have on the family (including other children).
b) No.
c) Refer to (a).
d) Yes.
e) The Australian Government is aware that some stakeholders raised privacy concerns about the item. The broader scope of the item to include all pregnancy related-issues will help to alleviate these concerns. At the systems level, Medicare Australia and general practices also have policies and procedures in place to ensure the privacy of all patients.
f) Refer to (e).
g) Refer to (a).
h) Refer to (a). The item is no longer restricted to women who are uncertain about proceeding with their pregnancy - it now encompasses women who have general concerns about their pregnancy. The revised item was developed in consultation with the relevant professions and the National Pregnancy Counselling Expert Advisory Committee.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2006-2007, 1 November 2006

Question: E06-139

OUTCOME 5: Primary Care

Topic: PIPS AND SIPS

Written Question on Notice

Senator McLucas asked:

The answer to E06-260 shows that in 2004-05 PIP/SIP expenditure was $55.066 million under budget due to lower than expected uptake on IT, Broadband and practice nurses. Please explain the basis of these lower than expected uptakes, in particular, the lower uptake of practice nurses.

Answer:

The key reason for the difference between the allocation and expenditure is that there are a number of different initiatives available through the Practice Incentives Program (PIP), all of which are demand driven. GPs can choose to participate in all or some of the PIP initiatives.

- The rural practice nurse initiative was not taken up to the extent originally forecast mainly because of the capacity of small practices to employ a practice nurse and the availability of nurses in rural and remote areas.

- There were delays in the start up of the urban practice nurse incentive which was announced originally as part of the Fairer Medicare package but implemented as part of Strengthening Medicare. A conservative approach was also taken in offering practices access to the practice nurse initiative because of the funding constraint and take up was not able to be accurately estimated.

- The Broadband Connectivity for Health Program was underspent because there was a short implementation timeframe and a subsequent slow take up of the Program in 2004-05.

- Funding was allocated to GP IT Development to introduce the cost of PBS medicines into the software commonly used by GPs. This component was implemented without cost.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2006-2007, 1 November 2006

Question: E06-143

OUTCOME 5: Primary Care

Topic: CHRONIC DISEASE MANAGEMENT

Written Question on Notice

Senator McLucas asked:

What will happen with item 10968 (psychology) which is now undermined by the new Medicare items which pay twice as much for a psychology visit?

Answer:

MBS item 10968 (psychology) will continue to be available for patients being managed under a GP Management Plan and Team Care Arrangements who are eligible to access this service.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2006-2007, 1 November 2006

Question: E06-144

OUTCOME 5: Primary Care

Topic: CHRONIC DISEASE MANAGEMENT

Written Question on Notice

Senator McLucas asked:

What is being done to improve the uptake of the dental items and reduce the out-of-pocket costs which can be as high as $500?

Answer:

Like doctors, dentists and dental specialists are able to set their own fees for services. Dental practitioners may choose to bulk bill the patient, but many charge above the rebate level. This is particularly the case for dental specialists.

Out-of-pocket costs incurred for eligible dental services count towards the extended Medicare Safety Net.

The Department of Health and Ageing is working closely with the Australian Dental Association (ADA) at the national and state/territory level to identify ways of making the dental items more attractive to dentists and patients. Uptake rates and out-of-pocket costs have been raised as important issues. The department will be holding further discussions with the ADA on these matters.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2006-2007, 1 November 2006

Question: E06-145

OUTCOME 5: Primary Care

Topic: PRIMARY CARE COLLABORATIVES

Written Question on Notice

Senator McLucas asked:

a) Will this Program be continued?

b) Will it have to wait until the May 2007 budget to know if further funding is forthcoming?

c) Doesn't this uncertainty mean that program expertise will be lost?

Answers:

a) Decisions about the continuation of the program beyond 2006-07 will be made as part of the 2007-08 Australian Government Budget process.

b) See a).

c) No. The Department is currently in discussions with Flinders University to look at possible arrangements to ensure that program expertise is not lost in the period leading to the 2007-08 Budget.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2006-2007, 1 November 2006

Question: E06-146

OUTCOME 5: Primary Care

Topic: PRIMARY CARE COLLABORATIVES

Written Question on Notice

Senator McLucas asked:

The Department annual report 2005-06 p317 shows that KPMG won a $289,000 tender to evaluate this program.

a) When was this evaluation study commenced?

b) When will it be concluded?

The annual report also indicates that funding of $11,192 was provided directly to RSM Bird Cameron to "review the National Primary Care Collaborative Budget".

c) Why is this being done separately from the program evaluation?

Answers:

a) The evaluation commenced in January 2005.

b) An interim evaluation report has been lodged. The Evaluation is expected to be finalised in the first half of 2007.

c) These were two separate tasks, requiring different expertise. RSM Bird Cameron was engaged to independently test and verify the National Primary Care Collaboratives budget, costing models and assumptions. RSM also assessed how the budget compared to current market rates. KPMG was engaged to assess the efficiency, effectiveness and appropriateness of the Australian Primary Care Collaboratives Program.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2006-2007, 1 November 2006

Question: E06-147

OUTCOME 5: Primary Care

Topic: ROUND THE CLOCK MEDICARE

Written Question on Notice

Senator McLucas asked:

(a) With reference to Round The Clock Medicare: Investing in After-Hours GP Services, please provide information (recipients, town, state, amount of grant) for grants announced to date:

1. for Operating Subsidies (please indicate if this is for establishing a dedicated after-hours service, extending an existing service to after-hours, or for a Medical Deputising Service to establish an after-hours clinic)

2. for Start Up Grants (please indicate if this is for establishing a dedicated after-hours service, extending an existing service to after-hours, or for a Medical Deputising Service to establish an after-hours clinic)

3. for Supplementary Grants (please indicate if this is a GP practice, a Medical Deputising Service or a GP co-operative).

(b) For Start Up Grants, please indicate if the relevant State Governments were consulted about the needs at the locations chosen.

(c) Please provide actual spending to date against budget.

Answer:

(a)
(1) The following table provides all requested details for Operating Subsidies funded in the 2005-06 round:

Operating Subsidies 2005-06

Name of Organisation	GST Excl	Locality	Type of service
Adelaide Hills Division of General Practice	$478,515	Mt Barker, SA	Establish a dedicated after hours service
Albury After Hours Clinic Pty Ltd	$382,100	Albury, VIC	Establish a dedicated after hours service
Liverpool Division of General Practice	$550,000	Liverpool, NSW	Establish a dedicated after hours service
Nepean Division of General Practice Incorporated	$600,000	Penrith, NSW	Establish a dedicated after hours service
Southern Health	$369,000	Dandenong, VIC	Establish a dedicated after hours service
Sunraysia Community Health Services	$453,109	Mildura West, VIC	Establish a dedicated after hours service
The Northern After Hours Clinic Ltd	$400,000	Epping, VIC	Establish a dedicated after hours service
Wonthaggi Medical Group	$500,000	Wonthaggi, VIC	Establish a dedicated after hours service

(2) The following table provides all requested details for Start Up Grants funded in the 2004-05 round:

Start Up Grants 2004-05

Adelaide Central & Eastern Division of General Practice	$200,000	Glenside, SA	Establish a dedicated after hours service
Chevron After Hours Medical Service	$200,000	Tweed Heads, NSW	Establish a dedicated after hours service
Melbourne Medical Locum Staff Pty Ltd	$200,000	Williamstown, VIC	Establish a dedicated after hours service

The following table provides all requested details for Start Up Grants funded in the 2005-06 round:

Start Up Grants 2005-06

After Hours Medical Care Pty Ltd	$200,000	Coolum, QLD	Establishment of a dedicated after hours service
Cobram District Hospital	$200,000	Cobram, VIC	Establishment of a dedicated after hours service
Eloirad Pty Ltd trading as Valewood Clinic	$200,000	Mulgrave, VIC	Existing practice, extending into after hours period
Fremantle Regional Division of GP trading as GP Network	$200,000	Fremantle, WA	Existing practice, extending its services
gpSolutions Pty Ltd	$200,000	Aldinga, SA	Medical deputising service to establish an after hours clinic
Primary Health Care Ltd	$200,000	Ballarat, VIC	Existing practice, extending into after hours period
Primary Health Care Ltd	$200,000	Browns Plains, QLD	Existing practice, extending into after hours period
Primary Health Care Ltd	$200,000	Charlestown, NSW	Existing practice, extending into after hours period
Primary Health Care Ltd	$200,000	Norwood, SA	Existing practice, extending into after hours period
Ramahyuck & District Aboriginal Corporation (Gippsland Family Practice)	$200,000	Sale, VIC	Existing practice, extending into after hours period
RUR Investments Pty Ltd trading as Fountain Valley Medical Centre	$200,000	Happy Valley, SA	Existing practice, extending into after hours period
Sunshine Health Care Trust	$200,000	St Albans, VIC	Establishment of a dedicated after hours service

(3) The following table provides all requested details for Supplementary Grants funded in the 2005-06 round:

Supplementary Grants 2005-06

Ashgrove West Group Practice	$98,095	Ashgrove West, QLD	GP practice
Australind Medical Centre Pty Ltd	$100,000	Australind, WA	GP practice
Ballajura Medical Centre	$100,000	Ballajura, WA	GP practice
Bannockburn Surgery Pty Ltd	$100,000	Bannockburn, VIC	GP practice
Banora Village Medical Centre	$100,000	Banora Point, NSW	GP practice
Berowra Family Medical Practice	$100,000	Berowra Heights, NSW	GP practice
Blackwood and District Community Hospital	$100,000	Belair, SA	Co-operative
Bridge Clinic - Murray Bridge SA	$43,000	Murray Bridge, SA	GP practice
Bundaberg After Hours Medical Service Pty Ltd	$100,000	Bundaberg, QLD	Co-operative
Camden GP After Hours Co-operative	$95,494	Camden, NSW	Co-operative
Canning Division of General Practice	$90,909	Armadale, WA	GP practice
Darwin After Hours Medical Service	$95,500	Stuart Park, NT	GP practice
Dubbo Plains Division of General Practice	$99,500	Dubbo, NSW	GP practice
Eastern Suburbs Medical Service	$100,000	Edgecliff, NSW	Medical Deputising Service
Eight to Eight Medical Centre	$100,000	Port Macquarie, NSW	GP practice
Family Care Medical Services (Aust) Pty Ltd	$91,000	Spring Hill, QLD	GP clinic operated by a Medical Deputising Service
Foster and Toora Medical Centres / BAFLIS Pty Ltd	$100,000	Foster, VIC	GP practice
Geelong City Medical Centre	$100,000	Geelong, VIC	GP practice
Gemini Medical Services Pty Ltd	$100,000	Jurien, WA	GP practice
Goulburn Valley Division of General Practice	$100,000	Shepparton, VIC	Co-operative
Gumeracha Medical Practice	$98,800	Gumeracha, SA	GP practice
Hamilton Medical Centre	$25,850	Hamilton, VIC	GP practice
Hazelbrook General Practice	$64,690	Hazelbrook, NSW	GP practice
Hepburn Health Service representing Daylesford After Hours Medical Service	$100,000	Daylesford, VIC	Co-operative
Hinchinbrook Heathcare	$90,909	Ingham, QLD	GP practice
Kiama Medical Practice	$100,000	Kiama, NSW	GP practice

Maffra Medical Group	$99,950	Maffra, VIC	GP practice
Mallacoota Medical Centre	$100,000	Mallacoota, VIC	GP practice
Mt Beauty Medical Centre Pty Ltd	$70,073	Mount Beauty, VIC	Co-operative
Mt Hotham Medical Centre	$99,887	Mt. Hotham, VIC	GP practice
Murray-Plains Division of General Practice	$71,900	Cohuna, VIC	GP practice
NM&IG Medical Pty Ltd	$100,000	Midland, WA	GP practice
North West Slopes (NSW) Division of General Practice	$85,699	Tamworth, NSW	Co-operative
Orbost Regional Health	$97,184	Orbost, VIC	GP practice
Otway Division of General Practice	$99,978	Camperdown, VIC	Co-operative
Perth and Hills Division of General Practice	$100,000	Guildford, WA	GP practice
Pittsworth Medical Centre	$71,760	Pittsworth, QLD	GP practice
Point Lonsdale Medical Group (PLMG) Unit Trust	$100,000	Point Lonsdale, VIC	GP practice
Regency Medical Centre	$100,000	Sefton Park, SA	GP practice
South East Alliance of General Practice	$100,000	Capalaba, QLD	Co-operative
St George Division of General Practice	$47,273	Hurstville, NSW	GP practice
St Mary's Medical Centre	$89,440	St Albans, VIC	GP practice
Sydney Medical Service Co-operative Ltd	$100,000	Panania, NSW	Co-operative
Symbion Medical Centre Operations Pty Ltd (Forrest Family Practice)	$100,000	Bunbury, WA	GP practice
Tatura Medical Centre Pty Ltd	$100,000	Tatura, VIC	GP practice
The Trustee for the Waikerie Medical Centre Unit Trust	$100,000	Waikerie, SA	Medical Deputising Service
Wangaratta After Hours Doctors Cooperative	$98,658	Wangaratta, VIC	Co-operative
Western Australia Deputising Medical Service (Inc)	$100,000	West Perth, WA	Medical Deputising Service
WWEM Service Pty Ltd	$97,600	Woy Woy, NSW	GP clinic operated by a Medical Deputising Service

(b) As part of the application process for Start up Grants, applicants are asked to provide written evidence of support for their proposal from the local GP community and relevant stakeholders such as local and state governments. This information is taken into account in the grant assessment process.

(c) $62.5 million over five years (commencing 2004-05) is available under the Round the Clock Medicare: Investing in After Hours GP Services Program. To date $11.26 million has been expended or committed.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2006-2007, 1 November 2006

Question: E06-190

OUTCOME 5: Primary Care

Topic: PIPS AND SIPS

Hansard Page: CA 35

Senator McLucas asked:

What is the number and percentage of practices and GPs participating in the different elements of PIP, including SIPs?

Answer:

The number and percentage of practices and GPs participating in the Practice Incentives Program (PIP) and the General Practice Immunisation Incentives (GPII) Scheme is provided in the attached tables.

Primary Care Practice Incentives Appropriation

1. PRACTICE INCENTIVES PROGRAM (PIP)

Table: Number and percentage of practices participating in elements of PIP as at May 2006

Element	Number of practices	Percentage of PIP practices	Comments
Practices participating in PIP	4,745		
Information Management/Information Technology (IM/IT)			
Tier 1	4,745	100%	
Tier 2	4,480	94%	
Tier 3	4,417	93%	
After hours			
Tier 1	4,601	97%	
Tier 2	3,120	66%	
Tier 3	1,296	27%	
Teaching	714	15%	
Quality Prescribing	1,203	25%	
Rural Loading	1,418	100%	
Diabetes			
Sign on Payments	4,295	91%	
Outcomes Payment	2,023	47%	Percentage of signed on practices.
Service Incentive Payments	2,911	68%	Percentage of signed on practices.
Asthma			
Sign on Payments	4,211	89%	
Service Incentive Payments	947	22%	Percentage of signed on practices.
Cervical Screening			
Sign on Payments	4,349	92%	
Outcomes Payment	3,187	73%	Percentage of signed on practices.
Service Incentive Payments	2,639	61%	Percentage of signed on practices.
Mental Health			
Sign on Payments	4,780	Not applicable	Payments are made to GPs, not practices.
Service Incentive Payments	1,561 (GPs)	33%	Percentage of signed on GPs.
Practice Nurses			
Urban areas of workforce shortage	640	53%	Percentage of eligible urban practices.
Rural and remote	1,116	79%	Percentage of rural and remote practices.
Procedural GP Payment			
Tier 1	38	3%	Percentage of rural practices.
Tier 2	74	5%	Percentage of rural practices.
Tier 3	274	19%	Percentage of rural practices.
Total	386		The total includes practices accessing more than one tier. The total number of unique practices accessing procedural payments is 336

Table: Number and percentage of GPs accessing Service Incentive Payments (SIPs) in May 2006

	Number of GPs accessing SIPs	Percentage of GPs accessing SIPs
Diabetes	5,892	Information not available.
Asthma	1,210	Information not available.
Cervical Screening	4,865	Information not available.
Mental Health	1,561	Information not available.

2. GENERAL PRACTICE IMMUNISATION INCENTIVES (GPII) SCHEME

Table: Number and percentage of practices participating in the GPII Scheme in 2005-06

GPII	Number of practices	Percentage of practices
Practices participating in GPII	5,608	Not applicable.
Outcomes Payment	4,802	86%

The number and percentage of GPs accessing SIPs for 2003-04 is outlined in the table below. More recent data is not available.

Table: Number of GPs accessing SIPs in 2003-04

	Number of GPs accessing SIPs	Percentage of GPs accessing SIPs
Service Incentive Payments	**17,330**	**71% (based on the number of GPs in Australia in 2003-04)**

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2006-2007, 1 November 2006

Question: E06-191

OUTCOME 5: Primary Care

Topic: PIPS AND SIPS

Hansard Page: CA 35

Senator McLucas asked:

What was the budgeted and actual expenditure of each of the elements of PIP, including SIPs, for the last five financial years?

Answer:

The allocation and expenditure of each of the elements of the Practice Incentives Program (PIP) from 2002-03 to 2006-07 is provided in the attached tables.

PIP and General Practice Immunisation Incentives (GPII) funding allocation and expenditure 2002-03 to 2006-07

Allocation

	2002-03	2003-04	2004-05	2005-06	2006-07
	$m	$m	$m	$m	$m
PIP and GPII (base)*	207.5	223.8	231.1	202.7 ***	217.3 ***
Diabetes**	14.3	17.0	14.4	14.6	7.3
Cervical Screening**	8.1	12.8	15.4	13.4	12.6
Rural Practice Nurses	23.6	25.1	26.6	20.2	27.8
Mental Health**	12.7	19.2	12.6	9.3	1.8
Asthma**	6.7	6.8	2.1	1.7	0.0
Urban Practice Nurses		18.5	20.1	19.7	21.6
Procedural GPs		1.5	6.6	4.9	12.4
Domestic Violence				0.3	1.9
Electronic Decision Support	2.8	6.5	18.2	15.8	16.0
GP IT Development	2.2	4.8	2.3		
GP Links	2.6	8.0			
Total	**280.5**	**344.0**	**349.4**	**302.6**	**318.6** #

* There is no separate allocation for the individual elements in the PIP and GPII base, i.e.the IM/IT, After Hours, Quality Prescribing, Rural Loading, Teaching and GPII Incentives.

** There is no separate allocation for the SIP components of the Asthma, Diabetes, Cervical Screening and Mental Health Initiatives.

*** The funding allocation in the Portfolio Budget Statements for 2005-06 was $340.1 million. Funding of $16.8 million from the PIP and GPII base allocation was transferred to the Broadband for Health Program and $20.8 million was returned to Consolidated Revenue.

#Variation due to rounding.

Expenditure

	2002-03	2003-04	2004-05	2005-06	2006-07
	$m	$m	$m	$m	$m
PIP and GPII (base)	250.9	225.8	222.2	225.7	60.6 **
Diabetes*	8.7	11.0	12.2	14.6	3.9 **
Cervical screening*	1.9	4.8	13.2	13.0	3.4 **
Rural Practice Nurses	18.6	20.1	20.7	21.4	6.1 **
Mental Health*	1.1	2.2	2.5	3.8	1.2 **
Asthma*	3.6	2.7	1.9	2.0	0.4 **
Urban Practice Nurses		3.3	14.8	15.8	8.4 **
Procedural GPs		0.8	3.3	4.9	1.6 **
Domestic Violence				0.0	0.0 **
Electronic Decision Support	0.0	0.0	0.0	0.0	0.0 **
GP IT Development	0.0	0.0	0.0		
GP Links	0.1	0.1			
Broadband			3.6		
Total	**284.9**	**270.8**	**294.4**	**301.2**	**85.6** **

* Includes SIP expenditure outlined in the table below.

**Expenditure to 31 October 2006.

Expenditure on SIPs									
	2002-03		**2003-04**		**2004-05**		**2005-06**	**2006-07**	
	$m		**$m**		**$m**		**$m**	**$m**	
Diabetes	3.6		4.5		5.2		5.8	1.6	*
Cervical Screening	1.7		1.8		2.0		2.2	0.6	*
Mental Health	0.9		2.1		2.5		3.5	1.1	*
Asthma	3.4		2.6		1.9		2.0	0.4	*
*Expenditure to 31 October 2006.									

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2006-2007, 1 November 2006

Question: E06-192

OUTCOME 5: Primary Care

Topic: PIP PRACTICE NURSE/ALLIED HEALTH WORKER INCENTIVE

Hansard Page: CA 38

Senator McLucas asked:

What are the minimum number of sessions that are prescribed for the Practice Nurse Incentive in return for $40,000?

Answer:

The minimum employment requirement for the Practice Incentives Program (PIP) practice nurse initiatives is dependent upon the size of the practice, which is determined by its Standardised Whole Patient Equivalent (SWPE) value. The SWPE value for a practice is the sum of the fractions of care the practice provides to each of its patients, weighted for the age and gender of patients.

Regardless of size, the practice must employ or retain the services of a practice nurse and/or allied health worker for a minimum of two sessions per week, averaged over the PIP payment quarter. A session is 3.5 hours. The employment requirement increases by one session for each additional 500 SWPEs, rounded down, as shown in the following table.

Standardised Whole Patient Equivalent (SWPE) range per practice	**Minimum sessions required per week averaged over the PIP payment period**
0-1,499	2
1,500-1,999	3
2,000-2,499	4
2,500-2,999	5
3,000-3,499	6
3,500-3,999	7
4,000-4,499	8
4,500-4,999	9
5,000 or more	10 (full time)

The practice nurse initiatives are capped at a maximum of 5,000 SWPEs per practice, which would require a practice to employ a full-time equivalent worker.

The PIP Urban Practice Nurse Incentive payments are $8.00 per SWPE and capped at $40,000 per annum. The PIP Rural Practice Nurse Incentive payments are $7.00 per SWPE and also capped at $40,000. A rural loading ranging from 15 to 50% depending on the remoteness of the practice is applied to the rural practice nurse payments.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2006-2007, 1 November 2006

Question: E06-193

OUTCOME 5: Primary Care

Topic: PIP PRACTICE NURSE/ALLIED HEALTH WORKER INCENTIVE

Hansard Page: CA 39

Senator McLucas asked:

What was the take-up of the various categories of allied health workers in the Practice Nurse/Allied Health Worker Incentive?

Answer:

Data is available on the number of Practice Incentives Program (PIP) practices accessing the incentive. Data is not collected on the take-up of the various categories of allied health workers in the PIP Practice Nurse/Allied Health Worker Incentive.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2006-2007, 1 November 2006

Question: E06-140

OUTCOME 5: Primary Care

Topic: CHRONIC DISEASE MANAGEMENT (CDM)

Written Question on Notice

Senator McLucas asked:

a) What does the data show about the continuing uptake of GP management plans?

b) How does this compare with the expected uptake?

c) Given the greater uptake than expected, what are the updated costs over the forward estimates? How does this compare with the expected costs?

Answer:

a) Data for 2005-06 shows that there has been strong uptake of the Chronic Disease Management Medicare items for GP Management Plans (GPMP) and Team Care Arrangements (TCA). Out of 645,882 GPMPs claimed during 2005-06, around 392,000 relate to GP managed care and approximately 254,000 relate to team-based care (patients who have team-based care will usually have both a GPMP and a TCA).

b) While estimates of uptake are prepared for the purpose of estimating likely costs of new Medicare items, actual service volumes for Medicare items are demand driven and are not tied to or tracked against targets. In broad terms, however, uptake of GPMPs claimed in 2005-06 for GP managed care has been marginally higher than the original estimates.

c) Costs over the forward estimates have not required updating. While first year outlays on the CDM items have been higher than original estimates, primarily due to greater than expected uptake of team care items, CDM plans are recommended to be prepared on a two yearly cycle and it is too early to be certain of the level of ongoing demand.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2006-2007, 1 November 2006

Question: E06-141

OUTCOME 5: Primary Care

Topic: CHRONIC DISEASE MANAGEMENT (CDM)

Written Question on Notice

Senator McLucas asked:

a) There have been reports that the Minister and the Professional Services Review will look at how doctors use these plans and whether they are being used appropriately. Is this being done? If not, why not?

b) Is it correct that GPs cannot use these plans to manage obese patients?

Answer:

d) Medicare Australia plans to undertake an audit of CDM care planning in early 2007, consistent with its audit program and audits of major new Medicare items. The audit should help identify whether the items are being used appropriately. De-identified data gathered through the Medicare Australia audit should also help inform a post-implementation review of the items being undertaken by the Department in the first half of 2007. The review will assess the implementation, uptake and use of the items and identify whether any modifications to the items or other actions are required to encourage quality use of the items for effective chronic disease management.

e) Obesity is not regarded as a chronic medical condition for the purposes of the CDM items. This approach has been confirmed with the representatives of GP organisations that assisted with the detailed design of the CDM items and with senior medical advisers in Medicare Australia. Obesity was also not regarded as an eligible condition for the former Enhanced Primary Care (EPC) multidisciplinary care planning items.

CDM guidance on the Department of Health and Ageing website provides that GPs have discretion to provide CDM items in particular cases where a patient did not meet the general criteria but the GP considered nonetheless that the patient required the CDM service. In these situations the GP would need to be satisfied that their peers would agree with their judgment.

Where a patient has a chronic medical condition and is obese, the management of their health and care needs under the CDM items can include management of their obesity.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2006-2007, 1 November 2006

Question: E06-002

OUTCOME 5: Primary Care

Topic: PREGNANCY COUNSELLING – ADVERTISING

Written Question on Notice

Senator Stott Despoja asked:

a) Is the Department planning on advertising the new MBS item number? If so how?
b) Will information regarding the new item number be readily accessible to all women?
c) Has the Department been allocated a specific advertising budget for the new MBS item number? If so, how much?

Answers:

a) and b)

Information about the new MBS items has been provided to individual practitioners and their representative groups. A fact sheet and answers to frequently asked questions about the new items, together with other relevant resources, are available on the Department of Health and Ageing's web site at:
http://www.health.gov.au/internet/wcms/publishing.nsf/Content/health-pcd-pregnancy-support

Information about the new items is also available from Medicare Australia's patient inquiry line on 132 011 and from all Medicare Australia offices.

The Department is also developing a communication strategy for the National Pregnancy Support Helpline and non-directive pregnancy support counselling MBS items. The Department will be responsible for placement of advertising which will be undertaken in accordance with Australian Government advertising guidelines.

c)

There is no specific advertising budget for the MBS items.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2006-2007, 1 November 2006

Question: E06-109

OUTCOME 6: Rural Health

Topic: RURAL HEALTH ISSUES

Written Question on Notice

Senator Nash asked:

Has the Medical Specialist Outreach Program reached its funding limits and how many applications have been rejected?

Answer:

Funding for the Medical Specialist Outreach Assistance Program (MSOAP) in all states and the Northern Territory is fully committed for 2006-07.

1255 MSOAP projects were supported and 21 were not supported in 2005-06.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2006-2007, 1 November 2006

Question: E06-148

OUTCOME 6: Rural Health

Topic: MEDICAL SPECIALIST OUTREACH ASSISTANCE PROGRAM (MSOAP)

Written Question on Notice

Senator McLucas asked:

a) How long has the MSOAP program been operating?
b) What does MSOAP pay for?
c) What is the cost (or average cost) per service delivered?
d) For the period of operation could we have, for each FY and 2006-07 YTD
   - Funding allocated to the program
   - Spending on the program
   - Number of services delivered, by state and territory, and by speciality
   - Number of participating specialists

Answer:

a) MSOAP has been operating since 1999.

b) MSOAP pays for travel expenses and meal allowances to enable specialists to commute to remote areas to provide services. Occasionally, services are funded by means of a sessional payment, but generally, services are funded through Medicare.

c) It is not possible to provide an average cost for services.

d) The information sought is detailed in the following tables. Details of the number of services delivered by state and territory and by speciality cannot be provided for 2006-07, as reporting by fundholders is not due until the end of January 2007.

