ACT Government | ACT Health

Our reference: **ACTHDFOI24-25.13**

[redacted]

Dear [redacted],

DECISION ON YOUR ACCESS APPLICATION

I refer to your application under section 30 of the *Freedom of Information Act 2016* (FOI Act), with the revised scope received by the ACT Health Directorate (ACTHD) on **Wednesday 12 March 2025.**

This application requested access to:

> *'All digital communications between directorate senior executives*, directorate liaison officers or ministerial liaison unit staff/ministerial and government relations staff (where applicable) and any ACT Minister and/or their staff. This request is for advice sent and received during the period covered by caretaker conventions in 2024, that being between 13/09/2024 and 06/11/2024 inclusive.*
> *Excluded information: Matters relating to individual constituent queries (including businesses and other members of the public), material referred on from MLAs, administrative material (eg, room bookings, HR and corporate support), and handwritten conversation notes.*
> **Senior Executives means any staff employed at the Senior Executive Service level.'*

I am an Information Officer appointed by the Director-General of ACTHD under section 18 of the FOI Act to deal with access applications made under Part 5 of the Act. ACTHD was required to provide a decision on your access application by **Wednesday 11 June 2025**, which included the 15-day extension to which you agreed.

I have identified 105 documents holding the information within scope of your access application. These are outlined in the schedule of documents included at Attachment A to this decision letter.

Decisions

I have decided to:

- grant full access to 37 documents; and
- grant partial access to 68 documents.

My access decisions are detailed further in the following statement of reasons and the documents released to you are provided as Attachment B to this letter.

In reaching my access decision, I have taken the following into account:

- The FOI Act;
- The contents of the documents that fall within the scope of your request;
- The views of relevant third parties; and
- The *Human Rights Act 2004*.

Full Access

I have decided to grant full access to the documents at references 2, 9, 11-15. 18-19, 21-25, 28-29, 34, 36-37, 51-52, 56, 58, 64, 68-69, 76, 80-83, 85, 95-96, 99, 101 and 103.

Partial Access

I have decided to grant partial access to the documents at references 1, 3-8, 10, 16-17, 20, 26-27, 30-33, 35, 38-50, 53-55, 57, 59-63, 65-67, 70-75, 77-79, 84, 86-94, 97-98, 100, 102 and 104-105. These documents contain information that I consider, on balance, to be contrary to the public interest to disclose under the test set out in Section 17 of the FOI Act.

Document 92 is partially comprised of cabinet information, and it is taken to be contrary to the public interest to release as Schedule 1.6 (1)(a) and (d) as the disclosure would reveal any deliberation of Cabinet (other than through the official publication of a Cabinet decision).

Public Interest Factors Favouring Disclosure

The following factors were considered relevant in favour of the disclosure of the documents:

- Schedule 2, 2.1 (a)(i) promote open discussion of public affairs and enhance the government's accountability,
- Schedule 2, 2.1 (a)(ii) contribute to positive and informed debate on important issues or matters of public interest,
- Schedule 2, 2.1 (a)(iii) inform the community of the government's operations, including the policies, guidelines and codes of conduct followed by the government in its dealings with members of the community;
- Schedule 2, 2.1(a)(iv) ensure effective oversight of expenditure of public funds, and
- Schedule 2, 2.1(a)(viii) reveal the reason for a government decision and any background or contextual information that informed the decision.

Public Interest Factors Favouring Non-Disclosure

The following factors were considered relevant in favour of the non-disclosure of the documents:

- Schedule 2, 2.2 (a)(ii) prejudice the protection of an individual's right to privacy or any other right under the Human Rights Act 2004;
- Schedule 2, 2.2 (a)(x) prejudice intergovernmental relations;
- Schedule 2, 2.2 (a)(xi) prejudice trade secrets, business affairs or research of an agency or person; and
- Schedule 2, 2.2(a)(xvi) prejudice a deliberative process of government.

Documents at references 1, 3-8, 10, 16-17, 20, 26-27, 30-33, 35, 38-50, 53-55, 57, 59-63, 65-67, 70-75, 77-79, 84, 86-91, 93-94, 97-98, 100, 102, 104-105 are partially comprised of personal information. These redactions are of ACT-Government employee's mobile numbers and signatures, Non-ACT Government employees email addresses, phone numbers and signatures. Further, attachments to document 72 (pages 497-625) have been removed in entirety noting that these would prejudice an individuals right personal privacy, and are not provided given the already significant size of the release package.

Document at reference 1 is also partially comprised of information which I consider may prejudice the intergovernmental relations with other jurisdictions.

Document at reference 73 is also partially comprised of information which I consider may prejudice the business affairs of a non-ACT Government entity and has not been disclosed.

Document at reference 89 also contains information which I consider is not within scope or the noted exclusions of the application and as such has been marked as out of scope.

Document at reference 105 is also partially comprised of information which I consider may prejudice the business affairs of a non-ACT Government entity and the deliberative process of government.

On balance, I have given significant consideration to the factors favouring disclosure and I believe the factors favouring non-disclosure outweighed these of the information requested. Therefore, I have determined the information identified is contrary to the public interest and would not advantage the public in disclosing this information.

For noting, document 5 contains a copy of the Draft 10-Year Fertility Roadmap for Australia, and the final published version can be found at the below website;
https://www.fertilitysociety.com.au/public/267/system/newsAttachments/Recomendations%20and%20Framework%20for%20Australia's%2010%20Yr%20Fertility%20Roadmap%20vFF%20Nov.pdf

Charges
Processing charges are not applicable to this request.

Disclosure Log
Under section 28 of the FOI Act, ACTHD maintains an online record of access applications called a disclosure log. The scope of your access application, my decision and documents released to you will be published in the disclosure log not less than three days but not more than 10 days after the date of this decision. Your personal contact details will not be published.
https://www.health.act.gov.au/about-our-health-system/freedom-information/disclosure-log.

Ombudsman review
My decision on your access request is a reviewable decision as identified in Schedule 3 of the FOI Act. You have the right to seek Ombudsman review of this outcome under section 73 of the Act within 20 working days from the day that my decision is published in ACT Health's disclosure log, or a longer period allowed by the Ombudsman.

If you wish to request a review of my decision you may write to the Ombudsman at:

The ACT Ombudsman
GPO Box 442
CANBERRA ACT 2601
Via email: ACTFOI@ombudsman.gov.au
Website: ombudsman.act.gov.au

ACT Civil and Administrative Tribunal (ACAT) review

Under section 84 of the Act, if a decision is made under section 82(1) on an Ombudsman review, you may apply to the ACAT for review of the Ombudsman decision. Further information may be obtained from the ACAT at:

ACT Civil and Administrative Tribunal
Allara House
15 Constitution Avenue
GPO Box 370
Canberra City ACT 2601
Telephone: (02) 6207 1740
http://www.acat.act.gov.au/

Further assistance

Should you have any queries in relation to your request, please do not hesitate to contact the FOI Coordinator on (02) 5124 9831 or email HealthFOI@act.gov.au.

Yours sincerely



Catherine Ellis
Senior Director
Ministerial and Government Services

11 June 2025

ACT Government | ACT Health

FREEDOM OF INFORMATION SCHEDULE OF DOCUMENTS

Please be aware that under the *Freedom of Information Act 2016*, some of the information provided to you will be released to the public through the ACT Government's Open Access Scheme. The Open Access release status column of the table below indicates what documents are intended for release online through open access.
Personal information or business affairs information will not be made available under this policy. If you think the content of your request would contain such information, please inform the contact officer immediately.
Information about what is published on open access is available online at: http://www.health.act.gov.au/public-information/consumers/freedom-information

APPLICANT NAME	WHAT ARE THE PARAMETERS OF THE REQUEST	FILE NUMBER
[redacted]	*'All digital communications between directorate senior executives*, directorate liaison officers or ministerial liaison unit staff/ministerial and government relations staff (where applicable) and any ACT Minister and/or their staff. This request is for advice sent and received during the period covered by caretaker conventions in 2024, that being between 13/09/2024 and 06/11/2024 inclusive.* *Excluded information: Matters relating to individual constituent queries (including businesses and other members of the public), material referred on from MLAs, administrative material (eg, room bookings, HR and corporate support), and handwritten conversation notes.* **Senior Executives means any staff employed at the Senior Executive Service level.'*	**ACTHDFOI24-25.13**

Ref Number	Page Number	Description	Date	Status Decision	Factor	Open Access release status
Part 1						
1.	1 – 7	Email – RE: MIN2024/00657: RE: advice please – Correspondence from Minister Butler	13 September 2024	Partial Release	Schedule 2.2(a)(ii) Privacy and Schedule 2.2(a)(x) intergovernmental relations	YES
2.	8 – 10	Email and attachment – FW: Ministerial Correspondence Update on status of interim arrangements for the appointment of a restrictive practices substitute decision-maker	13 September 2024	Full Release		YES
3.	11	Email – MIN24-00747 – Nominations for ACSQHC's board	13 September 2024	Partial Release	Schedule 2.2(a)(ii) Privacy	YES

4.	12 – 13	Email – RE: Letter – Joint response re Covid and Disability	13 September 2024	Partial Release	Schedule 2.2(a)(ii) Privacy	YES
5.	14 – 57	Email and attachment – FW: Advance Copy of the Draft 10-Year Fertility Roadmap for Australia	13 September 2024	Partial Release	Schedule 2.2(a)(ii) Privacy	YES
6.	58 – 64	Email and attachments – FW: Letter regarding the Audiology Decision RIS	13 September 2024	Partial Release	Schedule 2.2(a)(ii) Privacy	YES
7.	65 – 73	Email and attachment – FW: Letter from ACT ART providers – ART legislation	13 September 2024	Partial Release	Schedule 2.2(a)(ii) Privacy	YES
8.	74	Email – (COPY) MIN24-00307 – Public Health (Health Care Facility) Code of Practice 2021	16 September 2024	Partial Release	Schedule 2.2(a)(ii) Privacy	YES
9.	75 – 77	Email – FW: New AIHW embargo release available Practice Incentives Program Quality Improvement Measures annual data update 2023-24	16 September 2024	Full Release		YES
10.	78 – 79	Email – RE: Update to Safe Haven Hospital Design and Costings	16 September 2024	Partial Release	Schedule 2.2(a)(ii) Privacy	YES
11.	80 – 82	Email – FW: New AIHW embargo release available: BreastScreen Australia monitoring report 2024	17 September 2024	Full Release		YES
12.	83 – 85	Email and attachment – FW: Correspondence from the Minister for Health and Minister for Regional Health – M24/5151	19 September 2024	Full Release		YES
13.	86 – 87	Email – RE: Correspondence from the Minister for Health and Minister for Regional Health – M24/5151	19 September 2024	Full Release		YES
14.	88 – 91	Email and attachment – FW: Correspondence from Minister Fentiman	19 September 2024	Full Release		YES
15.	92 – 94	Email – FW: New AIHW embargo release available Oral health and dental care in Australia – update	20 September 2024	Full Release		YES
16.	95 – 96	Email – RE: Caveat Brief	20 September 2024	Partial Release	Schedule 2.2(a)(ii) Privacy	YES
17.	97 – 101	Email and attachment – Lung Foundation Australia concerns on Lung Cancer Screening readiness	23 September 2024	Partial Release	Schedule 2.2(a)(ii) Privacy	YES
18.	102 – 133	Email and attachments – FW: ACT Local Hospital Network Directorate- Audit report	24 September 2024	Full Release		YES
19.	134 – 217	Email and attachments – FW: ACT Health Directorate- Audit Report	24 September 2024	Full Release		YES
Part 2						
20.	218	Email – FW: Resignation from ACT MBA	24 September 2024	Partial Release	Schedule 2.2(a)(ii) Privacy	YES
21.	219 – 226	Email and attachments – FW: ACT Local Hospital Network Directorate- SOP Limited Assurance report	24 September 2024	Full Release		YES

22.	227 – 228	Email – FW: AIHW embargoed release updated Pharmaceutical Benefits Scheme prescriptions over time	24 September 2024	Full Release		YES
23.	229 – 231	Email – FW: AIHW release updated Australia's mothers and babies	24 September 2024	Full Release		YES
24.	232 – 243	Email and attachments – FW ACT Health Directorate- SOP limited assurance report	24 September 2024	Full Release		YES
25.	244 – 246	Email – FW: New AIHW embargo release available Medicare Benefits Scheme funded services monthly data	24 September 2024	Full Release		YES
26.	247 – 248	Email – FW: FMM Decision – A1287	25 September 2024	Partial Release	Schedule 2.2(a)(ii) Privacy	YES
27.	249	Email – RE: GBC24-00262	26 September 2024	Partial Release	Schedule 2.2(a)(ii) Privacy	YES
28.	250 – 252	Email – FW: New AIHW embargo release available Mental Health Services Online Report	27 September 2024	Full Release		YES
29.	253 – 255	Email – FW: New AIHW embargo releases available: National Core Maternity Indicators and Eye health measures for Aboriginal and Torres Strait Islander people 2024	30 September 2024	Full Release		YES
30.	256 – 257	Email – RE: Checking for corro – Transplant Australia	30 September 2024	Partial Release	Schedule 2.2(a)(ii) Privacy	YES
31.	258 – 259	Email – RE: Removal of Cabinet Documents ahead of Election	30 September 2024	Partial Release	Schedule 2.2(a)(ii) Privacy	YES
32.	260 – 263	Email and attachment – FW: Correspondence from CPMC on SIMG pathways	01 October 2024	Partial Release	Schedule 2.2(a)(ii) Privacy	YES
33.	264 – 288	Email and attachments – FW: Letter to Treasurer – NHRA Commonwealth Payments into the National Health Funding Pool for October 2024	01 October 2024	Partial Release	Schedule 2.2(a)(ii) Privacy	YES
34.	289	Email – FW: ACT Health Directorate- SOP limited assurance report [Attachments at reference 24]	01 October 2024	Full Release		YES
35.	290 – 292	Email and attachment – FW: Correspondence from the Hon Mark Butler MP	01 October 2024	Partial Release	Schedule 2.2(a)(ii) Privacy	YES
36.	293	Email – FW: ACT Health Directorate- Audit Report [Attachments at reference 19]	01 October 2024	Full Release		YES
37.	294	Email – FW: ACT Local Hospital Network Directorate- Audit report [Attachments at reference 18]	01 October 2024	Full Release		YES
38.	295 – 297	Email and attachment – FW: Invitation – Anaphylaxis reporting system consultation	01 October 2024	Partial Release	Schedule 2.2(a)(ii) Privacy	YES

39.	298 – 300	Email – MIN202400806 RE Letter from ACT ART providers – ART legislation	02 October 2024	Partial Release	Schedule 2.2(a)(ii) Privacy	YES
40.	301	Email – FW: New Aged Care Act Consultation: Service List	02 October 2024	Partial Release	Schedule 2.2(a)(ii) Privacy	YES
41.	302 – 304	Email and attachment – FW: Funding for expansion of cervical screening services to support the elimination of cervical in Australia by 2035	02 October 2024	Partial Release	Schedule 2.2(a)(ii) Privacy	YES
42.	305 – 307	Email – RE: Interchange Healthcare Cooperative	03 October 2024	Partial Release	Schedule 2.2(a)(ii) Privacy	YES
43.	308	Email – 20241004 GBC24/00295 – Transmittal of Annual Report to Minister for Health	03 October 2024	Partial Release	Schedule 2.2(a)(ii) Privacy	YES
44.	309 – 311	Email – MIN2024-00839: RE: VSC	03 October 2024	Partial Release	Schedule 2.2(a)(ii) Privacy	YES
45.	312	Email – MIN24/00795 – Compass Group – Cyber Security Threat Update	04 October 2024	Partial Release	Schedule 2.2(a)(ii) Privacy	YES
46.	313 – 319	Email and attachment – RE: Funding for expansion of cervical screening services to support the elimination	04 October 2024	Partial Release	Schedule 2.2(a)(ii) Privacy	YES
47.	320	Email – 20241004 GBC24/00294 – Transmittal of Annual Report to Minister for Mental Health & Pop Health	04 October 2024	Partial Release	Schedule 2.2(a)(ii) Privacy	YES
48.	321 – 323	Email – FW: PACFA program accreditation standards review: Second round public consultation now open	04 October 2024	Partial Release	Schedule 2.2(a)(ii) Privacy	YES
49.	324 – 332	Email and attachments – FW: FFA Schedule – Participant Follow-up Function	04 October 2024	Partial Release	Schedule 2.2(a)(ii) Privacy	YES
50.	333 – 337	Email and attachment – FW: Australian Breastfeeding Association – to Food Ministers	04 October 2024	Partial Release	Schedule 2.2(a)(ii) Privacy	YES
51.	338 – 347	Email and attachments – FW: 2024 Health of the Nation report: early signs of revival	08 October 2024	Full Release		YES
52.	348 – 349	Email – FW: New AIHW embargo release available: GEN Aged Care Data Residential Aged Care Quality Indicators (quarterly update)	08 October 2024	Full Release		YES
53.	350 – 356	Email and attachment – RE: VSC	08 October 2024	Partial Release	Schedule 2.2(a)(ii) Privacy	YES
54.	357 – 358	Email – FW: Lung Foundation Australia concerns on Lung Cancer Screening readiness [Attachment at reference 17]	08 October 2024	Partial Release	Schedule 2.2(a)(ii) Privacy	YES
55.	359 – 361	Email and attachment – FW: Official Information Act Request Consultation – Responses due 12pm AEST Thursday 12 September 2024	08 October 2024	Partial Release	Schedule 2.2(a)(ii) Privacy	YES
56.	362 – 365	Email and attachments – FW: ACT Local Hospital Network Directorate- Audit Management Report	09 October 2024	Full release		YES

57.	366 – 367	Email – RE: outstanding items	11 October 2024	Partial Release	Schedule 2.2(a)(ii) Privacy	YES
58.	368 – 369	Email – FW: New AIHW embargo release available: Young people under youth justice supervision	11 October 2024	Full Release		YES
Part 3						
59.	370 – 422	Email and attachments – FW: Requesting your support to promote the growing suite of Safer Baby Bundle resources	11 October 2024	Partial Release	Schedule 2.2(a)(ii) Privacy	YES
60.	423	Email – NOTING BRIEF: GBC2024/00321 - ACT Auditor-General Performance Audit Report on NTT	11 October 2024	Partial Release	Schedule 2.2(a)(ii) Privacy	YES
61.	424 – 426	Email – RE: Cabinet documents	14 October 2024	Partial Release	Schedule 2.2(a)(ii) Privacy	YES
62.	427 – 429	Email – RE: Correspondence from the Hon Mark Butler MP [Attachment at reference 35]	14 October 2024	Partial Release	Schedule 2.2(a)(ii) Privacy	YES
63.	430 – 432	Email – Re: Correspondence from the Hon Mark Butler MP – MIN2024/00833	15 October 2024	Partial Release	Schedule 2.2(a)(ii) Privacy	YES
64.	433	Teams message	16 October 2024	Full Release		YES
65.	434 – 435	Email – Re: Outstanding ACTHD items	16 October 2024	Partial Release	Schedule 2.2(a)(ii) Privacy	YES
66.	436 – 439	Email and attachment – FW: Response from the Royal Australian College of General Practitioners to letter	17 October 2024	Partial Release	Schedule 2.2(a)(ii) Privacy	YES
67.	440 – 441	Email – FW: FMM Decision - A1247, A1284, P1063	17 October 2024	Partial Release	Schedule 2.2(a)(ii) Privacy	YES
68.	442	Email – RE: Query regarding Mental Health Foundation	17 October 2024	Full Release		YES
69.	443 – 465	Email and attachments – FW: Canberra Health Services FY24 IT Audit Management Reports	18 October 2024	Full Release		YES
70.	466 – 467	Email – RE: Query regarding Mental Health Foundation	18 October 2024	Partial Release	Schedule 2.2(a)(ii) Privacy	YES
71.	468 – 494	Email and attachments – FW: Ahpra: ACT MBA recommendations for appointment (2024 R4) - Email 2 of 2	21 October 2024	Partial Release	Schedule 2.2(a)(ii) Privacy	YES
72.	495 – 624	Email and attachments – FW: Ahpra: ACT MBA recommendations for appointment (2024 R4) - Email 1 of 2 [Attachments at pages 497-625 have been removed as all information is personal privacy]	21 October 2024	Partial Release	Schedule 2.2(a)(ii) Privacy	YES
Part 4						
73.	626 – 629	Email – RE: Critical event outcome analysis	22 October 2024	Partial Release	Schedule 2.2(a)(ii) Privacy and Schedule 2.2(a)(xi) Business Affairs	YES
74.	630 – 634	Email and attachment – RE: Ahpra: ACT MBA recommendations for appointment (2024 R4) – Email 2 of 2	22 October 2024	Partial Release	Schedule 2.2(a)(ii) Privacy	YES
75.	635	Email – NOTING BRIEF: MIN2024/00864 - Consultation on National Water Guidelines	23 October 2024	Partial Release	Schedule 2.2(a)(ii) Privacy	YES

76.	636 – 638	Email – FW: New AIHW embargo release available First hospitalised falls among people living with dementia risk factors and outcomes	23 October 2024	Full Release		YES
77.	639 – 705	Email and attachment – ACTHD FOI Released Today - 23 October 2024	23 October 2024	Partial Release	Schedule 2.2(a)(ii) Privacy	YES
78.	706 – 707	Email – ACTHD FOI - Released 23 October 2024	24 October 2024	Partial Release	Schedule 2.2(a)(ii) Privacy	YES
79.	708 – 709	Email – RE: NOTING BRIEF: MIN2024/00864 - Consultation on National Water Guidelines	24 October 2024	Partial Release	Schedule 2.2(a)(ii) Privacy	YES
80.	710 – 711	Email – FW: AIHW forthcoming releases list	24 October 2024	Full Release		YES
81.	712 – 713	Email – FW Midwifery Futures Building the Australian midwifery workforce Final report published	25 October 2024	Full Release		YES
82.	714 – 715	Email – FW New AIHW embargo release available Medicare Benefits Scheme funded services: monthly data	25 October 2024	Full Release		YES
83.	716 – 718	Email – FW: New AIHW embargo release available: Alcohol available for consumption in Australia	25 October 2024	Full Release		YES
84.	719 – 720	Email – FW: FMM10 - agenda papers available	28 October 2024	Partial Release	Schedule 2.2(a)(ii) Privacy	YES
85.	721	Email – COVID Inquiry	29 October 2024	Full Release		YES
86.	722 – 723	Email – FW: FMM - Correspondence - Australian Breastfeeding Association	29 October 2024	Partial Release	Schedule 2.2(a)(ii) Privacy	YES
87.	724 – 727	Email and attachment – FW: Important Healthscope Announcement	29 October 2024	Partial Release	Schedule 2.2(a)(ii) Privacy	YES
88.	728 – 729	Email – RE: EMBARGOED: Strictly Confidential	29 October 2024	Partial Release	Schedule 2.2(a)(ii) Privacy	YES
89.	730 – 733	Text messages	29-30 October 2024	Partial Release	Schedule 2.2(a)(ii) Privacy Out of scope information	YES
90.	734 – 738	Email – RE: DUE 30/10: New AIHW embargo release available Medicare Benefits Scheme funded services: monthly data	30 October 2024	Partial Release	Schedule 2.2(a)(ii) Privacy	YES
91.	739 – 743	Email – Re: Information on Safe Havens	30 October 2024	Partial Release	Schedule 2.2(a)(ii) Privacy	YES
92.	744 – 749	Email and attachment – FW: FINAL Cost Pressures Slide Deck	01 November 2024	Partial Release	Schedule 1.6 Cabinet	YES
93.	750 – 760	Email and attachments – FW: ASMOF Letter: Correspondence to Chief minister and Minister for Health	01 November 2024	Partial Release	Schedule 2.2(a)(ii) Privacy	YES
94.	761 – 763	Email – RE: MIN2024-00839: RE: VSC	01 November 2024	Partial Release	Schedule 2.2(a)(ii) Privacy	YES
95.	764 – 766	Email – FW: New AIHW embargo release available: GEN: Residential aged care quality indicators (annual report)	04 November 2024	Full Release		YES

96.	767 – 769	Email – FW: New AIHW embargo release available: Pharmaceutical Benefits Scheme prescriptions: October data update	04 November 2024	Full Release		YES
97.	770 – 771	Email – FOR INFORMATION: Response to Comment - GBC2024/00215 - ACTHD Weekly Brief - 5 to 9 August 2024	04 November 2024	Partial Release	Schedule 2.2(a)(ii) Privacy	YES
98.	772 – 773	Email – FW: ANMF 100 Years Anniversary	05 November 2024	Partial Release	Schedule 2.2(a)(ii) Privacy	YES
99.	774 – 776	Email – FW: New AIHW embargo release available: Exploring how transitional aged care supports	05 November 2024	Full Release		YES
100.	777 – 778	Email – FW: DG RESPONSE (CARETAKER): Letter from ACT ART providers - ART legislation [Attachment at reference 7]	05 November 2024	Partial Release	Schedule 2.2(a)(ii) Privacy	YES
101.	779 – 781	Email – FW: 3 new AIHW embargo releases available: Health expenditure Australia 2022-23	06 November 2024	Full Release		YES
102.	782 – 784	Email – FW: ADVANCE ACCESS - Closing the Gap dashboard data update - Productivity Commission	06 November 2024	Partial Release	Schedule 2.2(a)(ii) Privacy	YES
103.	785 – 787	Email – FW: New AIHW embargo release available: Perinatal mental health screening in Australia - update	06 November 2024	Full Release		YES
104.	788 – 1003	Email and attachments – FW Correspondence from Minister Butler - Senate Inquiry into treatments for rare and less common cancers	06 November 2024	Partial Release	Schedule 2.2(a)(ii) Privacy	YES
105.	1004 – 1029	Email and attachments – FW: Australian Commission on Safey and Quality in Health Cares draft 2025-28 Work Plan and budget	06 November 2024	Partial Release	Schedule 2.2(a)(ii) Privacy, Schedule 2.2(a)(xi) Business Affairs and Schedule 2.2(a)(xvi) deliberative process of government	YES
Total Number of Documents						
105						

From: Smith, Kahlia
Sent: Friday, 13 September 2024 09:35
To: ACT Health DLO; Bransgrove, Meagen
Subject: RE: MIN2024/00657 : RE: advice please - Correspondence from Minister Butler

Importance: High

OFFICIAL

Apologies for the delay Tara – for directorate action indeed now.

Thanks
Kahlia

From: Gower, Tara **On Behalf Of** ACT Health DLO
Sent: Wednesday, September 11, 2024 2:51 PM
To: Smith, Kahlia ; Bransgrove, Meagen
Subject: RE: MIN2024/00657 : RE: advice please - Correspondence from Minister Butler

OFFICIAL

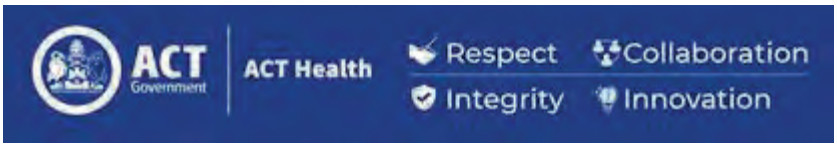
Hi Kahlia

Schedule 2.2(a)(x) [redacted]

Grateful for your advice if you would prefer a DG response and I will have to seek additional advice from the team to add to the letter.

Thank you
Tara

Tara Gower | Directorate Liaison Officer | ACT Health Directorate
Mob: Schedule 2.2(a)(ii) [redacted] Email: ACTHealthDLO@act.gov.au
Office of Rachel Stephen-Smith | Minister for Health
Office of Emma Davidson | Minister for Mental Health
Level 2, Legislative Assembly Building, Civic Square



From: Smith, Kahlia <Kahlia.Smith@act.gov.au>
Sent: Wednesday, September 11, 2024 10:02 AM
To: ACT Health DLO <ACTHealthDLO@act.gov.au>; Bransgrove, Meagen <Meagen.Bransgrove@act.gov.au>
Subject: RE: MIN2024/00657 : RE: advice please - Correspondence from Minister Butler
Importance: High

OFFICIAL

Hi Tara – I don't think it's really appropriate for the CMO to write to the Commonwealth Minister. Have they been unable to resolve this at officials level? What are other jurisdictions doing?

Thank you
Kahlia

From: Gower, Tara <Tara.Gower@act.gov.au> **On Behalf Of** ACT Health DLO
Sent: Tuesday, September 10, 2024 1:01 PM
To: Smith, Kahlia <Kahlia.Smith@act.gov.au>; Bransgrove, Meagen <Meagen.Bransgrove@act.gov.au>
Subject: RE: MIN2024/00657 : RE: advice please - Correspondence from Minister Butler

OFFICIAL

Hi Kahlia and Meg

Just on this one, the team have noted that the concerns from the States and Territories still apply.

Would you be comfortable for the draft response progressing from the Chief Medical Officer?

Thank you
Tara

Tara Gower | Directorate Liaison Officer | ACT Health Directorate
Mob: Schedule 2.2(a)(ii) Email: ACTHealthDLO@act.gov.au
Office of Rachel Stephen-Smith | Minister for Health
Office of Emma Davidson | Minister for Mental Health
Level 2, Legislative Assembly Building, Civic Square



From: Smith, Kahlia <Kahlia.Smith@act.gov.au>
Sent: Monday, August 12, 2024 12:56 PM
To: Bransgrove, Meagen <Meagen.Bransgrove@act.gov.au>; ACT Health DLO <ACTHealthDLO@act.gov.au>
Subject: RE: MIN2024/00657 : RE: advice please - Correspondence from Minister Butler
Importance: High

OFFICIAL

Thanks both – my feeling is we probably don't need to respond to this original letter just yet and we could wait until officials have progressed negotiations to the point at which we can respond if any concerns? Nothing in the letter jumps out to me as requiring a Ministerial response at this point in time.

Thanks

Kahlia

From: Bransgrove, Meagen <Meagen.Bransgrove@act.gov.au>
Sent: Monday, August 12, 2024 9:07 AM
To: ACT Health DLO <ACTHealthDLO@act.gov.au>; Smith, Kahlia <Kahlia.Smith@act.gov.au>
Subject: Re: MIN2024/00657 : RE: advice please - Correspondence from Minister Butler

OFFICIAL

Thanks Tara, given all of that - it seems there is a pathway for this initiative and to provide a response to Minister Butler.

Kahlia - over to you on what you would like to do next in relation to the response.

Thanks,

Meg

Get Outlook for iOS

From: Gower, Tara <Tara.Gower@act.gov.au> on behalf of ACT Health DLO <ACTHealthDLO@act.gov.au>
Sent: Friday, August 9, 2024 12:06:31 PM
To: Bransgrove, Meagen <Meagen.Bransgrove@act.gov.au>; Smith, Kahlia <Kahlia.Smith@act.gov.au>
Subject: RE: MIN2024/00657 : RE: advice please - Correspondence from Minister Butler

OFFICIAL

Hi Meg

Please see ACTHD advice below.

CHS Drugs and Therapeutics Committee

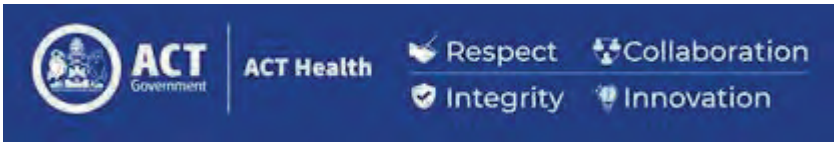
- Chief Pharmacist, Daniel Lalor, advised that the CHS Drug and Therapeutics Committee is used to providing governance for compassionate access programs. As requested by Minister Butler, each case will be assessed on its own merits, and the Committee will request an Individual Patient Use application be submitted for every patient. In terms of the FFA, it is unlikely that CHS will initiate anyone on the therapy, but may continue provision of supply when people come back to Canberra after initiating treatment elsewhere. In these instances, CHS would need to coordinate the transfer, which occurs from time to time, and there are good relationships with the Children's Hospital Network in Sydney. Mr Lalor also advised that oversight from the CHS Drug and Therapeutics Committee will satisfy the needs of the Commonwealth.

Jurisdictions

- The last touch point with States and Territories and the Commonwealth was on 19 July 2024.
- On 6 August 2024, the Commonwealth emailed jurisdictions to provide an update on the development of the FFA - Health Schedule for eflornithine (DFMO). The Commonwealth advised that Commonwealth Treasury has commenced discussions with State and Territory counterparts to agree on the preferred negotiation pathway for the FFA Schedule. An outcome of these discussions is expected later this month.
- The Commonwealth advised that they will be in a position to circulate the draft for consideration in the coming week or two once it has been through the required Commonwealth processes. The Commonwealth further advised that in lieu of an executed FFA agreement, the Commonwealth will reimburse States and Territories for the costs of purchasing DFMO from 10 July 2024. A number of jurisdictions have already placed orders, and in some cases, have received them and commenced treatment.
- It is hoped that States and Territories will meet in two weeks to discuss this matter.

Thank you
Tara

Tara Gower | Directorate Liaison Officer | ACT Health Directorate
Mob: Schedule 2.2(a)(ii) Email: ACTHealthDLO@act.gov.au
Office of Rachel Stephen-Smith | Minister for Health
Office of Emma Davidson | Minister for Mental Health
Level 2, Legislative Assembly Building, Civic Square



From: Bransgrove, Meagen <Meagen.Bransgrove@act.gov.au>
Sent: Monday, August 5, 2024 10:11 AM
To: ACT Health DLO <ACTHealthDLO@act.gov.au>; Smith, Kahlia <Kahlia.Smith@act.gov.au>
Subject: MIN2024/00657 : RE: advice please - Correspondence from Minister Butler
Importance: High

OFFICIAL

Thanks Tara, can you ask the Chief Medical Officer's team what is the view from CHS Drugs and Therapeutics Committee and other jurisdictions?

Thanks,

Meg

From: Gower, Tara <Tara.Gower@act.gov.au> **On Behalf Of** ACT Health DLO
Sent: Monday, August 5, 2024 10:09 AM
To: Smith, Kahlia <Kahlia.Smith@act.gov.au>
Cc: Bransgrove, Meagen <Meagen.Bransgrove@act.gov.au>
Subject: RE: advice please - Correspondence from Minister Butler

OFFICIAL

Hi Kahlia

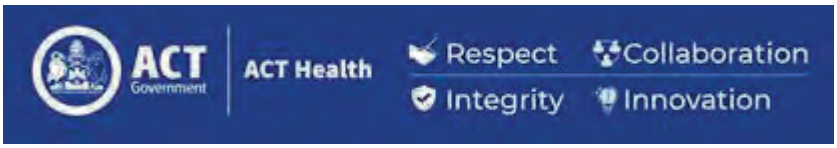
In the draft response, the team have noted:

"there are some concerns regarding the creation of an additional avenue for therapeutics to be brought into Australia without going through the current rigorous processes such as the Therapeutic Goods Administration, Pharmaceutical Benefits Advisory Council, the Medical Services Advisory Council or through the National Health Reform Agreement High-Cost Therapeutics program."

Thank you
Tara

Tara Gower | Directorate Liaison Officer | ACT Health Directorate
Mob: Schedule 2.2(a)(ii) Email: ACTHealthDLO@act.gov.au
Office of Rachel Stephen-Smith | Minister for Health

Office of Emma Davidson | Minister for Mental Health
Level 2, Legislative Assembly Building, Civic Square



From: Smith, Kahlia <Kahlia.Smith@act.gov.au>
Sent: Monday, August 5, 2024 9:58 AM
To: ACT Health DLO <ACTHealthDLO@act.gov.au>
Cc: Bransgrove, Meagen <Meagen.Bransgrove@act.gov.au>
Subject: RE: advice please - Correspondence from Minister Butler
Importance: High

OFFICIAL

Hi Tara – what are the concerns? It would be more appropriate for officials to speak to their counterparts in the first instance, with a Ministerial response to come.

Thanks

Kahlia

From: Gower, Tara <Tara.Gower@act.gov.au> **On Behalf Of** ACT Health DLO
Sent: Friday, August 2, 2024 11:59 AM
To: Smith, Kahlia <Kahlia.Smith@act.gov.au>
Subject: advice please - Correspondence from Minister Butler

OFFICIAL

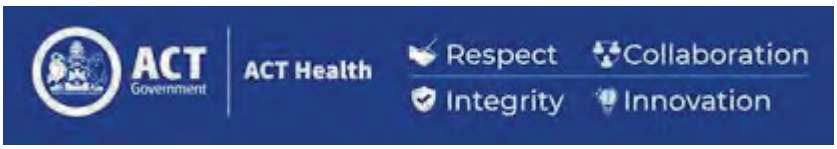
Hi Kahlia

The team have raised that they have some concerns with this matter.

Can you please advise if the MO is comfortable with a min response or perhaps a directorate response to Minister Butler from the Chief Medical Officer?

Thank you
Tara

Tara Gower | Directorate Liaison Officer | ACT Health Directorate
Mob: Schedule 2.2(a)(ii) Email: ACTHealthDLO@act.gov.au
Office of Rachel Stephen-Smith | Minister for Health
Office of Emma Davidson | Minister for Mental Health
Level 2, Legislative Assembly Building, Civic Square



From: STEPHEN-SMITH <STEPHEN-SMITH@act.gov.au>
Sent: Thursday, July 11, 2024 9:43 AM
To: CHS DLO <CHSDLO@act.gov.au>; ACT Health DLO <ACTHealthDLO@act.gov.au>
Cc: Bransgrove, Meagen <Meagen.Bransgrove@act.gov.au>; Smith, Kahlia <Kahlia.Smith@act.gov.au>
Subject: FW: Correspondence from Minister Butler [SEC=OFFICIAL]
Importance: High

Hi Team,

For appropriate action please.

Thank you,

Sally Cooke
Office Manager | Office of Rachel Stephen-Smith MLA
Minister for Health | Minister for Children, Youth and Family Services | Minister for Disability | Minister for Aboriginal and Torres Strait Islander Affairs
Member for Kurrajong
ACT Legislative Assembly, 196 London Circuit, Canberra ACT 2601 | P: (02) 6205 2661 | www.act.gov.au

From: Minister Butler <Minister.Butler@Health.gov.au>
Sent: Wednesday, July 10, 2024 9:24 AM
To: STEPHEN-SMITH <STEPHEN-SMITH@act.gov.au>
Subject: Correspondence from Minister Butler [SEC=OFFICIAL]

Caution: This email originated from outside of the ACT Government. Do not click links or open attachments unless you recognise the sender and know the content is safe.

Good morning

Please find attached correspondence from Minister Butler regarding temporary Commonwealth financial support for access to eflornithine (Difluoromethylornithine (DFMO)).

No hard copy to follow.

Kind regards

Office of the Hon Mark Butler MP
Minister for Health and Aged Care
E: Minister.Butler@health.gov.au
PO Box 6022, Parliament House, Canberra ACT 2600

"Important: This transmission is intended only for the use of the addressee and may contain confidential or legally privileged information. If you are not the intended recipient, you are notified that any use or dissemination of this

communication is strictly prohibited. If you receive this transmission in error please notify the author immediately and delete all copies of this transmission."

From:	Smith, Kahlia
To:	CSDDLO
Cc:	Goodwin, Jonathan; ACT Health DLO
Subject:	FW: Ministerial Correspondence | Update on status of interim arrangements for the appointment of a restrictive practices substitute decision-maker [SEC=OFFICIAL]
Date:	Friday, 13 September 2024 9:37:34 AM
Attachments:	image001.png Letter from Minister Wells to ACT - 10 September 2024.pdf image002.png image003.jpg image004.png image005.png
Importance:	High

Hi Teone – for CSD info also.
Thanks
Kahlia

From: STEPHEN-SMITH
Sent: Thursday, September 12, 2024 12:43 PM
To: ACT Health DLO
Cc: Smith, Kahlia
Subject: FW: Ministerial Correspondence | Update on status of interim arrangements for the appointment of a restrictive practices substitute decision-maker [SEC=OFFICIAL]
Hi Tara,
For appropriate action please.
Thank you,

Sally Cooke
Office Manager | Office of Rachel Stephen-Smith MLA
Minister for Health | Minister for Children, Youth and Family Services | Minister for Disability | Minister for Aboriginal and Torres Strait Islander Affairs
Member for Kurrajong
ACT Legislative Assembly, 196 London Circuit, Canberra ACT 2601 | P: (02) 6205 2661 | www.act.gov.au

From: agedcareprotections <agedcareprotections@Health.gov.au>
Sent: Thursday, September 12, 2024 12:33 PM
To: RATTENBURY <RATTENBURY@act.gov.au>
Cc: STEPHEN-SMITH <STEPHEN-SMITH@act.gov.au>
Subject: Ministerial Correspondence | Update on status of interim arrangements for the appointment of a restrictive practices substitute decision-maker [SEC=OFFICIAL]

Some people who received this message don't often get email from agedcareprotections@health.gov.au. Learn why this is important

Caution: This email originated from outside of the ACT Government. Do not click links or open attachments unless you recognise the sender and know the content is safe.

Dear Attorney-General
Please see **attached** correspondence from the Hon Anika Wells MP, Minister for Aged Care with an update on the status of the interim arrangements for the appointment of a restrictive practices substitute decision-maker under Commonwealth legislation.

Kind regards,

Consumer Protection Section

Strengthening Providers Branch
Australian Government Department of Health and Aged Care
E: agedcareprotections@health.gov.au

The Department of Health and Aged Care acknowledges First Nations peoples as the Traditional Owners of Country throughout Australia, and their continuing connection to land, sea and community. We pay our respects to them and their cultures, and to all Elders both past and present.

"Important: This transmission is intended only for the use of the addressee and may contain confidential or legally privileged information. If you are not the intended recipient, you are notified that any use or dissemination of this communication is strictly prohibited. If you receive this transmission in error please notify the author immediately and delete all copies of this transmission."

The Hon Anika Wells MP
Minister for Aged Care
Minister for Sport
Member for Lilley

Ref No: MS24-001130

Mr Shane Rattenbury MLA
Attorney-General
GPO Box 1020
CANBERRA ACT 2601
rattenbury@act.gov.au

Dear Attorney-General

Thank you for your response to my letter (Ref MS23-001598), dated 28 February, regarding interim arrangements for the appointment of a restrictive practices substitute decision-maker (RPSDM) under Commonwealth legislation. I am writing to provide you with an update on the status of these interim arrangements.

The interim arrangements to the *Aged Care Act 1997* (Aged Care Act) and Quality of Care Principles 2014 that came into effect on 1 December 2022 are due to sunset on 1 December 2024.

Some states and territories have confirmed they will not have an appropriate mechanism for appointment of an RPSDM in place by 1 December 2024. As a result, I intend to extend the interim arrangements.

The purpose of this extension is to provide all states and territories sufficient time to update their respective legislation, and ensure that providers in a state or territory without a jurisdictional mechanism in place, have appropriate persons identified in legislation from whom to seek consent for the use of restrictive practices, if all pre-conditions to use have been met. I propose to continue collaboration with states and territories through our respective officials represented on the National Working Group on Restrictive Practices and Consent in Aged Care.

The extended interim arrangements will also be reflected in the proposed new Aged Care Act, with a new sunset date of 1 December 2026. Once again, thank you for your ongoing commitment to protecting and respecting the decision-making rights of older people in need of this specialised support, and their families. I look forward to our governments working together to achieve the intended outcomes before December 2026.

Yours sincerely

Anika Wells

10 September 2024

cc: Ms Rachel Stephen-Smith MLA, Australian Capital Territory Minister for Health

From: Tomlinson, Benjamin
Sent: Friday, 13 September 2024 09:47
To: Cross, Rebecca
Cc: ACT Health DLO
Subject: MIN24-00747 - Nominations for ACSQHC's board

Importance: High

Hi Rebecca

Just a note regarding MIN24-00747. Unfortunately, it didn't arrive in time for the minister to consider ahead of caretaker. However, I was a little concerned that the Directorate's proposals for nominations to the ACSQHC's board were from Tasmania and Victoria respectively (and the brief came from the CMO recently from Tasmania and Robyn).

I would have thought it is the ACTHD's responsibility to think of ACT individuals to nominate and through this process just like the other jurisdictions and the Commonwealth takes a national perspective. A little bit concerning that ACTHD couldn't think of one individual from CHS, ANU, UC or any of the other national institutions that exist in the ACT to consider.

Also noting that CHS don't appear to have been consulted. Hopefully something for future rounds to consider no matter who is doing the job.

Happy caretaker and enjoy the next few weeks.

Ben

Ben Tomlinson
Chief of Staff
Office of Minister Rachel Stephen-Smith MLA
ACT Government
Ph: (02) 6205 9949 | Mob: Schedule 2.2(a)(ii) Email: Benjamin.Tomlinson@act.gov.au
ACT Legislative Assembly, 196 London Circuit, Canberra, ACT 2600

From: Wiggins, Taylor
Sent: Friday, 13 September 2024 11:27
To: ACT Health DLO
Cc: Davidson; Docker, Jake
Subject: RE: Letter - Joint response re Covid and Disability

Importance: High

OFFICIAL

Hi Tara,

I think if we've missed the cut off then it'll need to go to the DG for response.

Taylor Wiggins (she/her) | Adviser
Office of Emma Davidson| ACT Greens Member for Murrumbidgee
Ph: 6205 1941 E: davidson@act.gov.au

From: Gower, Tara **On Behalf Of** ACT Health DLO
Sent: Friday, September 13, 2024 11:26 AM
To: Wiggins, Taylor
Cc: Davidson
Subject: RE: Letter - Joint response re Covid and Disability

OFFICIAL

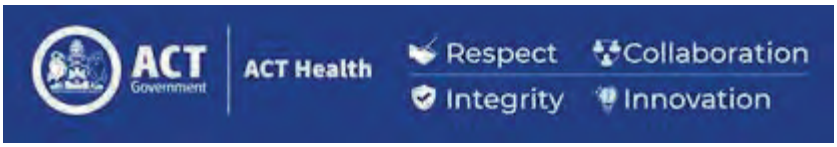
Hi Taylor

Minister Stephen-Smith has not signed the letter due to the caretaker cutoff.

Please let me know if you prefer me to direct this to the directorate for a DG response?

Thank you
Tara

Tara Gower | Directorate Liaison Officer | ACT Health Directorate
Mob: Schedule 2.2(a)(ii) Email: ACTHealthDLO@act.gov.au
Office of Rachel Stephen-Smith | Minister for Health
Office of Emma Davidson | Minister for Mental Health
Level 2, Legislative Assembly Building, Civic Square



From: Wiggins, Taylor <Taylor.Wiggins@act.gov.au>
Sent: Friday, September 13, 2024 11:06 AM

To: ACT Health DLO <ACTHealthDLO@act.gov.au>
Cc: Davidson <DAVIDSON@act.gov.au>
Subject: Letter - Joint response re Covid and Disability
Importance: High

Hey Tara,

Min signed the attached letter last night, also located here: G:\Davidson\DLO\MO_for_review\Taylor_to_Review\Letters signed by Emma 12 Sept\MIN24-00709 - Ltr (joint response) - COVID and disability – AFI

I note that it was supposed to be a joint letter, signed with RSS. Hoping you can progress it to make sure it's signed off and sent?

Let me know if you have any concerns.

Cheers,

Taylor Wiggins (she/her) | Adviser
Office of Emma Davidson | ACT Greens Member for Murrumbidgee
Minister for Community Services, Seniors and Veterans
Minister for Corrections and Justice Health
Minister for Mental Health
Minister for Population Health
Ph: 6205 1941 E: davidson@act.gov.au



We respectfully acknowledge the Ngunnawal people as the traditional custodians of the ACT and surrounding region. We acknowledge their deep and continuing connection to Country and pay our respects to Elders past and present. We acknowledge that other people and families also have a traditional connection to the lands of the ACT and region and we respect this connection to Country.

From: STEPHEN-SMITH
Sent: Friday, 13 September 2024 17:31
To: ACT Health DLO
Cc: Smith, Kahlia
Subject: FW: Advance Copy of the Draft 10-Year Fertility Roadmap for Australia
Attachments: 20240915 Draft findings recommendations and framework for FSANZ 10 year national fertility roadmap.pdf

Importance: High

Hi Tara,

For noting please.

Thank you,

Sally Cooke
Office Manager | Office of Rachel Stephen-Smith MLA
Minister for Health | Minister for Children, Youth and Family Services | Minister for Disability | Minister for Aboriginal and Torres Strait Islander Affairs
Member for Kurrajong
ACT Legislative Assembly, 196 London Circuit, Canberra ACT 2601 | P: (02) 6205 2661 | www.act.gov.au

From: FSANZ President
Sent: Friday, September 13, 2024 9:02 AM
To: Schedule 2.2(a)(ii) [redacted] STEPHEN-SMITH
Cc: Professor the Hon. Greg Hunt ; Rachel Swift
Subject: Advance Copy of the Draft 10-Year Fertility Roadmap for Australia

You don't often get email from president@fertilitysociety.com.au. Learn why this is important

Caution: This email originated from outside of the ACT Government. Do not click links or open attachments unless you recognise the sender and know the content is safe.

Dear Minister/Secretary,

I am pleased to provide you with an advance copy of the **Draft 10-Year Fertility Roadmap for Australia**, which is set to be released this weekend.

This report has been commissioned by FSANZ and prepared by Former Federal Health Minister, Professor the Hon. Greg Hunt, and Dr. Rachel Swift, PhD in Embryology and Rhodes Scholar. It has been developed through an extensive submission and interview process, with deep consultation involving FSANZ, the fertility sector, and the wider public.

We are grateful for the valuable contributions from a number of your jurisdictions. Their insights have been instrumental, and these perspectives have been carefully considered and incorporated into the report.

Following the official release, a final round of consultations will take place, after which FSANZ will provide a formal submission to the Government. At that stage, we will seek the opportunity to meet with Ministers or departmental representatives for a roundtable discussion.

The core recommendations of the Roadmap are summarized in **Recommendation 34**, which calls for the development of a **National Fertility Plan** with the following key components:

- A **Uniform National Fertility Law** to replace over 40 existing laws across jurisdictions;
- A **National Donor Registry**;
- A **National Donor Bank**;
- A **10-Year MRFF Fertility Mission**;
- The establishment of a **National Fertility Roundtable**, tasked with setting the Terms of Reference for both the Fertility Mission and the proposed legislative framework.

We appreciate your time and consideration of these recommendations and look forward to working constructively with you to improve outcomes for patients and expand access to ART in general, and IVF in particular for Australian families.

Sincerely,

Dr Petra Wale, PhD
President

FERTILITY SOCIETY
OF AUSTRALIA AND NEW ZEALAND

E | president@fertilitysociety.com.au
W | fertilitysociety.com.au



fsanzconference@fertilitysociety.com.au | FSANZ 2024

FERTILITY SOCIETY
OF AUSTRALIA AND NEW ZEALAND

RTAC
REPRODUCTIVE TECHNOLOGY ACCREDITATION COMMITTEE

Draft Findings, Recommendations and Framework for FSANZ 10 Year National Fertility Roadmap

September 2024

Professor the Hon. Greg Hunt and Dr. Rachel Swift

With grateful thanks to MinterEllison for their assistance during the process.

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FERTILITY SOCIETY OF AUSTRALIA AND NEW ZEALAND

RTAC REPRODUCTIVE TECHNOLOGY ACCREDITATION COMMITTEE

Executive Summary: Draft Framework and Emerging 10 Year Roadmap

Australia and New Zealand have two of the safest and most successful Assisted Reproductive Technology and IVF programs in the world.

In 2021,
20,690 babies
were born in Australia and New Zealand through IVF.



The 2021 Australian and New Zealand Assisted Reproduction Database (ANZARD) report found that "of these, 18,594 (89.9%) were from treatments performed in Australian ART Units, and 2,096 (10.1%) were from New Zealand ART Units."

Perhaps most significantly, the number of ART participants and births is set to grow significantly over the coming decade, with the continuing increase in the median age of the mother at time of birth, which brings with it associated fertility challenges. Furthermore, the median age of the father is also increasing. Data shows that advancement in a father's age is associated with greater delay in conception and additional complications during pregnancy. Other factors driving increased demand for ART include greater access by prospective parents who may not be able to naturally conceive, and increased numbers of couples seeking IVF to avoid inherited genetic conditions given expanded national carrier screening programs.

The primary goal of these programs is to allow as many families as possible to conceive safely, who might otherwise not be able to do so. These programs aim to support the birth of healthy children through ART in general, and IVF in particular.

The Fertility Society of Australia and New Zealand (FSANZ) serves as a central body for healthcare professionals, scientists and researchers working in fertility and reproductive medicine, promoting high standards of practice, research, and education. Against this background, FSANZ should consider a 10 Year National Fertility Roadmap based on four key pillars:

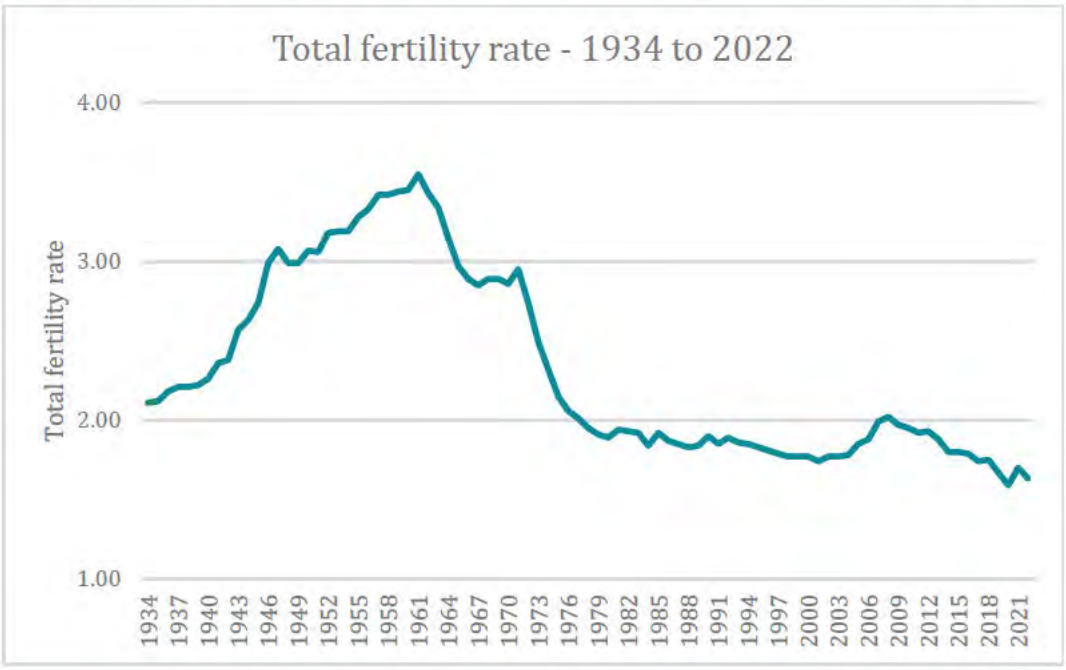
1	2	3	4
Governance	**Safety and Efficacy**	**Access**	**Research and Technology**

This in turn should contribute to >

1. Uniform National Laws to be developed and adopted by the Australian States and Commonwealth through the National Council of Health Ministers; and
2. The development of an Australian National Fertility Plan co-ordinated through the National Council of Health Ministers.

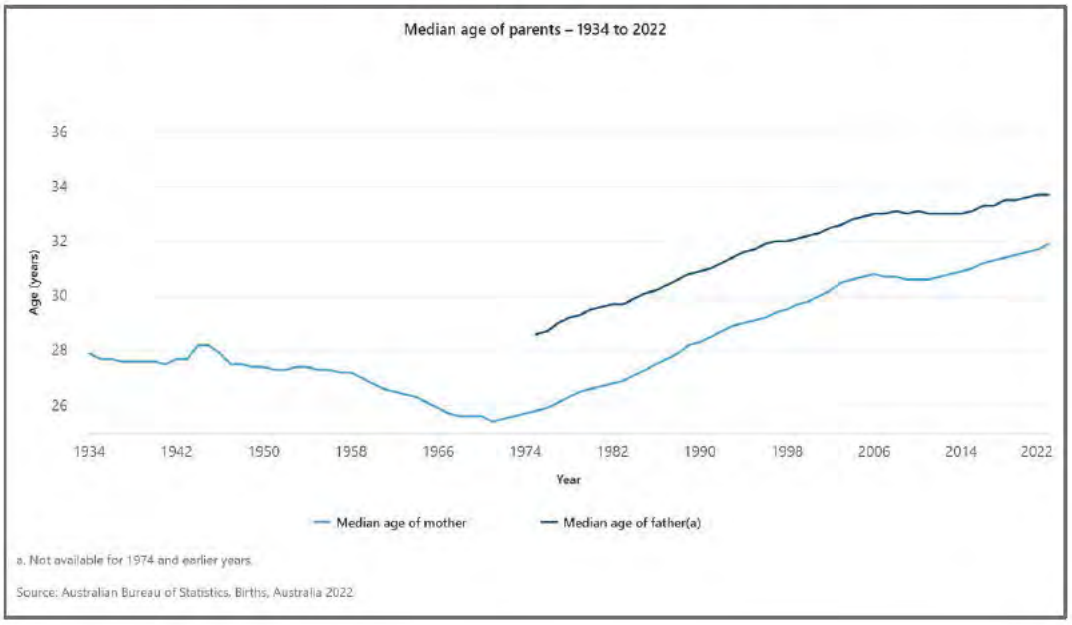
Introduction and National Trends: Declining Fertility and Increased IVF & ART in Australia

Australia's birthrate has declined from a total of 3.5 per woman in 1960 to 1.63 in 2022.
This is consistent with overall global trends and is more magnified in OECD member countries.



Data for 2022 shows a decrease of 9,312 births registrations. This follows higher birth registrations in 2001.
Source: Australian Bureau of Statistics, Births, Australia 2002

This declining fertility rate is associated with both a decreased overall birth rate and the median age of the mother increasing from 25.4 in 1971 to 31.9 in 2022.



This OECD wide trend, although less pronounced in Australia, has three important long-term implications for the nation:

First, there are long-term economic implications of a lower birth rate.

The Australian Treasury Intergenerational Report in 2021 concluded:

> *The Australian Economy is projected to grow at a slower pace over the next 40 years than it has over the past 40 years... Slower population growth is the main reason for the expected slowdown in economic growth.*[1]

As one submission noted, "this raised concerns that for the first time in an Intergenerational Report, the population projection is being revised downwards."

The national implication is an unbalanced population distribution, an increase in resources required to support the non-working population in areas such as health, aged care and welfare, and a commensurate decrease in the working and tax paying population as a percentage of the total national population.

Second, a later age of conception of either parent is associated with lower levels of natural fertility.

Once you turn 36, your chance of conceiving naturally is halved compared to your chance at 20 years of age. At the age of 41, this chance falls to just 4%. That's the success rate for couples per month of trying when the female is aged 41 to 42.

WHY IS THIS?

While a woman is born with 2 million eggs, these are the only eggs she will ever have. By the time she hits puberty that number has already dropped to 400,000. And as age progresses, the egg quantity and quality continues to decline."[2]

Third, a later age of conception therefore leads to an increased role for IVF in particular, and ART more generally, in supporting individual conception and national birth rates.

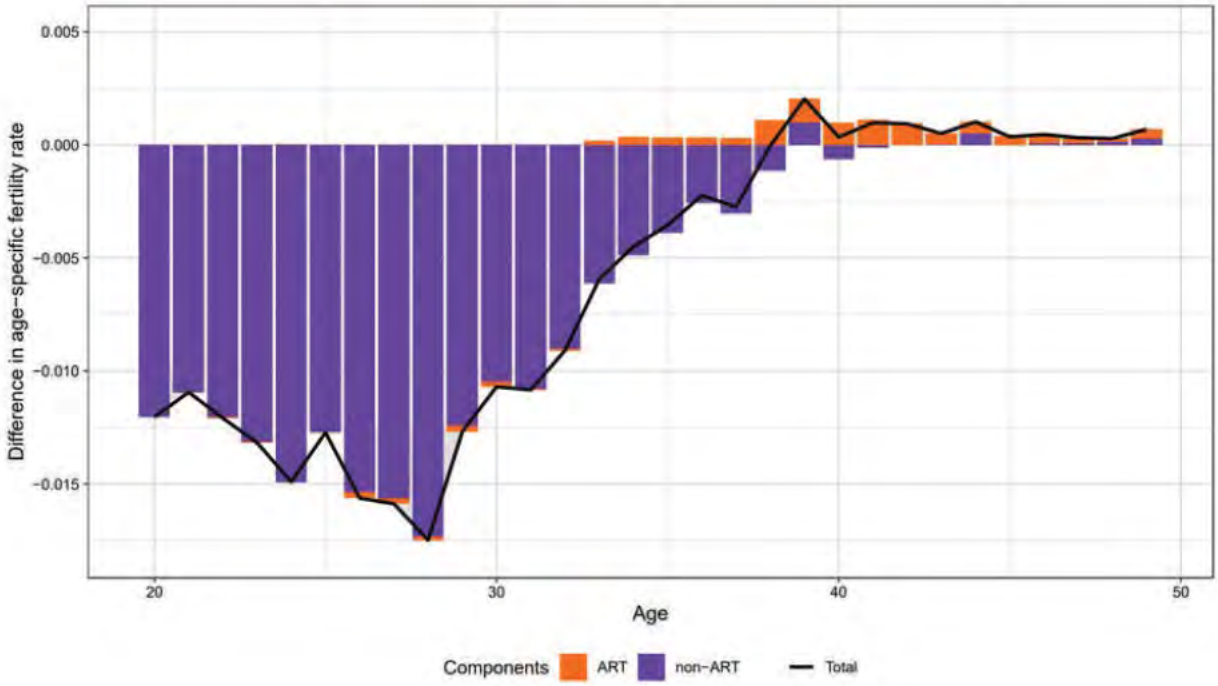
The National Perinatal Epidemiology and Statistics Unit (NPESU) at UNSW has shown that between 2010 and 2017 for example, ART contributed to an increase in women having babies at an older age. This trend has been ongoing and is projected to continue.

---

1 Australian Government. Department of the Treasury. 2021 Intergenerational Report. Available from URL: https://treasury.gov.au/publication/2021-intergenerational-report as cited in Aust N Z J Obstet Gynaecol 2024; 1–5

2 IVF Australia Age and Female Fertility Guide ivf.com.au

NPESU Change in fertility by age including IVF and natural conception



Source: Lazzari E, Potancokova M, Sobotka T, Chambers G (2023) Pop Res Pol Rev 42(6).

Against that background, Australia has one of the highest rates of ART utilisation, combined with one of the lowest net costs and best quality and safety outcomes of ART internationally.

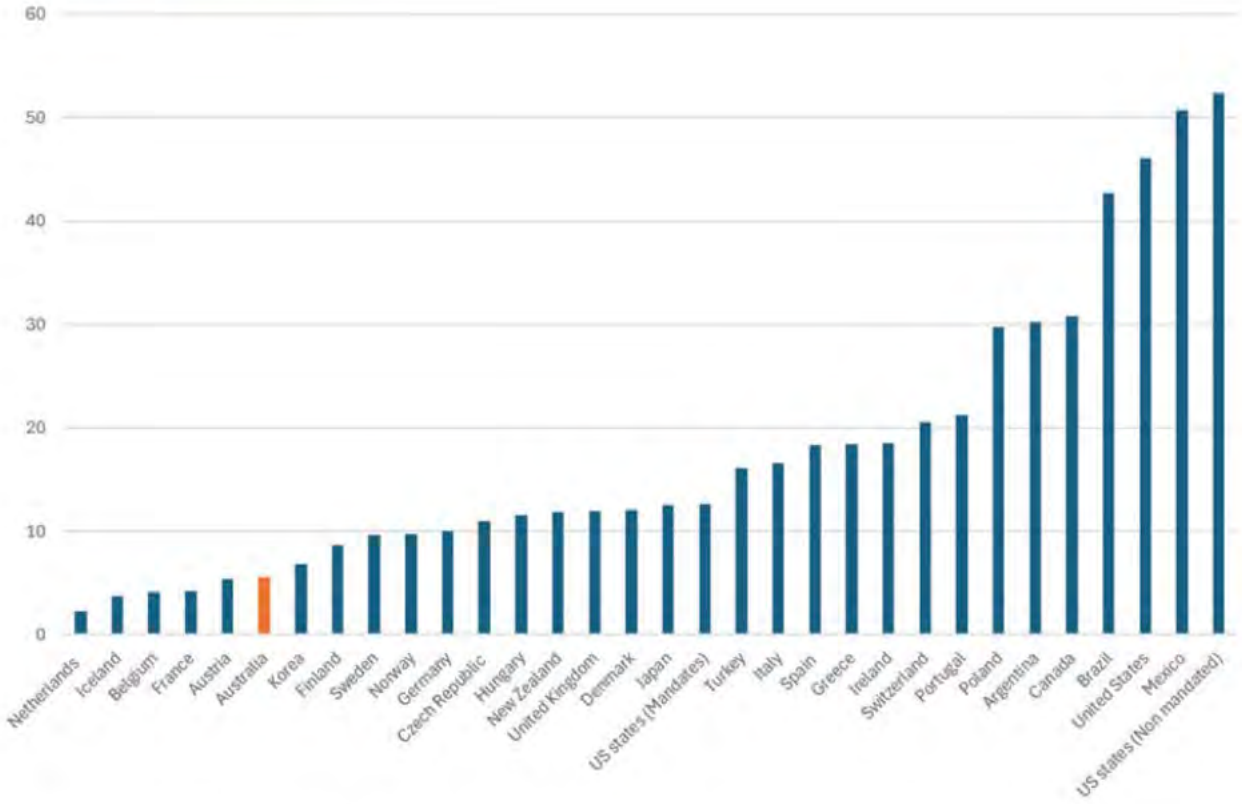
NPESU Contribution to Total Fertility Rate

Country	Level of access to ART	Increase in TFR	Government funding support	Cost of one IVF cycle as percentage of disposable income
USA	Low	1.30%	None	52% in States without insurance 13% in States with insurance
Czechia	Median	3.60%	Government funding with restrictions on age (39 years) & number of cycles (3-4)	11%
Australia	High	5%	Supportive government funding with no restrictions	6%

Sources: Tierney & Cai (2019). FnS 112: 1136-1143. Lazzari E, Chambers G. (2023). Pop Res Pol Rev 42(6). Kocourková J eta (2013) Nature Scientific Reports. 13:10854

In that context, a landmark UNSW comparison confirmed that Australia currently has the sixth most internationally affordable ART based on the average cost of a fresh ART cycle, with costs expressed as a percentage of net disposable income.

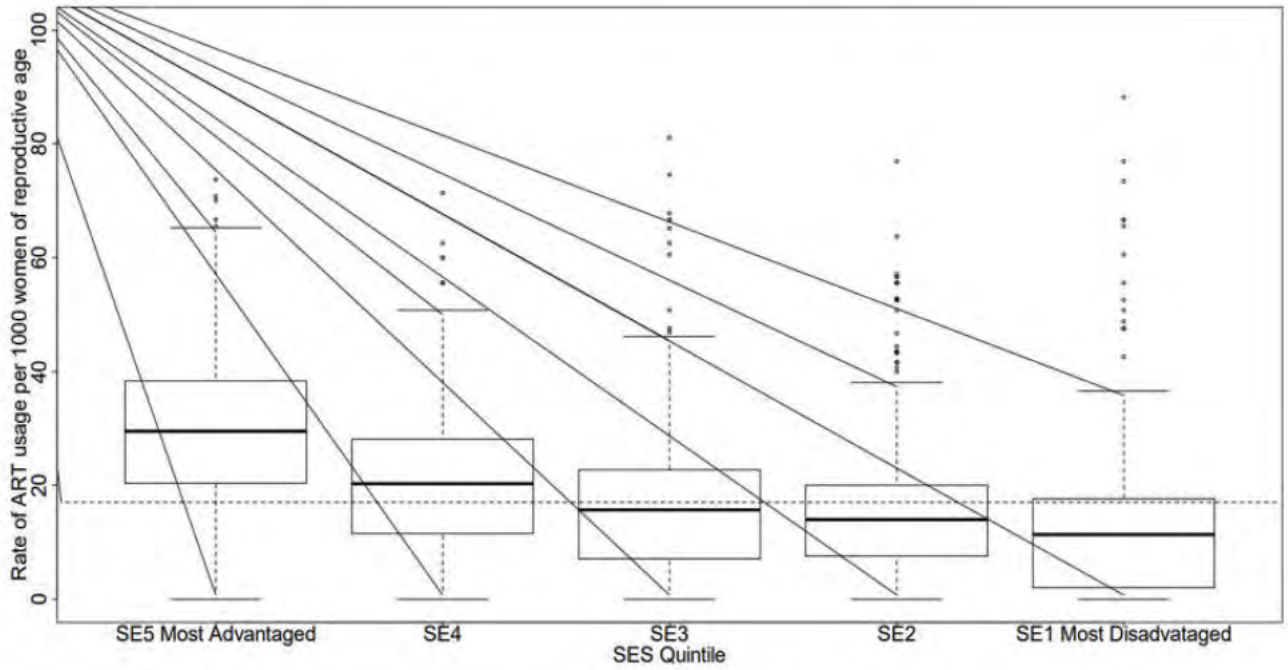
NPESU "ART Affordability"



Source: Chambers GM, et al (2014). Fertility and Sterility; 101(1) 191-198. [Plus Editorial] http://dx.doi.org/10.1016/j.fertnstert.2013.09.005

ART is nevertheless a significant economic burden on families, with up to $10,000 in out-of-pocket costs per treatment cycle in some cases. This is particularly so for lower socio-economic disadvantaged parents with the lowest rates of utilisation being for women in the most disadvantaged SES quintile.

NPESU "ART utilisation per 1000 women of reproductive age, Australia"



Source: Harris K, ... Chambers GM (2016).RBMO http://dx.doi.org/10.1016/j.rbmo.2016.07.012

Against this background, approximately 6% of Australian children are born through ART in general and IVF in particular with that number growing in both real and percentage terms and expected to grow significantly over the coming decade.

It is therefore recognised there is need for a long-term, 10-year, National Fertility Roadmap to ensure Australia and New Zealand maintain and improve their world-leading access and outcomes in ART in general, and, IVF in particular. This Roadmap will respond to the changing demographics demand and enhanced technological capability, including but not limited to Carrier Screening and Preimplantation Genetic Testing. In this context, the Roadmap is intended to help further improve governance, safety, efficacy, access, affordability, research and outcomes in IVF and ART more generally.

1. Governance

The primary issue raised in interviews and submissions is that the difference in laws and standards across over 30 pieces of legislation in 9 jurisdictions within Australia significantly impacts children, parents, donors, and the cost of ART in general, and, IVF in particular.

First, the lack of uniformity and consistency in legislation leads to varying rules regarding limits on the number of families a donor can contribute to and IVF regulation procedures. This creates challenges and potential risks for:

Children:

Differences in donor laws and the lack of a national register means that there is an increasing risk of children of serial or prolific donors unknowingly meeting and potentially partnering and having children of their own as adults. This is particularly so where there is unregulated donation in some communities. There should be a single national health standard for egg and sperm donation to ensure consistency and safe futures for children conceived by ART in general, and, IVF in particular.

There should also be a single national standard on the rights of children to seek information regarding their genetic parentage. Consideration should therefore be given to ensuring children have the right to know who donated under previous consent models and to families who are otherwise unaware that their genetic heritage differs from their social heritage.

Parents and Donors:

Given restrictions on egg donation and reported national shortages of donor eggs and sperm, there has been a growing reliance on imported gametes which may raise concerns about availability and traceability.

There should therefore be a single national health standard for egg and sperm donation to ensure consistency and safe futures for parents and donors involved in the IVF process.

There should also be a single national standard on the rights of donors for when children born from their donation choose to seek information regarding their genetic parentage.

Providers:

The friction caused by multiple laws in multiple jurisdictions increases the cost of co-ordinating IVF and therefore increases the costs of IVF to families which in turn also reduces access to IVF for many marginal, disadvantaged or lower socio-economic families.

Key Recommendations for Governance could therefore include:

Recommendation **1**

It is recommended that the Australian States and Territories work with the Commonwealth, patients, clinicians and the sector to develop a Uniform National Fertility Law for IVF which would be passed by a lead jurisdiction and adopted by others.

Recommendation **2**

The development process be facilitated through the Council of Australian Health Ministers supported by a Steering Committee composed of representatives from patients, donor conceived individuals, fertility specialists, industry experts, FSANZ professional groups (nursing, psycho-social, scientific and clinical) and legal practitioners with fertility expertise.

Recommendation **3**

As with other National Uniform Laws, while States and Territories would be strongly encouraged to maintain consistent laws there would be the capacity to vary specific sections to accommodate historic or other perspectives.

Rather than a State or Territory opting out of the National Fertility Law if there were an item that was not acceptable to that jurisdiction, the recommended approach would be for the jurisdiction to adopt the National Fertility Law and maintain a specific variation commensurate with the particular difference or reservation. Nevertheless, all jurisdictions would be strongly encouraged to adopt the National Fertility Law in full and if not to adopt the fewest possible number of variations.

Three key components of the National Fertility Law stand out. The establishment of a National Standard for donation, the harmonisation of the rights of both donors and children, and the creation of a single unified National Register to house donors and donor-conceived child information, ensuring the child's fundamental right to know about their biological origins.

In the current framework of assisted reproduction, the lack of a centralized, national system for tracking and storing genetic information of donors and donor-conceived individuals creates significant challenges in managing essential medical information. Without such a system, there is a heightened risk that individuals may be unaware of critical genetic links, leading to missed opportunities for early detection and prevention of hereditary conditions. Moreover, the absence of comprehensive records undermines the transparency and traceability of medical histories, which is crucial for ensuring donor-conceived individuals can make informed healthcare decisions. To address these pressing issues, it is vital to establish a single, National Register and genetic bank that securely stores donor information and ensures access to genetic identities, thereby supporting informed medical care and the safeguarding of individual health.

Some submissions noted that well intended State Laws had inadvertently contributed to the search for either unregulated black-market donations or made access to IVF more difficult.

> *We believe the development of this section of a National Uniform Law would need to take a broad view and consider the unintended consequences of existing legislation experienced by many Australian prospective parents today. We believe that much state legislation ignores many of these factors including the unregulated black market for sperm and international donor tourism. Unfortunately, some changes made in good faith in the past have had the unintended consequences of reducing access and increasing costs for patients who want the safety of a regulated sperm or egg donor program. Much of these practices have forced prospective parents into expensive, or dangerous situations which need to be addressed."*

In that context, the following recommendations would assist in providing national consistency for parents, children, donors, providers, practitioners and regulators.

Recommendation **4**

Develop a single National Health Standard for egg and sperm donation to ensure consistency and safety across all jurisdictions. This standard should cover donor limits and IVF regulation procedures.

Recommendation **5**

Establish a Single National Standard that guarantees the rights of children to seek information about their genetic parentage and respects the rights of donors regarding progeny seeking such information.

Recommendation **6**

Create a single National Register and genetic bank for donors and donor-conceived individuals, which provides a centralized system for tracking and accessing critical genetic information, ensuring that medical professionals and individuals are alerted to important hereditary conditions. This Register would facilitate transparency and traceability, enabling informed healthcare decisions and supporting the overall well-being of those involved. The National Register would also uphold the child's fundamental right to know their biological origins by securely housing and providing access to genetic information. This would provide the opportunity for donor-conceived individuals to learn about their heritage and identity.

Reproductive Technology Accreditation Committee (RTAC)

The accreditation and auditing of Australia's and New Zealand's ART clinics is overseen by the Reproductive Technology Accreditation Committee or RTAC.

RTAC was established by FSANZ and provides accreditation for registration by the Joint Accreditation System of Australia and New Zealand (JAS -ANZ).

RTAC oversees and implements the Australian and New Zealand Code of Practice and implements the International Code of Practice. The Scheme Rules "define the requirements for bodies providing audit and certification to these codes" (FSANZ RTAC Scheme & Code of Practices - fertilitysociety.com.au).

Although RTAC operates independently, its independence is sometimes questioned, and there are concerns about whether it has the capacity to handle the anticipated growth in IVF services and the ART sector across Australia and New Zealand.

Given this context and the evolving landscape, RTAC will need to adapt to adequately serve the future requirements, both domestically and as an international accreditation provider for ART clinics throughout the Asia-Pacific region.

The recent settlement of a major IVF provider case in relation to pre-implantation genetic testing for aneuploidy (niPGT-A) reaffirms the importance of continued improvement in both techniques and standards within the Australian IVF and related services sector. While the case was not within RTAC's current scope and settlement did not include acknowledgement of liability by any parties, other cases of patient concern underline the broader need for both a fully and visibly independent RTAC as provider regulator. They also highlight the necessity for RTAC to be fully resourced to effectively carry out its responsibilities.

In light of these concerns, it is recommended that changes be made to RTAC to equip it for the next 10 years and beyond.

Recommendation **7**

RTAC be established as a body independent of FSANZ with its own independent constitution, funding and Board.

Recommendation **8**

The establishment of an Independent RTAC could occur either under the Uniform National Law or as a company limited by guarantee. Australian States and Territories should work with the Commonwealth, patients, clinicians and the sector to develop an agreed model for RTAC.

Although it would ultimately be a matter for the Australian Commonwealth and States, the recommended model for RTAC is based on the Your IVF Success model and could contain five key pillars.

Recommendation 9

Establish an Independent RTAC based on, but not limited to, the following five key pillars:

1. **An Independent not-for-profit company set up by Guarantee with FSANZ, the Australian Commonwealth and the States as equal shareholders.**
2. **A Board comprising seven members, two members nominated by FSANZ, two from the provider sector and two by the Government (being one from State Health Departments and one from the Commonwealth) and an Independent Chair.**
3. **Increase certification and review capabilities, including through appointment of a full-time CEO with experience from the provider sector and a deep understanding of quality processes. It has been suggested that this review process could be conducted over a three-year period with different elements reviewed in each year of that cycle.**
4. **Recognition of RTAC within the Australian Uniform National Fertility Law.**
5. **Mandatory provision of IVF treatment and outcome data to the publicly accessible webpage (currently Your IVF Success) as a condition of continued accreditation preferably by 1 July 2026 or at such time as relevant legislative amendments are completed.**

An important feature of RTAC's independence is that it should be separated from full reliance on funding from the provider sector that it regulates. A hybrid funding model, drawing on both Government and private funding, would allow for more comprehensive review functions, while also ensuring both independence and appropriate contributions on a *pro rata* basis from the sector.

Recommendation 10

Funding for RTAC should be based on a hybrid model of industry sector support and Government funding. It is recommended that, in order to increase review capabilities and the ability to respond to complaints, RTAC have a Budget of $4m per annum commencing in 2025/26, to be indexed by 5% per annum to accommodate growth in IVF uptake. The proposed funding mechanism would be 50% by IVF providers and 50% by Governments with 25% coming from the Commonwealth and 25% from States and Territories on a pro rata basis. Funding should be agreed in 5-year cycles.

Recommendation 11

The revised RTAC should establish a formal complaints review process. Subject to the views of States and Commonwealth, this could include a 3-stage process:

STAGE 1	**Initial Complaints: Patients should first direct their complaints to the treating IVF clinic. Clinics are mandated to report all complaints to RTAC.**
STAGE 2	**Unresolved Complaints: If a complaint remains unresolved, it should be escalated to the relevant State or Territory Ombudsman, Commissioners, APRHA, or Complaints Office, as per the current FSANZ Complaints Handling Process. Clinics must notify RTAC in writing about any unresolved complaints.**
STAGE 3	**Any complaints submitted to RTAC which concern individual patient care will be referred to the treating clinic. If these are unresolved then they will be referred to the relevant authority. If a complaint is about the general operation of a clinic or of RTAC then these will be considered. Any legal matters should be referred to the relevant State authority. If RTAC identifies safety of efficacy concerns or breaches of the national Coode of Practice then they will have graduated powers to respond as set out in Recommendations 17 and 19.**

Recommendation 12

RTAC should be able to issue licence certificates that licensed facilities be required to display, as part of its new scope of practice under the new legislation.

It is also advised that RTAC be indemnified under legislation from suit other than for wilful malfeasance. This however would be a matter for consideration as part of the legislative process.

As part of the National Fertility Law, consideration should also be given to RTAC having graduated powers that could compel providers to undertake certain actions, desist from certain actions or refrain from certain activities until such time as safety or compliance were determined. A graduated set of powers would give greater flexibility to RTAC and providers.

A number of submissions and interviews identified the fact that RTAC's limited powers (which effectively encompass all or nothing certification of ART providers), limit their ability to support, encourage or require continuous improvement. Additionally, a clear set of benchmarks should be utilised when assessing clinics. Benchmarks may include documentation, processes for obtaining consent, laboratory and clinical outcomes.

Recommendation **13**

RTAC should have a graduated set of powers which would allow it to issue requirements for rectification or provision of information or to ensure that actions were taken or not taken until such time as rectification was completed.

Finally, it is important that there is an independent process for reviewing RTAC itself to ensure continued maintenance of regulator independence and standards. The process of independent review should be incorporated into the establishment of the Australian National Fertility Law for completion by 1 July 2026 and thereafter once every five years.

Recommendation **14**

RTAC itself should be reviewed independently as part of the process for establishing the Australian National Fertility Law and thereafter every five years.

Establishment of a National Fertility Law overseeing ART and IVF, coupled with a donor registry is a natural response to social and technical developments. It will however need to be accompanied with continuously increased oversight of individual clinics and providers to maximise patient safety and the efficacy of IVF in Australia and New Zealand.

2. Safety and Efficacy

The public online platform, Your IVF Success, affirms Australia has one of the safest and most effective IVF Programs in the world. As early as 2012, the NPESU produced the Australian and New Zealand Reproductive Database (ANZARD) Annual Report, which highlighted that the region had the lowest multiple birth rates in the world:

> *Australia and New Zealand are world leaders when it comes to safe IVF practice thanks to their focus on single-embryo transfer, according to the Assisted Reproductive Technology in Australia and New Zealand 2012 report by the National Perinatal Epidemiology and Statistics Unit at UNSW Australia.*
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> *The report confirms that Australia and New Zealand are leaders in this field of medicine. Multiple births are by far the greatest health risk to mothers and babies from IVF, and multiple embryo transfer clearly increases this risk. Australia and New Zealand share one of the lowest rates of IVF multiple births in the world (6.5%).*
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> —
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> *The vast majority (76.3%) of IVF cycles in both countries involve single-embryo transfer. For comparison, multiple birth occurs in about 30% of IVF births in the United States and in about 18% in the United Kingdom.*
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> —
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> *"These results make Australia and New Zealand the safest region in the world for women to have IVF," says* ***Associate Professor Mark Bowman****, President of the Fertility Society of Australia (FSA), which funds the annual report and national IVF register.*
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> —
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> *"Australia and New Zealand have the lowest ART multiple birth rates of any region in the world and yet maintain consistently high success rates," he says.*

Analysis completed by ANZARD in July 2024 for the report 'Assisted Reproductive Technologies – How Australia Compares', emphasises the continued high patient safety experienced in Australia.



