Community Affairs
Legislation Committee

Examination of Additional Estimates 2001-2002

Additional Information Received

VOLUME 6

Outcomes 3, 4, 6 - 9

HEALTH AND AGEING PORTFOLIO

MAY 2002

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. The title page of each report has been included in this document for reference purposes.

ADDITIONAL INFORMATION RELATING TO THE EXAMINATION OF ADDITIONAL EXPENDITURE FOR 2001-2002

Included in this volume are answers to written and oral questions taken on notice relating to the estimates hearing on 20 February 2002

HEALTH AND AGEING PORTFOLIO

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2001-2002, 20 February 2002

Question: E02000158

OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS

Topic: NATIONAL STRATEGY FOR AN AGEING AUSTRALIA

Hansard Page: CA 96

Senator West asked:

How are you going to apportion the $1.5m and how is that going to be spent?

Answer:

In 2001–2002, the planned expenditure is:

Amount ($ million)	**Project**
0.22	Awards
0.02	Mature Age Employment
0.06	Healthy Ageing
0.09	National Strategy for an Ageing Australia
0.04	Positive Images
0.05	International
0.02	Research
0.03	Health & Care
0.97	Support
1.5	TOTAL

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2001-2002, 20 February 2002

Question: E02000185

OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS

Topic: MONEY SPENT ON NATIONAL AGEING STRATEGY

Written Question on Notice

Senator Evans asked:

Please provide a budget breakdown of the money spent on producing the National Ageing Strategy to date and an explanatory note of each allocation?

Answer:

In the financial year 1998-99 the total expenditure on the National Strategy for an Ageing Australia was $22,800. The individual items of expenditure were:

- $4,900 for printing and distribution of 2,000 copies of the Background Paper;
- $1,700 for the development and printing of a brochure on the Strategy;
- $700 for the distribution of letters regarding the Strategy process; and
- $15,500 for research.

In the financial year 1999-2000 the total expenditure on the National Strategy was $187,800. The individual items of expenditure were:

- $61,800 on printing of the Strategy letterhead paper, brochures, banners, poster, feedback sheets, presentation folders, freight and research.
- $7,300 on a reprint of the Background paper;
- $16,000 on the printing and distribution of the Healthy Ageing Discussion Paper;
- $9,700 on presenting the Healthy Ageing Paper into alternative formats eg brail;
- $24,600 for printing and distribution of the Employment for Mature Age Workers Issues Paper;
- $7,400 for presenting the Employment Paper into alternative formats;
- $31,000 for printing and distribution of the Independence and Self Provision Discussion Paper;
- $7,400 for presenting the Independence and Self Provision Paper into alternative formats; and
- $22,600 for printing and distribution of the World Class Care Discussion Paper.

In the financial year 2000-01 the total expenditure on the National Strategy was $64,400. The individual items of expenditure were:

- $33,800 on printing and distribution of the Attitude, Lifestyle and Community Support Discussion Paper;
- $6,500 on the presenting of the World Class Care Paper into alternative formats; and
- $24,100 on consultation, development and promotion of the National Strategy at conferences and support for the Expert Group.

In 2001-02 the expenditure to date on the National Strategy has been $86,600. The individual items of expenditure were:

- $42,300 for printing of National Strategy and $8,900 for reprint; and
- $35,400 for consultation and promotion of the National Strategy including support for the Expert Group, displays, conferences and meetings.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2001-2002, 20 February 2002

Question: E02000186

OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS

Topic: NATIONAL AGEING STRATEGY – MRS BISHOP COPY

Written Question on Notice

Senator Evans asked:

Can you break down the $42,000 that was spent on the Bronwyn Bishop copy of the National Ageing Strategy?

Answer:

The expenditure for the National Strategy for an Ageing Australia produced for Mrs Bishop was:

- $9600 for printing 1554 copies of the eleven fact sheets;
- $27400 for printing 1554 copies of the National Strategy document;
- $5000 for printing of 1554 copies of the National Strategy presentation folder;

Total: $42,000

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2001-2002, 20 February 2002

Question: E02000187

OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS

Topic: NATIONAL AGEING STRATEGY – LAUNCH AGAINST CARETAKER CONVENTION

Written Question on Notice

Senator Evans asked:

(a) Did the Department express concern to the Minister that the launch of the Strategy may be against Caretaker conventions?
(b) If so how was the advice given?
(c) If the Department was not concerned about the caretaker conventions where did the concerns arrive from?
(d) Was PMC involved in the discussions?
(e) If so how?

Answer:

(a) Yes
(b) Verbal advice was given.
(c) See (a)
(d) Not aware
(e) See (d)

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2001-2002, 20 February 2002

Question: E02000188

OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS

Topic: NATIONAL AGEING STRATEGY – SECOND RELEASE

Written Question on Notice

Senator Evans asked:

Why weren't fact sheets produced for the second release?

Answer:

There was no need to produce additional copies of the fact sheets at this stage.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2001-2002, 20 February 2002

Question: E02000164

OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS

Topic: INTERNATIONAL YEAR OF OLDER PERSONS - $11 MILLION BUDGET ALLOCATIONS

Hansard Page: CA 96

Senator West asked:

What was the $11 million spent on?

Answer:

The major projects for the International Year were:

- the preparation and distribution of an information kit, community kit, media kit, national website, positive images video, newsletters, posters and brochures;
- Active Australia (promoting physical activity);
- National Awards Programs (eg Senior Australian of the Year Award, Commonwealth Media and Advertising Awards, Commonwealth Recognition Awards for Senior Australians);
- Australian Coalition ’99 to promote activities and events in the community (AC’99 was a national network of 1,244 non-government and business organisations);
- a comprehensive and integrated communications and public awareness strategy for IYOP;
- a community grants program; and
- Council On The Ageing (Peer Education).

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2001-2002, 20 February 2002

Question: E02000159

OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS

Topic: OLDER AUSTRALIANS – BASELINE AND FOLLOW UP RESEARCH ON COMMUNITY ATTITUDES - 1999

Hansard Page: CA 98 and 99

Senator West asked:

(a) How much was paid in consultants' fees?

(b) Are the reports available from evaluations that have been undertaken? (CA98) Have we had the last one? (CA99)

Answer:

(a) $0.1m for the 1998 initial 'baseline' research for the National Strategy for an Ageing Australia as well as the communication activities planned for the 1999 International Year of Older Persons; and

$0.4m ($0.2m from International Year of Older Persons funds and $0.2m from Departmental funds) in 1999-2000 to undertake additional research to:

- assess the impact of the International Year of Older Persons paid advertising; and
- conduct follow up research to the baseline research conducted in 1998 on community attitudes.

(b) Yes.

A summary of the research reports is available on the Older Australians website (www.olderaustralians.gov.au).

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2001-2002, 20 February 2002

Question: E02000078

OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS

Topic: 2001 AGED CARE APPROVALS ROUND

Written Question on Notice

Senator Denman asked:

The Commonwealth Department of Health and Aged Care Annual Report 2000-2001 (page 92) states that the Commonwealth announced its intention to advertise 8391 places for the 2001 Aged Care Approvals Round. However, on 30 January, Kevin Andrews announced the outcome of the 2001 Aged Care Approvals Round which included a total of 7 997 places. It seems 394 of the forecasted places have not been accounted.

What are the reasons for the readjustment in the number of places and why is there 394 less places?

Answer:

In the 2001 Aged Care Approvals Round, 8 391 places were advertised. On 30 January 2002, Minister Andrews announced the allocation of 7 997 places. Of these places, allocations are not made where the quality of applications is insufficient. It is planned that these places will be readvertised before the end of June 2002, as occurred in the 2000 Round.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2001-2002, 20 February 2002

Question: E02000079

OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS

Topic: 2001 AGED CARE APPROVALS ROUND

Written Question on Notice

Senator Denman asked:

Following the 2001 Aged Care Approvals Round, according to figures produced by the Commonwealth Department of Health and Aged Care in November 2001, there is still a shortage of 12,320 beds.

(a) How many places have been allocated for the 2002 Aged Care Approvals round?

(b) How many places have been allocated to Tasmania?

Answer:

Aged Care places for 2002 have not been approved.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2001-2002, 20 February 2002

Question: EO2000080

OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS

Topic: DEPARTMENT OF AGEING REVIEW - 'PHANTOM BEDS'

Written Question on Notice

Senator Denman asked:

The Australian newspaper, Tuesday 12 February, (p.5.) reports that a Department of Ageing review has found that almost 3000 approvals for beds awarded to nursing home owners more than 2 years ago have not been turned into actual aged-care places.

(a) How long before these 'phantom beds' will be able to be accessed?
(b) Given that some of these beds were allocated 2 years ago – what has been the delay in ascertaining that these beds are not operational?
(c) Given the high demand for nursing beds and long waiting lists, what processes does the Government intend to implement to ensure that all federal Government licences for beds are actually turned into aged care places?

Answer:

(a) Under the *Aged Care Act* (Act), approved providers have 2 years to have beds operational. It is expected that most of these outstanding allocations of more than 2 years will be operational within the next twelve months.

(b) Under the Act, at least 60 days prior to the end of the provisional allocation period, approved providers may apply for an extension to the provisional allocation period. The reasons for each case are assessed by the Department.

(c) Allocations are made subject to conditions applying to the recipient. Providers are required to report on these conditions quarterly. These conditions include the period within which a facility is to be operational and the premises built and details of milestones which were stated in the application. Failure to comply with these conditions may result in the Secretary or delegate of the Department revoking or varying the provisional allocation under section 15-4 of the Act.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2001-2002, 20 February 2002

Question: E02000181

OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS

Topic: "PHANTOM BED" REVIEW

Written Question on Notice

Senator Evans asked:

(a) Was the review referred to in the Herald Sun article on February 24, 2002 requested by Minister Andrews?
(b) When was it done?
(c) Was the information in the above review derived from a special audit or from the normal six month stock take?

Answer:

(a) Yes.

(b) The Review has commenced.

(c) A review is being undertaken over and above the regular monitoring of provisional allocations.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2001-2002, 20 February 2002

Question: E02000043

OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS

Topic: AGED CARE APPROVALS ROUND HANDBOOK 2001

Written Question on Notice

Senator Evans asked:

(a) Is it correct that the Aged Care Approvals Round Handbook 2001 indicated that there would be no high care beds available for the Cardinia Shire in Victoria?
(b) Is it also correct that there were two separate allocations of beds in the Cardinia Shire in the 2001 Round?
(c) How did this occur?
(d) Didn't this massively disadvantage other providers in the Shire?
(e) Does this represent the proper functioning of the system?
(f) If not, what action will be taken to rectify the situation?

Answer:

(a) No.
(b) One allocation of places was approved, for a service in Cardinia, under Restructuring Assistance, another service was approved for Extra Service Status using existing places.
(c) The National Restructuring places/packages pool included 250 high care places set aside for allocation on a competitive basis for services seeking to restructure. These places were available for allocation anywhere in Australia.
(d) No.
(e) Yes.
(f) Not applicable.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2001-2002, 20 February 2002

Question: E02000165

OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS

Topic: AGED CARE BEDS PER PLANNING REGION

Written Question on Notice

Senator Evans asked:

(a) How many aged care beds are there per planning region? Please include the most recent rounds and break down into low care, high care, operational and non operational.
(b) How does this compare by region for 1998, 1999, 2000 and 2001?

Answer:

(a & b) This information will be available when the current stocktake is finalised in mid March 2002.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2001-2002, 20 February 2002

Question: E02000166

OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS

Topic: OFF-LINE BEDS

Written Question on Notice

Senator Evans asked:

How many beds are currently off-line? Please break down by region and reason for being off-line?

Answer:

The latest data on off-line beds is currently being collated and checked as part of the overall 6 monthly stocktake of operational places.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2001-2002, 20 February 2002

Question: E02000167

OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS

Topic: BEDS COMING ONLINE – BRIEF TO MINISTER

Written Question on Notice

Senator Evans asked:

(a) Did the Department supply the Minister's office with a briefing saying that 4600 beds would come on line between September and December?

(b) If not does the Department know where this figure comes from?

Answer:

(a) No

(b) No

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2001-2002, 20 February 2002

Question: E02000168

OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS

Topic: ONLINE BEDS – SEPTEMBER AND DECEMBER

Written Question on Notice

Senator Evans asked:

How many actual(ly) beds came online during September and December? Please break down by region and identify if these are high or low care beds.

Answer:

Places and Homes which commenced between September 2001 and December 2001 are listed in Attachment A.

Places Online between September to December 2001

Attachment A E02000168

State	Region	High Care	Low Care
NSW	Central West	0	16
	Far North Coast	0	14
	Hunter	101	49
	Illawarra	35	61
	Inner West	0	2
	Mid North Coast	25	4
	Nepean	152	0
	New England	12	0
	Northern Sydney	14	17
	Orana/Far West	3	3
	South East Sydney	4	35
	South West Sydney	104	40
	Western Sydney	4	5
	Total	**454**	**246**

State	Region	High Care	Low Care
VIC	Barwon South-Western	0	8
	Eastern Metropolitan	40	63
	Grampians	30	5
	Hume	0	39
	Northern Metropolitan	0	65
	Southern Metropolitan	60	35
	Western Metropolitan	30	30
	Total	**160**	**245**

State	Region	High Care	Low Care
QLD	South Coast	0	9
	Brisbane South	0	5
	Wide Bay/ Burnett	0	40
	Fitzroy	0	20
	Total	**0**	**74**

Places Online between September to December 2001

Attachment A E02000168

State	Region	High Care	Low Care
WA	Goldfields	0	10
	Total	**0**	**10**

State	Region	High Care	Low Care
SA	Metro North	6	8
	Hills, Mallee & Southern	0	7
	Riverland	0	10
	South East	0	3
	Yorke Peninsula	3	0
	Total	**9**	**28**

State	Region	High Care	Low Care
TAS	Northern	5	10
	Total	**5**	**10**

State	Region	High Care	Low Care
NT	Darwin	8	0
	Total	**8**	**0**

State	Region	High Care	Low Care
ACT	ACT	0	14
	Total	**0**	**14**

State	High Care	Low Care	Total
NSW	454	246	700
VIC	160	245	405
QLD	0	74	74
WA	0	10	10
SA	9	28	37
TAS	5	10	15
NT	8	0	8
ACT	0	14	14
TOTAL	**636**	**627**	**1263**

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2001-2002, 20 February 2002

Question: E02000169

OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS

Topic: BED LICENCES

Written Question on Notice

Senator Evans asked:

(f) How many bed licences were sold last year?
(g) Was this more than in 1999, 2000, 2001?
(h) What were the reasons for their sale?
(i) How much are the licences worth? What were they worth in 1997, 1998, 1999, 2000, 2001?

Answer:

All transfers of aged care places between Approved Providers require Departmental approval. However details of the commercial arrangements between the Approved Providers in respect of the transfer of places is not required under Division 16 the Aged Care Act 1997. Therefore, the information requested is not held by the Department.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2001-2002, 20 February 2002

Question: E02000170

OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS

Topic: WAITING TIMES

Written Question on Notice

Senator Evans asked:

(j) What is the average waiting time between receiving an ACAT assessment and entering a residential aged care home? What is it by region? Can you produce a table showing the average waiting times for each year for 1999, 2000, 2001?

(k) What are the main reasons for extended waiting periods? How are these identified?

(l) When will the AIHW report on waiting periods be made public?

Answer:

(a) The Department has advised previously that the presentation of this data as averages is not appropriate because the distribution of the data is highly skewed.

(b) Advice from the Australian Institute of Health and Welfare (AIHW) would suggest that two key determinants for longer entry periods (from ACAT assessment to admission to residential aged care) are whether the resident used a community aged care package or residential respite care prior to admission. This would suggest that given ACAT assessments are valid for one year, these programs give new residents time after an ACAT assessment to look around for a home of choice and to make the necessary personal arrangements prior to entry to residential aged care.

(c) The AIHW advise that the published report on its statistical analysis of the entry period data will be released in May 2002 following its normal internal review and publication processes.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2001-2002, 20 February 2002

Question: E02000173

OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS

Topic: ENTRY ARRANGEMENTS WORKING PARTY

Written Question on Notice

Senator Evans asked:

(c) When was the entry arrangements working party set up?
(d) Who set this up?
(e) What is the membership of the group?
(f) How many times have they met?
(g) What are the expected outcomes of the group?
(h) Are there any established timelines for the group?

Answer:

(a) September 2001.
(b) Department of Health and Ageing, with Aged Care Working Group agreement.
(c) Residential aged care providers, aged care consumer representatives and Aged Care Assessment Team (ACAT) representatives.
(d) Three.
(e) A standard form for applying for a place in a residential aged care home, and a standard information package for prospective residents and their carers.
(f) The standard entry form and information package should be available for general use by the end of 2002.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2001-2002, 20 February 2002

Question: E020000174

OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS

Topic: COMMUNITY AGED CARE PACKAGES - NUMBERS

Written Question on Notice

Senator Evans asked:

How many Community Aged Care Packages are there in operation in each region? Please include the most recent allocations.

Answer:

As at 1 March 2002 the total number of operational Community Aged Care Packages (CACPs) was 24,822. The total number of allocated Packages was 26,625, which includes the 1,711 CACPs allocated on 30 January 2002. Few if any of the 30 January release show up in operational figures. At any given time there may be a small number of non-operational Packages due to transition arrangements around the operation of services.

The figures provided below show the allocations of Packages by Region including those announced 30 January 2002.

State	**CACP Region-**	**Total Allocated at 1 March 2002**
NSW	Central Coast	615
NSW	Central West	214
NSW	Far North Coast	509
NSW	Hunter	751
NSW	Illawarra	602
NSW	Inner West	681
NSW	Mid North Coast	558
NSW	Nepean	299

State	CACP Region-	Total Allocated at 1 March 2002
NSW	New England	300
NSW	Northern Sydney	945
NSW	Orana Far West	240
NSW	Riverina/Murray	451
NSW	South East Sydney	1361
NSW	South West Sydney	767
NSW	Southern Highlands	301
NSW	Western Sydney	684
VIC	Barwon-South Western	626
VIC	Eastern Metro	1274
VIC	Gippsland	407
VIC	Grampians	337
VIC	Hume	392
VIC	Loddon-Mallee	420
VIC	Northern Metro	930
VIC	Southern Metro	1628
VIC	Western Metro	682
QLD	Brisbane North	535
QLD	Brisbane South	603
QLD	Cabool	258
QLD	Central West	52
QLD	Darling Downs	309
QLD	Far North	264
QLD	Fitzroy	257
QLD	Logan River Valley	157
QLD	Mackay	118
QLD	North West	80
QLD	Northern	215
QLD	South Coast	577
QLD	South West	113
QLD	Sunshine Coast	373
QLD	West Moreton	107
QLD	Wide Bay	338
SA	Eyre Peninsula	71

State	CACP Region-	Total Allocated at 1 March 2002
SA	Hills, Mallee & Southern	201
SA	Metropolitan East	389
SA	Metropolitan North	328
SA	Metropolitan South	588
SA	Metropolitan West	496
SA	Mid North	55
SA	Riverland	50
SA	South East	94
SA	Whyalla, Flinders & Far North	93
SA	Yorke, Lower North & Barossa	155
WA	Goldfields	68
WA	Great Southern	103
WA	Kimberley	50
WA	Metropolitan East	362
WA	Metropolitan North	491
WA	Metropolitan South East	392
WA	Metropolitan South West	396
WA	Mid West	81
WA	Pilbara	50
WA	South West	192
WA	Wheatbelt	75
TAS	North Western	171
TAS	Northern	218
TAS	Southern	340
NT	Alice Springs	147
NT	Barkly	29
NT	Darwin	144
NT	East Arnhem	67
NT	Katherine	47
ACT	ACT	352
TOTAL		**26,625**

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2001-2002, 20 February 2002

Question: E02000175

OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS

Topic: COMMUNITY AGED CARE PACKAGES – ASSISTANCE HOURS

Written Question on Notice

Senator Evans asked:

On average how many hours per week are given to people receiving assistance through community aged care packages?

Answer:

Surveys last conducted in 2001 indicate that the average numbers of hours of service is between six and seven per week.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2001-2002, 20 February 2002

Question: E02000176

OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS

Topic: COMMUNITY AGED CARE PACKAGES DEPARTMENTAL SPONSORED CLIENT SURVEYS

Written Question on Notice

Senator Evans asked:

(a) Does the Department sponsor any customer/client satisfaction survey work?
(b) If so what are the current levels of satisfaction in each region?

Answer:

The Department does not directly sponsor any customer/client satisfaction work in the Community Aged Care Package (CACP) Programme. However, CACP Providers are funded under the *Aged Care Act 1997* to provide care in accordance with community care plans developed in consultation with individual clients to best meet their needs.

Providers are required to have internal complaint mechanisms in place to handle complaints. If concerns can not be resolved at the service provider level CACP care recipients have access to the Aged Care Complaints Resolution Scheme (CRS).

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2001-2002, 20 February 2002

Question: E02000177

OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS

Topic: CACPs - ACAT ASSESSED – WAITING FOR RESIDENTIAL BEDS

Written Question on Notice

Senator Evans asked:

(c) How many people receiving community aged care packages have been assessed by ACAT and are waiting for a bed?
(d) What special provisions are being made for these people?

Answer:

(a) This data cannot be readily collected or maintained on Departmental data systems.

(b) CACP Providers regularly reassess care recipients ongoing care needs and reconsider their individual care plan to assist the recipient manage in the community with appropriate support. Most providers balance service delivery across a range of needs for their care recipients and are able to meet increased needs for short periods of time.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2001-2002, 20 February 2002

Question: E02000178

OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS

Topic: DEATHS AFTER ACAT ASSESSMENT BUT BEFORE ENTRY INTO RESIDENTIAL CARE

Written Question on Notice

Senator Evans asked:

How many people have died after they have been assessed by ACAT but before they have gain(ed) entry into a residential care service?

Answer:

There are no data available to the Department to answer this question.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2001-2002, 20 February 2002

Question: E02000179

OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS

Topic: PROVIDERS NOT PROVIDING ACTUAL BEDS

Written Question on Notice

Senator Evans asked:

(a) What action is the Government taking against providers who have not provided actual beds?
(b) What is the process?

Answer:

(a) The actions available to the Department under the *Aged Care Act 1997* (the Act) are to vary or revoke the provisional allocation under section 15-4 of the Act. The approved provider may also surrender the allocation under section 15-6, or apply for a variation of the provisional allocation under section 15-5.

(b) The Department is currently conducting an analysis of each overdue provisional allocation, the reasons given for extensions and determining what actions under the Act might be warranted.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2001-2002, 20 February 2002

Question: E02000180

OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS

Topic: REASONS PROVIDERS NOT PROVIDING ACTUAL BEDS

Written Question on Notice

Senator Evans asked:

What are the main reasons providers give for not producing beds? Please break down percentage of reason (ie 20% because of local council restrictions etc)

Answer:

The review of provisional allocations requested by the Minister is currently underway.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2001-2002, 20 February 2002

Question: E02000182

OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS

Topic: OPERATIONAL BEDS - DAILY FIGURES

Written Question on Notice

Senator Evans asked:

Why can't the department on any given day determine how many beds are in operation given that they are paid a daily resident care subsidy?

Answer:

The payment system used by the Department does not track the number of beds in operation at any point in time.

Providers are paid a monthly advance which is then adjusted according to the detailed return provided by the service provider in the following month. The adjustment is paid on the basis of numbers of places actually occupied per day by a resident, not the number of beds available.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2001-2002, 20 February 2002

Question: E02000183

OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS

Topic: ALLOCATION TO OPERATIONAL - PROCESS

Written Question on Notice

Senator Evans asked:

(a) How does the department monitor the process from the point of allocation to the point of operational?
(b) Is it the same for new and old facilities?

Answer:
(a) All providers of provisional allocations are required to provide quarterly reports to the Department on their progress.

(b) Yes.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2001-2002, 20 February 2002

Question: E02000184

OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS

Topic: 1998 ALLOCATION NOT OPERATIONAL

Written Question on Notice

Senator Evans asked:

a) How long has the department been aware that there were beds allocated in 1998 that have not become operational?
(c) How was this discovered?

Answer:

(a) and (b) The Department monitors the status of allocated beds. Data is collected on an ongoing basis and under the *Aged Care Act* (Act), the provider must seek an extension if the two year requirement under the Act is not met.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2001-2002, 20 February 2002

Question: E02000189

OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS

Topic: TELEVISION ADVERTISING

Written Question on Notice

Senator Evans asked:

(a) During 2000-2001 the Government ran a series of television ads that promoted a number of the Government's initiatives/programs for older Australians. What advertisements were paid for by the Commonwealth Department of Health and Aged Care in this financial year? (2001-2002)
(b) How much did they cost? And how were they evaluated?
(c) What were the aims and objectives of the advertisements?