	1999-00	2000-01	2001-02	2002-03	2003-04	2004-05	2005-06	2006-07
Budget ($m)	1.683	1.688	8.331	15.046	15.340	16.194	15.493	15.450
Expenditure ($m)	1.755	0.688	9.567	13.140	10.044	13.775	15.404	7.635*

* YTD (31 October 2006)

MSOAP 2000/01	NSW	NT	Q	SA	Tas	Vic	WA
Physician - Palliative					2		
Psychiatry - Forensic					1		

MSOAP 2001/02	NSW	NT	Q	SA	Tas	Vic	WA
Anaesthetic - upskilling (SimMan)							4
Dermatology	2				2		
O&G - General							6
O&G - Gynaecology		38	1			1	
O&G - Obstetrics						1	
Obstetrics Training							1
Ophthalmology - General		31	1				
Paediatrics - General	1					3	1
Paediatrics - Haematology	1						
Paediatrics - Neurology						1	
Physician - Addiction Medicine (Drug and Alcohol)						1	
Physician - Cardiology	1	0					
Physician - Endocrinology			5				
Physician - General	1	15				5	5
Physician - Nephrology						1	
Physician - Neurology	1						
Physician - Palliative					2		
Physician - Rheumatology	1				2		
Psychiatry - Adult		0		9			
Psychiatry - Child and Adolescent	1			1	1		
Psychiatry - Forensic					1		
Psychiatry - General	5				2		
Psychiatry - Geriatric					1		
Psychiatry - Neurology	1						
Surgery - ENT		2					
Surgery - General	2	11				1	
Surgery - Orthopaedic	1					1	
Surgery - Urology	1				1		
Telepaediatrics (various sub-specialties)			5				

MSOAP 20002/03	NSW	NT	Qld	SA	Tas	Vic	WA
Anaesthetics			1				
Anaesthetic - upskilling (SimMan)	2						13
Anaesthetic -pain management							5
Dermatology	4		7	4	4		5
Endoscopy						1	
O&G - Fertility						2	

O&G - General	2					6	16
O&G - Gynaecology	2	45	6				7
Obstetrics Training							10
Ophthalmology - General	3	40	2	17		2	6
Ophthalmology - Surgery			1				
Opthalmology - Retinal						1	
Paediatric Cardiology						2	
Paediatric Orthopaedics						1	
Paediatrics - Developmental	1						
Paediatrics - Endocrinology	2					1	
Paediatrics - General	5		16	5		16	34
Paediatrics - Haematology	1						
Paediatrics - Neurology	2			2		1	
Physician - Addiction Medicine (Drug and Alcohol)						2	
Physician - Cardiology	2			3		1	6
Physician - Endocrinology	3		16				2
Physician - Gastroenterology	1			1		3	
Physician - General	6	30	1			12	30
Physician - Genetics	2						1
Physician - Geriatrics	1			5			2
Physician - Haematology	1						
Physician - Nephrology			12			2	1
Physician - Neurology	4			1	1	2	
Physician - Oncology							1
Physician - Palliative	2				2		
Physician - Respiratory	1		1				1
Physician - Rheumatology	1				3	1	2
Physician - Sexual Health	1						
Psychiatry - Adult				18		6	
Psychiatry - Child and Adolescent	2			6	2		
Psychiatry - Forensic					2		
Psychiatry - General	15				4		6
Psychiatry - Geriatric	3				2		
Psychiatry - Neurology	1						
Surgery - Colorectal	1						
Surgery - ENT		5	3			2	20
Surgery - ENT - upskilling							
Surgery - General	5	19	1		1	4	4
Surgery - Neuro	1					1	
Surgery - Orthopaedic	2					1	10
Surgery - Paediatric	1					2	
Surgery - Thoracic						1	
Surgery - Urology	1				1	3	3
Surgery - Vascular	1		1				
Telepaediatrics (various sub-specialties)			52				
Urology - Uro-oncology						1	

MSOAP 2003/04	NSW	NT	Qld	SA	Tas	Vic	WA
Anaesthetics			1				0
Anaesthetic - upskilling (SimMan)	2		2				15
Anaesthetic -pain management							3
Anaesthetics - Paediatrics						1	
Anaesthetics Upskilling (not sim man)						3	
Dermatology	8		22	4	4	1	6
Dermatology - TeleHealth - Tele-Derm			1				
Dermatology - upskilling			2				
Emergency Medicine - Upskilling						2	
Emergency Medicine - upskilling (SimMan)			17				
Fatigued Patients - upskilling			1				
Nuclear Medicine - upskilling			1				
O&G - Fertility	1					3	
O&G - General	3					7	12
O&G - Gynaecology	2	42	8	2			9
O&G - Obstetrics - upskilling			1				
Obstetrics Training							14
Ophthalmology - General	5	28	28	20		3	6
Ophthalmology - General - upskilling			1				
Ophthalmology - Surgery			1				
Opthalmology - Retinal						1	
Paediatric - Rehabilitation						1	
Paediatric Cardiology						3	
Paediatric Orthopaedics						1	
Paediatrics - Developmental	1						
Paediatrics - Endocrinology	2			1		2	
Paediatrics - General	6		38	2		18	31
Paediatrics - Haematology	1						
Paediatrics - Neurology	3			3		2	
Paediatrics - Rheumatology						2	
Physician - Addiction Medicine (Drug and Alcohol)						2	
Physician - Cardiology	5			9		2	7
Physician - Cardiology - upskilling			5				
Physician - Diabetes - upskilling			1				
Physician - Endocrinology	5		16	1			3
Physician - Gastroenterology	1			1		2	
Physician - General	6	30	6	1		9	28
Physician - Genetics	2						2
Physician - Geriatrics	1			8		7	1
Physician - Haematology	1						
Physician - Nephrology			12	2		5	1
Physician - Neurology	6			1	1	2	
Physician - Neurology - upskilling			1				

Physician - Oncology	1		3				1
Physician - Palliative	4				2		1
Physician - Palliative Upskilling						4	
Physician - Rehabilitation	2						
Physician - Renal - upskilling			1				
Physician - Respiratory	2		2				1
Physician - Rheumatology	4				3	1	2
Physician - Sexual Health	2						
Psychiatry - Adult		7	4	27		9	
Psychiatry - Child and Adolescent	2		6	7	2	3	
Psychiatry - Forensic					2		
MSOAP 2003/04 continued	**NSW**	**NT**	**Qld**	**SA**	**Tas**	**Vic**	**WA**
Psychiatry - General	18				4		3
Psychiatry - Geriatric	5				2		
Psychiatry - Neurology	1						
Radiology - upskilling			1				
Surgery - Cardio/Thoracic				1			
Surgery - Colorectal	1						
Surgery - ENT		11	13			4	18
Surgery - ENT - upskilling			1				
Surgery - General	5	12	6	2	1	7	5
Surgery - Neuro	3					2	
Surgery - Oral and Maxillo facial						1	
Surgery - Orthopaedic	3		4			3	9
Surgery - Orthopaedic - upskilling			2				
Surgery - Paediatric	1					2	
Surgery - Plastic / Reconstructive			1			1	1
Surgery - Plastic / Reconstructive - upskilling			2				
Surgery - Thoracic						1	
Surgery - Urology	1		1	1	1	4	1
Surgery - Vascular	2		1				
Telepaediatrics (various sub-specialties)			108				
Uro-gynaecology						1	

MSOAP 2004/05	**NSW**	**NT**	**Qld**	**SA**	**Tas**	**Vic**	**WA**
Anaesthetic - upskilling (SimMan)	2		1				11
Anaesthetic -pain management							3
Anaesthetics - Paediatrics						4	
Dermatology	8		27	4	4	1	6
Dermatology - TeleHealth - Tele-Derm			1				
Emergency Medicine - upskilling (SimMan)			17				
O&G - Fertility	1					2	
O&G - General	5					7	13

O&G - Gynaecology		52	15	2			7
Obstetrics Training							4
Ophthalmology - General	3	32	26	13		3	7
Ophthalmology - Surgery			1				
Opthalmology - Retinal						1	
Paediatric - Gastroenterology						1	
Paediatric - Rehabilitation						1	
Paediatric Cardiology						3	
Paediatric Orthopaedics						1	
Paediatrics - Developmental	1						
Paediatrics - Endocrinology	2			1		2	1
Paediatrics - General	6		78	2		17	38
Paediatrics - Haematology	1						
Paediatrics - Neurology	3			3		2	
Paediatrics - Rheumatology						2	
Physician - Addiction Medicine (Drug and Alcohol)						2	
Physician - Cardiology	4			7		4	7
Physician - Endocrinology	6		30	1			1
Physician - Gastroenterology	4			1		2	1
Physician - General	5	33	4	2		9	20
Physician - Genetics	2						1
Physician - Geriatrics	1		1	5		8	1
Physician - Haematology	1						
Physician - Nephrology			26	3		5	2
Physician - Neurology	7			1	1	2	
Physician - Oncology	1		1				1
Physician - Palliative	4			19	2		
Physician - Palliative Upskilling						4	
Physician - Rehabilitation	3						
Physician - Respiratory	2		1	1		1	2
Physician - Rheumatology	4			3	3	4	2
Physician - Sexual Health	2						
Psychiatry - Adult		11	3	19		10	
Psychiatry - Child and Adolescent	2		9	7	2	3	
Psychiatry - Forensic					2		
Psychiatry - General	19				4		8
Psychiatry - Geriatric	5				2		
Psychiatry - Neurology	1						
Surgery - Cardio/Thoracic				1			
Surgery - Colorectal	1						
Surgery - ENT	1	8	5			4	17
Surgery - General	5	10	5	2	1	10	6
Surgery - Neuro	3					2	
Surgery - Oral and Maxillo facial						1	
Surgery - Orthopaedic	3		6			5	10
Surgery - Paediatric	1					2	

MSOAP 2004/05 continued	NSW	NT	Qld	SA	Tas	Vic	WA
Surgery - Plastic / Reconstructive						1	1
Surgery - Thoracic						1	
Surgery - Urology	1		3	1	1	3	1
Surgery - Vascular	2		1				

MSOAP 2005/06	NSW	NT	Qld	SA	Tas	Vic	WA
Anaesthetic - upskilling (SimMan)	2						8
Anaesthetic -pain management				2			3
Anaesthetics Upskilling (not sim man)						9	
Child and Youth Telehealth			4				
Dermatology	12		31	3	4	3	7
Dermatology - TeleHealth - Tele-Derm			1				
Emergency Medicine - upskilling (SimMan)			10				
O&G - Fertility	1					2	
O&G - General	4				1	18	15
O&G - Gynaecology		55	16	2		1	7
Obstetrics Training							5
Ophthalmology - General	3	34	28	13		12	12
Ophthalmology - Surgery	1		2				
Opthalmology - Retinal						1	
Paediatric - Gastroenterology						1	
Paediatric - Rehabilitation						1	
Paediatric Cardiology						3	
Paediatric Orthopaedics						1	
Paediatrics - Allergies				1			
Paediatrics - Developmental	4						
Paediatrics - Endocrinology	3			1		3	1
Paediatrics - General	8		48	17		23	48
Paediatrics - Haematology	1						
Paediatrics - Neurology	3			2		2	
Paediatrics - Rheumatology						2	
Palliative Care Training							4
Physician - Addiction Medicine (Drug and Alcohol)						3	
Physician - Cardiology	5	14	1	8		5	7
Physician - Endocrinology	15		18	4		1	1
Physician - Gastroenterology	1			3		3	2
Physician - General	1	35	22	9		19	17
Physician - Genetics	3						1
Physician - Geriatrics	2		1	10		8	5
Physician - Haematology	1						
Physician - Nephrology	4		15	2		7	2
Physician - Neurology	11			6	1	2	
Physician - Oncology	1		2			4	1

Physician - Palliative	5			26	2		
Physician - Palliative Upskilling						4	
Physician - Rehabilitation	2						
Physician - Respiratory	7		2	1		1	2
Physician - Rheumatology	5			4	3	4	2
Physician - Sexual Health	9						
Psychiatry - Adult		25	24	23		14	
Psychiatry - Child and Adolescent	2		2	9	2	3	6
Psychiatry - Forensic	1				2		0
Psychiatry - General	20				4		11
Psychiatry - Geriatric	7				2		2
Psychiatry - Neurology	6						
Radiology			1				
Radiology - TeleHealth - Radiology Online			1				
Surgery - Cardio/Thoracic				1			
Surgery - Colorectal	1		3				
Surgery - ENT	1	8	5			10	21

MSOAP 2005/06	**NSW**	**NT**	**Qld**	**SA**	**Tas**	**Vic**	**WA**
Surgery - General	3	12	5	2	1	20	6
Surgery - Neuro	2			1		3	
Surgery - Oral and Maxillo facial						1	
Surgery - Orthopaedic	2		10			9	15
Surgery - Paediatric	1					2	
Surgery - Plastic / Reconstructive						2	1
Surgery - Thoracic						1	
Surgery - Urology			4	1	1	9	2
Surgery - Vascular	1		1	1			
Telepaediatrics (various sub-specialties)			245				

Answer to Senate Estimate Questions on Notice - Supplementary Budget Estimates 2006-2007.
Qestion E06-000E06000148
For the period of operation for each financial year and year to date please advise:
a/ the number of services delivered by state and territory
b/ number of participating specialists

	2000-01	2001-02	2002-03	2003-04	2004-05	2005-06
NSW						
Total number of services		19	82	118	119	161
Number of participating specialists		32	99	143	136	138
Northern Territory						
Total number of services		97	139	130	146	183
Number of participating specialists		13	14	12	19	24
Queensland						
Total number of services		5	61	198	164	305
Number of participating specialists		1	11	99	74	105
South Australia						
Total number of services		10	62	93	98	152
Number of participating specialists		6	37	51	55	78
Tasmania						
Total number of services	3	12	22	22	22	23
Number of participating specialists	3	16	25	25	25	28
Victoria						
Total number of services		15	77	122	220	217
Number of participating specialists		13	62	105	111	184
Western Australia						
Total number of services		17	187	179	171	214
Number of participating specialists		9	74	78	115	156

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2006-2007, 1 November 2006

Question: E06-195

OUTCOME 6: Rural Health

Topic: MEDICAL SPECIALIST OUTREACH ASSISTANCE PROGRAM (MSOAP)

Hansard Page: CA 101

Senator McLucas asked:

Is it possible to get a list of services types provided under the MSOAP program, by town and by state for the 2005-06 financial year?

Answer:

Service types by state have been provided in response to Question E06-148

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2006-2007, 1 November 2006

Question: E06-196

OUTCOME 6: Rural Health

Topic: MEDICAL SPECIALISTS OUTREACH ASSISTANCE PROGRAM (MSOAP)

Hansard Page: CA 102

Senator Moore asked:

How many applications for services were not approved under the MSOAP program in 2005-06?

Answer:

21 applications were not supported under the MSOAP program in 2005-06.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2006-2007, 1 November 2006

Question: E06-062

OUTCOME 7: Hearing Services

Topic: AUSTRALIAN GOVERNMENT RESOURCES FOR HEARING AWARENESS AND HEARING PREVENTION

Written Question on Notice

Senator McLucas asked:

What resources will the Government (through Office of Hearing Services, Australian Hearing or elsewhere) provide for hearing awareness and noise injury prevention programs, such as Hearing Awareness Week, Australia-wide?

Answer:

In 2006-07, the Office of Hearing Services (the Office) will send information kits containing material on hearing awareness, hearing prevention and the Australian Government Hearing Services Program (the Program) to all hearing services providers within the Program and a number of other relevant organisations. This will be at an estimated cost of $61,000 to the Australian Government.

The Office also conducts hearing awareness education and training at several conferences a year. An amount of $16,000 is allocated to this function.

Australian Hearing contributed $5,000 in 2006-07 to the Deafness Forum of Australia for sponsorship of Hearing Awareness Week and provided free hearing screenings to Australians as part of the week. Over 1,680 screenings took place around the nation and over 150 screenings were conducted at Parliament House in Canberra during the 2006 Hearing Awareness Week.

Australian Hearing produces information sheets on hearing prevention which are available to any interested party. Through the delivery of their programs, Australian Hearing also raises hearing awareness and provides information on hearing prevention to their clients.

The Department of Health and Ageing is aware that other areas of the Australian Government such as, the Department of Families, Community Services and Indigenous Affairs; and the Australian Safety and Compensation Council, will be contributing to hearing awareness and noise injury prevention programs.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2006-2007, 1 November 2006

Question: E06-064

OUTCOME 8: Indigenous Health

Topic: TRACHOMA - INDIGENOUS HEALTH

Written Question on Notice

Senator Evans asked:

The establishment of a National Trachoma Surveillance Unit, implementation of new National Guidelines for the Public Health Management of Trachoma in Australia, and funding to state and territory governments for training eye/trachoma health workers:

(a) Have the funding agreements for the implementation of the National Trachoma Surveillance Unit been signed and if so when? If not, why not?
(b) Have the funds been distributed to the States and Territories for training of health workers and if so when? If not, why not?
(c) Please provide the funding that each State and Territory will receive under this program and how this funding is to be spent.
(d) Has the training of health care workers commenced? Please provide details.
(e) Which organisation is responsible for the data collection and analysis component of this program?
(f) Are all the necessary agreements in place for this data collection and analysis?
(g) What funds will be provided for this purpose?

Answer:

(a) Yes. The contract for the establishment of a National Trachoma Surveillance and Reporting Unit was signed on 15 November 2006.

(b) Funding from the Australian Government was offered to the three jurisdictions where trachoma is reported (Western Australia, Northern Territory and South Australia). In response:

- A funding agreement with the Western Australian Health Department was signed on 19 September 2006.
- A funding agreement is currently being finalised with the Northern Territory Department of Health and Community Services.
- South Australia is currently finalising their funding proposal prior to negotiating a funding agreement.

(c) Of the $450,000 allocated for implementation and training, a total of $150,000 has been offered to each jurisdiction over two financial years (2006/07 – 2007/08).

Western Australia

- Funding Agreement - $100,000 (September 2006 – June 2007). The WA project aims to improve the management, data collection, screening and treatment of trachoma in Aboriginal communities through targeted training for primary health care workers and extension of trachoma screening programs in Western Australia. Training and screening will be undertaken in the Kimberley, Goldfields, Mid West Murchison, Pilbara and Carnarvon regions of Western Australia.
- A second funding submission will be lodged by Western Australia for $50,000 for 2007-2008.

Northern Territory

- Funding Agreement - $150,000 (commencement on signature – June 2008). The NT project aims to improve:
  - the training of health staff involved in trachoma screening; and
  - overall coordination of staffing, training, screening, community treatment and data collection by the employment of a public health nurse based in the Centre for Disease Control Alice Springs. It is proposed that trachoma screening in Central Australia will be introduced for the first time as a result of this project.

South Australia

- Funding agreement offered $150,000 over two financial years. Project proposal yet to be received.

(d) Details of training of health care workers are below.

Western Australia

Training commenced in WA in September. To date this has included the public health nurse from the Gascoyne region receiving on-the-job training in trachoma.

Northern Territory

Formal training has not commenced however, some staff have taken part in a pre-test of training material. This material will form a significant component of the training process.

(e) Data will initially be collected by the State/Territory jurisdictions and forwarded to the National Trachoma Surveillance and Reporting Unit for analysis and reporting. The Centre for Eye Research Australia Limited has been commissioned by the Department to establish the National Trachoma Surveillance and Reporting Unit.

(f) Not all agreements are in place. The National Trachoma Surveillance and Reporting Unit will seek agreements with State/Territory jurisdictions to use State/Territory data.

(g) No additional funding required.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2006-2007, 1 November 2006

Question: E06-065

OUTCOME 8: Indigenous Health

Topic: COMMUNICABLE DISEASES NETWORK AUSTRALIA (CDNA) GUIDELINES

Written Question on Notice

Senator Evans asked:

Have the CDNA Guidelines been finalised?

Answer:

Yes.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2006-2007, 1 November 2006

Question: E06-067

OUTCOME 8: Indigenous Health

Topic: TRACHOMA – AZITHROMYCIN

Written Question on Notice

Senator Evans asked:

What procedures are in place to monitor the levels of antibiotic resistance to azithromycin treatment?

Answer:

The National Trachoma Surveillance and Reporting Unit will be responsible for developing a methodology for monitoring antibiotic resistance to azithromycin for consideration by the Trachoma Reference Group and approval by the Department of Health and Ageing. Once the methodology is approved, the Unit will implement the methodology and provide a report on antibiotic resistance to azithromycin to the Department.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2006-2007, 1 November 2006

Question: E06-069

OUTCOME 8: Indigenous Health

Topic: HEALTHY FOR LIFE EXPENDITURE BREAKDOWN

Written Question on Notice

Senator Evans asked:

Is it possible to provide a rough breakdown of the overall amount of Healthy for Life funding that will be allocated to the different components/objectives of the Healthy for Life program? That is:

a) child and maternal health services
b) chronic disease management /prevention
c) workforce (i.e. scholarships)
d) any others?

Answer:

a) and b)
Healthy for Life provides $102.4 million, over four years, to improve the health of Aboriginal and Torres Strait Islander mothers, babies and children, enhance the quality of life for people with a chronic condition and reduce the incidence of adult chronic disease. Of this total, $99.43 million is being allocated to (a) and (b) above. It is not possible to separate out funding for child and maternal health from that for chronic disease prevention and management as the funding is being provided to and used by Healthy for Life sites as a single stream. All sites will undertake activities in both areas (ie (a) and (b)).

c) $2.97 million Healthy for Life funding has been allocated for approximately 86 new scholarships for Indigenous students, over four years, through the Puggy Hunter Memorial Scholarship Scheme.

d) There are no others.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2006-2007, 1 November 2006

Question: E06-070

OUTCOME 8: Indigenous Health

Topic: HEALTHY FOR LIFE SITES

Written Question on Notice

Senator Evans asked:

Please provide a list of all sites which have received Healthy for Life funding to date, including:

a) name and location of organisation
b) approximate size of Indigenous population serviced by that organisation
c) amount of funding provided, broken down by financial year
d) purpose of funding (i.e. child/maternal health service, chronic disease projects, etc), including breakdown allocated to different projects if funding has been provided to one organisation for multiple purposes/projects

Answer:

a) Information contained in tables 1 and 2 below.
b) Information contained in tables 1 and 2 below.
c) Funding is allocated to each approved Healthy For Life site in two phases. In phase one, each site is allocated $100,000 to conduct a service stock-take and develop an action plan for phase two. In phase two, each site is allocated up to $400,000 each financial year over the life of the program to implement its approved action plan. At this early stage of the program, with each site progressing at a different rate through phase one to phase two activity, it is not possible to provide a more detailed breakdown of funding provided to each site by financial year.
d) The purpose of the Healthy For Life funding is to achieve the following program objectives:

- improve the availability of child and maternal health care;
- improve the prevention, early detection and management of chronic disease;
- improve the Indigenous health workforce; and
- improve the long term health outcomes for Indigenous Australians.

Each Healthy For Life site will undertake activities across all four objectives. Funding is not allocated to specific activities, but rather to support the entire action plan developed by the site.

Table 1. Round 1 Sites

Organisation/s	Location	Approx. size of Indigenous population serviced by the site
Wellington Aboriginal Corp Health Service	Wellington NSW	811
South Eastern NSW Division of General Practice Ltd with Katungal Aboriginal Corporation	Moruya NSW	1,900
Hunter New England Health - Gunnedah Health Service	Gunnedah NSW	1,227
Sydney South West Area Health Service	Liverpool NSW	15,000
Anyinginyi Health Aboriginal Corporation	Tennant Creek NT	5,168
Central Australian Aboriginal Congress	Alice Springs NT	1,404
Wurli Wurlingang Health Service	Katherine NT	2,934
Sunrise Health Service Aboriginal Corporation	Katherine NT	3,300
Torres Strait and NPA, Queensland Health	Thursday Island QLD	10,000
Cape York Health Service District	Weipa QLD	6,295
Aboriginal and Islander Community Health Service Brisbane with Yulu Burri Ba Aboriginal Corporation for Community Health, and Inala Indigenous Health Service	Brisbane QLD	15,117
North and West Queensland Primary Health Care Association	Mt Isa QLD	4,469
Pika Wiya Health Service Inc	Port Augusta SA	2,400
Umoona Tjuutagku Health Service Inc	Coober Pedy SA	410
Nganampa Health Council Inc	Anangu Pitjantjatjara Lands SA	2,800
Southern Yorke Peninsula Health Service Inc., (Wakefield Health)	Minlation SA	1,070
Riverland Health Authority	Berri SA	800
Tasmanian Aboriginal Centre	Hobart TAS	3,200
Goolum Goolum Aboriginal Cooperative Ltd	Horsham VIC	474
Yarra Valley Community Health Service	Healesville VIC	1,484
Mildura Aboriginal Corporation with Coomealla Aboriginal Health Corporations, Swan Hill and district Aboriginal Co-operative, and Murray Valley Aboriginal Co-operative at Robinvale	Mildura VIC	2,151
Cummergunja Housing & Development Aboriginal Corporation -	Moama VIC	300
Derbarl Yerrigan Health Service Inc	Perth WA	15,462
Broome Regional Aboriginal Medical Service	Broome WA	4,179
Ngangganawili Aboriginal Community Controlled Health and Medical Service Aboriginal Corporation	Wiluna WA	366
Derby Aboriginal Health Service Council	Derby WA	4,127
Winnunga Nimmitijah Aboriginal Health Service	Canberra ACT	4,569

Table 2. Round 2 Sites

Organisation/s	Location	Approx. size of Indigenous population serviced by the site
New England Division of General Practice Ltd with Armajun AMS (Inverell), Armidale and District Services Incorporated (Pat Dixon Medical Centre)	Armidale NSW	3,867
Durri Aboriginal Corporation Medical Services	Kempsey NSW	20,000
Maari Ma Health Aboriginal Corporation	Broken Hill NSW	2,614
Walgett Aboriginal Medical Service Cooperative Ltd with Brewarrina and Bourke Aboriginal Medical Services, and Orana Haven Aboriginal Community Controlled Health Services	Walgett, Brewarrina, Bourke NSW	2,692
Marthakal Homelands Resource Centre Inc.	Elcho Island NT	3,115
NT Department of Health and Community Services	Millingimbi, Oenpelli NT	2,481
Layhnupuy Homelands Association Inc.	Nhulunbuy NT	2,500
Lyente Apurte Community Government Council Health Service	Santa Teresa NT	1,266
Katherine West Health Board	Katherine NT	3,000
Charleville and Western Districts Aboriginal and Torres Strait Islanders Corporation for Health	Charleville QLD	1,215
Townsville Aboriginal and Islander Health Service Limited (TAIHS)	Townsville QLD	6,920
North Coast Aboriginal Corporation for Community Health in partnership with Sunshine Coast Division of General Practice, Queensland Health Sunshine Coast Health District and Gympie Health Service District	Cotton Tree, Nambour, Gympie QLD	2,882
Aboriginal and Torres Strait Islander Community Health Service (Mackay) Ltd	Mackay QLD	5,188
Mulungu Aboriginal Corporation Medical Service with WuChopperen Health Service Ltd (through the Midin Clinic) and Mamu Medical Service Ltd	Mareeba, Cairns, Innisfail QLD	1,888
Port Lincoln Aboriginal Health Service	Port Lincoln SA	2,000
Whyalla Hospital and Health Service Inc, in partnership with Nunyara Wellbeing Centre	Whyalla SA	640
Nunkuwarrin Yunti of South Australia Inc in partnership with Central Northern Adelaide Health Service, and Children, Youth and Women's Health Service	Adelaide SA	15,000
Mid North Regional Health Service Inc	Port Pirie SA	679
Rumbalara Aboriginal Cooperative Ltd	Mooroopna VIC	2,432
Lake Tyers Health and Children's Services (consortium East Gippsland area) with Lakes Entrance Community Health, and Gippsland Lakes Community Health	Lakes Entrance VIC	1,574
Victorian Aboriginal Health Service Co-operative Ltd	Melbourne VIC	6,557
Western Districts Consortium under the	Warrnambool, Portland,	901

auspice of Gunditjmara (Warrnambool) with Dhauwurd-Wurrung (Portland), and Winda Mara (Heywood)	Heywood VIC	
WACHS Kimberley - Kimberley Population Health Unit	Kimberley WA	2,344
WA Country Health Service, Great Southern	Albany WA	978
Geraldton Regional Aboriginal Medical Service	Geraldton WA	1,765
Kimberley Aboriginal Medical Services Council	Kimberley WA	2,906

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2006-2007, 1 November 2006

Question: E06-071

OUTCOME 8: Indigenous Health

Topic: HEALTHY FOR LIFE – INDIGENOUS HEALTH

Written Question on Notice

Senator Evans asked:

a) Is funding for child and maternal health services funded by OATSIH programs other than Healthy for Life?
b) If so, approximately how much per annum and from which programs?