Single embryo transfer (SET) rates are a mark of ART safety because it markedly reduces the risk of multiple birth. The SET rates vary among countries and regions. Australia has been a world leader in SET rates and thus low multiple birth rates.

In 2021, 94% of ART cycles performed in Australia were SET, resulting in a multiple birth rate of 3%. Global average is around 16%.

The reforms proposed in Section 1 aim to simplify and align governance within a uniform national framework and to support population level safety, convenience and efficacy.

In addition to the macro level reforms, continuously improving clinical oversight is a fundamental task going forwards.

While there were a variety of views on RTAC, one submission noted the contribution which RTAC and the Code have made to having a world leading set of safe outcomes for ART and IVF.

> *Australia and New Zealand have two of the safest and most successful Assisted Reproductive Technology and IVF programs, in the world." It is our belief that a major contributor to this success is the professional industry standard that has been used to accredit units since the 1980s, that has evolved over four decades in line with evolving technology and community expectations.*
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> *Significantly, that evolution has included a major restructuring in moving to independent certifying bodies, which are themselves audited and accredited by JASANZ. These certifying bodies audit and recommend accreditation and/or corrective actions of individual units to RTAC, ensuring independence from RTAC and FSANZ in the assessment process. Care needs to be taken when reassessing any part of the current RTAC Code of Practice, updated 2023, which is a major contributor to these world class programs."*

Maintaining and enhancing the safety and efficacy of ART in general, and, IVF in particular is paramount for parent and child well-being and the success of the procedures. To ensure the highest standards, the following recommendations are therefore proposed to support patient safety and continued improvement of individual clinics.

Accreditation and Certification

An important feature of the RTAC Code of Practice which was widely identified, is that it can be adapted and modified quickly to respond to either changing practices, events or international research. Consequently, the continued clinical oversight of FSANZ – coupled with an Independent RTAC – was widely viewed as an appropriate balance.

Recommendation 15

The foundation for licensing of ART units should be compliance with the RTAC Code of Practice, as well as the International Code of Practice. RTAC should have the power to withhold, grant or vary licences depending on compliance with the Codes. This power should be vested in an independent and properly resourced RTAC.

To provide additional oversight and independence in the setting of the Code itself, it is also recommended that clinically qualified representatives with experience in treating fertility should be appointed by the Commonwealth, the States collectively, the New Zealand Government and RANZCOG.

Recommendation 16

FSANZ continue as the governing body for the Australian and New Zealand Code of Practice. However, four fertility-experienced, clinically qualified representatives should be included as standing members of a new advisory board overseeing the Code, with one each appointed by the Commonwealth, the States collectively, the New Zealand Government and RANZCOG. These representatives would join existing members from FSANZ professional groups (nursing, psycho-social, scientific and clinical), a patient representative and the RTAC CEO.

A number of submissions highlighted the importance of both systemic and clinic level psychological support. Psychological support during Assisted Reproductive Technology (ART) treatment is critically important, as the emotional toll of infertility can be profound. Patients often experience stress, anxiety and grief as they navigate the complexities of treatment and the uncertainty of outcomes. Effective psychological support helps patients cope with these challenges, offering strategies to manage emotional distress and providing a safe space to express their feelings. Beyond the immediate relief, this support plays a vital role in helping patients come to terms with their infertility diagnosis, fostering resilience and enabling them to make informed, empowered decisions about their reproductive future. By addressing the psychological aspects of infertility, healthcare providers can significantly enhance the overall well-being and success of those undergoing ART treatment.

The data shows that IVF treatment can be highly successful, with over a third of women achieving a live birth within their first complete ART cycle and 57% by the sixth cycle. The estimated cumulative live birth rate could reach 76% by the sixth cycle if all women continued treatment. However, this success is contingent upon patients enduring multiple treatment cycles, which can be physically and emotionally taxing.

To increase the chances of success, it is crucial to provide comprehensive psychological support, helping patients to participate most effectively in the appropriate number of treatment cycles to facilitate the best outcomes.

There was strong and widespread feedback that the Code of Practice should have clear standards which are enforceable through the provision, withholding or variation of licences.

Recommendation **17**

The National Code of Practice should include strong and clear accreditation criteria for ART Units including:

Patient Support:

i. **Informed Consent: Ensure that all patients undergoing ART procedures provide informed consent after being thoroughly educated about the risks, benefits, and alternatives. This includes clear information about the evidence-base for optional or adjuvant treatments, potential risks of harm or complications, success rates, and the use of their data.**

ii. **Psychological Support: Provide comprehensive psychological support services for ART patients to help them cope with the emotional and mental stress associated with infertility treatments. This includes counselling, support groups and mental health resources.**

iii. **Patient Feedback Mechanisms: Implement robust feedback mechanisms to gather patient experiences and insights. This could be included in the form of Patient Reported Outcome Measures (PROMs) and Patient Experience Measures (PREMS) as part of ANZARD. This feedback should be used to improve ART practices, patient education and address any patient safety concerns.**

Licensing of ART Units: strengthen RTAC authority by providing a mechanism through which an ART clinic can be refused a licence for various reasons, such as:

i. **Non-Compliance with Standards: If the ART Unit fails to comply with the Code of Practice and guidelines set by NHMRC, a licence can be denied or conditions imposed. This includes deficiencies in procedures, equipment, staff qualifications and quality control measures.**

ii. **Inadequate Corrective Actions: During the assessment process, if issues are identified and the ART Unit does not adequately address these issues or fails to provide sufficient evidence of corrective actions, RTAC can refuse to issue a licence or require rectification.**

iii. **Poor Assessment Results: If the ART Unit performs poorly during the on-site assessment, showing significant non-conformities or a lack of adherence to best practices, RTAC can decide against licensing the ART Unit or require rectification.**

iv. **Ethical and Legal Violations: If there are ethical concerns, legal violations, or evidence of misconduct within the ART Unit, RTAC can refuse a licence to uphold the integrity and reliability of the licensing process or require rectification.**

v. **Incomplete or Misleading Information: Providing incomplete, inaccurate or misleading information during the application or assessment process can result in a refusal of licence or a requirement of rectification.**

Recommendation 18

Real-time reporting: Identify and address any safety concerns by establishing real-time reporting systems for adverse events and complications related to ART procedures with a target of 1 July 2026 subject to readiness.

RTAC should have a role in ensuring that clinical research with the context of ART clinics adheres to ethical and regulatory requirements. This responsibility is particularly crucial in light of recent legal developments that highlight the significant financial and reputational risks ART clinics can face when ethical and regulatory requirements are not strictly followed.

Recommendation 19

Review the governance and practice of clinical research within the context of ART clinics to ensure that all ethical and regulatory requirements are fulfilled, and that clinical innovation is based on rigorous and independently validated pre-clinical and other research data, including randomised controlled trials where appropriate.

One area of professional development which has been raised, although not with universal support, is certification for ART practitioners, including fertility specialists, nurses and embryologists. This would have the benefit of establishing consistent standards across the sector. The risk, as has been seen in some sectors, is inadvertently excluding competent current practitioners and potentially creating a workforce exodus or shortage.

Therefore, careful consideration of the impact and the model would be required. It is suggested, but not raised to the level of a formal recommendation, that a pilot model certification program be developed on a voluntary basis for ART practitioners, including fertility specialists, nurses and embryologists. The pilot program should ensure that all personnel involved in ART procedures have the necessary skills and knowledge to perform their roles safely and effectively. This program should be developed carefully to ensure appropriate recognition of skills for ongoing providers with a target of 1 July 2026, subject to readiness.

In addition to the pilot program, there should also be strong consideration of an enhanced continuous professional development program for ART practitioners.

Recommendation 20

Develop a requirement for ongoing professional development and training for ART practitioners to keep them abreast of the latest advancements and innovations in the field. This includes accredited workshops, conferences, and other educational activities with a target of 1 July 2026 subject to readiness.

By ensuring improved governance coupled with enhanced clinic level safety and efficacy, Australia and New Zealand have the potential to consolidate the world's strongest and safest ART and IVF sector. However, in order for all Australian and New Zealand prospective parents to be able to participate, there are still improvements to be made in terms of access to fertility support.

3. Access

IVF access in Australia is determined by three primary factors being funding, legal access, and education and awareness. In addition, proximity to services can be a barrier to regional and remote patients including geographic access options. While over 20,000 children are born in Australia and New Zealand each year through IVF there are nevertheless potential actions in each of these three areas which can assist in improving access to safe and effective IVF.

Reducing economic barriers to IVF

Australia has broad based support for ART in general, and IVF in particular, based on Medicare Rebates for qualifying prospective parents undertaking treatment. However, the cost is not fully met in most cases via public funding, which therefore requires significant private contributions that accumulate with each additional cycle. There are no significant broad-based medical exclusions to access, nor are the number of cycles capped or age limits imposed.

While there are some State based programs in Australia to assist public patients, these are limited and inconsistent, often with long waiting periods.

New Zealand has a hybrid public and private program with public patients given full coverage but with highly prescribed clinical criteria including BMI, age and smoking status as qualifying factors. While the age and other limitations encourage greater success, they limit the pool of prospective parents. One consequence is that New Zealand has a significantly lower rate of children born to IVF than Australia.

In order to assist access in both countries the following key recommendations for access could include:

Recommendation **21**

States and Territories work with the Commonwealth, patients, clinicians and the sector to develop a National Partnership Agreement for Public Patient IVF. This Agreement could follow a similar format to the National Partnership on Public Dental Services for Adults.

While the distribution mechanism for public access could be a matter for individual States, in essence there are two broad options.

First, some jurisdictions may choose to establish public IVF units, such as the current Victorian trial. Alternatively, some jurisdictions may choose to provide a low-income subsidy to women which can be redeemed through private clinics as a supplement to the existing Medicare rebate. This is the format of the proposed NSW model.

While the form of public patient access may differ between States, there should be national uniformity on the threshold for low income and disadvantaged support at the individual level. It is recommended that concession card status be the primary operating distribution threshold for public patient access.

Recommendation **22**

A National Partnership Agreement for Public Patient IVF could be comparable to the Partnership Agreement on Dental Services. It would be funded by the Commonwealth but administered by the States and Territories on a pro rata basis.

Although there were differing views on public facilities versus public support for low-income patients, there was a clear view that if public facilities are established that should be done through a transparent tendering process.

Recommendation **23**

A National Partnership Agreement for Public Patient IVF would provide services to Australians from low and limited income backgrounds, such as concessions card holders, and could include prescribed groups with disadvantages and poor access to ART in general, and IVF in particular, such as First Nation and Torres Strait Islander Australians or Māori groups.

New Zealand may wish to consider a program of partial support or rebate for patients who are not lower income or who do not meet the requirements such as BMI. This could be a partial payment such as the Medicare rebate for cycles undertaken irrespective of in which system the treatment occurs. This could help overcome lower utilisation among some population groups, particularly Māori groups, who were identified by some interviewees as inadvertently disadvantaged in access to ART in general, and, IVF in particular, by the current rules.

Reducing Discriminatory Barriers to IVF Access

While Medicare access to support ART in general, and, IVF in particular, is broadly available, there are long standing barriers to access based on clinical definitions of fertility. In this context, there was near universal support in interviews and submissions for non-discriminatory access to fertility treatment in Australia.

One contributor expressly outlined the change in patient cohorts and the consequent need for non-discriminatory access to ART in general, and, IVF in particular:

> *"The world of Australian families has significantly changed. Nowadays many of our patients are single people or couples in same-sex relationships.*
>
> *It is a serious anomaly that while heterosexual couples receive Medicare support to resolve their fertility problems and have their families, people in other family circumstances (such as same sex couples or single women freezing their eggs) receive no support at all for their fertility problems.*
>
> *Future governments should consider this serious anomaly in planning future funding to allow the same access to fertility treatment for people outside traditional male female relationships. The ten-year plan for fertility should include a recognition of the strategic importance of fertility for the nation and support for non-discriminatory access to fertility treatment."*

In that context alongside uniform national legislation, the most widely supported recommendation to the inquiry was the need for non-discriminatory access to fertility treatment.

This view has been recently supported by the August 2024 joint statement of ANZSREI (Australian and New Zealand Society for Reproductive Endocrinology and Infertility) along with FSANZ and RANZCOG on the definition of infertility and the importance of non-discriminatory access to publicly funded IVF and ART.

"Definition of Infertility: Consensus Statement

August 2024

ANZSREI (Australian and New Zealand Society for Reproductive Endocrinology and Infertility), has extended its definition of Infertility. This extension is consistent with the American Society of Reproductive Medicine (ASRM) definition of Infertility which was accepted by the ASRM in 2023. These extensions are outlined below. This extension in definition has been endorsed by FSANZ (Fertility Society of Australia and New Zealand) and RANZCOG (Royal Australian and New Zealand College of Obstetricians and Gynaecologists).

The extensions are made to improve inclusiveness and equitable access to reproductive care irrespective of relationship status, sexual orientation or gender identity.

The revised definition states that infertility is a disease condition or status characterised by any of the following:

1. The inability to achieve a successful pregnancy based on a parent's medical, sexual and reproductive history, age, physical findings, diagnostic testing, or any combination of those factors.
2. The need for medical intervention, including, but not limited to, the use of donor gametes or donor embryos in order to achieve a successful pregnancy either as an individual or with a partner.
3. In patients having regular, unprotected intercourse and without any known aetiology for either partner suggestive of impaired reproductive ability, evaluation should be initiated at 12 months when the female partner is under 35 years of age and at 6 months when the female partner is 35 years of age or older.

Nothing in the definition should be used to deny or delay treatment to any individual, regardless of relationship status or sexual orientation."

Recommendation **24**

The ANZREI expanded Definition of Infertility be adopted as the basis for expanded and non-discriminatory access to IVF and ART. State and Medicare support for ART in general and IVF in particular, should be available to prospective parents wishing to conceive who are unable to do so or who are in need of donor eggs, sperm, or embryos in order to achieve a successful pregnancy.

A significant anomaly which was identified during the course of interviews and submissions was the difference in legal identity and rights of children born through IVF and sperm donation depending upon the marital or partnership status of the mother.

One submission highlighted that single parents by choice are now the largest group using donor sperm. This has created an unintended outcome whereby donors cannot claim parentage if the recipient mother is partnered, but they can if the recipient mother is single.

> *In recent decades, single mothers by choice (SMCs) have emerged as a new and rapidly growing non-traditional family structure in Australia and other parts of the world. SMCs are unpartnered women who choose to have a child, usually via some form of assisted conception, with the intention that they be their child's sole parent.*
>
> *While the exact number of SMC in Australia is unknown, according to the Victorian Assisted Reproductive Treatment Authority (2023; VARTA) Annual Report, single women are the largest group using donor sperm (53%) followed by same sex relationships (36%) and people in heterosexual relationships (11%).*

Problem >

S 60H of the Family Law Act (1975) outlines parentage of children born as a result of artificial conception procedures.

At present, unpartnered women who conceive using artificial conception procedures are omitted/not included in S 60H of the Family Law Act (1975; FLA) leaving SMCs and their children without the same legal protection and certainty provided to heterosexual and homosexual couples who use donor sperm to conceive their children.

Donors to lesbian and heterosexual couples are expressly excluded from legal parentage by s 60H, but no identical provision applies when the woman is unpartnered. The result is that sperm donors to SMCs, whether known or unknown (i.e., a donor from a fertility clinic), may apply to be legal parents.

A number of unpartnered women have come before the Family Court in matters where sperm donors have successfully applied for legal parentage. In these cases, judges have determined that s 60H does not apply to unpartnered women because they do not fit into any of the scenarios addressed by the section.

The Family Law Council in its report of parentage and the FLA in 2013 raised this concern stating that the FLA has a 'discriminatory effect' in relation to single women as opposed to women with partners. The prospect of unknown donors being legal parents has serious ramifications for SMCs and their children (and donors), particularly in Victoria, where parents can apply for "early access" to their sperm donor's identity, with his consent, through the VARTA Central Register. Victorian SMCs are now frequently meeting their child's "unknown" donor while their child is still a minor, often unaware they are putting themselves and their children at legal risk.

Solution > Urgent amendment of S 60H of the Family Law Act (1975) to include unpartnered women and their children stating that a donor is not a parent, aligning the rights of unpartnered women with the rights of heterosexual and lesbian couples."

Recommendation **25**

It is recommended that the National Fertility Law review and align the rights of unpartnered individuals and their children with the rights of partnered couples and consider amending the Family Law Act to remove discrimination based on marital status for donor recipients and their children.

Improving Access through Education

Evidence shows there is low community awareness about fertility and the factors that affect it, especially among men. This is in part because most fertility related information targets only women. A key pathway to improving access and reproductive outcomes is through public education providing education on lifetime fertility factors and options for both men and women. This would involve a greater role for community and patient education and awareness. At the same time, building awareness across the community of national fertility needs may also assist in increasing gamete and embryo donation.

Recommendation **26**

FSANZ engage pedagogy experts to assist in the development of nationally appropriate school-based curriculum on fertility. As part of this process, FSANZ engage with the state and federal Ministers for Health and Education.

Recommendation **27**

FSANZ work with Public Health and Community engagement experts to develop a wider community education campaign on fertility health promotion to enhance awareness of fertility and the factors that affect it. This should include campaign elements that specifically target men.

4. Research and Technology

Australia has one of the world's leading IVF Research programs through the combined work of our universities, the NH and MRC and the IVF and ART sector represented by FSANZ. However, given the prevalence of IVF which now accounts for over 6% of births in Australia and the expected growth, it is recommended that there should be a single National Fertility Mission conducted through the MRFF to help address declining national birth rates in both Australia and New Zealand.

ANZARD, Your IVF Success, Your Fertility Information and National Donor Registry

Australia has the oldest and arguably the most comprehensive IVF data set in the world in the form of ANZARD (The Australian and New Zealand Assisted Reproduction Data) which has been in operation since 1979.

It also has one of the world's leading IVF prediction tools in the form of the public online platform *Your IVF Success*.

ANZARD has been fundamental to the safety and success of Australia's IVF system to date and is critical to the continued safety. More recently, the public online platform Your IVF Success has provided information to help individuals and couples navigate the process of IVF.

While the current model is globally leading, there is the potential to improve the breadth of information provided to Australian IVF patients which in turn will support patient choice, procedural safety, success rates and research outcomes. This should include integrating Your Fertility Information, an online platform that provides trustworthy information and resources for the public about fertility health, infertility prevention, infertility treatment, donor conception and surrogacy. IVF patients should also be provided with evidence-based information about the risks, benefits and costs of IVF adjuvants and options. This information should be based on current evidence and provided in various formats to accommodate different levels of health literacy including translations for people from non-English speaking backgrounds.

ANZARD, is co-funded by FSANZ, UNSW and various grants. To ensure the long-term sustainability and continued excellence of ANZARD, there is a need for an ongoing funding model.

The Australian Federal Government funded YourIVFsuccess.com, a public online platform that provides information and tools to help individuals and couples navigate the process of IVF. It offers access to success rate data from Australian IVF clinics, educational resources about fertility treatments and a personalized treatment estimator. The platform aims to support informed decision-making by offering transparency and insights into the IVF process, helping users better understand their chances of success and explore different fertility options. Your IVF Success funding announced in 2019 is due to expire in mid-2025. This funding should be formalised to allow for the long-term stability of both ANZARD and the public online platform.

Recommendation 28

The Australian Federal Government should commit to 5-year funding for ANZARD Australia and New Zealand Reproductive Database, and Your IVF Success (currently provisioned for with an Australian Federal Government grant to NPESU at the UNSW).

A modest cost model as submitted by the NPESU is $1.3m per annum for five years for ANZARD. A similar modest cost 5-year funding arrangement for the Your IVF Success site should be funded by the Commonwealth – as is the case currently – and would require a base of $1m per annum.

If Australia were to establish a National Donor Registry, as set out in Recommendation 7, ANZARD (Australia and New Zealand Reproductive Database), which is currently housed by NPESU at the University of New South Wales (UNSW).would be the natural repository for such data, subject to periodic review. ANZARD would therefore carry out three primary data roles: custodian of the IVF data set, custodian of the public online platform (Your IVF Success) and its related data, and custodian of the National Donor Registry. Similar funding would need to be allocated to establish and maintain the National Donor Registry. It is also advised that the funding be over five years and $1m be allocated for once off development of the National Donor Registry.

Recommendation 29

ANZARD be the custodian of the National Donor Registry with the Federal Government to commit $1m to establish the Registry and $1m per annum for five years to maintain and operate the Registry.

Total Commonwealth funding to support IVF administration under a low operating-cost model would be $4.3m per annum. This would comprise



$1.3m for Australia ANZARD, which is currently housed by the NPESU at the UNSW.

$1m for the public online platform Your IVF Success and data set managed in conjunction with ANZARD

$1m for the National Donor Registry which could be added to the ANZARD portfolio; and

$1m as the Commonwealth contribution for a shared cost independent RTAC.

There is an inadvertent risk that the publishers of the public online platform Your IVF Success and ANZARD, as well as the new donor registry, could be sued by patients who are disappointed by their outcomes, by clinics that do not accept the statistics, or others. To mitigate against this risk, it would be appropriate to amend the 2002 Human Reproduction Act to indemnify the publishers and operators of ANZARD against consequential suits resulting from publication of relevant information, other than as a result of wilful misfeasance.

Carrier Screening

Whilst patient rebates through a Medicare item number currently apply to three genetic conditions, research through the MRFF funded Mackenzie's Mission Program shows that covering more conditions holds significant benefit to Australia, to families and to children born through IVF, by helping to reduce the risk of catastrophic and potentially terminal or lifelong genetic conditions in newborns.

The current process of using a Medicare item number to offer free screening is a critical step forward.

One option is, therefore, continuing to expand the range of conditions covered via Medicare funded Carrier Screening with the goal of achieving the full 1,300 conditions recommended through the Mackenzie's Mission MRFF Program.

An alternative model proposed by Australian Genomics in their submission is to offer Expanded Reproductive Carrier Screening (ERCS) through a nation-wide screening program, similar to that of Bowel Cancer Screening. Any screening program at scale would need to be partnered with the appropriate genetic counselling to manage both the biological underpinnings of screening, but also any considerations related to insurance or other post-screening considerations.

The background to this recommendation is MSAC application 1637. MSAC supported an initial program for Medicare funded Carrier Screening for Cystic Fibrosis, Fragile X and Spinal Muscular Atrophy. *"Expanded reproductive carrier testing of couples for joint carrier status of genes associated with autosomal recessive and X-linked conditions"* was considered by MSAC in July 2022. At that meeting, MSAC did not recommend public funding for the full 1,300 conditions proposed, however, the Public Summary Document (PSD) for 1637 recognised the unmet need for, and inequity of access to, ERCS in Australia. MSAC recommended that the Department of Health and Aged Care consider the most appropriate implementation methodology of ERCS, noting the need for infrastructure and coordination more conventionally associated with screening programs than Medicare-subsidised item numbers.

In considering the entirety of service provision for ERCS, Australian Genomics has submitted that an organised national screening program offers advantages in terms of governance; public awareness and information provision; referral and consent processes; provision of services for diverse population groups; sample collection, processing and testing; post-test counselling and clinical referral; and, critically, data management and security. It also allows for consistency in the information and handling provided to identified high risk couples.

Delivery of ERCS as an organised national screening program has the potential to mitigate many of the risks associated with population-scale genomic testing and provides opportunities for health system efficiency and economies of scale, while ensuring equity of access to all Australians who want ERCS.

Recommendation **30**

The Australian Government consider an Expanded National Carrier Screening Program to offer all Australian parents access to screening conditions proposed under Mackenzie's Mission. Alternatively, the Government support the expansion of the current Medicare funded Carrier Screening Model conditions recommended under the MRFF funded Mackenzie's Mission Research Program.

Donation for Research & Medical Research Future Fund Mission

Several submissions highlighted that patient safety and success rates of IVF are hampered by legal research frameworks that need updating.

Some submissions highlighted that, at present, it is too onerous a process for most clinics to apply for an NHMRC training licence, and thus as the law stands, clinics are unable to utilise material within their clinic that has ceased to grow and/or has been deemed non-transferable which is then simply discarded. Under NHMRC guidelines, these are classed as 'excess embryos' and even if a training licence were in place, the clinic requires patient consent for their 'unsuitable for transfer embryos' to be used for training.

(https://www.nhmrc.gov.au/sites/default/files/documents/attachments/embryo-research-licence/additional-information-on-obtaining-consent.pdf.)

One submission noted the need for an option of broad consent for IVF participants to offer donation of surplus or unviable materials for subsequent research or use by other prospective parents. This includes the capacity both for an upfront general consent for surplus eggs, sperm or embryos to be used for either or both of research, training or donation to other prospective parents. It also includes a dynamic consent model which would allow donors to subsequently change their decisions for any prospective use including the right to discard unused or unviable material.

Donation of reproductive materials for research is currently limited by several factors, primarily: the lack of information and understanding of potential ART patients of the opportunities for donation to research; the requirement that donation can only occur to identified current research projects; and unwieldy consent procedures that result in significant quantities of frozen gametes and embryos being discarded.

Consideration should be given to the adoption of three changes to current consent procedures:

1. The implementation of a dynamic consent interface for the maintenance of valid consent across the treatment period. Such online platforms are often used by genomic biobanks; within the context of ART, the implementation of an online consent platform for maintaining valid consent could also work as a means of providing clear and up-to-date information about research donation opportunities.

2. The removal of the requirement for specific consent. A model of broad consent is again becoming common in genomic research; it entails that rather than secondary consent having to be obtained to use biobanked material or data in subsequent research projects, initial consent is sufficiently broad as to be relevant for a variety of research uses. In the ART context, broad consent could be tailored to allow for consent to certain applications of research that may be considered controversial for some patients (e.g. research that involves embryo destruction).

3. Replacing the current requirement that abandoned reproductive materials (i.e., materials where the owner is no longer responding to contact from the clinic, which may include not paying storage fees) be discarded upon reaching storage limits. This is resulting in significant numbers of oocytes and other reproductive material being discarded when it could be used in research to enhance the safety and efficacy of ART procedures. Instead, then, the 'default' option for abandoned materials could be changed from discard to donation to research. That this is the disposition outcome in the situation of abandonment would need to be clear from the start of treatment, something which could be managed through robust and fit for purpose consent procedures such as a dynamic consent platform.

Recommendation 31

All clinics should be required to provide patients with a standard form optional donor consent with a plain English guide that would allow prospective IVF patients to donate surplus or unviable eggs, sperm or embryos or any combination thereof to research without the need for a subsequent second consent. Nationally accepted content forms could be authorized by RTAC. The Uniform National Law could contain any necessary legislative amendments.

A National Donor Bank may include either or both of two primary functions. First, the Bank may involve donation of eggs, gametes or embryos by others through a virtual network in which clinics may choose to participate. Second, it could also involve the contribution of excess materials for research.

While it is a matter for FSANZ first and Governments subsequently as to whether either or both of those functions are established, there was significant support through submissions and interviews for broader access to donated eggs, gametes or embryos, so as to reduce reliance on imported and black market donations with potentially lesser or, in the case of the black markets, no standards, for maintenance and provenance of donated material. This is particularly important for single mothers and same sex couples as well as others who may have difficulty in obtaining donated eggs, gametes or embryos within Australia.

Equally, there was strong support for a National Research Bank of excess materials for research and training to help ensure that Australian clinicians and clinical practice remain world leading and continue to improve.

In the case of donation for IVF, while up front consent is recommended it would be necessary to give potential donors both understanding and express choice about donation for IVF purposes to known recipients, to the broader clinic or to the virtual National Donor Bank. Donors should also have the option of a secondary consent prior to use. In addition, it would be crucial to offer psychological counselling for participants who consent to use of their surplus eggs, sperm, or embryos to other prospective parents. This counselling should address the emotional and psychological implications, helping participants fully understand the potential impact on themselves and their future. Donors should also have the option for reassessment of their consent, through dynamic consent, ensuring that the decision to donate aligns with their current values and emotional state.

A separate upfront consent is recommended for contribution of excess material to research with the option of a general donation to research or training or both. There should also be the option of a secondary consent prior to use and the ability to reassess consent.

It has also been proposed that those clinics and institutes requiring human embryos of a certain stage for research could apply to their HREC for ethics approval.

All eggs, sperm and embryos could be allocated from the National Donor Bank on a yearly basis. All excess embryos from the project would be returned to the Bank at the end of the project and be returned to the pool for reallocation.

An important consideration is that a National Fertility Research Mission under the MRFF could potentially be funded without having to seek additional funds from within the unallocated portion of the MRFF Missions forward projections under the existing 2nd Revised MRFF 10 Year Plan.

Recommendation 32

The Australian Government establish a 10-Year National Fertility Research Mission as a new mission under the Medical Research Future Fund with a representative from Scientists in Reproductive Technology (SIRT) to be included in the steering committee for the mission.

Recommendation 33

The 10-Year Nationality Fertility Research Mission would seek to address the following actions through multidisciplinary research:

Improving Australia's birth rate.	Benchmarking of Australia's IVF safety and effectiveness by global comparison.	Assessment and evaluation of emerging global technologies and techniques, including IVF options and adjuvants, to further improve IVF safety and effectiveness.
Use of broader ART techniques and practices to increase Australia's IVF safety and effectiveness.	Continued expansion of carrier screening as standard of care to reduce the number of children born with life threatening or debilitating genetic conditions.	Consideration of the emerging science around most effective ovulation stimulation procedures, timing and ages.
Consideration of future egg storage programs and practices in Australia and New Zealand.	Identification of global best practice for education of prospective parents.	Ongoing assessment of psychosocial implications and outcomes following ART use to ensure the practice reflects and promotes patient best interests.

Conclusion and Next Steps

FSANZ has developed its 10-Year National Fertility Roadmap based on four key pillars:

1	2	3	4
Governance	Safety and Efficacy	Access	Research and Technology

These pillars and the associated recommendations aim to improve the safety, efficacy and IVF experience for patients and ultimately help increase the number of healthy babies born through ART in Australia and New Zealand.

This in turn should contribute to the development of a National Fertility Plan co-ordinated through the National Council of Health Ministers.

In order to translate the FSANZ National Fertility Roadmap into concrete policy action and patient benefits, it is strongly recommended that the Australian and State and Territory Governments commit to a 10-year National Fertility Plan. This Plan would itself have a series of components including a National Fertility Law, National Donor Registry, National Donor Bank, a 10-Year MRFF Fertility Mission and a National Fertility Roundtable.

Recommendation 34

The Australian Government develop a National Fertility Plan which includes the following components:

- National Fertility Law
- National Donor Registry
- National Donor Bank
- A 10-Year MRFF Fertility Mission
- A National Fertility Roundtable which would help establish Terms of Reference for both the Mission and the proposed law.

Ultimately, Australia now has over **300,000 children that have been born through IVF** and this is increasing by over 20,000 new lives being brought into the world each year. Changing social needs and technological capabilities mean that the number of healthy babies is likely to increase significantly in the next 10 years. Against that background, FSANZ stands ready to work with the Australian, New Zealand and State Governments, clinicians and researchers, and above all else the Australian and New Zealand community in establishing a 10 Year National Fertility Plan to help improve safety, efficacy and access to IVF in Australia and New Zealand.

List of Australian Laws relating to IVF

1. *Health Insurance Act 1973 (Commonwealth)*
2. *Human Services (Medicare) Act 1973 (Commonwealth)*
3. *Mitochondrial Donation Law Reform (Maeves Law) Act 2022 (Commonwealth)*
4. *National Health Amendment (Pharmaceutical Benefits Scheme) Act 2012 (Commonwealth)*
5. *NHMRC Ethical guidelines on the use of assisted reproductive technology in clinical practice and research 2017 (updated 2023) (Commonwealth)*
6. *Private Health Insurance Act 2007 (Commonwealth)*
7. *Prohibition of Human Cloning for Reproduction Act 2002 (Commonwealth)*
8. *Research involving Human Embryos Act 2002 (Commonwealth)*
9. *Research Involving Human Embryos Regulations 2017 (Commonwealth)*
10. *Assisted Reproductive Technology Act 2024 (ACT)*
11. *Parentage (Surrogacy) Amendment Bill 2003 (ACT)*
12. *Assisted Reproductive Technology Act 2007(NSW)*
13. *Assisted Reproductive Technology Regulation 2014 (NSW)*
14. *Status of Children Act 1996 (NSW)*
15. *Status of Children Regulation (2019 (NSW)*
16. *Surrogacy Act 2010 (NSW)*
17. *Surrogacy Regulation 2016 (NSW)*
18. *Human Assisted Reproductive Technology Act 2004 (NZ)*
19. *Status of Children Act 1978 (NT)*
20. *Status of Children Regulations 1996 (NT)*
21. *Surrogacy Act 2022 (NT)*
22. *Surrogacy Regulations 2022 (NT)*
23. *Surrogacy Act 2010 (QLD)*
24. *Assisted Reproductive Treatment Act 1988 (SA)*
25. *Assisted Reproductive Treatment Regulations 2010 (SA)*
26. *Surrogacy Act 2019 (SA)*
27. *Surrogacy Regulations 2020 (SA)*
28. *Human Cloning for Reproduction and Other Prohibited Practices Act 2003 (TAS)*
29. *Surrogacy Act 2012 (TAS)*
30. *Assisted Reproductive Treatment Act 2008 (VIC)*
31. *Assisted Reproductive Treatment Regulations 2019 (VIC)*
32. *Health Services (Health Services Establishments) Regulations 2013 (VIC)*
33. *Health Services Act 1988 (VIC)*
34. *Status of Children Act 1974 (VIC)*
35. *Status of Children Regulations 2014 (VIC)*
36. *Artificial Conception Act 1985 (WA)*
37. *Human Reproductive Technology Act 1991 (WA)*
38. *Human Reproductive Technology Regulations 1993 (WA)*
39. *Human Tissue and Transplant Act 1982 (WA)*
40. *Human Tissue and Transplant Regulations 2024 (WA)*
41. *Surrogacy Act 2008 (WA)*

List of interview-based contributors to review

Interviewees	Organisation
Prof. Gordon Baker	Former FSANZ President (1988-1989)
Associate Prof. Kiri Beilby	Monash University
Tiffany Boughtwood	Australian Genomics
Associate Prof Sally Catt	Monash University
Dr. Fleur Cattrall	MelbourneIVF
Professor Georgina Chambers	Director National Perinatal Epidemiology and Statistics Unit, UNSW
Dr. Anne Coffey	Far North Fertility, Cairns
Dr. Chris Copeland	Chair, RTAC
Prof. Martin Delatycki	Victorian Clinical Genetics Services
Mr. Rick Forbes	FSANZ
Mr. Michael Gorton, AM	Principal, Russell Kennedy Lawyers
Dr. Matilda Haas	Australian Genomics
Dr. Karin Hammarberg	Monash University
Dr. Richard Henshaw	Past Chair of IVF Medical Directors, ANZ
Associate Prof. Peter Illingworth	Virtus Health
Dr. Molly Johnston	Monash Bioethics Centre
Ms. Rebecca Kerner	Chair, ANZICA
Dr. Sarah Lensen	University of Melbourne
Associate Prof. John McBain, AO	Former FSANZ President (1992)
Dr. Simon McDowell	Fertility Associates NZ
Prof. Catherine Mills	Monash Bioethics Centre
Dr. David Molloy	Director, Medical Affairs, Virtus Health
Ms. Jayne Mullen	Chairperson, Scientists in Reproductive Technology
Ms. Kate Munnings	CEO, Vitrafy
Mr. David Nathan	City Fertility
Mr. Stephen Page	Page Provan Lawyers
Dr. John Peek, CNZM	Fertility NZ
Dr. Adrianne Pope	Adrianne Pope Consulting
Prof. Stephen Robson	President, AMA & Former President RANZCOG
Ms. Rachel Samson	Clinical Psychologist & Reg 7 Family Consultant Federal Circuit and Family Court of Australia
Dr. Petra Wale	President, FSANZ

Additional interviewees may be added to this list once appropriate consents have been processed.

Written submissions to this review

A list of written submissions will be included once appropriate consents have been processed.

Key Facts

Key stats from the 2021 Australian and New Zealand Assisted Reproduction Database (ANZARD) Report

111,253 ART treatment cycles were performed in Australian and New Zealand ART Units in 2021 (102,157 and 9,096, respectively), representing an overall increase of **16.3% from 2020**



Of the 111,253 initiated ART cycles,

20,690 babies were born.

Of these, 18,594 (89.9%) were from treatments performed in Australian ART Units and 2,096 (10.1%) were from New Zealand ART Units.

Of the 108,273 autologous and recipient cycles,

11.9% were undertaken by **single female** and **4.1%** by **female-female intending parents**.

The proportion of births that were twins or triplets was **3%**



Women used their own **eggs or embryos** in

95% in 2021

62.3% were fresh cycles, and

377.3% were thaw cycles

Over a third (37.1%) of women who commenced ART in 2018 or 2019 achieved a **live birth in their first ART cycle**. After three complete ART cycles, women had between 53.6% and 63% chance of achieving a live birth.

There were **5,881** fertility preservation cycles performed in 2021, representing an increase of **61.5% from 2020.**



Full List of Recommendations

1. It is recommended that the Australian States and Territories work with the Commonwealth, patients, clinicians and the sector to develop a Uniform National Fertility Law for IVF which would be passed by a lead jurisdiction and adopted by others.

2. The development process be facilitated through the Council of Australian Health Ministers supported by a Steering Committee composed of representatives from patients, donor conceived individuals, fertility specialists, industry experts, FSANZ professional groups (nursing, psycho-social, scientific and clinical) and legal practitioners with fertility expertise.

3. As with other National Uniform Laws, while States and Territories would be strongly encouraged to maintain consistent laws there would be the capacity to vary specific sections to accommodate historic or other perspectives.

4. Develop a single National Health Standard for egg and sperm donation to ensure consistency and safety across all jurisdictions. This standard should cover donor limits and IVF regulation procedures.

5. Establish a Single National Standard that guarantees the rights of children to seek information about their genetic parentage and respects the rights of donors regarding progeny seeking such information.

6. Create a single National Register and genetic bank for donors and donor-conceived individuals, which provides a centralized system for tracking and accessing critical genetic information, ensuring that medical professionals and individuals are alerted to important hereditary conditions. This Register would facilitate transparency and traceability, enabling informed healthcare decisions and supporting the overall well-being of those involved. The National Register would also uphold the child's fundamental right to know their biological origins by securely housing and providing access to genetic information. This would provide the opportunity for donor-conceived individuals to learn about their heritage and identity.

7. RTAC be established as a body independent of FSANZ with its own independent constitution, funding and Board.

8. The establishment of an Independent RTAC could occur either under the Uniform National Law or as a company limited by guarantee. Australian States and Territories should work with the Commonwealth, patients, clinicians and the sector to develop an agreed model for RTAC.

9. Establish an Independent RTAC based on, but not limited to, the following five key pillars:

    - An Independent not-for-profit company set up by guarantee with FSANZ, the Australian Commonwealth and the States as equal shareholders.
    - A Board comprising seven members, two members nominated by FSANZ, two from the provider sector and two by the Government (being one from State Health Departments and one from the Commonwealth) and an Independent Chair.
    - Increase certification and review capabilities, including through appointment of a full-time CEO with experience from the provider sector and a deep understanding of quality processes. It has been suggested that this review process could be conducted over a three-year period with different elements reviewed in each year of that cycle.

- Recognition of RTAC within the Australian Uniform National Fertility Law.
- Mandatory provision of IVF treatment and outcome data to the publicly accessible webpage (currently Your IVF Success) as a condition of continued accreditation preferably by 1 July 2026 or at such time as relevant legislative amendments are completed.

10. Funding for RTAC should be based on a hybrid model of industry sector support and Government funding. It is recommended that, in order to increase review capabilities and the ability to respond to complaints, RTAC have a Budget of $4m per annum commencing in 2025/26, to be indexed by 5% per annum to accommodate growth in IVF uptake. The proposed funding mechanism would be 50% by IVF providers and 50% by Governments with 25% coming from the Commonwealth and 25% from States and Territories on a pro rata basis. Funding should be agreed in 5-year cycles.

11. The revised RTAC should establish a formal complaints review process. Subject to the views of States and Commonwealth, this could include a 3-stage process:
    - **Initial Complaints**: Patients should first direct their complaints to the treating IVF clinic. Clinics are mandated to report all complaints to RTAC.
    - **Unresolved Complaints**: If a complaint remains unresolved, it should be escalated to the relevant State or Territory Ombudsman, Commissioners, APRAH, or Complaints Office, as per the current FSANZ Complaints Handling Process. Clinics must notify RTAC in writing about any unresolved complaints.
    - **Any complaints submitted to RTAC** which **concern individual patient care will be** referred **to the** treating clinic. If these are unresolved then they will be referred to the relevant **authority**. If a complaint is **about** the general operation of a clinic or of RTAC then these will be considered. Any legal matters should be referred to the relevant State authority. If RTAC identifies safety of efficacy concerns or breaches of the national Code of Practice then they will have graduated powers to respond as set out in Recommendations 17 and 19.

12. RTAC should be able to issue licence certificates that licensed facilities be required to display as part of its new scope of practice under the new legislation.

13. RTAC should have a graduated set of powers which would allow it to issue requirements for rectification or provision of information or to ensure that actions were taken or not taken until such time as rectification was completed.

14. RTAC itself should be reviewed independently as part of the process for establishing the Australian National Fertility Law and thereafter every five years.

15. The foundation for licensing of ART units should be compliant with the RTAC Code of Practice, as well as the International Code of Practice. RTAC should have the power to withhold, grant or vary licensing depending on compliance with the Codes. This power should be vested in an independent and properly resourced RTAC.

16. FSANZ continue as the governing body for the Australian and New Zealand Code of Practice. However, four fertility-experienced, clinically qualified representatives should be included as standing members of a new advisory board overseeing the Code, with one each appointed by the Commonwealth, the States collectively, the New Zealand Government and RANZCOG. These representatives would join existing members from FSANZ professional groups (nursing, psycho-social, scientific and clinical), a patient representative and the RTAC CEO.

17. The National Code of Practice should include strong and clear accreditation criteria for ART Units including:

Patient Support:

i. Informed Consent: Ensure that all patients undergoing ART procedures provide informed consent after being thoroughly educated about the risks, benefits and alternatives. This includes clear information about the evidence-base for optional or adjuvant treatments, potential risks of harm or complications, success rates and the use of their data.

ii. Psychological Support: Provide comprehensive psychological support services for ART patients to help them cope with the emotional and mental stress associated with infertility treatments. This includes counselling, support groups and mental health resources.

iii. Patient Feedback Mechanisms: Implement robust feedback mechanisms to gather patient experiences and insights. This could be included in the form of Patient Reported Outcome Measures (PROMs) and Patient Experience Measures (PREMS) as part of ANZARD. This feedback should be used to improve ART practices, patient education and address any patient safety concerns.

Licensing of ART Units: strengthen RTAC authority by providing a mechanism through which an ART clinic can be refused a licence for various reasons, such as:

i. Non-Compliance with Standards: If the ART Unit fails to comply with the Code of Practice and guidelines set by NHMRC, a licence can be denied or conditions imposed. This includes deficiencies in procedures, equipment, staff qualifications and quality control measures.

ii. Inadequate Corrective Actions: During the assessment process, if issues are identified and the ART Unit does not adequately address these issues or fails to provide sufficient evidence of corrective actions, RTAC can refuse to issue a licence or require rectification.

iii. Poor Assessment Results: If the ART Unit performs poorly during the on-site assessment, showing significant non-conformities or a lack of adherence to best practices, RTAC can decide against licensing the ART Unit or require rectification.

iv. Ethical and Legal Violations: If there are ethical concerns, legal violations, or evidence of misconduct within the ART Unit, RTAC can refuse a licence to uphold the integrity and reliability of the licensing process or require rectification.

v. Incomplete or Misleading Information: Providing incomplete, inaccurate, or misleading information during the application or assessment process can result in a refusal of licence or a requirement of rectification.

18. Real-time reporting: Identify and address any safety concerns by establishing real-time reporting systems for adverse events and complications related to ART procedures with a target of 1 July 2026 subject to readiness.

19. Review the governance and practice of clinical research within the context of ART clinics to ensure that all ethical and regulatory requirements are fulfilled, and that clinical innovation is based on rigorous and independently validated pre-clinical and other research data, including randomised controlled trials where appropriate.

20. Develop a requirement for ongoing professional development and training for ART practitioners to keep them abreast of the latest advancements and innovations in the field. This includes accredited workshops, conferences and other educational activities with a target of 1 July 2026, subject to readiness.

21. States and Territories work with the Commonwealth, patients, clinicians and the sector to develop a National Partnership Agreement for Public Patient IVF. This Agreement could follow a similar format to the National Partnership on Public Dental Services for Adults.

22. The National Partnership Agreement for Public Patient IVF could be comparable to the partnership Agreement on Dental Services. It would be funded by the Commonwealth but administered by the States and Territories on a pro rata basis.

23. A National Partnership Agreement for Public Patient IVF would provide services to Australians from low and limited income backgrounds such as concessions card holders and could include prescribed groups with disadvantages and poor access to ART in general, and IVF in particular, such as First Nation and Torres Strait Islander Australians or Māori groups.

24. The ANZREI expanded Definition of Infertility be adopted as the basis for expanded and non-discriminatory access to IVF and ART. State and Medicare support for ART in general and IVF in particular, should be available to prospective parents wishing to conceive who are unable to do so or who are in need of donor eggs, sperm, or embryos in order to achieve a successful pregnancy.

25. It is recommended that the National Fertility Law review and align the rights of unpartnered individuals and their children with the rights of partnered couples and consider amending the Family Law Act to remove discrimination based on marital status for donor recipients and their children.

26. FSANZ engage pedagogy experts to assist in the development of nationally appropriate school-based curriculum on fertility. As part of this process, FSANZ engage with the state and federal Ministers for Health and Education.

27. FSANZ work with Public Health and Community engagement experts to develop a wider community education campaign on fertility health promotion to enhance awareness of fertility and the factors that affect it. This should include campaign elements that specifically target men.

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29. ANZARD be the custodian of the National Donor Registry with the Federal Government to commit $1m to establish the Registry and $1m per annum for five years to maintain and operate the Registry.

30. The Australian Government consider an Expanded National Carrier Screening Program to offer all Australian parents access to screening conditions proposed under Mackenzie's Mission. Alternatively, the Government support the expansion of the current Medicare funded Carrier Screening Model conditions recommended under the MRFF funded Mackenzie's Mission Research Program.

31. All clinics should be required to provide patients with a standard form optional donor consent with a plain English guide that would allow prospective IVF patients to donate surplus or unviable eggs, sperm or embryos or any combination thereof to research without the need for a subsequent second consent. Nationally accepted content forms could be authorized by RTAC. The Uniform National Law could contain any necessary legislative amendments.

32. The Australian Government establish a 10-Year National Fertility Research Mission as a new mission under the Medical Research Future Fund, with a representative from Scientists in Reproductive Technology (SIRT) to be included in the steering committee for the mission.

33. The 10-Year Nationality Fertility Research Mission would seek to address the following actions through multidisciplinary research:

    - Improving Australia's birth rate.
    - Benchmarking of Australia's IVF safety and effectiveness by global comparison.
    - Assessment and evaluation of emerging global technologies and techniques, including IVF options and adjuvants, to further improve IVF safety and effectiveness.
    - Use of broader ART techniques and practices to increase Australia's IVF safety and effectiveness.
    - Continued expansion of carrier screening as a standard of care to reduce the number of children born with life threatening or debilitating genetic conditions.
    - Consideration of the emerging science around most effective ovulation stimulation procedures, timing and ages.
    - Consideration of future egg storage programs and practices in Australia and New Zealand.
    - Identification of global best practice for education of prospective parents.
    - Ongoing assessment of psychosocial implications and outcomes following ART use to ensure the practice reflects and promotes patient best interests.

34. The Australian Government develop a National Fertility Plan which includes the following components:
    - National Fertility Law
    - National Donor Registry
    - National Donor Bank
    - A 10-Year MRFF Fertility Mission
    - A National Fertility Roundtable which would help establish Terms of Reference for both the Mission and the proposed law.

FERTILITY SOCIETY
OF AUSTRALIA AND NEW ZEALAND

RTAC
REPRODUCTIVE TECHNOLOGY ACCREDITATION COMMITTEE



From: STEPHEN-SMITH
Sent: Friday, 13 September 2024 17:33
To: ACT Health DLO
Cc: Smith, Kahlia
Subject: FW: Letter regarding the Audiology Decision RIS
Attachments: Letter to Minister Stephen- Smith re audiology regulation.pdf; Audiologists and Audiometrists in Australia.pdf

Importance: High

Hi Tara,

For directorate response.

Thank you,

Sally Cooke
Office Manager | Office of Rachel Stephen-Smith MLA
Minister for Health | Minister for Children, Youth and Family Services | Minister for Disability | Minister for Aboriginal and Torres Strait Islander Affairs
Member for Kurrajong
ACT Legislative Assembly, 196 London Circuit, Canberra ACT 2601 | P: (02) 6205 2661 | www.act.gov.au

---

From: CEO Australian College of Audiology
Sent: Friday, September 13, 2024 9:12 AM
To: STEPHEN-SMITH
Subject: Letter regarding the Audiology Decision RIS

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Caution: This email originated from outside of the ACT Government. Do not click links or open attachments unless you recognise the sender and know the content is safe.

Good morning,

Please forward the attached letter and supporting documentation to the Minister for their consideration.

Miguel A. Diaz
Chief Executive Officer

D Schedule 2.2(a)(ii)
E ceo@acaud.org

Working together for better hearing health for all Australians

Australian College of Audiology Ltd. (ACAud) Incorporating HAASA
ABN 32 615 408 323
Suite 7, 4th Floor, 201 Wickham Terrace, Spring Hill QLD 4000
P 07 3839 1622



M 0429 357 375
W **acaud.com.au**

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Australian College of Audiology Ltd.
ABN 32 615 408 323
Business Address:
Suite 7, 4th Floor
201 Wickham Terrace
SPRING HILL QLD 4000

Tel: 07 3839 1622
Email: acaud@acaud.org

September 10, 2024

Rachel Stephen-Smith, ACT Minister for Health

Dear Minister,

Re: Audiology Regulation

The Australian College of Audiology incorporating the Hearing Aid Audiology Society of Australia (ACAud) has been notified, by Queensland Health, of the decision taken at the August Health Ministers' Meeting (HMM), to give in principle support to the Audiology Decision RIS, pending further consultation.

ACAud strongly believes that any regulatory framework must include both audiologists and audiometrists. Excluding audiometrists from regulation risks creating a fragmented system that does not fully address the needs of Australians experiencing hearing loss.

While the push towards audiology regulation came through issues surrounding paediatric cochlear implants in the public hospital systems of Queensland and South Australia, there are some significant unintended consequences of regulation to the broader hearing sector including the community who rely on audiometrists for their hearing health.

Any regulatory framework should optimize the delivery of high-quality audiological services, foster innovation and enhance accessibility for all Australians needing these services.

Audiometrists play a critical role in the delivery of hearing services in the community. On average, an audiometrist can see up to 2,000 people with hearing difficulties each year. ACAud currently has around 800 audiometrist members who combined, provide services to more than 1.6 million people suffering hearing loss each year. Excluding audiometrists from any form of regulation risks leaving millions of Australians without access to adequate hearing services. Those likely to be most acutely impacted are people living in rural and regional Australia where audiometrists deliver the bulk of hearing services.

While ACAud is dedicated to collaborating with all stakeholders to ensure that any regulatory measures enhance the trust and quality of hearing health care services provided to the community, we must point out that we already enforce a robust quality assurance framework with four key pillars.

We highlighted this framework during the Decision RIS consultation process but it's worth noting again that these pillars include;

- a comprehensive sector wide Scope of Practice
- a Code of Conduct
- an Ethical Review Framework, including an independent review process
- National Competency Standards

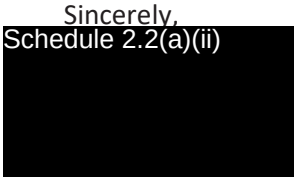
ACAud believes that this model provides the best balance between professional autonomy, high standards of care, and public protection.

Given the push for regulation has come as a result of issues in the public hospital system, ACAud still believes that a regulatory model that includes mandatory membership of a peak professional body (PPB) and national backing for the National Alliance of Self Regulating Health Professions (NASRHP), would ensure a unified approach, maintain high standards of practice and support the professional development of both audiologists and audiometrists.

We urge you to consider the inclusion of audiometrists in any regulatory decision and we have included an explanation of the roles of audiologists and audiometrists as an addendum to this letter to facilitate your consideration of both roles.

ACAud stands ready to assist in the development of any regulatory framework that strengthens the professions of audiology and audiometry. Without the inclusion of both, we risk the unintended consequence of negatively impacting the hearing health of millions of Australians.

Sincerely,



Miguel Diaz

Chief Executive Officer

Australian College of Audiology Ltd.
ABN 32 615 408 323
Business Address:
Suite 7, 4th Floor
201 Wickham Terrace
SPRING HILL QLD 4000

Tel: 07 3839 1622
Email: acaud@acaud.org

Audiologists and Audiometrists in Australia

There are a number of terms used to describe the person who tests your hearing and fits your hearing aid – and these can vary across the world.

In Australia, the most common terms you will hear are Audiologist and Audiometrist.

You may also see the terms Hearing Healthcare Professional or Clinician.

Audiologists in Australia, work with clients of all ages – from neo-nates to older adults – and clients with complex needs. They provide hearing services in a wide range of settings, including in hospitals, private practices, community health clinics, and residential aged care facilities, in person or via tele audiology.

They can assess hearing and auditory function, vestibular (balance) function, tinnitus, auditory processing function, and neural function. Audiologists can do this by performing diagnostic tests, including advanced tests using electrophysiological methods.

Audiologists provide aural, vestibular(balance) and tinnitus (re)habilitation as well as communication training. They can provide a range of (re)habilitation services including counselling and the prescription and fitting of devices/aids (e.g. bone conduction aids; earplugs (custom noise/swim/musician plugs); FM and other remote sensing systems; hearing aids; and assistive listening technology.

Audiologists have knowledge of implantable devices (e.g. cochlear implants, middle ear implantable hearing aids, fully implantable hearing aids, bone anchored hearing aids) and collaborate with other professionals in their applications in (re)habilitation. They have knowledge of infection control principles and practices related to audiological practice. Audiologists understand the principles of family/person-centred care and the impacts of hearing loss on communication, social engagement and quality of life.

Audiometrists in Australia, work with children, adults and clients with complex needs. They provide a range of hearing services in a variety of settings, including in hospitals, private practices, community health clinics, and residential aged care facilities, in person or via tele audiology.

They assess hearing and auditory function, tinnitus and provide (re)habilitation. Audiometrists can do this by performing a range of diagnostic tests and rehabilitation approaches including counselling and the prescription and fitting of non- implantable devices/aids (e.g. bone conduction aids; earplugs (custom noise/swim/musician plugs); FM and other remote sensing systems; hearing aids; and assistive listening technology).

Audiometrists have knowledge of implantable devices (e.g. cochlear implants, middle ear implantable hearing aids, fully implantable hearing aids, bone anchored hearing aids) and collaborate with other professionals in their applications in (re)habilitation.

Audiometrists also provide rehabilitation for tinnitus using education and hearing aids. They have knowledge of infection control principles and practices related to audiological practice. Audiometrists understand the principles of family/person-centred care and the impacts of hearing loss on communication, social engagement and quality of life.

Scope of Practice

Hearing Healthcare Professionals (HHPs) in Australia who fit hearing aids, whether they be Audiologists or Audiometrists will need to demonstrate a number of certifications, to enable them to practice within the Australian Scope of Practice for the industry.

Qualified Practicing (QP) Audiologist Qualifications:

QP audiologists must have an Australian university master's degree in clinical audiology (or equivalent) and either:

- current financial full accredited, fellow accredited, or life accredited membership with Audiology Australia
- current financial full/ordinary or fellow membership with the Australian College of Audiology incorporating HAASA, with a certificate of competency for Hearing Rehabilitation Specialist and Diagnostic Rehabilitation Specialist.

Qualified Practicing (QP)Audiometrist Qualifications:

QP Audiometrists must have either:

- an Australian tertiary diploma in audiometry
- a bachelor's degree in audiometry (or equivalent).
- They must also have current financial full/ordinary or fellow membership with the Australian College of Audiology incorporating HAASA, with a certificate of competency for Hearing Rehabilitation Specialist.

Qualified Practitioner (QP) number:

- Hearing Health Professionals (HHP) who wish to fit hearing aids as part of the Hearing Services Program (HSP) run by the Federal Government, or under Medicare, or compensation assessments for WorkCover must hold a valid QP number.
- This number is only awarded once an Audiologist or Audiometrist has gained their initial qualification and joined the Practitioner Professional body (PPB) of their choice (see below). They then follow a stringent process over a period of time, demonstrate their knowledge and skills and pass any examination requirements set by their PPB.

Clinical Currency:

- To gain this certification, all Audiologists and Audiometrists must belong to a PPB and demonstrate Clinical Currency via a Continuing Professional Development (CPD) program. Failure to meet the CPD program requirements will mean no Clinical Currency certification will be awarded.

There are two practitioner professional bodies (PPB) in Australia:

- Audiology Australia (AudA) – Audiologists only
- The Australian College of Audiology inc HAASA (ACAud) Audiologists and Audiometrists can join this association.

When you choose your HHP, you can request to see their qualifications and evidence of clinical currency. All Audiologists and Audiometrists are required to display these in their office along with the code of conduct.

Link to Scope of Practice: Scope of Practice – The Australian College of Audiology (acaud.com.au)

From: STEPHEN-SMITH
Sent: Friday, 13 September 2024 17:38
To: ACT Health DLO
Cc: Tomlinson, Benjamin; Smith, Kahlia
Subject: FW: Letter from ACT ART providers - ART legislation
Attachments: Letter to ACT Minister of Health - ACT ART Legislation (ART Providers - 13.9.2024).pdf

Importance: High

Hi Tara,

For directorate response please.

Thank you,

Sally Cooke
Office Manager | Office of Rachel Stephen-Smith MLA
Minister for Health | Minister for Children, Youth and Family Services | Minister for Disability | Minister for Aboriginal and Torres Strait Islander Affairs
Member for Kurrajong
ACT Legislative Assembly, 196 London Circuit, Canberra ACT 2601 | P: (02) 6205 2661 | www.act.gov.au

From Schedule 2.2(a)(ii)
Sent: Friday, September 13, 2024 5:33 PM
To: STEPHEN-SMITH
Cc: Tomlinson, Benjamin
Subject: Letter from ACT ART providers - ART legislation

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Dear Minister

Please see enclosed a joint letter from IVFAustralia, Genea and Compass Fertility for your consideration.

Regards,
Schedule 2.2(a)(ii)

Schedule 2.2(a)(ii)

Virtus Health Pty Limited
Level 3, 154 Pacific Highway

GREENWICH NSW 2065
AUSTRALIA
M: Schedule 2.2(a)(ii)
E: Schedule 2.2(a)(ii)
W: www.virtushealth.com.au

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13 September 2024

The Hon Rachel Stephen-Smith MLA
Minister for Health
ACT Government
GPO Box 158
Canberra ACT 2601

Dear Ms Stephen-Smith,

We are writing to you regarding the introduction of the *Assisted Reproductive Technology Act 2024* (ACT) (**ACT legislation**).

Since the introduction of the ACT legislation in March this year, ART providers in the Australian Capital Territory (**ACT**) have been working through these new laws to understand our obligations and the implications for our patients, fertility specialists and team members in our respective clinics across the ACT.

As members of the ART industry in the ACT, we would like to bring to your attention several critical issues and concerns about this new ACT legislation and its impact on current and future ART/fertility treatment using donated gametes (sperm, eggs or embryos) in the ACT.

Before we outline our concerns, we wish to commend the ACT Government for the flagged extension to the transitional arrangements so that they will soon apply to patients who have purchased gametes in storage, but who have not yet commenced treatment or achieved pregnancy. We believe that this amendment will result in the better realisation of the principles behind the transitional provisions, and we appreciate the ACT Government being willing to reconsider the issue.

We note the ACT Government's request to ART providers that we do not destroy gametes. We confirm that at no point in time has any signatory to this letter contemplated the destruction of any existing gametes due to any issues raised from the introduction of the ACT legislation, and have no intentions on destroying any existing gametes in any manner inconsistent with the instructions of our patients.

KEY ISSUES IN THE ACT LEGISLATION

There are six key issues in the ACT legislation, as set out below.

Before discussing the issues individually, we wish to make a point that applies to all of the issues. We understand that, in developing the ACT legislation, the ACT Government began with the *Assisted Reproductive Technology Act 2007* (NSW) (**NSW legislation**) and made changes that it thought necessary or desirable from there. A number of our concerns are based on the very fact that the ACT legislation has departed from the NSW legislation, resulting in adverse implications for participants in the ART industry in the ACT, including patients, intended parents and providers.

While all signatories to this letter are committed to providing ART treatment in the ACT, some of the signatories to this letter has been told by a number of international donor banks that that they are unlikely to continue to supply gametes to the ACT because of the disruption to their processes that would be required to enable compliance under the ACT legislation. As you may know, international gamete donor banks provide the majority of donor gametes used in the Australian, and ACT, ART industry, and the cessation of supply of gametes from international gamete donor banks will have a significant impact on our ability to fully service patients and intended parents in the ACT. A number of the issues we raise below are problematic because of the extent to which the ACT legislation diverges from the NSW legislation. We encourage the ACT Government

to give greater weight than it may have when preparing the ACT legislation to the issue of consistency with NSW legislation.

In addition, we note that, whilst some limited consultation was undertaken with ART providers prior to the introduction of the ACT legislation, critical aspects that ultimately made its way into the ACT legislation were not addressed during the consultation. In particular, the key issues raised in our letter were not included in the discussion paper that formed the basis for the consultation, and therefore were not responded to as part of the consultation. The lack of adequate consultation on the critical aspects of the ACT legislation had prevented ART providers from fully assessing the practical and operational impacts of these changes on both our patients and our ability to deliver ART services in the ACT until the legislation came into effect.

ISSUE 1: The right of donor-conceived persons to access donor identifying information from the age of 16

The ACT legislation stipulates an ART provider cannot use gametes in a manner inconsistent with a donor's consent. The lowering of the access age to donor identifying information from 18 to 16 years of age will have implications for ART providers wishing to use gametes in accordance with the terms of existing donors' consent.

With respect to gametes which have already been donated (and have already been acquired by, or allocated to, our patients), donors agreed to donate these gametes, and consented to the use of these gametes, on the condition that their identifying information would only be made available to the donor-conceived person once they turned 18. The lowering of the age of access to donor identifying information to 16 years of age, or lower than 16 years of age if the offspring is assessed as being sufficiently mature, will now place ART providers in a position where they may be acting in a manner inconsistent with the donor's consent (and hence in contravention of the new ACT legislation) when using these donated gametes in ART treatment after 28 March 2025.

We acknowledge and commend the ACT Government's recent commitment to amend the transitional provisions to extend the transitional arrangements to patients who are storing donor gametes, even if they have not yet created embryos or conceived, before the end of the transitional period. This amendment will address our concerns relating to some of the donor gametes to be used in the ACT, but not all of them. Specifically, if a person has donated before the commencement of the ACT legislation, with the effect that their consent will not address the possibility of offspring access by 16 years old or younger, and if their gametes have not be acquired before the end of the transitional period, then ART providers will have the predicament of having consents which may be inconsistent with the law on access to donor identifying information.

We have been proactively working with international gamete donor banks to find a solution, including seeking their support to attempt to update consents from donors, however we have received confirmation from a number of these international gamete donor banks that they are unable to assist in obtaining updated donor consents.

We believe this key issue will have a significant and immediate impact on a number of our patients. We believe that it is in our patient's best interests to inform them of the impact of these new laws so they are fully informed to make decisions on the creation of their families.

ISSUE 2: Disclosure of mandatory information relating to donors to a central donor register

Refreshing of mandatory information after each birth

The ACT legislation seems to require mandatory information relating to the donor to be refreshed before it is disclosed to the donor register. This has not previously been required and this information will be difficult to source and maintain.

Section 46 of the ACT legislation requires ART providers to collect certain identifying information from a donor at the time that donor's gametes are obtained ("**mandatory information**"). Mandatory information to be collected includes certain details about the donor's offspring and other ART providers to which the donor has previously donated. We understand the purpose of collecting this information is that the information collected would ultimately be disclosed to the ACT's central donor register following the birth of the donor-conceived child, so that children conceived from that donor, and their family, can gain access to that information.

However, rather than obliging ART providers to disclose the information already collected under section 46 at the time of the donation (as is the case under section 33 of the NSW legislation) the drafting of section 53 seems to have the effect of requiring ART providers to refresh the mandatory information collected from donors each time there is a live birth, before disclosing that information to the donor register.

If the intended outcome is to require ART providers to refresh the mandatory information before disclosing it to the donor register, we believe that this obligation imposes an unreasonable burden on ART providers. This is particularly the case for donated gametes which have been sourced from international gamete banks. The passage of time between donation of the gametes to the birth of a child could be years, and in the instance of international donors, the relationship with the donors rests with the international gamete banks. In our discussions with some international gamete banks, they have suggested that they will cease the supply of donated gametes to the ACT given the uniqueness of this legislative requirement in the world, and the relatively small size of the ACT donor recipient market.

ART providers are already required to obtain information necessary to monitor compliance with family limits. Creating an additional obligation on ART providers to refresh the mandatory information would be a significantly time-consuming, expensive and burdensome process that is not justified or outweighed by the benefits of including refreshed information (beyond what was already collected at the time of obtaining the gametes) in the ACT donor register.

In contrast to the difficulty, if not impossibility, of obtaining that information for ART providers for international donors, we think that the value of the information obtained will be relatively small. We note that information about the number of donor-conceived offspring is not necessarily relevant to family limits (which relates to number of families formed using a donor's gametes). Whether an ART provider reports the number of donor-conceived offspring at time of donation or time of live birth, that number may well change after the date of the report. If a parent accesses that information at the time of their own child's birth, that information may become out of date, as more children are created using that donor's gametes. If an offspring accesses that information at 16 years old, or even younger, that information may again be out of date. If, after the date of the last report for that donor in the ACT, more offspring are created outside of the ACT (whether in Australia or elsewhere), the ACT central register information will never be updated with reports of subsequent offspring.

If the obligation to refresh mandatory information was not the intended outcome of section 53, and the collection and disclosure obligations in the ACT legislation is in fact intended to mirror the NSW legislation (as we have previously been advised), we believe the unintended outcome of section 53 can be addressed by simply amending section 53 to mirror the equivalent provisions of the NSW legislation (which obliges ART

providers to disclose the mandatory information that was collected at the time of the obtaining the gamete (and not refreshed information)).

Strict liability offence

Section 46(4) specifies that failure to collect the mandatory information is a strict liability offence. Strict liability offences are only appropriate when all elements of the offence are under the control of the potential offender. The equivalent provisions in the NSW legislation create offences, but not strict liability offences.

We do not think that section 46, as currently drafted, reflects the practical realities of sourcing donor gametes. If it were the case that an ART provider collected gametes directly from the donor, then the ART provider would have "control" of all that donor's gametes, and would be in a position to ensure that it was aware of all mandatory information, including the mandatory information that may change over time, such as the sex and year of birth of each donor-conceived offspring of the donor.

As it is, ART providers in the ACT frequently source gametes from international gamete donor banks. Those gamete donor banks are subject to different laws, and have different practices, from Australian gamete donor banks. International gamete donor banks may provide the gametes of an ACT-used gamete to ART providers elsewhere in their country or elsewhere in the world. Those ART providers may fail to report back to the gamete donor bank on the sex and year of birth of each donor-conceived offspring of the donor.

We propose amending subsection 46(2) so that it reads, underlined words being added:

> *(2) An ART provider must take reasonable steps to collect the information mentioned in subsection (1) in relation to a gamete before using the gamete, or an embryo created from the gamete, for any purpose.*

We further propose inserting a new subsection 46(3):

> *(3) For the purposes of subsection 46(2), where an ART provider has obtained a gamete from a person other than the gamete provider, the ART provider will have failed to take reasonable steps if it has failed to ask that person for the information specified in subparagraphs 53(2)(a)(iv) and (vii).*

If a reasonable steps qualification is added, we do not think that it makes sense to make the offence created by section 46 into a strict liability offence. Accordingly, we propose deleting sub-section 46(4), which constitutes the offence created by section 46 into a strict liability offence.

Section 46 interacts closely with section 53. Under section 46, an ART provider must collect the mandatory information before obtaining a gamete. Under section 53, an ART provider must, within 2 months of a live birth, give refreshed mandatory information to the donor register.

Accordingly, we propose a similar a "reasonable steps" amendment to section 53. We propose inserting new subsections 53(3) and 53(4) to the following effect:

> *(3) The ART provider will comply with its obligation to give the information specified in subparagraphs 53(2)(a)(iv) and (vii) to the director-general if the ART provider has taken reasonable steps to collect that information.*
>
> *(4) For the purposes of subsection 53(3), where an ART provider has obtained a gamete from a person other than the gamete provider, the ART provider will have failed to take reasonable steps if it has failed to ask that person for the information specified in subparagraphs 53(2)(a)(iv) and (vii).*

ISSUE 3: Access to donor identifying information by parents from birth of donor-conceived person

The ACT legislation will provide a unique entitlement for parents of donor-conceived people to access identifying information about donors soon after the child is born, without any parameters or conditions attached. As far as we are aware, this is the first legislation of its kind locally and internationally.

We believe that the ability for parents of donor-conceived children to access the identity of their child's donor soon after the child's birth will create a significant disincentive for Australian donors donating gametes for use in the ACT in the future. We have had the experience of seeking to reconsent local donors whose gametes would be used in the ACT on the issue that parents of donor-conceived offspring would be able to access donor identifying information at the birth of donor-conceived offspring. Some of those donors have withdrawn their consent to their gametes being used in the ACT, on the basis that the ACT is a relatively small place and they did not want to take on the material increase in likelihood of being contacted, and so soon in the life of their offspring and so soon after having donated.

As for international gamete donor banks, the right of anonymity of donors until a child's adulthood is a significant consideration for donors, and a "selling point" for international gamete donor banks in obtaining donations. When one of the signatories to this letter discussed this issue with an international gamete donor bank, it indicated that it is unlikely that it will be willing to change its processes to procure donors who are willing to donate knowing that their right to anonymity will be lost soon after the child is born.

The likely unintended consequence of this legislation will be a significant reduction in the availability of donor gametes to the ACT. As a result, most ACT families requiring donated gametes are likely to have to travel to access donor services in NSW or other parts of the country.

We believe the ACT Government should consider limiting the rights of parents to access donor identifying information to limited circumstances where it is necessary to protect the child from harm, mirroring the NSW legislation. Under the NSW legislation, donor identifying information would only be accessible to parents of donor-conceived children if that information is necessary to save a child's life or prevent serious damage to the child. This change would align with the ACT Government's desire to mirror the ACT legislation with the NSW legislation.

ISSUE 4: Family limits – inadvertent prohibition on creating any offspring once family limit reached, even for families under the limit

We understand the ACT legislation's intention to include express family limits of 5 in the ACT and 10 in Australia was for the purpose of reducing the likelihood of consanguineous relationships, to assist in reducing prolific donors and to reduce the psychosocial impacts of having large numbers of genetic siblings. However, the current drafting in section 40 has the effect of limiting the number of families created from a single donor to 4 in the ACT and 9 in Australia, if the donor is in the ACT or Australia, respectively.

More alarmingly, where the family limit has been reached, an ART provider would breach section 40 if it uses the donor's gametes to provide ART treatment to anyone, including to families created before reaching the family limit. We believe that this is simply a mistake in the drafting.

Compare the equivalent provision in the NSW legislation, section 27. In the NSW legislation, an ART provider is prohibited from providing ART treatment using a donated gamete where the consequence of providing that ART treatment would be, if the ART treatment results in a child, to increase the number of women to whom the donor's offspring would be born to greater than 5 women.

By contrast, under section 40(1) of the ACT legislation, an ART provider is prohibited from providing any ART treatment using a donated gamete if the family limit (of 5 in the ACT or 10 in Australia) has been reached – regardless of whether the provision of the ART treatment will actually create a family over the family limit. That means that, even if the provision of ART treatment is to one of the families within the family limit, it is prohibited.

We feel sure that this is a drafting error, rather than an intended result. It is entirely out of step with family limit legislation elsewhere in Australia, and inconsistent with the stated intent in the Explanatory Memorandum to the bill for the ACT legislation. The aim of family limit provisions is to limit the number of families, not to limit the number of offspring within a family. Section 40 gives rise to the perverse result that it allows an ART provider to create an unlimited number of children for families created until the family limit is reached, but no children whatsoever once the family limit has been reached.

ISSUE 5: Family limits – automatic creation of two families for the purpose of family limits if a female same sex couple separates and both have children from the same donor

In the scenario of a same sex couple, even if they separate, we think that each of them should be able to use gametes of the same donor without that resulting in adding one more family to the count for the purposes of family limits. Unfortunately, that does not appear to be the result under section 40.

Consider the example of female same sex couple, Jane and Sue. Jane uses donor sperm to have a child. Jane and Sue then separate, and Sue now wishes to use the same donor's sperm to have a child, so that her child will be genetically related to Jane and Sue's child. On our reading of section 40, Sue and her child will count as a new family for the purpose of counting family limits.

We are not sure of the intent of the provision as regards to this issue but we think that this outcome is poor policy. Firstly, the aim of family limits provisions is to keep the number of families created with a single donor's gametes to moderate levels, and to reduce the risk of unwitting consanguinity. In our view, counting the family created by Sue and her child as a new family for the purpose of family limits has a negligible effect in terms of the aim of the family limits provision, but it reduces the availability of that donor's gametes for a (genuinely) new family. Secondly, if the family created by Jane and Sue having their initial child causes the family limit to be reached for that donor (or if other families have subsequently been created to reach the family limit for that donor), Sue would be prevented by the family limits provision from using the gametes of the donor used to create Jane and Sue's child. This seems to be an undesirable result, given the common desire, when having children created through ART, to have children who are genetically related.

As a final comment, assume that, when together as a couple, each of Jane and Sue had a child using the same donor's gametes. It is clear that, in this scenario, they would only count as one family. If Jane and Sue separate and each of Jane and Sue wishes to have another child, how would the family limit count apply in that scenario?

We think that the better policy result would be that, in the scenario of a same sex couple, even if they separate, each of them be able to use gametes of the same donor without that resulting in adding one more family to the count for the purposes of family limits.

ISSUE 6: Duration of transitional period

Given the considerable confusion and work to understand the full impact of the ACT legislation since it was introduced, we do not believe that ACT patients have had an appropriate opportunity to be fully informed of the significant impact of the ACT legislation on their ability to create families in the future. Fertility decisions of this magnitude typically have a decision horizon of greater than six months, for reasons including the

substantial financial commitment, the possibility that the initial attempts do not work, and the need to recover emotionally and physically after procedures. In our experience, at least 18 months' notice is more appropriate for these kinds of changes. We respectfully request that the transition period be extended to a duration of 18 months.

NEXT STEPS

We would welcome the opportunity for you to meet with us at your earliest convenience to discuss the issues we have outlined above. Given the impending end of the transitional period and the resultant impact on ACT patients, we believe that urgent action needs to be taken to start to address the key issues.

Please let us know when you would be available to address this significant and urgent issue, by contacting Kathleen Waite, Director of Operations – Genea on Schedule 2.2(a)(ii)

Your sincerely,

Schedule 2.2(a)(ii)

James Pyne
Chief Executive Officer – Virtus Health
Mana ing Director – IVF Australia

Schedule 2.2(a)(ii)

Tim Yeoh
Chief Executive Officer - Genea

Schedule 2.2(a)(ii)

Nicole Sides
Medical Director – Compass Fertility

Lowe, Shannon

From: Gower, Tara on behalf of ACT Health DLO
Sent: Monday, 16 September 2024 9:13 AM
To: Smith, Kahlia
Subject: (COPY) MIN24-00307 - Public Health (Health Care Facility) Code of Practice 2021

Hi Kahlia

Minister Davidson signed a brief agreeing to provide a copy of the summary report of health care facility annual reports to the Minister for Health noting the Minister was the responsible Minister when 2022-23 annual reports were required to be submitted.

I have placed a copy of the summary report in your folder here.

Thank you
Tara

Tara Gower | Directorate Liaison Officer | ACT Health Directorate
Mob: Schedule 2.2(a)(ii) Email: ACTHealthDLO@act.gov.au
Office of Rachel Stephen-Smith | Minister for Health
Office of Emma Davidson | Minister for Mental Health
Level 2, Legislative Assembly Building, Civic Square



From: STEPHEN-SMITH
Sent: Monday, 16 September 2024 12:50 PM
To: ACT Health DLO
Cc: Smith, Kahlia
Subject: FW: New AIHW embargo release available: Practice Incentives Program Quality Improvement Measures: annual data update 2023–24

Importance: High

Hi Tara,

For noting please.

Thank you,

Sally Cooke
Office Manager | Office of Rachel Stephen-Smith MLA
Minister for Health | Minister for Children, Youth and Family Services | Minister for Disability | Minister for Aboriginal and Torres Strait Islander Affairs
Member for Kurrajong
ACT Legislative Assembly, 196 London Circuit, Canberra ACT 2601 | P: (02) 6205 2661 | www.act.gov.au

From: communications@aihw.gov.au
Sent: Monday, September 16, 2024 10:28 AM
To: STEPHEN-SMITH
Subject: New AIHW embargo release available: Practice Incentives Program Quality Improvement Measures: annual data update 2023–24

Caution: This email originated from outside of the ACT Government. Do not click links or open attachments unless you recognise the sender and know the content is safe.

Dear all,

The latest AIHW release **Practice Incentives Program Quality Improvement Measures: annual data update 2023–24** is now available **under strict embargo** until public release on **Monday, 30 September 2024, at 12:01am**.

About the release:

The 4th national report presents the latest annual data update from the de-identified aggregate Practice Incentives Program Quality Improvement (PIPQI) Eligible Data Set covering 10 measures. Clinical information systems data from 5,563 general practices represent the recording status of clients' lifestyle behaviours and areas of significant health burden. Building on previous reports, it empowers practices and healthcare organisations to leverage primary healthcare data for nationwide improvements.

Please note: The release **will not be** accompanied by a media release.

Please click on the link and follow the instructions below:

- AIHW Stakeholder hub (https://pp.aihw.gov.au/login)
- Your user name is your **email address**
- Please select '**Forgot your password**' link if required.

The following Ministerial Offices are receiving access to the embargoed material:

- Office of the Prime Minister
- Senator the Hon. Katy Gallagher - Minister for Finance, Minister for the Public Service, Minister for Women
- The Hon. Mark Butler MP - Minister for Health and Aged Care
- The Hon. Linda Burney MP - Minister for Indigenous Australians
- The Hon. Ged Kearney MP - Assistant Minister for Indigenous Health
- The Hon. Amanda Rishworth MP - Minister for Social Services
- The Hon. Bill Shorten MP - Minister for the National Disability Insurance Scheme Minister for Government Services
- The Hon. Julie Collins MP - Minister for Housing, Minister for Homelessness, Minister for Small Business
- The Hon. Anne Aly MP - Minister for Early Childhood Education, Minister for Youth
- The Hon. Anika Wells MP - Minister for Aged Care, Minister for Sport
- The Hon. Justine Elliot MP - Assistant Minister for Social Services, Assistant Minister for the Prevention of Family Violence
- The Hon. Ged Kearney MP - Assistant Minister for Health and Aged Care
- The Hon. Emma McBride MP - Assistant Minister for Mental Health, Assistant Minister for Rural and Regional Health

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- Department of Social Services
- National Indigenous Australians Agency

The following state and territory health departments receive access to the embargoed material:

- ACT Health
- QLD Health
- NSW Ministry of Health
- NT Department of Health
- TAS Department of Health
- WA Department of Health
- SA Department of Health and Wellbeing
- VIC Department of Health and Human Services

If you would like any further information, please contact communications@aihw.gov.au or (02) 6249 5089.

Kind Regards,

Communications & Engagement Unit
Australian Institute of Health and Welfare
Communications@aihw.gov.au | @aihw | aihw |

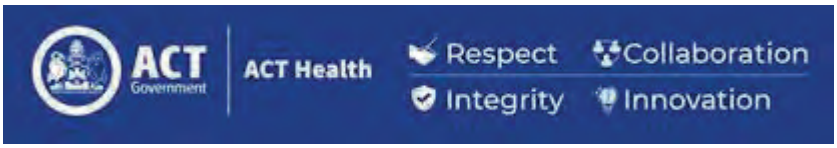


From: Gower, Tara on behalf of ACT Health DLO
Sent: Monday, 16 September 2024 3:27 PM
To: Ord, Jon; Wiggins, Taylor
Subject: RE: Update to Safe Haven Hospital Design and Costings

Thanks Jon – to comply with caretaker guidelines, this brief will be prepared for the incoming Minister.

Thank you
Tara

Tara Gower | Directorate Liaison Officer | ACT Health Directorate
Mob: Schedule 2.2(a)(ii) Email: ACTHealthDLO@act.gov.au
Office of Rachel Stephen-Smith | Minister for Health
Office of Emma Davidson | Minister for Mental Health
Level 2, Legislative Assembly Building, Civic Square



From: Ord, Jon
Sent: Monday, September 16, 2024 10:47 AM
To: ACT Health DLO ; Wiggins, Taylor
Subject: RE: Update to Safe Haven Hospital Design and Costings
Importance: High

OFFICIAL

Thank you.

If the Directorate considers that it is consistent with caretaker rules to provide it to MO, we will take it please.

If not, we are happy for it to be prepared for incoming Minister.