Answer:

The Commonwealth Department of Health and Ageing did not pay for any television advertising, specifically for older Australians, in the 2001-2002 financial year.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2001-2002, 20 February 2002

Question: E02000190

OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS

Topic: MELTON COURT

Written Question on Notice

Senator Evans asked:

(a) How did the government ensure that the residents of Melton Court Residential Care Service were looked after once it was found that there was an immediate and severe risk to the safety, health or well being of residents?
(b) What steps were taken in the lead up to the final sanction?
(c) How were residents and their families kept informed about the state of the nursing home?

Answer:

(a) Departmental officers conducted visits to the home following notification by the Agency of serious risk.
(b) Sanctions were imposed on 11 July 2001 and 23 July 2001.
(c) Letters to residents and relatives were sent on the following dates:
18 July, 25 July, 13 August , 23 October and 31 October 2001.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2001-2002, 20 February 2002

Question: E02000191

OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS

Topic: YARRA VIEW HOSTEL

Written Question on Notice

Senator Evans asked:

(a) What action was taken before sanctions were applied on the Yarra View Hostel?
(b) Who was involved?
(c) How long was the department aware of problems in the nursing home?
(d) What action did the department take to safe guard the care of residents?

Answer:

(a) Notice of Non-compliance: 22 October 2001
Notice to remedy and Notice of intention to impose sanctions: 22 November 2001

(b) The delegate of the Secretary

(c) 1 October 2001

(d) Departmental officers have conducted visits to the home

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2001-2002, 20 February 2002

Question: E02000192

OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS

Topic: SPOT CHECKS

Written Question on Notice

Senator Evans asked:

(a) How many spot checks were carried out last year in total?
(b) How many took place in the first 6 months of the year?
(c) How many took place over the election period?
(d) Where did these spot check(s) take place?
(e) How many occurred in the previous year?
(f) How many of last years spot checks took place at the same services?

Answer:

(a) In the calendar year to 31 December 2001 there were a total of 1,350 spot checks carried out.
(b) In the first 6 months of the year 2001 a total of 712 spot checks took place.
(c) 34 spot checks took place over the 2001 election period (8 October to 10 November).
(d) This is protected information under the *Aged Care Act 1997*.
(e) A total of 677 spot checks occurred in the year 2000.
(f) 243 spot checks took place at the same services during the calendar year to 31 December 2001.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2001-2002, 20 February 2002

Question: E02000153

OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS

Topic: CROYDON AGED CARE FACILITY

Hansard Page: CA 105

Senator West asked:

Can you take on notice and give me a chronology or a time line of the number of spot checks that were undertaken, the number of visits that have been undertaken to this nursing home?

Answer:

The Department conducted 49 visits between 15 August 2001 and 19 February 2002.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2001-2002, 20 February 2002

Question: E02000193

3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS

Topic: CROYDON NURSING HOME – AGENCY VISITS

Written Question on Notice

Senator Evans asked:

a) How many times did the Aged Care Standards and Accreditation Agency visit Croydon Nursing home between August and November?
b) What were the outcome(s) of these visits?
c) How was it documented?
d) Was the Minister kept informed about the Agency's concerns about Croydon?
e) If so how was this done?
f) If not, why?

Answer:

(a) Between 1 August and 30 November 2001, there were seven visits to the Croydon Nursing Home, arranged by the Aged Care Standards and Accreditation Agency. Two of these visits were review audits; five were spot checks.

(b) Non-compliance was identified at each visit. The first visit was a spot check, which resulted in a review audit being conducted. That review audit led to a decision in September 2001 to vary the home's period of accreditation to expire on 28 February 2002. Spot checks were carried out to monitor the home's progress in making improvements. A second review audit was conducted in November. This led to a decision not to revoke the home's accreditation, taking into account the appointment of an administrator to the home and the short period of accreditation remaining.

(c) Quality assessors record the findings of review audits in Review Audit Reports. These are published on the Agency's website, along with the decision by the Agency about the review audit. Quality assessors record the findings of support contacts (including spot checks) in Support Contact Records.

(d-f) The Agency informs the Department of Health and Ageing of all non-compliance found in aged care homes.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2001-2002, 20 February 2002

Question: E02000194

OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS

Topic: CROYDON NURSING HOME – AGENCY INITIAL CONCERNS

Written Question on Notice

Senator Evans asked:

(a) When did the Agency first become concerned about Croydon Nursing Home?
(b) How did the Agency first discover there were problems at Croydon Nursing Home?

Answer:

(a) August 2001.
(b) Information was released to the Agency from the (then) Department of Health and Aged Care.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2001-2002, 20 February 2002

Question: E02000195

OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS

Topic: CROYDON NURSING HOME – RESIDENTS AND FAMILY INFORMATION

Written Question on Notice

Senator Evans asked:

(a) What information was given to Croydon residents and family members about the Agency's concerns?
(b) How and when was this done?

Answer:

(a) Copy of the Aged Care Standards and Accreditation Agency Review Audit report of 7–16 August 2001.
Letters sent from the Department
Access to departmental staff

(b) Letters were sent on 14 September 2001, 11 December 2001, and 20 February 2002. The Agency report was distributed at a Resident/Relative meeting on 16 September 2001. Department staff attended resident/relative meetings on 16 September 2001, 18.November 2001, 17 December 2001, 11 January 2002, 24 January 2002, and 14 February 2002.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2001-2002, 20 February 2002

Question: E02000196

OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS

Topic: CROYDON NURSING HOME – REVIEW AUDIT

Written Question on Notice

Senator Evans asked:

(a) The review Audit decision found that the Nursing Home had failed 35 out of the 44 in their first report and 28 out of the 44 in the second report. In Senate Estimates hearing Ms Vesk reported that the home in fact failed 38. What is the correct figure?
(b) Why are there two figures?
(c) Are there any other reports that have the wrong figures?

Answer:

a) 36.
b) This was an error. The correct answer is 36.
c) Every effort is made to ensure accuracy.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2001-2002, 20 February 2002

Question: E02000197

OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS

Topic: CROYDON NURSING HOME – DECISION NOT TO REVOKE ACCREDITATION

Written Question on Notice

Senator Evans asked:

g) Having found that the home didn't meet 35 (38) outcomes what were the exact reasons for the decision not to revoke its accreditation?
h) Was the Minister's office informed of the possible consideration?
i) If so when and how was the Minister informed?

Answer:

(a) In September 2001, the Agency found that the home was not compliant with 36 expected outcomes of the Accreditation Standards and decided to vary the period of accreditation, to expire on 28 February 2002. The reduced period constituted the shortest reasonable time for the home to undertake the improvements necessary to achieve compliance with the Accreditation Standards and to undertake continuous improvement, before the site audit associated with assessment of an application for a further period of accreditation. The service had submitted a timetable for improvements and indicated additional budget allocations for resources. Of paramount concern in making any decision about accreditation is the health, safety and wellbeing of residents. Decision-makers need to consider the impact on residents of the consequences of decisions. For example, it must be weighed whether or not it is preferable for residents to remain in the familiar environment of the home, with nearby networks of family and friends, while the Agency and Department supervise implementation of improvements to the home.

(b) No. Such decisions are for the sole discretion of the Aged Care Standards and Accreditation Agency.

(c) Not applicable.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2001-2002, 20 February 2002

Question: E02000198

OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS

Topic: INVESTIGATING COMPLAINTS

Written Question on Notice

Senator Evans asked:

Outline a standard procedure for investigating complaints about nursing home standards?

Answer:

The Aged Care Complaints Resolution Scheme (the Scheme) was established under The Aged Care Act 1997 (the Act) and the Committee Principles 1997 (the Principles) to facilitate the resolution of complaints about Commonwealth funded aged care services.

10.38(2) of the Principles states that the affected care recipient or his or her representative, or anyone else, (**the complainant)** may make a complaint to the Secretary about anything that:
(a) may be a breech of the relevant approved providers' responsibilities under the Act or Aged Care Principles; and
(b) the complainant thinks is unfair or the affected care recipient is dissatisfied with the service.

The Scheme is predicated on a three-stage alternate dispute resolution model, incorporating negotiation, mediation and determination. Prior to entering into negotiation, an assessment is conducted to determine whether the complaint meets the above criteria and can, therefore, be accepted by the Scheme.

During the assessment process, the Scheme also attempts to identify issues which may be more appropriately dealt with by another agency. Where identified, the Scheme refers these matters.

A complainant may withdraw a complaint or agree to finalise the matter at any stage during the process.

<u>Negotiation</u>

Once a complaint is accepted, Complaints Resolution Scheme staff attempt to resolve the dispute by facilitating negotiation between the parties. The complainant may choose to involve an advocate in this and all subsequent stages of the processes.

Mediation

A complaint that cannot be resolved through negotiation is referred to a mediator for an initial mediation assessment and, where appropriate, mediation. Mediations are conducted by independent, external, accredited mediators.

Either party can decline to participate in a mediation. Where this occurs, the complaint is referred directly to a Complaints Resolution Committee for determination.

Determination

A complaint that cannot be resolved through negotiation or mediation is referred to a Complaint Resolution Committee. The Committee conducts a hearing and makes a written determination which, where appropriate, sets out a course of action for the service provider to address the issues raised in the complaint.

Review

All determinations are reviewable. Any party can apply for a review to the Commissioner for Complaints. The review process has one of three outcomes -
The original determination is confirmed, varied or set aside.

A copy of the determination, or reviewed determination, is provided to all parties and forwarded to the area in the Department responsible for compliance action. Follow up of the determination is carried out by this area within 6 weeks, or as otherwise specified in the determination.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2001-2002, 20 February 2002

Question: E02000199

OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS

Topic: COMMONWEALTH RESOURCES TO SUPPORT FACILITIES FACING SANCTIONS

Written Question on Notice

Senator Evans asked:

What resources are available to the agency and the Commonwealth to support a nursing home that is considered at risk of sanctions?

Answer:

Approved providers are expected to take all necessary steps to remedy matters. The Agency and the Department monitor the home to ensure the wellbeing of residents is being protected. If there is no serious risk to residents, the Agency identifies the necessary improvements to the approved provider, sets a timetable for the improvements and assesses progress in making them.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2001-2002, 20 February 2002

Question: E02000200

OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS

Topic: WORKFORCE PLANNING COMMITTEE

Written Question on Notice

Senator Evans asked:

(a) When is the Workforce Planning Committee going to produce a report?
(b) When will the LaTrobe report be released?

Answer:

(a) The Aged Care Workforce Committee is an ongoing committee and reports to the Minister for Aged Care after each meeting.

(b) The *Recruitment and Retention of Nurses in Residential Aged Care* report prepared by La Trobe University will be released after final consideration by the Aged Care Workforce Committee.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2001-2002, 20 February 2002

Question: E02000201

OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS

Topic: FUTURE WORKFORCE

Written Question on Notice

Senator Evans asked:

(a) When will the Department be able to identify how many nurses and other care staff will be needed in the future?
(b) Given that the Department is predicting future bed numbers they must have some idea of how many staff will be needed?

Answer:

(a) The Commonwealth does not specify ratio of nurses per head of population, or staff per resident ratio for residential aged care homes.

(b) Approved providers have the responsibility to ensure they have adequate numbers of appropriately trained staff to meet the needs of each resident.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2001-2002, 20 February 2002

Question: E02000202

OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS

Topic: WORKFORCE CONDITIONS

Written Question on Notice

Senator Evans asked:

What specific action is the Commonwealth currently undertaking to improve aged care nurses and care staff conditions to attract more people into the profession?

Answer:

Employment conditions, like industrial award issues, are matters between staff and providers at the enterprise level or as determined by the Federal or State industrial tribunals, under the relevant Commonwealth or State regulatory framework.

The Government is considering a range of new initiatives to encourage new and existing aged care workers into the aged care nursing workforce through support for their education, training and continuing development. Funding of $42.3 million over four years will provide up to 250 nursing scholarships (valued at up to $10,000 pa) as well as a range of new initiatives to support the training and education of personal care staff in smaller, less viable homes to improve their skills and provide quality care.

These initiatives will be implemented under the guidance of the reconstituted Aged Care Workforce Committee which was reformed in March 2002 with a broader representative base and new terms of reference.

The Department of Health and Ageing has agreed with an industry reference group to develop a range of options for reducing the paperwork requirements in aged care while still providing accountability for funding and meeting the required care standards.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2001-2002, 20 February 2002

Question: E02000203

OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS

Topic: PAY DISPARITY BETWEEN AGED CARE AND PUBLIC HOSPITALS

Written Question on Notice

Senator Evans asked:

What specific action is (has) the Commonwealth undertaken to respond to the parity pay issue between aged care and public hospitals?

Answer:

The Commonwealth Government does not set wages for aged care staff through either the award or enterprise bargaining structures. Employment and industrial award issues are matters between staff and providers at the enterprise level or as determined by the Federal or State industrial tribunals, under the relevant Commonwealth or State regulatory framework.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2001-2002, 20 February 2002

Question: E02000204

OUTCOME: 3. ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS

Topic: IMPACT ON ESSENTIAL COMMUNITY SERVICES OF NEW SACS AWARD

Written Question on Notice

Senator Evans asked:

(a) What does the Department believe will be the effect on nursing homes, community care packages and other essential community services with the introduction of the new SACS Award?
(b) Is the Department aware of any services that will be unable to operate full time because of the new Award? (Although SACS is a State issue it will have a direct impact on Commonwealth Services).

Answer:

(a) The Commonwealth is not a party to the SACS Award.

(b) As above.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2001-2002, 20 February 2002

Question: E02000205

OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS

Topic: PRE 1999 CERTIFICATION – FIRE STANDARDS TO MEET 2008 STANDARD

Written Question on Notice

Senator Evans asked:

What steps is the Department going to take to ensure that all nursing homes that received certification prior to 1999 are able to meet the fire safety standards that have been outlined for the agreed 2008 standard?

Answer:

All homes assessed under the 1997 Certification Assessment Instrument have been advised that they are expected to achieve the requirements of the 1999 Certification Assessment Instrument by the end of 2003. This means achieving a score of at least 19/25 for Section 1 - Safety, and 60/100 overall.

To assist the industry, the Department is offering free assessments against the 1999 Certification Assessment Instrument. This is intended to give homes a clear indication of the areas the home could be improved, and can then be used in the discussions with their building design professionals.

Free assessments are expected to commence in late March 2002.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2001-2002, 20 February 2002

Question: E02000206

OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS

Topic: LIMITATIONS OF THE AGED CARE ACT

Written Question on Notice

Senator Evans asked:

Does the current Aged Care Act mean that the Department can only 'encourage' all homes to meet the new industry standard?

Answer:

Under the *Aged Care Act 1997* (the Act), certification is not time limited.

However, there are a number of provisions in the Act which allow for the Secretary to the Department of Health and Ageing to review and, if appropriate, revoke or suspend a home's certification, including through the imposition of sanctions.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2001-2002, 20 February 2002

Question: E02000207

OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS

Topic: AVAILABLE PLACES FOR COMPLEX NEEDS GROUPS

Written Question on Notice

Senator Evans asked:

(a) How many places are available across Australia for people with high and complex needs?
(b) What modeling has been done about the future needs of this group?
(c) Is it expected that the number of people needing special assistance will rise?
(d) How are these people's needs being catered for?

Answer:

(a) When aged care places are allocated, they are subject to a number of conditions including that they are either for high care or low care. Other conditions can include priority of access for special needs groups or particular types of care that will be provided, for example, care for people with dementia. However, no places have been allocated for a specific category termed 'high and complex needs'. People who fall into such a category will access high care places.

    The number of high care residential aged care places allocated across Australia as at January 2002 is 79,360. There are also 290 Extended Aged Care at Home (EACH) packages that provide high level community care. People who access places in low care homes or community aged care places can also remain in those places as their care needs increase where the provider is able to meet those care needs. Therefore, the number of people actually receiving high level care is greater than the number of specified high care places.

(b) A working group has been established under the Aged Care Working Group – the peak departmental consultative body – to consider the care and accommodation needs of people with dementia. Membership comprises service providers, clinical experts and peak bodies involved in dementia care. They will report to the department to inform further policy work in relation to support for people with dementia and their carers.

(c) The provision of aged care places increases with increases in the aged population. (see also response to d) below).

(d) Approved providers have a responsibility under the *Aged Care Act 1997* to comply with the Accreditation Standards. The standards include, amongst other things, requirements relating to residents' health and personal care (eg. Residents receive appropriate clinical care; residents specialised nursing care needs are identified and met by appropriately qualified nursing staff).

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2001-2002, 20 February 2002

Question: E02000208

OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS

Topic: INAPPROPRIATE PLACEMENTS

Written Question on Notice

Senator Evans asked:

(a) Is the Department aware of any past/recent/current inappropriate placements of people in residential aged care facilities?
(b) Has the Department been made aware of any incidents in residential aged care facilities that have arisen from inappropriate placements?
(c) Is the Department currently undertaking any work in this area to ensure that resident and staff safety is paramount?

Answer:

(a) No. Commonwealth subsidy is only paid in respect of care recipients who have been assessed, by an Aged Care Assessment Team, as being eligible to receive residential aged care.

(b) See a.

(c) See a.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2001-2002, 20 February 2002

Question: E02000084

OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS

Topic: CONTINENCE AIDS ASSISTANCE SCHEME

Written Question on Notice

Senator Harradine asked:

(a) Does the Department provide any funding to the Continence Aids and Support Scheme and if so how much funding is provided?
(b) Has funding declined in recent years and if so why?
(c) If funding has declined, will the Department consider restoring funding to its previous levels in response to the many people affected by the cut in the subsidy?

Answer:
(a) Yes. In 2000-01 $8.337m was provided to the Continence Aids Assistance Scheme (CAAS).

(b) No.

(c) N/A.

- Doctors on Five Year Programs by State/Territory

Western Australia	51
Queensland	26
New South Wales	6
Victoria	39
South Australia	0
Northern Territory	3
Tasmania	6

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2001-2002, 20 February 2002

Question: E02000044

OUTCOME 4: QUALITY HEALTH CARE

Topic: NATIONAL SUICIDE PREVENTION

Written Question on Notice

Senator Evans asked:

(a) Why has the National Suicide Prevention program been rolled over?
(b) What is the delay?
(c) Has this happened before?

Answer:

(a) Allocations for financial years 2000-2001 were not fully expensed.

(b) In line with Government's commitment, funding decisions on suicide prevention are developed through community involvement in all jurisdictions and in relation to national initiatives and then recommended to the Minister by a National Advisory Council for Suicide Prevention (NACSP). This process is partially outside Departmental control and has taken longer than planned in some States/Territories.

(c) Yes. $6.976 million of the 1999-2000 allocation was rolled over into financial year 2000-2001.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2001-2002, 20 February 2002

Question: E02000022

OUTCOME 4: QUALITY HEALTH SERVICES

Topic: AUSTRALIAN DIVISIONS OF GENERAL PRACTICE

Written Question on Notice.

Senator Evans asked:

(a) Can you provide details of all funding provided by the department to Australian Divisions of General Practice (ADGP) in the last three years?
(b) What is the total funding each year?
(c) How is that broken up into funding for different projects?
(d) What was the basis of the special funding approved by the Minister for the Australian Divisions of GP's to assist in the implementation of the Governments budget initiatives? What benefits will the public see from this funding?

Answer:

(a) See attachment A

(b) The total funding for each financial year is:
- 1999/2000 – $3,085,996
- 2000/2001 – $3,475,382
- 2001/2002 – $2,646,017

(c) See attachment A

(d) The $25.8 million announced by the former Minister for Health and Aged Care, the Hon Dr Michael Wooldridge, is allocated to 123 individual Divisions of General Practice (not the Australian Divisions of General Practice) over the period 2001-2002 to 2003-2004. The funding is for implementation of the budget initiatives relating to asthma, diabetes, mental health and practice nurses.

The benefit to the public will be an integrated approach to chronic disease management in general practice that will assist in the prevention, diagnosis and management of chronic diseases.

Australian Divisions of General Practice (ADGP)

Description of the Services provided	Funding (inc GST)
1999/2000	
Develop evaluated models in key areas of GP/hospital collaboration through Division/hospital partnerships and disseminate the knowledge to the wider community	$12,000
Provision of national immunisation coordination services	$126,109
To develop effective roles for divisions of general practice in the accreditation support process, addressing identified target areas.	$250,000
ADGP core funding for ongoing operation 1999-2000	$1,415,000
Costs of participating in the GP Memorandum of Understanding	$540,000
Engagement of National Enhanced Primary Care coordinator under the GP Education, Support and Community Linkages (GPESCL) component associated with new MBS schedule items for enhanced primary care	$324,370
Project management of General Practice National Innovations Funding Pool – second round 1999/2000	$418,517
TOTAL – 1999/2000	*$3,085,996*
2000/2001	
Services for national primary mental health coordinator position within the Australian Divisions of General Practice	$379,720
Services for postgraduate primary care psychiatry scholarships for GPs	$66,000
ADGP core funding for ongoing operation 2000-2001	$2,059,462
Provision of national immunisation coordination services	$145,200
Management and Coordination of the National Divisions Youth Alliance, which aims to enhance the capacity of GPs and Divisions to work in partnership with others to improve health outcomes for young people.	$825,000
TOTAL – 2000/2001	*$3,475,382*
2001/2002	
Services in relation to coordinating the convening of a workshop for Primary Mental Health Care Development and Liaison Officers.	$9,320
ADGP core funding for ongoing operation 2001-2002	$2,043,500
Development and dissemination of familiarisation training required for General Practitioners (GPs) to deliver quality primary mental health care under the 'Better Outcomes in Mental Health Care' initiative.	$434,797
Provision of national immunisation coordination services	$158,400
TOTAL – 2001/2002	*$2,646,017*

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2001-2002, 20 February 2002

Question: E02000038

OUTCOME 4: QUALITY HEALTH CARE

Topic: GP Training Program

Written Question on Notice

Senator Evans asked:

(a) Can you explain the new system for GP Training and the nature of the contract signed with GPET Pty Ltd.
(b) Can the Department explain the rationale for the new GP Training arrangements?
(c) Are they in place?
(d) Is everything working smoothly?
(e) Is there any overlap with the potential providers?
(f) Is the new arrangement cheaper or more expensive then the previous arrangements? What were the costings for the old regime and the new regime.
(g) When was the decision made to adopt the new arrangements?
(h) Why were they announced only days before the election?
(i) Have any concerns been expressed about the likelihood of success of the new arrangements?

Answer:

(a) Under the new training arrangements, the Department has funded General Practice Education and Training (GPET) Limited to manage general practice vocational training under a regionalised and contestable arrangement.

The regionalisation of vocational training will provide opportunities for a range of organisations to be involved in the delivery of general practice education and training in urban, rural and remote areas.

This approach will bring benefits including more innovation and flexibility in the way general practice education and training is provided.

GPET's current contract covers the period from October 2001 to December 2004. Funding under the contract has been provided for 15 months from October 2001 to December 2002. Funding for future years will be provided on the basis of specified deliverables to be negotiated for each funding period between GPET and the Department.

(b) The Government has undertaken major reform in the area of general practice vocational training to better meet the needs of the profession and the broader community. This reform has come about after a great deal of representation from doctors over the years regarding the limited flexibility in the previous vocational training arrangements.

This reform included introduction of a 200 place rural training pathway to help ensure that doctors are better equipped to provide the broad range of medical activities that are characteristic of rural and remote medical practice.

(c) Implementation of the new arrangements is well underway, with GPET approving 15 consortia to provide training from 2002, and continuing to work with developmental consortia in 2002 with a view to commencement from 2003.

(d) GPET is working closely with consortia and GPEA to ensure a smooth transition to the new arrangements and to ensure that all registrars are provided with appropriate vocational training.

(e) No

(f) The RACGP were funded $32.1 million to deliver training in the 2001 calendar year. GPET has been funded $54.4 million for the establishment of consortia and delivery of training for a 15 month period from October 2001 to December 2002.

(g) In June 2000, the then Minister for Health and Aged Care, the Hon Dr Michael Wooldridge, announced new arrangements for funding and delivery of general practice vocational training.

(h) The new arrangements were announced in June 2000. The Department had two interim contracts with GPET prior to entering into the long term contract. The current GPET contract was entered into on 8 October 2001 following lengthy negotiation with GPET.