Answer:

(a) Yes.

(b) The Office of Aboriginal and Torres Strait Islander Health (OATSIH) has allocated approximately $1.9 million in 2006-07 to Indigenous Health Services to provide an ear and hearing health program that targets Aboriginal and Torres Strait Islander children up to five years old through screening and early intervention. In addition, approximately $0.64 million has been allocated to other hearing programs which are in the main targeted at Indigenous mothers and children up to eight years of age.

Also, Indigenous Health Services have the discretion to use their primary health care funding to target key health issues in their individual communities. This means that health services determine the level of expenditure they should make in each area of primary health care service delivery in response to identified health needs, including child and maternal health services.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2006-2007, 1 November 2006

Question: E06-072

OUTCOME 8: Indigenous Health

Topic: SUBSTANCE ABUSE SERVICES FUNDING ANNOUNCED AT COAG SUMMIT ON VIOLENCE AND ABUSE

Written Question on Notice

Senator Evans asked:

a) Is OATSIH responsible for implementing the drug and alcohol rehabilitation services initiative for Indigenous communities announced by Family and Community Services and Indigenous Affairs Minister Mal Brough at the June intergovernmental summit on violence and abuse in Indigenous communities?
b) What is the exact amount of funding allocated to this initiative? Over what time frame? Please provide a breakdown including the allocation for this financial year and the out-years.
c) What exactly will the money be used for? Please provide a description of what kinds of services will be funded through this measure.
d) How will the distribution of the funding between the states and territories be determined?
e) Have any states/territories indicated that they will provide matching funding? If so, which ones and how much?
f) How will the individual sites to be funded be determined?
g) Has any of the money been rolled out yet? If so, what are the details? That is, which state/territory, community, how much, and what is funding being provided for.
h) If not, when is the rollout of this funding due to commence?

Answer:

a) Yes.

b) $49.649 million broken down over four years, as follows:

2006-07	$2.292 million
2007-08	$17.652 million
2008-09	$15.172 million
2009-10	$14.533 million

c) Under this measure, funding will be provided to:
- expand existing effective services;
- create new services, including new service types;
- establish safe places to sober up;
- establish new multidisciplinary teams with skills in substance use and associated issues; and
- develop services to support individuals leaving rehabilitation and returning to their communities to prevent relapse.

The Department is working with the relevant jurisdictions to develop investment plans for the initiative. The final mix of services provided will depend on the outcomes of the bilateral negotiations with each state and territory.

d) The distribution of funding between the states and territories will be based on the need for additional drug and alcohol treatment and rehabilitation services in regional and remote areas.

e) No. There is no requirement for matching funding by the states and territories.

f) The individual sites to be recommended for funding will be agreed through bilateral negotiations with each jurisdiction. The recommended sites will be based on the results of existing or specially commissioned planning processes.

g) No.

h) The rollout of funding is due to commence in March 2007.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2006-2007, 1 November 2006

Question: E06-073

OUTCOME 8: Indigenous Health

Topic: INDIGENOUS CHILDREN'S HEALTH CHECK

Written Question on Notice

Senator Evans asked:

What is the exact amount of funding allocated to the trial extension of the Indigenous Child Health Check announced at the June intergovernmental summit on violence and abuse in Indigenous communities? Over what time frame? Please provide a breakdown including allocation for this financial year and the out-years.

Answer:

$3.821 million has been allocated over two years (2006-07 and 2007-08) for the accelerated roll-out of the MBS Aboriginal and Torres Strait Islander Child Health Check.

Funding breakdown for the accelerated roll-out of the Child Health Check:

	2006-2007	**2007-2008**
Departmental funding allocation	$383,000	$346,000
Administered funding allocation	$1,555,000	$1,537,000
Total	$1,938,000	$1,883,000

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2006-2007, 1 November 2006

Question: E06-074

OUTCOME 8: Indigenous Health

Topic: INDIGENOUS CHILDREN'S HEALTH CHECK

Written Question on Notice

Senator Evans asked:

According to the communiqué from the intergovernmental summit "a special team to conduct some 2000 checks with a further team to provide support and follow-up treatment will be provided by the Commonwealth. Is 2000 checks still the target?

Answer:

Yes.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2006-2007, 1 November 2006

Question: E06-075

OUTCOME 8: Indigenous Health

Topic: INDIGENOUS CHILDREN'S HEALTH CHECK

Written Question on Notice

Senator Evans asked:

Please provide a brief overview of the planned roll-out, including information on:

a) anticipated composition of the health checks team and the back-up/support team;
b) how the teams will be resourced, for example will it operate from an existing primary health care service;
c) how long the teams are anticipated to be in place for.

Answer:

a) Discussions are currently underway between the Australian and State and Territory Governments, primary health care services and other key stakeholders regarding the overall implementation of this initiative.

These discussions include negotiations relating to the composition of the initial child health check teams and back-up/support team for each site. As a guide, it is expected that each child health check team will comprise a General Practitioner, Registered Nurse, two Aboriginal Health Workers and an allied health worker. At this stage it is expected that the follow up teams will comprise a Registered Nurse and an Aboriginal Health Worker.

b) The teams will be funded to work with the existing primary health care infrastructure in each community/region. Before commencement an implementation plan will be developed in conjunction with primary health care services and affected communities to ensure teams are well oriented, supported and resourced.

c) It is expected that each team, including back-up/support, will be in place for approximately 6 months.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2006-2007, 1 November 2006

Question: E06-076

OUTCOME 8: Indigenous Health

Topic: INDIGENOUS CHILDREN'S HEALTH CHECK

Written Question on Notice

Senator Evans asked:

a) Please provide figures on take up of the Indigenous Child Health Check for each year since it was introduced.
b) Is it possible to disaggregate these figures by state/territory and region? If so please provide disaggregated figures.
c) Is it possible to disaggregate these figures by service provider - i.e. AMS/ACCHO versus non-Indigenous primary care provider? If so please provide disaggregated figures.

Answer:

a) The Aboriginal and Torres Strait Islander Child Health Check was introduced as a Medicare Benefits Schedule item in May 2006. The total number of Child Health Checks provided from 1 May 2006 to 31 October 2006 in Australia was 2,348.

b) Table 1 disaggregates these figures by state/territory and Table 2 disaggregates them by region.

Table 1: Number of Indigenous Child Health Checks, by State of Patient, by Month of Processing

2006	**NSW**	**VIC**	**QLD**	**SA**	**WA**	**TAS**	**NT**	**ACT**	**TOTAL**
May	46	4	41	1	28	0	8	0	128
June	120	5	83	5	42	0	40	0	295
July	135	4	61	1	46	0	9	0	256
August	170	5	285	1	53	0	37	0	551
September	133	0	247	5	61	0	45	0	491
October	138	4	292	5	56	0	132	0	627
Total	742	22	1009	18	286	0	271	0	2,348

Table 2: Number of Indigenous Child Health Checks, by Region of Patient

	May to October 2006
Major City	348
Inner Regional	356
Outer Regional	882
Remote	401
Very Remote	361
Total	2,348

c) Data is not available for Aboriginal and Torres Strait Islander Child Health Checks disaggregated by service-provider type.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2006-2007, 1 November 2006

Question: E06-077

OUTCOME 8: Indigenous Health

Topic: OPAL FUEL ROLLOUT TO TWO ADDITIONAL REGIONS

Written Question on Notice

Senator Evans asked:

Regarding the $20.1 million for DOHA included in this year's budget for the Petrol Sniffing Prevention Program to expand the roll-out of OPAL fuel to the central desert and two additional regions:

a) Have the two regions to be included in the expanded OPAL roll-out been identified?
b) If so which regions have been identified and when will the roll-out to these regions commence?
c) If not when is the process of identifying the additional regions expected to be completed, and when is the roll-out anticipated to commence?

Answer:

a) Two potential new regions have been identified and agreed to by Minister Brough. The Office of Indigenous Policy Coordination (OIPC) are currently negotiating with the relevant State and Territory Governments regarding the new regions.
b) They are expected to be agreed and announced by early 2007. The rollout of unleaded *Opal* fuel into the two new regions will commence following a communications campaign in the relevant regions in the first half of 2007.
c) Not applicable.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2006-2007, 1 November 2006

Question: E06-078

OUTCOME 8: Indigenous Health

Topic: OPAL FUEL/PETROL SNIFFING PREVENTION PROGRAM

Written Question on Notice

Senator Evans asked:

Please provide an update on the rollout of unleaded *Opal* fuel in Alice Springs, including:

d) What proportion of petrol stations in Alice Springs are now carrying unleaded *Opal* fuel?

e) What actions are being taken to address problems with the rollout, including supply-line problems?

f) What is being done to address consumer concerns about the quality of unleaded *Opal* fuel?

Answer:

a) Of the 11 service stations in Alice Springs, four are currently selling unleaded *Opal* fuel.

b) and c) The supply-line issues were internal to Shell and the Department has been advised that these issues have now been resolved.

The primary issue with the rollout in Alice Springs has been consumer concerns about the quality of unleaded *Opal* fuel. The following actions have been and are being undertaken:

- BP Australia took samples of unleaded *Opal* fuel from all petrol stations in Alice Springs and conducted a supply chain audit. The analysis showed that all the unleaded *Opal* fuel tested met Australian Fuel Standards for unleaded fuel.

- Fuel samples were also examined by BP Australia from the two cars that had experienced engine problems in Alice Springs. In the first sample, the fuel was actually premium unleaded, not unleaded *Opal* fuel. The second sample was a fuel mixture whereby some existing unleaded regular petrol in a petrol tank had been topped up with unleaded *Opal* fuel. This sample showed signs of ageing along with discoloration and low vapour pressure. The original fuel in the tank (not unleaded *Opal* fuel) had passed its 'use by' date.

- To better understand the negative response to unleaded *Opal* fuel, market research was undertaken with a series of focus group tests in Alice Springs.

- The research will guide the development of a communication strategy which is expected to be released in February 2007.

- On 24 October 2006, the Department met with all Alice Springs fuel distributors, including Shell and Woolworths, to discuss strategies for the complete replacement of regular unleaded petrol with unleaded *Opal* fuel. All fuel distributors indicated they are committed to the full replacement with unleaded *Opal* fuel.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2006-2007, 1 November 2006

Question: E06-079

OUTCOME 8: Indigenous Health

Topic: OPAL FUEL/PETROL SNIFFING PREVENTION PROGRAM

Written Question on Notice

Senator Evans asked:

Please provide details of all spending on OPAL fuel for 2005/06 and 2006/07 to date. Please include:

g) The communities which have requested OPAL fuel
h) Communities which have received OPAL fuel
i) Reasons for any delays in the provision of OPAL fuel
j) Reasons for underspends in the program

Answer:

Unleaded *Opal* fuel administered funding as at 13 November 2006:

	2005-06	**2006-07**
Unleaded *Opal* fuel Spend	$1,722,474.00	$1,655,317.00

a) The total number of communities which requested unleaded *Opal* fuel is 73.
b) The total number of communities that are currently receiving unleaded *Opal* fuel is 68.
c) There are a number of reasons for delays in delivering unleaded *Opal* fuel to program participants, they are as follows:
   - Logistical issues in distributing unleaded *Opal* fuel to new participants;
   - Waiting for current regular unleaded petrol to be used; and
   - Environmental impacts and constraints caused by weather in north Australia.
d) $2.35 million was rephased from 2005-06 to 2006-07 to better reflect the pattern of consumption of unleaded *Opal* fuel that has emerged.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2006-2007, 1 November 2006

Question: E06-081

OUTCOME 8: Indigenous Health

Topic: NATIONAL ABORIGINAL COMMUNITY CONTROLLED HEALTH ORGANISATION (NACCHO) REVIEW

Written Question on Notice

Senator Evans asked:

According to the Department's 2005-06 Annual Report (p.320), $33,550 was paid to Korda Mentha Pty Ltd in 2005-06 for a review of the National Aboriginal Community Controlled Health Organisation:

a) What was the nature of the review?

b) Will the report of the review be made public?

Answer:

(a) The review examined the financial management, administration and performance of NACCHO.

(b) No.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2006-2007, 1 November 2006

Question: E06-082

OUTCOME 8: Indigenous Health

Topic: SHARED RESPONSIBILITY AGREEMENTS (SRAs)

Written Question on Notice

Senator Evans asked:

Please provide a detailed list of all the SRAs which involve a health component, including the current status of each agreement and the health component.

Answer:

The Department has contributed funding to eighteen signed SRAs:

- *Barmera Bicycle Workshop* (SA) - $13,500 to facilitate provision of healthy and safe activities as incentive for children to attend school, through the establishment of a bicycle workshop and associated activities e.g. a nutrition program. The funding for this SRA has not yet been spent. This project started in October 2006. The community has constructed the workshop and they have been collecting bicycle parts, with a view that the SRA activities will commence in December 2006. Funding will be fully committed and expended by the end of the financial year;
- *Baryulgil Market Garden* (NSW) - $25,000 extension to support an existing SRA involving the Baryulgil Public School and Bulgarr Ngaru Aboriginal Medical Service, to improve local nutrition and educational outcomes. Funding for this SRA has been spent and the project is underway;
- *Borroloola and AACAP* (NT) - $60,000 to provide funding for alcohol and other drug mentoring, as part of a comprehensive program to build 'job readiness' skills and improve housing infrastructure in the community. All funds have been expended and the project has been completed;
- *Bowen Positive Families SRA (QLD)* - $85,000 to provide funding for a Youth Health Promotion Officer to address youth boredom and misbehaviour. Project underway and Promotion Officer employed. $32,783 has been paid to date and the remaining funds will be expended by 30 June 2007;
- *Bundaberg Wellness Centre* (QLD) - $229,200 to establish a wellness centre to improve linkages to health and social services for Indigenous Australians in Bundaberg. This project is underway. $150,000 has been paid to date, with $29,000 payable 1 January 2007 and $50,000 allocated for evaluation (tender process to commence in near future). The Bundaberg Wellness Centre is part way through its initial establishment phase, with recruitment of staff in progress. It is anticipated

that following the first year establishment phase (through SRA process) recurrent funding from 1 July 2007 will be sought from OATSIH Enhancement and Expansion funding to support the Centre as an ongoing access to mainstream/brokerage model;

- *Bundaberg Youth* (QLD) - $6,000 to develop a program and resource (including show bag) to address youth pregnancy and sexually transmitted diseases. Funding for this SRA has been spent and the project has been completed;
- *Cape Barren Island Well-being Centre* (TAS) - $212,341 towards the establishment of the Cape Barren Island Community Well-being Centre. Funding for this SRA has been spent and the project completed;
- *Cunnamulla Leadership and Governance* (QLD) - $90,000 towards the cost of a project officer and the leadership components of this SRA, for the purpose of capacity building in relation to developing and promoting positive leadership and governance in the community, enabling community members to become proactive and skilled in the running of Indigenous organisations through workshops on leadership, self esteem and self care, and linking mentors with young people in the community. This project is underway, with consultants engaged and three leadership workshops held to date. $45,000 has been paid, with $45,000 to be paid over the next 6 months;
- *Inala Rugby League Community* (QLD) - $50,000, through the West Inala Panthers Junior Rugby League Football Club toward employment of a part-time Indigenous Men's Health and Sport Development Officer. The project is underway and all funds have been paid. The Men's Health and Sport Development Officer has been employed (current contract expires 30 June 2007);
- *Larrakia Nation Aboriginal Corporation* (NT) - $70,000 towards supporting the Larrakia Tank Art – Youth at Risk Project and engaging young people at risk in the Darwin town camps. All funds have been expended and the project has been completed;
- *Lockhart River 'Empower the Community'* (QLD) - $109,830 for the employment of a number of part-time community education and diversion coordinators and funding for two local people to undertake drug and alcohol diversionary activities. The funding for this SRA is recurrent and the project is ongoing. Supplementary to the Lockhart River SRA is an additional $160,000 to build staff accommodation and consulting rooms to enable enhanced health service delivery planned through the Improved Primary Health Care and Healthy For Life initiatives in the region. Capital Works: All funds ($160,000) have been transferred to auspicing organisation and the project is underway with design work and plans completed. An identified funds shortfall has held up further progress and it is anticipated that an additional $70,000 will be sourced from OATSIH Enhancement and Expansion funding;
- *Maningrida Youth Development Centre* (NT) - $593,175 contribution to the capital and operational costs of the centre, specifically the Substance Misuse Program. The full amount of $593,175 was released by the Department to Malabam Health Board in the 2005/06 financial year. Funding for 2006/07 is $171,713, of which, $85,856 has been released. It is anticipated that funds will be expended by March 2007. The Substance Misuse Program is ongoing and funds will be expended at the end of each financial year. The project is being implemented;
- *Milyakburra Store* (NT) - $70,000 toward improving community nutrition by promoting a fresh food policy and air conditioning the store. The project was funded through Angurugu Council. $70,000 was released to the Angurugu Council

on signing of the agreement. No funds have been used at this point as the Angurugu Council is currently waiting on invoices from the Milyakburra Store. The CEO of Angurugu is following up the invoices and it is expected that the funds will be fully acquitted in the 2006/07 financial year. The project is in place;

- *Nauiyu Swimming Pool - Building Healthy Communities* (NT) - $332,389. Funding provided to Royal Life Saving Society of Australia (RLSSA) to implement the Nauiyu Community Aquatic Recreation project for the conduct of a capacity building project by the RLSSA over 2 years until June 2008. Includes employment of a project officer at the community and project coordination by RLSSA, as well as training and operational costs for the project. (signed 25 October 2006). Payments have been released for: Phase 1 (development of Project Plan) - $35,269 and Phase 2 (implementation of Project Plan) $40,405. Future payments will be made quarterly. The 2 year project is being implemented. A local person has been employed as the Project Officer and aquatic programs have commenced. Programs include training community members in life-guarding, pool operation and health promotion, swim and survive, and water familiarisation for children 0 – 4 years;
- *Western Desert Nganampa Walytja Palyantjaku Tjutaku* (NT) - $80,000 for the purchase of a vehicle to facilitate access to health services and the maintenance of social networks for renal patients and their families while they are in Alice Springs. The SRA was signed on 22 June 2005. Funds have been expended for the purchase of two vehicles and the vehicles are in use;
- *Wanarn Store* (WA) - $250,000 to build a nutrition and training centre attached to the store. An additional $100,000 was provided in 2006-07 to reflect cost increases since the original approval for building a nutrition and training centre attached to the store. This SRA is attached to the Ngaanyatjarra RPA. The Department is finalising the process for funding this SRA with the Office of Indigenous Policy Coordination (OIPC) and Indigenous Business Australia (IBA). Funds should be released by February 2007;
- *Watarru Swimming Pool* (SA) – up to $1.35 million. A swimming pool which requires the community to implement a 'no school, no pool' policy. To date, $33,000 has been spent on the feasibility study. The funding agreement for building the pool is in draft stage and has been sent to the community. It is anticipated that the funding agreement will be signed by the end of November 2006. The swimming pool is due for completion by December 2007 and the funding is expected to be fully expended by this time;
- *Yungngora* SRA (WA) - $50,000 towards the establishment of an ablution block and laundry. Funding for this SRA has been spent and the project completed.

The Office of Indigenous Policy and Coordination maintains a web site with details of all signed SRAs: www.oipc.gov.au

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2006-2007, 1 November 2006

Question: E06-083

OUTCOME 8: Indigenous Health

Topic: TRACHOMA INITIATIVES IN MULAN

Written Question on Notice

Senator Evans asked:

Specifically, to the extent that trachoma rates have recently increased in Mulan, despite the SRA, what initiatives is the Department involved in to address this increase?

Answer:

The Department has provided funding to Western Australia to enhance their current trachoma control programs, and the training of health care workers to detect, screen and treat trachoma in line with the national Trachoma Guidelines.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2006-2007, 1 November 2006

Question: E06-084

OUTCOME 8: Indigenous Health

Topic: PRIMARY HEALTH CARE ACCESS PROGRAM (PHCAP) EXPENDITURE, UNDERSPENDS AND OVERSPENDS

Written Question on Notice

Senator Evans asked:

a) Please provide 2005-06 expenditures and 2006-07 expenditures to date on PHCAP by specific site? This request is for the update of tables provided at previous Senate Estimates (eg E03-106)Where there are underspends and overspends, please provide the reasons.

Answer:

a) 2005-06 PHCAP Expense against New Funding Allocation

In addition to PHCAP funding distributed in previous years identified in response to question E05000338 provided in November 2005, the table below provides details of the 2005-06 expense associated with new funding other than major capital works.

New PHCAP 2005-06 allocation and expense

State	OATSIH Planning Region	2005-06 expense ($m)	2005-06 Allocations ($m)	Over/Under spends
ACT	ACT	0.285	0.285	-
	Subtotal - ACT	0.285	0.285	-
NSW	Greater Southern - NSW	0.264	0.264	-
	Hunter	0.262	0.165	- 0.097
	Inner Greater Western	0.645	0.610	- 0.035
	New England	0.509	0.509	-
	North Coast - NSW	1.163	1.210	0.047
	North Sydney Central Coast	0.089	0.089	-
	NSW State-wide	0.563	0.442	- 0.121
	Outer Greater Western	0.854	0.698	- 0.156
	South East Sydney_Illawarra	0.523	0.523	-
	Sydney South West	0.186	0.163	- 0.023
	Sydney West	0.042	0.042	-
	Subtotal - NSW	5.101	4.716	- 0.385
NT	Alice Springs	1.068	1.163	0.095
	Arnhem	0.429	0.481	0.052
	Barkly	0.050	0.050	-
	Darwin Rural	1.219	1.277	0.059
	Darwin Urban	0.125	0.071	- 0.054
	Katherine	0.120	0.063	- 0.057
	NT State-wide	0.230	0.263	0.033
	Subtotal - NT	3.240	3.368	0.128
QLD	Cape York	1.250	1.283	0.033
	Central Queensland	0.744	0.623	- 0.121

	Far North QLD	1.112	1.112		-
	Far South West Qld	0.120	0.120		-
	North QLD	0.502	0.502		-
	North West QLD	0.196	0.202		0.006
	QLD State-wide	0.578	0.747		0.169
	South East Qld - Metro	0.770	0.770		-
	South West QLD	0.196	0.196		-
	Torres LGA	0.308	0.308		-
	Wide Bay/Sunshine Coast	0.398	0.384	-	0.014
	Subtotal - QLD	6.175	6.247		0.072
SA	Eyre Peninsula	0.106	0.106		-
	Hills Mallee Southern	0.024	0.024		-
	Mid North S.A	0.026	0.026		-
	SA State-wide	0.088	0.088		-
	South East SA	0.048	0.048		-
	Whyalla, Flinders & Far North	0.308	0.326		0.018
	Subtotal - SA	0.600	0.618		0.018
TAS	North West Tas	0.216	0.176	-	0.040
	North Tas	0.014	0.044		0.030
	TAS State-wide	0.018	-	-	0.018
	South TAS	0.080	0.080		-
	Subtotal - TAS	0.328	0.300	-	0.028
VIC	Barwon South West	0.013	0.013		-
	East Metro Vic	0.057	0.057		-
	Gippsland	0.038	0.038		-
	Grampians	0.013	0.013		-
	Loddon Mallee	0.173	0.173		-
	North Metro Vic	0.222	0.210	-	0.012
	South Metro Vic	0.086	0.056	-	0.030
	Subtotal - VIC	0.600	0.558	-	0.042
WA	Goldfields	0.419	0.114	-	0.305
	Gt Southern W.A	0.118	0.118		-
	Kimberley	1.027	0.892	-	0.135
	Metropolitan W.A	0.834	0.856		0.022
	Midwest W.A	0.162	0.096	-	0.066
	WA State-wide	0.064	0.064		-
	Wheatbelt	1.519	1.519		-
	Subtotal - WA	4.143	3.660	-	0.483
	Total	**20.472**	**19.752**	**-**	**0.720**

2006-07 PHCAP Expense

Given delays in the signing of service contracts, a more meaningful date for reporting on PHCAP expenditure for 2006-07 would be 30 December 2006. Figures available for 2006-07 will be provided at the next Senate Estimates hearing.

b) The total actual expense associated with new PHCAP initiatives in 2005-06 slightly exceeded the total initial allocation. There were marginal differences between the allocation and expense in the OATSIH Planning Regions in most states/territories and any shortfall was influenced by the capacity of the sector and workforce availability in those regions. Total PHCAP expense for 2005-06, including the flow-on commitments from previous years' initiatives, was $57.7 million. The remaining PHCAP allocation was directed and committed to major capital works activities.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2006-2007, 1 November 2006

Question: E06-091

OUTCOME 8: Indigenous Health

Topic: INDIGENOUS MEN'S HEALTH

Written Question on Notice

Senator Evans asked:

What OATSIH resources are currently being directed specifically towards Aboriginal and Torres Strait Islander male health?

Answer:

The Office for Aboriginal and Torres Strait Islander Health (OATSIH) does not provide any funds specifically for Aboriginal and Torres Strait Islander male health. However, Indigenous Health Services have the discretion to use their primary health care funding to target key health issues in their individual communities and this may include allocation of resources for Indigenous gender-specific projects. This means that health services determine the level of expenditure they should make in each area of primary health care service delivery in response to identified health needs, including male health services.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2006-2007, 1 November 2006

Question: E06-092

OUTCOME 8: Indigenous Health

Topic: FRAMEWORK FOR MALE HEALTH

Written Question on Notice

Senator Evans asked:

a) Is there a Framework for Improving the Health and Wellbeing of Aboriginal and Torres Strait Islander Men?

b) If so what is OATSIH/the Department doing to advance this Framework?

Answer:

a) Yes.

b) The Department, through the Office for Aboriginal and Torres Islander Health (OATSIH), provided Secretariat support to the Aboriginal and Torres Strait Islander Male Health Working Party tasked with developing the *National Framework for Improving the Health and Wellbeing of Aboriginal and Torres Strait Islander Males* (The Framework). The Framework was published in June 2004.

OATSIH has also funded the publication *Indigenous Male Health: a Report for Indigenous Males, Their Families and Communities, and Those Committed to Improving Indigenous Male Health* by Dr Mark Wenitong.

These key resources contribute to establishing future strategies and responses for improving Aboriginal and Torres Strait Islander male health and an understanding of the particular circumstances of Indigenous males.

The provision of health services for Indigenous males currently occurs through Indigenous-specific and mainstream health and substance use services in direct response to locally identified needs and priorities.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2006-2007, 1 November 2006

Question: E06-197

OUTCOME 8: Indigenous Health

Topic: MUTITJULU REVIEW AND ACCESS TO CLIENT RECORDS

Hansard Page: CA 89, 91-92

Senator Crossin asked:

a) What were the clinical service delivery issues at Mutitjulu prior to December 2005 which triggered the Department commissioning a review of the service at that time?
b) Is OATSIH aware of unauthorised access to Mutitjulu client records in 2005?
c) Has there been a formal complaint to the Minister about unauthorised access to Mutitjulu client records?
d) Who was the consultant who conducted the December 2005 review?
e) When was the review report finalised?
f) How much did the review cost?
g) Did the review report include any mention of unauthorised access to Mutitjulu client records?