Kind Regards,
Jon

From: Gower, Tara <Tara.Gower@act.gov.au> **On Behalf Of** ACT Health DLO
Sent: Monday, September 16, 2024 10:36 AM
To: Ord, Jon <Jon.Ord@act.gov.au>; Wiggins, Taylor <Taylor.Wiggins@act.gov.au>
Subject: Update to Safe Haven Hospital Design and Costings

OFFICIAL

Hi Jon and Taylor

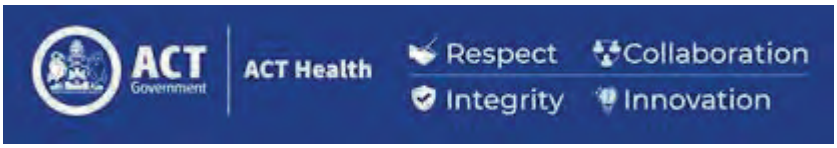
At the last min briefing, ACTHD noted that an information brief will progress to the MO on Safe Haven Hospital Design and Costings.

This unfortunately did not progress prior to Caretaker.

Can you please advise if the MO would still like to receive this brief or can a brief be prepared for the incoming Minister?

Thank you
Tara

Tara Gower | Directorate Liaison Officer | ACT Health Directorate
Mob: Schedule 2.2(a)(ii) Email: ACTHealthDLO@act.gov.au
Office of Rachel Stephen-Smith | Minister for Health
Office of Emma Davidson | Minister for Mental Health
Level 2, Legislative Assembly Building, Civic Square



From: STEPHEN-SMITH
Sent: Tuesday, 17 September 2024 11:12
To: ACT Health DLO
Cc: Smith, Kahlia
Subject: FW: New AIHW embargo release available: BreastScreen Australia monitoring report 2024

Importance: High

Hi Tara,

For noting please.

Thank you,

Sally Cooke
Office Manager | Office of Rachel Stephen-Smith MLA
Minister for Health | Minister for Children, Youth and Family Services | Minister for Disability | Minister for Aboriginal and Torres Strait Islander Affairs
Member for Kurrajong
ACT Legislative Assembly, 196 London Circuit, Canberra ACT 2601 | P: (02) 6205 2661 | www.act.gov.au

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From: communications@aihw.gov.au
Sent: Tuesday, September 17, 2024 11:10 AM
To: STEPHEN-SMITH
Subject: New AIHW embargo release available: BreastScreen Australia monitoring report 2024

Caution: This email originated from outside of the ACT Government. Do not click links or open attachments unless you recognise the sender and know the content is safe.

Dear all,

The latest AIHW release **BreastScreen Australia monitoring report 2024** is now available **under strict embargo** until public release on **Tuesday, 1 October 2024, at 12:01am**.

About the release:

Cancer screening involves testing for signs of cancer or precancerous conditions in people without obvious symptoms. BreastScreen Australia is one of Australia's three population-based cancer screening programs. It aims to reduce illness and death from breast cancer through an organised approach to the early detection of breast cancer, using screening mammography to detect unsuspected breast cancer in women. Early detection provides an opportunity for early treatment, which can reduce illness and death.

BreastScreen Australia provides free 2-yearly screening mammograms to women aged 40 and over, and actively targets women aged 50–74.

This report is the latest in the annual *BreastScreen Australia monitoring report* series and presents the latest data available for each performance indicator.

Please note: The release **will not be** accompanied by a media release.

Please click on the link and follow the instructions below:

- AIHW Stakeholder hub (https://pp.aihw.gov.au/login)
- Your user name is your **email address**
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- Senator the Hon. Katy Gallagher - Minister for Finance, Minister for the Public Service, Minister for Women
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- The Hon. Linda Burney MP - Minister for Indigenous Australians
- The Hon. Ged Kearney MP - Assistant Minister for Indigenous Health
- The Hon. Amanda Rishworth MP - Minister for Social Services
- The Hon. Bill Shorten MP - Minister for the National Disability Insurance Scheme Minister for Government Services
- The Hon. Julie Collins MP - Minister for Housing, Minister for Homelessness, Minister for Small Business
- The Hon. Anne Aly MP - Minister for Early Childhood Education, Minister for Youth
- The Hon. Anika Wells MP - Minister for Aged Care, Minister for Sport
- The Hon. Justine Elliot MP - Assistant Minister for Social Services, Assistant Minister for the Prevention of Family Violence
- The Hon. Ged Kearney MP - Assistant Minister for Health and Aged Care
- The Hon. Emma McBride MP - Assistant Minister for Mental Health, Assistant Minister for Rural and Regional Health

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- Department of Health and Aged Care
- Department of Social Services
- National Indigenous Australians Agency

The following state and territory health departments receive access to the embargoed material:

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- QLD Health
- NSW Ministry of Health
- NT Department of Health
- TAS Department of Health
- WA Department of Health
- SA Department of Health and Wellbeing
- VIC Department of Health and Human Services

If you would like any further information, please contact communications@aihw.gov.au or (02) 6249 5089.

Kind Regards,

Communications & Engagement Unit

Australian Institute of Health and Welfare

Communications@aihw.gov.au | @aihw | aihw |



From: STEPHEN-SMITH
Sent: Thursday, 19 September 2024 11:55
To: ACT Health DLO
Cc: Smith, Kahlia
Subject: FW: Correspondence from the Minister for Health and Minister for Regional Health - M24/5151
Attachments: 18092024153651-0001.pdf

Importance: High

Hi Tara,

For directorate response please.

Thank you,

Sally Cooke
Office Manager | Office of Rachel Stephen-Smith MLA
Minister for Health | Minister for Children, Youth and Family Services | Minister for Disability | Minister for Aboriginal and Torres Strait Islander Affairs
Member for Kurrajong
ACT Legislative Assembly, 196 London Circuit, Canberra ACT 2601 | P: (02) 6205 2661 | www.act.gov.au

From: MOH-Minister
Sent: Thursday, September 19, 2024 11:37 AM
To: STEPHEN-SMITH
Subject: Correspondence from the Minister for Health and Minister for Regional Health - M24/5151

Caution: This email originated from outside of the ACT Government. Do not click links or open attachments unless you recognise the sender and know the content is safe.

Please find attached a response to your Ministerial correspondence.

The attached response includes information regarding an appropriate contact point and/or alternatively provides the contact details for the Ministerial office should you wish to make further representations.

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NSW Health

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Views expressed in this message are those of the individual sender, and are not necessarily the views of NSW Health or any of its entities.

The Hon Ryan Park MP
Minister for Health
Minister for Regional Health
Minister for the Illawarra and the South Coast

NSW GOVERNMENT

Ref: M24/5151

Ms Rachel Stephen-Smith MLA
Minister for Health
Minister for Aboriginal and Torres Strait Islander Affairs
Minister for Children, Youth and Family Services
Minister for Disability
stephen-smith@act.gov.au

Cross border arrangements between NSW and ACT

Dear Minister Rachel

Thank you for writing about outstanding proposed cross-border arrangement matters under the next Addendum to the National Health Reform Agreement (NHRA) 2025-30.

I acknowledge your concerns and appreciate your advocacy on this matter.

In relation to the ACT proposal for NSW to make capital contributions under cross-border arrangements, NSW maintains that capital investment by jurisdictions is a sovereign decision of governments. It is based on local needs and investment priorities. Mandated contributions to the capital investment of neighbouring jurisdictions reduces autonomy. It would require mechanisms to provide necessary oversight and decision-making authority for the resident jurisdiction regarding capital planning, project delivery, and asset management. There is also insufficient evidence to support calculation of a capital contribution, or a threshold for its application.

I am informed that the Independent Hospital and Aged Care Pricing Authority has advised jurisdictions against requiring the authority to price capital. This is on the basis that there would likely be an insufficient sample to accurately determine a national price. Therefore, NSW remains unable to support the inclusion of capital in cross-border arrangements under the NHRA.

NSW considers that contributions for block funded Teaching, Training and Research (TTR) are not appropriate to include in the NHRA. There are challenges with calculating block funded TTR contributions, as they are usually attributed at a workforce, not patient, level. Patient facing TTR is also already paid through activity-based funding contributions. NSW remains committed to working with the ACT to develop an evidence-based methodology for payment of TTR under the current NSW-ACT Cross-border Intergovernmental Agreement. To this end, I have asked the NSW Ministry of Health to arrange a meeting through the Health Cross Border Governance Committee to progress this work.

Thank you again for writing. For more information, please contact Mr Gregory Westenberg, Executive Director, Government Relations, at gregory.westenberg@health.nsw.gov.au or on 9461 7963.

Yours sincerely

Ryan Park MP
Minister for Health
Minister for Regional Health
Minister for the Illawarra and the South Coast

52 Martin Place Sydney NSW 2000
GPO Box 5341 Sydney NSW 2001

02 7225 6050
nsw.gov.au/ministerpark

From: Smith, Kahlia
Sent: Thursday, 19 September 2024 1:00 PM
To: STEPHEN-SMITH; ACT Health DLO
Subject: RE: Correspondence from the Minister for Health and Minister for Regional Health - M24/5151

Importance: High

Thanks Tara – just for directorate action please.

Thanks
Kahlia

From: STEPHEN-SMITH
Sent: Thursday, September 19, 2024 11:55 AM
To: ACT Health DLO
Cc: Smith, Kahlia
Subject: FW: Correspondence from the Minister for Health and Minister for Regional Health - M24/5151

Hi Tara,

For directorate response please.

Thank you,

Sally Cooke
Office Manager | Office of Rachel Stephen-Smith MLA
Minister for Health | Minister for Children, Youth and Family Services | Minister for Disability | Minister for Aboriginal and Torres Strait Islander Affairs
Member for Kurrajong
ACT Legislative Assembly, 196 London Circuit, Canberra ACT 2601 | P: (02) 6205 2661 | www.act.gov.au

---

From: MOH-Minister <MOH-Minister@health.nsw.gov.au>
Sent: Thursday, September 19, 2024 11:37 AM
To: STEPHEN-SMITH <STEPHEN-SMITH@act.gov.au>
Subject: Correspondence from the Minister for Health and Minister for Regional Health - M24/5151

Caution: This email originated from outside of the ACT Government. Do not click links or open attachments unless you recognise the sender and know the content is safe.

Please find attached a response to your Ministerial correspondence.

The attached response includes information regarding an appropriate contact point and/or alternatively provides the contact details for the Ministerial office should you wish to make further representations.

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From: STEPHEN-SMITH
Sent: Thursday, 19 September 2024 14:07
To: ACT Health DLO
Cc: Smith, Kahlia
Subject: FW: Correspondence from Minister Fentiman
Attachments: 240919 Letter to Hon Rachel Stephen-Smith MP & Hon Chris Steel MP 24-15067.pdf

Importance: High

Hi Tara,

For directorate action please.

Thank you,

Sally Cooke
Office Manager | Office of Rachel Stephen-Smith MLA
Minister for Health | Minister for Children, Youth and Family Services | Minister for Disability | Minister for Aboriginal and Torres Strait Islander Affairs
Member for Kurrajong
ACT Legislative Assembly, 196 London Circuit, Canberra ACT 2601 | P: (02) 6205 2661 | www.act.gov.au

---

From: Health
Sent: Thursday, September 19, 2024 1:27 PM
To: STEPHEN-SMITH ; STEEL
Subject: Correspondence from Minister Fentiman

Caution: This email originated from outside of the ACT Government. Do not click links or open attachments unless you recognise the sender and know the content is safe.

Good afternoon,

Please find attached correspondence from the Hon. Shannon Fentiman MP.

Kind regards

Office of The Hon. Shannon Fentiman MP
Minister for Health, Mental Health, and Ambulance Services
Minister for Women
P (07) 3035 6100| Email: Health@ministerial.qld.gov.au

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Queensland Government

Minister for Health, Mental Health and Ambulance Services
Minister for Women

1 William Street Brisbane Qld 4000
GPO Box 48 Brisbane
Queensland 4001 Australia
Telephone +61 7 3035 6100

C-ECTF-24/15067

The Honourable Rachel Stephen-Smith MP
Minister for Health
Minister for Aboriginal and Torres Strait Islander Affairs
Minister for Families and Community Services

19 SEP 2024

Email: stephen-smith@act.gov.au

The Honourable Chris Steel MP
Minister for Tertiary Education
Minister for Transport
Minister for City Services
Minister for Multicultural Affairs
Minister for Recycling and Waste Reduction
Minister for Roads and Active Travel

Email: steel@act.gov.au

Dear Ministers

We write to update you on the ongoing collaboration between Queensland Health and the Queensland Department of Transport and Main Roads (TMR) to increase registration on the Australian Organ Donor Register (AODR).

Queensland has the fourth lowest rate of organ donor registration in the country, having just over 30 per cent of the population registered on the AODR. This registration rate does not reflect the views of the community, with recent research indicating that up to eight in 10 Queenslanders are supportive of organ donation.

In an effort to increase the number of Queenslanders registered as organ donors, Queensland Health recently partnered with the TMR to launch a new feature on the TMR licence renewals and vehicle registration webpages, which links directly to the AODR website. The link is embedded in the TMR online customer transaction portal, an application which is accessed by close to four million Queenslanders who either renew their driver licence or pay vehicle registration online each year.

We are pleased to advise that in the eight weeks since the feature went live, Queensland has seen a significant uptick in AODR registrations, with an additional 8,514 Queenslanders registering with the AODR through the TMR links. Importantly, we are seeing a conversion rate of over 50 per cent for both the driver licence and vehicle registration renewal links. The Organ and Tissue Authority has advised that both of these links have consistently been among the highest performing, in both views and conversions, of all AODR website links since their implementation in July 2024.

While we expected to see significant uptake immediately after the go-live date on 22 July 2024, we have been pleased to note that levels of engagement have continued to remain high two months after the launch, with Queensland continuing to average over 150 registrations per day as a direct result of this initiative.

We know that around nine in 10 families say yes to donation where their family member is registered on the AODR, with this number falling to around four in 10 where families are unsure of what their loved one's intentions are. Increasing registration on the AODR is clearly important to increasing rates of organ donation in Australia, and subsequently saving more lives through organ transplantation. To this end, we are very pleased to see the success this initiative has had for registration rates in Queensland. We hope that in sharing this update with you, the Australian Capital Territory Government may consider whether a similar initiative would be appropriate for your jurisdiction.

We are also pleased to advise that the Miles Government has committed to going one step further and reintroducing the ability to indicate organ donation preferences on the Queensland driver licence once the current licensing database is replaced. We look forward to updating you further once this work commences.

Yours sincerely

Shannon Fentiman MP
Minister for Health, Mental Health and Ambulance Services
Minister for Women
Member for Waterford

Bart Mellish MP
Minister for Transport and Main Roads
Minister for Digital Services
Member for Aspley

From: STEPHEN-SMITH
Sent: Friday, 20 September 2024 12:54
To: ACT Health DLO
Cc: Smith, Kahlia
Subject: FW: New AIHW embargo release available: Oral health and dental care in Australia – update

Importance: High

Hi Tara,

For noting please.

Thank you,

Sally Cooke
Office Manager | Office of Rachel Stephen-Smith MLA
Minister for Health | Minister for Children, Youth and Family Services | Minister for Disability | Minister for Aboriginal and Torres Strait Islander Affairs
Member for Kurrajong
ACT Legislative Assembly, 196 London Circuit, Canberra ACT 2601 | P: (02) 6205 2661 | www.act.gov.au

From: communications@aihw.gov.au
Sent: Friday, September 20, 2024 12:51 PM
To: STEPHEN-SMITH
Subject: New AIHW embargo release available: Oral health and dental care in Australia – update

Caution: This email originated from outside of the ACT Government. Do not click links or open attachments unless you recognise the sender and know the content is safe.

Dear all,

The latest AIHW release **Oral health and dental care in Australia – update** is now available **under strict embargo** until public release on **Friday, 4 October 2024, at 12:01am**.

About the release:

This report presents key data, information and trends over time, via a suite of interactive data visualisations, describing the oral health status of Australians and their use of dental care services. It is added to and updated as data becomes available. Poor oral health – mainly tooth decay, gum disease and tooth loss – may result in a person experiencing pain, discomfort and feelings of embarrassment. Around 1 in 3 adults have reported feeling uncomfortable about their dental appearance.

This update includes:

- an update to the healthy mouths chapter
    - Addition of the *self-reported measures of oral health* section
- an update to the healthy lives chapter
    - An update of the *social impacts of poor oral health* section
- an update of the dental care chapter
    - national dental telephone interview survey
    - child dental benefits schedule
    - public dental waiting times
- an update of the hospitalisations chapter
    - dental procedures
    - potentially preventable hospitalisations
    - dental procedures requiring general anaesthetic
- an update of the prescribing chapter
- an update of the patient experience chapter
- an update to the costs chapter
    - expenditure
    - barriers
- an update of the disease expenditure chapter
- an update to the private health insurance chapter
    - Health expenditure by private health insurance funds
- an update of the dental workforce chapter
- an update to the priority populations chapter
    - People who are socially disadvantaged or on low incomes
        - Prisoners

Please note: The release **will not be** accompanied by a media release.

Please click on the link and follow the instructions below:

- AIHW Stakeholder hub (https://pp.aihw.gov.au/login)
- Your user name is your **email address**
- Please select '**Forgot your password**' link if required.

The following Ministerial Offices are receiving access to the embargoed material:

- Office of the Prime Minister
- Senator the Hon. Katy Gallagher - Minister for Finance, Minister for the Public Service, Minister for Women
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- The Hon. Linda Burney MP - Minister for Indigenous Australians
- The Hon. Ged Kearney MP - Assistant Minister for Indigenous Health
- The Hon. Amanda Rishworth MP - Minister for Social Services
- The Hon. Bill Shorten MP - Minister for the National Disability Insurance Scheme Minister for Government Services
- The Hon. Julie Collins MP - Minister for Housing, Minister for Homelessness, Minister for Small Business
- The Hon. Anne Aly MP - Minister for Early Childhood Education, Minister for Youth

- The Hon. Anika Wells MP - Minister for Aged Care, Minister for Sport
- The Hon. Justine Elliot MP - Assistant Minister for Social Services, Assistant Minister for the Prevention of Family Violence
- The Hon. Ged Kearney MP - Assistant Minister for Health and Aged Care
- The Hon. Emma McBride MP - Assistant Minister for Mental Health, Assistant Minister for Rural and Regional Health

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- Department of Social Services
- National Indigenous Australians Agency

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- QLD Health
- NSW Ministry of Health
- NT Department of Health
- TAS Department of Health
- WA Department of Health
- SA Department of Health and Wellbeing
- VIC Department of Health and Human Services

If you would like any further information, please contact communications@aihw.gov.au or (02) 6249 5089.

Kind Regards,

Communications & Engagement Unit

Australian Institute of Health and Welfare

Communications@aihw.gov.au | @aihw | aihw |

From: Bransgrove, Meagen
Sent: Friday, 20 September 2024 13:50
To: Smith, Kahlia; ACT Health DLO
Cc: Tomlinson, Benjamin
Subject: RE: Caveat Brief

Importance: High

OFFICIAL

Thanks Tara, why is ACTHD progressing a caveat brief on the hospital meal system?

Thanks,

Meg

From: Smith, Kahlia
Sent: Friday, September 20, 2024 1:34 PM
To: Bransgrove, Meagen
Subject: FW: Caveat Brief

OFFICIAL

Surely one for you?

From: Gower, Tara <Tara.Gower@act.gov.au> **On Behalf Of** ACT Health DLO
Sent: Friday, September 20, 2024 12:34 PM
To: Tomlinson, Benjamin <Benjamin.Tomlinson@act.gov.au>; Smith, Kahlia <Kahlia.Smith@act.gov.au>
Subject: Caveat Brief

OFFICIAL

Hi Ben and Kahlia

Just flagging that I am expecting a Caveat Brief to progress on the hospital meal system.

I will let you know once its available in the Minister's folder.

Thank you
Tara

Tara Gower | Directorate Liaison Officer | ACT Health Directorate
Mob: Schedule 2.2(a)(ii) Email: ACTHealthDLO@act.gov.au
Office of Rachel Stephen-Smith | Minister for Health
Office of Emma Davidson | Minister for Mental Health
Level 2, Legislative Assembly Building, Civic Square


ACT
Government
ACT Health
Respect
Collaboration
Integrity
Innovation

From: Gower, Tara on behalf of ACT Health DLO
Sent: Monday, 23 September 2024 4:34 PM
To: Davidson
Subject: Lung Foundation Australia concerns on Lung Cancer Screening readiness
Attachments: 240905L_ACT_LFA Lung Cancer Screening concerns_LFAn.pdf

Importance: High

Hi Maxine

Can you please confirm the office received this letter?

If so, is the office preparing a response as I have received this from Minister Stephen-Smith's office for a Directorate response.

Thank you
Tara

Tara Gower | Directorate Liaison Officer | ACT Health Directorate
Mob: Schedule 2.2(a)(ii) Email: ACTHealthDLO@act.gov.au
Office of Rachel Stephen-Smith | Minister for Health
Office of Emma Davidson | Minister for Mental Health
Level 2, Legislative Assembly Building, Civic Square



From: Zoe Scovell Schedule 2.2(a)(ii)
Sent: Thursday, September 5, 2024 3:24 PM
To: STEPHEN-SMITH <STEPHEN-SMITH@act.gov.au>; Davidson <DAVIDSON@act.gov.au>
Subject: Lung Foundation Australia concerns on Lung Cancer Screening readiness

Some people who received this message don't often get email from Schedule 2.2(a)(ii) Learn why this is important

Caution: This email originated from outside of the ACT Government. Do not click links or open attachments unless you recognise the sender and know the content is safe.

Dear Ministers,

Please find attached a letter from Lung Foundation Australia CEO, Mark Brooke, detailing our organisation's concerns about state and territory preparedness for the National Lung Cancer Screening Program.

Kind regards,

Zoe Scovell

Health Policy Insights Officer

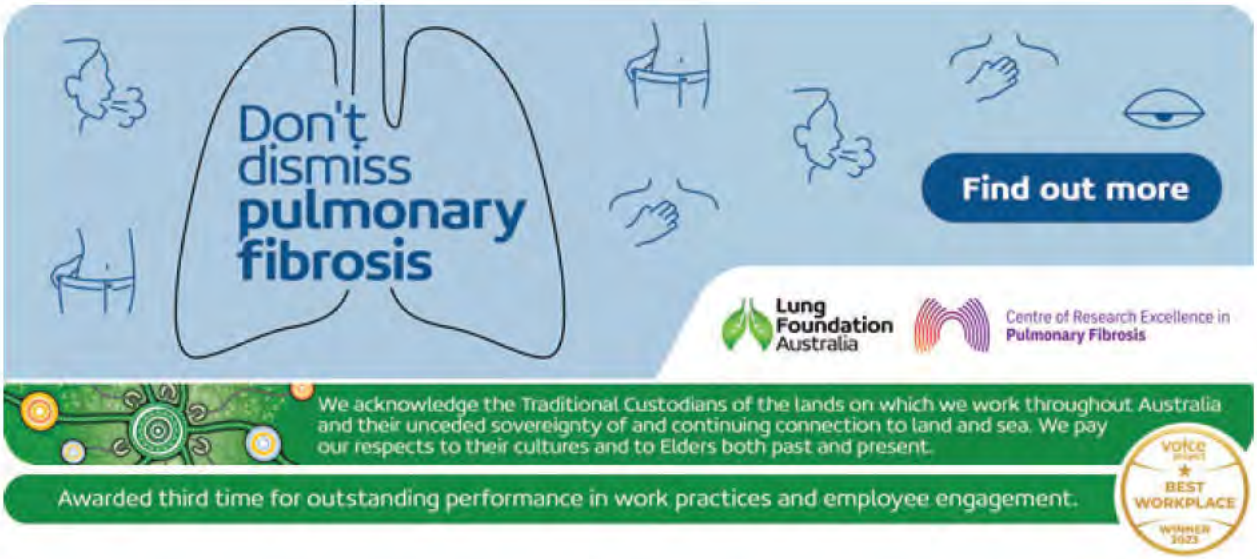
Policy, Advocacy and Prevention team

A Brisbane, Yuggera Country

T Schedule 2.2(a)(ii) [redacted]

E [redacted]

W lungfoundation.com.au



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Lung Foundation Australia

5 September 2024

Hon. Rachel Stephen-Smith
Minister for Health
GPO Box 1020, Canberra, ACT 2601
Via email only: stephen-smith@act.gov.au

Hon. Emma Davidson
Minister for Population Health
GPO Box 1020, Canberra, ACT 2601
Via email only: davidson@act.gov.au

Dear Ministers,

Re: Preparedness for the National Lung Cancer Screening Program

On behalf of the Lung Foundation Australia (LFA) I first would like to thank you for your support of the National Lung Cancer Screening Program (NLCSP) commencing on 1 July 2025. LFA is the national community organisation and health peak advisory body caring for and supporting the 15,000 people diagnosed with lung cancer each year. As we near closer towards the July 2025 commencement, we write to seek your reassurance that you and your department are putting in place the necessary plans, policies, systems, and resources to effectively support those diagnosed with lung cancer, and this live-saving program more broadly.

Background to the NLCSP

As you know the Australian Government is investing $267 million in the NLCSP, the first new screening program in over 20 years. The program will partly address the substantial burden of lung cancer by transforming Australia's fifth most common and our nation's leading cause of cancer death. Aboriginal and Torres Strait Islander people and those living in regional and remote communities have even poorer outcomes.

You may not be aware that the NLCSP has been under investigation since 2019. Cancer Australia, on behalf of the Australian Government's Department of Health and Aged Care, spent over three years consulting with patients, clinicians and state and territory Governments on the feasibility and viability of this screening program, which was affirmed by the Medical and Scientific Advisory Committee.

It is anticipated that 12,000 lives will be saved over the next 10 years, and that this screening program will dramatically improve outcomes for patients who are diagnosed with lung cancer – the #1 cause of cancer death in Australia and globally.

Federal funding was announced in May 2023 providing the Commonwealth, states and territories over 2 years to get ready for screening.

The Australian Government's Department of Health and Aged Care, with implementation partners in Cancer Australia and National Aboriginal Community Controlled Health Organisation (NACCHO), has established a comprehensive and thorough plan and have been making considerable progress.

These efforts are supported by appropriate working groups and stakeholder input, including a State and Territory Program Advisory Group to support the program's implementation. I have presented to this Committee and hope to again in the future.

Need for clear action and effort locally

My Board and LFA's Lung Cancer Patient Advisory Committee are alarmed at reports that hospitals have not received communication or advice on how to prepare for this program. LFA has received concerning feedback from health care professionals and clinicians from across Australia that the implementation of the program and the readiness of services to support patients varies from state to state and in some instances from one health district to the next.

Recently, Lung Foundation Australia and the Thoracic Society of Australia and New Zealand in partnership with Curtin University researchers commissioned the National Lung Cancer Landscape Survey. This survey highlights unwarranted variations of care for lung cancer patients in every state or territory and reinforces the urgent need for all Health Departments to prioritise the implementation of the NLCSP. https://pubmed.ncbi.nlm.nih.gov/38431910/

On behalf of Lung Cancer Screening participants and lung cancer patients we ask you Minister to ensure that a comprehensive implementation plan (including workforce, equipment, and systems audit) is completed urgently.

Our advice is that Health and Hospital Districts, regions and MDTs should be working towards a standardised readiness checklist which can be tailored to the local needs of their community i.e., workforce, regionality, patient profiles, caseloads etc.

Late-stage diagnosis of lung cancer is unacceptable and the NLCSP will reduce the burden of lung cancer on patients, their families, the health system, and the community.

We write to seek your reassurance that you and your department are putting in place the necessary plans, policies, systems, and resources to support people diagnosed with lung cancer.

Preparedness in the program will facilitate a shift to early stage one and two diagnoses, thereby alleviating the burden on the hospital system and saving lives.

I am happy to meet to discuss our concerns, please contact Priscilla Fisher on Schedule 2.2(a)(ii) or email Schedule 2.2(a)(ii)

Lung Foundation Australia

Yours sincerely,

Schedule 2.2(a)(ii)

Mark Brooke
Chief Executive Officer
Lung Foundation Australia

FREE CALL
1800 654 301

Level 4, 12 Cribb Street, Milton QLD 4064
PO Box 1949, Milton QLD
enquiries@lungfoundation.com.au | www.lungfoundation.com.au

ABN: 36 051 131 901

From: STEPHEN-SMITH
Sent: Tuesday, 24 September 2024 09:14
To: ACT Health DLO
Cc: Bransgrove, Meagen; Smith, Kahlia
Subject: FW: ACT Local Hospital Network Directorate- Audit report
Attachments: 5. Attachment A- LHN 24 Covering letter to the Minister for Health.pdf; 3. Attachment A- LHN 24 Auditor's Report AC.pdf; LHN Financial Statements 2023-24.pdf

Importance: High

OFFICIAL

Hi Tara,

For appropriate action please.

Thank you,

Sally Cooke
Office Manager | Office of Rachel Stephen-Smith MLA
Minister for Health | Minister for Children, Youth and Family Services | Minister for Disability | Minister for Aboriginal and Torres Strait Islander Affairs
Member for Kurrajong
ACT Legislative Assembly, 196 London Circuit, Canberra ACT 2601 | P: (02) 6205 2661 | www.act.gov.au

From: Akram, Aamir
Sent: Monday, September 23, 2024 7:42 PM
To: STEPHEN-SMITH
Cc: Anjum, Rehan ; Mazhar, Tehmina ; Sharma, Ajay
Subject: ACT Local Hospital Network Directorate- Audit report

OFFICIAL

Dear Ms Stephen-Smith,

Please find attached the cover letter and the auditor report for the audit of ACT Local Hospital Network Directorate for the year ended 30 June 2024.

If you have any queries, please feel free to contact us.

Kind Regards,

Aamir Akram| ACCA, B.com | Acting Senior Auditor | Financial Services
Phone: (02) 6207 0955 | Email: Aamir.akram@act.gov.au
ACT Audit Office | Auditor-General An Officer of the ACT Legislative Assembly
Nara Centre, Level 4, 3 Constitution Avenue, Canberra | PO Box 158 Canberra ACT 2601 | www.audit.act.gov.au

Communications from the ACT Audit Office may contain protected information for the purposes of Part 5A of the Auditor-General Act 1996 (ACT).

ACT Audit Office

AUDITOR-GENERAL AN OFFICER OF THE ACT LEGISLATIVE ASSEMBLY

OFFICIAL: SENSITIVE

Ms Rachel Stephen-Smith MLA
Minister for Health
ACT Legislative Assembly

stephen-smith@act.gov.au

Dear Ms Stephen-Smith

INDEPENDENT AUDITOR'S REPORT
ACT LOCAL HOSPITAL NETWORK DIRECTORATE
FINANCIAL STATEMENTS FOR THE YEAR ENDED 30 JUNE 2024

The ACT Audit Office has completed the audit of the financial statements of the ACT Local Hospital Network Directorate for the year ended 30 June 2024.

I have attached a copy of the audited financial statements and an unmodified independent auditor's report.

I have provided the audited financial statements and independent auditor's report to the Director-General of the ACT Health Directorate, Ms Rebecca Cross.

Yours sincerely

Ajay Sharma PSM
Assistant Auditor-General, Financial Audit
23 September 2024

ACT Audit Office

AUDITOR-GENERAL AN OFFICER OF THE ACT LEGISLATIVE ASSEMBLY

INDEPENDENT AUDITOR'S REPORT

To the Members of the ACT Legislative Assembly

Opinion

I have audited the financial statements of the ACT Local Hospital Network Directorate (Directorate) for the year ended 30 June 2024 which comprise the operating statement, balance sheet, statement of changes in equity, statement of cash flows, statement of appropriation and notes to the financial statements, including a summary of significant accounting policies and other explanatory information.

In my opinion, the financial statements:

(i) present fairly, in all material respects, the Directorate's financial position as at 30 June 2024, and its financial performance and cash flows for the year then ended; and

(ii) are presented in accordance with the *Financial Management Act 1996* and comply with Australian Accounting Standards.

Basis for opinion

I conducted the audit in accordance with the Australian Auditing Standards. My responsibilities under the standards are further described in the 'Auditor's responsibilities for the audit of the financial statements' section of this report.

I am independent of the Directorate in accordance with the ethical requirements of the Accounting Professional and Ethical Standards Board's APES 110 *Code of Ethics for Professional Accountants (including Independence Standards)* (Code). I have also fulfilled my other ethical responsibilities in accordance with the Code.

I believe that the audit evidence obtained is sufficient and appropriate to provide a basis for my opinion.

Responsibilities of the Directorate for the financial statements

The Director-General of the ACT Health Directorate is responsible for:

- preparing and fairly presenting the financial statements in accordance with the *Financial Management Act 1996* and relevant Australian Accounting Standards;
- determining the internal controls necessary for the preparation and fair presentation of the financial statements so that they are free from material misstatements, whether due to error or fraud; and
- assessing the ability of the Directorate to continue as a going concern and disclosing, as applicable, matters relating to going concern and using the going concern basis of accounting in preparing the financial statements.

Auditor's responsibilities for the audit of the financial statements

Under the *Financial Management Act 1996*, the Auditor-General is responsible for issuing an audit report that includes an independent opinion on the financial statements of the Directorate.

My objective is to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes my opinion.

Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with Australian Auditing Standards will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of the financial statements.

As part of an audit in accordance with Australian Auditing Standards, I exercise professional judgement and maintain professional scepticism throughout the audit. I also:

- identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, design and perform audit procedures responsive to those risks, and obtain audit evidence that is sufficient and appropriate to provide a basis for my opinion. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control;
- obtain an understanding of internal controls relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for expressing an opinion on the effectiveness of the Directorate's internal controls;
- evaluate the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by the Directorate;
- conclude on the appropriateness of the Directorate's use of the going concern basis of accounting and, based on audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the Directorate's ability to continue as a going concern. If I conclude that a material uncertainty exists, I am required to draw attention in this report to the related disclosures in the financial statements or, if such disclosures are inadequate, to modify my opinion. I base my conclusions on the audit evidence obtained up to the date of this report. However, future events or conditions may cause the Directorate to cease to continue as a going concern; and
- evaluate the overall presentation, structure and content of the financial statements, including the disclosures, and whether they represent the underlying transactions and events in a manner that achieves fair presentation.

I communicated with the Director-General of the ACT Health Directorate regarding, among other matters, the planned scope and timing of the audit and significant audit findings, including any significant deficiencies in internal control that I identified during my audit.



Ajay Sharma PSM
Assistant Auditor-General, Financial Audit
23 September 2024

ACT Local Hospital Network

Financial Statements

For the Year Ended

30 June 2024

INDEPENDENT AUDITOR'S REPORT

[Insert the Report from the ACT Audit Office]

ACT Local Hospital Network
Financial Statements
For the Year Ended 30 June 2024

Statement of Responsibility

In my opinion, the ACT Local Hospital Network's financial statements fairly reflect the financial operations for the year ended 30 June 2024 and its financial position on that date.



Rebecca Cross

Director-General

ACT Health Directorate

23 September 2024

ACT Local Hospital Network
Financial Statements
For the Year Ended 30 June 2024

Statement by the Chief Finance Officer

In my opinion, the ACT Local Hospital Network's financial statements have been prepared in accordance with the Australian Accounting Standards, are in agreement with its accounts and records and fairly reflect its financial operations for the year ended 30 June 2024 and the financial position on that date.



Mukunthan G¬neshalingam

Chief Finance Officer

ACT Local Hospital Network

23 September 2024

ACT Local Hospital Network
Content of Financial Statements
For the Year Ended 30 June 2024

Financial Statements
Operating Statement
Balance Sheet
Statement of Changes in Equity
Statement of Cash Flows
Statement of Appropriation

Overview Notes
Note 1 Objectives of the ACT Local Hospital Network
Note 2 Basis of Preparation of the Financial Statements
Note 3 Impact of Accounting Standards Issued But Yet to be Applied

Income Notes
Note 4 Sales of Goods and Services from Contracts with Customers
Note 5 Grants and Contributions Revenue

Expense Notes
Note 6 Grants and Purchased Services
Note 7 Transfer Expenses

Asset Notes
Note 8 Cash
Note 9 Receivables

Liability Note
Note 10 Payables

Other Notes
Note 11 Financial Instruments
Note 12 Commitments
Note 13 Related Party Disclosures
Note 14 Budgetary Reporting

ACT LOCAL HOSPITAL NETWORK
OPERATING STATEMENT
FOR THE YEAR ENDED 30 JUNE 2024

	Note No.	Actual 2024 $'000	Original Budget 2024 $'000	Actual 2023 $'000
Income				
Controlled Recurrent Payments	#, 14	1,162,877	1,051,992	1,050,818
Sales of Goods and Services from Contracts with Customers	4	169,227	122,102	126,537
Grants and Contributions Revenue	5	496,782	545,045	522,268
Total Income		**1,828,886**	**1,719,139**	**1,699,623**
Expenses				
Grants and Purchased Services	6	1,828,091	1,710,093	1,671,513
Transfer Expenses	7	9,051	9,046	21,150
Total Expenses		**1,837,142**	**1,719,139**	**1,692,663**
Operating Result		**(8,256)**	**-**	**6,960**
Total Comprehensive Result		**(8,256)**	**-**	**6,960**

The above Operating Statement is to be read in conjunction with the accompanying notes.

The ACT Local Hospital Network has only one output class and as such the above Operating Statement is also the Operating Statement for the ACT Local Hospital Network output class.

Refer to the Statement of Appropriation.

ACT LOCAL HOSPITAL NETWORK
BALANCE SHEET
AS AT 30 JUNE 2024

	Note No.	Actual 2024 $'000	Original Budget 2024 $'000	Actual 2023 $'000
Current Assets				
Cash	8	-	2,171	3,386
Receivables	9, 14	38,328	55,430	21,372
Total Current Assets		**38,328**	**57,601**	**24,758**
Total Assets		**38,328**	**57,601**	**24,758**
Current Liabilities				
Payables	10, 14	23,843	45,408	5,605
Total Current Liabilities		**23,843**	**45,408**	**5,605**
Total Liabilities		**23,843**	**45,408**	**5,605**
Net Assets		**14,485**	**12,193**	**19,153**
Equity				
Accumulated Funds		14,485	12,193	19,153
Total Equity		**14,485**	**12,193**	**19,153**

The above Balance Sheet is to be read in conjunction with the accompanying notes.

The ACT Local Hospital Network has one output class and as such the above Balance Sheet is also the Balance Sheet for the ACT Local Hospital Network output class.

ACT Local Hospital Network
Statement of Changes in Equity
For the Year Ended 30 June 2024

	Accumulated Funds Actual 2024 $'000	Total Equity Actual 2024 $'000	Total Equity Original Budget 2024 $'000
Balance at 1 July 2023	**19,153**	**19,153**	**8,605**
Comprehensive Income			
Operating Result	(8,256)	(8,256)	-
Total Comprehensive Result	**(8,256)**	**(8,256)**	**-**
Transactions Involving Owners Affecting Accumulated Funds			
Capital Injections	3,588	3,588	3,588
Total Transactions Involving Owners Affecting Accumulated Funds	**3,588**	**3,588**	**3,588**
Balance at 30 June 2024	**14,485**	**14,485**	**12,193**

	Accumulated Funds Actual 2023 $'000	Total Equity Actual 2023 $'000
Balance at 1 July 2022	**12,193**	**12,193**
Comprehensive Income		
Operating Result	6,960	6,960
Total Comprehensive Result	**6,960**	**6,960**
Balance at 30 June 2023	**19,153**	**19,153**

The above Statement of Changes in Equity is to be read in conjunction with the accompanying notes.

ACT Local Hospital Network
Statement of Cash Flows
For the Year Ended 30 June 2024

	Note No.	Actual 2024 $'000	Original Budget 2024 $'000	Actual 2023 $'000
Cash Flows from Operating Activities				
Receipts				
Controlled Recurrent Payments	#, 14	1,162,877	1,051,992	1,050,818
Sales of Goods and Services from Contracts with Customers		150,174	122,102	190,769
Grants and Contributions Receipts		496,782	545,045	522,268
Goods and Services Tax Input Tax Credits from the Australian Taxation Office		2,589	25,425	30,233
Transfers from ACT Health Directorate		150,174	122,102	160,572
Total Receipts from Operating Activities		**1,962,596**	**1,866,666**	**1,954,660**
Payments				
Grants and Purchased Services		1,818,904	1,722,727	1,731,782
Goods and Services Tax Paid to Suppliers		492	25,425	30,894
Transfers to ACT Health Directorate		150,174	122,102	190,769
Total Payments from Operating Activities		**1,969,570**	**1,870,254**	**1,953,445**
Net Cash (Outflows)/Inflows from Operating Activities	8	**(6,974)**	**(3,588)**	**1,215**
Cash Flows from Financing Activities				
Receipts				
Capital Injections		3,588	3,588	-
Total Receipts from Financing Activities		**3,588**	**3,588**	**-**
Net Cash Inflows from Financing Activities		**3,588**	**3,588**	**-**
Net (Decrease)/Increase in Cash		**(3,386)**	**-**	**1,215**
Cash at the Beginning of the Reporting Period		3,386	2,171	2,171
Cash at the End of the Reporting Period	8	**-**	**2,171**	**3,386**

The above Statement of Cash Flows is to be read in conjunction with the accompanying notes.

Refer to the Statement of Appropriation.

ACT LOCAL HOSPITAL NETWORK
STATEMENT OF APPROPRIATION
FOR THE YEAR ENDED 30 JUNE 2024

Description and Material Accounting Policies relating to Controlled Recurrent Payments

Controlled Recurrent Payments (CRP) are revenue received from the ACT Government to fund the costs of delivering outputs.

CRP is recognised as revenue when the ACT Local Hospital Network (LHN) gains control over the funding which is obtained upon the receipt of cash, given they do not contain enforceable and sufficiently specific performance obligations as defined by AASB 15 *Revenue from Contracts with Customers*.

Capital injection appropriations are not recognised as income, but instead are recognised as equity injections and a cash inflow which is used to purchase/build an asset(s) or to reduce a liability(s).

Column Heading Explanations

The Original Budget column shows the amounts that appear in the Statement of Cash Flows in the Budget Papers. This amount also appears in the Statement of Cash Flows.

The Total Appropriated column is inclusive of all appropriation variations occurring after the Original Budget.

The Appropriation Drawn column shows the total amount of appropriation received by LHN during the year. This amount appears in the Statement of Cash Flows.

	Original Budget 2024 $'000	Total Appropriated 2024 $'000	Appropriation Drawn 2024 $'000	Appropriation Drawn 2023 $'000
Controlled Recurrent Payments	1,051,992	1,174,522	1,162,877	1,050,818
Capital Injections	3,588	3,588	3,588	-
Total Controlled Appropriation	**1,055,580**	**1,178,110**	**1,166,465**	**1,050,818**

The above Statement of Appropriation is to be read in conjunction with the accompanying notes.

Reconciliation of Appropriation for 2023-24	Controlled Recurrent Payments $'000	Capital Injections $'000
Original Appropriation	1,051,992	3,588
Supplementary Appropriation (FMA s.13)	75,187	-
Variation of appropriations for Commonwealth grants (FMA s.17)	245	-
Treasurer's Advance (FMA s.18)	47,098	-
Total Appropriated	**1,174,522**	**3,588**
Appropriation Drawn	**1,162,877**	**3,588**

FMA - *Financial Management Act 1996*

ACT LOCAL HOSPITAL NETWORK
STATEMENT OF APPROPRIATION (CONTINUED)
FOR THE YEAR ENDED 30 JUNE 2024

Controlled Recurrent Payments

Variances between 'Original Budget' and 'Total Appropriated'

The difference of $122.5 million is mainly due to additional appropriation received through the mid-year budget review and a Treasurer's Advance for supporting sustainable ACT public health services, expanding inpatient services at University of Canberra Hospital, and infectious disease prevention and response.

Variances between '2023-24 and 2022-23 Controlled Recurrent Payments Appropriation Drawn'

The increase of $112.1 million is mainly due to indexation, new initiatives and additional funding received during mid-year budget review, including funding for supporting sustainable ACT public health services, expanding inpatient services at University of Canberra Hospital, and infectious disease prevention and response.

ACT LOCAL HOSPITAL NETWORK
NOTES TO AND FORMING PART OF THE FINANCIAL STATEMENTS
FOR THE YEAR ENDED 30 JUNE 2024

Note 1. Objectives of the ACT Local Hospital Network

The ACT Local Hospital Network (LHN), established in accordance with the *National Health Reform Agreement 2020-25*, and managed in accordance with the *Health* (*National Health Funding Pool and Administration) Act 2013*, is administered by the Director-General of the ACT Health Directorate. The LHN is supported by the ACT Health Directorate's staff.

The LHN receives funding from the Commonwealth, the ACT and other state and territory governments. Funding from other state and territory governments is mainly received from the NSW Government for patients accessing services from the surrounding NSW region.

Note 2. Basis of Preparation of the Financial Statements

Legislative Requirement

The *Financial Management Act 1996* (FMA) requires the preparation of annual financial statements for ACT Government Directorates.

The FMA and the *Financial Management Guidelines* issued under the Act, require the LHN's financial statements to include:

i. an Operating Statement for the year;

ii. a Balance Sheet at the end of the year;

iii. a Statement of Changes in Equity for the year;

iv. a Statement of Cash Flows for the year;

v. a Statement of Appropriation for the year;

vi. the material accounting policies adopted for the year; and

vii. other statements as necessary to fairly reflect the financial operations of the LHN during the year and its financial position at the end of the year.

These general-purpose financial statements have been prepared in accordance with:

i. Australian Accounting Standards (as required by the FMA); and

ii. ACT Accounting and Disclosure Policies.

Accrual Accounting

The financial statements have been prepared using the accrual basis of accounting.

Currency

These financial statements are presented in Australian dollars, which is the LHN's functional currency.

Individual Not-For-Profit Reporting Entity

The LHN is an individual not-for-profit reporting entity.

Reporting Period

These financial statements state the financial performance, changes in equity and cash flows of the LHN for the year ended 30 June 2024 together with the financial position of the LHN as at 30 June 2024.

ACT LOCAL HOSPITAL NETWORK
NOTES TO AND FORMING PART OF THE FINANCIAL STATEMENTS
FOR THE YEAR ENDED 30 JUNE 2024

Note 2. Basis of Preparation of the Financial Statements (Continued)

Comparative Figures

Budget Figures

To facilitate a comparison with the Budget Papers, as required by the *Financial Management Act 1996*, budget information for 2023-24 has been presented in the financial statements. Budget numbers in the financial statements are the original budget numbers that appear in the 2023-24 Budget Papers.

Prior Year Comparatives

Comparative information has been disclosed in respect of the previous period for amounts reported in the financial statements, except where an Australian Accounting Standard does not require comparative information to be disclosed.

Where the presentation or classification of items in the financial statements is amended, the comparative amounts have been reclassified where practical. Where a reclassification has occurred, the nature, amount and reason for the reclassification is provided.

Rounding

All amounts in the financial statements have been rounded to the nearest thousand dollars ($'000). Use of "-" represents zero amounts or amounts rounded down to zero.

Going Concern

The 2023-24 financial statements have been prepared on a going concern basis as the LHN has been funded in the ACT Government 2024-25 Budget and the Budget Papers including forward estimates for the LHN.

Note 3. Impact of Accounting Standards Issued But Yet to be Applied

All Australian Accounting Standards and Interpretations issued but yet to be applied are applicable to future reporting periods and will be adopted from their application date.

Standards and Interpretations issued but yet to be applied have been assessed as not being relevant to the LHN or will have an immaterial financial impact on the LHN. However, AASB 18 *Presentation and Disclosure in Financial Statements* (applicable 1 January 2028 for not-for-profit public sector entities) does contain some major presentation/disclosure changes that will impact on the LHN including:

- that operating, investing and financing categories as well as additional subtotals have to be included in the agency's operating statement;
- the disclosure of management-defined performance measures and reconciliations of these measures with the subtotals required by AASB Standards; and
- enhanced requirements for the grouping (aggregation and disaggregation) of information in the financial statements and in the notes.

ACT LOCAL HOSPITAL NETWORK
NOTES TO AND FORMING PART OF THE FINANCIAL STATEMENTS
FOR THE YEAR ENDED 30 JUNE 2024

Income Notes

Material Accounting Policies - Income

Income Recognition

The following material accounting policies relate to each income note unless stated otherwise in the individual note. Revenue is recognised in accordance with AASB 15 *Revenue from Contracts with Customers* where the contract is enforceable and contains sufficiently specific performance obligations, otherwise revenue is in the scope of AASB 1058 *Income of Not-for-Profit Entities*.

AASB 15

The core principle of AASB 15 *Revenue from Contracts with Customers*, is that revenue is recognised on a basis that reflects the transfer of promised goods or services to customers at an amount that reflects the consideration the entity expects to receive in exchange for those goods or services. Revenue is recognised by applying a five-step model as follows:

1. identify the contract with the customer;
2. identify the performance obligations;
3. determine the transaction price;
4. allocate the transaction price; and
5. recognise revenue as or when control of the performance obligation is transferred to the customer.

Generally, the timing of the payment for sale of goods and rendering of services corresponds closely to the timing of satisfaction of the performance obligations, however where there is a difference, it will result in the recognition of a receivable, contract asset or contract liability.

None of the revenue streams of the LHN has any significant financing terms as there is less than 12 months between receipt of funds and satisfaction of performance obligations.

AASB 1058

Where revenue streams are in the scope of AASB 1058 *Income of Not-for-Profit Entities*, the LHN recognises the asset received (generally cash or other financial assets) at fair value, recognises any related amount (e.g., liability or equity) in accordance with an accounting standard and recognises revenue as the residual between the fair value of the asset and the related amount on receipt of the asset.

ACT LOCAL HOSPITAL NETWORK
NOTES TO AND FORMING PART OF THE FINANCIAL STATEMENTS
FOR THE YEAR ENDED 30 JUNE 2024

Note 4. Sales of Goods and Services from Contracts with Customers

Description and Material Accounting Policies Relating to the Sale of Goods and Services

Revenue is recognised either over time or at a point in time.

The LHN earns revenue from providing public health services to residents of other States and Territories. The LHN has assessed its revenue from contracts with customers and uses key judgements in determining the satisfaction of performance obligations.

Key judgements are also used in determining the transaction price and the amounts allocated to performance obligations. Public hospital services are dependent on patient numbers and complexities of treatments provided and are quantified as National Weighted Activity Units (NWAU). The final price payable for services each year is calculated using the price per NWAU determined by the Independent Hospital and Aged Care Pricing Authority (IHACPA) and the services provided.

As a result, the LHN determined the services to be classified as revenue from contracts with customers which have been included in this note as Cross Border (Interstate) Health Revenue.

Cross Border Health Revenues

Initial revenue from Cross Border (Interstate) Health services for the current year is recognised over time on a monthly basis based on patient numbers estimated from projected growth of prior year actuals. Thereafter revenue for actual patient numbers and complexities of treatments provided are recognised following an acquittal process undertaken in subsequent years. Variations to the revenue recognised are accounted for in the year of settlement.

The *National Health Reform Agreement* (NHRA) specifies that each jurisdiction will make funding contributions through the *National Health Funding Pool* for services provided by other jurisdictions to its residents either on an ad hoc basis reflecting actual activity, or on a regular basis as scheduled through a Cross Border agreement.

	2024 $'000	2023 $'000
Non-ACT Government Customers		
Cross Border (Interstate) Health Revenue	169,227	126,537
Total Sales of Goods and Services from Non-ACT Government Customers	**169,227**	**126,537**
Total Sales of Goods and Services from Contracts with Customers [a]	**169,227**	**126,537**

a. The increase in 'Cross Border Health Revenue' of $42.7 million is mainly due to an increase in interstate residents treated in ACT public hospitals and the additional receipts following activity reconciliations for prior years being completed with final back-adjustment payments being settled in 2023-24.

ACT LOCAL HOSPITAL NETWORK
NOTES TO AND FORMING PART OF THE FINANCIAL STATEMENTS
FOR THE YEAR ENDED 30 JUNE 2024

Note 5. Grants and Contributions Revenue

Description and Material Accounting Policies Relating to Grants and Contributions Revenue

Commonwealth Grants relate to Activity Based Funding, Block Funding and Public Health Funding under the NHRA.

Activity Based Funding refers to a national system for funding public hospital services using national classifications, National Weighted Activity Unit (NWAU) and a National Efficient Price (NEP).

Activity Based Funding covers all admitted, non-admitted and emergency department services that meet the Independent Hospital and Aged Care Pricing Authority (IHACPA) criteria for inclusion on the 'General List of In-Scope Public Hospital Services'.

Block Funding is provided to support other public hospital functions that are recognised by IHACPA as services acceptable to be funded on this basis and that conform to IHACPA's national pricing model.

Public Health funding is provided to fund health promotion and preventive activities undertaken by the State/Territory Health Department.

Significant Accounting Judgement and Estimates – Grants from the Commonwealth

Actual NWAUs are settled following an acquittal process undertaken in the following financial year and variations to the revenue recognised are accounted for in the year of settlement.

Commonwealth Grants are calculated and paid using estimates of NWAU activity. These estimates are based on expected number of patients treated during the year and are recognised as revenue upon receipt. Grants from the Commonwealth are recognised as revenue when the LHN gains control over the funding.

LHN has determined that the agreements/arrangements relating to 'Grants from the Commonwealth' line items included in this note do not contain sufficiently specific performance obligations for recognising revenue from contracts with customers under AASB 15 *Revenue from Contracts with Customers*. None of the arrangements require LHN to provide an equal amount in return for the consideration received. As such, AASB 1058 *Income of Not-for-Profit Entities* has been applied for recognising this revenue.

	2024 $'000	2023 $'000
Non-ACT Government Grants and Contributions		
Grants from the Commonwealth [a]	496,782	522,268
Total Non-ACT Government Grants and Contributions	**496,782**	**522,268**
Total Grants and Contributions	**496,782**	**522,268**

a. The decrease in 'Grants from the Commonwealth' of $25.5 million mainly relates to lower funding receipts through the *National Partnership on COVID-19 Response* (NPCR) due to the scale back of the Territory's public health emergency response to COVID-19 and the NPCR ceasing at the end of December 2022.

ACT LOCAL HOSPITAL NETWORK
NOTES TO AND FORMING PART OF THE FINANCIAL STATEMENTS
FOR THE YEAR ENDED 30 JUNE 2024

Note 6. Grants and Purchased Services

Description and Material Accounting Policies Relating to Grants and Purchased Services

Grants and Purchased Services reflect public hospital payments to Canberra Health Services, Queen Elizabeth II and to States and Territories for Cross Border patient services.

	2024 $'000	2023 $'000
Grants and Purchased Services		
Payments to Service Providers		
- Canberra Health Services [a]	1,773,280	1,354,037
- Calvary Public Hospital [a]	1,826	287,880
- Queen Elizabeth II	4,120	4,020
- Private Hospital Financial Viability Payments [b]	-	4,348
- Private Hospitals (State Directed) [c]	-	845
Cross Border (Interstate) Health Costs [d]	48,865	20,383
Total Grants and Purchased Services	**1,828,091**	**1,671,513**

a. The increase in payments to Canberra Health Services ($419.2 million) and decrease in payments to Calvary Public Hospital ($286.1 million) is mainly because funding previously provided to Calvary Public Hospital is now provided to Canberra Health Services due to the acquisition of Calvary Public Hospital by the Territory on 3 July 2023 and due to the growth in demand for services and indexation.

b. 'Private Hospital Financial Viability Payments' (FVP) relate to the NPCR commitment where the Commonwealth provided 100 per cent FVP to guarantee ongoing minimum viability for private hospitals. The decrease of $4.3 million in 2023-24 is due to the NPCR related payments for private hospitals ceasing at the end of September 2022.

c. 'Private Hospitals (State Directed)' relates to the purchase of public hospital services from private hospitals to supplement the increase in demand for health services due to the COVID-19 pandemic. The decrease of $0.8 million is due to the agreement ceasing in 2022-23.

d. The increase in 'Cross Border (Interstate) Health Costs' of $28.5 million mainly relates to prior year reconciliations being completed and an increase in ACT residents treated in interstate public hospitals.

ACT LOCAL HOSPITAL NETWORK
NOTES TO AND FORMING PART OF THE FINANCIAL STATEMENTS
FOR THE YEAR ENDED 30 JUNE 2024

Note 7. Transfer Expenses

Description and Material Accounting Policies Relating to Transfer Expenses

The Commonwealth Government's contribution to public health funding through the *National Health Reforms Agreement* (NHRA) is passed through to the ACT Health Directorate. Public health payments fund health promotion, and preventive activities for which activities are undertaken by State and Territory Health Departments.

	2024 $'000	2023 $'000
Transfer Expenses [a]	9,051	21,150
Total Transfer Expenses	**9,051**	**21,150**

a. The decrease in 'Transfer Expenses' of $12.1 million mainly relates to a decrease in payments to the ACT Health Directorate due to the scale back of the Territory's public health emergency response to COVID-19 and the NPCR ceasing at the end of December 2022.

Asset Notes

Material Accounting Policies – Assets

Assets – Current and Non-Current

Assets are classified as current where they are expected to be realised within 12 months after the reporting date. Assets, which do not fall within the current classification, are classified as non-current.

Note 8. Cash

Description and Material Accounting Policies Relating to Cash

Cash includes cash at bank.

The LHN operates three bank accounts, two with Westpac Banking Corporation as part of the whole-of-government banking arrangements and the other with the Reserve Bank of Australia as part of the requirements under the NHRA. The LHN does not receive any interest on these accounts.

(a) Cash Balances	2024 $'000	2023 $'000
Current Cash		
Deposits Held at Call with a Financial Institution [a]	-	3,386
Total Cash	**-**	**3,386**

a. The decrease in 'Deposits Held at Call with a Financial Institution' of $3.4 million mainly relates to funds being utilised to settle outstanding payments to health service providers during the year.

ACT LOCAL HOSPITAL NETWORK
NOTES TO AND FORMING PART OF THE FINANCIAL STATEMENTS
FOR THE YEAR ENDED 30 JUNE 2024

Note 8. Cash (Continued)

(b) Reconciliation of Cash at the End of the Reporting Period in the Statement of Cash Flows to the Equivalent Items in the Balance Sheet

	2024 $'000	2023 $'000
Total Cash Recorded in the Balance Sheet	-	3,386
Cash at the End of the Reporting Period as Recorded in the Statement of Cash Flows	**-**	**3,386**

(c) Reconciliation of Operating Result to Net Cash Inflows/(Outflows) from Operating Activities

	2024 $'000	2023 $'000
Operating Result	(8,256)	6,960
Cash Before Changes in Operating Assets and Liabilities	**(8,256)**	**6,960**
Changes in Operating Assets and Liabilities		
(Increase)/Decrease in Receivables	(16,956)	34,058
Increase/(Decrease) in Payables	18,238	(39,803)
Net Changes in Operating Assets and Liabilities	**1,282**	**(5,745)**
Net Cash (Outflows)/Inflows from Operating Activities	**(6,974)**	**1,215**

Note 9. Receivables

Description and Material Accounting Policies Relating to Receivables

Accounts receivables are measured at amortised cost, with any adjustments to the carrying amount being recorded in the Operating Statement. Accrued revenue relates to outstanding payments for the estimated number of interstate patients treated in ACT public hospitals.

	2024 $'000	2023 $'000
Current Receivables		
Accrued Revenue [a]	38,328	19,275
Net GST Receivable	-	2,097
Total Current Receivables	**38,328**	**21,372**

No receivables are past due or impaired. All receivables are with other State and Territory Governments.

a. The increase in 'Accrued Revenue' of $19.1 million mainly relates to higher outstanding Cross Border Health receipts due to an increase in estimated number of interstate residents being treated in ACT public hospitals.

ACT LOCAL HOSPITAL NETWORK
NOTES TO AND FORMING PART OF THE FINANCIAL STATEMENTS
FOR THE YEAR ENDED 30 JUNE 2024

Liability Notes

Material Accounting Policies – Liability

Liabilities – Current and Non-Current

Liabilities are classified as current when they are due to be settled within 12 months after the reporting date or the LHN does not have an unconditional right to defer settlement of the liability for at least 12 months after the reporting date. Liabilities, which do not fall within the current classification, are classified as non-current.

Note 10. Payables

Description and Material Accounting Policies Relating to Payables

Payables consist of Accrued Expenses.

Payables are initially recognised at fair value based on the transaction cost and subsequent to initial recognition at amortised cost, with any adjustments to the carrying amount being recorded in the Operating Statement. Accrued Expenses relate to outstanding payments for the estimated number of ACT residents treated in other State and Territory public hospitals and payments to public health service providers.

	2024 $'000	2023 $'000
Current Payables		
Accrued Expenses [a]	23,843	5,605
Total Current Payables	**23,843**	**5,605**

No payables are overdue.

a. The increase in 'Accrued Expenses' of $18.2 million mainly relates to higher outstanding Cross Border Health payments due to an increase in estimated number of ACT residents being treated in interstate public hospitals.

ACT LOCAL HOSPITAL NETWORK
NOTES TO AND FORMING PART OF THE FINANCIAL STATEMENTS
FOR THE YEAR ENDED 30 JUNE 2024

Note 11. Financial Instruments

Material Accounting Policies Relating to Financial Instruments

Details of the material accounting policies and methods adopted, including the criteria for recognition, the basis of measurement, and the basis on which income and expenses are recognised, with respect to each class of financial asset and financial liability are disclosed in the note to which they relate. In addition to these policies, the following are also accounting policies relating to financial assets and liabilities.

Financial assets are subsequently measured at amortised cost, fair value through other comprehensive income or fair value through profit or loss on the basis of both:

(a) the business model for managing the financial assets; and

(b) the contractual cash flow characteristics of the financial assets.

The following are the classification of the LHN's financial assets under AASB 9 *Financial Instruments*:

Items	Business Model Held to collect principal and interest/sell	Solely for payment of Principal and Interest SPPI Test (basic lending characteristics)	Classification
Cash	Held to collect	Yes	Amortised cost
Receivables	Held to collect	Yes	Amortised cost

Financial liabilities are measured at amortised cost.

Credit Risk

Credit risk is the risk that one party to a financial instrument will fail to discharge an obligation and cause the other party to incur a financial loss. The LHN's credit risk is limited to the amount of the financial assets it holds net of provision for impairment. The LHN's financial assets consist of cash and receivables.

Cash is held with the Westpac Banking Corporation and the Reserve Bank of Australia, both of which are high credit, quality financial institutions, in accordance with whole of ACT Government banking arrangements.

The LHN's receivables mainly consist of amounts owed by New South Wales Health and the Department of Health and Human Services in Victoria. As the New South Wales and the Victorian Governments have AA+ and AA credit ratings respectively, it is considered that there is a very low risk of default for these receivables.

There have been no significant changes in credit risk exposure since the last reporting period.

Liquidity Risk

Liquidity risk is the risk that the LHN will encounter difficulties in meeting obligations associated with financial liabilities that are settled by delivering cash or another financial asset.

The main source of cash to pay these obligations is appropriation from the ACT Government and Grants from the Commonwealth. The LHN manages its liquidity risk through forecasting Controlled Recurrent Payments drawdown to cover its financial liabilities when they fall due.

The LHN's exposure to liquidity risk and the management of this risk has not changed since the previous reporting period.

ACT LOCAL HOSPITAL NETWORK
NOTES TO AND FORMING PART OF THE FINANCIAL STATEMENTS
FOR THE YEAR ENDED 30 JUNE 2024

Note 11. Financial Instruments (Continued)

Carrying Amounts and Fair Value of Financial Assets and Liabilities

	Note No.	Carrying Amount 2024 $'000	Fair Value 2024 $'000	Carrying Amount 2023 $'000	Fair Value 2023 $'000
Financial Assets					
Cash	8	-	-	3,386	3,386
Receivables	9	38,328	38,328	19,275	19,275
Total Financial Assets		**38,328**	**38,328**	**22,661**	**22,661**
Financial Liabilities					
Payables	10	23,843	23,843	5,605	5,605
Total Financial Liabilities		**23,843**	**23,843**	**5,605**	**5,605**

All financial assets and liabilities of the LHN are non-interest bearing and are shown on an undiscounted Cash Flow basis.

Carrying Amount of Each Category of Financial Asset and Financial Liability

	2024 $'000	2023 $'000
Financial Assets		
Financial Assets Measured at Amortised Cost	38,328	19,275
Financial Liabilities		
Financial Liabilities Measured at Amortised Cost	23,843	5,605

Note 12. Commitments

Description and Material Accounting Policies Relating to Commitments
Commitments are a firm intention, but not a present obligation, at the end of the reporting period to incur future expenditure. As such, commitments do not constitute a liability. Commitments usually arise from contracts, but can arise from other things like placing an order.

Commitments contracted at reporting date but not recognised as liabilities are as follows:

	2024 $'000	2023 $'000
Commitments		
Payable:		
Within One Year	4,646	4,532
Later than one year but not later than five years	4,762	9,407
Total Commitments	**9,408**	**13,940**

Commitments relate to services provided under contract for the provision of residential primary health care for families of young children at the Queen Elizabeth II Family Centre.

All amounts shown in this note are inclusive of GST.

Note 13. Related Party Disclosures

Description and Material Accounting Policies Relating to Related Party Disclosures

A related party is a person that controls or has significant influence over the reporting entity or is a member of the Key Management Personnel (KMP) of the reporting entity or its parent entity and includes their close family members and entities in which the KMP and/or their close family members individually or jointly have controlling interests.

KMP are those persons having authority and responsibility for planning, directing and controlling the activities of the LHN, directly or indirectly.

KMP of the LHN are the Portfolio Minister, the Director-General of the ACT Health Directorate and individuals from the ACT Health Directorate with a significant influence in strategic decisions impacting the LHN.

The Head of Service and the ACT Executive comprising the Cabinet Ministers are KMP of the ACT Government and are therefore related parties of the LHN.

This note does not include typical citizen transactions between the KMP and the LHN that occur on terms and conditions no different to those applying to the general public.

ACT LOCAL HOSPITAL NETWORK
NOTES TO AND FORMING PART OF THE FINANCIAL STATEMENTS
FOR THE YEAR ENDED 30 JUNE 2024

Note 13. Related Party Disclosures (Continued)

(A) Controlling Entity

The LHN is an ACT Government controlled entity.

(B) Key Management Personnel

B.1 Compensation of Key Management Personnel

Compensation of all Cabinet Ministers, including the Portfolio Minister, is disclosed in the note on related party disclosures included in the ACT Executive's financial statements for the year ended 30 June 2024.

Compensation of the Head of Service is included in the note on related party disclosures included in the Chief Minister, Treasury and Economic Development Directorate's (CMTEDD) financial statements for the year ended 30 June 2024.

Key Management Personnel (KMP) of the LHN other than the Portfolio Minister are employees of the ACT Health Directorate and are compensated by the ACT Health Directorate. Compensation of these KMP is included in the note on related party disclosures included in the ACT Health Directorate's financial statements for the year ended 30 June 2024.

The LHN itself does not compensate any of its KMP.

B.2 Transactions with Key Management Personnel

No disclosure is required for typical citizen transactions between the KMP and the LHN that occur on terms and conditions no different to those applying to the general public, where no discretion is applied and no influence is exerted by the related parties over the terms and conditions of these transactions.

B.3 Transactions with parties related to Key Management Personnel

There were no transactions with parties related to KMP, including transactions with KMP's close family members or other related entities that were material to the financial statements of the LHN.

(C) Transactions with other ACT Government Controlled Entities

The LHN has entered into transactions with other ACT Government Entities in 2022-23 and 2023-24 consistent with day-to-day business operations provided under varying terms and conditions. The Statement of Appropriation, *Note 6 Grants and Purchased Services* and *Note 7 Transfer Expenses* of the Financial Statements provide the details of transactions with other ACT Government Entities.

ACT LOCAL HOSPITAL NETWORK
NOTES TO AND FORMING PART OF THE FINANCIAL STATEMENTS
FOR THE YEAR ENDED 30 JUNE 2024

Note 14. Budgetary Reporting

Significant Accounting Judgements and Estimates – Budgetary Reporting

Significant judgements have been applied in determining what variances are considered 'major variances'. Variances are considered major if both of the following criteria are met:

- The line item is a significant line item: where either the line item actual amount accounts for more than 10% of the relevant associated actual category amount (Income, Expenses, Assets, Liabilities and Equity totals) or more than 10% of the sub-element (e.g. Current Liabilities and Receipts from Operating Activities totals) of the financial statements; and
- The variances (original budget to actual) are greater than plus (+) or minus (-) 10% and $15 million for the financial statement line item.

Original Budget refers to the amounts presented to the Legislative Assembly in the original budgeted financial statements in respect of the reporting period Budget Statements. These amounts have not been adjusted to reflect supplementary appropriation or appropriation instruments.

Note: # in the 'Variance %' column represents a variance that is greater than 999 per cent or less than -999 per cent.

Operating Statement Line Items	Variance Explanation	Actual 2023-24 $'000	Original Budget 2023-24 $'000	Variance $'000	Variance %
Revenue					
Controlled Recurrent Payments	a	1,162,877	1,051,992	110,885	11

Variance Explanations

a. Controlled Recurrent Payments were higher than budget mainly due to additional appropriation received through the mid-year budget review and a Treasurer's Advance for supporting sustainable ACT public health services, expanding inpatient services at University of Canberra Hospital, increased insurance premiums, and infectious disease prevention and response.

ACT LOCAL HOSPITAL NETWORK
NOTES TO AND FORMING PART OF THE FINANCIAL STATEMENTS
FOR THE YEAR ENDED 30 JUNE 2024

Note 14. Budgetary Reporting (Continued)

Balance Sheet Line Items	Variance Explanation	Actual 2023-24 $'000	Original Budget 2023-24 $'000	Variance $'000	Variance %
Assets					
Receivables	a	38,328	55,430	(17,102)	(31)
Liabilities					
Payables	a	23,843	45,408	(21,565)	(47)

Variance Explanations

a. Receivables and payables were lower than budget mainly due to lower outstanding Cross Border Health receipts and payments following multiple prior year reconciliations being completed with final back-adjustment payments being settled in 2023-24.

ACT LOCAL HOSPITAL NETWORK
NOTES TO AND FORMING PART OF THE FINANCIAL STATEMENTS
FOR THE YEAR ENDED 30 JUNE 2024

Note 14. Budgetary Reporting (Continued)

Statement of Cash Flows Line Items

Statement of Cash Flows Line Items	Variance Explanation	Actual 2023-24 $'000	Original Budget 2023-24 $'000	Variance $'000	Variance %
Receipts					
Controlled Recurrent Payments	a	1,162,877	1,051,992	110,885	11

Variance Explanations

a. Controlled Recurrent Payments were higher than budget mainly due to additional appropriation received through the mid-year budget review and a Treasurer's Advance for supporting sustainable ACT public health services, expanding inpatient services at University of Canberra Hospital, increased insurance premiums, and infectious disease prevention and response.

Lowe, Shannon

From: STEPHEN-SMITH
Sent: Tuesday, 24 September 2024 11:19 AM
To: ACT Health DLO
Cc: Bransgrove, Meagen; Smith, Kahlia
Subject: FW: ACT Health Directorate- Audit Report
Attachments: 5. Attachment A4 - AHD24 Covering letter to the Minister for Health.pdf; 3. Attachment A2 - AHD24 Auditor's Report.pdf; AHD Financial Statement 2023-2024.pdf

Importance: High

OFFICIAL

Hi Tara,

For appropriate action please.

Thank you,

Sally Cooke
Office Manager | Office of Rachel Stephen-Smith MLA
Minister for Health | Minister for Children, Youth and Family Services | Minister for Disability | Minister for Aboriginal and Torres Strait Islander Affairs
Member for Kurrajong
ACT Legislative Assembly, 196 London Circuit, Canberra ACT 2601 | P: (02) 6205 2661 | www.act.gov.au

From: Akram, Aamir
Sent: Tuesday, September 24, 2024 10:26 AM
To: STEPHEN-SMITH
Cc: Anjum, Rehan ; Sharma, Ajay ; Mazhar, Tehmina ; Ali, Hassan
Subject: ACT Health Directorate- Audit Report

OFFICIAL

Dear Ms Stephen-Smith,

Please find attached the cover letter and the auditor report for the audit of ACT Health Directorate for the year ended 30 June 2024.

If you have any queries, please feel free to contact us.

Kind Regards,

Aamir Akram| ACCA, B.com | Acting Senior Auditor | Financial Services
Phone: (02) 6207 0955 | Email: Aamir.akram@act.gov.au
ACT Audit Office | **Auditor-General** An Officer of the ACT Legislative Assembly

Nara Centre, Level 4, 3 Constitution Avenue, Canberra | PO Box 158 Canberra ACT 2601 | www.audit.act.gov.au

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ACT Audit Office

AUDITOR-GENERAL AN OFFICER OF THE ACT LEGISLATIVE ASSEMBLY

OFFICIAL: SENSITIVE

Ms Rachel Stephen-Smith MLA
Minister for Health
ACT Legislative Assembly

Stephen-Smith@act.gov.au

Dear Ms Stephen-Smith

INDEPENDENT AUDITOR'S REPORT
ACT HEALTH DIRECTORATE
FINANCIAL STATEMENTS FOR THE YEAR ENDED 30 JUNE 2024

The ACT Audit Office has completed the audit of the financial statements of the ACT Health Directorate for the year ended 30 June 2024.

I have attached a copy of the audited financial statements and an unmodified independent auditor's report.

I have provided the audited financial statements and independent auditor's report to the Director-General of the ACT Health Directorate, Ms Rebecca Cross.

Yours sincerely

Michael Harris
Auditor-General
23 September 2024

ACT Audit Office

AUDITOR-GENERAL AN OFFICER OF THE ACT LEGISLATIVE ASSEMBLY

INDEPENDENT AUDITOR'S REPORT

To the Members of the ACT Legislative Assembly

Opinion

I have audited the financial statements of the ACT Health Directorate (Directorate) for the year ended 30 June 2024 which comprise the:

- Controlled financial statements – operating statement, balance sheet, statement of changes in equity, statement of cash flows and statement of appropriation;
- Territorial financial statements – statement of income and expenses on behalf of the Territory, statement of assets and liabilities on behalf of the Territory, statement of cash flows on behalf of the Territory and Territorial statement of appropriation; and
- Notes to the financial statements, including a summary of significant accounting policies and other explanatory information.

In my opinion, the financial statements:

(i) present fairly, in all material respects, the Directorate's financial position as at 30 June 2024, and its financial performance and cash flows for the year then ended; and

(ii) are presented in accordance with the *Financial Management Act 1996* and comply with Australian Accounting Standards.

Basis for opinion

I conducted the audit in accordance with the Australian Auditing Standards. My responsibilities under the standards are further described in the 'Auditor's responsibilities for the audit of the financial statements' section of this report.

I am independent of the Directorate in accordance with the ethical requirements of the Accounting Professional and Ethical Standards Board's APES 110 *Code of Ethics for Professional Accountants (including Independence Standards)* (Code). I have also fulfilled my other ethical responsibilities in accordance with the Code.

I believe that the audit evidence obtained is sufficient and appropriate to provide a basis for my opinion.

Responsibilities of the Directorate for the financial statements

The Director-General is responsible for:

- preparing and fairly presenting the financial statements in accordance with the *Financial Management Act 1996* and relevant Australian Accounting Standards;
- determining the internal controls necessary for the preparation and fair presentation of the financial statements so that they are free from material misstatements, whether due to error or fraud; and
- assessing the ability of the Directorate to continue as a going concern and disclosing, as applicable, matters relating to going concern and using the going concern basis of accounting in preparing the financial statements.

Auditor's responsibilities for the audit of the financial statements

Under the *Financial Management Act 1996*, the Auditor-General is responsible for issuing an audit report that includes an independent opinion on the financial statements of the Directorate.

My objective is to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes my opinion.

Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with Australian Auditing Standards will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of the financial statements.

As part of an audit in accordance with Australian Auditing Standards, I exercise professional judgement and maintain professional scepticism throughout the audit. I also:

- identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, design and perform audit procedures responsive to those risks, and obtain audit evidence that is sufficient and appropriate to provide a basis for my opinion. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control;
- obtain an understanding of internal controls relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for expressing an opinion on the effectiveness of the Directorate's internal controls;
- evaluate the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by the Directorate;
- conclude on the appropriateness of the Directorate's use of the going concern basis of accounting and, based on audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the Directorate's ability to continue as a going concern. If I conclude that a material uncertainty exists, I am required to draw attention in this report to the related disclosures in the financial statements or, if such disclosures are inadequate, to modify my opinion. I base my conclusions on the audit evidence obtained up to the date of this report. However, future events or conditions may cause the Directorate to cease to continue as a going concern; and
- evaluate the overall presentation, structure and content of the financial statements, including the disclosures, and whether they represent the underlying transactions and events in a manner that achieves fair presentation.

I communicate with the Directorate regarding, among other matters, the planned scope and timing of the audit and significant audit findings, including any significant deficiencies in internal control that I identify during my audit.



Michael Harris
Auditor-General
23 September 2024

ACT Health Directorate

Financial Statements

For The Year Ended

30 June 2024

INDEPENDENT AUDITOR'S REPORT

[Insert the Report from the ACT Audit Office.]

ACT HEALTH DIRECTORATE
FINANCIAL STATEMENTS
FOR THE YEAR ENDED 30 JUNE 2024

Statement of Responsibility

In my opinion, the ACT Health Directorate's financial statements fairly reflect the financial operations for the year ended 30 June 2024 and its financial position on that date.



Rebecca Cross

Director-General

ACT Health Directorate

23 September 2024

ACT HEALTH DIRECTORATE
FINANCIAL STATEMENTS
FOR THE YEAR ENDED 30 JUNE 2024

Statement by the Chief Finance Officer

In my opinion, the ACT Health Directorate's financial statements have been prepared in accordance with the Australian Accounting Standards, are in agreement with its accounts and records and fairly reflect its financial operations for the year ended 30 June 2024 and the financial position on that date.



Mukun·' an ~anes' alingam

Chief Finance Officer

ACT Health Directorate

23 September 2024

ACT Health Directorate

Controlled Financial Statements

For the Year Ended
30 June 2024

ACT HEALTH DIRECTORATE
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FOR THE YEAR ENDED 30 JUNE 2024

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ACT HEALTH DIRECTORATE
OPERATING STATEMENT
FOR THE YEAR ENDED 30 JUNE 2024

	Note No.	Actual 2024 $'000	Original Budget 2024 $'000	Actual 2023 $'000
Income				
Controlled Recurrent Payments	#, 23	344,867	296,101	312,048
Sales of Goods and Services from Contracts with Customers		1,902	11,095	1,641
Grants and Contributions Revenue	4, 23	183,995	11,549	220,949
Other Income	23	6,620	126,367	9,287
Total Income		**537,384**	**445,112**	**543,925**
Expenses				
Employee Expenses	5, 23	138,682	121,149	135,513
Supplies and Services	6, 23	131,081	100,053	160,588
Depreciation and Amortisation	11, 12	29,608	41,438	25,464
Grants and Purchased Services	7, 23	247,583	222,431	240,799
Other Expenses	8	625	2,136	1,437
Total Expenses		**547,579**	**487,207**	**563,801**
Operating Result		**(10,195)**	**(42,095)**	**(19,876)**
Other Comprehensive Income				
Items that will not be reclassified subsequently to profit or loss				
Increase in the Asset Revaluation Surplus	11	260	-	673
Total Other Comprehensive Result		**260**	**-**	**673**
Total Comprehensive Result		**(9,935)**	**(42,095)**	**(19,203)**

The above Operating Statement is to be read in conjunction with the accompanying notes.

The Directorate has only one output class and as such the above Operating Statement is also the Directorate's Operating Statement for the Public Health Services output class. Functions of this output class involve undertaking collaborative leadership, strategic policy, programs and planning, improving population health and keeping Canberrans healthy, and enabling a strong and safe health system.

Refer to the Statement of Appropriation.

ACT HEALTH DIRECTORATE
BALANCE SHEET
AS AT 30 JUNE 2024

	Note No.	Actual 2024 $'000	Original Budget 2024 $'000	Actual 2023 $'000
Current Assets				
Cash	9, 23	15,899	365	79
Receivables	10	5,047	3,531	6,950
Other Assets	13	5,341	10,790	6,290
Total Current Assets		**26,287**	**14,686**	**13,319**
Non-Current Assets				
Property, Plant and Equipment	11, 23	64,030	94,667	98,341
Intangible Assets	12, 23	93,523	27,304	109,978
Capital Works in Progress	11, 12, 23	83,756	170,380	27,123
Total Non-Current Assets		**241,309**	**292,351**	**235,442**
Total Assets		**267,596**	**307,037**	**248,761**
Current Liabilities				
Payables	14	27,184	33,000	30,377
Lease Liabilities		322	978	427
Employee Benefits	15	42,105	52,066	39,901
Other Liabilities	17	1,620	1,726	1,703
Total Current Liabilities		**71,231**	**87,770**	**72,408**
Non-Current Liabilities				
Lease Liabilities		234	672	410
Employee Benefits	15	2,263	2,008	1,857
Other Provisions	16	2,704	2,832	3,542
Other Liabilities	17	7,054	7,993	8,093
Total Non-Current Liabilities		**12,255**	**13,505**	**13,902**
Total Liabilities		**83,486**	**101,275**	**86,310**
Net Assets		**184,110**	**205,762**	**162,451**
Equity				
Accumulated Funds	23	164,850	188,822	143,451
Asset Revaluation Surplus		19,260	16,940	19,000
Total Equity		**184,110**	**205,762**	**162,451**

The above Balance Sheet is to be read in conjunction with the accompanying notes.

The Directorate has only one output class and as such the above Balance Sheet is also the Directorate's Balance Sheet for the Public Health Services output class. A separate disaggregated disclosure statement has not been included in these financial statements.

ACT HEALTH DIRECTORATE
STATEMENT OF CHANGES IN EQUITY
FOR THE YEAR ENDED 30 JUNE 2024

	Note No.	Accumulated Funds Actual 2024 $'000	Asset Revaluation Surplus Actual 2024 $'000	Total Equity Actual 2024 $'000	Total Equity Original Budget 2024 $'000
Balance at 1 July 2023		**143,451**	**19,000**	**162,451**	**152,237**
Comprehensive Income					
Operating Result		(10,195)	-	(10,195)	(42,095)
Increase in the Asset Revaluation Surplus	11	-	260	260	-
Total Comprehensive Result		**(10,195)**	**260**	**(9,935)**	**(42,095)**
Transactions Involving Owners Affecting Accumulated Funds					
Land Asset Assumed (Clare Holland House)	11	5,140	-	5,140	**-**
Net Assets transferred to Canberra Health Services	11	(37,893)	-	(37,893)	-
Capital Injections	#	64,346	-	64,346	95,620
Total Transactions Involving Owners Affecting Accumulated Funds		**31,593**	**-**	**31,593**	**95,620**
Balance at 30 June 2024		**164,850**	**19,260**	**184,110**	**205,762**

The above Statement of Changes in Equity is to be read in conjunction with the accompanying notes.