(i) Yes. These concerns have been addressed through discussions and progress in implementation of the new arrangements.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2001-2002, 20 February 2002

Question: E02000025

OUTCOME 4: QUALITY HEALTH CARE

Topic: VOCATIONALLY REGISTERED GPs

Written Question on Notice

Senator Evans asked:

Is it true that vocationally registered (VR) GPs are required to "make arrangements" to remain VR. If this is the case why is the Department paying them to do something they are already required to do?

Answer:

Vocationally registered general practitioners are required to meet the minimum requirements of the Royal Australian College of General Practitioners (RACGP) Quality Assurance and Continuing Professional Development Program to remain vocationally registered. This is a requirement under the Regulation 5 of the Health Insurance (Vocational Registration of General Practitioners) Regulations.

The Department does not pay vocationally registered GPs to remain vocationally registered.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2001-2002, 20 February 2002

Question: E02000114

OUTCOME 4: QUALITY HEALTH CARE

Topic: VOCATIONALLY REGISTERED GENERAL PRACTITIONERS

Hansard Page: CA89

Senator West asked:

Update QON E083 figures.

Answer:

Note: There are minor differences between the following table and that provided in November 2000 in part due to the availability of later information for the given time period.

Table 1: Number of medical practitioners billing Medicare in RRMAs[(a)] 3 to 7, by type of practitioner, 1997-98 to 2000-01

	Number of medical practitioners					**Percentage Change Over 4 years**
	1996/97	**1997/98**	**1998/99**	**1999/00**	**2000/01**	
Vocationally registered general practitioners	3967	4081	4141	4199	4264	7.5
General practice registrars	393	359	409	411	514	30.7
Other non-specialist medical practitioners (OMPs)	1229	1266	1418	1600	1585	29.0
Total	**5589**	**5706**	**5968**	**6210**	**6363**	**13.8**

(a) The region categories are as per the Rural, Remote and Metropolitan Areas Classification, 1991 census edition, Commonwealth Department of Primary Industries and Energy, Commonwealth Department of Human Services and Health, November 1994. RRMAs 3 to 7 include all rural and remote centres.

UPDATE ON DOCTOR NUMBERS

(19 February 2002)

Number of non-specialist medical practitioners billing Medicare, full-time workload equivalents (FWEs) and full-time equivalents (FTEs), by region,
1999-2000 to 2000-01

	Total metropolitan		**Total rural & remote**	
	1999-00	**2000-01**	**1999-00**	**2000-01**
Number of GPs	18024	17905	6210	6363
% change		*-0.7*		*+2.5*
FWEs	12797	12701	3636	3792
% change		*-0.8*		*+4.3*
FTEs	10587	10555	3287	3417
% change		*-0.3*		*+4.0*

Source: Medicare statistics, Department of Health and Ageing

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2001-2002, 20 February 2002

Question: E02000113

OUTCOME 4: QUALITY HEALTH CARE

Topic: RURAL DOCTOR NUMBERS

Hansard Page: CA88

Senator West asked:

Update QON E082 figures for past five years. (Figures on Number of GPs and FWE in the five categorised locations, large rural, small rural, other rural, remote and other remote).

Answer:

Note: There are minor differences between the following tables and those provided in November 2000 in part due to the availability of later information for the given time period.

Table 1: Number of medical practitioners billing Medicare by region[(a)],1997-98 to 2000-01

Region	**Number of medical practitioners**					**Percentage Change**
	1996/97	**1997/98**	**1998/99**	**1999/2000**	**2000/01**	**Over 4 years**
Large rural centre	1362	1349	1377	1390	1435	5.4
Small rural centre	1306	1323	1375	1474	1493	14.3
Other rural area	2301	2325	2435	2542	2629	14.3
Remote centre	246	257	296	309	311	26.4
Other remote area	374	452	485	495	495	32.4
Total rural & remote	**5589**	**5706**	**5968**	**6210**	**6363**	**13.8**

(a) The region categories are as per the Rural, Remote and Metropolitan Areas Classification, 1991 census edition, Commonwealth Department of Primary Industries and Energy, Commonwealth Department of Human Services and Health, Nov 1994.

Table 2: Full-time workload equivalents[(a)] (FWEs) for medical practitioners billing Medicare by region[(b)],1997-98 to 2000-01

Region	Number of medical practitioners					Percentage Change
	1996/97	1997/98	1998/99	1999/2000	2000/01	Over 4 years
Large rural centre	927	946	942	933	964	4.0
Small rural centre	925	933	931	952	990	7.0
Other rural area	1476	1482	1482	1495	1571	6.4
Remote centre	118	124	119	116	122	3.4
Other remote area	126	136	141	141	145	15.0
Total rural & remote	**3572**	**3620**	**3615**	**3636**	**3792**	**6.2**

(a) "FWE" values are derived for each practitioner by dividing the schedule fee value of their services by the average for full time practitioners of that sub speciality over the reference period
(b) The region categories are as per the Rural, Remote and Metropolitan Areas Classification, 1991 census edition, Commonwealth Department of Primary Industries and Energy, Commonwealth Department of Human Services and Health, Nov 1994.

Table 3: Full-time equivalents[(a)] (FTEs) for medical practitioners billing Medicare by region[(b)],1997-98 to 2000-01

Region	Number of medical practitioners					Percentage Change
	1996/97	1997/98	1998/99	1999/2000	2000/01	Over 4 years
Large rural centre	796	815	814	818	837	5.2
Small rural centre	808	819	820	848	882	9.2
Other rural area	1345	1353	1359	1383	1447	7.6
Remote centre	100	105	105	104	110	10.0
Other remote area	115	124	134	133	142	23.5
Total rural & remote	**3164**	**3216**	**3232**	**3287**	**3417**	**8.0**

(a) "FTE" values are derived for each practitioner by dividing the schedule fee value of their services by the average for full time practitioners of that sub speciality over the reference period
(b) The region categories are as per the Rural, Remote and Metropolitan Areas Classification, 1991 census edition, Commonwealth Department of Primary Industries and Energy, Commonwealth Department of Human Services and Health, Nov 1994.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2001-2002, 20 February 2002

Question: E02000006

OUTCOME 4: QUALITY HEALTH CARE

Topic: PRE-ELECTION ANNOUNCEMENTS - GRANT TO ACRRM.

Hansard Page: CA62

Senator Evans asked:

(a) Can the Department confirm that a $5.6m grant was signed off by the Minister to the Australian College of Rural and Remote Medicine (ACRRM) only hours before the Government went into caretaker mode?
(b) Where did the idea for this grant originate, how was it assessed and what alternative proposals were considered? Where did the funds to make this grant come from.
(c) Doesn't this grant mean that Australia now has two doctor organisations competing to deliver 'continuing medical education' services to doctors? How will the effectiveness of these arrangements be assessed?

Answer:

(a) On 8 October 2001, before the writs were issued, the former Minister for Health and Aged Care, Dr Michael Wooldridge, gave policy approval to funding of up to $5.6 million over a three year period to assist the Australian College of Rural and Remote Medicine (ACRRM) to develop and implement a Professional Development Program, following an application from the College.

(b) ACRRM has previously been funded by the Department to develop and trial innovative approaches to rural training and to build an integrated program for rural professional skills development. The Professional Development Program builds on the work ACRRM has undertaken in this area and is specifically designed to meet the needs of rural and remote general practitioners.

The second part of this question, regarding funding, was answered during Senate Additional Estimates hearings on 20 February 2002 (Hansard page CA 61).

(c) The grant means that ACRRM can develop an alternative Professional Development Program to that provided by the Royal Australian College of General Practitioners (RACGP). The ACRRM program will provide more choice for doctors, particularly for those in rural areas as it focuses specifically on professional development needs of rural and remote practitioners.

The effectiveness of the ACRRM program will be assessed by the number of doctors who undertake the ACRRM professional development program who continue to meet Vocational Recognition requirements.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2001-2002, 20 February 2002

Question: E02000106

OUTCOME 4: QUALITY HEALTH CARE

Topic: FUNDING CONTRACTS FOR RACGP AND ACRRM.

Hansard Page: CA63

Senator Evans asked:

(a) Provide a list of all contracts that the department currently holds with the ACRRM and with the RACGP, any other contracts that they have held in the last three years?
(b) In doing that, would you give us a brief description of what they are contracted for?

Answer:

(a) Attachment A provides details with respect to ACRRM and Attachment B provides details with respect to RACGP. In Attachment B, grant agreements commenced since January 2001 are excluded since they are covered in the answer to E02000021.

(b) See (a) above.

Attachment A to E020000106

AUSTRALIAN COLLEGE OF RURAL AND REMOTE MEDICINE (ACRRM)

This table details the contracts or grant agreements the Department of Health and Ageing currently holds, and/or has held in the last three years, with the Australian College of Rural and Remote Medicine (ACRRM) and provides a brief description of the subject of the contract or grant agreement.

DESCRIPTION	**START DATE**	**FINISH DATE**	**PRICE***
Rural & Remote Area Placement Program (RRAPP) - Variation **TOTAL**	March 2000 May 2001	March 2003 March 2003	$2,110,000 $156,800 **$2,266800**
Develop a program to facilitate the development of innovative models of rural medical training and professional development (the agreement has been novated from the Department to General Practice Education and Training Ltd)	January 2001	May 2002	$3,740,000

* amounts shown are inclusive of GST. The net funding by the Government is 1/11th less than that shown

ROYAL AUSTRALIAN COLLEGE OF GENERAL PRACTITIONERS

This table details the contracts or grant agreements the Department of Health and Ageing currently holds, and/or has held in the last three years, with the Royal Australian College of General Practitioners (RACGP) and provides a brief description of the subject of the contract or grant agreement. This table excludes grant agreements entered into since January 2001 as these are covered in the answer to E02000021.

No.	DESCRIPTION	START DATE	FINISH DATE	PRICE*
1	General Practice Evaluation Program (GPEP 761) – Influencing prescribing behaviour in general practice – a five year follow up study.	January 1999	March 2001	$49,175
2	Developing Standards and Guidelines for MBS items related to case conferencing, care planning & assessment for persons aged over 75 years.	September 1999	July 2000	$89,000
3	Underwrite the costs of participating in the MOU with general practitioners. The GP MoU provided funding for a range of rural projects that were negotiated in the process of developing the GP MoU. Not all of these funds were allocated to the RACGP.	December 1999	June 2002	$370,000
4	Develop an implementation strategy for evidence based best practice clinical practice guidelines for general practitioners.	January 2000	July 2000	$91,100
5	Rural Undergraduate Support and Coordination (RUSC) program funding to support the coordination and management of curriculum placements in the Northern Territory (Top End) for medical students from 8 universities. - Variation - Variation **TOTAL**	January 2000 January 2001 January 2002	December 2000 December 2001 June 2002	$120,000 $132,000 $60,000 **$312,000**
6	RACGP Training Program – provides vocational training to medical practitioners seeking vocational recognition as general practitioners (Fellowship of the RACGP). - Variation - Variation **TOTAL**	January 2000 January 2001 February 2001	December 2001 January 2001 December 2001	$22,700,000 $1,862,500 $30,263,000 **$54,825,500**
7	Development of resources to assist general practitioners identify patients at risk of falling and to develop intervention and management strategies.	April 2000	June 2001	$55,550

8	Presentation of Health Professional Guidelines at the Sharing Health Care Education and Training Induction Session and assessment of demonstration project education and training need. - Variation **TOTAL**	June 2000 February 2002	June 2001 March 2002	$176,000 $5,581 **$181,581**
9	Undertake specific tasks related to indigenous health training, emergency medicine training, support for doctors in indigenous communities, developing alternative pathways, subsidies for medical indemnity insurance and website database for teaching practices. - Variation, Alternative Pathways - Variation, Alternative Pathways - Targeted research on rural medical family issues and capacity building activities **TOTAL**	June 2000 March 2001 August 2001 February 2001	June 2002 June 2002 December 2001 June 2002	$7,420,000 $45,595 $19,140 $192,500 **$7,677,235**
10	Continence care and resource model under the National Continence Management Strategy.	June 2000	April 2001	$330,793
11	Booklet produced as part of the Journal of the RACGP entitled - Hepatitis 'C' *A Management Guide for general practitioners.*	June 2000	June 2000	$81,000
12	Sponsorship of the inaugural Women in General Practice conference and Workshops – progressing the agenda of women in general practice.	July 2000	July 2000	$5,500
13	Services to develop a simple, overarching plain English document that describes general practice to an audience that is external to general practice, including consumers, government and other health providers in relation to a response to recommendation 32 of the General Practice Strategy Review.	October 2000	October 2001	$15,770
14	Develop and trial a clinical audit package as part of the GP Education, Support and Community Linkage component associated with the new MBS items for EPC.	December 2000	November 2001	$231,480
15	Services for analysis of submissions received by the Locum Relief Review Group.	December 2000	April 2001	$11,000
16	Developing supplementary guidelines for the enhanced primary care Medicare Benefits Schedule items	February 2002	July 2002	$119,658
17	Develop an educational and awareness program under the National Continence Management Strategy, for general practitioners to enable them to manage urinary and faecal incontinence in all age groups	February 2002	May 2003	$319,000

* amounts shown are inclusive of GST. The net funding by the Government is $1/11^{th}$ less than that shown

Commonwealth Department of Health and Ageing
Health Services Division
GPO Box 9848, Canberra ACT 2601

Senator Susan Knowles
Chair
Senate Community Affairs Legislation Committee
Parliament House
CANBERRA ACT 2600

Dear Senator Knowles

Senate Additional Estimates Hearings 20 February 2002

I am writing to clarify information I provided to the Committee at the Additional Estimates Hearing on 20 February 2002.

When asked by Senator Evans about discussions in relation to GP House, I stated that "the next concrete move in the context of those ongoing discussions was that Dr Hemming, the president of the RACGP, wrote to the minister on 6 September 2001 to propose a framework for making this happen". (page CA64)

A subsequent file search has identified that the department inadvertently omitted information that should have been included in that response in that there was other activity in relation to this project prior to receipt of the letter from Dr Hemming, Chairman of RACGP, to the then Minister, Dr Wooldridge, of 6 September 2001. This information was not at hand at the time of answering the question.

While detailed advice on this matter will be included in response to Question on Notice E02000015 from the hearing, I wished to give you early notice of this omission.

In addition, at Hansard page CA73 advice was given that it was the Department's understanding that RACGP would be occupying 200 square metres of a 1,000 square metre floor. The lettable area of the fourth floor is in fact 2,121 square metres not 1,000 metres as indicated.

Yours sincerely,

Andrew Stuart
First Assistant Secretary
Health Services Division
7 March 2002

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2001-2002, 20 February 2002

Question: E02000107

OUTCOME 4: QUALITY HEALTH CARE

Topic: GP HOUSE – LETTER FROM DR HEMMING – SAME AS E02000014(a)

Hansard Page: CA64

Senator Evans asked:

Is the department able to make the letter (written by Dr Hemming on 6 September 2001 on the GP House proposal) available to the Committee.

Answer:

Yes. A copy of the letter is attached.

Attachment for EC200107

THE ROYAL AUSTRALIAN COLLEGE OF GENERAL PRACTITIONERS

Minister for Health
10 SEP 2001
M01011392 3/10/01

RECEIVED
21 SEP 2001
Parliamentary Section

Private & Confidential

Hon. Dr Michael Wooldridge, M.P.
Minister for Health & Aged Care
MG 48, Parliament House
Canberra ACT 2600

Dear Minister,

Re: proposal for the co-location of GP organisations in Canberra

I am writing in relation to a proposal formulated to achieve a greater sense of unity and co-operation among GP and GP-related organisations in this country. As you are aware, there has been for some time a concern among many GP organisations at a lack of common purpose in the GP sector in respect of national primary health care strategy and objectives. From time to time, the concept has been mooted of having GP and GP-related organisations co-locate in Canberra as a way of fostering and advancing a greater degree of communication and understanding between such organisations, and facilitating more meaningful dialogue with key stakeholders, particularly the Commonwealth Government. I know that you have been an early and enthusiastic supporter of this concept. Up till now, as you know, no viable proposal has been advanced to ensure its realisation.

The RACGP has committed significant resources to developing this concept, and after almost twelve months of investigation and analysis, we are now in a position to assume a sponsorship role in bringing a co-location project to reality. My purpose in writing, therefore, is to seek Commonwealth Government support for the proposal.

In essence, we propose that the RACGP be the lead agency in an initiative to co-locate a number of existing and newly created GP and GP-related organisations in office accommodation—positioned within the Parliamentary precinct—proposed to be called 'GP House'. There are a number of organisations whose interest and benefit in co-location would make them suitable and interested co-tenants. Initially, the organisations that are proposed to co-locate might involve, at least, the following:

- Royal Australian College of General Practitioners (RACGP), including the ACT sub-faculty of the NSW Faculty
- Australian Divisions of General Practice (ADGP)
- Australian College of Rural & Remote Medicine (ACRRM)
- General Practice Registrar's Association (GPRA)
- National Primary Health Care Research Institute (NPHCRI)

College House, 1 Palmerston Crescent, South Melbourne VICTORIA 3205 • TEL (03) 9214 1414 • FAX (03) 9214 1400

- General Practice Computing Group (GPCG)
- National Rural Health Alliance (NRHA)

Beyond those organisations, there may well be benefit to other key GP stakeholder organisations, such as General Practice Education & Training (GPET), in co-locating in 'GP House', as indeed may be the case with other medical colleges.

In our view, the benefits of this proposal to the GP organisations concerned—and to key stakeholders—are considerable. Co-location offers the prospect of:

- diminishing the fragmentation of general practice, which has been to the detriment both of the sector and general practitioners;
- increasing the dialogue and discussion among co-tenanted GP organisations of the strategic issues and imperatives in primary health care and, hence, enhancing the possibility of achieving over time a higher level of consensus—a shared sense—about national primary health care strategy and policy objectives;
- providing a 'one-stop' shop for Government and other stakeholders in their dealings with GP and GP-related organisations across a range of representative areas;
- raising the standard of communication infrastructure available to GP organisations, most of which are too small to otherwise afford the expensive technical facilities required. This would significantly improve the effectiveness of communication with GPs, especially in rural and remote areas; and
- enabling a better and more effective service to the GP and GP-related memberships as professional awareness and organisation capacity grows.

In short, the proposed co-location has the potential to significantly raise professional standards in GP and GP-related organisations and, hence, make an important contribution to improved national primary health care.

The RACGP is distinctly, if not uniquely, well placed to sponsor a Canberra co-location by organisations and representative associations involved in primary health care, in general, and general practice, in particular. The College is a reputable, not-for-profit organisation with substantial financial reserves and, unlike many other potential co-tenants, is not constrained in its capacity legally to enter into the kind of longer-term contractual arrangements that may be necessary to realise this proposal.

However, the economics of a proposed co-location are such that this proposal would not be viable without the support of the Commonwealth in the form of a financial contribution to the establishment of 'GP House'. The current proposal being considered by us involves a new development at 44 Sydney Avenue, Barton. This will be a quality building in an outstanding location close to Parliament House. In all the 60 or so building or lease or development alternatives in Canberra we have explored over the past several months for this

purpose, nothing has come close to matching this development in terms of the 'fit' it represents for the key requirements of a building for co-locating GP organisations. The building is anticipated to commence construction later this year and be completed ready for occupancy by December 2002.

The proposal would involve the RACGP in investing $5 million in the project, and we are seeking a matching Commonwealth grant of $5 million to enable the project to proceed. This contribution by the Commonwealth would bring purchase of a majority position in the property within the reach of the RACGP and avoid exposing it to unacceptable commercial risk in relation to subsequent sub-leases to co-locating tenants. It should be said that $2 million of the Commonwealth's contribution would be expended in providing shared facilities and infrastructure for co-locating GP and GP-related organisations.

I have asked our CEO, Ms. Liz Furler, to write to your department setting out in greater detail the financial basis of this proposal, and the anticipated co-tenancy arrangements.

Finally, the College fully supports the co-location proposal as having the potential to make a significant contribution to a more cohesive and responsive general practice sector of the health care community. We believe that it is a realistic and achievable proposal and we look forward to your support in making it happen.

Yours sincerely,

Dr Paul Hemming
President
RACGP
6 September 2001

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2001-2002, 20 February 2002

Question: E02000108

OUTCOME 4: QUALITY HEALTH CARE

Topic: GP HOUSE – CONTRACT BETWEEN THE DEPARTMENT AND RACGP

Hansard Page: CA65

Senator Evans asked:

Is the Department able to provide the Committee with a copy of the contract (between the Commonwealth and RACGP for GP House)?

Answer:

Yes. A copy of the contract is attached. Please note this contract was executed in counterpart, consistent with Clause 22.1 of the contract. Consequently the two signed counterparts of page 19 of the contract are attached.

[Note: The attachment is not available electronically so has not been included in the electronic/printed volume]

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2001-2002, 20 February 2002

Question: E02000015

OUTCOME 4: QUALITY HEALTH CARE

Topic: GP HOUSE

Hansard Page: Written Question on Notice

Senator Evans asked:

(a) Can you explain in detail how this measure came about?
(b) Who suggested it? Precisely when? Was the Minister's office involved in the genesis of the measure at all?
(c) Who developed it? Which area in the Department worked on it? What input did the Minister or his office have in the development?
(d) How many times did the proposal in any form pass between the Department and the Minister's office?
(e) When did the Minister approve the proposal? Did he change it in any way?
(f) Did it go to Cabinet? When?
(g) When was it announced – apart from the letter to the RACGP in late September?
(h) Overall how would you describe the level of the Minister's involvement with this proposal?

Answer:

(a) The idea of co-locating GP groups had been discussed for some time in the industry.

Minister Wooldridge made reference to the possibility of bringing together national GP organisations in December 2000 when he gave a speech at the formal opening of the Australian Divisions of General Practice (ADGP) premises in Belconnen, ACT. Initially, the Department had informal discussions with the ADGP about establishing a "GP Precinct' in the Belconnen premises partially occupied by the ADGP. During the ensuing months, the Department had informal discussions with ADGP, RACGP and other GP groups about how this idea might be realised.

During the discussions it became clear that other GP groups did not favour a location in Belconnen. Subsequently, the Department looked for potential leased space in Barton, Deakin and the city, but no options were found of suitable size, location and availability. A new building then appeared to be the best option.

During the period from January to May 2001 it became apparent that RACGP was the only national GP organisation of sufficient size and independent means equipped to mount the independent development of a new building. The RACGP engaged a consultant to assist it in considering the options in relation to a Canberra presence. That consultant developed a draft of the GP House proposal and it was first provided to the Department as a draft on 9 August 2001.

On 23 August 2001 the Department provided written advice to Minister Wooldridge regarding possible sources of funding for GP House, should he wish to make a grant available for this purpose. On 29 August 2001 Minister Fahey received a letter from Dr Wooldridge seeking $5m via transfers between outcomes. Dr Hemming wrote formally to the Minister about the proposal on 6 September 2001 and the CEO of the RACGP wrote to the Department on the same date providing a more detailed proposal. There were discussions between the Minister's office and the Department as a response to Dr Hemming's letter was prepared.

(b) The concept of co-location of GP organisations was first raised with the Department by the Minister around August 2000.

(c) The proposal in Dr Hemming's letter of 6 September 2001 was developed by the RACGP. The proposal was handled in the General Practice Branch of Health Services Division. Budget Branch of Portfolio Strategies Division coordinated funding advice. Legal Services Branch assisted in the development of the agreement. The Minister's office was kept informed of progress.

(d) The 6 September proposal to the Minister from the RACGP was passed to the Department on 21 September 2001. The Department provided written advice on the broad terms of the GP House agreement to the Minister on 27 September 2001.

(e) The Minister gave approval for the broad terms of the agreement with the RACGP on 27 September 2001 without variation and signed the response to the RACGP.

(f) No.

(g) Answered during Senate Additional Estimates hearings on 20 February 2002 – refer CA82.

(h) See (a), (b), (d) and (e) above.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2001-2002, 20 February 2002

Question: E02000019

OUTCOME 4: QUALITY HEALTH CARE

Topic: GP HOUSE

Hansard Page: Written Question on Notice

Senator Evans asked:

(a) Why was the RACGP chosen as the recipient of this grant?
(b) What was the process for coming to this decision?
(c) Were any other organisations considered?
(d) Does the Department have guidelines about when funding needs to go to tender?
(e) Was a tender considered for this project? If not, why not?

Answer:

(a) Already answered at the Senate Additional Estimates hearing on 20 February 2002 (refer Hansard page CA79 and the answer to Question E02000015 (a)).

(b) Already answered at the Senate Additional Estimates hearing on 20 February 2002 (refer Hansard page CA64 and the answer to Question E02000015 (a)).

(c) Already answered at the Senate Additional Estimates hearing on 20 February 2002 (refer Hansard pages CA64 and 79).

