Community Affairs
Legislation Committee

Examination of Budget Estimates 2003-2004

Additional Information Received

VOLUME 7

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

HEALTH AND AGEING PORTFOLIO

FEBRUARY 2004

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

ADDITIONAL INFORMATION RELATING TO THE EXAMINATION OF BUDGET EXPENDITURE FOR 2003-2004

Included in this volume are answers to written and oral questions taken on notice and tabled papers relating to the SUPPLEMENTARY budget estimates hearing on 5 November 2003

HEALTH AND AGEING PORTFOLIO

Biography of reviewer

- Professor Hogan brings a wealth of economic and business expertise to the Review.

- He is currently Adjunct Professor of Economics at the University of Technology, Sydney, and has had a distinguished career including 30 years as Economics Professor at the University of Sydney, of which he is now Emeritus Professor.

- Professor Hogan's academic career has been complemented by a successful business career. In 1986 he was appointed to the Board of the Westpac Banking Corporation, a position he held until December 2001. He has also had Directorships at the AMP Society from 1993 to 1996 and the Australian Guarantee Corporation.

- The Fraser Government appointed Professor Hogan to the following positions:

  – 1976-81: Member, Panel of Economic Advisers to the Federal Treasurer;

  – 1976-81: Member, Australian Population and Immigration Council;

  – 1977-82: Member, Australian Manufacturing Council;

  – 1980-81: Member, Independent Public Inquiry into Domestic Airfares (The Holcroft Inquiry) for the Federal Government;

  – 1982-83: Member, Economic Advisory Group of the Federal Government; and

  – 1982-83: Member, Australian Council on Population and Ethnic Affairs.

- Professor Hogan's work overseas included posts in Pakistan for the Harvard University Development Advisory Service, and missions, mostly in the Philippines, for the World Bank in Washington, D.C. He worked in Pakistan, India, Malaysia and Thailand on industrialisation and trade projects sponsored by the Nuffield Foundation; and he was involved in industrialisation and trade initiatives in Papua New Guinea for the National Investment and Development Authority.

- Professor Hogan has agreed to do the Review for $114,960 per annum in line with the fees paid under Remuneration Tribunal arrangements for part-time holders of public office.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2003-2004, 5 November 2003

Question: E03-001

OUTCOME 3: Enhanced Quality of Life for Older Australians

Topic: STOCKTAKE OF AGED CARE PLACES

Written Question on Notice

Senator Denman asked:

With reference to the statement on page 122 of the Department's Annual Report for 2002-03, that almost half of the 6,561 new aged care places were allocated to rural and regional Australia, could these figures be provided by aged care planning regions?

Answer:

The distribution of new aged care places allocated to rural and regional Australia in the 2002 allocation round is set out below:

State or Territory	Aged Care Planning Region	Total
NSW	Central Coast	157
	Central West	37
	Far North Coast	110
	Hunter	120
	Illawarra	157
	Mid North Coast	190
	Nepean	75
	New England	42
	Orana Far West	26
	Riverina/Murray	38
	Southern Highlands	62
		1014
VIC	Barwon-South Western	273
	Gippsland	202
	Grampians	18
	Hume	203
	Loddon-Mallee	78
		774

State or Territory	Aged Care Planning Region	Total
QLD	Cabool	16
	Central West	3
	Darling Downs	57
	Far North	62
	Fitzroy	21
	Logan River Valley	128
	Mackay	15
	Northern	40
	North West	15
	South Coast	135
	South West	-
	Sunshine Coast	102
	West Moreton	10
	Wide Bay	68
		672
WA	Goldfields	-
	Great Southern	38
	Kimberley	-
	Mid West	-
	Pilbara	10
	South West	94
	Wheatbelt	-
		142
SA	Eyre Peninsula	-
	Hills, Mallee & Southern	25
	Mid North	5
	Riverland	20
	South East	54
	Whyalla, Flinders & Far North	15
	Yorke, Lower North & Barossa	42
		161
TAS	Northern	23
	North Western	40
	Southern	89
		152
ACT	ACT	79
		79
NT	Alice Springs	20
	Barkly	-
	Darwin	27
	East Arnhem	20
	Katherine	10
		77
TOTAL		**3071**

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2003-2004, 5 November 2003

Revised Question: E03-001

OUTCOME 3: Enhanced Quality of Life for Older Australians

Topic: STOCKTAKE OF AGED CARE PLACES

Written Question on Notice

Senator Denman asked:

(a) With reference to the statement on page 122 of the Department's Annual Report for 2002-03, that almost half of the 6,561 new aged care places were allocated to rural and regional Australia, could these figures be provided by aged care planning regions?

(b) With reference to the statement on page 123 of the Department's Annual Report for 2002-03, that 18 new Multipurpose Services were introduced in 2002-2003, could details be provided (i) of the location of these new services and (ii) the allocation by aged care planning regions of all 83 services?

Answer:

(a) The distribution of new aged care places allocated to rural and regional Australia in the 2002 allocation round is set out below:

State or Territory	Aged Care Planning Region	Total
NSW	Central Coast	157
	Central West	37
	Far North Coast	110
	Hunter	120
	Illawarra	157
	Mid North Coast	190
	Nepean	75
	New England	42
	Orana Far West	26
	Riverina/Murray	38
	Southern Highlands	62
		1014
VIC	Barwon-South Western	273
	Gippsland	202
	Grampians	18

State or Territory	Aged Care Planning Region	Total
	Hume	203
	Loddon-Mallee	78
		774
QLD	Cabool	16
	Central West	3
	Darling Downs	57
	Far North	62
	Fitzroy	21
	Logan River Valley	128
	Mackay	15
	Northern	40
	North West	15
	South Coast	135
	South West	-
	Sunshine Coast	102
	West Moreton	10
	Wide Bay	68
		672
WA	Goldfields	-
	Great Southern	38
	Kimberley	-
	Mid West	-
	Pilbara	10
	South West	94
	Wheatbelt	-
		142
SA	Eyre Peninsula	-
	Hills, Mallee & Southern	25
	Mid North	5
	Riverland	20
	South East	54
	Whyalla, Flinders & Far North	15
	Yorke, Lower North & Barossa	42
		161
TAS	Northern	23
	North Western	40
	Southern	89
		152
ACT	ACT	79
		79
NT	Alice Springs	20
	Barkly	-
	Darwin	27
	East Arnhem	20
	Katherine	10
		77

State or Territory	Aged Care Planning Region	Total
TOTAL		**3071**

(b)

(i)

LOCATIONS OF MPS THAT COMMENCED OPERATION IN 2002/03	
A total of 19 MPS commenced operation in 2002/2003. The locations of the 19 MPS are as follows:	
NSW	***Boggabri***
	Vegetable Creek
	Gilgandra
	Collarenebri
	Gulargambone
	Blayney
	Denman
	Brewarrina
QLD	Blackall
	Barcaldine
SA	Murray Mallee (Lameroo, Pinnaroo, Karoonda)
WA	Quairaiding
	Bruce Rock
	Dumbleyung
	Corrigin
	Nannup
	Morawa/Perenjori
	Mullewa
TAS	Tasman

(ii)

OPERATIONAL MPS AT JUNE 2003						
		Current Place Allocation				
		High	**SGNH**	**Low**	**CACP**	**Planning Region**
NSW	Baradine	5	0	8	0	Orana Far West
	Urana	6	0	12	0	Riverina Murray
	Urbenville	9	0	9	0	New England
	Braidwood	10	0	16	0	Southern Highlands
	Delegate	8	0	0	2	Southern Highlands
	Dorrigo	10	0	11	2	Mid North Coast
	Tumbarumba	10	0	16	2	Riverina Murray
	Warren	10	0	20	0	Orana Far West
	Culcairn	0	10	12	0	Riverina Murray
	Trangie	8	0	10	0	Orana Far West
	Trundle	0	4	5	0	Central West
	Lake Cargelligo	0	8	8	0	Central West
	Oberon	0	8	12	0	Central West

	Grenfell	0	20	14	0	Central West
	Coolamon	12	0	0	0	Riverina Murray
	Jerilderie	7	0	5	5	Riverina Murray
	Lord Howe Island	1	0	0	4	South East Sydney
	Boggabri	7	0	9	2	New England
	Vegetable Creek	7	0	6	3	New England
	Gilgandra	19	0	0	0	Orana Far West
	Collarenebri	6	0	4	5	Orana Far West
	Gulargambone	8	0	4	2	Orana Far West
	Blayney	20	0	0	0	Central West
	Denman	11	0	0	0	Hunter
	Brewarrina	9	0	3	4	Orana Far West
VIC	Corryong/Walwa	4	20	26	8	Hume
	Orbost	0	15	26	0	Gippsland
	Apollo	3	4	21	0	Barwon South Western
	Timboon	0	8	6	0	Barwon South Western
	Mallee Track	0	30	28	0	Lodden Mallee
	Robinvale	0	14	5	3	Lodden Mallee
	Alpine (Tawonga, Myrtleford, Bright)	30	50	10	0	Hume
QLD	Clermont	16	0	16	5	Mackay
	Cooktown	5	0	5	5	Far North
	Dirranbandi	2	0	4	0	South West
	Quilpie	4	0	5	0	South West
	Mundubbera	7	0	7	0	Wide Bay
	Inglewood	8	0	4	6	Darling Downs
	Mossman	22	0	7	12	Far North
	Texas	6	0	4	7	Darling Downs
	Woorabinda	4	0	11	4	Fitzroy
	Theodore	4	0	6	7	Fitzroy
	Alpha	3	0	2	0	Fitzroy
	Bauhinia Shire (Sprinsure)	5	0	5	0	Fitzroy
	Blackall	10	0	9	6	Central West
	Barcaldine	6	0	8	8	Central West
SA	Midwest (Wudinna, Elliston, Streaky Bay)	16	0	27	0	Eyre Peninsula
	Ceduna/Yalata	14	0	35	0	Eyre Peninsula
	*Nganampa	15	0	10	0	Whyalla Flinder Far Nth
	Kangaroo Island	10	5	24	4	Hills Mallee & Southern
	Eastern Eyre	11	0	36	5	Eyre Peninsula
	Murray Mallee (Lameroo, Pinnaroo, Karoonda)	18	0	21	0	Hills Mallee & Southern
WA						
	Dalwallinu	4	0	6	1	Wheatbelt
	Boyup Brook	6	0	8	2	Southwest
	Northampton/Kalb	7	0	14	3	Midwest
	Katanning	6	18	8	15	Great Southern
	Leonora/Laverton	1	3	8	0	Goldfields
	Murchison	2	3	10	2	Midwest
	Eastern Wheatbelt	5	20	24	6	Wheatbelt
	York	4	7	13	3	Wheatbelt
	Denmark	12	4	20	3	Great Southern
	Kondinin	4	0	5	4	Great Southern

	Lake Grace	4	0	6	1	Great Southern
	Ravensthorpe	3	0	4	4	Goldfields
	Norseman	3	0	4	2	Goldfields
	Cunderdin	4	0	5	1.00	Wheatbelt
	Augusta	4	12	20	4.00	Southwest
	North Midlands	3	0	12	1.00	Midwest
	Beverley	0	4	14	1.00	Wheatbelt
	Dongara/Mingenew/Eneabba	11	0	16	4.00	Mid West
	Pemberton	0	0	3	3.00	Southwest
	Mortlock	10	0	14	3	Wheatbelt
	Moora	7	0	9	2	Wheatbelt
	Quairaiding	4	0	6	0	Wheatbelt
	Bruce Rock	4	0	6	0	Wheatbelt
	Dumbleyung	3	0	3	1	Great Southern
	Corrigin	4	0	10	1	Wheatbelt
	Nannup	0	7	0	0	Southwest
	Morawa/Perenjori	2	0	13	1	Midwest
	Mullewa	5	0	5	2	Midwest
TAS	Beaconsfield	12	0	10	0	Northern
	Campbell Town	13	0	10	6	Northern
	Tasman	22	0	12	0	Southern
* Now funded under the Aboriginal and Torres Strait Islander Aged Care Strategy and has ceased operations as an MPS						

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2003-2004, 5 November 2003

Question: E03-002

OUTCOME 3: Enhanced Quality of Life for Older Australians

Topic: HOME AND COMMUNITY CARE

Written Question on Notice

Senator Denman asked:

(a) Can the Department provide figures by aged care planning region of the numbers of clients receiving services under the HACC programme in (i) 2001-02 and (ii) 2002-03? If not, can the figures be provided by any other statistical divisional breakup?

(b) Can the Department provide figures by aged care planning region of the numbers of clients receiving services under the HACC programme who received less hours of service in 2002-03 than they did in 2001-02? If not, can the figures be provided by any other statistical divisional breakup?

(c) Can the Department provide figures by aged care planning region of the numbers of clients receiving services under the HACC programme in 2002-03 who previously received services under the Veterans' Home Care Programme? If not, can the figures be provided by any other statistical divisional breakup?

Answer:

(a) Information on client numbers by HACC region for 2002-03 is available from the Department of Health and Ageing's website (http://www.hacc.health.gov.au) and from the Home and Community Care Program Minimum Data Set 2002-03 Annual Bulletin.

(b) The Department cannot provide this information as HACC client data is de-identified at agency source and therefore individuals cannot be tracked from year to year.

(c) The Department does not have access to Veterans' Home Care data on individuals.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2003-04, 5 November 2003

Question E03–088

OUTCOME 3: Enhanced Quality of Life for Older Australians

Topic: ALBURY AND DISTRICT NURSING HOME

Written Question on Notice

Senator Forshaw asked:

(a) Is it true that the problems, in particular medication management and staff training, identified at the Albury and District Nursing Home in July 2003 have in fact been raised repeatedly with the nursing home and/or the Agency since 2000?

(b) If so, how is it that the home was found to comply with all 44 Accreditation Standards in January 2003 and then only six months later, in July 2003, fail nine of those same standards?

(c) How does the Agency explain that two inspections undertaken in a six-month period by different inspectors produce totally different reports?

Answer:

(a) Albury and District Nursing Home was found to be non-compliant with the requirements of expected outcome 2.7 medication management, following a review audit in May 2001; and following a review audit in July 2003. Non-compliance with the Accreditation Standards was found following the home's accreditation audit in 2000 and the review audit of May 2001. By September 2001, the home had made the necessary improvements to achieve compliance with the Accreditation Standards, and no non-compliance was identified again until July 2003. To monitor its ongoing compliance with the Accreditation Standards, the Agency arranged visits to Albury and District Nursing Home on four occasions between October 2001 and January 2003, and at none of these visits was non-compliance identified. It was not until the review audit in July 2003 that the home was found to be non-compliant in medication management again.

(b) As explained in (a), from late 2000 until late August 2001, the home had non-compliance and intensive monitoring to ensure that progress on required improvements were being made. The accreditation audit in September 2001 found that the home complied with all expected outcomes and it was granted 18 months accreditation, recognising the home's history of non-compliance and the newness of the systems. Visits to the home to assess whether it was maintaining compliance were made the following March, September and December, and in January 2003 an accreditation audit was conducted. At all of these visits no non-compliance was identified. In its decision to accredit the home following the January 2003 accreditation audit, the Agency noted that "…the service has retained the changes to its management and that it has been successful in consolidating changes to is management, policies, procedures, practices and infrastructure in order to comply with the Accreditation Standards. The service complies with the Accreditation Standards but it is appropriate that the Approved Provider continue to closely monitor, review and evaluate ongoing effectiveness over time". Following advice from the Department of Health and Ageing that there had been changes to the directors and management company of the home, a review audit was planned. It is not possible for the Agency to categorically determine the specific causes of the home's deterioration in compliance over a period of six months however significant changes at the home included change of directors of the approved provider, and the expiration of the management company's contract.

(c) The reports reflect the different situation at the home at two points in time. An aged care home is sensitive to changes in both staffing and management as well as the changing mix of residents. The obligation is always on the approved provider to comply with the requirements of the Act at all times. The changes in compliance with the Accreditation Standards at Albury and District Nursing Home may have been attributed to fundamental changes in management and directorship. New management have now been appointed and the Agency is closely monitoring the home, and has noted improvements are being made.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2003-04, 5 November 2003

Question E03-089

OUTCOME 3: Enhanced Quality of Life for Older Australians

Topic: ANNANDALE NURSING HOME

Written question on notice

Senator Forshaw asked:

(a) How many times was the Annandale Nursing Home inspected in the last two years? Please provide dates and the type of inspection (eg review audit, spot check etc). In particular, were any spot checks carried out since the facility was last accredited in March 2001?
(b) According to the report from the Aged Care Standards and Accreditation Agency a review audit was carried out just recently in September/October 2003 and that the nursing home failed 16 of the 44 Accreditation Standards. What prompted the inspection? Was it due to complaints by residents, families and/or staff?
(c) In light of the finding by the Agency that a "serious risk to the health, safety or well-being of residents was identified in relation to health and personal care and infection control issues", why was the approved accreditation period reduced by only one month?

Answer:

(a) Visits arranged by the Agency:

24-25 January 2001: accreditation audit
22 June 2001: support visit
17 October 2002: support visit
18 March 2003: support visit
26 August 2003: spot check (support visit)
26 September - 1 October 2003: spot check (review audit)
8 October 2003: support visit
13 October 2003: support visit
16 October 2003: spot check (support visit)
24 October 2003: support visit
4 November 2003: support visit
21 November 2003: support visit
27 November 2003: spot check (support visit)

Visits arranged by the Department:

14 August 2003: spot check visit
23 August 2003: RCS audit
29 August 2003: Complaints Resolution Scheme visit
2 October - 7 October 2003 inclusive: spot check visits
9 October 2003: spot check visit
11 October 2003: spot check visit
12 October 2003: spot check visit
14 October 2003: spot check visit
15 October 2003: spot check visit
20 October 2003: spot check visit
21 November 2003: RCS audit

(b) The Agency's decision to conduct the review audit in September 2003 was based on concerns about non-compliance at the home. At its spot check in August the Agency identified non-compliance and placed the home on a compulsory Timetable for Improvement under s4.6(4) of the *Accreditation Grant Principles 1999*. The Agency later received further information from the Department of Health and Ageing in September and decided to conduct the review audit.

(c) The home's accreditation was due to expire to in March 2004. In making its decision about the review audit, the Agency took into account the fact that the approved provider had taken significant steps to remedy the non-compliance and had in fact removed the serious risk within about two weeks of its identification. The home had also employed appropriately qualified staff and engaged external assistance to implement the changes necessary to address the non-compliance.

In deciding to vary the period of accreditation, the material issue was not that the accreditation period was reduced by one month, but that the decision meant the home only had about three and half months accreditation remaining. This short period of time ensured the security of the residents while enabling sufficient time for an accreditation audit and decision to be made prior to the expiry of the home's accreditation on 2 February 2004. The home underwent an accreditation audit in December 2003, and was subsequently accredited for one year.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2003-04, 5 November 2003

Question E03-090

OUTCOME 3 : Enhanced Quality of Care for Older Australians

Topic: ARMITAGE MANOR

Written question on notice

Senator Forshaw asked:

(a) When did inspectors last visit the Armitage Manor Hostel, Victoria, prior to the review audit in August 2003?
(b) According to reports, Armitage Manor Hostel passed only 19 of 44 Accreditation Standards in August 2003. Is that the lowest number of any facility that has been allowed to keep its accreditation?
(c) Is it correct that at times only one staff member was available to look after 60 residents?
(d) Has the facility been directed or requested to employ extra staff? If so, how many and in what capacity?
(e) Given the number and serious nature of the standards, which this nursing home failed to comply with, why did the Agency conclude that the health and safety of the residents were not at “serious risk”?
(f) On what basis did the Department of Health and Ageing come to a different conclusion to the Agency regarding the degree of risk for residents?

Answer:

(a) A support visit was conducted at Armitage Manor in late July 2003.

(b) No.

(c) and (d)

The expected outcome 1.6, which requires that there are appropriately skilled and qualified staff sufficient to ensure that services are delivered in accordance with the Accreditation Standards, was found non-compliant. This issue was raised with the home by the assessment team during the review audit, and was a 'required improvement' given in writing from the Agency to the home. The home has now increased staff across all shifts and has advised that there are no instances where only one staff member is on duty. A full audit in December 2003 found the home to be compliant with 44 of the 44 expected outcomes of the Accreditation Standards.

(e) The Agency concluded that while there was extensive non-compliance it did not constitute serious risk because:

- Management had identified and accepted the underlying and immediate issues
- Management had begun action to address them
- They had employed staff with the skills to address them (eg increasing the hours of a registered nurse division one from 16 hours per week to full-time, to review all residents' clinical care and specialised nursing care needs, and an executive director of nursing had been appointed)
- That the actions taken had significantly reduced the impact of the deficiencies on residents' health, safety and wellbeing
- The actions taken were improvements to the system.

In making its decision, the Agency considered all those actions taken by the provider subsequent to the review audit.

(f) The Department of Health and Ageing made a decision to impose sanctions because of an immediate and severe risk to the health, safety or wellbeing of residents at Armitage Manor. This decision was made on the basis of an unannounced site visit to the home on 19 September 2003. This new evidence combined with the information from the Agency review audit led the decision-maker to a view that the situation now represented an immediate and severe risk.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2003-04, 5 November 2003

Question E03-091

OUTCOME 3 : Enhanced Quality of Care for Older Australians

Topic: AGED CARE STANDARDS AND ACCREDITATION AGENCY

Written Question on Notice

Senator Forshaw asked:

(a) What progress has been made on developing a framework for evaluating the outcomes of the Accreditation program as recommended by the ANAO?
(b) Has the costing system for accreditation activities been introduced? Is there any data available?
(c) What is the Agency doing to ensure that all Agency assessors have the same level of training and skills so that there can be consistency in the accreditation assessments?
(d) How much does it cost to undertake a spot check? (Note this question was taken on notice at the Estimates hearing on 5 June 2003 but an answer has not been provided?)
(e) How much does it cost, on average, to undertake an accreditation audit?

Answer:

(a) The ANAO's recommendation was that the Agency and the Department plan an evaluation of the impact of accreditation on the quality of care in the residential aged care industry. A steering committee of officers from both the Department and Agency has been established, has agreed an overall approach, and is preparing a detailed project plan for the evaluation. The aged care reforms of 1997 included a number of quality initiatives such as building certification, the Accreditation Standards, the Complaints Resolution Scheme, User Rights initiatives and Specified Care and Services. The impact of these and other initiatives needs to be considered in examining what improvements have occurred and to what initiatives they may be attributed. A competitive tender process will be conducted to identify suitable bodies to carry out an external review, that will be supported by an advisory committee comprising the steering committee and representatives of the aged care sector and professional bodies. It is expected that the evaluation will report in late 2004-05.

(b) The Agency has developed a cost model for budget purposes. The model estimates the cost of each type of activity in relation to each home individually. The model includes all direct costs associated with each individual home. The general ledger has been redeveloped so that actual costs (at functional level) are captured by both function and organisational unit. The Agency is currently piloting a job activity recording system that will capture the actual costs as they are incurred for each home. It will attribute a share of the costs where a cost such as travel relates to a number of homes at the one location. Averages for accreditation audits and spot checks could be misleading given the range of costs that relate to individual visits. The job activity recording system will also be used to validate the budgeting system.

(c) All assessors are required to undertake the same core training as a prerequisite to registration, and must meet the same requirements for registration as a quality assessor with Quality Society of Australasia (QSA). All assessors have completed the same standardised audit methodology training and undertook standard assessment. All assessors have been provided with an Audit Handbook which sets out the standard procedures and methodology for audits as well as guidelines in relation to use of evidence. A document, "Results and Processes in relation the Expected Outcomes of the Accreditation Standards" provides guidance on the assessment of expected outcomes and their scope. The Audit Handbook and Results and Processes document are publicly available on the Agency's website (www.accreditation.aust.com). Audit reports are reviewed for consistency with Agency standards and feedback is provided to assessors to assist them to ensure that reports meet Agency requirements. Audits are conducted by teams of at least two assessors, and the team is required to discuss and compare information, providing an internal check on consistency of assessment. Further improvements are being made to the registration requirements and training of assessors. These include more detailed identification of competency standards and more detailed criteria for assessment of applicants for registration, and improved training for the members of panels that advise on the suitability of applicants.

(d) see answer (b)

(e) see answer (b)

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2003-04, 5 November 2003

Question E03-092

OUTCOME 3: Enhanced Quality of Care for Older Australians

Topic: RELATING TO QUESTION EO3-213 ESTIMATES JUNE 2003

Written Question on Notice

Senator Forshaw asked:

(a) I refer to the answer given to Question on Notice EO3-213. Given the answer provided is it correct that:
  (i) no written guidelines on staffing are given to inspectors;
  (ii) no details of staff numbers are recorded by inspectors to enable the Agency to assess appropriate standards and ratios; and
  (iii) that the Agency believes that one staff member being responsible for 49 residents, including 12 high care, as occurred at Alroy House Aged Care Facility, Singleton NSW, is adequate?

(b) Why have the details of the number, names and locations of residential facilities that have failed accreditation standard 1.6 since May 2002 not been provided as requested in paragraph (g) of the question?

(c) In respect to this issue the answer also states: "It should be noted that the non-compliance may have been rectified subsequent to the decision (either on reconsideration, at a support contact or a subsequent audit)." Doesn't the Agency/Department actually know when a non-compliance has been rectified? Does it require the facility to advise the Agency/Department when it has been rectified?

Answer:

(a) Quality assessors examine the compliance of individual homes with the expected outcomes of the Accreditation Standards. The most critical 'guideline' for assessors to consider are the legislated expected outcomes, which include 1.6, Human resource management. This outcome requires that there are appropriately skilled and qualified staff sufficient to ensure that services are delivered in accordance with the Accreditation Standards and the home's philosophy and objectives. The *Audit handbook for quality assessors* and the *Results and processes in relation to the expected outcomes of the Accreditation Standards* are the key documents to assist audit methodology and the results and processes to consider in assessing compliance. Staff numbers and qualifications are considered in respect of audits of individual homes and these are recorded as appropriate in reports prepared by assessment teams. In respect of Alroy House Aged Care Facility, the Agency did require improvements to be made, including implementation of effective monitoring of residents with challenging behaviours and

ensuring staff provide care in accordance with the service's requirements. A support visit to the home in September 2003 found that the home had made these improvements.

(b) The answer to question EO3-213 from June Estimates pointed out that the information was publicly available as reports are published on the Agency's website. This continues to be the case.

(c) The Agency continues to monitor all homes, and homes that have had non-compliance are closely monitored until the non-compliance is resolved. The question EO3-213 only asked how many homes had been found non-compliant with 1.6. The point the Agency was trying to make was that while non-compliance may be identified at a point in time, the home is told about it and monitored for progress on making the required improvements, and usually achieves compliance quite quickly. The legislation requires the Agency to provide information in writing to an approved provider when non-compliance is identified, and to tell the approved provider about any required improvements. Support contacts are undertaken to monitor a home's compliance with the Accreditation Standards, however, there is no publicly available report produced from support contacts. Hence while the published report and decision may say that a home was non-compliant at a certain date, the home may have rectified the non-compliance subsequently.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2003-2004, 5 November 2003

Question: E03-093

OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS

Topic: ELDERLY PERSONS IN HOSPITALS

Written Question on Notice

Senator Forshaw asked:

(a) What progress has been made on the project commissioned by the Health Ministers Advisory Council on older Australians in hospital (as discussed at Senate Estimates on 3 June 2003?)

(b) Is the information/data available yet? Has it been publicly released?

(c) Can the Committee be supplied with a copy?

Answer:

(a) The study "Examination of Length of Stay for Older Persons in Acute and Sub-Acute Sectors" overseen by the Australian Health Ministers Advisory Council (AHMAC) Care of Older Australians Working Group has been finalised.

(b) The report has been published on the website of the Department of Health and Ageing at http://www.health.gov.au/minconf.htm.

(c) See web link under (b).

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2003-2004, 5 November 2003

Question: E03-175

OUTCOME 3: Enhanced Quality of Life for Older Australians

Topic: POPULATION STATISTICS FOR 2003 AGED CARE PLACE ALLOCATION ROUND

Hansard Page: CA 44

Senator Forshaw asked:

Can you give me the statistics on which the Department is basing the allocation of aged care places for the 2003 round – particularly looking for population projections that the Department has for people aged 70 years and over by aged care planning region?

Answer:

The population projections used by the Department for aged care planning and allocation purposes in 2003 were small area projections developed by the Australian Bureau of Statistics – *Population Projections by SLA (ASGC 1996) 1999 – 2019.* These projections were based upon the *1998 Australian Bureau of Statistics Population Projections – Series C.*

These products are available from the Australian Bureau of Statistics.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2003-2004, 5 November 2003

Question: E03-176

OUTCOME 3: Enhanced Quality of Life for Older Australians

Topic: RCS CATEGORIES - WAGE CARE RATES IN THE AGED CARE SECTOR

Hansard Page: CA45

Senator Moore asked:

The answer we received in terms of the allocations talked about the allocation that the Department had made to take into account the awareness that there is a growing gap between the wage rates in the aged care sector. It states that additional funding is being provided through residential aged subsidies, and it involves an increase …. above increases that will flow on from normal indexation, as follows:

- 1.5 per cent in the basic subsidy rates for RCS categories 1-4; and
- 0.75 per cent in the basic rates for RCS categories 5-7.

Why were 1.5 and 0.75 the added supplements given in that argument?

Answer:

- Provision of funding of $211m over four years to allow residential aged care providers to attract and retain more aged care nurses was an election commitment made by the Government.

- In implementing this initiative, consideration was given to the fact that high care residents of aged care homes are more likely to require the type and level of care nurses provide. This resulted in a higher weighting being given to residential subsidies at the RCS 1-4 levels and a smaller proportion being applied at the RCS 5-7 levels.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2003-2004, 5 November 2003

Question: E03-177

OUTCOME 3: Enhanced Quality of Life for Older Australians

Topic: AUSTRALIAN GOVERNMENT AGED CARE NURSING SCHOLARSHIPS

Hansard Page: CA45

Senator Moore asked:

(a) I would like information about the Nursing Scholarships that are mentioned in the Annual Report and where they went across the board etc?

(b) How were they determined?

(c) What is the assessment criteria and success rate for people studying to achieve their qualifications?

(d) How were the scholarships given etc?

Answer:

(a) & (d)

The Australian Government offered 100 Undergraduate and 114 Continuing Professional Development aged care nursing scholarships in the 2003 academic year.

Due to withdrawals, 97 Undergraduate scholarships were taken up in the 2003 academic year. The location of the Undergraduate scholarship recipients is listed below:

- New South Wales – 25
- Queensland – 24
- Victoria – 24
- South Australia – 10
- Tasmania - 10
- Western Australia - 3
- Northern Territory - 1

Due to withdrawals, 107 Continuing Professional Development scholarships were taken in the 2003 academic year. The location of the Continuing Professional Development scholarship recipients is listed below:

- New South Wales – 46
- Victoria – 29
- Queensland – 18
- Tasmania – 6
- South Australia – 5
- Western Australia – 2
- Northern Territory – 1

In 2004 the Australian Government is offering 200 Undergraduate, approximately 110 Continuing Professional Development and up to 7 Honours aged care nursing scholarships.

(b) & (d)
The selection and ranking of applications is overseen by a selection advisory group chaired by the Royal College of Nursing Australia, which comprises representation from the following organisations:

- Australian Nursing Federation
- Council of Remote Area Nurses of Australia
- Association for Australian Rural Nurses
- National Seniors Association
- National Rural Health Alliance
- Aged and Community Services Australia
- Australian Nursing Homes and Extended Care Association
- Congress of Aboriginal and Torres Strait Islander Nurses
- Geriaction
- National Rural Health Network
- Chief Nursing Officers of the States and Territories
- Australian Council of the Deans of Nursing

(c) The criteria for the Australian Government Aged Care Nursing Scholarships have been developed within Government policy parameters and in consultation with the Aged Care Workforce Committee and the scholarship fund administrators – the Royal College of Nursing Australia.

The criteria for each of the Scholarship schemes (Undergraduate, Continuing Professional Development and Honours) are set out in **Attachment A.**

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2003-2004, 5 November 2003

Question: E03-178

OUTCOME 3: Enhanced Quality of Life for Older Australians

Topic: RCS REVIEWS

Hansard Page: CA 46 and 47

Senator Forshaw asked:

(a) What is the cost to the Department for undertaking RCS reviews?

(b) Can we have a copy of the Business Rules?

Answer:

(a) In 2003-04 approximately $7.6 million was allocated to the RCS Review Program.

(b) The business rules for Resident Classification Scale Appraisals are detailed in Chapter Five of the Resident Classification Manual. This is available from the following web site:
http://www.ageing.health.gov.au/manuals/rcm/download/chap5.pdf

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2003-2004, 5 November 2003

Question: E03-179

OUTCOME 3: Enhanced Quality of Life for Older Australians

Topic: PAPERWORK REVIEW

Hansard Page: CA49

Senator Forshaw asked:

Can you provide a detailed list of the Paperwork pilots?

What details on the pilots are posted on the website?

Answer:

The three Paperwork Review projects are:

- Reducing the number of questions on the Resident Classification Scale. This project has investigated possible refinements to the current RCS by reducing or combining questions.

- Using independent assessors to appraise the relative care needs of residents. This project has piloted the use of independent assessors in the direct assessment of residents in 21 aged care services in four States (Queensland, New South Wales, Victoria and Western Australia).

- Enhancing Chapter Five of the Resident Classification Manual. The project is reviewing the current guidance provided to industry to assist it in its use of the RCS.

Details of the projects are expected to be posted on the website
The address is:
http://www.ageing.health.gov.au/rcspage/rcsreview.htm

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2003-2004, 5 November 2003

Question: E03-180

OUTCOME 3: Enhanced Quality of Life for Older Australians

Topic: COMMUNITY CARE REVIEW

Hansard Page: CA 50

Senator Forshaw asked:

How many meetings on the Community Care Review have been held with State, Territory and Commonwealth officials since the end of May?

Answer:

Two.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Supplementary Budget Estimates 2003-2004, 5 November 2003

Question: E03-181

OUTCOME 3: Enhanced Quality of Life for Older Australians

Topic: ALBURY AND DISTRICT PRIVATE NURSING HOME - COMPLAINTS

Hansard Page: CA54

Senator Forshaw asked:

Where did the complaints come from without identifying individuals. Was it residents' families or the union?

Answer:

This is Protected Information under the *Aged Care Act 1997*.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2003-2004, 5 November 2003

Question: E03-182

OUTCOME 3: Enhanced Quality of Life for Older Australians

Topic: FIRE SAFETY

Hansard Page: CA50

Senator Forshaw asked:

Can we have a copy of the fire safety regulation form of declaration that the state, territory and local government bodies have to sign.

Answer:

The Fire Safety Declaration form is at the following website address:

www.health.gov.au/certification

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE
HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2003-04, 5 November 2003

Question E03-152

OUTCOME 3 : Enhanced Quality of Care for Older Australians

Topic: ACCREDITATION AUDITING GUIDELINES FOR QUALITY ASSESSORS

Hansard Page: CA 56

Senator Forshaw asked:

Can you provide us with a full set of the guidelines that inspectors have when they visit the facilities to make these assessments? Can you provide them or give us some information?

Answer:

There are two key documents that provide guidance on audit methodology, use of evidence and the expected outcomes of the Accreditation Standards. These are the *Audit Handbook for Quality Assessors* and *Results and Processes in relation to the expected outcomes of the Accreditation Standards*. Both these documents are available for downloading free of charge on the Agency's website, under 'Industry Information'. The web addresses are: www.accreditation.aust.com/industry/audithandbook.html and www.accreditation.aust.com/industry/resultsandprocesses.html

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2003-2004, 5 November 2003

Question: E03-161

OUTCOME 3: Enhanced Quality of Life for Older Australians

Topic: TRACHOMA

Hansard Page: CA 92

Senator Crossin asked:

In relation to the Vision 2020 resolution:

(a) What action has the Department taken to progress the sentiment of that resolution?

(b) What has happened since the passing of the resolution?

Answer:

(a) and (b)
The Department of Health and Ageing has met with Vision 2020 Australia at the Chief Executive Officer level to discuss ways to progress the World Health Vision 2020 resolution in Australia. The Department will be working with Vision 2020 to draft a national Vision 2020 plan for Australia by 2005.

The Department has commissioned the Australian Institute of Health and Welfare to produce a statistical Bulletin on the prevalence of avoidable blindness and visual impairment associated with ageing.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2003-2004, 5 November 2003

Question: E03-005

OUTCOME 3: Enhanced Quality of Life for Older Australians

Topic: PSYCHOGERIATRIC CARE UNIT PROGRAM

Written Question on Notice

Senator Denman asked:

(a) I refer to the advice in the Department's Annual Report that an extra $10 million over four years has been provided for the expansion of the Psychogeriatric Care Programme, and that the programme was being reviewed to guide expansion to full national coverage of the programme in 2004. At what stage is the review?

(b) Is the Department able to advise on the extent of the coverage of the programme nation wide by next year?

Answer:

(a) A final report is due in the first quarter of 2004.

(b) Pending submission of the Review's final report, it is too early to predict mechanisms or timing for the program's expansion to full national coverage.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2003-2004, 5 November 2003

Question: E03-006

OUTCOME 3: Enhanced Quality of Life for Older Australians

Topic: NATIONAL DEMENTIA HELPLINE

Written Question on Notice

Senator Denman asked:

What is the amount of funding currently provided to the 24 hour National Dementia Helpline? Is this an ongoing funding or for a fixed period?

Answer:

The Dementia Helpline is a component of the Dementia Education and Support Program, which will receive $1.5 million for the Helpline, other information services, support groups and counselling in 2003-04.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2003-2004, 5 November 2003

Question: E03-007

OUTCOME 3: Enhanced Quality of Life for Older Australians

Topic: EARLY STAGE DEMENTIA SUPPORT AND RESPITE PROJECT

Written Question on Notice

Senator Denman asked:

What is the amount of funding currently provided to the Early Stage Dementia Support programme? Is this an ongoing funding or for a fixed period?

Answer:

The Early Stage Dementia Support and Respite Project receives nearly $1.5 million for support groups for people with dementia and their carers, and other information products.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2003-2004, 5 November 2003

Question: E03-008

OUTCOME 3: Enhanced Quality of Life for Older Australians

Topic: CARER EDUCATION AND WORKFORCE TRAINING PROJECT

Written Question on Notice

Senator Denman asked:

What is the amount of funding currently provided to the Carer Education and Workforce Training initiative? Is this an ongoing funding or for a fixed period? Is it possible to delineate the amount of funding under this initiative which relates to those who care for dementia sufferers?

Answer:

$1.1 million for accredited training for respite workers and carers of people with dementia and is contracted until June 2004.

All funding for this project relates to carers of people living with dementia, including paid carers and family carers.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2003-2004, 5 November 2003

Question: E03-009

OUTCOME 3: Enhanced Quality of Life for Older Australians

Topic: DEMENTIA SUPPORT AGENCIES

Written Question on Notice

Senator Denman asked:

(a) Is the Department working with the States and Territories in order to ensure that dementia support agencies and treatment centres are co-ordinated in order to ensure that they are best able to cope with the anticipated significant increase in the number of Australians who will suffer from some form of dementia by 2020?

(b) If so what is the nature of this work.

Answer:

(a) Yes.

(b) The Department is working with States and Territories to co-ordinate residential and community care, including dementia care, through the allocation of residential aged care places and Community Aged Care Packages, and through the Home and Community Care Program.

For residential aged care places and Community Aged Care Packages, this work is achieved through the Aged Care Planning Advisory Committee (ACPAC).

The Home and Community Care Program is a joint Australian, State and Territory Government initiative and planning is done through a collaborative approach across these jurisdictions.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2003-2004, 5 November 2003

Question: E03-010

OUTCOME 3: Enhanced Quality of Life for Older Australians

Topic: RESEARCH INTO DEMENTIA

Written Question on Notice

Senator Denman asked:

Is the Department aware of the amount of funding from any source which is being made available towards research into dementia, including Alzheimer's Disease?

Answer:

The Australian Government provided $5.94 million in 2003 through the National Health and Medical Research Council for research specifically related to dementia and Alzheimer's Disease.

The Prime Minister also announced Australian Government funding of $250,000 for the *Hazel Hawke Alzheimer's Research and Care Fund* in Federal Parliament on 1 December 2003.