Refer to the Statement of Appropriation.

ACT HEALTH DIRECTORATE
STATEMENT OF CHANGES IN EQUITY (CONTINUED)
FOR THE YEAR ENDED 30 JUNE 2024

	Note No.	Accumulated Funds Actual 2023 $'000	Asset Revaluation Surplus Actual 2023 $'000	Total Equity Actual 2023 $'000
Balance at 1 July 2022		**98,142**	**18,327**	**116,469**
Comprehensive Income				
Operating Result		(19,876)	-	(19,876)
Increase in the Asset Revaluation Surplus	11	-	673	673
Total Comprehensive Result		**(19,876)**	**673**	**(19,203)**
Transactions Involving Owners Affecting Accumulated Funds				
Capital Injections	#	65,185	-	65,185
Total Transactions Involving Owners Affecting Accumulated Funds		**65,185**	**-**	**65,185**
Balance at 30 June 2023		**143,451**	**19,000**	**162,451**

The above Statement of Changes in Equity is to be read in conjunction with the accompanying notes.

Refer to the Statement of Appropriation.

ACT HEALTH DIRECTORATE
STATEMENT OF CASH FLOWS
FOR THE YEAR ENDED 30 JUNE 2024

	Note No.	Actual 2024 $'000	Original Budget 2024 $'000	Actual 2023 $'000
Cash Flows from Operating Activities				
Receipts				
Controlled Recurrent Payments	23	344,867	296,101	312,048
Sales of Goods and Services from Contracts with Customers		1,902	11,095	1,619
Grants and Contributions Receipts	23	171,981	122,102	217,918
Goods and Services Tax Input Tax Credits from the Australian Taxation Office		17,975	15,165	18,311
Goods and Services Tax Collected from Customers		88	681	119
Other		9,585	4,269	7,503
Total Receipts from Operating Activities		**546,398**	**449,413**	**557,518**
Payments				
Employee Payments	23	136,073	116,927	135,327
Supplies and Services	23	124,771	93,833	154,550
Grants and Purchased Services	23	248,123	219,856	241,747
Goods and Services Tax Paid to Suppliers		19,182	15,846	18,525
Other		1,826	2,136	1,715
Total Payments from Operating Activities		**529,975**	**448,598**	**551,864**
Net Cash Inflows from Operating Activities	9	**16,423**	**815**	**5,654**
Cash Flows from Investing Activities				
Receipts				
Proceeds from the Sale of Property, Plant and Equipment		38	-	44
Total Receipts from Investing Activities		**38**	**-**	**44**
Payments				
Purchase of Property, Plant and Equipment		10,803	4,101	36,074
Purchase of Capital Works	23	53,702	92,219	34,053
Total Payments from Investing Activities		**64,505**	**96,320**	**70,127**
Net Cash (Outflows) from Investing Activities		**(64,467)**	**(96,320)**	**(70,083)**

ACT HEALTH DIRECTORATE
STATEMENT OF CASH FLOWS (CONTINUED)
FOR THE YEAR ENDED 30 JUNE 2024

	Note No.	Actual 2024 $'000	Original Budget 2024 $'000	Actual 2023 $'000
Cash Flows from Financing Activities				
Receipts				
Capital Injections	23	64,346	95,620	65,185
Total Receipts from Financing Activities		**64,346**	**95,620**	**65,185**
Payments				
Repayment of Lease Liabilities - Principal		481	55	914
Total Payments from Financing Activities		**481**	**55**	**914**
Net Cash Inflows from Financing Activities		**63,865**	**95,565**	**64,271**
Net Increase/(Decrease) in Cash		**15,820**	**60**	**(157)**
Cash at the Beginning of the Reporting Period		79	305	236
Cash at the End of the Reporting Period	9	**15,899**	**365**	**79**

The above Statement of Cash Flows is to be read in conjunction with the accompanying notes.

ACT HEALTH DIRECTORATE
CONTROLLED STATEMENT OF APPROPRIATION
FOR THE YEAR ENDED 30 JUNE 2024

Description and Material Accounting Policies Relating to Controlled Recurrent Payments

Controlled Recurrent Payments (CRP) are revenue received from the ACT Government to fund the costs of delivering outputs.

CRP is recognised when the Directorate gains control over the funding which is obtained upon the receipt of cash, given they do not contain enforceable and sufficiently specific performance obligations as defined by AASB 15 *Revenue from Contracts with Customers*.

Capital injection appropriations are not recognised as income, but instead are recognised as equity injections and cash inflow which is used to purchase/build an asset(s) or to reduce a liability(s).

Column Heading Explanations

The *Original Budget* column shows the amounts that appear in the Statement of Cash Flows in the Budget Papers. This amount also appears in the Statement of Cash Flows.

The *Total Appropriated* column is inclusive of all appropriation variations occurring after the Original Budget.

The *Appropriation Drawn* column shows the total amount of appropriation received by the Directorate during the year. This amount appears in the Statement of Cash Flows.

	Original Budget 2024 $'000	Total Appropriated 2024 $'000	Appropriation Drawn 2024 $'000	Appropriation Drawn 2023 $'000
Controlled				
Controlled Recurrent Payments	296,101	370,731	344,867	312,048
Capital Injections	95,620	132,592	64,346	65,185
Total Controlled Appropriation	**391,721**	**503,323**	**409,213**	**377,233**

The above Controlled Statement of Appropriation should be read in conjunction with the accompanying notes.

Reconciliation of Appropriation for 2023-24	Controlled Recurrent Payments $'000	Capital Injections $'000
Original Budget Appropriation for 2023-24	296,101	95,620
Supplementary Appropriation (FMA s.13)	74,630	36,972
Total Appropriated	370,731	132,592
Controlled Appropriation Drawn	**344,867**	**64,346**

FMA - *Financial Management Act 1996*

ACT HEALTH DIRECTORATE
CONTROLLED STATEMENT OF APPROPRIATION
FOR THE YEAR ENDED 30 JUNE 2024

Controlled Recurrent Payments

Variances between 'Original Budget' and 'Total Appropriated'

The difference of $74.6 million is mainly due to additional appropriation received through the mid-year budget review for multiple initiatives, including continuing delivery of the Digital Health Strategy and the North Canberra Hospital transition.

Variances between 'Total Appropriated' and 'Appropriation Drawn'

The difference of $25.9 million mainly relates to appropriation for multiple projects and initiatives being reprofiled from 2023-24 to 2024-25 due to delays in procurement activities and amended project schedules, and underspend in initiatives, including continuing delivery of the Digital Health Strategy and the North Canberra Hospital transition.

Variances between '2023-24 and 2022-23 Controlled Recurrent Payments Appropriation Drawn'

The increase of $32.8 million is mainly due to an increase for indexation, and new initiatives including, continuing delivery of the Digital Health Strategy and the North Canberra Hospital transition.

Capital Injections

Variances between 'Original Budget' and 'Total Appropriated'

The difference of $37.0 million is mainly due to additional appropriation received through the mid-year budget review for multiple initiatives, including continuing delivery of the Digital Health Strategy, the North Canberra Hospital transition, and the Canberra Hospital Critical Services Building.

Variances between 'Total Appropriated' and 'Appropriation Drawn'

The difference of $68.2 million is mainly due to multiple projects being reprofiled from 2023-24 to 2024-25 and Capital Injections relating to North Canberra Hospital being transferred to Major Projects Canberra (MPC) and Canberra Health Services (CHS).

ACT HEALTH DIRECTORATE
NOTES TO AND FORMING PART OF THE FINANCIAL STATEMENTS
FOR THE YEAR ENDED 30 JUNE 2024

Note 1. Objectives of the ACT Health Directorate

The ACT Health Directorate (the Directorate) is responsible for strategic direction and leadership of the ACT health system. The Directorate provides a strong policy and population health capability based on a foundation of world-leading health and medical research.

The Directorate develops and implements strategies to meet community needs and expectations, striving for an innovative, effective and sustainable health service, now and into the future.

The Directorate engages with its partners and stakeholders to ensure better health outcomes for all in the ACT and surrounding regions.

The Directorate's key functions include:

- providing strategic leadership, policy advice, and oversight of the public health system;
- leading engagement and negotiation with other jurisdictions on health funding agreements and national policy initiatives;
- administering the ACT Government's legislative program on health matters;
- engaging with health system partners and stakeholders to ensure health outcomes and impacts are considered in whole-of-government policy and health services planning;
- delivering effective communications to ensure the ACT community can make informed decisions about their health and wellbeing;
- supporting and enabling clinical excellence, safe high-quality care, and research across the public health system;
- delivering a range of health prevention, promotion, and protection services;
- implementing innovative digital technologies across the public health system and supporting Information and Communication Technology (ICT) solutions that enable person-centred care;
- conducting health system planning and evaluation for sustainable services, workforce and infrastructure, that supports effective resource allocation, innovation, and safe high-quality care;
- delivering Territory-wide health infrastructure strategy and design, including public hospital campus planning and planning for new health services;
- commissioning value-based care that improves health outcomes; and
- monitoring and evaluating health system performance to ensure it meets community expectations and performance criteria.

The Directorate's work and vision is underpinned by the *ACT Health Directorate Strategic Plan 2020-25,* which provides a foundation for our high performing organisation that values its people and reflects the way we work with our partner organisations.

ACT HEALTH DIRECTORATE
NOTES TO AND FORMING PART OF THE FINANCIAL STATEMENTS
FOR THE YEAR ENDED 30 JUNE 2024

Note 2. Basis of Preparation of the Financial Statements

Legislative Requirement

The *Financial Management Act 1996* (FMA) requires the preparation of annual financial statements for ACT Government Directorates.

The FMA and the *Financial Management Guidelines* issued under the Act, requires the ACT Health Directorate's (the Directorate's) financial statements to include:

i. an Operating Statement for the year;

ii. a Balance Sheet at the end of the year;

iii. a Statement of Changes in Equity for the year;

iv. a Statement of Cash Flows for the year;

v. a Statement of Appropriation for the year;

vi. the material accounting policies adopted for the year; and

vii. other statements as necessary to fairly reflect the financial operations of the Directorate during the reporting period and its financial position at the end of the year.

These general-purpose financial statements have been prepared in accordance with:

i. Australian Accounting Standards (as required by the FMA); and

ii. ACT Accounting and Disclosure Policies.

Accrual Accounting

The financial statements have been prepared using the accrual basis of accounting. The financial statements are prepared according to the historical cost convention, except for property, plant and equipment, which are valued at fair value in accordance with (re)valuation policies applicable to the Directorate during the reporting period.

Currency

These financial statements are presented in Australian dollars, which is the Directorate's functional currency.

Individual Not-For-Profit Reporting Entity

The Directorate is an individual not-for-profit reporting entity.

Controlled and Territorial Items

The Directorate produces Controlled and Territorial financial statements. The Controlled financial statements include income, expenses, assets and liabilities over which the Directorate has control. The Territorial financial statements include income, expenses, assets and liabilities that the Directorate administers on behalf of the ACT Government but does not control.

ACT HEALTH DIRECTORATE
NOTES TO AND FORMING PART OF THE FINANCIAL STATEMENTS
FOR THE YEAR ENDED 30 JUNE 2024

Note 2. Basis of Preparation of the Financial Statements (Continued)

Controlled and Territorial Items (Continued)

The purpose of the distinction between Controlled and Territorial is to enable an assessment of the Directorate's performance against the decisions it has made in relation to the resources it controls, while maintaining accountability for all resources under its responsibility.

The basis of preparation described applies to both Controlled and Territorial financial statements except where specified otherwise.

Reporting Period

These financial statements state the financial performance, changes in equity and cash flows of the Directorate for the year ended 30 June 2024 together with the financial position of the Directorate as at 30 June 2024.

Comparative Figures

Budget Figures
To facilitate a comparison with the Budget Papers, as required by the *Financial Management Act 1996*, budget information for 2023-24 has been presented in the financial statements. Budget numbers in the financial statements are the original budget numbers that appear in the 2023-24 Budget Papers.

Prior Year Comparative Figures
Comparative information has been disclosed in respect of the previous period for amounts reported in the financial statements, except where an Australian Accounting Standard does not require comparative information to be disclosed.

Where the presentation or classification of items in the financial statements is amended, the comparative amounts have been reclassified where practical. Where a reclassification has occurred, the nature, amount and reason for the reclassification is provided.

Rounding

All amounts in the financial statements have been rounded to the nearest thousand dollars ($'000). Use of "-" represents zero amounts or amounts rounded down to zero.

Going Concern

The 2023-24 financial statements have been prepared on a going concern basis as the Directorate has been funded in the ACT Government 2024-25 Budget and Budget Papers include forward estimates for the Directorate.

COVID-19 Impacts

ACT Health has assessed the impact of the COVID-19 pandemic on its financial statements. From this assessment the Directorate has concluded that COVID-19 has not had a material impact on its operations.

ACT HEALTH DIRECTORATE
NOTES TO AND FORMING PART OF THE FINANCIAL STATEMENTS
FOR THE YEAR ENDED 30 JUNE 2024

Note 3. Impact of Accounting Standards issued but yet to be applied

All Australian Accounting Standards and Interpretations issued but yet to be applied are applicable to future reporting periods and will be adopted from their application date.

Standards and Interpretations issued but yet to be applied have been assessed as not being relevant to the Directorate or will have an immaterial financial impact on the Directorate. However, AASB 18 *Presentation and Disclosure in Financial Statements* (applicable 1 January 2028 for not-for-profit public sector entities) does contain some major presentation/disclosure changes that will impact on the Directorate including:

- that operating, investing and financing categories as well as additional subtotals have to be included in the agency's operating statement;

- the disclosure of management-defined performance measures and reconciliations of these measures with the subtotals required by AASB Standards; and

- enhanced requirements for the grouping (aggregation and disaggregation) of information in the financial statements and in the notes.

ACT HEALTH DIRECTORATE
NOTES TO AND FORMING PART OF THE FINANCIAL STATEMENTS
FOR THE YEAR ENDED 30 JUNE 2024

Income Notes

Material Accounting Policies – Income

Income Recognition
The following material accounting policies relate to each income note unless stated otherwise in the individual note. Revenue is recognised in accordance with AASB 15 *Revenue from Contracts with Customers* where the contract is enforceable and contains sufficiently specific performance obligations, otherwise revenue is in the scope of AASB 1058 *Income of Not-for-Profit Entities*.

AASB 15
The core principle of AASB 15 *Revenue from Contracts with Customers* is that revenue is recognised on a basis that reflects the transfer of promised goods or services to customers at an amount that reflects the consideration the entity expects to receive in exchange for those goods or services. Revenue is recognised by applying a five step model as follows:

1. identify the contract with the customer;
2. identify the performance obligations;
3. determine the transaction price;
4. allocate the transaction price; and
5. recognise revenue as or when control of the performance obligation is transferred to the customer.

Generally, the timing of the payment for sale of goods and rendering of services corresponds closely to the timing of satisfaction of the performance obligations, however where there is a difference, it will result in the recognition of a receivable, contract asset or contract liability.

None of the revenue streams of the Directorate have any significant financing terms as there is less than 12 months between receipt of funds and satisfaction of performance obligations.

AASB 1058
Where revenue streams are in the scope of AASB 1058 *Income of Not-for-Profit Entities*, the Directorate recognises the asset received (generally cash or other financial asset) at fair value, recognises any related amount (e.g. liability or equity) in accordance with an accounting standard and recognises revenue as the residual between the fair value of the asset and the related amount on receipt of the asset.

ACT HEALTH DIRECTORATE
NOTES TO AND FORMING PART OF THE FINANCIAL STATEMENTS
FOR THE YEAR ENDED 30 JUNE 2024

Note 4. Grants and Contributions Revenue

Description and Material Accounting Policies Relating to Grants and Contributions Revenue

General Grants and Contributions Accounting Policy

Where the Directorate receives an asset or services for significantly less than fair value then the transaction is in the scope of AASB 1058 *Income of Not-for-Profit Entities* and revenue is recognised on receipt of the asset/services. The related expense and/or asset is recognised in the line item to which it relates, when the services are received.

Goods and services received free of charge from ACT Government agencies are recognised as resources received free of charge, whereas goods and services received free of charge from entities external to the ACT Government are recognised as grants, donations, or contributions.

All the services listed below are recognised in the Operating Statement or Balance Sheet as appropriate as services received free of charge given they are reliably measurable and would have been purchased if not provided to the Directorate free of charge.

Contributions of services are recognised only if their fair value can be measured reliably, and the services would have been purchased if they had not been donated.

Legal Services

Legal Services were received free of charge from the ACT Government Solicitor's Office (GSO) and the ACT Parliamentary Counsel's Office (PSO). The GSO and PSO provided the Directorate with the fair value of the services provided.

Chief Minister, Treasury and Economic Development Directorate (CMTEDD) Resource Received Free of Charge

Shared Services Resource Received Free of Charge

The Directorate is required by the ACT Government to use Shared Services for its financial and HR processing. Shared Services is part of Chief Minister, Treasury and Economic Development Directorate (CMTEDD). Given Shared Services is directly appropriated by the ACT Government to provide certain services at a fixed cost to the Directorate, it means that the AHD does not have to pay for these services.

Digital, Data and Technology Solutions Group (DDTS)

The DDTS group in CMTEDD provides information and communication technology (ICT) services to the Directorate. DDTS is directly appropriated by the ACT Government to provide these ICT services to the Directorate and as such the Directorate receives these services free of charge.

Project Management Services provided by Major Projects Canberra (MPC)

MPC provides procurement and infrastructure delivery services to the Directorate free of charge. MPC is directly appropriated to deliver these services and as such, the Directorate is required to use these services. The fair value of these services provided are capitalised on the Balance Sheet as they are directly attributable to the creation of the assets for which the service is provided.

Other Resources Received Free of Charge

'Other Resources Received Free of Charge' relates to multiple services received free of charge from other ACT Government agencies including whole-of-government communications and engagement services, emergency network access, records management, fleet care for emergency vehicles and ACT Land Information System search services. Fair value of these services was provided by the respective Directorates.

Note 4. Grants and Contributions Revenue (Continued)

Other Grants and Contributions

The Directorate has determined that the agreements/arrangements relating to 'Other Grants and Contributions' line items included in this note are not enforceable and they do not contain sufficiently specific performance obligations for recognising revenue from contracts with customers under AASB 15 *Revenue from Contracts with Customers*. None of the arrangements require the Directorate to provide an equal amount in return for the consideration received. As such, AASB 1058 *Income of Not-for-Profit Entities* has been applied for recognising this revenue. This revenue is recognised upon receipt of the donation and the grant funding line item.

The Directorate received funding from the ACT Local Hospital Network (LHN) for the provision of public health services, health promotion and preventive activities.

The Directorate also received Cross Border (Interstate) Health revenue through the National Health Funding Pool on behalf of the Australian Capital Territory for the provision of public hospital services to interstate residents. This revenue may be passed on to the LHN during the reporting period to be disbursed to the health service providers. These amounts are recorded as 'Transfers from the ACT Local Hospital Network' and 'Transfers to the ACT Local Hospital Network' in the financial statements.

'Local Hospital Network Funding' and 'Transfers from the ACT Local Hospital Network' are recognised as revenue when the Directorate gains control over the funding. Control over funding is obtained on the receipt of cash.

	2024 $'000	2023 $'000
Resources Received Free of Charge		
Legal Services	920	1,018
Finance Services Provided by Shared Services	576	720
Human Resources Services Provided by Shared Services	1,024	1,027
Project Management Services provided by Major Projects Canberra	1,697	769
Information and Communication Technology services provided by the Digital, Data and Technology Solutions Group [a]	7,522	-
Other Resources Received Free of Charge	210	206
Total Resources Received Free of Charge	**11,949**	**3,740**
Other Grants and Contributions		
Local Hospital Network Funding [b]	9,051	21,151
Transfers from the ACT Local Hospital Network [c]	150,431	190,769
Grants without Sufficient Performance Obligations [d]	12,507	5,240
Donations	57	49
Total Other Grants and Contributions	**172,046**	**217,209**
Total Grants and Contributions	**183,995**	**220,949**

ACT HEALTH DIRECTORATE
NOTES TO AND FORMING PART OF THE FINANCIAL STATEMENTS
FOR THE YEAR ENDED 30 JUNE 2024

Note 4. Grants and Contributions Revenue (Continued)

Resources Provided Free of Charge

The Directorate provided ICT services free of charge to Canberra Health Services throughout the financial year. These services have been recognised in the Directorate's Operating Statement as expenses in the relevant expense line items. Therefore, the figures included in this note are disclosures only and the total Resources Provided Free of Charge does not appear as a separate line item in the Operating Statement.

	2024 $'000	2023 $'000
Resources Provided Free of Charge		
ICT services to Canberra Health Services	70,140	70,531
Total Provided to Canberra Health Services	**70,140**	**70,531**
ICT services to Calvary Public Health	-	12,747
Total Provided to Calvary Public Hospital	**-**	**12,747**
Total Resources Provided Free of Charge [e]	**70,140**	**83,278**

a. The increase in 'Information and Communication Technology (ICT) services' received free of charge is due to the Digital, Data and Technology Solutions (DDTS) Group being directly appropriated for ICT infrastructure support provided from 2023-24.

b. The decrease in 'Local Hospital Network Funding' of $12.1 million mainly relates to lower funding receipts through the *National Partnership on COVID-19 Response* (NPCR) due to the scale back of the Territory's public health emergency response to COVID-19 and the NPCR ceasing at the end of December 2022.

c. The decrease in 'Transfers from the ACT Local Hospital Network' of $40.3 million is mainly due to higher receipts received in the prior year from Cross Border Health activity reconciliations than received in the current year.

d. The increase in 'Grants without Sufficient Performance Obligations' of $7.3 million relates to the receipt of Department of Veterans' Affairs revenue to be on-passed to Canberra Health Services.

e. The decrease in 'ICT services to Calvary Public Health' is due to services now being provided to Canberra Health Services following acquisition by the ACT Government in July 2023. However, this has been partially offset by a reduction due to a portion of ICT infrastructure support now being provided by the DDTS Group.

Note 5. Employee Expenses

Description and Material Accounting Policies Relating to Employee Expenses

Employee benefits include:

- short-term employee benefits such as wages and salaries, annual leave loading, and applicable on-costs, if expected to be settled wholly before twelve months after the end of the annual reporting period in which the employees render the related services;
- other long-term benefits such as long service leave and annual leave; and
- termination benefits.

On-costs include annual leave, long service leave, superannuation and other costs that are incurred when employees take annual and long service leave.

Employees of the Directorate will have different superannuation arrangements due to the type of superannuation schemes available at the time of commencing employment, including both defined benefit and defined contribution superannuation scheme arrangements.

For employees who are members of the defined benefit Commonwealth Superannuation Scheme (CSS) and Public Sector Superannuation Scheme (PSS) the Directorate makes employer superannuation contribution payments to the Territory Banking Account at a rate determined by the Chief Minister, Treasury and Economic Development Directorate. The Directorate also makes productivity superannuation contribution payments on behalf of these employees to the Commonwealth Superannuation Corporation, which is responsible for administration of the schemes.

For employees who are members of defined contribution superannuation schemes (the Public Sector Superannuation Scheme Accumulation Plan (PSSAP) and schemes of employee choice) the Directorate makes employer superannuation contribution payments directly to the employees' relevant superannuation fund.

All defined benefit employer superannuation contributions are recognised as expenses on the same basis as the employer superannuation contributions made to defined contribution schemes. The accruing superannuation liability obligations are expensed as they are incurred and extinguished as they are paid.

ACT HEALTH DIRECTORATE
NOTES TO AND FORMING PART OF THE FINANCIAL STATEMENTS
FOR THE YEAR ENDED 30 JUNE 2024

Note 5. Employee Expenses (Continued)

	2024 $'000	2023 $'000
Wages and Salaries	111,884	111,671
Annual Leave Expense [a]	2,226	928
Long Service Leave Expense [a]	2,421	461
Workers' Compensation Insurance Premium	1,241	1,349
Termination Expense	164	-
Superannuation Contributions to the Territory Banking Account	8,234	8,290
Productivity Benefit	686	706
Superannuation to External Providers	10,078	10,723
Other Employee Benefits and On-Costs	1,748	1,385
Total Employee Expenses	**138,682**	**135,513**
	No.	**No.**
Average full-time equivalent staff (FTE) staff levels during the year were: [b]	856	943

a. The increase in 'Annual Leave Expense' of $1.3 million and 'Long Service Leave Expense' of $2.0 million is mainly due to the impact of salary and wage increases following the finalisation of new Enterprise Bargaining Agreements and long service leave earned exceeding leave taken.

b. The decrease in full-time equivalent staff levels is mainly due to the completion of large-scale capital projects including the Digital Health Record implementation in 2022-23.

ACT HEALTH DIRECTORATE
NOTES TO AND FORMING PART OF THE FINANCIAL STATEMENTS
FOR THE YEAR ENDED 30 JUNE 2024

Note 6. Supplies and Services

Description and Material Accounting Policies Relating to Supplies and Services

General - Supplies and Services

Purchases of Supplies and Services generally represent the day-to-day running costs incurred in normal operations, recognised in the reporting period in which these expenses are incurred.

	2024 $'000	2023 $'000
Cleaning Services	627	1,025
Clinical Expenses/Medical Surgical Supplies [a]	1,394	12,054
Communications [b]	2,704	5,042
Computer Expenses [b]	62,438	93,504
Contractors and Consultants	16,595	15,647
General Administration	7,493	8,761
Hire Charges [a]	1	3,717
ICT Equipment and Rental Charges [c]	2,306	5,602
Lease Rental Payments	4,549	3,459
Legal Expenses [d]	24,111	1,922
Repairs and Maintenance	3,030	3,613
Staff Development and Recruitment	3,152	2,746
Other [e]	2,681	3,496
Total Supplies and Services	**131,081**	**160,588**

a. The decrease in 'Clinical Expense/Medical Surgical Supplies' of $10.7 million and 'Hire Charges' of $3.7 million mainly relates to lower expenses for COVID-19 quarantine, testing and pathology, vaccination centres including pop-up clinics and medical equipment purchase due to the scale back of the Territory's COVID-19 Public Health Emergency response.

b. The decrease in 'Computer Expenses' of $31.1 million and 'Communications' of $2.3 million mainly relates to appropriation of ICT infrastructure support being directly appropriated to the DDTS Group and decreased messaging service requirements for the COVID-19 response.

c. The decrease in 'ICT Equipment and Rental Charges' of $3.3 million mainly relates to the completion of Digital Health Record system.

d. The increase in 'Legal Expenses' of $22.2 million mainly relates to the Calvary Public Hospital acquisition.

e. Audit fees are included in 'Other'. Audit fees consist of financial audit services provided to the Directorate by the ACT Audit Office. The audit fee for the audit of the Directorate's (including Local Hospital Network) 2023-24 financial statements is $269,138 (2022-23: $243,015). No other services were provided by the ACT Audit Office.

ACT HEALTH DIRECTORATE
NOTES TO AND FORMING PART OF THE FINANCIAL STATEMENTS
FOR THE YEAR ENDED 30 JUNE 2024

Note 7. Grants and Purchased Services

Description and Material Accounting Policies Relating to Grants and Purchased Services

Grants are amounts provided to organisations or individuals for a specific purpose directed at achieving goals and objectives consistent with Government policy on health promotion. Grants may be for capital, current or recurrent purposes and subject to terms and conditions set out in a contract, agreement, or by legislation.

Grants are goods or services that are provided to another entity without receiving approximately equal value in return. Recurrent Grants expenditure is generally recognised when the services have been performed by the grantee or the grant eligibility criteria has been satisfied.

Purchased Services are amounts paid to obtain services from other ACT Government agencies and external parties. These transactions are reciprocal in nature.

Purchased Services also include transfers to the Local Hospital Network relating to the on-passing of revenue received through the National Health Funding Pool for the provision of public hospital services to interstate residents.

	2024 $'000	2023 $'000
Recurrent Grants		
Grants	744	2,195
Total Grants	**744**	**2,195**
Purchased Services		
Non-Government Organisations [a]	83,208	76,475
Payments to Service Providers [b]	13,456	1,557
Transfers to the ACT Local Hospital Network [c]	150,175	160,572
Total Purchased Services	**246,839**	**238,604**
Total Grants and Purchased Services	**247,583**	**240,799**

a. The increase in 'Non-Government Organisations' of $6.7 million is mainly due to indexation and increased support for mental health related initiatives.

b. The increase in 'Payments to Service Providers' of $11.9 million is mainly relating to the on-passing of Department of Veterans' Affairs revenue to Canberra Health Services.

c. The decrease in 'Transfers to the ACT Local Hospital Network' of $10.4 million is due to lower Cross Border Health revenue being received following activity reconciliations for prior years, for on-passing to the ACT Local Hospital Network.

Note 8. Other Expenses

Description and Material Accounting Policies Relating to Other Expenses

Waivers

A waiver is the relinquishment of a legal claim to a debt. The Treasurer may in writing, waive the right to payment of an amount owing to the Territory. In the current financial year the Treasurer has waived salary overpayment. Waivers are expensed during the year in which the right to payment was waived.

Impairment Losses – Non-Financial Assets

Impairment loss expenses are recognised for property, plant and equipment when their carrying amount is higher than their recoverable amount, with the difference between the two being the amount of the impairment loss. Impairment losses for plant and equipment and leasehold improvements are recognised as an expense in the Operating Statement. Impairment losses for land, buildings and community assets, are only recognised as an expense when the amount of the impairment is greater than the balance in the Asset Revaluation Surplus for the relevant class of asset.

Expense impairment losses of assets includes Leasehold improvements and Plant and Equipment (See *Note 11 'Property, Plant and Equipment'*).

Impairment Losses and Write-Offs - Receivables

A matrix is used to calculate the amount of lifetime expected credit loss which factors practical and justifiable forward-looking information, including forecast economic changes expected to impact the Directorate's receivables (See *Note 10 Receivables*).

	2024 $'000	2023 $'000
Waivers	26	-
Impairment Losses		
Expected Credit Loss Expense - Accounts Receivables (see *Note 10*)	3	(13)
Expected Credit Loss Expense - Plant and Equipment (see *Note 11*)	435	606
Expected Credit Loss Expense – Intangibles (see Note 12)	918	-
Write-offs		
Irrecoverable Debts	-	2
Losses arising from Sale of Assets	31	6
Expenses arising from a change in Make Good Provision estimate [a]	(837)	710
Other Expenses	49	126
Total Other Expenses	**625**	**1,437**

a. The decrease in "Expenses arising from a change in Make Good Provision estimate" of $0.8 million relates to the decrease in the provision to reflect current market assessments for vendor costs to demolish and remove fit out at the Directorate's leased office building in Phillip, ACT.

Note 8. Other Expenses (Continued)

	No.	2024 $'000	No.	2023 $'000
Breakdown of Waivers				
Waiver of Salary Overpayment	5	26	-	-
Total Waivers	**5**	**26**		**-**

Asset Notes

Material Accounting Policies – Assets

Assets – Current and Non-Current

Assets are classified as current where they are expected to be realised within 12 months after the reporting date. Assets, which do not fall within the current classification, are classified as non-current.

Note 9. Cash

Description and Material Accounting Policies Relating to Cash

Cash

The Directorate holds one bank account with Westpac Banking Corporation as part of the whole-of-government banking arrangements. As part of these arrangements, the Directorate does not receive any interest on this account, as the account held is a Set-Off Account. Cash includes cash at bank and cash on hand.

(a) Cash Balances

	2024 $'000	2023 $'000
Current Cash		
Cash on Hand	3	3
Cash at Bank [a]	15,896	76
Total Cash	**15,899**	**79**

a. The increase in 'Cash at Bank' of $15.8 million is due to the timing of payment to settle outstanding invoices in early 2024-25.

ACT HEALTH DIRECTORATE
NOTES TO AND FORMING PART OF THE FINANCIAL STATEMENTS
FOR THE YEAR ENDED 30 JUNE 2024

Note 9. Cash (Continued)

(b) Reconciliation of Cash at the End of the Reporting Period in the Statement of Cash Flows to the Equivalent Items in the Balance Sheet.

	2024 $'000	2023 $'000
Total Cash Recorded in the Balance Sheet	15,899	79
Cash at the End of the Reporting Period as Recorded in the Statement of Cash Flows	**15,899**	**79**

(c) Reconciliation of the Operating Result to the Net Cash Inflows/(Outflows) from Operating Activities

Operating Result	(10,195)	(19,875)
Add/(Less) Non-Cash Items		
Depreciation of Property, Plant and Equipment	6,075	6,413
Amortisation of Intangibles	23,533	19,050
Bad and Doubtful Debts	29	(11)
Finance Cost on Make Good	(837)	710
Lease Incentives	(1,039)	(1,039)
Assets transferred from Other ACT Government Entities	-	1,712
MPC fees received free of charge	(1,697)	-
Add/(Less) Items Classified as Investing or Financing		
Net Gain on Disposal of Non-Current Assets	1,345	568
Finance Lease Charges	26	25
Gains from the Contribution of Assets	-	(1,712)
Accrual for Capital Works	(3,123)	1,942
Accrual for Property, Plant and Equipment	150	15
Cash Before Changes in Operating Assets and Liabilities	**14,267**	**7,798**
Changes in Operating Assets and Liabilities		
Decrease/(Increase) in Receivables	1,873	(3,843)
Decrease in Other Assets	949	4,403
(Decrease) in Payables	(3,192)	(1,478)
Increase/(Decrease) in Employee Benefits	2,609	(164)
(Decrease) in Other Liabilities	(83)	(1,062)
Net Changes in Operating Assets and Liabilities	**2,156**	**(2,144)**
Net Cash Inflows from Operating Activities	**16,423**	**5,654**

ACT HEALTH DIRECTORATE
NOTES TO AND FORMING PART OF THE FINANCIAL STATEMENTS
FOR THE YEAR ENDED 30 JUNE 2024

Note 9. Cash (Continued)

	2024 $'000	2023 $'000
(d) Non-Cash Financing and Investing Activities		
Acquisition of Assets by Assuming Liabilities or by Means of a Lease	174	223
(e) Reconciliation of Lease liabilities arising from financing activities		
Carrying Amount at the Beginning of the Reporting Period	(837)	(1,502)
Cash Flow Changes:		
- Cash Paid	481	913
Non-Cash Changes:		
- New Leases	(174)	(223)
- Disposals	102	80
- Depreciation Writeback	(102)	(80)
- Other Movements	(26)	(25)
Carrying Amount at the End of the Reporting Period	**(556)**	**(837)**

Note 10. Receivables

Description and Material Accounting Policies Relating to Receivables

Accounts Receivables

Accounts receivable (including trade receivables and other receivables) are measured at amortised cost, with any adjustments to the carrying amount being recorded in the Operating Statement (see *Note 8* '*Other Expenses'*). Receivables relating to the Sale of Goods and Services from Contracts with Customers are recognised when invoiced, as this is the point in time that the consideration is unconditional because only the passage of time is required before the payment.

Expected Credit Losses – Accounts Receivables

The allowance for expected credit losses represents the amount of trade receivables and other receivables the Directorate estimates will not be repaid. The allowance for expected credit losses is based on objective evidence and a review of overdue balances.

The Directorate measures expected credit losses of a financial instrument in a way that reflects:

a) an unbiased and probability-weighted amount that is determined by evaluating a range of possible outcomes;
b) the time value of money; and
c) reasonable and supportable information that is available without undue cost or effort at the reporting date about past events, current conditions and forecasts of future economic conditions.

The amount of the expected credit loss is recognised in the Operating Statement (see *Note 8* '*Other Expenses'*). Where the Directorate has no reasonable expectation of recovering an amount owed by a debtor and ceases action to collect the debt, as the cost to recover the debt is more than the debt is worth, the debt is written-off by directly reducing the receivable against the loss allowance.

The Directorate applied the simplified approach under AASB 9 *Financial Instruments*, meaning that the allowance for expected credit losses of accounts receivables is measured at the lifetime expected credit losses at each reporting date. The Directorate has established a provision matrix based on its historical credit loss experience, adjusted for forward looking factors specific to the debtors and the economic environment.

Loss rates are calculated separately for groupings of customers with similar loss patterns. The Directorate has determined there are two material groups for measuring expected credit losses based on the sale of services reflecting customer profiles for revenue streams. The calculations reflect historical observed default rates calculated using credit losses experienced on past sales transactions since the formation of the Directorate in October 2018. The historical default rates are then adjusted by reasonable and supportable forward-looking information for expected changes in macroeconomic indicators that affect the future recovery of those receivables.

The Directorate has made a significant estimate in the calculation of the expected credit loss allowance for receivables in the Financial Statements. This estimate is based on a number of categorisations of receivables and the use of an expected credit loss provision matrix. These categorisations are considered by management to be appropriate and accurate.

ACT HEALTH DIRECTORATE
NOTES TO AND FORMING PART OF THE FINANCIAL STATEMENTS
FOR THE YEAR ENDED 30 JUNE 2024

Note 10. Receivables (Continued)

	2024 $'000	2023 $'000
Current Receivables		
Trade and Other Receivables	1,461	1,074
Less: Expected Credit Loss Allowance	(6)	(3)
Accrued Revenue	1,431	4,837
Net GST Receivable	2,161	1,042
Total Current Receivables	**5,047**	**6,950**
Total Receivables [a]	**5,047**	**6,950**

a. The decrease in 'Receivables' of $1.9 million mainly relates to lower outstanding receipts from Canberra Health Services and Major Projects Canberra for project based ICT services provided during the year.

Expected Credit Loss Allowance

Ageing of Receivables

Ageing of Receivables	Total	Days Past Due				
		Not Overdue	1-30 Days	31-60 Days	61-90 days	>91 Days
30 June 2024						
Expected credit loss rate						
Trade Receivables		0.6%	1.1%	1.9%	3.9%	5.1%
Estimated total gross carrying amount at default ($'000)	2,588	2,359	-	157	72	-
Expected credit loss allowance ($'000)	(5.8)	-	-	(3.0)	(2.8)	-
30 June 2023						
Expected credit loss rate						
Trade Receivables		0.8%	1.5%	3.0%	7.5%	11.2%
Estimated total gross carrying amount at default ($'000)	1,489	1,475	8	-	-	6
Expected credit loss allowance ($'000)	(3.3)	(2.5)	(0.1)	-	-	(0.7)

Reconciliation of the Loss Allowance Accounts Receivable	2024 $'000	2023 $'000
Expected Credit Loss Allowance at the Beginning of the Reporting Period	3	16
Expected Credit Loss Expense	29	67
Reduction in Allowance from Amounts Recovered During the Reporting Period	(26)	(80)
Expected Credit Loss Allowance at the End of the Reporting Period	**6**	**3**

The maximum exposure to credit risk at the end of the reporting period for Receivables is the carrying amount of the asset inclusive of any Expected Credit Loss Allowance as shown in the table above.

ACT HEALTH DIRECTORATE
NOTES TO AND FORMING PART OF THE FINANCIAL STATEMENTS
FOR THE YEAR ENDED 30 JUNE 2024

Note 11. Property, Plant and Equipment

Description and Material Accounting Policies relating to Property, Plant and Equipment

The Directorate has the following seven classes of assets. Property, Plant and Equipment does not include assets held for sale or investment property.

- *Land* is defined as the ground, including the soil covering, land under roads and railway lines, and any associated surface waters. Land incorporates the vegetation on the land and earthworks associated with the vegetation. Land includes leasehold land held by the Directorate.
- *Buildings* are structures that have a roof and walls which stand permanently in one place. These structures are separately identifiable from the land they are constructed upon and as such do not include this land. Buildings held by the Directorate include community health centres and land improvements including retaining walls, and landscaping adjoining a building. Right-of-use building assets are not included in the building asset class.
- *Leasehold improvements* are capital expenditure items incurred in relation to leased assets. Leasehold Improvements held by the Directorate include fit-outs in leased buildings.
- *Plant and Equipment* are tangible assets like machinery, apparatus, appliances, containers, implements or tools that are used by the Directorate to produce goods or assist in providing services to the community. Plant and Equipment are assets that are used directly by the Directorate rather than directly by the general community. Plant and Equipment tend to be smaller and more mobile in nature than other types of property, plant and equipment like buildings, roads and land. Plant and Equipment includes medical equipment, mobile plant, office and computer equipment, furniture and fittings, and other mechanical and electronic equipment. Right-of-use plant and equipment are not included in the plant and equipment asset class.
- *Right-Of-Use (ROU) Plant and Equipment* has the same definition as plant and equipment, with the exception that they are held under a lease. Right-Of-Use Plant and Equipment held by the Directorate includes motor vehicles and ICT equipment.
- *Community assets* are those assets that are provided primary for general community use or service. Typically, these assets are used directly by the public for recreational purposes rather than used directly by the Directorate itself. Community assets held by the Directorate include various public artworks located at Queen Elizabeth II Family Centre and the Bowes Street Office building.
- *Capital Works in Progress (CWIP)* is property, plant and equipment that is in the process of being constructed and as such is not yet in use or available for use. That is, CWIP is property, plant and equipment which is not in a location and condition necessary for it to be capable of operating in a manner intended by management. Works in Progress relating to intangible assets is not included in this PPE asset class. CWIP held by the Directorate include buildings and leasehold improvements under construction.

Note 11. Property, Plant and Equipment (Continued)

Acquisition and Recognition of Property, Plant and Equipment

Property, Plant and Equipment is initially recorded at cost, which comprises its purchase price, any directly attributable costs and the initial estimate of the costs of dismantling and removing the item and restoring the site on which it is located. For right-of-use assets, cost comprises the initial amount of the lease liability, initial direct costs, prepaid lease payments, estimated cost of removal and restoration less any lease incentives received.

Capital works in progress are recognised at the time the construction activity occurs. These assets are measured at the cost of constructing the asset. The cost includes direct construction costs (e.g. direct materials and direct labour) 'directly attributable' costs in bringing the asset to a location and condition ready for use, and the initial estimate of the costs of dismantling and removing the item and restoring the site on which it is located. Directly attributable costs included in capital works in progress by the Directorate are the cost of site preparation, initial delivery and handling costs of materials, installation and assembly costs, functional testing and professional fees.

Where Property, Plant and Equipment is acquired at no cost, or minimal cost, cost is its fair value as at the date of acquisition. However, Property, Plant and Equipment acquired at no cost or minimal cost as part of a Restructuring of Administrative Arrangements is measured at the transferor's book value.

All Property, Plant and Equipment with a value of $5,000 or more is capitalised.

Measurement of Property, Plant and Equipment After Initial Recognition

Property, Plant and Equipment is valued using the cost or revaluation model of valuation. The Directorate measures land, buildings, leasehold improvements and community assets at fair value. Plant and equipment are measured at cost.

After the commencement date, all right-of-use assets are measured at cost, less any accumulated depreciation and accumulated losses, and adjusted for any remeasurement of the lease liability. Right-of-use assets are presented in Property, Plant and Equipment in their own separate asset class.

Valuation of Non-Current Assets

JLL Valuation Services, an independent valuer, performed all revaluations of the Directorate's assets. JLL Valuation Services hold a recognised and relevant professional qualification and have recent experience in the location and category of the assets involved.

The Directorate has made a significant estimate regarding the fair value of its assets. Land and buildings have been recorded at the market value of similar properties as determined by an independent valuer. In some circumstances, buildings that are purpose built may in fact realise more or less in the market. The valuation uses significant judgements and estimates to determine fair value, including the appropriate indexation figure and quantum of assets held. The fair value of assets is subject to management assessment between formal valuations.

Note 11. Property, Plant and Equipment (Continued)

Revaluation

Land, buildings and leasehold improvements are revalued every 3 years. Towards the end of each financial year the Directorate assesses whether there are any 'indicators' that the carrying amount of their property, plant and equipment is materially different to fair value. Where these indicators exist the asset will be revalued regardless of when the last valuation took place. Any accumulated depreciation relating to buildings and leasehold improvements at the date of revaluation is written-back against the gross carrying amount of the asset and the net amount is restated to the revalued amount of the asset.

JLL Valuation Services, an independent valuer, performed revaluations of the Directorate's assets. The latest valuation of Land, Buildings and Leasehold Improvements was performed as at 30 June 2023. JLL performed an assessment for any indicators that the carrying amount of the Directorate's Land, Buildings and Leasehold Improvements is materially different from the fair value as at 30 June 2024. The next valuation will be undertaken during 2025-26.

Impairment of Assets

At each reporting date, the Directorate assesses whether there is any indication of impairment for assets that are held at cost subsequent to initial recognition and for non-specialised PPE measured at fair value subsequent to initial recognition. Property, Plant and Equipment is also reviewed for impairment whenever events or changes in circumstances indicate that the carrying amount may not be recoverable.

Any resulting impairment losses for land, buildings and leasehold improvement assets are recognised as a decrease in the Asset Revaluation Surplus relating to these classes of assets. This is because these asset classes contain non-specialised assets that are measured at fair value and have an Asset Revaluation Surplus attached to them. Where the impairment loss is greater than the balance in the Asset Revaluation Surplus for the relevant class of asset, the difference is expensed in the Operating Statement.

Impairment losses for plant and equipment and leasehold improvements are recognised in the Operating Statement (see *Note 8* '*Other Expenses'*), as plant and equipment is carried at cost, and leasehold improvements are carried at fair value, but do not have an Asset Revaluation Surplus attached to them. The carrying amount of the asset is reduced to its recoverable amount.

Non-financial assets that have previously been impaired are reviewed for possible reversal of impairment at each reporting date.

Depreciation and Useful Life

Depreciation is the systematic allocation of the cost of an asset less its residual value over its useful life. Depreciation commences when property, plant and equipment is ready for its intended use.

Depreciation is applied to physical assets such as buildings, leasehold improvements and plant and equipment.

Land and Community assets have an unlimited useful life and are therefore not depreciated. The vegetation on the land and earthworks associated with that vegetation have been assessed as having an unlimited useful life and are therefore also not depreciated.

Right-of-use buildings, right-of-use plant and equipment, as well as leasehold improvements are depreciated over the estimated useful life of each asset, or the unexpired period of the relevant lease, whichever is shorter.

All depreciation is calculated after first deducting any residual values, which remain for each asset.

ACT HEALTH DIRECTORATE
NOTES TO AND FORMING PART OF THE FINANCIAL STATEMENTS
FOR THE YEAR ENDED 30 JUNE 2024

Note 11. Property, Plant and Equipment (Continued)

Depreciation for non-current assets is determined as follows:

Class of Asset	Depreciation Method	Useful Life (Years)
Buildings	Straight Line	40-80
Leasehold Improvements	Straight Line	2-10
Plant and Equipment	Straight Line	1-20

'Useful Life (Years)' listed in the above table remain unchanged compared to 2022-23.

The Directorate has made a significant estimate in determining the useful lives of its Property, Plant and Equipment. The estimation of useful lives of Property, Plant and Equipment is based on the historical experience of similar assets and in some cases has been based on valuations provided by JLL Valuation Services. The useful lives are assessed on an annual basis and adjustments are made when necessary.

ACT HEALTH DIRECTORATE
NOTES TO AND FORMING PART OF THE FINANCIAL STATEMENTS
FOR THE YEAR ENDED 30 JUNE 2024

Note 11. Property, Plant and Equipment (Continued)

Reconciliation of Property, Plant and Equipment – 2023-24

	Land [a]	Buildings [a]	Leasehold Improvements	Plant and Equipment	Right-of-use Plant and Equipment	Community Assets	Total
	$'000	$'000	$'000	$'000	$'000	$'000	$'000
Carrying Amount at the Beginning of the Reporting Period	**23,493**	**51,635**	**7,832**	**14,474**	**830**	**78**	**98,341**
Additions	5,140	497	66	2,377	174	-	**8,254**
Revaluation Increment recognised through Other Comprehensive Income	260	-	-	-	-	-	**260**
Asset Transferred to Another Entity [a]	(6,940)	(29,843)	-	-	-	-	**(36,783)**
Depreciation Write Back for Asset Transfer	-	630	-	-	-	-	**630**
Disposals	-	-	-	(696)	(102)	-	**(798)**
Depreciation	-	(1,231)	(830)	(3,534)	(463)	-	**(6,058)**
Depreciation Write Back for Asset Disposals	-	-	-	669	102	-	**771**
Impairment Losses Recognised through the Operating Statement	-	-	-	(716)	-	-	**(716)**
Depreciation Write Back for Impairment Losses	-	-	-	281	-	-	**281**
Other Movements	-	-	-	(153)	-	-	**(153)**
Carrying Amount at the End of the Reporting Period	**21,953**	**21,688**	**7,068**	**12,702**	**541**	**78**	**64,030**
Carrying Amount at the End of the Reporting Period is represented by:							
Gross Book Value	21,953	22,290	7,909	33,251	7,545	78	93,025
Accumulated Depreciation	-	(602)	(841)	(20,549)	(7,004)	-	(28,995)
Carrying Amount at the End of the Reporting Period	**21,953**	**21,688**	**7,068**	**12,702**	**541**	**78**	**64,030**

a. The decrease in land of $6.9 million and building of $29.8 million is due to the transfer of assets held by the Directorate to Canberra Health Services.

ACT HEALTH DIRECTORATE
NOTES TO AND FORMING PART OF THE FINANCIAL STATEMENTS
FOR THE YEAR ENDED 30 JUNE 2024

Note 11. Property, Plant and Equipment (Continued)

Reconciliation of Property, Plant and Equipment – 2022-23

	Land	Buildings	Leasehold Improvements	Plant and Equipment	Right-of-use Plant and Equipment	Community Assets	Total
	$'000	$'000	$'000	$'000	$'000	$'000	$'000
Carrying Amount at the Beginning of the Reporting Period	**20,117**	**50,539**	**6,977**	**4,875**	**1,490**	**63**	**84,061**
Additions	2,508	4,262	481	12,084	223	15	**19,573**
Revaluation Increment/(Decrement) recognised through Other Comprehensive Income	868	(6,769)	(1,065)	-	-	-	**(6,966)**
Depreciation Write Back for Revaluation	-	5,513	2,125	-	-	-	**7,638**
Disposals	-	-	(26)	(98)	(80)	-	**(204)**
Depreciation	-	(1,910)	(686)	(2,480)	(883)	-	**(5,959)**
Depreciation Write Back for Asset Disposals	-	-	26	92	80	-	**198**
Carrying Amount at the End of the Reporting Period	**23,493**	**51,635**	**7,832**	**14,473**	**830**	**78**	**98,341**
Carrying Amount at the End of the Reporting Period is represented by:							
Gross Book Value	23,493	51,635	7,843	32,438	7,471	78	122,958
Accumulated Depreciation	-	-	(11)	(17,965)	(6,641)	-	(24,617)
Carrying Amount at the End of the Reporting Period	**23,493**	**51,635**	**7,832**	**14,473**	**830**	**78**	**98,341**

	2024 $'000	2023 $'000
Reconciliation of Depreciation and Amortisation Amounts from the Notes to the Amounts on the Face of the Operating Statement		
Depreciation Expense (from Note *11 Property, Plant and Equipment* above)	6,058	5,959
Amortisation Expense (from Note *12 Intangible Assets*)	23,550	19,505
Total Depreciation and Amortisation Expense on the operating Statement	**29,608**	**25,464**

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Note 11. Property, Plant and Equipment (Continued)

Reconciliation of Capital Works in Progress – 2023-24

	Building Works in Progress $'000	Plant and Equipment Works in Progress $'000	Total $'000
Carrying Amount at the Beginning of the Reporting Period	**12,378**	**1,748**	**14,126**
Additions	46,643	2,071	48,714
Capital Works in Progress Transferred to Another Entity	(1,740)	-	(1,740)
Completed and Transferred to another class of Property, Plant and Equipment	(545)	(1,934)	(2,479)
Capital Works Expensed	(941)	-	(941)
Carrying Amount at the End of the Reporting Period [a]	**55,795**	**1,885**	**57,680**

a. The increase in Building Works in Progress is mainly due to redeveloping and expanding the services of the Watson Health Precinct, Canberra Hospital Master Plan - Phase 2 Implementation, and developing the Community Based residential eating disorder treatment centre.

Reconciliation of Capital Works in Progress 2022-23

	Building Works in Progress $'000	Plant and Equipment Works in Progress $'000	Total $'000
Carrying Amount at the Beginning of the Reporting Period	**4,772**	**8,348**	**13,120**
Additions	14,218	5,072	19,290
Completed and Transferred to another class of Property, Plant and Equipment	(5,797)	(11,444)	(17,241)
Capital Works Expensed	(815)	(228)	(1,043)
Carrying Amount at the End of the Reporting Period	**12,378**	**1,748**	**14,126**

Note 11. Property, Plant and Equipment (Continued)

	2024 $'000	2023 $'000
Reconciliation of Capital Works in Progress Amounts from the Notes to the Amounts on the Face of the Balance Sheet		
Capital Works in Progress (from Note 11 *Property, Plant and Equipment* directly above)	57,680	14,126
Intangible Works in Progress (from Note 12 *Intangible Assets*)	26,076	12,997
Total Capital Works in Progress on the Balance Sheet	**83,756**	**27,123**

In last year's financial statements the Capital Works in Progress balance was disclosed in a separate Capital Works in Progress Note. However, in this year's financial statements Capital Works in Progress related to PPE is disclosed in this note to provide better information for all PPE related assets.

Fair Value Hierarchy

The Fair Value Hierarchy below reflects the significance of the inputs used in determining fair value. The Fair Value Hierarchy is made up of the following three levels:

- Level 1 – quoted prices (unadjusted) in active markets for identical assets that the Directorate can access at the measurement date;
- Level 2 – inputs other than quoted prices included within Level 1 that are observable for the asset, either directly or indirectly; and
- Level 3 – inputs that are unobservable for particular assets.

Details of the Directorate's Property, Plant and Equipment at fair value and information about the Fair Value Hierarchy as at 30 June is as follows:

	Classification According to Fair Value Hierarchy		
	Level 2 $'000	**Level 3 $'000**	**Total $'000**
2024			
Property, Plant and Equipment at Fair Value			
Land	21,953	-	21,953
Buildings	368	21,320	21,688
Leasehold Improvements	-	7,068	7,068
Community Assets	-	78	78
	22,321	**28,466**	**50,787**

	Level 2 $'000	**Level 3 $'000**	**Total $'000**
2023			
Property, Plant and Equipment at Fair Value			
Land	23,493	-	23,493
Buildings	375	51,260	51,635
Leasehold Improvements	-	7,832	7,832
Community Assets	-	78	78
	23,868	**59,170**	**83,038**

Note 11. Property, Plant and Equipment (Continued)

Transfers between Categories

There have been no transfers between hierarchy Levels during the current reporting period.

Nine Land assets with a fair value of $19.4 million were transferred from Level 3 to Level 2 in the 2023 reporting period. The independent valuation was not reported as being subject to 'material valuation uncertainty' as defined by Valuation Protocol – Significant Valuation Uncertainty of the Australian Property Institute (API). As such they were of the view Land is a Level 2 asset.

Valuation Techniques, Inputs and processes:

Level 2 Valuation Techniques and Inputs

Land and Buildings

Valuation Technique: The valuation technique used to value land and buildings is the market approach that reflects recent transaction prices for similar properties and buildings (comparable in location and size).

Significant Unobservable Inputs: Prices and other relevant information generated by market transactions involving comparable land and buildings were considered. Regard was taken of the Crown Lease terms and tenure, the Australian Capital Territory Plan and the National Capital Plan, where applicable, as well as current zoning.

Level 3 Valuation Techniques and Significant Unobservable Inputs

Land

Valuation Technique: Land is valued using the market approach adjusted to reflect the specialised nature of the land being valued, where applicable.

Significant Unobservable Inputs: Selecting land with similar approximate utility. In determining the value of land with similar approximate utility significant adjustment to market based data was required.

Building and Leasehold improvements

Valuation Technique: Buildings and Leasehold Improvements were considered specialised assets by the Valuers and measured using the cost approach to fair value.

Significant Unobservable Inputs: Estimating the cost to a market participant to construct assets of comparable utility adjusted for obsolescence. For Buildings, historical cost per square metre of floor area was also used in measuring fair value. In determining the value of buildings and leasehold improvements assets regard was given to the age and condition of the assets, their estimated replacement cost and current use. This required the use of data internal to the ACT Health Directorate.

Community Assets

Valuation technique: Community assets where there is no active market (produced by non-recognised artists) are valued using unobservable inputs.

Significant Unobservable Inputs: In determining the value of these artworks, unobservable inputs were developed with regard given to aesthetic quality, medium, valuer knowledge of the market, and recent sales of works by artists with similar standing/style to the non-recognised artists.

There has been no change to the above valuation techniques during the reporting period.

Transfers in and out of a fair value level are recognised on the date of the event or change in circumstances that caused the transfer.

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Note 11. Property, Plant and Equipment (Continued)

Fair Value Measurements using Significant Unobservable Inputs (Level 3)

2024	Land $'000	Buildings $'000	Leasehold Improvement $'000	Community Assets $'000	Total $'000
Fair Value at the Beginning of the Reporting	**-**	**51,260**	**7,832**	**78**	**59,170**
Additions	5,140	497	66	-	**5,703**
Revaluation Increments Recognised through Other Comprehensive income	260	-	-	-	**260**
Depreciation	-	(1,224)	(830)	-	**(2,054)**
(Disposal) through Other Comprehensive income	(5,400)	(29,843)	-	-	**(35,243)**
Depreciation write back from retirement	-	630	-	-	**630**
Fair Value at the End of the Reporting Period	**-**	**21,320**	**7,068**	**78**	**28,466**

Change in unrealised gains or losses for the period are included in profit or loss for assets held at the end of the reporting period.

2023	Land $'000	Buildings $'000	Leasehold Improvement $'000	Community Assets $'000	Total $'000
Fair Value at the Beginning of the Reporting	**19,397**	**50,159**	**6,977**	**63**	**76,596**
Additions	-	4,261	481	15	**4,757**
Revaluation (Decrements) Recognised through Other Comprehensive Income	-	(6,769)	(1,010)	-	**(7,779)**
Transfer to Level 2	(19,397)	-	-	-	**(19,397)**
Depreciation	-	(1,904)	(686)	-	**(2,590)**
Depreciation Write back	-	5,513	2,125	-	**7,638**
(Disposal) through Other Comprehensive income	-	-	(81)	-	**(81)**
Depreciation Write back from retirement	-	-	26	-	**26**
Fair Value at the End of the Reporting Period	**-**	**51,260**	**7,832**	**78**	**59,170**

Change in unrealised gains or losses for the period are included in profit or loss for assets held at the end of the reporting period.

Note 12. Intangible Assets

Description and Material Accounting Policies Relating to Intangible Assets

The Directorate has internally generated software, externally purchased software and software works in progress. This consists of software systems which provide an on-going support to public health systems across the Territory. Software Works in Progress is software that is in the process of being developed and as such is not yet in use or available for use. That is, software which is not in a location and condition necessary for it to be capable of operating in a manner intended by management. Software Works in Progress does not include Property, Plant and Equipment Capital Work in Progress.

Recognition

Externally purchased software is recognised and capitalised when:

- it is probable that the expected future economic benefits that are attributable to the software will flow to the Directorate;
- the cost of the software can be measured reliably; and
- the acquisition cost is equal to or exceeds $50,000.

Internally generated software is recognised when it meets the general recognition criteria outlined above and where it also meets the specific recognition criteria relating to intangible assets arising from the development phase of an internal project.

Software Works in Progress is recognised at the time the software is being built.

Measurement

Intangible Assets are measured at cost, which comprises its purchase price and any directly attributable costs of preparing the asset for its intended use.

Software Works in Progress is measured at the cost of constructing the asset. The cost includes direct construction costs (e.g. direct materials and direct labour), and 'directly attributable' costs in bringing the asset to a location and condition ready for use. 'Directly attributable' costs included in Software Works in Progress by the Directorate are the cost of initial delivery and handling costs of materials, installation and assembly costs, functional testing and professional fees.

Where intangible assets are acquired at no cost, or minimal cost, its cost is its fair value as at the date of acquisition. However, intangible assets acquired at no or minimal cost as part of a restructuring of administrative arrangements is measured at the transferor's book value.

Amortisation

Capitalised software and other intangibles have a finite useful life. Software is amortised on a straight-line basis over its useful life, over a period not exceeding 10 years. Amortisation commences when intangible assets are ready for their intended use.

Impairment

The Directorate assesses at each reporting date, whether there is any indication that an intangible asset may be impaired. Intangible assets are also reviewed for impairment whenever events or changes in circumstances indicate that the carrying amount may not be recoverable. However, intangible assets that are not yet available for use are tested annually for impairment regardless of whether there is an indication of impairment, or more frequently if events or circumstances indicate they might be impaired.

Impairment losses for intangible assets are recognised in the Operating Statement (see *Note 8* '*Other Expenses'*), as intangibles are carried at cost. The carrying amount of the intangible asset is reduced to its recoverable amount.

ACT HEALTH DIRECTORATE
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Note 12. Intangible Assets (Continued)

	Internally Generated Software $'000	Externally Purchased Software $'000	Software Works in Progress $'000	Total $'000
Reconciliation of Intangible Assets 2023-24				
Carrying Amount at the Beginning of the Reporting Period	**100,493**	**9,485**	**12,997**	**122,975**
Additions	5,850	2,163	20,662	28,675
Impairment Losses Recognised in the Operating Result	-	(3,108)	-	(3,108)
Amortisation Write Back for Impairment Losses	-	2,190	-	2,190
Amortisation	(16,714)	(6,836)	-	(23,550)
Disposals	-	(14,631)	-	(14,631)
Amortisation Write Back for Asset Disposals	-	14,631	-	14,631
Capital Works in Progress Completed and Transferred to another class of Intangible Assets	-	-	(7,508)	(7,508)
Capital Works Expensed	-	-	(75)	(75)
Carrying Amount at the End of the Reporting Period	**89,629**	**3,894**	**26,076**	**119,599**
Carrying Amount at the End of the Reporting Period is represented by:				
Gross Book Value	169,468	40,425	26,076	**235,969**
Accumulated Amortisation	(79,839)	(36,531)	-	**(116,370)**
Carrying Amount at the End of the Reporting Period	**89,629**	**3,894**	**26,076**	**119,599**

ACT HEALTH DIRECTORATE
NOTES TO AND FORMING PART OF THE FINANCIAL STATEMENTS
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Note 12. Intangible Assets (Continued)

	Internally Generated Software $'000	Externally Purchased Software $'000	Software Works in Progress $'000	Total $'000
Reconciliation of Intangible Assets 2022-23				
Carrying Amount at the Beginning of the Reporting Period	**2,155**	**14,917**	**77,158**	**94,230**
Additions	108,226	4,831	58,817	**171,874**
Impairment Losses recognised in the Operating Result	-	(3,591)	-	**(3,591)**
Amortisation Write Back for Impairment Losses	-	2,945	-	**2,945**
Amortisation	(9,888)	(9,617)	-	**(19,505)**
Disposals	(11,514)	(30,624)	-	**(42,138)**
Amortisation Write Back for Asset Disposals	11,514	30,624	-	**42,138**
Capital Works in Progress Completed and Transferred to another class of Intangible Assets	-	-	(113,974)	**(113,974)**
Capital Works Expensed	-	-	(9,004)	**(9,004)**
Carrying Amount at the End of the Reporting Period	**100,493**	**9,485**	**12,997**	**122,975**
Carrying Amount at the End of the Reporting Period is represented by:				
Gross Book Value	167,633	51,986	12,997	**232,616**
Accumulated Amortisation	(67,140)	(42,501)	-	**(109,641)**
Carrying Amount at the End of the Reporting Period	**100,493**	**9,485**	**12,997**	**122,975**

	2024 $'000	2023 $'000
Reconciliation of Intangible Assets from the Notes to the Amount on the Face of the Balance Sheet		
Total Intangible Assets included in this Note	119,599	122,975
Less: Software Works in Progress	26,076	12,997
Total Intangibles Assets on the Balance Sheet	**93,523**	**109,978**

In last year's financial statements the Capital Works in Progress balances relating to intangible assets were disclosed in a separate Capital Works in Progress Note. However, in this year's financial statements Capital Works in Progress related to intangible assets is disclosed in this note to provide better information for all intangible related assets.

Note 13. Other Assets

	2024 $'000	2023 $'000
Current Other Assets		
Prepayments	5,341	6,290
Total Current Other Assets	**5,341**	**6,290**
Total Other Assets	**5,341**	**6,290**

Liability Notes

Material Accounting Policies – Liability

Liabilities – Current and Non-Current

Liabilities are classified as current when they are due to be settled within 12 months after the reporting date or the Directorate does not have an unconditional right to defer settlement of the liability for at least 12 months after the reporting date. Liabilities, which do not fall within the current classification, are classified as non-current.

Note 14. Payables

Description and Material Accounting Policies Relating to Payables

Payables

Payables include Trade Payables and Accrued Expenses.

Payables are initially recognised at fair value based on the transaction cost and subsequent to initial recognition at amortised cost, with any adjustments to the carrying amount being recorded in the Operating Statement. All amounts are now normally settled within 14 days after the invoice date.

	2024 $'000	2023 $'000
Current Payables		
Current Payables		
Trade Payables [a]	1,828	10,138
Accrued Expenses [b]	25,356	20,239
Total Current Payables	**27,184**	**30,377**
Total Payables	**27,184**	**30,377**

a. The decrease in 'Trade Payables' of $8.3 million mainly relates to the timing of invoice receipts from suppliers at the end of 2022-23.

b. The increase in 'Accrued Expenses' of $5.1 million mainly relates to costs accrued for projects undertaken by Canberra Health Services.

ACT HEALTH DIRECTORATE
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Note 14. Payables (Continued)

	2024 $'000	2023 $'000
Payables are aged as followed:		
Not Overdue	27,057	21,227
Overdue for Less than 30 Days	127	4,122
Overdue for 30 to 60 Days	-	1,746
Overdue for More than 60 Days	-	3,282
Total Payables	**27,184**	**30,377**

Note 15. Employee Benefits

Description and Material Accounting Policies Relating to Employee Benefits

Accrued Wages and Salaries

Accrued wages and salaries are measured at the amount that remains unpaid to employees at the end of the reporting period.

Annual and Long Service Leave

Annual and long service leave, including applicable on-costs, that are not expected to be wholly settled before twelve months after the end of the reporting period when the employees render the related service, are measured at the present value. The present value is determined based on estimated future payments to be made in respect of services provided by employees up to the end of the reporting period.

Consideration is given to the future wage and salary levels, experience of employee departures and periods of service. At the end of each reporting period, the present value of future annual leave and long service leave payments is estimated using market yields on Commonwealth Government bonds with terms to maturity that match, as closely as possible, the estimated future cash flows.

Annual leave liabilities have been estimated on the assumption that they will be wholly settled within three years. In 2023-24 the rate used to estimate the present value of future:

- Annual leave payments is 98.2% (98.2% in 2022-23); and
- Payments for long service leave is 91.2% (93.0% in 2022-23).

The long service leave liability is estimated with reference to the minimum period of qualifying service. For employees with less than the required minimum period of 7 years of qualifying service, the probability that employees will reach the required minimum period has been taken into account in estimating the provision for long service leave and applicable on-costs.

On-costs only become payable if the employee takes annual and long service leave while in-service. The probability that employees will take annual and long service leave while in service has been taken into account in estimating the liability for on-costs.

Significant judgements have been applied in estimating the liability for employee benefits. The estimated liability for annual and long service leave requires a consideration of the future wage and salary levels, experience of employee departures, probability that leave will be taken in service and periods of service. The estimate also includes an assessment of the probability that employees will meet the minimum service period required to qualify for long service leave and that on-costs will become payable.

Significant judgements have been applied in estimating the annual and long service leave liabilities, given that the Directorate uses the whole-of-government present value, probability and on-cost factors. These factors are issued by ACT Treasury and apply to all ACT Government agencies. ACT Treasury organises an actuarial review to be undertaken every three years by the Australian Government Actuary to estimate each of these factors. The latest assessment was undertaken in December 2021, with the next review expected to be undertaken by late 2024.

Annual leave and long service leave liabilities are classified as current liabilities in the Balance Sheet where there are no unconditional rights to defer the settlement of the liability for at least 12 months. Conditional long service leave liabilities are classified as non-current because the Directorate has an unconditional right to defer the settlement of the liability until the employee has completed the requisite years of service.

Note 15. Employee Benefits (Continued)

Description and Material Accounting Policies Relating to Employee Benefits (Continued)

Superannuation Liability

The employer superannuation benefits payable to the Directorate employees, who are members of the defined benefit CSS or PSS Schemes, are recognised in the financial statements of the Superannuation Provision Account.

	2024 $'000	2023 $'000
Current Employee Benefits		
Annual Leave [a]	15,060	14,710
Long Service Leave [a]	20,921	19,775
Accrued Salaries	6,124	5,416
Total Current Employee Benefits	**42,105**	**39,901**
Non-Current Employee Benefits		
Long Service Leave	2,263	1,857
Total Non-Current Employee Benefits	**2,263**	**1,857**
Total Employee Benefits	**44,368**	**41,758**

As at 30 June 2024, the Directorate employed 891 Full Time Equivalent (FTE) staff. There were 846 FTE at 30 June 2023. The year-on-year increase in FTE is mainly due to the timing of staff engaged for delivery of initiatives.

a. The increase in 'Annual Leave' of $0.4 million and 'Long Service Leave' of $1.6 million is mainly due to the impact of salary and wage increases following the finalisation of new Enterprise Bargaining Agreements and long service leave earned exceeding leave taken.

Estimate of when Leave is Payable	2024 $'000	2023 $'000
Estimated Amount Payable within 12 months		
Annual Leave	10,437	9,010
Long Service Leave	1,948	1,516
Accrued Salaries	6,124	5,417
Total Employee Benefits Payable within 12 months	**18,509**	**15,943**
Estimated Amount Payable after 12 months		
Annual Leave	4,623	5,699
Long Service Leave	21,236	20,116
Total Employee Benefits Payable after 12 months	**25,859**	**25,815**
Total Employee Benefits	**44,368**	**41,758**

Note 16. Other Provisions

Description and Material Accounting Policies Relating to Other Provisions

Provision for Make Good

In 2016-17 the Directorate entered into a Memorandum of Understanding with the ACT Property Group for the lease of office space in Penrhyn House on Bowes Street in Woden. Before moving into the premises, the Directorate constructed leasehold improvements in the building. There are clauses within the agreement which require the Directorate, upon cessation of the tenancy, to return the office space to the condition it was in before it was leased (this is referred to as 'Make Good'). The tenancy runs for 15 years and ends in 2031-32.

The Provision for Make Good is measured at the present value of the estimated future expenditure required to remove the leasehold improvements. This is calculated by discounting its nominal value using a rate that reflects a current market assessment of the risk specific to the liability. This initial estimate of the restoration costs has been capitalised into the cost of the leasehold improvement.

	2024 $'000	2023 $'000
Non-Current Other Provisions		
Provision for Make Good [a]	2,704	3,542
Total Other Provisions	**2,704**	**3,542**

Reconciliation of Other Provisions	**Provision for Make Good**	
	2024 $'000	**2023 $'000**
Provision at the Beginning of the Reporting Period	**3,542**	**2,832**
Additional Provision Recognised	-	707
Provision reversed during the Year [a]	(841)	-
Unwinding of discount	3	3
Provision at the End of the Reporting Period	**2,704**	**3,542**

a. The decrease of 'Provision for Make Good' of $0.8 million relates to the decrease in the provision to reflect current market assessments for vendor costs to demolish and remove fit out at the Directorate's leased office building.

Note 17. Other Liabilities

Description and Material Accounting Policies Relating to Other Liabilities

Unearned Revenue

Unearned revenue is recognised as a liability if there is a present obligation to return the funds received, otherwise all are recorded as revenue. Unearned revenue arises from transactions that are not contracts with customers.

Lease Incentive Liabilities

Lease incentive liabilities represent liabilities over the multi-year lease for the Directorate's office building at Bowes Street.

	2024 $'000	2023 $'000
Current Other Liabilities		
Unearned Revenue	581	664
Lease Incentive Liabilities	1,039	1,039
Total Current Other Liabilities	**1,620**	**1,703**
Non-Current Other Liabilities		
Lease Incentive Liabilities [a]	7,054	8,093
Total Non-Current Other Liabilities	**7,054**	**8,093**
Total Other Liabilities	**8,674**	**9,796**

a. The decrease in 'Lease Incentive Liabilities' reflects the progressive consumption of a lease incentive, related to the Directorate's office accommodation, over the term of the lease.

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Note 18. Financial Instruments

Material Accounting Policies Relating to Financial Instruments

Details of the material accounting policies and methods adopted, including the criteria for recognition, the basis of measurement, and the basis on which income and expenses are recognised, with respect to each class of financial asset and financial liability are disclosed in the note to which they relate. In addition to these policies, the following are also accounting policies relating to financial assets and liabilities.

Financial assets are subsequently measured at amortised cost, fair value through other comprehensive income or fair value through profit or loss on the basis of both:

(a) the business model for managing the financial assets; and

(b) the contractual cash flow characteristics of the financial assets.

The following are the classification of the Directorate's financial assets under AASB 9 *Financial Instruments*:

Items	Business Model Held to collect principal and interest/sell	Solely for payment of Principal and Interest SPPI Test (basic lending characteristics)	Classification
Cash	Held to collect	Yes	Amortised cost
Accounts Receivables	Held to collect	Yes	Amortised cost
Accrued Revenue	Held to collect	Yes	Amortised cost

Financial liabilities are measured at amortised cost.

Credit Risk

Credit risk is the risk that one party to a financial instrument will fail to discharge an obligation and cause the other party to incur a financial loss. The Directorate's credit risk is limited to the amount of the financial assets it holds net of any provision for impairment.

Credit risk is managed by the Directorate for cash at bank by holding bank balances with the ACT Government's bank, Westpac Banking Corporation (Westpac). Westpac holds an AA- issuer credit rating with S&P Global Ratings. An 'AA-' credit rating is defined as 'very strong capacity to meet its financial commitments'.

The Directorate's receivables are predominantly from other ACT Government entities and the Commonwealth Government. Inter-agency receivables between ACT Government agencies are generally expected to have low credit risks. As the Commonwealth Government has an AAA credit rating, it is considered that there is a very low risk of default for those receivables. The Directorate expects to collect all financial assets that are not past due or impaired.

Accounts receivable is always measured at lifetime expected credit losses (the simplified approach).

There have been no significant changes in credit risk exposure since last reporting period.

Note 18. Financial Instruments (Continued)

Liquidity Risk

Liquidity risk is the risk that the Directorate will encounter difficulties in meeting its financial obligations associated with financial liabilities that are settled by delivering cash or another financial asset.

To limit its exposure to liquidity risk, the Directorate is able to draw down additional Controlled Recurrent Payments in the next reporting period to cover its financial liabilities when they fall due. This ensures the Directorate has enough liquidity to meet its emerging financial liabilities.

The Directorate's exposure to liquidity risk and the management of this risk has not changed since the previous reporting period.

	Note No.	Carrying Amount 2024 $'000	Fair Value Amount 2024 $'000	Carrying Amount 2023 $'000	Fair Value Amount 2023 $'000
Financial Assets					
Cash	9	15,899	15,899	79	79
Receivables	10	2,886	2,886	5,908	5,908
Total Financial Assets		**18,785**	**18,785**	**5,987**	**5,987**
Financial Liabilities					
Payables	14	27,184	27,184	30,377	30,377
Lease Liabilities		556	556	837	837
Total Financial Liabilities		**27,740**	**27,740**	**31,214**	**31,214**

Note that the GST receivable/payable and the FBT Payable have not been included in the receivables/payables line item above given they are statutory assets/liabilities.

Fair Value Hierarchy

The Directorate's financial assets and liabilities are measured, subsequent to initial recognition, at amortised cost and as such are not subject to the Fair Value Hierarchy.

All financial liabilities of the Directorate are non-interest bearing and are shown on an undiscounted Cash Flow basis.

Carrying Amount of Each Category of Financial Asset and Financial Liability

	2024 $'000	2023 $'000
Financial Assets		
Financial Assets Measured at Amortised Cost	2,886	5,908
Financial Liabilities		
Financial Liabilities Measured at Amortised Cost	27,740	31,214

ACT HEALTH DIRECTORATE
NOTES TO AND FORMING PART OF THE FINANCIAL STATEMENTS
FOR THE YEAR ENDED 30 JUNE 2024

Note 19. Commitments

Description and Material Accounting Policies Relating to Commitments

Commitments are a firm intention, but not a present obligation, at the end of the reporting period to incur future expenditure. As such, commitments do not constitute a liability. Commitments usually arise from contracts, but can arise from other things like placing an order.

Commitments are measured at their nominal value and are inclusive of GST.

Capital Commitments

Capital Commitments contracted at reporting date, include security upgrades and new computer software, that have not been recognised as liabilities are as follows:

	2024 $'000	2023 $'000
Capital Commitments - Property, Plant and Equipment		
Payable:		
Within one year	39,127	15,899
Later than one year but not later than five years	6,370	3
Total Capital Commitments - Property, Plant and Equipment [a]	**45,497**	**15,902**
Capital Commitments - Intangible Assets		
Payable:		
Within One Year	6,442	6,812
Later than one year but not later than five years	-	6,583
Total Capital Commitments - Intangible Assets [b]	**6,442**	**13,395**
Total Capital Commitments	**51,939**	**29,297**

a. The increase in 'Capital Commitments for Property, Plant and Equipment' of $29.6 million mainly relates to infrastructure projects including The Canberra Hospital Master Plan, Southside Hydrotherapy Pool and upgrades to the Watson Health Precinct.

b. The decrease in 'Capital Commitments for Intangible Assets' of $7.0 million is mainly due to settlement of commitments relating to the Digital Health Record system.

Note 19. Commitments (Continued)

Other Commitments - Non-Government Organisations (NGO's) and Information Communication Technology (ICT)

Other commitments include payments to NGO for the provision of public health services and payments to ICT suppliers. Services contracted at reporting date but not recognised as liabilities, are payable as follows:

	2024 $'000	2023 $'000
Non-cancellable other commitments are as follows:		
Within one year	83,257	84,832
Later than one year but not later than five years	144,046	74,118
Later than five years	23,446	-
Total Other Commitments [a]	**250,749**	**158,950**

a. The increase in 'Other Commitments' of $91.8 million is mainly due to new multi-year contracts for ICT and Non-Government Organisations delivering community health care programs and services.

Other Commitments – ICT Equipment and Accommodation

The Directorate has several contractual commitments for payments related to buildings and computer assets.

	2024 $'000	2023 $'000
Non-cancellable other commitments are as follows:		
Within one year	7,498	7,279
Later than one year but not later than five years	26,532	25,721
Later than five years	18,324	24,276
Total Other Commitments - ICT Equipment and Accommodation	**52,354**	**57,276**

Other Commitments - Motor Vehicles

	2024 $'000	2023 $'000
Non-cancellable other commitments are as follows:		
Within one year	11	24
Total Other Commitments - Motor Vehicle	**11**	**24**

Amounts for Capital Commitments, Other Commitments - NGO's and ICT and Other Commitments – Motor Vehicles are inclusive of GST.

Amounts for Other Commitments - ICT Equipment and Accommodation are exclusive of GST in line with the ACT Government policy excluding GST for payments between Government-Related Entities.

Note 20. Contingent Liabilities

Material Accounting Policies Relating to Contingent Liabilities

Contingent liabilities are not recognised in the Balance Sheet due to the uncertainty regarding any possible amount or timing of any underlying claim or obligation. Instead, they are disclosed and, if quantifiable, the best estimate is disclosed.

Contingent Liabilities

Legal Claims

The Directorate is subject to 3 legal actions (2022-23 – 86 actions). The Directorate's maximum exposure under the ACT Insurance Authority insurance policy is estimated at $30,000 as at 30 June 2024 (2022-23 $3,645,300), which has not been provided for in the financial statements due to uncertainties relating to the liabilities at 30 June 2024. The reduction is due to contingent liabilities relating to North Canberra Hospital (previously Calvary Public Hospital Bruce) being included under Canberra Health Services.

Calvary Acquisition Just Terms Compensation

As a result of the enactment of the *Health Infrastructure Enabling Act 2023* on 2 June 2023, the Directorate has contingent liabilities associated with the payment of compensation relating to the acquisition of the Calvary Public Hospital Bruce by the Territory, which may include payments associated to the public hospital land and other assets, any mortgage or other interest in the land or other assets, and other matters including termination of the network agreement, termination of contracts, any redundancies payable to employees and anything else prescribed by regulation.

A reliable estimate of the value of the possible compensable just terms items mentioned above could not be made at 30 June 2024 given commercial negotiations were still underway at the time of finalising these financial statements.

Note 21. Third Party Monies

Description and Material Accounting Policies Relating to Third Party Monies

The Directorate holds funds in trust relating to the activities of the Health Directorate Human Research Ethics Committee. There are no additional assets and liabilities other than cash in relation to the committee. Therefore, the below information only provides cash disclosures of activities during the year, and financial position at the reporting date. The trust bank account has been set up in accordance with section 51 of the *Financial Management Act 1996* to collect and hold the deposit.

	2024 $'000	2023 $'000
Human Research Ethics Committee Account		
Balance at the Beginning of the Reporting Period	**158**	**9**
Cash Receipts	188	249
Cash Payments	(100)	(100)
Balance at the End of the Reporting Period	**246**	**158**

ACT HEALTH DIRECTORATE
NOTES TO AND FORMING PART OF THE FINANCIAL STATEMENTS
FOR THE YEAR ENDED 30 JUNE 2024

Note 22. Related Party Disclosures

Description and Material Accounting Policies Relating to Related Party Disclosures

A related party is a person that controls or has significant influence over the reporting entity, or is a member of the Key Management Personnel (KMP) of the reporting entity or its parent entity, and includes their close family members and entities in which the KMP and/or their close family members individually or jointly have controlling interests.

KMP are those persons having authority and responsibility for planning, directing and controlling the activities of the Directorate, directly or indirectly.

KMP of the Directorate are the Portfolio Minister, Director-General, Deputy Directors-General and Coordinator-General for Mental Health.

The Head of Service and the ACT Executive comprising the Cabinet Ministers are KMP of the ACT Government and therefore related parties of the Directorate.

This note does not include typical citizen transactions between the KMP and the Directorate that occur on terms and conditions no different to those applying to the general public.