(d) Tendering is a process relevant to procurement and the application of the Commonwealth Procurement Guidelines. The Commonwealth Procurement Guidelines do not apply to grant funding decisions.

The Department has *Grants Administration Guidelines*. The *Grants Administration Guidelines* provide guidance on appropriate methods for calling for applications for funding. The *Guidelines* state that there may be circumstances where the Department may need to select a grantee directly, for example, if the grantee is the only body able to supply the services sought.

(e) Already answered at the Senate Additional Estimates hearing on 20 February 2002 (refer Hansard page CA79).

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2001-2002, 20 February 2002

Question: E02000109

OUTCOME 4: QUALITY HEALTH CARE

Topic: GP HOUSE – COSTINGS

Hansard Page: CA66

Senator Evans asked:

Could you please take on notice the costings: whether the $10 million-odd you described is the cost of the building plus the purchase of the land or whether they are two separate costs.

Answer:

The "$10 million-odd" is not the cost of the building plus the purchase of the land.

According to the more detailed proposal provided by the Chief Executive Officer of the RACGP on 6 September 2001, there are two components to this money.

1. $8 million is to purchase the RACGP shareholding in the Unit Trust that will own the land and the building at 44 Sydney Avenue, Forrest. $3.1 million of the $5 million provided by Government is a contribution to that $8 million. The remaining $4.9 million is being contributed by the RACGP from its own funds.

2. $2.1 million is the cost of the fit-out of the fourth floor of the building that is to be occupied by the GP organisations. Of that $2.1 million, $1.9 million of the Government's $5 million grant will fund the fit-out of the space to be occupied by the non-RACGP tenants of the floor. RACGP will contribute the remaining $0.2 million for the fit-out of the space on the fourth floor that it will occupy itself.

The following table shows the breakdown:

	Equity Purchase	Fit-out	Total
RACGP	$4.9m	$0.2m	$5.1m
Commonwealth	$3.1m	$1.9m	$5.0m
Total	**$8.0m**	**$2.1m**	**$10.1m**

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2001-2002, 20 February 2002

Question: E02000111

OUTCOME 4: QUALITY HEALTH CARE

Topic: GP HOUSE – SQUARE METREAGE

Hansard Page: CA73

Senator Evans asked:

What is the square metreage of the building (GP House)?

Answer:

The Commonwealth is not a party to the contract with the developer. However, according to the developer's (BECTON) website, the building will be 11,000 square metres. The nett lettable area is 10,000 square metres.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2001-2002, 20 February 2002

Question: E02000016

OUTCOME 4: QUALITY HEALTH CARE

Topic: GP HOUSE – FUNDING OF THE MEASURE

Hansard Page: Written Question on Notice

Senator Christopher Evans asked:

(a) The description of this measure says a grant of $5 million will be given to the RACGP but the table for the measure shows no impact. Can you explain this?
(b) Where did the money come from to fund this measure?
(c) Is it correct that funding was taken from Specialist Medical Outreach Service and Asthma Management Programme?
(d) Can you explain what each of these programs do?
(e) What was the total funding for Specialist Medical Outreach Service (annually and over four years)?
(f) What could $5m have paid for in this program?
(g) What was the total funding for Asthma Management Program (annually and over four years)?
(h) What could $5m have paid for in this program?
(i) Did the Department suggest 'GP House" should be funded in this way?
(j) If so, when was this recommendation made?
(k) Was the recommendation made in writing?

Answer:

(a) The impact on the portfolio was budget neutral. The proposed expenditure against Outcome 4 was offset by transfers from Outcome 5 ($4 million) and Outcome 9 ($1 million). Refer pages 65, 81 and 105 of the Health and Ageing Portfolio Additional Estimates Statements 2001-2002.

(b) Refer (a) above.

(c) Yes.

(d) The Medical Specialist Outreach Assistance Program (MSOAP) aims to increase the access of rural and remote communities to specialist medical services by addressing some of the financial disincentives to specialists who may wish to provide outreach services. The program funds costs associated with new or expanded outreach services that have been identified as being of high priority.

The community awareness and support element of the Asthma Management Program (funded by Outcome 9) includes best practice management of asthma, particularly in general practice. It also provides infrastructure support and information to the community and to health professionals to promote effective asthma management.

(e) The funds allocated to the MSOAP in the 2000-2001 Budget were:
- 2000/01 $5 million
- 2001/02 $14.3 million
- 2002/03 $14.5 million
- 2003/04 $14.7 million.

(f) As the program was underspending, it is not appropriate to speculate on a hypothetical situation

(g) Total funding for asthma management from the GP Asthma Initiative over the 4 year period is $48.4 million, as set out:
- 2001/02 $7.6 million
- 2002/03 $12.3 million
- 2003/04 $14.1 million
- 2004/05 $14.4 million.

The amounts for the Outcome 9 community awareness and support element were:
- 2001/02 $2.6 million
- 2002/03 $3.3million
- 2003/04 $4.9 million
- 2004/05 $5.0 million.

(h) As the program was underspending, it is not appropriate to speculate on a hypothetical situation.

(i) The Department suggested ‘GP House’ could be funded in this way.

(j) The Department provided options for funding the project in a Minute to the Minister dated 23 August 2001.

(k) See (j) above.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2001-2002, 20 February 2002

Question: E02000017

OUTCOME 4: QUALITY HEALTH CARE

Topic: GP HOUSE

Hansard Page: Written Question on Notice

Senator Christopher Evans asked:

(a) If the argument is that the other programs spending was slow why weren't these funds rolled over?
(b) Wouldn't it have been more normal for a rollover (or re-phasing) to have occurred?
(c) Have funds from either of these programs (SMOS and AMP) been rolled over before?
(d) If not, isn't it usual that funds are rolled over at least once before they are taken away?
(e) Have there ever been rollovers for programs like these before?

Answer:

(a) The Minister for Finance and Administration decides on rollover on a case by case basis based on advice from the Department of Finance and Administration.

There was a slower than estimated roll-out of both the Medical Specialist Outreach Assistance Program (MSOAP) and the Outcome 9 community awareness and support component of the Asthma Management Program. Both Programs were fully funded for the following year and were expected to reach their planned activity levels in the future.

In respect of MSOAP there were underspends also during 2000/01 (reported in the Annual Report 2000-2001, Vol 2, p.422). In 2000/01 rephasing was sought but we were advised by the Department of Finance and Administration that this would not be permitted and the funding was lost to the portfolio. When underspends again emerged in the following year, there was an expectation that a rollover was not likely to be agreed.

In respect of the Asthma Management Program, there was no precedent specific to the program to indicate whether or not a rollover was likely. However, the Department noted that on a case-by-case basis rollovers had been rejected in other programs in the past.

There were therefore one-off savings available and these funds were reallocated to Outcome 4 in accordance with Budget Advice 2000/10 issued by the Department of Finance.

(a) Decisions on the rephasing of funds are made on a case by case basis as part of the Government deliberations on the preparation of appropriation bills. The decision depends on the nature of the program, the nature of future funding, whether or not additional funding together with the future year's allocation can be spent or is needed in subsequent years.

(b) No.

(c) No, see answer to (b).

(d) Yes. There has been rephasing of funds for programs like these in the past. The requests and decisions have been made on a case by case basis.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2001-2002, 20 February 2002

Question: E02000018

OUTCOME 4: QUALITY HEALTH CARE

Topic: GP HOUSE

Hansard Page: Written Question on Notice

Senator Christopher Evans asked:

a) What is the policy rationale for the project?
b) What benefit will taxpayers get from the $5m spent?
c) How will the Department measure this benefit?

Answer:

a) To promote communication and cohesion in general practice through the co-location of national general practice organisations. There is a widely recognised need for the different GP organisations in Australia to work better together to create a stronger general practice sector.

b) Already answered at the Senate Additional Estimates hearings on 20 February 2002 (refer Hansard page CA72)

c) The benefit would be measured by the achievement of co-location of general practice organisations consistent with the terms of the funding agreement.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2001-2002, 20 February 2002

Question: E02000021

OUTCOME 4: QUALITY HEALTH CARE

Topic: GP House – Other Grants to the RACGP

Hansard Page: Written Question on Notice

Senator Christopher Evans asked:

(a) What grants have been made to the Royal Australian College of GP's since January 2001?

(b) Which of these were approved by the former Minister and which by the current Minister? Do any of these grants relate to the delivery of public health services?

(c) What assessment was undertaken by the Department in deciding to move the GP Computing Group program from the AMA to the RACGP? What evaluation has been done since that program was moved and what has been the impact on services?

Answer:

(a) The attached table provides details regarding new grants to the RACGP commencing from January 2001. New contracts for services and variations to existing contracts since January 2001 are detailed in Attachment B of Question E02000106.

(b) The attached table provides information on which Minister gave policy approval for the grant. None of these grants involve the direct delivery by the RACGP of public health services.

(c) The contract with the Australian Medical Association (AMA) to auspice the GPCG ended on 30 June 2001. The Department assessed options on the most appropriate organisation with relevant expertise to auspice the GPCG for the new funding period from 1 July 2001 to 30 June 2004.

The RACGP was selected as the most appropriate body to auspice the GPCG:

- the focus in general practice information technology and management had changed from introducing information technology to enabling general practitioners to effectively use the information made available through technology;
- standards and training are the key issues for information management in general practice for the next few years;

- the RACGP is well recognised as a standards organisation and sets the standards for general practice;
- the RACGP has a large role in information management – this and the standards aspect both complement the GPCG's changing role in the GP industry; and
- the RACGP is the key body in developing training programs for Australian general practitioners.

Consequently the RACGP was invited to submit a proposal against the Department's Statement of Requirement. Subsequently a Departmental evaluation committee assessed the extent to which the proposal from the RACGP complied with the Department's Statement of Requirement.

The terms of the agreement require annual assessment of the GPCG's performance. The first contract year will end on 30 September 2002. The annual review has not yet commenced.

E02000021
Attachment

NEW GRANT AGREEMENTS WITH THE ROYAL AUSTRALIAN COLLEGE OF GENERAL PRACTITIONERS

SINCE JANUARY 2001

No.	DESCRIPTION	START DATE	FINISH DATE	PRICE*	MINISTERIAL POLICY APPROVAL
1	Grant under National Continence Management Strategy – the prevalence and factors relating to stress incontinence in pregnancy and childbirth	April 2001	February 2002	$93,769	Minister Bishop
2	Accommodation project fundholder deed – fundholding for round one accommodation projects for general practitioner registrars and medical students in rural and remote areas. No handling or administrative fees are provided to RACGP. These funds are held in trust by the RACGP until disbursed to grant recipients who are approved by the Minister.	April 2001	April 2003	$3,000,000	Minister Wooldridge
3	RACGP General Practitioners Registrar Research Workshop 13-15 June 2001 – part contribution to facilitate the attendance of additional registrars to the workshop	May 2001	October 2001	$20,000	Departmental Approval
4	Accommodation project fundholder deed – fundholding for round two accommodation projects for GP registrars and medical students in rural and remote areas. (See explanation above for round one accommodation projects)	June 2001	June 2003	$2,984,275	Minister Wooldridge
5	Provision of operational support for the General Practice Computing Group	July 2001	June 2004	$3,082,342	Minister Wooldridge
6	Employ a project officer to support the Evaluation Policy and Advisory Group (EPAG) in their work on after hours primary medical care.	September 2001	September 2002	$124,080	Departmental Approval
7	Establishment grant to facilitate the co-location of the RACGP, ADGP and other national general practice organisations in 'GP House' in Canberra.	September 2001	10 years from co-location.	$5,500,000	Minister Wooldridge

8	Printing and distribution of preventative guidelines for general practice promoting population and evidence based preventative care in general practice.	October 2001	November 2001	$85,196	Departmental Approval
9	Funding to provide assistance in making application to the ACCC in relation to the Trade Practices Act.	October 2001	October 2001	$33,854	Departmental Approval
10	After Hours Primary Medical Care seeding grant. The RACGP will in collaboration with Hospital General Practice Fremantle Foundation, undertake a comprehensive consultation process to identify the issues affecting disadvantaged people in relation to after hours primary medical care in the Fremantle region of WA and develop a business plan.	November 2001	June 2002	$49,927	Minister Wooldridge

* amounts shown are inclusive of GST. The net funding by the Commonwealth is $1/11^{th}$ less than that shown

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2001-2002, 20 February 2002

Question: E02000112

OUTCOME 4: QUALITY HEALTH CARE

Topic: COMPARISON OF SUICIDE LEVELS IN COUNTRY AND CITY AREAS

Hansard Page: CA 78

Senator Denman asked:

Do ABS reports (ABS document NO.3302.0, *Death, Australia* and ABS document No.3303.0, *Causes of Death, Australia*.) give a break down of deaths for regional areas? Are suicide levels in country areas higher than in city areas, and so on?

Answer:

The Australian Bureau of Statistics draws together coronial data to give suicide statistics nationally with data published annually in *Causes of Death, Australia*. Data is available for the sex, age group, method of suicide, marital status and State/Territory of those who have suicided. It can also be disaggregated on the basis of Capital City (the Statistical Division*)*, Other Urban (total population of more than 20,000*)* and Rural (the balance) locations.

The attached tables provided by the Australian Bureau of Statistics give the breakdown of deaths by regions in terms of both rates (Attachment A) and number of deaths (Attachments B and C).

The ABS produced a special report in 2000, *ABS Suicides 3309.0 1921-1998*, which examines the trend in suicide rates. Since data was first disaggregated in 1998, allowing urban and rural comparison, persons living in capital cities have had the lowest rate of suicides and rural areas have had a higher rate of suicides.

REGIONAL COMPARISON BY SEX AND AGE FOR 2000 - SUICIDE RATES

Australian Bureau of Statistics
Deaths collection
Regions by Sex by Age At Death
Intentional self-harm (X60-X84) 2000

AGE SPECIFIC RATES	Under 15	15-24	25-34	35-44	45-54	55-64	65-74	75-84	85+	All Ages (a)
MALES										
Capital City - AUST	0.2	16.5	28.3	26.8	20.2	13.3	13.3	20.2	45.1	16.9
Other Urban - AUST	0.5	22	36.6	37.5	22.6	20.6	29	23.6	61.1	23.1
Rural - AUST	0.5	23.2	47	34.4	29.1	21.3	25.1	30.6	38.5	25.1
Total - AUST	0.3	19	32.7	30.2	22.4	16.6	19.2	22.9	46.8	19.7
FEMALES										
Capital City - AUST	0.1	5.1	7.1	8.8	4.6	6.8	7.3	4	5.5	5.1
Other Urban - AUST	0	6.5	6.9	7.6	7.5	4.9	2.2	10.6	0	5.2
Rural - AUST	0	6.8	8.5	10.4	4.9	4.2	6.3	2.5	0	5.4
Total - AUST	0.1	5.7	7.3	9	5.2	5.9	6.1	5.1	3.5	5.2
PERSONS										
Capital City - AUST	0.2	10.9	17.7	17.8	12.3	10.1	10.1	10.6	17.3	11
Other Urban - AUST	0.3	14.4	21.8	22.4	15.1	12.7	14.9	16.1	19.2	14
Rural - AUST	0.3	15.5	28.1	22.6	17.6	13.1	15.9	15.1	13.3	15.1
Total - AUST	0.2	12.5	20.1	19.6	13.8	11.3	12.4	12.5	16.9	12.3

(a) All ages is an age standardised rate using the indirect method and Australia 2000 as the standard

REGIONAL COMPARISON BY SEX AND AGE FOR 2000 - NUMBER OF DEATHS
Australian Bureau of Statistics
Deaths collection
Table 1
Regions by registration years and Sex by Age At Death
Intentional self-harm (X60-X84)

			Under 15	15 - 24	25 - 34	35 - 44	45 - 54	55 - 64	65 - 74	75 - 84	85 +	Not stated	ALL AGES
2000	Capital City - AUST	Males	3	151	279	253	167	72	49	41	21	1	1037
2000	Capital City - AUST	Females	1	45	70	84	38	36	30	12	6	0	322
2000	Capital City - AUST	Persons	4	196	349	337	205	108	79	53	27	1	1359
2000	Other Urban - AUST	Males	2	56	90	96	52	33	36	16	9	0	390
2000	Other Urban - AUST	Females	0	16	17	20	17	8	3	10	0	0	91
2000	Other Urban - AUST	Persons	2	72	107	116	69	41	39	26	9	0	481
2000	Rural - AUST	Males	2	50	103	92	71	38	33	20	6	0	415
2000	Rural - AUST	Females	0	13	18	27	11	7	8	2	0	0	86
2000	Rural - AUST	Persons	2	63	121	119	82	45	41	22	6	0	501
2000	Undefined (a)	Males	0	6	3	3	1	3	2	0	0	0	18
2000	Undefined (a)	Females	0	1	1	1	1	0	0	0	0	0	4
2000	Undefined (a)	Persons	0	7	4	4	2	3	2	0	0	0	22
2000	Total - AUST	Males	7	263	475	444	291	146	120	77	36	1	1860
2000	Total - AUST	Females	1	75	106	132	67	51	41	24	6	0	503
2000	Total - AUST	Persons	8	338	581	576	358	197	161	101	42	1	2363

(a) Undefined Overseas and No Abodes - Australia

REGIONAL COMPARISON ACROSS YEARS - NUMBER OF DEATHS

Australian Bureau of Statistics
Deaths collection
Regions by Registration years
Intentional self-harm (X60-X84)

	1997	**1998**	**1999**	**2000**
Capital City - NSW	526	496	497	396
Other Urban - NSW	218	226	192	182
Rural - NSW	187	133	167	139
Undefined Overseas & No Abodes - NSW	3	7	13	13
TOTAL - NSW	**934**	**862**	**869**	**730**
Capital City - VIC	459	388	375	336
Other Urban - VIC	93	67	67	75
Rural - VIC	115	123	110	98
Undefined Overseas & No Abodes - VIC	2	1	0	2
TOTAL - VIC	**669**	**579**	**552**	**511**
Capital City - QLD	224	269	221	226
Other Urban - QLD	182	183	150	188
Rural - QLD	125	122	103	122
Undefined Overseas & No Abodes - QLD	4	5	6	5
TOTAL - QLD	**535**	**579**	**480**	**541**
Capital City - SA	144	172	147	143
Other Ural - SA	3	7	7	7
Rural - SA	48	62	46	47
Undefined Overseas & No Abodes - SA	1	3	0	2
TOTAL - SA	**196**	**244**	**200**	**199**
Capital City - WA	176	181	155	190
Other Urban - WA	18	26	19	19
Rural - WA	60	73	58	52
Undefined Overseas & No Abodes - WA	1	7	4	0
TOTAL - WA	**255**	**287**	**236**	**261**
Capital City - TAS	20	37	34	20
Other Urban - TAS	13	15	27	10
Rural - TAS	18	7	17	20
TOTAL - TAS	**51**	**59**	**78**	**50**

Capital City - NT	20	16	13	19
Rural - NT	18	23	19	23
Undefined Overseas & No Abodes- NT	0	3	0	0
TOTAL - NT	**38**	**42**	**32**	**42**
TOTAL - ACT	**42**	**31**	**45**	**29**
Capital City - AUST	1609	1589	1487	1359
Other Urban - AUST	527	524	462	481
Rural - AUST	571	544	520	501
Undefined Overseas & No Abodes - AUST	13	26	23	22
Total - AUSTRALIA	**2720**	**2683**	**2492**	**2363**

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2001-2002, 20 February 2002

Question: E02000115

OUTCOME 4: QUALITY HEALTH CARE

Topic: RAMUS – NUMBER OF STUDENTS

Hansard Page: CA90

Senator West asked:

How many students applied for RAMUS in the last round?

Answer:

Three hundred and ninety-five students applied for the Rural Australia Medical Undergraduate Scholarship (RAMUS) in the last round (2001).

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2001-2002, 20 February 2002

Question: E02000116

OUTCOME 4: QUALITY HEALTH CARE

Topic: RAMUS – PROGRAMME GUIDELINES

Hansard Page: CA91

Senator West asked:

(a) What are the program guidelines and regulations of RAMUS?
(b) Are there any academic conditions to these scholarships?
(c) If, due to some course failures, a student takes longer than their scheduled years to complete their degree, do we pay them for their extra years? Have there been any cases where this has happened?
(d) Do we attempt to get their scholarship back if a student leaves university due to failure?
(e) If a student does fail one year and loses their scholarship, but then does very well in their second year, can they get their scholarship back?

Answer:

(a) The RAMUS Scheme program guidelines provide information on the aims of the Scheme, the assessment and selection criteria and ongoing eligibility.

(b) A scholarship holder must be enrolled as a full-time student in an accredited Australian undergraduate or graduate medical course.

(c) A scholarship holder who fails to meet the academic requirements of the medical course is eligible to receive scholarship payments, provided their medical school permits them to repeat the academic year. The RAMUS guidelines provide for the RAMUS national management agency to review the case, if a scholarship holder had more than one repeat year. The Department has not been advised of any cases where this has happened.

(d) Students who do not fulfil the terms of the scholarship are required to forfeit the remainder of their scholarship. If the student withdraws from their medical course and fails to inform the management agency, the student is required to refund any payments received since withdrawal.

(e) The scholarship is not withdrawn if a student does not pass a year, provided that their medical school permits them to repeat the academic year. If a student withdraws from their course and is accepted back in the following year, they would not receive the scholarship automatically. The student would need to apply in the next scholarship application round. The new application would be assessed against the eligibility and selection criteria, to determine its' ranking, as part of that round.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2001-2002, 20 February 2002

Question: E02000117

OUTCOME 4: QUALITY HEALTH CARE

Topic: RAMUS – ANNOUNCEMENT 2001

Hansard Page: CA92

Senator West asked:

When were the 2001 (RAMUS) scholarships announced?

Answer:

The 2001 scholarships were announced on 30 April 2001.

Commonwealth Department of Health and Ageing
Aged and Community Care
GPO Box 9848, Canberra ACT 2601

Senator S. C. Knowles
Chair
Senate Community Affair Legislation Committe
Suite No S1 32, Telelift No 20-6
Parliament House
CANBERRA ACT 2600

Dear Senator Knowles

I am writing to you to in relation to the answers I provided to the Senate Community Affairs Legislation Committee hearing held on 20 February 2002.

At the hearing I said in part that the Aboriginal and Torres Strait Islander Services Division contracted some years ago with Australian Hearing Services to provide additional services in regions (CA107). I believe that this statement may be ambiguous and I would like to clarify that Australian Hearing Services was contracted to undertake training of indigenous health workers and maintenance of equipment. It is, of course, also the case that eligible indigenous Australians are eligible for hearing services and devices under the *Hearing Services Administration Act* 1997 and as well Australian Hearing Services receives Community Service Obligations funding to assist it to provide services to eligible indigenous Australians.

On another issue, Senator Crossin said that there should not be a need for this person (from Lajamanu) to go to Katherine to receive hearing services and my response was "that is correct" (CA109). This may have inadvertently led to the impression that services are provided at Lajamanu on a regular basis. To clarify, Lajamanu is not an Australian Hearing Services' site and therefore people from Lajamanu do travel to Katherine to receive hearing services. Should the number of referrals from Lajamanu increase Australian Hearing Services would reassess the need to provide services on site at Lajamanu.

Yours sincerely

[Signed]

Mary Murnane
Deputy Secretary

21 March 2002

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2001-2002, 20 February 2002

Question: E02000154

OUTCOME 6: HEARING SERVICES

Topic: ADEQUACY OF HEARING SERVICES

Hansard Page: CA 107

Senator Crossin asked:

How does the Department assess the adequacy of the current number and location of service providers in terms of hearing services? [For Aboriginal and Torres Strait Islanders]

Answer:

Australian Hearing determines the number and location of its outreach services for Aboriginal and Torres Strait Islanders on the basis of, the number of clients being referred by medical services and/or primary care agencies, the number of children already identified with permanent hearing impairment, and the level of available support and infrastructure.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2001-2002, 20 February 2002

Question: E02000155

OUTCOME 6: HEARING SERVICES

Topic: ACCESS TO AUSTRALIAN HEARING SERVICES

Hansard Page: CA 107 - 108

Senator Crossin asked:

(a) Do you currently have information about the accessibility of hearing services to Aboriginal and Torres Strait Islander adults and children across Australia?

(b) Are you aware of the fact that Aboriginal people in the Walpiri communities, which are outside Alice Springs, are in fact missing out on screening and treatment services because they have been advised they cannot get any local provision; and people from communities like Yuendumu and Lajamanu, which are east of the Stuart Highway in the Northern Territory, have to actually travel to Katherine for assessment and treatment.

(c) Would you be able to provide reasons as to why that is the case?