Allocation of Training Places in the Autralian General Practice Training Program in 2003

Training Providers	Training Places - Allocations			Training Places - Acceptances		
	Rural	**General**	**Total**	**Rural**	**General**	**Total**
New South Wales						
Central West Consortium	8	3	11	9	4	13
Coast City Country Training	15	9	24	15	10	25
Institute of GP Education	0	21	21	0	22	22
New England Area Training Service	9	1	10	7	1	8
North Coast NSW	8	2	10	6	2	8
Rhedwest	9	1	10	7	2	9
Sydney Institute of GPET	0	21	21	0	21	21
Valley to Coast	3	20	23	3	20	23
Westwest	0	21	21	0	21	21
Total	**52**	**99**	**151**	**47**	**103**	**150**
Victoria						
Bogong Regional Training Network	10	2	12	11	2	13
Gippsland	12	0	12	14	0	14
Greater Green Triangle	12	0	12	13	0	13
Victoria Felix	16	4	20	16	4	20
Victoria Metro Alliance	0	59	59	0	59	59
Total	**50**	**65**	**115**	**54**	**65**	**119**
Queensland						
Central & Southern QLD Training	20	35	55	20	37	57
Rural & Regional QLD Training	18	4	22	15	2	17
Tropical Medical Training	10	10	20	7	10	17
Total	**48**	**49**	**97**	**42**	**49**	**91**
South Australia						
Adelaide to Outback Training Program	10	7	17	8	10	18
Sturt Fleurieu	10	7	17	9	7	16
Total	**20**	**14**	**34**	**17**	**17**	**34**

Training Providers	Training Places - Allocations			Training Places - Acceptances		
	Rural	**General**	**Total**	**Rural**	**General**	**Total**
Western Australia						
WAGPET	25	28	53	13	25	38
Total	**25**	**28**	**53**	**13**	**25**	**38**
Northern Territory						
Northern Territory GPE	9	3	12	10	1	11
Total	**9**	**3**	**12**	**10**	**1**	**11**
Tasmania						
GPT Tasmania	7	5	12	7	5	12
Total	**7**	**5**	**12**	**7**	**5**	**12**
Grand Total	**211**	**263**	**474 ***	**190**	**265**	**455**

* Number of places allocated is oversubscribed to take account of the attrition rate of registrars early in the training year.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2003-2004, 5 November 2003

Question: E03-003

OUTCOME 4: Quality Health Care

Topic: MENTAL HEALTH

Written Question on Notice

Senator Denman asked:

(a) Referring to the answer to Question E03-048 (a), given the previous Minister's view on the need for the establishment of an independent commission, does the Department or the Minister have a view on the most appropriate way to assess the progress of mental health reform in Australia and the investigation of ongoing abuse or neglect?

(b) Referring to the answer to Question E03-048 (b) insofar as poor distribution and costs associated with the provision of mental health services is a factor in their non-utilisation, what requirements if any does the Commonwealth place on the States and Territories under the Australian Health Care Agreements.

Answer:

(a) Yes. The Australian Health Care Agreements require annual public reporting in the report '*The State of Our Public Hospitals'* on the performance of State and Territory Governments against the objectives of the Agreements. This includes reporting on progress in mental health reform. In response to investigation of abuse and neglect, all States and Territories have appropriate legislative arrangements in place including health complaint mechanisms.

(b) There are no specific requirements placed on State and Territory governments as to how they provide services within their responsibilities. However, the Australian Health Care Agreements require States and Territories to provide information on the provision of health services including hospital separations. The Agreements also commit States and Territories to the continuing development of performance reporting on the efficiency, quality, appropriateness, accessibility and equity of health services.

In addition, the Steering Committee for the Review of Commonwealth/State Service Provision publishes annually *The Report on Government Services.* This report presents an analysis of the performance of various aspects of Commonwealth, State and Territory health service provision including mental health services.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2003-2004, 5 November 2003

Question: E03-050

OUTCOME 4: Quality Health Care

Topic: CSL

Written Question on Notice

Senator Harradine asked:

(a) Is the Department able to explain the implications and details of the current contract with CSL to provide plasma products in Australia?

(b) Does this contractual obligation have a negative impact upon people with haemophilia accessing recombinant products?

Answer:

(a) No. Contract details are commercial-in-confidence.

(b) No. The contract simply identifies the terms on which the Commonwealth purchases recombinant products from CSL.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2003-2004, 5 November 2003

Question: E03-051

OUTCOME 4: Quality Health Care

Topic: ADMINISTRATION OF BLOOD SECTOR AGENCIES

Written Question on Notice

Senator Harradine asked:

In view of recent national audit office reports into the administration of blood sector agencies, will there be greater transparency and input from stakeholders into policy decisions and if so, how?

Answer:

The most recent report from the Australian National Audit Office (No 4 *Management of the Extension Option Review – Plasma Fractionation Agreement*, 28 August 2003) did not contain any recommendations or commentary concerning the need for greater transparency and input from stakeholders into policy decisions.

National blood policy decisions are taken by the Australian Health Ministers' Conference. Health Ministers will take account of the views of various stakeholders in their decision-making processes.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2003-2004, 5 November 2003

Question: E03-052

OUTCOME 4: Quality Health Care

Topic: HAEMOPHILIA FOUNDATION AUSTRALIA

Written Question on Notice

Senator Harradine asked:

How many representatives from Haemophilia Foundation Australia are on the National Blood Authority Board or on their various committees?

Answer:

The National Blood Authority (NBA) advises:

- the Haemophilia Foundation Australia (HFA) is not represented on the National Blood Authority Board; and

- since its commencement on 1 July 2003, the NBA has only established one committee, the Government Blood Advisory Committee, which comprises government officials from the Australian, State and Territory governments.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2003-2004, 5 November 2003

Question: E03 - 186

OUTCOME 4: Quality Health Care

Topic: OUTBACK DIGITAL NETWORK

Hansard Page: CA 94

Senator Eggleston asked:

To what extent is the Commonwealth involved in sponsoring those sorts of services in Indigenous communities across the north of WA, the Northern Territory and Cape York, if at all?

Answer:

Outback Digital Network is funded by a Networking The Nation development grant, which is administered by the Department of Communication, Information, Technology and the Arts.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2003-2004, 5 November 2003

Question: E03-138

OUTCOME 4: Quality Health Care

Topic: AUSTRALIAN DIVISIONS OF GENERAL PRACTICE

Written Question on Notice

Senator McLucas asked:

(a) What is the total level of funding provided by the Commonwealth to the ADGP each year?

(b) Ask for a break out of how these funds are used.

(c) Is the Department aware that the Deputy Chairman of the ADGP, Dr Vlad Matic, has recently resigned over concerns about the state of the organisation's finances?

(d) What rights and ability does the Department have to examine the organisation's financial situation?

(e) Has the Department moved to do this?

(f) Will the Department move to do this?

(g) Is it correct that the ADGP spending has ballooned out by $300,000 in the past year?

(h) The Ministerial Review of the Role of the Divisions of General practice was described as being "underway" on 25 March 2003. What is the timeline for the completion of this review?

(i) Is a copy of this report available?

Answer:

(a) In 2003-04 the Department of Health & Ageing expects to provide funding of $3,511,756.

(b) This funding is provided from the following programs:

Program	Expected Funding
Divisions of General Practice Program	$2,452,217
National Divisions Youth Alliance	$240,000
After Hours Primary Medical Care Program	$70,475
Enhanced Divisional Quality Use of Medicines Initiative	$50,000
General Practice Immunisation Incentives Scheme	$109,400
Integrated Care Program	$34,654
National Primary Mental Health Care Initiative	$282,736
Nursing in General Practice (Practice Nurses) Initiative	$122,274
Palliative Care Initiative	$150,000
Total	$3,511,756

(c) Yes.

(d) The funding agreements with the ADGP allow the Department of Health and Ageing, or any person authorised in writing by the Secretary, to have access to the records of the ADGP relating directly or indirectly to the funding received from the Department of Health and Ageing.

(e) Yes.

(f) See (e).

(g) The ADGP has advised the Department of Health and Ageing that it has a projected (unaudited) overspend of approximately $500,000 in funding received from the Department in 2002-03.

(h) The review of the Role of Divisions of General Practice was completed in June 2003.

(i) Yes, hardcopy attached.

[*The Future Role of the Divisions Network: report of the review of the role of Divisions of General PracticeI,* June 2003 has not been included in the electronic or printed volume]

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2003-2004, 5 November 2003

Question: E03-138

OUTCOME 4: Quality Health Care

Topic: AUSTRALIAN DIVISIONS OF GENERAL PRACTICE

Written Question on Notice

Senator McLucas asked:

(b) What is the total level of funding provided by the Commonwealth to the ADGP each year?

(b) Ask for a break out of how these funds are used.

(c) Is the Department aware that the Deputy Chairman of the ADGP, Dr Vlad Matic, has recently resigned over concerns about the state of the organisation's finances?

(d) What rights and ability does the Department have to examine the organisation's financial situation?

(e) Has the Department moved to do this?

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National Primary Mental Health Care Initiative	$282,736
Nursing in General Practice (Practice Nurses) Initiative	$122,274
Palliative Care Initiative	$150,000
Total	$3,511,756

(c) Yes.

(d) The funding agreements with the ADGP allow the Department of Health and Ageing, or any person authorised in writing by the Secretary, to have access to the records of the ADGP relating directly or indirectly to the funding received from the Department of Health and Ageing.

(e) Yes.

(f) See (e).

(g) The ADGP has advised the Department of Health and Ageing that it has a projected (unaudited) overspend of approximately $500,000 in funding received from the Department in 2002-03.

(h) The review of the Role of Divisions of General Practice was completed in June 2003.

(i) Yes, hardcopy attached.

[*The Future Role of the Divisions Network: report of the review of the role of Divisions of General PracticeI,* June 2003 has not been included in the electronic or printed volume]

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2003-2004, 5 November 2003

Question: E03-159

OUTCOME 4: Quality Health Care

Topic: NATIONAL DATABASE FOR MENTAL HEALTH AREA

Hansard Page: CA 72

Senator Moore asked:

What is the latest update on getting the pilot operating in the second half of 2003 on the mainstream database in the mental health area?

Answer:

The national database for mental health and community services has been developed by Lifeline and is named 'Just look'. It contains approximately 15,000 records of low or no cost community agencies and services.

'Just look' has been piloted by Lifeline telephone counsellors since June 2003. 'Just look' training has been conducted in Lifeline Centres and is now part of the *Lifeline Certificate IV in Telephone Counselling*.

'Just look' was launched on 4 December 2003 at Parliament House by the Minister for Ageing, the Hon Julie Bishop MP.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2003-2004, 5 November 2003

Question: E03-187

OUTCOME 5: Rural Health Care

Topic: NURSING SCHOLARSHIPS

Hansard Page: CA 82

Senator Moore asked:

(a) I would like information about the Nursing Scholarships that are mentioned in the Annual Report and where they went across the board etc?

(b) How were they determined?

(c) What is the assessment criteria and success rate for people studying to achieve their qualifications?

(d) How were the scholarships given etc?

Answer:

(a) The Australian Government Rural and Remote Nurse Scholarship Program, reported on under Outcome 5 in the Department's Annual Report, is one of a range of strategies to increase the number of registered and enrolled nurses in rural and remote Australia by removing some of the barriers to undertake nursing studies, professional development and skills training. The Program targets registered and enrolled nurses, former registered or enrolled nurses, and potential and current undergraduate nursing students with a rural or remote background.

There are four schemes that make up the Scholarship Program: an Undergraduate Scheme, a Postgraduate and Conference Scheme, a Re-entry and Upskilling Scheme, and an Enrolled Nurse to Registered Nurse Scheme. Funding of $25 million over the first four years has been provided for the Program and is broken up as follows: Undergraduate $15.66 million; Postgraduate $1.98 million; Re-entry and Upskilling Scheme $5.72 million; and Enrolled Nurse to Registered Nurse $1.65 million.

Undergraduate Scheme

The Scheme allocates a minimum of 110 full-term equivalent scholarships each year, of which 10 are specifically allocated for Indigenous nursing students. In response to the high rates of subscription to this Scheme, funding to support an additional 30 and 32 full term equivalent scholarships was made available to this Scheme in 2002 and 2004 respectively.

2003 Undergraduate Scheme Recipients by State

NT	NSW	Qld	SA	Tas	Vic	WA	ACT	**TOTAL**
1	34	17	9	4	37	6	1	109

Postgraduate and Conference Scheme

The objective of this Scheme is to assist professional development and skill training for registered and enrolled nurses working in rural and remote areas as well as those wishing to train and practise in these areas. The scholarships provide funding for either continuing nursing education (registered or enrolled) or conference attendance.

Continuing nursing education includes the provision of funds for relevant postgraduate courses, short courses and upskilling programs to improve the knowledge base of rural and remote nurses and further their professional development. Conference scholarships provide a contribution towards travel and registration fees at relevant conferences to assist rural and remote nurses to build on their knowledge of current clinical issues and offer opportunities to expand their professional networks.

2003 Postgraduate/Conference Remote and Rural Nursing Scholarships Recipients by State

	NT	NSW	QLD	SA	Tas	Vic	WA	ACT	**Total**
Conference	7	14	10	5	4	12	4	0	56
Continuing nursing education	14	13	15	19	9	16	16	0	102
Total	21	27	25	24	13	28	20	0	**158**

Re-entry and Upskilling Scholarship Scheme

These scholarships provide recipients with financial assistance to undertake either a re-entry course that will fulfil the State or Territory requirements for nurse registration or contribute towards an upskilling course to allow additional qualifications.

2003 Re-entry and Upskilling Scholarships Recipients by State

NT	NSW	QLD	SA	TAS	VIC	WA	ACT	**TOTAL**
8	51	40	23	15	54	36	1	**228**

Enrolled Nurse to Registered Nurse Progression Scholarship Scheme

This Scheme is designed to provide a means for career progression for rural enrolled nurses while helping to address the overall shortage of registered nurses in rural and remote areas of Australia. The Scheme was advertised for the first time in July 2003 and the scholarships will be awarded in time for students to commence at the beginning of 2004.

(b) Guidelines have been developed for each scheme under the Australian Government Rural and Remote Nurse Scholarship Program which outline the selection criteria. These guidelines are provided to applicants to assist them when making their application. A selection committee (as described below) considers all applications against the selection criteria.

(c) General eligibility criteria for the Australian Government Rural and Remote Nurse Scholarship Program includes the following:

- Australian citizenship or permanent residency;
- current residency in a defined rural or remote area; and
- enrolment or intention to enrol in an accredited Australian nursing program or course or appropriate clinical placement relevant to rural or remote practice.

Specific additional selection criteria varies amongst the schemes but includes items covering:

- financial need;
- recency and longevity of rural experience;
- current or previous nursing registration in an Australian State or Territory;
- commitment to rural practice (shown by undertaking rural clinical placements); and
- intention to study at a rural campus.

There is a high success rate for the Scholarship Program. However, some students have withdrawn or deferred due to family circumstances.

(d) Following the closing of each Scholarship round, a selection committee is formed to assess applications. Members of the committees vary but are taken from the following organisations:

- Department of Health and Ageing;
- Royal College of Nursing, Australia;
- Council of Remote Area Nurses of Australia;
- Congress of Aboriginal and Torres Strait Islander Nurses
- Association for Australian Rural Nurses;
- National Rural Health Alliance;
- Australian Council of Deans of Nursing;
- National Aboriginal and Torres Strait Islander Health Organisations;
- National Rural Health Network;
- Australian Nursing Federation; and
- Chief Nursing Officers of the States and Territories.

Successful applicants are then advised by post.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2003-04, 5 November 2003

Question:E03-191

OUTCOME 5: RURAL HEALTH
Topic: PBS SAFETY NET

Written Question on Notice

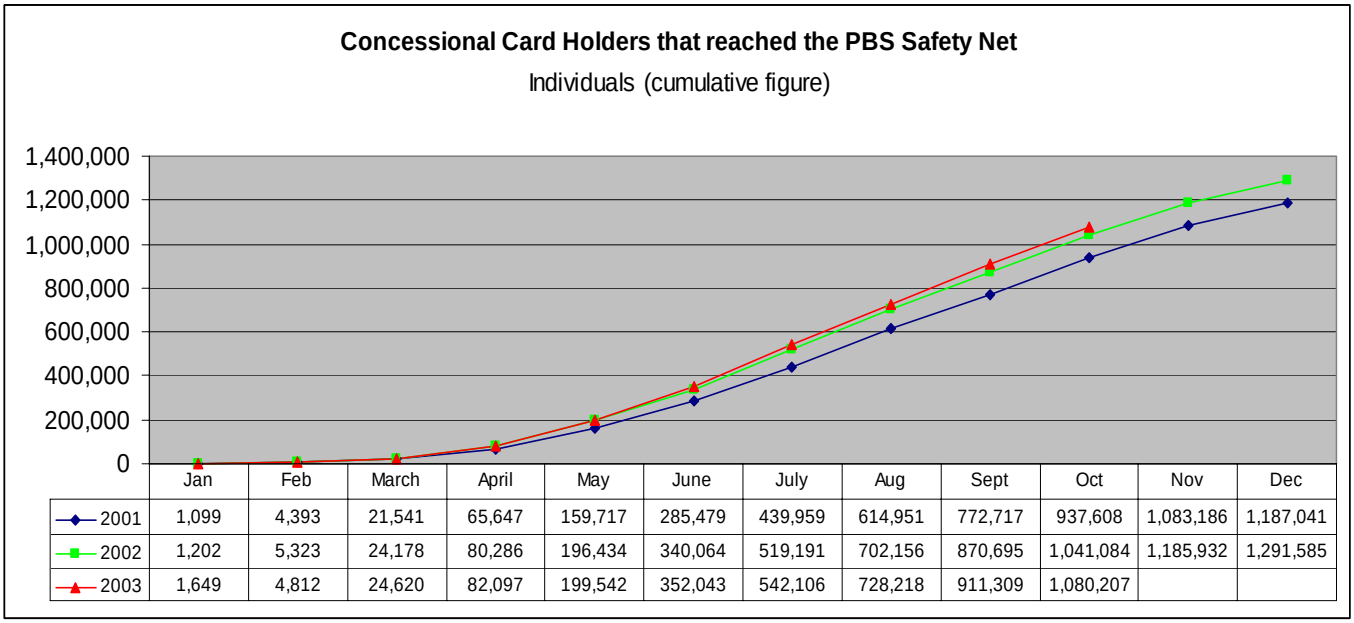
Senator McLucas asked:

(a) How many individuals and families reach the safety net for concession card holders each year? What is known about when in the calendar year the safety net is reached?

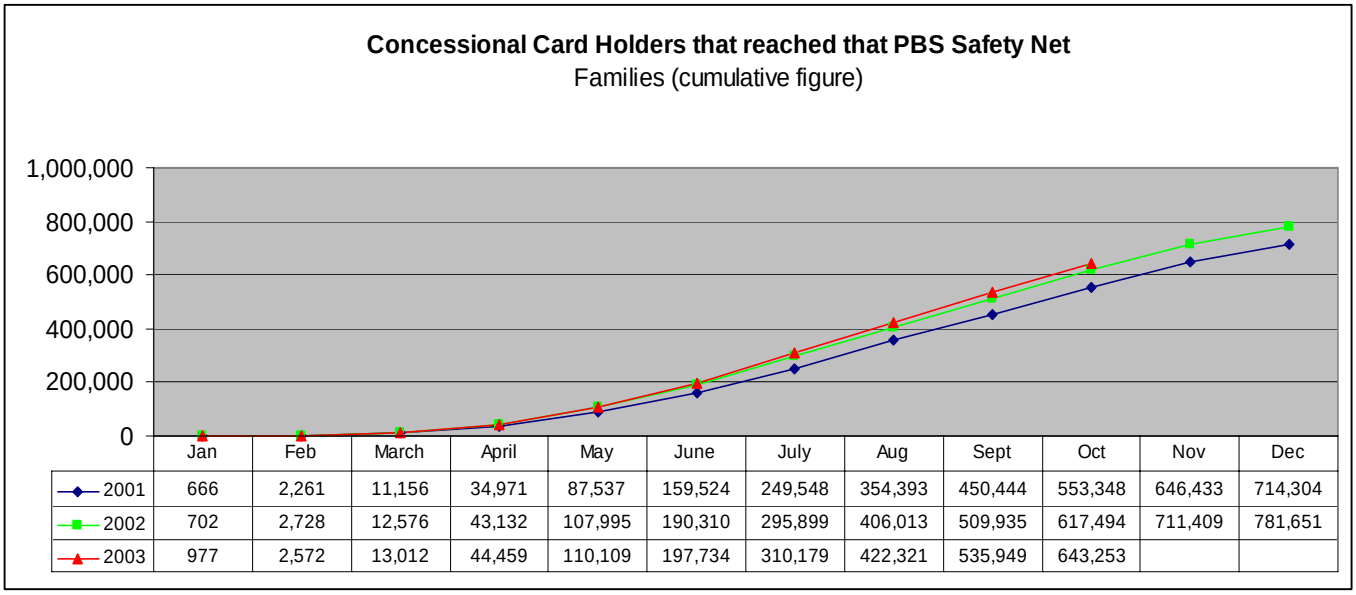
(b) How many individuals and families reach the general safety net each year? What is known about when in the calendar year the safety net is reached?

Answer:

(a) The total number of individuals and families that reached the PBS safety net for concession card holders in 2001, 2002 and 2003, and what is known about when in the calendar year the safety net is reached, is shown in the following graphs:

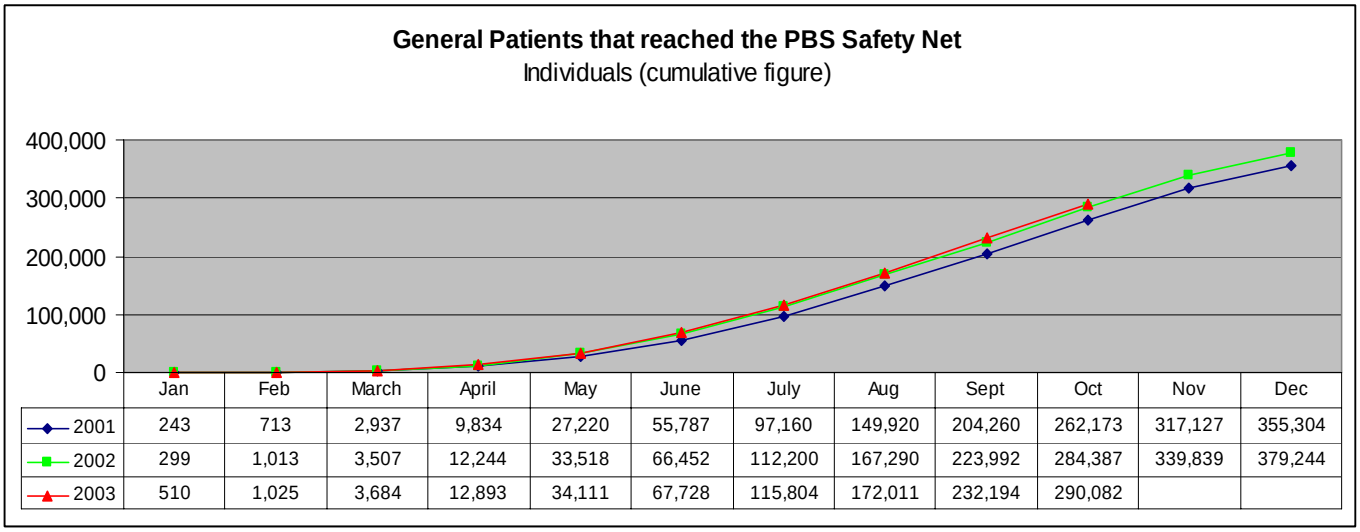


	Jan	Feb	March	April	May	June	July	Aug	Sept	Oct	Nov	Dec
2001	1,099	4,393	21,541	65,647	159,717	285,479	439,959	614,951	772,717	937,608	1,083,186	1,187,041
2002	1,202	5,323	24,178	80,286	196,434	340,064	519,191	702,156	870,695	1,041,084	1,185,932	1,291,585
2003	1,649	4,812	24,620	82,097	199,542	352,043	542,106	728,218	911,309	1,080,207		

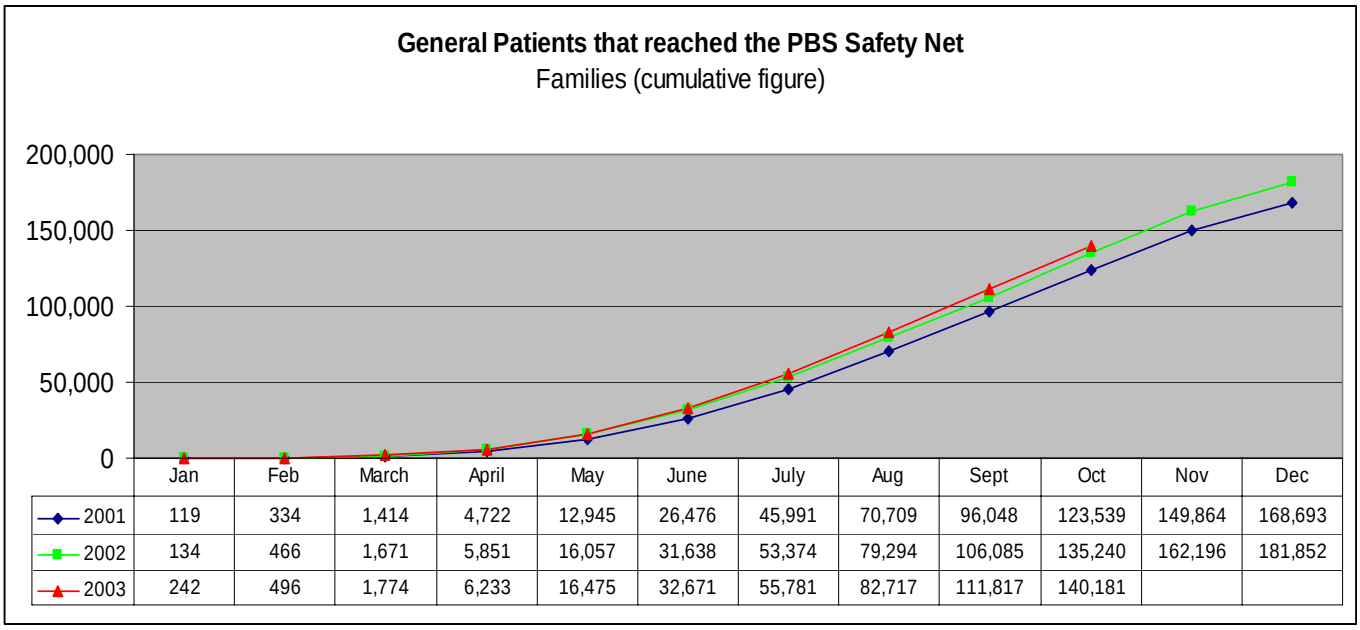


	Jan	Feb	March	April	May	June	July	Aug	Sept	Oct	Nov	Dec
2001	666	2,261	11,156	34,971	87,537	159,524	249,548	354,393	450,444	553,348	646,433	714,304
2002	702	2,728	12,576	43,132	107,995	190,310	295,899	406,013	509,935	617,494	711,409	781,651
2003	977	2,572	13,012	44,459	110,109	197,734	310,179	422,321	535,949	643,253		

(a) The total number of individuals and families that reached the PBS general safety net each year, and what is known about when in the calendar year the safety net is reached, is shown in the following graphs:



	Jan	Feb	March	April	May	June	July	Aug	Sept	Oct	Nov	Dec
2001	243	713	2,937	9,834	27,220	55,787	97,160	149,920	204,260	262,173	317,127	355,304
2002	299	1,013	3,507	12,244	33,518	66,452	112,200	167,290	223,992	284,387	339,839	379,244
2003	510	1,025	3,684	12,893	34,111	67,728	115,804	172,011	232,194	290,082		



	Jan	Feb	March	April	May	June	July	Aug	Sept	Oct	Nov	Dec
2001	119	334	1,414	4,722	12,945	26,476	45,991	70,709	96,048	123,539	149,864	168,693
2002	134	466	1,671	5,851	16,057	31,638	53,374	79,294	106,085	135,240	162,196	181,852
2003	242	496	1,774	6,233	16,475	32,671	55,781	82,717	111,817	140,181		

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2003-2004, 5 November 2003

Question: E03-070

OUTCOME 7: Aboriginal and Torres Strait Islander Health

Topic: HEARING SERVICES

Written Question on Notice

Senator Crossin asked:

The figures you provided "on notice" indicate that out of a total of 32,099 clients, only 1,328 Indigenous Australians accessed Australian Hearing Services in the period 1 July 2002 to 31 March 2003 and that 1,160 of these clients were children.

(a) What have you done to address this appalling statistic given that chronic suppurative otitis media affects up to ten times [the number of] children in many Aboriginal communities?

(b) Given that the MJA states that this is an indictment of the poor living conditions in these communities what is Australian Hearing Services doing to address these underlying causes?

(c) Is Australian Hearing Services working with any other government or non-government agencies to address issues such as poor nutrition, crowded living conditions, maternal & child health, education & employment opportunities etc? If yes, can you please provide details? If not, why not?

(d) Is Australian Hearing participating in the COAG trial sites around Australia?

Answer:

(a) In August 2003 the Office of Hearing Services and the Office for Aboriginal and Torres Strait Islander Health jointly released the *Work Plan for Future Actions in Ear and Hearing Health.* The Work Plan aims to position ear health within a comprehensive, population-based approach to family, maternal and child health, and to increase access to early involvement of Ear Nose and Throat specialists and audiologists in the clinical management of ear disease. Through these policy principles the Offices are continuing to investigate ways to facilitate children being treated earlier so that problems do not continue and adversely affect later years.

The key actions of the Work Plan are drawn from the policy principles and strategies outlined in the *Report on Commonwealth Funded Hearing Services to Aboriginal and Torres Strait Islander Peoples: Strategies for Future Action.* The Office for Aboriginal and Torres Strait Islander Health plans to reorient the National Aboriginal and Torres Strait Islander Hearing Strategy into the ongoing development of its national child and maternal health policy framework, including:

- A sharper focus on the 0-5 age group;
- Improving the quality and relevance of training to support the above; and
- Improving early detection and management of otitis media through the uptake of the *Recommendations for Clinical Care Guidelines on the Management of Otitis Media in Aboriginal and Torres Strait Islander Populations.*

A Feasibility study announced in the 2003 budget is currently underway and is investigating alternative options for the delivery of Community Service Obligation funded hearing services. This includes hearing services delivered to Indigenous children and adults.

(b) Australian Hearing is not responsible for addressing the poor living conditions in Aboriginal Communities.

The issues of living conditions in Indigenous communities requires coordinated whole of government responses. An example of this is the ATSIC/Army Community Assistance Program (AACAP) initiated in 1996 which helps improve essential services for Indigenous Australians living in remote communities such as water, sewerage, power systems, roads, airstrips and community housing, and provides opportunistic health services during the Army's deployment.

(c) Australian Hearing works closely with the Office of Hearing Services and the Office for Aboriginal and Torres Strait Islander Health in addressing hearing health issues in Aboriginal Communities. This includes working with the Office of Hearing Services in delivering Community Service Obligation funded services and with the Office for Aboriginal and Torres Strait Islander Health in delivering hearing training to Aboriginal Health Workers.

Australian Hearing liaises with Aboriginal Community Controlled Health Organisations to deliver hearing services. Australian Hearing also works with schools to improve the educational outcomes for Indigenous children. This includes working with teachers and the installation of soundfield amplification systems in classrooms.

(d) While Australian Hearing is not currently involved, as the projects develop it may become relevant that agencies such as Australian Hearing are engaged on specific issues such as audiological and specialist access. An essential element of the Indigenous Communities COAG trial sites is the development of coordinated responses to community generated concerns which may include environmental, health and well being issues.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2003-2004, 5 November 2003

Question: E03-071

OUTCOME 7: Aboriginal and Torres Strait Islander Health

Topic: PETROL SNIFFING COMMITMENT

Written Question on Notice

Senator Crossin asked:

(a) Going back to November 2002 Estimates, the figures you provided 'on notice' indicated that out of an overall OATSIH commitment of $21 million to Aboriginal and Torres Strait Islander Substance Use, only $1,664,000 was allocated to petrol sniffing and $1 million of this is for the Comgas Scheme. Is this correct and has this changed since? What is your current commitment to petrol sniffing under this Program?

(b) Regarding the reasons for the underspend of $261,035 out of the $400,000 you committed to the petrol sniffing diversion projects, are these projects now back on track and have their operations changed much in light of the Review of Petrol Sniffing Programs in Central Australia you commissioned?

Answer:

(a) In 2003-04, $1,701,659 has been allocated to address petrol sniffing through the OATSIH Substance Use Program. This increase in funding is due to undertaking an evaluation of the Comgas Scheme and indexation on recurrent funding. In addition, funding has been provided to petrol sniffing projects via the National Drug Strategy.

(b) Funding of the three petrol sniffing diversion projects in the Northern Territory was re-phased last year because of delays in finalising contractual arrangements with community organisations delivering the program. These delays were primarily due to the extensive consultations and negotiations required with a large number of Indigenous communities across the Northern Territory.

The *Review of Petrol Sniffing Programs in Central Australia* was commissioned by OATSIH to assess the effectiveness, efficiency and appropriateness of three OATSIH programs delivered at the Intjartnama, Ilpurla and Mt Theo/Yuendumu communities. This Review does not apply to the petrol sniffing diversion projects funded under the National Illicit Drug Strategy Diversions Program.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2003-2004, 5 November 2003

Question: E03-072

OUTCOME 7: Aboriginal and Torres Strait Islander Health

Topic: REVIEW OF PETROL SNIFFING PROGRAMS IN CENTRAL AUSTRALIA

Written Question on Notice

Senator Crossin asked:

(a) On the last page of the summary of the [Network Australia Consulting Pty Ltd, November 2002] Review of Petrol Sniffing Programs in Central Australia (provided 'on notice') the Department lists the ways in which it will implement the Review's recommendations. What commitments to reducing petrol sniffing has the Department actually made in light of this review?

(b) Will the Department increase its funding commitment to the three petrol sniffing diversion programs in light of the Review? If yes, by how much? If not, why not?

(c) Has the Department ensured that the key recommendations of the review have been implemented? How, in what ways?

Answer:

(a) The Department maintains its commitment to addressing petrol sniffing. The Department has modified its funding agreements with each of the three services to reflect the recommendations of the Review and is engaged in discussions with services and other stakeholders involved in addressing petrol sniffing.

(b) The Department allocates recurrent funding to the three petrol sniffing programs that were the subject of the Review. $591,659 was allocated to these programs in 2003-04. The Department is not currently considering proposals for increased funding for these services. Consideration of the need for additional funding will be made following implementation of the recommendations.

(c) The Department is implementing the key recommendations of the Review through working closely with the services concerned. Improvements have been made in the three services in the areas of health and safety of clients, case management and information collection, governance and business planning processes, and maintaining linkages with each other and throughout the region.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2003-2004, 5 November 2003

Question: E03-073

OUTCOME 7: Aboriginal and Torres Strait Islander Health

Topic: PETROL SNIFFING

Written Question on Notice

Senator Crossin asked:

(a) Has the Department implemented the various 'discussions' (with the petrol sniffing services and other organisations concerned with substance abuse) and started to work with FaCS to facilitate the substantial provision of activities for young and working age people in remote communities? Please give us some examples and not just in the AP Lands where the COAG trials are going on.

(b) Has the implementation of these commitments actually resulted in a reduction in the number of petrol sniffers in the Central Australian region? If yes, can we see the figures? If no, why not?

Answer:

(a) Discussions between the Department, services and other organisations have and continue to take place through the Central Australian Cross Border Reference Group on Volatile Substance Use (chaired by ATSIC Commissioner Alison Anderson) and through the Central Australian Youth Linkup Service consortium (CAYLUS) funded under the COAG Illicit Drug Diversion Initiative in the Northern Territory.

As a result of CAYLUS activity, the majority of the thirteen communities in the consortium now have organised youth activities, including school holiday and after-school programs, and sporting and traditional activities. CAYLUS activity has also resulted in FaCS funding for three youth workers being reinstated and a new youth worker position being funded by the Northern Territory Department of Sports and Recreation. Projects ranging from buying sports equipment to establishing a youth camp and setting up a youth centre are under way in seven of the communities.

In addition, the Department is involved in discussions with BP Australia, the Department of Family and Community Services and other bodies and agencies regarding BP Australia's desire to contribute to responses to petrol sniffing in Central Australia.

(b) Reliable figures are not yet available. CAYLUS has commenced the collection of baseline data on the numbers of petrol sniffers in communities involved in the program throughout Central Australia. The three services at the Intjartnama, Ilpurla and Mt Theo/Yuendumu communities reviewed by the Department in 2002 will be included as part of this data set.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2003-2004, 5 November 2003

Question: E03-074

OUTCOME 7: Aboriginal and Torres Strait Islander Health

Topic: NETWORK CONSULTING REVIEW – TERMS OF REFERENCE

Written Question on Notice

Senator Crossin asked:

Could you please clarify – the Terms of Reference of the Network Consulting Review (2002) refer to compliance with Coroner Donald's recommendations. This Coronial Inquiry into the death of a young petrol sniffer took place in October 1994. However, there has since been another very comprehensive Coronial Inquiry into the deaths of three young petrol sniffers in SA. This inquiry by SA Coroner, Wayne Chivell, took place in May, June and September 2002. Are you going to update your petrol sniffing strategies in light of the recommendations in this latest Coronial Inquiry or are you going to stick with the 1994 inquiry recommendations?

Answer:

The Department is implementing those recommendations from the 2002 Coronial Inquiry that are relevant to it. The Department has taken a lead role in supporting the Central Australian Cross Border Reference Group on Volatile Substance Use (chaired by Commissioner Alison Anderson). In this forum information is shared and implementation of recommendations is coordinated across departments, sectors and jurisdictions. The Reference Group is currently undertaking a feasibility study into the establishment of detoxification, rehabilitation and treatment models addressing volatile substance use in the Cross Border region of Central Australia. The Department continues to fund the Comgas Scheme.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2003-2004, 5 November 2003

Question: E03- 075

OUTCOME 7: Aboriginal and Torres Strait Islander Health

Topic: SA CORONIAL INQUIRY – PETROL SNIFFING DEATHS

Written Question on Notice

Senator Crossin asked:

I was told that in light of the SA Coronial Inquiry into petrol sniffing that, in the future, death certificates would identify the cause of death of chronic petrol sniffers as 'inhalation of petrol' rather than 'respiratory failure'. Is this true? How many deaths in Australia have been registered as 'inhalation of petrol' since the SA Coronial inquiry?

Answer:

The Department does not currently have information regarding the number of deaths in Australia registered as 'inhalation of petrol' since the SA Coronial Inquiry. The identification of the cause of death on death certificates is the responsibility of State and Territory governments.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2003-2004, 5 November 2003

Question: E03 - 076

OUTCOME 7: Aboriginal and Torres Strait Islander Health

Topic: PETROL SNIFFING AREAS

Written Question on Notice

Senator Crossin asked:

(a) On another note: the petrol sniffing problem does seem to be concentrated in the Central Australian region and in the AP Lands in particular (Tregenza 2002: estimates 125 permanent addicts in the AP Lands). Can you please clarify that the three petrol sniffing program sites are all located in "dry communities"?

(b) Is it then fair to say that petrol sniffing is more prevalent in dry communities than others? If yes, have you considered the likelihood of petrol sniffing becoming more prevalent in other communities that are becoming partly or entirely 'dry' as part of alcohol/substance abuse initiatives? (For example, Cape York?). If yes, how and what are you doing about it? If not, why not?

(c) Does the prevalence of petrol sniffing in dry communities suggest that a more comprehensive strategy is needed?

Answer:

(a) Petrol sniffing is not confined to Central Australia and periodically occurs in other areas. All communities around the three Central Australian programs that were the subject of the Review are dry, but alcohol still finds its way into some communities.

(b) Petrol sniffing can be found in dry communities and those where alcohol is sold. The extent of substitution of petrol sniffing for alcohol consumption is not well known. It is important to note that communities are responsible for deciding on whether and how the supply of alcohol will be controlled. For example, some communities in the Cape York region are developing and implementing Alcohol Management Plans.

Trends of substitution with changing supply of substances will be addressed by the Central Australian Cross Border Reference Group on Volatile Substance Use (chaired by ATSIC Commissioner Alison Anderson) through the feasibility study which will also explore treatment options in the Cross Border region.

(c) The *National Drug Strategy Aboriginal and Torres Strait Islander Peoples Complementary Action Plan* provides a national direction for reducing the harm associated with use of alcohol, tobacco and other substances by Aboriginal and Torres Strait Islander people. Control of supply, demand management, harm reduction, early intervention and treatment are important and need to be addressed across all forms of substance use.

The Department understands substance use as often being closely related to broader social and economic factors that impact on the social and emotional well-being of Aboriginal and Torres Strait Islander peoples, for example, poverty, education, employment, health and boredom.

The Department recognises that strategies addressing substance use are most successful when the communities in question play a central role in their inception, development and implementation.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2003-2004, 5 November 2003

Question: E03-077

OUTCOME 7: Aboriginal and Torres Strait Islander Health

Topic: ALCOHOL CONSUMPTION

Written Question on Notice

Senator Crossin asked:

What does this say about current substance abuse strategies which are primarily focussed on the reduction of alcohol consumption to counteract the breakdown of society in some Indigenous communities?

Answer:

The Department takes a holistic approach to addressing Aboriginal and Torres Strait Islander substance use. This approach involves:

- supply initiatives (eg substitution of Avgas for petrol);
- prevention (eg diversionary activities, health promotion campaigns);
- early intervention (eg brief interventions, outstation programs); and
- treatment approaches (eg residential rehabilitation, group work, counselling).

While the Department funds some programs that are directed at specific substances, it also focuses on substance use generally in recognition that:

- there are complex links between substance use and emotional and social well being;
- the tools needed to undertake prevention and early intervention programs are often the same, regardless of the substance; and
- there are high levels of comorbidity and high rates of multiple substance use.