(A) Controlling Entity

The ACT Health Directorate is an ACT Government controlled entity.

(B) Key Management Personnel

B.1 Compensation of Key Management Personnel

Compensation of all Cabinet Ministers, including the Portfolio Minister, is disclosed in the note on related party disclosures included in the ACT Executive's financial statements for the year ended 30 June 2024.

Compensation of the Head of Service is included in the note on related party disclosures included in the Chief Minister, Treasury and Economic Development Directorate's (CMTEDD) financial statements for the year ended 30 June 2024.

Compensation by ACT Health Directorate to KMP is set out below.

	2024	2023
	$'000	$'000
Short-term employee benefits	1,585	1,223
Post-employment benefit	279	243
Other long-term benefit	37	29
Total Compensation by the ACT Health Directorate to KMP	**1,901**	**1,495**

Note 22. Related Party Disclosures (Continued)

(C) Transactions with other ACT Government Controlled Entities

The Directorate has entered transactions with other ACT Government entities in 2022-23 and 2023-24 consistent with day-to-day business operations provided under varying terms and conditions. The notes to the Financial Statements provide the details of transactions with other ACT Government Entities. Below is a summary of the material transactions with other ACT Government Entities.

Revenue

- Appropriation (Statement of Appropriation) - The Directorate's main ongoing source of funding is received from the ACT Government through the Territory Banking Account. This funding is in the form of Controlled Recurrent Payments (CRP), Payments for Expenses on Behalf of the Territory (EBT) and Capital Injections (CI) appropriation. Total Appropriation drawn in 2023-24 includes CRP of $344.9 million in 2023-24 ($312.0 million in 2022-23) and CI of $64.3 million in 2023-24 ($65.2 million in 2022-23).
- Grants and Contributions Revenue (Note 4) – The Directorate received multiple Grants and Contributions from other ACT Government agencies including transfers from the ACT Local Hospital Network (LHN) relating to Cross Border Health Receipts of $150.4 million in 2023-24 ($190.8 million in 2022-23), the provision of public health services of $9.1 million in 2023-24 ($21.2 million in 2022-23). The Directorate also recognised revenue relating to resources received free of charge from other ACT Government agencies of $11.9 million in 2023-24 ($3.7 million in 2022-23).
- Other Revenue – The Directorate received revenue from Canberra Health Services (CHS) of $1.8 million in 2023-24 ($3.5 million in 2022-23) and Major Projects Canberra (MPC) of $3.8 million in 2023-24 ($5.2 million in 2022-23) for the provision of project based ICT services.

Expenses

- Employee Expenses (Note 5) – The Directorate made payments of $4.8 million for project salary cost in 2023-24 ($1.0 million in 2022-23) and $1.2 million for workers compensation in 2023-24 ($1.3 million in 2022-23).
- Supplies and Services (Note 6) - The Directorate made payments of $51.8 million in 2023-24 ($70.9 million in 2022-23) to other ACT Government agencies which included payments for ICT services of $17.9 million in 2023-24 ($49.9 million in 2022-23), rental and maintenance charges of $7.3 million in 2023-24 ($5.2 million in 2022-23), project cost of $6.2 million in 2023-24 ($0.2 million in 2022-23), and Communications of $2.5 million in 2023-24 ($5.6 million in 2022-23). The Directorate also recognised expenses relating to resources received free of charge from other ACT Government agencies of $10.3 million in 2023-24 ($1.8 million in 2022-23).
- Grants and Purchased Services (Note 7) – The Directorate transferred $150.2 million to the LHN in 2023-24 ($160.6 million in 2022-23). The Directorate also paid $12.0 million in 2023-24 ($0 million in 2022-23) to CHS relating to the on-passing of revenue received from Department of Veterans' Affairs.

Assets

- Receivables (Note 10) – The Directorate recognised of $1.0 million of receivables from CHS and $1.3 million from MPC at 30 June 2024 ($0.7 million from CHS and $3.1 million from MPC at 30 June 2023) relating to charges for the provision of project based ICT services.
- Property, Plant and Equipment (Note 11) – The Directorate transferred land and building assets (Clare Holland House and North Canberra Hospital Carpark) and Capital Works in Progress of $37.9 million at 30 June 2024 to CHS.

ACT HEALTH DIRECTORATE
NOTES TO AND FORMING PART OF THE FINANCIAL STATEMENTS
FOR THE YEAR ENDED 30 JUNE 2024

Liabilities

- Payables (Note 14) – The Directorate recognised payables of $4.1 million at 30 June 2024 ($0.3 million at 30 June 2023) to CHS for project costs, and $6.1 million at 30 June 2024 ($6.4 million at 30 June 2023) to Digital, Data and Technology Solutions for ICT services.

ACT HEALTH DIRECTORATE
NOTES TO AND FORMING PART OF THE FINANCIAL STATEMENTS
FOR THE YEAR ENDED 30 JUNE 2024

Note 23. Budgetary Reporting

Significant Accounting Judgements and Estimates – Budgetary Reporting

Significant judgements have been applied in determining what variances are considered 'major variances'. Variances are considered major if both of the following criteria are met:

- The line item is a significant line item: where either the line item actual amount accounts for more than 10% of the relevant associated actual category amount (Income, Expenses, Assets, liabilities and Equity totals) or more than 10% of the sub-element (e.g. Current Liabilities and Receipts from Operating Activities totals) of the financial statements; and
- The variances (original budget to actual) are greater than plus (+) or minus (-) 10% and $15 million for the financial statement line item.

Original Budget refers to the amounts presented to the Legislative Assembly in the original budgeted financial statements in respect of the reporting period Budget Statements. These amounts have not been adjusted to reflect supplementary appropriation or appropriation instruments.

Note: # in the 'Variance %' column represents a variance that is greater than 999 per cent or less than -999 per cent.

Operating Statement Line Items	Variance Explanation	Actual 2024 $'000	Original Budget 2024 $'000	Variance $'000	Variance %
Revenue					
Controlled Recurrent Payments	a	344,867	296,101	48,766	16
Grants and Contributions	b	183,995	11,549	172,446	1,493
Other Income	b	6,620	126,367	(119,747)	(95)
Expenses					
Employee Expenses	c	138,682	121,149	17,533	14
Supplies and Services	c	131,081	100,053	31,028	31
Grants and Purchased Services	d	247,583	222,431	25,152	11

Variance Explanations

a. Controlled Recurrent Payments were higher than budget mainly due to the additional appropriation received through the mid-year budget review for multiple initiatives, including continuing delivery of the Digital Health Strategy and the North Canberra Hospital Transition.

b. Grants and Contributions were higher than budget mainly due to the increased revenue in relation to Department of Veterans' Affairs and Cross Border Health receipts resulting from a higher than anticipated number of interstate residents treated in the ACT public hospitals and multiple prior year reconciliations being completed with final back-adjustment payments being settled in 2023-24. Budget for these amounts was recorded under 'Other Income'.

c. Employee Expenses and Supplies and Services were higher than budget mainly due to additional costs to deliver mid-year budget initiatives including continuing delivery of the Digital Health Strategy and the North Canberra Hospital Transition.

d. Grants and Purchased Services were higher than budget mainly due to increased on-passing of Department of Veterans' Affairs revenue and additional Cross Border Health revenue received during the year.

ACT HEALTH DIRECTORATE
NOTES TO AND FORMING PART OF THE FINANCIAL STATEMENTS
FOR THE YEAR ENDED 30 JUNE 2024

Note 23. Budgetary Reporting (Continued)

Balance Sheet Line Items	Variance Explanation	Actual 2024 $'000	Original Budget 2024 $'000	Variance $'000	Variance %
Assets					
Cash	a	15,899	365	15,534	4,256
Property, Plant and Equipment	b	64,030	94,667	(30,637)	(32)
Intangible Assets	c	93,523	27,304	66,219	243
Capital Works in Progress	c	83,756	170,380	(86,624)	(51)
Equity					
Accumulated Funds	d	164,850	188,822	(23,972)	(13)

Variance Explanations

a. Cash was higher than budget due to the timing of the payment to settle outstanding invoices in early 2024-25.

b. Property, Plant and Equipment was lower than budget due to transfer of assets held by the Directorate to Canberra Health Services.

c. Intangible Assets were higher than budget mainly due to the completion of several computer software development projects including the Digital Health Record and the Notifiable Diseases Management System. Budget for 'Intangible Assets' was recorded under 'Capital Works in Progress'.

d. Accumulated Funds were lower than budget mainly due to the transfer of assets held by the Directorate to Canberra Health Services through Equity.

ACT HEALTH DIRECTORATE
NOTES TO AND FORMING PART OF THE FINANCIAL STATEMENTS
FOR THE YEAR ENDED 30 JUNE 2024

Note 23. Budgetary Reporting (Continued)

Statement of Cash Flows Line Items	Variance Explanation	Actual 2024 $'000	Original Budget 2024 $'000	Variance $'000	Variance %
Receipts					
Controlled Recurrent Payments	a	344,867	296,101	48,766	16
Grants and Contributions Receipts	b	171,981	122,102	49,879	41
Payments					
Employee	c	136,073	116,927	19,146	16
Supplies and Services	c	124,771	93,833	30,938	33
Grants and Purchased Services	d	248,123	219,856	28,267	13
Purchase of Capital Works	e	53,702	92,219	(38,517)	(42)
Capital Injections	e	64,346	95,620	(31,274)	(33)

Variance Explanations

a. Controlled Recurrent Payments were higher than budget mainly due to the additional appropriation received through the mid-year budget review for multiple initiatives, including continuing delivery of the Digital Health Strategy and the North Canberra Hospital Transition.

b. Grants and Contributions Receipts were higher than budget mainly due to the increase in Cross Border Health receipts resulting from a higher than anticipated number of interstate residents treated in ACT public hospitals and multiple prior year reconciliations being completed with final back-adjustment payments being settled in 2023-24 and increased revenue in relation to Department of Veterans' Affairs.

c. Employee Expenses and Supplies and Services were higher than budget mainly due to additional costs to deliver mid-year budget initiatives, including continuing delivery of the Digital Health Strategy and the North Canberra Hospital Transition.

d. Grants and Purchased Services were higher than budget mainly due to the on-passing of Department of Veterans' Affairs revenue and additional Cross Border Health revenue received during the year.

e. Purchase of Capital Works and Capital Injections were lower than budget mainly due to multiple projects being reprofiled from 2023-24 to 2024-25 (including Watson Health Precinct Redevelopment and design works for the new Northside Hospital), and the transfer of funding relating to North Canberra Hospital to Major Projects Canberra and Canberra Health Services.

ACT Health Directorate

Territorial Financial Statements

For the Year Ended

30 June 2024

ACT HEALTH DIRECTORATE
CONTENT OF TERRITORIAL FINANCIAL STATEMENTS
FOR THE YEAR ENDED 30 JUNE 2024

Financial

Statement of Income and Expenses on Behalf of the Territory
Statement of Assets and Liabilities on Behalf of the Territory
Statement of Changes in Equity on Behalf of the Territory
Statement of Cash Flows on Behalf of the Territory
Territorial Statement of Appropriation

Overview Notes

Note 24 Basis of Preparation of the Financial Statements - Territorial

Income Note

Note 25 Fees - Territorial

Expenses Notes

Note 26 Grants - Territorial
Note 27 Transfer Payments to Government - Territorial

Assets Notes

Note 28 Cash - Territorial
Note 29 Receivables - Territorial

Liabilities Notes

Note 30 Advance from the Territory Banking Account - Territorial

Other Notes

Note 31 Financial Instruments - Territorial
Note 32 Budgetary Reporting - Territorial

ACT HEALTH DIRECTORATE
STATEMENT OF INCOME AND EXPENSES ON BEHALF OF THE TERRITORY
FOR THE YEAR ENDED 30 JUNE 2024

	Note No.	Actual 2024 $'000	Original Budget 2024 $'000	Actual 2023 $'000
Income				
Payments for Expenses on Behalf of the Territory	#	200	13,799	11,657
Fees	25, 32	1,976	1,617	1,765
Total Income		**2,176**	**15,416**	**13,422**
Total Income		**2,176**	**15,416**	**13,422**
Expenses				
Grants	26, 32	544	13,799	11,295
Transfer Payments to Government	27, 32	1,960	1,617	1,771
Total Expenses		**2,504**	**15,416**	**13,066**
Operating Result		**(328)**	**-**	**356**

The above Statement of Income and Expenses on Behalf of the Territory is to be read in conjunction with the accompanying notes.

The funds which flow through the Directorate's Territorial accounts are the receipt of regulatory licence fees and the receipt and on-passing of monies for capital works at Winnunga Nimmityjah Aboriginal Health Service.

Refer to the Territorial Statement of Appropriation

ACT HEALTH DIRECTORATE
STATEMENT OF ASSETS AND LIABILITIES ON BEHALF OF THE TERRITORY
AS AT 30 JUNE 2024

	Note No.	Actual 2024 $'000	Original Budget 2024 $'000	Actual 2023 $'000
Current Assets				
Cash	28, 32	272	594	561
Receivables	29	-	7	38
Total Current Assets		**272**	**601**	**599**
Total Assets		**272**	**601**	**599**
Current Liabilities				
Advance from the Territory Banking Account	30	244	244	244
Payables		1	358	-
Total Current Liabilities		**245**	**602**	**244**
Total Liabilities		**245**	**602**	**244**
Net Assets		**27**	**(1)**	**355**
Equity				
Accumulated Funds	32	27	-	355
Total Equity		**27**	**-**	**355**

The above Statement of Assets and Liabilities on Behalf of the Territory is to be read in conjunction with the accompanying notes.

Due to the nature of territorial accounting, the Statement of Assets and Liabilities on Behalf of the Territory includes (as applicable) liabilities to, and receivables from, the Territory Banking Account.

ACT HEALTH DIRECTORATE
STATEMENT OF CHANGES IN EQUITY ON BEHALF OF THE TERRITORY
FOR THE YEAR ENDED 30 JUNE 2024

	Accumulated Funds Actual 2024 $'000	Total Equity Actual 2024 $'000	Original Budget 2024 $'000
Balance at 1 July 2023	**355**	**355**	**-**
Comprehensive Income			
Operating Result	(328)	(328)	-
Total Comprehensive Result	**(328)**	**(328)**	**-**
Balance at 30 June 2024	**27**	**27**	**-**

	Accumulated Funds Actual 2023 $'000	Total Equity Actual 2023 $'000
Balance at 1 July 2022	**(1)**	**(1)**
Comprehensive Income		
Operating Result	356	356
Total Comprehensive Result	**356**	**356**
Balance at 30 June 2023	**355**	**355**

The above Statement of Changes in Equity on Behalf of the Territory is to be read in conjunction with the accompanying notes.

ACT HEALTH DIRECTORATE
STATEMENT OF CASH FLOWS ON BEHALF OF THE TERRITORY
FOR THE YEAR ENDED 30 JUNE 2024

	Note No.	Actual 2024 $'000	Original Budget 2024 $'000	Actual 2023 $'000
Cash Flows from Operating Activities				
Receipts				
Payment for Expenses on Behalf of the Territory		200	13,799	11,657
Fees	32	1,976	1,617	1,840
Goods and Services Tax Input Tax Credits from the Australian Taxation Office		38	86	1,060
Total Receipts from Operating Activities		**2,214**	**15,502**	**14,557**
Payments				
Grants	32	546	13,799	11,657
Transfer of Territory Receipts to the ACT Government	32	1,957	1,617	1,768
Goods and Services Tax Paid to Suppliers		-	86	1,165
Total Payments from Operating Activities		**2,503**	**15,502**	**14,590**
Net Cash (Outflows) from Operating Activities	28	**(289)**	**-**	**(33)**
Net (Decrease) in Cash and Cash Equivalents		**(289)**	**-**	**(33)**
Cash and Cash Equivalents at the Beginning of the Reporting Period		561	594	594
Cash and Cash Equivalents at the End of the Reporting Period	28	**272**	**594**	**561**

The above Statement of Cash Flows on Behalf of the Territory is to be read in conjunction with the accompanying notes.

ACT HEALTH DIRECTORATE
TERRITORIAL STATEMENT OF APPROPRIATION
FOR THE YEAR ENDED 30 JUNE 2024

Description and Material Accounting Policies Relating to Payment for Expenses on Behalf of the Territory

The Directorate receives appropriation to fund a number of expenses incurred on behalf of the Territory, the main one being the payments of grants to various non-government organisations (See *Note* 26 *'Grants – Territorial'*).

Payment for Expenses on behalf of the Territory is recognised when the Directorate receives the cash.

	Original Budget 2024 $'000	Total Appropriated 2024 $'000	Appropriation Drawn 2024 $'000	Appropriation Drawn 2023 $'000
Territorial				
Expenses on Behalf of the Territory	13,799	853	200	11,657
Total Territorial Appropriation	**13,799**	**853**	**200**	**11,657**

The above Territorial Statement of Appropriation is to be read in conjunction with the accompanying notes.

Column Heading Explanations

The *Original Budget* column shows the amounts that appear in the Statement of Cash Flows in the Budget Papers. This amount also appears in the Statement of Cash Flows.

The *Total Appropriated* column is inclusive of all appropriation variations occurring after the Original Budget.

The *Appropriation Drawn* is the total amount of appropriation received by the Directorate during the year. These amounts appear in the Statement of Cash Flows on Behalf of the Territory.

Reconciliation of Territorial Appropriation for 2023-24	Payment for Expenses on Behalf of the Territory $'000
Original Budget Appropriation for 2023-24	13,799
Rollover of Undisbursed Appropriation (FMA s.16B)	3,677
Supplementary Appropriation (FMA s.13)	(16,623)
Total Appropriated	853
Territorial Appropriation Drawn	**200**

FMA - *Financial Management Act 1996*

Variances between 'Original Budget' and 'Total Appropriated'

The difference of $12.9 million relates to funding for North Canberra Hospital projects being transferred to Canberra Health Services. This amount is $16.6 million, which includes a rollover of $3.7 million of undisbursed appropriation from 2022-23.

Variances between 'Total Appropriated' and 'Appropriation Drawn'

The difference of $0.7 million is mainly due to funding relating to Watson Health Precinct Redevelopment project being reprofiled from 2023-24 to 2024-25 to reflect an amended project schedule.

Variances between '2022-23 and 2023-24 Payments for Expenses on Behalf of the Territory Appropriation Drawn'

The difference of $11.5 million is mainly due to funding for North Canberra Hospital projects being transferred to Canberra Health Services.

ACT HEALTH DIRECTORATE
NOTES TO AND FORMING PART OF THE FINANCIAL STATEMENTS
FOR THE YEAR ENDED 30 JUNE 2024

Note 24. Basis of Preparation of the Financial Statements - Territorial

The basis of preparation of the statements are contained in *Note 2 'Basis of Preparation of the Financial Statements'* and apply to both the Controlled and Territorial financial statements.

Note 25. Fees – Territorial

Description and Material Accounting Policies Relating to Fees - Territorial

The Directorate collects fees on behalf of the Territory.

Fees

Fees refers to the collection of licence fees, including from food businesses, smoke free places, boarding houses and for radiation equipment. Fees are generally either recognised as revenue at the time of receipt or when the fee is incurred.

	2024 $'000	2023 $'000
Fees		
Fees for Regulatory Services [a]	1,976	1,765
Total Fees	**1,976**	**1,765**

a. The increase in 'Fees for Regulatory Services' of $0.2 million was mainly due to the receipt of higher revenue from food business registrations and licencing fees.

ACT HEALTH DIRECTORATE
NOTES TO AND FORMING PART OF THE FINANCIAL STATEMENTS
FOR THE YEAR ENDED 30 JUNE 2024

Note 26. Grants – Territorial

Description and Material Accounting Policies Relating to Grants – Territorial

Grants are amounts provided, by the Directorate, to non-ACT Government agencies for general assistance or for a particular purpose. Grants may be for capital, current or recurrent purposes and the category reflects the use of the grant. The grants given are usually subject to terms and conditions set out in the contract, correspondence, or by legislation.

	2024 $'000	2023 $'000
Capital Grants		
Capital Grants to External Parties [a]	544	11,295
Total Capital Grants	**544**	**11,295**

a. The decrease in 'Capital Grants to External Parties' of $10.8 million is mainly due to funding relating to North Canberra Hospital being transferred to Canberra Health Services.

Note 27. Transfer Payments to Government – Territorial

Description and Material Accounting Policies Relating to Transfer Payments to Government – Territorial

'Transfer Payments to Government' represents the transfer of money, which the Directorate has collected on behalf of the Territory, to Government. The money collected by the Directorate on behalf of the Territory includes licence fees collected.

	2024 $'000	2023 $'000
Payments to the Territory Banking Account [a]	1,960	1,771
Total Transfer Payments to Government	**1,960**	**1,771**

a. The increase in 'Payments to the Territory Banking Account' of $0.2 million relates to the transfer of receipts of 'Fees for Regulatory Services'.

ACT HEALTH DIRECTORATE
NOTES TO AND FORMING PART OF THE FINANCIAL STATEMENTS
FOR THE YEAR ENDED 30 JUNE 2024

Note 28. Cash – Territorial

Description and Material Accounting Policies Relating to Cash – Territorial

Under the whole-of-government banking arrangements, given the Directorate holds Set-Off Bank accounts, interest is not earned on 'Cash at Bank'.

	2024 $'000	2023 $'000
(a) Cash Balance		
Cash at Bank	272	561
Total Cash	**272**	**561**

Note 28. Cash – Territorial (Continued)

(b) Reconciliation of Cash at the end of the Reporting Period in the Statement of Cash Flows on Behalf of the Territory to the Related Items in the Statement of Assets and Liabilities on Behalf of the Territory.

	2024 $'000	2023 $'000
Total Cash Recorded in the Statement of Assets and Liabilities on Behalf of the Territory	272	561
Cash at the End of the Reporting Period as Recorded in the Statement of Cash Flows on Behalf of the Territory	**272**	**561**

(c) Reconciliation of the Operating Result to Net Cash Inflows from Operating Activities

Operating Result	(328)	356
Cash Before Changes in Operating Assets and Liabilities	**(328)**	**356**
Changes in Operating Assets and Liabilities		
Decrease/(Increase) in Receivables	112	(106)
(Decrease) in Payables	(73)	(283)
Net Changes in Operating Assets and Liabilities	**39**	**(389)**
Net Cash (Outflows) from Operating Activities	**(289)**	**(33)**

Note 29. Receivables – Territorial

Description and Material Accounting Policies Relating to Receivables and Contract Assets - Territorial

The Directorate's territorial receivables arise from the collection of GST. Receivables relating to the GST are recognised when the GST is incurred.

	2024 $'000	2023 $'000
Current Receivables		
Net GST Receivable	-	38
Total Current Receivables	**-**	**38**
Total Receivables	**-**	**38**

No receivables are past due or impaired. All receivables are from Non-ACT Government entities.

Note 30. Advance from the Territory Banking Account - Territorial

Description and Material Accounting Policies Relating to Advance from the Territory Banking Account – Territorial

The cash advance is for the purpose of funding the Goods and Services Tax (GST) cash outlay due to the timing difference between the GST payment and receiving of refunds from the Australian Taxation Office.

	2024 $'000	2023 $'000
Advance from the Territory Banking Account	244	244
Total Advance from the Territory Banking Account	**244**	**244**

Note 31. Financial Instruments - Territorial

Material Accounting Policies Relating to Financial Instruments - Territorial

Details of the material accounting policies and methods adopted, including the criteria for recognition, the basis of measurement, and the basis on which income and expenses are recognised, with respect to each class of financial asset and financial liability are disclosed in the note to which they relate. In addition to these policies, the following are also accounting policies relating to financial assets and liabilities.

Financial assets are subsequently 'measured at amortised cost', 'fair value through other comprehensive income' or 'fair value through profit or loss' on the basis of both:

(a) the business model for managing the financial assets; and

(b) the contractual cash flow characteristics of the financial assets.

All territorial financial assets and financial liabilities are measured at amortised cost.

Credit Risk

Credit risk is the risk that one party to a financial instrument will fail to discharge an obligation and cause the other party to incur a financial loss. The Directorate's credit risk is limited to the amount of the financial assets held less any provision for losses.

The Directorate's Territorial financial assets only consist of Cash.

Credit risk for Cash is managed by the Directorate by holding bank balances with the ACT Government's bank, Westpac Banking Corporation (Westpac). Westpac holds an AA- issuer credit rating with S&P Global Ratings. An 'AA-' credit rating is defined as a 'very strong capacity to meet financial commitments'.

Liquidity Risk

Liquidity risk is the risk that the Directorate will encounter difficulties in meeting its financial obligations as they fall due. The Directorate's only Territorial financial obligation relates to an advance received from the Territory Banking Account. The Directorate's exposure to liquidity risk is therefore insignificant.

The Directorate's exposure to liquidity risk and the management of this risk has not changed since the previous reporting period.

ACT HEALTH DIRECTORATE
NOTES TO AND FORMING PART OF THE FINANCIAL STATEMENTS
FOR THE YEAR ENDED 30 JUNE 2024

Note 31. Financial Instruments – Territorial (Continued)

	Note No.	Carrying Amount 2024 $'000	Fair Value 2024 $'000	Carrying Amount 2023 $'000	Fair Value 2023 $'000
Financial Assets					
Cash	28	272	272	561	561
Total Financial Assets		**272**	**272**	**561**	**561**
Financial Liabilities					
Advance from the Territory Banking Account	30	244	244	244	244
Payables		1	1	-	-
Total Financial Liabilities		**245**	**245**	**244**	**244**
Net Financial Assets		**27**	**27**	**317**	**317**

All financial assets and liabilities of the Directorate are non-interest-bearing and are shown on an undiscounted cash flow basis.

GST receivable is not included in financial assets due to being statutory in nature.

Carrying Amount of Each Class of Financial Liability

	2024 $'000	2023 $'000
Financial Liabilities		
Financial Liabilities Measured at Amortised Cost	1	-

ACT HEALTH DIRECTORATE
NOTES TO AND FORMING PART OF THE FINANCIAL STATEMENTS
FOR THE YEAR ENDED 30 JUNE 2024

Note 32. Budgetary Reporting - Territorial

Significant Accounting Judgements and Estimates – Budgetary Reporting – Territorial

Significant judgements have been applied in determining what variances are considered 'major variances'. Variances are considered major if both of the following criteria are met:

- The line item is a significant line item: where either the line item actual amount accounts for more than 10% of the relevant associated actual category amount (Income, Expenses, Assets, liabilities and Equity totals) or more than 10% of the sub-element (e.g. Current Liabilities and Receipts from Operating Activities totals) of the financial statements; and
- The variances (original budget to actual) are greater than plus (+) or minus (-) 10% for the financial statement line item.

Original budget refers to the amounts presented to the Legislative Assembly in the original budgeted financial statements in respect of the reporting period Budget Statements. These amounts have not been adjusted to reflect supplementary appropriation or appropriation instruments.

Note: # in the line item Variance % column represents a variance that is greater than 999 per cent or less than -999 per cent.

Statement of Income and Expenses on Behalf of the Territory Line Items	Variance Explanation	Actual 2024 $'000	Original Budget 2024 $'000	Variance $'000	Variance %
Revenue					
Fees	a	1,976	1,617	359	22
Expenses					
Grants	b	544	13,799	(13,255)	(96)
Transfer Payments to Government	c	1,960	1,617	343	21

Variance Explanations

a. Fees were higher than budget mainly due to higher revenue from food business registrations and licencing fees.

b. Grants were lower than budget due to funding relating to North Canberra Hospital being transferred to Canberra Health Services.

c. Transfer Payments to Government were higher than budget mainly due to the flow on effects of higher revenue received.

ACT HEALTH DIRECTORATE
NOTES TO AND FORMING PART OF THE FINANCIAL STATEMENTS
FOR THE YEAR ENDED 30 JUNE 2024

Note 32. Budgetary Reporting – Territorial - (Continued)

Statement of Assets and Liabilities on Behalf of the Territory Line Items	Variance Explanation	Actual 2024 $'000	Original Budget 2024 $'000	Variance $'000	Variance %
Assets					
Cash	a	272	594	(322)	(54)
Equity					
Accumulated Funds	b	27	-	27	#

Variance Explanations

a. Cash were lower than budget mainly as the funds were utilised to settle payments in 2023-24.

b. Accumulated funds were higher than budget mainly due to the flow-on effect of the operating activities.

ACT HEALTH DIRECTORATE
NOTES TO AND FORMING PART OF THE FINANCIAL STATEMENTS
FOR THE YEAR ENDED 30 JUNE 2024

Note 32. Budgetary Reporting – Territorial - (Continued)

Statement of Cash Flows on Behalf of the Territory Line Items	Variance Explanation	Actual 2024 $'000	Original Budget 2024 $'000	Variance $'000	Variance %
Receipts					
Fees	a	1,976	1,617	359	22
Payments					
Grants	b	546	13,799	(13,253)	(96)
Transfer of Territory Receipts to the ACT Government	c	1,957	1,617	340	21

Variance Explanations

a. Fees were higher than budget mainly due to higher revenue from food business registrations and licencing fees.

b. Grants were lower than budget due to funding relating to North Canberra Hospital being transferred to Canberra Health Services.

c. Transfer of Territory Receipts to the ACT Government were higher than budget mainly due to the flow on effects of higher revenue received during the year.

From: STEPHEN-SMITH
Sent: Tuesday, 24 September 2024 11:20
To: ACT Health DLO
Cc: Smith, Kahlia; Bransgrove, Meagen
Subject: FW: Resignation from ACT MBA

Importance: High

Hi Tara,

For appropriate action please.

Thank you,

Sally Cooke
Office Manager | Office of Rachel Stephen-Smith MLA
Minister for Health | Minister for Children, Youth and Family Services | Minister for Disability | Minister for Aboriginal and Torres Strait Islander Affairs
Member for Kurrajong
ACT Legislative Assembly, 196 London Circuit, Canberra ACT 2601 | P: (02) 6205 2661 | www.act.gov.au

Schedule 2.2(a)(ii)

[redacted]

From: STEPHEN-SMITH
Sent: Tuesday, 24 September 2024 11:21
To: ACT Health DLO
Cc: Bransgrove, Meagen; Smith, Kahlia
Subject: FW: ACT Local Hospital Network Directorate- SOP Limited Assurance report
Attachments: 5. Attach A4 - ACT LHN 24 Covering Letter to the Minister for Health.pdf; 3. Attach A2 ACT LHN 24 Limited Assurance Report.pdf; LHN Statement of Performance 2023-24.pdf

Importance: High

OFFICIAL

Hi Tara,

For appropriate action please.

Thank you,

Sally Cooke
Office Manager | Office of Rachel Stephen-Smith MLA
Minister for Health | Minister for Children, Youth and Family Services | Minister for Disability | Minister for Aboriginal and Torres Strait Islander Affairs
Member for Kurrajong
ACT Legislative Assembly, 196 London Circuit, Canberra ACT 2601 | P: (02) 6205 2661 | www.act.gov.au

From: Akram, Aamir
Sent: Tuesday, September 24, 2024 10:44 AM
To: STEPHEN-SMITH
Cc: Anjum, Rehan ; Mazhar, Tehmina ; Sharma, Ajay
Subject: ACT Local Hospital Network Directorate- SOP Limited Assurance report

OFFICIAL

Dear Ms Stephen-Smith,

Please find attached the cover letter and the limited assurance report for the audit of Statement of Performance of ACT Local Hospital Network Directorate for the year ended 30 June 2024.

If you have any queries, please feel free to contact us.

Kind Regards,

Aamir Akram| ACCA, B.com | Acting Senior Auditor | Financial Services
Phone: (02) 6207 0955 | Email: Aamir.akram@act.gov.au
ACT Audit Office | Auditor-General An Officer of the ACT Legislative Assembly
Nara Centre, Level 4, 3 Constitution Avenue, Canberra | PO Box 158 Canberra ACT 2601 | www.audit.act.gov.au

Communications from the ACT Audit Office may contain protected information for the purposes of Part 5A of the Auditor-General Act 1996 (ACT).

ACT Audit Office

AUDITOR-GENERAL AN OFFICER OF THE ACT LEGISLATIVE ASSEMBLY

OFFICIAL: SENSITIVE

Ms Rachel Stephen-Smith MLA
Minister for Health
ACT Legislative Assembly

stephen-smith@act.gov.au

Dear Ms Stephen-Smith

LIMITED ASSURANCE REPORT
ACT LOCAL HOSPITAL NETWORK DIRECTORATE
STATEMENT OF PERFORMANCE FOR THE YEAR ENDED 30 JUNE 2024

The ACT Audit Office has completed the limited assurance engagement on the statement of performance of the ACT Local Hospital Network Directorate for the year ended 30 June 2024.

Attached is a copy of the statement of performance and an unmodified limited assurance report.

I have provided the statement of performance and limited assurance report to the Director-General of the ACT Health Directorate, Ms Rebecca Cross.

Yours sincerely

Ajay Sharma PSM
Assistant Auditor-General, Financial Audit
24 September 2024

ACT Audit Office

AUDITOR-GENERAL AN OFFICER OF THE ACT LEGISLATIVE ASSEMBLY

INDEPENDENT LIMITED ASSURANCE REPORT

To the Members of the ACT Legislative Assembly

Conclusion

I have undertaken a limited assurance engagement on the statement of performance of the ACT Local Hospital Network Directorate (Directorate) for the year ended 30 June 2024.

Based on the procedures performed and evidence obtained, nothing has come to my attention to indicate the results of the accountability indicators reported in the statement of performance for the year ended 30 June 2024 are not in agreement with the Directorate's records or do not fairly reflect, in all material respects, the performance of the Directorate, in accordance with the *Financial Management Act 1996*.

Basis for conclusion

I have conducted the engagement in accordance with the Standard on Assurance Engagements ASAE 3000 *Assurance Engagements Other than Audits or Reviews of Historical Financial Information*. My responsibilities under the standard and legislation are described in the 'Auditor-General's responsibilities' section of this report.

I have complied with the independence and other relevant ethical requirements relating to assurance engagements, and the ACT Audit Office applies Australian Auditing Standard ASQM 1 *Quality Management for Firms that Perform Audits and Reviews of Financial Reports and Other Financial Information, Other Assurance Engagements and Related Services Engagements.*

I believe that sufficient and appropriate evidence was obtained to provide a basis for my conclusion.

The Directorate's responsibilities for the statement of performance

The Director-General of the ACT Health Directorate is responsible for:

- preparing and fairly presenting the statement of performance in accordance with the *Financial Management Act 1996* and *Financial Management (Statement of Performance Scrutiny) Guidelines 2019*; and
- determining the internal controls necessary for the preparation and fair presentation of the statement of performance so that the results of accountability indicators and accompanying information are free from material misstatements, whether due to error or fraud.

Auditor-General's responsibilities

Under the *Financial Management Act 1996* and *Financial Management (Statement of Performance Scrutiny) Guidelines 2019*, the Auditor-General is responsible for issuing a limited assurance report on the statement of performance of the Directorate.

My objective is to provide limited assurance on whether anything has come to my attention that indicates the results of the accountability indicators reported in the statement of performance are not in agreement with the Directorate's records or do not fairly reflect, in all material respects, the performance of the Directorate, in accordance with the *Financial Management Act 1996*.

In a limited assurance engagement, I perform procedures such as making inquiries with representatives of the Directorate, performing analytical review procedures and examining selected evidence supporting the results of accountability indicators. The procedures used depend on my judgement, including the assessment of the risks of material misstatement of the results reported for the accountability indicators.

Limitations on the scope

The procedures performed in a limited assurance engagement are less in extent than those required in a reasonable assurance engagement and consequently the level of assurance obtained is substantially lower than the assurance that would have been obtained had a reasonable assurance engagement been performed. Accordingly, I do not express a reasonable assurance opinion on the statement of performance.

This limited assurance engagement does not provide assurance on the:

- relevance or appropriateness of the accountability indicators reported in the statement of performance or the related performance targets;
- accuracy of explanations provided for variations between actual and targeted performance due to the often subjective nature of such explanations; or
- adequacy of controls implemented by the Directorate.



Ajay Sharma PSM
Assistant Auditor-General, Financial Audit
24 September 2024

ACT Local Hospital Network
Statement of Performance
For the Year Ended 30 June 2024

Statement of Responsibility

In my opinion, the Statement of Performance is in agreement with the ACT Local Hospital Network Directorate's records and fairly reflects the service performance of the Directorate for the period 1 July 2023 to 30 June 2024 and also fairly reflects the judgements exercised in preparing it.



Rebecca Cross
Director-General
ACT Health Directorate

23 September 2024

ACT Local Hospital Network
Statement of Performance
For the Year Ended 30 June 2024

OUTPUT CLASS 1: ACT Local Hospital Network

Output 1.1 ACT Local Hospital Network

The LHN will receive funding under the National Health Reform Agreement (NHRA) and purchase public hospital services from Canberra Health Services and Tresillian Family Care Centres.

The NHRA commits the Commonwealth to fund public hospitals using Activity Based Funding where practicable using the National Efficient Price (NEP) determined by the Independent Health and Aged Care Pricing Authority (IHACPA). The NEP is based on the projected average cost of a National Weighted Activity Unit (NWAU). The LHN also receives block funding from the Commonwealth for services not in scope to be funded on an activity basis.

An NWAU is a measure of health service activity expressed as a common unit, against which the NEP is paid. It provides a way of comparing and valuing each public hospital service (whether it is an admission, emergency department presentation or outpatient episode), by weighting it for its clinical complexity. The average hospital service is worth one NWAU, the most intensive and expensive activities are worth multiple NWAU's, while the simplest and least expensive activities are worth fractions of an NWAU. NWAU's are reviewed and updated by the Commonwealth annually.

The 2023-24 National Efficient Price is $6,032 per NWAU.

Accountability Indicators	Original Target 2023-24	Amended Target 2023-34	Actual Result 2023-24	Variance %	Notes
a) Number of elective surgeries performed	15,500		15,213	(2)	
b) Percentage of Category 1 elective surgery patients admitted for surgery within clinically recommended timeframes (30 days)	100%		72%	(28)	1
c) Percentage of Category 2 elective surgery patients admitted for surgery within clinically recommended timeframes (90 days)	80%		44%	(45)	2
d) Percentage of Category 3 elective surgery patients admitted for surgery within clinically recommended timeframes (365 days)	93%		68%	(27)	2
j) Total in scope NWAUs {23}	187,173		193,786	4	
k) Funding and performance agreements in place with all ACT Local Hospital Network non-government providers	100%		100%	-	
TOTAL COST ($'000)	1,719,139	1,768,043	1,837,142	4	
CONTROLLED RECURRENT PAYMENTS ($'000)	1,051,992	1,127,638	1,162,877	3	

The above Statement of Performance should be read in conjunction with the accompanying notes.

Amended Targets: the increase in total cost and controlled recurrent payments reflects additional funding provided through the 2nd Appropriation Act mainly associated with *Supporting sustainable ACT public health services*, *Expanded inpatient services at University of Canberra Hospital* and *Increased insurance premiums*.

ACT Local Hospital Network
Statement of Performance
For the Year Ended 30 June 2024

The above Accountability Indicators were examined by the ACT Audit Office in accordance with the *Financial Management Act 1996.* The Total Cost and Controlled Recurrent Payments measures were not examined by the ACT Audit Office as this is not required by the *Financial Management (Statement of Performance Scrutiny) Guidelines 2019.*

Output 1.1 ACT Local Hospital Network (continued)

j. Activity purchased by the ACT Local Hospital Network is consistent with the criteria in the National Health Reform Agreement. National Weighted Activity Unit (NWAU) is the 'currency' that is used to express the price weights for all services that are funded on an activity basis. NWAU {23} is the currency as defined by the Independent Hospital Pricing Authority in the National Price Determination 2023-24. NWAU {23} is not directly comparable to NWAU {22}. These measures combine the results for Canberra Hospital, University of Canberra Hospital, North Canberra Hospital and Clare Holland House for services that meets the Independent Hospital Pricing Authority's criteria for inclusion on the 'General List of In-Scope Public Hospital Services'.

k. Canberra Health Services (CHS) is excluded from this measure as the mechanism to monitor CHS funding and performance is through the CHS Budget Statements.

Explanation of Material Variances (>5%)

1. There are two major influences on the lower Category 1 timeliness: urology was greatly affected by the fire damage to multiple theatres at North Canberra Hospital (NCH) as well as the loss of important urology equipment not available elsewhere within the Territory causing a large backlog of Category 1 patients, which at one stage was over 200; and vascular surgery which, until the Critical Services Building was commissioned, only had access to a hybrid theatre at a private hospital.
2. Category 2 and 3 timeliness has suffered considerably due to the number of overdue patients increasing to over 2,000 as a result of COVID-19 disruptions, fire damage and the long period of significant theatre time loss at NCH that followed.

From: STEPHEN-SMITH
Sent: Tuesday, 24 September 2024 11:34
To: ACT Health DLO
Cc: Smith, Kahlia
Subject: FW: AIHW embargoed release updated: Pharmaceutical Benefits Scheme prescriptions over time

Importance: High

Hi Tara,

For noting please.

Thank you,

Sally Cooke
Office Manager | Office of Rachel Stephen-Smith MLA
Minister for Health | Minister for Children, Youth and Family Services | Minister for Disability | Minister for Aboriginal and Torres Strait Islander Affairs
Member for Kurrajong
ACT Legislative Assembly, 196 London Circuit, Canberra ACT 2601 | P: (02) 6205 2661 | www.act.gov.au

From: communications@aihw.gov.au
Sent: Tuesday, September 24, 2024 11:04 AM
To: STEPHEN-SMITH
Subject: AIHW embargoed release updated: Pharmaceutical Benefits Scheme prescriptions over time

Caution: This email originated from outside of the ACT Government. Do not click links or open attachments unless you recognise the sender and know the content is safe.

Dear all,

The AIHW release, ***Pharmaceutical Benefits Scheme prescriptions over time*** currently under strict embargo until public release on **Thursday, 26 September 2024, at 12:01am** **has been updated.**

About the changes

In the section **Government spending on medicines has increased**, the figures have been adjusted to provide financial year statistics which caused a change of some figures as per below:

Australian Government spending on all PBS medicines per person (the PBS expenditure rate) has increased over time. In **the financial year** 20**22**-23, this expenditure rate was an average of **$641**~~$641.52~~ per person, an increase of ~~4.9~~**13**% (or ~~$29.90~~**$72** per person) compared to 20**21**-22 and an increase of ~~16.2~~**19**% (or ~~$89.62~~**$102** per person) compared to 202~~0~~**1-21 (having adjusted for inflation)**.

In other sections, some numbers in text have been rounded (numbers between 0-10 reported to 1 decimal place, numbers between 10-100 reported to 0 decimal places; e.g 12.6 is rounded to 13).

PLEASE NOTE: no numbers have changed in the analysis. The original number is still reported in data tables and Tableau figures. This has been done to ensure this web report is consistent with AIHW writing style used in other published web reports.

About the release:

This report describes trends in the use of prescription medicines covered by the Pharmaceutical Benefits Scheme (PBS) and the Repatriation Pharmaceutical Benefits Scheme (RPBS). It provides data on the usage rates of and Australian Government spending on prescription medicines.

This report is a companion to the Australian Institute of Health and Welfare's (AIHW) release, *Pharmaceutical Benefits Scheme prescriptions: monthly data* Also scheduled for release on Thursday 26 September.

Please note: The release **will not be** accompanied by a media release.

To access the updated embargoed release please click on the link and follow the instructions below:

- AIHW Stakeholder hub (https://pp.aihw.gov.au/login)
- Your user name is your **email address**
- Please select **'Forgot your password'** link if required.

If you would like any further information, please contact communications@aihw.gov.au or (02) 6249 5089.

Kind Regards

AIHW Communications & Engagement Team

From: STEPHEN-SMITH
Sent: Tuesday, 24 September 2024 11:35
To: ACT Health DLO
Cc: Smith, Kahlia
Subject: FW: AIHW release updated: Australia's mothers and babies

Importance: High

Hi Tara,

For noting please.

Thank you,

Sally Cooke
Office Manager | Office of Rachel Stephen-Smith MLA
Minister for Health | Minister for Children, Youth and Family Services | Minister for Disability | Minister for Aboriginal and Torres Strait Islander Affairs
Member for Kurrajong
ACT Legislative Assembly, 196 London Circuit, Canberra ACT 2601 | P: (02) 6205 2661 | www.act.gov.au

---

From: communications@aihw.gov.au
Sent: Tuesday, September 24, 2024 11:00 AM
To: STEPHEN-SMITH
Subject: AIHW release updated: Australia's mothers and babies

Caution: This email originated from outside of the ACT Government. Do not click links or open attachments unless you recognise the sender and know the content is safe.

Dear all,

The AIHW release, *Australia's mothers and babies* was updated prior to it's public release today, Tuesday 24 September.

About the changes

- The new data on the 'Breastfeeding' has been removed and reverted back to the previous published version of 2020-21 data due to the identification of a data quality issue with the reported 2022 data. These data will be updated to 2022 data in a new update. Please **do not use the 2022 data** you were provided access to in the embargoed version of this release. To view revised version see: https://www.aihw.gov.au/reports/mothers-babies/australias-mothers-babies/contents/breastfeeding

- NSW's PHN and SA3 in 'Data Tables: National Perinatal Data Collection annual update 2022' have been removed from Tables 5.3 and 5.9. Please use new values if reporting any data on smoking in the first 20 weeks of pregnancy by SA3 or PHN. To view revised version see: https://www.aihw.gov.au/reports/mothers-babies/australias-mothers-babies/data

About the release:

Australia's mothers and babies describes the pregnancy and birth experiences and outcomes of mothers and babies in Australia over time.

On these web pages users can explore the characteristics and experiences of mothers and their babies through interactive data visualisations, and in-depth information and trends. The data cover the antenatal period, labour and birth, and outcomes for babies at birth. This update includes expanded trends for some topics. The data also provides information on stillbirths, neonatal and maternal deaths, including causes, maternal characteristics, timing and investigations.

The data are drawn from the National Perinatal Data Collection (NPDC), the National Maternal Mortality Data Collection (NMMDC), and the National Perinatal Mortality Data Collection (NPMDC). These data collections are coordinated by the AIHW, in collaboration with the state and territory governments, with data provided from all public and private maternity services across Australia.

Australia's mothers and babies is updated several times a year. In this update, the latest available data from the NPDC – for the 2022 calendar year – is presented. This includes preliminary 2022 data on perinatal deaths (stillbirths and neonatal deaths). In this update, the preliminary perinatal deaths data for 2022, drawn from the NPDC, have been moved from the 'Baby outcomes' chapter to the 'Stillbirths and neonatal deaths' chapter, so they are co-located with final data on perinatal deaths from the NPMDC for 2021.

Sections based on NPMDC and NMMDC data cover the 2021 calendar year; they will be updated with 2022 data once they are finalised later this year.

Please note: The release **will not be** accompanied by a media release.

To access the updated embargoed release please click on the link and follow the instructions below:

- AIHW Stakeholder hub (https://pp.aihw.gov.au/login)
- Your user name is your **email address**
- Please select **'Forgot your password'** link if required.

If you would like any further information, please contact communications@aihw.gov.au or (02) 6249 5089.

Kind Regards

AIHW Communications & Engagement Team

From: STEPHEN-SMITH
Sent: Tuesday, 24 September 2024 14:52
To: ACT Health DLO
Cc: Smith, Kahlia; Bransgrove, Meagen
Subject: FW: ACT Health Directorate- SOP limited assurance report
Attachments: Att. A.4 AHD24 Covering Letter to the Minister for Health.pdf; Att. A.2 AHD24 Limited Assurance Report.pdf; Att. B.1 AHD Statement of performance 2023-24.pdf

Importance: High

OFFICIAL

Hi Tara,

For appropriate action please.

Thank you,

Sally Cooke
Office Manager | Office of Rachel Stephen-Smith MLA
Minister for Health | Minister for Children, Youth and Family Services | Minister for Disability | Minister for Aboriginal and Torres Strait Islander Affairs
Member for Kurrajong
ACT Legislative Assembly, 196 London Circuit, Canberra ACT 2601 | P: (02) 6205 2661 | www.act.gov.au

From: Akram, Aamir
Sent: Tuesday, September 24, 2024 2:51 PM
To: STEPHEN-SMITH
Cc: Anjum, Rehan ; Sharma, Ajay ; Mazhar, Tehmina
Subject: ACT Health Directorate- SOP limited assurance report

OFFICIAL

Dear Ms Stephen-Smith,

Please find attached the cover letter and the limited assurance report for the audit of Statement of Performance of ACT Health Directorate for the year ended 30 June 2024.

If you have any queries, please feel free to contact us.

Kind Regards,

Aamir Akram| ACCA, B.com | Acting Senior Auditor | Financial Services
Phone: (02) 6207 0955 | Email: Aamir.akram@act.gov.au
ACT Audit Office | Auditor-General An Officer of the ACT Legislative Assembly
Nara Centre, Level 4, 3 Constitution Avenue, Canberra | PO Box 158 Canberra ACT 2601 | www.audit.act.gov.au

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ACT Audit Office

AUDITOR-GENERAL AN OFFICER OF THE ACT LEGISLATIVE ASSEMBLY

OFFICIAL: SENSITIVE

Ms Rachel Stephen-Smith MLA
Minister for Health
ACT Legislative Assembly

stephen-smith@act.gov.au

Dear Ms Stephen-Smith

LIMITED ASSURANCE REPORT
ACT HEALTH DIRECTORATE
STATEMENT OF PERFORMANCE FOR THE YEAR ENDED 30 JUNE 2024

The ACT Audit Office has completed the limited assurance engagement on the statement of performance of the ACT Health Directorate for the year ended 30 June 2024.

Attached is a copy of the statement of performance and an unmodified limited assurance report.

I have provided the statement of performance and limited assurance report to the Director-General of the ACT Health Directorate, Ms Rebecca Cross.

Yours sincerely



Michael Harris
Auditor-General
24 September 2024

ACT Audit Office

AUDITOR-GENERAL AN OFFICER OF THE ACT LEGISLATIVE ASSEMBLY

INDEPENDENT LIMITED ASSURANCE REPORT

To the Members of the ACT Legislative Assembly

Conclusion

I have undertaken a limited assurance engagement on the statement of performance of the ACT Health Directorate (Directorate) for the year ended 30 June 2024.

Based on the procedures performed and evidence obtained, nothing has come to my attention to indicate the results of the accountability indicators reported in the statement of performance for the year ended 30 June 2024 are not in agreement with the Directorate's records or do not fairly reflect, in all material respects, the performance of the Directorate, in accordance with the *Financial Management Act 1996*.

Basis for conclusion

I have conducted the engagement in accordance with the Standard on Assurance Engagements ASAE 3000 *Assurance Engagements Other than Audits or Reviews of Historical Financial Information*. My responsibilities under the standard and legislation are described in the 'Auditor-General's responsibilities' section of this report.

I have complied with the independence and other relevant ethical requirements relating to assurance engagements, and the ACT Audit Office applies Australian Auditing Standard ASQM 1 *Quality Management for Firms that Perform Audits and Reviews of Financial Reports and Other Financial Information, Other Assurance Engagements and Related Services Engagements.*

I believe that sufficient and appropriate evidence was obtained to provide a basis for my conclusion.

The Directorate's responsibilities for the statement of performance

The Director-General of the ACT Health Directorate is responsible for:

- preparing and fairly presenting the statement of performance in accordance with the *Financial Management Act 1996* and *Financial Management (Statement of Performance Scrutiny) Guidelines 2019*; and
- determining the internal controls necessary for the preparation and fair presentation of the statement of performance so that the results of accountability indicators and accompanying information are free from material misstatements, whether due to error or fraud.

Auditor-General's responsibilities

Under the *Financial Management Act 1996* and *Financial Management (Statement of Performance Scrutiny) Guidelines 2019*, the Auditor-General is responsible for issuing a limited assurance report on the statement of performance of the Directorate.

My objective is to provide limited assurance on whether anything has come to my attention that indicates the results of the accountability indicators reported in the statement of performance are not in agreement with the Directorate's records or do not fairly reflect, in all material respects, the performance of the Directorate, in accordance with the *Financial Management Act 1996*.

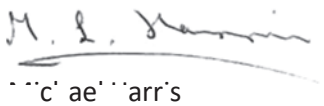
In a limited assurance engagement, I perform procedures such as making inquiries with representatives of the Directorate, performing analytical review procedures and examining selected evidence supporting the results of accountability indicators. The procedures used depend on my judgement, including the assessment of the risks of material misstatement of the results reported for the accountability indicators.

Limitations on the scope

The procedures performed in a limited assurance engagement are less in extent than those required in a reasonable assurance engagement and consequently the level of assurance obtained is substantially lower than the assurance that would have been obtained had a reasonable assurance engagement been performed. Accordingly, I do not express a reasonable assurance opinion on the statement of performance.

This limited assurance engagement does not provide assurance on the:

- relevance or appropriateness of the accountability indicators reported in the statement of performance or the related performance targets;
- accuracy of explanations provided for variations between actual and targeted performance due to the often subjective nature of such explanations; or
- adequacy of controls implemented by the Directorate.



M. L. Harris
Auditor-General
24 September 2024

ACT Health Directorate
Statement of Performance
For the Year Ended 30 June 2024

Statement of Responsibility

In my opinion, the Statement of Performance is in agreement with the ACT Health Directorate's records and fairly reflects the service performance of the Directorate for the period 1 July 2023 to 30 June 2024 and also fairly reflects the judgements exercised in preparing it.



Rebecca Cross
Director-General
ACT Health Directorate

23 September 2024

ACT Health Directorate
Statement of Performance
For the Year Ended 30 June 2024

OUTPUT CLASS 1: Public Health Services

OUTPUT 1.1: Collaborative leadership, strategic policy, programs and planning

The Directorate provides strategic leadership and direction for the health system through co-design, development, implementation and administration of policies, programs, and strategies.

This includes:

- developing strategic policy for the health system, including working with the Commonwealth and key service providers on priority health improvement initiatives;
- engaging with partners and stakeholders to develop health services plans, based on analysis of need, for sustainable health system services;
- investing in health services, workforce, and major capital investment to support health service usability and sustainability;
- driving service improvement and innovation through a collaborative policy cycle;
- providing responsive policy advice to government, reflecting the changing nature of the health sector and community need;
- supporting delivery of high-quality health services by working collaboratively with service providers and commissioned partner programs;
- conducting research programs that translate research evidence into improved healthcare;
- leading the development of strategies, policies, and programs supporting funding sustainability;
- leading the health workforce and clinical training strategy including building strong partnerships with key academic institutions and training providers; and
- commissioning and managing contracts for the provision of health services, including partnerships with community sector organisations, peak bodies, and advocacy groups.

The Directorate recognises the diversity of the ACT community and seeks to reflect that in our engagement, policies, and programs in order to ensure that what is created is inclusive, fit for purpose and culturally appropriate.

Accountability Indicators	Original Target 2023-24	Amended Target 2023-24	Actual Result 2023-24	Variance %	Notes
a. Population Health - number of planned campaigns released annually	3		3	-	
b. Number of clinical services plans released	2		1	(50)	1
c. Health system strategic documents released	3		2	(33)	2
d. Annual progress report on the implementation of the Office for Mental Health and Wellbeing Workplan published	1		1	-	
TOTAL COST ($'000)	195,239	210,047	196,733	(6)	3
CONTROLLED RECURRENT PAYMENTS ($'000)	127,481	138,996	124,638	(10)	3

The above Statement of Performance should be read in conjunction with the accompanying notes.

Amended Targets: the increase in total cost and controlled recurrent payments reflects additional funding provided through the 2nd Appropriation Act mainly associated with *Transitioning North Canberra Hospital from Calvary Health Care to Canberra Health Services*.

ACT Health Directorate
Statement of Performance
For the Year Ended 30 June 2024

The above Accountability Indicators were examined by the ACT Audit Office in accordance with the *Financial Management Act 1996.* The Total Cost and Controlled Recurrent Payments measures were not examined by the ACT Audit Office as this is not required by the *Financial Management (Statement of Performance Scrutiny) Guidelines 2019.*

Output 1.1 Collaborative leadership, strategic policy, programs and planning (continued)

Explanation of Measures

a. This indicator reports the Directorate's activity in developing communication campaigns that support continued good health in the ACT community. Campaigns to be undertaken for 2023-24 are:
    i. Winter Wellness;
    ii. Summer Safety; and
    iii. Vaping/e-cigarettes campaign.
b. This indicator reports the Directorate's health system leadership activity in identifying and addressing service demand and reform. The following clinical services plans are due to be released in the 2023-24 financial year:
    i. ACT Child and Adolescent Clinical Services Plan; and
    ii. Northside Clinical Services Plan.
c. This indicator reports the Directorate's activity in leading, developing, and implementing government health initiatives through release of strategic documents that guide and support improved health outcomes for the ACT community. The following strategic documents are due to be released in the 2023-24 financial year:
    i. ACT Disability Health Strategy;
    ii. ACT Aboriginal and Torres Strait Islander Health Workforce Action Plan; and
    iii. ACT Mental Health Workforce Strategy Action Plan.
d. The annual progress report on the implementation of the office for Mental Health and Wellbeing Workplan is completed as a standalone component of ACT Health Directorate's Annual Report.

Explanation of Material Variance (>5%)

1. The variance from original target is due to the Northside Clinical Services Plan being delayed due to priority being given to the Northside Hospital redevelopment and community centres planning. The plan is expected to be finalised in the later part of 2024.
2. The ACT Health Directorate is committed to developing the ACT Aboriginal and Torres Strait Islander Health Workforce Action Plan. Initial planning commenced in 2023, however resourcing for a senior officer to lead this work was only recently allocated and this position commenced in July 2024. It is now anticipated that the plan will be finalised in 2025. This work will involve engagement with the Aboriginal and Torres Strait Islander Community.
3. The lower actual result than revised target for both total cost and controlled recurrent payments relates to reprofiling of expenses from 2023-24 into 2024-25 mainly associated with the *Ngunnawal Bush Healing Farm Residential Service*, *Youth Mental Health and Suicide Prevention Support,* and *Strengthening mental health support for families and young children* and lower costs associated with *Transitioning North Canberra Hospital from Calvary Health Care to Canberra Health Services*.

ACT Health Directorate
Statement of Performance
For the Year Ended 30 June 2024

OUTPUT CLASS 1: Public Health Services

Output 1.2: Population health and keeping Canberrans healthy

The Directorate seeks to improve the health of the ACT population through:

- evidence-based promotion of healthy lifestyles and interventions to address the range of risk and protective factors that determine the health of our community;
- influencing the social and environmental conditions that impact on population and individual health;
- improving the health and wellbeing of the ACT population by promoting healthy behaviours and lifestyles through ongoing monitoring and evaluation of health programs and policy;
- undertaking setting based, and priority population focussed activities and initiatives to increase healthy choices and encourage healthy behaviours;
- supporting programs and activities aimed to reduce the use of harmful substances and risk-taking behaviours;
- environmental monitoring of air and water quality;
- regulation and other public health responses to ensure food is safe for human consumption;
- preventing, identifying, and providing a timely response to potential public health incidents; and
- reducing the occurrence of infectious diseases.

Accountability indicators	Original Target 2023-24	Amended Target 2023-24	Actual Result 2023-24	Variance %	Notes
a. Total number of inspections and proactive site visits of food business	2,500		2,450	(2)	
b. Percentage of children in the ACT who have been fully immunised as defined by the Australian Immunisation Register:					
i. 12 to 15 months	95%		95%	-	
ii. 24 to 27 months	95%		94%	(1)	
iii. 60 to 63 months	95%		96%	1	
c. Percentage of Aboriginal and Torres Strait Islander children in the ACT who have been fully immunised as defined by the Australian Immunisation Register for the ACT Aboriginal and Torres Strait Islander population:					
i. 12 to 15 months	95%		90%	(5)	1
ii. 24 to 27 months	95%		91%	(4)	
iii. 60 to 63 months	95%		96%	1	
TOTAL COST ($'000)	110,892	114,727	124,720	9	2
CONTROLLED RECURRENT PAYMENTS ($'000)	52,843	53,173	51,862	(2)	

The above Statement of Performance should be read in conjunction with the accompanying notes.

ACT Health Directorate
Statement of Performance
For the Year Ended 30 June 2024

Amended Targets: the increase in controlled recurrent payments reflects the transfer of funding for the *Integrated responses to hoarding and squalor* and *Research Governance Transition* programs. The increase in total cost relates mainly to Department of Veterans' Affairs funding flowing through the Health Directorate.

The above Accountability Indicators were examined by the ACT Audit Office in accordance with the *Financial Management Act 1996.* The Total Cost and Controlled Recurrent Payments measures were not examined by the ACT Audit Office as this is not required by the *Financial Management (Statement of Performance Scrutiny) Guidelines 2019.*

Output 1.2 Population health and keeping Canberrans healthy (Continued)

Explanation of Measures

a. Total number of inspections where compliance has been assessed according to the *ACT Food Act 2001* and the Food Standards code, and proactive site visits of food businesses conducted by the Health Protection Service.
b. Percentage of ACT children - 12 to 15 months, 24 to 27 months and 60 to 63 months - who have been fully immunised in accordance with the Australian Childhood Immunisation Register.
c. Percentage of ACT Aboriginal and Torres Strait Islander children - 12 to 15 months, 24 to 27 months and 60 to 63 months - who have been fully immunised in accordance with the Australian Childhood Immunisation Register.

Explanation of Material Variance (>5%)

1. The COVID-19 pandemic resulted in disruption to health infrastructure, resourcing processes and changes in health seeking behaviour, impacting routine immunisation services in many countries including Australia. The Health Protection Service has initiated activities to promote awareness and catch up of missed vaccines. This includes social awareness campaigns and communicating with immunisation providers to raise awareness and encourage steps to increase vaccination rates. The Immunisation Section has also undertaken formative research to understand attitudes and perception regarding coverage in these cohorts. It is important to note that due to the low sizes of the target population, vaccination coverage statistics in this cohort can be quite dynamic.
2. The higher actual result than revised target for total cost is mainly due to increased cross border funding flowing through the Health Directorate.

ACT Health Directorate
Statement of Performance
For the Year Ended 30 June 2024

OUTPUT CLASS 1: ACT Health Directorate

Output 1.3 Enabling a strong and safe health system

The Directorate supports an integrated health system that allows people access to appropriate treatment, care, or support in a timely manner. The Directorate collaborates with stakeholders on strategic policy and service system planning to ensure funding is targeted to provide safe, high-quality programs and services that offer seamless transition through hospital and community care as needed.

Accountability Indicators	Original Target 2023-24	Amended Target 2023-24	Actual Result 2023-24	Variance %	Notes
a. ACT health system digital services are reliable and efficient:					
i. Percentage of calls answered measures all phone calls placed to the Digital Solutions Division's Service Desk answered within 240 seconds	80%		73%	(9)	1
ii. Percentage of JIRA requests for assistance resolved within the 24-hour Service Level Agreement timeframe	80%		79%	(1)	
TOTAL COST ($'000)	181,076	242,688	226,126	(7)	2
CONTROLLED RECURRENT PAYMENTS ($'000)	115,777	176,325	168,368	(5)	2

The above Statement of Performance should be read in conjunction with the accompanying notes.

Amended Targets: the increase in total cost and controlled recurrent payments reflects additional funding provided through the 2nd Appropriation Act mainly associated with *Transitioning North Canberra Hospital from Calvary Health Care to Canberra Health Services* and the *Ongoing delivery of the Digital Health Strategy*.

The above Accountability Indicators were examined by the ACT Audit Office in accordance with the *Financial Management Act 1996.* The Total Cost and Controlled Recurrent Payments measures were not examined by the ACT Audit Office as this is not required by the *Financial Management (Statement of Performance Scrutiny) Guidelines 2019.*

Explanation of Measures

a. These indicators report the Directorate's responsiveness and effectiveness in managing digital system issues. This percentage is based on the callers' wait time in the queue and includes abandoned calls in the overall percentage. They are calculated on a monthly average.

ACT Health Directorate
Statement of Performance
For the Year Ended 30 June 2024

Explanation of Material Variance (>5%)

1. The Service Desk team have seen a 33% reduction in staffing contributed to illness and staff turnover due to receiving promotions elsewhere in the ACT Government. In addition, resources have also been diverted to support the Canberra Hospital Expansion Project with the Building 5 commissioning to support the rollout of end user devices. On top of this there was a transition to the Whole of Government Identity Access platform in late May. While there hasn't been a significant increase in call volumes, complexity of calls (and therefore call duration) has increased. In addition, the number of service desk tickets related to network account creation has increased, resulting in resources needing to be redirected from the phones to action time sensitive access requests.
2. The lower actual result than revised target for total cost and controlled recurrent payments relates mainly to initiatives being reprofiled from 2023-24 to 2024-25 mainly for the *Northside Hospital Transition, Imaging environment server infrastructure* and *Pharmacy Inventory Management System Upgrade*, as well as underspends in the *Digital Health Strategy* and the *North Canberra Hospital Transition*.

From: STEPHEN-SMITH
Sent: Tuesday, 24 September 2024 16:30
To: ACT Health DLO
Cc: Bransgrove, Meagen; Smith, Kahlia
Subject: FW: New AIHW embargo release available: Medicare Benefits Scheme funded services: monthly data

Importance: High

Hi Tara,

For noting please.

Thank you,

Sally Cooke
Office Manager | Office of Rachel Stephen-Smith MLA
Minister for Health | Minister for Children, Youth and Family Services | Minister for Disability | Minister for Aboriginal and Torres Strait Islander Affairs
Member for Kurrajong
ACT Legislative Assembly, 196 London Circuit, Canberra ACT 2601 | P: (02) 6205 2661 | www.act.gov.au

From: communications@aihw.gov.au
Sent: Tuesday, September 24, 2024 4:16 PM
To: STEPHEN-SMITH
Subject: New AIHW embargo release available: Medicare Benefits Scheme funded services: monthly data

Caution: This email originated from outside of the ACT Government. Do not click links or open attachments unless you recognise the sender and know the content is safe.

Dear all,

The latest AIHW release *Medicare Benefits Scheme funded services: monthly data* is now available **under strict embargo** until public release on **Friday 27 Sepetember at 12:01am.**

About the release:

The Australian Government subsidises the cost of health services covered by the Medicare Benefits Scheme (MBS) for all Australians since 1984. This report presents monthly data on the usage rates of these health services as well as the MBS subsidy rate (that is, the proportion of the cost of these

services funded through the MBS, as opposed to via patient contributions and other arrangements such as private health insurance).

Data in this report is updated monthly.

The release will not be accompanied by a media release.

Please click on the link and follow the instructions below:

- AIHW Stakeholder hub (https://pp.aihw.gov.au/login)
- Your user name is your email address
- Please select 'Forgot your password' link if required.

The following Ministerial Offices are receiving access to the embargoed material:

- Office of the Prime Minister
- Senator the Hon. Katy Gallagher - Minister for Finance, Minister for the Public Service, Minister for Women
- The Hon. Mark Butler MP - Minister for Health and Aged Care
- The Hon. Linda Burney MP - Minister for Indigenous Australians
- The Hon Ged Kearney MP - Assistant Minister for Indigenous Health
- The Hon. Amanda Rishworth MP - Minister for Social Services
- The Hon. Bill Shorten MP - Minister for the National Disability Insurance Scheme Minister for Government Services
- The Hon. Julie Collins MP - Minister for Housing, Minister for Homelessness, Minister for Small Business
- The Hon. Anne Aly MP - Minister for Early Childhood Education, Minister for Youth
- The Hon. Anika Wells MP - Minister for Aged Care, Minister for Sport
- The Hon. Justine Elliot MP - Assistant Minister for Social Services, Assistant Minister for the Prevention of Family Violence
- The Hon. Ged Kearney MP - Assistant Minister for Health and Aged Care

- The Hon. Emma McBride MP - Assistant Minister for Mental Health, Assistant Minister for Rural and Regional Health

The following federal departments receive access to the embargoed material:

- Department of the Prime Minister and Cabinet
- Department of Health and Aged Care
- Department of Social Services
- National Indigenous Australians Agency

The following state and territory health departments receive access to the embargoed material:

- ACT Health
- QLD Health
- NSW Ministry of Health
- NT Department of Health
- TAS Department of Health
- WA Department of Health
- SA Department of Health and Wellbeing
- VIC Department of Health and Human Services

If you would like any further information, please contact communications@aihw.gov.au or (02) 6249 5089.

Kind Regards

AIHW Communications & Engagement Team

From: Docker, Jake
Sent: Wednesday, 25 September 2024 14:57
To: ACT Health DLO
Subject: FW: FMM Decision - A1287 [SEC=OFFICIAL]

Importance: High

Hello,

FYI,

Jake

From: Davidson
Sent: Wednesday, September 25, 2024 2:09 PM
To: Docker, Jake
Subject: FW: FMM Decision - A1287 [SEC=OFFICIAL]

Hi Jake,

One for your action.

Thanks,

Maxine Harris (She/Her)
Office Manager
Office of Emma Davidson|ACT Greens Member for Murrumbidgee
Minister for Community Services, Seniors and Veterans | Minister for Mental Health
Minister for Corrections and Justice Health | Minister for Population Health
GPO Box 1020, Canberra ACT 2601
02 6205 1941
Davidson@act.gov.au

From: FoodRegulationSecretariat <FoodRegulationSecretariat@health.gov.au>
Sent: Wednesday, September 25, 2024 1:53 PM
Subject: FMM Decision - A1287 [SEC=OFFICIAL]

Caution: This email originated from outside of the ACT Government. Do not click links or open attachments unless you recognise the sender and know the content is safe.

Dear Food Ministers' Meeting (FMM) members
CC Food Regulation Standing Committee contacts

On 18 September 2024 the FMM agreed to **not seek a review** in relation to the following:

- A1287 – Food derived from short-stature corn line MON94804

Yours sincerely

Schedule 2.2(a)(ii)

A/g Director – Food Regulation and Governance

Website: www.foodregulation.gov.au | Email: secretariat@foodregulation.gov.au
Phone: +61 2 6289 5128 | Postal Address: MDP 570, GPO Box 9848, Canberra ACT 2601

"Important: This transmission is intended only for the use of the addressee and may contain confidential or legally privileged information. If you are not the intended recipient, you are notified that any use or dissemination of this communication is strictly prohibited. If you receive this transmission in error please notify the author immediately and delete all copies of this transmission."

Lowe, Shannon

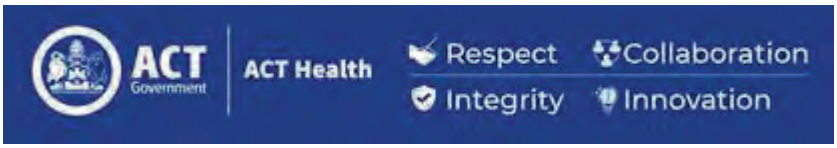
From: Gower, Tara on behalf of ACT Health DLO
Sent: Thursday, 26 September 2024 11:02 AM
To: Bransgrove, Meagen
Subject: RE: GBC24-00262

Hi Meg

Revised response back in your folder here.

Thank you
Tara

Tara Gower | Directorate Liaison Officer | ACT Health Directorate
Mob: Schedule 2.2(a)(ii) | Email: ACTHealthDLO@act.gov.au
Office of Rachel Stephen-Smith | Minister for Health
Office of Emma Davidson | Minister for Mental Health
Level 2, Legislative Assembly Building, Civic Square



From: Bransgrove, Meagen
Sent: Friday, September 20, 2024 9:49 AM
To: ACT Health DLO
Subject: GBC24-00262
Importance: High

Hi Tara,

Comment on this one – can the new table be checked that information inserted is correct and further information be inserted that should be available.

Now located here.

Thanks,

Meg Bransgrove
Senior Adviser
Office of Minister Rachel Stephen-Smith MLA
ACT Government
Email: meagen.bransgrove@act.gov.au
M: Schedule 2.2(a)(ii)
ACT Legislative Assembly, 196 London Circuit, Canberra, ACT 2600

From: STEPHEN-SMITH
Sent: Friday, 27 September 2024 11:01
To: ACT Health DLO; CHS DLO
Cc: Smith, Kahlia; Bransgrove, Meagen
Subject: FW: New AIHW embargo release available: Mental Health Services Online Report

Importance: High

For noting, please.

Kind regards,

Meg

From: communications@aihw.gov.au
Sent: Thursday, September 26, 2024 11:57 AM
To: STEPHEN-SMITH
Subject: New AIHW embargo release available: Mental Health Services Online Report

Caution: This email originated from outside of the ACT Government. Do not click links or open attachments unless you recognise the sender and know the content is safe.

Dear all,

The latest AIHW release ***Mental Health Services Online Report*** is now available **under strict embargo** until its public release on **Thursday 10 October 2024 at 12:01am.**

About the release:

The Mental Health Services Online Report has been updated with new data.

This release updates the following sections:

- Community mental health care (CMHC) 2022-23 national data
- Residential mental health care (RMHC) 2022-23 national data
- Admitted patient care (APC) 2022-23 national data
- Service activity monitoring – June 2024 data
- Income and employment support – new section
- Involuntary treatment – partial update with CMHC & RMHC data
- Australia's mental health system

Please note state and territory data for CMHC, RMHC & APC will be available on the website in December 2024.

The release will not be accompanied by a media release.

Please click on the link and follow the instructions below:

- AIHW Stakeholder hub (https://pp.aihw.gov.au/login)
- Your user name is your email address
- Please select 'Forgot your password' link if required.

The following Ministerial Offices are receiving access to the embargoed material:

- Office of the Prime Minister
- Senator the Hon. Katy Gallagher - Minister for Finance, Minister for the Public Service, Minister for Women
- The Hon. Mark Butler MP - Minister for Health and Aged Care
- Senator the Hon Malarndirri McCarthy - Minister for Indigenous Australians
- The Hon Ged Kearney MP - Assistant Minister for Indigenous Health
- The Hon. Amanda Rishworth MP - Minister for Social Services
- The Hon. Bill Shorten MP - Minister for the National Disability Insurance Scheme Minister for Government Services
- The Hon. Julie Collins MP - Minister for Housing, Minister for Homelessness, Minister for Small Business
- The Hon. Anne Aly MP - Minister for Early Childhood Education, Minister for Youth
- The Hon. Anika Wells MP - Minister for Aged Care, Minister for Sport
- The Hon. Justine Elliot MP - Assistant Minister for Social Services, Assistant Minister for the Prevention of Family Violence
- The Hon. Ged Kearney MP - Assistant Minister for Health and Aged Care
- The Hon. Emma McBride MP - Assistant Minister for Mental Health, Assistant Minister for Rural and Regional Health

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- NT Department of Health
- TAS Department of Health
- WA Department of Health
- SA Department of Health and Wellbeing
- VIC Department of Health and Human Services

If you would like any further information, please contact communications@aihw.gov.au or (02) 6249 5089.

Kind Regards

AIHW Communications & Engagement Team

From: STEPHEN-SMITH
Sent: Monday, 30 September 2024 2:23 PM
To: ACT Health DLO
Cc: Elliffe, Martin; Smith, Kahlia
Subject: FW: New AIHW embargo releases available: National Core Maternity Indicators and Eye health measures for Aboriginal and Torres Strait Islander people 2024

Importance: High

Hi Tara,

For noting please.

Thank you,

Sally Cooke
Office Manager | Office of Rachel Stephen-Smith MLA
Minister for Health | Minister for Children, Youth and Family Services | Minister for Disability | Minister for Aboriginal and Torres Strait Islander Affairs
Member for Kurrajong
ACT Legislative Assembly, 196 London Circuit, Canberra ACT 2601 | P: (02) 6205 2661 | www.act.gov.au

From: communications@aihw.gov.au
Sent: Monday, 30 September 2024 2:09 PM
To: STEPHEN-SMITH
Subject: New AIHW embargo releases available: National Core Maternity Indicators and Eye health measures for Aboriginal and Torres Strait Islander people 2024

Caution: This email originated from outside of the ACT Government. Do not click links or open attachments unless you recognise the sender and know the content is safe.

Dear all,

There are 2 new embargoed AIHW releases available **under strict embargo** to view:

- **Eye health measures for Aboriginal and Torres Strait Islander people 2024** will be published **Thursday, 10 October 2024, at 12:01am**.
- **National Core Maternity Indicators – update** will be published **Tuesday, 15 October 2024, at 12:01am**.

About the releases:

The National Core Maternity Indicators (NCMIs) present information on measures of clinical activity and outcomes. The purpose of the NCMIs is to assist in improving the quality of maternity services in Australia by establishing baseline data for monitoring and evaluating practice change. These indicators cover data for the majority of women who gave birth in Australia from 2004 to 2022 and are grouped into 3 broad topic areas – antenatal period, labour and birth, and birth outcomes.

Please note: The release **will not be** accompanied by a media release.

Eye health measures for Aboriginal and Torres Strait Islander people 2024: Eye diseases and vision problems are the most common long-term health conditions reported by Aboriginal and Torres Strait Islander (First Nations) people. This is the eighth annual report to update the Eye health measures for Aboriginal and Torres Strait Islander people. The measures cover the prevalence of eye health conditions, diagnosis and treatment services, the eye health workforce and outreach services. The report provides an evidence base for monitoring changes in eye health amongst First Nations people over time, their access and use of eye health services, and for identifying gaps in service delivery. This report includes the latest available data against each measure where possible.

Please note: The release **will be** accompanied by a media release. This will be made available to you in the AIHW stakeholder hub at least 48 hours prior to public release.

Please click on the link and follow the instructions below:

- AIHW Stakeholder hub (https://pp.aihw.gov.au/login)
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- Please select '**Forgot your password**' link if required.

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- Senator the Hon. Malarndirri McCarthy- Minister for Indigenous Australians
- The Hon. Ged Kearney MP - Assistant Minister for Indigenous Health
- The Hon. Amanda Rishworth MP - Minister for Social Services
- The Hon. Bill Shorten MP - Minister for the National Disability Insurance Scheme Minister for Government Services
- The Hon. Julie Collins MP - Minister for Housing, Minister for Homelessness, Minister for Small Business
- The Hon. Anne Aly MP - Minister for Early Childhood Education, Minister for Youth
- The Hon. Anika Wells MP - Minister for Aged Care, Minister for Sport
- The Hon. Justine Elliot MP - Assistant Minister for Social Services, Assistant Minister for the Prevention of Family Violence
- The Hon. Ged Kearney MP - Assistant Minister for Health and Aged Care
- The Hon. Emma McBride MP - Assistant Minister for Mental Health, Assistant Minister for Rural and Regional Health

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- QLD Health
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- NT Department of Health
- TAS Department of Health
- WA Department of Health
- SA Department of Health and Wellbeing
- VIC Department of Health and Human Services

If you would like any further information, please contact communications@aihw.gov.au or (02) 6249 5089.

Kind Regards,

Communications & Engagement Unit

Australian Institute of Health and Welfare

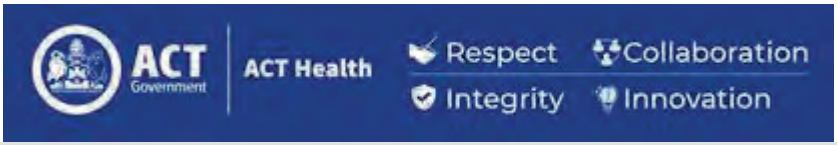
Communications@aihw.gov.au | @aihw | aihw |



From: Gower, Tara on behalf of ACT Health DLO
Sent: Monday, 30 September 2024 3:17 PM
To: Davidson
Subject: RE: Checking for corro - Transplant Australia

Thanks Maxine 😊
Thank you
Tara

Tara Gower | Directorate Liaison Officer | ACT Health Directorate
Mob: Schedule 2.2(a)(ii) | Email: ACTHealthDLO@act.gov.au
Office of Rachel Stephen-Smith | Minister for Health
Office of Emma Davidson | Minister for Mental Health
Level 2, Legislative Assembly Building, Civic Square



From: Davidson
Sent: Monday, September 30, 2024 3:08 PM
To: ACT Health DLO
Subject: RE: Checking for corro - Transplant Australia
Importance: High

OFFICIAL

Good Morning Tara,
I couldn't find anything from Transplant Australia post the Transplant Games requests.
I'm fairly confident we haven't received anything here.
Thanks,

Maxine Harris (She/Her)
Office Manager
Office of Emma Davidson|ACT Greens Member for Murrumbidgee
Minister for Community Services, Seniors and Veterans | Minister for Mental Health
Minister for Corrections and Justice Health | Minister for Population Health
✉ GPO Box 1020, Canberra ACT 2601
☏ 02 6205 1941
💻 Davidson@act.gov.au

From: Gower, Tara <Tara.Gower@act.gov.au> **On Behalf Of** ACT Health DLO
Sent: Monday, 30 September 2024 9:26 AM
To: Davidson <DAVIDSON@act.gov.au>
Subject: Checking for corro - Transplant Australia
Importance: High

OFFICIAL

Hi Maxine
I've been asked by the Pop Health Division to confirm whether the MO has received any correspondence regarding funding requests from Transplant Australia recently (last few weeks, anything post the Transplant Games requests).
The specific request they received from the commonwealth is: *"The Commonwealth and South Australia have received separate funding proposals from Transplant Australia (TA). The Commonwealth are seeking information from other S&TS on whether other jurisdiction has also received a proposal from TA?*
*We'd appreciate your advice by **COB 30 September 2024."***
Grateful for your advice.
Thank you
Tara

Tara Gower | Directorate Liaison Officer | ACT Health Directorate
Mob: Schedule 2.2(a)(ii) | Email: ACTHealthDLO@act.gov.au
Office of Rachel Stephen-Smith | Minister for Health
Office of Emma Davidson | Minister for Mental Health
Level 2, Legislative Assembly Building, Civic Square



From: Ord, Jon
Sent: Monday, 30 September 2024 15:33
To: ACT Health DLO
Cc: CHS DLO; CSDDLO; MPESDLO
Subject: RE: Removal of Cabinet Documents ahead of Election

Importance: High

Follow Up Flag: Follow up
Flag Status: Completed

OFFICIAL

Hi – happy for you to go through all folders and remove whatever you need to.

Thank you.
Jon

From: Gower, Tara **On Behalf Of** ACT Health DLO
Sent: Thursday, 26 September 2024 12:39 PM
To: Ord, Jon
Cc: CHS DLO ; CSDDLO ; MPESDLO ; ACT Health DLO
Subject: Removal of Cabinet Documents ahead of Election

OFFICIAL

Hi Jon

Ahead of the election, we are aware that MOs have been notified that all cabinet documents need to be removed from Minister's drives.

Please note we DLOs intend on removing all cabinet documents from the drive on **Friday, 18 October 2024.**

We understand the MO may need to refer to documents over the coming weeks so please let us know if you have any issues with this deadline.