Answer:

(a) All eligible Aboriginal and Torres Strait Islander adults are able to receive regular Voucher Services.

In addition, eligible Aboriginal and Torres Strait Islanders have access under the Community Services Obligations to services delivered by Australian Hearing. These services are largely provided under an outreach program, known as Australian Hearing Specialist Program for Indigenous Australians.

(b)& (c) Primary Health Care programs implemented through State/Territory Health Services and/or Aboriginal Community Controlled Health Services provide screening services.

Australian Hearing provides services to children (most often referred through primary health care programs) who have, or are suspected of having, a permanent hearing impairment, which usually results in the fitting of hearing aids. Currently children referred from Yuendumu and Lajamanu receive services at Alice Springs and Katherine respectively.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2001-2002, 20 February 2002

Question: E02000156

OUTCOME 6: HEARING SERVICES

Topic: TRAVEL SUBSIDY FOR REMOTE CLIENTS

Hansard Page: CA 108

Senator Crossin asked:

Does the current system provide travel costs for remote users of services who need to travel large distances to access services?

Answer:

No.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2001-2002, 20 February 2002

Question: E02000157

OUTCOME 6: HEARING SERVICES

Topic: OFFICE OF HEARING SERVICES DEFINITION OF REMOTE

Hansard Page: CA 108-109

Senator Crossin asked:

(a) Could you perhaps provide for me what the Office of Hearing Services seems to define as 'remote'?

(b) Why is Hermannsburg not remote, but Katherine is classified as remote?

Answer:

(a) For the purposes of the Voucher System, ARIA (Access/Remoteness Index for Australia) is used by the Office of Hearing Services to define remote and very remote.

The definition of remote for Community Services Obligations delivered by Australian Hearing is a different one to that used in the Voucher System. Schedule 2 of the *Declared Hearing Services Determination 1997* made under the *Australian Hearing Services Act 1991* lists the postcodes of remote areas.

(b) Australian Hearing has a Remote Voucher Site at Hermannsburg, Northern Territory.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2001-2002, 20 February 2002

Question: E02000161

OUTCOME 7: ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH

Topic: FORMAL DATA SHARING ARRANGEMENTS

Hansard Page: CA 107

Senator Crossin asked:

Does the Department have formal data sharing arrangements with all State and Territory governments and community controlled health organisations to provide information about the number and location of Aboriginal and Torres Strait Islander children and adults with treatable hearing losses.

Answer:

Neither the Department nor Australian Hearing has formal data sharing arrangements with State and Territory governments or community controlled health organisations in relation to treatable hearing losses.

In addition, there are no 'by-product' datasets or registers resulting from national data collections to provide information about the number and location of Aboriginal and Torres Strait Islander children and adults with treatable hearing losses.

At the local service provider level sharing of information would occur as part of the routine referral mechanisms between primary, secondary and tertiary hearing services. This information exchange would be self-regulated by locally agreed arrangements.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2001-2002, 20 February 2002

Question: E02000081

OUTCOME 7: ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH

Topic: PORTFOLIO ADDITIONAL ESTIMATES STATEMENTS

Written Question on Notice

Senator Denman asked:

On Page 18 of the Portfolio Additional Estimates Statements, additional funding appears to be going to Output 1, there is a reduction in funding of $7,140,000 to Output 2 (Infrastructure to support the development and operation of high quality health care services for Aboriginal and Torres Strait Islander Health).

(a) Could you please advise which services are going to be affected by this reduction in funding?
(b) Which areas are going to be affected by this reduction?

Answer:

(a) No existing services are going to be affected by this transfer of funding between the "Infrastructure" and "Services" notional items. The revised estimate for "Infrastructure" is consistent with the actual expenditure of $17.9M in 2000-01. The funds transferred are growth funds. The revised estimates reflect the increasing maturity of the program overall, with greater resources required for delivery of services after strategies have been developed. They also reflect the uncertainty of funding requirements at the time that the original estimates were made. Additional funds are being used to provide an increase in local service delivery, in particular capital projects through the Primary Health Care Access Program.

(b) No existing areas will be affected by the transfer.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2001-2002, 20 February 2002

Question: E02000045

OUTCOME 7: ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH

Topic: INCREASE IN ABORIGINAL DEATH RATES

Written Question on Notice

Senator Evans asked:

(a) Has the Department examined the ABS report on Aboriginal mortality rates and does it agree with the figures?

(b) How does the Department explain the increase in death rates despite the efforts to target Aboriginal health and provide increased resources?

(c) Is it the case that the funds are just not making the impact required because too much is being spent centrally and there is not a focus on actually increasing resources at the primary health level in communities?

(d) Has the Dept directed that Aboriginal health funds should be withdrawn from urban Aboriginal health services to "mainstream" Aboriginal people in the city and make a more visible presence in remote Aboriginal communities? How will this impact on Aboriginal people dependent on health services in large rural towns?

Answer:

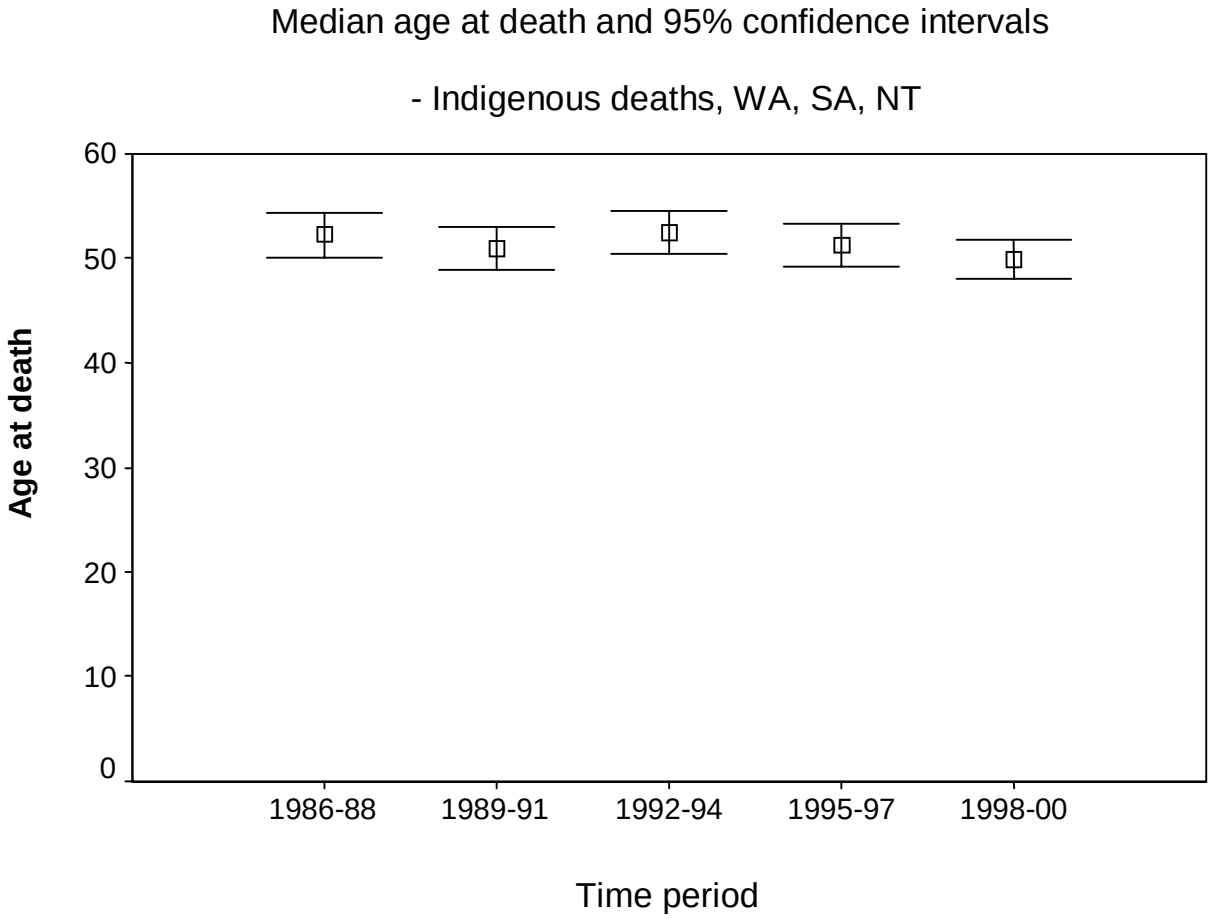
(a) The Department has examined the ABS report on deaths of Aboriginal and Torres Strait Islander people. The ABS has advised that given the volatility in measures of Indigenous mortality, caution should be exercised in assessing trends in Indigenous mortality over time. This is due to the small size of the change over time, the small population and problems with the identification of Indigenous deaths. Any improvement in Indigenous identification will show up as increased mortality rates. The ABS has advised that median age of death is a more reliable indicator than death rates. Time series analysis of median age at death suggests the median age has remained relatively stable (see attached Table).

(b) Due to the small size of the population and the problems with identification it is not possible at this stage to state whether the death rate for Aboriginal and Torres Strait Islander people has improved or worsened. Reliability of data aside, it will take time before investment of increased resources in Indigenous health services is translated into health indicators such as death rates.

(c) Over 90% of the administered funds for Outcome 7 (Improved health status for Aboriginal and Torres Strait Islander people) are spent on service provision for primary health care in communities and capital works projects in local communities. The remainder is spent on the infrastructure required to support the primary health care system. This includes funds for Aboriginal health worker training and other workforce initiatives, developing and facilitating the implementation of specific health strategies and through research and data improvements, improving the evidence base.

The recent initiative, the Primary Health Care Access Program, will further increase the funding available for primary health care in communities. By 2003/04 $55m per annum will be available through this program and the majority of these funds will be available for direct service provision.

(d) The Department has not directed that Aboriginal health funds should be withdrawn from urban Aboriginal health services.


Median age at death and 95% confidence intervals
- Indigenous deaths, WA, SA, NT
Age at death
60
50
40
30
20
10
0
1986-88
1989-91
1992-94
1995-97
1998-00
Time period

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2001-2002, 20 February 2002

Question: E02000001

OUTCOME 8: CHOICE THROUGH PRIVATE HEALTH

Topic: DETAILS OF SOCIAL RESEARCH

Written Question on Notice

Senator Evans asked:

When will the Department release the reports on the advertising and polling previously sought by this Committee, concerning:

(a) 30% rebate advertising in 1999
(b) the Lifetime Health Cover advertising in 2000; and
(c) the Gap Cover advertising in 2001?

Answer:

The reports will not be released as the research is still being used for ongoing policy development and consideration on private health matters.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2001-2002, 20 February 2002

Question: E02000122

OUTCOME 8: CHOICE THROUGH PRIVATE HEALTH

Topic: BUSH NURSING, SMALL COMMUNITY AND REGIONAL PRIVATE HOSPITAL PROGRAM

Hansard Page: CA110

Senator West asked:

In respect of the 2000-01 budget measure for assistance to small rural private hospitals, of the amount for 2001-02: Do you have a breakdown of how you expect that to be spent, and on what particular items?

Answer:

In respect of $4.623m administered funding under this program for 2001-02, $3.387 million of the $4.623 was committed to eligible hospitals as at 18 February 2002. In addition, the allocation of the remaining $1.236 million is currently under discussion with the hospitals listed below and a range of other eligible hospitals under the program.

State	**Hospital**	**Committed 2001-02**	**Items being funded**
VIC	Ballan Bush Nursing Hospital	45,441.80	Management support services, board governance training, staff training to support Occupational Health and safety requirements.
	Warley Hospital	87,561.81	Architectural review and relocation of the day surgery recovery area, upgrade of information technology, employment of community support officer to assist with coordinating post discharge care for patients from metropolitan hospitals and for community rehabilitation patients, promotional materials and brochures, staff training including advanced life support and educational journals and texts.
	Walwa Bush Nursing Hospital	25,692.00	Purchase part time management and administration support services.
	Chiltern Bush Nursing Hospital	83,318.19	Management support services.

State	Hospital	Committed 2001-02	Items being funded
	Euroa Bush Nursing Hospital	126,264.18	Capital works including minor refurbishment of kitchen and kitchen equipment, installation of a new telephone system and purchase of a telemedicine vision phone, architectural review and plan development, staff training including advanced life-skills, information systems training including financial management programs, management and leadership training, clinical nurse training, resident classification system training, and professional conferences seminars, journals and texts, part time management and financial management services, upgrade of information technology, subsidisation of hospital accreditation, marketing and promotional material.
	Nagambie Hospital	87,200.00	Management services for human and financial resources, and to manage the implementation of recommendations contained in both the Australian Health Care Associates report (a previously conducted financial feasibility report) and the strategic service planning report.
	Cobden Bush Nursing Hospital	120,000.00	Capital works for the relocation of emergency stabilisation department
QLD	Crows Nest & District Co-op Hospital	300,750.00	Capital works for facility redevelopment to meet compliance requirements for collocated facilities, board governance training, nurse staff training, marketing strategies and products, information technology upgrade and training, subsidisation of hospital accreditation.
	Mater Hospital, Yeppoon	27,272.70	Capital works for facility redevelopment to provide more specialists consulting rooms and an area for after hours emergency services, a contribution towards some specialist recruitment and equipment costs, appointment of a regional coordinator to facilitate the investigation of innovative models of care and service delivery, upgrade existing information technology resources.
	Clifton Co-operative Hospital	280,750.00	Capital works for facility redevelopment to meet compliance requirements for collocated facilities, board governance training, nurse staff training, marketing strategies and products, information technology upgrade and training, subsidisation of hospital accreditation.

State	Hospital	Committed 2001-02	Items being funded
	Pittsworth & District Hospital	150,750.00	Capital works for facility redevelopment to meet compliance requirements for collocated facilities, board governance training, nurse staff training, marketing strategies and products, information technology upgrade and training, subsidisation of hospital accreditation.
	Mater Misericordiae Private Hospital, Gladstone	27,272.70	Capital works for facility redevelopment to provide more specialists consulting rooms, a contribution towards some specialist recruitment and equipment costs, appointment of a regional coordinator to facilitate the investigation of innovative models of care and service delivery, upgrade existing information technology resources.
	Friendly Society Private Hospital, Bundaberg	120,000.00	Capital works for development of facilities for after hours medical services, redevelopment of medical consulting suites and the development of a sleep study unit.
	Mater Misericordiae Private Hospital Bundaberg	119,091.00	Capital works for facility redevelopment of day procedure unit and to provide more specialists consulting rooms, a contribution towards some specialist recruitment and equipment costs, appointment of a regional coordinator to facilitate the investigation of innovative models of care and service delivery.
	Allora District Co-operative Hospital	230,750.00	Capital works for facility redevelopment to meet compliance requirements for collocated facilities, board governance training, nurse staff training, marketing strategies and products, information technology upgrade and training, subsidisation of hospital accreditation.
	Killarney & District Memorial Hospital	260,750.00	Capital works for facility redevelopment to meet compliance requirements for collocated facilities, board governance training, nurse staff training, marketing strategies and products, information technology upgrade and training, subsidisation of hospital accreditation.
SA	Keith and District Hospital Inc	268,649.62	Development of an Architectural master plan, Capital works including the redevelopment of existing infrastructure to accommodate Aged Care places and the upgrade of fire safety to meet Commonwealth certification requirements, upgrade of information technology, staff training including advanced life support and a variety of specialist education workshops.

State	Hospital	Committed 2001-02	Items being funded
	Moonta Health and Aged Care Service Inc	441,008.71	Development of an Architectural master plan, Capital works including the redevelopment of existing infrastructure to accommodate Aged Care places, upgrade of information technology, staff training including advanced life support and a variety of specialist education workshops.
	Ardrossan Community Hospital	210,599.53	Development of an Architectural master plan, Capital works including the redevelopment of existing infrastructure to accommodate Aged Care places, upgrade of information technology, staff training including advanced life support and a variety of specialist education workshops.
	Hamley Bridge Memorial Hospital	57,849.61	Development of an Architectural master plan, Capital works including the redevelopment of existing infrastructure to accommodate Aged Care places, upgrade of information technology, staff training including advanced life support and a variety of specialist education workshops.
	Mallala District Hospital	282,149.71	Development of an Architectural master plan, Capital works including the redevelopment of existing infrastructure to accommodate Aged Care places, upgrade of information technology, staff training including advanced life support and a variety of specialist education workshops.
WA	St John of God Geraldton	34,545.46	Establishment of a medical specialist fly in-fly out service including a coordinator position, the purchase of essential surgical equipment, and travel and accommodation costs for medical specialists.
TOTAL		3,387,667.02	

* Some of these hospitals also have multi year funding commitments under this program in respect of 2002-03 and 2003-04

NB. Funding was provided for the appointment of a development coordinator to progress implementation plans across groups of hospitals in both the Darling Downs in Queensland (Crows Nest & District Hospital, Clifton Co-operative hospital, Pittsworth & District Hospital, Allora District Co-operative Hospital and Killarney & District Memorial Hospital), and the group of South Australian Hospitals (Keith and District Hospital Inc, Moonta Health and Aged Care Service Inc, Ardrossan Community Hospital, Hamley Bridge Memorial Hospital, Mallala District Hospital)

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2001-2002, 20 February 2002

Question: E02000123

OUTCOME 8: CHOICE THROUGH PRIVATE HEALTH

Topic: NAGAMBIE BUSH NURSING HOSPITAL

Hansard Page: CA110

Senator West asked:

I understand that Nagambie Hospital has also effectively closed and has turned itself into a nursing home because no help was available; is that correct?

Answer:

On 21 May 2001 Nagambie Bush Nursing Hospital announced the suspension of acute services (15 acute beds) pending the completion of the Strategic Service Planning Process that was being funded through the Commonwealth's Bush Nursing, Small Community and Regional Private Hospitals (BNSCRPH) Programme.

An agreement between Nagambie Bush Nursing Hospital and the Commonwealth was signed on 7 June 2001, that allowed Nagambie to employ an Executive Assistant to assist with management issues at the hospital. This Agreement, at a cost of $95,920, was to assist the hospital in both the strategic service planning process, and the implementation of recommendations that arose from the strategic service plan.

Nagambie Bush Nursing Hospital completed their strategic service planning process in November 2001. The hospital has endorsed a report that came out of this consultative process recommending implementation of a mixture of services designed to best meet the needs of the local community, which includes the reintroduction of acute services. In addition to this Nagambie Bush Nursing Hospital will operate 27 low care places and 10 high care aged care places. Nagambie Bush Nursing Hospital, like many other small community hospitals provides both aged and acute services that are managed through the same management structure.

In November 2001, Nagambie Bush Nursing Hospital indicated to the Commonwealth that the hospital would like to access additional funds through this programme to implement several initiatives identified in the Strategic Service Planning process. The most recent advice from Nagambie Bush Nursing Hospital is that bringing online residential aged care is their priority, following this the reintroduction of acute services is to be considered in late 2002.

30% REBATE ADDITIONAL ESTIMATES 2001-02 REVISION

- The revised total cost of the 30% Rebate for 2001-02 is estimated to be $2,221 million:
  - $1,952 million in outlays, administered through the Health Department; and
  - $269 million in tax revenue.

- This is $40 million or 1.83% higher than the 2001-02 Budget estimate of $2,181 million in 2001-02. The difference between the two forecasts agreed at Additional Estimates and the Budget Estimates reduce to $23 million for 2002-03 and $5 million for 2003-04.

Variation between 2001-02 Additional Estimates ($ million) from the Budget 2001-02

Year	2001-02 Budget Estimates	2001-02 Additional Estimates	Variation	Variation (%)
2000-01	2,078	2,127	49	2.36%
2001-02	2,181	2,221	40	1.83%
2002-03	2,291	2,314	23	1.00%
2003-04	2,424	2,429	5	0.21%
2004-05	2,564	2,550	-14	-0.55%

Reasons:

- **A change in the assumption of the participation rate:** It is assumed in these estimates that the number of insured people will remain constant, but population growth will lead to a fall in participation rates. In other words, the actual numbers of people with private health insurance will stay the same but the proportion of the population with Private Health Insurance will not keep up with the growth in population. The percentage of the population will decline from the current 44.9% by about 0.35% pa.
- **A minor adjustment to the tax vs outlays predictions:** A split between outlays and revenue of 11.9% to 88.1% was used in the Budget estimate, while split of 12.2% to 87.8% was used for the Additional estimate. Since the amount of Rebate claimed as a taxation offset is processed in the following financial year (due to the tax processing cycle), any change to the taxation offset component will have an effect on the total cost of the Rebate.
- **Change in the base year estimates in the model:** When the Budget estimate was finalised in March 2001 only the claims for the Rebate up to February 2001 were available. The new estimate incorporates the actual claiming data for 2000-01 on which the estimates for the forward years are based. Claiming patterns towards the end of 2001 indicated a trend upward

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2001-2002, 20 February 2002

Question: E02000124

OUTCOME 8: CHOICE THROUGH PRIVATE HEALTH

Topic: 30% REBATE ON PRIVATE HEALTH INSURANCE

Hansard Page: CA111

Senator McLucas asked:

In the budget papers the funding that is shown is the tax, the amount that is paid through the ATO and the full amount that is paid through the Health Insurance Commission, which would include over-the-counter claims or premium reduction claims. That is aggregated. Can this information be disaggregated?

Answer:

In 2000-01 the following amounts were paid under the three claiming methods for the 30% Rebate:

taxation offset	197 ($m)
premium reduction	4 ($m)
over-the-counter claims	1,926 ($m)

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2001-2002, 20 February 2002

Question: E02000129

OUTCOME 8: CHOICE THROUGH PRIVATE HEALTH

Topic: 30% REBATE ON PRIVATE HEALTH INSURANCE

Hansard page: CA115

Senator McLucas asked:

If there are any other factors (in relation to the 30% Rebate estimates), if you would like to provide them later that would be useful.

Answer:

The factors and assumptions outlined at the Estimates Hearing of 20 February 2002 are the major factors currently considered in determining forward estimates for the 30% Rebate. The Department is reviewing data on private health insurance that reflects the major changes in membership profile of recent years. The Department will consider the results of the review when determining future adjustments to the forward estimates.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2001-2002, 20 February 2002

Question: E02000125

OUTCOME 8: CHOICE THROUGH PRIVATE HEALTH

Topic: MEDICARE LEVY SURCHARGE

Hansard Page: CA CA113

Senator Crowley asked:

I think I may have missed it, but do you have figures on what amount of tax is collected from people whose income is above $50,000 but they are not buying private health insurance? Can we have the number of people and the amount, or would you only be able to give me the amount?

Answer:

For the financial year 1998/99, the most recent year for which relevant statistics have been published, the Medicare Levy Surcharge was collected from 191,207 people who earned over $50,000 with payments totalling $129,844,476.
(Source: A Summary of Taxation and Superannuation Statistics 1998/99, published by the ATO.)

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2001-2002, 20 February 2002

Question: E02000126

OUTCOME 8: CHOICE THROUGH PRIVATE HEALTH INSURANCE

Topic: HIGH CLAIMS BY NEW MEMBERS

Hansard Page: CA 114

Senator McLucas asked:

Why are the funds getting higher than anticipated claims from their newer members? Do you have any information as to why that is the case?

Answer:

As stated to the Committee on 20 February 2002 there is insufficient time series data yet to draw reliable conclusions. In addition, the data on health insurance membership and claims currently available do not distinguish between 'new' and 'old' member episodes. However, the Private Health Insurance Administration Council will collect an expanded set of data commencing June quarter 2002, which will allow such an analysis.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2001-2002, 20 February 2002

Question: E02000127

OUTCOME 8: CHOICE THROUGH PRIVATE HEALTH

Topic: PHI MEMBERS BY GENDER AND AGE

Hansard Page: CA 114

Senator Senator Crowley asked:

Do you have a gender and age breakdown on the people who have signed up?

Answer:

Yes, PHIAC has a gender and age breakdown of the people who have hospital insurance. In addition PHIAC has details of the number of persons by certified age of entry under Lifetime Health Cover. Details are attached.

Table 7, from Quarterly Statistics - December 2001 – Hospital Table Membership and Coverage – Ancillary Table Membership and Coverage, show the demographic distribution of persons with hospital insurance by age cohort for recent quarters.
Table 9, from Quarterly Statistics - December 2001 – Hospital Table Membership and Coverage – Ancillary Table Membership and Coverage shows persons by certified age of entry over recent quarters.