Answer:

a) The clinical service delivery issues that triggered the commissioning of a review of Mutitjulu Health Service were:
    1. high level of staff vacancies and staff turnover;
    2. lack of staff stability, security and work overload impacting upon service delivery;
    3. internal disputes between staff impacting upon community use of the clinic;
    4. confusion amongst staff and between staff and board members regarding roles and responsibilities; and
    5. claims of insufficient resources to provide a regional service.
b) OATSIH has not been informed of any unauthorised access to Mutitjulu Health Service client records in 2005.
c) There has been no formal complaint to the Minister regarding unauthorised access to Mutitjulu Health Service client records.
d) The consultant engaged to undertake the December 2005 review was the Institute For Healthy Communities Australia Ltd.
e) The review report of Mutitjulu clinical services was completed in February 2006.
f) The review cost $26,272 (GST inclusive).
g) The review report did not refer to any unauthorised access to Mutitjulu Health Service client records.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2006-2007, 1 November 2006

Question: E06-198

OUTCOME 8: Indigenous Health

Topic: MUTITJULU ADMINISTRATOR

Hansard Page: CA 90

Senator Evans asked:

h) Where is the Administrator located?
i) How many times has the Administrator visited the community?

Answer:

The Administrator and Administration process is the responsibility of the Office of the Registrar for Aboriginal Corporations (ORAC). Information from ORAC indicates that:

a) Whilst the Administrator is primarily located in Perth, Western Australia, the Mutitjulu Health Service has three nurses and a Health Service Manager on-site.
b) Since March 2006, the Administrator has visited the Health Service in the Mutitjulu community on 18 occasions, approximately 5 days per fortnight, with at least two visits each month. The Administrator of Mutitjulu Health Service is also the Administrator of the College at Mutitjulu, therefore the business conducted during these visits related to activities on behalf of both Administrations.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2006-2007, 1 November 2006

Question: E06-228

OUTCOME 8: Indigenous Health

Topic: WADEYE COAG TRIAL – HEALTH STATISTICS

Written Question on Notice

Senator Evans asked:

Does the Department have any data on rates of infectious and chronic disease in Wadeye, in particular:
a) gastroenteritis
b) skin infections
c) respiratory tract infections
d) chronic otitis media
e) post-streptococcal glomerulonephritis (kidney disease caused by strep infection – either in the throat or skin)
f) bronchiectasis
g) rheumatic heart disease

If so please provide this data.

Answer:

No. The Department does not hold this data. The Northern Territory Department of Health and Community Services may hold some of this data but there would likely be concerns about releasing it at a community level.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2006-2007, 1 November 2006

Question: E06-229

OUTCOME 8: Indigenous Health

Topic: Wadeye COAG Trial – Health Statistics

Written Question on Notice

Senator Evans asked:

Can the Department provide information on how rates of these infectious/chronic diseases compare over time, in particular since the commencement of the COAG trial in 2003

Answer:

No. See response to E06-228.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2006-2007, 1 November 2006

Question: E06-230

OUTCOME 8: Indigenous Health

TOPIC: WADEYE COAG TRIAL – HEALTH STATISTICS

Written Question on Notice

Senator Christopher Evans asked:

Can the Department provide information on how rates of these infectious/chronic diseases compare to rates of these conditions:
a) elsewhere in Australia
b) elsewhere in the world

Answer:

No. See response to E06-228.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2006-2007, 1 November 2006

Question: E06-066

OUTCOME 8: Indigenous Health

Topic: TRACHOMA – CDNA GUIDELINES

Written Question on Notice

Senator Evans asked:

a) Have the Guidelines been distributed?
b) How were they distributed?
c) Who was responsible?
d) Where did the guidelines go?
e) What is being done to get them implemented?
f) What is the funding for this?

Answer:

a) Yes.

b) Hard copies of the Guidelines were distributed by mail to key professional and trachoma interest groups. They are also available via the Departmental web site at http://www.health.gov.au/internet/wcms/publishing.nsf/Content/cda-cdna-pubs-trachoma.htm

c) Department of Health and Ageing.

d) The Guidelines were distributed to key professional and interest groups, including universities, peak organisations, State and Territory health agencies and public health units.

e) Negotiations with and funding to State/Territory jurisdictions to train health care workers in line with the recommendations of the Guidelines are occurring.

f) A total of $450,000 over two years.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2006-2007, 1 November 2006

Question: E06-068

OUTCOME 8: Indigenous Health

Topic: HEALTHY FOR LIFE EXPENDITURE

Written Question on Notice

Senator Evans asked:

a) How much Healthy for Life funding was spent in 2005-06?
b) What is anticipated to be spent in 2006-07 and the out-years?

Answer:

a) A total of $8.2 million Healthy For Life funding was spent in 2005-06.

b) Consistent with the four year Budget appropriation for the Healthy For Life measure (as adjusted in the 2006-07 Budget), it is anticipated that the following funding will be spent in 2006-07 and the out-years:

	2006-07 ($m)	2007-08 ($m)	2008-09 ($m)
Departmental Expenses:	2.9	2.9	2.6
Administered Expenses:	21.4	27.6	36.8
Total:	24.3	30.5	39.4

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2006-2007, 1 November 2006

Question: E06-080

OUTCOME 8: Indigenous Health

Topic: NATIONAL ABORIGINAL COMMUNITY CONTROLLED HEALTH ORGANISATION (NACCHO) FUNDING

Written Question on Notice

Senator Evans asked:

Please provide the following information with respect to NACCHO:

a) Federal health funds administered by NACCHO for each financial year since 2000-01, and projected expenditure for 2006-07 and the out-years (2007-08, 2008-09 and 2010-11)
b) How far ahead is NACCHO advised of renewed funding commitments?
c) What is the length of the funding cycle for Aboriginal Community Controlled Health Services (ACCHS)?
d) If 12 months, has any consideration been given to a triennial funding cycle? If so, are there any plans to introduce a triennial funding cycle? If not, why not?
e) What is being done to address health service gaps in services provided by ACCHSs, as identified by the Service Activity Reporting Process.

Answer:

a) Federal health funding for NACCHO is as follows:

Year	Total Department of Health and Ageing funds
2000-01[1]	$1,929,408.40
2001-02	$2,696,660.10
2002-03	$2,528,213.10
2003-04	$2,539,682.30
2004-05	$2,140,046.20
2005-06	$2,437,128.10
2006-07	$2,216,068.90

1 Funding figures for 2000-01 to 2005-06 are actual figures. The funding figure for 2006-07 is a projected figure.

Funding is negotiated on an annual basis and as such details of funding are not available for years beyond the current 2006-07 contract.

b) For the 2006-07 financial year, NACCHO was advised in the quarter prior to the end of the 2005-06 financial year that funding would be renewed. Contracts were exchanged between NACCHO and the Office for Aboriginal and Torres Strait Islander Health in July 2006.

c) 12 months.

d) Yes, the Office for Aboriginal and Torres Strait Islander Health (OATSIH) is currently investigating the provision of triennial funding to organisations which have a demonstrated record of sound financial and operational management.

e) OATSIH's Service Activity Reporting (SAR) data is sourced from Indigenous health organisations and identifies, at the time of survey, the number of funded health service positions occupied or unfilled in these organisations.

For those positions proving difficult to fill permanently, especially in rural and remote areas, OATSIH is currently discussing with the Indigenous health sector the need for further assistance in the recruitment and retention of health professionals over and above the range of mainstream health workforce measures currently available in rural and remote areas. Mainstream health workforce measures are detailed in Outcomes 5 and 12.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2006-2007, 1 November 2006

Question: E06-093

OUTCOME 8: Indigenous Health

Topic: OATSIH FUNDING FOR MALE-SPECIFIC PROJECTS

Written Question on Notice

Senator Evans asked:

a) Have any grants been provided by OATSIH/DOHA in the last 12 months to male-specific Indigenous health projects?

If so, please provide details, including:
b) amounts of funding provided
c) program/s funding provided from
d) organisation/s funding provided to
e) project/s funding provided for
f) period of time funding provided for
g) details of any evaluations on effectiveness of programs funded
h) If none in the last 12 months, has any Departmental/OATSIH funding been provided for specific Indigenous men's/male health projects at all?

Answer:

a) Yes.

b) – f)
Indigenous Health Services have the discretion to use their general primary health care funding to target key health issues and priorities in their individual communities and this may include allocation of resources for Indigenous gender-specific projects. OATSIH has also funded a number of male-specific Indigenous health projects in the last 12 months (please see details in the table below).

g) There has been no evaluation of the effectiveness of the male-specific programs funded.

h) Not applicable.

OATSIH male-specific health grants

b) amounts of funding provided (GST inclusive)	c) programs funding provided from	d) organisations funding provided to	e) project/s funding provided for	f) period of time funding provided for
New South Wales				
$29, 702.20	Primary Health Care Access Program	Ngaimpe Aboriginal Corporation (The Glen)	Residential Rehabilitation Service (Male Residents)	2005/2006
$19, 142.73	Primary Health Care Access Program	Bulgarr Ngaru Medical Aboriginal Corporation	Male Mental Health Worker	2005/2006
$16, 068	Primary Health Care Access Program	Bourke Aboriginal Medical Service	Male Mental Health Support Worker	2005/2006
$19, 444	Primary Health Care Access Program	North Coast Area Health Service (Bugalwena Health Service)	Male Support Worker (Goori Fathers Program joint funded with State Health)	2005/2006
$60, 000	Primary Health Care Access Program	Durri Aboriginal Corporation Medical Service	Employ a Male Aboriginal Health Worker to be shared between Bowraville Health Outpost and Nambucca Health Outpost	2005/2006
$522,054	Substance Use and Primary Health Care Access Program	Namatjira Haven (Bundjalung Tribal Society)	Residential Rehabilitation Service (Male Residents)	2006/2007
$804, 276	Substance Use	Benelong's Haven Ltd	Residential Rehabilitation Service (Male Residents & Families)	2006/2007
$327, 372	Substance Use and Primary Health Care Access Program	Oolong Aboriginal Corporation Inc	Residential Rehabilitation Service (Male Residents)	2006/2007
$10, 000	Primary Health Care Access Program	Central Coast Aboriginal Men's Group Incorporated	Organise the NSW Aboriginal Men's Health and Wellbeing Learning and Sharing Circle	2006/2007
Queensland				
$10, 110	Communicable Diseases	Kalwun Health Service	Shed for Sexual Health Men's Business	2005/2006
$7, 500	Primary Health Care Access Program	Krurungal Corporation for Welfare Rescue & Housing	Equipment for Men's Group diversionary activities	2005/2006
$211, 424	Primary Health Care Access Program and Substance Abuse	Yaamba Aboriginal and Torres Strait Islander Corporation for Men	Provision of substance use support	2005/2006
$35, 000	Primary Health Care Access Program	Mamu Medical Service	Male Counselor	2006/2007
$46, 667	Primary Health Care Access Program	Northern Peninsular Area Women's Shelter	Men's Health Project Officer	2006/2007
$215, 038	Primary Health Care Access Program and Substance Use	Yaamba Aboriginal and Torres Strait Islander Corporation for Men	Provision of substance use support	2006/2007

Northern Territory				
$159, 011	Communicable Diseases	Central Australian Aboriginal Congress	Community based sexual health screening program for men	2005/2006
$1, 319, 028	Primary Health Care Access Program and Substance Use	Central Australian Aboriginal Alcohol Programmes Unit	Residential rehabilitation for men	2005/2006
$185, 322	Substance Use	Ilpurla Aboriginal Corporation	Substance use outstation service targeted at males	2005/2006
$163, 045	Primary Health Care Access Program	Pintubi Health Service	Men's Health Coordinator for Luritja-Pintubi zone	2006/2007
$162, 191	Communicable Diseases	Central Australian Aboriginal Congress	Community-based Sexual Health screening program for men	2006/2007
$486, 276	Substance Use	Central Australian Aboriginal Alcohol Programmes Unit	Residential rehabilitation for men	2006/2007
$123, 101	Primary Health Care Access Program	Central Australian Aboriginal Congress (auspice for Western Arrernte Health Aboriginal Corporation)	Men's health coordinator for Western Arrernte zone	2006/2007
$2, 968, 230	Primary Health Care Access Program and Substance Use	Ilpurla Aboriginal Corporation	Redevelopment of existing substance use outstation facility	2006/2007
Western Australia				
$85, 000	Primary Health Care Access Program	Palmerston Association Incorporated	Walking Tall Program, a substance abuse counseling program	2006/2007
$126, 780.50	Primary Health Care Access Program	Palyalatju Maparnpa Aboriginal Corporation Health Committee – Men's Health Program	Employ a male nurse	2006/2007
Central Office				
$22, 000	Substance Use	Queensland Aboriginal and Islander Health Council	Travel grants for 10 Aboriginal and Torres Strait Islander male participants to attend the 6th National Men's Health Conference in 2005.	2005/2006

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2006-2007, 1 November 2006

Question: E06-231

OUTCOME 8: Indigenous Health

Topic: WADEYE COAG TRIAL – HEALTH STATISTICS

Written Question on Notice

Senator Evans asked:

Can the Department provide an estimate of total health expenditure on Wadeye per annum since 2003, broken down by:

a) OATSIH expenditure (PHCAP, Healthy for Life etc)
b) Medicare expenditure (including PBS)
c) Other

Answer:

a) The Office for Aboriginal and Torres Strait Islander Health administered expenditure by activity for Wadeye is detailed in Table A below.
b) Medicare expenditure is not available at this level for confidentiality reasons.
c) The Department of the Prime Minister and Cabinet has taken responsibility for compiling expenditure details of all Australian Government agencies expenditure relating to all trial sites.

d)
Table A – OATSIH administered expenditure in Wadeye

OATSIH Program Funding	**2003-04**	**2004-05**	**2005-06**	***TOTAL EXPENDITURE 2003-04 to 2005-06***	**2006-07 (Allocated expenditure)**
Fit out and purchase of a mobile clinic and a re-stockable First Aid kit for Wadeye outstations	$110,000			*$110,000*	
Remote Area Nurse to deliver the outstation service and restocking of First Aid Kits		$196,883	$201,215	*$398,098*	
Recruit a GP and 2 community health workers and ongoing staffing for the health centre		$131,058 [2]	$401,824	*$532,882*	$409,860
Improved Primary Health Care Initiative – expand existing primary health care team			$813,275 [3]	*$813,275*	$1,672,535

[1] 2004-05 amount is a part year effect – full amount of $401,824 expended in 2005-06.
[2] Total approved funding over four years is $12,281,818, including $5,812,500 for capital works (including $686,000 in previously approved capital works funding).

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2006-2007, 1 November 2006

Question: E06-232

OUTCOME 8: Indigenous Health

Topic: WADEYE COAG TRIAL – HEALTH STATISTICS

Written Question on Notice

Senator Evans asked:

Can the Department provide an estimate of total health expenditure on Wadeye per annum since 2003, broken down by:
a) Commonwealth government
b) Territory government.

Answer:

a) The Department of Health and Ageing administered expenditure by activity for Wadeye is detailed in Table A below.

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

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

Department of Health and Ageing Program Funding	**2003-04**	**2004-05**	**2005-06**	***TOTAL FUNDING 2003-04 to 2005-06***	**2006-07 (Allocated expenditure)**
Nutrition Project (recurrent as of 2005-06)		$125,000	$125,000	*$250,000*	
Upgrading aged care facilities					$287,852
Flexible Aged Care Service	$525,636	$586,148	$471,451	*$1,583,235*	$718,394
Aged Care contribution to the whole of government funding for the establishment of the Thamurrurr School Transition, Employment & Training Board			$50,000	*$50,000*	
Funding provider (70%) to NT Department of Health and Community Services (NT DHCS) – Home and Community Care (HACC)	$21,649	$40,040	$70,040	*$131,729*	$60,040
Fit out and purchase of a mobile clinic and a re-stockable first aid kit for Wadeye outstations	$110,000			*$110,000*	
Remote Area Nurse to deliver the outstation service and restocking of First aid Kits		$196,883	$201,215	*$398,098*	
Recruit a GP and 2 community health workers and ongoing staffing for the health centre		$131,058 [4]	$401,824	*$532,882*	$409,860
Improved Primary Health Care Initiative – expand existing primary health care team			$813,275 [5]	*$813,275*	$1,672,535

[1] 2004-05 amount is a part year effect – full amount of $401,824 expended in 2005-06.
[2] Total approved funding over four years is $12,281,818, including $5,812,500 for capital works (including $686,000 in previously approved capital works funding).

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2006-2007, 1 November 2006

Question: E06-063

OUTCOME 8: Indigenous Health

Topic: OATSIH EXPENDITURE AND NUMBER OF STAFF

Written Question on Notice

Senator Evans asked:

Please provide the following information with respect to the Office for Aboriginal and Torres Strait Islander Health:

a) breakdown of all administered OATSIH expenditure by program for 2005-06, 2006-07 and projected expenditure for the out-years (2007-08, 2008-09 and 2009-10)
b) a list of OATSIH's departmental (administrative) expenditure for 2005-06, 2006-07 and projected expenditure for the out years (2007-08, 2008-09 and 2009-10)
c) the number of staff employed within OATSIH at each level, and approximately how many staff are assigned to each of OATSIH's programs.

Answer:

a) OATSIH has a one line appropriation for the Aboriginal and Torres Strait Islander Health Program. OATSIH administered expenses for 2005-06 and projected expenses for 2006-07, 2007-08, 2008-09 and 2009-10 are as follows:

Actual Administered Expenses	Projected Administered Expenses			
2005-06 $'000	2006-07 $'000	2007-08 $'000	2008-09 $'000	2009-10 $'000
297,928	377,971	383,834	408,370	430,748

b) OATSIH's departmental expenses for 2005-06 and projected expenses for 2006-07, 2007-08, 2008-09 and 2009-10 are as follows:

Actual Departmental Expenses	Projected Departmental Expenses			
2005-06 $'000	2006-07 $'000	2007-08 $'000	2008-09 $'000	2009-10 $'000
43,225	47,613	45,886	45,507	45,134

c) As at 30 June 2006 the Aboriginal and Torres Strait Islander Health Program was supported by 332 staff of which 259 work in the OATSIH administrative structure.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2006-2007, 1 November 2006

Question: E06-223

OUTCOME 9: Private Health

Topic: SALE OF MEDIBANK PRIVATE

Hansard Page: CA 18

Senator McLucas asked:

a) You would be aware that opinion polling nationally does not show that the sale of Medibank Private is a good idea. Have you done any polling or any analysis of that?
b) So you have data on that member sentiment about the sale? How would you provide that to me?

Answer:

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

b) Medibank Private operates in a highly competitive environment. Customer feedback and opinions allow us to improve the value proposition of our product offerings to our customers. The ongoing feedback we receive from members would be extremely valuable to our competitors. As a result, Medibank Private is unable to provide any further information.

   Any queries in regards to issues surrounding the privatisation of Medibank Private should be directed to our shareholder Minister, Senator the Hon Nick Minchin, Minister for Finance and Administration.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2006-2007, 1 November 2006

Question: E06-224

OUTCOME 9: Private Health

Topic: MEDIBANK PRIVATE - NEW MEMBERS

Hansard Page: CA 19

Senator McLucas asked:

Could you provide us, for this current calendar year, with a month-by-month snapshot of the number of new members you have received, the number that have withdrawn and a split on age?

Answer:

Owing to commercial considerations, there is no public disclosure of month to month figures by any of the Private Health Insurance funds.

Percentage increase in new to fund memberships from January – October 2006 compared to the corresponding period in 2005:

18-24	51%	
25-34	44%	
35-49	51%	
50-64	40%	
65+		14%

Percentage change in memberships withdrawn in the period January – October 2006 in comparison to 2005:

18-24	4%	
25-34	4%	
35-49	-2%	
50-64	10%	
65+		22%

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2006-2007, 1 November 2006

Question: E06-225

OUTCOME 9: Private Health

Topic: STAFF COMMUNICATION - MEDIBANK PRIVATE SALE

Hansard Page: CA 21

Senator Moore asked:

You may want to take on notice what methodologies you have put in place within the organisation to let them know what is going on because, as we talked about before, they are seeing all the media as well. It might be easier to take that on notice, if you can give us a brief on what the staff communication methods are.

Answer:

Medibank Private has kept staff fully up to date during the privatisation process through the following:

- face to face briefings – on the day of major announcements the Managing Director addressed all staff face to face and via a nationwide phone hook up;
- breaking news on intranet – available from every desktop;
- weekly staff email (FYI) – circulation distributed to all staff;
- dedicated privatisation intranet page including interactive Q&A function; and
- 'hot off the presses' emails from the Managing Director for major announcements as back up for face to face briefings.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2006-2007, 1 November 2006

Question: E06-226

OUTCOME 9: Private Health

Topic: SALE OF MEDIBANK PRIVATE - LETTER

Hansard Page: CA 17

Senator McLucas Asked:

Mr Savvides-At the rate change announcement just prior to April this year, all members were notified of their contribution changes as a result of their policies and in that letter we also noted the intention of the shareholder to pursue the sale of the organisation.
Senator McLucas-Could you table one of these letters?

Answer:

The letter attached accompanied the end of financial year mail out to all contributors incorporating a Private Health Insurance Statement and Lifetime Health Cover Statement.

medibank
PRIVATE

Medibank Private Limited
ABN 47 080 890 259
is a registered health
benefits organisation

GPO Box 9999
in your capital city
Telephone 132 331
medibank.com.au

July 2006

Dear Member,

This pack contains necessary and useful information regarding your Medibank Private cover. It is important you read and understand the enclosed items as they may relate to your 2005-2006 tax return.

In this pack...

You'll find your **Private Health Insurance Statement** for the 2005-2006 tax year, which you may need when completing your tax return. This Statement shows the premiums you have paid Medibank Private in the 2005-2006 tax year and your entitlement to the Federal Government Rebate. On the reverse of this page is a helpful guide, providing you with an explanation of how to read your Private Health Insurance Statement.

Members with hospital cover will also find a **Lifetime Health Cover (LHC) Statement** in this pack. Your LHC Statement provides a summary of the benefits of your hospital cover and shows any LHC loading that applies to you or your spouse or partner. Although you do not need this Statement for taxation purposes, you should read it as it gives you an update of the hospital benefits your cover provides and states your current LHC status.

We're here to help

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

If you have any questions about the information contained in this pack, more details are available at medibank.com.au where you can conveniently view and print a copy of your 2005-2006 Private Health Insurance Statement. You can also call us on 132 331 or drop into a Medibank Private Retail Centre if you would like more information or to discuss the different cover options we offer.

Yours faithfully,

George Savvides
Managing Director

Information provided in this letter is correct at the date of issue and is based, in part, on information provided by you. Medibank Private membership, including entitlement to and payment of benefits, is subject to our Fund Rules and policies. Premium rates, and the Fund Rules and policies, change from time to time. Your personal information is handled in accordance with our Privacy Policy. You can view a copy of our Fund Rules and Privacy Policy at any Medibank Private Retail Centre, or online at medibank.com.au

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2006-2007, 1 November 2006

Question: E06-227

OUTCOME 9: Private Health

Topic: MEDIBANK PRIVATE - INQUIRIES

Hansard Page: CA 18

Senator McLucas asked:

Senator McLucas-What were the others?
Mr Savvides-Just inquiries, wanting more information-119. For a classification called 'feedback'-I am not sure what that means-it is 47. For 'process' it is one. For 'outbound' it is two-that is when we are calling out and in the outbound communication they raised the question then. So that totals the 208. I can table that for you, Senator.

Answer:

Medibank Private completes an average of approximately 6000 customer interactions every day. The following table represents recorded contacts regarding privatisation during the period 5 May – 24 October 2006.

Complaint	39
Enquiry	119
Feedback	47
Process	1
Outbound	2
Total	208

The number of complaints regarding privatisation represents 0.01% of all complaints during this period.

The majority of the calls related to privatisation or where privatisation was mentioned in the course of the call were enquiries which require little or no follow up from Medibank Private's customer service representatives.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2006-2007, 1 November 2006

Question: E06-156

OUTCOME 10: Health System Capacity and Quality

Topic: BROADBAND FOR HEALTH PROGRAM

Written Question on Notice & Hansard p.CA106

Senators McLucas & Moore asked:

a) How many practices / GPs have taken up this program?
b) What percentage is that of the eligible number?
c) Where are the GPs who have not taken this program primarily?
d) How many PIP practices have claimed both the Broadband for Health incentive and the IM/IT incentive?

Answer:

a) As at 30 June 2006, 3,884 eligible practices have taken up this program. An eligible practice is a general practice, Aboriginal community controlled health service, GP after hours location, or Royal Flying Doctors Service.

b) This represents 56% of the total number of eligible practices.

c) The distribution of practices that have not taken up the program is as follows:

Region	**Percentage not taken up**	**Percentage take up**
Capital Cities/Major Metropolitan Areas	45%	55%
Rural Area	42%	58%
Remote Areas	12%	88%

d) In June 2006 there were 2,500 identified PIP practices on the Broadband for Health program. However, the program does not capture the PIP practice identification number and thus it is not possible to match those PIP practices that may have also received a PIP IM/IT incentive.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2006-2007, 1 November 2006

Question: E06-157

OUTCOME 10: Health System Capacity and Quality

Topic: BROADBAND FOR HEALTH PROGRAM

Written Question on Notice

Senator McLucas asked:

Which areas of the country cannot utilise this program, either because there is not an approved ISP, or because telecom services are inadequate?

Answer:

The Broadband for Health program covers all of Australia using a variety of technologies including ADSL, Wireless and Satellite. Eligible organisations across Australia have access to at least 2 providers.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2006-2007, 1 November 2006

Question: E06-158

OUTCOME 10: Health System Capacity and Quality

Topic: BROADBAND FOR HEALTH PROGRAM

Written Question on Notice

Senator McLucas asked:

a) Are pharmacists eligible for funding under this program?
b) How much funding is available to pharmacists?
c) What is the uptake rate among pharmacists?

Answer:

a) Yes.

b) $9 million has been made available.

c) As at 30 June 2006, 80% of eligible pharmacies have taken up the program.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2006-2007, 1 November 2006

Question: E06-159

OUTCOME 10: Health System Capacity and Quality

Topic: BROADBAND FOR HEALTH PROGRAM

Written Question on Notice

Senator McLucas asked:

a) How many ISPs are now involved?

b) Which areas of the country cannot utilise this program, either because there is not an approved ISP, or because telecom services are inadequate?

Answer:

a) There are currently 63 service providers involved in the program.

b) The Broadband for Health program covers all of Australia using a variety of technologies including ADSL, Wireless and Satellite. Eligible organisations across Australia have access to at least 2 providers.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2006-2007, 1 November 2006

Question: E06-160

OUTCOME 10: Health System Capacity and Quality

Topic: BROADBAND FOR HEALTH PROGRAM

Written Question on Notice

Senator McLucas asked:

We have heard that many GPs are waiting 4-5 months for the broadband subsidy once they have signed up. We understand that in October there were some 2500 payments still outstanding (of 3600 practices signed up).

a) Can the Department confirm this delay that affected at least 2500 practices?
b) What has been done to address the delay?
c) How many approved payments remain to be made?
d) We understand that one problem is that the grant isn't paid until the ISP gives a statement of supply and the ISP is often reluctant to do this. How is this being addressed?
e) Another complaint is that ISPs push doctors to take a whole package of services which they don't need, but do not supply all the services which might be needed. How is this being addressed?