The COAG whole of government work also aims at a more holistic approach. Where substance use has been identified by the community as a priority issue, it will be addressed in the broader context of health and health-related issues. The possible use in trial sites of Community Participation Agreements (CPA), managed by Aboriginal and Torres Strait Islander Services (ATSIS), also offers opportunities to more broadly support the capacity of individuals and communities to manage their health issues. The CPAs were introduced by the Australian Government as one part of the *Australians Working Together* package. The objective of this initiative is to support capacity building in remote Indigenous communities to promote increased community participation in areas of family and community governance as well as education, training, cultural and employment activities in regions that have little or no viable labour market. This program is being developed by ATSIS in conjunction with Centrelink and the Department of Family and Community Services.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2003-2004, 5 November 2003

Question: E03-078

OUTCOME 7: Aboriginal and Torres Strait Islander Health

Topic: ALCOHOL CONSUMPTION – SOCIAL BREAKDOWN

Written Question on Notice

Senator Crossin asked:

Does it suggest that the underlying causes of social breakdown in some Indigenous communities run much deeper than high levels of alcohol consumption?

Answer:

The Department recognises substance use as a symptom of social breakdown in Aboriginal and Torres Strait Islander communities. Removal and alienation from land, loss of culture and racism continue to impact on the social, emotional, spiritual and physical well being of Aboriginal and Torres Strait Islander individuals, families and communities.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2003-2004, 5 November 2003

Question: E03 - 079

OUTCOME 7: Aboriginal and Torres Strait Islander Health

Topic: COAG TRIALS

Written Question on Notice

Senator Crossin asked:

(a) Can you please tell us about the whole-of-government initiatives that have taken place in the AP Lands since the COAG trials began?
(b) During the November estimates you mentioned difficulties with operating the COAG trials in one State, given the cross-border context of the region. Have communities in other nearby states (ie: NT & WA) expressed interest in having the COAG trials extended to them? In particular, given that the cross-border communities are closely knit, are there complaints that one set of communities are being favoured at the expense of others, and how are you responding to this?
(c) Prior to the COAG trials there was, according to a number of reports, a distinct lack of co-ordination and communication across the different services and programs operating in the area. How has this changed since? And what structures are in place to ensure the shared initiatives are continued and strengthened?

Answer:

(a) Key achievements to date in the Anangu Pitjantjatjara Yankunytjatjara (APY) Lands since the COAG trials began include:
- Agreement to a Shared Responsibility Agreement which forms the overarching commitment by all partners to working together on an agreed set of key priorities. Considerable work has been undertaken to develop the Shared Responsibility Agreement, which includes five broad regional reform priorities. The APY Lands COAG Steering Committee endorsed the Shared Responsibility Agreement on the 12 September 2003. It is anticipated that the Shared Responsibility Agreement will be signed in early 2004 by the four partners: Australian and State governments, ATSIC and the APY Executive;
- Agreement in principle to implementation of a Regional Stores Policy addressing nutrition as a key health issue through the availability and affordability of healthy food supplies and employment and training opportunities for Anangu in the stores ; and

- Agreement in principle to progress a Rural Transaction Centre initiative for basic infrastructure across eight communities so that access can be gained to a wide range of financial and government services and employment and training opportunities for Anangu related to these services.

(b) To our knowledge, no other community has expressed interest in having the COAG trial extended to their area. To our knowledge no complaints that one set of communities are being favoured at the expense of others have been received.

There has been some work around Justice issues in the cross border region, which were discussed at a Tri-State (WA, SA and NT) Justice Forum. COAG trial officers initiated discussions with Commonwealth Attorney General's Department who now have become involved in investigating any necessary changes to Commonwealth legislation to progress the outcomes of this forum.

Collaboration between stakeholders involved in addressing petrol sniffing is being progressed through a Central Australian Cross Border Reference Group on Volatile Substance Use and the South Australian Inter-Governmental Inter-Agency Collaboration Committee on the Anangu Pitjantjatjara Lands along with the COAG AP Lands Steering Committee.

(c) Co-ordination and communication across the different services and programs operating in the area is being improved through the documentation in a Shared Responsibility Agreement and associated schedules of the contribution of the communities and governments to meeting and sustaining agreed priorities and outcomes.

Structures are in place to ensure the shared initiatives are continued and strengthened, including:

- A COAG Steering Committee was established in April 2003 to provide the overall direction to the APY Lands pilot. The membership comprises the Secretary of Department of Health and Ageing, the Chair and Director of APY, the CEO of the South Australian Department of Aboriginal Affairs and Reconciliation (DAARE) and the ATSIC Commissioner for South Australia.

- For the trials, accountability for progress in each site rests with a Departmental Secretary (or sponsor), whose agency will act as a lead agent within the trial site(s). The Secretaries are members of the Secretaries' Group on Indigenous Issues, chaired by the Secretary of the Department of Immigration, Multicultural and Indigenous Affairs, which meets once a month to oversee progress.

- The Secretaries are supported by the Indigenous Communities Coordination Taskforce (ICCT) and their own Departments. The ICCT is responsible to the Secretaries' Group for leading coordination across Commonwealth agencies and with State and Territory Governments, and for monitoring Commonwealth performance, including feedback to and from Indigenous communities, under the whole of government initiative.

- At the national level the relevant senior officers from the agencies represented on the Secretaries Group meet on a regular basis to provide feedback and guidance. In addition, the department has employed a dedicated senior project officer based in its South Australian office to improve links and build partnerships between Commonwealth and State agencies and communities on the APY Lands.

- A pre-existing partnership arrangement in the APY Lands has also continued, known as the APY Lands Inter-Governmental Inter-Agency Collaboration Committee (Tier 1) which consists of state government agencies responsible for program and service delivery on the APY Lands and the Secretary of the Department of Health and Ageing. Its work has focused mainly on information and planning to develop a more coordinated approach in the APY Lands. A similar group comprising Commonwealth agency representatives also meets regularly.

  Community engagement at this site has now been firmly established. This has been achieved through: a two week joint Commonwealth/State/ATSIC community consultation in April/May 2003; a two day community workshop in Alice Springs on 10 - 11 September 2003 attended by the APY Executive, community council and homeland chairpersons, Anangu service provider representatives and government agencies; and through ongoing field visits, meetings and communication with the APY Land Council.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2003-2004, 5 November 2003

Question: E03-080

OUTCOME 7: Aboriginal and Torres Strait Islander Health

Topic: SERVICES TO AP LANDS

Written Question on Notice

Senator Crossin asked:

(a) In relation to services on the AP Lands, other than primary health care, can you please tell us how many staff are employed in the following areas, whether they are Anangu or non-Anangu and which Commonwealth or State department they report to?
*Disability Services and Advocacy
*Aged Care Support Project and Advocacy
*Emotional and Social Wellbeing
*Young People's Projects
*Young Mothers and Children's Projects
*Cross Border Carer respite Centre

(b) Do these workers work just in the AP Lands or across three states?

(c) How often do the workers in these different programs have to complete funding reports?

(d) And how many different government funding programs do they have to report to?

(e) How long do these reports take to complete and in what language are they required?

(f) What is the backlog of clients requiring services in each of these projects?

(g) How are the COAG trials addressing these issues?

Answer:

(a) Most services in the Anangu Pitjantjatjara Yankunytjatjara (APY) Lands are delivered through one of the Anangu regional organisations: Anangu Pitjantjatjara Services, Ngaanyatjara, Pitjantjatjara and Yankunytjatjara (NPY) Women's Council, Nganampa Health Council and Pitjantjatjara Yankunytjatjara Education Committee. In relation to the specific services identified in this question, funding is provided to two organisations, NPY Women's Council and Nganampa Health Service. Information on staff employed by these two organisations follows:

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2003-2004, 5 November 2003

Question: E03-081

OUTCOME 7: Aboriginal and Torres Strait Islander Health

Topic: NPY WOMEN'S COUNCIL

Written Question on Notice

Senator Crossin asked:

According to a report by the Fred Hollows Foundation, the NPY Women's Council, a key organisation in the AP Lands, currently "acquits 59 grants for their 17 programs … [and] receives funding from 6 separate government departments and 7 other bodies".

Are the COAG trials going to address the extraordinary reporting requirements of workers/projects on the AP Lands so that workers can spend more time 'on the ground' rather than in the office reporting to government? If so, how? If not, why not?

Answer:

One of the aims of the COAG trial process is to re-engineer government programs so that they are more coordinated and accessible to Indigenous communities. At the broad level, it will be a focus of the Indigenous Communities Coordination Taskforce in its future work.

In relation to the Anangu Pitjantjatjara Yankunytjatjara (APY) Lands, the Department of Health and Ageing has trialed an Integrated Funding Agreement (IFA) with the NPY Women's Council (NPYWC) for all projects delivered from Department funding. The IFA was not continued in 2003-04 at the request of NPYWC and separate contracts were issued for all projects with the exception of the Office for Aboriginal and Torres Strait Islander Health (OATSIH). A single OATSIH contract was issued with one schedule for each of the three OATSIH programs.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2003-2004, 5 November 2003

Question: E03-082

OUTCOME 7: Aboriginal and Torres Strait Islander Health

Topic: TREGENZA REPORT 2002

Written Question on Notice

Senator Crossin asked:

The Tregenza Report 2002 on the delivery of services to people with disabilities on the Anangu Pitjantjatjara Lands recommends that a "one-stop-shop", a day drop in centre and a respite facility be established on the AP lands, are these recommendations being considered in the COAG trials?

Answer:

Issues relating to the consideration of recommendations arising from the Tregenza Report 2002 on the delivery of services to people with disabilities on the Anangu Pitjantjatjara Yankunytjatjara (APY) Lands 2002 are the responsibility of the Department of Family and Community Services and the South Australian State Government. For full details, including how recommendations are being addressed, this question should also be addressed to the Minister for Family and Community Services.

However, many structures are currently in place to improve co-operation and ensure that initiatives under the COAG whole of government trials are coordinated at the national, state and community levels, and between portfolios responsible for issues relating to people with disabilities on the Anangu Pitjantjatjara Yankunytjatjara (APY) Lands. At this stage this coordination has focussed on the key priorities identified through community consultations and documented in the draft Shared Responsibility Agreement (SRA).

The draft SRA for this COAG trial identifies as a priority improving the health and well being of Anangu through the implementation by all partners of responses to problems related to substance use. This will include cooperation with all stakeholders who work with people with disabilities on the APY Lands.

For further information on these coordinating structures, please refer to the answer to question E03 - 079.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2003-2004, 5 November 2003

Question: E03-083

OUTCOME 7: Aboriginal and Torres Strait Islander Health

Topic: HEALTH ISSUES OF ANANGU IN THE AP LANDS

Written Question on Notice

Senator Crossin asked:

How are you working in with Housing & Infrastructure programs when addressing the health issues of Anangu in the AP Lands?

Answer:

Issues relating to housing and infrastructure programs are the responsibility of Aboriginal and Torres Strait Islander Services (ATSIS) and the Department of Family and Community Services. For detailed information this question should also be addressed to the Minister for Immigration and Multicultural and Indigenous Affairs, as the Minister responsible for the Aboriginal and Torres Strait Islander Commission Act and the Minister for Family and Community Services.

However, many structures are currently in place to improve co-operation and ensure that initiatives under the COAG whole of government trials are co-ordinated at the national, state and community levels, and between portfolios responsible for health, housing and infrastructure programs.

The draft Shared Responsibility Agreement (SRA) for this COAG trial identifies improving infrastructure, including community housing, as a priority. This will mean greater co-operation with all stakeholders who have housing responsibilities on the Anangu Pitjantjatjara Yankunytjatjara (APY) Lands. The Department also has a Memorandum of Understanding with ATSIS in relation to the provision of health worker housing.

As lead agency, the Department is also collaborating with ATSIS in relation to the quantum, purpose and timing of funding for essential services (power and water) for APY homelands.

For further information on these priorities and coordinating structures, please refer to the answer to question E03 – 079.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2003-2004, 5 November 2003

Question: E03-084

OUTCOME 7: Aboriginal and Torres Strait Islander Health

Topic: COAG TRIAL SITES

Written Question on Notice

Senator Crossin asked:

What involvement does the Health Department have with other COAG trial sites? What tasks has the Department been called on to complete in other trial sites? Can you please provide details on this?

Answer:

Initial work in each site has involved the lead agency and the Indigenous Communities Coordination Taskforce in community consultations and the development of Shared Responsibility Agreements (SRAs) which document key priorities and respective roles and responsibilities. Health priorities therefore sit with other priorities identified by communities. The mix is different for each trial site and work has progressed in different ways and at different rates in each area. To date SRAs have been signed in NSW, Victoria and the Northern Territory. Agreement has been reached on the SRA for the Anangu Pitjantjatjara Yankunytjatjara (APY) Lands with signing expected in early 2004.

NSW

The lead agency is the Department of Education, Science and Training and formal announcement of the site was made on 1 September 2003. Specific collaboration in relation to health is yet to be determined but identified priorities in the SRA are “improving the health and wellbeing of children and young people” and “helping families to raise healthy children”. Representatives of the Department of Health and Ageing’s (DOHA) State office participate on a Commonwealth Agencies Group.

Victoria

The lead agency is the Department of Employment and Workplace Relations and the site was formally announced in September 2003. The Victorian Compact Agreement identifies the “development of a comprehensive strategy for the primary and public health requirements of Aboriginal people, including mental health”, as a strategic area for action. DOHA participates on a group of COAG agencies, which is currently looking at funding a Community Resource Unit, and a consultant to facilitate youth input to the project. The Department is also looking into simplified funding agreements to make accountability requirements less onerous.

NT

The lead agency is Department of Family and Community Services (FaCS) and the site was formally announced in November 2002. Priorities include women and family, and youth. Capital funding for a purpose-built aged care facility at Wadeye is currently being considered in collaboration with the Northern Territory Government. A health mapping project is also being undertaken to identify gaps in services. DOHA participates on the Community Action Group of the Women and Families Priority Working Group

Qld

The lead agency is Department of Employment and Workplace Relations and the site was formally announced in September 2002. The department has supported the development of whole-of-health plans in sixteen Cape York communities including the five priority COAG communities. This will lead to more integrated service provision by Commonwealth and State services, which includes but goes beyond, the Alcohol Management Plans. The Department is also contributing funding for Cape York Partnerships to support a range of activities associated with the Cape York Substance Abuse Strategy, and funding to allow the expansion of the Financial Income Management pilot project run by FaCS, including to additional Cape York communities.

ACT

The lead agency is Environment Australia, and site priorities are youth and education. The ACT office has been involved in discussions to date but specific involvement has yet to be identified through consultations with the community. The implementation of joint contracting arrangements between Australian Government agencies, ACT Government agencies and community groups is being considered.

Tasmania

The lead Agency is the Department of Immigration, Multicultural and Indigenous Affairs (DIMIA). Priorities are still to be agreed with the community through State and DIMIA led consultations but the focus is likely to be family violence. No specific health activity has been determined at this stage.

WA

The lead agency is the Department of Transport and Regional Services. A Community Initiatives Coordinator has commenced and is initiating meetings with communities and major stakeholders. Substance use and alcohol issues have been identified as priorities, work has progressed on grog and justice forums and DOHA State office staff have participated in a Grog Management/Justice Workshop. Sexual health funding has been recently increased to provide for population screening for sexually transmissible infections. DOHA and WA Health officers have jointly negotiated with organisations and communities to put in place new arrangements and contracts for the delivery of health services in the region.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2003-2004, 5 November 2003

Question: E03-085

OUTCOME 7: Aboriginal and Torres Strait Islander Health

Topic: SWIMMING POOLS AND INDIGENOUS HEALTH

Written Question on Notice

Senator Crossin asked:

An article published in the British Medical Journal in August shows that installing salt water swimming pools in Aboriginal communities could lead to a dramatic reduction in rates of renal failure, rheumatic fever and hearing loss. Has the Department pushed for this cost-effective approach in the COAG trials? If not, why not?

Answer:

The study showed that following the introduction of swimming pools into the communities there was a significant reduction in pyoderma (skin infection) and in perforation of tympanic membranes (eardrums). In addition there was an improvement in school attendance due to the "no school, no pool" policy.

Long term effects of swimming pool introduction are currently unknown. Cost effectiveness studies of swimming pool introduction are also currently not available.

Streptococcal skin infection, a common cause of pyoderma, is associated with chronic renal failure and perforated eardrums are associated with hearing loss. There is currently insufficient evidence to clearly link streptococcal skin infection with rheumatic heart disease. It is hoped that the benefits gained from swimming pools in these communities may also contribute in the long term to a reduction in renal failure and hearing loss.

An essential element of the Indigenous Communities COAG trial sites is the development of coordinated responses to community generated concerns which may include environmental, health and well being issues. The need for a swimming pool, identified by a Trial site, would be facilitated through established planning and implementation processes outlined in respective Shared Responsibility Agreements.

For example, the Wadeye Pilot Site in the Northern Territory has secured funding for the construction and maintenance of a swimming pool, under the Shared Responsibility Agreement.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2003-2004, 5 November 2003

Question: E03-160

OUTCOME 7: Aboriginal and Torres Strait Islander Health

Topic: PRIMARY HEALTH CARE ACCESS PROGRAM (PHCAP)

Hansard Page: CA 89 - 90

Senator Crossin asked:

I take you to information that you provided to me to answer E03-106. This is the table you produced for me on the Primary Health Care Access Program (PHCAP).

(a) I am specifically after an update on the 2002-03 expenditures to date, as per this table.

(b) Can you also include in that table the proposed rollout for the PHCAP for 2003-04?

Answer:

	Budgeted amounts 2002-03	**2002-03 PHCAP allocations for agreed capital works (construction in progress)**	**2002-03 PHCAP funding actual expenditure - Recurrent (including one-offs) to 30 June 2003**	**Budgeted amounts 2003-04**	**Agreed estimated population level (Indigenous Australians)**
Northern Territory wide	$329,000		$281,480	$230,000	
Tiwi	$3,824,499 (1)	$2,272,727	$1,572,042	$1,669,532	2,000
Katherine West	$2,978,727		$2,623,647	$2,905,945	3,060
Sunrise	$200,000		$200,000	$200,000	2,275
Anmatjera	$3,733,856 (1)	$3,640,521	$1,651,886	$518,460	1,464
Eastern Arrernte-Alyawarra	$2,427,676 (1)	$2,312,583	$68,214	$431,147	877
Northern Barkly	$718,341(1)	$624,750	$418,027	$782,172	821
Warlpiri	$2,702,681 (1)	$2,610,960	$1,537,110	$886,391	1,404
Luritja Pintupi	$2,644,516 (1)	$2,549,635	$1,121,807	$285,810	1,298

Darwin				$434,250 (2)	12,000
South East Top End				$3,277,702 (1) (2)	1,310
South Australia					
Northern Metro	$1,270,942 (1)	$491,460	$779,482	$535,000	4,115
	Budgeted amounts 2002-03	**2002-03 PHCAP allocations for agreed capital works (construction in progress)**	**2002-03 PHCAP funding actual expenditure – Recurrent (including one-offs) to 30 June 2003**	**Budgeted amounts 2003-04**	**Agreed estimated population level (Indigenous Australians)**
Wakefield	$403,893 (1)	$344,850	$389,043	$172,500	758
Hills Mallee Southern	$0		$0	$622,500 (1)	1,390
Port Augusta sub-region	$348,000	$74,000	$348,000	$430,000(1)	3,068
Riverland	$72,350		$72,350	$466,500 (1)	623
Queensland					
Queensland wide	$13,000		$13,000	$0	
Atherton/Croydon	$36,000		$9,230	$319,000	4,180
Inland/Mt Isa	$36,000		$9,230	$409,000	4,315
Central Highlands	$36,000		$9,230	$277,000	1,688
Torres	$50,000		$50,000	$528,852	6,850
Near South West	$36,000		$9,230	$320,613	1,210
Capacity Building sites QLD					
Gulf	$165,000		$165,000	$508,750	3,796
Cook	$551,000		$402,000	$484,260	3,240
NSW					
Wilcannia	$696,450		$696,450	$873,861	1,000
Western Australia					
Proposed 2 PHCAP sites and 2 capacity building sites				$500,000 (2)	Not yet known
Perth/Bunbury	$2,733,137		$2,733,137	$1,421,392	1990

Victoria 1 site				$75,000 (2)	Not yet known
ACT 1 site				$50,000 (2)	Not yet known
Tasmania 1site				$50,000 (2)	Not yet known
TOTAL	**$26,007,068**	**$14,921,486**	**$15,900,861**	**$19,665,637**	

(1) includes capital allocations for works currently underway.

(2) budgeted estimates only

Principles for the New Prostheses Arrangements

Under the new arrangements the Government announced a set of broad principles for prostheses:

(a) Health fund hospital tables must cover all MBS admitted hospital procedures, unless any are expressly excluded. Exclusions for funding specified MBS procedures and items provided during those procedures (eg common exclusions are reproductive services, cardiac surgery, joint replacement surgery) must be explicitly agreed by the fund member on joining.
(b) Coverage includes agreed benefits for hospital and medical costs incurred in providing that treatment.
(c) Funds must provide, under their basic hospital cover, no gap cover for the cost of appropriate, clinically necessary prostheses, human tissue, medical devices and other single use items for each MBS admitted hospital procedure for which the health fund member is covered.
(d) Funds may offer other products that cover more expensive prostheses or prostheses not related to MBS items on a no gap or other basis as long as they meet the requirements relating to no gap cover.
(e) Items to be covered must be listed on the Australian Register of Therapeutic Goods (ARTG) and provided in accordance with any restrictions or caveats on their listing. For items that deliver medication, such as antibiotic-coated implants, the medication must also be listed on the ARTG. This ensures that the items are safe and efficacious when used in accordance with their listing.
(f) Appropriate and clinically necessary items for each MBS procedure are those that can be proven to be cost-effective for use in that procedure subject to any caveats and requirements listed on the MBS Schedule, and on the Pharmaceutical Benefits Schedule for the medication component of any items that deliver medication.
(g) Funds may negotiate hospital benefits that bundle the cost of prostheses and other items for each MBS procedure.
(h) Where the amount of benefit is not sufficient to cover the cost of a prostheses or other single use item that is more expensive than a substitutable item that meets principle (d), the differential cost or gap is payable by the patient unless covered by another PHI product.
(i) The clinician should be required where reasonably possible to ensure that the patient is fully informed of the total costs of the procedure including any gap costs for prostheses or other single use items. Where the clinician considers that there is a reasonable risk that a patient may be found during surgery to need a more expensive item, the patient should be informed of the possible additional costs.
(j) Funds are not required to cover new prostheses in their products unless they have been subject to a positive assessment in relation to safety, effectiveness and cost-effectiveness of the Medical Services Advisory Committee (MSAC) or a process of equivalent standard.

(k) Procedures that have been assessed and not recommended as cost-effective by the MSAC for inclusion under the MBS Schedule cannot be funded under health fund hospital tables, and nor can prostheses, human tissue and medical devices when used in those procedures.
(l) Funds and private hospitals jointly implement these arrangements in consultation with clinicians and consumers.

Attendees to 31st October Meeting on Prosthesis

AHIA

Russell Schneider (AHIA)
Colleen McGann (St Lukes Health)
Dr Stan Goldstein (HCF)
Dr Bert Boffa (BUPA)
Bruce Levy (Medibank Private)
Michele Van Est (MBF)
Greg Kovacs (AHIA)
Murray Rye (DVA/AHIA)

HIRMAA

Norman Branson
Lyn McDonald-Duke

MIAA

David Ross (MIAA)
Craig Stamp (Bausch & Lomb)
John Cooper (GM Zimmer)
Warren Ryan (Medtronic)
Rob Scherini (Johnson and Johnson Medical)
Brent Scott (Stryker)

Manufacturers (non-MIAA)

Mary Taylor (Taylor Bryant)
Kathy Mitrangis (Getz Bros)

APHA

Paul Mackey
Peter Kahn
Darryl Goldman

Catholic Health Australia

Madonna McGahan (CHA
Colin Smeaton
Damian Kelly
Patrick Tobin

AMA

John O'Dea
Colin Smeal
Prof. Peter Thursby – Vascular Surgeon

PHIO

John Powlay (Ombudsman)

ACCC

Sitesh Bhojani (Commissioner)
Bruce Cooper

Consumer Health Forum

Matthew Blackmore

Department of Health and Ageing

Veronica Hancock
Dr Bernie Towler
Christine Francis
Margaret Noris
Jen Nixon

Acute Care Division

Private Health Insurance Branch

Insurance Industry Section

Draft condition section 73B

Limitation on Ancillary Health Benefits

(xvi) Subject to conditions (xvii), (xviii) and (xix), the registered health benefits organization must not pay a contributor ancillary health benefits in relation to goods and services which are primarily for the purpose of sport, recreation or entertainment.

(xvii) The organization may continue to pay ancillary health benefits in relation to goods and services which are primarily for the purpose of sport, recreation or entertainment until 31 December 2003.

(xviii) Before ceasing the payment of these benefits the organisation must provide contributors with a minimum of 60 days written notice of the change.

(xix) Condition (xvi) does not prevent an organization from paying ancillary health benefits as defined in subsection 67(4) of the National Health Act 1953 in relation to goods or services which are part of a health management program, or in relation to the health management program itself. The health management program must be approved by the organization and intended to prevent or ameliorate a specific health condition or conditions.

24/6/03

Pete

For your consideration & advice.

fB.

RECEIVED
27 JUN 2003
Ack. 79654

Mr Charles Maskell-Knight
Principal Adviser
Acute Care Division
Department of Health & Ageing
GPO Box 9848
Canberra ACT 2601

PHIAC
Private Health Insurance Administration Council
Suites 1 & 2 • Swish Building
31 Thesiger Court
Deakin ACT 2600
Phone (02) 6215 7500
Fax (02) 6215 7977
E mail phiac@phiac.gov.au
ABN 50 831 702 014

24 June 2003

Dear Mr Maskell-Knight,

Efficiency Indicators – Quarter Ended March 2003

Your letter of 26 May 2003 refers.

Please find **enclosed** the results of the first collection of efficiency indicators, collected for the quarter ended 31 March 2003. These indicators have also been forwarded to the Private Health Insurance Ombudsman for consideration. An electronic version of the indicators can be made available to you at your request.

Please note that it was not possible to collect information relating to the "Member Service" indicators; arrangements for this data collection to be incorporated into the broader PHIAC statistical collection is underway.

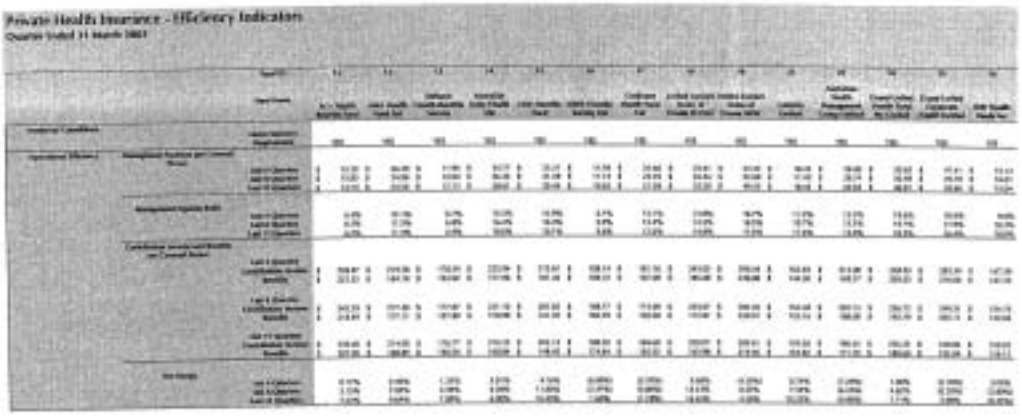
Your letter noted that the loss ratio was no longer included in the suite of measures. The loss ratio was excluded as it is a similar measure to the net margin. While there are some differences in the attribution of certain costs to the underlying component measures for the loss ratio and net margin, the differences are irrelevant to the efficiency indicators. In mathematical terms, 1 minus loss ratio equals net margin.

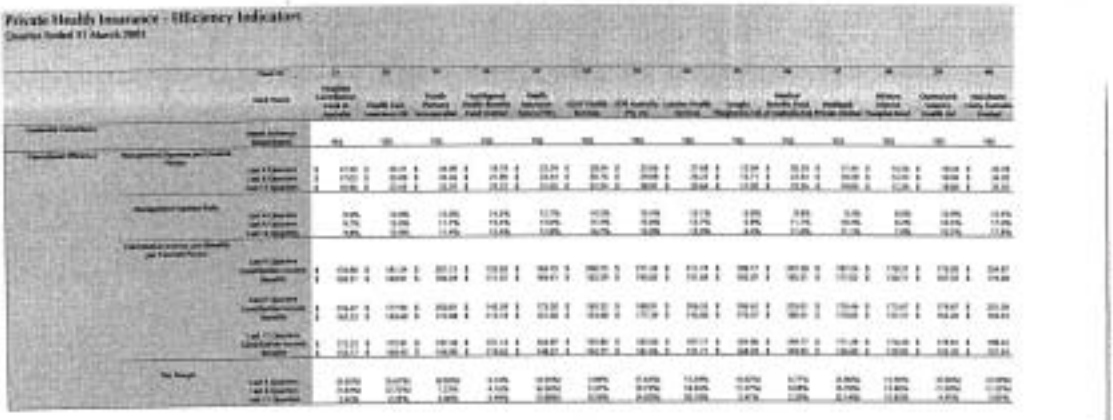
PHIAC is continuing working toward the development of an indicator for contracting efficiency, with a view to some additional measurement around premium levels, benefits outlays and reinsurance outcomes. Finalisation of this work is in part dependant upon the settling of reinsurance arrangements currently underway. Conclusion of this work is likely to be available toward the middle of 2004.

PHIAC will keep you updated on the progress of the data collections as they develop.

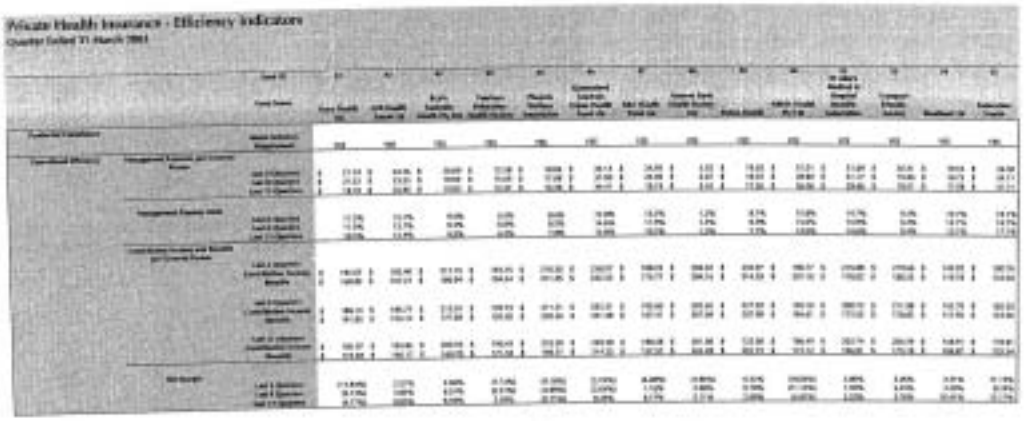
Yours sincerely,

Gayle Ginnane
Chief Executive Officer


Private Health Insurance - Efficiency Indicators



Private Health Insurance - Efficiency Indicators


Private Health Insurance - Efficiency Indicators

→ Neil Smith
FYI + file please.
DM 2/9

Australian Government
Private Health Insurance Administration Council

31 Thesiger Court
DEAKIN ACT 2600
Phone (02) 6215 7900
Fax (02) 6215 7977
Email phiac@phiac.gov.au

linda
+ FYI
+ File
Vogelle
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RECEIVED
5 - SEP 2003
Cont. 83974

Mr Charles Maskell-Knight
Principal Adviser
Acute Care Division
Department of Health & Ageing
GPO Box 9848
Canberra ACT 2601

3 September 2003

Dear Mr Maskell-Knight,

Efficiency Indicators – Quarter Ended June 2003 SECOND ? - QUIT USE MAY 2003 qtr

Please find **enclosed** the results of the first collection of efficiency indicators, collected for the quarter ended 30 June 2003. These indicators have also been forwarded to the Private Health Insurance Ombudsman for consideration. An electronic version of the indicators can be made available to you at your request.

Please note that additional disclosure has been included into the management expense ratio indicator. Individual fund management expense ratios that are greater than one standard deviation above the mean have been colour coded in red. PHIAC considers that management expense ratios in excess of one standard deviation above the mean are unusually high and may warrant further enquiry.

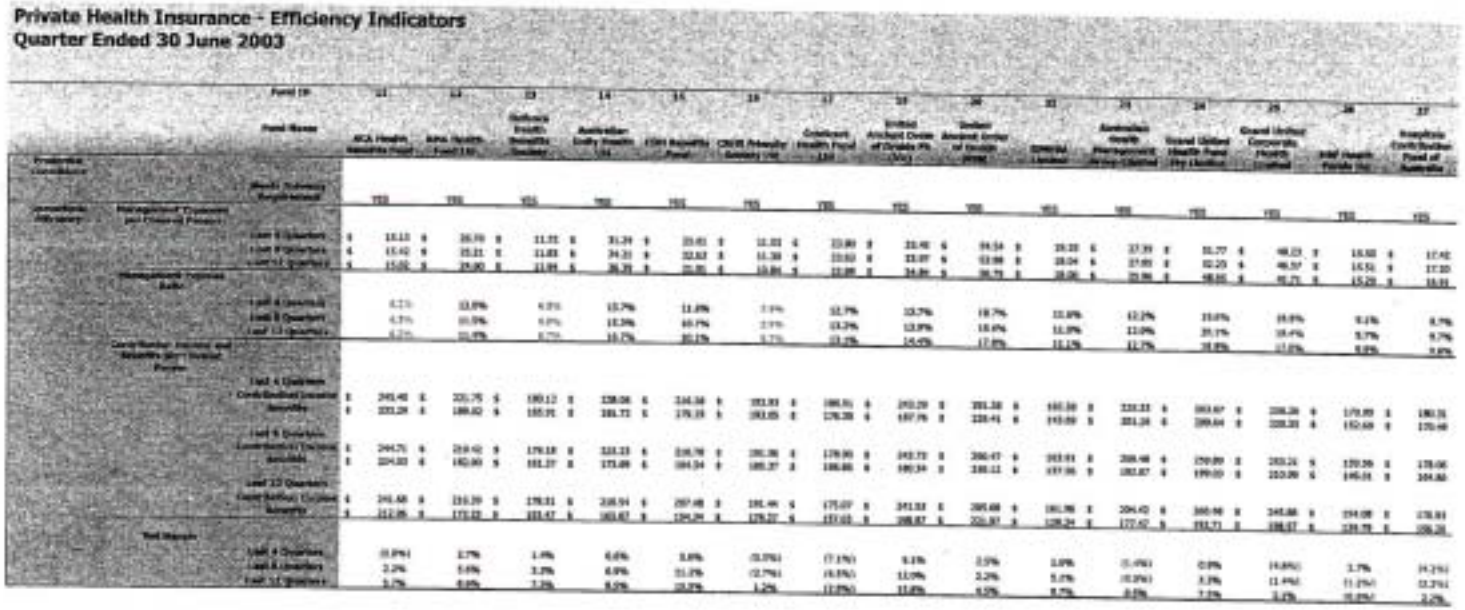
In addition, management expenses less than one standard deviation below the mean have been indicated in orange, highlighting unusually low management expense ratios. Unusually low management expense ratios are sometimes the result of funds receiving services support from related entities and are usually limited to restricted membership organisations. It should be noted that such artificially low management expense ratios lower the mean management expense ratio.

For ease of reading, the net margin amounts included in the indicators have also been colour coded (red reflecting net margin losses). PHIAC would be concerned where longer term losses are likely to exceed the comparative risk free rate of return.

Yours sincerely,

Paul Groeneswegen
Senior Industry Analyst

Private Health Insurance - Efficiency Indicators
Quarter Ended 30 June 2003



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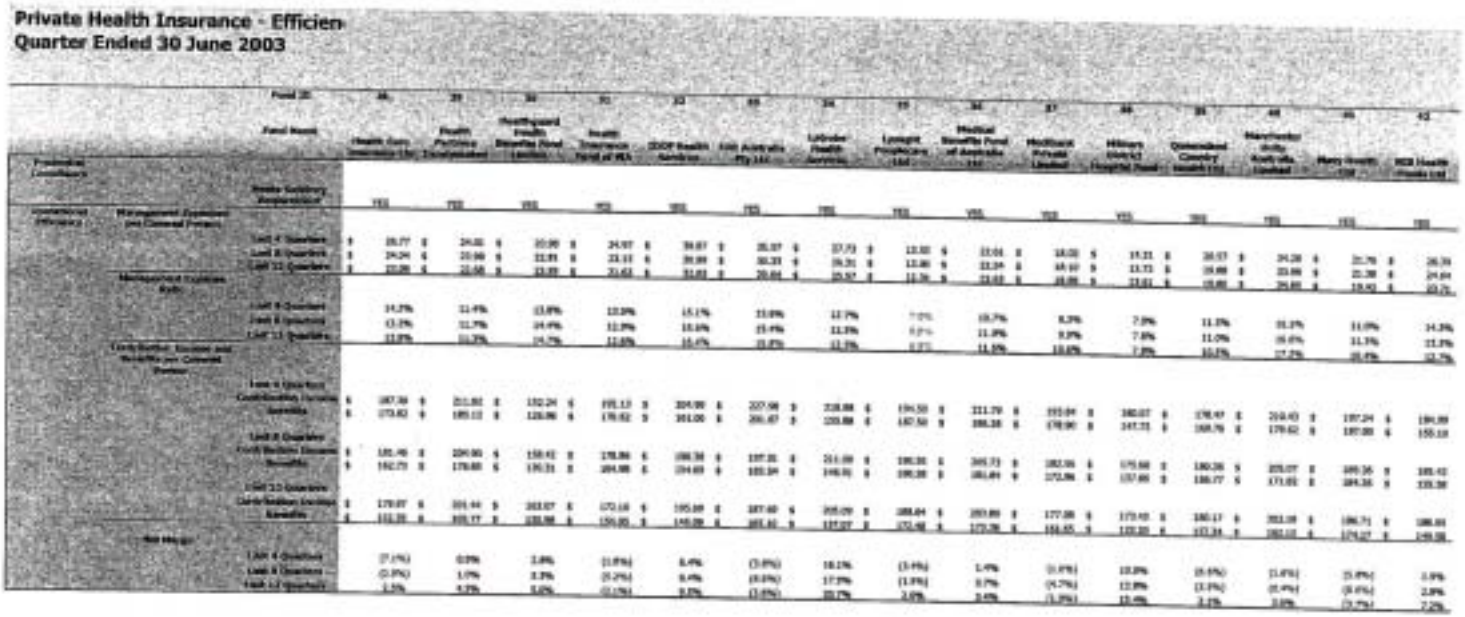
Quarter Ended 30 June 2003

Private Health Insurance - Efficien
Quarter Ended 30 June 2003



Private Health Insurance - Efficien
Quarter Ended 30 June 2003

		Fund ID	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
		Fund Name	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Prudential Compliance		Meets Solvency Requirements	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES
Operational Efficiency	Management Expenses per Insured Person	Last 4 Quarters	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
		Last 8 Quarters	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
		Last 12 Quarters	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	Management Expense Ratio	Last 4 Quarters	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
		Last 8 Quarters	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
		Last 12 Quarters	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	Contribution Income and Benefits per Insured Person	Last 4 Quarters Contribution Income	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
		Benefits	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
		Last 8 Quarters Contribution Income	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
		Benefits	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
		Last 12 Quarters Contribution Income	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
		Benefits	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	Net Margin	Last 4 Quarters	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
		Last 8 Quarters	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
		Last 12 Quarters	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]

COMMERCIAL IN CONFIDENCE

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2003-04, 5 November 2003

Question:E03-153

OUTCOME 8: Choice Through Private Health

Topic: Non Ongoing Employees

Written Question on Notice

Senator Carr asked:

(a) How many employees are employed as a non-ongoing employee in each year of the previous 6 years?

(b) What percentage of total agency employees are non-ongoing employees for each of these years?

(c) How many of these have been employed for more than 1 year as a non-ongoing employee?

(d) How many of these have been employed for more than 2 years as a non-ongoing employee?

(e) How many of these have been employed for more than 3 years as a non-ongoing employee?

(f) How many employees were employed on fixed-term contracts, in each year of the previous 6 years?

(g) What percentage of the total number of employees is this for each of these years?

(h) What was the percentage of total employees for contract employees, for each year of the previous 6 years?

(i) How many employees were employed on fixed term contracts at each classification level, for each year of the past six years?

(j) How many employees on a fixed term contract, for each year of the past six years, have been employed more than once on a fixed term contract? Please provide details of position classification in each instance.

Answer:

(a) Medibank Private is unable to fully address this question.