Table 7

Coverage of Hospital Insurance Tables
Offered by Registered Health Benefits Organisations
Persons Covered by Gender and Age Cohort

Age Group	Quarter Ending 31 Mar 2000	Quarter Ending 31 Mar 2000	Quarter Ending 30 Jun 2000	Quarter Ending 30 Jun 2000	Quarter Ending 30 Sep 2000	Quarter Ending 30 Sep 2000	Quarter Ending 31 Dec 2000	Quarter Ending 31 Dec 2000	Quarter Ending 31 Mar 2001	Quarter Ending 31 Mar 2001	Quarter Ending 30 Jun 2001	Quarter Ending 30 Jun 2001	Quarter Ending 30 Sep 2001	Quarter Ending 30 Sep 2001	Quarter Ending 31 Dec 2001	Quarter Ending 31 Dec 2001
Gender	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male
0-4	164,513	176,812	233,240	249,672	247,318	264,599	241,886	258,932	238,734	255,804	236,782	253,922	235,884	252,663	235,311	251,420
5-9	187,250	198,702	272,660	287,486	296,883	312,912	290,848	307,070	287,606	303,554	284,576	300,568	282,273	298,235	280,652	296,117
10-14	307,522	317,264	296,236	310,487	322,999	338,700	319,033	334,521	315,734	332,161	314,999	329,945	312,735	327,771	310,861	326,025
15-19	307,054	211,606	278,895	293,886	306,308	311,265	306,964	314,869	306,438	315,585	309,909	319,972	313,502	324,760	315,912	327,758
20-24	139,865	125,497	176,076	154,741	195,873	169,788	192,767	168,134	192,327	171,796	193,865	174,227	202,512	183,006	209,139	189,665
25-29	162,199	125,338	217,764	183,700	223,739	190,776	216,811	191,875	212,245	189,196	209,843	188,714	209,425	189,360	209,386	189,687
30-34	212,593	171,070	322,906	276,418	353,138	306,694	343,344	299,998	345,823	296,283	344,056	292,335	343,131	290,579	342,198	288,886
35-39	244,245	211,239	360,686	335,952	393,105	360,394	386,397	359,074	391,001	362,173	376,400	342,221	371,744	337,309	368,946	334,006
40-44	262,879	234,167	377,811	348,763	409,788	382,681	406,321	379,838	404,642	376,513	403,178	374,768	401,825	372,570	399,992	371,114
45-49	275,177	251,249	378,543	350,562	405,809	382,169	402,286	378,045	401,344	376,514	400,834	375,506	400,027	373,992	399,784	372,727
50-54	276,025	265,150	361,172	354,838	395,157	379,442	387,021	380,012	388,528	380,745	389,605	380,022	388,395	377,448	386,805	373,952
55-59	212,372	213,211	283,360	270,056	276,170	265,359	279,114	267,301	282,364	280,091	285,949	283,395	292,298	289,011	301,243	306,071
60-64	166,072	166,885	193,141	198,738	198,788	207,008	201,582	209,734	203,117	211,080	204,151	212,564	206,838	214,639	210,241	218,255
65-69	138,628	139,532	148,117	144,723	147,882	145,487	149,033	146,974	150,273	148,224	151,071	148,945	153,144	150,743	155,946	153,600
70-74	132,579	114,929	139,607	122,679	138,937	123,250	139,829	125,347	140,172	126,513	140,131	126,755	140,564	127,831	141,199	129,076
75-79	108,164	57,039	113,316	60,829	112,942	61,157	113,574	62,949	114,521	64,906	115,104	67,091	115,954	69,554	116,880	72,095
80-84	69,111	30,573	72,171	32,153	72,567	32,032	73,579	32,477	74,409	32,855	75,319	33,091	76,037	33,519	77,095	34,121
85-89	42,751	16,911	44,405	17,707	44,333	17,437	44,481	17,443	44,886	17,624	45,390	17,783	45,800	17,915	46,109	17,970
90-94	16,069	5,228	16,780	5,457	16,832	5,413	16,988	5,454	17,332	5,542	17,656	5,663	17,867	5,761	18,143	5,880
95+	3,988	1,158	4,573	1,674	4,642	1,783	4,519	1,567	4,592	1,546	4,589	1,520	4,655	1,473	4,721	1,450
Total	3,229,047	2,927,560	4,271,449	3,964,530	4,541,990	4,248,266	4,518,148	4,224,594	4,507,088	4,212,805	4,503,445	4,208,997	4,514,702	4,218,229	4,529,263	4,229,666

Source: Private Health Insurance Administration Council
Recipients may freely use these statistics, however the source must be acknowledged.

Lifetime Health Cover

Table 9.

Hospital Membership

Number of adult beneficiaries

Certified Age At Entry	30 September 2000			31 December 2000			30 June 2001			30 September 2001			31 December 2001			LHC Loading %
	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	
30	3,059,761	3,313,762	6,373,523	2,926,149	3,267,781	6,193,930	2,906,812	3,254,681	6,161,493	2,901,894	3,251,502	6,153,396	2,898,467	3,246,844	6,145,311	0%
31	475	400	875	952	811	1,763	2,266	1,970	4,236	3,065	2,687	5,752	3,863	3,420	7,283	2%
32	416	336	752	776	636	1,412	1,865	1,575	3,440	2,516	2,158	4,674	3,114	2,806	5,920	4%
33	323	340	663	650	564	1,214	1,504	1,349	2,853	2,086	1,926	4,012	2,661	2,374	5,035	6%
34	345	279	624	610	558	1,168	1,434	1,270	2,704	1,940	1,716	3,656	2,418	2,141	4,559	8%
35	305	265	570	594	513	1,107	1,289	1,171	2,460	1,808	1,604	3,412	2,261	1,974	4,235	10%
36	279	287	566	524	543	1,067	1,181	1,102	2,283	1,657	1,556	3,213	2,031	1,954	3,985	12%
37	290	232	522	504	424	928	1,152	975	2,127	1,579	1,355	2,934	1,945	1,697	3,642	14%
38	275	288	563	490	475	965	1,042	1,023	2,065	1,400	1,378	2,778	1,790	1,736	3,526	16%
39	250	218	468	435	396	831	963	894	1,857	1,296	1,254	2,550	1,653	1,568	3,221	18%
40	229	236	465	432	419	851	906	859	1,765	1,254	1,172	2,426	1,572	1,479	3,051	20%
41	221	206	427	400	356	756	824	800	1,624	1,115	1,048	2,163	1,433	1,361	2,794	22%
42	191	200	391	358	363	721	756	737	1,493	1,049	1,028	2,077	1,300	1,307	2,607	24%
43	203	179	382	329	295	624	706	690	1,396	966	949	1,915	1,210	1,209	2,419	26%
44	177	165	342	305	294	599	657	657	1,314	909	877	1,786	1,180	1,095	2,275	28%
45	175	171	346	283	304	587	631	647	1,278	846	901	1,747	1,088	1,109	2,197	30%
46	165	174	339	293	275	568	556	591	1,147	775	761	1,536	989	998	1,987	32%
47	148	157	305	260	245	505	530	523	1,053	731	736	1,467	923	923	1,846	34%
48	142	125	267	246	212	458	522	526	1,048	682	711	1,393	848	874	1,722	36%
49	137	135	272	228	221	449	500	417	917	682	587	1,269	842	758	1,600	38%
50	117	144	261	207	210	417	388	412	800	532	610	1,142	650	757	1,407	40%
51	120	109	229	183	189	372	384	422	806	529	555	1,084	704	695	1,399	42%
52	117	112	229	206	195	401	408	356	764	511	501	1,012	640	615	1,255	44%
53	105	103	208	187	179	366	336	380	716	465	478	943	601	598	1,199	46%
54	75	96	171	135	151	286	309	323	632	451	453	904	571	569	1,140	48%
55	74	61	135	122	99	221	237	270	507	342	370	712	441	476	917	50%
56	65	76	141	116	115	231	244	243	487	319	328	647	396	415	811	52%
57	66	53	119	104	85	189	212	203	415	294	254	548	369	346	715	54%
58	42	60	102	75	75	150	176	176	352	240	236	476	319	302	621	56%
59	52	41	93	82	75	157	154	170	324	187	231	418	253	281	534	58%
60	54	39	93	85	73	158	151	152	303	189	214	403	253	268	521	60%
61	46	46	92	59	79	138	130	172	302	166	217	383	203	272	475	62%
62	39	50	89	50	81	131	113	158	271	165	224	389	219	299	518	64%
63	29	41	70	52	68	120	120	154	274	166	213	379	210	269	479	66%
64	29	25	54	43	64	107	91	152	243	122	188	310	160	239	399	68%
65	37	50	87	74	92	166	170	252	422	254	380	634	345	518	863	70%
Total	**3,065,574**	**3,319,261**	**6,384,835**	**2,936,598**	**3,277,515**	**6,214,113**	**2,929,719**	**3,276,452**	**6,206,171**	**2,933,182**	**3,281,358**	**6,214,540**	**2,937,922**	**3,284,546**	**6,222,468**	
No. paying penalty	**5,813**	**5,499**	**11,312**	**10,449**	**9,734**	**20,183**	**22,907**	**21,771**	**44,678**	**31,288**	**29,856**	**61,144**	**39,455**	**37,702**	**77,157**	
% paying penalty	0.2%	0.2%	0.2%	0.4%	0.3%	0.3%	0.8%	0.7%	0.7%	1.1%	0.9%	1.0%	1.3%	1.1%	1.2%	

Source: Private Health Insurance Administration Council

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2001-2002, 20 February 2002

Question: E02000130

OUTCOME 8: CHOICE THROUGH PRIVATE HEALTH

Topic: PHI - ANCILLARIES

Hansard Page: CA 115

Senator McLucas asked:

How much is being spent in the ancillary section on things like free gym membership, sporting aids and those sorts of things.

Answer:

In the December quarter 2001 $11.6 million was paid in benefits by private health insurance funds in the category Fitness & Lifestyle Courses/Equipment. This was 0.73% of total benefits paid of $1,587 million for ancillary and hospital services . See Attached.
This data is available from PHIAC's quarterly PHIAC A Report.

ATTACHMENT E02000130

Ancillary Services December quarter 2001

Non-Contractual Ancillaries	Benefits Paid $'000	% of Ancillary	% of total Hospital + Ancillary
Accidental Death / Funeral Expenses	871	0.20%	0.05%
Acupuncture / Acupressure	4,231	0.96%	0.27%
Ambulance	7,120	1.61%	0.45%
Chiropractic	30,502	6.91%	1.92%
Community, Home, District Nursing	112	0.03%	0.01%
Dental	231,611	52.49%	14.59%
Dietetics	1,025	0.23%	0.06%
Domestic Assistance	1	0.00%	0.00%
Ex gratia Payments	332	0.08%	0.02%
Fitness & Lifestyle Courses/Equipment	**11,599**	**2.63%**	**0.73%**
Hearing Aids and Audiology	2,090	0.47%	0.13%
Hypnotherapy	33	0.01%	0.00%
Maternity Services	53	0.01%	0.00%
Natural Therapies	5,471	1.24%	0.34%
Occupational Therapy	1,097	0.25%	0.07%
Optical	71,865	16.29%	4.53%
Orthoptics (Eye Therapy)	40	0.01%	0.00%
Osteopathic Services	713	0.16%	0.04%
Overseas	18	0.00%	0.00%
Pharmacy	14,570	3.30%	0.92%
Physiotherapy	32,238	7.31%	2.03%
Podiatry (Chiropody)	10,125	2.29%	0.64%
Prostheses, Aids and Appliances	5,536	1.25%	0.35%
Psych/Group Therapy	5,424	1.23%	0.34%
School	14	0.00%	0.00%
Sickness and Accident	367	0.08%	0.02%
Speech Therapy	1,997	0.45%	0.13%
Theatre Fees	19	0.00%	0.00%
Travel and Accommodation	649	0.15%	0.04%
Other Services	1,490	0.34%	0.09%
Total non-Contractual Ancillaries	441,211	100.00%	27.80%

Total Hospital and Ancillary Benefits	1,587,235

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2001-2002, 20 February 2002

Question: E02000131

OUTCOME 8: CHOICE THROUGH PRIVATE HEALTH

Topic: SCHEDULE FEE

Hansard Page: CA 118

Senator Crowley asked:

Do you have any data on how many doctors are charging the schedule fee versus how many are charging above it? And could you also provide the amount above the schedule fee?

Answer:

No. PHIAC does not collect the number of doctors charging the schedule fee. However, PHIAC does collect the number of services charged at above the schedule fee, where a private health fund was paying benefits. See Attached.
In the December quarter 2001 there were 2,550,000 medical services for which private health insurance benefits were paid where the amount charged was greater than the schedule fee. This was 70% of total medical services where private health insurance benefits were paid. This data was extracted from the PHIAC publication Quarterly Gap Payment and Medical Benefit Statistics December 2001

Table 1 **Australia**

Total services with no gap (Agreement/Scheme for no gap between fund and provider, or amount charged no more than MBS)

	Amount Charged*	Medicare Benefit	Fund Benefit	Gap(d)	No. of Services	% of Services	Amount Charged/ CMBS (%)	Average charge per service	Average gap per service
<= MBS Fee	75,110,164	56,759,533	18,350,891	-260	1,100,294	30%	99%	$ 68.26	$ (0.00)
>MBS to 125% MBS Fe	78,754,750	49,539,043	27,215,706	1	979,359	27%	116%	$ 78.45	$ 0.00
>125% to 150% MBS Fe	107,648,980	58,906,644	48,742,336	0	632,844	17%	137%	$ 170.10	$ -
>150% to 200% MBS Fe	15,183,276	7,023,525	8,159,746	6	72,464	2%	162%	$ 209.47	$ 0.00
>200% MBS Fee	11,994,059	3,992,215	7,991,846	-2	27,578	1%	225%	$ 434.56	$ (0.00)
Total	288,691,231	176,220,961	110,460,525	255	2,811,549	73%	121%	$ 101.97	$ (0.00)

Total services where there was a gap (An Agreement/Scheme for Known gap, or amount charged more than MBS)

	Amount Charged*	Medicare Benefit	Fund Benefit	Gap(d)	No. of Services	% of Services	Amount Charged/ CMBS (%)	Average charge per service	Average gap per service
<= MBS Fee									
>MBS to 125% MBS Fe	33,234,717	22,062,213	9,092,233	3,079,271	282,939	8%	113%	$ 117.48	$ 10.99
>125% to 150% MBS Fe	40,386,064	21,966,418	10,086,875	8,332,773	224,191	6%	139%	$ 180.14	$ 37.17
>150% to 200% MBS Fe	52,882,694	23,083,357	8,828,837	20,970,500	227,481	6%	172%	$ 232.47	$ 92.19
>200% MBS Fee	48,599,472	13,600,773	5,648,980	29,339,719	105,260	3%	268%	$ 461.61	$ 278.74
Total	175,092,947	80,713,760	32,656,925	61,722,263	839,870	23%	153%	$ 208.49	$ 73.46

Total all Services

	Amount Charged*	Medicare Benefit	Fund Benefit	Gap(d)	No. of Services	% of Services	Amount Charged/ CMBS (%)	Average charge per service	Average gap per service
<= MBS Fee	75,110,164	56,759,533	18,350,891	-260	1,100,294	30%	99%	$ 68.26	$ (0.00)
>MBS to 125% MBS Fe	109,989,467	71,602,256	36,307,939	3,079,272	1,261,297	35%	115%	$ 87.20	$ 2.44
>125% to 150% MBS Fe	148,035,044	80,873,060	58,829,211	8,332,773	857,035	23%	137%	$ 172.73	$ 9.72
>150% to 200% MBS Fe	68,065,972	30,106,883	16,988,583	20,970,506	299,965	8%	170%	$ 226.91	$ 69.91
>200% MBS Fee	60,573,531	17,592,988	13,640,826	29,339,717	132,838	4%	259%	$ 456.00	$ 220.97
Total	461,774,178	256,934,720	143,117,450	61,722,008	3,651,419	100%	135%	$ 126.46	$ 16.90

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2001-2002, 20 February 2002

Question: E020000128

OUTCOME 8: CHOICE THROUGH PRIVATE HEALTH CARE

Topic: HIGH CLAIMS – ANALYSIS OF ACTIVITY

Hansard Page: CA 114

Senator McLucas asked:

Following on from the Minister's comment about the analysis of activity and service that people are requesting from the funds, are you going to do an analysis of the type of service that has been requested?

Answer:

There has been insufficient time since the introduction of Lifetime Health Cover to draw reliable conclusions from time series data about any changes to casemix or service utilisation. However, as stated to the Committee on 20 February 2002, the Department will be undertaking this type of analysis over time, including reviewing trends in MBS and Hospital Casemix Protocol data.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2001-2002, 20 February 2002

Questions: E02000047

OUTCOME 8: CHOICE THROUGH PRIVATE HEALTH

Topic: COST OF GAP INSURANCE

Written Question on Notice

Senator Evans asked:

(a) How much has the cost of gap insurance added to premiums? Wasn't the Senate told that there would be no inflationary effect but in fact most funds are paying significantly increased rebates because fewer doctors charge the scheduled fee?

(b) A Labor amendment requires a review of the cost of gap insurance after two years. When will this review be established?

Answer:

(a) The Department is analysing relevant data as it becomes available but is not in a position to draw conclusions about the effect of gap cover arrangements on health insurance premiums at this stage. More specifically, it is not possible to obtain quality time series data because the majority of gap cover schemes have been operating for less than 12 months.

(b) A review of the operation of gap cover schemes will be established as soon as practicable after 1 July 2002 to allow a report of the review to be tabled in Parliament no later than 31 December 2002. This is required under Section 4 of the *Health Legislation Amendment (Gap Cover Schemes) Act 2000*.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2001-2002, 20 February 2002

Question: E02000048

OUTCOME 8: CHOICE THROUGH PRIVATE HEALTH

Topic: PRESSURE ON PREMIUMS

Written Question on Notice

Senator Evans asked:

The former Minister said that the introduction of Lifetime Health Cover would produce downward pressure on premiums. What advice was this based on and how far downwards did the Department expect premiums to go?

Answer:

The former Minister said in July 2000 that there would be downward pressure on premiums. He did not say that premiums would reduce and went on to say in the same forum: “if you look in the forward estimates, we allowed for seven per cent growth in the expenditure”. There was no expectation that premiums would reduce.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2001-2002, 20 February 2002

Question: E02000049

OUTCOME 8: CHOICE THROUGH PRIVATE HEALTH

Topic: HBF APPLICATION FOR PREMIUM INCREASE LAST YEAR

Written Question on Notice

Senator Evans asked:

(a) What advice did the former Minister get when he rejected the application for an increase by HBF WA?

(b) Did the Department recommend rejecting the HBF application last year? If so, why? If not, why was the application rejected?

Answer:

(a) The former Minister received advice relevant to the criteria set out in subsections 78 (4) and 78(4A) of the *National Health Act 1953*, which are whether a proposed premium increase:
- would or might result in a breach of the Act or of a condition of registration of an organisation;
- imposes an unreasonable or inequitable condition affecting the rights of any contributors;
- might, having regard to the advice of the Private Health Insurance Administration Council (PHIAC), adversely affect the financial stability of a health benefits fund; or
- would be contrary to the public interest.

(b) The decision and the former Minister's reasons are available in the public domain as they were tabled in a statement of reasons in both Houses of the Parliament on 28 March 2001.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2001-2002, 20 February 2002

Question: E02000050

OUTCOME 8: CHOICE THROUGH PRIVATE HEALTH

Topic: MATTERS RELATING TO PREMIUM INCREASES TO BE ADDRESSED BY PHIAC

Written Question on Notice

Senate Evans asked:

What is PHIAC's estimate of the likely profit or loss for the 44 PHI funds this financial year? Does PHIAC agree that all of these funds made the correct decision on prudential grounds in not seeking an increase? Can PHIAC explain why several funds appear to be claiming that their estimates of claiming by new members were far too low?

Answer:

PHIAC has not undertaken any projection or forecast of industry profitability in relation to the current financial year.

Data provided to PHIAC by registered health benefits organisations does not indicate that a breach of prudential requirements is likely for those funds that did not seek an increase.

PHIAC is not able to comment on the assumptions of individual funds regarding expected claiming rates by new members. These assumptions are made having regard to the membership profile of the funds and are specific to each fund.

On an industry basis however, the level of benefits payments made by the funds has continued to increase. The level of benefits paid in the 6 months to 31 December 2001 was $3.088 billion, an increase of 12.8% from the 6 months to 30 June 2001 ($2.739 billion) and an increase of 25.8% from the 6 months to 31 December 2000 ($2.455 billion).

The majority of this benefits growth has been for hospital benefits. Hospital benefits totalled $2.215 billion for the 6 months to 31 December 2001, an increase of 13.8% from the 6 months to 30 June 2001 ($1.947 billion) and an increase of 25.4% from the 6 months to 31 December 2000 ($1.766 billion).

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2001-2002, 20 February 2002

Question: E02000051

OUTCOME 8: CHOICE THROUGH PRIVATE HEALTH

Topic: SECOND TIER DEFAULTS

Written Question on Notice

Senator Evans asked:

(a) Can you explain the new system called the 'second tier default' payment that will come into effect from 1 March for payment of hospitals by private health funds?

(b) Will the rates paid by health funds as a second tier default be publicly available?

(c) Can the Department provide the Committee with copies of the second tier default rates and if not why not?

(d) Will the new system guarantee that small private hospitals will be protected and will be able to access reasonable remuneration for treating privately insured patients?

(e) How many private hospitals will not qualify for registration under the new arrangements?

(f) What payments will they get from health funds for treating private patients?

(g) What is involved in meeting the criteria to get registered?

(h) Will it cost small hospitals a lot to meet the qualifying condition? If so won't they be effectively excluded?

(i) Will public hospitals be entitled to payment of the second tier default for private patients they treat?

(j) What would a public hospital have to do to meet the qualifying criteria?

(k) If they are being excluded entirely what is the argument for this?

Question: E02000051

Answer:

(a) In August 2001 revised second tier default benefits arrangements were introduced which allow a private hospital, which meets certain quality and other criteria and does not have a hospital purchaser-provider agreement, a higher level of benefits than the minimum default benefits, which are set by the Commonwealth.
From 1 March 2002, private hospitals who wish to apply or renew their second tier approval must be assessed by an 'approved accreditation agency' as being fully compliant with specific quality criteria in clause 3 of the Second Tier Benefits Schedule or have provided evidence to the committee that it has arranged for a second tier assessment to be conducted by an 'approved accreditation agency' before 31 August 2002.

(b) Under the current legislation health funds are required to make available their second tier schedules to private hospitals who request them and the Department of Health and Ageing. However there is nothing to stop health funds individually making their schedules available to other parties or to the public in general.

(c) Because the rates are based on commercially contracted arrangements, the Department is unable to provide individual health fund second tier schedules.

(d) The second tier arrangements are designed to provide non-contracted private hospitals which meet statutory quality criteria a higher default benefit as an alternate to contracted benefits from funds.

(e) It is not possible to determine prospectively how many hospitals will not qualify for second tier benefits as individual private hospitals have discretion as to whether to apply for second tier eligibility and all applications are assessed by an independent industry selection committee.

(f) Private hospitals assessed as eligible for second tier will receive no less than 85% of the average of schedule rates referred to in the relevant health fund's hospital purchaser-provider agreements that are in force on 1 August each year. The average is calculated for comparable hospitals in each State for an equivalent episode of hospital care.

(g) The facilities wishing to apply for second tier eligibility must demonstrate that they have met a required number of quality and administrative conditions outlined in Schedule 6, *Second Tier Benefits for Overnight and Day Only Treatment*, of paragraph (bj) of Schedule 1 to the *National Health Act 1953*. These include provision of informed financial consent to patients, accreditation by an accredited agency and accreditation against additional quality requirements as set out in the above Schedule.

(h) Any costs in meeting these quality criteria will depend on the extent to which the facility already has the required quality criteria in place.

(i) Currently the second tier provision only applies to private hospitals.

(j) See answer to (i)

(k) The second tier provisions are relevant default arrangements in a contracting environment. At the present time the second tier provision only applies to private hospitals because public hospitals do not negotiate individual contract rates with health funds although primary legislation and Commonwealth policy does not preclude this. The choice of public hospitals to negotiate contracts with health funds is entirely a matter for State and Territory governments.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2001-2002, 20 February 2002

Question: E02000052

OUTCOME 8: CHOICE THROUGH PRIVATE HEALTH

Topic: PROSTHESES

Written Question on Notice

Senator Evans asked:

(a) When did the Minister approve the exclusion of medical devices from health insurance due to the changes to Schedule 5 of the Ministerial Determination?
(b) What will be the savings to health funds from these exclusions?
(c) What other exclusions of procedures or devices are the health funds seeking?
(d) Has the Department examined whether these changes should only apply to new members rather than changing the basis of insurance for those existing members?
(e) What are the procedures for health funds to advise hospitals which people have coverage for which procedures or devices?
(f) With the increasing number of exclusions, is it not probable that many people will have a procedure done in the belief that they have health insurance only to discover the health fund claims later that they are not actually covered for that procedure or all costs associated with it leaving them with a large gap payment?