Answer:

a) Yes.

b) A large number of applications (4,000) were lodged in June 2006. Payment is made by Medicare Australia which assigned additional resources to process the applications. All 2005-06 applications that did not require additional information were completed by 30 October 2006.

c) All approved applications for 2005-06 have been processed and paid.

d) The practice does not have to provide Medicare Australia with the statement of supply to obtain the incentive.

e) Practices are not required to take up any services over and above the installation and 12 months subscription, in order to qualify for the incentive.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2006-2007, 1 November 2006

Question: E06-237

OUTCOME 10: Health System Capacity and Quality

Topic: BROADBAND FOR HEALTH PROGRAM

Hansard p.CA104

Senator Moore asked:

Can we get the details of funds that were provided each year and the actual spending on the Program against estimates in each year

Answer:

FY	Allocated	Expenditure
2004/05	$19.9 million.	$2 m
2005/06	$31.3 million	$28.7 m
2006/07	$10.2 million	$81,000 ytd

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2006-2007, 1 November 2006

Question: E06-238

OUTCOME 10: Health System Capacity and Quality

Topic: BROADBAND FOR HEALTH PROGRAM

Hansard p. CA105-108

Senator Moore asked:

a) ISPs – who does the assessment of program
b) How many signed up for landline and how many for satellite
c) How does this program link in to the IMIT PIP
d) Number of PIP practices who have claimed both up until end of May, percentage of total and numbers
e) Whether accurate that significant delay in getting payments for claims

Answer:

a) The assessment is carried out by the department.

b) Broadband for Health records locations, not the number of professionals at a location, and therefore is unable to provide data on the number of health professionals covered. However, as at 30 June 2006 the following number of locations are connected to a Broadband for Health qualified service:

Practices	3,884	56% of eligible practices. (Terrestrial 98%, Wireless 1.5%, and Satellite 0.5%)
Pharmacies	3,968	80% of eligible pharmacies. (Terrestrial 99%, Satellite 1%)

c) The PIP IM/IT subsidy and the Broadband for Health incentives do not overlap. In November 2006, PIP included a security incentive which was previously provided by the Broadband for Health project up until 30 June 2006.

d) In June 2006 there were 2500 identified PIP practices on the Broadband for Health program. However, the program does not capture the PIP practice identification number and thus it is not possible to match those PIP practices that may have also received a PIP IM/IT incentive.

e) Yes. A large number of applications (4,000) were lodged in June 2006. Payment is made by Medicare Australia which assigned additional resources to process the applications. All 2005-06 applications that did not require additional information were completed by 30 October 2006

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2006-2007, 1 November 2006

Question: E06-239

OUTCOME 10: Health System Capacity and Quality

Topic: HEALTHCONNECT – MARKETING STRATEGY

Written Question on Notice

Senator Moore asked:

Can we get some information on your marketing strategy and what processes are intended to be used.

Answer:

To market the Broadband for Health program the department has:

- engaged key stakeholders such as the Australian Divisions of General Practice and the Pharmacy Guild to utilise their networks to ensure maximum penetration of target health groups;
- established a Broadband for Health working group whose membership ensures the majority of interest groups are represented;
- developed a wide range of written material which has been disseminated to all eligible health organisations; and
- utilised a range of mediums including email and website updates to promote success stories such as the Easter Goldfields Regional Reference Site.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2006-2007, 1 November 2006

Question: E06-155

OUTCOME 10: Health System Capacity and Quality

Topic: BROADBAND FOR HEALTH PROGRAM

Written Question on Notice

Senator McLucas asked:

a) Please detail the funds provided to Broadband for Health and its component programs (such as Managed Health Networks) since the program's inception.
b) Please provide details of actual spending on the program against estimates for each financial year and YTD.
c) Can you tell us how the $10 million allocated in December 2005 to Managed Health Networks is being spent?

Answer:

a)

2004-05	$19.9 million.	Broadband for Health program
2005-06	$31.3 million.	$14.3 million Broadband For Health $17 million Managed Health Network (allocated over two years)
2006-07	$10.2 million.	Broadband for Health program

b)

FY	Allocated	Expenditure
2004-05	$19.9 m	$2 m
2005-06	$31.3 m	$28.7 m
2006-07	$10.2 m	$81,000 ytd

c) The funds are being spent to support improved communication and information sharing between health care providers. This includes the development of infrastructure and software applications to assist health care professionals use secure electronic messaging, online claiming and the electronic delivery of referrals and results.

The Department has recently offered funding agreements to those applicants that were successful through the Managed Health Networks Grants funding application process. Agreements are yet to be executed, however it is anticipated that through this process the 2006-07 funding allocation will be fully committed.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2006-2007, 1 November 2006

Question: E06-161

OUTCOME 10: Health System Capacity and Quality

Topic: HEALTHCONNECT

Written Question on Notice

Senator McLucas asked:

Please provide the following information for 2006-07 YTD:

a) How much HealthConnect funds have been distributed?
b) Which projects did they go to?
c) How does the actual expenditure balance against expected expenditure?
d) What new funding agreements have been delivered?
e) What new projects have been agreed?

Answer:

a) No funds have been distributed for 2006-07 at this stage.

b) The Department is working with States and Territories to finalise funding arrangements for Health*Connect* activities for 2006-07.

c) To date there has been no expenditure for 2006-07. At this stage the Department envisages that the total appropriation will be fully expended for Health*Connect* activities in 2006-07.

d) Agreements are in final stages of discussion and are expected to be executed shortly.

e) Negotiations are continuing with a number of jurisdictions for funding under the Health*Connect* Program in 2006-07 and agreements are expected to be entered into soon.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2006-2007, 1 November 2006

Question: E06-240

OUTCOME 10: Health System Capacity and Quality

Topic: HEALTHCONNECT

Hansard Page: CA 109

Senator Moore asked:

Please provide the following information for 2006-07 YTD:

a) How much HealthConnect funds have been distributed?
b) Which projects did they go to?
c) How does the actual expenditure balance against expected expenditure?
d) What new funding agreements have been delivered?
e) What new projects have been agreed?

Answer:

Please refer to response to Senate Estimates Question E06-161.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2006-2007, 1 November 2006

Question: E06-102

OUTCOME 11: Mental Health

Topic: PROGRAMS TO SUPPORT THE PROVISION OF RURAL PSYCHIATRIC SERVICES

Written Question on Notice

Senator Nash asked:

What programs are in place to specifically support the provision of rural psychiatric services?

Answer:

The Medical Specialist Outreach Assistance Program provides medical specialist services, including psychiatric services, into rural and remote Australia.

The Department is working with the Royal Australian and New Zealand College of Psychiatrists to increase uptake of the Medical Benefits Schedule telepsychiatry items.

The *Mental Health Services in Rural and Remote Areas* initiative, complements the new series of Medicare Benefits Schedule funded services to provide better access to mental health care, and builds on the Access to Allied Psychological Services (ATAPS) component of the Better Outcomes in Mental Health Care program and the More Allied Health Services (MAHS) program.

The *Mental Health Services in Rural and Remote Areas* measure supports the services of allied mental health workers in rural and remote areas and may therefore take some of the pressure off psychiatrists.

The issue is also being addressed through the Australian Government's $191.6 million *New Funding for Mental Health Nurses* initiative. This initiative will fund private psychiatry services, general practices and other appropriate organisations to engage mental health nurses to assist in the provision of coordinated clinical care for patients with severe mental disorders. Under this initiative, services located within rural and remote areas will be entitled to a loading of up to 25%.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2006-2007, 1 November 2006

Question: E06-163

OUTCOME 11: Mental Health

Topic: ACCESS TO PSYCHOLOGISTS AND PSYCHIATRISTS

Written Question on Notice

Senator McLucas asked:

Please provide a breakdown of how the $538 million will be spent over 5 years on GP mental health services, psychiatric services, individual psychology services, group psychology services and other allied mental health services.

Answer:

The $538 million allocated to the Better Access to Mental Health Care initiative over the five year period to 2010-11 consists of four main funding elements.

The largest of these elements, at $410.7 million, covers the costs associated with the new Medicare Benefits Schedule (MBS) items for general practitioners, psychiatrists, clinical psychologists and other allied mental health professionals.

As a proportion of these new MBS items will result in prescriptions for patients who are newly diagnosed with a mental disorder as a result of the Better Access initiative, $31.8 million has been allocated for the impact of these new items on the Pharmaceutical Benefits Scheme.

In addition, $84.7 million has been allocated to support GPs and other allied mental health professionals participation in mental health education and training.

Funding of $10.8 million has also been allocated to enable the Department of Health and Ageing and Medicare Australia to manage and administer the initiative.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2006-2007, 1 November 2006

Question: E06-181

OUTCOME 11: Mental Health

Topic: BETTER OUTCOMES IN MENTAL HEALTH CARE (BOiMHC)

Hansard Page: CA 73

Senator Webber asked:

Can we have the forward estimates of budget allocations for Better Outcomes for Mental Health?

Answer:

The commitment under the Better Outcomes Program to the Access to Allied Psychological Services (ATAPS) initiative and the GP Psych Support service is continuing to June 2009.

All figures GST exc and rounded	**CURRENT**	**FORWARD ESTIMATES**		**TOTAL**
COMPONENT	**2006-07**	**2007-08**	**2008-09**	**2006-09**
BOiMHC Support components (Outcome 11) Access to Allied Psychological Services (ATAPS) Education and Training (to Nov 1 2006*) GP Psych Support Service *Sub total*	***27.2m***	***27.8m****	***28.4m****	***83.4m****
Related MBS/SIP components (Outcome 2)	2.0m	1.6m	2.4m	6.0m
DVA	0.2m	0.2m	0.2m	0.6m
Departmental	1.9m	2.0m	2.0m	5.9m
Sub total	**4.1m**	**3.8m**	**4.6m**	**12.5m**
TOTAL BOIMHC Program	**31.3m**	**31.6m**	**33.0m**	**95.9m**

* These figures may differ marginally from previous submissions as they include indexation.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2006-2007, 1 November 2006

Question: E06-105

OUTCOME 12: Health Workforce Capacity

Topic: RURAL HEALTH ISSUES

Written Question on Notice

Senator Nash asked:

How much funding does the Commonwealth provide to assist with the orientation and support of overseas trained doctors being placed in rural areas?

Answer:

The Department provides $5,943,474 (2004 - 2007) to Rural Workforce Agencies to provide additional assistance to Overseas Trained Doctors (OTDs) on the 5 Year OTD Program and all trained doctors on the Rural Locum Relief Program (RLRP).

Funding is -	5 year OTD	$2,552,274
	RLRP	$3,391,200
	TOTAL	$ 5,943,474 over 2004/05 – 2006/07.

The Department also provides $1,053,975 (2005 - 2007) to develop and implement online education programs.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2006-2007, 1 November 2006

Question: E06-185

OUTCOME 12: Health Workforce Capacity

Topic: DISTRICTS OF WORKFORCE SHORTAGE

Hansard Page: CA 97

Senator Moore asked:

Mr Dennis, either you or Mr Kalisch, is there a possibility of seeing the overlay of what is an area of workforce shortage, and what is an area of need? In Queensland for instance, I do not know what areas of need have been determined by the State Government. I take it from the previous answer the State Government has what it calls area of need. I would like to be aware of what the differences are.

Answer:

It is not currently possible to overlay Area of Need with District (area) of Workforce Shortage. The Department of Health and Ageing does not have a list of the locations which have been designated an Area of Need across Australia as these designations are made by the States respectively. Neither Area of Need, nor District of Workforce Shortage designations are static determinations. They are both subject to changes in the movement of doctors into and out of an area, combined with changes in population numbers. District of Workforce Shortage and Area of Need, being the responsibility of different levels of Government generally operate independently of each other.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2006-2007, 1 November 2006

Question: E06-186

OUTCOME 12: Health Workforce Capacity

Topic: MEDICARE BILLING DATA

Hansard Page: CA 98

Senator Moore asked:

It would just be useful to look at the cycle. You would have to plan your work around that as well, I would imagine. Can you take that on notice, that standard kind of information?

Answer:

The cycle is based on the Medicare billing statistics which are updated on a quarterly basis. The quarterly periods covered by the data and their date of provision to the Department for determination of Districts of Workforce Shortage status application are:

Quarterly Period	**Date of provision to the Department**
January to March (quarter 1)	late May
April to June (quarter 2)	late August
July to September (quarter 3)	late November
October to December (quarter 4)	late February

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2006-2007, 1 November 2006

Question: E06-099

OUTCOME 12: Health Workforce Capacity

Topic: RURAL HEALTH ISSUES

Written Question on Notice

Senator Nash asked:

How many of the available places in the Pre-vocational General Practice Placements Program (PGPPP) have been filled?

Answer:

In 2005-06, 111 placements occurred with up to 240 placements expected to be undertaken in 2006-07.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2006-2007, 1 November 2006

Question: E06-100

OUTCOME 12: Health Workforce Capacity

Topic: RURAL HEALTH ISSUES

Written Question on Notice

Senator Nash asked:

Is NSW Health releasing doctors for the PGPPP program?

Answer:

NSW Health advised the Department that no Prevocational General Practice Placement Program (PGPPP) placements are to be established, in private general practices, involving New South Wales trainees until they consider the recommendations from the report by the Medical Specialist Training Steering Committee into medical specialist training in the private sector.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2006-2007, 1 November 2006

Question: E06-101

OUTCOME 12: Health Workforce Capacity

Topic: RURAL HEALTH ISSUES

Written Question on Notice

Senator Nash asked:

If the PGPPP is not fully subscribed, why is this the case and what action is being taken to fix the problem?

Answer:

The number of placements which have been approved to date equates to over 300 per year. However, current uptake of the placements is lower as a result of NSW refusing to accept the Program arrangements. Despite the Commonwealth Government's efforts to resolve this issue, NSW Health wants to add further conditions and limitations before allowing the state's junior doctors to participate in the Prevocational General Practice Placement Program (the Program).

The lack of junior doctors able to participate in the Program due to workforce pressures has also affected the uptake of the placements. However, it is envisaged that recent relaxation of rules surrounding Overseas Trained Doctors and Former Overseas Medical Students will enable more doctors to be considered for placements and thereby increase the number of placements undertaken.

It is also envisaged that the increase in funds available to general practices participating in the Program and the increase to the amount of Medicare billing that junior doctors are able to access will result in a substantial increase to placement numbers.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2006-2007, 1 November 2006

Question: E06-103

OUTCOME 12: Health Workforce Capacity

Topic: RURAL HEALTH ISSUES

Written Question on Notice

Senator Nash asked:

Over the last 5 years, what percentage of entrants to the rural GP training pathway have been Australian trained?

Answer:

Between 2003-2006, an average of 46.7% of entrants on the Rural Pathway of the Australian General Practice Training Program (AGPTP) were Australian Medical Graduates.
(No breakdown of the type of entrants on the AGPTP is available for 2002).

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2006-2007, 1 November 2006

Question: E06-151

OUTCOME 12: Health Workforce Capacity

Topic: RURAL PROCEDURAL GPS

Written Question on Notice

Senator McLucas asked:

How many procedural GPs are there in Australia?

Answer:

According to the *Rural Workforce Agencies Minimum Data Set* Report as at 30 November 2004, the known number of procedural GPs nationally was 933. No further data is available.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2006-2007, 1 November 2006

Question: E06-154

OUTCOME 12: Health Workforce Capacity

Topic: RURAL PROCEDURAL GPS

Written Question on Notice

Senator McLucas asked:

Can we assume that the Minister's announcement of 22 December 2005 of $10 million for emergency medicine training and the Minister's announcement of 9 January 2006 of $5.2 million a year for the doubling of the PIP were funded from the $75 million initially allocated to this program but as yet unspent?

Answer:

The Strengthening Medicare package provided funding of $10 million over four years to the Practice Incentives Program (PIP) component, which aims to encourage GPs in rural and remote areas to provide procedural services. The $5.2 million extra funding for the increased PIP payments will not be drawn from the $10 million allocation but will be drawn from the PIP base.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2006-2007, 1 November 2006

Question: E06-106

OUTCOME 12: Health Workforce Capacity

Topic: RURAL HEALTH ISSUES

Written Question on Notice

Senator Nash asked:

Has the Commonwealth examined whether or not payments under the retention program should be extended to specialists?

Answer:

The Commonwealth has previously considered whether specialists should be included in the Rural Retention Program. When the Program was implemented the decision was made to exclude specialists as the Program's focus is on Primary Care.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2006-2007, 1 November 2006

Question: E06-149

OUTCOME 12: Health Workforce Capacity

Topic: RURAL PROCEDURAL GPS

Written Question on Notice

Senator McLucas asked:

For 2004-05, 2005-06 and 2006-07 YTD, please provide the following:

a. The funding available for the Rural Procedural GPs Program
b. The funding spent on the Rural Procedural GPs Program
c. The number of procedural GPs who took part in the program and the average amount each received.
d. How many procedural GPs Took courses in:
    i. Obstetrics
    ii. Anaesthesiology
    iii. Surgery
    iv. Emergency medicine
e. Of the GPs who received funding in 2004-05, how many received further funding in 2005-06?

Answer:

The Rural Procedural GPs fund two programs, the Practice Incentives Program (PIP) Procedural Payment and Training for Rural and Remote Procedural GPs Program. A response for each Program is provided separately in the tables below.

PIP Procedural Payment

	2004-05	**2005-06**	**2006-07**
a. Funding allocated	$3.0 million	$3.0 million	$3.0 million
b. Expenditure	$3.3 million	$4.9 million	$1.6 million as at August 2006
c. Number of GPs participating in August each year.	749	754	747
c. Average payment per GP	See table below		
d. This question refers to the Training for Rural and Remote Procedural GPs program not the PIP procedural payment.			
e. Information is not available.			

c. Average payment per GP

	2004-05 (based on August data)	**2005-06** (based on August data)	**2006-07** (based on August data)
Tier 1	Around 7% of GPs accessed Tier 1 payments of $1,000	Around 6% of GPs accessed Tier 1 payments of $1,000	Around 6% of GPs accessed Tier 1 payments of $2,000
Tier 2	Around 13% of GPs accessed Tier 2 payments of $2,000	Around 13% of GPs accessed Tier 2 payments of $2,000	Around 14% of GPs accessed Tier 2 payments of $4,000
Tier 3	Around 80% of GPs accessed Tier 3 payments of $5,000	Around 80% of GPs accessed Tier 3 payments of $5,000	Around 80% of GPs accessed Tier 3 payments of $10,000

*May not total 100% due to rounding

Training for Rural and Remote Procedural GPs Payments

	2004-05	**2005-06**	**2006-07**
a. Funding allocated	$22.5 million	$22.5 million	$22.5 million
b. Expenditure	$4 million	$5.7 million	$5 million as at November 2006
c. Number of GPs participating	477	766	814
c. Average payment per GP	$7,800.00	$7,100.00	$6,100.00
d. Information is not available.			
e. GPs receiving continued funding	477	325	

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2006-2007, 1 November 2006

Question: E06-150

OUTCOME 12: Health Workforce Capacity

Topic: RURAL PROCEDURAL GPS

Written Question on Notice

Senator McLucas asked:

When this program was set up, how many rural procedural GPs were expected to participate?

Answer:

It was anticipated that around 1,000 procedural GPs would participate in the Rural Procedural GP Program.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2006-2007, 1 November 2006

Question: E06-153

OUTCOME: 12 Health Workforce Capacity

Topic: RURAL PROCEDURAL GPS

Written Question on Notice

Senator McLucas asked:

How many procedural GPs (total) have accessed the program?

Answer:

The total number of unique GPs who have accessed PIP procedural payments in a financial year is not available. However, in August 2006, 340 practices accessed payments which related to around 747 GPs.

To 30 September 2006, 1389 GPs have registered for the Training for Rural and Remote Procedural GPs Program. This number includes 423 who have registered for the Emergency Medicine component of the Program. To date, 814 GPs have received payment under the program.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2006-2007, 1 November 2006

Question: E06-104

OUTCOME 12: Health Workforce Capacity

Topic: HIGHER EDUCATION CONTRIBUTION SCHEME (HECS) REIMBURSEMENT PROGRAM

Written Question on Notice

Senator Nash asked:

What proportion of available funding under the HECS reimbursement program has been spent in each of the years since the program was introduced.

Answer:

HECS Reimbursement Scheme allocation and expenditure ($ million)

	2002-03	**2003-04**	**2004-05**	**2005-06**	**TOTAL**
Allocation ($m)	1.2	3.4	3.1	5.2	12.9
Expenditure ($m)	0.4	1.6	1.7	2.1	5.8
Proportion of Expenditure	33.33%	47.06%	54.84%	40.38%	44.96%

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2006-07, 1 November 2006

Question: E06-166

OUTCOME 12: Health Workforce Capacity

Topic: MORE DOCTORS FOR OUTER METROPOLITAN AREAS MEASURE

Written Question on Notice

Senator McLucas asked:

a) How many GPs/ FTE GPs / specialists / FTE specialists / practices have relocated under this scheme?
b) What was originally budgeted per FY for this scheme?
c) What was the actual expenditure per FY?
d) What have been the changes and extensions to this scheme?
e) Of the $80.797 million underspent in 2004-05, how much of this was due to underspends in the More Doctors in OM Areas?

Answer:

a) Number of GPs/FTE GPs, specialists/FTE specialists and practices that have relocated under the scheme

The breakdown of figures is provided in the table below.

	2002-03	**2003-04**	**2004-05**	**2005-06**	**2006-07**	**Total**
Number of GPs	64	105	54	15	21*	**259**
Number of Specialists	0	8	5	3	0	**16**
Total GPS and Specialists	64	113	59	18	21*	**275**

*Figure correct as 7 November 2006

FTE figures are unavailable. The Relocation Incentive Grant is available to doctors to relocate their location of practice. It is not available to practices.

b) Original budget per financial year for the scheme

The More Doctors for Outer Metropolitan Areas Measure was provided funding of $80 million over fours years from 2002 to 2006. The totals of the administered funding, as appropriated at that time, are provided below:

	2002-03	**2003-04**	**2004-05**	**2005-06**	**Total**
Total Administered (Financial Year)	$9.9m	$15.7m	$22.8m	$22.8m	**$71.2m**

This was subsequently reduced through Budget processes in later years in response to underspends in the Outer Metropolitan Specialist Trainees Program component of the measure to provide funding for Practice Nurses and Rural Proceduralists. The breakdown of the final budget is provided below:

	2002-03	2003-04	2004-05	2005-06	Total
Total adjusted Administered (Financial Year)	$9.9m	$7.03m	$12.4m	$13.87m	**$43.2m**

Under the 2006-07 Budget, the measure was provided a further $64.5million to attract up to a further 265 general practitioners and specialists and up to 50 specialist training placements to meet ongoing needs in outer metropolitan areas. The breakdown of the funding is as follows:

	2006-07	2007-08	2008-09	2009-10	Total
Administered*	$12.76m	$13.14m	$14.02m	$15.49m	**$55.41**
Total Financial Year	$15m	$15.4m	$16.3m	$17.8m	**$64.5m**

* Of the administered funds per financial year, $6.8 million, $7.39 million, $7.56 million and $8.25 million have been allocated to the Relocation Incentive Grant and Specialist Training Program components of the measure for financial years 2006-07, 2007-08, 2008-09 and 2009-10, respectively.

c) Actual expenditure per financial year for the scheme

The table below provides actual expenditure by financial year for Outcomes 4 and 9:

	2002-03	2003-04	2004-05	2005-06	Total
Total Outcomes 4 and 9	$436,205	$2.01m	$3.16m	$3.85m	**$9.46m**

The More Doctors for Outer Metropolitan Areas Measure comprises four programs, namely the:

- Outer Metropolitan Relocation Incentive Grant Program;
- Outer Metropolitan Other Medical Practitioners Program;
- Outer Metropolitan Registrars Program; and
- Outer Metropolitan Specialist Trainees Program.

Funding for the Outer Metropolitan Registrars Program is provided through Outcome 4, while the other three components are in part funded through Outcome 9. A large proportion of the program budget is for Medicare monies through Outcome 2 associated with the Medicare billing of doctors under the Outer Metropolitan Specialist Trainees Program. The actual expenditure amount for these Medicare billings is not readily identifiable.

d) Changes and extensions to the scheme

A number of changes were put in place with the announcement in the 2006 Budget of the extension of the Measure for a further four years.

- From 1 July 2006, the maximum size of the Relocation Incentive Grant was increased to up to $30,000 for doctors relocating to established practices, and to up to $40,000 for doctors establishing new practices in outer metropolitan areas.

- The entire outer metropolitan zone of all State capital cities is now eligible for the grant for the next four years.

- The eligibility criteria applicable to GP Registrars completing the General Pathway of the Australian General Practice Training Program have been modified so that it is now easier for this target group to qualify for the grant, regardless of the location of their final training placement.

- Part of the $64.5 million also covers funding of up to 250 General Practice registrar placements each year under the Outer Metropolitan Registrars Program, and establishment of up to 50 specialist training positions in private settings through which specialist trainees could rotate under the Outer Metropolitan Specialist Trainees Program.

e) Underspend in 2004-05

While there was an underspend in 2004-05 in the above named Program, the origin of the figure of $80.797 million is uncertain. It is therefore not prudent to calculate the underspend as a proportion of this figure.

The underspend in 2004-05 was due to low Medicare billing under Outcome 2 under the Outer Metropolitan Specialist Trainees Program. It is not possible to identify separately all the Medicare billing which accrued under the Specialist Trainees Program. Nevertheless, of the $9.2 million allocated in 2004-05 for Outcome 2, it is believed that less than $1 million was actually billed by doctors on the Specialist Trainees Program.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2006-2007, 1 November 2006

Question: E06-187

OUTCOME 12: Health Workforce Capacity

Topic: MORE DOCTORS FOR OUTER METROPOLITAN AREAS MEASURE

Written Question on Notice

Senator Moore asked:

Because we have talked here a few times about how the scheme was operating, we want to know how many GPs, full-time equivalent GPs, specialists, full-time equivalent specialists or practices have relocated under the scheme. And that is that particular scheme: More Doctors for Outer Metropolitan Areas.

Answer:

The Relocation Incentive Grant is only available to individual doctors, not practices.

The Number of GPs and specialists that have relocated under the scheme is provided in the table below.

	2002-03	**2003-04**	**2004-05**	**2005-06**	**2006-07**	**Total**
Number of GPs	64	105	54	15	21*	**259**
Number of Specialists	0	8	5	3	0	**16**
Total GPS and Specialists	64	113	59	18	21*	**275**

*Figure correct as 7 November 2006

FTE figures are unavailable.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2006-2007, 1 November 2006

Question: E06-184

OUTCOME 12: Health Workforce Capacity

Topic: DISTRICTS OF WORKFORCE SHORTAGE

Hansard Page: CA 97

Senator Moore asked:

How many – and this has been highlighted – special cases have been considered for provision of a Medicare provider number to a GP in an area not officially recognised as an area of workforce shortage, and how many provider numbers have been issued?

Answer:

Since July 2004, in total, less than 100 exemptions overall have been granted to doctors to work in locations which were not at the time considered to be districts of workforce shortage.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2006-2007, 1 November 2006

Question: E06-164

OUTCOME 12: Health Workforce Capacity

Topic: MEDICARE PROVIDER NUMBERS

Written Question on Notice

Senator McLucas asked:

a) Since July 2004 how many Medicare provider numbers have been issued to GPs in designated areas of workforce shortage? How many doctors does this involve?

b) How many of these GPs were overseas trained doctors who would not be eligible to work outside districts of workforce shortage?

c) Please provide this breakdown by State and RRMA.

d) How many 'special cases' have been considered for provision of a Medicare provider number to a GP in an area not officially recognised as a district of workforce shortage, and how many provider numbers have been issued.

e) Are there any plans to reconsider the currently designated districts of workforce shortage?

f) Have there been any changes to the districts of workforce shortage in the last 5 years. Please identify these.

g) Why is the ACT not recognised as a district of workforce shortage?

Answer

a) Australian trained and overseas trained doctors (GPs) can practice in districts of workforce shortage. Information on overseas trained doctors in districts of workforce shortage is readily available. However, information on Australian trained GPs in districts of workforce shortages is not readily available but can be determined. This later information will be requested by the Department and provided once available.