Medibank Private has recently transitioned to a new payroll system and processes, which occurred during mid 2003. Medibank Private's old payroll system and processes did not have the capacity to record non-ongoing employees and accordingly, records are only available for non-ongoing employees for 2003.

As at 1 July 2003, Medibank Private had 72 non-ongoing employees.

Medibank Private defines a 'non-ongoing employee' as a contractor engaged for a service who performs duties that may otherwise typically be performed by a Medibank Private employee and who is not paid through the Medibank Private payroll system but is paid through an employment agency or through a consultancy.

(b) As at 1 July 2003 approximately 5.8% of Medibank Private's employees were non-ongoing employees.

(c) Medibank Private cannot address this question as outlined at a).

(d) Medibank Private cannot address this question as outlined at a).

(e) Medibank Private cannot address this question as outlined at a).

(f) Medibank Private is unable to address this question fully.

Medibank Private has relevant data on the number of employees employed on fixed-term contracts for the past four years only. This is due to the fact that Medibank Private's payroll systems and processes did not have the capacity to record data on employees on fixed-term contracts prior to this period.

The data for employees on fixed-term contracts for the past four years at Medibank Private is as follows:

2000	39
2001	150
2002	46
2003	24

Medibank Private defines an employee on a fixed-term contract as a person engaged by Medibank Private for a fixed period who is paid through Medibank Private's payroll. They are not paid through an employment agency or consultancy.

(g) The percentage of total number of employees on fixed-term contracts for each of these years is:

2000	3.8%
2001	11%
2002	3.5%
2003	1.6%

(h) Information on employees on fixed-term contracts for the last four years is provided at f) and g) and information on non-ongoing employees is provided at a) and b).

(i) Medibank Private has the following data on employees employed on fixed-term contracts at each classification level for the past four years only:

2000	AO	2	2001	AO	5
	CSO	22		CSO	117
	EO	2		EO	8
	Sales	13		Sales	20
2002	EO	4	2003	EO	2
	CSO	19		CSO	12
	Sales	23		Sales	10

AO = Administrative Officer
CSO = Customer Service Officer
EO = Executive Officer

(j) Medibank Private has recently transitioned to a new payroll system and processes. Medibank Private's old payroll systems and processes did not have the capacity to record employees who had been employed more than once on a fixed term contract and accordingly, no information is held for each of the past six years.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2003-2004, 5 November 2003

Question: E03-126

OUTCOME 8: Choice Through Private Health

Topic: WITHDRAWAL OF COMPLEMENTARY AND ALTERNATIVE THERAPY BENEFITS

Written Question on Notice

Senator McLucas asked:

(a) What investigations, considerations and decisions is the Minister/the Department taking in regard to this issue?

(b) Is the AHIA being asked to look at what should be subject to health insurance cover OR what aspects of health insurance should attract the 30% rebate?

(c) Will decisions made about PHI cover of complementary medicine be linked to the new recommendations made as part of the TGA report (for example – that practitioners should be registered)?

(d) At least one health fund is still aggressively marketing their package that provides coverage for many alternative therapies, at least some of which are likely to fail the test for effectiveness. What action has been taken to inform consumers who are purchasing such products that there may be changes to what will attract the 30% rebate?

Answer:

(a) & (b)
The former Minister, Senator the Hon Kay Patterson, asked the Australian Health Insurance Association (AHIA) to consider the development of a framework to assess whether a therapy should be covered under ancillary benefits.

(c) The framework is still being developed.

(d) No decision has yet been taken so action at this stage is not appropriate.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2003-04, 5 November 2003

Question: E03-127

OUTCOME 8 : Choice Through Private Health

Topic: PHI PACKAGES

Written Question on Notice

Senator McLucas asked:

(a) How many PHI packages does Medibank Private sell where customers are effectively paying less for the package than they would pay if they were forced to pay the 1% PHI levy ? (ie how many packages costing less than $500 to singles earning more than $50,000 pa or package costing less than $1000 to families earning more than $100,000 pa)

(b) Does PHIAC have data on how many packages (as above) are sold that could be described as enabling purchasers to evade the tax penalty, but with large up-front deductibles (ie over $1000) such that they are unlikely to be used?

(c) Has the Ombudsman received any complaints about the marketing of this type of product?

Answer:

(a) Medibank Private has 24 products costing less than $500 per annum for single members and $1,000 per annum for a family membership currently available for sale.

The products are provided below by Single or Family Membership and also by State / Territory with the cost per annum indicated.

Single Membership

Northern Territory

PackagePlus Product (Combined Hospital and Ancillary product)

HealthyPlus	$466.80

Hospital Products

First Choice Hospital Level 2	$446.40
First Choice Hospital Level 3	$334.20
First Choice Saver Hospital Level 1	$399.00
First Choice Saver Hospital Level 2	$323.40
Smart Choice Hospital Level 1	$441.00
Smart Choice Hospital Level 2	$367.80
Blue Ribbon Hospital Level 2	$469.80

NSW/ACT

Hospital Products

First Choice Hospital Level 3	$474.60
First Choice Saver Hospital Level 2	$474.60

Western Australia

Hospital Products

First Choice Hospital Level 3	$482.40
First Choice Saver Hospital Level 2	$454.20

Family Membership

Northern Territory

PackagePlus Product (Combined Hospital and Ancillary product)

HealthyPlus	$933.60

Hospital Products

First Choice Hospital Level 2	$892.80
First Choice Hospital Level 3	$668.40
First Choice Saver Hospital Level 1	$798.00
First Choice Saver Hospital Level 2	$646.80

Smart Choice Hospital Level 1	$882.00
Smart Choice Hospital Level 2	$735.60
Blue Ribbon Hospital Level 2	$939.60

NSW/ACT

Hospital Products

First Choice Hospital Level 3	$949.20
First Choice Saver Hospital Level 2	$949.20

Western Australia

Hospital Products

First Choice Hospital Level 3	$964.80
First Choice Saver Hospital Level 2	$908.40

(b) PHIAC does not have data on the cost of the contribution rates in their statistics therefore PHIAC are unable to respond to this question.

However PHIAC does have some statistics on the number of persons with reduced cover, some lifetime exclusions and an FED in excess of $500 for singles and $1000 for families.

At September Quarter 2003, there were 45,735 contributors in this category or 0.01% of total memberships. However as PHIAC had no data on the income levels of those contributors, it is also not possible to say that these packages avoid the tax penalty.

(c) No. However, the Ombudsman does from time to time receive complaints relating to restrictions and exclusions, which are associated with such lower cost health fund products.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2003-2004, 5 November 2003

Question: E03 - 130

OUTCOME 8: Choice Through Private Health

Topic: DENTAL HEALTH COVER

Written Question on Notice

Senator McLucas asked:

(a) How many consumer units have PHI cover for dental services?
(b) Can these numbers be provided by:
    (i) State
    (ii) Income
    (iii) Age

Answer:

(a) Most people with ancillary cover are covered for dental services; 8.24 million people were covered by ancillary policies in September 2003.
(b) The following table shows the number of people covered by ancillary policies by State and age for September 2003. This information is not available by income.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2003-2004, 5 November 2003

Question: E03-131

OUTCOME 8: Choice Through Private Health

Topic: PRIVATE HOSPITAL COVER- SECOND TIER DEFAULT BENEFIT

Written Question on Notice

Senator McLucas asked:

There is evidence that health funds are pursuing selective contracting and volume capping arrangements with private hospitals. There now appears to be an increasing breakdown in contracting arrangements between funds and hospitals.

(a) What can the Minister/Department do to address this and help ensure such contracts are renewed?

(b) Does this breakdown in contracting arrangements increase the importance of the Second Tier Default Benefit in ensuring that people with private health cover have the majority of their bills paid?

(c) Is it still proposed to delete this default benefit?

(d) If so, why? What protections will be available to patients who find themselves out-of-pocket when they use private health cover?

(e) Who has the Minister and the Department consulted with over the removal of this default benefit?

(f) Which groups support the removal of the STDB and who has lobbied to have it retained?

(g) What consultations have taken place with consumers?

(h) How will this measure save money? How will the savings be made across the years 2003-04 to 2006-07?

(i) How will the Government ensure that any savings to the industry are passed on to consumers in the form of lower premiums?

(j) Is this measure likely to see more people dropping their PHI, with premiums increasing for those who remain with PHI cover?

Answer:

(a) Health funds and hospitals must engage in the commercial realities of the market place and they should do so in a manner that does not expose their clients to uncertainty or risk. In the event of difficulties in contract negotiations, the Private Health Insurance Ombudsman can be invited to mediate, alternatively either party may seek to involve the Australian Competition and Consumer Commission.

(b) The Department does not consider that there has been an increased breakdown in contracting arrangements between funds and hospitals.

(c) This issue is currently under consideration.

(d) See (c).

(e) The proposal to abolish the second tier default benefit was one of a series of reforms recommended by the review of the private health industry. As part of the review submissions were invited from the private health industry.

(f) The following peak industry bodies have made public statements opposing the abolition of the second tier: Australian Private Hospitals Association; Australian Medical Association; and the Australasian Day Surgery Association. The Australian Health Insurance Association does not oppose its abolition.

(g) A peak health consumer organisation, which represents a range of consumer groups, provided a submission which was considered as part of the Government's private health industry review.

(h) The abolition of the second tier default benefit was one of a range of measures to contain future private health insurance premium increases in the 2003-04 budget (along with changes to prostheses and reinsurance arrangements). The Department has not published disaggregated savings figures from these changes as the exact figures associated with each one may send signals to the market about the expected effect of each change. The savings indicated below will result from all the measures to contain future increases in private health insurance premiums.

Expenses ($m)

	2003-04	**2004-05**	**2005-06**	**2006-07**	**TOTAL**
Private Health Insurance Premiums – Further Measures to Contain Future Increases	-0.1	-10.4	-14.4	-24.7	-49.6

(i) All health fund premium increases are closely scrutinised by the independent prudential regulator, the Private Health Insurance Administration Council**.** However, funds wishing to increase their premiums by the Consumer Price Index or less, have a less burdensome application process than funds seeking larger increases. The Minister is empowered under the *National Health Act 1953* to disallow premium increases.

(j) The question calls for speculation on events that have not yet occurred.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2003-2004, 5 November 2003

Question: E03 - 132

OUTCOME 8: Choice Through Private Health

Topic: SECOND TIER DEFAULT BENEFIT AND PRIVATE REHABILITATION FACILITIES

Written Question on Notice

Senator McLucas asked:

(k) Is it correct that in February this year the Department (and/or the Minister) confirmed that mandatory coverage of rehabilitation services by PHI funds would be retained?

(l) Please provide the documents where this confirmation is made.

(m) Is it the case that the private health funds have refused to recognise a payment system to rehabilitation hospitals based on the AN-SNAP classes (as put forward in a Determination in August 2001)?

(n) Does this mean that some 40 private rehabilitation hospitals are ineligible for the Second Tier Default benefit?

(o) Why have the funds refused to accept this new payment system?

(p) What has the Department/ Minister done to address this issue?

(q) Could the old payment system be reintroduced?

(r) What effect will the removal of the STDB have on private rehabilitation hospitals currently without contracts with health funds?

(s) What sort of out-of-pocket expenses are patients facing because of this impasse?

(t) Does the fact that private rehabilitation hospitals are increasingly unable to reach a contract with health insurance funds undermine the commitment to mandatory coverage?

(u) What is the Minister/ Department proposing to do about this?

Answer:

(k) Paragraph (bf) of Schedule 1 of the *National Health Act 1953* states that funds are obliged to provide benefits for rehabilitation services in all their hospital tables. At a meeting between Departmental officials and the National Private Rehabilitation Group in February 2003 the Department confirmed that there were no plans to change this legislation.

(l) Paragraph (bf) of Schedule 1 of the *National Health Act 1953* is attached (Attachment A).

(m) The Department is unaware of any funds refusing to base their second tier benefit payments to rehabilitation hospitals on AN-SNAP classes as required by the Second Tier Benefit Determination. This Determination permits funds to either:

- use the AN-SNAP rehabilitation classification system to calculate second tier benefits if their payment of benefits for the past 12 months have been directly linked to the AN-SNAP rehabilitation classification system; or
- negotiate with the relevant hospital a specific benefit level based on the AN-SNAP classification if the fund does not have the payment of benefit for the previous 12 months directly linked to the AN-SNAP rehabilitation classification system.

Where benefits for rehabilitation hospitals are not tied to second tier, funds are not required to base their payments on the AN-SNAP rehabilitation classification system.

(n) No. One of the eligibility requirements for second tier is that rehabilitation hospitals classify their data using AN-SNAP. The Department is aware of only one rehabilitation hospital not using the AN-SNAP classification system. Where a health fund does not include AN-SNAP as a basis for calculating rehabilitation benefits in its contracts, the health fund and relevant facility are required to negotiate a specific second tier benefit level based on the AN-SNAP classification system.

(o) As discussed in (c) using the AN-SNAP rehabilitation classification payment model is not mandatory and it is understood that funds believe that other payment models are to be preferred.

(p) As discussed in (c) the use of the AN-SNAP rehabilitation classification system has not been mandated therefore the Department has not intervened.

(q) As discussed in (c) the Determination permits funds the flexibility to use either payment system.

(r) The question calls for speculation on events that have not yet occurred.

(s) The question calls for speculation on events that have not yet occurred.

(t) If a specialist rehabilitation hospital is unable to negotiate a contract with a health fund the facility automatically receives the government determined basic default benefit, or if eligible, the second tier default benefit.

(u) The question of the Second Tier Default Benefit is currently under consideration.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2003-2004, 5 November 2003

Question: E03-133

OUTCOME 8: Choice Through Private Health

Topic: NEW PROSTHESES ARRANGEMENTS

Written Question on Notice

Senator McLucas asked:

(a) What discussions have been held with the stakeholders on this? Please provide dates and minutes of any meetings held.

(b) Is this proposal supported by :
  (i) The health insurance industry?
  (ii) The private hospitals?
  (iii) Those public hospitals who serve private pay patients?
  (iv) Manufacturers of prostheses
  (v) Consumer groups?

(c) How does this proposal make budget savings? What are these savings and how are they achieved across the years 2003-04 to 2006-07?

(d) What processes are in place to ensure that any reduced costs to PHI funds are translated into lower premiums?

Answer:

(a) While there have been a number of meetings held with individual stakeholders, formal consultative meetings were held on 30 May, 23 July, 1 September and 31 October 2003. Planning meetings for Clinical Working Groups were held on 28 August, 10 and 24 September and 8 October 2003. Outcomes outlining work in progress from the meetings with stakeholders are provided at Attachment 1.

(b) The development work on the proposal is not yet complete.

(c) The savings from this proposal mainly derive from some price reductions and from constraining the rate of increase in unit costs for prostheses. This will flow through to containing future private health insurance premium increases and consequently the cost to Government of the 30 per cent rebate for private health insurance.

The Department has not published disaggregated savings figures from these changes as the exact figures associated with each one may send signals to the market about the expected effect of each change. The savings indicated below will result from all measures to contain future increases in private health insurance premiums.

Expenses ($m)

	2003-04	**2004-05**	**2005-06**	**2006-07**	**TOTAL**
Private Health Insurance Premiums – Further Measures to Contain Future Increases.	-0.1	-10.4	-14.4	-24.7	-49.6

(d) In the form for submission of notifications of changes to premiums for April 2004, health insurance funds have been asked to quantify the impact of the new arrangements for prostheses in their premium forecasts.

Attachment 1

Outcomes from Meeting I to Discuss the New Prostheses Arrangements

30 May 2003

OUTCOMES

This meeting (1) agreed that:

- A second meeting is to be organised to discuss possible implementation models and ongoing management of the new arrangements (Department to organise)
  - The meeting is to be in the week commencing 14th July (Dept)
  - Clinicians to attend (orthopaedic surgeons (AOA) and cardiologists (AMA))
  - PHIO and ACCC to attend to represent consumer interests (Dept)
  - Paper/s to be distributed a week beforehand including
- implementation strategy (health funds and hospitals)
- discussion paper of NZ and Japanese arrangements (Dept)
- paper on MSAC process and options for involvement in prostheses arrangements (Dept)
  - Chris Sheedy to attend meeting to speak to above paper/technicalities (Dept)

- A third meeting is to be organised for a larger group to discuss options agreed by the above meeting. The meeting is to include:
  - above group and
  - prosthesis suppliers.

- A fourth meeting is to be organised to workshop clearly developed proposition/s. Meeting to include all who are interested, in particular:
  - above group
  - direct consumer representatives and
  - a facilitator.

Outcomes from Meeting II to Discuss the New Prostheses Arrangements

23 July 2003

OUTCOMES

- The new arrangements need to be in place by 1 July 2004.
- Comments on AHIA and APHA papers to be sent electronically to the Department of Health and Ageing and these comments would be then circulated to all attendees. These comments are required by Tuesday (29 July) cob.
- A small subset of members of the meeting, comprising representatives from AHIA, APHA and CHA, AMA, Sitesh Bhojani, John Powlay and the Department of Health and Ageing, would meet to identify areas in the AHIA paper that need to be developed or modified and to write the next draft of the paper. This group will meet next Thursday, 31 July.
- The Department will circulate the revised version of the paper for further comment before another possible rewrite.
- This iteration of the paper will then be circulated to attendees and also manufacturers and suppliers by 22 August.
- This paper will be discussed at the next meeting to be held on Monday, 1 September 2-5pm.
- A clinician subgroup will be formed to identify categories within the MBS items to assist in the implementation of the new arrangements for, eg hips, and pacemakers/defibrillators.

Outcomes from Meeting III to Discuss the New Prostheses Arrangements

1 September 2003

OUTCOMES

- Issues relevant to the successful implementation of the new arrangements were identified.
- A single draft paper is to be prepared by a group convened by the AHIA including hospital, clinical, supplier and Department representation encompasses all stakeholder issues as discussed in this meeting.
- The paper is to outline options in relation to the issues identified at the meeting where agreement still needs to be reached. Advantages and disadvantages of these options will also be set out in the paper.
- The paper will be circulated to all attendees by 4 October, to be discussed at the national workshop, to be held on Friday 10 October 9.30am – 1.30pm.
- The aim of this workshop will be to agree on how the process can be furthered so the implementation of the new arrangements on a trial basis with prosthetic hips, pacemakers and lenses can occur by 31 December 2003 and full implementation by 30 June 2004.
- The Clinical Working Group will progress with its evaluation of items on the Schedule, looking at two different types, hips and one other, to report back at the next meeting.
- Hospital Casemix Protocol (HCP) data will be circulated before the meeting at 10 October as background for discussion on the way ahead.

Outcomes of Meeting IV to Discuss the New Prostheses Arrangements

Friday, 31 October 2003

Outcomes

- It was agreed that this would be the final industry meeting involving all stakeholders.
- Further consideration of outstanding issues would be considered in smaller meetings of relevant stakeholders.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2003-2004, 5 November 2003

Question: E03-134

OUTCOME 8: Choice Through Private Health

Topic: NEW PROSTHESES ARRANGEMENTS

Written Question on Notice

Senator McLucas asked:

In a Joint Submission on Prostheses Arrangements made to the Department in May 2002 by the AHIA, APHA and CHA a number of recommendations were made. These included:

(i) That cost effectiveness and outcome measures are currently poorly assessed and should be made by one body and publicised.
(ii) That a National Prostheses Outcomes Register be established.
(iii) That it was unclear how the Private Health Industry Medical Devices Expert Committee (PHIMDEC) evaluated products for inclusion on Schedule 5 and that PHIMDEC should be abolished and its functions assumed by the National Procedure Banding Committee.
(iv) That steps should be taken to ensure that consumers' rights are protected.

(a) What has been done to address these recommendations?

(b) If no progress, why not?

Answer:

(a) The joint submission described in the question from the Australian Private Hospitals Association (APHA), Catholic Health Australia (CHA) and the Australian Health Insurance Association (AHIA) was received in response to the Prostheses Review Forum held on the 26 March 2002.

The new arrangements for prostheses announced by the Government on 3 April 2003 are based on principles tabled at the Additional Estimates hearing on the 5 November 2003. The principles are a refinement of this joint proposal by health funds and hospitals, focussing on safety, quality and cost - effectiveness of prosthetic items.

As outlined in the answer to EO3 – 133, there has been several stakeholder meetings to progress the development of the new arrangements. The development work on a proposal is not yet complete.

(b) Not applicable.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2003-2004, 5 November 2003

Question: E03-170

OUTCOME 8: Choice Through Private Health

Topic: PROSTHESES

Hansard Page: CA60

Senator Lees asked:

(a) Do they have it so we can look, for example, at what specifically is changing, at where new technology is being used and at where perhaps some old prostheses are not being used at all?
(b) Could you get things like the numbers on each of the types of prostheses?

Answer:

(a) The Private Health Insurance Administration Council (PHIAC) reports a total benefit paid on prostheses for all private health insurance funds. This total cannot be broken down to individual benefit or use of a prostheses type in any way.

(b) The Department has collected patient level data in the Hospital Casemix Protocol (HCP) Collection on prosthetic item charges since 1995/1996. Specific prosthetic item data however was only included in the collection in 2001/2002, and is not yet available.

The table below indicates the number of episodes in which the six prostheses to be initially reviewed were used. This data is based on reporting from health funds who have obtained the data from hospitals, based on episode level not individual item level. The HCP Casemix Protocol dataset covers approximately 50 percent of the PHIAC total benefits paid.

Hospital Casemix Protocol data 2001/02 indicating number of times the item was used (not the number of items used).

Prosthetic Item Group	**DRG Code**	**Number of hospital episodes indicating item used (not number of items used)**
Cardiac Stents	F15Z	4,538
Lenses	C08Z, C09Z	41,700
Hip Replacements	I03	8,743
Cardiac Pacemakers	F12Z	1,950
Defibrillators	F01Z	285
Knee Replacements	I04	9,096

It is not possible to estimate how many items were used within each hospital episode as more than one item can be used within each specific DRG code.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2003-2004, 5 November 2003

Question: E03-171

OUTCOME 8: Choice Through Private Health

Topic: PROSTHESES

Hansard Page: CA 61

Senator Lees asked:

Do you have a breakdown of some of the cost of those items? I am just trying to get a ballpark figure of the value, particularly of the newer technology, of those we are looking at. Do you have any breakdowns in each of those five areas of the likely costs of various ones?

Answer:

The costs of individual prosthetic items are a matter of commercial confidentiality between health funds, suppliers and, sometimes, hospitals.

The Department's Hospital Casemix Protocol (HCP) dataset that includes data on prostheses, represents 73 per cent of privately insured hospital episodes. The total prosthetic charges for 2001/2002 for the six items that are part of the initial review are identified in the table below.

Prosthesis Type	**Total charge (million)**
Lenses	$14
Cardiac Defibrillator	$12
Cardiac Pacemaker	$24
Cardiac Stents	$13
Hips	$73
Knees	$61

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2003-2004, 5 November 2003

Question: E03-172

OUTCOME 8: Choice Through Private Health

Topic: PROSTHESES

Hansard Page: CA 63

Senator Lees asked:

What sort of savings are you looking to make from the new system? What are you aiming to do?

Answer:

The savings from this proposal mainly derive from some price reductions and from constraining the rate of increase in unit costs for prostheses. This will flow through to containing future private health insurance premium increases and consequently the cost to Government of the 30 per cent rebate for private health insurance.

The Department has not published disaggregated savings figures from these changes as the exact figures associated with each one may send signals to the market about the expected effect of each change. The savings indicated below will result from all measures to contain future increases in private health insurance premiums.

Expenses ($m)

	2003-04	**2004-05**	**2005-06**	**2006-07**	**TOTAL**
Department of Health and Ageing	-0.1	-10.4	-14.4	-24.7	-49.6

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2003-2004, 5 November 2003

Question: E03 - 173

OUTCOME 8: Choice Through Private Health

Topic: REDEFINITION OF ITEMS COVERED BY ANCILLARY BENEFITS

Hansard page: CA64

Senator McLucas asked:

Is there a dollar figure on that proportion of benefits paid?

Answer:

The total amount of ancillary benefits paid in relation to the “Fitness and Lifestyle” category for 2002 – 2003 was $65.6 million, 3.1% of all benefits paid via ancillary health benefits, or 0.87% of all benefits paid in 2002 - 2003.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2003-2004, 5 November 2003

Question: E03-174

OUTCOME 8: Choice Through Private Health

Topic: WITHDRAWAL OF COMPLEMENTARY AND ALTERNATIVE THERAPY BENEFITS

Hansard page: CA65

Senator McLucas asked:

Is it possible to get a copy of the correspondence between the Minister and the AHIA? Rather than me asking the questions, that would clarify very quickly what the Minister has asked the industry to do.

Answer:

A copy of the letter from the then Minister for Health and Ageing, Senator the Hon Kay Patterson, to the AHIA is provided at Attachment A. The AHIA have yet to respond to this letter.

Attachment A.

SENATOR THE HON KAY PATTERSON
Minister for Health and Ageing

Mr Terry Smith, MBE, RFD, ED
President
Australian Health Insurance Association
C/- National Secretariat
4 Campion Street
DEAKIN ACT 2600

Dear Mr Smith

The purpose of this letter is to ask the AHIA to consider at its Executive meeting on Friday 19 September 2003 the development of a framework to assess whether a therapy should be covered under ancillary health benefits.

As you are aware, I believe that ancillary benefits should only be paid for services that deliver direct health benefits to health fund members. The AHIA has also acknowledged that ancillary benefits should deliver direct health benefits to health fund members and we have already made an important step in the right direction by regulating to remove the payment of 'lifestyle' ancillary benefits. However, there may be scope for further focusing of ancillary benefits.

I am increasingly concerned that the payment of benefits for services without demonstrated direct health benefits is exposing the health insurance industry and the Government to criticism that could erode public support for important Government reforms such as the Rebate and Lifetime Health Cover.

Of course the framework would need to recognise that some of these benefits provide consumers with choice and allow funds to differentiate their products thereby facilitating competition.

Senior officers of my Department will be available to discuss this issue at the Executive meeting this Friday.

Yours sincerely

Senator Kay Patterson
15 SEP 2003

4 Treasury Place
Melbourne Vic 3002
Tel: (03) 9637 9577
Fax: (03) 9650 8804
Website: www.health.gov.au

Suite MG 48
Parliament House
Canberra ACT 2600
Tel: (02) 6277 7220
Fax: (02) 6273 4146

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2003-04, 5 November 2003

Question:E03-147

OUTCOME 8: Choice Through Private Health

Topic: MEDIBANK PRIVATE – CLOSURE OF HOSPITAL PRODUCTS

Hansard Page: CA 69

Senator McLucas asked:

(k) How many complaints did Medibank Private receive from members following the letter that Level 3 would be abolished?

(l) In terms of complaints through a Member of Parliament?

(m) What about complaints by phone? Do you log the phone complaints as well?

Answer:

(a) Medibank Private received a total of 395 member complaints for all products that were migrated on 1 November 2003.

(b) Two complaints were received through a Member of Parliament.

(c) Complaints received by phone totalled 133.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2003-04, 5 November 2003

Question: E03-148

OUTCOME 8: Choice Through Private Health

Topic: MEDIBANK PRIVATE – CLOSURE OF HOSPITAL PRODUCTS

Hansard Page: CA 69

Senator McLucas asked:

(a) Could you provide me with a list of those products that you have migrated?

(b) I have asked for the number of complaints – I think specifically about Blue Ribbon Hospital Cover Level 3. However, if the complaints are about all those changed products – if they are separate leave them as separate. If they are not, do not bother separating them.

Answer:

(a) Medibank Private products that were closed and had members migrated on 1 November 2003 include the following:

Basic Private Hospital Nil Excess
Basic Private Hospital Excess 1
Basic Private Hospital Excess 2
Blue Ribbon Option A Excess 1
Blue Ribbon Option A Excess 2
Blue Ribbon Hospital Excess 3
Premier Hospital Nil Excess
Premier Hospital Excess
Public Hospital Excess 1
Public Hospital Excess 2
Single Dental
Smart Choice Option A Excess 1
Smart Choice Option A Excess 2
Smart Choice Hospital Excess 3
Value Hospital Nil Excess
Value Hospital Excess

It is worth noting that, apart from Blue Ribbon Hospital Excess 3 and Smart Choice Hospital Excess 3, fourteen products were no longer sold and also were formally closed. These fourteen products had a combined total of approximately 4,200 policies nationally.

Blue Ribbon Hospital Excess 3 had approximately 35,000 policies affected nationally and Smart Choice Hospital Excess 3 had approximately 41,000 policies affected nationally.

(b) The total number of complaints received for all the above products was 395.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2003-2004, 5 November 2003

Question: E03-135

OUTCOME 9: Health Investment

Topic: Health Services Research

Written Question on Notice

Senator McLucas asked:

(a) Please outline the research that the NH&MRC has funded on health services and health policy since 1999.

(b) What consultations have been held on this research? Please provide relevant documentation.

The NH&MRC has said that there were conflicts over what sort of research should be funded.

(c) What were the conflicts, and what is the progress towards resolving them - or how have they been resolved?

(d) What funds have been allocated for this type of research since 1999? What funds have been spent?

Answer:

(a) Funding for health services research and health policy research has been provided through the following NHMRC schemes:

- Program Grants
- Project Grants
- Population Health Capacity Grants
- Strategic Research Development Grants
- Fellowships
- Scholarships
- Career Development Awards

A detailed list of grants and awards is at *Attachment 1*.

In September 2001 funding of $50 million was approved by the former Minister, the Hon. Dr Michael Wooldridge, MP, to specifically support health services research. Following extensive consultation (see (b) below), a call for Expressions of Interest for the first round of Health Services Research Grants was advertised in the *Weekend Australian* and via the NHMRC website on 11 October 2003 (see *Attachment 2*). The theme for the first round of grants is the *Economics and Financing of Health,* a subject area identified as being of importance through a national consultation process undertaken by the Joint Health Services Research Committee in late 2002.

While it would have been desirable to call for proposals earlier, it was evident that there were significant differences about the overall objective of a program of health services research. As a consequence, the allocation for health services research was deferred in order to ensure the link between health research and health care delivery is firmly established.

(b)

- In late 2001 the NHMRC established the Joint Health Services Research Committee (JHSRC) comprising representatives of the NHMRC, the Commonwealth Department of Health and Ageing, State and Territory health departments, and a consumer representative. The JHSRC was assigned two main functions:
  - to develop plans to increase the focus on health services research; and
  - to oversight the establishment of the Health Services Research Program.

  Given the lack of health services research capacity in Australia and the need to better understand what is meant by 'policy informed by research', the JHSRC released a policy discussion document (see *Attachment 3*) which was the basis of nation wide consultations undertaken in October and November 2002. These consultations, held in Sydney, Perth, Adelaide, Melbourne, Brisbane and Canberra, were invaluable in drafting documentation and policy for the scheme. As a result of the consultations, the policy discussion document was extensively revised and a two-stage application process was adopted (see *Attachment 4*).

- In addition to the JHSRC, in late 2002 the former Research Committee established a specific Health Services Research Working Group (RC-HSRWG). The role of the RC-HSRWG was to examine current application documentation for all NHMRC funding schemes and determine whether there was any unintentional bias against health services research. No bias was identified, rather the problems confronting Australian health services researchers were seen to be associated with capacity, critical mass, and insecure relationships with health services research purchasers.

- On 1 April 2003, the RC-HSRWG hosted a health services research workshop titled *Reaching for the Clouds.* The workshop, held in Canberra, was attended by approximately 30 of Australia's leading health services researchers and policy makers. Mr Jonathan Lomas, Director of the Canadian Health Services Research Foundation, prepared a discussion document focussing on the role of the NHMRC in funding health services research (*Attachment 5*), which he presented at the workshop.

The NHMRC has said that there were conflicts over what sort of research should be funded.

(c)

- Both the Wills Review and the Government's response clearly articulated the barriers and difficulties in establishing and sustaining a priority driven research program in Australia. The complexity of the task is demonstrated by the fact that while there has been substantial support for establishing a Health Services Research program, there is significant disagreement about what actually constitutes health services research.

- In addition to definitional concerns, the consultation meetings included debate about issues such as the topic areas which should be the focus of calls for research, the appropriate emphasis on research compared to capacity building, and how to engage policy makers in the research process. These issues were further considered and addressed through the re-drafting of the policy framework and application documentation.

- The merging of the former RC and the SRDC for the 2003 - 2006 triennium provided an opportunity to consolidate a range of disparate health services research activities within the NHMRC. A new *Health Services Research Working Group* has been established for the 2003-2006 triennium, to oversight all health services research initiatives. A list of members and the Terms of Reference for the Working Group are at *Attachments 6 and 7*.

(d) The table below provides an overview of NHMRC spending on health services research (as identified by the investigators) since 1997. The breakdown of this funding is at *Attachment 1*.

Health Services Research Funding 2000 - 2008					
1997-1999 $	**2000 $**	**2001 $**	**2002 $**	**2003 $**	**2004 - 2008 $**
2,697,865	2,425,841	3,063,84	4,838,230	8,452,688	17,988,777

These figures ***do not include*** the $50 million, approved in September 2001, for grants under the Health Services Research Program, which will be awarded over the next five years. It is anticipated that funding for the first round of Health Services Research Grants (advertised 11 October 2003) will be awarded in mid-2004. $10 million has been allocated to round one with a further $40 million to be spent in subsequent rounds.

Supporting documentation:

Attachment 1 -Funding details for health services research initiatives

Attachment 2 - Copy of Advertisement: Call for Expressions of Interest -Health Services Research Grants

Attachment 3 - Consultation Discussion Document

Attachment 4 - Health Services Research Grants - *Program Framework, Guide to Applicants* and *Application Form*

Attachment 5 - *Reaching for the Clouds: Options for the Support of Health Services Research in the National Health and Medical Research Council of Australia* - Mr Jonathan Lomas

Attachment 6 - Membership of Health Services Research Working Group (2003 - 2006)

Attachment 7 -Health Services Research Working Group - Terms of Reference

NHMRC FUNDED HEALTH SERVICES RESEARCH 2000 - 2003

Grant Types: All NHMRC Grant Types
Where: 2000 - 2003 budget > 0
Broad Research Area: Health Services Research
Keywords: Health Services Research
GMS Category A: 004 Health Services Research
Report Run: 20 Nov 2003
Source: NHMRC Research Management Information System (RMIS) and Grants Management System (GMS)

Grant Id	Grant Type	Scientific Title	Chief Investigator	Admin Institution	Start Yr	Duration	Total
974109	NHMRC Project Grant	Population Linkages Studies of Health Care Utilisation and Outcomes	Prof D'Arcy J. Holman	University of Western Australia	1997	4	$ 546,101
974313	FELLOWSHIP	The impact of new policy directions on health occupations and institutions	Ms Janette M Lewis	University of Melbourne	1997	5	$ 220,871
974908	SCHOLARSHIP	Human rights and health in Australia	Ms Beatrice Loff	Monash University	1997	4	$ 77,703
974949	SCHOLARSHIP	Factors influencing service provision	Dr David S Brennan	University of Adelaide	1997	3	$ 66,005
978501	SCHOLARSHIP	Cost-effectiveness of screening and treatment of renal disease	Mr Philip R A Baker	University of Queensland	1997	4	$ 61,044
980028	NHMRC Project Grant	Development of a one-day treatment for adult stuttering	Prof Mark Onslow	University of Sydney	1998	3	$ 160,863

980261	NHMRC Project Grant	Economic analysis of arthritis and joint replacment surgery	Prof Peter M Brooks	University of New South Wales	1998	3	$	220,509
980371	NHMRC Project Grant	Antenatal day care: a randomised controlled trial	A/Pr Deborah Turnbull	University of Adelaide	1998	3	$	171,717
981918	NHMRC Project Grant	Effect of home ventilatory support on clinical outcomes for patients on long term home oxygen therapy	A/Pr R Douglas McEvoy	Repatriation General Hospital, Daw Park	1998	3	$	284,244
987411	SCHOLARSHIP	Cost-effectiveness of two forms of physiotherapy for osteoarthritis of the knee	Dr Marlene H Fransen	University of Sydney	1998	3	$	59,427
990582	NHMRC Project Grant	A multi-purpose Australian co-morbidity scoring system for use with linked hospital morbidity data	Prof D'Arcy J. Holman	University of Western Australia	1999	3	$	296,559
990626	NHMRC Project Grant	Noncompliance with health advice: a comprehensive framework	Dr Jeanne Daly	La Trobe University	1999	2	$	111,360
990633	NHMRC Project Grant	Effect of maternal posturing on the incidence of persistent occiput posterior position at birth	Prof Marie E Chamberlain	University of Sydney	1999	2	$	92,820
990805	NHMRC Project Grant	Inter-Practitioner Variability in the Management of Colorectal Cancer and its Impact on Tumour Relapses	Dr David Leong	University of Newcastle	1999	4	$	269,108
990871	NHMRC Project Grant	Economic evaluation of screening using choice modelling	Prof Jane P Hall	University of Sydney	1999	3	$	214,810
990894	NHMRC Project Grant	Preventing complications of cholecystectomy:population trends,case selection & intraoperative cholangiography	Prof David R Fletcher	University of Western Australia	1999	3	$	220,744
991023	NHMRC Project Grant	Evaluation of a Patient Education Program for Improving Cancer Pain Management	A/Pr Patsy M Yates	Queensland University of Technology	1999	2	$	123,600

991189	NHMRC Project Grant	Ageing men at risk: Health, housing and service use	A/Pr Cherry L Russell	University of Sydney	1999	3	$	255,647
991191	NHMRC Project Grant	A train-the-trainer model for the prevention of anxiety disorders in children and youth.	Dr Paula M Barrett	Griffith University	1999	2	$	144,926
991255	NHMRC Project Grant	RCT: Economic evaluation of Positron Emission Tomography in management of Non Small Cell Lung Cancer	Ms Rosalie C Viney	University of Sydney	1999	3	$	289,948
991364	NHMRC Project Grant	Simultaneous validation of the AQOL instrument and the DALY using post-deliberation utilities	Prof Jeffrey R.J. Richardson	Monash University	1999	3	$	350,118
991475	NHMRC Project Grant	Trends in the presentation, management and outcome of key cancers in Western Australia	Dr Michael J Byrne	University of Western Australia	1999	3	$	347,878
991755	NHMRC Project Grant	Evaluating outcomes of assertive case management of heavy service users in integrated mental health	Prof Peter M Yellowlees	University of Queensland	1999	4	$	210,102
997026	FELLOWSHIP	an evaluation of palliative care services for patients with leukaemia and associated haematological disorders	Dr Pamela D McGrath	Queensland University of Technology	1999	3	$	91,888
997030	FELLOWSHIP	Component 1:Reducing impact of cancer diagnonis Component 2;Doctor-patient communication and therapy	Dr Penelope E Schofield	University of Melbourne	1999	6	$	253,103
997032	FELLOWSHIP	Predicting functional outcomes quality of life & healthcare utilisation following stroke & head injury	Dr Leigh R Tooth	University of Queensland	1999	5	$	225,748
997096	FELLOWSHIP	A study of hospital staff's attitude to family-centred care in metro & rural Aust, (quant res meth in paed nur	Dr Linda E Shields	Mater Misericordiae Health Services Brisbane Limited	1999	5	$	190,325
997439	SCHOLARSHIP	Evaluation of the delivery of specialist services for the treatment of surgical disease in remote environm	Dr Russell L Gruen	Flinders University	1999	4	$	93,423

997509	SCHOLARSHIP	Health services and other factors whicha ffect cancer survival in Aboriginal people in the Northern Territo	Dr John R Condon	Menzies School of Health Research	1999	5	$	109,381
997557	SCHOLARSHIP	What makes effective teams: Using personal construct theory to investigate health environments	Ms Sharon M Mickan	University of Queensland	1999	3	$	57,682
997674	SCHOLARSHIP	Evaluating pregnancy care and outcomes for indigenous Australian women	Dr Jennifer M Hunt	La Trobe University	1999	4	$	108,073
7604	SCHOLARSHIP	Evaluation of post acute care services. A multicentre randomised controlled study	Dr Wen K Lim	University of Melbourne	2000	2	$	39,120
7610	SCHOLARSHIP	The use, reliability and validity of work-related assessments used by therapists in occupational rehabilitatio	Ms Eveline J Innes	Curtin University of Technology	2000	2	$	35,360
7612	SCHOLARSHIP	Partnerships in health promotion: what influences how they are formed and shaped?	Mr Frank Tesoriero	Flinders University	2000	2	$	47,387
100944	NHMRC Project Grant	Alternatives to homologous blood transfusion - development of evidence- based decision aids.	Prof David A Henry	University of Newcastle	2000	2	$	213,697
104509	NHMRC Project Grant	Nurses' pain management decisions in the post surgery context: A naturalistic study	A/Pr Mari A Botti	Deakin University	2000	1	$	56,368
104899	NHMRC Project Grant	The influence of acupuncture stimulation on the induction of labour : a randomised controlled trial	Dr Caroline A Smith	University of Adelaide	2000	2	$	123,874
107252	NHMRC Project Grant	Preparing cancer patients for clinical decision making: a randomised trial of preconsultation preparation packages.	Prof Martin HN Tattersall	University of Sydney	2000	3	$	228,428
107279	NHMRC Project Grant	Measuring patient preferences for treatment of colorectal cancer using discrete choice modelling	Dr Glen Salkeld	University of Sydney	2000	3	$	188,912