Please note cabinet documents also include CNRs, ARFs and business cases. Please let us know if you would like DLOs to remove these also or would the MO prefer to remove these particular files?

Please also note any cabinet documents in MOs 'to keep' folders also need to be removed. Please let us know again if you need us to help identify these records in your personal folders.

Thank you
Tara

Tara Gower | Directorate Liaison Officer | ACT Health Directorate
Mob: Schedule 2.2(a)(ii) | Email: ACTHealthDLO@act.gov.au
Office of Rachel Stephen-Smith | Minister for Health
Office of Emma Davidson | Minister for Mental Health
Level 2, Legislative Assembly Building, Civic Square


ACT
Government
ACT Health
Respect
Collaboration
Integrity
Innovation

From: STEPHEN-SMITH
Sent: Tuesday, 1 October 2024 08:27
To: ACT Health DLO
Cc: Bransgrove, Meagen
Subject: FW: Correspondence from CPMC on SIMG pathways
Attachments: 20240930_SIMG_Letter_RSS.pdf

Importance: High

For appropriate action.

B

From: CPMC EA
Sent: Monday, 30 September 2024 3:31 PM
To: STEPHEN-SMITH ; Schedule 2.2(a)(ii) [redacted]
Cc: CPMC CEO ; Sanjay Jeganathan, CPMC Chair
Subject: Correspondence from CPMC on SIMG pathways

You don't often get email from ea@cpmc.edu.au. Learn why this is important

Caution: This email originated from outside of the ACT Government. Do not click links or open attachments unless you recognise the sender and know the content is safe.

Dear Health Ministers

Please find attached a letter from A/Prof Jeganathan on behalf of CPMC, regarding SIMG pathways.

Kind Regards,

Georgina

Georgina Ellershaw
Executive Assistant
Council of Presidents of Medical Colleges
15 Gracie St, North Melbourne VIC 3051
ea@cpmc.edu.au / www.cpmc.edu.au
P: 1300 603 157

CPMC Council of Presidents of Medical Colleges

CPMC Council of Presidents of Medical Colleges

15 Gracie Street
NORTH MELBOURNE VIC 3051
E-mail: ceo@cpmc.edu.au
ACN: 46 101 213 478

30 September 2024

Hon. Rachel Stephen-Smith
ACT Minister for Health
Chair, Health Ministers Meeting
GPO Box 825
Canberra ACT 2601

Via email: Stephen-smith@act.gov.au

Dear Minister Stephen-Smith,

Re: Urgent Call to Halt Implementation of AHPRA's Expedited SIMG Pathways Due to Failure to Address Critical Rural, Regional and Urban Specialty Shortages

I write to you in your capacity as Chair of the Health Minister's Meeting to express our grave concerns about the proposed implementation of expedited pathways for Specialist International Medical Graduates (SIMGs) by the Australian Health Practitioner Regulation Agency (AHPRA).

We are calling for a pause to the implementation of these pathways. While we acknowledge the pressing need to address workforce challenges in our healthcare system, the current AHPRA proposal for expedited SIMG pathways is a broad-brush solution that fails to target the heart of our healthcare crisis – the severe shortages of specialists and GPs in the bush and many critical specialities across all parts of Australia including metro areas.

We have raised these concerns with AHPRA and the Medical Board of Australia (MBA) multiple times, but they have not been addressed.

We remain committed to working with AHPRA and the MBA to address specialist and GP workforce shortages but with appropriate patient safety measures in place.

Our key concerns are:

1. Failure to Address Unique Challenges: The proposal does not include specific mechanisms to direct SIMGs to areas of greatest need, particularly in rural and remote locations. The MBA has told us that addressing these challenges is not their role or responsibility.
2. Lack of Crucial Information: AHPRA and the MBA have not provided any details about implementing these pathways, including information on qualification criteria, assessment processes, supervision arrangements, and monitoring processes. A fundamental change to regulatory settings would require a detailed plan to be made available for proper scrutiny before implementation.

3. Risk of Exacerbating Shortages: There is potential for exacerbation of shortages in crucial specialities, as SIMGs may not fill these specific gaps.
4. Absence of Retention Strategies: The proposal lacks long-term retention strategies for underserved rural communities and high-need specialisations. Again, the MBA has told us that addressing these challenges is not their role or responsibility.
5. The risk to Domestic Training: The two-tier specialist registration pathway implicit in this proposal threatens the system's ability to provide training for domestic trainees. The implementation of an equivalent system in New Zealand has created a situation where in ten (10) specialities, hospitals are not able to train local graduates as the overseas trained doctors who staff them, do not have links to the specialist colleges.

We respectfully request:

1. An immediate pause to the implementation of the expedited SIMG pathways as currently proposed.
2. Changes to the pathways, emphasising:
    a. Integration of the accelerated SIMG assessment program undertaken by the Specialist colleges since the release of the Kruk Report.
    b. Robust incentives and support systems for SIMGs to practice in areas of critical shortage, both geographically and by speciality.
    c. Integration with broader strategies to address specific workforce gaps in rural areas and critical medical fields.
    d. Specialty-specific approaches that consider the unique challenges of rural practice and understaffed specialisations.
3. Full disclosure of AHPRA and the MBA's plans for implementation, including details on qualification criteria, assessment processes, supervision arrangements, monitoring processes, and management of unsuitable candidates.
4. Enhancing consultation with medical colleges, rural health stakeholders, and speciality bodies to ensure proposed solutions meet on-the-ground needs.
5. Developing a comprehensive strategy that increases overall numbers but ensures every Australian, whether in the heart of a major city or the remotest parts of the Outback, has access to the specialist care they need across all crucial medical fields.
6. Implementing a robust monitoring and evaluation system to assess the impact of these pathways on workforce distribution and patient care.

We emphasise that simply fast-tracking the entry of international medical graduates without addressing the fundamental shortages in specific areas and specialities will not solve our workforce crisis. The latest MBA report reveals a significant influx of international medical talent without these new policies: a 27% (1,205) increase in Specialist International Medical Graduates and 5,500 new doctors in total in the past year alone, all within the existing system.[1] This will only exacerbate the current problems. We need a targeted approach that not only attracts skilled professionals but also ensures they fill the most critical gaps in our healthcare system.

Colleges exist to teach, train, and maintain excellence in specialist care. We are working to increase access and equity in the delivery of care and are committed to continuing to do so. The CPMC is committed to working collaboratively with AHPRA, the MBA, rural health organisations, and speciality bodies to develop a more effective strategy that addresses specific shortages. In the interim, medical colleges will continue to expedite SIMG assessments while emphasising the need for targeted placements in areas of greatest need.

[1] Medical Board of Australia, "Report on Specialist Medical Colleges Specialist Pathway Data," 2023.

We look forward to engaging in constructive dialogue to develop solutions that address the core challenges of our medical workforce, particularly in regional and underserved areas and across all critical specialities.

Yours sincerely

Schedule 2.2(a)(ii)

A/Prof Sanjay Jeganathan
Chair
Council of Presidents of Medical Colleges

cc: Hon. Mark Butler, Federal Minister for Health, Susan O'Dwyer, Anne Tonkin, Martin Fletcher, National Health Secretariat, State and Territory Chief Medical Officers

From: STEPHEN-SMITH
Sent: Tuesday, 1 October 2024 9:41 AM
To: ACT Health DLO
Cc: Smith, Kahlia
Subject: FW: Letter to Treasurer ~ NHRA Commonwealth Payments into the National Health Funding Pool for October 2024 [SEC=OFFICIAL]
Attachments: ACT - Letter to Ministers - October Payment Advice.pdf; Letter to Treasurer~ NHRA Commonwealth Payments into the National Health Funding Pool for October 2024.pdf

Importance: High

FYI

From: nhfa Administrator
Sent: Tuesday, 24 September 2024 3:51 PM
To: STEPHEN-SMITH
Cc: DGACTHealth ; Ganeshalingam, Muku ; WHITE, Shannon ; CUNNINGHAM, Toni ; IMBRIANO, Beci ; NICHOLLS, Ben
Subject: Letter to Treasurer ~ NHRA Commonwealth Payments into the National Health Funding Pool for October 2024 [SEC=OFFICIAL]

Caution: This email originated from outside of the ACT Government. Do not click links or open attachments unless you recognise the sender and know the content is safe.

Good afternoon,

I am writing to provide you with a copy of the advice given to the Commonwealth Treasurer on Monday, 23 September 2024.

Kind Regards,
Sarah Bell on behalf of

Toni Cunningham
Administrator of the National Health Funding Pool
Improving the transparency of public hospital funding in Australia

T Schedule 2.2(a)(ii) W: publichospitalfunding.gov.au
GPO Box 1252 Canberra City ACT 2601

The Administrator and the National Health Funding Body acknowledges the traditional owners of country throughout Australia, and their continuing connection to land, water and community. We pay our respects to them and their cultures and to elders both past and present.

"Important: This transmission is intended only for the use of the addressee and may contain confidential or legally privileged information. If you are not the intended recipient, you are notified that any use or dissemination of this communication is strictly prohibited. If you receive this transmission in error please notify the author immediately and delete all copies of this transmission."

Administrator
National Health
Funding Pool

GPO Box 1252,
Canberra ACT 2601
1300 930 522
publichospitalfunding.gov.au

Ms Rachel Stephen-Smith MLA
Minister for Health
GPO Box 1020
CANBERRA ACT 2601
stephen-smith@act.gov.au

24 September 2024

Dear Minister,

Commonwealth Payments into the National Health Funding Pool for 2024-25 – October 2024 Payment Advice

In accordance with section 245(3) of the National Health Reform Act 2011, I am writing to you with a copy of the advice I provided to the Commonwealth Treasurer on 23 September 2024.

The advice details the 2024-25 amounts to be paid by the Commonwealth into the National Health Funding Pool.

If you wish to discuss any aspect of the payment calculations please contact me on Schedule 2.2(a)(ii) or at nhfa.administrator@nhfa.gov.au, or alternatively Mr Shannon White, Chief Executive Officer, National Health Funding Body on (02) 6289 7249 or at shannon.white@nhfb.gov.au.

Yours sincerely,

Schedule 2.2(a)(ii)

Toni Cunningham
Administrator
National Health Funding Pool

Administrator
National Health
Funding Pool

Office of the Administrator
GPO Box 1252, Canberra ACT 2601
nhfa.administrator@nhfa.gov.au

The Hon Ryan Park
Treasurer
PO Box 6022
Parliament House
Canberra ACT 2600
department@treasury.gov.au

23 September 2024

Dear Treasurer,

Commonwealth National Health Reform (NHR) Payments into the National Health Funding Pool for 2024-25 – October 2024 Payment Advice

In accordance with section 238(1)(a) of the *National Health Reform Act 2011* (the Act), I am writing to advise you of the 2024-25 amounts to be paid by the Commonwealth into the National Health Funding Pool (the Pool) for each State and Territory. The payment advice details the total annual and monthly allocation for each State and Territory, by funding stream and Local Hospital Network (LHN).

This advice supersedes the July 2024 Payment Advice and incorporates the following updates:

- Revised 2024-25 activity estimates for New South Wales and South Australia to align with their service agreements.

The Commonwealth's contribution to the Pool for the 2024-25 period is **$30.154 billion**, reflecting a net decrease of **-$7 million** compared to the July 2024 Payment Advice. A detailed summary of the estimated Commonwealth National Health Reform (NHR) funding for 2024-25 by State and Territory, along with the variance from the July 2024 Payment Advice entitlement, is provided in Attachment A.

My complete payment advice (see Attachment B) consists of the following information:

- **Summary of Commonwealth Payments into the Pool 2024-25 as at October 2024**. This summary provides the total annual State and Territory funding entitlement by funding stream and service category, including the impact of the National Funding Cap.
- **Monthly cash flow of Commonwealth Payments into the Pool in 2024-25 by LHN**. Table A in the attachment specifies the amounts to be paid into the Pool by the Commonwealth Treasury, including the payments to be made on Tuesday, 08 October 2024.

In accordance with section 245(3) of the Act, I will be providing a copy of this advice to all Health Ministers.

If you wish to discuss any aspect of the payment, please contact me on Schedule 2.2(a)(ii) or at nhfa.administrator@nhfa.gov.au, or alternatively Mr Shannon White, Chief Executive Officer, National Health Funding Body on (02) 6289 7249 or at shannon.white@nhfb.gov.au.

Yours sincerely,

Schedule 2.2(a)(ii)

Toni Cunningham
Administrator
National Health Funding Pool

Attachment A: 2024-25 Commonwealth NHR payments for each State and Territory

Attachment B: October 2024 Payment Advice

Attachment A

2024-25 Commonwealth NHR payments for each State and Territory

State	2024-25 Payments July	2024-25 Payments October	Variance ($)
New South Wales	$8,888,553,622.54	$8,881,981,864.06	-$6,571,758.48
Victoria	$7,290,833,378.68	$7,290,833,378.68	-
Queensland	$7,070,154,486.06	$7,070,154,486.06	-
Western Australia	$3,238,387,221.49	$3,238,387,221.49	-
South Australia	$2,045,085,485.65	$2,045,085,485.65	-
Tasmania	$658,010,878.58	$658,010,878.58	-
Australian Capital Territory	$543,944,000.22	$543,944,000.22	-
Northern Territory	$425,742,643.93	$425,742,643.93	-
NATIONAL TOTAL	**$30,160,711,717.15**	**$30,154,139,958.67**	**-$6,571,758.48**

Attachment B

October 2024 Payment Advice

Summary of Commonwealth Payments into the National Health Funding Pool as at October 2024

Table 1 - Uncapped Calculations	NSW	VIC	QLD	WA	SA	TAS	ACT	NT	Total
Emergency Department	$1,040,471,694.47	$760,452,252.65	$996,333,065.56	$398,894,982.84	$211,940,088.18	$68,341,028.88	$54,187,773.17	$68,851,290.22	$3,599,472,175.97
Acute Admitted	$4,326,167,540.93	$4,067,687,976.85	$3,747,005,855.96	$1,643,688,422.98	$1,051,386,012.28	$375,899,497.03	$289,983,144.70	$257,150,412.81	$15,758,968,863.54
Admitted Mental Health	$412,418,009.60	$283,196,067.63	$326,698,885.36	$189,457,442.24	$97,357,629.08	$19,561,213.16	$27,471,012.51	$13,010,478.50	$1,369,170,738.08
Sub-acute	$446,755,753.72	$451,001,679.06	$440,193,473.42	$129,414,095.19	$152,177,395.94	$26,869,143.97	$42,365,745.82	$25,131,989.36	$1,713,909,276.48
Non-admitted	$1,359,553,653.34	$674,099,026.38	$1,029,970,469.65	$434,850,532.29	$273,806,929.25	$65,065,871.24	$83,554,858.77	$51,737,064.19	$3,972,638,405.11
Total Activity Based Funding (Uncapped)	$7,585,366,652.06	$6,236,437,002.57	$6,540,201,749.95	$2,796,305,475.54	$1,786,668,054.73	$555,736,754.28	$497,562,534.97	$415,881,235.08	$26,414,159,459.18
Teaching Training and Research	$303,917,429.15	$176,380,232.51	$129,846,090.45	$137,261,509.25	$44,042,031.67	$19,599,860.89	$11,316,303.05	$14,446,096.56	$836,809,553.53
Small Rural Hospitals	$339,869,754.30	$117,201,483.35	$276,736,417.61	$138,671,976.74	$102,593,823.86	$32,049,846.40	$1,576,871.71	$0.00	$1,008,700,173.97
Other Mental Health	$438,050,440.20	$572,165,149.25	$340,303,644.64	$180,782,294.39	$73,978,862.75	$56,295,820.91	$24,463,862.21	$10,863,328.60	$1,696,903,402.95
Non-admitted Home Ventilation	$10,912,072.50	$5,449,708.80	$6,453,041.40	$7,014,537.90	$1,242,467.55	$2,445,555.60	$710,952.30	$44,261.91	$34,272,597.96
Other Non-admitted Services	$0.00	$10,666.35	$3,950,773.65	$0.00	$8,494,962.25	$0.00	$0.00	$0.00	$12,456,402.25
Other Public Hospital Programs	$1,866,924.90	$14,704,650.00	$3,342,150.00	$0.00	$10,866,600.00	$0.00	$0.00	$0.00	$30,780,324.90
Highly Specialised Therapies	$29,477,850.95	$48,056,867.50	$13,104,713.51	$4,400,000.00	$0.00	$0.00	$0.00	$0.00	$95,039,431.96
Total Block Funding	$1,124,094,472.00	$933,968,757.76	$773,736,831.26	$468,130,318.28	$241,218,748.08	$110,391,083.80	$38,067,989.27	$25,353,687.07	$3,714,961,887.52
Public Health Funding	$172,520,740.00	$142,357,659.00	$113,176,906.00	$59,723,307.00	$38,139,673.00	$11,730,124.00	$9,698,848.00	$5,184,635.00	$552,531,892.00
NHR Funding (Uncapped)	$8,881,981,864.06	$7,312,763,419.33	$7,427,115,487.21	$3,324,159,100.82	$2,066,026,475.81	$677,857,962.08	$545,329,372.24	$446,419,557.15	$30,681,653,238.70

Table 2 - Soft Cap Calculations (State-based Soft Cap)	NSW	VIC	QLD	WA	SA	TAS	ACT	NT	Total
2023-24 Funding Entitlement	$8,346,059,739.47	$6,845,852,937.73	$6,638,642,709.92	$3,040,739,175.11	$1,920,268,061.64	$617,850,590.22	$510,745,540.11	$399,758,351.11	$28,319,917,105.31
2024-25 Funding Entitlement (Uncapped)	$8,881,981,864.06	$7,312,763,419.33	$7,427,115,487.21	$3,324,159,100.82	$2,066,026,475.81	$677,857,962.08	$545,329,372.24	$446,419,557.15	$30,681,653,238.70
State Growth (Percent)	6.42%	6.82%	11.88%	9.32%	7.59%	9.71%	6.77%	11.67%	8.34%
Soft Cap (Dollar)	$8,888,553,622.54	$7,290,833,378.68	$7,070,154,486.06	$3,238,387,221.49	$2,045,085,485.65	$658,010,878.58	$543,944,000.22	$425,742,643.93	$30,160,711,717.15
Soft Cap (Percent)	6.50%	6.50%	6.50%	6.50%	6.50%	6.50%	6.50%	6.50%	6.50%
Emergency Department	$1,040,471,694.47	$757,778,169.87	$941,953,695.91	$386,659,562.70	$209,456,003.19	$65,900,358.73	$54,036,897.21	$65,428,120.25	$3,521,684,502.33
Acute Admitted	$4,326,167,540.93	$4,053,384,206.50	$3,542,496,115.62	$1,593,271,096.87	$1,039,063,038.19	$362,474,959.88	$289,175,739.59	$244,365,328.22	$15,450,398,025.80
Admitted Mental Health	$412,418,009.60	$282,200,226.37	$308,867,820.56	$183,646,159.81	$96,216,530.07	$18,862,621.56	$27,394,524.49	$12,363,619.46	$1,341,969,511.92
Sub-acute	$446,755,753.72	$449,415,759.86	$416,167,929.72	$125,444,539.56	$150,393,771.20	$25,909,563.49	$42,247,786.14	$23,882,469.26	$1,680,217,572.95
Non-admitted	$1,359,553,653.34	$671,728,599.32	$973,755,186.99	$421,512,237.27	$270,597,721.92	$62,742,167.12	$83,322,215.52	$49,164,784.67	$3,892,376,566.15
Total Activity Based Funding (Soft Cap)	$7,585,366,652.06	$6,214,506,961.92	$6,183,240,748.80	$2,710,533,596.21	$1,765,727,064.57	$535,889,670.78	$496,177,162.95	$395,204,321.86	$25,886,646,179.15
Payment in respect of 2024-25	$8,881,981,864.06	$7,290,833,378.68	$7,070,154,486.06	$3,238,387,221.49	$2,045,085,485.65	$658,010,878.58	$543,944,000.22	$425,742,643.93	$30,154,139,958.67

Table 3 - National Funding Cap Calculations	NSW	VIC	QLD	WA	SA	TAS	ACT	NT	Total
Amount over the National Funding Cap	$0.00	$21,930,040.65	$356,961,001.15	$85,771,879.33	$20,940,990.16	$19,847,083.50	$1,385,372.02	$20,676,913.22	$527,513,280.03
Amount under the National Funding Cap	$6,571,758.48	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$6,571,758.48
Redistribution Funding Pool (Percent)	1.25%	1.25%	1.25%	1.25%	1.25%	1.25%	1.25%	1.25%	1.25%
Redistribution Funding Payable (Dollar)	$0.00	$273,204.36	$4,447,018.82	$1,068,545.75	$260,882.78	$247,254.89	$17,258.96	$257,592.92	$6,571,758.48
Adjustment for the National Funding Cap	$0.00	$21,656,836.29	$352,513,982.33	$84,703,333.58	$20,680,107.38	$19,599,828.61	$1,368,113.06	$20,419,320.30	$520,941,521.55
Emergency Department	$1,040,471,694.47	$757,811,483.58	$942,631,153.89	$386,811,991.52	$209,486,949.91	$65,930,764.59	$54,038,776.82	$65,470,766.10	$3,522,653,580.88
Acute Admitted	$4,326,167,540.93	$4,053,562,402.82	$3,545,043,897.20	$1,593,899,195.73	$1,039,216,557.76	$362,642,202.71	$289,185,798.24	$244,524,604.76	$15,454,242,200.15
Admitted Mental Health	$412,418,009.60	$282,212,632.56	$309,089,959.90	$183,718,556.75	$96,230,745.88	$18,871,324.61	$27,395,477.38	$12,371,678.03	$1,342,308,384.71
Sub-acute	$446,755,753.72	$449,435,517.24	$416,467,239.85	$125,493,992.26	$150,415,991.59	$25,921,517.94	$42,249,255.68	$23,898,035.78	$1,680,637,304.06
Non-admitted	$1,359,553,653.34	$671,758,130.08	$974,455,516.78	$421,678,405.70	$270,637,702.21	$62,771,115.82	$83,325,113.79	$49,196,830.11	$3,893,376,467.83
Total Activity Based Funding (National Funding Cap	$7,585,366,652.06	$6,214,780,166.28	$6,187,687,767.62	$2,711,602,141.96	$1,765,987,947.35	$536,136,925.67	$496,194,421.91	$395,461,914.78	$25,893,217,937.63
NHR Funding after National Cap	$8,881,981,864.06	$7,291,106,583.04	$7,074,601,504.88	$3,239,455,767.24	$2,045,346,368.43	$658,258,133.47	$543,961,259.18	$426,000,236.85	$30,160,711,717.15

Table 4 - Payments in respect of prior year services	NSW	VIC	QLD	WA	SA	TAS	ACT	NT	Total
Payment in respect of 2023-24	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00

Table 5 - Total payments in respect of services	NSW	VIC	QLD	WA	SA	TAS	ACT	NT	Total
TOTAL PAYABLE IN 2024-25	$8,881,981,864.06	$7,290,833,378.68	$7,070,154,486.06	$3,238,387,221.49	$2,045,085,485.65	$658,010,878.58	$543,944,000.22	$425,742,643.93	$30,154,139,958.67

Additional information as at October 2024

Table 6 - 2024-25 NWAUs (NWAU24)	NSW	VIC	QLD	WA	SA	TAS	ACT	NT	Total
Emergency Department	422,484.91	299,784.00	383,386.53	154,368.75	87,127.00	26,333.65	23,349.00	32,297.00	1,429,130.83
Acute Admitted	1,756,646.07	1,603,556.00	1,441,838.69	636,092.54	432,217.00	144,844.23	124,951.00	120,625.00	6,260,770.53
Admitted Mental Health	167,462.88	111,641.00	125,712.93	73,318.32	40,023.00	7,537.46	11,837.00	6,103.00	543,635.59
Sub-acute	181,405.77	177,793.00	169,385.37	50,082.08	62,559.00	10,353.41	18,255.00	11,789.00	681,622.63
Non-admitted	552,048.56	265,742.00	396,330.12	168,283.22	112,560.00	25,071.64	36,003.00	24,269.00	1,580,307.54
Total	3,080,048.19	2,458,516.00	2,516,653.63	1,082,144.91	734,486.00	214,140.39	214,395.00	195,083.00	10,495,467.13

Table 7 - 2023-24 NWAUs (NWAU24)	NSW	VIC	QLD	WA	SA	TAS	ACT	NT	Total
Emergency Department	416,943.97	292,404.06	356,591.17	150,551.10	89,998.72	25,904.76	23,133.18	30,986.79	1,386,513.76
Acute Admitted	1,733,351.19	1,594,684.37	1,390,429.95	630,669.24	425,942.78	135,841.93	123,803.36	116,477.88	6,151,200.71
Admitted Mental Health	180,905.37	114,506.94	122,127.02	76,575.79	54,008.56	7,078.53	11,727.44	6,332.32	573,261.97
Sub-acute	176,856.47	173,232.96	148,684.47	44,817.81	59,513.86	11,723.58	18,086.70	8,034.38	640,950.24
Non-admitted	550,984.58	255,271.14	368,281.13	142,885.70	92,032.60	25,326.66	35,670.24	26,101.82	1,496,553.88
Total	3,059,041.59	2,430,099.49	2,386,113.74	1,045,499.64	721,496.53	205,875.46	212,420.93	187,933.19	10,248,480.56

Table 8 - 2023-24 Commonwealth ABF Amounts	NSW	VIC	QLD	WA	SA	TAS	ACT	NT	Total
Emergency Department	$926,940,191.31	$666,347,506.94	$816,803,223.42	$349,399,981.13	$196,037,167.64	$60,506,404.34	$47,940,623.62	$56,902,863.10	$3,120,877,961.50
Acute Admitted	$4,081,436,093.52	$3,878,869,064.41	$3,464,695,181.76	$1,560,392,218.95	$986,293,719.40	$337,148,997.43	$272,017,361.42	$234,215,138.21	$14,815,067,775.10
Admitted Mental Health	$397,129,288.58	$268,430,957.10	$289,891,340.47	$186,088,771.88	$125,881,639.29	$17,814,598.93	$25,976,965.80	$12,149,899.01	$1,323,363,461.06
Sub-acute	$420,189,042.09	$420,502,748.30	$366,472,887.13	$111,245,383.24	$137,942,003.17	$29,545,666.57	$41,474,613.10	$16,393,835.65	$1,543,766,179.25
Non-admitted	$1,291,981,299.20	$615,610,538.43	$902,768,467.19	$351,776,859.87	$212,464,684.64	$61,811,839.38	$77,836,041.48	$51,908,462.00	$3,566,158,192.19
Total	$7,117,675,914.70	$5,849,760,815.18	$5,840,631,099.97	$2,558,903,215.07	$1,658,619,214.14	$506,827,506.65	$465,245,605.42	$371,570,197.97	$24,369,233,569.10

Table 9 - IHACPA 2024-25 NEC Determination	NSW	VIC	QLD	WA	SA	TAS	ACT	NT	Total
Teaching Training and Research	$842,676,453.00	$430,754,863.00	$500,779,160.00	$345,266,425.00	$127,066,265.00	$51,828,322.00	$63,667,394.00	$44,700,298.00	$2,406,739,180.00
Small Rural Hospitals	$871,328,264.78	$279,342,529.46	$784,548,947.86	$371,175,533.43	$294,118,846.76	$82,276,955.30	$4,685,397.00	$0.00	$2,687,476,474.59
Other Mental Health	$1,117,652,257.51	$1,212,137,734.00	$1,063,169,735.18	$537,178,983.00	$197,227,811.00	$163,712,325.00	$65,995,595.00	$36,397,395.00	$4,393,471,835.69
Non-admitted Home Ventilation	$24,249,050.00	$12,110,464.00	$14,340,092.00	$15,587,862.00	$2,761,039.00	$5,434,568.00	$1,579,894.00	$98,259.00	$76,161,228.00
Other Non-admitted Services	$0.00	$23,703.00	$8,779,497.00	$0.00	$7,769,119.00	$0.00	$0.00	$0.00	$16,572,319.00
Other Public Hospital Programs	$4,148,722.00	$32,677,000.00	$7,427,000.00	$0.00	$24,148,000.00	$0.00	$0.00	$0.00	$68,400,722.00
Highly Specialised Therapies	$60,057,239.00	$98,110,535.00	$26,209,427.00	$8,800,000.00	$0.00	$0.00	$0.00	$0.00	$193,177,201.00
Total	$2,920,111,986.29	$2,065,156,828.46	$2,405,253,859.04	$1,278,008,803.43	$653,091,080.76	$303,252,170.30	$135,928,280.00	$81,195,952.00	$9,841,998,960.28

Table 10 - IHACPA 2023-24 NEC Determination (Backcasted)	NSW	VIC	QLD	WA	SA	TAS	ACT	NT	Total
Teaching Training and Research	$794,228,514.00	$401,328,701.00	$427,527,390.00	$325,416,046.00	$122,194,386.00	$50,367,658.00	$61,873,075.00	$42,130,347.00	$2,225,066,117.00
Small Rural Hospitals	$832,946,218.92	$266,689,058.67	$696,335,383.82	$350,817,998.54	$283,631,730.15	$78,613,966.42	$4,553,350.00	$0.00	$2,513,587,706.52
Other Mental Health	$1,053,395,153.23	$1,183,694,162.77	$991,147,823.49	$483,386,412.92	$182,343,317.00	$147,870,036.00	$64,135,661.00	$34,304,802.00	$4,140,277,368.41
Non-admitted Home Ventilation	$22,854,901.00	$21,534,682.00	$18,302,644.00	$14,691,670.00	$2,735,817.00	$2,944,712.00	$1,535,368.00	$92,610.00	$84,692,404.00
Other Non-admitted Services	$0.00	$22,709.00	$8,218,828.00	$0.00	$7,525,723.00	$0.00	$0.00	$0.00	$15,767,260.00
Other Public Hospital Programs	$0.00	$0.00	$7,374,390.00	$0.00	$19,551,875.00	$0.00	$0.00	$0.00	$26,926,265.00
Highly Specialised Therapies	$34,903,992.00	$38,812,851.00	$25,383,166.00	$8,800,000.00	$0.00	$0.00	$0.00	$0.00	$107,900,009.00
Total	$2,738,328,779.15	$1,912,082,164.44	$2,174,289,625.31	$1,183,112,127.46	$617,982,848.15	$279,796,372.42	$132,097,454.00	$76,527,759.00	$9,114,217,129.93

Table 11 - 2023-24 Commonwealth Block Funding	NSW	VIC	QLD	WA	SA	TAS	ACT	NT	Total
Teaching Training and Research	$282,115,856.60	$163,138,459.61	$96,882,793.95	$128,328,838.70	$41,849,686.12	$18,942,562.09	$10,508,859.50	$13,289,618.61	$755,056,675.18
Small Rural Hospitals	$346,489,007.52	$111,507,421.49	$258,334,945.31	$129,511,086.04	$97,874,621.39	$30,401,501.40	$1,517,450.56	$0.00	$975,636,033.71
Other Mental Health	$409,134,743.27	$559,365,542.20	$307,893,784.38	$156,575,637.85	$67,280,840.45	$49,166,790.86	$23,626,891.91	$9,921,661.75	$1,582,965,892.67
Non-admitted Home Ventilation	$10,284,705.45	$9,690,606.90	$8,236,189.80	$6,611,251.50	$1,231,117.65	$1,325,120.40	$690,915.60	$41,719.86	$38,111,627.16
Other Non-admitted Services	$0.00	$10,219.05	$3,698,472.60	$0.00	$8,385,434.05	$0.00	$0.00	$0.00	$12,094,125.70
Other Public Hospital Programs	$0.00	$0.00	$3,318,475.50	$0.00	$8,798,343.75	$0.00	$0.00	$0.00	$12,116,819.25
Highly Specialised Therapies	$16,901,227.45	$18,408,025.50	$12,691,583.01	$4,400,000.00	$0.00	$0.00	$0.00	$0.00	$52,400,835.96
Total	$1,064,925,540.29	$862,120,274.75	$691,056,244.55	$425,426,814.09	$225,420,043.41	$99,835,974.75	$36,344,117.57	$23,253,000.22	$3,428,382,009.63

Additional information as at October 2024

Table 12 - Commonwealth funding percentage rate by service category (Uncapped)	NSW	VIC	QLD	WA	SA	TAS	ACT	NT	Total
Emergency Department	38.09%	39.24%	40.20%	39.97%	37.63%	40.14%	35.90%	32.97%	38.96%
Acute Admitted	38.09%	39.24%	40.20%	39.97%	37.63%	40.14%	35.90%	32.97%	38.93%
Admitted Mental Health	38.09%	39.24%	40.20%	39.97%	37.63%	40.14%	35.90%	32.97%	38.96%
Sub-acute	38.09%	39.24%	40.20%	39.97%	37.63%	40.14%	35.90%	32.97%	38.89%
Non-admitted	38.09%	39.24%	40.20%	39.97%	37.63%	40.14%	35.90%	32.97%	38.88%
Total	38.09%	39.24%	40.20%	39.97%	37.63%	40.14%	35.90%	32.97%	38.93%

Table 13 - Commonwealth funding percentage rate by service category (State-based Soft Cap)	NSW	VIC	QLD	WA	SA	TAS	ACT	NT	Total
Emergency Department	38.09%	39.10%	38.00%	38.74%	37.19%	38.71%	35.80%	31.34%	38.12%
Acute Admitted	38.09%	39.10%	38.00%	38.74%	37.19%	38.71%	35.80%	31.34%	38.17%
Admitted Mental Health	38.09%	39.10%	38.00%	38.74%	37.19%	38.71%	35.80%	31.34%	38.18%
Sub-acute	38.09%	39.10%	38.00%	38.74%	37.19%	38.71%	35.80%	31.34%	38.13%
Non-admitted	38.09%	39.10%	38.00%	38.74%	37.19%	38.71%	35.80%	31.34%	38.10%
Total	38.09%	39.10%	38.00%	38.74%	37.19%	38.71%	35.80%	31.34%	38.15%

Table 14 - Commonwealth funding percentage rate by service category (National Funding Cap)	NSW	VIC	QLD	WA	SA	TAS	ACT	NT	Total
Emergency Department	38.09%	39.10%	38.03%	38.76%	37.19%	38.73%	35.80%	31.36%	38.13%
Acute Admitted	38.09%	39.10%	38.03%	38.76%	37.19%	38.73%	35.80%	31.36%	38.18%
Admitted Mental Health	38.09%	39.10%	38.03%	38.76%	37.19%	38.73%	35.80%	31.36%	38.19%
Sub-acute	38.09%	39.10%	38.03%	38.76%	37.19%	38.73%	35.80%	31.36%	38.14%
Non-admitted	38.09%	39.10%	38.03%	38.76%	37.19%	38.73%	35.80%	31.36%	38.11%
Total	38.09%	39.10%	38.03%	38.76%	37.19%	38.73%	35.80%	31.36%	38.16%

Monthly cash flow of Commonwealth Payments into the National Health Funding Pool as at October 2024

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Table A - Commonwealth Payments into the National Health Funding Pool, 2024-25	Jul 2024	Aug 2024	Sep 2024	Oct 2024	Nov 2024	Dec 2024	Jan 2025	Feb 2025	Mar 2025	Apr 2025	May 2025	Jun 2025	Total
Albury NSW Local Health District	$4,666,482.10	$4,666,482.10	$4,666,482.10	$4,684,104.93	$4,684,104.93	$4,684,104.93	$4,684,104.93	$4,684,104.93	$4,684,104.93	$4,684,104.93	$4,684,104.93	$4,684,104.90	$56,156,390.64
Central Coast Local Health District	$30,071,435.72	$30,071,435.72	$30,071,435.72	$30,203,724.29	$30,203,724.29	$30,203,724.29	$30,203,724.29	$30,203,724.29	$30,203,724.29	$30,203,724.29	$30,203,724.29	$30,203,724.23	$362,047,825.71
Contracted Services	$797,888.64	$797,888.64	$797,888.64	$800,901.84	$800,901.84	$800,901.84	$800,901.84	$800,901.84	$800,901.84	$800,901.84	$800,901.84	$800,901.86	$9,601,782.50
Far West Local Health District	$2,596,940.17	$2,596,940.17	$2,596,940.17	$2,498,460.00	$2,498,460.00	$2,498,460.00	$2,498,460.00	$2,498,460.00	$2,498,460.00	$2,498,460.00	$2,498,460.00	$2,498,460.03	$30,276,960.54
Hunter New England Local Health District	$73,956,353.63	$73,956,353.63	$73,956,353.63	$72,998,919.60	$72,998,919.60	$72,998,919.60	$72,998,919.60	$72,998,919.60	$72,998,919.60	$72,998,919.60	$72,998,919.60	$72,998,919.63	$878,859,337.32
Illawarra Shoalhaven Local Health District	$35,088,511.92	$35,088,511.92	$35,088,511.92	$36,343,733.14	$36,343,733.14	$36,343,733.14	$36,343,733.14	$36,343,733.14	$36,343,733.14	$36,343,733.14	$36,343,733.14	$36,343,733.07	$432,359,133.95
Mid North Coast Local Health District	$23,620,128.95	$23,620,128.95	$23,620,128.95	$23,595,551.76	$23,595,551.76	$23,595,551.76	$23,595,551.76	$23,595,551.76	$23,595,551.76	$23,595,551.76	$23,595,551.76	$23,595,551.78	$283,220,352.71
Murrumbidgee Local Health District	$16,195,921.66	$16,195,921.66	$16,195,921.66	$16,445,341.22	$16,445,341.22	$16,445,341.22	$16,445,341.22	$16,445,341.22	$16,445,341.22	$16,445,341.22	$16,445,341.22	$16,445,341.13	$196,595,835.87
Nepean Blue Mountains Local Health District	$33,780,003.06	$33,780,003.06	$33,780,003.06	$32,811,055.83	$32,811,055.83	$32,811,055.83	$32,811,055.83	$32,811,055.83	$32,811,055.83	$32,811,055.83	$32,811,055.83	$32,811,055.91	$396,639,511.73
Northern NSW Local Health District	$29,773,427.14	$29,773,427.14	$29,773,427.14	$29,522,370.99	$29,522,370.99	$29,522,370.99	$29,522,370.99	$29,522,370.99	$29,522,370.99	$29,522,370.99	$29,522,370.99	$29,522,371.04	$355,021,620.38
Northern Sydney Local Health District	$49,204,626.13	$49,204,626.13	$49,204,626.13	$50,119,604.95	$50,119,604.95	$50,119,604.95	$50,119,604.95	$50,119,604.95	$50,119,604.95	$50,119,604.95	$50,119,604.95	$50,119,605.00	$598,690,322.99
South Eastern Sydney Local Health District	$59,260,906.16	$59,260,906.16	$59,260,906.16	$58,733,979.10	$58,733,979.10	$58,733,979.10	$58,733,979.10	$58,733,979.10	$58,733,979.10	$58,733,979.10	$58,733,979.10	$58,733,979.08	$706,388,530.36
South Western Sydney Local Health District	$74,902,324.66	$74,902,324.66	$74,902,324.66	$75,208,454.61	$75,208,454.61	$75,208,454.61	$75,208,454.61	$75,208,454.61	$75,208,454.61	$75,208,454.61	$75,208,454.61	$75,208,454.69	$901,583,065.55
Southern NSW Local Health District	$13,035,024.43	$13,035,024.43	$13,035,024.43	$13,264,150.48	$13,264,150.48	$13,264,150.48	$13,264,150.48	$13,264,150.48	$13,264,150.48	$13,264,150.48	$13,264,150.48	$13,264,150.45	$158,482,427.58
St Vincent's Health Network	$14,835,761.34	$14,835,761.34	$14,835,761.34	$15,317,647.07	$15,317,647.07	$15,317,647.07	$15,317,647.07	$15,317,647.07	$15,317,647.07	$15,317,647.07	$15,317,647.07	$15,317,647.12	$182,366,107.70
Sydney Children's Hospitals Network	$23,982,946.50	$23,982,946.50	$23,982,946.50	$24,737,999.67	$24,737,999.67	$24,737,999.67	$24,737,999.67	$24,737,999.67	$24,737,999.67	$24,737,999.67	$24,737,999.67	$24,737,999.58	$294,590,836.44
Sydney Local Health District	$58,965,365.92	$58,965,365.92	$58,965,365.92	$58,310,117.38	$58,310,117.38	$58,310,117.38	$58,310,117.38	$58,310,117.38	$58,310,117.38	$58,310,117.38	$58,310,117.38	$58,310,117.47	$701,687,154.27
Western NSW Local Health District	$25,880,224.98	$25,880,224.98	$25,880,224.98	$25,577,746.44	$25,577,746.44	$25,577,746.44	$25,577,746.44	$25,577,746.44	$25,577,746.44	$25,577,746.44	$25,577,746.44	$25,577,746.47	$307,840,392.93
Western Sydney Local Health District	$62,047,261.16	$62,047,261.16	$62,047,261.16	$60,757,475.48	$60,757,475.48	$60,757,475.48	$60,757,475.48	$60,757,475.48	$60,757,475.48	$60,757,475.48	$60,757,475.48	$60,757,475.57	$732,959,062.89
Total Activity Based Funding	**$632,661,534.27**	**$632,661,534.27**	**$632,661,534.27**	**$631,931,338.78**	**$631,931,338.78**	**$631,931,338.78**	**$631,931,338.78**	**$631,931,338.78**	**$631,931,338.78**	**$631,931,338.78**	**$631,931,338.78**	**$631,931,339.01**	**$7,585,366,652.06**
Teaching Training and Research	$25,326,452.43	$25,326,452.43	$25,326,452.43	$25,326,452.43	$25,326,452.43	$25,326,452.43	$25,326,452.43	$25,326,452.43	$25,326,452.43	$25,326,452.43	$25,326,452.43	$25,326,452.42	$303,917,429.15
Small Rural Hospitals	$28,322,479.53	$28,322,479.53	$28,322,479.53	$28,322,479.52	$28,322,479.52	$28,322,479.52	$28,322,479.52	$28,322,479.52	$28,322,479.52	$28,322,479.52	$28,322,479.52	$28,322,479.55	$339,869,754.30
Other Mental Health	$36,504,203.35	$36,504,203.35	$36,504,203.35	$36,504,203.35	$36,504,203.35	$36,504,203.35	$36,504,203.35	$36,504,203.35	$36,504,203.35	$36,504,203.35	$36,504,203.35	$36,504,203.35	$438,050,440.20
Non-admitted Home Ventilation	$909,339.38	$909,339.38	$909,339.38	$909,339.37	$909,339.37	$909,339.37	$909,339.37	$909,339.37	$909,339.37	$909,339.37	$909,339.37	$909,339.40	$10,912,072.50
Other Non-admitted Services	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Other Public Hospital Programs	$155,577.08	$155,577.08	$155,577.08	$155,577.07	$155,577.07	$155,577.07	$155,577.07	$155,577.07	$155,577.07	$155,577.07	$155,577.07	$155,577.10	$1,866,924.90
Highly Specialised Therapies	$2,456,487.58	$2,456,487.58	$2,456,487.58	$2,456,487.58	$2,456,487.58	$2,456,487.58	$2,456,487.58	$2,456,487.58	$2,456,487.58	$2,456,487.58	$2,456,487.58	$2,456,487.57	$29,477,850.95
Total Block Funding	**$93,674,539.35**	**$93,674,539.35**	**$93,674,539.35**	**$93,674,539.32**	**$93,674,539.32**	**$93,674,539.32**	**$93,674,539.32**	**$93,674,539.32**	**$93,674,539.32**	**$93,674,539.32**	**$93,674,539.32**	**$93,674,539.39**	**$1,124,094,472.00**
Public Health Funding	**$14,376,728.33**	**$14,376,728.33**	**$14,376,728.33**	**$14,376,728.33**	**$14,376,728.33**	**$14,376,728.33**	**$14,376,728.33**	**$14,376,728.33**	**$14,376,728.33**	**$14,376,728.33**	**$14,376,728.33**	**$14,376,728.37**	**$172,520,740.00**
Total Payable in 2024-25	**$740,712,801.95**	**$740,712,801.95**	**$740,712,801.95**	**$739,982,606.43**	**$739,982,606.43**	**$739,982,606.43**	**$739,982,606.43**	**$739,982,606.43**	**$739,982,606.43**	**$739,982,606.43**	**$739,982,606.43**	**$739,982,606.77**	**$8,881,981,864.06**

Table B - Payments in respect of 2024-25 (subject to State-based Soft Cap)	Jul 2024	Aug 2024	Sep 2024	Oct 2024	Nov 2024	Dec 2024	Jan 2025	Feb 2025	Mar 2025	Apr 2025	May 2025	Jun 2025	Total
Albury NSW Local Health District	$4,666,482.10	$4,666,482.10	$4,666,482.10	$4,684,104.93	$4,684,104.93	$4,684,104.93	$4,684,104.93	$4,684,104.93	$4,684,104.93	$4,684,104.93	$4,684,104.93	$4,684,104.90	$56,156,390.64
Central Coast Local Health District	$30,071,435.72	$30,071,435.72	$30,071,435.72	$30,203,724.29	$30,203,724.29	$30,203,724.29	$30,203,724.29	$30,203,724.29	$30,203,724.29	$30,203,724.29	$30,203,724.29	$30,203,724.23	$362,047,825.71
Contracted Services	$797,888.64	$797,888.64	$797,888.64	$800,901.84	$800,901.84	$800,901.84	$800,901.84	$800,901.84	$800,901.84	$800,901.84	$800,901.84	$800,901.86	$9,601,782.50
Far West Local Health District	$2,596,940.17	$2,596,940.17	$2,596,940.17	$2,498,460.00	$2,498,460.00	$2,498,460.00	$2,498,460.00	$2,498,460.00	$2,498,460.00	$2,498,460.00	$2,498,460.00	$2,498,460.03	$30,276,960.54
Hunter New England Local Health District	$73,956,353.63	$73,956,353.63	$73,956,353.63	$72,998,919.60	$72,998,919.60	$72,998,919.60	$72,998,919.60	$72,998,919.60	$72,998,919.60	$72,998,919.60	$72,998,919.60	$72,998,919.63	$878,859,337.32
Illawarra Shoalhaven Local Health District	$35,088,511.92	$35,088,511.92	$35,088,511.92	$36,343,733.14	$36,343,733.14	$36,343,733.14	$36,343,733.14	$36,343,733.14	$36,343,733.14	$36,343,733.14	$36,343,733.14	$36,343,733.07	$432,359,133.95
Mid North Coast Local Health District	$23,620,128.95	$23,620,128.95	$23,620,128.95	$23,595,551.76	$23,595,551.76	$23,595,551.76	$23,595,551.76	$23,595,551.76	$23,595,551.76	$23,595,551.76	$23,595,551.76	$23,595,551.78	$283,220,352.71
Murrumbidgee Local Health District	$16,195,921.66	$16,195,921.66	$16,195,921.66	$16,445,341.22	$16,445,341.22	$16,445,341.22	$16,445,341.22	$16,445,341.22	$16,445,341.22	$16,445,341.22	$16,445,341.22	$16,445,341.13	$196,595,835.87
Nepean Blue Mountains Local Health District	$33,780,003.06	$33,780,003.06	$33,780,003.06	$32,811,055.83	$32,811,055.83	$32,811,055.83	$32,811,055.83	$32,811,055.83	$32,811,055.83	$32,811,055.83	$32,811,055.83	$32,811,055.91	$396,639,511.73
Northern NSW Local Health District	$29,773,427.14	$29,773,427.14	$29,773,427.14	$29,522,370.99	$29,522,370.99	$29,522,370.99	$29,522,370.99	$29,522,370.99	$29,522,370.99	$29,522,370.99	$29,522,370.99	$29,522,371.04	$355,021,620.38
Northern Sydney Local Health District	$49,204,626.13	$49,204,626.13	$49,204,626.13	$50,119,604.95	$50,119,604.95	$50,119,604.95	$50,119,604.95	$50,119,604.95	$50,119,604.95	$50,119,604.95	$50,119,604.95	$50,119,605.00	$598,690,322.99
South Eastern Sydney Local Health District	$59,260,906.16	$59,260,906.16	$59,260,906.16	$58,733,979.10	$58,733,979.10	$58,733,979.10	$58,733,979.10	$58,733,979.10	$58,733,979.10	$58,733,979.10	$58,733,979.10	$58,733,979.08	$706,388,530.36
South Western Sydney Local Health District	$74,902,324.66	$74,902,324.66	$74,902,324.66	$75,208,454.61	$75,208,454.61	$75,208,454.61	$75,208,454.61	$75,208,454.61	$75,208,454.61	$75,208,454.61	$75,208,454.61	$75,208,454.69	$901,583,065.55
Southern NSW Local Health District	$13,035,024.43	$13,035,024.43	$13,035,024.43	$13,264,150.48	$13,264,150.48	$13,264,150.48	$13,264,150.48	$13,264,150.48	$13,264,150.48	$13,264,150.48	$13,264,150.48	$13,264,150.45	$158,482,427.58
St Vincent's Health Network	$14,835,761.34	$14,835,761.34	$14,835,761.34	$15,317,647.07	$15,317,647.07	$15,317,647.07	$15,317,647.07	$15,317,647.07	$15,317,647.07	$15,317,647.07	$15,317,647.07	$15,317,647.12	$182,366,107.70
Sydney Children's Hospitals Network	$23,982,946.50	$23,982,946.50	$23,982,946.50	$24,737,999.67	$24,737,999.67	$24,737,999.67	$24,737,999.67	$24,737,999.67	$24,737,999.67	$24,737,999.67	$24,737,999.67	$24,737,999.58	$294,590,836.44
Sydney Local Health District	$58,965,365.92	$58,965,365.92	$58,965,365.92	$58,310,117.38	$58,310,117.38	$58,310,117.38	$58,310,117.38	$58,310,117.38	$58,310,117.38	$58,310,117.38	$58,310,117.38	$58,310,117.47	$701,687,154.27
Western NSW Local Health District	$25,880,224.98	$25,880,224.98	$25,880,224.98	$25,577,746.44	$25,577,746.44	$25,577,746.44	$25,577,746.44	$25,577,746.44	$25,577,746.44	$25,577,746.44	$25,577,746.44	$25,577,746.47	$307,840,392.93
Western Sydney Local Health District	$62,047,261.16	$62,047,261.16	$62,047,261.16	$60,757,475.48	$60,757,475.48	$60,757,475.48	$60,757,475.48	$60,757,475.48	$60,757,475.48	$60,757,475.48	$60,757,475.48	$60,757,475.57	$732,959,062.89
Total Activity Based Funding	**$632,661,534.27**	**$632,661,534.27**	**$632,661,534.27**	**$631,931,338.78**	**$631,931,338.78**	**$631,931,338.78**	**$631,931,338.78**	**$631,931,338.78**	**$631,931,338.78**	**$631,931,338.78**	**$631,931,338.78**	**$631,931,339.01**	**$7,585,366,652.06**
Teaching Training and Research	$25,326,452.43	$25,326,452.43	$25,326,452.43	$25,326,452.43	$25,326,452.43	$25,326,452.43	$25,326,452.43	$25,326,452.43	$25,326,452.43	$25,326,452.43	$25,326,452.43	$25,326,452.42	$303,917,429.15
Small Rural Hospitals	$28,322,479.53	$28,322,479.53	$28,322,479.53	$28,322,479.52	$28,322,479.52	$28,322,479.52	$28,322,479.52	$28,322,479.52	$28,322,479.52	$28,322,479.52	$28,322,479.52	$28,322,479.55	$339,869,754.30
Other Mental Health	$36,504,203.35	$36,504,203.35	$36,504,203.35	$36,504,203.35	$36,504,203.35	$36,504,203.35	$36,504,203.35	$36,504,203.35	$36,504,203.35	$36,504,203.35	$36,504,203.35	$36,504,203.35	$438,050,440.20
Non-admitted Home Ventilation	$909,339.38	$909,339.38	$909,339.38	$909,339.37	$909,339.37	$909,339.37	$909,339.37	$909,339.37	$909,339.37	$909,339.37	$909,339.37	$909,339.40	$10,912,072.50
Other Non-admitted Services	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Other Public Hospital Programs	$155,577.08	$155,577.08	$155,577.08	$155,577.07	$155,577.07	$155,577.07	$155,577.07	$155,577.07	$155,577.07	$155,577.07	$155,577.07	$155,577.10	$1,866,924.90
Highly Specialised Therapies	$2,456,487.58	$2,456,487.58	$2,456,487.58	$2,456,487.58	$2,456,487.58	$2,456,487.58	$2,456,487.58	$2,456,487.58	$2,456,487.58	$2,456,487.58	$2,456,487.58	$2,456,487.57	$29,477,850.95
Total Block Funding	**$93,674,539.35**	**$93,674,539.35**	**$93,674,539.35**	**$93,674,539.32**	**$93,674,539.32**	**$93,674,539.32**	**$93,674,539.32**	**$93,674,539.32**	**$93,674,539.32**	**$93,674,539.32**	**$93,674,539.32**	**$93,674,539.39**	**$1,124,094,472.00**
Public Health Funding	**$14,376,728.33**	**$14,376,728.33**	**$14,376,728.33**	**$14,376,728.33**	**$14,376,728.33**	**$14,376,728.33**	**$14,376,728.33**	**$14,376,728.33**	**$14,376,728.33**	**$14,376,728.33**	**$14,376,728.33**	**$14,376,728.37**	**$172,520,740.00**
Payments in respect of 2024-25	**$740,712,801.95**	**$740,712,801.95**	**$740,712,801.95**	**$739,982,606.43**	**$739,982,606.43**	**$739,982,606.43**	**$739,982,606.43**	**$739,982,606.43**	**$739,982,606.43**	**$739,982,606.43**	**$739,982,606.43**	**$739,982,606.77**	**$8,881,981,864.06**

Table C - Payments in respect of prior year services	Jul 2024	Aug 2024	Sep 2024	Oct 2024	Nov 2024	Dec 2024	Jan 2025	Feb 2025	Mar 2025	Apr 2025	May 2025	Jun 2025	Total
Albury NSW Local Health District	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Central Coast Local Health District	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Contracted Services	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Far West Local Health District	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Hunter New England Local Health District	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Illawarra Shoalhaven Local Health District	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Mid North Coast Local Health District	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Murrumbidgee Local Health District	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Nepean Blue Mountains Local Health District	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Northern NSW Local Health District	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Northern Sydney Local Health District	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
South Eastern Sydney Local Health District	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
South Western Sydney Local Health District	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Southern NSW Local Health District	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
St Vincent's Health Network	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Sydney Children's Hospitals Network	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Sydney Local Health District	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Western NSW Local Health District	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Western Sydney Local Health District	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Total Activity Based Funding	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**
Teaching Training and Research	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Small Rural Hospitals	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Other Mental Health	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Non-admitted Home Ventilation	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Other Non-admitted Services	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Other Public Hospital Programs	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Highly Specialised Therapies	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Total Block Funding	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**
Public Health Funding	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**
Payments in respect of prior year services	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**

Monthly cash flow of Commonwealth Payments into the National Health Funding Pool as at October 2024

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Table A - Commonwealth Payments into the National Health Funding Pool, 2024-25	Jul 2024	Aug 2024	Sep 2024	Oct 2024	Nov 2024	Dec 2024	Jan 2025	Feb 2025	Mar 2025	Apr 2025	May 2025	Jun 2025	Total
Albury Wodonga Health	$6,482,829.01	$6,482,829.01	$6,482,829.01	$6,482,829.01	$6,482,829.01	$6,482,829.01	$6,482,829.01	$6,482,829.01	$6,482,829.01	$6,482,829.01	$6,482,829.01	$6,482,829.05	$77,793,948.16
Alfred Health	$39,093,717.07	$39,093,717.07	$39,093,717.07	$39,093,717.07	$39,093,717.07	$39,093,717.07	$39,093,717.07	$39,093,717.07	$39,093,717.07	$39,093,717.07	$39,093,717.07	$39,093,717.10	$469,124,604.87
Austin Health	$32,335,784.91	$32,335,784.91	$32,335,784.91	$32,335,784.91	$32,335,784.91	$32,335,784.91	$32,335,784.91	$32,335,784.91	$32,335,784.91	$32,335,784.91	$32,335,784.91	$32,335,784.83	$388,029,418.84
Bairnsdale Regional Health Service	$3,367,380.58	$3,367,380.58	$3,367,380.58	$3,367,380.58	$3,367,380.58	$3,367,380.58	$3,367,380.58	$3,367,380.58	$3,367,380.58	$3,367,380.58	$3,367,380.58	$3,367,380.53	$40,408,566.91
Barwon Health	$24,600,035.85	$24,600,035.85	$24,600,035.85	$24,600,035.85	$24,600,035.85	$24,600,035.85	$24,600,035.85	$24,600,035.85	$24,600,035.85	$24,600,035.85	$24,600,035.85	$24,600,035.92	$295,200,430.27
Bass Coast Health	$3,104,284.22	$3,104,284.22	$3,104,284.22	$3,104,284.22	$3,104,284.22	$3,104,284.22	$3,104,284.22	$3,104,284.22	$3,104,284.22	$3,104,284.22	$3,104,284.22	$3,104,284.23	$37,251,410.65
Benalla Health	$905,144.15	$905,144.15	$905,144.15	$905,144.15	$905,144.15	$905,144.15	$905,144.15	$905,144.15	$905,144.15	$905,144.15	$905,144.15	$905,144.11	$10,861,729.76
Bendigo Health	$14,744,138.85	$14,744,138.85	$14,744,138.85	$14,744,138.85	$14,744,138.85	$14,744,138.85	$14,744,138.85	$14,744,138.85	$14,744,138.85	$14,744,138.85	$14,744,138.85	$14,744,138.68	$176,929,666.03
Calvary Health Care Bethlehem Limited	$948,537.14	$948,537.14	$948,537.14	$948,537.14	$948,537.14	$948,537.14	$948,537.14	$948,537.14	$948,537.14	$948,537.14	$948,537.14	$948,537.15	$11,382,445.69
Central Gippsland Health Service	$2,785,366.78	$2,785,366.78	$2,785,366.78	$2,785,366.78	$2,785,366.78	$2,785,366.78	$2,785,366.78	$2,785,366.78	$2,785,366.78	$2,785,366.78	$2,785,366.78	$2,785,366.79	$33,424,401.37
Colac Area Health	$1,385,205.48	$1,385,205.48	$1,385,205.48	$1,385,205.48	$1,385,205.48	$1,385,205.48	$1,385,205.48	$1,385,205.48	$1,385,205.48	$1,385,205.48	$1,385,205.48	$1,385,205.37	$16,622,465.65
Contracted Services LHN Victoria	$2,478,245.50	$2,478,245.50	$2,478,245.50	$2,478,245.50	$2,478,245.50	$2,478,245.50	$2,478,245.50	$2,478,245.50	$2,478,245.50	$2,478,245.50	$2,478,245.50	$2,478,245.44	$29,738,945.94
Dental Health Services Victoria	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Dhelkaya Health	$1,242,387.76	$1,242,387.76	$1,242,387.76	$1,242,387.76	$1,242,387.76	$1,242,387.76	$1,242,387.76	$1,242,387.76	$1,242,387.76	$1,242,387.76	$1,242,387.76	$1,242,387.70	$14,908,653.06
East Grampians Health Service	$1,002,883.71	$1,002,883.71	$1,002,883.71	$1,002,883.71	$1,002,883.71	$1,002,883.71	$1,002,883.71	$1,002,883.71	$1,002,883.71	$1,002,883.71	$1,002,883.71	$1,002,883.65	$12,034,604.46
Eastern Health	$38,036,486.81	$38,036,486.81	$38,036,486.81	$38,036,486.81	$38,036,486.81	$38,036,486.81	$38,036,486.81	$38,036,486.81	$38,036,486.81	$38,036,486.81	$38,036,486.81	$38,036,486.70	$456,437,841.61
Echuca Regional Health	$3,055,835.74	$3,055,835.74	$3,055,835.74	$3,055,835.74	$3,055,835.74	$3,055,835.74	$3,055,835.74	$3,055,835.74	$3,055,835.74	$3,055,835.74	$3,055,835.74	$3,055,835.65	$36,670,028.79
Gippsland Southern Health Service	$924,102.25	$924,102.25	$924,102.25	$924,102.25	$924,102.25	$924,102.25	$924,102.25	$924,102.25	$924,102.25	$924,102.25	$924,102.25	$924,102.27	$11,089,227.02
Goulburn Valley Health	$10,147,430.54	$10,147,430.54	$10,147,430.54	$10,147,430.54	$10,147,430.54	$10,147,430.54	$10,147,430.54	$10,147,430.54	$10,147,430.54	$10,147,430.54	$10,147,430.54	$10,147,430.45	$121,769,166.39
Grampians Health	$17,189,102.33	$17,189,102.33	$17,189,102.33	$17,189,102.33	$17,189,102.33	$17,189,102.33	$17,189,102.33	$17,189,102.33	$17,189,102.33	$17,189,102.33	$17,189,102.33	$17,189,102.30	$206,269,227.93
Kyabram District Health Service	$689,443.05	$689,443.05	$689,443.05	$689,443.05	$689,443.05	$689,443.05	$689,443.05	$689,443.05	$689,443.05	$689,443.05	$689,443.05	$689,443.07	$8,273,316.62
Latrobe Regional Health	$9,233,439.26	$9,233,439.26	$9,233,439.26	$9,233,439.26	$9,233,439.26	$9,233,439.26	$9,233,439.26	$9,233,439.26	$9,233,439.26	$9,233,439.26	$9,233,439.26	$9,233,439.38	$110,801,271.24
Maryborough District Health Service	$949,379.72	$949,379.72	$949,379.72	$949,379.72	$949,379.72	$949,379.72	$949,379.72	$949,379.72	$949,379.72	$949,379.72	$949,379.72	$949,379.75	$11,392,556.67
Melbourne Health	$36,073,901.74	$36,073,901.74	$36,073,901.74	$36,073,901.74	$36,073,901.74	$36,073,901.74	$36,073,901.74	$36,073,901.74	$36,073,901.74	$36,073,901.74	$36,073,901.74	$36,073,901.72	$432,886,820.86
Mercy Hospitals Victoria Limited	$16,671,756.74	$16,671,756.74	$16,671,756.74	$16,671,756.74	$16,671,756.74	$16,671,756.74	$16,671,756.74	$16,671,756.74	$16,671,756.74	$16,671,756.74	$16,671,756.74	$16,671,756.61	$200,061,080.75
Mildura Base Public Hospital	$4,998,198.83	$4,998,198.83	$4,998,198.83	$4,998,198.83	$4,998,198.83	$4,998,198.83	$4,998,198.83	$4,998,198.83	$4,998,198.83	$4,998,198.83	$4,998,198.83	$4,998,198.69	$59,978,385.82
Monash Health	$72,007,302.86	$72,007,302.86	$72,007,302.86	$72,007,302.86	$72,007,302.86	$72,007,302.86	$72,007,302.86	$72,007,302.86	$72,007,302.86	$72,007,302.86	$72,007,302.86	$72,007,302.87	$864,087,634.33
Northeast Health Wangaratta	$5,864,162.89	$5,864,162.89	$5,864,162.89	$5,864,162.89	$5,864,162.89	$5,864,162.89	$5,864,162.89	$5,864,162.89	$5,864,162.89	$5,864,162.89	$5,864,162.89	$5,864,162.81	$70,369,954.60
Northern Health	$25,673,275.19	$25,673,275.19	$25,673,275.19	$25,673,275.19	$25,673,275.19	$25,673,275.19	$25,673,275.19	$25,673,275.19	$25,673,275.19	$25,673,275.19	$25,673,275.19	$25,673,275.22	$308,079,302.31
Peninsula Health	$24,119,974.54	$24,119,974.54	$24,119,974.54	$24,119,974.54	$24,119,974.54	$24,119,974.54	$24,119,974.54	$24,119,974.54	$24,119,974.54	$24,119,974.54	$24,119,974.54	$24,119,974.45	$289,439,694.39
Peter Maccallum Cancer Institute	$6,868,099.82	$6,868,099.82	$6,868,099.82	$6,868,099.82	$6,868,099.82	$6,868,099.82	$6,868,099.82	$6,868,099.82	$6,868,099.82	$6,868,099.82	$6,868,099.82	$6,868,099.79	$82,417,197.81
Portland District Health	$1,220,269.98	$1,220,269.98	$1,220,269.98	$1,220,269.98	$1,220,269.98	$1,220,269.98	$1,220,269.98	$1,220,269.98	$1,220,269.98	$1,220,269.98	$1,220,269.98	$1,220,269.81	$14,643,239.59
South West Healthcare	$6,310,520.90	$6,310,520.90	$6,310,520.90	$6,310,520.90	$6,310,520.90	$6,310,520.90	$6,310,520.90	$6,310,520.90	$6,310,520.90	$6,310,520.90	$6,310,520.90	$6,310,521.05	$75,726,250.95
St Vincent's Hospital (Melbourne) Limited	$22,218,055.41	$22,218,055.41	$22,218,055.41	$22,218,055.41	$22,218,055.41	$22,218,055.41	$22,218,055.41	$22,218,055.41	$22,218,055.41	$22,218,055.41	$22,218,055.41	$22,218,055.30	$266,616,664.81
Swan Hill District Hospital	$1,993,549.96	$1,993,549.96	$1,993,549.96	$1,993,549.96	$1,993,549.96	$1,993,549.96	$1,993,549.96	$1,993,549.96	$1,993,549.96	$1,993,549.96	$1,993,549.96	$1,993,550.04	$23,922,599.60
The Royal Children's Hospital	$21,416,759.54	$21,416,759.54	$21,416,759.54	$21,416,759.54	$21,416,759.54	$21,416,759.54	$21,416,759.54	$21,416,759.54	$21,416,759.54	$21,416,759.54	$21,416,759.54	$21,416,759.48	$257,001,114.42
The Royal Victorian Eye And Ear Hospital	$4,382,692.38	$4,382,692.38	$4,382,692.38	$4,382,692.38	$4,382,692.38	$4,382,692.38	$4,382,692.38	$4,382,692.38	$4,382,692.38	$4,382,692.38	$4,382,692.38	$4,382,692.29	$52,592,308.47
The Royal Women's Hospital	$9,469,783.63	$9,469,783.63	$9,469,783.63	$9,469,783.63	$9,469,783.63	$9,469,783.63	$9,469,783.63	$9,469,783.63	$9,469,783.63	$9,469,783.63	$9,469,783.63	$9,469,783.69	$113,637,403.62
West Gippsland Healthcare Group	$3,621,840.47	$3,621,840.47	$3,621,840.47	$3,621,840.47	$3,621,840.47	$3,621,840.47	$3,621,840.47	$3,621,840.47	$3,621,840.47	$3,621,840.47	$3,621,840.47	$3,621,840.38	$43,462,085.55
Western District Health Service	$1,962,374.42	$1,962,374.42	$1,962,374.42	$1,962,374.42	$1,962,374.42	$1,962,374.42	$1,962,374.42	$1,962,374.42	$1,962,374.42	$1,962,374.42	$1,962,374.42	$1,962,374.39	$23,548,493.01
Western Health	$38,301,900.25	$38,301,900.25	$38,301,900.25	$38,301,900.25	$38,301,900.25	$38,301,900.25	$38,301,900.25	$38,301,900.25	$38,301,900.25	$38,301,900.25	$38,301,900.25	$38,301,900.35	$459,622,803.10
Total Activity Based Funding	**$517,875,580.26**	**$517,875,580.26**	**$517,875,580.26**	**$517,875,580.26**	**$517,875,580.26**	**$517,875,580.26**	**$517,875,580.26**	**$517,875,580.26**	**$517,875,580.26**	**$517,875,580.26**	**$517,875,580.26**	**$517,875,579.06**	**$6,214,506,961.92**
Teaching Training and Research	$14,698,352.71	$14,698,352.71	$14,698,352.71	$14,698,352.71	$14,698,352.71	$14,698,352.71	$14,698,352.71	$14,698,352.71	$14,698,352.71	$14,698,352.71	$14,698,352.71	$14,698,352.70	$176,380,232.51
Small Rural Hospitals	$9,766,790.28	$9,766,790.28	$9,766,790.28	$9,766,790.28	$9,766,790.28	$9,766,790.28	$9,766,790.28	$9,766,790.28	$9,766,790.28	$9,766,790.28	$9,766,790.28	$9,766,790.27	$117,201,483.35
Other Mental Health	$47,680,429.10	$47,680,429.10	$47,680,429.10	$47,680,429.10	$47,680,429.10	$47,680,429.10	$47,680,429.10	$47,680,429.10	$47,680,429.10	$47,680,429.10	$47,680,429.10	$47,680,429.15	$572,165,149.25
Non-admitted Home Ventilation	$454,142.40	$454,142.40	$454,142.40	$454,142.40	$454,142.40	$454,142.40	$454,142.40	$454,142.40	$454,142.40	$454,142.40	$454,142.40	$454,142.40	$5,449,708.80
Other Non-admitted Services	$888.86	$888.86	$888.86	$888.86	$888.86	$888.86	$888.86	$888.86	$888.86	$888.86	$888.86	$888.89	$10,666.35
Other Public Hospital Programs	$1,225,387.50	$1,225,387.50	$1,225,387.50	$1,225,387.50	$1,225,387.50	$1,225,387.50	$1,225,387.50	$1,225,387.50	$1,225,387.50	$1,225,387.50	$1,225,387.50	$1,225,387.50	$14,704,650.00
Highly Specialised Therapies	$4,004,738.96	$4,004,738.96	$4,004,738.96	$4,004,738.96	$4,004,738.96	$4,004,738.96	$4,004,738.96	$4,004,738.96	$4,004,738.96	$4,004,738.96	$4,004,738.96	$4,004,738.94	$48,056,867.50
Total Block Funding	**$77,830,729.81**	**$77,830,729.81**	**$77,830,729.81**	**$77,830,729.81**	**$77,830,729.81**	**$77,830,729.81**	**$77,830,729.81**	**$77,830,729.81**	**$77,830,729.81**	**$77,830,729.81**	**$77,830,729.81**	**$77,830,729.85**	**$933,968,757.76**
Public Health Funding	**$11,863,138.25**	**$11,863,138.25**	**$11,863,138.25**	**$11,863,138.25**	**$11,863,138.25**	**$11,863,138.25**	**$11,863,138.25**	**$11,863,138.25**	**$11,863,138.25**	**$11,863,138.25**	**$11,863,138.25**	**$11,863,138.25**	**$142,357,659.00**
Total Payable in 2024-25	**$607,569,448.32**	**$607,569,448.32**	**$607,569,448.32**	**$607,569,448.32**	**$607,569,448.32**	**$607,569,448.32**	**$607,569,448.32**	**$607,569,448.32**	**$607,569,448.32**	**$607,569,448.32**	**$607,569,448.32**	**$607,569,447.16**	**$7,290,833,378.68**

Table B - Payments in respect of 2024-25 (subject to State-based Soft Cap)	Jul 2024	Aug 2024	Sep 2024	Oct 2024	Nov 2024	Dec 2024	Jan 2025	Feb 2025	Mar 2025	Apr 2025	May 2025	Jun 2025	Total
Albury Wodonga Health	$6,482,829.01	$6,482,829.01	$6,482,829.01	$6,482,829.01	$6,482,829.01	$6,482,829.01	$6,482,829.01	$6,482,829.01	$6,482,829.01	$6,482,829.01	$6,482,829.01	$6,482,829.05	$77,793,948.16
Alfred Health	$39,093,717.07	$39,093,717.07	$39,093,717.07	$39,093,717.07	$39,093,717.07	$39,093,717.07	$39,093,717.07	$39,093,717.07	$39,093,717.07	$39,093,717.07	$39,093,717.07	$39,093,717.10	$469,124,604.87
Austin Health	$32,335,784.91	$32,335,784.91	$32,335,784.91	$32,335,784.91	$32,335,784.91	$32,335,784.91	$32,335,784.91	$32,335,784.91	$32,335,784.91	$32,335,784.91	$32,335,784.91	$32,335,784.83	$388,029,418.84
Bairnsdale Regional Health Service	$3,367,380.58	$3,367,380.58	$3,367,380.58	$3,367,380.58	$3,367,380.58	$3,367,380.58	$3,367,380.58	$3,367,380.58	$3,367,380.58	$3,367,380.58	$3,367,380.58	$3,367,380.53	$40,408,566.91
Barwon Health	$24,600,035.85	$24,600,035.85	$24,600,035.85	$24,600,035.85	$24,600,035.85	$24,600,035.85	$24,600,035.85	$24,600,035.85	$24,600,035.85	$24,600,035.85	$24,600,035.85	$24,600,035.92	$295,200,430.27
Bass Coast Health	$3,104,284.22	$3,104,284.22	$3,104,284.22	$3,104,284.22	$3,104,284.22	$3,104,284.22	$3,104,284.22	$3,104,284.22	$3,104,284.22	$3,104,284.22	$3,104,284.22	$3,104,284.23	$37,251,410.65
Benalla Health	$905,144.15	$905,144.15	$905,144.15	$905,144.15	$905,144.15	$905,144.15	$905,144.15	$905,144.15	$905,144.15	$905,144.15	$905,144.15	$905,144.11	$10,861,729.76
Bendigo Health	$14,744,138.85	$14,744,138.85	$14,744,138.85	$14,744,138.85	$14,744,138.85	$14,744,138.85	$14,744,138.85	$14,744,138.85	$14,744,138.85	$14,744,138.85	$14,744,138.85	$14,744,138.68	$176,929,666.03
Calvary Health Care Bethlehem Limited	$948,537.14	$948,537.14	$948,537.14	$948,537.14	$948,537.14	$948,537.14	$948,537.14	$948,537.14	$948,537.14	$948,537.14	$948,537.14	$948,537.15	$11,382,445.69
Central Gippsland Health Service	$2,785,366.78	$2,785,366.78	$2,785,366.78	$2,785,366.78	$2,785,366.78	$2,785,366.78	$2,785,366.78	$2,785,366.78	$2,785,366.78	$2,785,366.78	$2,785,366.78	$2,785,366.79	$33,424,401.37
Colac Area Health	$1,385,205.48	$1,385,205.48	$1,385,205.48	$1,385,205.48	$1,385,205.48	$1,385,205.48	$1,385,205.48	$1,385,205.48	$1,385,205.48	$1,385,205.48	$1,385,205.48	$1,385,205.37	$16,622,465.65
Contracted Services LHN Victoria	$2,478,245.50	$2,478,245.50	$2,478,245.50	$2,478,245.50	$2,478,245.50	$2,478,245.50	$2,478,245.50	$2,478,245.50	$2,478,245.50	$2,478,245.50	$2,478,245.50	$2,478,245.44	$29,738,945.94
Dental Health Services Victoria	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Dhelkaya Health	$1,242,387.76	$1,242,387.76	$1,242,387.76	$1,242,387.76	$1,242,387.76	$1,242,387.76	$1,242,387.76	$1,242,387.76	$1,242,387.76	$1,242,387.76	$1,242,387.76	$1,242,387.70	$14,908,653.06
East Grampians Health Service	$1,002,883.71	$1,002,883.71	$1,002,883.71	$1,002,883.71	$1,002,883.71	$1,002,883.71	$1,002,883.71	$1,002,883.71	$1,002,883.71	$1,002,883.71	$1,002,883.71	$1,002,883.65	$12,034,604.46
Eastern Health	$38,036,486.81	$38,036,486.81	$38,036,486.81	$38,036,486.81	$38,036,486.81	$38,036,486.81	$38,036,486.81	$38,036,486.81	$38,036,486.81	$38,036,486.81	$38,036,486.81	$38,036,486.70	$456,437,841.61
Echuca Regional Health	$3,055,835.74	$3,055,835.74	$3,055,835.74	$3,055,835.74	$3,055,835.74	$3,055,835.74	$3,055,835.74	$3,055,835.74	$3,055,835.74	$3,055,835.74	$3,055,835.74	$3,055,835.65	$36,670,028.79
Gippsland Southern Health Service	$924,102.25	$924,102.25	$924,102.25	$924,102.25	$924,102.25	$924,102.25	$924,102.25	$924,102.25	$924,102.25	$924,102.25	$924,102.25	$924,102.27	$11,089,227.02
Goulburn Valley Health	$10,147,430.54	$10,147,430.54	$10,147,430.54	$10,147,430.54	$10,147,430.54	$10,147,430.54	$10,147,430.54	$10,147,430.54	$10,147,430.54	$10,147,430.54	$10,147,430.54	$10,147,430.45	$121,769,166.39
Grampians Health	$17,189,102.33	$17,189,102.33	$17,189,102.33	$17,189,102.33	$17,189,102.33	$17,189,102.33	$17,189,102.33	$17,189,102.33	$17,189,102.33	$17,189,102.33	$17,189,102.33	$17,189,102.30	$206,269,227.93
Kyabram District Health Service	$689,443.05	$689,443.05	$689,443.05	$689,443.05	$689,443.05	$689,443.05	$689,443.05	$689,443.05	$689,443.05	$689,443.05	$689,443.05	$689,443.07	$8,273,316.62
Latrobe Regional Health	$9,233,439.26	$9,233,439.26	$9,233,439.26	$9,233,439.26	$9,233,439.26	$9,233,439.26	$9,233,439.26	$9,233,439.26	$9,233,439.26	$9,233,439.26	$9,233,439.26	$9,233,439.38	$110,801,271.24
Maryborough District Health Service	$949,379.72	$949,379.72	$949,379.72	$949,379.72	$949,379.72	$949,379.72	$949,379.72	$949,379.72	$949,379.72	$949,379.72	$949,379.72	$949,379.75	$11,392,556.67
Melbourne Health	$36,073,901.74	$36,073,901.74	$36,073,901.74	$36,073,901.74	$36,073,901.74	$36,073,901.74	$36,073,901.74	$36,073,901.74	$36,073,901.74	$36,073,901.74	$36,073,901.74	$36,073,901.72	$432,886,820.86
Mercy Hospitals Victoria Limited	$16,671,756.74	$16,671,756.74	$16,671,756.74	$16,671,756.74	$16,671,756.74	$16,671,756.74	$16,671,756.74	$16,671,756.74	$16,671,756.74	$16,671,756.74	$16,671,756.74	$16,671,756.61	$200,061,080.75
Mildura Base Public Hospital	$4,998,198.83	$4,998,198.83	$4,998,198.83	$4,998,198.83	$4,998,198.83	$4,998,198.83	$4,998,198.83	$4,998,198.83	$4,998,198.83	$4,998,198.83	$4,998,198.83	$4,998,198.69	$59,978,385.82
Monash Health	$72,007,302.86	$72,007,302.86	$72,007,302.86	$72,007,302.86	$72,007,302.86	$72,007,302.86	$72,007,302.86	$72,007,302.86	$72,007,302.86	$72,007,302.86	$72,007,302.86	$72,007,302.87	$864,087,634.33
Northeast Health Wangaratta	$5,864,162.89	$5,864,162.89	$5,864,162.89	$5,864,162.89	$5,864,162.89	$5,864,162.89	$5,864,162.89	$5,864,162.89	$5,864,162.89	$5,864,162.89	$5,864,162.89	$5,864,162.81	$70,369,954.60
Northern Health	$25,673,275.19	$25,673,275.19	$25,673,275.19	$25,673,275.19	$25,673,275.19	$25,673,275.19	$25,673,275.19	$25,673,275.19	$25,673,275.19	$25,673,275.19	$25,673,275.19	$25,673,275.22	$308,079,302.31
Peninsula Health	$24,119,974.54	$24,119,974.54	$24,119,974.54	$24,119,974.54	$24,119,974.54	$24,119,974.54	$24,119,974.54	$24,119,974.54	$24,119,974.54	$24,119,974.54	$24,119,974.54	$24,119,974.45	$289,439,694.39
Peter Maccallum Cancer Institute	$6,868,099.82	$6,868,099.82	$6,868,099.82	$6,868,099.82	$6,868,099.82	$6,868,099.82	$6,868,099.82	$6,868,099.82	$6,868,099.82	$6,868,099.82	$6,868,099.82	$6,868,099.79	$82,417,197.81
Portland District Health	$1,220,269.98	$1,220,269.98	$1,220,269.98	$1,220,269.98	$1,220,269.98	$1,220,269.98	$1,220,269.98	$1,220,269.98	$1,220,269.98	$1,220,269.98	$1,220,269.98	$1,220,269.81	$14,643,239.59
South West Healthcare	$6,310,520.90	$6,310,520.90	$6,310,520.90	$6,310,520.90	$6,310,520.90	$6,310,520.90	$6,310,520.90	$6,310,520.90	$6,310,520.90	$6,310,520.90	$6,310,520.90	$6,310,521.05	$75,726,250.95
St Vincent's Hospital (Melbourne) Limited	$22,218,055.41	$22,218,055.41	$22,218,055.41	$22,218,055.41	$22,218,055.41	$22,218,055.41	$22,218,055.41	$22,218,055.41	$22,218,055.41	$22,218,055.41	$22,218,055.41	$22,218,055.30	$266,616,664.81
Swan Hill District Hospital	$1,993,549.96	$1,993,549.96	$1,993,549.96	$1,993,549.96	$1,993,549.96	$1,993,549.96	$1,993,549.96	$1,993,549.96	$1,993,549.96	$1,993,549.96	$1,993,549.96	$1,993,550.04	$23,922,599.60
The Royal Children's Hospital	$21,416,759.54	$21,416,759.54	$21,416,759.54	$21,416,759.54	$21,416,759.54	$21,416,759.54	$21,416,759.54	$21,416,759.54	$21,416,759.54	$21,416,759.54	$21,416,759.54	$21,416,759.48	$257,001,114.42
The Royal Victorian Eye And Ear Hospital	$4,382,692.38	$4,382,692.38	$4,382,692.38	$4,382,692.38	$4,382,692.38	$4,382,692.38	$4,382,692.38	$4,382,692.38	$4,382,692.38	$4,382,692.38	$4,382,692.38	$4,382,692.29	$52,592,308.47
The Royal Women's Hospital	$9,469,783.63	$9,469,783.63	$9,469,783.63	$9,469,783.63	$9,469,783.63	$9,469,783.63	$9,469,783.63	$9,469,783.63	$9,469,783.63	$9,469,783.63	$9,469,783.63	$9,469,783.69	$113,637,403.62
West Gippsland Healthcare Group	$3,621,840.47	$3,621,840.47	$3,621,840.47	$3,621,840.47	$3,621,840.47	$3,621,840.47	$3,621,840.47	$3,621,840.47	$3,621,840.47	$3,621,840.47	$3,621,840.47	$3,621,840.38	$43,462,085.55
Western District Health Service	$1,962,374.42	$1,962,374.42	$1,962,374.42	$1,962,374.42	$1,962,374.42	$1,962,374.42	$1,962,374.42	$1,962,374.42	$1,962,374.42	$1,962,374.42	$1,962,374.42	$1,962,374.39	$23,548,493.01
Western Health	$38,301,900.25	$38,301,900.25	$38,301,900.25	$38,301,900.25	$38,301,900.25	$38,301,900.25	$38,301,900.25	$38,301,900.25	$38,301,900.25	$38,301,900.25	$38,301,900.25	$38,301,900.35	$459,622,803.10
Total Activity Based Funding	**$517,875,580.26**	**$517,875,580.26**	**$517,875,580.26**	**$517,875,580.26**	**$517,875,580.26**	**$517,875,580.26**	**$517,875,580.26**	**$517,875,580.26**	**$517,875,580.26**	**$517,875,580.26**	**$517,875,580.26**	**$517,875,579.06**	**$6,214,506,961.92**
Teaching Training and Research	$14,698,352.71	$14,698,352.71	$14,698,352.71	$14,698,352.71	$14,698,352.71	$14,698,352.71	$14,698,352.71	$14,698,352.71	$14,698,352.71	$14,698,352.71	$14,698,352.71	$14,698,352.70	$176,380,232.51
Small Rural Hospitals	$9,766,790.28	$9,766,790.28	$9,766,790.28	$9,766,790.28	$9,766,790.28	$9,766,790.28	$9,766,790.28	$9,766,790.28	$9,766,790.28	$9,766,790.28	$9,766,790.28	$9,766,790.27	$117,201,483.35
Other Mental Health	$47,680,429.10	$47,680,429.10	$47,680,429.10	$47,680,429.10	$47,680,429.10	$47,680,429.10	$47,680,429.10	$47,680,429.10	$47,680,429.10	$47,680,429.10	$47,680,429.10	$47,680,429.15	$572,165,149.25
Non-admitted Home Ventilation	$454,142.40	$454,142.40	$454,142.40	$454,142.40	$454,142.40	$454,142.40	$454,142.40	$454,142.40	$454,142.40	$454,142.40	$454,142.40	$454,142.40	$5,449,708.80
Other Non-admitted Services	$888.86	$888.86	$888.86	$888.86	$888.86	$888.86	$888.86	$888.86	$888.86	$888.86	$888.86	$888.89	$10,666.35
Other Public Hospital Programs	$1,225,387.50	$1,225,387.50	$1,225,387.50	$1,225,387.50	$1,225,387.50	$1,225,387.50	$1,225,387.50	$1,225,387.50	$1,225,387.50	$1,225,387.50	$1,225,387.50	$1,225,387.50	$14,704,650.00
Highly Specialised Therapies	$4,004,738.96	$4,004,738.96	$4,004,738.96	$4,004,738.96	$4,004,738.96	$4,004,738.96	$4,004,738.96	$4,004,738.96	$4,004,738.96	$4,004,738.96	$4,004,738.96	$4,004,738.94	$48,056,867.50
Total Block Funding	**$77,830,729.81**	**$77,830,729.81**	**$77,830,729.81**	**$77,830,729.81**	**$77,830,729.81**	**$77,830,729.81**	**$77,830,729.81**	**$77,830,729.81**	**$77,830,729.81**	**$77,830,729.81**	**$77,830,729.81**	**$77,830,729.85**	**$933,968,757.76**
Public Health Funding	**$11,863,138.25**	**$11,863,138.25**	**$11,863,138.25**	**$11,863,138.25**	**$11,863,138.25**	**$11,863,138.25**	**$11,863,138.25**	**$11,863,138.25**	**$11,863,138.25**	**$11,863,138.25**	**$11,863,138.25**	**$11,863,138.25**	**$142,357,659.00**
Payments in respect of 2024-25	**$607,569,448.32**	**$607,569,448.32**	**$607,569,448.32**	**$607,569,448.32**	**$607,569,448.32**	**$607,569,448.32**	**$607,569,448.32**	**$607,569,448.32**	**$607,569,448.32**	**$607,569,448.32**	**$607,569,448.32**	**$607,569,447.16**	**$7,290,833,378.68**