   Since 1 July 2004, a total of 4,828 exemptions have been granted to 2,737 overseas trained general practitioners across Australia.

b) As at November 2006, 2,737 overseas trained general practitioners would not otherwise be eligible to work outside districts of workforce shortage.

c) A break down of the numbers of exemptions granted by State/Territory and Rural, Remote and Metropolitan Areas (RRMA) is at Attachment A. It should be noted that the '0' exemptions granted for RRMA areas is due to a State/Territory not having a particular RRMA region.

d) Since July 2004, in total, less than 100 exemptions overall have been granted to doctors to work in locations which were not at the time considered to be districts of workforce shortage.

e) District of workforce shortage status is not a static determination. It is based on a national average calculated from the ratio of population to full-time equivalent general practitioners. This information is updated quarterly and is based upon Medicare billing data and the latest Australian Bureau of Statistics population data at the Statistical Local Area (SLA) level. The next scheduled update of this data is due in January 2007.

f) In the past five years many locations have changed status. As the data underpinning district of workforce shortage status is updated quarterly, information is not readily available to identify the SLAs which have changed status.

g) Canberra is a metropolitan area with a RRMA 1 category. Many of the suburbs within Canberra Outer Metropolitan regions of Belconnen and Tuggeranong and Weston are considered to be districts of workforce shortage.

Total number of doctors (GP's) granted exemptions in each RRMA since 1 July 2004

Approved

STATE	RRMA 1*	RRMA 2	RRMA 3	RRMA 4	RRMA 5	RRMA 6	RRMA 7	Total
ACT	11	0	0	0	0	0	0	11
NSW	70	53	22	48	79	0	24	296
QLD	215	177	168	123	257	87	171	1198
VIC	177	16	16	47	107	0	7	370
SA	72	0	24	61	69	0	27	253
NT	20	0	0	0	5	21	31	77
WA	123	0	0	54	94	91	96	458
TAS	12	0	3	13	39	0	7	74
Total	700	246	233	346	650	199	363	2737

Rejected

STATE	RRMA 1*	RRMA 2	RRMA 3	RRMA 4	RRMA 5	RRMA 6	RRMA 7	Total
ACT	0	0	0	0	0	0	0	0
NSW	30	5	2	2	3	0	0	42
QLD	25	26	22	11	2	2	2	90
VIC	41	1	1	3	5	0	0	51
SA	10	0	1	4	2	0	0	17
NT	0	0	0	0	0	1	0	1
WA	29	0	0	5	0	0	0	34
TAS	2	0	0	0	3	0	0	5
Total	137	32	26	25	15	3	2	240

Total number of exemptions (GP's) in each RRMA since 1 July 2004

Approved

STATE	RRMA 1*	RRMA 2	RRMA 3	RRMA 4	RRMA 5	RRMA 6	RRMA 7	Total
ACT	18	0	0	0	0	0	0	18
NSW	144	69	30	64	125	0	34	466
QLD	457	261	357	172	431	169	302	2149
VIC	313	35	29	67	164	0	10	618
SA	117	0	30	97	127	0	43	414
NT	34	0	0	0	5	34	40	113
WA	282	0	0	88	180	195	187	932
TAS	16	0	4	19	70	0	9	118
Total	1381	365	450	507	1102	398	625	4828

Rejected

STATE	RRMA 1*	RRMA 2	RRMA 3	RRMA 4	RRMA 5	RRMA 6	RRMA 7	Total
ACT	3	0	0	0	0	0	0	3
NSW	33	5	2	2	4	0	0	46
QLD	32	28	26	12	32	2	3	135
VIC	52	1	1	3	5	0	0	62
SA	13	0	1	4	2	0	0	20
NT	0	0	0	0	0	1	0	1
WA	33	0	0	5	0	0	1	39
TAS	5	0	0	0	3	0	0	8
Total	171	34	30	26	46	3	4	314

** Outer Metropolitan*

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2006-2007, 1 November 2006

Question: E06-182

OUTCOME 12: Health Workforce Capacity

Topic: MEDICARE PROVIDER NUMBERS

Hansard Page: CA 97

Senator Moore asked:

So the areas that you would use in the way you would designate doctors would be areas of workforce shortage. Since July 2004, how many Medicare provider numbers have been issued to GPs in designated areas of workforce shortage?

Answer:

Australian trained and overseas trained doctors (GPs) can practice in districts of workforce shortage. Information on overseas trained doctors in districts of workforce shortage is readily available. However, information on Australian trained GPs in districts of workforce shortages is not readily available but can be determined. This later information will be requested and provided.

Since 1 July 2004, a total of 4,828 exemptions have been granted to 2,737 overseas trained general practitioners across Australia.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2006-2007, 1 November 2006

Question: E06-165

OUTCOME 12: Health Workforce Capacity

Topic: OTD SUPPORT SCHEMES

Written Question on Notice

Senator McLucas asked:

a) How many Overseas Trained Doctors have been awarded scholarships under this provision?
b) How many of these doctors have sat the AMC clinical exams (part 1 and 2)?
c) How many of these doctors have passed the AMC clinical exams?
d) How long are doctors with scholarships given to sit the exams?
e) What happens if they don't sit the exams?
f) How much was budgeted for this program?
g) How much has been spent to date?
h) Will this program be continued?

Answer:

a) – c) and e) – h)
Questions answered at the Supplementary Budget Estimates Hearing, 1 November 2006 (Hansard transcript CA 97-100).

d) There is no specified time requirement for doctors to sit exams. It is anticipated that timeframes would be consistent with doctors' individual learning plans which are integral to the scholarship process.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2006-2007, 1 November 2006

Question: E06-183

OUTCOME 12: Health Workforce Capacity

Topic: GP PROVIDER NUMBERS

Hansard Page: CA 97

Senator Moore asked:

How many of these GPs were overseas trained doctors who would not be eligible to work outside such designated areas? Could we have – and I believe we have had this in the past – this data broken down by state and RRMA?

Answer:

As at November 2006, 2,737 overseas trained general practitioners would not otherwise be eligible to work outside districts of workforce shortage. A break down of the numbers of exemptions granted by State/Territory and Rural, Remote and Metropolitan Areas (RRMA) is at Attachment A. It should be noted that the '0' exemptions granted for RRMA areas is due to a State/Territory not having a particular RRMA region.

Q183 Attachment A

Total number of doctors (GP's) granted exemptions in each RRMA since 1 July 2004

Approved

STATE	RRMA 1*	RRMA 2	RRMA 3	RRMA 4	RRMA 5	RRMA 6	RRMA 7	Total
ACT	11	0	0	0	0	0	0	11
NSW	70	53	22	48	79	0	24	296
QLD	215	177	168	123	257	87	171	1198
VIC	177	16	16	47	107	0	7	370
SA	72	0	24	61	69	0	27	253
NT	20	0	0	0	5	21	31	77
WA	123	0	0	54	94	91	96	458
TAS	12	0	3	13	39	0	7	74
Total	700	246	233	346	650	199	363	2737

Rejected

STATE	RRMA 1*	RRMA 2	RRMA 3	RRMA 4	RRMA 5	RRMA 6	RRMA 7	Total
ACT	0	0	0	0	0	0	0	0
NSW	30	5	2	2	3	0	0	42
QLD	25	26	22	11	2	2	2	90
VIC	41	1	1	3	5	0	0	51
SA	10	0	1	4	2	0	0	17
NT	0	0	0	0	0	1	0	1
WA	29	0	0	5	0	0	0	34
TAS	2	0	0	0	3	0	0	5
Total	137	32	26	25	15	3	2	240

Total number of exemptions (GP's) in each RRMA since 1 July 2004

Approved

STATE	RRMA 1*	RRMA 2	RRMA 3	RRMA 4	RRMA 5	RRMA 6	RRMA 7	Total
ACT	18	0	0	0	0	0	0	18
NSW	144	69	30	64	125	0	34	466
QLD	457	261	357	172	431	169	302	2149
VIC	313	35	29	67	164	0	10	618
SA	117	0	30	97	127	0	43	414
NT	34	0	0	0	5	34	40	113
WA	282	0	0	88	180	195	187	932
TAS	16	0	4	19	70	0	9	118
Total	1381	365	450	507	1102	398	625	4828

Rejected

STATE	RRMA 1*	RRMA 2	RRMA 3	RRMA 4	RRMA 5	RRMA 6	RRMA 7	Total
ACT	3	0	0	0	0	0	0	3
NSW	33	5	2	2	4	0	0	46
QLD	32	28	26	12	32	2	3	135
VIC	52	1	1	3	5	0	0	62
SA	13	0	1	4	2	0	0	20
NT	0	0	0	0	0	1	0	1
WA	33	0	0	5	0	0	1	39
TAS	5	0	0	0	3	0	0	8
Total	171	34	30	26	46	3	4	314

* ***Outer Metropolitan***

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2006-2007, 1 November 2006

Question: E06-108

OUTCOME 12: Health Workforce Capacity

Topic: RURAL HEALTH ISSUES

Written Question on Notice

Senator Nash asked:

What support measures are provided to bonded medical school students and how do they compare to Medical Rural Bonded Scholarship Scheme?

Answer:

Support measures for students on the Medical Rural Bonded Scholarship Scheme are provided through the Australian College of Rural and Remote Medicine using a program of support, communication and networking mechanisms. The support is delivered through meetings, forums and conferences, a web site and an on-line education facility.

Students on the Bonded Medical Places Scheme are able to access support through the multi-disciplinary Rural Health Clubs. These clubs promote rural and remote practice to their members through information exchange, placement opportunities, support and advocacy.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2006-2007, 1 November 2006

Question: E06-189

OUTCOME 12: Health Workforce Capacity

Topic: More Doctors for Outer Metropolitan Areas Measure

Written Question on Notice

Senator Claire Moore asked:

Can you tell us how much of the $80.797 million underspend in 2004-05 was due to underspending in this particular program, the More Doctors for Outer Metropolitan Areas program? What was the underspend in this particular program, the More Doctors for Outer Metropolitan Areas program? Over the period there have been years when there has been underspending, which has stimulated more work in the program. Can you take on notice, when you are giving us that other data, what a historical snapshot of the underspends would be?

Answer:

Underspend in 2004-05

While there was an underspend in 2004-05 in the above named Program, the origin of the figure of $80.797 million is uncertain in relation to the More Doctors for Outer Metropolitan Areas measure. It is therefore not prudent to calculate the underspend as a proportion of this figure.

The underspend in 2004-05 was due to low Medicare billing under Outcome 2 under the Outer Metropolitan Specialist Trainees Program. It is not possible to identify separately all the Medicare billing which accrued under the Specialist Trainees Program. Nevertheless, of the $9.2 million allocated in 2004-05 for Outcome 2, it is believed that less than $1 million was actually billed by doctors on the Specialist Trainees Program.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2006-2007, 1 November 2006

Question: E06-188

OUTCOME 12: Health Workforce Capacity

Topic: More Doctors for Outer Metropolitan Areas Measure

Written Question on Notice

Senator Claire Moore asked:

If you could get that for us in terms of an historical snapshot of what was budgeted, how much was spent each year, the success rate in terms of what I asked for—that is, how many doctors or practices moved.

Historical snapshot of what was budgeted

The More Doctors for Outer Metropolitan Areas Measure was provided funding of $80 million to attract 150 doctors to outer metropolitan areas over four years from 2002 to 2006. The program was successful as it achieved this target within two years. By 30 June 2006, 275 doctors had agreed to relocate to outer metropolitan practices. Of this number, 259 doctors were confirmed to have relocated to practices in outer metropolitan areas. Additionally, as at 30 December 2005, 463 general practice registrars have undertaken six month placements in outer metropolitan areas as part of the Outer Metropolitan Registrars Program.

The totals of the administered funding, as appropriated at that time, are provided below:

	2002-03	**2003-04**	**2004-05**	**2005-06**	**Total**
Total Administered (Financial Year)	$9.9m	$15.7m	$22.8m	$22.8m	**$71.2m**

This was subsequently reduced through Budget processes in later years in response to underspends in the Outer Metropolitan Specialist Trainees Program component of the measure to provide funding for Practice Nurses and Rural Proceduralists. The breakdown of the final budget is provided below:

	2002-03	**2003-04**	**2004-05**	**2005-06**	**Total**
Total adjusted Administered (Financial Year)	$9.9m	$7.03m	$12.4m	$13.87m	**$43.2m**

Under the 2006-07 Budget, the measure was provided a further $64.5 million to attract up to a further 265 general practitioners and specialists and up to 50 specialist training placements to meet ongoing needs in outer metropolitan areas. The breakdown of the funding is as follows:

	2006-07	2007-08	2008-09	2009-10	Total
Administered*	$12.76m	$13.14m	$14.02m	$15.49m	**$55.41**
Total Financial Year	$15m	$15.4m	$16.3m	$17.8m	**$64.5m**

* Of the administered funds per financial year, $6.8 million, $7.39 million, $7.56 million and $8.25 million have been allocated to the Relocation Incentive Grant and Specialist Training Program components of the measure for financial years 2006-07, 2007-08, 2008-09 and 2009-10, respectively.

Historical snapshot of how much was spent each year

The table below provides actual expenditure by financial year for Outcomes 4 and 9:

	2002-03	2003-04	2004-05	2005-06	Total
Total Outcomes 4 and 9	$436,205	$2.01m	$3.16m	$3.85m	**$9.46m**

The More Doctors for Outer Metropolitan Areas Measure comprises four programs, namely the:

- Outer Metropolitan Relocation Incentive Grant Program;
- Outer Metropolitan Other Medical Practitioners Program;
- Outer Metropolitan Registrars Program; and
- Outer Metropolitan Specialist Trainees Program.

Funding for the Outer Metropolitan Registrars Program is provided through Outcome 4, while the other three components are in part funded through Outcome 9. A large proportion of the program budget is for Medicare monies through Outcome 2 associated with the Medicare billing of doctors under the Outer Metropolitan Specialist Trainees Program. The actual expenditure amount for these Medicare billings is not readily identifiable.

Australian Government

Department of Health and Ageing

Senator Gary Humphries
Chair
Senate Community Affairs Committee
Parliament House
Canberra ACT 2600

Dear Senator

CORRECTION OF INFORMATION GIVEN TO SUPPLEMENTARY BUDGET ESTIMATES HEARING, 1 NOVEMBER 2006

I write to correct an answer I gave during the Community Affairs Committee's examination of outcome 12 of the Department of Health and Ageing's Supplementary Budget Estimates, on 1 November 2006.

In response to a question from Senator Webber, I mistakenly stated "There were 338 scholarships, 90 of those candidates were eligible to sit the clinical exam; five of those have now passed, and they are continuing on with their learning plan and other things. Also, of those scholarships, 49 have passed the MCQ."

My answer was not correct. The number of scholarships awarded is 328. Please accept that there was no intention on my part to mislead the Committee, I simply mis-read the figures I had read in a brief prior to the hearing.

Also, by way of an update, since 1 November 2006, an additional 43 permanent resident overseas trained doctors awarded the scholarship have passed the Australian Medical Council Clinical examination and an additional 22 have passed the Multiple Choice Question examination.

As I undertook my response to Senator Webber on 1 November 2006, these figures will not be provided as an answer to a question on notice.

Yours sincerely

Maria Jolly
Acting Assistant Secretary
Mental Health & Workforce Division

7 February 2007

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Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2006-07, 1 November 2006

Question: E06-112

OUTCOMES: 1 - Population Health (TGA) and **13 - Acute Care (NBA)**

Topic: BLOOD PLASMA REVIEW

Written Question on Notice

Senator McLucas asked:

Please provide a list of all meetings that the TGA and the NBA have held with State and Territory officials since January 2006 on issues to do with blood and blood products. Please include date, location, attendees and topics discussed.

Answer:

Therapeutics Goods Administration (TGA)
The TGA is an observer on the Jurisdictional Blood Committee, a subcommittee of Australian Health Ministers' Advisory Council (AHMAC). TGA is represented by the TGA National Manager and on occasion he may delegate to the Director of Office of Devices Blood and Tissues and the Head of the Blood and Tissues Unit, Office of Devices Blood and Tissues.

National Blood Authority (NBA)
The NBA was established to manage the national blood supply on behalf of all governments who have agreed to jointly fund the national blood supply and to implement a nationally agreed framework for the management of safety and quality issues within the Australian blood sector. In that role it is the NBA's responsibility to meet on a regular basis with representatives of all governments to discuss blood and blood products.

The NBA provides secretariat services (and has observer/expert status) for the Jurisdictional Blood Committee (JBC), the main Commonwealth/state/territory body that oversights blood and blood matters for Health Ministers. Most formal interaction has occurred through this Committee. Meetings have been held in Canberra or via teleconference on:

- 24 January 2006;
- 2 March 2006 (teleconference);
- 21 April 2006;
- 13 June 2006 (teleconference);
- 22 June 2006;
- 1 September 2006; and
- 16 November 2006.

Topics have included:

- Australian Red Cross Blood Society (ARCBS) Deed matters
- ARCBS Funding claims for prior financial years

- Funding policy for blood services provided by the Australian Red Cross Society
- JBC Strategic Framework
- Bacterial Contamination of ARCBS Products
- 2006-07 and 2007-08 National Supply Plans and Budgets
- Product Supply and Funding Policy issues
- Plasma Derived factor VIII and IX Supply issues including plasma for next generation Intragam P
- NBA operational matters
- TGA issues including Trans Tasman Regulatory Authority and Blood Products Regulatory Authority and National Blood Management System status report
- ARCBS infrastructure and capital issues
- ARCBS Interim National Emergency Blood Management Plan
- Plasma Fractionation Review processes
- Administration matters including AHMAC/ Australian Health Ministers' Conference (AHMC) papers and incoming correspondence
- ARCBS business study
- Transfusion safety data
- Overseas supply policy
- IVIg criteria for use
- Schedule 4 procedures
- Inventory Management priorities including QLD Pacific Commerce Ordering and Receipting system pilot
- Review of the National Blood Arrangements
- 2006 JBC Annual Report

Attendees have been JBC members (see list). The NBA has attended all these meetings.

In addition to these formal meetings, staff from the NBA are in regular contact with various JBC members and other representatives within the states and territories to gather the views of the jurisdictions on a range of issues covering the work of the NBA as determined by JBC. We do not keep records of all these occurrences. These discussions would typically cover issues such as:

- Supply plan performance, adjustment and requirements
- Invoicing and acquittal procedures
- Risk mitigation procedures and practices
- JBC procedures such as finalisation of minutes and action items
- Inventory management issues
- Supplier contract performance
- Product specific status and issues such as intensive product management around products in short supply
- Options and strategies to improve practices relating to the use and management of blood and blood products.

Name	Title	Organisation
Ms Kerry Flanagan	First Assistant Secretary Acute Care Division	Commonwealth Department of Health and Ageing
Mr Bill Heiler	Director, Clinical Policy	NSW Department of Health
Dr Chris Brook	Director, Rural and Regional Health and Aged Care Services	Victorian Department of Human Services
Dr Peter Lewis-Hughes	Executive Director, Clinical and Statewide Services	Queensland Health
Ms Joan Bedford	Senior Portfolio Officer Statewide Contracting Health System Support	Health Department of WA
Ms Susan Ireland	Manager Blood, Organ and Tissue Programs	SA Department of Health
Dr Paul McCann	Senior Medical Consultant Acute Health Services	Tasmanian Department of Health and Human Services
Dr Paul Dugdale	Chief Health Officer	ACT Health
Ms Meri Fletcher	Director Policy & Services Development Acute Care	NT Department of Health & Community Services

Secretariat		
Ms Stephanie Gunn	Deputy General Manager, Corporate Management	National Blood Authority
Ms Judith Shackley	Manager, Secretariat	National Blood Authority
Ms Nada Martinovic	Secretariat Officer	National Blood Authority

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2006-07, 1 November 2006

Question E06-113

OUTCOMES: 1 - Population Health (TGA) and **13 - Acute Care (NBA**)

Topic BLOOD PLASMA REVIEW

Written Question on Notice:

Senator McLucas asked:

Please provide a list of all meetings that the TGA and the NBA have held with CSL since January 2006 on issues to do with blood and blood products. Please include date, location, attendees and topics discussed.

Answer:

Therapeutics Goods Administration (TGA)
CSL is a manufacturer and product sponsor of registered medicines, including blood products and reagent red blood cell in vitro diagnostics. The TGA as the regulator of these products holds regular meetings with CSL on a whole range of regulatory issues which may include issues on manufacturer audits, product applications, product safety issues, adverse reaction reports, recalls and batch testing.

Date	Location	Attendees	Topics Discussed
24 March 2006	Therapeutic Goods Administration, Narrabundah Lane, Symonston ACT 2609	TGA • Head of Blood and Tissues • Clinical Unit Head, Drug Safety and Evaluation Branch • Medical Officer, Drugs Safety and Evaluation Branch • Medical Officer, Drugs Safety and Evaluation Branch CSL • Medical and	• Product Registration Issues

		Research Director • Head of Regulatory Affairs • Consultant • Consultant	
20 – 23 March 2006	CSL Bioplasma 189 Camp Road Broadmeadows VIC	TGA • 2 x TGA specialist auditors	• Routine GMP Audit of the facility
3 April 2006	CSL Bioplasma 189 Camp Road	TGA 2 x TGA specialist auditors	• Routine GMP Audit of the facility
8-9 May 2006	CSL Bioplasma 189 Camp Road	TGA • Evaluator, Blood and Tissues Unit, Office of Devices Blood and Tissues CSL • Principal Regulatory Affairs Associate • General Manager	• Educational visit regarding the physical and functional aspects of the facility.
2 June 2006	CSL Bioplasma 189 Camp Road	TGA • National Manager • Director, Office of Devices Blood and Tissues • Head of Blood and Tissues Unit, Office of Devices Blood and Tissues CSL • President, CSL Bioplasma • General Manager • Medical and Research Director • Head of Regulatory Affairs • Quality Director • Manufacturing Director	• Regulatory Issues
5 July 2006	CSL Bioplasma 189 Camp Road	TGA • Assistant Secretary, Manufacturers	• Meeting to discuss audit findings

		Assessment Branch • TGA Specialist Auditor <u>CSL</u> • Quality Director • General Manager • Quality Assurance Manager	
23 Aug 2006	CSL Bioplasma, 189 Camp Road	<u>TGA</u> • Director, Office of Devices Blood and Tissues • Head of Blood and Tissues Unit, Office of Devices Blood and Tissues <u>CSL</u> • Medical and Research Director • General Manager • Quality Director • Principal Regulatory Affairs Associate • Regulatory Affairs Manager (International) • Acting Head, Regulatory Affairs • Principal Regulatory Affairs Associate • Regulatory Affairs Manager (Compliance)	• Consultation on proposed Australia New Zealand Therapeutic Products Authority (ANZTPA) Blood Rule.
30 Aug 2006	Therapeutic Goods Administration, Narrabundah Lane, Symonston ACT 2609	<u>TGA</u> • Head of Blood and Tissues Unit, Office of Devices Blood and Tissues • Section Head, Blood Products, Blood and Tissues Unit, Office of	• Product safety issues.

		Devices Blood and Tissues • Clinical Unit Head, Drug Safety and Evaluation Branch • Team Leader, Immunology, TGA Laboratories Branch <u>CSL</u> • Senior Regulatory Affairs Associate • Medical and Research Director • Research and Development Manager • Head of Virology • Project Manager • Senior Scientist	
6 Sept 2006	Teleconference	<u>TGA</u> • Team Leader, Viral Safety, TGA Laboratories Branch • Evaluator, Viral Safety, TGA Laboratories Branch <u>CSL</u> • Head of Virology • Senior Scientist	• Product safety issues
28 Nov 2006	Therapeutic Goods Administration, Symonston, Canberra	<u>TGA</u> • Clinical Unit Head, Drug Safety and Evaluation Branch • Clinical Advisor, Blood and Tissues Unit, Office of Devices Blood and Tissues	• Product clinical issues

		• Head of Blood and Tissues Unit, Office of Devices Blood and Tissues <u>CSL</u> • Senior Regulatory Affairs Associate • Medical and Research Director • Acting Head of Regulatory Affairs • Clinical Programme Manager <u>New Zealand</u> • Stewart Jessamine (via teleconference)	

National Blood Authority (NBA)

The NBA was established to manage the national blood supply on behalf of all governments who have agreed to jointly fund the national blood supply and to implement a nationally agreed framework for the management of safety and quality issues within the Australian Blood sector.

In that role it is the NBA's responsibility to meet on a regular basis with CSL to discuss issues relating to the supply of product provided for under the various contractual obligations established between the parties.

These meetings can be either formal face to face meetings such as for annual stock take purposes and formal contract review meetings or phone based discussions in relation to specific product or contract related issues. We do not keep records of all these occurrences.

Issues that may be covered in these formal and informal meetings include:

- Management and operation of the Plasma Products Agreement (PPA)
- Management of product in short supply
- Supply planning requirements
- Data clarification
- Supply trends, production yields and status of batch processes

Some of the more significant meetings that the NBA has held with CSL include:

Date	Location	Attendees	Topics Discussed
18 January 2006	Teleconference	Shannon Gibson Jeff Davies Vito Micucci Peter DeGraaff and others	Monthly Operational Report (MOR) Meeting
22 February 2006	Teleconference	Shannon Gibson Jeff Davies Vito Micucci Di Black Liz Campbell Peter DeGraaff and others	MOR Meeting
16 March 2006	CSL	Shannon Gibson John Lontos Ravi Hattarki Cheryll McLeod Barry Melgaard and others	NBA Tour of CSL Operations
17 March 2006	Teleconference	Shannon Gibson Cheryll McLeod Peter DeGraaff Barry Melgaard Rob Clifford	Review March NBA Plan and Issues with Over Supply
21 March 2006	Teleconference	Shannon Gibson Jeff Davies	MOR Meeting

		Angelo Chiodo Liz Campbell Cheryll McLeod Di Black Vito Micucci Peter DeGraaff Barry Melgaard Rob Clifford Niv Sivapalan	
21 March 2006	Teleconference	Shannon Gibson Cheryll McLeod Peter DeGraaff Barry Melgaard Niv Sivapalan	NBA Confirmed Quarterly Requirements (CQR) Quarter 2
24 March 2006	Teleconference	Shannon Gibson Cheryll McLeod Peter DeGraaff Barry Melgaard and others	NBA CQR Quarter 2 Follow Up
29 March 2006	National Blood Authority	Jeff Davies Shannon Gibson Peter DeGraaff Barry Melgaard Rob Clifford David Knight	Proposal for Distribution of Hyperimmune Products
19 April 2006	Teleconference	Shannon Gibson Jeff Davies Angelo Chiodo Liz Campbell Cheryll McLeod Di Black Vito Micucci Peter DeGraaff Barry Melgaard	MOR Meeting
22 May 2006	CSL	Jeff Davies Vito Micucci Liz Campbell Shannon Gibson Di Black Peter DeGraaff Barry Melgaard	MOR Meeting
26 May 2006	Teleconference	Shannon Gibson Cheryll McLeod Peter DeGraaff Barry Melgaard	Review NBA Revised Annual Supply Estimates (ASE's)
21 June 2006	Teleconference	Barry Melgaard Peter Hade Rob Clifford Niv Sivapalan Shane Marshall Jeff Davies Shannon Gibson	MOR and CQR Review

		Vito Micucci Di Black Liz Campbell	
23 June 2006	National Blood Authority	Barry Melgaard Niv Sivapalan Shane Marshall Peter Hade Rob Clifford Jeff Davies and others	CQR Planning
26 June 2006	National Blood Authority	Sandra Cochrane Helen Fowler Niv Sivapalan Shane Marshall Tony Glen Susan James Peter Hade Rob Clifford Barry Melgaard Peter DeGraaff Shannon Gibson Jeff Davies	Supply Planning Meeting for 2007-08
26 June 2006	National Blood Authority	Barry Melgaard Andrew Bartlett Rob Clifford Shannon Gibson	ARs, Reconciliation Report, FXI, FXIII and e-portal training
27 June 2006	National Blood Authority	Peter DeGraaff Peter Hade and others	Tender Debrief,
28 June 2006	Parkville and Broadmeadows, Melbourne	NBA and CSL teams	Stocktake
4 July 2006	Teleconference	Sam Houcher Shannon Gibson Peter DeGraaff Barry Melgaard Rob Clifford	PPA Report Review
6 July 2006	National Blood Authority	Peter DeGraaff Shane Marshall Barry Melgaard Rob Clifford Tony Glen Peter Hade CSL	OPM Meeting with CSL and ARCBS
20 July 2006	National Blood Authority	Rob Clifford Peter Hade Niv Sivapalan Shane Marshall Peter DeGraaff Shannon Gibson Jeff Davies Vito Micucci	MOR Meeting

		Di Black Liz Campbell	
3 August 2006	Teleconference	Jeff Davies Peter DeGraaff	Tele with Peter and Jeff
21 August 2006	Teleconference	Jeff Davies Peter DeGraaff	IG Next Gen
23 August 2006	Teleconference	Shannon Gibson Cheryll McLeod Peter DeGraaff Barry Melgaard Rob Clifford	NBA S&OP Plan
24 August 2006	Teleconference	Shannon Gibson Jeff Davies Vito Micucci Di Black Liz Campbell Peter DeGraaff Barry Melgaard Rob Clifford	MOR Meeting
5 September 2006	CSL	Peter DeGraaff Rob Clifford Shannon Gibson Sam Haouchar Alan Olsen	Goods Receipt Verification
20 September 2006	Teleconference	Peter DeGraaff Rob Clifford Shannon Gibson Jeff Davies Vito Micucci Di Black Liz Campbell	MOR Meeting
5 October 2006	National Blood Authority	Peter DeGraaff Peter Hade Jeff Davies Tom Giarla Shannon Gibson	Range of Operational Issues
12 October 2006	National Blood Authority	Shane Marshall Tian Erho Sandra Cochrane Helen Fowler Peter Hade Rob Clifford John Cullen Debbie Hurlbut Sherrie Choikee CSL	CSL IPM Meeting
26 October 2006	Teleconference	Michael Stone Rob Clifford Peter Hade Shannon Gibson Jeff Davies Vito Micucci	MOR Meeting

		Di Black Liz Campbell	
2 November 2006	National Blood Authority	Michael Stone Peter Hade Jeff Davies Shannon Gibson	Contingency Planning Meeting
13 November 2006	CSL	Jeff Davies Darryl Maher Liz Campbell Shannon Gibson Vito Micucci Michael Stone Peter Hade Leigh McJames	Meeting with NBA and CSL
14 November 2006	CSL	Michael Stone Peter Hade Jeff Davies Darryl Maher Liz Campbell Shannon Gibson Vito Micucci	Range of Operational Issues
23 November 2006	Teleconference	Leigh McJames Michael Stone Peter Hade Shannon Gibson Jeff Davies Vito Micucci Di Black Liz Campbell	MOR Meeting
29 November 2006	National Blood Authority	Julie Bland Rob Clifford William Hogan CSL	CSL National Blood Supply Change Program (NBSCP)
8 December 2006	CSL	Debbie Hurlbut Shannon Gibson Mark Disco	Plant Tour for Debbie Hurlbut
8 December 2006	CSL	Debbie Hurlbut Sam Haouchar Rey Sumaru Shannon Gibson	Exploring Options of Data Communications with NBA

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2006-07, 1 November 2006

Question: E06-114

OUTCOMES: 1 - Population Health (TGA) and 13 - **Acute Care (NBA)**

Topic: BLOOD PLASMA REVIEW

Written Question on Notice

Senator McLucas asked:

Please provide a list of all meetings that the TGA and the NBA have held with ARCBS since January 2006 on issues to do with blood and blood products. Please include date, location, attendees and topics discussed.