107305	NHMRC Project Grant	Service pathways for ageing caregivers of adults with intellectual disability	A/Pr Gwynnyth M Llewellyn	University of Sydney	2000	2	$	143,614
107314	NHMRC Project Grant	Health care priorities: the community's preferences for using community preferences	Ms Virginia L Wiseman	University of Sydney	2000	1	$	52,355
107416	NHMRC Project Grant	Predictors of Poor Professional Performance in Junior Medical Staff	Prof Stewart Dunn	University of Sydney	2000	3	$	205,902
124471	NHMRC Project Grant	Measuring the productive efficiency of hospitals - a comparison of parametric and non-parametric approaches	Dr Stuart J Peacock	Monash University	2000	2	$	61,257
131201	NHMRC Project Grant	Randomised trial of continuity of nursing care in vascular surgery	Prof Jeanette E Ward	Royal Prince Alfred Hospital	2000	3	$	190,649
7024	FELLOWSHIP	PROMOTING EVIDENCE-BASED SURGICAL PRACTICE	Dr Jane M Young	University of Western Australia	2001	2	$	101,007
7097	FELLOWSHIP	PREVENTABLE HOSPITAL ADMISSIONS: CONTRIBUTING FACTORS &POTENTIAL SOLUTIONS	Dr Margaret Stevens	University of Western Australia	2001	1	$	36,617
100603	NHMRC Project Grant	An Investigation into the Policies and Provision of Seclusion in Three Health Care Settings in South Australia	Dr Colin A Holmes	University of Western Sydney, Nepean	2001	1	$	61,088
102464	NHMRC Project Grant	Clinical correlates of the wish to hasten death among the terminally ill	A/Pr Brian Kelly	University of Queensland	2001	1	$	131,360
139055	NHMRC Project Grant	The Quality of Surgical Care Project: Quality Assurance, Clinical Audit and Outcomes Evaluation in Western Australia	Dr James B Semmens	University of Western Australia	2001	3	$	346,018
139071	NHMRC Project Grant	The Western Australian Record Linkage Project: Population-Based Studies of Health System Utilisation and Outcomes	Prof D'Arcy J. Holman	University of Western Australia	2001	5	$	975,923

139172	FELLOWSHIP	The use of linked administrative heath data for disease surveillance and studies of locational and social disadvantaged	Ms Katherine J Brameld	University of Western Australia	2001	2	$	77,477
141772	NHMRC Project Grant	An investigation of the relationship between the pharmaceutical industry, medical profession and medical practitioners	A/Pr Ian H Kerridge	University of Newcastle	2001	2	$	276,735
141783	SRDC Untied	Impact of alternative funding methods on the efficiency and equity of hospital care in Australia	A/Pr Robert W Gibberd	University of Newcastle	2001	2	$	180,500
142617	SCHOLARSHIP	The impact of continuity of nursing care on outcomes following cerebrovascular surgery	Mrs Sandra J Middleton	Royal Prince Alfred Hospital	2001	2	$	48,185
143662	NHMRC Project Grant	Supply, demand and the distribution of health services in Australia	Prof Jeffrey R.J. Richardson	Monash University	2001	3	$	308,038
143766	SCHOLARSHIP	The measurement of the effect of educational, training and other programs on the intention of future health professional	Dr George T Somers	Monash University	2001	3	$	83,480
148656	SRDC Untied	Improving technical and allocative efficiency of hospital care through use (and development) of casemix measures	Prof Stephen J Duckett	La Trobe University	2001	2	$	84,984
151928	SCHOLARSHIP	Fresh Air For The Kids-A systematic health promotion approach to smoking cessation for adults in the child health contex	Dr Robert D Roseby	Murdoch Childrens Research Institute	2001	3	$	69,147
156402	SRDC Untied	Improving the cost-effectiveness of health services for the prevention and treatment of coronary heart disease	Dr Theo Vos	Alfred Hospital	2001	2	$	206,383
157172	FELLOWSHIP	Computer delivered brief intervention for alcohol abuse in general practice: a randomised clinical trial	Dr Anthony P Shakeshaft	University of New South Wales	2001	3	$	110,027
157914	NHMRC Project Grant	Glucose Intolerance in Pregnancy : a randomised trial of current management practices	A/Pr Caroline A Crowther	University of Adelaide	2001	3	$	346,527

219157	SRDC Untied	Sustainability of the hospital quality improvement kit program	Dr Karen Luxford	NSW Cancer Council	2001	1	$	10,000
219160	SRDC Untied	Issues impacting on the implementation, sustainability & transferability of eveidence based medicine in residential care	Prof Maria Crotty	Flinders University	2001	1	$	10,250
219161	SRDC Untied	Evidence Based Practice foryoung people who self harm: can it be sustained & does it improve outcome? A 2 yr follow up	A/Pr Stewart L Einfeld	South Eastern Sydney Area Health Service	2001	1	$	9,737
219163	SRDC Untied	An intervention to reduce inappropriate admissions to special care nurseries in NSW	Prof David Henderson-Smart	University of Sydney	2001	1	$	10,000
219164	SRDC Untied	Sustainability of a mulifaceted educational program for increasing evidence based perinatal care	Ms Vicki J Flenady	Mater Misericordiae Health Services Brisbane Limited	2001	1	$	9,975
991754	NHMRC Project Grant	A controlled treatment trial of substance abuse in schizophrenia	A/Pr David J Kavanagh	University of Queensland	2001	2	$	229,221
997153	SCHOLARSHIP	Identification of best practice in health policyand planning for bilateral AID programs	Dr Peter S Hill	University of Queensland	2001	1	$	19,661
148963	SRDC Tied	Evaluation of a methadone maintenance program for heroin dependent young female offenders.	Dr Friederike CM Veit	Murdoch Childrens Research Institute	2002	2	$	212,538
158045	SCHOLARSHIP	Efficiency in provision of private dental services in Australia	Dr Suzanna Mihailidis	University of Adelaide	2002	3	$	97,579
158059	FELLOWSHIP	An investigation of the outcomes of dental treatment	Dr David S Brennan	University of Adelaide	2002	1	$	22,221
180409	SRDC Tied	Examination of cultural and ethical core components of palliative care	Dr Jennifer Philip	Alfred Hospital	2002	4	$	85,257

187029	SCHOLARSHIP	Pulmonary complications after cardiac surgery: risk factors and clinical interventions.	Ms Rochelle M Wynne	Deakin University	2002	3	$	74,106
187304	SRDC Tied	The Psychosocial Process of Decision Making in Palliative Care: Analysis and Theory development	Ms Susan F Lee	Edith Cowan University	2002	3	$	61,559
187664	SRDC Tied	Exploration of the Scope of Practice & Role Preparation of the Australian Palliative Care Nurse Practitioner	Mr David A Stephenson	Flinders University	2002	2	$	49,217
189409	NHMRC Project Grant	Suicide ideation, attempts, help-seeking behaviour and compliance within the Gold Coast District	Prof Diego De Leo	Griffith University	2002	1	$	111,320
191203	NHMRC Project Grant	An evaluation of trust in a primary health care system	A/Pr Rae Walker	La Trobe University	2002	2	$	135,550
191214	NHMRC Project Grant	Effectiveness of training somatosensation in the hand after stroke: A randomized controlled trial.	Dr Leeanne M Carey	La Trobe University	2002	3	$	180,660
192107	NHMRC Project Grant	Theoretically guided improvement in the treatment of social phobia: A randomised controlled trial.	Prof Ronald M Rapee	Macquarie University	2002	3	$	302,830
193335	SCHOLARSHIP	Diploma of Indigenous Primary Health Care (specialising in nutrition)	Ms Joan Ann Koops	Menzies School of Health Research	2002	2	$	28,963
194346	SCHOLARSHIP	An integrated analysis of the health workforce in rural Australia	Ms Catherine Joyce	Monash University	2002	3	$	71,570
199926	SRDC Tied	Palliative care in high intensity transplant care settings	Ms Cecelia G Boyd	Queensland University of Technology	2002	4	$	79,454
209185	SCHOLARSHIP	Development and validation of a measure of primary care provision in Australian General Practice.	Ms Donna M Southern	University of Melbourne	2002	3	$	58,532

209191	SCHOLARSHIP	Measuring and describing patterns of interactions between GPsand other primary health care providers	Mr Lucio Naccarella	University of Melbourne	2002	3	$	58,532
209200	NHMRC Project Grant	Prevention of childhood anxiety: A parent-focused approach, targeting the school transition	Dr Margaret L Brechman-Toussaint	University of New England	2002	2	$	60,220
209701	SCHOLARSHIP	Health care attitudes of people of low socia-economic status upon health care utilisation	Ms Vanessa K Rose	University of New South Wales	2002	3	$	48,622
209874	FELLOWSHIP	Multilevel cohort study of Aust U/Grads and recent grads in medicine and allied health professions on their attitudes to	Dr Helen M Tolhurst	University of Newcastle	2002	4	$	307,119
210190	NHMRC Project Grant	Evaluating the Active Communication Education program for older people with hearing impairment	A/Pr Louise M Hickson	University of Queensland	2002	3	$	240,550
210272	NHMRC Project Grant	Building best practice in child protection at the intersection of child protection and adult mental health services	Dr Yvonne Darlington	University of Queensland	2002	3	$	294,590
210347	FELLOWSHIP	Impaired self-awareness & employment outcome following acquired brain injury: Evaluation of an employment rehabilitation	Dr Tamara L Ownsworth	University of Queensland	2002	5	$	252,003
210365	SCHOLARSHIP	Fostering people-Health Partnership: A computer delivered problem based learning course for primary health care workers	Mr Jared M Dart	University of Queensland	2002	2	$	47,452
210366	SRDC Untied	An economic analysis of Australian aged care residential facilities: expenditure and health outcome determinandts	Ms Susan A Gargett	University of Queensland	2002	3	$	58,532
210413	CAREER DEVELOPMENT AWARDS	Optimising the therapeutic management of individuals with chronic cardiac disease	Prof SIMON STEWART	University of South Australia	2002	5	$	464,000
211088	NHMRC Project Grant	Inter-hospital variations in outcomes of very preterm infants admitted to neonatal intensive care units	Prof David Henderson-Smart	University of Sydney	2002	2	$	130,440

211151	NHMRC Project Grant	Selective attention and fear avoidance in the maintenance and management of pain associated with rheumatoid arthritis	Dr Ann Louise Sharpe	University of Sydney	2002	3	$	195,660
211231	NHMRC Project Grant	Randomised Control Trial of Three Treatments for Adolescent Stutterers	Prof Mark Onslow	University of Sydney	2002	3	$	376,320
211256	NHMRC Project Grant	Enhancing mobility after hip fracture	A/Pr Ian D Cameron	University of Sydney	2002	3	$	209,865
211610	SCHOLARSHIP	Improving health through infant feeding: testing the child health nurse's role in developing community capacity	Ms Susan Kruske	University of Technology Sydney	2002	3	$	74,106
212112	SCHOLARSHIP	Inequalities in health care for people with cancer: a WA linked database study	Ms Sonja E Hall	University of Western Australia	2002	3	$	74,106
212124	SRDC Untied	A Predictive model for the utilization of homecare services	Ms Janine Calver	University of Western Australia	2002	2	$	34,383
216741	CAREER DEVELOPMENT AWARDS	Prenatal genetic testing for birth defects	Dr Jane L. Halliday	Murdoch Childrens Research Institute	2002	5	$	371,200
216742	FELLOWSHIP	Re-orientation of primary health care toward health promotion, prevention & early intervention in young people	Dr Lena A Sanci	Murdoch Childrens Research Institute	2002	4	$	308,871
216744	FELLOWSHIP	Long-term residual impairments in executive skills following childhood traumatic brain injury (TBI)	Dr Cathy (Agata) Catroppa	Murdoch Childrens Research Institute	2002	5	$	125,003
219101	SRDC Tied	A ramdomised trial of telephone support for chronic heart failure patients at high rish of re-hospital	Prof Henry Krum	Monash University	2002	3	$	368,350
219109	SRDC Tied	Sustainability & Transferability of an effective community based management system for diabetes in remote indigenous com	Dr Robyn McDermott	The Dr Edward Koch Foundation Limited	2002	2	$	414,600

219111	SRDC Tied	Promoting Partnerships in peer-led self-management of chronic disease	A/Pr Hal Swerissen	La Trobe University	2002	3	$	400,000
219128	SRDC Tied	An evidence based capacity building approach to improving vascular health in an Aboriginal Community	A/Pr Steven Boyages	DO NOT USE - Westmead Hospital	2002	4	$	140,001
219130	SRDC Tied	The investigation of innovative telemedicine models to support palliative care delivery in rural and remote Australia	Prof Ian N Olver	University of Adelaide	2002	3	$	86,870
219131	SRDC Tied	Innovative models of palliative care health service delivery to rural areas: A national, multi-disciplinary study.	Dr Pamela D McGrath	University of Queensland	2002	3	$	137,659
219135	SRDC Tied	Development of the	A/Pr Kathryn J White	Edith Cowan University	2002	3	$	150,000
219140	SRDC Tied	Assessment of the effectiveness of Australian models of palliative care delivery in four neurodegenerative disorders	Prof Linda J Kristjanson	Edith Cowan University	2002	3	$	150,000
219142	SRDC Tied	Palliative Care constituency, utilisation & impact on health care: a Western Australia based epidemiology & sociological	Dr Beverley McNamara	University of Western Australia	2002	3	$	150,000
219152	SRDC Tied	Improving Care of the dying with chronic heart failure	A/Pr Patricia M DAVIDSON	South Eastern Sydney Area Health Service	2002	3	$	130,000
219153	SRDC Tied	Palliative Care in aged care facilities for residents with a non-cancer diagnosis	A/Pr Carol F Grbich	Flinders University	2002	2	$	70,000
219162	SRDC Untied	Sustainability of Evidence Based Behavioural Change Intervention: Converting Evidence into Practice Airway Disease DEPAD	Prof Peter R Gibson	John Hunter Hospital	2002	1	$	10,024
219165	SRDC Untied	Sustainability & transferability of a successful diabetes recall system in remote indigenous communities	Dr Robyn McDermott	The Dr Edward Koch Foundation Limited	2002	1	$	10,000

219196	SRDC Tied	Self-perceived oral health needs in small rural communities in New South Wales	Dr Deborah Cockrell	University of Sydney	2002	2	$	40,000
219197	SRDC Tied	A controlled multi-faceted community intervention trial to improve the oral health of preschool aged child in rural VIC	A/Pr Nicky Kilpatrick	Murdoch Childrens Research Institute	2002	4	$	100,000
219202	SRDC Tied	Comparison of three workforce models to improve oral health & public dental care for disadvantaged adults living in rura	A/Pr Judith Walker	University of Tasmania	2002	4	$	98,131
219208	SRDC Untied	Focus group evaluation of the sustainability of best practice guidelines for both patients & health professionals in a m	A/Pr Brian Smith	University of Adelaide	2002	1	$	10,000
219704	SCHOLARSHIP	The effects of vibration on the clearance of secretions in patients with excesive secretions	Ms Bredge McCarren	University of Sydney	2002	3	$	61,559
220901	SRDC Tied	Intergration of palliative care into aged care	Mrs Susan Irvine	University of Melbourne	2002	1	$	12,164
237100	NHMRC Project Grant	Development of therapeutically useful Human Artificial Chromosomes for gene delivery and optimal gene expression	Prof Andy Choo	Murdoch Childrens Research Institute	2002	3	$	496,986
252818	SCHOLARSHIP	Examination of delivery of family-centred care(FCC) in Australia, England & the Nordic countries: an ongoing project	Dr Leigh R Tooth	University of Queensland	2002	1	$	13,163
219154	SRDC Tied	Renal dialysis abatement: decision-making & social impact of the transition to terminal care	Prof Michael Ashby	DO NOT USE - Monash Medical Centre	2003	2	$	100,000
219195	SRDC Tied	A best practice oral health model for australian residential care	A/Pr Jane M Chalmers	University of Adelaide	2003	1	$	58,900
219198	SRDC Tied	Dental Care and oral health for the indigenous communities of South Australia's Mid-north	A/Pr Lindsay C Richards	University of Adelaide	2003	3	$	100,000

219210	SRDC Untied	An evaluation of the intro. of case Conferences for Consultant Psychiatrists as new Item Numbers on the Medicare BS	Dr Jane E Pirkis	University of Melbourne	2003	3	$ 99,800
219211	SRDC Untied	Alcohol & other drug use disorders comorbid with psychosis, depression & anxiety: Treatment outcomes	Prof Vaughan J Carr	University of Newcastle	2003	4	$ 100,000
219213	SRDC Untied	Evaluation of adult mental health services using routine outcome measures	A/Pr Tom Trauer	University of Melbourne	2003	3	$ 99,234
219304	SRDC Untied	How well do health & community services help older people with neurodegenerative disorders & their family caregivers?	Prof Annette J DOBSON	University of Queensland	2003	3	$ 124,706
219309	SRDC Tied	Understanding factors contributing to nausea: Clinical and Patient perspectives	A/Pr Patsy M Yates	Queensland University of Technology	2003	3	$ 100,000
219327	PROGRAM	Evaluation of an Integrated Strategy to Promote the Health of People with Chronic or Recurring Mental Disorders	A/Pr David J Kavanagh	University of Queensland	2003	5	$ 2,500,000
222829	NHMRC Project Grant	Evaluation of multidisciplinary care plans for patients with diabetes	Prof Nicholas A Zwar	University of New South Wales	2003	1	$ 83,500
222978	SCHOLARSHIP	Improving the quality of health care: identifying strategies to achieve behaviour change among providers of health care	Dr Anthony P Shakeshaft	University of New South Wales	2003	1	$ 12,500
229922	NHMRC Project Grant	Late life transitions and pathways to healthy ageing	Prof Mary A Luszcz	Flinders University	2003	2	$ 397,200
229949	NHMRC Project Grant	The evidence-based consumer: making informed decisions about menopause, hormone replacement and complementary therapies	Prof Louis S Pilotto	Flinders University	2003	2	$ 97,750
230854	NHMRC Project Grant	Regulation of growth hormone action by sex steroids: metabolic implications for health and disease	Prof Ken KY Ho	Garvan Institute of Medical Research	2003	3	$ 353,250

233502	NHMRC Project Grant	The quality of rural procedural medical practice	Prof Richard Hays	James Cook University	2003	2	$	141,425
233511	NHMRC Project Grant	A randomized trial of the impact of a multi-intervention anti-tobacco strategy in 8 Indigenous communities.	Dr Robyn McDermott	James Cook University	2003	3	$	567,750
236204	NHMRC Project Grant	IMPAKT: Improving Indigenous patients' access to kidney transplantation.	Dr Alan Cass	Menzies School of Health Research	2003	3	$	444,725
236877	NHMRC Project Grant	An ethical analysis of the disclosure of surgeons' performance data to patients within the informed consent process	Dr Justin G Oakley	Monash University	2003	3	$	148,938
237106	NHMRC Project Grant	Predictors and correlates of developmental language problems: A longitudinal study from infancy to pre-school age	Prof Sheena Reilly	Murdoch Childrens Research Institute	2003	5	$	533,250
237124	NHMRC Project Grant	A randomised controlled trial of a decision aid for prenatal screening and diagnosis	Dr Jane L. Halliday	Murdoch Childrens Research Institute	2003	3	$	269,625
237161	SCHOLARSHIP	A controlled multifaceted community intervention trial to improve the oral health of preschool aged children in rural Vi	Mr Mark G Gussy	Murdoch Childrens Research Institute	2003	3	$	74,667
237170	SCHOLARSHIP	An analysis of 'Adverse Events' and the effectiveness of an intervention strategy in a paediatric hospital.	Dr Karen L Dunn	Murdoch Childrens Research Institute	2003	3	$	85,296
250325	NHMRC Project Grant	The influence of acupuncture on reducing women's pain from primary dysmenorrhoea: a randomised controlled trial	A/Pr Caroline A Crowther	University of Adelaide	2003	3	$	310,875
251561	NHMRC Project Grant	Social aspects and cultural meanings of gynaecological cancer diagnosis, treatment and adjustment of Victorian women	Prof Lenore H Manderson	University of Melbourne	2003	2	$	158,500
251721	NHMRC Project Grant	The effectiveness of a school-based parent education program in the promotion of adolescent health: a randomised trial	A/Pr John W Toumbourou	University of Melbourne	2003	3	$	422,900

251750	CAREER DEVELOPMENT AWARDS	Priority setting in population health: past experience and future directions.	A/Pr Robert Carter	University of Melbourne	2003	5	$ 334,000
251795	SCHOLARSHIP	Impact of socio-economic disadvantage on cronic disease management in primary care: A diabetes case study	Dr John S Furler	University of Melbourne	2003	4	$ 85,296
252473	NHMRC Project Grant	After Hours Medical Care and Personal Safety Needs of Urban General Practitioners	Dr Malcolm C Ireland	University of Newcastle	2003	2	$ 73,250
252719	NHMRC Project Grant	Implementation and evaluation of a diabetes intervention program in indigenous Australian Communities.	A/Pr Joanne T Shaw	University of Queensland	2003	3	$ 65,000
252771	NHMRC Project Grant	Physiological mechanisms of efficacy of cervical flexor muscle retraining	A/Pr Gwendolen A Jull	University of Queensland	2003	3	$ 264,750
252786	NHMRC Project Grant	Are cardiac conditions in older women managed appropriately?	Prof Annette J DOBSON	University of Queensland	2003	3	$ 289,494
252952	SCHOLARSHIP	Are Cardiac conditions in older women managed appropriately?	Ms Lindy J Humphreyes-Reid	University of Queensland	2003	4	$ 74,667
252961	SCHOLARSHIP	The role of innate immune response in the genetic susceptibility to inflammatory bowel disease.	Dr Georgia Hume	University of Queensland	2003	3	$ 85,296
253836	NHMRC Project Grant	A controlled trial of an opportunistic intervention to reduce suicide risk among alcohol and other substance misusers	Dr Thiagarajan Sitharthan	University of Sydney	2003	3	$ 361,000
253926	SCHOLARSHIP	General Practice Aged Care Health Assessments in Australia: Equitable, Effective or Caring	Dr Gerard F Gill	University of Tasmania	2003	2	$ 56,864
254202	PROGRAM	Individual decision making, welfare measurement and policy evaluation in the health sector: a microeconometric approach	Prof Jane P Hall	University of Technology Sydney	2003	5	$ 6,825,000

254559	NHMRC Project Grant	A population based study of the use of acute hospital services by elderly people living in residential care.	Dr Judith C Finn	University of Western Australia	2003	2	$ 127,000
254664	NHMRC Project Grant	A Randomised controlled trial of evidence based medicine in the management of hypertension	Dr Douglas A Pritchard	University of Western Australia	2003	3	$ 319,475
262050	SCHOLARSHIP	Community Pharmacy Pracice Change: implementation and dissemination of cognitive pharmaceutical services	Ms Alison S Roberts	University of Sydney	2003	2	$ 49,778
262061	SCHOLARSHIP	Research into the relationship between effectiveness of voluntary cancer support groups and organisational factors	Ms Laura T Kirsten	University of Sydney	2003	2	$ 49,778
262121	CAPACITY	HERON: using population health data to improve health services, policy and planning	Prof Bruce B Armstrong	University of Sydney	2003	6	$ 2,500,000
263811	SCHOLARSHIP	How is the legal and ethical obligation to obtain informed consent understood and discharges by physiotherapists?	Ms Clare M Delany	University of Melbourne	2003	3	$ 51,752
263812	SCHOLARSHIP	Can a DOTS program alone be effective in controlling tuberculosis in areas of high drug resistance?	Ms Helen S Cox	University of Melbourne	2003	3	$ 74,667
301199	PROGRAM	Burden of disease&cost effectiveness of intervention options:informing policy choices & health system reform in Thailand	Prof Alan D Lopez	University of Queensland	2003	5	$ 787,980

HEALTH SERVICES RESEARCH PROGRAM

Call for Expressions of Interest

The Health Services Research Program has been specifically designed to support consortia, comprising researchers, clinicians and health service providers, with the capacity to engage policy makers.

Broadly, the objectives of the Health Services Research Program are to:

- increase expertise and capacity in policy and service delivery-related research to improve health care;
- facilitate and develop better collaboration between researchers, policy makers and health service providers;
- increase linkage between researchers, policy makers and providers; and
- support high quality health services research in identified priority areas.

The first round of Health Services Research Grants will focus on the *Economics and Financing of Health*, an area identified as being of importance through a national consultation process undertaken by the NHMRC in late 2002.

Total funding of $10 million, over five years, will be available for round one. Applicants should note that the NHMRC proposes to fund *up to four* consortia in this round.

Further information on the Health Services Research Program and pro forma for Expressions of Interest are available on the NHMRC website at http://www.nhmrc.gov.au (Apply for Funding).

Applicants are advised to read the supporting documentation before making any enquiries.

Contact: Requests for further information should be directed to Louise Hodda on (02) 6289 9129.

Closing date: Friday, 6 February 2004. Late applications will not be considered.

Joint Health Systems Research Committee (JHSRC)

CONSULTATION DOCUMENT 1

HEALTH POLICY RESEARCH GRANTS:

POLICY AND APPROACH

HEALTH POLICY RESEARCH GRANTS

Objectives

The overall objective of the Health Policy Research Grants program is to:

a) Support high quality, policy relevant research in areas of identified priority;

b) Develop increased capacity in policy relevant research in Australia.

Background

In the past, research which contributes directly to a better functioning health care system by informing and initiating stronger policy development has been funded either through the competitive grants processes of NHMRC (where research ideas are generated by investigators) or through commissioned research funded by government (where the research issues are generated by policy makers). Neither process explicitly seeks to develop links between policy makers and researchers. Likewise neither process develops a longer-term framework to develop a more strategic approach to policy relevant research.

Commissioned research is often criticised, especially by researchers as seeking quick answers for small amounts of funding and with an insufficient understanding of the questions that can be answered satisfactorily. It can therefore result in poor quality research which is neither publishable nor meets the needs of policy makers.

On the other hand, investigator initiated research is often seen by policy makers as concerned with questions of theoretical interest to the researchers; but which may not address the real issues facing policy makers. While the results are published, they frequently do not impact on policy or practice within the time frames required by policy makers.

The intent of the Health Policy Research Grants program is to address these issues by supporting high quality and policy relevant research and by developing a critical mass of researchers in the field, within a framework that encourages collaborative links between researchers and policy makers.

Approach

In achieving its objectives, the Health Policy Research Grant program will:

- Provide long term and substantial funding to enable the development of programs of research and effective linkages between researchers and policy makers. Funds of up to $2 million per annum will be available to funded programs over a five-year period.

- Encourage the integral involvement of policy makers, health service providers and consumers in all aspects of the research including the identification of research questions, conduct of the research and uptake of the findings into policy and practice. Applicants will be required to demonstrate that the application is a collaboration between researchers and policy makers or health service providers.

- Seek to develop a critical mass of researchers in the field; applicants will be required to describe strategies for developing capacity.

Selection Criteria and Framework

The Health Policy Research Grants program will support research that meets several criteria:

- ***A policy relevant research program addressing questions of major significance:*** The research programs funded as part of the Health Policy Research Grants program will address questions of major significance in Australia with identifiable benefits in improving health and informing the development of health policy. In developing their application, the policy makers and the researchers on the team will work together to develop a proposed research program; it is envisaged that the research program will address issues of policy relevance in one or more specific health service programs. However, in order to meet the goals of the program, the research questions should have application and relevance beyond the specific health service, demographic or geographical location - findings should be applicable to other health issues or programs and to other parts of Australia.

- ***Approach builds Australia's skills in policy relevant research:*** It is recognised both in Australia and overseas that there is a need for more high quality policy relevant research. The Health Policy Research Grants program seeks to develop Australia's workforce, skills and infrastructure in this type of research. Successful applicants will be able to demonstrate how their proposal will: develop new independent researchers in policy relevant research; develop new approaches and methods; and provide training in policy relevant research approaches, including data sets from the health system.

- ***Interfacing between researchers and policy makers/health service providers:*** The Health Policy Research Grants program will support research which seeks to improve understanding and communication between researchers and decision makers and to improve mechanisms for integration of research into policy and practice. To achieve these goals, it is anticipated that the application will come from a team that includes

- both researchers and the users of research (similar to the Department of Industry, Science and Resources (DISR) CRC program), including people who work in health policy, health care delivery and the management of health systems. It will also address questions of interest to all members of the team. The team will be able to demonstrate that it has established mechanisms to ensure that the research is relevant to the needs of the policy makers, that the research will inform policy decisions, and that there are strategies in place to use the findings to further develop programs or policies. Policy makers might include those at the local, state or national level. The selection panels will consider the extent to which the application has included individuals with all relevant expertise to ensuring that the program of research is effectively completed, policy relevant and informs policy and practice.

- ***Scientifically excellent research:*** If the research is to reliably inform policy development and be genuinely useful to policy makers, it must be of an excellent standard, and of a level capable of acceptance for publication in high quality peer review journals. Applicants will be required to propose a detailed research program that will undergo peer review for its excellence, rigour and feasibility, amongst other criteria. It is expected that the proposal will be around a program of research, often involving different specific projects as part of an integrated set of objectives. These applications will address two or more of the specific areas identified as priority questions and may also include other aspects that the applicant can argue successfully further enhance the objectives.

- Successful teams will be led and include researchers with a track record of research excellence. This will be broadly defined to include record of scientific achievement,

record of research which contributes to policy and practice and record of achievement in capacity building.

- This is a new initiative of NHMRC and applicants from all relevant fields are encouraged to apply.

Eligibility

Note that NHMRC will apply its Access Policy in accord with the Exemptions Clause, in the case of this strategically important initiative. Thus, applications from all with relevant expertise and experience will be encouraged. The NHMRC Access Policy is available on the NHMRC website at http://www.nhmrc.gov.au/research/general/access.htm

Health Policy Research Grants are designed to support teams of researchers and policy makers (consortia). Potential applicants should note that the JHSRC will fund up to two applications per call and therefore it is anticipated that successful applicants will have established records of achievement in the area at an internationally competitive level.

In relation to a call for applications, NHMRC reserves the right not to make a grant recommendation to the Minister when the applications are not of sufficient research merit and/or do not meet the selection criteria.

Governance Principles

Appropriate governance for the collaborative research program is fundamental to the success of the undertaking. While the JHSRC does not wish to be prescriptive about the governance structure to be implemented by the collaboration, the collaboration must clearly identify and agree an appropriate organisational structure and research advisory mechanism for the collaboration.

The following guidance is offered to applicants:

- There must be one entity only, either existing or created for the purposes of the collaboration, with whom the NHMRC can contract. Parties to the collaboration must all agree to the nomination of that entity as the contractor for the purposes of the collaboration.

- The agreements between participants in the collaboration should make clear the rights and responsibilities of parties and put all parties on an equal footing.

  - Agreed mechanisms to ensure that the needs of members of the collaboration can be satisfactorily addressed must be negotiated and entered into by all parties to the collaboration to protect the interests of parties to the contract.

- There must be a structure which is stable, understood by all, and which is capable of delivering the outcomes agreed by the collaboration. It should include:

  - a body which provides review and advice to the collaboration on the content and progress of research and has appropriate representation of all stakeholders including, inter alia, appropriate health jurisdictions and consumers;

  - an operational structure which assures accountability;

- a nominated individual who is clearly identified as responsible for managing the research collaboration and who may have the title of Director or similar; and

- There should be clearly stated responsibilities and reporting mechanisms for each body and position in that structure.

- Governance provisions should be sufficiently flexible to ensure the collaboration's ability to adapt to changing requirements of the initiative.

- There must be mechanisms for reporting and monitoring against contractual requirements, and review and monitoring of progress against objectives.

Provided that the collaboration partners are able to demonstrate that the principles outlined above can be met, the process and structure by which they are achieved may be one adapted to the needs of the collaboration.

Establishment of the governance structure for the collaboration must be well advanced in its conceptualisation and establishment and articulated in the application for funding.

Intellectual Property

Consortia are expected to have appropriate policies and procedures in place to identify, protect and manage intellectual property arising from the research. The policies and procedures must comply with the *Interim Guidelines for Intellectual Property Management for Health and Medical Research* released by the NHMRC. This document is available on the NHMRC website at http://www.nhmrc.gov.au/research/general/ipmgtsyn.htm

Consortia must ensure that there is a written agreement between participating organisations on the ownership of intellectual property and associated rights in relation to the research supported by Health Policy Research Grants.

Joint Health Systems Research Committee (JHSRC)

CONSULTATION DOCUMENT 2

HEALTH POLICY RESEARCH GRANTS:

APPLICATION AND SELECTION FRAMEWORK

APPLICATION

It is anticipated that advertisements for the Health Policy Research Grants program will be placed in early 2003 with a closing date for applications two months later.

Applicants will be asked to provide information about the:

- Proposed program of research covering the goals and aims, strategies, significance and expected achievements in up to 12 pages. Detailed research plans are not required.

- Strategies for building capacity in policy relevant research.

- Record of achievement in scientific contribution, policy relevant research and in relevant capacity building.

- Potential contribution of their program to improving policy and/or practice and health outcomes.

- Potential contribution to improving understanding and communication between researchers and decision-makers and to improving integration of research into policy and practice.

- Proposed strategies for ensuring collaboration and effective ongoing working relationships within the team and particularly between policy makers, service providers and consumers and research members of the team.

The JHSRC reserves the right to broker collaborations and/or communicate with researchers to refine proposals as required.

SELECTION PROCESS:

Applications will be assessed in a two-phase process. In phase 1, a review panel established by the NHMRC Research Committee, will consider the quality of the proposed research program, the quality of the proposed strategies to build research capacity and the record of achievement of the team in undertaking excellent policy relevant research and in developing capacity. The applications will be rank ordered; those applications that are judged as ‘very good’, ‘excellent’ or ‘outstanding ‘ will move to the second assessment phase.

In phase 2, the rank ordered list will be considered by a panel established by the JHSRC to include policy makers, consumer and health department (Commonwealth and State government) nominees. It will consider the significance of the application to policy and health and the strategies established for ensuring collaboration between researchers and policy makers within the project team.

This two-phase approach has previously been successfully used by NHMRC in considering applications for Indigenous research through its Indigenous Health Review Panel.

Phase 1: Assessment of Research Merit

In this phase, the Review Panel will assess the applications against four criteria:

1. Quality of proposed research program (30%)

The research program will be peer reviewed and assessed against criteria based broadly on those for NHMRC New Program Grants. These are: the relevance and significance of the proposal, national/international competitiveness of the proposed research, innovativeness, and potential for future contribution to knowledge, approach/feasibility.

2. Quality of proposed strategies for capacity building (25%)

The panel will assess the extent to which the proposal will develop Australia's workforce, skills and infrastructure in policy relevant research and in interfacing research and policy and practice. Successful applicants will be able to demonstrate how their proposal will develop new independent researchers in policy relevant research, develop new approaches and methods, and provide training in policy relevant research approaches. A specific budget will be identified by the applicants for this purpose and applications will be judged against the feasibility of the plan to achieve the stated outcomes.

3. Record of achievement (45%)

The record of achievement will be assessed as follows:

a) Scientific achievement (15 pts): This will be assessed using a modified version of the record of research achievement for NHMRC New Program Grants including: publications, invitations to present work internationally or nationally, IP development and commercialisation activities, attraction of funding, awards, authorship of internal Departmental technical and/or policy documents, postgraduate training and career development record, other relevant achievements.

b) Contribution to policy and practice (15 pts): The extent to which the previous research of the team has contributed to changes in policy and practice will be assessed.

c) Record of achievement in capacity building (15 pts): The extent to which the team can demonstrate previous success in building capacity in health services research generally and in policy relevant research in particular will be assessed.

Phase 2: Assessment of significance and policy relevance

Applications reaching the second phase will be judged according to the following criteria:

1. Significance of proposed research to health and policy (60%)

The panel will assess the significance of the proposed research program evaluating:

a) Contribution to improving health and health policy (20%): the panel will assess the extent to which the proposed research program is likely to result in findings of major significance to health in Australia and to inform the development of health policy.

b) Addressing priority questions (20%): The panel will consider the extent to which the application addresses the priority questions identified by the JHSRC. Additional points will be awarded for applications which are focused more directly on the priority questions and which address more of the priority questions.

c) Contribution nationally and generalisable findings (20%). The panel will consider the extent to which the questions addressed by the

program are of national/international significance and apply to a range of health systems and delivery programs.

2. Strategies for interfacing research with policy and practice (40%)

The panel will assess the extent to which the application demonstrates that it has in place effective strategies for interfacing research with policy and practice, mechanisms for integration of research-based knowledge into policy and practice and approaches to ensuring excellent understanding and communication between researchers and decision-makers.

a) Communication and understanding between researchers and decision makers (20%): governance and communication structures which ensure that the policy makers, health providers and consumers are involved in developing the research questions, implementing the research and contributing to the uptake of findings into policy and practice.

b) Mechanisms for integration of research based knowledge into policy and practice (20%): strategies to ensure that the findings will be used to inform policy and practice. It is anticipated that this might be demonstrated by ensuring appropriate structures are in place, full commitment of the policy makers to the program (eg provision of additional funding or other support) as well as articulated strategies.

Joint Health Systems Research Committee (JHSRC)

CONSULTATION DOCUMENT 3

HEALTH POLICY RESEARCH GRANTS: ROUND 1

ECONOMICS AND FINANCING OF HEALTH

The first call for applications under the Health Policy Research Grants program will be in the area of Economics and Financing of Health.

Research questions

The JHSRC has identified a series of priority research questions within a systems approach to Economics and Financing of Health.

Though consortia are not necessarily expected to address the research questions across the five themes in their proposed research plan, coverage of two or more themes is strongly encouraged.

Question 1: Cost Effectiveness

What are the relationships between the benefits and costs of:
- new medical technologies;
- new drugs;
- health promotion;
- disease and injury prevention and early intervention services;
- clinical practice guidelines; and
- competing health care interventions.

Question 2: Workforce

What are the determinants of the supply of, and demand for, different categories of the health workforce, and how do those determinants interact with government policy and regulation? In particular, what are the determinants of the workforce available to service rural and remote communities?

Question 3: Financing Modes

What are the impacts of different public and private health service financing modes, on services offered (including safety and quality) and on outcomes, and what impacts do policy changes in one sector have on other sectors?

Can the costs of current health financing arrangements be reduced without impacting negatively on access and equity? How might financial incentives be designed to promote better delivery of care to high users (eg people with chronic illness)?

Question 4: Governance Modes

What are the impacts of different forms of governance on services and outcomes? In particular, what are the impacts of trends towards corporatisation and vertical integration in the private sector, and what are the impacts of the division of responsibilities between the Commonwealth and the States in the public sector?

Question 5: Return on Investment in Early Intervention and Prevention

Are health funders in Australia investing optimally in health promotion and disease prevention so as to minimise the economic and illness burden of chronic disease? What is the economic evidence for introducing various prevention programs?

Attachment 4

HEALTH SERVICES RESEARCH GRANTS

PROGRAM FRAMEWORK

Secretariat Contact
Telephone: (02) 6289 9129
Fax: (02) 6289 9129
Email: louise.hodda@nhmrc.gov.au

CONTENTS

ATTACHMENTS

PART A - HEALTH SERVICES RESEARCH GRANTS PROGRAM POLICY

A.1 BACKGROUND

In the past, the majority of research projects that have made direct contributions towards a more efficient and effective Australian health care system have been funded either through the competitive grants processes of the NHMRC or through commissioned 'research' funded by governments.

Unsurprisingly there are strengths and weaknesses in each approach. For example, in some cases, investigator initiated research has been seen by policy makers as concerned with questions of theoretical interest to the researchers, but which may not address the real issues facing policy makers. In contrast, some researchers may view commissioned research as a means of government agencies seeking quick solutions, using small amounts of funding and with an insufficient understanding of research methodologies. More often than not, neither process has delivered mutually beneficial outcomes nor developed strong linkages between policy makers and researchers.

In 1999, the *Health and Medical Research Strategic Review* (the Wills Review), acknowledged that there was a disproportionately small amount of NHMRC funding specifically allocated to health services research. In identifying this need, Wills drew on prior recommendations made by Dr Jonathan Lomas, Director of the Canadian Health Services Research Foundation, which included suggestions for improved dissemination and uptake of research findings through:

- increased interaction between the primary customer, the health system, and researchers on the initiation of research programs which would help increase understanding and the relevance of results; and

- a move from ad-hoc occasional contact between researchers and decision-makers to formal, ongoing channels of communication.

In order to address the gaps identified by Wills, in early 2001, funding of $50 million was announced for the establishment of an NHMRC program that would support high quality and policy relevant research. The program was also devised to develop a critical mass of researchers in the field of health services research while encouraging collaborative links between researchers and policy makers. The program was originally referred to as the *Collaborative Streams Program* and has since been re-named the *Health Services Research Grants Program*.

A.2 OBJECTIVES OF THE HEALTH SERVICES RESEARCH GRANTS PROGRAM

The Health Services Research Grants Program has been specifically designed to support consortia, comprising researchers, clinicians and health service providers, with the capacity to engage policy makers.