Table C - Payments in respect of prior year services	Jul 2024	Aug 2024	Sep 2024	Oct 2024	Nov 2024	Dec 2024	Jan 2025	Feb 2025	Mar 2025	Apr 2025	May 2025	Jun 2025	Total
Albury Wodonga Health	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Alfred Health	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Austin Health	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Bairnsdale Regional Health Service	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Barwon Health	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Bass Coast Health	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Benalla Health	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Bendigo Health	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Calvary Health Care Bethlehem Limited	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Central Gippsland Health Service	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Colac Area Health	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Contracted Services LHN Victoria	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Dental Health Services Victoria	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Dhelkaya Health	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
East Grampians Health Service	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Eastern Health	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Echuca Regional Health	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Gippsland Southern Health Service	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Goulburn Valley Health	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Grampians Health	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Kyabram District Health Service	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Latrobe Regional Health	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Maryborough District Health Service	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Melbourne Health	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Mercy Hospitals Victoria Limited	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Mildura Base Public Hospital	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Monash Health	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Northeast Health Wangaratta	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Northern Health	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Peninsula Health	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Peter Maccallum Cancer Institute	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Portland District Health	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
South West Healthcare	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
St Vincent's Hospital (Melbourne) Limited	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Swan Hill District Hospital	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
The Royal Children's Hospital	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
The Royal Victorian Eye And Ear Hospital	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
The Royal Women's Hospital	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
West Gippsland Healthcare Group	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Western District Health Service	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Western Health	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Total Activity Based Funding	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**
Teaching Training and Research	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Small Rural Hospitals	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Other Mental Health	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Non-admitted Home Ventilation	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Other Non-admitted Services	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Other Public Hospital Programs	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Highly Specialised Therapies	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Total Block Funding	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**
Public Health Funding	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**
Payments in respect of prior year services	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**

Monthly cash flow of Commonwealth Payments into the National Health Funding Pool as at October 2024

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Table A - Commonwealth Payments into the National Health Funding Pool, 2024-25	Jul 2024	Aug 2024	Sep 2024	Oct 2024	Nov 2024	Dec 2024	Jan 2025	Feb 2025	Mar 2025	Apr 2025	May 2025	Jun 2025	Total
Cairns And Hinterland Hospital And Health Service	$32,044,078.12	$32,044,078.12	$32,044,078.12	$32,044,078.12	$32,044,078.12	$32,044,078.12	$32,044,078.12	$32,044,078.12	$32,044,078.12	$32,044,078.12	$32,044,078.12	$32,044,078.25	$384,528,937.57
Central Queensland Hospital And Health Service	$17,470,411.91	$17,470,411.91	$17,470,411.91	$17,470,411.91	$17,470,411.91	$17,470,411.91	$17,470,411.91	$17,470,411.91	$17,470,411.91	$17,470,411.91	$17,470,411.91	$17,470,411.90	$209,644,942.91
Children's Health Queensland Hospital And Health Service	$20,163,797.55	$20,163,797.55	$20,163,797.55	$20,163,797.55	$20,163,797.55	$20,163,797.55	$20,163,797.55	$20,163,797.55	$20,163,797.55	$20,163,797.55	$20,163,797.55	$20,163,797.59	$241,965,570.64
Darling Downs Hospital And Health Service	$23,034,282.63	$23,034,282.63	$23,034,282.63	$23,034,282.63	$23,034,282.63	$23,034,282.63	$23,034,282.63	$23,034,282.63	$23,034,282.63	$23,034,282.63	$23,034,282.63	$23,034,282.54	$276,411,391.47
Gold Coast Hospital And Health Service	$59,791,197.02	$59,791,197.02	$59,791,197.02	$59,791,197.02	$59,791,197.02	$59,791,197.02	$59,791,197.02	$59,791,197.02	$59,791,197.02	$59,791,197.02	$59,791,197.02	$59,791,196.99	$717,494,364.21
Mackay Hospital And Health Service	$15,877,011.40	$15,877,011.40	$15,877,011.40	$15,877,011.40	$15,877,011.40	$15,877,011.40	$15,877,011.40	$15,877,011.40	$15,877,011.40	$15,877,011.40	$15,877,011.40	$15,877,011.56	$190,524,136.96
Mater Misericordiae Health Service Brisbane	$21,512,855.82	$21,512,855.82	$21,512,855.82	$21,512,855.82	$21,512,855.82	$21,512,855.82	$21,512,855.82	$21,512,855.82	$21,512,855.82	$21,512,855.82	$21,512,855.82	$21,512,855.76	$258,154,269.78
Metro North Hospital And Health Service	$108,204,957.62	$108,204,957.62	$108,204,957.62	$108,204,957.62	$108,204,957.62	$108,204,957.62	$108,204,957.62	$108,204,957.62	$108,204,957.62	$108,204,957.62	$108,204,957.62	$108,204,957.65	$1,298,459,491.47
Metro South Hospital And Health Service	$93,346,789.41	$93,346,789.41	$93,346,789.41	$93,346,789.41	$93,346,789.41	$93,346,789.41	$93,346,789.41	$93,346,789.41	$93,346,789.41	$93,346,789.41	$93,346,789.41	$93,346,789.29	$1,120,161,472.80
North West Hospital And Health Service	$3,832,506.61	$3,832,506.61	$3,832,506.61	$3,832,506.61	$3,832,506.61	$3,832,506.61	$3,832,506.61	$3,832,506.61	$3,832,506.61	$3,832,506.61	$3,832,506.61	$3,832,506.54	$45,990,079.25
Queensland Health Virtual LHN	$1,684,089.62	$1,684,089.62	$1,684,089.62	$1,684,089.62	$1,684,089.62	$1,684,089.62	$1,684,089.62	$1,684,089.62	$1,684,089.62	$1,684,089.62	$1,684,089.62	$1,684,089.68	$20,209,075.50
South West Hospital And Health Service	$902,731.81	$902,731.81	$902,731.81	$902,731.81	$902,731.81	$902,731.81	$902,731.81	$902,731.81	$902,731.81	$902,731.81	$902,731.81	$902,731.85	$10,832,781.76
Sunshine Coast Hospital And Health Service	$40,810,667.24	$40,810,667.24	$40,810,667.24	$40,810,667.24	$40,810,667.24	$40,810,667.24	$40,810,667.24	$40,810,667.24	$40,810,667.24	$40,810,667.24	$40,810,667.24	$40,810,667.21	$489,728,006.85
Townsville Hospital And Health Service	$32,636,799.60	$32,636,799.60	$32,636,799.60	$32,636,799.60	$32,636,799.60	$32,636,799.60	$32,636,799.60	$32,636,799.60	$32,636,799.60	$32,636,799.60	$32,636,799.60	$32,636,799.56	$391,641,595.16
West Moreton Hospital And Health Service	$21,570,260.83	$21,570,260.83	$21,570,260.83	$21,570,260.83	$21,570,260.83	$21,570,260.83	$21,570,260.83	$21,570,260.83	$21,570,260.83	$21,570,260.83	$21,570,260.83	$21,570,260.94	$258,843,130.07
Wide Bay Hospital And Health Service	$22,387,625.20	$22,387,625.20	$22,387,625.20	$22,387,625.20	$22,387,625.20	$22,387,625.20	$22,387,625.20	$22,387,625.20	$22,387,625.20	$22,387,625.20	$22,387,625.20	$22,387,625.20	$268,651,502.40
Total Activity Based Funding	**$515,270,062.39**	**$515,270,062.39**	**$515,270,062.39**	**$515,270,062.39**	**$515,270,062.39**	**$515,270,062.39**	**$515,270,062.39**	**$515,270,062.39**	**$515,270,062.39**	**$515,270,062.39**	**$515,270,062.39**	**$515,270,062.51**	**$6,183,240,748.80**
Teaching Training and Research	$10,820,507.54	$10,820,507.54	$10,820,507.54	$10,820,507.54	$10,820,507.54	$10,820,507.54	$10,820,507.54	$10,820,507.54	$10,820,507.54	$10,820,507.54	$10,820,507.54	$10,820,507.51	$129,846,090.45
Small Rural Hospitals	$23,061,368.13	$23,061,368.13	$23,061,368.13	$23,061,368.13	$23,061,368.13	$23,061,368.13	$23,061,368.13	$23,061,368.13	$23,061,368.13	$23,061,368.13	$23,061,368.13	$23,061,368.18	$276,736,417.61
Other Mental Health	$28,358,637.05	$28,358,637.05	$28,358,637.05	$28,358,637.05	$28,358,637.05	$28,358,637.05	$28,358,637.05	$28,358,637.05	$28,358,637.05	$28,358,637.05	$28,358,637.05	$28,358,637.09	$340,303,644.64
Non-admitted Home Ventilation	$537,753.45	$537,753.45	$537,753.45	$537,753.45	$537,753.45	$537,753.45	$537,753.45	$537,753.45	$537,753.45	$537,753.45	$537,753.45	$537,753.45	$6,453,041.40
Other Non-admitted Services	$329,231.14	$329,231.14	$329,231.14	$329,231.14	$329,231.14	$329,231.14	$329,231.14	$329,231.14	$329,231.14	$329,231.14	$329,231.14	$329,231.11	$3,950,773.65
Other Public Hospital Programs	$278,512.50	$278,512.50	$278,512.50	$278,512.50	$278,512.50	$278,512.50	$278,512.50	$278,512.50	$278,512.50	$278,512.50	$278,512.50	$278,512.50	$3,342,150.00
Highly Specialised Therapies	$1,092,059.46	$1,092,059.46	$1,092,059.46	$1,092,059.46	$1,092,059.46	$1,092,059.46	$1,092,059.46	$1,092,059.46	$1,092,059.46	$1,092,059.46	$1,092,059.46	$1,092,059.45	$13,104,713.51
Total Block Funding	**$64,478,069.27**	**$64,478,069.27**	**$64,478,069.27**	**$64,478,069.27**	**$64,478,069.27**	**$64,478,069.27**	**$64,478,069.27**	**$64,478,069.27**	**$64,478,069.27**	**$64,478,069.27**	**$64,478,069.27**	**$64,478,069.29**	**$773,736,831.26**
Public Health Funding	**$9,431,408.83**	**$9,431,408.83**	**$9,431,408.83**	**$9,431,408.83**	**$9,431,408.83**	**$9,431,408.83**	**$9,431,408.83**	**$9,431,408.83**	**$9,431,408.83**	**$9,431,408.83**	**$9,431,408.83**	**$9,431,408.87**	**$113,176,906.00**
Total Payable in 2024-25	**$589,179,540.49**	**$589,179,540.49**	**$589,179,540.49**	**$589,179,540.49**	**$589,179,540.49**	**$589,179,540.49**	**$589,179,540.49**	**$589,179,540.49**	**$589,179,540.49**	**$589,179,540.49**	**$589,179,540.49**	**$589,179,540.67**	**$7,070,154,486.06**

Table B - Payments in respect of 2024-25 (subject to State-based Soft Cap)	Jul 2024	Aug 2024	Sep 2024	Oct 2024	Nov 2024	Dec 2024	Jan 2025	Feb 2025	Mar 2025	Apr 2025	May 2025	Jun 2025	Total
Cairns And Hinterland Hospital And Health Service	$32,044,078.12	$32,044,078.12	$32,044,078.12	$32,044,078.12	$32,044,078.12	$32,044,078.12	$32,044,078.12	$32,044,078.12	$32,044,078.12	$32,044,078.12	$32,044,078.12	$32,044,078.25	$384,528,937.57
Central Queensland Hospital And Health Service	$17,470,411.91	$17,470,411.91	$17,470,411.91	$17,470,411.91	$17,470,411.91	$17,470,411.91	$17,470,411.91	$17,470,411.91	$17,470,411.91	$17,470,411.91	$17,470,411.91	$17,470,411.90	$209,644,942.91
Children's Health Queensland Hospital And Health Service	$20,163,797.55	$20,163,797.55	$20,163,797.55	$20,163,797.55	$20,163,797.55	$20,163,797.55	$20,163,797.55	$20,163,797.55	$20,163,797.55	$20,163,797.55	$20,163,797.55	$20,163,797.59	$241,965,570.64
Darling Downs Hospital And Health Service	$23,034,282.63	$23,034,282.63	$23,034,282.63	$23,034,282.63	$23,034,282.63	$23,034,282.63	$23,034,282.63	$23,034,282.63	$23,034,282.63	$23,034,282.63	$23,034,282.63	$23,034,282.54	$276,411,391.47
Gold Coast Hospital And Health Service	$59,791,197.02	$59,791,197.02	$59,791,197.02	$59,791,197.02	$59,791,197.02	$59,791,197.02	$59,791,197.02	$59,791,197.02	$59,791,197.02	$59,791,197.02	$59,791,197.02	$59,791,196.99	$717,494,364.21
Mackay Hospital And Health Service	$15,877,011.40	$15,877,011.40	$15,877,011.40	$15,877,011.40	$15,877,011.40	$15,877,011.40	$15,877,011.40	$15,877,011.40	$15,877,011.40	$15,877,011.40	$15,877,011.40	$15,877,011.56	$190,524,136.96
Mater Misericordiae Health Service Brisbane	$21,512,855.82	$21,512,855.82	$21,512,855.82	$21,512,855.82	$21,512,855.82	$21,512,855.82	$21,512,855.82	$21,512,855.82	$21,512,855.82	$21,512,855.82	$21,512,855.82	$21,512,855.76	$258,154,269.78
Metro North Hospital And Health Service	$108,204,957.62	$108,204,957.62	$108,204,957.62	$108,204,957.62	$108,204,957.62	$108,204,957.62	$108,204,957.62	$108,204,957.62	$108,204,957.62	$108,204,957.62	$108,204,957.62	$108,204,957.65	$1,298,459,491.47
Metro South Hospital And Health Service	$93,346,789.41	$93,346,789.41	$93,346,789.41	$93,346,789.41	$93,346,789.41	$93,346,789.41	$93,346,789.41	$93,346,789.41	$93,346,789.41	$93,346,789.41	$93,346,789.41	$93,346,789.29	$1,120,161,472.80
North West Hospital And Health Service	$3,832,506.61	$3,832,506.61	$3,832,506.61	$3,832,506.61	$3,832,506.61	$3,832,506.61	$3,832,506.61	$3,832,506.61	$3,832,506.61	$3,832,506.61	$3,832,506.61	$3,832,506.54	$45,990,079.25
Queensland Health Virtual LHN	$1,684,089.62	$1,684,089.62	$1,684,089.62	$1,684,089.62	$1,684,089.62	$1,684,089.62	$1,684,089.62	$1,684,089.62	$1,684,089.62	$1,684,089.62	$1,684,089.62	$1,684,089.68	$20,209,075.50
South West Hospital And Health Service	$902,731.81	$902,731.81	$902,731.81	$902,731.81	$902,731.81	$902,731.81	$902,731.81	$902,731.81	$902,731.81	$902,731.81	$902,731.81	$902,731.85	$10,832,781.76
Sunshine Coast Hospital And Health Service	$40,810,667.24	$40,810,667.24	$40,810,667.24	$40,810,667.24	$40,810,667.24	$40,810,667.24	$40,810,667.24	$40,810,667.24	$40,810,667.24	$40,810,667.24	$40,810,667.24	$40,810,667.21	$489,728,006.85
Townsville Hospital And Health Service	$32,636,799.60	$32,636,799.60	$32,636,799.60	$32,636,799.60	$32,636,799.60	$32,636,799.60	$32,636,799.60	$32,636,799.60	$32,636,799.60	$32,636,799.60	$32,636,799.60	$32,636,799.56	$391,641,595.16
West Moreton Hospital And Health Service	$21,570,260.83	$21,570,260.83	$21,570,260.83	$21,570,260.83	$21,570,260.83	$21,570,260.83	$21,570,260.83	$21,570,260.83	$21,570,260.83	$21,570,260.83	$21,570,260.83	$21,570,260.94	$258,843,130.07
Wide Bay Hospital And Health Service	$22,387,625.20	$22,387,625.20	$22,387,625.20	$22,387,625.20	$22,387,625.20	$22,387,625.20	$22,387,625.20	$22,387,625.20	$22,387,625.20	$22,387,625.20	$22,387,625.20	$22,387,625.20	$268,651,502.40
Total Activity Based Funding	**$515,270,062.39**	**$515,270,062.39**	**$515,270,062.39**	**$515,270,062.39**	**$515,270,062.39**	**$515,270,062.39**	**$515,270,062.39**	**$515,270,062.39**	**$515,270,062.39**	**$515,270,062.39**	**$515,270,062.39**	**$515,270,062.51**	**$6,183,240,748.80**
Teaching Training and Research	$10,820,507.54	$10,820,507.54	$10,820,507.54	$10,820,507.54	$10,820,507.54	$10,820,507.54	$10,820,507.54	$10,820,507.54	$10,820,507.54	$10,820,507.54	$10,820,507.54	$10,820,507.51	$129,846,090.45
Small Rural Hospitals	$23,061,368.13	$23,061,368.13	$23,061,368.13	$23,061,368.13	$23,061,368.13	$23,061,368.13	$23,061,368.13	$23,061,368.13	$23,061,368.13	$23,061,368.13	$23,061,368.13	$23,061,368.18	$276,736,417.61
Other Mental Health	$28,358,637.05	$28,358,637.05	$28,358,637.05	$28,358,637.05	$28,358,637.05	$28,358,637.05	$28,358,637.05	$28,358,637.05	$28,358,637.05	$28,358,637.05	$28,358,637.05	$28,358,637.09	$340,303,644.64
Non-admitted Home Ventilation	$537,753.45	$537,753.45	$537,753.45	$537,753.45	$537,753.45	$537,753.45	$537,753.45	$537,753.45	$537,753.45	$537,753.45	$537,753.45	$537,753.45	$6,453,041.40
Other Non-admitted Services	$329,231.14	$329,231.14	$329,231.14	$329,231.14	$329,231.14	$329,231.14	$329,231.14	$329,231.14	$329,231.14	$329,231.14	$329,231.14	$329,231.11	$3,950,773.65
Other Public Hospital Programs	$278,512.50	$278,512.50	$278,512.50	$278,512.50	$278,512.50	$278,512.50	$278,512.50	$278,512.50	$278,512.50	$278,512.50	$278,512.50	$278,512.50	$3,342,150.00
Highly Specialised Therapies	$1,092,059.46	$1,092,059.46	$1,092,059.46	$1,092,059.46	$1,092,059.46	$1,092,059.46	$1,092,059.46	$1,092,059.46	$1,092,059.46	$1,092,059.46	$1,092,059.46	$1,092,059.45	$13,104,713.51
Total Block Funding	**$64,478,069.27**	**$64,478,069.27**	**$64,478,069.27**	**$64,478,069.27**	**$64,478,069.27**	**$64,478,069.27**	**$64,478,069.27**	**$64,478,069.27**	**$64,478,069.27**	**$64,478,069.27**	**$64,478,069.27**	**$64,478,069.29**	**$773,736,831.26**
Public Health Funding	**$9,431,408.83**	**$9,431,408.83**	**$9,431,408.83**	**$9,431,408.83**	**$9,431,408.83**	**$9,431,408.83**	**$9,431,408.83**	**$9,431,408.83**	**$9,431,408.83**	**$9,431,408.83**	**$9,431,408.83**	**$9,431,408.87**	**$113,176,906.00**
Payments in respect of 2024-25	**$589,179,540.49**	**$589,179,540.49**	**$589,179,540.49**	**$589,179,540.49**	**$589,179,540.49**	**$589,179,540.49**	**$589,179,540.49**	**$589,179,540.49**	**$589,179,540.49**	**$589,179,540.49**	**$589,179,540.49**	**$589,179,540.67**	**$7,070,154,486.06**

Table C - Payments in respect of prior year services	Jul 2024	Aug 2024	Sep 2024	Oct 2024	Nov 2024	Dec 2024	Jan 2025	Feb 2025	Mar 2025	Apr 2025	May 2025	Jun 2025	Total
Cairns And Hinterland Hospital And Health Service	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Central Queensland Hospital And Health Service	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Children's Health Queensland Hospital And Health Service	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Darling Downs Hospital And Health Service	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Gold Coast Hospital And Health Service	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Mackay Hospital And Health Service	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Mater Misericordiae Health Service Brisbane	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Metro North Hospital And Health Service	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Metro South Hospital And Health Service	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
North West Hospital And Health Service	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Queensland Health Virtual LHN	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
South West Hospital And Health Service	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Sunshine Coast Hospital And Health Service	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Townsville Hospital And Health Service	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
West Moreton Hospital And Health Service	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Wide Bay Hospital And Health Service	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Total Activity Based Funding	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**
Teaching Training and Research	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Small Rural Hospitals	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Other Mental Health	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Non-admitted Home Ventilation	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Other Non-admitted Services	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Other Public Hospital Programs	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Highly Specialised Therapies	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Total Block Funding	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**
Public Health Funding	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**
Payments in respect of prior year services	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**

Monthly cash flow of Commonwealth Payments into the National Health Funding Pool as at October 2024

Western Australia (page 1 of 2)

Table A - Commonwealth Payments into the National Health Funding Pool, 2024-25	Jul 2024	Aug 2024	Sep 2024	Oct 2024	Nov 2024	Dec 2024	Jan 2025	Feb 2025	Mar 2025	Apr 2025	May 2025	Jun 2025	Total
Child And Adolescent Health Service	$16,464,404.77	$16,464,404.77	$16,464,404.77	$16,464,404.77	$16,464,404.77	$16,464,404.77	$16,464,404.77	$16,464,404.77	$16,464,404.77	$16,464,404.77	$16,464,404.77	$16,464,404.87	$197,572,857.34
East Metropolitan Health Service	$49,976,799.00	$49,976,799.00	$49,976,799.00	$49,976,799.00	$49,976,799.00	$49,976,799.00	$49,976,799.00	$49,976,799.00	$49,976,799.00	$49,976,799.00	$49,976,799.00	$49,976,799.10	$599,721,588.10
North Metropolitan Health Service	$55,563,527.48	$55,563,527.48	$55,563,527.48	$55,563,527.48	$55,563,527.48	$55,563,527.48	$55,563,527.48	$55,563,527.48	$55,563,527.48	$55,563,527.48	$55,563,527.48	$55,563,527.52	$666,762,329.80
Notional LHN - Royal Street	$5,189,574.16	$5,189,574.16	$5,189,574.16	$5,189,574.16	$5,189,574.16	$5,189,574.16	$5,189,574.16	$5,189,574.16	$5,189,574.16	$5,189,574.16	$5,189,574.16	$5,189,574.23	$62,274,889.99
South Metropolitan Health Service	$57,949,093.61	$57,949,093.61	$57,949,093.61	$57,949,093.61	$57,949,093.61	$57,949,093.61	$57,949,093.61	$57,949,093.61	$57,949,093.61	$57,949,093.61	$57,949,093.61	$57,949,093.51	$695,389,123.22
WA Country Health Service	$40,734,400.66	$40,734,400.66	$40,734,400.66	$40,734,400.66	$40,734,400.66	$40,734,400.66	$40,734,400.66	$40,734,400.66	$40,734,400.66	$40,734,400.66	$40,734,400.66	$40,734,400.50	$488,812,807.76
Total Activity Based Funding	**$225,877,799.68**	**$225,877,799.68**	**$225,877,799.68**	**$225,877,799.68**	**$225,877,799.68**	**$225,877,799.68**	**$225,877,799.68**	**$225,877,799.68**	**$225,877,799.68**	**$225,877,799.68**	**$225,877,799.68**	**$225,877,799.73**	**$2,710,533,596.21**
Teaching Training and Research	$11,438,459.10	$11,438,459.10	$11,438,459.10	$11,438,459.10	$11,438,459.10	$11,438,459.10	$11,438,459.10	$11,438,459.10	$11,438,459.10	$11,438,459.10	$11,438,459.10	$11,438,459.15	$137,261,509.25
Small Rural Hospitals	$11,555,998.06	$11,555,998.06	$11,555,998.06	$11,555,998.06	$11,555,998.06	$11,555,998.06	$11,555,998.06	$11,555,998.06	$11,555,998.06	$11,555,998.06	$11,555,998.06	$11,555,998.08	$138,671,976.74
Other Mental Health	$15,065,191.20	$15,065,191.20	$15,065,191.20	$15,065,191.20	$15,065,191.20	$15,065,191.20	$15,065,191.20	$15,065,191.20	$15,065,191.20	$15,065,191.20	$15,065,191.20	$15,065,191.19	$180,782,294.39
Non-admitted Home Ventilation	$584,544.83	$584,544.83	$584,544.83	$584,544.83	$584,544.83	$584,544.83	$584,544.83	$584,544.83	$584,544.83	$584,544.83	$584,544.83	$584,544.77	$7,014,537.90
Other Non-admitted Services	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Other Public Hospital Programs	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Highly Specialised Therapies	$366,666.67	$366,666.67	$366,666.67	$366,666.67	$366,666.67	$366,666.67	$366,666.67	$366,666.67	$366,666.67	$366,666.67	$366,666.67	$366,666.63	$4,400,000.00
Total Block Funding	**$39,010,859.86**	**$39,010,859.86**	**$39,010,859.86**	**$39,010,859.86**	**$39,010,859.86**	**$39,010,859.86**	**$39,010,859.86**	**$39,010,859.86**	**$39,010,859.86**	**$39,010,859.86**	**$39,010,859.86**	**$39,010,859.82**	**$468,130,318.28**
Public Health Funding	**$4,976,942.25**	**$4,976,942.25**	**$4,976,942.25**	**$4,976,942.25**	**$4,976,942.25**	**$4,976,942.25**	**$4,976,942.25**	**$4,976,942.25**	**$4,976,942.25**	**$4,976,942.25**	**$4,976,942.25**	**$4,976,942.25**	**$59,723,307.00**
Total Payable in 2024-25	**$269,865,601.79**	**$269,865,601.79**	**$269,865,601.79**	**$269,865,601.79**	**$269,865,601.79**	**$269,865,601.79**	**$269,865,601.79**	**$269,865,601.79**	**$269,865,601.79**	**$269,865,601.79**	**$269,865,601.79**	**$269,865,601.80**	**$3,238,387,221.49**

Table B - Payments in respect of 2024-25 (subject to State-based Soft Cap)	Jul 2024	Aug 2024	Sep 2024	Oct 2024	Nov 2024	Dec 2024	Jan 2025	Feb 2025	Mar 2025	Apr 2025	May 2025	Jun 2025	Total
Child And Adolescent Health Service	$16,464,404.77	$16,464,404.77	$16,464,404.77	$16,464,404.77	$16,464,404.77	$16,464,404.77	$16,464,404.77	$16,464,404.77	$16,464,404.77	$16,464,404.77	$16,464,404.77	$16,464,404.87	$197,572,857.34
East Metropolitan Health Service	$49,976,799.00	$49,976,799.00	$49,976,799.00	$49,976,799.00	$49,976,799.00	$49,976,799.00	$49,976,799.00	$49,976,799.00	$49,976,799.00	$49,976,799.00	$49,976,799.00	$49,976,799.10	$599,721,588.10
North Metropolitan Health Service	$55,563,527.48	$55,563,527.48	$55,563,527.48	$55,563,527.48	$55,563,527.48	$55,563,527.48	$55,563,527.48	$55,563,527.48	$55,563,527.48	$55,563,527.48	$55,563,527.48	$55,563,527.52	$666,762,329.80
Notional LHN - Royal Street	$5,189,574.16	$5,189,574.16	$5,189,574.16	$5,189,574.16	$5,189,574.16	$5,189,574.16	$5,189,574.16	$5,189,574.16	$5,189,574.16	$5,189,574.16	$5,189,574.16	$5,189,574.23	$62,274,889.99
South Metropolitan Health Service	$57,949,093.61	$57,949,093.61	$57,949,093.61	$57,949,093.61	$57,949,093.61	$57,949,093.61	$57,949,093.61	$57,949,093.61	$57,949,093.61	$57,949,093.61	$57,949,093.61	$57,949,093.51	$695,389,123.22
WA Country Health Service	$40,734,400.66	$40,734,400.66	$40,734,400.66	$40,734,400.66	$40,734,400.66	$40,734,400.66	$40,734,400.66	$40,734,400.66	$40,734,400.66	$40,734,400.66	$40,734,400.66	$40,734,400.50	$488,812,807.76
Total Activity Based Funding	**$225,877,799.68**	**$225,877,799.68**	**$225,877,799.68**	**$225,877,799.68**	**$225,877,799.68**	**$225,877,799.68**	**$225,877,799.68**	**$225,877,799.68**	**$225,877,799.68**	**$225,877,799.68**	**$225,877,799.68**	**$225,877,799.73**	**$2,710,533,596.21**
Teaching Training and Research	$11,438,459.10	$11,438,459.10	$11,438,459.10	$11,438,459.10	$11,438,459.10	$11,438,459.10	$11,438,459.10	$11,438,459.10	$11,438,459.10	$11,438,459.10	$11,438,459.10	$11,438,459.15	$137,261,509.25
Small Rural Hospitals	$11,555,998.06	$11,555,998.06	$11,555,998.06	$11,555,998.06	$11,555,998.06	$11,555,998.06	$11,555,998.06	$11,555,998.06	$11,555,998.06	$11,555,998.06	$11,555,998.06	$11,555,998.08	$138,671,976.74
Other Mental Health	$15,065,191.20	$15,065,191.20	$15,065,191.20	$15,065,191.20	$15,065,191.20	$15,065,191.20	$15,065,191.20	$15,065,191.20	$15,065,191.20	$15,065,191.20	$15,065,191.20	$15,065,191.19	$180,782,294.39
Non-admitted Home Ventilation	$584,544.83	$584,544.83	$584,544.83	$584,544.83	$584,544.83	$584,544.83	$584,544.83	$584,544.83	$584,544.83	$584,544.83	$584,544.83	$584,544.77	$7,014,537.90
Other Non-admitted Services	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Other Public Hospital Programs	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Highly Specialised Therapies	$366,666.67	$366,666.67	$366,666.67	$366,666.67	$366,666.67	$366,666.67	$366,666.67	$366,666.67	$366,666.67	$366,666.67	$366,666.67	$366,666.63	$4,400,000.00
Total Block Funding	**$39,010,859.86**	**$39,010,859.86**	**$39,010,859.86**	**$39,010,859.86**	**$39,010,859.86**	**$39,010,859.86**	**$39,010,859.86**	**$39,010,859.86**	**$39,010,859.86**	**$39,010,859.86**	**$39,010,859.86**	**$39,010,859.82**	**$468,130,318.28**
Public Health Funding	**$4,976,942.25**	**$4,976,942.25**	**$4,976,942.25**	**$4,976,942.25**	**$4,976,942.25**	**$4,976,942.25**	**$4,976,942.25**	**$4,976,942.25**	**$4,976,942.25**	**$4,976,942.25**	**$4,976,942.25**	**$4,976,942.25**	**$59,723,307.00**
Payments in respect of 2024-25	**$269,865,601.79**	**$269,865,601.79**	**$269,865,601.79**	**$269,865,601.79**	**$269,865,601.79**	**$269,865,601.79**	**$269,865,601.79**	**$269,865,601.79**	**$269,865,601.79**	**$269,865,601.79**	**$269,865,601.79**	**$269,865,601.80**	**$3,238,387,221.49**

Table C - Payments in respect of prior year services	Jul 2024	Aug 2024	Sep 2024	Oct 2024	Nov 2024	Dec 2024	Jan 2025	Feb 2025	Mar 2025	Apr 2025	May 2025	Jun 2025	Total
Child And Adolescent Health Service	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
East Metropolitan Health Service	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
North Metropolitan Health Service	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Notional LHN - Royal Street	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
South Metropolitan Health Service	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
WA Country Health Service	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Total Activity Based Funding	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**
Teaching Training and Research	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Small Rural Hospitals	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Other Mental Health	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Non-admitted Home Ventilation	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Other Non-admitted Services	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Other Public Hospital Programs	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Highly Specialised Therapies	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Total Block Funding	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**
Public Health Funding	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**
Payments in respect of prior year services	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**

Monthly cash flow of Commonwealth Payments into the National Health Funding Pool as at October 2024

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Table A - Commonwealth Payments into the National Health Funding Pool, 2024-25	Jul 2024	Aug 2024	Sep 2024	Oct 2024	Nov 2024	Dec 2024	Jan 2025	Feb 2025	Mar 2025	Apr 2025	May 2025	Jun 2025	Total
Barossa Hills Fleurieu Local Health Network	$5,523,560.79	$5,523,560.79	$5,523,560.79	$5,523,962.51	$5,523,962.51	$5,523,962.51	$5,523,962.51	$5,523,962.51	$5,523,962.51	$5,523,962.51	$5,523,962.51	$5,523,962.49	$66,286,344.94
Central Adelaide Local Health Network	$46,993,948.03	$46,993,948.03	$46,993,948.03	$46,994,012.92	$46,994,012.92	$46,994,012.92	$46,994,012.92	$46,994,012.92	$46,994,012.92	$46,994,012.92	$46,994,012.92	$46,994,012.91	$563,927,960.36
Central Office Services	$2,742,124.92	$2,742,124.92	$2,742,124.92	$2,742,222.30	$2,742,222.30	$2,742,222.30	$2,742,222.30	$2,742,222.30	$2,742,222.30	$2,742,222.30	$2,742,222.30	$2,742,222.27	$32,906,375.43
Eyre And Far North Local Health Network	$1,903,085.73	$1,903,085.73	$1,903,085.73	$1,902,959.19	$1,902,959.19	$1,902,959.19	$1,902,959.19	$1,902,959.19	$1,902,959.19	$1,902,959.19	$1,902,959.19	$1,902,959.13	$22,835,889.84
Flinders And Upper North Local Health Network	$3,624,471.38	$3,624,471.38	$3,624,471.38	$3,624,479.28	$3,624,479.28	$3,624,479.28	$3,624,479.28	$3,624,479.28	$3,624,479.28	$3,624,479.28	$3,624,479.28	$3,624,479.28	$43,493,727.66
Limestone Coast Local Health Network	$3,424,970.89	$3,424,970.89	$3,424,970.89	$3,424,933.36	$3,424,933.36	$3,424,933.36	$3,424,933.36	$3,424,933.36	$3,424,933.36	$3,424,933.36	$3,424,933.36	$3,424,933.28	$41,099,312.83
Northern Adelaide Local Health Network	$25,658,414.92	$25,658,414.92	$25,658,414.92	$25,658,425.01	$25,658,425.01	$25,658,425.01	$25,658,425.01	$25,658,425.01	$25,658,425.01	$25,658,425.01	$25,658,425.01	$25,658,425.09	$307,901,069.93
Riverland Mallee Coorong Local Health Network	$3,151,996.20	$3,151,996.20	$3,151,996.20	$3,151,847.80	$3,151,847.80	$3,151,847.80	$3,151,847.80	$3,151,847.80	$3,151,847.80	$3,151,847.80	$3,151,847.80	$3,151,847.69	$37,822,618.69
Southern Adelaide Local Health Network	$37,462,678.64	$37,462,678.64	$37,462,678.64	$37,462,593.86	$37,462,593.86	$37,462,593.86	$37,462,593.86	$37,462,593.86	$37,462,593.86	$37,462,593.86	$37,462,593.86	$37,462,593.83	$449,551,380.63
Women's And Children's Health Network	$14,010,299.02	$14,010,299.02	$14,010,299.02	$14,010,289.14	$14,010,289.14	$14,010,289.14	$14,010,289.14	$14,010,289.14	$14,010,289.14	$14,010,289.14	$14,010,289.14	$14,010,289.16	$168,123,499.34
Yorke And Northern Local Health Network	$2,648,371.55	$2,648,371.55	$2,648,371.55	$2,648,196.70	$2,648,196.70	$2,648,196.70	$2,648,196.70	$2,648,196.70	$2,648,196.70	$2,648,196.70	$2,648,196.70	$2,648,196.67	$31,778,884.92
Total Activity Based Funding	**$147,143,922.07**	**$147,143,922.07**	**$147,143,922.07**	**$147,143,922.07**	**$147,143,922.07**	**$147,143,922.07**	**$147,143,922.07**	**$147,143,922.07**	**$147,143,922.07**	**$147,143,922.07**	**$147,143,922.07**	**$147,143,921.80**	**$1,765,727,064.57**
Teaching Training and Research	$3,670,169.31	$3,670,169.31	$3,670,169.31	$3,670,169.30	$3,670,169.30	$3,670,169.30	$3,670,169.30	$3,670,169.30	$3,670,169.30	$3,670,169.30	$3,670,169.30	$3,670,169.34	$44,042,031.67
Small Rural Hospitals	$8,549,485.32	$8,549,485.32	$8,549,485.32	$8,549,485.32	$8,549,485.32	$8,549,485.32	$8,549,485.32	$8,549,485.32	$8,549,485.32	$8,549,485.32	$8,549,485.32	$8,549,485.34	$102,593,823.86
Other Mental Health	$6,164,905.23	$6,164,905.23	$6,164,905.23	$6,164,905.23	$6,164,905.23	$6,164,905.23	$6,164,905.23	$6,164,905.23	$6,164,905.23	$6,164,905.23	$6,164,905.23	$6,164,905.22	$73,978,862.75
Non-admitted Home Ventilation	$103,538.96	$103,538.96	$103,538.96	$103,538.96	$103,538.96	$103,538.96	$103,538.96	$103,538.96	$103,538.96	$103,538.96	$103,538.96	$103,538.99	$1,242,467.55
Other Non-admitted Services	$707,913.52	$707,913.52	$707,913.52	$707,913.52	$707,913.52	$707,913.52	$707,913.52	$707,913.52	$707,913.52	$707,913.52	$707,913.52	$707,913.53	$8,494,962.25
Other Public Hospital Programs	$905,550.00	$905,550.00	$905,550.00	$905,550.00	$905,550.00	$905,550.00	$905,550.00	$905,550.00	$905,550.00	$905,550.00	$905,550.00	$905,550.00	$10,866,600.00
Highly Specialised Therapies	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Total Block Funding	**$20,101,562.34**	**$20,101,562.34**	**$20,101,562.34**	**$20,101,562.33**	**$20,101,562.33**	**$20,101,562.33**	**$20,101,562.33**	**$20,101,562.33**	**$20,101,562.33**	**$20,101,562.33**	**$20,101,562.33**	**$20,101,562.42**	**$241,218,748.08**
Public Health Funding	**$3,178,306.08**	**$3,178,306.08**	**$3,178,306.08**	**$3,178,306.08**	**$3,178,306.08**	**$3,178,306.08**	**$3,178,306.08**	**$3,178,306.08**	**$3,178,306.08**	**$3,178,306.08**	**$3,178,306.08**	**$3,178,306.12**	**$38,139,673.00**
Total Payable in 2024-25	**$170,423,790.49**	**$170,423,790.49**	**$170,423,790.49**	**$170,423,790.48**	**$170,423,790.48**	**$170,423,790.48**	**$170,423,790.48**	**$170,423,790.48**	**$170,423,790.48**	**$170,423,790.48**	**$170,423,790.48**	**$170,423,790.34**	**$2,045,085,485.65**

Table B - Payments in respect of 2024-25 (subject to State-based Soft Cap)	Jul 2024	Aug 2024	Sep 2024	Oct 2024	Nov 2024	Dec 2024	Jan 2025	Feb 2025	Mar 2025	Apr 2025	May 2025	Jun 2025	Total
Barossa Hills Fleurieu Local Health Network	$5,523,560.79	$5,523,560.79	$5,523,560.79	$5,523,962.51	$5,523,962.51	$5,523,962.51	$5,523,962.51	$5,523,962.51	$5,523,962.51	$5,523,962.51	$5,523,962.51	$5,523,962.49	$66,286,344.94
Central Adelaide Local Health Network	$46,993,948.03	$46,993,948.03	$46,993,948.03	$46,994,012.92	$46,994,012.92	$46,994,012.92	$46,994,012.92	$46,994,012.92	$46,994,012.92	$46,994,012.92	$46,994,012.92	$46,994,012.91	$563,927,960.36
Central Office Services	$2,742,124.92	$2,742,124.92	$2,742,124.92	$2,742,222.30	$2,742,222.30	$2,742,222.30	$2,742,222.30	$2,742,222.30	$2,742,222.30	$2,742,222.30	$2,742,222.30	$2,742,222.27	$32,906,375.43
Eyre And Far North Local Health Network	$1,903,085.73	$1,903,085.73	$1,903,085.73	$1,902,959.19	$1,902,959.19	$1,902,959.19	$1,902,959.19	$1,902,959.19	$1,902,959.19	$1,902,959.19	$1,902,959.19	$1,902,959.13	$22,835,889.84
Flinders And Upper North Local Health Network	$3,624,471.38	$3,624,471.38	$3,624,471.38	$3,624,479.28	$3,624,479.28	$3,624,479.28	$3,624,479.28	$3,624,479.28	$3,624,479.28	$3,624,479.28	$3,624,479.28	$3,624,479.28	$43,493,727.66
Limestone Coast Local Health Network	$3,424,970.89	$3,424,970.89	$3,424,970.89	$3,424,933.36	$3,424,933.36	$3,424,933.36	$3,424,933.36	$3,424,933.36	$3,424,933.36	$3,424,933.36	$3,424,933.36	$3,424,933.28	$41,099,312.83
Northern Adelaide Local Health Network	$25,658,414.92	$25,658,414.92	$25,658,414.92	$25,658,425.01	$25,658,425.01	$25,658,425.01	$25,658,425.01	$25,658,425.01	$25,658,425.01	$25,658,425.01	$25,658,425.01	$25,658,425.09	$307,901,069.93
Riverland Mallee Coorong Local Health Network	$3,151,996.20	$3,151,996.20	$3,151,996.20	$3,151,847.80	$3,151,847.80	$3,151,847.80	$3,151,847.80	$3,151,847.80	$3,151,847.80	$3,151,847.80	$3,151,847.80	$3,151,847.69	$37,822,618.69
Southern Adelaide Local Health Network	$37,462,678.64	$37,462,678.64	$37,462,678.64	$37,462,593.86	$37,462,593.86	$37,462,593.86	$37,462,593.86	$37,462,593.86	$37,462,593.86	$37,462,593.86	$37,462,593.86	$37,462,593.83	$449,551,380.63
Women's And Children's Health Network	$14,010,299.02	$14,010,299.02	$14,010,299.02	$14,010,289.14	$14,010,289.14	$14,010,289.14	$14,010,289.14	$14,010,289.14	$14,010,289.14	$14,010,289.14	$14,010,289.14	$14,010,289.16	$168,123,499.34
Yorke And Northern Local Health Network	$2,648,371.55	$2,648,371.55	$2,648,371.55	$2,648,196.70	$2,648,196.70	$2,648,196.70	$2,648,196.70	$2,648,196.70	$2,648,196.70	$2,648,196.70	$2,648,196.70	$2,648,196.67	$31,778,884.92
Total Activity Based Funding	**$147,143,922.07**	**$147,143,922.07**	**$147,143,922.07**	**$147,143,922.07**	**$147,143,922.07**	**$147,143,922.07**	**$147,143,922.07**	**$147,143,922.07**	**$147,143,922.07**	**$147,143,922.07**	**$147,143,922.07**	**$147,143,921.80**	**$1,765,727,064.57**
Teaching Training and Research	$3,670,169.31	$3,670,169.31	$3,670,169.31	$3,670,169.30	$3,670,169.30	$3,670,169.30	$3,670,169.30	$3,670,169.30	$3,670,169.30	$3,670,169.30	$3,670,169.30	$3,670,169.34	$44,042,031.67
Small Rural Hospitals	$8,549,485.32	$8,549,485.32	$8,549,485.32	$8,549,485.32	$8,549,485.32	$8,549,485.32	$8,549,485.32	$8,549,485.32	$8,549,485.32	$8,549,485.32	$8,549,485.32	$8,549,485.34	$102,593,823.86
Other Mental Health	$6,164,905.23	$6,164,905.23	$6,164,905.23	$6,164,905.23	$6,164,905.23	$6,164,905.23	$6,164,905.23	$6,164,905.23	$6,164,905.23	$6,164,905.23	$6,164,905.23	$6,164,905.22	$73,978,862.75
Non-admitted Home Ventilation	$103,538.96	$103,538.96	$103,538.96	$103,538.96	$103,538.96	$103,538.96	$103,538.96	$103,538.96	$103,538.96	$103,538.96	$103,538.96	$103,538.99	$1,242,467.55
Other Non-admitted Services	$707,913.52	$707,913.52	$707,913.52	$707,913.52	$707,913.52	$707,913.52	$707,913.52	$707,913.52	$707,913.52	$707,913.52	$707,913.52	$707,913.53	$8,494,962.25
Other Public Hospital Programs	$905,550.00	$905,550.00	$905,550.00	$905,550.00	$905,550.00	$905,550.00	$905,550.00	$905,550.00	$905,550.00	$905,550.00	$905,550.00	$905,550.00	$10,866,600.00
Highly Specialised Therapies	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Total Block Funding	**$20,101,562.34**	**$20,101,562.34**	**$20,101,562.34**	**$20,101,562.33**	**$20,101,562.33**	**$20,101,562.33**	**$20,101,562.33**	**$20,101,562.33**	**$20,101,562.33**	**$20,101,562.33**	**$20,101,562.33**	**$20,101,562.42**	**$241,218,748.08**
Public Health Funding	**$3,178,306.08**	**$3,178,306.08**	**$3,178,306.08**	**$3,178,306.08**	**$3,178,306.08**	**$3,178,306.08**	**$3,178,306.08**	**$3,178,306.08**	**$3,178,306.08**	**$3,178,306.08**	**$3,178,306.08**	**$3,178,306.12**	**$38,139,673.00**
Payments in respect of 2024-25	**$170,423,790.49**	**$170,423,790.49**	**$170,423,790.49**	**$170,423,790.48**	**$170,423,790.48**	**$170,423,790.48**	**$170,423,790.48**	**$170,423,790.48**	**$170,423,790.48**	**$170,423,790.48**	**$170,423,790.48**	**$170,423,790.34**	**$2,045,085,485.65**

Table C - Payments in respect of prior year services	Jul 2024	Aug 2024	Sep 2024	Oct 2024	Nov 2024	Dec 2024	Jan 2025	Feb 2025	Mar 2025	Apr 2025	May 2025	Jun 2025	Total
Barossa Hills Fleurieu Local Health Network	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Central Adelaide Local Health Network	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Central Office Services	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Eyre And Far North Local Health Network	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Flinders And Upper North Local Health Network	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Limestone Coast Local Health Network	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Northern Adelaide Local Health Network	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Riverland Mallee Coorong Local Health Network	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Southern Adelaide Local Health Network	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Women's And Children's Health Network	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Yorke And Northern Local Health Network	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Total Activity Based Funding	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**
Teaching Training and Research	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Small Rural Hospitals	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Other Mental Health	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Non-admitted Home Ventilation	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Other Non-admitted Services	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Other Public Hospital Programs	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Highly Specialised Therapies	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Total Block Funding	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**
Public Health Funding	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**
Payments in respect of prior year services	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**

Monthly cash flow of Commonwealth Payments into the National Health Funding Pool as at October 2024

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Table A - Commonwealth Payments into the National Health Funding Pool, 2024-25	Jul 2024	Aug 2024	Sep 2024	Oct 2024	Nov 2024	Dec 2024	Jan 2025	Feb 2025	Mar 2025	Apr 2025	May 2025	Jun 2025	Total
Tasmanian Health Service	$44,657,472.57	$44,657,472.57	$44,657,472.57	$44,657,472.57	$44,657,472.57	$44,657,472.57	$44,657,472.57	$44,657,472.57	$44,657,472.57	$44,657,472.57	$44,657,472.57	$44,657,472.51	$535,889,670.78
Total Activity Based Funding	**$44,657,472.57**	**$44,657,472.57**	**$44,657,472.57**	**$44,657,472.57**	**$44,657,472.57**	**$44,657,472.57**	**$44,657,472.57**	**$44,657,472.57**	**$44,657,472.57**	**$44,657,472.57**	**$44,657,472.57**	**$44,657,472.51**	**$535,889,670.78**
Teaching Training and Research	$1,633,321.74	$1,633,321.74	$1,633,321.74	$1,633,321.74	$1,633,321.74	$1,633,321.74	$1,633,321.74	$1,633,321.74	$1,633,321.74	$1,633,321.74	$1,633,321.74	$1,633,321.75	$19,599,860.89
Small Rural Hospitals	$2,670,820.53	$2,670,820.53	$2,670,820.53	$2,670,820.53	$2,670,820.53	$2,670,820.53	$2,670,820.53	$2,670,820.53	$2,670,820.53	$2,670,820.53	$2,670,820.53	$2,670,820.57	$32,049,846.40
Other Mental Health	$4,691,318.41	$4,691,318.41	$4,691,318.41	$4,691,318.41	$4,691,318.41	$4,691,318.41	$4,691,318.41	$4,691,318.41	$4,691,318.41	$4,691,318.41	$4,691,318.41	$4,691,318.40	$56,295,820.91
Non-admitted Home Ventilation	$203,796.30	$203,796.30	$203,796.30	$203,796.30	$203,796.30	$203,796.30	$203,796.30	$203,796.30	$203,796.30	$203,796.30	$203,796.30	$203,796.30	$2,445,555.60
Other Non-admitted Services	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Other Public Hospital Programs	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Highly Specialised Therapies	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Total Block Funding	**$9,199,256.98**	**$9,199,256.98**	**$9,199,256.98**	**$9,199,256.98**	**$9,199,256.98**	**$9,199,256.98**	**$9,199,256.98**	**$9,199,256.98**	**$9,199,256.98**	**$9,199,256.98**	**$9,199,256.98**	**$9,199,257.02**	**$110,391,083.80**
Public Health Funding	**$977,510.33**	**$977,510.33**	**$977,510.33**	**$977,510.33**	**$977,510.33**	**$977,510.33**	**$977,510.33**	**$977,510.33**	**$977,510.33**	**$977,510.33**	**$977,510.33**	**$977,510.37**	**$11,730,124.00**
Total Payable in 2024-25	**$54,834,239.88**	**$54,834,239.88**	**$54,834,239.88**	**$54,834,239.88**	**$54,834,239.88**	**$54,834,239.88**	**$54,834,239.88**	**$54,834,239.88**	**$54,834,239.88**	**$54,834,239.88**	**$54,834,239.88**	**$54,834,239.90**	**$658,010,878.58**

Table B - Payments in respect of 2024-25 (subject to State-based Soft Cap)	Jul 2024	Aug 2024	Sep 2024	Oct 2024	Nov 2024	Dec 2024	Jan 2025	Feb 2025	Mar 2025	Apr 2025	May 2025	Jun 2025	Total
Tasmanian Health Service	$44,657,472.57	$44,657,472.57	$44,657,472.57	$44,657,472.57	$44,657,472.57	$44,657,472.57	$44,657,472.57	$44,657,472.57	$44,657,472.57	$44,657,472.57	$44,657,472.57	$44,657,472.51	$535,889,670.78
Total Activity Based Funding	**$44,657,472.57**	**$44,657,472.57**	**$44,657,472.57**	**$44,657,472.57**	**$44,657,472.57**	**$44,657,472.57**	**$44,657,472.57**	**$44,657,472.57**	**$44,657,472.57**	**$44,657,472.57**	**$44,657,472.57**	**$44,657,472.51**	**$535,889,670.78**
Teaching Training and Research	$1,633,321.74	$1,633,321.74	$1,633,321.74	$1,633,321.74	$1,633,321.74	$1,633,321.74	$1,633,321.74	$1,633,321.74	$1,633,321.74	$1,633,321.74	$1,633,321.74	$1,633,321.75	$19,599,860.89
Small Rural Hospitals	$2,670,820.53	$2,670,820.53	$2,670,820.53	$2,670,820.53	$2,670,820.53	$2,670,820.53	$2,670,820.53	$2,670,820.53	$2,670,820.53	$2,670,820.53	$2,670,820.53	$2,670,820.57	$32,049,846.40
Other Mental Health	$4,691,318.41	$4,691,318.41	$4,691,318.41	$4,691,318.41	$4,691,318.41	$4,691,318.41	$4,691,318.41	$4,691,318.41	$4,691,318.41	$4,691,318.41	$4,691,318.41	$4,691,318.40	$56,295,820.91
Non-admitted Home Ventilation	$203,796.30	$203,796.30	$203,796.30	$203,796.30	$203,796.30	$203,796.30	$203,796.30	$203,796.30	$203,796.30	$203,796.30	$203,796.30	$203,796.30	$2,445,555.60
Other Non-admitted Services	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Other Public Hospital Programs	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Highly Specialised Therapies	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Total Block Funding	**$9,199,256.98**	**$9,199,256.98**	**$9,199,256.98**	**$9,199,256.98**	**$9,199,256.98**	**$9,199,256.98**	**$9,199,256.98**	**$9,199,256.98**	**$9,199,256.98**	**$9,199,256.98**	**$9,199,256.98**	**$9,199,257.02**	**$110,391,083.80**
Public Health Funding	**$977,510.33**	**$977,510.33**	**$977,510.33**	**$977,510.33**	**$977,510.33**	**$977,510.33**	**$977,510.33**	**$977,510.33**	**$977,510.33**	**$977,510.33**	**$977,510.33**	**$977,510.37**	**$11,730,124.00**
Payments in respect of 2024-25	**$54,834,239.88**	**$54,834,239.88**	**$54,834,239.88**	**$54,834,239.88**	**$54,834,239.88**	**$54,834,239.88**	**$54,834,239.88**	**$54,834,239.88**	**$54,834,239.88**	**$54,834,239.88**	**$54,834,239.88**	**$54,834,239.90**	**$658,010,878.58**

Table C - Payments in respect of prior year services	Jul 2024	Aug 2024	Sep 2024	Oct 2024	Nov 2024	Dec 2024	Jan 2025	Feb 2025	Mar 2025	Apr 2025	May 2025	Jun 2025	Total
Tasmanian Health Service	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Total Activity Based Funding	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**
Teaching Training and Research	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Small Rural Hospitals	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Other Mental Health	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Non-admitted Home Ventilation	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Other Non-admitted Services	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Other Public Hospital Programs	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Highly Specialised Therapies	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Total Block Funding	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**
Public Health Funding	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**
Payments in respect of prior year services	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**

Monthly cash flow of Commonwealth Payments into the National Health Funding Pool as at October 2024

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Table A - Commonwealth Payments into the National Health Funding Pool, 2024-25	Jul 2024	Aug 2024	Sep 2024	Oct 2024	Nov 2024	Dec 2024	Jan 2025	Feb 2025	Mar 2025	Apr 2025	May 2025	Jun 2025	Total
ACT Local Hospital Network	$41,348,096.92	$41,348,096.92	$41,348,096.92	$41,348,096.92	$41,348,096.92	$41,348,096.92	$41,348,096.92	$41,348,096.92	$41,348,096.92	$41,348,096.92	$41,348,096.92	$41,348,096.83	$496,177,162.95
Total Activity Based Funding	**$41,348,096.92**	**$41,348,096.92**	**$41,348,096.92**	**$41,348,096.92**	**$41,348,096.92**	**$41,348,096.92**	**$41,348,096.92**	**$41,348,096.92**	**$41,348,096.92**	**$41,348,096.92**	**$41,348,096.92**	**$41,348,096.83**	**$496,177,162.95**
Teaching Training and Research	$943,025.25	$943,025.25	$943,025.25	$943,025.25	$943,025.25	$943,025.25	$943,025.25	$943,025.25	$943,025.25	$943,025.25	$943,025.25	$943,025.30	$11,316,303.05
Small Rural Hospitals	$131,405.98	$131,405.98	$131,405.98	$131,405.98	$131,405.98	$131,405.98	$131,405.98	$131,405.98	$131,405.98	$131,405.98	$131,405.98	$131,405.93	$1,576,871.71
Other Mental Health	$2,038,655.18	$2,038,655.18	$2,038,655.18	$2,038,655.18	$2,038,655.18	$2,038,655.18	$2,038,655.18	$2,038,655.18	$2,038,655.18	$2,038,655.18	$2,038,655.18	$2,038,655.23	$24,463,862.21
Non-admitted Home Ventilation	$59,246.03	$59,246.03	$59,246.03	$59,246.03	$59,246.03	$59,246.03	$59,246.03	$59,246.03	$59,246.03	$59,246.03	$59,246.03	$59,245.97	$710,952.30
Other Non-admitted Services	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Other Public Hospital Programs	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Highly Specialised Therapies	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Total Block Funding	**$3,172,332.44**	**$3,172,332.44**	**$3,172,332.44**	**$3,172,332.44**	**$3,172,332.44**	**$3,172,332.44**	**$3,172,332.44**	**$3,172,332.44**	**$3,172,332.44**	**$3,172,332.44**	**$3,172,332.44**	**$3,172,332.43**	**$38,067,989.27**
Public Health Funding	**$808,237.33**	**$808,237.33**	**$808,237.33**	**$808,237.33**	**$808,237.33**	**$808,237.33**	**$808,237.33**	**$808,237.33**	**$808,237.33**	**$808,237.33**	**$808,237.33**	**$808,237.37**	**$9,698,848.00**
Total Payable in 2024-25	**$45,328,666.69**	**$45,328,666.69**	**$45,328,666.69**	**$45,328,666.69**	**$45,328,666.69**	**$45,328,666.69**	**$45,328,666.69**	**$45,328,666.69**	**$45,328,666.69**	**$45,328,666.69**	**$45,328,666.69**	**$45,328,666.63**	**$543,944,000.22**

Table B - Payments in respect of 2024-25 (subject to State-based Soft Cap)	Jul 2024	Aug 2024	Sep 2024	Oct 2024	Nov 2024	Dec 2024	Jan 2025	Feb 2025	Mar 2025	Apr 2025	May 2025	Jun 2025	Total
ACT Local Hospital Network	$41,348,096.92	$41,348,096.92	$41,348,096.92	$41,348,096.92	$41,348,096.92	$41,348,096.92	$41,348,096.92	$41,348,096.92	$41,348,096.92	$41,348,096.92	$41,348,096.92	$41,348,096.83	$496,177,162.95
Total Activity Based Funding	**$41,348,096.92**	**$41,348,096.92**	**$41,348,096.92**	**$41,348,096.92**	**$41,348,096.92**	**$41,348,096.92**	**$41,348,096.92**	**$41,348,096.92**	**$41,348,096.92**	**$41,348,096.92**	**$41,348,096.92**	**$41,348,096.83**	**$496,177,162.95**
Teaching Training and Research	$943,025.25	$943,025.25	$943,025.25	$943,025.25	$943,025.25	$943,025.25	$943,025.25	$943,025.25	$943,025.25	$943,025.25	$943,025.25	$943,025.30	$11,316,303.05
Small Rural Hospitals	$131,405.98	$131,405.98	$131,405.98	$131,405.98	$131,405.98	$131,405.98	$131,405.98	$131,405.98	$131,405.98	$131,405.98	$131,405.98	$131,405.93	$1,576,871.71
Other Mental Health	$2,038,655.18	$2,038,655.18	$2,038,655.18	$2,038,655.18	$2,038,655.18	$2,038,655.18	$2,038,655.18	$2,038,655.18	$2,038,655.18	$2,038,655.18	$2,038,655.18	$2,038,655.23	$24,463,862.21
Non-admitted Home Ventilation	$59,246.03	$59,246.03	$59,246.03	$59,246.03	$59,246.03	$59,246.03	$59,246.03	$59,246.03	$59,246.03	$59,246.03	$59,246.03	$59,245.97	$710,952.30
Other Non-admitted Services	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Other Public Hospital Programs	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Highly Specialised Therapies	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Total Block Funding	**$3,172,332.44**	**$3,172,332.44**	**$3,172,332.44**	**$3,172,332.44**	**$3,172,332.44**	**$3,172,332.44**	**$3,172,332.44**	**$3,172,332.44**	**$3,172,332.44**	**$3,172,332.44**	**$3,172,332.44**	**$3,172,332.43**	**$38,067,989.27**
Public Health Funding	**$808,237.33**	**$808,237.33**	**$808,237.33**	**$808,237.33**	**$808,237.33**	**$808,237.33**	**$808,237.33**	**$808,237.33**	**$808,237.33**	**$808,237.33**	**$808,237.33**	**$808,237.37**	**$9,698,848.00**
Payments in respect of 2024-25	**$45,328,666.69**	**$45,328,666.69**	**$45,328,666.69**	**$45,328,666.69**	**$45,328,666.69**	**$45,328,666.69**	**$45,328,666.69**	**$45,328,666.69**	**$45,328,666.69**	**$45,328,666.69**	**$45,328,666.69**	**$45,328,666.63**	**$543,944,000.22**

Table C - Payments in respect of prior year services	Jul 2024	Aug 2024	Sep 2024	Oct 2024	Nov 2024	Dec 2024	Jan 2025	Feb 2025	Mar 2025	Apr 2025	May 2025	Jun 2025	Total
ACT Local Hospital Network	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Total Activity Based Funding	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**
Teaching Training and Research	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Small Rural Hospitals	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Other Mental Health	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Non-admitted Home Ventilation	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Other Non-admitted Services	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Other Public Hospital Programs	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Highly Specialised Therapies	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Total Block Funding	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**
Public Health Funding	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**
Payments in respect of prior year services	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**

Monthly cash flow of Commonwealth Payments into the National Health Funding Pool as at October 2024

Northern Territory (page 1 of 1)

Table A - Commonwealth Payments into the National Health Funding Pool, 2024-25	Jul 2024	Aug 2024	Sep 2024	Oct 2024	Nov 2024	Dec 2024	Jan 2025	Feb 2025	Mar 2025	Apr 2025	May 2025	Jun 2025	Total
NT Regional Health Services	$32,933,693.48	$32,933,693.48	$32,933,693.48	$32,933,693.48	$32,933,693.48	$32,933,693.48	$32,933,693.48	$32,933,693.48	$32,933,693.48	$32,933,693.48	$32,933,693.48	$32,933,693.58	$395,204,321.86
Total Activity Based Funding	**$32,933,693.48**	**$32,933,693.48**	**$32,933,693.48**	**$32,933,693.48**	**$32,933,693.48**	**$32,933,693.48**	**$32,933,693.48**	**$32,933,693.48**	**$32,933,693.48**	**$32,933,693.48**	**$32,933,693.48**	**$32,933,693.58**	**$395,204,321.86**
Teaching Training and Research	$1,203,841.38	$1,203,841.38	$1,203,841.38	$1,203,841.38	$1,203,841.38	$1,203,841.38	$1,203,841.38	$1,203,841.38	$1,203,841.38	$1,203,841.38	$1,203,841.38	$1,203,841.38	$14,446,096.56
Small Rural Hospitals	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Other Mental Health	$905,277.38	$905,277.38	$905,277.38	$905,277.38	$905,277.38	$905,277.38	$905,277.38	$905,277.38	$905,277.38	$905,277.38	$905,277.38	$905,277.42	$10,863,328.60
Non-admitted Home Ventilation	$3,688.49	$3,688.49	$3,688.49	$3,688.49	$3,688.49	$3,688.49	$3,688.49	$3,688.49	$3,688.49	$3,688.49	$3,688.49	$3,688.52	$44,261.91
Other Non-admitted Services	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Other Public Hospital Programs	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Highly Specialised Therapies	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Total Block Funding	**$2,112,807.25**	**$2,112,807.25**	**$2,112,807.25**	**$2,112,807.25**	**$2,112,807.25**	**$2,112,807.25**	**$2,112,807.25**	**$2,112,807.25**	**$2,112,807.25**	**$2,112,807.25**	**$2,112,807.25**	**$2,112,807.32**	**$25,353,687.07**
Public Health Funding	**$432,052.92**	**$432,052.92**	**$432,052.92**	**$432,052.92**	**$432,052.92**	**$432,052.92**	**$432,052.92**	**$432,052.92**	**$432,052.92**	**$432,052.92**	**$432,052.92**	**$432,052.88**	**$5,184,635.00**
Total Payable in 2024-25	**$35,478,553.65**	**$35,478,553.65**	**$35,478,553.65**	**$35,478,553.65**	**$35,478,553.65**	**$35,478,553.65**	**$35,478,553.65**	**$35,478,553.65**	**$35,478,553.65**	**$35,478,553.65**	**$35,478,553.65**	**$35,478,553.78**	**$425,742,643.93**

Table B - Payments in respect of 2024-25 (subject to State-based Soft Cap)	Jul 2024	Aug 2024	Sep 2024	Oct 2024	Nov 2024	Dec 2024	Jan 2025	Feb 2025	Mar 2025	Apr 2025	May 2025	Jun 2025	Total
NT Regional Health Services	$32,933,693.48	$32,933,693.48	$32,933,693.48	$32,933,693.48	$32,933,693.48	$32,933,693.48	$32,933,693.48	$32,933,693.48	$32,933,693.48	$32,933,693.48	$32,933,693.48	$32,933,693.58	$395,204,321.86
Total Activity Based Funding	**$32,933,693.48**	**$32,933,693.48**	**$32,933,693.48**	**$32,933,693.48**	**$32,933,693.48**	**$32,933,693.48**	**$32,933,693.48**	**$32,933,693.48**	**$32,933,693.48**	**$32,933,693.48**	**$32,933,693.48**	**$32,933,693.58**	**$395,204,321.86**
Teaching Training and Research	$1,203,841.38	$1,203,841.38	$1,203,841.38	$1,203,841.38	$1,203,841.38	$1,203,841.38	$1,203,841.38	$1,203,841.38	$1,203,841.38	$1,203,841.38	$1,203,841.38	$1,203,841.38	$14,446,096.56
Small Rural Hospitals	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Other Mental Health	$905,277.38	$905,277.38	$905,277.38	$905,277.38	$905,277.38	$905,277.38	$905,277.38	$905,277.38	$905,277.38	$905,277.38	$905,277.38	$905,277.42	$10,863,328.60
Non-admitted Home Ventilation	$3,688.49	$3,688.49	$3,688.49	$3,688.49	$3,688.49	$3,688.49	$3,688.49	$3,688.49	$3,688.49	$3,688.49	$3,688.49	$3,688.52	$44,261.91
Other Non-admitted Services	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Other Public Hospital Programs	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Highly Specialised Therapies	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Total Block Funding	**$2,112,807.25**	**$2,112,807.25**	**$2,112,807.25**	**$2,112,807.25**	**$2,112,807.25**	**$2,112,807.25**	**$2,112,807.25**	**$2,112,807.25**	**$2,112,807.25**	**$2,112,807.25**	**$2,112,807.25**	**$2,112,807.32**	**$25,353,687.07**
Public Health Funding	**$432,052.92**	**$432,052.92**	**$432,052.92**	**$432,052.92**	**$432,052.92**	**$432,052.92**	**$432,052.92**	**$432,052.92**	**$432,052.92**	**$432,052.92**	**$432,052.92**	**$432,052.88**	**$5,184,635.00**
Payments in respect of 2024-25	**$35,478,553.65**	**$35,478,553.65**	**$35,478,553.65**	**$35,478,553.65**	**$35,478,553.65**	**$35,478,553.65**	**$35,478,553.65**	**$35,478,553.65**	**$35,478,553.65**	**$35,478,553.65**	**$35,478,553.65**	**$35,478,553.78**	**$425,742,643.93**

Table C - Payments in respect of prior year services	Jul 2024	Aug 2024	Sep 2024	Oct 2024	Nov 2024	Dec 2024	Jan 2025	Feb 2025	Mar 2025	Apr 2025	May 2025	Jun 2025	Total
NT Regional Health Services	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Total Activity Based Funding	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**
Teaching Training and Research	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Small Rural Hospitals	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Other Mental Health	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Non-admitted Home Ventilation	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Other Non-admitted Services	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Other Public Hospital Programs	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Highly Specialised Therapies	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Total Block Funding	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**
Public Health Funding	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**
Payments in respect of prior year services	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**

From: STEPHEN-SMITH
Sent: Tuesday, 1 October 2024 09:42
To: ACT Health DLO
Cc: Smith, Kahlia; Bransgrove, Meagen
Subject: FW: ACT Health Directorate- SOP limited assurance report
Attachments: Att. A.4 AHD24 Covering Letter to the Minister for Health.pdf; Att. A.2 AHD24 Limited Assurance Report.pdf; Att. B.1 AHD Statement of performance 2023-24.pdf

Importance: High

OFFICIAL

FYI

From: Akram, Aamir
Sent: Tuesday, 24 September 2024 2:51 PM
To: STEPHEN-SMITH
Cc: Anjum, Rehan ; Sharma, Ajay ; Mazhar, Tehmina
Subject: ACT Health Directorate- SOP limited assurance report

OFFICIAL

Dear Ms Stephen-Smith,

Please find attached the cover letter and the limited assurance report for the audit of Statement of Performance of ACT Health Directorate for the year ended 30 June 2024.

If you have any queries, please feel free to contact us.

Kind Regards,

Aamir Akram| ACCA, B.com | Acting Senior Auditor | Financial Services
Phone: (02) 6207 0955 | Email: Aamir.akram@act.gov.au
ACT Audit Office | **Auditor-General** An Officer of the ACT Legislative Assembly
Nara Centre, Level 4, 3 Constitution Avenue, Canberra | PO Box 158 Canberra ACT 2601 | www.audit.act.gov.au

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From: STEPHEN-SMITH
Sent: Tuesday, 1 October 2024 09:46
To: ACT Health DLO
Cc: Smith, Kahlia
Subject: FW: Correspondence from the Hon Mark Butler MP [SEC=OFFICIAL]
Attachments: MS24-000647 - signed letter to Minister Stephen-Smith.pdf

Importance: High

Hi team

See attached. To prepare a response for an incoming minister please.

Ben

From Schedule 2.2(a)(ii)
Sent: Tuesday, 24 September 2024 1:36 PM
To: STEPHEN-SMITH
Cc: AIHW MoU
Subject: Correspondence from the Hon Mark Butler MP [SEC=OFFICIAL]

You don't often get email from Schedule 2.2(a)(ii) Learn why this is important

Caution: This email originated from outside of the ACT Government. Do not click links or open attachments unless you recognise the sender and know the content is safe.

Dear Minister
Please find attached a letter from the Minister for Health and Aged Care, the Hon Mark Butler MP, seeking nominations for the Board of the Australian Institute of Health and Welfare.
Kind regards

Schedule 2.2(a)(ii)
Assistant Director – Evaluation and Strategic Advice Section
Health Modelling, Partnerships and Evaluation Branch
Health Economics and Research Division
Australian Government Department of Health and Aged Care
T: Schedule 2.2(a)(ii)
E:
PO Box 9848, Canberra ACT 2601, Australia

The Department of Health and Aged Care acknowledges the traditional owners of country throughout Australia, and their continuing connection to land, sea and community. We pay our respects to them and their cultures, and to elders both past and present.

"Important: This transmission is intended only for the use of the addressee and may contain confidential or legally privileged information. If you are not the intended recipient, you are notified that any use or dissemination of this communication is strictly prohibited. If you receive this transmission in error please notify the author immediately and delete all copies of this transmission."

The Hon Mark Butler MP
Minister for Health and Aged Care

Ref No: MS24-000647

Ms Rachel Stephen-Smith MLA
Minister for Health
GPO Box 1020
CANBERRA ACT 2601
Stephen-Smith@act.gov.au

Dear Minister Rachel

I am writing to seek your nominations for two suitable persons to be members of the Board of the Australian Institute of Health and Welfare (AIHW).

The AIHW is a statutory authority, established in 1987 by the *Australian Institute of Health and Welfare Act 1987* (Act). Its central functions are to collect and produce health and welfare related statistics and information.

The AIHW Board consists of a Chair, Deputy Chair, Chief Executive Officer, up to three members nominated by state and territory health ministers, and not more than six other members. Appointments to the AIHW Board are made by me as the Minister for Health and Aged Care, under section 11 of the Act for a term of up to five years.

On 4 June 2024, Dr Zoran Bolevich commenced his role as the new AIHW Chief Executive Officer. Following the announcement of his appointment, Dr Bolevich resigned his position as a non-Executive member of the AIHW Board. Ms Marilyn Chilvers has also recently resigned her position from the Board, effective 26 September 2024. These members were nominated by state and territory health ministers. I am seeking your nominations to fill these two vacancies.

To ensure breadth of skills and experience, I am seeking one person, such as a Deputy Secretary or equivalent level, with experience in strategic use of health information and statistics. Another person with similar skills and experience in welfare and community services is required to fill the second vacancy.

The Board is the accountable authority of the AIHW and ensures the proper, efficient and effective performance of the AIHW's functions. Candidates should have sufficient senior executive experience and be willing to participate openly in Board discussions and deliberations. The Board usually meets four times per year for one day in Canberra.

A member of the Board is a Part-Time Office Holder under the *Remuneration Tribunal Act 1973* and is entitled to $42,940 per annum and Tier 2 travel allowance in accordance with *Remuneration Tribunal (Remuneration and Allowances for Holders of Part-Time Public Office) Determination 2024*. Please note that a full-time employee of a territory is not entitled to remuneration under the Remuneration Tribunal Act.

The AIHW's relationship with states and territories is essential to its role as an authoritative source of information for governments and the Australian community. I look forward to receiving your response by Thursday 24 October 2024. If you require further information, the contact officer in the Department of Health and Aged Care is Dr Jian Wang on (02) 6289 6859 or email at Jian.Wang@health.gov.au.

Yours sincerely



Mark Butler

23 / 09 / 2024

From: STEPHEN-SMITH
Sent: Tuesday, 1 October 2024 09:52
To: ACT Health DLO
Cc: Smith, Kahlia; Bransgrove, Meagen
Subject: FW: ACT Health Directorate- Audit Report
Attachments: 5. Attachment A4 - AHD24 Covering letter to the Minister for Health.pdf; 3. Attachment A2 - AHD24 Auditor's Report.pdf; AHD Financial Statement 2023-2024.pdf

Importance: High

OFFICIAL

FYI

From: Akram, Aamir
Sent: Tuesday, 24 September 2024 10:26 AM
To: STEPHEN-SMITH
Cc: Anjum, Rehan ; Sharma, Ajay ; Mazhar, Tehmina ; Ali, Hassan
Subject: ACT Health Directorate- Audit Report

OFFICIAL

Dear Ms Stephen-Smith,

Please find attached the cover letter and the auditor report for the audit of ACT Health Directorate for the year ended 30 June 2024.

If you have any queries, please feel free to contact us.

Kind Regards,

Aamir Akram| ACCA, B.com | Acting Senior Auditor | Financial Services
Phone: (02) 6207 0955 | Email: Aamir.akram@act.gov.au
ACT Audit Office | **Auditor-General** An Officer of the ACT Legislative Assembly
Nara Centre, Level 4, 3 Constitution Avenue, Canberra | PO Box 158 Canberra ACT 2601 | www.audit.act.gov.au

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From: STEPHEN-SMITH
Sent: Tuesday, 1 October 2024 09:52
To: ACT Health DLO
Cc: Smith, Kahlia
Subject: FW: ACT Local Hospital Network Directorate- Audit report
Attachments: 5. Attachment A- LHN 24 Covering letter to the Minister for Health.pdf; 3. Attachment A- LHN 24 Auditor's Report AC.pdf; LHN Financial Statements 2023-24.pdf

Importance: High

OFFICIAL

FYI

From: Akram, Aamir
Sent: Monday, 23 September 2024 7:42 PM
To: STEPHEN-SMITH
Cc: Anjum, Rehan ; Mazhar, Tehmina ; Sharma, Ajay
Subject: ACT Local Hospital Network Directorate- Audit report

OFFICIAL

Dear Ms Stephen-Smith,

Please find attached the cover letter and the auditor report for the audit of ACT Local Hospital Network Directorate for the year ended 30 June 2024.

If you have any queries, please feel free to contact us.

Kind Regards,

Aamir Akram| ACCA, B.com | Acting Senior Auditor | Financial Services
Phone: (02) 6207 0955 | Email: Aamir.akram@act.gov.au
ACT Audit Office | **Auditor-General** An Officer of the ACT Legislative Assembly
Nara Centre, Level 4, 3 Constitution Avenue, Canberra | PO Box 158 Canberra ACT 2601 | www.audit.act.gov.au

Communications from the ACT Audit Office may contain protected information for the purposes of Part 5A of the Auditor-General Act 1996 (ACT).

From: STEPHEN-SMITH
Sent: Tuesday, 1 October 2024 10:08
To: ACT Health DLO
Cc: Smith, Kahlia
Subject: FW: Invitation - Anaphylaxis reporting system consultation
Attachments: Letter of Invitation_DoH anaphylaxis reporting meeting_R Stephen-Smith.pdf

Importance: High

For appropriate action

From: Sandra Vale
Sent: Friday, 20 September 2024 8:32 AM
To: STEPHEN-SMITH
Cc: ACT Health System Council Secretariat
Subject: Invitation - Anaphylaxis reporting system consultation

Some people who received this message don't often get email from Schedule 2.2(a)(ii) Learn why this is important

Caution: This email originated from outside of the ACT Government. Do not click links or open attachments unless you recognise the sender and know the content is safe.

Dear Minister Stephen-Smith,

Please find attached a letter of invitation from the National Allergy Council for you to nominate a representative to attend a consultation regarding the development of a national Anaphylaxis Reporting System.

We look forward to receiving the details of your nominated representative.

Please feel welcome to contact me should you require further information.

Kind regards,
Sandra

national allergy council

Dr Sandra Vale (PhD)
Chief Executive Officer
National Allergy Council
The National Allergy Council continues to implement the National Allergy Strategy as a partnership between the Australasian Society of Clinical Immunology and Allergy (ASCIA) and Allergy & Anaphylaxis Australia.
M Schedule 2.2(a)(ii)
E
W nationalallergycouncil.org.au

19 September 2024

Hon. Rachel Stephen-Smith MLA
Minister for Health
GPO Box 1020
CANBERRA ACT 2601
stephen-smith@act.gov.au

Dear Minister Stephen-Smith,

RE: Invitation to the National Allergy Council anaphylaxis reporting system meeting

The National Allergy Council, a partnership between Australasian Society of Clinical Immunology and Allergy (ASCIA), and Allergy & Anaphylaxis Australia (A&AA) has been funded by the Australian Government Department of Health to scope and plan implementation of an anaphylaxis reporting system for Australia. We believe it is critical to understand the needs and challenges for each state and territory in relation to collecting data on anaphylaxis and as such, we would welcome a representative from the Australian Capital Territory Department of Health to attend a meeting of all state and territory health department representatives.

We therefore, invite you to nominate a senior ACT Department of Health representative to participate in an in person meeting to discuss an anaphylaxis reporting system for Australia.