Answer:

(a) The Schedule (Schedule 5 – Surgically Implanted Prostheses, Human Tissue Items and Other Medical Devices under paragraph (bj) of Schedule 1, Section 73BA of the *National Health Act* 1953) is updated regularly in February and August each year. Each update usually has a significant number of additions and deletions.

(b) As changes to the Schedule, including additions and deletions, take place regularly, savings or additional expenditure by health funds is unknown and unable to be estimated.

(c) Deletions are not sought by the health funds. Deletions are either sought by manufacturers/suppliers as products are no longer in the market, or considered by the Private Health Industry Medical Devices Expert Committee (PHIMDEC), following concerns raised by an industry Review Advisory Committee during 1997-1999 as to whether these items are within the scope of the prostheses schedule under the *National Health Act* 1953.

(d) No. Additions and deletions to the prostheses schedule do not distinguish between existing and new members.

(e) As part of the consultation with the private health industry on the pre-existing ailment waiting period, the Department developed best practice guidelines that call for a health fund to inform the hospital and patient about eligibility for benefits for all possible charges incurred, including prostheses charges, prior to admission or as soon as practicable thereafter. The information should include details of any out-of-pocket expenses that may arise due to excesses, copayments, benefits exclusions or restricted benefits, and those additional expenses associated with choice of hospital and/or medical gaps.

Advice of eligibility for benefits is provided via telephone or facsimile, depending on the arrangements in place between the hospital and the fund. The Department is working with the Health Insurance Commission and the private health industry to investigate the possibility of establishing electronic systems for checking benefit eligibility.

(f) The current simplified billing and informed financial consent arrangements have been introduced to reduce the possibility of patients receiving multiple bills and being faced with unforeseen out-of-pocket expenses after hospital treatment as a private patient. This is achieved by aggregating bills; streamlining claims procedures; and ensuring patients are provided with information relating to the cost of their procedure prior to treatment, where possible.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2001-2002, 20 February 2002

Question: E02000053

OUTCOME 8: CHOICE THROUGH PRIVATE HEALTH

Topic: POSSIBLE MERGER OF AXA/MBF

Written Question on Notice

Senator Evans asked:

What role does the Department or PHIAC have in approving the merger of AXA/MBF?

Answer:

In the event that two or more registered health funds want to merge, *the National Health Act 1953* (the Act) requires those funds to apply to the Private Health Insurance Administration Council (PHIAC) for approval. PHIAC would convene a registration committee to consider the application.

The Department is a member of the registration committee, which may make recommendations to PHIAC on a change in health fund status.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2001-2002, 20 February 2002

Question: E02000054

OUTCOME 8: CHOICE THROUGH PRIVATE HEALTH

Topic: STATUS OF GOLDFIELDS MEDICAL FUND

Written Question on Notice

Senator Evans asked:

What is the Status of the Goldfields Medical Fund? How long is the administration period expected to last? Are major changes to the administration or structure of the fund expected?

Answer:

Goldfields Medical Fund is currently under administration pursuant to 82XD of the National Health Act 1953.

The initial appointment was for a three month period, however, it is possible that a further period may be required.

Any changes to the administration or structure of the fund are dependent on the advice of the administrator which has not yet been received.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2001-2002, 28/29 May 2001

Question: E02000055

OUTCOME 8: CHOICE THROUGH PRIVATE

Topic: PRIVATE HEALTH INITIATIVES

Written Question on Notice

Senator Evans asked:

(a) Is the Department aware of recent study by James Butler at NCEPH which found that: "Ironically, a government-funded reduction in premiums appears to have had a much more muted effect on private health insurance uptake than an unfounded announcement of an increase in premiums [through Lifetime Health Cover]"?

(b) Does the Department agree with this analysis?

(c) If not, what research has been undertaken to determine which of the policies had the greatest effect?

Answer:

(a) Yes.

(b) No.

(c) The Department does not consider that there is a valid methodology to enable such an analysis to be undertaken.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2001-2002, 20 February 2002

Question: E02000056

OUTCOME 8 – CHOICE THROUGH PRIVATE HEALTH

Topic: MEDIBANK PRIVATE PROFITS

Written Questions on Notice

Senator Evans asked:

(a) Why did Medibank Private perform so poorly to its major rivals?
(b) What is the outlook for the next year?
(c) What targets has the Board of Medibank Private set for profits and reserve levels for the future?
(d) Why has Medibank Private administration costs increased so substantially when it has been closing offices and sacking staff around Australia?
(e) How much money did Medibank Private spend on marketing and advertising during the last two years?
(f) A memorable Medibank Private ad showed a taxi driver who got his own boat to tour the Greek Islands as a result of joining Medibank Private. How many such prizes did Medibank Private award, what was the cost and who won them?
(g) The Health Insurance Industry has claimed that it now has to put up its premiums because the number of members claiming will increase. However isn't it true that the new members who joined because of the Lifetime Health Cover penalty premiums were generally younger and healthier than the long-standing members?
(h) Shouldn't this group be cheaper to service and more profitable to service as in theory they should be building up reserves to provide for their health demands in older age?

Answer:

(a) Over the past 4 years Medibank Private has generated surpluses totalling $267m (21% of industry surplus over that period) building its reserves to a record level of $557.9m at 30 June 2001. Over the same period Medibank Private has contained its premium levels to amongst the lowest in the industry to maximise the affordability and therefore access to the benefits of private health insurance to its members. Consequently profits generated by Medibank Private are lower than its competitors.

(b) Forecasts for Medibank Private operations are commercial in confidence.

(c) Medibank Private profit targets are commercial in confidence.

(d) Medibank Private has seen an increase in administration costs in the 2000/01financial year. This has resulted from the significant increase in membership from Lifetime Health Cover which led to higher telecommunication, printing, postage, and merchant banking fees as a result of the increased volumes. There was also an increase in non-IT consulting fees required to assist the organisation in meeting the new challenges of the business.

Medibank Private has taken several steps to reduce these costs including the closure of State based offices (these steps initially incur costs), however this did not take effect until late January 2002 and as such only initial savings have been realised to date.

(e) As set out in the Medibank Private Annual Report 2000/01, the Marketing costs for the period were:

- 2000/01 of $32,039,000
- 1999/2000 of $47,012,000.

(f) We believe the advertising you are referring to was in relation to a Sweepstake competition. The promotion offered the chance to win one of 10 sweepstake holiday or Private Health Insurance prizes to the value of $5,000 each.

A summary of prizes presented by Medibank Private follows:

- Private Health Cover to the value of $5,000 – this prize was won by seven Australian residents.
- Holiday to the value of $5,000 – this prize was won by three Australian residents.

(g) As noted earlier, premium levels set by Medibank Private represent a balance between the need to maintain appropriate reserve levels and the affordability of premiums. Notwithstanding the relatively lower age of post-LHC members, Medibank Private has been required to adjust its premiums this year (for the first time in three years). This is a result of higher than expected utilisation of Private Health insurance as well as increases in medical inflation (hospital charges, nursing wages, pharmacy costs, prosthesis costs).

(h) While it is possible to identify specific segments of membership who may be more profitable than others, the community rated basis of private health insurance in Australia requires funds to charge all members the same level of premiums regardless of their health status. However, it is true that post-LHC members were on average younger and therefore on average lower users of health services. This has enabled most funds to contain premium levels over the past 18 months.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2001-2002, 20 February 2002

Question: E02000057

OUTCOME 8: CHOICE THROUGH PRIVATE HEALTH

Topic: MEDIBANK PRIVATE – CLOSURE OF OFFICES AND MEMBER SERVICE

Written Questions on Notice

Senator Evans asked:

(a) Why did Medibank Private break its previous commitment to maintain its corporate office in Canberra?
(b) What savings will be generated by the move and were these assessed against the increased costs of making the move?
(c) What pay-outs have been made to staff leaving the Canberra office in the last two years and what costs will now be incurred in axing the 45 permanent and 25 casual jobs that have now been lost?
(d) What has been the cost of employing additional people in Melbourne over the last two years?
(e) What are the equivalent pay rates for staff in these two cities?
(f) What is the increased rental and operating costs in Melbourne compared to Canberra?
(g) What payments have been made to executives as part of relocation packages?
(h) What bonuses will be paid to Melbourne based executives in the next year?

Answer:

(a) Medibank Private has for the past four years since separation from the HIC continuously reviewed the structure and location of all of its major activities. These decisions were taken to improve the overall efficiency and competitiveness of the company.

(b) A number of factors were considered when making the decision to close the Canberra Office including the ongoing financial impact. There is an estimated saving of $891,830 per annum generated through reduced travel, accommodation and office accommodation costs. Any one-off relocation costs need to be offset against the long-term savings.

(c) There has been a total of 21 redundancy payments made to Canberra based staff over the past two years totalling $1,193,505 (this excludes costs incurred as a result of the Medibank Private business decision to outsource IT). The costs in replacing the remaining staff based in Canberra will be $2.5 million. This includes the cost of redundancy and transitioning allowances, recruitment, relocation, project management, lease break and fit-out write off costs.

(d) Through the transition period from Canberra to Melbourne, few additional (duplicated) employees have been required, with the exception of 4 individuals at a total estimated cost of $81,000. However, it is noted that the overall business of Medibank Private has expanded to meet the growth experienced from Lifetime Health Cover.

(e) The equivalent pay rates for staff in ACT & Victoria are:
- Average base salary for ACT was $72,091.
- Average base salary for VIC was $81,608.

(f) The rental per square metre:
- in Canberra is $338
- in Melbourne is $281

(g) None of the Canberra based executives have chosen to relocate to Melbourne, therefore Medibank Private has not incurred any associated relocation costs.

(h) Any Executive Bonuses paid to Melbourne executives are based on a combination of individual performance and corporate performance, to be assessed at the end of each financial year. Therefore, any bonus payments will not be known until the completion of this assessment process after 30 June 2002. It is noted however, that Medibank Private regards all executive bonuses as confidential.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2001-2002, 20 February 2002

Question: E02000058

OUTCOME 8: CHOICE THROUGH PRIVATE HEALTH

Topic: MEDIBANK PRIVATE – CLOSURE OF OFFICES AND MEMBER SERVICES (CLOSURE OF CUSTOMER CENTRES)

Written Question on Notice

Senator Evans asked:

(a) Why has Medibank Private centralised in Sydney and Melbourne when many organisations are taking advantage of available labour to local call centre operations in regional areas?

(b) Given Medibank Private has adopted three Regions (one of which is in Perth) why did it not maintain a customer service centre in Perth? Hasn't this decision wasted the opportunity to use the time difference to provide better coverage at lower cost?

Answer:

(a) Medibank Private currently operates call centres in Melbourne, Sydney, Brisbane and Perth. Medibank Private would not benefit from providing these services regionally, as they already operate from these suitable sites. Key factors in looking at sites to consolidate call centre and processing functions is the ability to scale existing operations and access to appropriately skilled labour markets. Given the large scale of operations already in existence in Melbourne, Brisbane and Sydney these were determined to be primary target locations. In addition, the existing operations in Perth were also expanded to provide member access to call centre services across a greater span of hours.

(b) As noted above, Medibank Private has expanded call centre operations in Perth. All staff employed in customer service activities in Perth were offered employment in the expanded call centre operations. There would be no cost benefit for Medibank Private to centralise its customer service centre operations to the Customer Service Centre in Perth. By rationalising call centre operations in Adelaide and Hobart and expanding its existing call centre operations in Perth Medibank Private has taken full advantage of economies of scale and time differences to minimise servicing costs and maximise the hours in which members may contact the fund.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2001-2002, 20 February 2002

Question: E02000059

OUTCOME 8: CHOICE THROUGH PRIVATE HEALTH

Topic: SALE OF MEDIBANK PRIVATE

Written Question on Notice

Senator Evans asked:

(a) What work has been undertaken within Medibank Private towards its privatisation?
(b) Has money been spent on consultants or legal advice to determine the options for sale of Medibank Private?
(c) Has the business been valued, and if so what is Medibank Private currently worth?
(d) Has Medibank Private provided information to other Government agencies about potential privatisation?
(e) What was that advice?
(f) Has Medibank Private had discussions with private companies about the possibility of it being sold?
(g) In particular what discussions have taken place with Mayne Health?

Answer:

(a) The Commonwealth's ownership of Medibank Private is an issue for the Commonwealth not Medibank Private.

(b) As part of its annual planning process, Medibank Private identifies and considers a range of key issues, including the potential impact on its operating plans, should the Commonwealth (in its capacity as shareholder) ever elect to change its ownership of Medibank Private. To assist Medibank Private in considering and defining the key issues and potential impact on its operating plan of any change in its ownership, it has received specialist advice on a commercial basis. Where appropriate, such advice is reviewed as part of the annual planning process. Medibank Private's annual planning process and all operational plans are commercial in confidence.

(c) Medibank Private has valued it own private health insurance business on an internal basis only. These valuation results are not only preliminary and untested, but commercial in confidence.

(d) The Commonwealth's ownership of Medibank Private is an issue for the Commonwealth not Medibank Private.

To support the annual planning process referred to above, Medibank Private did seek generic advice from the former Commonwealth office OASITO on the process involved in the sale of a Commonwealth owned asset. The discussions with OASITO were of an exploratory nature only to understand how a potential change in its ownership (should it ever be considered by the Commonwealth) could impact on Medibank Private's operating plans. The matter has not been progressed and the advice has no current status.

(e) Details of Medibank Private's current and future operating plans are commercial in confidence.

(f) The Commonwealth's ownership of Medibank Private is an issue for the Commonwealth not Medibank Private. Medibank Private itself has never raised the question of its ownership with any private companies.

(g) Medibank Private has never had any formal or informal discussions with Mayne Group in relation to its Commonwealth ownership.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2001-2002, 20 February 2002

Question: E02000060

OUTCOME 8: CHOICE THROUGH PRIVATE HEALTH

Topic: SALE OF MEDIBANK PRIVATE (TAKEOVER OF OTHER FUNDS)

Written Question on Notice

Senator Evans asked:

Does Medibank Private think there are too many private health funds in Australia and should there be some rationalistion?

Answer:

As a matter of principle, Medibank Private believes that the ultimate driver of any industry rationalisation should be an attempt to capture greater industry efficiency. Ultimately, it is Medibank Private's view that greater industry efficiency will benefit consumers.

While Medibank Private believes that rationalisation opportunities do exist, it is still investigating and evaluating the potential industry efficiencies to be gained by rationalisation.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2001-2002, 20 February 2002

Question: E02000061

OUTCOME 8: CHOICE THROUGH PRIVATE HEALTH

Topic: SALE OF MEDIBANK PRIVATE (TAKEOVER OF OTHER HEALTH FUNDS)

Written Questions on Notice

Senator Evans asked:

Has Medibank Private given consideration to a takeover or buy out of other registered health funds?

Answer:

In the early 1990's Medibank private acquired the fund known as "Health Australia", but since that time has not acquired any other health fund. Any acquisition decision would be subject to the approval of Medibank Private's Commonwealth Shareholder.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2001-2002, 20 February 2002

Question: E02000062

OUTCOME 8: CHOICE THROUGH PRIVATE HEALTH

Topic: MEDIBANK PRIVATE (CHANGE OF CONSTITUTION)

Written Question on Notice

Senator Evans asked:

(a) In October last year, Medibank Private wrote to all its members about a change in its constitution. How many responses did you get to this letter?
(b) Has the Constitution of Medibank Private now been changed, and what is the legal effect of this?
(c) Are the Minister for Health and Minister for Finance still responsible for approval of our activities?
(d) Exactly what was the purpose of the change in the Medibank Private constitution?
(e) What new activities will Medibank Private be able to carry out as a result of this change?
(f) Exactly what joint ventures or new products will Medibank Private be launching as a result of the new constitution?
(g) Will this include products developed jointly with health care providers to health packages?

Answer:

(a) Medibank Private received 12,150 member inquires in relation to the letter notifying members of the changes to its constitution. This represented an inquiry rate of approximately 0.87% of the 1.4 million notification letters mailed.

(b) The Medibank Private constitution has been changed. These changes came into effect on 3 December 2001. The legal effect was to revise and add new clauses to the Memorandum of Association and the Articles of Association. The changes to the Medibank Private Memorandum of Association were to revise clause 2 and to add a new clause 2A. The change to the Medibank Private Articles of Association was to add a new clause 60. A revised copy of the Medibank Private constitution highlighting the relevant changes is attached for reference.

(c) The Minister for Health and Ageing and the Minister for Finance and Administration are still responsible for the approval of Medibank activities. The revised Clause 2 of the Medibank Private Memorandum of Association specifically states:

"The objects of the company are as follows:

- *to conduct, as a registered health benefits organisation under the National Health Act 1953 (Cth), the business of the health benefits fund known as Medibank Private;*
- *with the approval in writing of the Minister, to engage or participate in any other business or activity; and*
- *to do, or engage or participate in, anything incidental, conducive or related to any business or activity referred to in paragraph (a) or paragraph (b).*
- *For the purposes of this Memorandum, "Minister" means the Ministers for Finance and Administration and for Health and Aged Care or either of them, or the Minister(s) (howsoever titled) designated as responsible for the company."*

(d) The changes to the constitution were implemented to allow Medibank Private the legal flexibility to respond to:
- Key changes in the health industry and health insurance sector including increasing medical costs; and
- Enhanced private health insurance product offerings being launched by Medibank Privates key competitors.

(e) The changes to the Constitution will allow Medibank Private to undertake new business activities if approved by the Shareholder Ministers.

(f) No proposals have been submitted to the Shareholder Ministers.

(g) Medibank will consider a number of enhancements to its private health insurance products. This may include jointly developing initiatives with health care providers.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2001-2002, 20 February 2002

Question: E02000063

OUTCOME 8: CHOICE THROUGH PRIVATE HEALTH

Topic: MEDIBANK PRIVATE (CHANGE OF CONSTITUTION)

Written Question on Notice

Senator Evans asked:

(a) What protection exists for the members of Medibank Private if you enter into a joint venture and use your membership lists for other purposes?
(b) Do you have a privacy policy that ensures member's details are not used for commercial purposes without express permission?

Answer:

(a) Medibank is bound by the National Privacy principles ('NPPs') in the *Privacy Act 1998* (Cth). These govern the use and disclosure of member information.

(b) A copy of this document is enclosed for your information.

Introduction

Medibank Private appreciates and highly values the relationship we have with you. As an important part of this relationship, we are committed to protecting the personal information that you entrust to us.

To provide our services to you, we ask that you give us certain information, including your name, address, age, and contact details. Where you have a family policy we may also ask you for similar information on each dependant covered under your membership, where appropriate. The information you provide to us is mostly personal and may also include sensitive or health information. This is explained in more detail below.

We understand that the confidentiality of personal information is vitally important to you and we are committed to ensuring that all information entrusted to us is protected against misuse. Your personal information is also vital to us, as it enables us to provide you with the level of service that you expect from us.

Our privacy policy sets out Medibank Private's commitment to both your privacy and the protection of your personal information against misuse. Please read this privacy policy carefully and if you have any questions, please contact us. This Privacy Policy may be amended from time to time and notice of any changes will be sent out to you. Further copies of this privacy policy are available at your nearest Retail Centre or can be downloaded from our website, medibank.com.au.

"You" And This Privacy Policy

Medibank Private's services are available to members, that is, the contributor and where the contributor has a family policy, the contributor and his or her dependants. Where applicable "**dependants**" includes the contributor's spouse, in accordance with the terms of the relevant policy. Medibank Private may hold personal information relating to the contributor and where applicable, all dependants.

Our commitment to appropriately handle the personal information of individuals extends not only to the contributor but also to the contributor's dependants. Therefore, any reference in this section of the privacy policy to "you" may e taken where the context permits, as a reference to both you the contributor and your other dependants.

So that they are protected, special consideration needs to be given to the rights of young persons and those with impaired capacity. For the purposes of this policy and unless circumstances suggest otherwise, a dependant under the age of 16 years will be regarded as a young person in respect of whom special provisions may apply. These special provisions relate primarily to rights concerning access to and correction of their personal information and complaints procedures.

National Privacy Principles

The Federal Government's National Privacy Principles which are set out in the *Privacy Act* 1988 (Cth) (the "Privacy Act") represent a legal obligation which must be observed by many private sector organisations including Medibank Private. We are committed to the protection of your privacy by acting in accordance with the requirements of the Privacy Act and the National Privacy Principles.

The National Privacy Principles control the way in which Medibank Private may collect, store, use and disclose your personal information including any sensitive information entrusted to us. Your personal information is any information, or an opinion about you where your identity is apparent, or can reasonably be ascertained. It will therefore include virtually any information which is in some way linked to your name, address, or other identifying features. Personal information may include sensitive information and health information.

A copy of the National Privacy Principles may be obtained from the Office of the Federal Privacy Commissioner or the Commissioner's website, www.privacy.gov.au.

Your personal information.

The amount and type of personal information we hold about you depends on the nature of your relationship with us and the extent to which you have used our services or made claims. As a minimum we will have a record of your name, address, age, dependants and contact details including telephone numbers and in some cases facsimile numbers and email addresses. Post office box numbers and other contact details may also be held.

We may also hold sensitive information about you, including information about your health and wellbeing collected over a period of time. This information is generally collected from you and your dependants. It may also be collected from government agencies or from health service providers including hospitals, doctors and other medical and related professionals as well as a range of other service providers. These service providers may have provided health services to you, or one of any number of other services associated with your general wellbeing, which are provided as part of a range of services offered by us. This sensitive or health information may include details of where, when and from whom you received any health or other services and the nature of those services.

We may also hold information relating to your financial affairs, including bank account and credit card details, tax file numbers and Medicare numbers as well as details concerning your premium payments and claims history. We may also hold information concerning your employer if you pay your premiums through a payroll deduction scheme. We may also hold personal information about you including health information which may be exempt from the strict compliance requirements of the National Privacy Principles. This may include information which we are required to collect from, use, or disclose to various Government agencies including the Health Insurance Commission, the Private Health Insurance Administration Council and the Federal and State health departments. If you are an employee of Medibank Private, it may include certain information forming part of your employee records. How we use and disclose this personal information from time to time will govern whether or not it is subject to the National Privacy Principles.

Collection Of Your Personal Information

Medibank Private collects, stores, uses and discloses your personal information for a range of purposes.

We collect your personal information primarily to enable us to provide health benefits to you and to otherwise fulfil our legal obligations as a registered health benefits organisation. This is the primary purpose of us collecting your personal information. We also collect your personal information for a range of other purposes related to the primary purpose (**secondary purposes**) and for certain unrelated secondary purposes, but only if you have given your consent to these unrelated secondary purposes. We call all these purposes the "approved purposes".

We will only collect your personal information where that personal information is necessary for one or more of the functions or activities we perform when providing health benefits to you, or in connection with any one of a number of related or unrelated secondary purposes detailed in this privacy policy.

When collecting this personal information, we will do so only by lawful and fair means and not in an unreasonably intrusive way. When collecting personal information about you which, for the purposes of the Privacy Act is regarded as sensitive information or health information, we will collect that information from you or from third parties only with your consent or as authorised by the National Privacy Principles.

At or before the time we collect personal information about you (or if that is not practicable, as soon as practicable thereafter), we will provide you with a statement outlining certain basic facts concerning us and our information handling processes as required by the National Privacy Principles.

Where it is reasonable and practicable to do so, we will only collect personal information about you, from you directly and not from third parties. However, in many instances this will not be practicable. If we collect personal information about you from a third party, then if required by law we will take reasonable steps to ensure that you receive from that third party privacy information similar to that set out in our own Privacy Disclosure Statement or we will provide to you a Privacy Disclosure Statement.

Should you prefer and where lawful and practicable we will also allow you to deal with us on an anonymous basis.

Use And Disclosure Of Your Personal Information

To ensure that we can effectively provide you with the quality of health benefits and other services that Medibank Private prides itself on, we will use and disclose your personal information for the approved purposes and in a variety of ways associated with the approved purposes, including the following:

- to conduct claims processing and control;
- to address information technology, systems maintenance and development;
- to address information technology requirements, systems maintenance and development issues;
- to analyse and process the information for product development, marketing and research purposes and to improve and extend our range of services;

- to take steps to improve your health and general wellbeing by sending you health-related information, to heighten your awareness of what you can do to prevent, alleviate or cure health related problems that you may have. We may also take steps to develop or identify other products or services that may be of use or benefit to, or of interest to you and to inform you of these products or services. This may include information which we supply about our own products and services, or the products or services of others;
- to investigate and resolve complaints concerning the provision of services by us or others associated with us;
- marketing directly to you in accordance with the National Privacy Principles;
- by disclosure of your personal information to any other organisation or person involved in carrying out any necessary function or activity on our behalf, including complaints handling and fraud prevention, whether within Australia or overseas;
- by disclosure of your personal information to others, whether within Australia or overseas, but only for the provision of services which are properly considered to be part of approved purposes;
- by disclosure of your personal information in a manner authorised or required by law;
- for any unrelated secondary purpose to which you consent;
- for compliance with any legislative and regulatory provisions; and
- to transfer assets to any third party, or part of a group reorganisation.