Broadly, the objectives of the Health Services Research Grants Program are to:

- develop increased expertise and capacity in policy and service delivery-related research to improve health care;

- facilitate and develop better collaboration between researchers, policy makers and health service providers;

- increase the number and quality of linkages between researchers, policy makers and providers; and

- support high quality health services research projects in identified priority areas.

To achieve these objectives, the Health Services Research Grant Program aims to:

- Provide long-term and substantial funding to enable the development of programs of research and promote effective linkages between researchers, policy makers and service providers;

- Increase capacity for health services research within Australia; and

- Encourage the integral involvement of policy makers, health service providers and consumers in the identification of research questions, conduct of the research and uptake of the findings.

A.3 HEALTH SERVICES RESEARCH WORKING GROUP

Throughout the NHMRC 2000 – 2003 triennium, the Joint Health Services Research Committee (JHSRC) was responsible for guiding the development of a health services research grants program. This committee was disbanded at the end of the last triennium and a new committee, the Health Services Research Working Group was established to oversight the program for the 2003-2006 triennium. The Health Services Research Working Group will report to the Strategic Research Initiatives Working Committee, under the auspices of NHMRC's Research Committee.

The Health Services Research Working Group comprises 12 members with broad stakeholder interest in health services research. Membership includes, but is not limited to, the Commonwealth Department of Health and Ageing, consumers, the Australian Health Ministers' Advisory Council(AHMAC), the State and Commonwealth Research Issues Forum (SCRIF), the Office of the NHMRC and a number of health services researchers.

Two main functions of the Health Services Research Working Group are to:

- Identify strategies to enable NHMRC as a research funding agency to encourage closer working relationships between key stakeholders, particularly health care providers, policy makers, health service researchers and consumers; and

- Oversight the development and implementation of the Health Services Research Grants Program

A.4 HEALTH SERVICES RESEARCH GRANTS PROGRAM - FIRST ROUND

A.4.1 Funding

Funding of up to $2 million per annum, over a maximum of five years (total $10 million), will be available to successful applicants in round 1. The maximum amount that consortia may receive per annum is $1 million (total $5 million over 5 years).

Applicants should note that the NHMRC may fund *up to four* consortia in the first round.

A.4.2 Theme

The first round of Health Services Research Grants will focus on the *Economics and Financing of Health*. This subject area was identified as being of importance through a national consultation process undertaken by the JHSRC in late 2002. Following consultations, the JHSRC further identified a series of priority research questions. These questions were subsequently refined by the Health Services research Working Group. A copy of the questions is at Attachment B.

It should be noted that the questions at Attachment B are only ***indicative of the type of questions that could be addressed***. The NHMRC encourages as wide enquiry as possible and applicants may wish to provide proposals based on other key areas of the *Economics and Financing of Health*, that can be demonstrated to be of comparable importance. The NHMRC particularly encourages research that will draw together partners from a range of research disciplines, service delivery and policy areas. Research that draws linkages with the National Health Priority Areas and builds on the work of the National Research Priorities are encouraged. Proposals will be judged on their overall importance, relevance and feasibility against the objectives of the scheme.

The themes for future rounds of Health Services Research Grants have not yet been determined. These may be related to the National Research Priorities and other specific priority areas identified by the NHMRC.

A.5 FURTHER INFORMATION

Further specific information on the Health Services Research Grants Program can be found in Part B of this document or by contacting the Secretariat on (02) 6289 9129 or via email at louise.hodda@nhmrc.gov.au.

PART B - APPLICATION AND ASSESSMENT PROCESS

The application process for the first round of Health Services Research Grants will comprise two stages.

- Stage 1 - *Expressions of Interest*

  The Expression of Interest stage is designed to ensure that only information essential to select a short-list of candidates is requested.

- Stage 2 - *Full Applications*

  Short-listed applicants will be asked to submit a detailed proposal.

The current timeline for the application process is at Attachment A.

STAGE 1 - EXPRESSIONS OF INTEREST

B.1 ELIGIBILITY

B.1.1 Administering Institution

Please note that the NHMRC can only pay funds to an NHMRC registered Administering Institution. Therefore, if your proposed Administering Institution is not yet registered with the NHMRC, it must do so.

The NHMRC will recognise only one institution as the Administering Institution. The Administering Institution must have in place policies and procedures for the management of public funds and the proper conduct of research in relation to ethics and good scientific conduct. Further information on the requirements for NHMRC Administering Institutions is available at: http://www.nhmrc.gov.au/research/project/instruct/applicat.htm

B.1.2 Research Team

It is anticipated that consortia will comprise multi-disciplinary teams that will implement new and innovative approaches.

Applicants do not need to necessarily demonstrate that the proposed team has a history of working together, however, applicants should be able to show that the composition of the team is viable and be able to explain how they will ensure productive working partnerships.

All Chief Investigators must have Australian Citizenship *or* permanent Australian residency status.

The majority of the research program is to be undertaken within Australia, however, international partners may be included in the team as Associate Investigators.

B.1.3 Holders of NHMRC and other grants

Applicants that are current holders of other research grants are eligible to apply for funding under the Health Services Research Grants Program. However, applicants must be able to demonstrate that:

- the proposed research program is new;
- the proposed research program does not duplicate work funded from another source; and
- the consortia is able to meet the agreed program deliverables.

B.1.4 Intellectual Property

Institutions and consortia are expected to have appropriate policies and procedures in place to identify, protect and manage intellectual property arising from the research. These policies and procedures must comply with the *Interim Guidelines for Intellectual Property Management for Health and Medical Research* released by the NHMRC. This document is available on the NHMRC website at: http://www.nhmrc.gov.au/research/general/ipmgtsyn.htm

Consortia must ensure that there is a written agreement between participating organisations on the ownership of intellectual property and associated rights in relation to the research supported by the Health Services Research Grants Program.

B.1.5 Access Policy

In allocating these grants, the NHMRC will apply its Access Policy. The NHMRC Access Policy is available on the NHMRC website at: http://www.nhmrc.gov.au/research/general/access.htm.

B.2 SUBMISSION OF EXPRESSION OF INTEREST

The NHMRC recognises that extensive consultations will need to occur between all potential stakeholders. Given that only a limited number of grants are likely to be funded (maximum of four) it is imperative that Expressions of Interest contain the most relevant information.

Applicants should use the *Stage 1 - Guide to Applicants* and *Stage 1 - Expressions of Interest Form* to submit their initial proposal.

This documentation is available from the NHMRC website at http://www.nhmrc.gov.au (Hot Issues)

Applications must be submitted electronically and in hard copy in accordance with the instructions contained in the *Stage 1 - Guide to Applicants*.

B.3 SHORT-LISTING

The Health Services Research Working Group will consider the Expressions of Interest against the assessment criteria outlined at Attachment C. The Working Group may be complemented by a limited number of overseas experts to provide assistance.

Proposals will be short-listed and applicants accordingly notified of the outcome.

B.4 UNSUCCESSFUL APPLICANTS

Applicants may contact the NHMRC seeking clarification with regard to the outcome of their application for funding under the Health Services Research Grants Program. The Office of the NHMRC will provide a written response to all requests for clarification.

Formal complaints against the administrative process can be made to the Commissioner of Complaints under section 59 of the *National Health and Medical Research Council Act 1992.* The Act is available from the NHMRC website at: http://www.nhmrc.gov.au/aboutus/index.htm

B.5 IMPORTANT NOTES - STAGE 1

The NHMRC reserves the right to broker collaborations and/or communicate with researchers to refine proposals as required. Brokered collaborations may then be invited to submit a detailed proposal for Stage 2.

STAGE 2 - FULL APPLICATION

B.6 ELIGIBILITY

Only short-listed applicants from Stage 1 will be eligible to submit a full application.

B.7 SUBMISSION OF FULL APPLICATION

For Stage 2, applicants will be asked to give a detailed account of the proposed research program. This may include supporting documentation outlining the commitment of all partners, whether cash, in-kind or other.

Applicants should use the *Stage 2 - Guide to Applicants* and *Stage 2 - Full Application Form* to submit their Stage 2 proposal.

This documentation will be available from the NHMRC website on completion of the short-listing process.

Applications must be submitted electronically and in hard copy in accordance with the instructions contained in the *Stage 2 - Guide to Applicants*.

B.8 PEER REVIEW

Stage 2 applications will be assessed by external peer review. It is likely that external peer reviewers will also include internationals with relevant expertise.

Peer reviewers will be asked to assess applications for their excellence and rigour in accordance with the criteria at Attachment C. Peer reviewers will not be asked to make comparative assessments (comparative assessment is the prerogative of the Health Services Research Working Group). Peer reviewers will be asked to provide their assessments to the Working Group for further consideration.

Applicants will be provided with de-identified copies of assessor comments and be given an opportunity to respond.

B.9 CONSIDERATION BY THE HEALTH SERVICES RESEARCH WORKING GROUP

In making their funding recommendations, the Health Services Research Working Group will consider:

- the full application against the selection criteria;
- comments from peer review; and
- responses to assessor comments.

The Working Group will also consider other factors such as the feasibility of the proposal against the objectives of the program, the governance arrangements for the consortia and its research program, and the budget sought. Applications should clearly demonstrate to the Working Group an understanding of what would constitute an appropriate organisational structure, financial

management system and research advisory mechanism for the consortia and the management of its activities. Applicants need to be able to demonstrate that the governance structure will ensure a fully functional and collaborative partnership.

The Health Services Research Working Group will make recommendations for funding to the NHMRC Research Committee, through the Strategic Research Initiatives Working Committee.

The Research Committee will forward its recommendations to the Minister for Health and Ageing. The final decision on successful applications will rest with the Minister.

Note:

The Working Group may draw on international experts to assist with their deliberations.

B.10 SUCCESSFUL APPLICANTS

The conditions of award for the Health Services Research Grants will be set out in a Deed of Agreement between the Commonwealth and the Administering Institution.

A program may not commence, nor grant funds be expended, prior to:

- the Deed of Agreement being in place;
- the appropriate Schedule being signed; and
- all required ethics clearances and approvals having been obtained.

B.11 UNSUCCESSFUL APPLICANTS

Applicants may contact the NHMRC seeking clarification with regard to the outcome of their application for funding under the Health Services Research Grants Program. The Office of the NHMRC will provide a written response to all requests for clarification.

Formal complaints, against the administrative process, can be made to the Commissioner of Complaints under section 59 of the *National Health and Medical Research Council Act 1992*. The Act is available from the NHMRC website at: http://www.nhmrc.gov.au/aboutus/index.htm

B.12 EVALUATION OF THE PROGRAM

The NHMRC will monitor the activities of the Program and may conduct a full evaluation upon completion of the programs.

B.13 IMPORTANT NOTES - STAGE 2

i. The NHMRC reserves the right not to make a grant recommendation to the Minister if applications are not of sufficient research merit and/or do not meet the specified criteria.

ii. The selection criteria for Round One, the *Economics and Financing of Health*, may be changed for future rounds in accordance with the specified theme and/or feedback from the first round.

iii. Research funded by the NHMRC must comply with established guidelines, including the *Joint NHMRC/AVCC Statement and Guidelines on Research Practice*, which can be found at: http://www.nhmrc.gov.au/research/policy.htm.

iv. It is the responsibility of the applicant to ensure that a copy of the application is referred to the relevant Institutional Ethics Committee or other approval body.

Attachment A

CURRENT TIMEFRAME
(11 October 2003)

1. Call for Research - *Economics and Financing of Health* • Call for Expressions of Interest - NHMRC Website • Call for Expressions of Interest - *The Weekend Australian*	Saturday, 11 October 2003
2. Closing date for submissions of Expressions of Interest (Stage1)	Friday, 6 February 2004
3. EOI submissions collated and sent to the HSR Working Group and supplementary international reviewers	Friday, 13 February 2004
4. Meeting of the HSR Working Group and supplementary international reviewers to rank submissions and determine a short-list	Wednesday, 10 March 2004
5. Request for full applications (Stage 2)	Monday, 15 March 2004
6. Closing date for submission of full applications (Stage 2)	Friday, 28 May 2004
7. Feedback provided	TBA
8. Responses to feedback due/possible interviews	TBA
9. Recommendation sent to the Strategic Research Initiatives Working Committee	TBA
10. Recommendations sent to Research Committee	TBA
11. Recommendations sent to the Minister for Health & Ageing	TBA
12. Advice to applicants/Announcement	TBA

THE ECONOMICS AND FINANCING OF HEALTH

Indicative Questions

- What are the relationships between the benefits and costs of:

  - Health promotion;
  - Disease and injury prevention and early intervention services;
  - Clinical practice guidelines;
  - Competing health care interventions;
  - Screening;
  - Other clinical efforts.

- What is the evidence supporting the hypothesis that the fragmented nature of the current health system results in personal, social and economic loss? What is the evidence that a more integrated system may address these issues? Would a more integrated system improve access through service accessibility and affordability?

- What is the future role of the acute hospital and sub-acute / rehabilitation area, especially in light of ever more rapidly advancing technology?

- What are the impacts of different public and private health service financing modes on services offered (including safety and quality) and on outcomes? What impacts do policy changes in one sector have on other sectors?

- Can the costs of current health financing arrangements be reduced without impacting negatively on access and equity? How might financial incentives be designed to promote better delivery of care to high users (e.g. people with chronic illness)?

- What are the impacts of different forms of governance on services and outcomes?

- What is the value of quantitative and qualitative research methodologies? Who is responsible for making decisions about hierarchies of evidence? How can different forms of evidence best be used to improve the health care system?

- What is the evidence that a primary / community centred health care system, incorporating a greater emphasis on illness prevention and health promotion, is the preferred development path for health systems?

- Are health funders in Australia investing optimally in health promotion and disease prevention so as to minimise the economic and illness burden? What is the economic evidence for introducing various prevention programs?

- Could the current system's failings be addressed by other means - for example, major investment in information technology?

- How can the consumer be placed in a better position to participate in informed decision making?

- Are models such as Managed Care, Managed Competition or Capitation Payments, suited or adaptable to the Australian health care system? What research, including trials of scale, might be warranted to test their benefit, if any? Are there other models that might be considered?

- What are the traps and pitfalls of new models, and how do these compare with the weaknesses of the current system? How would participants be recruited to any new system? What would be the incentive(s) and demonstrable benefits?

Attachment C

ASSESSMENT CRITERIA

The following criteria include the contributions of all members of the research team *and* its partners, except where specified otherwise.

➢ Quality, significance and contribution of the research to policy and practice (40%)

- demonstrated importance of the selected research program to Australia;
- level of expected social benefit to Australia from the outcomes of the proposed research;
- potential for wider application of the research;
- extent to which the applicants have addressed relevant links with the users of research;
- extent to which the applicants have established effective mechanisms to ensure that the research is relevant to the needs of the policy makers, will inform policy decisions, and may be used to further develop programs or policies;
- potential for implementation of the research findings;
- extent to which the proposal is of the highest standard, and the importance of possible research findings (for example, likelihood of acceptance for publication).

➢ Quality of proposed strategies for health services research capacity building (20%)

- extent to which the team can demonstrate previous success in building capacity in policy relevant research;
- potential of the proposal to develop Australia's health services research workforce, both in size and level of expertise and the relevance of these to policy and practice;
- strategies for involvement of end users including policy makers and consumers;
- development of additional research infrastructure.

➢ Quality and robustness of the collaboration (20%)

- composition and multi-disciplinary nature of the research team;
- level and nature of commitment from partners;
- quality and robustness of the governance structure that will underpin the research program;
- evidence of suitable and robust links between various stakeholders.

- **Record of achievement (20%)**

Research Team

- extent to which applicants' previous research, policy or practice activities have contributed to changes in policy and practice;
- record of outputs and outcomes of research;
- achievements in service delivery;
- publication records (various types);
- relevant grant funding history;
- invitations to present work nationally or internationally.

Additional requirements particularly for the Team Leader

- experience in organising and setting up a consortia;
- experience managing a multi-disciplinary team;
- success in team leadership;
- track record in effective mentoring and high level professional development.

Attachment 5

Discussion Document
Committee Draft
March 2003

Reaching for the Clouds

Options for the Support of Health Services Research in the National Health and Medical Research Council of Australia

Jonathan Lomas
Executive Director
Canadian Health Services Research Foundation

Prepared for the HSR Working Party of the National Health and Medical Research Council's Research Committee

This paper explores some options for the support of health services research by the National Health and Medical Research Council of Australia. The assumptions upon which my analysis and options are based are described in the first section. This is followed by a brief foray into international experiences with applied health services research, and their implications for who should be responsible for its funding and support. The paper then presents a framework to isolate the various components of evidence-based decision-making, and concludes by mapping these components onto possible funding roles for a research support agency. Throughout are questions for discussion around the NH&MRC role in health services research.

What is health services research? A section on assumptions

Health services research is like cloud cover - you can't easily describe it, but you know when it's there.

Although a number of bodies have tried to formalize a definition, there are contradictions and limitations in each. For instance, dominant UK and US definitions do not agree on whether it incorporates applied **and** basic science elements or only an applied element. The UK House of Lords Select Committee that spawned that country's R & D strategy in the 1990s, called it "*all strategic and applied research* concerned with the health needs of the community as a whole, including the provision of services to meet those needs". In the U.S. the Institute of Medicine created the somewhat more cumbersome definition of "a multi-disciplinary field of inquiry, *both basic and applied*, that examines the use, costs, quality, accessibility, delivery, organization, financing and outcomes of health care services to increase knowledge and understanding of the structure, processes, and effects of health services for individuals and populations" (*emphases added*).

There are other differences across countries in the conception of health services research. For instance, in North America and the UK it has become increasingly differentiated from clinical epidemiology and its biomedical roots, and more allied with the social sciences. In other European countries (and, to a lesser extent, Australia) it is still significantly entwined with clinical epidemiology and, in some instances (e.g. Italy and France) hardly differentiated at all. Public health, population health and technology assessment are all incorporated or not in the definition, depending upon the country and culture.

Figure 1 provides one particular view of the relationship of health services research to these potentially overlapping areas. It allies health services research more with the social sciences than the physical sciences, and this assumption underpins the remainder of this options paper.

Figure 1

HSR related domains Fig 1.pdf

I also assume in this paper that the majority of health services research of interest to the NH&MRC will be conducted by university-based health services researchers. My other assumptions about the particular characteristics of health services research that might influence how to approach support for this endeavour are:

1. **It is not a discipline; it is a relatively new field of inquiry**. It is a domain where many disciplines and many methodologies meet. A corollary to this is that it is neutral about methods, using multiple methods derived from different disciplines, and matched to the nature of the research question and the pragmatics of the context. For this reason, it often struggles to gain recognition in the face of self-confident disciplinary proponents whose areas are well established in the thinking, structures, and processes of funding agencies and universities.

2. **It is driven either directly or indirectly by the questions and issues encountered by those working in health services**. As described in the Wills report and subsequent NH&MRC documents, the balance between investigator-initiated and needs-driven applications for funding is very different from biomedical research. Careful assessment of research priorities is therefore a central part of health services research. Furthermore, whereas clinical research is often concerned with efficacy studies ("will this work under ideal circumstances?"), health services research is largely concerned with effectiveness questions ("will this work under real-world circumstances?"). This lack of "laboratory purity" sometimes leads competitors for the available funds to accuse it of being second-rate science.

3. **It is not only concerned with the production of research, but also with its use by those working in health care**. Rather than academic colleagues being the sole audience for the work done by health services researchers, its communication to and use by decision makers without a research background is also important. Sensitivity to these audience considerations is, therefore, important for funders and doers of health services research, implying that additional tasks beyond scholarly presentation and journal publication need to be funded for adequate dissemination and uptake of results.

These common features emphasize that health services research, even more than other categories of investigation, really is a process rather than a product. It involves:

> assembling an inter-disciplinary team skilled in the mix of required methodologies,
> gaining input from non-researchers in health services to refine and make relevant the questions under investigation, i.e. to help set the research agenda,
> linking with those non-researchers during conduct of the research to keep them informed and to keep the research relevant and 'on-track', and
> communicating and disseminating the findings in formats and venues of relevance to the non-researchers who can use the findings in their health service decision-making.

Separating or integrating health services research? Implications from some international experiences

Perhaps because of these characteristics, agencies to support health services research, particularly those with a focus on applied not basic research in the field, have often been separated from those supporting more traditional medical research.

In the UK, although the Medical Research Council provides some support to health services research, it is small and explicitly committed to the "basic science" element. Under the NHS R & D strategy a "Service Delivery and Organization" program was established in 1999 with an annual budget of about 5 million pounds and an applied mission. In addition, the R & D strategy includes programs for health technology assessment, new emerging technologies, and a health policy program.

The United States has had an agency separate from its National Institutes of Health dedicated to the support of health services research since 1989. In 2003 this agency, the Agency for Healthcare Research and Quality, will have a (US)$300 million budget and almost 300 staff to support a broad array of basic and applied health services research projects, training and dissemination activities.

In Canada our own foundation, the Canadian Health Services Research Foundation, was created in 1997 as an independent agency, separate from the Canadian Institutes of Health Research (CIHR - formerly the Medical Research Council of Canada). Although there is an Institute of Health Services and Policy Research in CIHR it, akin to the UK situation, has more of a remit around the basic science elements, leaving the Foundation to take the lead on applied projects, training and dissemination with an annual budget of (Can)$12 million and approximately 35 staff.

One exception to this trend to separate the applied HSR area from the peak health research funding body is the Netherlands. In 2001 ZonMw was created as the peak health research funding body by a merger between a ministry of health-based applied health research funding organization (Zon) and the more traditional medical research council-like organization (Mw) that was embedded within the national research organization (NWO). The motivation, however, was more to detach the medical research component from the more traditional overall research funding body (NWO), and to combine it with the more applied Zon. The intent was made clear by the addition of a strong "implementation" mandate for the research funded by the new organization, complete with the creation of an eight-member implementation unit tasked to work with each funded project in its last year of funding.

This brief overview of relevant country experiences suggests a fundamental question for the NH&MRC in Australia:

Question 1.
Should applied health services research continue to be funded through the peak medical research funding body, or should a separate or affiliated agency be created to undertake this distinct function?

There are obviously pros and cons to separating out the function, and the most obvious dividing line is the applied versus the basic research mission.

On the negative side, the fixed administrative costs of running a funding agency would be duplicated. In addition, applied research may lose some of the “clout” from being closely affiliated with the peak agency and the consequent budgetary largesse that seems often to flow to the biomedical component of health research. Also, with a separate budget it is more prone to untoward political interference - and budget reductions - should its activities encroach on sacred policy ground.This has certainly been the case in the United States where increases in the NIH budget have consistently outstripped those for AHRQ. Indeed, in a former incarnation as the Agency for Health Care Policy and Research, its budget was decimated in the mid-1990s by the US Congress after a foray into creating practice guidelines raised the ire of various influential stakeholders.

A final con to separating an agency is the increasing demand for inter-disciplinary approaches. This may be compromised by creating a “ghetto” for health services research and isolating it somewhat from the contents of the medically-oriented disciplines which are often the subject of its studies. This reasoning led the Canadian government to fold its ministry of health-based National Health Research and Development Program into the newly created, and aggressively inter-disciplinary, Canadian Institutes of Health Research.

In favour of separation, the predominantly medical culture of peak health research funding agencies often makes it difficult for health services research to compete on a level and fair playing field for the funds. This has been demonstrated by the Canadian Institutes of Health Research in its recent analyses of the relative ratings assigned by committee members to “medical” versus “health” applications for funding. The social science dominated health committees assigned, on a five-point scale, a rating that was on average 0.46 lower than the basic science dominated medical committees - a difference that has significant repercussions for the relative proportions of applications that receive funding. As the author of this report, Warren Thorngate, commented “Health committee internal reviewers show more disagreement and give lower ratings to their applications, on average, than do medical committees ... [therefore] is it fair for applications from medical and from health areas to compete for the same pot of money? There is no definite answer, though most perspectives on the question suggest that separate pots should be created.”

Of course, the separation of funding pots does not require a separate agency. There are, however, other reasons in support of a separate agency. For instance, when an agency’s culture is dominated by investigator-initiated approaches to research support, the needs-driven focus of applied health services research becomes an idiosyncratic outlier. The applied component may not be well supported, with its relatively expensive corollary activities such as priority-assessment exercises, different application forms and application assessment processes, greater attention to dissemination, and often more focus on the local than the international context of the research . For instance, can existing evaluation procedures and committees easily accommodate the use of non-researchers with knowledge of the potential value of the research?

These idiosyncrasies argue against the use of “one-size-fits-all” application forms and processes; the demand for administrative efficiency, however, tends to override this and results in a failure to adapt the forms and processes used in medical areas to the unique needs-driven agenda of

applied health services research. A staff mentality of processing research applications has little room to accommodate health services research's more dominant paradigm of nurturing research relationships - both between disciplines and between researchers, research results and decision-makers in the health system.

Hence, while there are compelling financial and disciplinary reasons to integrate the funding of applied health services research within a peak funding agency, there are some equally compelling organizational culture reasons to question the wisdom of this approach. The international trend is certainly away from integration and toward separation, at least for the applied component of health services research.

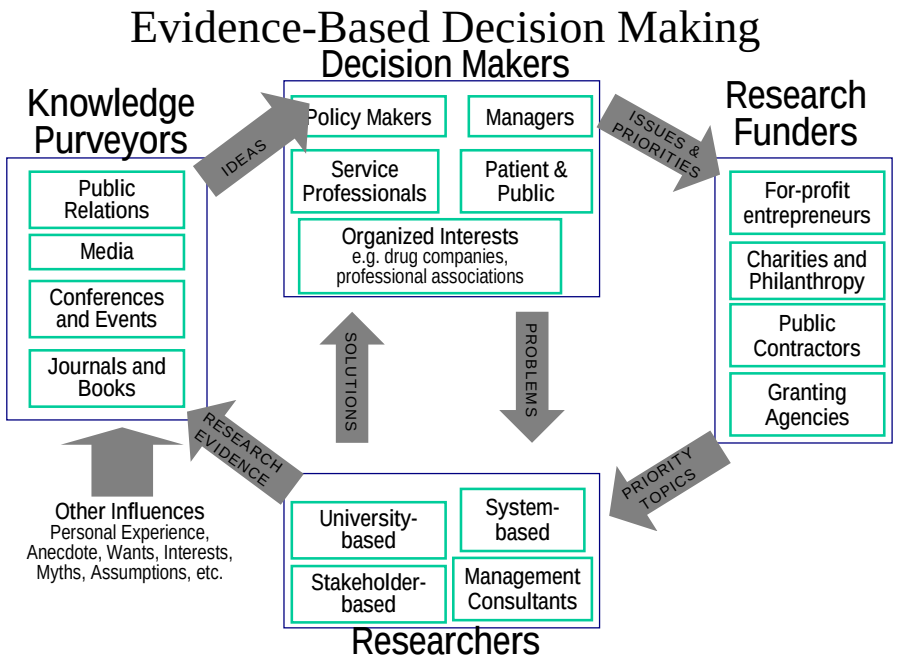
A framework for evidence-based decision-making

If health services research is a basic science then it is a basic science of evidence-based decision-making. To fully understand what might be needed to support health services research it is therefore useful to explore the elements of evidence-based decision-making to see where health services research might fit.

Figure 2 below provides a schematic connecting the four groups of actors involved in evidence-based decision-making - decision-makers, researchers, research funders, and knowledge purveyors

.

Figure 2



Let us start at the vertical core with the relationship between researchers - the producers of evidence - and decision-makers - the users of evidence. At the top, the heterogeneity of decision-makers is recognized with at least policy makers, managers, service professionals, the public/patients, and various interest groups having quite different needs and uses for health services research. In a traditional view, these needs are labelled as problems and are presented to researchers in a variety of settings, who work on them and return them to decision makers as solutions (this "problem-solution" exchange being represented by the arrows in the centre of the figure).

Unfortunately, this model seems to be inappropriately imported from the corporate sector. The natural linkages that afford ongoing communication between these researchers and decision makers in large corporations such as IBM and General Electric are not present in the health system. In the health sector the decision makers and the researchers are all in separate organizations, and there is little or no infrastructure to encourage ongoing linkage and exchange between them.

This raises the need for intermediary organizations and structures - the right-hand side of the figure. Research funders are an obvious vehicle for this intermediary role. By facilitating the expression of priorities and issues by decision-makers, they can encourage the production of evidence for decision-making by communicating these priority topics to the research community and using the incentive of their funding to draw the researchers into the study of those areas. This emulates at least that half of the IBM or General Electric process that communicates the problems on which to work.

We are still left, however, with the need to communicate the resulting solutions - the knowledge purveyors of the left hand side of the figure. The routes through which health sector decision-makers usually gain their information are not those routinely used by researchers. The ideas that flow into the policy and managerial process - the inputs to evidence-based decision-making - are more likely to come from the newspaper than from the scholarly journal. The sources for these ideas are largely influences other than the research evidence - anecdote, myth, human interest and so on.

Hence it is clear that to improve evidence-based decision-making will require concerted actions around all links in this (to borrow a phrase from the Wills report) "virtuous cycle". If the goal is more use of research by those financing, organizing, delivering and even using health services, then support of health services research requires a lot more than just funding research and researchers. A menu of these options is the subject of the next and final section of the paper.

Before moving to this menu, however, it is important to clarify the objective that a research funding agency is pursuing. There is a danger that by responding comprehensively to all of the options, an agency might drift significantly from its "core business". In a sense, this raises Question 1 again, but from a different slant.

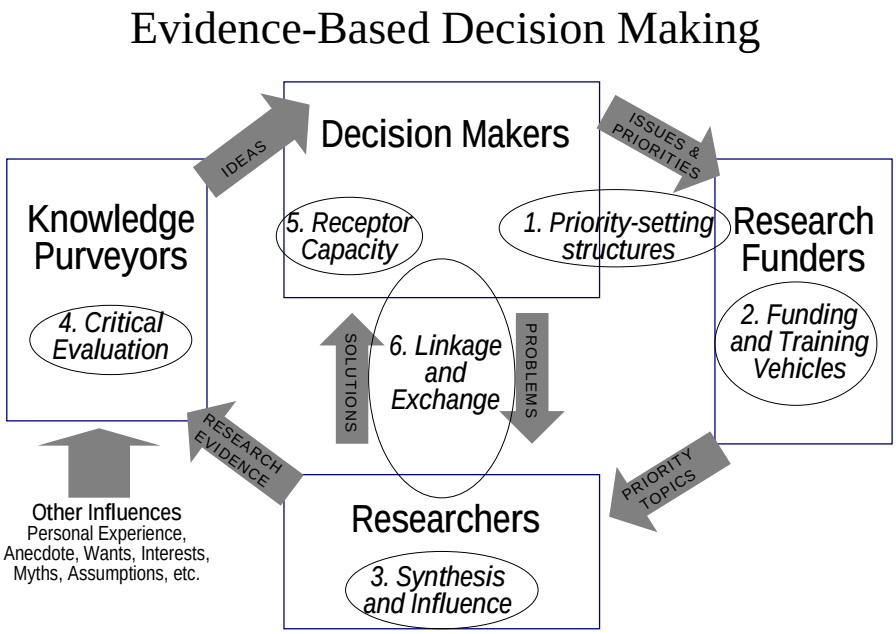
Question 2:
At what point does the NH&MRC compromise its mission when it is not only creating new knowledge, but also in pursuit of the system-wide application of that new knowledge?

Some of the activities implied by the virtuous cycle above represent radical departures from the usual activities of a research funding agency. For instance, training programs would need to target more than researchers, levels of funding for disseminating the research might approach those for producing it, and the agency might have as much interest in the capacity of the users of research to do their task - decision-makers - as they have in the producers to do theirs - researchers. Clearly defining the limits to the mission of NH&MRC will help to draw a line in the pursuit of a role for health services research in evidence-based decision-making.

A menu of options for supporting the role of health services research

Taking the evidence-based decision-making figure as a starting point, there are at least six areas where a variety of support programs could enhance the role of health services research. These are numbered in Figure 3 below.

Figure 3



"Funding and training vehicles" (2) captures the familiar territory of most agencies. Some are involved in "priority-setting structures" (1) and fewer again in "synthesis and influence" (3). The areas of "critical evaluation" for knowledge purveyors (4), "receptor capacity" for decision-makers (5), and "linkage and exchange" between researchers and decision-makers (6) are largely alien to most agencies.

The philosophy of encouraging "linkage and exchange" is, however, evident in many agencies, without being labelled. To the extent that the consumer movement has taken root in many

agencies, patients and the public are now interacting regularly with researchers. Many research centres have sprung up with advisory roles or board membership for clinicians, managers and policy-makers as tools to link them with the research world and vice-versa. These approaches are well founded in the evidence on effective knowledge transfer, where the best predictor of research use is the early and ongoing involvement of those who might use it. In the options that follow, this commitment to ongoing linkage and exchange as a tool for the application of research findings will be encountered early and often.

1. Priority-setting structures

These are needed to link at least some of the funding vehicles with the priorities of the various decision-maker groups. Many have vanished down the foggy road in search of the appropriate balance between investigator-initiated and priority-driven research. But without a "clearing-house" that gives a definitive stamp to one set of priorities, the debate is moot as investigators have no way to judge what is a priority; they are faced with a forest of competing priorities released by a variety of interests.

If the priority-setting mechanism is designed to support evidence-based decision-making then it will favour the input of the various decision-making groups. They are skilled in identifying issues, not research questions. Hence their input will often need to be translated into feasible research themes and questions - a role for the research funding agency. They are skilled at dealing with the short-term actions, research is focussed on medium- to long-term developments. Hence, the need to blend researcher foresight with decision-maker intimacy to arrive at a menu of both feasible and applicable priorities.

Question 3.
Should the NH&MRC take on the task of assessing national priorities for health services research in partnership with peak organization/s representing decision-makers in the health sector?

2. Funding and training vehicles

a) Using Potential Impact Criteria for Research

The criteria for providing funds for research are generally dominated by assessing standards of international excellence for the science alone. Priority themes, with usually wide and liberally interpreted boundaries, may also guide the investigator into certain fields. The potential impact of the research - an aggregate of its relevance to a priority, the adequacy of its dissemination plans, and the extent to which potential users are involved - is rarely considered on a par with its scientific merit. The introduction to the review process of these three criteria for assessing potential impact, alongside those used for scientific merit, unleashes a series of implications.

First, that the application must address these aspects of the research process and, therefore, researchers must think about the potential impact of their research. Second, that the assessment of the application against potential impact criteria will require a new set of skills on review panels, skills that are largely the domain of decision-makers. Third, that projects that are at least in part a collaboration between a research team and decision-makers will be advantaged in application processes as long as their science is satisfactory. Fourth, that program funding rather than individual project funding makes the investment of researcher time in an ongoing link with decision-makers more worthwhile. Research funding can thus become an incentive for linkage and exchange between the research and decision-making worlds.

A number of innovative research funding vehicles that reflect this philosophy have sprung up in the last few years, some notably in Australia. The coordinated care trials being one such attempt that might have benefited from the imprimatur and formal structures of a peak health research funding agency such as NH&MRC. There is also the Collaborating Centre for Research on Aboriginal and Tropical Health, led out of the Menzies School of Health Research, that has adopted many of these linkage and exchange principles in its programs.

Question 4.
Should the NH&MRC use assessment of potential impact on a par with scientific merit for at least some of its funding allocation processes?

b) Using Linkage and Exchange in Training

Most countries have a shortage of health services researchers. The training of the next generation is therefore a priority. If they continue to be trained in disciplinary silos, isolated from the systems that will be the subject of their future study, then we are unlikely to serve well the goal of evidence-based decision-making. Creating opportunities for the exposure of trainee health services researchers to the decision-making environment will therefore be important for future skills. This can be done in a number of ways.

First, creating funding for training centres or programs, rather than providing single stipends directly to trainees, allows for influence over the content of the curriculum. This example has been set in Australia by the Commonwealth's Public Health Education and Research Program (PHERP) for many years now. In this model, funding can require training centres to have linkages with decision-making organizations, offering both the students and the decision-makers exposure to each other's worlds. Second, even if single student stipends continue to be offered, at least a portion of them can be assigned for use only with supervisors who have projects funded under the potential impact approach. Third, postdoctoral awards can include the linkage experience with decision-makers as part of the award requirements, alongside teaching and additional research skills.

Question 5.
Should the NH&MRC apportion at least some funding to support training awards which provide students with substantive links to decision-making organizations?

c) Attracting the Social Scientists

There is a great deal of value in having interdisciplinary skills to tackle the kinds of priority problems that are the focus of health services research. This inter-disciplinary character, however, leaves health services research with no clear entry path from the disciplinary-based undergraduate training programs. In order to recruit trainees to a career in health services research more effective marketing is needed to divert social scientists from their natural disciplinary trajectory.

Question 6.
Should the NH&MRC develop a marketing campaign to attract undergraduate social scientists to graduate health services research training?

3. Synthesis and influence

Two lessons have clearly emerged from the last two decades of work on dissemination of research. One lesson concerns the unit of transfer, and the other the mode of transfer. First, individual studies are of less importance to the decision-maker than are syntheses of knowledge with actionable messages around a specific issue. Australia has been an early adopter of this insight with such things as support for the Cochrane Collaboration to turn individual studies into synthesised knowledge (although the actionable messages have often been missing from Cochrane products). Second, the scholarly journal article is far from the appropriate format for research dissemination. More readily accessible electronic, paper and (increasingly) personal presentation of results to influentials in the target audience/s seems to yield far greater benefit.

There are at least two funding implications of these lessons. First, that the not inconsequential costs of dissemination and influence need to be incorporated into project or program funding for researchers, and some effort needs to go into training them and/or others in the skills needed to do this well. Second, that synthesis needs to be recognized as a legitimate research endeavour, complete with its own science, programs of funding and support mechanisms.

Question 7.
Should the NH&MRC create funding vehicles to support the synthesis of research findings, and should it incorporate funding and/or training for dissemination activities into existing and future programs?

A major challenge in implementing programs of this kind is the unfriendly incentive structure in universities for synthesis and dissemination activities. Without changes to these incentives, that reward erudition above application and scientific specialization over societal synthesis, then such programs will be swimming against the current.

Question 8.
Should the NH&MRC launch an initiative to increase the value and status accorded research synthesis and dissemination in universities?

4. Critical evaluation

The large number and variety of knowledge purveyors makes it difficult to know where to concentrate efforts to ensure better representation of research in the decision-making process. The media are the most common target for those wishing to get their message into the policy world, and hence may yield the highest benefit in any “research literacy” campaign. Programs for journalists that teach critical research appraisal, and also create skills in finding research, have been offered in some countries such as Norway and the US with some success. Their objective is to create more of a level playing field for high quality research when it is pitted against powerful anecdotes and stories which are backed by interest group public relations.

Question 9.
Should the NH&MRC launch a program to teach critical appraisal of research to journalists?

5. Receptor capacity

Most of the innovation in research dissemination has focussed on more effectively "pushing" relevant evidence from the research world to the decision-making world. Little or no attention has gone into how to equip the decision-making world to more effectively "pull" evidence from the research community. Yet if evidence-based decision-making is to advance, this receptor capacity for research among decision makers is as important as are disseminations skills among researchers. It is the yin to the researcher's yang.

Some programs may focus on the individual skills of decision-makers, with (say) fellowships for decision-makers to learn how to use research more effectively or funding for practitioner-scientists like clinical epidemiologists or manager-researchers. Alternatively, programs may focus on building the infrastructure for evidence-based decision-making, with assistance provided for the creation of such things as R&D units, knowledge brokers, and knowledge networks in hospitals, health authorities and agencies.

Question 10.
Should the NH&MRC invest in programs to improve the capacity of decision-makers and their organizations to use research?

6. Linkage and exchange

Researchers and decision-makers in the health sector will become increasingly interdependent if evidence-based decision-making advances. Through incentives such as the serious application of potential impact criteria to funding requests, and the requirement for training environments to provide exposure to decision-makers, a demand for linkage and exchange opportunities will emerge. Support of these through the grant-funding programs is one route. However, stand-alone exchanges that periodically bring researchers and decision-makers together to discuss priority topics are another route.

Question 11.
Should the NH&MRC organize and/or support periodic exchanges between researchers and decision-makers on priority topics?

Conclusion

Many options are outlined in this paper, and eleven questions are posed for discussion. However, the central strategic question, the answer to which will help to resolve all the others, is "**At what point does the NH&MRC compromise its mission when it is not only creating new knowledge, but it is also pursuing the system-wide application of that new knowledge?**" The answer to this will determine how far the NH&MRC's future strategies can and should go in helping to establish health services research as the basic science of evidence-based decision–making.

Health Services Research Working Group

A minimum of seven members, representing the diversity of stakeholders in health services research.