Answer:

Therapeutics Goods Administration (TGA)
The Australian Red Cross Blood Service (ARCBS) is the manufacturer of labile blood components and the supplier of plasma to CSL for the manufacture of plasma derived blood products. CSL is the sponsor of the plasma derived products which are distributed within Australia by the ARCBS.

The TGA as the regulator of these products holds regular meetings with ARCBS on a whole range of regulatory issues which may include issues on manufacturer audits, product standards, product safety issues, adverse reaction reports, recalls and QC testing.

Date	Location	Attendees	Topics Discussed
10 Jan 2006	ARCBS, Springwood QLD	TGA • Blood, Tissue & Cellular Therapies Audit Team Manager ARCBS • Quality Department Representative	• Routine Good Manufacturing Practice (GMP) Audit
17 Jan 2006	ARCBS, Sale VIC	TGA • GMP Specialist Auditor ARCBS • Quality Department Representative	• Routine GMP Audit

23 – 24 Jan 2006	ARCBS, Hobart TAS	TGA • 3 x GMP Specialist Auditors ARCBS • Quality Department Representatives x 2	• Routine GMP Audit
24 Jan 2006	ARCBS, Sydney NSW	TGA • Blood, Tissue & Cellular Therapies Audit Team Manager • Section Head, Therapeutic Goods Administration Laboratories Branch	• Regulatory GMP Audit
25 Jan 2006	Manufacturers Assessment Branch, Therapeutic Goods Administration, Melbourne Office, Level 8, Casselden Place, Melbourne	TGA • Blood, Tissue & Cellular Therapies Audit Team Manager • GMP Specialist Auditor ARCBS • Quality Manager ARCBS Queensland • Project Manager – Brisbane Operations Centre	• New Brisbane Manufacturing facility
25 Jan 06	Manufacturers Assessment Branch, Therapeutic Goods Administration, Melbourne Office, Level 8, Casselden Place, Melbourne – participation via teleconference	TGA • Director, Office of Devices Blood and Tissues • Blood, Tissue & Cellular Therapies Audit Team Manager • Section Head, Therapeutic Goods Administration Laboratories Branch • Clinical Adviser, Blood and Tissues Unit, Office of Blood Devices and Tissues ARCBS • Transfusion Medicine	• Transfusion associated bacterial contamination

		Specialist • Transfusion Medicine Specialist • National Quality Manager • National Regulatory Affairs Manager • NSW Health Representatives	
30 Jan 2006	ARCBS, Nepean NSW	TGA • GMP Specialist Auditor ARCBS • Quality Department Representative	• Routine Audit
31 Jan 2006	ARCBS, Dubbo NSW	TGA • GMP Specialist Auditor ARCBS • Quality Department Representative	• Routine Audit
1 Feb 2006	ARCBS, Bourke Street VIC	TGA • GMP Specialist Auditor ARCBS • Quality Department Representative	• Routine Audit
1 Feb 2006	ARCBS, Orange NSW	TGA • GMP Specialist Auditor ARCBS • Quality Department Representative	• Routine Audit
2 Feb 2006	ARCBS, Shepparton VIC	TGA • GMP Specialist Auditor ARCBS • Quality Department Representative	• Routine Audit

13 Feb 2006	ARCBS, Mildura VIC	TGA • GMP Specialist Auditor ARCBS • Quality Department Representative	• Routine Audit
14 Feb 2006	ARCBS, Horsham VIC	TGA • GMP Specialist Auditor ARCBS • Quality Department Representative	• Routine Audit
14 Feb 2006	Via teleconference	TGA • Head of Blood and Tissues Unit, Office of Devices Blood and Tissues • Clinical Advisor, Blood and Tissues Unit, Office of Devices Blood and Tissues • Blood, Tissue & Cellular Therapies Audit Team Manager • Chief Microbiologist, TGA Laboratories ARCBS • National Operations Manager • Chief Medical Officer • National Donor Medical Services Manager • National Govt & International Relations Manager • National Change, Learning & Development Manager • National Quality Manager	• Microbial contamination rates

16 Feb 2006	Via teleconference	TGA • Clinical Advisor, Blood and Tissues Unit, Office of Devices Blood and Tissues ARCBS • National Operations Manager • Transfusion Medicine Specialist NSW • National Change, Learning & Development Manager • National Quality Manager • National Regulatory Affairs Manager	• Microbial contamination rates
16 Feb 2006	ARCBS, Traralgon VIC	TGA • GMP Specialist Auditor ARCBS • Quality Department Representative	• Routine Audit
24 Feb 2006	Therapeutic Goods Administration, Narrabundah Lane, Symonston ACT 2609	TGA • Director, Office of Devices Blood and Tissues • Head of Blood and Tissues Unit, Office of Devices Blood and Tissues • Clinical Advisor, Blood and Tissues Unit, Office of Devices Blood and Tissues • Manufacturers Assessment Branch Auditor • Head Medical Devices Assessment Section, Office of Devices Blood and Tissues • Manager, IVD Assessment, Medical Device Assessment Section, Office of	• Sector bilateral update against Business Plan, updates and trends

		Devices Blood and Tissues • Head Policy and Regulatory Liaison Section, Office of Devices Blood and Tissues ARCBS • Chief Executive Officer • National Operations Manager • National Quality & Systems Manager • National Quality Manager • National Donor & Product Safety Specialist • National Regulatory Affairs Manager	
27 Feb 2006	ARCBS, Currie Street SA	TGA • GMP Specialist Auditor ARCBS • Quality Department Representative	• Routine Audit
28 Feb 2006	ARCBS, Midland WA	TGA • GMP Specialist Auditor ARCBS • Quality Department Representative	• Routine Audit
1 Mar 2006	ARCBS, Townsville QLD	TGA • GMP Specialist Auditor ARCBS • Quality Department Representative	• Routine Audit
1 Mar 2006	ARCBS, Rockingham WA	TGA • GMP Specialist Auditor ARCBS Quality Department Representative	• Routine Audit

2 Mar 2006	ARCBS, Fremantle WA	TGA • GMP Specialist Auditor ARCBS • Quality Department Representative	• Routine Audit
27 Mar 06		TGA • National Manager ARCBS • ARCBS Board	• ARCBS Board regulatory discussion
29 Mar 2006	ARCBS, Broome WA	TGA • Blood, Tissue & Cellular Therapies Audit Team Manager	• Routine Audit
31 Mar 2006	ARCBS, Cannington WA	TGA • Blood, Tissue & Cellular Therapies Audit Team Manager ARCBS • Quality Department Representative	• Routine Audit
6 Apr 2006	ARCBS, Wollongong NSW	TGA • GMP Specialist Auditor ARCBS • Quality Department Representative	• Routine Audit
10 Apr 2006	ARCBS, Gosford NSW	TGA • GMP Specialist Auditor ARCBS • Quality Department Representative	• Routine Audit
12 – 13 Apr 2006	ARCBS, ACT	TGA • Blood, Tissue & Cellular Therapies Audit Team Manager • GMP Specialist Auditor	• Routine Audit

		ARCBS • Quality Department Representative	
2 May 2006	ARCBS, Swan Hill VIC	TGA • GMP Specialist Auditor ARCBS • Quality Department Representative	• Routine Audit
24 May 06	ARCBS, Taree NSW	TGA • GMP Specialist Auditor ARCBS • Quality Department Representative	• Routine Audit
30 May – 1 Jun 2006	ARCBS, Southbank VIC	TGA • 3x GMP Specialist Auditor ARCBS • Quality Department and OU Representatives x 6	• Routine Audit
12 Jun 2006	Manufacturers Assessment Branch, Therapeutic Goods Administration, Geoscience Building Cnr Hindmarsh & Jerrabomberra Drives Symonston ACT 2609	TGA • Audit Team Manager, Manufacturers Assessment Branch, Therapeutic Goods Administration ARCBS • National Quality & Systems Manager • National Blood Management Systems Manager	• National Blood Management System
20 Jun 2006	Manufacturers Assessment Branch, Therapeutic Goods Administration, Melbourne Office, Level 8, Casselden Place, Melbourne	TGA • Blood, Tissue & Cellular Therapies Audit Team Manager ARCBS • National Regulatory Affairs Manager Regulatory Affairs Associate	• GMP matters, TMF changes, notification of licence changes, Manufacturers Assessment Branch (MAB) structure

28 – 29 Jun 2006	ARCBS, Darwin NT	TGA • GMP Specialist Auditor ARCBS • Quality Department Representative	• Routine Audit
29 Jun 2006	ARCBS, Southport QLD	TGA • Blood, Tissue & Cellular Therapies Audit Team Manager ARCBS • Quality Department Representative	• Routine Audit
5 July 2006	Therapeutic Goods Administration, Narrabundah Lane, Symonston ACT 2609	TGA • Head of Blood and Tissues Unit, Office of Devices Blood and Tissues • Section Head, Blood Products, Blood and Tissues Unit, Office of Devices Blood and Tissues • Clinical Advisor, Blood and Tissues Unit, Office of Devices Blood and Tissues ARCBS • National Donor & Product Safety Specialist • National Regulatory Affairs Manager	• Sector bilateral update against Business Plan, updates and trends.
17 – 20 Jul 2006	ARCBS, Sydney	TGA • 2 x GMP Specialist Auditor ARCBS • Quality Department Representatives x 4	• Routine Audit
21 Jul 2006	ARCBS, Tamworth NSW	TGA • GMP Specialist Auditor ARCBS Quality Department Representative	• Routine Audit

27 Jul 2006	ARCBS, Parramatta NSW	TGA • Blood, Tissue & Cellular Therapies Audit Team Manager ARCBS • Quality Department Representative	• Routine Audit
23 Aug 2006	ARCBS South Melbourne	TGA • Director, Office of Devices Blood and Tissues • Head of Blood and Tissues Unit, Office of Devices Blood and Tissues ARCBS • National Donor & Product Safety Specialist • National Regulatory Affairs Manager	• Consultation on proposed Australia New Zealand Therapeutic Products Authority (ANZTPA) Blood Rule
30 Aug 2006	Sydney	TGA • Clinical Advisor, Blood and Tissues Unit, Office of Devices Blood and Tissues. • Evaluator, Blood Products ARCBS • Various	• ARCBS Strategic Risk Management Forum
6 Sept 2006	ARCBS Level 6, 464 St Kilda Road VIC	TGA • Assistant Secretary, Manufacturers Assessment Branch, Therapeutic Goods Administration • Blood, Tissue & Cellular Therapies Audit Team Manager ARCBS • National Quality & Systems Manager • National Blood Management Systems Manager • National Operations Manager	• National Blood Management System • Brief overview of GMP regulation • Overview of the Blood, Tissues and Cellular Therapies Technical Expert Reference Group

		• National Regulatory Affairs Manager	
13 Sept 2006	ARCBS, Ballarat VIC	TGA • GMP Specialist Auditor ARCBS • Quality Department Representative	• Routine Audit
14 Sept 2006	ARCBS, Wangaratta VIC	TGA • GMP Specialist Auditor ARCBS • Quality Department Representative	• Routine Audit
15 Sept 2006	Manufacturers Assessment Branch, Therapeutic Goods Administration, Geoscience Building Cnr Hindmarsh & Jerrabomberra Drives Symonston ACT 2609	TGA • Audit Team Manager, Manufacturers Assessment Branch, Therapeutic Goods Administration ARCBS • National Blood Management Systems Manager	• National Blood Management System
4 Oct 2006	ARCBS, Mackay QLD	TGA • GMP Specialist Auditor ARCBS • Quality Department Representative	• Routine Audit
4 Oct 2006	ARCBS, Clarence Street Sydney	TGA • Audit Team Manager, Manufacturers Assessment Branch, Therapeutic Goods Administration ARCBS • National Quality Manager • NBMS Config & Validation Team Member (by teleconference)	• National Blood Management System

5 – 6 Oct 2006	ARCBS, Cairns and Mareeba QLD	TGA • GMP Specialist Auditor ARCBS • Quality Department Representative	• Routine Audit
23 Oct 2006	ARCBS, SA	TGA • GMP Specialist Auditor ARCBS • Quality Department Representative	• Routine Audit
1 Nov 2006	ARCBS, Launceston TAS	TGA • Blood, Tissue & Cellular Therapies Audit Team Manager ARCBS • Quality Department Representative	• Routine Audit
2 Nov 2006	ARCBS, Burnie TAS	TGA • Blood, Tissue & Cellular Therapies Audit Team Manager ARCBS • Quality Department Representative	• Routine Audit
2 Nov 2006	ARCBS, Springwood QLD	TGA • GMP Specialist Auditor ARCBS • Quality Department Representative	• Routine Audit
3 Nov 2006	ARCBS, Lismore NSW	TGA • GMP Specialist Auditor ARCBS • Quality Department Representative	• Routine Audit
15 Nov 2006	Sydney	TGA • Section Head, Recalls,	• Review the implementation of the

		Office of Devices Blood and Tissues • Deputy Recall Coordinator, Office of Devices Blood and Tissues • Administrative Officer, Recalls Unit, Office of Devices, Blood and Tissues • Clinical Advisor, Blood and Tissues Unit, Office of Devices Blood and Tissues (via teleconference) <u>ARCBS</u> • National Quality Manager • National Quality Database Co-ordinator	Monthly Reporting of Donor Initiated Recalls
17 Nov 2006	Via Teleconference	<u>TGA</u> • Blood, Tissue and Cellular Therapies Audit Manager, Manufacturers Assessment Branch • Clinical Advisor, Blood and Tissues Unit, Office of Devices Blood and Tissues <u>ARCBS</u> ▪ National Regulatory Affairs Manager	• MABTERG, Manufacturing Processes and Protocols

National Blood Authority (NBA)

The NBA was established to manage the national blood supply on behalf of all governments who have agreed to jointly fund the national blood supply and to implement a nationally agreed framework for the management of safety and quality issues within the Australian Blood sector.

In that role it is the NBA's responsibility to meet on a regular basis with ARCBS to discuss issues relating to the supply of product provided for under the various contractual obligations established between the parties. These meetings are either formal face to face meetings such as for contract review meetings or phone based discussions relating to specific product or contract related issues. We do not keep records of all these occurrences.

Issues that may be covered in these discussions include:

- Performance against agreed supply plan targets
- Funding and resource requests to governments
- Negotiations to sign the Deed
- Progress with implementation of the Deed, in particular scoping projects for the improvement in the management of blood inventory
- Risk management and contingency preparedness
- Priorities for the transfusion medicine services arm of ARCBS
- Effective management of product in short supply
- Ordering, Receipting invoicing and acquittal procedures
- Scope and process for the implementation of the Business Study agreed as a side letter to the Deed
- Capital planning
- Supply planning
- Development of protocols for the management of the Deed

Some of the more significant meetings that the NBA has held with ARCBS include:

Date	Locations	Attendees	Topics Discussed
4 April 2006	ARCBS Brisbane	ARCBS Risk Management NBA Fresh Blood Products	Establishment of National Managed Fund
26 May 2006	NBA Canberra	ARCBS Government and International Relations NBA Fresh Blood Products	Deed Implementation Meeting
26 June 2006	NBA Canberra	ARCBS Government and International Relations Transfusion Medicine NBA Fresh Blood Products and Supply Planning	Supply Planning Meeting
28 June 2006	ARCBS Melbourne	ARCBS Government and International Relations Transfusion Medicine NBA Fresh Blood Products	Deed Implementation Meeting
29 June	ARCBS	ARCBS	CFO Meeting

2006	Melbourne	Government and International Relations Capital Planning NBA Fresh Blood Products	2006-07 Budget and Annual Capital Plan and Strategic Capital Investment Plan
5 September 2006	NBA Canberra	ARCBS Government and International Relations NBA Fresh Blood Products and Supply Planning	Deed Implementation Meeting and Supply Planning Issues
21 September 2006	NBA Canberra	ARCBS Government and International Relations NBA Fresh Blood Products	Deed of Agreement Protocols
3 October 2006	ARCBS Melbourne	ARCBS Government and International Relations NBA Fresh Blood Products	Financial and Deed Implementation Meeting
3 November 2006	NBA Canberra	ARCBS Risk Management NBA Fresh Blood Products	National Managed Fund
23 November 2006	NBA Canberra	ARCBS Government and International Relations NBA Fresh Blood Products	Deed Implementation Meeting
30 November 2006	ARCBS Brisbane	ARCBS Risk Management NBA Fresh Blood Products	National Managed Fund
1 December 2006	Teleconference	ARCBS Government and International	Supply Planning and Mid-Year

		Relations NBA Fresh Blood Products and Supply Planning	
6 December 2006	NBA Canberra	ARCBS Executive NBA Executive	Quarterly CEO Meeting #1 FY 2005-06 in Review, and review of Quarter 1 2006-07 -Annual Business Planning -Capital Planning -ARCBS Funding -Key Performance Indicators -Third Party Reviews -ARCBS Risk Management -Deed Implementation Progress -ARCBS Service Level Agreements with Approved Health Providers and other joint initiatives -ARCBS Business Study -2007-08 Supply Plan and Budget

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2006-2007, 1 November 2006

Question: E06-107

OUTCOME 13: Acute Care

Topic: WHAT STATISTICS ARE AVAILABLE ON THE CLOSURE OR DOWNGRADING OF RURAL PUBLIC HOSPITALS

Written Question on Notice

Senator Nash asked:

What statistics are available on the closure or downgrading of rural public hospitals?

Answer:

Data held by the department allows comparison over time, of the number of public hospitals and episodes for different 'peer groups' in rural areas. The table below shows change between 2000-01 and 2004-05 for comparative purposes.

Rural Hospitals and Separations by AIHW Peer Groups

		Year			
		2000-01		2004-05	
AIHW Peer Group	Rural Area	Episodes	Hospitals	Episodes	Hospitals
Large Hospitals	Outer Regional Australia	165,683	11	238,853	13
	Remote Australia	22,636	1	29,776	1
Medium Hospitals - Group 1	Outer Regional Australia	38,757	6	31,452	5
	Remote Australia	12,015	2	13,925	2
	Very Remote Australia	7,312	1	6,427	1
Medium Hospitals - Group 2	Outer Regional Australia	74,907	25	74,451	24
	Remote Australia	19,292	6	17,684	6
	Very Remote Australia	12,272	4	21,579	7
Small Acute Rural	Outer Regional Australia	95,880	158	90,452	161
	Remote Australia	30,832	65	27,903	69
	Very Remote Australia	29,590	57	21,496	54
Total		**509,176**	**336**	**573,998**	**343**

Notes:

Large Hospitals are greater than 8000 separations per annum
Medium Hospitals - Group 1 are between 5000 and 8000 separations per annum
Medium Hospitals - Group 2 are between 2000 and 5000 separations per annum

Small Acute Rural Hospitals are less than 2000 separations per annum

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2006-2007, 1 November 2006

Question: E06-115

OUTCOME 13: Acute Care

Topic: PLASMA FRACTIONATION REVIEW

Written Question on Notice

Senator McLucas asked:

Please provide a list of all meetings that Banscott Health Consulting and Royce have held with the TGA, the NBA, CSL, the ARCBS and members of the Flood review since January 2006 on issues to do with blood and blood products.

Please include date, location, attendees and topics discussed.

Answer:

Banscott Health Consulting

- On 11 April 2006, Mr Alan Bansemer from Banscott Consulting attended the Plasma Fractionation Review Committee meeting as an observer. The meeting was held in Canberra and was attended by all Review Committee members, Dr Alison Turner and Mr Peter DeGraaff from the National Blood Authority (NBA), officers from Baxter Healthcare and the Review secretariat. The topics discussed at this meeting were the Baxter Healthcare and the National Blood Authority's submissions to the Review which primarily addressed the Review's terms of reference.

- On 15 June 2006, Mr Bansemer attended the Review Committee consultation meeting in Sydney as an observer. From the committee, Mr Philip Flood AO, Sir Peter Lawler and Professor Kevin Rickard AM attended the meeting. Other attendees were: Professor Henry Ekert, officers from Octapharma, NSW Health, the NSW IVIg User Group, the Australasian Society of Clinical Immunology & Allergy (ASCIA), MDA Pharma and the Review secretariat. The topics discussed at this meeting arose from the presentations to the Review from Octapharma, NSW Health, NSW IVIg User Group/ASCIA and MDA Pharma which primarily addressed the Review's terms of reference.

- On 11 July 2006, Mr Bansemer attended the Review Committee meeting held in Canberra as an observer. The meeting was attended by all the Review Committee members as well as Ms Rita Maclachlan, Professor Albert Farrugia and Dr Tony Gould from the Therapeutic Goods Administration (TGA), Mr Peter DeGraaff (NBA), Dr Brian McNamee, Dr Jeff Davies, Dr Darryl Maher, Mr Sam Lovick and Mr Paul Bordonaro from CSL Limited and the Review secretariat. Also attending at separate sessions were officers from the New Zealand Ministry of Health and Allen Consulting Group. The topics discussed were the presentations to the Review from CSL Limited, the New Zealand Ministry of Health and Allen Consulting Group which primarily addressed the Review's terms of reference.

Royce (Vic) Pty Ltd

- On 18 January 2006, the Review secretariat held a teleconference in Canberra with Dr Glenn Smith and Ms Rita MacLachlan from the Therapeutic Goods Administration to obtain background information on the Australian regulatory requirements for the supply of plasma products. Officers from Royce (Vic) Pty Ltd attended the meeting to help inform work on the public consultation and communications strategy for the Review.

- On 18 January 2006, an officer from the department met with Dr Alison Turner and Mr Peter DeGraaff from the National Blood Authority in Canberra to obtain background information on the role of the NBA in the current arrangements for the supply of blood and blood products in Australia. Officers from Royce (Vic) Pty Ltd attended the meeting to help inform work on the public consultation and communications strategy for the Review.

- On 23 January 2006, the Review secretariat met with Ms Joanne and Ms Sarah Pohlen from the Australian Red Cross Blood Service (ARCBS) in Melbourne to obtain background information on the role of the ARCBS in the collection and supply of blood and blood products in Australia. Officers from Royce (Vic) Pty Ltd attended the meeting to help inform work on the public consultation and communications strategy for the Review.

- On 7 February 2006, Royce (Vic) Pty Ltd met with the Review Chair, Mr Flood AO and the Review secretariat in Canberra. Royce provided Mr Flood with information about the proposed public consultation and communications strategy for the Review.

- On 8 February 2006, the Review secretariat met with Mr Paul Bordanaro, Dr Tom Giarla, Mr Peter Walsh and Dr Rachel David from CSL Limited in Melbourne to obtain background information on the role of CSL Limited in implementation of current plasma fractionation arrangements for Australia. Officers from Royce (Vic) Pty Ltd attended the meeting to help inform work on the public consultation and communications strategy for the Review.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2006-07, 1 November 2006

Question: E06-167

OUTCOME 13: Acute Care

Topic: AUSTRALIAN HEALTH CARE AGREEMENT FUNDING

Hansard Page: CA 131 -132 and Written Question on Notice

Senator McLucas asked:

For the previous agreement (1998-2003) and the current agreement (2003-2008) please provide:

a) Total Commonwealth funds by state and by financial year

b) Please provide Commonwealth funds in AHCAs less these amounts by state and by financial year.

c) Funding for the mental health components by state and by financial year.

d) Does the data on Commonwealth hospital spending that is published by the AIHW include mental health, DVA funds and 30% rebate for private patients in public hospitals? If so, why are these not broken out to more accurately reflect what the Commonwealth pays to public hospitals?

Answer:

a)
Commonwealth expenditure by state and by financial year under the previous Agreements and the current Agreements is outlined in tables 1 and 2 respectively.

Table 1: Health Care Grants to the states and territories under the 1998-2003 Australian Health Care Agreements

	1998-99	1999-00	2000-01	2001-02	2002-03	TOTAL
	$ Millions					
NSW	1,904.5	1,999.6	2,167.2	2,260.0	2,432.2	**10,763.4**
VIC	1,366.0	1,447.3	1,534.5	1,617.5	1,763.6	**7,728.9**
QLD	1,045.9	1,101.8	1,175.1	1,253.3	1,351.9	**5,928.0**
WA	569.6	569.7	585.7	659.4	717.9	**3,102.3**
SA	477.6	503.4	534.8	578.9	612.2	**2,706.9**
TAS	127.8	129.8	141.0	145.7	159.5	**703.7**
ACT	71.1	74.2	78.9	89.5	93.2	**406.9**
NT	81.3	67.2	69.7	73.9	79.1	**371.3**
TOTAL	**5,643.8**	**5,892.8**	**6,286.8**	**6,678.2**	**7,209.6**	**31,711.3**

Notes
1. Totals may not add exactly due to rounding.
2. Amounts include payments for National Health Development Fund (NHDF).