Medibank Private contracts out various services associated with our functions and activities. This may
involve the disclosure of your personal information to other persons and organisations, both within Australia and overseas. These contracts typically involve the analysing and processing of personal information for:

- product development;
- marketing and research purposes;
- IT systems maintenance and development; and
- claims processing and control.

Where Medibank Private does disclose your personal information to other parties, it has in place arrangements or understandings with those third parties to ensure that your personal information is handled in a manner consistent with our obligations under this privacy policy. Where appropriate we will ensure that your personal information is de-identified before being used, or disclosed, or destroyed, or de-identified if it is no longer necessary that it be retained. The types of persons and organisations to which Medibank Private may disclose your personal information include the following:

- organisations we have arrangements or agreements with for the purpose of promoting our products or services and any agents used by us in administering such arrangements or agreements;
- our agents, contractors and external advisers who carry on our functions and activities, or who assist us to carry on our functions and activities from time to time, for example mail and telephone field houses, recruiting organisations and research providers;
- government agencies, health service providers including hospitals, doctors, specialists and other medical and related professionals as well as a range of other service providers responsible for providing to you any one of a number of other services associated with your health and general wellbeing;

- your executor, administrator, trustee, guardian, attorney or legal personal representative, or your employer if you are part of a payroll deduction scheme;
- payment systems operators;
- regulatory bodies, complaints processors, complaints adjudicators, government agencies, law enforcement bodies and courts; and
- other parties to whom we are permitted, authorised or required by law to disclose information.

Consent And Personal Information

We will only collect sensitive or health information from you or about you from third parties with your consent or where you are a dependant under the age of 16 years with the consent of an appropriate adult who may be a parent or guardian, who is the member named in the policy under which your cover is provided (the "**contributor**") or their agent.

By supplying sensitive or health information about yourself and your dependants or when making a claim for benefits or otherwise making use of our services, which may involve the collection of sensitive or health information from third parties you will be taken to have given:

- your consent to the collection of that sensitive or health information about you from you or those third parties; or
- on behalf of any dependants aged under 16 years their consent to the collection of sensitive or health information about them from you or those third parties; or
- on behalf of any dependants aged 16 years and over the consent to the collection of sensitive or health information about them from you or those third parties with the authority of those dependants.

We will only use your personal information for any approved purposes which are unrelated to the provision of health benefits services, with your consent. Once we have obtained your consent, by remaining a member or otherwise making use of our services you are taken to have consented to the use of your personal information and that of your dependants for any approved purposes which are unrelated secondary purposes, unless and until your consent is withdrawn.

You may withdraw your consent to the use of personal information for any unrelated secondary purposes (whether for yourself or any dependant aged under 16 years), by completing and sending to us the notification of withdrawal of consent form which is available at any Medibank Private Retail Centre or can be downloaded from our website, medibank.com.au.

By continuing your relationship with us, you are taken to have agreed to the following on your own behalf and that of your dependants:

- you consent to the use and disclosure of your personal information and the personal information of your dependants for the approved purposes identified in this privacy policy;
- you will give to your dependants aged 16 years and over, a copy of this privacy policy and make them aware of the contents of it;

- you will make, or will authorise the making of all claims under a valid family policy for yourself and all dependants covered by the family policy and will ensure that each claim includes the sensitive information of a dependant aged 16 years and over, only with the consent of that dependant; and
- you authorise all health service providers including hospitals, doctors, specialists and other medical and related professionals and members of your family (where appropriate) to supply from time to time to Medibank Private full and complete details of all or any medical treatment, hospitalisation, injury, disease, ailment or diagnoses concerning you or your dependants. You acknowledge that you have the consent of each dependant aged 16 years and over to give this authority on his or her behalf.

Security And Quality Of Your Personal Information

Medibank Private will take reasonable steps to ensure that any of your personal information that we collect, store, use or disclose is accurate, complete and up-to-date.

We will also take reasonable steps to protect your personal information from misuse, loss and from unauthorised access, modification or disclosure in accordance with the requirements of our privacy policy and the National Privacy Principles.

Requests For Access To And Correction of Your Personal Information

You have a right of access to your personal information. You may request details of the personal information we hold about you, or about any dependant aged under 16 years, or about any dependant of impaired capacity by writing to or contacting Member Enquiries (see contact details on the back of this brochure). Member Enquiries is committed to processing your access request promptly.

No fee will be charged for the making of the request. We may charge an administrative fee for the provision of this information to cover our costs. However, we will inform you of any fee at the time a request is made.

ACCESS RIGHTS

Depending upon the nature of your request, we may ask you to complete a personal information access request form, and require you to properly identify yourself to verify your right to
receive the personal information requested. We will release to you details of the personal information we hold which we are required by law and our privacy policy to release. However, we may not release personal information to you to the extent that:

- providing access would pose a serious threat (or in the case of personal information other than health information, a serious and imminent threat) to the life or health of any individual; or
- providing access would have an unreasonable impact upon the privacy of other individuals; or
- your request for access is frivolous or vexatious; or
- it is otherwise appropriate for us to deny access in accordance with the National Privacy Principles.

DENIAL OF ACCESS

We will not deny you access to any personal information following an access request without providing you with a reason for the denial. However, if we deny you access, we will consider the use of an agreed intermediary to receive the personal information instead of you, or to reach an amicable solution that meets the needs of both parties.

Where providing access would reveal evaluative information generated within Medibank Private in connection with a commercially sensitive decision-making process, we may give you an explanation for the commercially sensitive decision rather than direct access to the information.

If you are aware that any of your personal information is inaccurate, incomplete or out-of-date following an access request, or because your circumstances have changed, please inform us so that we can update our records. We will correct any personal information that is not correct and will not refuse to make a correction without providing you with a reason for the refusal. However, if we do refuse to make a correction, we will take reasonable steps to include, with the disputed information, a statement from you claiming that the disputed information in your opinion is not accurate, complete or up-to-date.

Access and correction rights of young persons and persons suffering an impairment

Medibank Private believes that the personal information of young persons and persons of impaired capacity requires special consideration.

Medibank Private regards itself initially:

- as answerable to any dependant aged 16 years and over in respect of any request for access to and correction of personal information relating to that dependant – to the exclusion of that dependant's parents or other relevant adults. For example, Medibank Private will provide access to and correction rights in respect of the personal information of a dependant to that dependant and not to the parents or other relevant adults. An exception to this will be where the dependant is not able to exercise sound judgement, perhaps because of a mental impairment, in which event Medibank Private will respond to any access request in accordance with the Privacy Act and the National Privacy Principles;
- as answerable to any person lawfully representing the interests of a dependant aged under 16 years or any person of impaired capacity in respect of any request for access to or correction of personal information relating to that person – to the exclusion of that person and adults other than the lawful representative. For example, Medibank Private will provide access to and correction rights in respect of the personal information of that person to the lawful representative and not to others. An exception to this may be where the dependant aged under 16 years, shows himself or herself to be capable of exercising sound judgement. In all instances, Medibank Private will respond to all access and correction requests by and in respect of young persons and persons of impaired capacity in a responsible manner having regard to the interests of the persons involved and at all times in accordance with its obligations under the Privacy Act and the National Privacy Principles.

Medibank Private's Online Privacy Policy
If you communicate with Medibank Private via the Internet or by email, you should be aware of our commitment to your privacy in the online environment. For more information, please refer to Medibank Private's online privacy policy, which can be found on our website medibank.com.au

Complaints
You can complain to us about any breach of our privacy obligations to you, including a breach of this privacy policy. You may also contact us to discuss any issues you have or concerns arising out of the way in which we use your personal information. Complaints about possible breaches of our privacy policy should be directed to Member Enquiries (see contact details on the back of this brochure).

Member Enquiries is committed to discussing with you any concerns you may have and to addressing these concerns promptly and appropriately. You may require more general information from us concerning how we handle your personal information and we will take reasonable steps to provide this to you. Please ask at any Medibank Private Retail Centre, or contact Member Enquiries on 132 331.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2001-2002, 20 February 2002

Question: E02000120

OUTCOME 9: HEALTH INVESTMENT

Topic: IMPLICATION OF THE TRADE PRACTICES ACT REVIEW ON RURAL GP'S

Hansard Page: CA 93

Senator McLucas asked:

(a) I am interested to know whether any GP organisations got any funding to make submissions to the ACCC.
(b) Also, was there any opportunity for other types of organisations to make submissions to the ACCC?
(c) What was the consultation process?
(d) How were they advised?
(e) Has the AMA received funding to make submissions to the ACCC?
(f) If funds were made available to either GP organisations, community organisations or whomever, how much were they and where did they come from?

Answer:

(a) The RACGP received funding of $33,854.40 from the Department to make an application to the ACCC. The funds were drawn from the program for General Practice Support for Training and Infrastructure.

(b) Yes.

(c) The ACCC undertakes a public consultation process seeking comments on the application from interested parties. The Commission maintains Public Registers of documents relating to these applications. Information about accessing these hardcopy registers is kept on the Internet at www.accc.gov.au/adjudication/fs-adjudicate.htm.

(d) That is a matter for the ACCC.

(e) Not from the Department.

(f) Refer to (a).

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2001-2002, 20 February 2002

Question: E02000119

OUTCOME 9: HEALTH INVESTMENT

Topic: NUMBERS OF TEMPORARY RESIDENT DOCTORS WORKING IN OUTER METROPOLITAN AREAS OF SYDNEY

Hansard Page: CA 89

Senator West asked:

Aren't there some areas of outer metropolitan Sydney that are (districts of workforce shortage)?

Answer:

Currently there are two overseas-trained restricted general practitioners working under exemptions granted to restrictions in the *Health Insurance Act 1973* in Rural Remote and Metropolitan Area classification 1 areas in New South Wales. This classification applies to the Sydney metropolitan area generally.

The doctors referred to are working in the outer metropolitan areas of Kariong and Warilla.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2001-2002, 20 February 2002

Question: E02000121

OUTCOME 9: HEALTH INVESTMENT

Topic: TROPICAL HEALTH INSTITUTE IN TOWNSVILLE

Hansard Page: CA 119

Senator McLucas asked:

I would be very interested, Mr Wells, if you could find some more information about whether or not this is a project that North Queensland can expect.
The other question is: I would like to know where the funds will be taken from, where will the appropriation come from, to build that institute, I think it is called?

Answer:

There is no commitment to fund a Tropical Health Institute in North Queensland.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2001-2002, 20 February 2002

Question: E02000005

OUTCOME 9: HEALTH INVESTMENT

Topic: PRE-ELECTION ANNOUNCEMENTS – TROPICAL HEALTH INSTITUTE

Written Question on Notice

Senator Evans asked:

On 24th October Peter Lindsay, the member for Herbert announced $6.1 million for a new "tropical health institute" in Townsville with "nodes" in Mt Isa, Mackay and Cairns. What commitment did the former Health Minister make to this project and where were the funds taken from to fund it?

Answer:

There is no commitment to fund a Tropical Health Institute in Townsville, Queensland.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2001-2002, 20 February 2002

Question: E02000012

OUTCOME 9: HEALTH INVESTMENT

Topic: DEEP VEIN THROMBOSIS - DATA

Written Question on Notice

Senator Evans asked:

(a) What has happened with the announced "data matching" study to look at the incidence of Deep Vein thrombosis amongst international flyers? When did this study commence and when will it report?

(b) What evaluation did the Department make of the proposal from the Australian Society of Thrombosis and Haemostasis to test the extent of the problem and identify risk factors.

(c) Now the airlines have recognised the risks of DVT by showing new in flight videos warning of the dangers, will the Department re-examine the Society's research proposal so that some serious work can be done to assess this important health risk?

Answer:

(a) The Department of Health and Ageing is conducting a study linking state hospital data with travel data from the Department of Immigration and Multicultural Affairs. The study commenced in September 2001. Preliminary results are expected by September 2002.

(b) The Australian Society of Thrombosis and Haemostasis (ASTH) proposal was evaluated by Commonwealth medical staff. The Department however, decided that an internal study using available existing government data should first be conducted to determine the scale of the problem before other more expensive prospective studies were considered.

(c) The Department has recently offered to meet with Dr Baker of the ASTH to discuss their proposed project. The true risk of DVT is unknown. The only studies to assess the risk involve small sample sizes and have produced inconclusive results. The Department, in collaboration with Professor D'Arcy Holman from WA, will examine around 12,000 cases of DVT in its own study. It is expected that statistically significant results will be obtained.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2001-2002, 20 February 2002

Question: E02000036

OUTCOME 9: HEALTH INVESTMENT

Topic: NURSING NUMBERS

Hansard Page: CA 7

Senator Evans asked:

(a) Has the Department seen recent reports that Australia is failing to train enough nurses?
(b) Does the Department agree?
(c) What information does the Department have on this issue?
(d) How many nurses are there in Australia?
(e) How many are needed?
(f) What is the age profile?
(g) In what areas are there shortages?
(h) What action does the department intend to take?

Answer:

(a) Yes.

(b) The employment of nurses is a State and Territory Government responsibility. The National Nurse Education Review is expected to provide advice on this matter.

(c) The Department is informed on this issue by the following reports:

- Department of Employment, Science and Education. 2002. Students, Selected Higher Education Statistics 1991-2002. DETYA, Canberra.
- Australian Institute of Health and Welfare (AIHW) 2001. Nursing labour force 1999. (page 25). AIHW cat. no. HWL 14. Canberra: AIHW (National Health Labour Force Series).
- Nursing Education Review Secretariat. 2001. National Review of Nursing Education Discussion Paper (page 87). DETYA No 6793.HERC01A, Canberra.

(d) The 'Nursing Labour Force 1999' report, published in September 2001 by the Australian Institute of Health and Welfare states:
The National Nursing Labour Force Survey, conducted in conjunction with renewal of registration in 1997, enumerated a total of 255,551 nurses, comprising 202,183 registered nurses and 53,369 enrolled nurses. (Australian Institute of Health and Welfare (AIHW) 2001. Nursing labour force 1999. (page 7). AIHW cat. no. HWL 14. Canberra: AIHW (National Health Labour Force Series)).

(e) The level of need is determined by each State and Territory Government. According to the 'Nursing Labour Force 1999' report, Australia is ranked the fourth highest country in relation to registered nurses per 100,000 population of OECD countries after Ireland, Switzerland and Finland. (Australian Institute of Health and Welfare (AIHW) 2001. Nursing labour force 1999. (page 28). AIHW cat. no. HWL 14. Canberra: AIHW (National Health Labour Force Series)).

(f) Unpublished data on the age profile of employed registered and enrolled nurses provided by the Australian Institute of Health and Welfare is at Attachment 1.

(g) The Department of Employment and Workplace Relations monitors occupational labour markets in Australia and assesses whether skill shortages exist. Information on nursing is published in the 'Nursing Labour Force 1999' report. As at February 2001, Australia-wide shortages of registered nurse occupations were in: operating theatre, critical/intensive care, accident/emergency, cardiothoracic, neo-natal intensive care, neurological, paediatric, aged care, midwifery, renal, oncology, palliative care, perioperative, indigenous health, general registered nurse and mental health. (Australian Institute of Health and Welfare (AIHW) 2001. Nursing labour force 1999. (page 24). AIHW cat. no. HWL 14. Canberra: AIHW (National Health Labour Force Series)).

(h) The Department's actions will be determined by government policy that will be informed by the findings of the National Review of Nursing Education, the Senate Inquiry into Nursing in Australia and the Critical Care Nursing and Midwifery Workforce Reviews currently being undertaken by the Australian Health Workforce Advisory Committee.

All nurses employed in nursing: occupation, sex and age, Australia, 1999 **E2000036**

Occupation	<25	25–29	30–34	35–39	40–44	45–49	50–54	55–59	60–64	65+	Total
						Males					
Nurse clinician	779	2,155	2,302	2,261	2,762	2,099	1,164	560	300	74	14,456
Clinical nurse manager	0	52	128	214	260	182	90	24	19	0	969
Administrator/manager	2	60	184	293	451	351	214	80	27	12	1,676
Teacher/educator	3	27	75	90	107	87	41	17	12	1	461
Researcher	2	9	14	17	14	19	3	6	0	0	82
Other	3	12	38	33	48	41	26	10	10	0	220
Total	*789*	*2,314*	*2,741*	*2,908*	*3,641*	*2,779*	*1,539*	*699*	*367*	*87*	*17,864*
						Females					
Nurse clinician	8,577	20,297	22,305	29,219	33,705	26,983	19,466	11,093	4,544	1,264	177,453
Clinical nurse manager	45	405	772	1,140	1,690	1,573	1,232	677	250	61	7,845
Administrator/manager	21	349	795	1,698	2,459	2,541	2,293	1,372	636	190	12,353
Teacher/educator	59	252	516	768	928	745	581	345	142	36	4,371
Researcher	18	105	167	285	260	218	170	72	22	15	1,332
Other	55	221	394	587	785	796	686	452	213	63	4,251
Total	*8,776*	*21,629*	*24,949*	*33,698*	*39,827*	*32,856*	*24,428*	*14,010*	*5,806*	*1,628*	*207,605*
						Persons					
Nurse clinician	9,356	22,452	24,607	31,479	36,468	29,082	20,630	11,654	4,843	1,338	191,909
Clinical nurse manager	45	457	900	1,354	1,950	1,754	1,322	702	269	61	8,814
Administrator/manager	24	409	979	1,992	2,910	2,893	2,507	1,452	663	201	14,029
Teacher/educator	62	279	591	858	1,035	832	622	361	154	37	4,832
Researcher	20	114	181	302	273	237	173	78	22	15	1,414
Other	58	233	432	620	832	837	712	462	222	63	4,471
Total	**9,565**	**23,943**	**27,690**	**36,606**	**43,468**	**35,635**	**25,966**	**14,709**	**6,173**	**1,715**	**225,470**

Source: AIHW, Nursing labour force survey, 1999

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2001-2002, 20 February 2002

Question: E02000064

OUTCOME 9: HEALTH INVESTMENT

Topic: NHMRC SPENDING

Written Question on Notice

Senator Evans asked:

(a) Can the NH&MRC provide a table showing the growth in actual funding provided as project grants for each of the last five years showing how the change to accrual accounting has been dealt with?

(b) What are the number of grants made as project grants in each year and what has been the trend in the average number of grants made?

Answer:

The following table summarises the number and value of project grants awarded by the NHMRC by calender year. The table shows an increase in the level of new awards for project grants in 2000 as a result of additional funding allocated by the government in the 1999-00 Federal Budget to implement the *Health and Medical Research Strategic Review*. Although the number of new project grants fell in 2002, the success rate of applications has remained constant at around 24%.

The introduction of accrual accounting has had no real effect on the value or level of funding allocated to project grants. In 1999-00 the Department of Health and Ageing adopted an accounting policy that expended the full value of research awards each year because research grants were assessed as being non-reciprocal and were unavoidable following acceptance. This resulted in a rise in expenses reported in the Department's financial statements during the past two years. The accounting treatment of research grants was recently reviewed, and in line with AAS29 and the Finance Minister's Orders, the policy has reverted to recognising expenditure progressively over the duration of the grant.

Grants commencing	1997	1998	1999	2000	2001	2002
Number of New Project Grants Awarded	525	404	354	449	459	408
Number of Continuing Project Grants	756	791	834	758	802	887
Project Grant Funding	$92.6	$97.0	$103.0	$112.2	$120.9	$123.9

- 1997-2001 information is drawn from the NHMRC's annual *Grants Book*
- Funding for research fellows was separated from project grants from 2001
- 2002 project grant funding is an estimate and is subject to acceptance of funds and variations to continuing grants

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2001-2002, 20 February 2002

Question: E0200065

OUTCOME 9: HEALTH INVESTMENT

Topic: NHMRC SPENDING

Written Question on Notice

Senator Evans asked:

(a) Of the other categories of research funding listed in the Prime Minister's press release of 31st October, which of these existed in 1999 and what was the funding provided in each category?
(b) What categories of funding have been terminated since 1999?

Answer:

The main categories of research funding listed in the Prime Minister's announcement of 31 October 2001 were Project Grants, Program Grants and Fellowships Grants. All of these grants existed in one form or another in 1999. However, Program Grants have substantially changed in character since 1999 and now represent the premier vehicle by which the NHMRC funds teams of high-achieving health and medical researchers.

The other categories listed in the Prime Minister's press release included Training Awards, Career Development Awards*, Partnership Grants*, Block Funded Institutes, establishing the Juvenile Diabetes Research Foundation Vaccine Centre*, National Research Capacity*, Burnet Awards*, the Transitional Institute Grant*, Equipment Grants and Population Health Capacity Building*. Those marked with an asterisk (*) have been introduced post-1999.

In 1999, funding for new and continuing grants was provided as follows:
- Project Grants ($102,986,391 – 1188 grants);
- Program Grants ($13,649,992 – 21 grants);
- Unit Grants ($2,874,512 – 5 grants);
- Block Funded Institutes ($25,791,132 – 6 grants);
- R Douglas Wright Awards ($1,045,806 – 16 grants); and
- Training Awards ($14,446,648 – 445 grants);

The categories of funding that have been terminated since 1999 are:

- Block Funded Institutes – these are being phased out in favour of funding through regular NHMRC competitive research schemes. Funding will cease in 2004. No new Block Funded Institutes have been created since 1999;
- Unit Grants – these are being phased out. Funding is still being provided in 2002 under the heading of National Research Capacity;
- R Douglas Wright Awards – these have been completely revamped and the closest category of award in 2002 is the Career Development Award;
- Burnet Fellowships and Eccles Awards – these schemes have been amalgamated into the new Burnet Award which aims to promote the return of eminent Australian researchers from overseas;
- A range of project grants (for example, Five-year Extended Project Grants and Extended Epidemiology Project Grants) are now simply classified as Project Grants; and
- Priming Grants are now called New Investigator Grants, which are treated as a sub-set of project grants.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2001-2002, 20 February 2002

Question: E02000066

OUTCOME 9: HEALTH INVESTMENT

Topic: NHMRC SPENDING

Written Question on Notice

Senator Evans asked:

(a) What were the circumstances that led to the Prime Minister making the announcement of the 2002 research grants during the election campaign?
(b) Did the NH&MRC obtain advice about how the caretaker conventions should apply to Government announcement of new financial commitments during the caretaker period?

Answer:

(a) The Research Committee of the NHMRC is authorised by Council to make recommendations to the Commonwealth on expenditure on public health research and training and medical research and training.

Under the *National Health and Medical Research Council Act 1992* the NHMRC is required to provide recommendations to the Minister on grant funding by 31 October and advise successful applicants by 30 November in each year.

Research Committee met on 24-25 September 2001 to consider advice from its peer review committees on funding. Following agreement at that meeting, the Chief Executive Officer of the NHMRC wrote to the Minister on 27 September 2001 transmitting Research Committee's recommendations. The Minister approved the funding on 1 October 2001.

Following receipt of Ministerial approval, the NHMRC began detailed preparations for the grant announcement. This included updating computer systems to reflect the approved status (or otherwise) for each grant application, the approved budget for each successful grant, the preparation of letters to applicants and the preparation of media releases (including obtaining permission to use details from individual grants).

The Department was advised that the Prime Minister wished to make the announcement, which he did on 31 October 2001. The letters to applicants were couriered to their respective institutions on the day of the Prime Minister's announcement.

(b) The funding was approved before the election was called and before the operation of the caretaker period. If the announcement had not been made during the election period the NHMRC might have found itself in breach of its legislation which requires it to advise applicants by 30 November 2001.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2001-2002, 20 February 2002

Question: E02000082

OUTCOME 9: HEALTH INVESTMENT

Topic: NHMRC FUNDING

Written Question on Notice

Senator Carr asked:

The increases in NHMRC funding provided as a result of the Wills report cease in 12-18 months. Given the fundamental importance of this funding to a wide range of research, including medical research, will you describe what provision has been made to maintain the current levels of funding when the term of the wills-inspired funding expires?

Answer:

The increased level of funding announced in conjunction with the Wills review is ongoing.