Membership is to include, but is not limited to, the following:

Member of Research Committee, *Chair of Strategic Research Initiatives Committee*	**Ms Kim Boyer** (Chairperson)
At least one representative of the Commonwealth Department of Health and Ageing	**Ms Mary Murnane** Deputy Secretary of the Department of Health and Ageing
A representative of the Office of the NHMRC	**Ms Suzanne Northcott** Executive Director, Centre for Research Management and Policy, Office of NHMRC
	Mr Clive Deverall Member of Research Committee
At least one representative nominated by the Australian Health Ministers' Advisory Council(AHMAC)/State and Commonwealth Research Issues Forum (SCRIF)	**Mr Andrew Stanley** Director, Research & Evaluation Dept of Human Services, SA
At least two health services researchers	**A/Professor Helen Lapsley** School of Health Services UNSW **Professor Mark Harris** School of Public Health and Community Medicine UNSW **Professor Stuart Peacock** Business Economics, Monash University **A/Professor Karen Grimmer** Centre for Allied Health Research, University of SA
Representative of the Aboriginal and Torres Strait Islander Community	**Mr Stanley Nangala** Director, Aboriginal and Torres Strait Islander health Unit, Department of Health and Community Services, NT

Other	**Mr David Filby** Executive Director, Strategic Planning and Population Health Division, Department of Human Services, SA **Dr Steve Guthridge** Director, Health Gains Planning, Department of Health and Community Services, NT

Health Services Research Working Group (HSRWG)

Terms of Reference

Objective

The objective of the HSRWG is to develop a strategic approach to health services research within the NHMRC, and provide leadership in developing a robust health services research sector in Australia.

Functions

- To identify strategies to enable NHMRC as a research funding agency to encourage closer working relationships between key stakeholders, particularly governments, health service researchers and consumer representatives. This will include increased support for policy and service delivery relevant research and to facilitate the translation of research into policy and practice.

- To make recommendations to the Strategic Policy Committee on key mechanisms to guide the development, design and implementation of health services research initiatives within the NHMRC.

- To establish, facilitate and oversee the operation of a comprehensive priority driven grants program.

- To monitor the use of NHMRC funds for health services research.

- To liaise with relevant stakeholders in planning and monitoring health services research initiatives. This will include consideration of Aboriginal and Torres Strait Islander health issues.

- To advise and make recommendations to the Strategic Policy Committee on all matters relating to health services research.

- Other functions referred to it by the Strategic Policy Committee.

HSRWG COMPOSITION:

Chairperson - a member of Research Committee

A minimum of seven members, representing the diversity of stakeholders in health services research.

Membership is to include, but is not limited to, the following:

- At least one representative of the Commonwealth Department of health and Ageing
- A representative of the Office of the NHMRC
- A consumer representative
- At least one representative nominated by the Australian health Ministers' Advisory Council(AHMAC)/State and Commonwealth Research Issues Forum (SCRIF)
- At least two health services researchers

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2003-2004, 5 November 2003

Question: E03-136

OUTCOME: 9 - Health Investment

Topic: HEALTH*CONNECT*

Written question on notice and Hansard Page CA 80

Senator McLucas asked:

The Commonwealth has completed a report into Health*Connect* which was released last month.

(a) Could a copy of this report be provided?

(b) How much money has been spent to date on this system?

(c) Does that also include funding on Medi*Connect*?

(d) Of the GPs currently signed up to Health*Connect*, how many are actually using the system during a consultation?

(e) How much money has been spent on Medi*Connect*?

Answer:

(a) Yes.
The report may be accessed at: http://www.health.gov.au/healthconnect/researchrep/irr.html

(b) As at end June 2003, the Department has spent $12.4m on Health*Connect*.

(c) No.

(d) 110 GPs across the Hobart and Northern Territory trials.

(e) As at end June 2003, the Department and Health Insurance Commission have spent $31.8m on Medi*Connect*.

Medi*Connect* Expenditure Summary 2000 - 2003

Department	Expenditure
2000-2001	2,504,000
2001-2002	2,010,000
2002-2003	3,721,000
TOTAL	**8,235,000**
Health Insurance Commission	
2000-2001	9,354,000
2001-2002	9,357,000
2002-2003	4,790,000
TOTAL	**23,519,000**

Departmental Expenditure	**2000-01 Expenditure ($'000)**	**2001-02 Expenditure ($'000)**	**2002-03 Expenditure ($'000)**
MEDI*CONNECT* PROJECT MANAGEMENT			
Governance of Medi*Connect*	**805**	**1,386**	**1,640**
Medi*Connect* Program Office	805	1,386	1,640
MEDI*CONNECT* PROJECT ACTIVITY			
MEDI*CONNECT* DESIGN	**70**	**76**	**0**
Interoperability		76	
System Architecture on Medi*Connect*	70		
MEDI*CONNECT* COMMUNICATIONS	**693**	**204**	**66**
Communications activities (including Medicine Coding)	334	165	66
Research on communications	149	39	
Consumer Health Forum Consultations	210		
MEDI*CONNECT* TRIALS	**0**	**0**	**838**
Software development			687
Launceston Trial			64
Ballarat Trial			87
MEDI*CONNECT* RESEARCH AND EVALUATION	**0**	**61**	**535**
Field test evaluation		61	535
OTHER PROJECTS	**936**	**283**	**642**
Others	936	283	642

Health Insurance Commission Expenditure			
Medi*Connect* Development	6,108	2,885	3,692
Software Vendor Testing			612
Infrastructure		4,140	3,959
Operational			15
Carry forward			2,108

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2003-2004, 5 November 2003

Question: E03-096

OUTCOME 9: Health Investment

Topic: IP Rights and National Institute of Health

Written Question on Notice

Senator Carr asked:

(a) What work has the NHMRC undertaken in the past year relating to the issue of the IP rights and the National Institute of Health?

(b) Can you provide copies of relevant reports and/or other documents?

(c) Can you summarise NHMRC current position relating to the NIH claim?

(d) Has the NHMRC considered this issue in terms of possible AUSFTA negotiations?

(e) Can you provide the Committee with the relevant reports and other documentation?

(f) What would be the effect on medical and health research in Australia if such rights or control to IP were conceded under and AUSFTA agreement?

Answer:

(a) A contact group of relevant Commonwealth Departments and research support agencies was formed to discuss the issue of IP rights and the NIH. This group met on several occasions and nominated the National Health and Medical Research Council (NHMRC) as the lead agency in negotiations with the NIH. The NHMRC has informed the Canadian Institutes of Health Research and the Medical Research Council of the UK on its approach to this issue.

Over the last year the NHMRC has:

- met with senior officers of the NIH, most recently on 14 July 2003
- offered to assist the Office of Extramural Research at the NIH in drafting of alternatives to the NIH's policy
- provided feedback to a letter drafted by the NIH setting out the obligations of awardees to the NIH under the Bayh-Dole Act
- surveyed Australian researchers in receipt of funding from the NIH to ascertain their understanding of their requirements to the NIH.

The relevant Ministers have been kept informed of developments on this issue,

including: Senator the Hon Kay Patterson, former Minister for Health and Ageing; the Hon Dr Brendan Nelson MP, Minister for Education, Science and Training; the Hon Peter McGauran MP, Minister for Science; and the Hon Mark Vaile MP, Minister for Trade.

The Science and Technology Advisor at the USA's Embassy in Australia, Dr Miriam Baltuck, has been assisting in discussions between the NHMRC and the NIH.

(b) Given that negotiations have not been decisively concluded, provision of such documents may prejudice future discussions.

(c) The position of the NHMRC is that there should be no change to the NIH's IP policy in relation to foreign grantees.

(d) Refer to response for E03-95.

(e) Refer to response for E03-95.

(f) There are many Australian researchers impacted by National Institutes of Health (NIH) policies. They were awarded $20.2 million research funds from the NIH in 2002. This is the second highest amount of funding provided to overseas researchers by the NIH, the highest amount being awarded to Canadian researchers, with the UK a close third. The policy, if implemented, would provide a substantial disincentive for health and medical research collaborations between the US and the Australia. It is also highly likely it would capture (even if unintentionally) IP resulting from NHMRC supported research, as many of the Australian researchers in receipt of NIH support also receive funds from the NHMRC.

Implementing the policy may also result in the adoption of similar IP policies by the large American philanthropic organisations eg. the Gates Foundation which has, for example, recently invested $50 million in CRC for Vaccine Technology to develop a vaccine/immunotherapy for malaria.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2003-2004, 5 November 2003

Question: E03-097

OUTCOME 9: Health Investment

Topic: National Institute of Health

Written Question on Notice

Senator Carr asked:

NIH officials have said on a number of occasions that they are puzzled by the abnormally low notification of inventions by Australian researchers.

(a) Is this an issue for the NHMRC?

(b) What is being done to address this?

Answer:

(a) The Bayh-Dole Act of 1980 (PL 96-517) mandates the grantees of any US Federal funding agreement to report any inventions that are derived or first actually reduced to practice through the funded research. Since October 1995 this can be reported to the NIH either by paper correspondence, or as a feature of the Interagency Edison Internet-based invention reporting system (http://iedison.gov). Using either approach, utilisation reporting involves responding to eight questions relating to the status of commercialisation, extent of licensing, and an indication as to whether of not any invention-related products have reached the market.

Notification of invention derived from NIH funded research conducted by Australian researchers is the responsibility of the individual researcher. The NHMRC, however, has offered to assist the NIH in improving compliance of Australian researchers.

(b) The NHMRC recently surveyed Australian researchers funded by the NIH to ascertain the level of invention, preferred method of notification and extent of commercialisation. The results are currently being collated for consideration by the Australian Contact Group (see response to Question E03-096 (a)) before being forwarded to the NIH in de-identified form.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2003-2004, 5 November 2003

Question: E03-069

OUTCOME 9: Health Investment

Topic: UNSW ADMINISTRATION OF NHMRC FUNDS

Written Question on Notice

Senator Carr asked:

NHMRC has been in correspondence with Dr Clara He of UNSW regarding complaints made by Dr He about apparent maladministration by the University of funds attached to her NHMRC grant (ID 113949).

Dr He outlines in detail a series of apparently inappropriate uses by colleagues from her laboratory of her Visa card, to purchase materials and items for projects other than Dr He's own project. It is alleged by Dr He that some at least of these purchases were of items required by other researchers Professor Bruce Hall and Dr Hodgkinson.

Further, Dr He says that her application to have her project transferred from UNSW to Liverpool Hospital was reviewed on behalf of UNSW by Professor Hall, and that this was inappropriate, owing to other circumstances related to her role in raising questions about Professor Hall's research and personal conduct.

In a letter to Dr He dated 27 October 2003, Ms Suzanne Northcott replies on behalf of NHMRC that Dr He should seek to resolve these matters with the University. She notes that the University is responsible for administration of the matters raised by Dr He.

(a) Is the NHMRC satisfied with the management by UNSW of its funds - the funds associated with NHMRC Grant ID 113949?

(b) Has NHMRC raised these matters with the University?

(c) What steps has NHMRC taken to assure itself that Commonwealth funds are being appropriately, transparently and fairly accounted for and expended, with regard to Dr He's NHMRC Project Grant?

(d) Will NHMRC investigate these matters?

(e) Can NHMRC provide a report to the Committee on actions taken, and to be taken, on these matters, and on the outcome of any action or discussions?

Answer:

(a) At this point yes (see answer to question (c) below).

(b) Yes.

(c) An investigation into allegations of the misuse of funds relating to NHMRC grant 113949 was undertaken by the Department of Health and Ageing's Audit and Fraud Control Branch (AFCB) in 2002. The report of the AFCB found that "it would not be possible to substantiate a case that Professor Hall misused funds for grant 113949 in a manner which implies an offence under the Criminal Code".

A recommendation of the AFCB report was that "the NHMRC closely scrutinise the final report on this grant to determine whether this project was conducted in line with the application and grant agreement, and whether any variations are acceptable". The NHMRC will undertake a close review of the final report on this grant, which is due no later than 30 June 2004.

(d) Not at this point, pending receipt of the final report on this grant.

(e) Since the NHMRC became aware of the allegations of misappropriation of Commonwealth funds associated with Project Grant ID 113949, it has been liaising with the Department's AFCB (as per answer to question (c) above).

- NHMRC's response to the AFCB report included advice that the NHMRC was in the process of developing advice for Administering Institutions to clarify issues surrounding the 'pooling of funds' for the purpose of managing grants, both in relation to salaries and consumables. Advice on this matter was sent to Research Administration Officers and Finance Officers of Administering Institutions on 30 October 2003.

- The NHMRC has received regular correspondence from Dr He (Chief Investigator A on Project Grant App ID 113949), in relation to funds associated with this grant.

- NHMRC's position is that it is unable to consider the information provided until it considers the findings of the final report for this grant.

- On 8 August 2003, the NHMRC wrote to Dr He to remind her that under the *Conditions of Award* the University is responsible for management of these grant funds, and that she should work with the University to resolve the matters raised by her allegations relating to misuse of grant funds. NHMRC also wrote to UNSW and advised that it should work with Dr He to resolve these matters and to advise NHMRC of the outcome.

- In addition, Dr He has made further allegations in her correspondence to the NHMRC that other people without authorisation have used a credit card issued in her name. The NHMRC's advice to Dr He was that such offences are a State matter and concerns should be communicated directly to the NSW police.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2003-2004, 5 November 2003

Question: E03-094

OUTCOME 9: Health Investment

Topic: IP Rights and the AUSFTA

Written Question on Notice

Senator Carr asked:

A year ago, the US National Institute for Health sought to gain total control of IP rights resulting from overseas research partially funded by the National Institute of Health.

(a) How was this matter resolved?

(b) Is this a permanent solution, or an interim one?

Answer:

(a) Implementation of the policy to gain total control of IP rights resulting from overseas research funded by the National Institute of Health (NIH) was delayed indefinitely following objections put forward by the National Health and Medical Research Council (NHMRC).

(b) This is an interim solution. The NHMRC is awaiting further advice from the NIH.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2003-2004, 5 November 2003

Question: E03-056

OUTCOME 9: Health Investment

Topic: NHMRC - HUMAN EMBRYOS ACT

Written Question on Notice

Senator Harradine asked:

(a) In the Leaders' Forum meeting on 29 August, the leaders of NSW, Victoria, Queensland, Western Australia, the Northern Territory and the ACT agreed to drop the 5 April 2002 restriction that is set out in the Research Involving Human Embryos Act. Tasmania and South Australia have kept the restriction. Is it possible for some states and territories to opt out without the agreement of COAG? Isn't it possible for them to change their legislation as they wish, depending on the support of their respective parliaments?

(b) At the Leaders' Forum, it was agreed that "heads of governments will sign an Intergovernmental Agreement that will ensure this legislation remains nationally consistent". Is the Department aware of this Intergovernmental Agreement? If so, would you please explain the terms of the agreement?

Answer:

(a) The Leaders' Forum was an informal political gathering of State and Territory leaders. It has no other status. Under the Commonwealth legislation, the restriction on the use of excess Assisted Reproductive Technology (ART) embryos created after 5 April 2002 lapses on 5 April 2005, unless an earlier date is determined by COAG. COAG has not determined such a date.

(b) Yes. The purpose of the Intergovernmental Agreement, (when it has been signed), would be to facilitate the implementation and maintenance of the nationally consistent legislative scheme for the regulation of the use of excess ART embryos and the prohibition of human cloning and certain other practices regarded as unacceptable by COAG and now contained in Commonwealth, State and Territory legislation.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2003-2004, 5 November 2003

Question: E03-057

OUTCOME 9: Health Investment

Topic: RESEARCH INVOLVING HUMAN EMBRYOS ACT

Written Question on Notice

Senator Harradine asked:

Is the legislation in each of the states and territories consistent with the Research Involving Human Embryos Act? At the moment the situation is that:

South Australia legally cannot remove the 5 April date. NSW, Victoria, Queensland, the Northern Territory and the ACT have agreed to remove the 5 April date. The Australian Government and Tasmania intend to keep the 5 April date.

Does that mean we now have nationally inconsistent legislation?

Answer:

It is the decision of the responsible Australian Government Minister as to whether or not to declare a State's legislation to be corresponding State law for the purposes of the Commonwealth *Research Involving Human Embryos Act 2002.*

On 3 October 2003, the (former) Minister with portfolio responsibility for human cloning and embryo research declared the South Australian embryo research legislation to be corresponding for the purposes of the Commonwealth *Research Involving Human Embryos Act 2002.*

The responsible Minister has not yet made a decision on legislation in Queensland, New South Wales, Victoria or Tasmania. Legislation has not been passed in Western Australia, the Northern Territory or the Australian Capital Territory.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2003-2004, 5 November 2003

Question: E03-058

OUTCOME 9: Health Investment

Topic: Prohibition of Human Cloning Act

Written Question on Notice

Senator Harradine asked:

(a) Given that the Prohibition of Human Cloning Act prohibits all human cloning, how did the NHMRC come to advise that the position the Australian Government should take should be to support some human cloning?

(b) Professor Pettigrew told the United Nations that "whilst the current legislation bans all forms of human cloning, the provision in the legislation for a review is consistent also with a moratorium on some forms of cloning, should these be determined by the Australian Parliament …". Is Professor Pettigrew saying that there is effectively a moratorium in place in Australia rather than a ban?

(c) Aren't Professor Pettigrew's comments and the position he is representing anticipating the results of the review of the legislation? The position assumes that human cloning will be allowed for experimentation, but will not be allowed for human reproduction.

(d) Who is to conduct the review of the legislation? Is the review to consider the ethical issues surrounding any change to the law?

Answer:

(a) The NHMRC did not advise which position the Australian Government should take.

(b) No

(c) No.

(d) The Minister for Ageing with portfolio responsibility for human cloning and embryo research will decide. The scope of the review is specified in section 47 of the *Research Involving Human Embryos Act 2002* and section 25 of the *Prohibition of human Cloning Act 2002*.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2003-2004, 5 November 2003

Question: E03-059

OUTCOME 9: Health Investment

Topic: United Nations – Human Cloning

Written Question on Notice

Senator Harradine asked:

(a) Doesn't the position the NHMRC put to the UN ignore the fact that human cloning involves the same procedure, whatever use is made of the cloned embryo? Isn't it a fact that human cloning would generally be expected to be undertaken by somatic cell nuclear transfer, then the cloned embryo would be either experimented on or implanted in a woman's uterus?

(b) Was the Australian Government's position at the UN on human cloning cleared by the then minister responsible for human cloning issues, Kevin Andrews? Was he not the minister to whom the Department was responsible on these issues?

(c) The NHMRC's legislation states that its role is to "advise, and make recommendations to, the Commonwealth, the States and Territories". That is Commonwealth legislation so why can't we see the results of the Department's work in the form of reports prepared for COAG? Is the Department not accountable to the Australian Parliament?

Answer:

(a) No. While the technique known as Somatic Cell Nuclear Transfer has been used to successfully clone mammals such as sheep, it is not known whether it will work with humans. Human cloning may be achieved by a number of different processes including the one described.

(b) No. The Government determined the Australian position.

(c) COAG directed the NHMRC to prepare the reports for COAG. While the NHMRC is accountable to the Australian Parliament, only COAG can decide whether and to whom the reports should be released.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2003-2004, 5 November 2003

Question: E03-060

OUTCOME 9: Health Investment

Topic: NHMRC - COAG Reports

Written Question on Notice

Senator Harradine asked:

I note that the Department has not been willing to provide me with reports prepared for COAG, which feed into decisions on Australian government policy.

(a) As an Australian Government agency, should the NHMRC undertake work for COAG - not an Australian Government institution - if that precludes the NHMRC from the normal processes of accountability to the Australian Parliament?

(b) Should the NHMRC deliberately enter into agreements which mean that it cannot meet its obligations to Parliament?

(c) Why is the Department giving higher priority to COAG - an informal organisation created to coordinate work between Australian governments - than to Parliament?

Answer:

(a) The NHMRC, through its legislation includes representation from the Australian Government and all State and Territory Governments. COAG is chaired by the Prime Minister and is made up by all Premiers and Chief Ministers. The NHMRC takes direction from the Government.

(b) No.

(c) Neither the Department nor the NHMRC has done so.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2003-2004, 5 November 2003

Question: E03-061

OUTCOME 9: Health Investment

Topic: NHMRC Licensing Committee

Written Question on Notice

Senator Harradine asked:

(a) Has the Licensing Committee met since its 4 June 2003 meeting? If so, please provide me with a copy of the minutes for each meeting.

(b) I note that at the 4 June meeting the Committee was informed of the development of an Inter-Government Agreement (IGA) signed by the Prime Minister, Premiers and Chief Ministers and lower level bilateral agreements covering communications, the roles of the Commonwealth and the states and territories, inspectors, cost sharing and so on. Would the Department please inform me of the progress of these agreements. Please provide a copy of each of the agreements.

Answer:

(a) Yes, the NHMRC Licensing Committee met on 30 July 2003, on 29-30 September and on 18-19 December 2003.

Minutes from the 30 July and 29-30 September meetings are attached. Minutes from the 18-19 December meeting have not yet been finalised.

(b) A draft Inter-governmental Agreement was developed by officials from the Commonwealth and each State and Territory and finalised through the Council of Australian Governments Senior Officials. The draft IGA is with the COAG secretariat. Formal development of bilateral agreements is under discussion.

NHMRC LICENSING COMMITTEE

Minutes of the Meeting of 30 and 31 July 2003

ATTENDANCE

Members:

Professor Jock Findlay (Chairperson)
Dr Megan Best (30th only)
Dr Kerry Breen (30th only)
Professor Don Chalmers
Dr Peter Illingworth
Dr Graham Kay
Dr Christopher Newell
Ms Helen Szoke
Dr Julia Nicholls

Secretariat

Clive Morris
Tony Rolfe
Leanne K Mundy
Rhonda Stilling
Carmel Boyd
Alison Mackerras

As required for particular sessions:

Greg Ash
Phillip Hoskin
Anna Manzoney

Item 1: ..... Opening

Professor Jock Findlay opened the meeting at 9.00am, providing a brief overview of the meeting schedule and changes to the Agenda and Induction Day.

Decisions:

Meeting to carry over to 12.00pm on Thursday 31 July to facilitate revised commencement time for the Induction Session (1.00pm and conclude at 4.30pm).

Item 1.1: ..... Confidentiality

Members were reminded of their responsibility to adhere to the Council confidentiality procedures as outlined at Attachments 1 and 2. These requirements are in place for all NHMRC Licensing Committee activities.

Decisions:

Confidentiality to be a standing item on all future agendas for the Licensing Committee.

Item 1.2: .....Chairman's Report

The Chairperson briefed the Committee on his attendance at the Council Meeting of 5-6 June 2003.

Item 2: ..... Minutes of meeting 4 June 2003

The Committee endorsed the draft minutes with one change to Item 7 - Consideration of Applications. This needs to reflect that Application 309704 was reviewed and the Committee required further information.

Decisions:

The Committee endorsed the draft minutes with one change to Item 7- Consideration of Applications.

Item 2.1: ..... Action Arising

The Committee noted the Attachment to this item and agreed that this form of reporting on action arising should accompany each draft record of meeting.

Members noted that information pertaining to advice contained in the National Statement about research merit and the requirements of those undertaking research will be provided shortly.

Decisions:

Action list to be made available to members after each meeting.

Item 3: ..... NHMRC Activities

This item will be a standing item on each agenda. The Executive Secretary of Council advised members that he would provide a briefing on matters being considered by Council and, where possible, attend meetings to answer any queries relating to the business of Council.

The Committee was briefed on:

- the NHMRC Strategic Plan which has been cleared by the Minister and is being tabled in Parliament (copies were later distributed);
- Wills Review and other reviews involving the NHMRC;
- performance measurement;
- an audit of the NHMRC being conducted by the Australian National Audit Office;
- Members Handbook and operational matters, where he invited feedback;
- a joint meeting of Council and all NHMRC Principal Committee members that will occur on 17 March 2004.

The member in common with AHEC, briefed the Committee on relevant AHEC issues considered at the previous meeting of AHEC:

- the review of the National Statement;
- resourcing for implementation of an electronic application form for institutional ethics committees
- re-establishment of the working party responsible for revision of the Ethical Guidelines on Assisted Reproductive Technology
- initiatives directed at the improvement of HRECs.

Members also noted the report to AHEC on relevant Licensing Committee considerations.

The Committee was briefed on the new Branch structure, including the addition of a new section with responsibility for biotechnology, other expert committees and performance evaluation. The Branch is now called the Centre for Compliance and Evaluation.

Members were updated on progress toward achieving nationally consistent legislation:

- four States have legislation in place (NSW, Vic, Qld and SA)
- legislation has been introduced in WA but not yet debated;
- legislation is yet to be drafted in Tas, NT and Act

The next stage in the process for NSW, Vic, Qld and SA is for the Minister to determine whether to declare this legislation to be corresponding legislation.

Decisions:

Member in common with AHEC to:

- report to AHEC on relevant matters following each Licensing Committee meeting;
- report to the Licensing Committee on any relevant matters following each AHEC meeting.

Members to be kept informed of progress on the establishment of nationally consistent legislation.

Item 4: ..... Administrative Arrangements

a) Member's Handbook

Members noted the NHMRC Members Handbook.

b) Council Operating Procedures

Members noted Council Operating Procedures and agreed to implement the procedures for consideration of issues out of session detailed at Attachment 2 to the agenda paper.

The Committee agreed to establish the following procedures to progress consideration of applications for a licence:

- establish a small Working Committee for each licence application, to be comprised of two members - one with expertise in ethical/regulatory/consumer matters and one with technical scientific expertise. The role of the Working Committee will be to advise the Committee on issues and seek expert advice if necessary. These processes were discussed further at Item 8 -Assessment Process.

It was noted that the full Committee must ultimately make the all decisions and that the Working Committee would hold no form of delegation.

The agreed progress of business is as follows:

- applications received within the NHMRC Secretariat;
- application forwarded to the Chairperson;
- the Chairperson allocates to a two-member Working Committee with particular expertise as outlined above;
- the Working Committee considers the application and seeks all necessary additional information
- the full Committee considers the application and all additional information.

Decisions:

Committee agreed to implement the procedures for consideration of issues out of session detailed at Attachment 2 to the agenda paper.

Committee agreed to a process to progress consideration of applications.

Item 5: .....Conflict of Interest

The NHMRC Licensing Committee Secretariat reiterated to the Committee that all business discussed at meetings remains confidential. It was also agreed by the Chairperson that this item become a standing agenda item providing members with

the opportunity to declare any conflict of interest in relation to matters being discussed by the Committee. It was agreed that all declared conflict of interest will be recorded in writing by the Secretariat.

The Committee was asked to note the Council Operating procedures in relation to Conflict of Interest and to sign the form provided at Attachment 3.

Decisions:

Committee members to sign the form provided at Attachment 3 and return to the Secretariat.

Item 6: .....Report to Parliament

The Committee noted their obligation to provide a report to parliament on NHMRC Licensing Committee business outcomes at six monthly intervals. The next report will be due on 31 December 2003, and will cover activities in the period 1 April to 30 September 2003.

Item 7: ..... Development of Procedural Guidelines

Item 7.1: Consent

Members noted the draft paper prepared to provide licence applicants and HREC members with guidance on the NHMRC Licensing Committee's interpretation of what constitutes proper consent. This paper is based on the NHMRC's *National Statement on Ethical Conduct in Research Involving Humans* and the *Ethical Guidelines on Assisted Reproductive Technology* (1996).

It was agreed that the draft paper would be finalised by a joint Licensing Committee/AHEC Working Committee. The paper will include advice about what is required at the time of application and once a licence has been issued. This is necessary to meet the requirement to provide written advice that consent has been obtained before an excess ART embryo is used. The Committee also agreed that an essential element of the process is that patients must have determined their embryos to be excess to their reproductive requirements before they are approached with a request to use them for research.

The final paper will be made available to HRECs and applicants and placed on the Embryo Research web site. Consideration will also be given to holding a joint LC/AHEC training day for HRECs.

Once the paper has been finalised, the booklets that constitute the embryo research information kit (including the application form) will be updated to reflect the advice given in the paper and facilitate the provision of the information required by the Licensing Committee.

The Licensing Committee process flow chart and associated checklist will also be expanded to reflect the agreed processes for obtaining proper consent.

It was agreed that the consent forms require a field or space to record an identity code which allows individual embryos to be identified at all stages of any licensed activity (for example by allocating a unique barcode to each embryo). In addition the form of written advice required before an excess ART embryo is used would include a requirement to list the identity codes of individual embryos.

Decisions:

Draft paper to be finalised by a joint LC/AHEC Working Committee.

Once finalised, the paper will be made available to applicants and HRECs and placed on the web site.

The content of the paper will be reflected in all relevant documents, including the application form and information books.

Consideration will be given to holding a joint LC/AHEC training day for HRECs.

The consent forms and written advice required before an embryo is used will need to include identity codes to allow tracking of individual embryos.

Item 7.2: .....Damage or Destroy

The Committee considered the evidence that would be required to determine whether an activity may damage or destroy an embryo. It was agreed that onus should be placed on applicants to provide evidence in support of any claim that the proposed activity would not damage or destroy an embryo. Such evidence could include reference to animal and other human research studies. This could also be referred to additional experts as required.

The application form and instructions to applicants will be amended to strengthen the requirement for evidence in support of claims that the proposed activity will not damage or destroy an embryo.

In addition, the licence for any non-harmful use of embryos would need to include a condition that if at any stage it becomes apparent that harm occurs the licence holder must immediately cease work and inform the Committee.

Reporting on non-harmful use including embryos created post 5 April 2002 would also include a requirement for the licence holder to address the outcome of the work in terms of impact on the embryos.

Decisions:

Strengthen the requirement for evidence in support of claims that the proposed activity will not damage or destroy an embryo – amend application form and instructions to applicants.

Seek advice from experts as required.

Include a condition in licences for non-harmful activities using embryos created post 5 April 2002 that if at any stage it becomes apparent that harm occurs the licence holder must immediately cease work and inform the Committee.

Reporting on non-harmful use to include a requirement for the licence holder to address the outcome of the work in terms of impact on the embryos.

Item 7.3: ..... Likelihood of Significant Advance

It was agreed that a Working Committee will consider names for inclusion in a list of experts who would be suitable to provide additional advice to the Licensing Committee on the likelihood of a significant advance in knowledge or improvement in technologies for treatment. The Working Committee will bring a recommendation back to the Committee at its next meeting.

Members noted that the Secretariat has sought legal advice on the seeking of advice from external experts. The Committee will be informed as soon as the advice becomes available.

Decisions:

Working Committee to bring a recommendation on suitable external experts back to the Committee at its September meeting.

Secretariat to advise the Committee on the outcome of legal advice pertaining to the seeking of advice from external experts.

Item 7.4: ..... Succumb

Members discussed the issues related to 'live' embryos and those which have 'succumbed'.

The following guidance was endorsed by the Committee"

'An embryo is considered to be a live embryo unless:

- when maintained in suitable culture conditions, the embryo has not undergone cell division between successive observations at least 24 hours apart; or
- the embryo has been allowed to succumb by standing at room temperature for a period of not less than 24 hours.

This guidance will be made available on the NHMRC web site and all relevant documents updated.

Decisions:

The Committee agreed to the guidance of a live embryo, as detailed above.

Secretariat will place this definition on the embryo research web site and update all relevant documents.

Item 7.5: Number of Embryos

The Committee noted the legislative requirement for it to have regard to restricting the number of excess ART embryos to that likely to be necessary to achieve the goals of the activity proposed in the application. It was agreed that the number of excess ART embryos authorised by each licence would be determined on a case by case basis taking into consideration the nature of the proposed activity. In making this determination the Committee will be required to take into account the likely survival rate of thawed embryos but will assume a high proportion of thawed embryos will survive.

The Committee further agreed that the number authorised for use would be the number that could be removed from frozen storage. The licence would also contain the condition that, once the goal of the activity has been achieved, no further embryos can be removed from frozen storage. The licence holder would then be required to report (using the coding system referred to at item 7.1) on the number of embryos used to achieve the goal.

Decisions:
The number of excess ART embryos authorised by each licence will be determined on a case by case basis taking into consideration the nature of the proposed activity and the likely survival rate of thawed embryos.

The number of embryos authorised for use will be the number that can be removed from frozen storage.

The licence will contain the condition that, once the goal of the activity has been achieved, no further embryos can be removed from frozen storage. The licence holder will be required to report (using the coding system referred to at item 7.1) on the number of embryos used to achieve the goal. If the number of embryos allowed to be thawed by the licence proves to be insufficient to complete the activity, the licence holder may apply for a variation of the licence.

7.6: .....Skills and experience of staff using embryos

At the previous meeting it was agreed that applicants would be required to provide a CV for the Principal Supervisor at the time of application. The Committee further discussed the requirements for information about other personnel involved in the activity proposed in the application. It was agreed that the applicant would be required to provide a brief CV for each person involved in the use of the embryos. The licence will then stipulate each individual who is authorised by the licence to use excess ART embryos. It will be a condition of licence that the licence holder must immediately notify the Licensing Committee in writing of any changes to persons for whom permission is sought to use embryos. A CV must be provided and the licence holder must await formal notification of variation before the new individual may commence any work that involves the use of the embryos.

A Working Committee will review additional CVs in the first instance.

Decisions:

CV to be provided for each person involved in the use of excess ART embryos.

The licence will specify each person authorised to use excess ART embryos.

The licence will contain a condition that before any additional person may be involved in the use of embryos the licence holder must seek and obtain a variation to the licence.

A Working Committee will review additional CVs in the first instance.

Item 8: .....Assessment Process

In order to progress applications as quickly as possible, the Committee agreed to the process outlined at agenda item 4.

The Secretariat agreed to incorporate these changes into the workflow diagram and associated checklist provided at Attachments 1 and 2. It was suggested that it might be easier to separate “licence” and “monitoring” into separate charts for easier interpretation.

The NHMRC Secretariat also acknowledged the need to update the existing information found within the four booklets and on the website. The Committee agreed that this process would be beneficial and suggested the addition of a covering letter to stakeholders outlining where changes to the documents have occurred. The Secretariat agreed to circulate changes to the Committee for comment prior to finalisation.

Decision:

The Committee agreed to the assessment process outlined at agenda item 4.

The Secretariat agreed to incorporate these changes into the work flow diagram and associated checklist provided at Attachments 1 and 2, and separate "licence" and "monitoring" into separate charts for easier interpretation.

Secretariat to update NHMRC Booklets 1-4 and circulate to the Committee prior to finalisation.

Item 9: ..... Consideration of Applications

Members were asked to declare any conflict of interest. All declared conflict of interest was dealt with in accordance with NHMRC procedures.

Applications 309701, 309702, 309703

The Committee discussed responses to the questions raised with the applicant.

The Committee continued to be concerned about the process for obtaining consent and the way meetings of the HREC were conducted. The main issues about consent were the timing and content of the information provided to clients and whether consent could be withdrawn after stem cells had been successfully obtained. The Committee noted that the HREC is compliant with the National Statement.

The Committee noted that many questions about the scientific content of the applications remained unanswered. The issue of whether post-5 April 2002 embryos could be used in 309701 is unresolved. The scope of the 6 projects described in 309702 requires a great breadth of scientific expertise. The applicant is to be requested to provide brief CVs for all relevant staff. The scientific content of 309702 is sufficiently diverse that the Committee considered splitting the application into 6 licences but did not make a decision on this issue. On the basis of the information received in response to the questions, the Committee could not see how embryos could be transferred from 309701 to 309702 without compromising the validity of the results for 309701. The Committee considered that the scientific and other goals for 309703 had not been adequately explained. The Committee appointed Dr Graham Kay and Dr Julia Nicholls as the Working Committee (spokespersons) for these applications.

Decisions:

Committee Chair, the Working Committee for these applications and relevant members of the Secretariat will conduct a meeting with the applicant to resolve outstanding issues. Working Committee to report on the outcome of the meeting at the next meeting of the Licensing Committee.

Application 309704

The Committee agreed that the applicant's responses to their questions were satisfactory and decided that, in principle, a licence will be issued.

With respect to the requirements of Section 21 of the *Research Involving Human Embryos Act 2002*, the Committee:

- decided to issue a licence (21(2));
- was satisfied that appropriate protocols are in place to obtain proper consent (21(3)(a)(i)) and ensure compliance with any restrictions on that consent (21(3)(a)(ii));
- noted that the activity will damage or destroy the embryos, and was satisfied that protocols are in place to ensure compliance with the requirement that only embryos created prior to 5 April 2002 are used (21(3)(b));
- was satisfied that the activity had been considered and approved by an HREC in accordance with 21(3)(c);
- had regard to restricting the number of embryos (21(4)(a))
- had regard to the likelihood of the activity being a significant advance (21(4)(b));
- had regard to the relevant guidelines and the HREC assessment of the proposed activity (21(4)(c) and 21(4)(d)).

The Committee discussed the conditions which would be attached to the licence and decided that each member should see and approve the draft licence and covering letter before the final decision is taken to issue the draft licence.

Decisions:

Issue a licence. Secretariat to prepare the licence and conditions with advice from Legal Services Branch and circulate to members.

Applications 309700, 309705, 309706

The Committee queried whether the requirements of the *Research Involving Human Embryos Act 2002* permits use of excess ART embryos for training and/or quality assurance. They considered that the number of embryos requested for training were excessive and have still not been adequately justified. Other avenues for training (eg dead human embryos or mouse embryos) have not been sufficiently explored in the documents provided to the Committee.

With respect to 309706 and the quality assurance aspect of 309705, the Committee queried the necessity for using excess ART embryos for quality assurance activities on several grounds. They considered that since all embryos in culture should be being observed, the information gained from these observations could be used for quality assurance purposes in addition to the primary purpose of treatment of IVF patients. The Committee also considered that the information that would be gained from using 40 embryos per year for quality assurance would be statistically insignificant. The applicant still has not clarified what "site-specific issues" are.

The Committee considered that the consent process needed to place more emphasis on the clinics volunteering oral explanations of the proposed activities instead of the onus being on the client to request those explanations.

The Committee concluded that these applications were still a long way from what is required. Dr Megan Best and Dr Peter Illingworth were appointed as the Working Committee (spokesperson) for these applications. It was agreed that the Chair, the Working Committee and relevant members of Secretariat would visit the applicant to resolve outstanding issues.

The Committee discussed but did not resolve whether these applications (if approved) would result in one licence for training across all of the applicant's sites and another for QA across all sites or whether separate licences are required for each activity at each site to facilitate monitoring.

The Committee concluded that the feasibility of using dead embryos for some aspects of PGD may need to be discussed further with the applicant.

Decision:

Committee Chair, the Working committee for these applications and relevant members of the Secretariat will visit the applicant to resolve outstanding issues.

Working Committee to report on the outcome of the visit at the next meeting of the Licensing Committee.

Item 10: .....Licence

The Secretariat informed the Committee that the draft licence is yet to receive legal opinion. Once advice has been provided the Secretariat will circulate the draft licence to the Committee for comments.

It was agreed that the Committee would reconvene via teleconference once the draft licence has been amended to take account of Member's comments.

Decision:

The draft licence will be circulated for comment once considered by Legal Services Branch. Secretariat will schedule a teleconference to discuss comments arising from the draft licence.

.....

The Director of the Monitoring and Compliance Section informed the Committee that he had been successful in his appointment to the position of Chief Inspector and hopes to appoint two additional inspectors and one analyst by the end of September 2003. The analyst will also be able to provide back up as an inspector if endorsed by the Chairman of the Committee.

The Secretariat will continue with the information seminars for interested stakeholders, with the next session to be held in Brisbane on Monday 4 August 2003.

The Committee was briefed on the NHMRC's progress to engage states in bilateral agreements. To date discussions have taken place with NSW, SA and VIC regarding bilateral agreements and all have indicated that they will accept Commonwealth inspectors without State inspector participation. It is anticipated that bilateral agreement discussions will be conducted with Queensland on 4 August 2003.

The potential need for a Memorandum of Understanding with Statutory Bodies as required was also canvassed.

The Committee was informed that standard operating procedures (SOP's) for inspections of licence holders' premises will be tabled at the next meeting.

Members were asked to comment on the draft of the fifth handbook "General Information about monitoring and compliance with the *Prohibition of Human Cloning Act 2002* and the *Research Involving Human Embryos Act 2002*" before printing and distribution. The booklet will also be placed on the Embryo Research web site when endorsed for publication by the Licensing Committee.

It is anticipated that, once a licence has been issued, the Inspectors will visit the Licence Holder to educate and provide support to ensure they will remain compliant with the licence conditions and the legislation. Inspectors will also be paying particular attention to proper consent and identification tracking of excess ART embryos.

The Committee was interested in occasional representation on inspection visits as a familiarisation exercise to raise member's awareness of the process. The Committee also raised the possibility of accompanying the NHMRC Inspectors on occasional site visits conducted in their State. It was agreed that this approach would be beneficial to building a rapport with IVF groups. The Committee also noted, however, that this would require agreement from the licence holder.

Decisions:

Committee to consider implementation of MOU with Statutory Bodies as required.

NHMRC Secretariat to circulate Booklet 5 for comment before finalisation.

NHMRC Secretariat to table SOPs for inspections of licence holders' premises at the next meeting.

Secretariat to explore the possibility of Committee members occasionally accompanying the NHMRC Inspectors on site visits as a familiarisation exercise.

Item 12: .....Communications

The Director of the NHMRC Communications Unit reinforced the Committee's responsibility to direct all media contact to the Communications Unit in the first instance. The Unit is available at all times should any member have concerns pertaining to contact with the media.