Table 2: Health Care Grants to the states and territories under the 2003-08 Australian Health Care Agreements

	2003-04	2004-05	2005-06	2006-07	2007-08	TOTAL
	$ Millions					
NSW	2,535.7	2,663.4	2,795.8	2,927.4	3,068.1	**13,990.3**
VIC	1,813.8	1,926.4	2,002.7	2,122.3	2,224.5	**10,089.7**
QLD	1,419.2	1,522.1	1,615.0	1,698.9	1,795.4	**8,050.6**
WA	730.4	795.7	817.1	866.3	915.4	**4,124.9**
SA	634.3	665.5	697.8	735.2	761.6	**3,494.5**
TAS	168.2	178.8	185.3	194.4	203.0	**929.6**
ACT	98.6	104.6	107.2	115.6	118.9	**544.8**
NT	92.7	98.3	103.8	110.0	116.0	**520.9**
TOTAL*	**7,492.8**	**7,954.7**	**8,324.7**	**8,770.2**	**9,203.0**	**41,745.3**

Notes
1. Totals may not add exactly due to rounding.
2. Funding for 2003-04 to 2005-06 is actual. Funding for 2006-07 and 2007-08 is that estimated at Budget 2006-07.
3. Amounts include payments for the Pathways Home Program.

b)
Key components of the 1998-03 Australian Health Care Agreements funding by financial year are outlined in tables 3 and 4 respectively.

Table 3: Key components of 1998-03 AHCAs funding by state

	General	Mental health	Palliative care	Quality Improvement	Adjustments	NHDF	Total
	$ Millions						
NSW	10,280.0	89.6	51.7	234.3	21.8	86.0	**10,763.4**
VIC	7,367.8	65.8	37.9	171.9	22.5	63.0	**7,728.9**
QLD	5,579.5	49.8	27.5	125.1	101.0	45.0	**5,928.0**
WA	2,919.5	26.1	14.1	63.9	55.7	23.0	**3,102.3**
SA	2,593.7	20.7	12.5	56.7	2.2	21.0	**2,706.9**
TAS	664.7	6.5	3.8	17.2	5.0	6.5	**703.7**
ACT	379.5	5.4	2.2	9.8	3.6	6.4	**406.9**
NT	335.5	5.4	3.2	5.1	20.1	1.9	**371.3**
TOTAL	**30,120.1**	**269.5**	**153.0**	**684.1**	**231.9**	**252.8**	**31,711.3**

Table 4: Key components of 1998-03 AHCAs funding by financial year

	1998-99	1999-00	2000-01	2001-02	2002-03	TOTAL
	$s Millions					
General	5279.9	5635.8	5987.2	6379.1	6838.3	**30120.1**
Mental health	50.0	51.6	53.5	55.7	58.6	**271.6**
Palliative care	28.4	29.3	30.4	31.6	33.3	**153.0**
Quality Improvement	75.0	103.3	133.8	167.0	205.0	**684.1**
Adjustments*	210.5	34.9	12.2	-3.6	-22.2	**231.9**
NHDF**	0.0	37.9	69.7	48.5	96.7	**252.8**

* Adjustments includes 1998-99 transition payments to equalise funding increases relative to the effects of horizontal fiscal equalisation under the previous Agreements; the Critical and Urgent Treatment Waiting list initiative accessed by Queensland and ACT; state specific health initiatives including payments to Qld for PNG nationals moving across the Torres Strait islands; broad banding of certain Commonwealth Government payments; adjustments for rephrasing requested by some states and territories.

** National Health Development Fund

Key components of the 2003-08 Australian Health Care Agreements funding by financial year are outlined in tables 5 and 6 respectively.

Table 5: Key components of 2003-08 AHCAs funding by state

	General	Palliative care	Safety and quality	Mental health	Torres Strait	Woomera	Compliance payment	Pathways Home
	$ Millions							
NSW	13,542.8	62.5	266.3	108.4	-	-	479.1	86.0
VIC	9,747.3	46.1	194.7	80.0	-	-	358.1	63.0
QLD	7,731.3	35.1	143.9	63.5	15.6	-	332.7	45.0
WA	3,977.1	17.6	72.9	32.6	-	-	164.5	23.0
SA	3,352.7	14.9	63.9	24.6	-	5.7	148.9	21.0
TAS	865.9	4.6	19.4	7.8	-	-	61.0	6.5
ACT	508.7	2.7	11.3	6.7	-	-	30.0	6.4
NT	450.3	4.0	5.8	6.7	-	-	71.2	1.4
TOTAL	**40,176.1**	**187.3**	**778.1**	**330.2**	**15.6**	**5.7**	**1,645.7**	**252.3**

Table 6: Key components of 2003-08 AHCAs funding by financial year

	2003-04	2004-05	2005-06	2006-07	2007-08	TOTAL
	$ Millions					
General	7,226.2	7,612.0	8,006.5	8,441.0	8,890.5	**40,176.1**
Palliative care	34.6	36.0	37.4	38.9	40.5	**187.3**
Safety and quality	149.5	152.7	155.6	158.7	161.7	**778.1**
Mental health	61.0	63.4	65.9	68.6	71.3	**330.2**
Torres Strait	2.8	3.0	3.1	3.3	3.4	**15.6**
Woomera	1.1	1.1	1.1	1.2	1.2	**5.7**
Compliance payment	296.4	312.0	328.0	345.5	363.7	**1,645.7**
Pathways Home	17.6	86.5	55.1	58.6	34.4	**252.3**

c)
Commonwealth mental health funding to states and territories under the 1998-03 and 2003-08 AHCAs is outlined in tables 7 and 8 below:

Table 7: Mental Health Funding across the states and territories by financial year – 1998-03 AHCAs

	1998-99	1999-00	2000-01	2001-02	2002-03	TOTAL
	$ Millions					
NSW	16.7	17.2	17.8	18.5	19.4	**89.6**
VIC	12.2	12.6	13.1	13.6	14.3	**65.8**
QLD	9.1	9.5	9.9	10.4	11.0	**49.8**
WA	4.8	5.0	5.2	5.4	5.7	**26.1**
SA	3.9	4.0	4.1	4.3	4.5	**20.7**
TAS	1.2	1.3	1.3	1.3	1.4	**6.5**
ACT	1.0	1.0	1.1	1.1	1.2	**5.4**
NT	1.0	1.0	1.1	1.1	1.2	**5.4**
TOTAL	**50.0**	**51.6**	**53.5**	**55.7**	**58.6**	**269.5**

Table 8: Mental Health Funding across the states and territories by financial year – 2003-08 AHCAs

	2003-04	2004-05	2005-06	2006-07	2007-08	TOTAL
	$ Millions					
NSW	20.2	20.9	21.6	22.4	23.3	**108.4**
VIC	14.8	15.4	16.0	16.6	17.2	**80.0**
QLD	11.6	12.1	12.7	13.3	13.9	**63.5**
WA	5.9	6.2	6.5	6.8	7.1	**32.6**
SA	4.6	4.8	4.9	5.1	5.3	**24.6**
TAS	1.5	1.5	1.6	1.6	1.7	**7.8**
ACT	1.2	1.3	1.3	1.4	1.4	**6.7**
NT	1.2	1.3	1.3	1.4	1.5	**6.7**
TOTAL	**61.0**	**63.4**	**65.9**	**68.6**	**71.3**	**330.2**

d) AIHW estimates of Commonwealth Government hospital spending

The AIHW advised that estimates of Australian Government expenditure on public hospitals, as published in *Health Expenditure Australia 2004-05*, includes payments to the states and territories under the AHCAs as well as other Specific Purpose Payments (SPPs) regarded as expenditure on public hospitals. This includes payments for high-cost drugs and blood transfusion services. A proportion of the 30% rebate on private health insurance is also included as are payments for veterans in public hospitals.

More detailed advice on the AIHW's policy regarding presentation of hospital expenditure data in their publications would need to be requested of the AIHW direct.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2006-2007, 1 November 2006

Question: E06-097

OUTCOME 14: Health and Medical Research

Topic: LICENSING COMMITTEE

Written Question on Notice

Senator Fielding asked:

The NHMRC Licensing Committee has provided minutes of its meetings to the Community Affairs Committee. Please provide copies of minutes for any further meetings.

Answer:

Minutes of the NHMRC's Embryo Research Licensing Committee meetings will be provided once they have been endorsed.

NHMRC LICENSING COMMITTEE

MINUTES OF THE MEETING OF 24TH – 25TH AUGUST 2006

THE HILTON HOTEL, BRISBANE

9.00am to 5.00pm Thursday 24th August 2006

9.00am to 12.30pm Friday 25th August 2006

Attendance

Members	**Secretariat**
Professor Jock Findlay (Chairperson)	Dr Harry Rothenfluh
Professor Don Chalmers	Dr Alison Mackerras
Professor Geoffrey Driscoll	Ms Erica Sherburn
Dr Peter McCullagh	
Dr Stephen Junk	
A/Prof. Christopher Newell	
Dr Julia Nicholls	
Dr Helen Szoke	

Observers

Dr Marian Scarrabelotti (member of AHEC)

NHMRC

Professor Warwick Anderson

Professor Michael Good

Dr Greg Ash

Mr Nigel Harding

Item 1: Opening

Item 1.1: Committee Membership

Professor Findlay welcomed new and continuing members to the meeting and invited each person to introduce themselves.

Item 1.2: Apologies

The Committee noted that Professor Don Chalmers would be unable to attend the Friday session of the meeting.

Item 1.3: Confidentiality and Conflict of Interest

Members were reminded of their obligations in respect of confidentiality and conflict of interest declarations.

Item 1.4: Confirmation of Agenda

The order of consideration of the agenda items was altered to accommodate the availability of members and invited speakers.

Item 1.5: Chairperson's Report

The Chair reported that he had been overseas from 30 June to 6 August and thanked Professor Chalmers for serving as Acting Chair during that period.

The Chair attended the NHMRC Governance Workshop on 14-15 August 2006.

Item 1.6: Out of Session Activities

On 29 June 2006, members of the Licensing Committee appointed for the previous triennium approved a variation to the Standard Conditions of Licence specifying additional reporting requirements for licence holders and reflecting the NHMRC's new address. A variation to each licence authorising the use of excess ART embryos for the derivation of human embryonic stem cells was also approved. The variation requires that a report be submitted 6 months after the expiry, revocation or surrender of a licence (see Item 8.2.1).

Item 1.7: CEO Briefing on NHMRC governance arrangements and strategic planning issues

The CEO of the NHMRC, Professor Warwick Anderson, provided an outline of his vision and strategic goals for the NHMRC during its first triennium as a statutory authority.

Item 2: Minutes and Actions Arising from Previous Meeting

Five members appointed for the previous triennium were present at both the May and August meetings. These members, who constitute a quorum for the previous committee, endorsed the draft minutes of the 26 May 2006 meeting subject to minor editorial corrections. All members noted the table outlining the progress of the actions arising from that meeting.

Item 3: NHMRC Activities

Item 3.1: Council Activities

Members noted the report provided by the new Chair of Council, Professor Michael Good.

Item 3.2: Interaction with GTRAP

Members noted that the arrangements for all expert committees are currently being reviewed and will be considered by the Council of NHMRC. Members noted the issues which had been under consideration by GTRAP immediately prior to 30 June 2006.

Item 3.3: Secretariat Activities

Members were provided with a verbal report on Secretariat staff movements.

Item 3.3:1: New Contact Details of Secretariat Staff

Members noted the information provided.

Item 4: Budget

Secretariat updated members on the NHMRC budget to support Licensing Committee and advised of the process for accessing funding for special projects, such as Licensing Committee workshops.

Decisions: Secretariat to prepare a business case for funding for Licensing Committee workshops.

Item 5: Justification for the Use of Viable Excess ART Embryos in Training Licences

Members discussed the Committee's guidelines for the use of viable excess ART embryos in training licences in the context of additional information presented by the secretariat and concluded that the current conditions applied to the use of viable excess ART embryos for training embryologists were appropriate.

Decision: The Committee agreed that there should be no change to its current policy on the use of excess ART embryos for training embryologists.

Actions Arising: Add date of review to information on website.

Item 6: Review Advice on Whether an Embryo Is Live or Dead

Members discussed this issue in the light of recent developments in reproductive science.

The committee noted that there may be rare circumstances in which cells from an embryo that has not divided for 24 hours may be capable of some form of process that initiates organised development if placed in an appropriate environment. The committee considered that such a use of cells from these embryos should be a

licensed activity and that the following words should be added to the current advice on the NHMRC website:

> The Licensing Committee has further determined that, notwithstanding the lack of cell division within a 24 hour period, where any cell development may still be initiated (for example, in an attempt to derive an embryonic stem cell line) an embryo research licence should be obtained before conducting such work.

Decision: The additional words should be added to the website and the information kit.

Actions Arising: Follow up decision as noted above.

Item 7: Review Criteria for Embryonic Stem Cell Lines

Members noted the information provided. Members stated that the Licensing Committee does not have a regulatory role in the use of stem cell lines but the committee needs sufficient information about the criteria used to be able to determine whether licence holders are achieving a significant advance with their use of excess ART embryos.

The committee requested that the secretariat determine what criteria are used by other bodies to determine whether an embryonic stem cell line is “established” and suitable for inclusion in a stem cell bank.

The committee decided to maintain a watching brief on international developments in this area and noted that relevant stakeholders would have to be consulted before it made any changes to the criteria currently included in licences.

Decision: Maintain a watching brief on developments in this area.

Actions Arising: Secretariat to seek information noted above.

Item 8: Licence Considerations

Item 8.1: Applications

Item 8.1.1: Licence Application 309710

Members discussed the revised application received in July and noted the working group’s comments. Members have concerns about the timing and content of the information provided at each stage of the consent process. The Committee requested the working group and members of the secretariat visit the applicant to discuss the outstanding issues.

Decisions: Working group to visit the applicant

Actions arising: Secretariat to arrange for the working group to meet with the applicant.

Item 8.1.2: Licence Application 309711

Members noted that the applicant had not provided any additional information since the May meeting and requested that the working group follow this up during their visit to the applicant (see Item 8.1.1).

Actions arising: Working group to request information about the applicant's intentions with respect to the application.

Item 8.2 Variations

Item 8.2.1: Summary of All Variations

Members noted the information provided on this item.

Members noted an inconsistency between some of the special conditions attached to Licence 309702B. The inconsistency arose when the Special Conditions were varied in November 2005.

Action Arising: Secretariat to write to the licence holder advising that Special Condition 9105 of licence 309702B has been varied to ensure consistency with Special Conditions 9101 and 9103.

Item 8.3: Consent

Item 8.3.1: Advice Received to Date

Members noted the information provided.

Decision: The Licensing Committee expressed concern about licence holders who were yet to commence the activity authorised by the licence. The committee requested that the Secretariat write to the licence holders who have not yet commenced the licensed uses of excess ART embryos to ascertain a likely start date for the projects and report back to the committee.

Action Arising: Secretariat to write letters.

Item 9: Good Manufacturing Practice (GMP) laboratories

Members welcomed the presentation by Ms Allison McLean, CEO of Q-Gen Pty Ltd on the requirements for deriving embryonic stem cells under GMP conditions.

Item 10: Compliance

Item 10.1: Monitoring Inspection Reports

Members noted that three monitoring inspections had been conducted since the 26 May 2006 Committee meeting.

Item 10.1.1: Report on the Monitoring Inspection of Melbourne IVF Licence 309709

This monitoring inspection was conducted on 8 June 2006.

Decision:

The Committee was satisfied with the outcomes.

Action Arising:

A summary of the monitoring inspection is to be included in the next Licensing Committee Report to Parliament for the period 1 April 2006 to 30 September 2006.

Item 10.1.2: Report on the Monitoring Inspection of Stem Cell Sciences

This monitoring inspection was conducted on 9 June 2006.

Decision:

The Committee was satisfied with the outcomes.

Action Arising:

A summary of the monitoring inspection is to be included in the next Licensing Committee Report to Parliament for the period 1 April 2006 to 30 September 2006.

Item 10.1.3: Report on the Monitoring Inspection of Melbourne IVF Licence 309704

This monitoring inspection was conducted on 2 August 2006.

Decision:

The Committee was satisfied with the outcomes.

Action Arising:

A summary of the monitoring inspection is to be included in the next Licensing Committee Report to Parliament for the period 1 April 2006 to 30 September 2006.

Item 10.2: Trade in Human Eggs

Members noted the actions taken by NHMRC inspectors in response to media reports that there is a trade in human eggs in Australia. Members were satisfied that the facts do not support a belief that an offence under section 23 of the *Prohibition of Human Cloning Act 2002* has taken place. Inspectors will maintain a watching brief on this matter.

Decision:

The Committee was satisfied with the actions taken by the inspectors and agreed that a watching brief should be maintained.

Action Arising:

Inspectors to continue monitoring relevant information sources.

Item 10.3: Number of embryonic stem cell lines in Australia

Members noted the recent publication in Nature of the number of human embryonic stem cell lines produced in the world. Members advised that information on the number of lines produced in Australia was potentially misleading.

Item 10.4: Update on Compliance Communication Arrangements with States & Territories

Members noted that the MOU with Tasmania has recently been signed and that other communication arrangements are progressing.

Item 11: Review of Legislation

Members noted recent developments in response to the Lockhart reports.

Item 12: Licensing Committee Projects

Members noted the successful conclusion of several projects and progress on others. The updated information kit was tabled at the meeting.

Item 13: Communications Activities

Item 13.1: Information Exchange Visits

Members noted the report on the Information Exchange Visit to the HREC of the Queen Elizabeth Hospital and Lyell McEwan Hospital, South Australia, on 24 July 2006.

Item 13.2: Communications Working Group Update

The Communications Working Group has not met since the May Licensing Committee meeting.

Dr Szoke advised that she is unable to continue being a member of this working group. Professor Driscoll has agreed to replace her.

Item 13.3: Consumer Issues

Members noted that the Consumer Issues workshop held on 30 May 2006 was very successful and agreed that similar workshops should be held in the future. Members agreed that the secretariat should assist the Communications working group to

develop an action plan based on the information obtained at the workshop and present the plan at the December meeting.

Members identified the need for a closer relationship with Access, as this is the largest and most influential IVF consumer group in Australia. The Committee agreed that the Chair should write to the CEO of Access to explore avenues for more effective communication between Access and the Committee.

Decision: Chair to write to ACCESS **Action Arising:** Secretariat to write letter for Chair's signature.

Item 13.4: Licensing Committee Bulletin

The Committee agreed that it would be desirable to continue publishing the Licensing Committee bulletin and that the next issue should be published in December 2006.

Item 14: Licensing Committee Meeting dates

The list of proposed meeting dates for 2007 will be circulated for comment.

Action Arising: Secretariat to identify potential meeting dates and circulate to members.

Item 15: Other Business

The meeting concluded at 11.50am on Friday 25 August 2006.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2006-2007, 1 November 2006

Question: E06-177

OUTCOME 14: Health and Medical Research

Topic: NATIONAL ADULT STEM CELL CENTRE

Hansard Page: CA 138

Senator Patterson asked:

Was there any work done by the NHMRC on whether that institute would have got a grant, yes or no?

Answer:

No.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2006-2007, 1 November 2006

Question: E06-179

OUTCOME 14: Health and Medical Research

Topic: NHMRC – Membership of old and new committee members (Council and AHEC)

Hansard Page: CA 136

Senator Moore asked:

This is another mechanical aspect, but when the new major committee and the AHEC were formed a number of people who were on the previous committee were not reappointed for various reasons, and there was media comment about that. That was possibly good, that people are interested enough to comment about it. Could we get some information because I have seen on the website the new ones on the current committees and the people that were reappointed, or who are going again? Is that possible?

Answer:

Australian Health Ethics Committee

(Members names in **bold*** are reappointed from the previous triennium)

Professor Colin Thomson
Dr Rosanna Capolingua
Ms Sharon Caris
Mr Christopher Coyne*
A/Prof Terry Dunbar*
Rev Dr Gerald Gleeson
Professor Paul Griffiths
Mr Barry Maley
Professor Margaret O'Connor
Dr Gregory Pike
Professor Peter Sainsbury
Dr Marian Scarrabelotti
Dr NicholasTonti-Filippini*
Dr Nikolajs Zeps

National Health Committee
(Members names in **bold*** are reappointed from the previous triennium)

Professor Colin Masters
Ms Rebecca James
Dr Kathryn Antioch*
Dr Katrine Baghurst*

Dr John Carnie
Dr Jon Currie
Associate Professor Terry Dunbar
Dr Anne Johnson
Dr Mark Wenitong*
Professor Harvey Whiteford
Dr Helen Zorbas*

Human Genetics Advisory Committee
(Members names in **bold*** are reappointed from the previous triennium)

Professor RJA (Ron) Trent*
Reverend Martin Robinson*
Professor Jonathan Izant*
Dr Rosanna Capolingua*
Dr Sandra Hacker AO*
Dr Kristine Barlow-Stewart*
Emeritus Professor Jack Martin AO FAA FRS*
Professor Don Chalmers*
Professor David Weisbrot*
Professor Siaw-Teng Liaw*
Associate Professor Jane Halliday*
Dr Sally Goold OAM*
Ms Belinda Hope*
Mr David Shaw

Embryo Research Licensing Committee
(Members names in **bold*** are reappointed from the previous triennium)

Professor John (Jock) Findlay AM*
Dr Peter McCullagh
Dr Marian Scarrabelotti
Professor Donald Chalmers*
Professor Geoffrey Driscoll
Dr Stephen Junk
Dr Julia Nicholls*
Associate Professor Christopher Newell AM*
Dr Helen Szoke*

National Health and Medical Research Council

(Members names in **bold*** are reappointed from the previous triennium)

Professor Michael Good
Professor Colin Thomson
Professor James Best
Professor Colin Masters
Professor John (Jock) Findlay (Chair of Embryo Research Licensing Committee)*
Professor Ron Trent*
Professor Christopher Baggoley
Dr David Boadle*
Professor Timothy Davis
Dr Paul Dugdale*
Dr Robert Hall*
Professor John Horvath*
A/Professor Christopher Newell
Dr Denise Robinson
A/Professor Cindy Shannon
Dr Colin Sutton
Dr Simon Towler
Dr Tarun Weeramanthri*
Dr Jeannette Young*

Research Committee
(Members names in **bold*** are reappointed from the previous triennium)

Professor James Best
Dr Jon Nicolas Currie
Professor Timothy Mark Earls Davis
Associate Professor Jacinta Kim Elston*
Professor Ian Frazer
Associate Professor Matthew Todd Gillespie
Professor Robert M Graham
Mrs Elizabeth Grant*
Professor Cashel D'Arcy James Holman
Associate Professor Bronwyn Anne Kingwell*
Professor Margaret Mary O'Connor
Professor Kerin O'Dea
Professor Sally Redman
Dr Nicholas Samaras
Professor Peter Allen Silburn
Professor Ronald John Anthony Trent*

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2006-2007, 1 November 2006

Question: E06-045

OUTCOME 15: Biosecurity and Emergency Response

Topic: CONSULTANCY ON OPERATION

Senator McLucas asked:

a) When was the consultancy to Templeton Galt for $320,000 "to provide expert advice for the national pandemic flu exercise" sourced and signed?
b) On what basis was this given to Templeton Galt? What relevant expertise did Templeton Galt bring to this exercise?
c) How many people form Templeton Galt worked on this exercise? For what period of time?
d) Has Templeton Galt done other work for the Department? If so, what was this and when?
e) In making the decision to use Templeton Galt, what information did the Department have available to it about other work that Templeton Galt has done on the flu pandemic for the Commonwealth Government?
f) This consultancy was let through direct sourcing. How was the Templeton Galt name put into consideration?

Answer:

a) The original contract was signed on 17 May 2006.

b) Due to the unique nature of this project, specialised skills in the coordination and management of large scale exercises were required by the consultant. The consultant employed by Templeton Galt Pty Ltd had the necessary skills and expertise required to undertake and fulfil the project requirements.

c) One. The consultant was employed for a period of seven and a half months.

d) Templeton Galt Pty Ltd did not undertake other work for the Department during the period 1st July 2005 to 5th December 2006.

e) The Pandemic Influenza Exercise Steering Group considered that the qualifications for the Exercise Director include specific and extensive exercise experience. Recommendations were sought through relevant senior public servants with experience in the management of exercises. Responses indicated that Mr Don Murray, a Templeton Galt Pty Ltd employee, had the necessary qualifications, skills and experience.

f) The direct sourcing that was entered into met the Commonwealth Procurement Guidelines.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2006-2007, 1 November 2006

Question: E06-044

OUTCOME 15: Biosecurity and Emergency Response

Topic: CONSULTANCIES – ISSUES RELATED TO AVIAN FLU PANDEMIC

Written Question on Notice

Senator McLucas asked:

Please supply a list for each financial year since 2003-04 for consultancies on issues related to avian flu pandemic. The list should include name of consultancy, funding awarded, description of work, expected outcome (eg report) and delivery date.

Answer:

Please see Attachment A: CONSULTANCIES ON ISSUES RELATING TO AVIAN FLU PANDEMIC

CONSULTANCIES ON ISSUES RELATING TO AVIAN FLU PANDEMIC				
Annual Report 03/04				
Name of Consultancy	**Funding Awarded**	**Description of work**	**Expected Outcome**	**Delivery Date**
Blake Dawson Waldron	$206,000	Legal advice regarding the influenza vaccine Request For Tender	Advice on the tender and contract negotiation process.	February 2005
Annual Report 04/05				
Name of Consultancy	**Funding Awarded**	**Description of work**	**Expected Outcome**	**Delivery Date**
Biosecurity & Biocontainment	$14,300	Analysis of the technical relationship between the WHO Influenza Collaborating Centre and CSL Limited	Produce a report documenting, in detail, the nature and extent of the relationship between the WHO Centre and CSL Limited carefully considering the roles and responsibilities undertaken by CSL Limited as part of its funding support for the Centre. Also advise in detail the improvements in skills facility and equipment which would be necessary for the WHO Centre to develop the capacity for production of candidate vaccine strains independent from industry.	30 November 2004
Biosecurity & Biocontainment	$96,555	Examine Australia's diagnostic laboratory capacity & stockpile of diagnostic test kits	Implementation of measures to enhance Australia's capacity to diagnose pathogens responsible for health emergencies.	31 December 2004

Annual Report 05/06				
Name of Consultancy	**Funding Awarded**	**Description of work**	**Expected Outcome**	**Delivery Date**
ANU	$79,335	The use of mathematical models to assess public health responses to an outbreak of a highly infectious viral respiratory disease	Mathematical models which will generate data on the potential characteristics of the spread of pandemic influenza within Australia.	8 April 2006
Blue Moon Research and Planning Pty Ltd	$69,245	Qualitative research on pandemic influenza, May 2006	Production of a Discussion Guide for the mainstream and indigenous research.	31 December 2006
Blue Moon Research and Planning Pty Ltd	$198,000	Qualitative research on pandemic influenza, November 2007	Production of a Discussion Guide exploring the perceptions, awareness, attitudes and intentions relevant to pandemic influenza amongst the general public, general practitioners and pharmacists.	31 December 2006
Interflu Pty Ltd	$90,000	Consultancy to provide expert and informed advice on the World Health Organization (WHO) centre	To receive expert and informed advice relating to the transition stage of relocating the WHO Centre to its new host institution.	The principal agreement was signed on 24 November 2005. A Deed of Variation extended the contract to 30 June 2007.
Lucas Partners Pty Ltd	$109,000	Executive search agency services to select candidates for possible recruitment as World Health Organization influenza centre director	A suitable WHO centre Director appointed	16 October 2006 appointment of new WHO Centre Director announced.
OOSW Consulting Pty Ltd	$25,000	Development of a report into Australia's border protection capabilities and arrangements	A report into Australia's border protection capabilities and arrangements.	30 March 2006

Templeton Galt Pty Ltd	$320,000	Consultancy to provide expert advice for the national pandemic influenza exercise	The Consultant must provide expertise to the Department of Health & Ageing to direct a successful National Pandemic Influenza Exercise	17 November 2006