In addition, Ms Manzoney briefed the Committee on current projects being undertaken by the NHMRC, including:

- Media training available for Committee members;
- Unit is currently arranging for the CEO to meet with relevant State politicians;
- Revision of presentations for key stakeholders;
- International Collaboration with the UK Wellcome Trust, MRC in New Zealand;
- E Newsletter, e-mail formatted newsletter being developed for key stakeholders.

Item 13: .....Database

The NHMRC Secretariat provided the Committee with a brief update on the progress of the development of the database. A Business Case is being drafted to incorporate legislative requirements, compliance tools and a specialised reporting function. Once the Business Plan has captured the desired functions of the database, a tender process will be undertaken to seek a specialist to build the software.

The Committee acknowledged that in the interim, information pertaining to licences issues will need to be placed on the website in accordance with the legislative requirements outlined in the *Research Involving Human Embryos Act 2002.*

The Committee acknowledged a need for representatives of the Committee to work in conjunction with the NHMRC to achieve the desired outcomes. Ms Helen Szoke and Dr Christopher Newell will form this working party.

Decisions:

The Committee noted this Item and endorsed Ms Helen Szoke and Dr Christopher Newell would form a working party to work closely with the NHMRC.

Item 14: .....Review and Evaluation

The Committee was reminded of the requirement for an independent review of the legislation, which is due for completion by January 2005. The persons undertaking the review must consult the Commonwealth and the States as well as a broad range of persons with experience of relevant disciplines.

Decisions:

The matter will be placed on the Agenda for the next meeting

Item 15: .....Meeting Schedule

The Chairperson indicated a preference to conduct two-day meetings commencing at 10.00am on the first day and concluding at lunchtime on the second day. The Committee agreed that the following dates would be suitable to conduct NHMRC Licensing Committee meetings:

- Wednesday 10 and Thursday 11 September 2003 in Melbourne;
  (Secretariat note: subsequently changed to 29-30 September)

  Secretariat will also:

  - contact the Minister's office to invite the Minister to meet the Committee; and
  - ascertain whether it would be possible for Members to undertake an orientation visit to one of the Melbourne based ART Clinics.

- Thursday 18 December 2003 in either Melbourne or Canberra

Decisions:

A two-day meeting will be held for meetings with a lengthy agenda – commencing at 10.00am on day one and finishing at midday on day two.

Item 16: ..... Other Business

Accountability in accordance with the *Research Involving Human Embryos Act 2002* was discussed. Members raised the impact of budget on their capacity to meet the objectives of the legislation. It was agreed that, while the Committee has no expenditure delegation, they would be informed in broad terms about the budget allocation for the Secretariat.

Decisions:
Secretariat to provide members with a copy of the budget at the next meeting.

NHMRC LICENSING COMMITTEE

Minutes of the Meeting of 29 and 30 September 2003
Melbourne

10.10 am – 5.45pm Monday 29 September 2003
9.00am – 12.00pm Tuesday 30 September 2003

ATTENDANCE

Members:

Professor Jock Findlay (Chairperson)
Dr Megan Best
Dr Kerry Breen
Professor Don Chalmers
Dr Peter Illingworth
Dr Graham Kay
Dr Christopher Newell
Dr Julia Nicholls
Ms Helen Szoke

Secretariat

Clive Morris (29th only)
Tony Rolfe
Phillip Hoskin
Rhonda Stilling (29th only)
Alison Mackerras

Item 1: ..... Opening

The meeting commenced at 10.10 am. Professor Findlay reminded members that the Minister would join the Committee at 5.00. This would provide an opportunity to discuss the process for appointment of a replacement for Dr Breen (refer Item 3), the role of the Licensing Committee in the review of the legislation and other matters of particular interest to the Committee.

(Secretariat Note: due to portfolio changes announced by the Prime Minister during the day, it was necessary for the Minister to cancel the planned meeting with the Committee).

Item 1.1: .....Confidentiality and Conflict of Interest

Members were reminded of their obligations in respect of confidentiality and conflict of interest.

Item 1.2: .....Chairman's Report

Members noted the Chairman's report to the 149th meeting of Council held on 18-19 September 2003. The Chairman also reported that he had participated in a CREGART Working Party on the review of the ART guidelines, been a member of the Licensing Committee Working Committee that conducted site visits to Sydney and Monash IVF, attended a meeting of Council Management Committee, and undertaken media training.

Item 2: .....Minutes of meeting 30 and 31 July 2003

The Committee endorsed the draft minutes of the meeting of 30-31 July 2003 with the following amendment:

- delete third paragraph of section 7.5 as this discussion is redundant based on other discussions at the meeting.

Decisions:

The minutes were endorsed with two amendments as detailed above.

Item 2.1: .....Action Arising

The schedule detailing action arising and progress on action was noted. Secretariat was asked to place the need for a list of assessors on the agenda for the next meeting.

Decisions:

Requirement for a list of assessors to be placed on the agenda for the next meeting.

Item 3: ..... NHMRC Activities

a) Council Activities

Members noted the report on Council activities prepared by the Council Secretary.

b) AHEC Activities

Dr Breen provided feedback on relevant activity of AHEC:

- CREGART (ART Guidelines) - members to hold discussions with those statutory bodies in all jurisdictions that have made a submission in order to ensure that guidelines are relevant. AHEC will provide a copy of the draft guidelines to the Licensing Committee before finalisation;
- AHEC has responded to the Australian Law Reform Commission Inquiry into Gene Patenting and Human Health.

The need to maintain strong links between the Licensing Committee and AHEC was highlighted.

c) Resignation of Dr Breen

Members noted the impending resignation of Dr Breen and thanked him for his valuable contribution to the work of the Committee. It was noted that Dr Breen's resignation will not take effect until his replacement has been appointed in accordance with the requirements of the legislation.

d) NHMRC Working Committee on Privacy

Members noted the terms of Reference for the NHMRC Working Party on Privacy and that Ms Szoke is a member of this committee. The Working Party will first engage a consultant to undertake an overview of privacy regulation in Australia and overseas. The second phase of the task will involve defining stakeholders. The Committee requested that the list of stakeholders be made available to it once finalised.

e) Business Plan for NHMRC Licensing Committee

Members noted the requirement for the Committee to prepare a Business plan linked to the NHMRC's Strategic plan for 2003-2006. It was agreed that members would provide feedback on the draft business plan, focussing on strategies required to implement the responsibilities of the Licensing Committee. The draft will then be revised and made available for further discussion at the December meeting.

f) Budget

Members noted the budget tabled by the Secretariat. This budget is based on the total funds provided by the government to implement the legislation. It will be reviewed in October 2004.

Decisions:

AHEC to provide a copy of the revised ART Guidelines to the Licensing Committee before finalisation.

With respect to the NHMRC Working Party on Privacy, the list of stakeholders is to be provided to Members when it is finalised.

Members will provide comment on the draft Business Plan. Secretariat will then provide a revised draft for discussion at the December meeting.

Item 4: ..... Development of Procedural Guidelines

Item 4.1: .....Consent

Members noted that the joint Licensing Committee/AHEC Working Committee held a teleconference to finalise the draft paper on consent, and that this draft had been considered by AHEC at its meeting of 24-25 September 2003. Dr Breen provided feedback on AHEC's consideration of the draft. A further meeting of the joint Working Committee will be held to resolve AHEC concerns. AHEC will then be asked to endorse the paper out of session. Given the need for expediency, it was

agreed to attempt to have both Committees sign off on the paper out of session within the shortest possible timeframe.

The joint working Committee will also draft a checklist for use by applicants. This will be based on the final document.

Decisions:

The joint Licensing Committee/AHEC Working Committee will meet as soon as possible to resolve AHEC concerns with the draft paper, allowing both Committees to then endorse the paper out of session.

Joint Working Committee also to draft a checklist for use by applicants.

Item 4.2: ..... Likelihood of Significant Advance

This matter was discussed in conjunction with Item 5.

Item 4.3: ..... Number of Embryos

The Committee acknowledged that not all of embryos thawed would be suitable for use in the licensed activity. It was agreed, however, that the Committee will approve the number of embryos that can be thawed for use in the licensed activity. If the licence holder subsequently finds that insufficient embryos are suitable for use, it will be necessary to seek a variation to the number approved by the licence. The request for a variation would need to provide justification for any increase sought.

Members noted that the licence holder will be required to record an outcome for each embryo that is thawed, and to report on the outcome for each embryo.

It was agreed that the application form will be revised to require the applicant to indicate the number of embryos that they wish to thaw and the number that they anticipate will be suitable for use.

Decisions:

The Committee will approve the number of embryos that can be thawed for use in the licensed activity. If the licence holder subsequently finds that insufficient embryos are suitable for use, it will be necessary to seek a variation to the number approved by the licence. The request for a variation would need to provide justification for any increase sought.

The application form will be revised to require the applicant to indicate the number of embryos that they wish to thaw and the number that they anticipate will be suitable for use.

Item 5: .....Assessment Process

Members noted the revised assessment process as reflected in the flow chart and checklist. It was agreed that the inclusion of horizontal segments delineating initial secretariat responsibility, Working Committee tasks and full Committee consideration within the flow chart would aid clarity. The Committee also agreed that appropriate Secretariat assistance for applicants throughout the process is essential.

The Secretariat will make editorial amendments suggested by the Committee. This process will be applied to the receipt and consideration of all future applications. Future amendments to the process will be made to address any gaps or inefficiencies, as they become apparent.

Members considered legal advice about the use of external experts in the consideration of applications to assist in the Committee when determining the likelihood of a significant advance in knowledge or improvement in technologies. This advice was provided by the Department's Legal Services Branch.

Secretariat was asked to obtain additional legal advice to:

- clarify whether section 30 of the Research Involving Human Embryos Act 2002 is different to the confidentiality requirements binding the NHMRC;
- determine whether it would be necessary to divulge to the applicant the identity of the assessor;
- ascertain the feasibility of a model based on the establishment of a standing Working Committee with the task of providing advice to the Licensing Committee about the likelihood of a significant advance in knowledge or improvement in technologies. This Working Committee would comprise **all** experts appointed to it by the Licensing Committee. While the full membership of the Working Committee would be publicly known, the identity of those used in relation to any particular application would not be divulged.

Decisions:

The process outlined in the flow chart and associated checklist will be applied to the receipt and consideration of all future applications.

Secretariat to seek additional legal advice as detailed above.

Item 6: ..... Review of the Information Booklets/Application Form

The Secretariat informed the Committee that the existing four information booklets, and any future documents, would be revised/written with the assistance of a technical editor to ensure consistency of style, format etc. It is also envisaged that rather than a series of separate documents, the information would be incorporated as chapters in a single loose-leaf manual. This will facilitate the addition of further material and replacement of sections as they are updated.

Members acknowledged the need for continuous evaluation of the material provided in this manual. It was agreed that a feedback sheet/s should be incorporated in the manual to allow users to input into this evaluation process.

Decisions:

The Committee will ensure that all published material will be evaluated regularly to ensure continued validity and relevance. Feedback sheets will be incorporated in all information manuals.

Item 7: .....Monitoring and Compliance

Item 7.1: Progress of the Monitoring and Compliance Section

Members noted the paper provided and the progress outlined by the Secretariat. It was suggested that it would be useful for the Section to arrange visits to any groups that were identified through the information sessions as having a strong interest in this matter.

The Secretariat provided an update of progress with corresponding State laws.

Decisions:

Monitoring and Compliance Section to establish a program of visits to those groups that were identified through the information sessions as having a strong interest in any activity relevant to the legislation.

Item 7.2: .....Analyst/ Project Manager

Members noted the appointment of Ms Jenny Simpson as the Analyst/Project Manager to the Monitoring and Compliance Section.

Item 7.3: .....Senior Inspector

Members noted the appointment of Dr Harry Rothenflugh as the Senior Inspector to the Monitoring and Compliance Section.

Item 7.4: .....ISO 9001: 2000

Members noted the intention of the Monitoring and Compliance section to implement a Quality Management System under ISO 9001:2000.

Item 7.5: Standard Operating Procedures

Members endorsed the draft Licence Inspection Standard Operating Procedures, noting that these are for internal use only. In the area of post-inspection procedures, the Committee indicated that the final draft report should be submitted to the Branch Head and Chair of the Licensing Committee before being submitted to the full Licensing Committee.

Decisions:

Members endorsed the Licence Inspection Standard Operating Procedures with the following amendment:

- in the area of post-inspection procedures, the final draft report should be submitted to the Branch head and chair of the Licensing Committee before being submitted to the full Licensing Committee.

Item 7.6: Monitoring Procedures for Inspections and Audits of Licence Holders; and

Item 7.7: Compliance Procedures for Human Cloning

These items were discussed together. The Committee expressed concern about the tone of these documents. It was agreed they must reflect a balance between legislated responsibilities and acknowledgment of what the legislation allows. It was agreed that this concern will be addressed with the assistance of the editor responsible for the revision of the earlier documents – refer Item 6. In addition, a fifth document will be prepared to bridge the transition between advice given about making an application (the existing document 4) and the information about inspections and audits of licence holders and prohibited practices.

This fifth document will provide useful information to licence holders. It could, for example, include information about:

- when licensed activities may commence;
- how to inform the licensing committee that consent has been obtained;
- how to seek a variation to a licence;
- the information about the licence that will be made publicly available and where this information can be accessed;
- who to contact with queries about the license;
- reporting requirements;
- the availability of the Monitoring and Compliance Section to assist with procedures to ensure that licence holders are able to comply with licence conditions.

The Secretariat will draft this document in consultation with the Monitoring and Compliance Section and provide a draft to members for comment.

Comments on Inspections and Audits of Licence holders and Compliance Procedures for Human Cloning were noted. Further comments can be forwarded to the Secretariat.

Decisions:

Secretariat to reconsider the tone of the language used in the documents titled 'Inspections and Audits of Licence Holders' and 'Compliance Procedures for Human Cloning' and prepare a further document that will bridge the transition between advice given about making an application (the existing document 4) and the information about inspections and audits of licence holders and prohibited practices.

Members noted the summary of members' comments on the draft documents, and discussed each comment. Secretariat will now finalise the document based on this discussion.

Draft letters of advice were approved by the committee.

Decision:

License to be finalised by Secretariat based on feedback from the Committee. Each individual licence will be forwarded to the Committee for clearance before it is issued.

Draft letters of advice were approved.

Item 9: ..... Consideration of Applications

Members were asked to declare any conflict of interest. All declared conflicts of interest were dealt with in accordance with NHMRC procedures.

Item 9.1: .....Applications 309701, 309702,309703

The Committee commended the applicant on the time and effort they had put into revising the applications.

309701
The revised application addressed many of the issues raised in earlier rounds and at the site visit. The project described in the new application will investigate fewer compounds and thus requires fewer embryos. The Committee acknowledged that the applicant had attempted to incorporate their requirements into the consent and Participant Information documents. The Committee concluded that the most effective way to resolve the outstanding questions would be for the spokespersons to visit the applicant again. This meeting was to occur on 10 October 2003.

309702
The Committee considered that the revised application justified the proposed activities far more successfully than the earlier versions had done but there were still some questions that had not been satisfactorily resolved. As with 309701, the Committee concluded that the most effective way to resolve the outstanding questions would be for the spokespersons to visit the applicant again.

309703
The Committee considered that the rewritten application addressed their previous concerns about this project. There were a few minor details in the Stage 1 Participant Information and Consent Form that still needed to be changed.

The Committee concluded that, subject to the amendments being made to the Stage 1 documents, a licence would be issued for this project.

With respect to the requirements of Section 21 of the *Research Involving Human Embryos Act 2002*, the Committee:

- decided to issue a licence (21(2));
- was satisfied that appropriate protocols are in place to obtain proper consent (21(3)(a)(i)) and ensure compliance with any restrictions on that consent (21(3)(a)(ii));
- noted that the activity will damage or destroy the embryos, and was satisfied that protocols are in place to ensure compliance with the requirement that only embryos created prior to 5 April 2002 are used (21(3)(b));
- was satisfied that the activity had been considered and approved by an HREC in accordance with 21(3)(c);
- had regard to restricting the number of embryos (21(4)(a))
- had regard to the likelihood of the activity being a significant advance in knowledge or improvement in technologies (21(4)(b));
- had regard to the relevant guidelines and the HREC assessment of the proposed activity (21(4)(c) and 21(4)(d)).

Members noted that it is difficult to say how many embryos would be required to yield a given number of stem cell lines. They determined that the applicant would use half the permitted number of embryos and then report progress to the Committee. The Committee agreed that the applicant would be authorised to thaw a total of 50 embryos in connection with this licensed activity.

Decisions:

The spokespersons will visit the applicant again to resolve outstanding questions related to applications 309701 and 309702.
Subject to satisfactory amendment of the Stage 1 Consent and Participant Information documents, a licence will be issued for application 309703.

Item 9.2: .....Applications 309700, 309705, 309706

Members noted the revised documents provided by the applicant and that the applications to use excess ART embryos for Quality Assurance purposes (309706 and part of 309705) had been withdrawn.

The Committee reiterated their decision from the first meeting that some aspects of 309700 are not part of training and should be submitted as a separate application.

Some members expressed the view that training activities don't meet the criteria of the Act with respect to "significant advance in knowledge or improvement in technologies." Secretariat was asked to seek a legal opinion on the use of use of excess ART embryos for training purposes and to inform the applicant that no further action is required pending resolution of this issue.

The Committee did not reach a decision about the applications for use of excess embryos for training (309700 and part of 309705).

Decisions:

The withdrawal of the QA application should be acknowledged. The applicant should be requested to submit a separate application for those aspects of 309700 not related to the training activity.

Secretariat to seek a legal opinion on the use of use of excess ART embryos for training purposes and inform the applicant that no further action is required pending resolution of this issue

Item 9.3 Application 309704

The Committee noted that the applicant had provided CVs as requested.

The Committee decided that, as general policy, the description of the activity at Item 7 of the licence should be a plain English statement of about 100 words that accurately reflects the licensed activity. The statement should be prepared by the Secretariat in consultation with the applicant. It was noted that the reporting dates were chosen to mesh with the preparation of the report to Parliament.

The Secretariat are to progress the finalisation of the licence as soon as possible.

Decision:

The licence is to be finalised. The description of the activity at Item 7 of the licence should be a plain English statement of about 100 words that accurately reflects the licensed activity and that the Secretariat should work with the applicant to decide the wording for the statement.

Item 9.4 New Applications 309707

This item was added to accommodate information about recently received applications. The Secretariat has received Application 309707 . Professor Chalmers and Dr Kay were appointed as the spokespersons for this application. Since the embryos will be provided by an exisiting applicant the consent process uses the documents already discussed in the context of those applications. For this reason Dr Best will also be a spokesperson for the application.

Members noted that two further applications are pending (309708 and. 309709).

Decision:

A Working Committee comprised of Professor Chalmers, Dr Kay and Dr Best was appointed to continue assessment of Application 309707.

Item 10: .....Communications

Members were advised that a contractor will be appointed before December to help with communication activities.

Item 11: .....Database

Members noted the information provided.

Item 12: .....Review and Evaluation of Legislation

The Secretariat informed the Committee about the process to be used for the review of the legislation. This will be an independent review, with the Licensing Committee expected to contribute to the review. It was agreed that the Chairman would attempt to arrange a meeting with the new Minister to discuss the review of the Act and the activities of the Licensing Committee.

Members requested that a record of issues/difficulties with the legislation be maintained to ensure that the Committee's submission to the review reflects these concerns.

Decisions:

The Chairman will attempt to arrange a meeting with the new Minister to discuss the review of the Act and the activities of the Licensing Committee in the review of the legislation.

Secretariat to maintain a record of issues highlighted by the Committee.

Item 13: .....Meeting Schedule

Members noted the dates of the next two meetings (18-19 December 2003 and in conjunction with the joint Council and Principal Committee meeting on 17 March 2004). Members requested that proposed dates for other meetings in 2004 be circulated soon so that the dates can be finalised as soon as possible. Members also requested that the dates of meetings be communicated to applicants.

Dr Newell gave his apologies in advance for the Council meeting (and associated Licensing Committee meeting) on 17 March 2004.

Decisions:

The Secretariat is to circulate proposed meeting dates for next year as soon as possible.

Item 14: .....Information Items

Item 14.1: ... Australian Law Reform Commission Inquiry – Gene Patenting

The Secretariat informed the Committee that a wide range of input had been discussed by Council at its meeting of 18-19 September 2003. Council has agreed that its submission to the Inquiry will address themes/areas of weakness and highlight significant issues. The draft submission will be circulated to all Committee members.

Item 14.2: ..... Discussion of Options for Establishment of a Stem Cell Bank

Dr Morris informed the Committee of the background to the paper discussing options for a National Stem Cell Bank or Register in Australia. Members noted that this was a training exercise conducted by a group of graduates recently appointed to the Department's staff.

Item 15: ..... Other Business

Members noted that the next report on Committee activities must be tabled in Parliament on or before 31 December 2003. The report will be based on the previous report and a draft will be circulated for comment as soon as possible after 31 October 2003. Members agreed that the level of detail about applications would be similar to that provided on the public database.

The meeting concluded at 12 pm on 30 September 2003.

The next meeting will be held in Canberra on 18-19 December 2003.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2003-2004, 5 November 2003

Question: E03-062

OUTCOME 9: Health Investment

Topic: NHMRC Licensing Committee

Written Question on Notice

Senator Harradine asked:

(a) Have the inspectors commenced inspecting premises? If so have they detected any breaches of the legislation and what were those breaches? Please provide further details and copies of their reports.

(b) Have any breaches been referred to the Australian Federal Police?

(c) Has the Licensing Committee developed a definition of "succumb"? If so, what is it?

Answer:

(a) NHMRC Inspectors are visiting IVF clinics and research organisations in order to exchange information and increase awareness of the requirements of the *Research involving Human Embryos Act 2002* and the *Prohibition of Human Cloning Act 2002*.

(b) No breaches have been identified.

(c) The Embryo Research Licensing Committee of the NHMRC has determined that:

An embryo is considered to be a live embryo unless:

- When maintained in suitable culture conditions, the embryo has not undergone cell division between successive observations not less than 24 hours apart, or
- The embryo has been allowed to succumb by standing at room temperature for a period of not less than 24 hours.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2003-2004, 5 November 2003

Question: E03-063

OUTCOME 9: Health Investment

Topic: NHMRC Licensing Committee

Written Question on Notice

Senator Harradine asked:

(a) I note the Licensing Committee has been working on a report on the reporting requirements contained in the relevant legislation. Please provide a copy of the report.

(b) I note that the Licensing Committee is developing a communications strategy. What is the extent of its dialogue with interest groups? Which interest groups are involved? Please provide a copy of the strategy.

(c) I note that the Licensing Committee has been developing its database. When will the public have access to aspects of the database on the Internet?

Answer:

(a) Section 19 (3) of the *Research Involving Human Embryos Act (2002)* requires that the NHMRC Licensing Committee cause a report to be tabled in either House of Parliament on or before 30 June of each year; and 31 December of each year. The first two reports have been tabled.

(b) While the Licensing Committee has discussed the development of a communications strategy, it is in the formative stages of development. Officers from the NHMRC Secretariat held information exchange sessions with potential applicants and members of Human Research Ethics Committees in Adelaide, Melbourne, Sydney, Brisbane and Perth.

(c) The public will have access to the information specified in the legislation when a licence is issued by the Licensing Committee. These details will be available on the NHMRC website.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2003-2004, 5 November 2003

Question: E03-064

OUTCOME 9: Health Investment

Topic: NHMRC Licensing Committee - Applications

Written Question on Notice

Senator Harradine asked:

How many applications have been received by the Licensing Committee? Please provide a list of all applications, including the names of the institutions making the application. Please provide a list of all applications approved, including the names of the institutions making the application.

Answer:

The Licensing Committee has received ten applications.

The Licensing Committee has determined, in the interests of confidentiality and privacy, to not release any specific details about individual applications.

The Licensing Committee has not yet issued any licences.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2003-2004, 5 November 2003

Question: E03-065

OUTCOME 9: Health Investment

Topic: EXPERT COMMITTEE ON HUMAN EMBRYO AND STEM CELL RESEARCH

Written Question on Notice

Senator Harradine asked:

(a) Has the Expert Committee on Human Embryo and Stem Cell Research been established yet? If so, please provide a list of its members.

(b) Has the Expert Committee on Human Embryo and Stem Cell Research provided advice to the NHMRC? If so, please provide a description of the advice and copies of the advice.

Answer:

(a) As outlined in the response to Question E03-068, the NHMRC did not establish the Committee referred to in this question. However, the role and membership of the Gene and related Therapies Research Advisory Panel (GTRAP) has been expanded to include human stem cell research.

The membership of the core group of GTRAP and the members of GTRAP's Human Stem Cell Research Expert Group is included below:

CORE GROUP	
Prof R J A Trent (Chair) Prof Lyn Beazley (Deputy Chair) Assoc Prof Annemarie Hennessy Sister R Dunne RSM	Mr C Coyne [AHEC Nominee] Prof J Pittard [GTTAC Nominee] Dr G Dickson [TGA Nominee]
HUMAN STEM CELL RESEARCH EXPERT GROUP	Assoc Prof P Simmons Prof P Bartlett

(b) No.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2003-2004, 5 November 2003

Question: E03-068

OUTCOME 9: Health Investment

Topic: Expert Committee on Human Embryos and Stem Cell Research

Written Question on Notice

Senator Harradine asked:

(a) In answer to Question E03-031 (a) the Department referred to revised terms of reference for the establishment of the Expert Committee of the Research Committee of the NHMRC. Please provide a copy of the revised terms of reference.

(b) What was the reason for changing the name of the expert committee from "Expert Committee on Human Embryo and Stem Cell Research" to "Expert Committee on Human Stem Cell Research"?

(c) The answer to E03-031 (a) states that the expert committee will be reconstituted for the 2003-06 Triennium. When will this reconstitution take place? What is the process for appointments to the Expert Committee (for example, are the appointments advertised)? What is the proposed budget for the Expert Committee?

Answer:

(a) Following the start of the new triennium in May 2003, the Research Committee decided that rather than establishing a new stand alone committee, it would restructure the membership and terms of reference of its Gene and related Therapies Research Advisory Panel (GTRAP) to include the required expertise. GTRAP is an expert committee established as a working committee of the Research Committee.

The Terms of Reference for GTRAP are:

"GTRAP is a subcommittee of the Research Committee, a principal committee of the NHMRC. GTRAP reports directly to the Research Committee although it maintains an active link with AHEC through the NHMRC secretariat and a member in common.

Through the NHMRC Research Committee, GTRAP:

- Provides advice to Council on scientific, medical and technical issues related to gene and related therapies, xenotransplantation and human stem cell research;

- Provides scientific, medical and technical advice to HRECs, scientists and other interested parties during the formulation and ethical review of research in gene and related therapies, xenotransplantation and human stem cell research. In relation to human stem cell research this would be limited to those cells that fall within the scope of the proposed Class 3 risk category outlined by the Therapeutic Goods Administration in their Discussion Paper 'The Regulation of Human Tissues and Emerging Biological Therapies';
- Functions as a source of information on gene and related therapies, xenotransplantation and human stem cell research to the public and other interested parties;
- Maintains a register of research trials in which gene therapy or a related technology including xenotransplantation has been used."

(b) Prior to the establishment of the Licensing Committee, the NHMRC considered that an expert committee was needed to provide authoritative technical advice to Council, researchers, ethics committees and other interested parties on scientific aspects of human embryos and stem cell research. Consistent with the passage of the *Research Involving Human Embryos Act 2002*, and the subsequent establishment of the NHMRC Licensing Committee, Council revised the terms of reference for the proposed expert committee to cover only human stem cell research.

(c) See the answer to part (a) above.

Appointments to the Expert Panel are made in consultation between the Chair of GTRAP and the Chair of the Research Committee, having regard to the expertise of the potential nominees. Full details of the membership of GTRAP are available through the NHMRC's website - http://www.nhmrc.gov.au/research/gtrap/about.htm#memberships.

The Expert Panel does not have a budget separate from that of GTRAP. GTRAP met for the first time for the new Triennium on 17 October 2003. A working budget for GTRAP is not yet finalised.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2003-2004, 5 November 2003

Question: E03-066

OUTCOME 9: Health Investment

Topic: Human Research Ethics Committees

Written Question on Notice

Senator Harradine asked:

In question E03-073 (a) (June 2003) I asked for an explanation of why its has been decided that HREC work should not be open to the public. An answer was provided that explained what the NHMRC has advised HRECs, but not the rationale behind why a framework has not been established to require HRECs to be more transparent. Please answer the question.

Answer:

Institutions which establish Human Research Ethics Committees (HRECs) are responsible for determining the manner in which an HREC works. This includes the need to be cognisant of any administrative or legislative requirements within their jurisdiction. For this reason NHMRC has not been prescriptive about the way in which an HREC should publicise or report its work. Paragraph 2.2 of the *National Statement on Ethical Conduct in Research Involving Humans* (1999) contains the appropriate reference.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2003-2004, 5 November 2003

Question: E03-067

OUTCOME 9: Health Investment

Topic: Review of the Customs Regulation ban on export of Human Embryos

Written Question on Notice

Senator Harradine asked:

I have asked at two previous estimates committees about the inter-departmental review of customs regulation ban of export of human embryos, but answers in some cases were either not available or not given.

(a) What are the terms of reference of the committee?

(b) What are the names of the officers on the committee and their departmental affiliations?

(c) I understand that the committee met for the first time on 25 July, but without terms of reference. How does a committee know what it should usefully do if it does not have terms of reference?

(d) Please provide me with copies of the minutes for the 25 July meeting and any subsequent meetings.

(e) I refer to my earlier question (E03-269 (d)), what is the aim of the review ie. will it be focused on achieving an ethical outcome, advancing the research interests of scientists in this area or a commercial outcome?

(f) What is the committee's work plan? What is the timeline it is following to develop recommendations for Ministers?

Answer:

(a) The terms of reference for the Committee are to:

- Review the current operations of the Customs (Prohibited Exports) Regulations 1958 as they relate to human embryos;
- Provide options to Ministers**,** before the end of 2003, for the longer-term regulation of the export of human embryos, that are consistent with the *Prohibition of Human Cloning Act 2002* and the *Research Involving Human Embryos Act 2002*, taking account of the impact of those options on people and organisations that may be affected;

- Review and provide advice to Ministers on the operations of the Customs (Prohibited Imports) Regulations 1956 as they relate to the prohibition on the import of viable materials derived from human embryo clones, 12-months following implementation of that ban. In consultation with Ministers, provide advice to the persons undertaking the review of the Prohibition of Human Cloning Act 2002; and
- Provide advice on other relevant matters as required by Government.

(b) The officers on the Committee are acting in an official capacity as representatives of their departments. The views they express are not personal views. To disclose their names would unreasonably infringe on their privacy. The Committee comprises representatives from the following Commonwealth Departments and organisations:
- Department of the Prime Minister and Cabinet;
- Department of Industry, Tourism and Resources;
- Department of Foreign Affairs and Trade;
- Attorney-General's Department;
- Australian Customs Service;
- Department of Health and Ageing (Portfolio Strategies Division and Therapeutic Goods Administration); and
- NHMRC.

(c) The Committee met on 25 July to develop draft Terms of Reference for consideration by Ministers.

(d) The minutes contain preliminary discussion of advice that will be provided to Ministers. Public disclosure of such discussion would be premature and could create a misleading impression as to matters that will be considered, and the decision that will be made by Government.

(e) It is anticipated that the review will consider the current arrangements for the exportation of human embryos and provide advice to relevant Ministers relating to long-term arrangements for the exportation of human embryos. Advice will take into account the broad range of interests and priorities relating to this issue, so that Government can make a balanced decision that takes into account the needs of affected individuals and organisations. It is also anticipated that the IDC will review the ban on the importation of viable materials from human embryo clones, 12 months following its implementation.

(f) The Committee's task is to provide advice to relevant Ministers relating to long-term arrangements for the exportation of human embryos prior to the sunset of the current regulation in March 2004.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2003-2004, 5 November 2003

Question:E03-053

OUTCOME 9: Health Investment

Topic: DONOR CONCEPTION ISSUES

Written Question on Notice

Senator Harradine asked:

(a) Does the Department acknowledge inconsistencies in the recognition of the rights of donor offspring to have medical and personal information about their donor? For example, only Victoria provides access to identifying information on donors and acknowledges in legislation the right for children conceived through donor insemination to know their genetic and medical histories.

(b) Does the Department have any role in trying to have nationally consistent uniform legislation so that biological parentage can be established regardless of where a person's conception took place?

Answer:

(a) Yes. The Department acknowledges inconsistencies in the recognition of the rights of donor offspring to have medical and personal information about their donor.

(b) No. Health Ministers decided in July 2000 that each jurisdiction would work independently to legislate assisted reproductive technology.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2003-2004, 5 November 2003

Question: E03-055

OUTCOME 9: Health Investment

Topic: DONOR CONCEPTION ISSUES

Written Question on Notice

Senator Harradine asked:

All states except for Victoria allow for the importation of gametes from other states and from overseas. Sperm can and is being transferred from state to state and from countries such as the UK and Denmark. This makes it even more difficult for donor offspring to trace their biological origins. Is the Department doing anything to rectify this situation?

Answer:

No. Health Ministers decided in July 2000 that each jurisdiction would work independently to legislate assisted reproductive technology.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2003-2004, 5 November 2003

Question: E03-054

OUTCOME 9: Health Investment

Topic: NATIONAL BIOETHICS CONSULTATIVE COMMITTEE

Written Question on Notice

Senator Harradine asked:

As the Department would know records concerning donor conception can be legally destroyed after a specific time, in most states there is no legal requirement to keep records.

(a) Does the Department accept the recommendation in Reproductive Technology, the National Bioethics Consultative Committee final report to the Australian Health

Minister (August 1989) that "…existing and future information and records concerning offspring conceived as a result of gamete donation should be kept indefinitely"?

(b) Is the Department or any of its agencies carrying out any work to ensure records are kept?

Answer:

(a) No. The Department has no comment on the recommendation contained in the 1989 report to Health Ministers by the National Bioethics Consultative Committee. Health Ministers decided in July 2000 that each jurisdiction would work independently to legislate assisted reproductive technology.

(b) No. The *Privacy Amendment (Private Sector) Act 2000* requires private sector organisations to destroy or permanently de-identify personal information that is no longer needed for any authorised use or disclosure under the legislation. Some States and Territories regulate retention periods for health information held by health service providers in their public and/or private sectors. The Department has no statutory authority in this area.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2003-2004, 5 November 2003

Question: E03-185

OUTCOME 9: Health Investment

Topic: Biotechnology Australia Stem Cell Fact Sheet 26

Hansard page CA83

Senator Harradine asked:

What involvement did the NHMRC have in the preparation of the Biotechnology Australia Fact Sheet 26 and which area of the NHMRC was involved?

Answer:

Biotechnology Australia initiated an update of the Fact Sheet in May 2003. Biotechnology Australia sought feedback from the NHMRC Centre for Compliance and Evaluation on the revised Fact Sheet. Some minor changes were made by the NHMRC which were included prior to the Fact Sheet being placed on the Biotechnology Australia website.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2003-2004, 5 November 2003

Question: E03-123

OUTCOME 9: Health Investment

Topic: MORE DOCTORS FOR OUTER METROPOLITAN AREAS

Written Question on Notice

Senator McLucas asked:

This program was announced in the 2002-03 Budget, with a total of $80 million over 4 years.

(a) As initially outlined in the 2002-03 Budget papers, how much money was spent on this program?

(b) How many doctors were attracted to outer metro areas?

(c) Please provide a breakdown by GP and speciality.

(d) Please provide the geographic locations to which these doctors went.

This year the focus of this program was changed, with relocation incentive grants provided to doctors moving to outer metro areas.

(e) How much money has been spent on this new focus of the program?

(f) How many doctors have been attracted to outer metro areas under this version of the program?

Please provide a breakdown of these numbers by:

(i) GP vs specialists

(ii) Geographic location where doctors went

(iii) Established practices vs new practices

Answers:

(a) It is estimated that around $1.8 million will be spent by the end of 2003 on programs included in the More Doctors for Outer Metropolitan Areas measure at the time of its announcement in the 2002-03 Budget.

(b) As at 26 November 2003, 29 doctors have relocated to outer metropolitan areas under these programs. In addition, 23 general practice trainees (registrars) undertook a training placement in outer metropolitan areas in the first half of 2003 and a similar number are undertaking such placements in the second half of the year.

(c) All of the doctors concerned were general practitioners or general practice registrars with the exception of one who was a specialist trainee.

(d) The 29 doctors have relocated to outer metropolitan areas in the following States:

New South Wales	8
Queensland	13
Victoria	4
Western Australia, South Australia, Tasmania*	4

The 23 registrars who undertook placements in the first half of 2003 worked in outer metropolitan areas in the following States:

New South Wales	4
Queensland	3
Victoria	6
Western Australia	5
South Australia and Tasmania*	5

(e) As of 26 November 2003, around $1 million has been spent on the Relocation Incentive Grant Scheme.

(f) As of 26 November 2003, 103 doctors have been approved to access the Relocation Incentive Grant, including the 29 doctors referred to at (b) above.

i) The 103 approved doctors consist of 96 general practitioners and 7 specialists.

ii) The 103 approved doctors have relocated, or are relocating, to outer metropolitan areas in the following States:

New South Wales	22
Queensland	30
Victoria	36
Western Australia	10
South Australia & Tasmania*	5

iii) 68 of the doctors have been approved to join established practices and 35 doctors have been approved to establish new practices.

*For privacy reasons, participation rates for States are combined where the number of doctors in a particular State is less than 3.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2003-2004, 5 November 2003

Question: E03-143

OUTCOME 9: Health Investment

Topic: MULTIDISCIPLINARY CARE

Written Question on Notice

Senator McLucas asked:

The National Breast Cancer Centre has completed a 3 year study on the impact, acceptability and cost of implementing strategies to increase multidisciplinary care. This report was submitted to the Minister in August.

(a) When will the report be released?

(b) When will the Minister announce the Government's response to this report?

(c) Is the Minister committed to multidisciplinary care for cancer patients?

(d) If so, what actions will he take to ensure that radiology treatment is more readily available to cancer patients?

(e) What progress has been made on addressing the recommendations of the report on the shortage of radiology services completed fourteen months ago by Peter Baume?

Answer:

(a) The National Breast Cancer Centre released the report on 26 November 2003.

(b) The report is currently informing the development of a National Service Improvement Framework for Cancer. This National Service Improvement Framework will reflect the patient journey and pathways of care, and will aim to identify ideal care, current care and critical intervention points. The Minister will consider the recommendations of the report within the context of the National Service Improvement Framework.

(c) The Minister is committed to providing evidence-based health care for all Australians. Multidisciplinary care will be an important component of the National Service Improvement Framework for cancer.

(d) Over the past year, the Australian Government has assisted many States and Territories to improve access to cancer services with funding for radiotherapy services including:

- $12 million towards a new cancer treatment centre in Traralgon, Victoria and the expansion of the existing Geelong radiotherapy centre;
  - up to $8 million towards the establishment of a new private radiotherapy service in Toowoomba, Queensland;
  - $6 million to Western Australia for radiotherapy equipment and improved access for regional patients;
  - $3.2 million to increase the number of radiation therapy students by 50% across both the 2002 and 2003 intakes and approximately $1 million towards a range of other workforce projects; and
  - $150,000 to the Northern Territory to study the feasibility of a radiotherapy service in Darwin.

This funding is from the '*Better treatment for cancer patients – radiation oncology*' 2002-03 Budget measure, totalling $72.7 million over four years. As a result of this expenditure more patients will be able to have radiotherapy and cancer treatment closer to their homes.

(e) The Australian, State and Territory Governments have announced continued and increased action to improve radiotherapy services for cancer patients.

This is a major step in responding to the report of the Baume Inquiry into Radiation Oncology that was commissioned by the Australian Government and released in 2002.

Addressing the five key actions identified by the Baume Inquiry, Health Ministers have agreed to:

- work together to reduce fragmentation in radiotherapy, and continue to implement reforms to the radiotherapy sector already commenced;
- implement a service development framework for radiation oncology, which will enable a systematic, national approach to making staff and equipment available to meet demonstrated need;
- individual State and Territory strategies to raise awareness of Patient Travel Assistance Schemes that are available to radiotherapy patients and a range of actions to help patients to access those schemes;
- develop and implement projects to address workforce shortages, which are currently the main impediment to better patient access; and
- the development of a comprehensive quality program for all radiation oncology services.

This response has been developed by the intergovernmental Radiation Oncology Jurisdictional Implementation Group (ROJIG), whose report was endorsed at the Australian Health Ministers' Conference on 28 November 2003.

The report also provides a full response to the 96 recommendations of the Baume Inquiry.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2003-2004, 5 November 2003

Question: E03-193

OUTCOME 9: Health Investment

Topic: A FAIRER MEDICARE - ADDITIONAL MEDICAL SCHOOL PLACES

Written Question on Notice

Senator Stott Despoja asked:

Has the Department considered any changes to this scheme in light of public opposition by medical students to this policy?

Answer:

As part of the MedicarePlus package, the Government announced that students taking up one of the new places under the Bonded Medical Places Scheme will be permitted to count up to three years vocational training undertaken in rural areas towards meeting the six year bonding requirement. Under the original A Fairer Medicare package, only work undertaken following completion of vocational training counted for this purpose.