Details of the meeting:
Time: 10:00am – 4:00pm
Date: Thursday 21nd November 2024
Venue: Park Royal Airport Hotel - Melbourne

Key representation from the National Allergy Council, the Australasian Society of Clinical Immunology and Allergy (ASCIA), and Allergy & Anaphylaxis Australia will participate in this meeting. We have also invited the Victorian Health Department to provide details about the establishment and operation of the current Victorian Anaphylaxis Notification System that was launched after the death of a child from a packaged food that remained in the market place for 6 weeks after his death.

The need for an anaphylaxis reporting system was again highlighted in a recent Parliamentary Enquiry into Allergies and Anaphylaxis. To date we have undertaken a review of international anaphylaxis registries to identify important features for an Australian anaphylaxis registry. We have also engaged with the Victorian Anaphylaxis Notification System team to learn what works well and what can be improved. We are now at the stage where we have proposed priorities for data collection and a proposed model for state-based standard reporting of anaphylaxis, with the potential to contribute to a national system.

We are aware that the development of an anaphylaxis reporting system is a major task and that there may be significant challenges to progressing such a system. However once established, the benefits are numerous and include:

- Collection of deidentified data regarding anaphylaxis;
- The ability to remove unsafe foods (due to undeclared allergens) from the marketplace quickly;
- Prompt investigation of food premises that serve food that triggers an allergic reaction in someone who declares their food allergy;
- Provision of timely, relevant information to facilitate improved clinical care and appropriate consumer education;
- Capture fatalities and near misses as a result of anaphylaxis;

- Data collection to enable informed policy changes and health system improvements.

We look forward to receiving the contact details of your nominated representative so that we can liaise with them directly about the meeting. The National Allergy Council will provide reimbursement for nominated representative's travel costs (discounted economy airfare, taxi, public transport, tolls, parking) and will also arrange accommodation at the venue hotel, if required.

Should you wish to discuss this invitation, please contact Sandra Vale, National Allergy Council CEO by email Schedule 2.2(a)(ii) or phone Schedule 2.2(a)(ii)

Kind regards,

Schedule 2.2(a)(ii)

Ms Maria Said AM Dr Brynn Wainstein
Project Co-leads
National Allergy Council Anaphylaxis Reporting

CC: Ms Rebecca Cross
Director-General, ACT Health Directorate
ACTHealthSystemCouncil@act.gov.au

From: Smith, Kahlia
Sent: Wednesday, 2 October 2024 11:13
To: ACT Health DLO
Subject: MIN2024/00806 : RE: Letter from ACT ART providers - ART legislation

Importance: High

Follow Up Flag: Follow up
Flag Status: Completed

OFFICIAL

DLO Note – refer to notes in DLO Handover

Hi Tara – yes, that's okay thank you.

Kahlia

From: Gower, Tara <Tara.Gower@act.gov.au> **On Behalf Of** ACT Health DLO
Sent: Tuesday, 1 October 2024 1:04 PM
To: Smith, Kahlia <Kahlia.Smith@act.gov.au>
Subject: RE: Letter from ACT ART providers - ART legislation

OFFICIAL

Hi Kahlia

Apologies for the delay and the team have advised that there is a further delay noting some staff leave, progress on ART legislation and FOI requests.

Are you comfortable receiving advice on Friday, 11 October 2024 ?

Thank you
Tara

Tara Gower | Directorate Liaison Officer | ACT Health Directorate
Mob: Schedule 2.2(a)(ii) | Email: ACTHealthDLO@act.gov.au
Office of Rachel Stephen-Smith | Minister for Health
Office of Emma Davidson | Minister for Mental Health
Level 2, Legislative Assembly Building, Civic Square



From: Smith, Kahlia <Kahlia.Smith@act.gov.au>
Sent: Monday, September 16, 2024 10:40 AM
To: STEPHEN-SMITH <STEPHEN-SMITH@act.gov.au>; ACT Health DLO <ACTHealthDLO@act.gov.au>
Cc: Tomlinson, Benjamin <Benjamin.Tomlinson@act.gov.au>
Subject: RE: Letter from ACT ART providers - ART legislation
Importance: High

Hi Tara – could I please also request some factual dot points on the issues raised in this letter, please?

Thank you

Kahlia

From: STEPHEN-SMITH <STEPHEN-SMITH@act.gov.au>
Sent: Friday, September 13, 2024 5:38 PM
To: ACT Health DLO <ACTHealthDLO@act.gov.au>
Cc: Tomlinson, Benjamin <Benjamin.Tomlinson@act.gov.au>; Smith, Kahlia <Kahlia.Smith@act.gov.au>
Subject: FW: Letter from ACT ART providers - ART legislation

Hi Tara,

For directorate response please.

Thank you,

Sally Cooke
Office Manager | Office of Rachel Stephen-Smith MLA
Minister for Health | Minister for Children, Youth and Family Services | Minister for Disability | Minister for Aboriginal and Torres Strait Islander Affairs
Member for Kurrajong
ACT Legislative Assembly, 196 London Circuit, Canberra ACT 2601 | P: (02) 6205 2661 | www.act.gov.au

---

From: Schedule 2.2(a)(ii) [redacted]
Sent: Friday, September 13, 2024 5:33 PM
To: STEPHEN-SMITH <STEPHEN-SMITH@act.gov.au>
Cc: Tomlinson, Benjamin <Benjamin.Tomlinson@act.gov.au>
Subject: Letter from ACT ART providers - ART legislation

Some people who received this message don't often get email from Schedule 2.2(a)(ii) [redacted] Learn why this is important

Caution: This email originated from outside of the ACT Government. Do not click links or open attachments unless you recognise the sender and know the content is safe.

Dear Minister

Please see enclosed a joint letter from IVFAustralia, Genea and Compass Fertility for your consideration.

Regards
Schedule 2.2(a)(ii) [redacted]

Schedule 2.2(a)(ii)

Virtus Health Pty Limited
Level 3, 154 Pacific Highway
GREENWICH NSW 2065
AUSTRALIA
M: Schedule 2.2(a)(ii)
E:
W:

Fertility Services
Specialist Day Hospitals
Diagnostics & Advanced Science

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From: STEPHEN-SMITH
Sent: Wednesday, 2 October 2024 12:52
To: ACT Health DLO
Cc: Smith, Kahlia
Subject: FW: New Aged Care Act Consultation: Service List [SEC=OFFICIAL]

Importance: High

For info

From Schedule 2.2(a)(ii)
Sent: Tuesday, 1 October 2024 6:10 PM
Subject: New Aged Care Act Consultation: Service List [SEC=OFFICIAL]

Some people who received this message don't often get email from Schedule 2.2(a)(ii) Learn why this is important

Caution: This email originated from outside of the ACT Government. Do not click links or open attachments unless you recognise the sender and know the content is safe.

Good afternoon,

Today marks the beginning of the next phase of consultation for the new Aged Care Act. We are now inviting feedback on some of the Rules that will sit under the new aged care laws. Consultation on the Rules will ensure everyone is ready for the start of the new Aged Care Act from 1 July 2025.

The Rules will be released in stages, beginning with the Service List which outlines the care and services that will be available to older people under the new Act. **The Service List is now available on the** Department of Health and Aged Care website.

You can make a public submission via our online form. Submissions close on 31 October 2024.

This new round of consultation builds on previous feedback received on the foundations of the new Aged Care Act, the exposure draft of the Bill and separate consultations on related policy.

Kind regards,

Schedule 2.2(a)(ii)
A/g Assistant Secretary
New Aged Care Act Transition Branch| Quality & Assurance Division | Ageing & Aged Care Group
Australian Government Department of Health and Aged Care
Yaradhang Building | Level 9 South | PO Box 9848, Canberra ACT 2601
Ph Schedule 2.2(a)(ii) **Email** Schedule 2.2(a)(ii)
Executive Assistant Schedule 2.2(a)(ii)

The Department of Health and Aged Care acknowledges the Traditional Custodians of Australia and their continued connection to land, sea and community. We pay our respects to all Elders past and present.

From: STEPHEN-SMITH
Sent: Wednesday, 2 October 2024 12:53 PM
To: ACT Health DLO
Cc: Smith, Kahlia
Subject: FW: Funding for expansion of cervical screening services to support the elimination of cervical cancer in Australia by 2035 [SEC=OFFICIAL]
Attachments: Letter to ACT Health Minister - signed.pdf

Importance: High

Follow Up Flag: Follow up
Flag Status: Completed

Hi

For appropriate response however may need to advise that an extension is needed.

B

From: Schedule 2.2(a)(ii)
Sent: Tuesday, 1 October 2024 6:27 PM
To: STEPHEN-SMITH
Cc: Kelly, Chris ; AHM-ACT Schedule 2.2(a)(ii)
Subject: Funding for expansion of cervical screening services to support the elimination of cervical cancer in Australia by 2035 [SEC=OFFICIAL]

Some people who received this message don't often get email from Schedule 2.2(a)(ii) Learn why this is important

Caution: This email originated from outside of the ACT Government. Do not click links or open attachments unless you recognise the sender and know the content is safe.

Good afternoon

Please find attached a letter from the Minister for Health and Aged Care, the Hon Mark Butler MP to the Hon Ryan Park MP, Minister for Health, regarding the allocated funding for states and territories to expand cervical screening services and support the elimination of cervical cancer in Australia by 2035.

Please let us know if you have any questions.

Kind regards

Schedule 2.2(a)(ii)

Director – Cervical Screening Section
Cancer Screening Programs Branch

Cancer, Hearing and Chronic Conditions Division | Primary & Community Care Group
Australian Government Department of Health and Aged Care
T: Schedule 2.2(a)(ii)
Location: Sirius Level 4
PO Box 9848, Canberra ACT 2601, Australia

The Department of Health and Aged Care acknowledges First Nations peoples as the Traditional Owners of Country throughout Australia, and their continuing connection to land, sea and community. We pay our respects to them and their cultures, and to all Elders both past and present.



The Hon Mark Butler MP
Minister for Health and Aged Care

Ref No: MS24-900342

Ms Rachel Stephen-Smith MLA
Minister for Health
GPO Box 1020
CANBERRA ACT 2601
stephen-smith@act.gov.au

Dear Minister Rachel

Australia is committed to becoming the first country in the world to eliminate cervical cancer, with the announcement of the National Strategy for the Elimination of Cervical Cancer and a $48.2 million investment to support implementation. To achieve this goal, we must ensure underrepresented communities with lower screening rates and a higher risk of cervical cancer and death have equitable access to cervical screening and follow up services.

Within the announced budget, $18 million has been allocated for states and territories to expand cervical screening services including:

- $9.7 million to enable nurses, First Nations Health Practitioners, and midwives to sign pathology request forms for cervical screening tests
- $8.3 million to implement innovative screening models to reach under screened populations including LGBTIQA+, culturally and linguistically diverse people and people with a disability.

The Department of Health and Aged Care has been working with your officials to design proposals for how the available funding could be utilised in Australian Capital Territory to expand access to cervical screening services. Your department has agreed to provide its proposals by 14 October 2024 noting that funding allocations will be determined once the proposals have been received. However, please let me know if Australian Capital Territory decide not to proceed with a proposal.

I look forward to working with you on this important measure to support the elimination of cervical cancer in Australia.

Yours sincerely

Mark Butler

30 / 09 / 2024

From: Tomlinson, Benjamin
Sent: Thursday, 3 October 2024 11:49
To: ACT Health DLO
Cc: Smith, Kahlia
Subject: RE: Interchange Healthcare Cooperative

Importance: High

OFFICIAL

Thank you Tara

From: Gower, Tara **On Behalf Of** ACT Health DLO
Sent: Wednesday, 2 October 2024 4:30 PM
To: Tomlinson, Benjamin
Cc: Smith, Kahlia
Subject: RE: Interchange Healthcare Cooperative

OFFICIAL

Hi Ben

Please see updated tabled below:

	2019-20	2020-21	2021-22	2022-23	2023-24	2024-25
Subsidisation of the Interchange Health Co-Operative Limited Memberships to Clients with Complex Needs	-	-	-	$24,999.96	$17,147.57	-
To lead development of a community of practice for endorsed prescribers in the ACT	-	-	-	$150,000	-	-

Integration of Social Workers in General Practice Pilot	-	-	$97,500	-	-	-
COVID-19 Community Support	-	-	$110,000	-	-	-
Top up funding from ACTHD underspend					$25,000	-
Opioid Management (OMT)						$60,000
Total	**-**	**-**	**$207,500**	**$174,999.96**	**$42,147.57**	**$60,000**

Thank you
Tara

Tara Gower | Directorate Liaison Officer | ACT Health Directorate
Mob: Schedule 2.2(a)(ii) | Email: ACTHealthDLO@act.gov.au
Office of Rachel Stephen-Smith | Minister for Health
Office of Emma Davidson | Minister for Mental Health
Level 2, Legislative Assembly Building, Civic Square



From: Tomlinson, Benjamin <Benjamin.Tomlinson@act.gov.au>
Sent: Tuesday, October 1, 2024 2:17 PM
To: ACT Health DLO <ACTHealthDLO@act.gov.au>
Cc: Smith, Kahlia <Kahlia.Smith@act.gov.au>
Subject: Interchange Healthcare Cooperative
Importance: High

Good afternoon Tara

Can the Directorate please provide me advice on any funding that is being provided to Interchange Healthcare Cooperative in 2024-25.

I have included a table below that has previously been provided and added in a new column:

	2019-20	2020-21	2021-22	2022-23	2023-24	2024-25
Subsidisation of the Interchange Health Co-Operative Limited Memberships to Clients with Complex Needs	-	-	-	$24,999.96	$17,147.57	
To lead development of a community of practice for endorsed prescribers in the ACT	-	-	-	$150,000	-	
Integration of Social Workers in General Practice Pilot	-	-	$97,500	-	-	
COVID-19 Community Support	-	-	$110,000	-	-	
Top up funding from ACTHD underspend					$25,000	
Total	**-**	**-**	**$207,500**	**$174,999.96**	**$42,147.57**	

Thank you
Ben

Lowe, Shannon

From: Gower, Tara on behalf of ACT Health DLO
Sent: Thursday, 3 October 2024 4:44 PM
To: Tomlinson, Benjamin; Bransgrove, Meagen; Smith, Kahlia; Elliffe, Martin
Subject: 20241004 GBC24/00295 - Transmittal of Annual Report to Minister for Health

Good afternoon all

I have placed this Noting Brief in the Minister's folder here.

Please note the critical date of tomorrow, 4 October 2024.

Thank you
Tara

Tara Gower | Directorate Liaison Officer | ACT Health Directorate
Mob: Schedule 2.2(a)(ii) | Email: ACTHealthDLO@act.gov.au
Office of Rachel Stephen-Smith | Minister for Health
Office of Emma Davidson | Minister for Mental Health
Level 2, Legislative Assembly Building, Civic Square



From: Elliffe, Martin
Sent: Thursday, 3 October 2024 17:28
To: ACT Health DLO
Subject: MIN2024-00839 : RE: VSC

Importance: High

Follow Up Flag: Follow up
Flag Status: Completed

OFFICIAL

DLO Note – refer to notes in DLO Handover

Hi Tara,

Further to the below, can we please get an update on the work underway to prepare for the implementation of VSC and providing training for practitioners?

The AMA has reached out to Meg again today to reiterate their concerns regarding lack of training and no GTPs having been approved.

Has there been any progress on these issues? And what discussions has the team had with the AMA since the last update?

I believe the team were going to send through a timeline and info on comms and training for non-GP specialists, but I don't think I've seen that come through yet.

And has the DG responded to Mr Somerville's letter yet? Is so, grateful if we could get a copy for our info.

Thanks,
Martin

Martin Elliffe (he/him)
Adviser | Office of Minister Rachel Stephen-Smith MLA
Minister for Health | Minister for Children, Youth and Family Services | Minister for Disability | Minister for Aboriginal and Torres Strait Islander Affairs
Member for Kurrajong
M: Schedule 2.2(a)(ii) Email: martin.elliffe@act.gov.au
ACT Legislative Assembly, 196 London Circuit, Canberra, ACT 2601

From: Travers, Maria <Maria.Travers@act.gov.au>
Sent: Wednesday, September 11, 2024 9:44 PM
To: Bransgrove, Meagen <Meagen.Bransgrove@act.gov.au>; Smith, Kahlia <Kahlia.Smith@act.gov.au>
Cc: Cross, Rebecca <Rebecca.Cross@act.gov.au>; Hudson, Robyn <Robyn.Hudson@act.gov.au>; Elliffe, Martin

<Martin.Elliffe@act.gov.au>
Subject: RE: VSC

OFFICIAL

Hi Meg, so sorry for the delay in responding.

We are not aware of any GTPs currently under development, and we will most probably only become aware of a GTP when it is submitted for consideration by the Board.

Maria

Maria Travers
A/g Executive Group Manager
Policy Partnerships and Programs Division
Mobile: Schedule 2.2(a)(ii) |Email: maria.travers@act.gov.au
2-6 Bowes Street Phillip ACT 2606| www.health.act.gov.au





I acknowledge the Ngunnawal people as traditional custodians of the ACT and recognise any other people or families with connection to the lands of the ACT and region. I acknowledge and respect their continuing culture and the contribution they make to the life of this city and this region.
Please consider the environment before printing this email.

From: Bransgrove, Meagen <Meagen.Bransgrove@act.gov.au>
Sent: Monday, September 9, 2024 2:06 PM
To: Travers, Maria <Maria.Travers@act.gov.au>; Smith, Kahlia <Kahlia.Smith@act.gov.au>
Cc: Cross, Rebecca <Rebecca.Cross@act.gov.au>; Hudson, Robyn <Robyn.Hudson@act.gov.au>; Elliffe, Martin <Martin.Elliffe@act.gov.au>
Subject: RE: VSC

OFFICIAL

Thanks Maria, that's helpful. Is there further on the general treatment plans in terms of number of GTP's currently under development etc?

Thanks,

Meg

From: Travers, Maria <Maria.Travers@act.gov.au>
Sent: Monday, September 9, 2024 12:36 PM
To: Smith, Kahlia <Kahlia.Smith@act.gov.au>; Bransgrove, Meagen <Meagen.Bransgrove@act.gov.au>

Cc: Cross, Rebecca <Rebecca.Cross@act.gov.au>; Hudson, Robyn <Robyn.Hudson@act.gov.au>
Subject: VSC

OFFICIAL

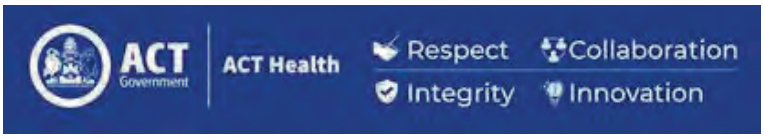
Hi Kahlia and Meg

Things are actually better that I just advised the Minister (which is aways good). Please see the attached Advisory Note which is on its way to the MO, and sorry I didn't have all the detail on hand at the time.

We will also provide you with a timeline and info on comms and training for non-GP specialists.

Maria

Maria Travers
A/g Executive Group Manager
Policy Partnerships and Programs Division
Mobile: Schedule 2.2(a)(ii) |Email: maria.travers@act.gov.au
2-6 Bowes Street Phillip ACT 2606| www.health.act.gov.au





I acknowledge the Ngunnawal people as traditional custodians of the ACT and recognise any other people or families with connection to the lands of the ACT and region. I acknowledge and respect their continuing culture and the contribution they make to the life of this city and this region.

Please consider the environment before printing this email.

Lowes Shannon

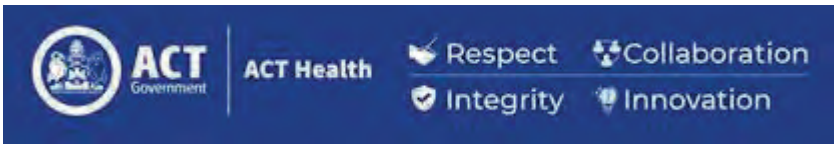
From: Gower, Tara on behalf of ACT Health DLO
Sent: Friday, 4 October 2024 8:59 AM
To: Tomlinson, Benjamin; Bransgrove, Meagen; Smith, Kahlia
Subject: MIN24/00795 - Compass Group - Cyber Security Threat Update

Good morning all

I have placed this Caveat Brief in the Minister's folder here.

Thank you
Tara

Tara Gower | Directorate Liaison Officer | ACT Health Directorate
Mob: Schedule 2.2(a)(ii) | Email: ACTHealthDLO@act.gov.au
Office of Rachel Stephen-Smith | Minister for Health
Office of Emma Davidson | Minister for Mental Health
Level 2, Legislative Assembly Building, Civic Square



Lowe, Shannon

From: Gower, Tara on behalf of ACT Health DLO
Sent: Friday, 4 October 2024 9:53 AM
To: STEPHEN-SMITH
Cc: Smith, Kahlia
Subject: RE: Funding for expansion of cervical screening services to support the elimination of cervical cancer in Australia by 2035 [SEC=OFFICIAL]
Attachments: RE: Funding for expansion of cervical screening services to support the elimination of cervical cancer in Australia by 2035 [SEC=OFFICIAL]

Hi Ben

I asked the team to confirm in writing that formal negotiations will not occur until after Caretaker.

This has been confirmed by the Commonwealth (refer to email attached).

I will now ask the team to prepare a Directorate response.

Thank you
Tara

Tara Gower | Directorate Liaison Officer | ACT Health Directorate
Mob: Schedule 2.2(a)(ii) | Email: ACTHealthDLO@act.gov.au
Office of Rachel Stephen-Smith | Minister for Health
Office of Emma Davidson | Minister for Mental Health
Level 2, Legislative Assembly Building, Civic Square



From: STEPHEN-SMITH
Sent: Thursday, 3 October 2024 1:39 PM
To: ACT Health DLO ; STEPHEN-SMITH
Cc: Smith, Kahlia
Subject: RE: Funding for expansion of cervical screening services to support the elimination of cervical cancer in Australia by 2035 [SEC=OFFICIAL]
Importance: High

OFFICIAL

Well from my reading it appears what you stated below is that it is official level response by 14 October and then formal negotiations. If that is not the case than it should be for an incoming minister and an extension requested.

From: Gower, Tara <Tara.Gower@act.gov.au> **On Behalf Of** ACT Health DLO
Sent: Thursday, 3 October 2024 12:18 PM
To: STEPHEN-SMITH <STEPHEN-SMITH@act.gov.au>

Cc: Smith, Kahlia <Kahlia.Smith@act.gov.au>
Subject: RE: Funding for expansion of cervical screening services to support the elimination of cervical cancer in Australia by 2035 [SEC=OFFICIAL]

OFFICIAL

Thanks Ben – to confirm, a DG response to meet the deadline?

Thank you
Tara

Tara Gower | Directorate Liaison Officer | ACT Health Directorate
Mob: Schedule 2.2(a)(ii) | Email: ACTHealthDLO@act.gov.au
Office of Rachel Stephen-Smith | Minister for Health
Office of Emma Davidson | Minister for Mental Health
Level 2, Legislative Assembly Building, Civic Square



From: STEPHEN-SMITH <STEPHEN-SMITH@act.gov.au>
Sent: Thursday, October 3, 2024 12:01 PM
To: ACT Health DLO <ACTHealthDLO@act.gov.au>; STEPHEN-SMITH <STEPHEN-SMITH@act.gov.au>
Cc: Smith, Kahlia <Kahlia.Smith@act.gov.au>
Subject: RE: Funding for expansion of cervical screening services to support the elimination of cervical cancer in Australia by 2035 [SEC=OFFICIAL]
Importance: High

OFFICIAL

No worries that sounds sensible.

From: Gower, Tara <Tara.Gower@act.gov.au> **On Behalf Of** ACT Health DLO
Sent: Thursday, 3 October 2024 11:35 AM
To: STEPHEN-SMITH <STEPHEN-SMITH@act.gov.au>
Cc: Smith, Kahlia <Kahlia.Smith@act.gov.au>
Subject: RE: Funding for expansion of cervical screening services to support the elimination of cervical cancer in Australia by 2035 [SEC=OFFICIAL]

OFFICIAL

Hi Ben

The team has confirmed that they have been developing a proposal for submission. The ACT proposal has been developed following liaison with a key local stakeholder including CHS and two NGOs (CHN and SHFPACT).

The team are currently working to submit the bid by the due date of 14 October 2024.

Grateful for your advice if the MO would like an incoming Minister response or a DG Response to meet the 14 October deadline.

I understand that the current timeline proposed by the Commonwealth is that formal negotiations with jurisdictions are not scheduled to commence until after caretaker.

Thank you
Tara

Tara Gower | Directorate Liaison Officer | ACT Health Directorate
Mob: Schedule 2.2(a)(ii) | Email: ACTHealthDLO@act.gov.au
Office of Rachel Stephen-Smith | Minister for Health
Office of Emma Davidson | Minister for Mental Health
Level 2, Legislative Assembly Building, Civic Square



From: STEPHEN-SMITH <STEPHEN-SMITH@act.gov.au>
Sent: Wednesday, October 2, 2024 12:53 PM
To: ACT Health DLO <ACTHealthDLO@act.gov.au>
Cc: Smith, Kahlia <Kahlia.Smith@act.gov.au>
Subject: FW: Funding for expansion of cervical screening services to support the elimination of cervical cancer in Australia by 2035 [SEC=OFFICIAL]
Importance: High

Hi

For appropriate response however may need to advise that an extension is needed.

B

From: Schedule 2.2(a)(ii)
Sent: Tuesday, 1 October 2024 6:27 PM
To: STEPHEN-SMITH <STEPHEN-SMITH@act.gov.au>
Cc: Kelly, Chris <Chris.Kelly@act.gov.au>; AHM-ACT <AHM-ACT@act.gov.au>; Schedule 2.2(a)(ii) Schedule 2.2(a)(ii)
Subject: Funding for expansion of cervical screening services to support the elimination of cervical cancer in Australia by 2035 [SEC=OFFICIAL]

Some people who received this message don't often get email from Schedule 2.2(a)(ii) Learn why this is important

Caution: This email originated from outside of the ACT Government. Do not click links or open attachments unless you recognise the sender and know the content is safe.

Good afternoon

Please find attached a letter from the Minister for Health and Aged Care, the Hon Mark Butler MP to the Hon Ryan Park MP, Minister for Health, regarding the allocated funding for states and territories to expand cervical screening services and support the elimination of cervical cancer in Australia by 2035.

Please let us know if you have any questions.

Kind regards

Schedule 2.2(a)(ii)

Director – Cervical Screening Section
Cancer Screening Programs Branch

Cancer, Hearing and Chronic Conditions Division | Primary & Community Care Group
Australian Government Department of Health and Aged Care
T: Schedule 2.2(a)(ii)
Location: Sirius Level 4

PO Box 9848, Canberra ACT 2601, Australia

The Department of Health and Aged Care acknowledges First Nations peoples as the Traditional Owners of Country throughout Australia, and their continuing connection to land, sea and community. We pay our respects to them and their cultures, and to all Elders both past and present.



From: Schedule 2.2(a)(ii)
To: Kelly, Chris
Cc: Knox, Ros; Seymour, Danielle; Pepar, AnnaJ Schedule 2.2(a)(ii)
Subject: RE: Funding for expansion of cervical screening services to support the elimination of cervical cancer in Australia by 2035 [SEC=OFFICIAL]
Date: Friday, 4 October 2024 8:47:04 AM
Attachments: image005.png
image006.jpg
image007.png
image002.png

UNOFFICIAL

Caution: This email originated from outside of the ACT Government. Do not click links or open attachments unless you recognise the sender and know the content is safe.

Thanks Chris. It's great to hear that you are aiming to submit your proposal by the due date. Confirming that the formal without prejudice FAA negotiations between the Commonwealth and the ACT will not be scheduled to commence until after ACT caretakers' convention ends (noting that it is expected to be late October at this point).

Regards

Schedule 2.2(a)(ii)
Director – Cervical Screening Section
Cancer Screening Programs Branch
Cancer, Hearing and Chronic Conditions Division | Primary & Community Care Group
Australian Government Department of Health and Aged Care
T: Schedule 2.2(a)(ii)
Location: Sirius Level 4
PO Box 9848, Canberra ACT 2601, Australia
The Department of Health and Aged Care acknowledges First Nations peoples as the Traditional Owners of Country throughout Australia, and their continuing connection to land, sea and community. We pay our respects to them and their cultures, and to all Elders both past and present.

From: Kelly, Chris <Chris.Kelly@act.gov.au>
Sent: Thursday, October 3, 2024 4:08 PM
To Schedule 2.2(a)(ii)
Cc: Knox, Ros <Ros.Knox@act.gov.au>; Seymour, Danielle <danielle.seymour@act.gov.au>; Pepar, AnnaJ <annaj.pepar@act.gov.au>
Subject: RE: Funding for expansion of cervical screening services to support the elimination of cervical cancer in Australia by 2035 [SEC=OFFICIAL]

REMINDER: Think before you click! This email originated from outside our organisation. Only click links or open attachments if you recognise the sender and know the content is safe.

UNOFFICIAL

Hi Schedule 2.2(a)(ii)

We are currently working to submit a FFA proposal by the (extension) due date of 14/10/24 and are liaising with our Ministers Office on timings related to the upcoming ACT election, noting ACT won't be able to commence formal negotiations on the FFA until after our caretaker conventions cease. Under the 2024 conventions, the caretakers period ends with the election of the Chief Minister on the first sitting day of the Legislative Assembly following the election. This is expected to be late October at this point.

Post our discussion by phone today, I am seeking your confirmation by return email that the Commonwealth accepts that the formal without prejudice FAA negotiations for activities related to the National Cervical Screening Program between the Commonwealth and the ACT will not be scheduled to commence until after ACT caretakers' convention ends.

Regards

Chris
Chris Kelly | Director
he/him
Ph: **+61 2** 5124 9059 | Email: chris.kelly@act.gov.au
Preventive and Population Health Policy | Population Health Division | ACT Health Directorate
Level 3, 2-6 Bowes Street, Woden | GPO Box 825 Canberra City ACT 2601 health.act.gov.au

ACTH Email signature Values

I acknowledge the Ngunnawal people as traditional custodians of the ACT and recognise any other people or families with connection to the lands of the ACT and region. I acknowledge and respect their continuing culture and the contribution they make to the life of this city and this region.

From Schedule 2.2(a)(ii)
Sent: Tuesday, 1 October 2024 6:27 PM
To: STEPHEN-SMITH <STEPHEN-SMITH@act.gov.au>
Cc: Kelly, Chris <Chris.Kelly@act.gov.au>; AHM-ACT <AHM-ACT@act.gov.au>; Schedule 2.2(a)(ii) Schedule 2.2(a)(ii)
Subject: Funding for expansion of cervical screening services to support the elimination of cervical cancer in Australia by 2035 [SEC=OFFICIAL]

Caution: This email originated from outside of the ACT Government. Do not click links

or open attachments unless you recognise the sender and know the content is safe.

Good afternoon

Please find attached a letter from the Minister for Health and Aged Care, the Hon Mark Butler MP to the Hon Ryan Park MP, Minister for Health, regarding the allocated funding for states and territories to expand cervical screening services and support the elimination of cervical cancer in Australia by 2035.

Please let us know if you have any questions.

Kind regards

Schedule 2.2(a)(ii)

Director – Cervical Screening Section
Cancer Screening Programs Branch
Cancer, Hearing and Chronic Conditions Division | Primary & Community Care Group
Australian Government Department of Health and Aged Care
T: Schedule 2.2(a)(ii)
Location: Sirius Level 4
PO Box 9848, Canberra ACT 2601, Australia

The Department of Health and Aged Care acknowledges First Nations peoples as the Traditional Owners of Country throughout Australia, and their continuing connection to land, sea and community. We pay our respects to them and their cultures, and to all Elders both past and present.

This email, and any attachments, may be confidential and also privileged. If you are not the intended recipient, please notify the sender and delete all copies of this transmission along with any attachments immediately. You should not copy or use it for any purpose, nor disclose its contents to any other person.

Lowes Shannon

From: Gower, Tara on behalf of ACT Health DLO
Sent: Friday, 4 October 2024 12:35 PM
To: Wiggins, Taylor; Docker, Jake; Ord, Jon
Subject: 20241004 GBC24/00294 - Transmittal of Annual Report to Minister for Mental Health & Pop Health

Good afternoon all

In the first instance, I have placed this Noting Brief in Taylor's folder here.

Please note the critical date of today, 4 October 2024.

Thank you
Tara

Tara Gower | Directorate Liaison Officer | ACT Health Directorate
Mob: Schedule 2.2(a)(ii) | Email: ACTHealthDLO@act.gov.au
Office of Rachel Stephen-Smith | Minister for Health
Office of Emma Davidson | Minister for Mental Health
Level 2, Legislative Assembly Building, Civic Square



From: STEPHEN-SMITH
Sent: Friday, 4 October 2024 15:34
To: ACT Health DLO
Cc: Bransgrove, Meagen
Subject: FW: PACFA program accreditation standards review: Second round public consultation now open

Importance: High

For ACTHD action as appropriate.

b

From: Standards Review
Sent: Friday, 4 October 2024 3:32 PM
To: STEPHEN-SMITH
Cc: CEO ; Nghi Robinson
Subject: PACFA program accreditation standards review: Second round public consultation now open

You don't often get email from Schedule 2.2(a)(ii) Learn why this is important

Caution: This email originated from outside of the ACT Government. Do not click links or open attachments unless you recognise the sender and know the content is safe.

Dear Rachel,

We are sending a gentle reminder on the below email regarding the second round of public consultation for PACFA's program accreditation standards review.

As you may be aware, the Psychotherapy and Counselling Federation of Australia is currently reviewing the Program Accreditation Standards for Counselling Programs in Australia.

Following an initial review period and consultation with a wide range of stakeholders, draft standards have been prepared and are now available for consideration.

PACFA invites all education providers and interested stakeholders to participate in the second round of public consultation, which commenced on Monday 2 September 2024 and closes on Monday 14 October 2024. In this final phase, stakeholders are encouraged to provide feedback, suggestions, or considerations for the Draft PACFA Accreditation Standards for Counselling Programs (Draft Accreditation Standards).

We welcome responses to the survey from anyone with an interest in the program accreditation standards. To participate in the survey, please:

- Watch the presentation, read the consultation paper, and review the relevant reference documents.
- Complete the online survey.
- Alternatively, fill in this Word template document and email your response to Schedule 2.2(a)(ii)

The deadline to submit your response to the survey is **COB Monday 14 October 2024.**

If you have any queries regarding the consultation phase or the review process, please do not hesitate to contact us at Schedule 2.2(a)(ii)

Thank you for taking the time to contribute to this important review.

Kind regards,

Jessica Hazell on behalf of

Johanna de Wever (she/her) | **Chief Executive Officer**
Psychotherapy and Counselling Federation of Australia

Creative Cubes
333 Drummond St, Carlton Vic 3053
Schedule 2.2(a)(ii)

www.pacfa.org.au

PACFA acknowledges the Wurundjeri Woi-wurrung people of the Kulin nations as the traditional custodians of the land on which we work, and pays respect to their Elders, past, present and emerging. We honour their continuing connection to culture, land, knowledge and community; sovereignty was never ceded.

From: Standards Review Schedule 2.2(a)(ii)
Sent: Tuesday, 3 September 2024 3:35 PM
To: stephen-smith@act.gov.au
Cc: CEO <CEO@pacfa.org.au>; Schedule 2.2(a)(ii)
Subject: PACFA program accreditation standards review: Second round public consultation now open

Dear Rachel,

As you may be aware, the Psychotherapy and Counselling Federation of Australia is currently reviewing the Program Accreditation Standards for Counselling Programs in Australia.

Following an initial review period and consultation with a wide range of stakeholders, draft standards have been prepared and are now available for consideration.

PACFA invites all education providers and interested stakeholders to participate in the second round of public consultation, which opens on Monday 2 September 2024 and closes on Monday 14 October 2024. In this final phase, stakeholders are encouraged to provide feedback, suggestions, or considerations for the Draft PACFA Accreditation Standards for Counselling Programs (Draft Accreditation Standards).

We welcome responses to the survey from anyone with an interest in the program accreditation standards. To participate in the survey, please:

- Watch the presentation, read the consultation paper, and review the relevant reference documents.
- Complete the online survey.

• Alternatively, fill in this Word template document and email your response to Schedule 2.2(a)(ii)

The deadline to submit your response to the survey is **COB Monday 14 October 2024.**

We look forward to receiving your feedback and thank you for your participation.

Please note that PACFA will not publish any individual survey responses but may publish a summary of the responses received, without identifying information.

If you have any queries regarding the consultation phase or the review process, please contact Jessica Hazell, Education Project Officer, Accreditation at Schedule 2.2(a)(ii)

Thank you for taking the time to contribute to this important review.

Kind regards,

Johanna de Wever (she/her) | **Chief Executive Officer**
Psychotherapy and Counselling Federation of Australia

Creative Cubes
333 Drummond St, Carlton Vic 3053
Schedule 2.2(a)(ii)

www.pacfa.org.au

PACFA acknowledges the Wurundjeri Woi-wurrung people of the Kulin nations as the traditional custodians of the land on which we work, and pays respect to their Elders, past, present and emerging. We honour their continuing connection to culture, land, knowledge and community; sovereignty was never ceded.

From: STEPHEN-SMITH
Sent: Friday, 4 October 2024 15:36
To: ACT Health DLO
Cc: Smith, Kahlia
Subject: FW: FFA Schedule - Participant Follow-up Function [SEC=OFFICIAL]
Attachments: Federation Funding Agreement Health Schedule- National Bowel Cancer Screening Program - Participant Follow-up Function - MS24-001111.pdf; Signed letter of offer to Ms Rachel Stephen-Smith MLA - ACT - MS24-001111.pdf

Importance: High

For appropriate action.

B

From: NBCSP
Sent: Friday, 4 October 2024 2:12 PM
To: STEPHEN-SMITH
Cc: NBCSP
Subject: FFA Schedule - Participant Follow-up Function [SEC=OFFICIAL]

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Good afternoon

Please see attached a letter from the Minister for Health and Aged Care, the Hon Mark Butler MP to Ms Rachel Stephen-Smith MLA, Minister for Health regarding the Federation Funding Agreement (FFA) Health Schedule – National Bowel Cancer Screening Program (NBCSP) – Participant Follow-up Function (Schedule).

Also attached is a copy of the Schedule signed by Minister Butler. To accept the offer, please return a signed copy of the Schedule to the department at NBCSP@health.gov.au. Once agreed, the Schedule will be published on the Federal Financial Relations website.

Please contact Amy Leech, National Bowel Cancer Screening Program, at Schedule 2.2(a)(ii) [redacted] you require more information.

Kind regards,

Schedule 2.2(a)(ii) [redacted]

National Bowel Cancer Screening Program

Cancer Hearing & Program Support Division
Australian Government Department of Health
E: NBCSP@health.gov.au

The Department of Health acknowledges the traditional owners of country throughout Australia, and their continuing connection to land, sea and community. We pay our respects to the individuals, their cultures, and to elders both past and present.

"Important: This transmission is intended only for the use of the addressee and may contain confidential or legally privileged information. If you are not the intended recipient, you are notified that any use or dissemination of this communication is strictly prohibited. If you receive this transmission in error please notify the author immediately and delete all copies of this transmission."

Schedule

National Bowel Cancer Screening Program – Participant Follow-up Function

FEDERATION FUNDING AGREEMENT - HEALTH

Table 1: Formalities and operation of schedule	
Parties	Commonwealth New South Wales Victoria Queensland Western Australia South Australia Tasmania Australian Capital Territory Northern Territory
Duration	This Schedule is expected to expire on 30 June 2028
Purpose	This Schedule will support follow up participants of the National Bowel Cancer Screening Program (NBCSP) who receive a positive immunochemical faecal occult blood test (iFOBT) result and who have not progressed along the screening pathway for appropriate medical care, including clinical or diagnostic assessment by a healthcare provider and/or specialist. **The Participant Follow-up Function (PFUF) is undertaken in accordance with nationally consistent guidelines and protocols with key activities including:** (a) contacting participants of the NBCSP where there is no record on the National Cancer Screening Register (NCSR) indicating that the participant has attended the necessary follow-up following a positive iFOBT; (b) making timely updates to a participant's record on the NCSR following contact; (c) providing advice regarding the PFUF to the Commonwealth via the NBCSP Program Delivery Advisory Group, as needed; (d) participating in PFUF information sharing forums, including those facilitated by the Commonwealth and the NCSR; and (e) where viable and at the discretion of state and territory health departments, and with necessary permissions from jurisdictional health services, progressing follow up of missing Colonoscopy, Histopathology and Adverse Events reports or other program related work to ensure data quality and completeness, in a manner that is agreed with the Commonwealth.

Estimated financial contributions	The Commonwealth will provide an estimated total financial contribution to the States of $38.829 million in respect of this Schedule.

$	2024-25	2025-26	2026-27	2027-28	Total
NSW	$2,765,409	$2,874,327	$2,980,116	$3,081,836	**$11,701,688**
Vic	$2,275,268	$2,364,344	$2,450,860	$2,534,048	**$9,624,520**
Qld	$1,836,252	$1,907,555	$1,976,808	$2,043,398	**$7,764,013**
SA	$671,126	$695,259	$718,699	$741,238	**$2,826,322**
WA	$1,006,315	$1,044,018	$1,080,638	$1,115,849	**$4,246,820**
TAS	$260,346	$267,849	$275,136	$282,144	**$1,085,475**
NT	$155,913	$159,189	$162,371	$165,430	**$642,903**
ACT	$225,371	$231,459	$237,372	$243,057	**$937,259**
TOTAL	**$9,196,000**	**$9,544,000**	**$9,882,000**	**$10,207,000**	**$38,829,000**

Additional terms

Additional Terms:

The Commonwealth will support the delivery of the PFUF by:

(a) providing States and Territories (the States) with nationally consistent guidelines and protocols that guide delivery of the follow-up function, providing clarifications as needed;

(b) maintaining the NCSR and ensuring the States are provided with electronic worklists identifying participants for follow-up;

(c) providing the States with nationally consistent guidance and protocols for follow up of missing Colonoscopy, Histopathology and Adverse Events reports, or other program related work, agreed jointly by the Commonwealth and the States;

(d) providing a template for the mandatory Pre-Configured Reporting (PCR) 701-705 for PFUF Annual Reporting. This template may be updated periodically in consultation with the States. States are required to provide these reports and may use their own templates if they prefer, as long as they include the required PCR.

(e) providing advice to the NBCSP Program Delivery Advisory Group on the PFUF role, as needed.

The Parties acknowledge that the purposes of this agreement, reference to 'nationally consistent guidelines and protocols' includes the NBCSP Participant Follow-Up Function Minimum Guidelines, the PCR 701-705 for PFUF Annual Reporting and other relevant guidelines produced by the NCSR, such as quick reference guides and the NCSR User Guide. These operational documents may be varied periodically in consultation with the States to ensure national consistency and maintain data integrity of the NCSR, while allowing for tailored operational processes that meet jurisdiction-specific needs. Such updates to these operational documents do not constitute a variation of the FFA Schedule.

	The Parties agree that States will support the effective and nationally consistent delivery of the PFUF through activities including: (a) having regard to the nationally consistent guidelines and protocols redeveloped by the Commonwealth in consultation with the States; (b) delivering the PFUF for NBCSP participants who receive a positive iFOBT result and who have not progressed along the screening pathway for appropriate medical care, including clinical assessment by a healthcare provider resulting in diagnostic assessment such as colonoscopy or other clinically relevant procedure; (c) making timely updates to NBCSP participant's records; (d) participating in the NBCSP Program Delivery Advisory Group and providing advice as required. The parties agree that the States will provide an annual report to the Commonwealth that, at a minimum, contains; data reports generated from the NCSR for the relevant jurisdictions which includes information outlining the impact of PFUF activities, demonstrating the delivery of participant follow-up outcomes. At the discretion of the States, annual reporting may also include feedback of any lessons learned to support the continuous improvement of delivery of the PFUF. The Commonwealth supports the provision of health and emergency services through the public hospital system through the National Health Reform Agreement (NHRA). The NHRA provides that the Commonwealth will not fund a service where the same service, or any part of the same service, is otherwise funded by the Commonwealth. States will ensure that any claim for funding under the NHRA is not funding services, or any part of a service, provided for under this agreement and will maintain appropriate records. The Parties acknowledge that the Commonwealth is separately supporting the States to expand existing direct access colonoscopy triage models for participants of the NBCSP that return a positive bowel cancer screening result and improve access to and reporting of public diagnostic colonoscopy services. The Parties acknowledge that during the term of this Schedule the Commonwealth will conduct a review of the PFUF program in consultation with the States to assess its performance and assure its ongoing effectiveness.

Table 2: Performance requirements, reporting and payment summary			
Output	**Performance milestones**	**Report due**	**Payment**
Delivery of the NBCSP PFUF	Provision of an Annual performance report covering the period 1 April 2024 to 31 March 2025, as prescribed in Table 1.	30 April 2025	100% of annual allocation in accordance with Table 1.
	Provision of an Annual performance report covering the period 1 April 2025 to 31 March 2026, as prescribed in Table 1.	30 April 2026	
	Provision of an Annual performance report covering the period 1 April 2026 to 31 March 2027, as prescribed in Table 1.	30 April 2027	
	Provision of an Annual performance report covering the period 1 April 2027 to 31 March 2028, as prescribed in Table 1.	30 April 2028	

The Parties have confirmed their commitment to this schedule as follows:

Signed *for and on behalf of the Commonwealth of Australia by*

The Honourable Mark Butler MP
Minister for Health and Aged Care
08 / 10 / 2024

Signed *for and on behalf of the State of New South Wales by*

The Honourable Ryan Park MP
Minister for Health
/ / 2024

Signed *for and on behalf of the State of Victoria by*

The Honourable Mary-Anne Thomas MP
Minister for Health
/ / 2024

Signed *for and on behalf of the State of Queensland by*

The Honourable Shannon Fentiman MP
Minister for Health, Mental Health and Ambulance Services
/ /2024

Signed *for and on behalf of the State of Western Australia by*

The Honourable Amber-Jade Sanderson MP
Minister for Health
/ / 2024

Signed *for and on behalf of the State of South Australia by*

The Honourable Chris Picton MP
Minister for Health and Wellbeing
/ / 2024

Signed *for and on behalf of the State of Tasmania by*

The Honourable Guy Barnett MP
Minister for Health
/ / 2024

Signed *for and on behalf of the Australian Capital Territory by*

The Honourable Rachel Stephen-Smith MLA
Minister for Health
/ / 2024

Signed *for and on behalf of the Northern Territory by*

The Honourable Steven Edgington
Minister for Health
/ / 2024

The Hon Mark Butler MP
Minister for Health and Aged Care

Ref No: MS24-001111

Ms Rachel Stephen-Smith MLA
Minister for Health
GPO Box 1020
CANBERRA ACT 2601
stephen-smith@act.gov.au

Dear Minister Rachel

I am pleased to offer the Federation Funding Agreement (FFA) Health Schedule – National Bowel Cancer Screening Program (NBCSP) – Participant Follow-up Function (Schedule) for your agreement and co-signature.

The Australian Government committed $38.829 million over four years in the 2024–25 Budget for continuation of the NBCSP Participant Follow-up Function.

The aim of the NBCSP is to increase early detection of bowel cancer through effective screening, follow-up, and consistent care to improve patient outcomes and reduce mortality rates. The funding made available under this Schedule supports states and territories to follow-up with NBCSP participants who return a positive screening test result to ensure they access appropriate diagnostic and follow up care.

Officials in the Department of Health and Aged Care have been working with state and territory contacts, including in Australian Capital Territory, to negotiate this Schedule. I understand that in principle agreement has now been reached and to formalise the arrangement I have included a copy of the Schedule for your consideration. Please sign the Schedule and return to nbcsp@health.gov.au at your earliest convenience.

I look forward to our continued partnership on this important measure.

Yours sincerely

Mark Butler

23 / 10 / 2024

Encl (1) Federation Funding Agreement – National Bowel Cancer Screening Program – Participant Follow-up Function

From: Docker, Jake
Sent: Friday, 4 October 2024 15:40
To: ACT Health DLO
Subject: FW: Australian Breastfeeding Association - to Food Ministers
Attachments: Australian Breastfeeding Association - to Food Ministers Ms Emma Davidson MLA ACT.pdf

Importance: High

Hi Tara-

Given caretaker conventions- I am forwarding this to the ACTHD to consider a directorate response.

Thanks,

Jake Docker | Adviser, Population Health & Community Services
Office of Emma Davidson| ACT Greens Member for Murrumbidgee
E: jake.docker@act.gov.au

From: Davidson
Sent: Friday, 4 October 2024 1:10 PM
To: Docker, Jake
Subject: FW: Australian Breastfeeding Association - to Food Ministers

Good Afternoon Jake,

One for your consideration.

Thanks,

Maxine Harris (She/Her)
Office Manager
Office of Emma Davidson|ACT Greens Member for Murrumbidgee
Minister for Community Services, Seniors and Veterans | Minister for Mental Health
Minister for Corrections and Justice Health | Minister for Population Health
GPO Box 1020, Canberra ACT 2601
02 6205 1941
Davidson@act.gov.au

From: ACT NSW BP Schedule 2.2(a)(ii)
Sent: Friday, 4 October 2024 7:03 AM
To: Davidson <DAVIDSON@act.gov.au>
Subject: Australian Breastfeeding Association - to Food Ministers

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Caution: This email originated from outside of the ACT Government. Do not click links or open attachments unless you recognise the sender and know the content is safe.

Attention:

Ms Emma Davidson MLA

Minister for Population Health

Please find attached a letter from the Australian Breastfeeding Association in relation to an issue we would like raised by the Minister at the upcoming Food Ministers' meeting.

Kind regards,

Kathryn

--

Kathryn Barwick
Breastfeeding Counsellor / Educator
Trainer / Assessor
ACT/NSW Branch President

Australian Breastfeeding Association / RTO: 21659

I acknowledge the traditional custodians of the land on which I live, and pay my respects to Elders past, present, and of the future.

Like most of us at ABA, I am a volunteer balancing ABA activities with family life and other commitments. I am sending this email at a time that works best for me, and encourage you to reply at the time that works best for you.


1964
2024
Australian
Breastfeeding
Association
celebrating 60 years of
trusted breastfeeding support

Australian Breastfeeding Association

Level 3, Suite 3.02
11 Queens Road
Melbourne VIC 3004

Phone (03) 9690 4620

PO Box 33221
Melbourne VIC 3004

ABN: 64005081523
RTO: 21659

Ms Emma Davidson MLA

ACT Minister for Population Health.

davidson@act.gov.au

Dear Minister

Re: Food Ministers Meeting – 15 November 2024

I am the ACT/NSW representative of the Australian Breastfeeding Association (ABA), Australia's peak breastfeeding information, education and support organisation, and a critical part of Australia's public health infrastructure.

I am writing to you in your role as the ACT Minister for Population Health and member of the Food Ministers' Meeting, to ask you to act to protect breastfeeding by supporting measures to strengthen the regulation of marketing infant formulas and toddler milks in Australia.

Australia's federalised system requires State and Territory governments to work with the Federal Government to implement key breastfeeding policies. In 2019 the *Australian National Breastfeeding Strategy: 2019 and beyond* (ANBS) was developed by the Federal Department of Health and agreed to by all states and territories through Council of Australian Governments (COAG) Health Council processes and then launched on 3 August 2019, during World Breastfeeding Week. The ANBS identified a critical area for Federal action is effective regulation of the marketing of commercial milk formulas and recommended a review of the Marketing in Australia of Infant Formula: Manufacturers and Importers Agreement (MAIF Agreement).

The leading recommendation of the subsequent MAIF Review: Final Report (DOHAC, 2023) indicated that a legislated, prescribed mandatory code is the appropriate framework to restrict the marketing of infant formula in Australia as it will "embed stronger monitoring and reporting and be enforceable under law." Also cited are the "improved public health and associated economic benefits" of this stronger model.

The MAIF Agreement has proved to be a weak industry code of practice and is currently before the Australian Competition and Consumer Commission (ACCC). In submissions to the ACCC, ABA and other public health organisations presented evidence and called for the MAIF Agreement **not** to be re-authorised and, instead, for the Australian Government to **legislate in full** the *World Health Organization International Code of Breast-milk Substitutes* and subsequent World Health Assembly resolutions (**the WHO Code**).

On 20 September 2024, the ACCC issued a Draft Determination to not reauthorise the MAIF Agreement, citing "several factors that undermine the likely effectiveness of the MAIF Agreement" which include:

- "that the MAIF Agreement is voluntary, does not extend to retailers, and carries no sanctions for a breach, other than the publication of a breach finding on the Department of Health and Aged Care's website, often well after the breach occurred

- the ability for signatories to advertise toddler milk products, which often has almost identical packaging to infant formula and can have the effect of cross promoting infant formula

Australian Breastfeeding Association

- the MAIF Agreement's inability to effectively regulate modern digital marketing practices such as social media advertising and marketing using data algorithms

- the effectiveness of the MAIF Complaints Committee."

Without strong regulation of marketing infant formulas and toddler milks led by the Federal Government, State and Territory investments in breastfeeding through breastfeeding programs are undermined by misleading formula and toddler milk advertising.

In your role as the ACT Minister for Population Health and member of the Food Ministers' Meeting, we ask you to:

1. Advocate at the upcoming Food Ministers' Meeting and in other national forums to reject industry self-regulation and call for **Federal legislation of the WHO Code in full.** This includes:

    - Coverage of commercial milk formulas for ages 0-36 months, retailers and digital media.
    - Not relying on the approved changes to P1028 Infant formula, introducing requirements for infant formula labelling and packaging to be distinguished from toddler milks, as a sole measure.

2. Urge the Federal Government to develop an **implementation plan** for the **Australian National Breastfeeding Strategy 2019** (ANBS) and **fund** this in the next Federal budget.

3. Review the progress of ANBS implementation and funding at state/territory level.

Your commitment to breastfeeding and environments free of milk formula marketing will help protect breastfeeding and the rights of Australian parents to make informed decisions about feeding their infants, free from commercial interests; decisions that profoundly affect their child's future health outcomes. Your support will also help improve health equity, 'first food' security and mitigate climate change.

I would welcome the opportunity to meet with you and discuss the urgent need for effective policy on milk formula marketing and the implementation of the ANBS to protect breastfeeding and create healthier, more food secure and climate change resilient communities.

Yours sincerely

Kathryn Barwick

Branch President

Australian Breastfeeding Association

ACT/NSW Branch

From: STEPHEN-SMITH
Sent: Tuesday, 8 October 2024 10:14
To: ACT Health DLO
Cc: Smith, Kahlia
Subject: FW: 2024 Health of the Nation report: early signs of revival
Attachments: ID-6887-HOTN-2024-Assets-Socials-V1-FACEBOOK_46.jpg; ID-6887-HOTN-2024-Assets-Socials-V1-FACEBOOK_73.jpg; ID-6887-HOTN-2024-Assets-Socials-V1-FACEBOOK_98.jpg; ID-6887-HOTN-2024-Assets-Socials-V1-INSTA_46.jpg; ID-6887-HOTN-2024-Assets-Socials-V1-INSTA_73.jpg; ID-6887-HOTN-2024-Assets-Socials-V1-INSTA_98.jpg
Importance: High

Hi Tara,

For noting please.

Thank you,

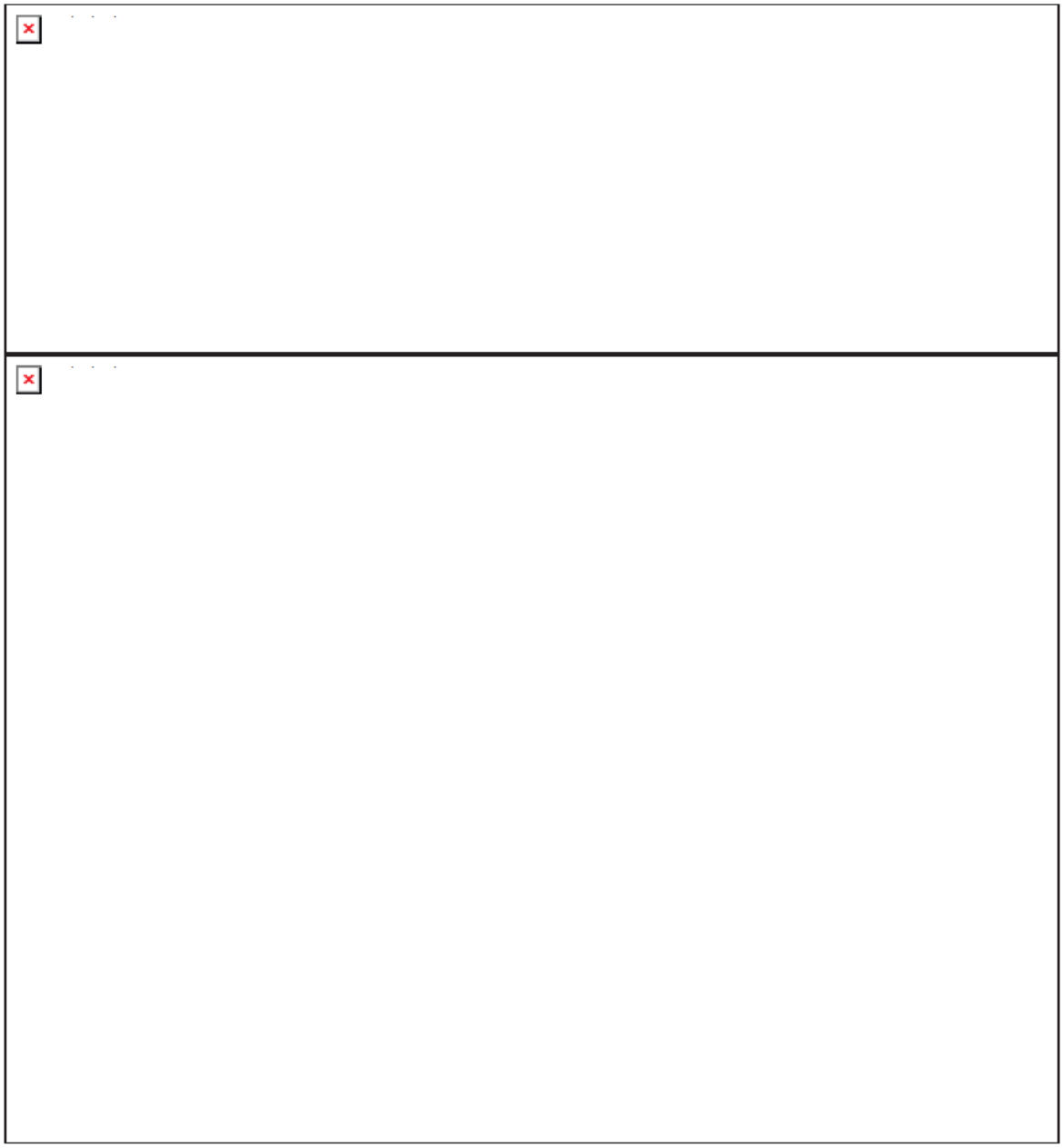
Sally Cooke
Office Manager | Office of Rachel Stephen-Smith MLA
Minister for Health | Minister for Children, Youth and Family Services | Minister for Disability | Minister for Aboriginal and Torres Strait Islander Affairs
Member for Kurrajong
ACT Legislative Assembly, 196 London Circuit, Canberra ACT 2601 | P: (02) 6205 2661 | www.act.gov.au

From: RACGP
Sent: Tuesday, 8 October 2024 10:10 AM
To: STEPHEN-SMITH
Subject: 2024 Health of the Nation report: early signs of revival

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Dear Ms Stephen-Smith,

Our annual Health of the Nation report launches today! This captures our members' insights on the state of general practice in Australia. Over 3,000 GPs from every state and territory contributed to this year's survey.

I'm pleased to report early signs of a revival in general practice, particularly our GP workforce. Job satisfaction is up, and more GPs are recommending general practice as a career. This is reflected in our GP Training numbers – we're oversubscribed and on track to train a record number of future GPs in 2025.

Read the 2024 Health of the Nation report

Every year more than 22 million Australians choose to see a GP for their health care – they deserve an affordable system. There is no substitute for the quality care you get from a GP who knows you, and your history. Studies show patients who see the same GP are healthier and live longer.

We need to accelerate this turnaround and ensure general practice can thrive for patients in every community. It's time for meaningful investment in general practice care.

Please help us share the findings and call for change – every community needs GPs, and access to affordable GP care.

Share our social tiles with the hashtag #HOTN24 @RACGP

Kind regards,
Dr Nicole Higgins
RACGP President

Did you find this email **helpful**? Yes / No

The Royal Australian College of General Practitioners Ltd (RACGP) ABN 34 000 223 807
RACGP House, 100 Wellington Parade, East Melbourne, VIC 3002 Australia

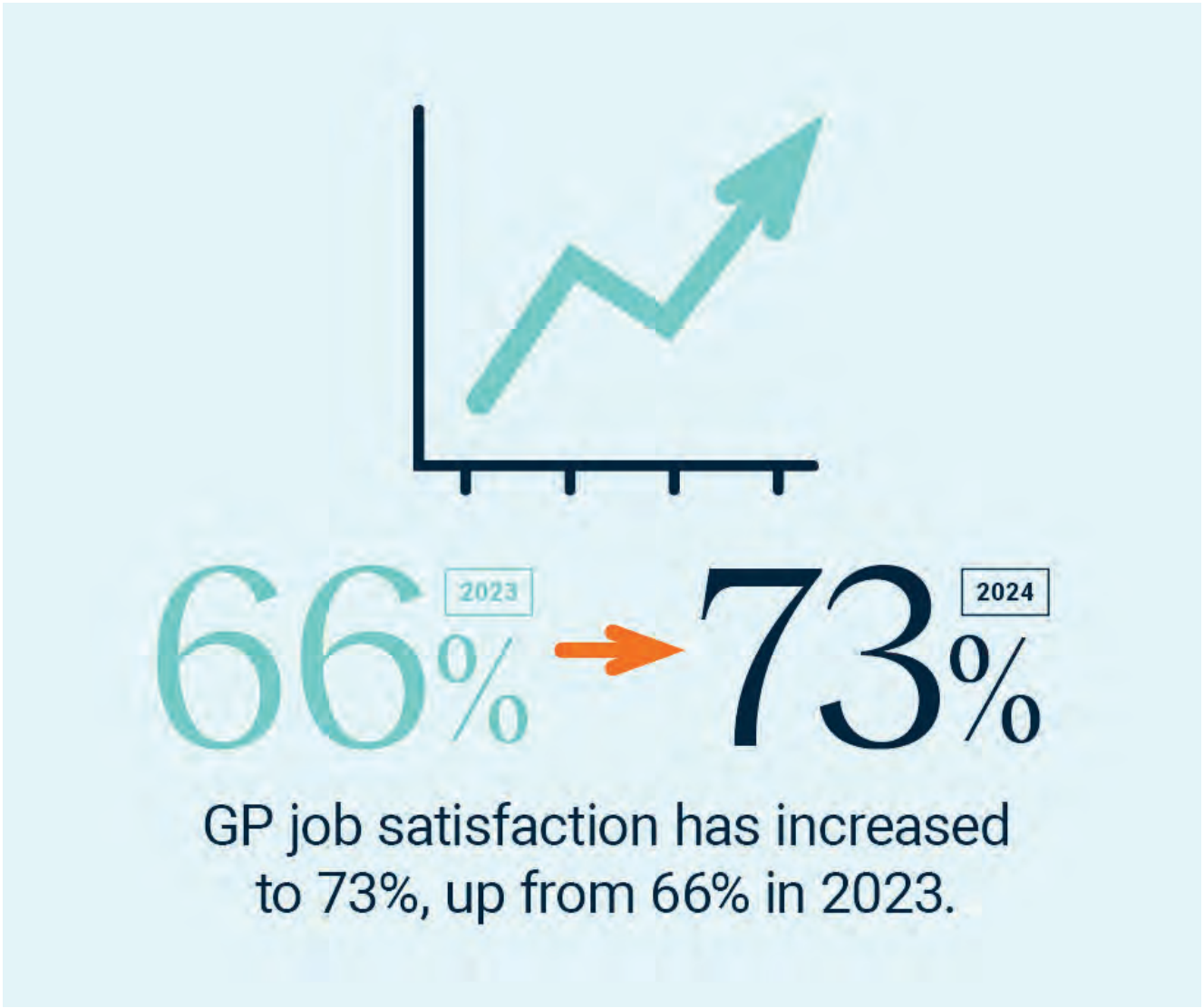
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1800 472 247
www.racgp.org.au

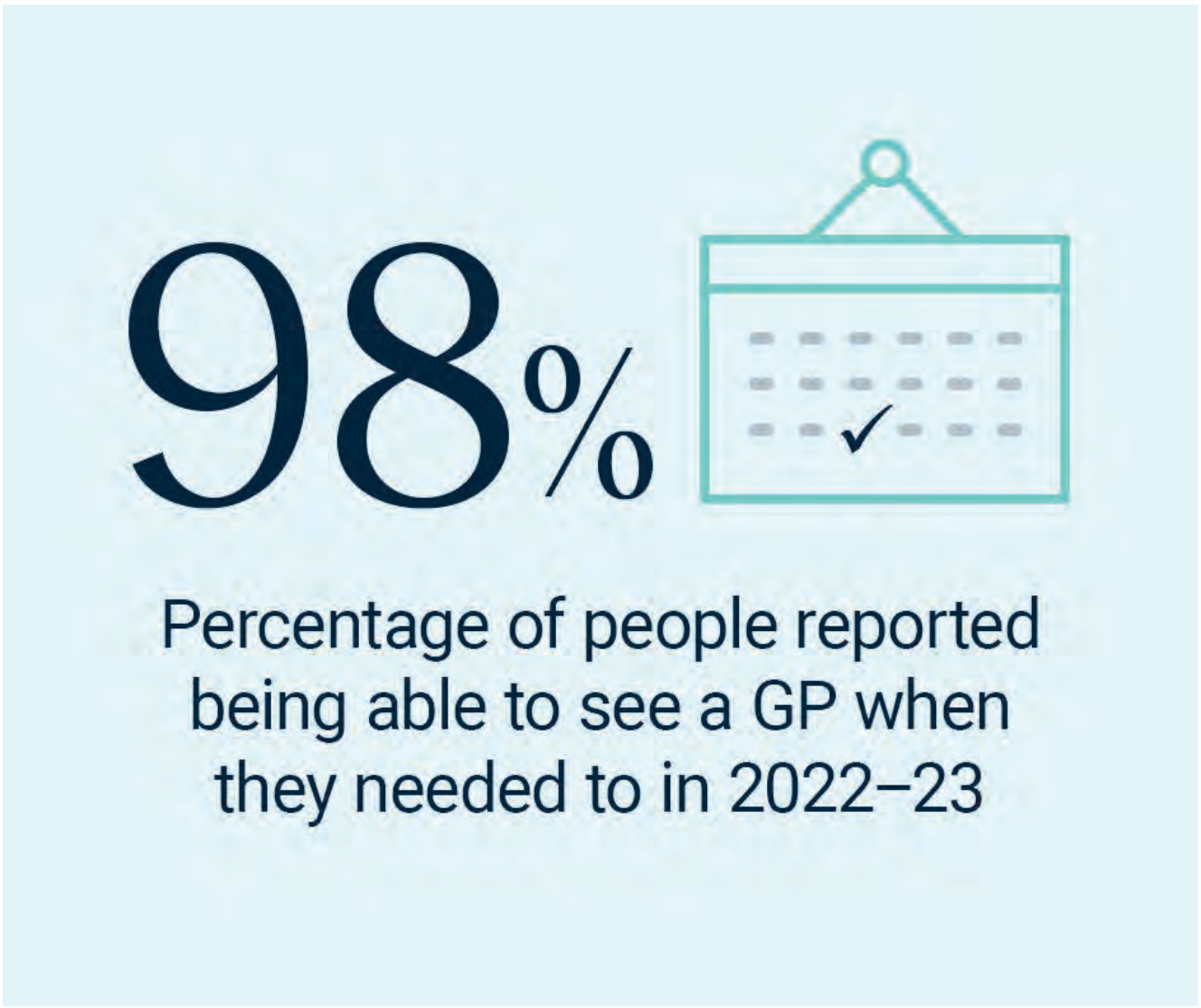
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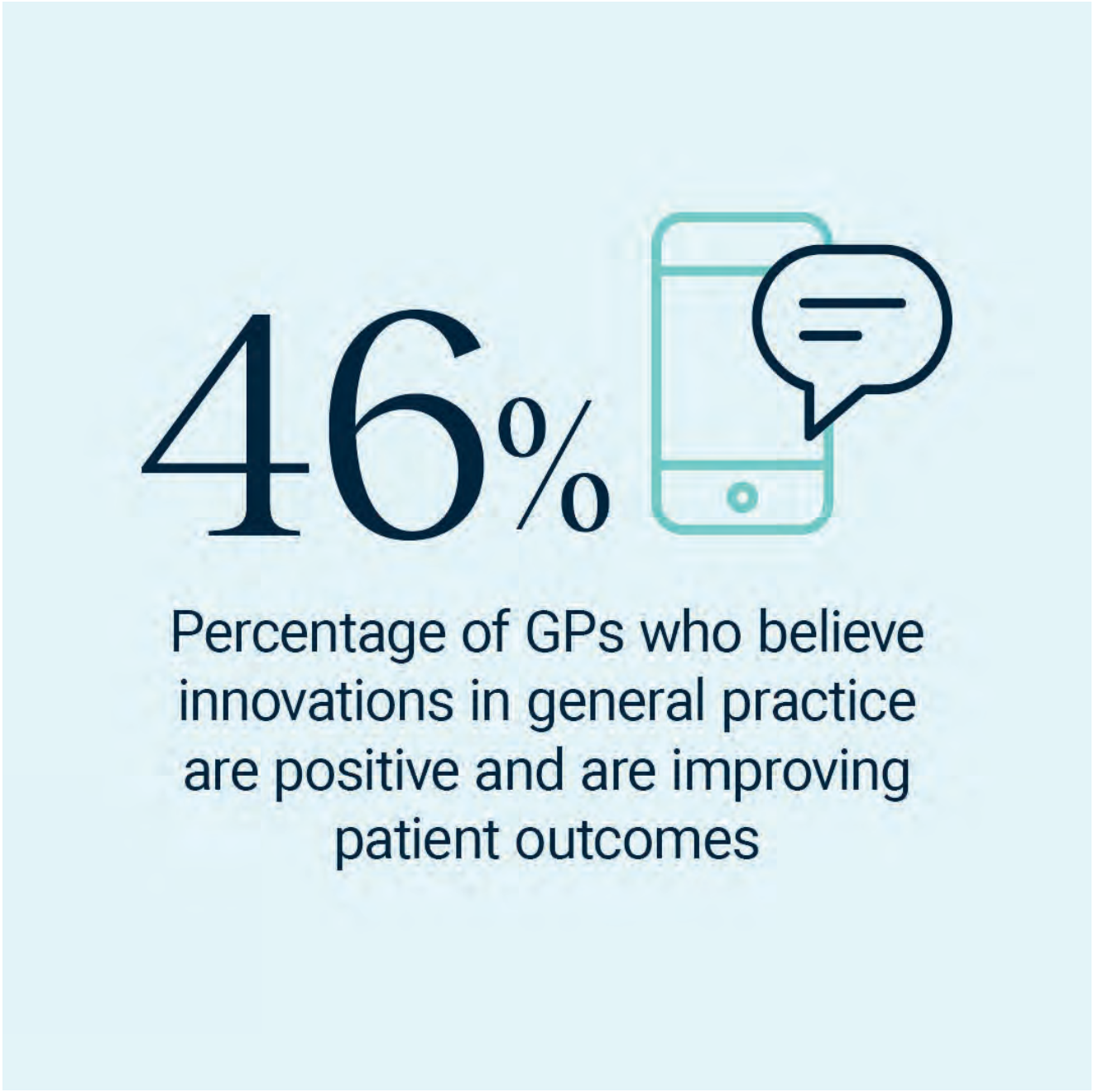
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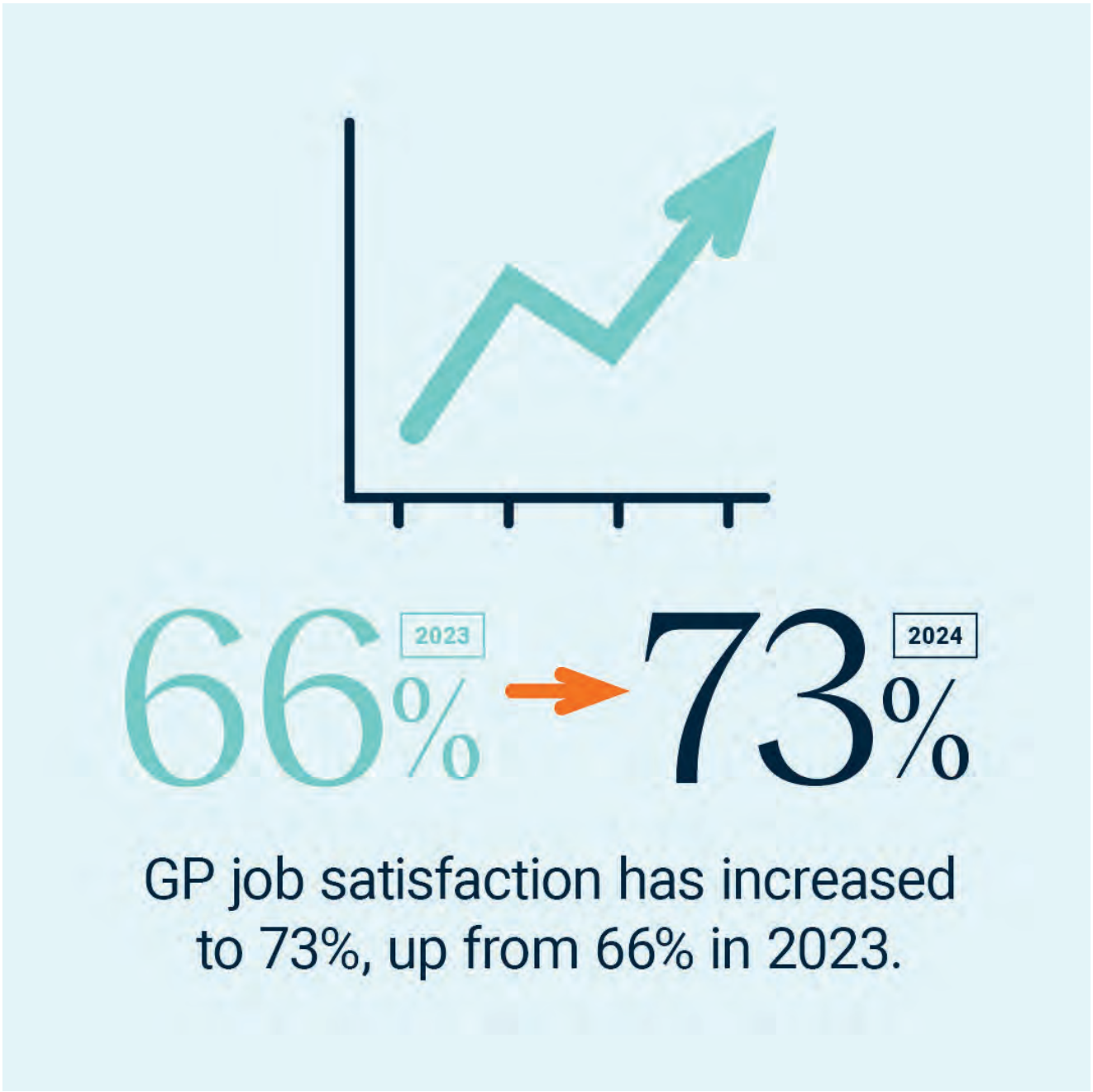
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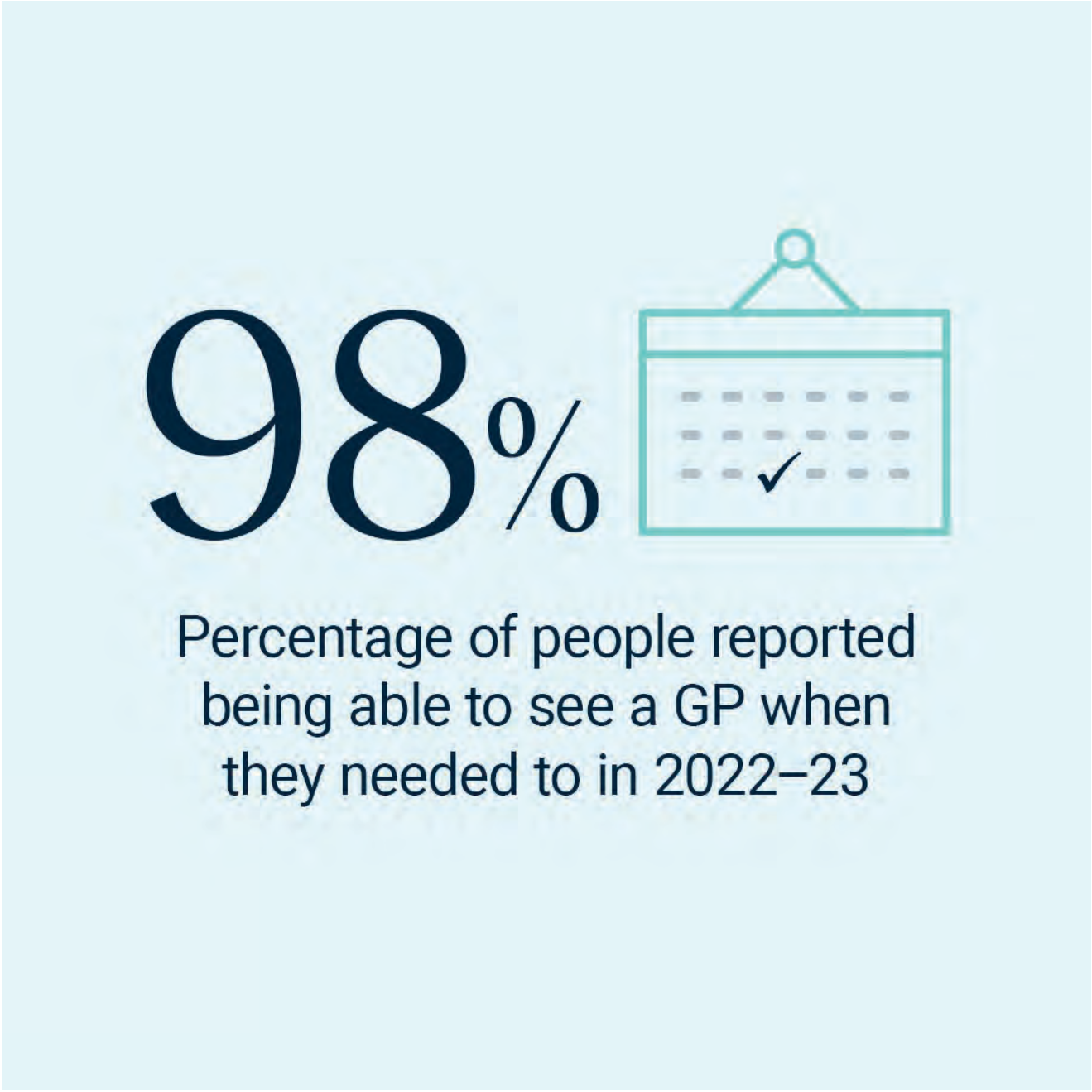

46%
Percentage of GPs who believe innovations in general practice are positive and are improving patient outcomes


66% 2023
73% 2024
GP job satisfaction has increased to 73%, up from 66% in 2023.


98%
Percentage of people reported being able to see a GP when they needed to in 2022–23


46%
Percentage of GPs who believe innovations in general practice are positive and are improving patient outcomes


66%
2023
73%
2024
GP job satisfaction has increased to 73%, up from 66% in 2023.


98%
Percentage of people reported being able to see a GP when they needed to in 2022–23

From: STEPHEN-SMITH
Sent: Tuesday, 8 October 2024 12:09 PM
To: ACT Health DLO
Cc: Smith, Kahlia
Subject: FW: New AIHW embargo release available: GEN Aged Care Data: Residential Aged Care Quality Indicators (quarterly update)

Importance: High

Hi Tara,

For noting please.

Thank you,

Sally Cooke
Office Manager | Office of Rachel Stephen-Smith MLA
Minister for Health | Minister for Children, Youth and Family Services | Minister for Disability | Minister for Aboriginal and Torres Strait Islander Affairs
Member for Kurrajong
ACT Legislative Assembly, 196 London Circuit, Canberra ACT 2601 | P: (02) 6205 2661 | www.act.gov.au

From: communications@aihw.gov.au
Sent: Tuesday, 8 October 2024 11:09 AM
To: STEPHEN-SMITH
Subject: New AIHW embargo release available: GEN Aged Care Data: Residential Aged Care Quality Indicators (quarterly update)

Caution: This email originated from outside of the ACT Government. Do not click links or open attachments unless you recognise the sender and know the content is safe.

Dear all,

The latest AIHW release *GEN Aged Care Data: Residential Aged Care Quality Indicators (quarterly update)* is now available **under strict embargo** until public release on **Tuesday, 22 October at 12:01am**

About the release:

GEN Aged Care Data: Residential Aged Care Quality Indicators (quarterly update)-

Quality indicators (QI) measure aspects of service provision that contribute to the quality of care given by residential aged care services (RACS). Since 1 July 2019, participation in the National Aged Care Mandatory Quality Indicator Program (QI Program) has been a requirement for all Australian Government-subsidised RACS. Until 30 June 2021, the QI Program included 3 QIs (pressure injuries, use of physical restraint, unplanned weight loss). On 1 July 2021, the QI Program expanded to include 5 QIs:

- Pressure injuries
- Use of physical restraint
- Unplanned weight loss
- Falls and major injury
- Medication management

On 1 April 2023, the QI Program was further expanded to include 6 new QIs, for a total of 11 QIs:

- Activities of daily living
- Incontinence care
- Hospitalisations
- Workforce
- Consumer experience
- Quality of life

The releases **will not be** accompanied by a media release.

Please click on link and follow the instructions below:

- AIHW Stakeholder hub (https://pp.aihw.gov.au/login)
- Your username is your **email address**
- Please select '**Forgot your password'** link if required.

Embargo access conditions

By accessing the AIHW Stakeholder hub you agree to the following:

Access to the Stakeholder hub is provided to you for background and research purposes. It is conditional on your organisation not commenting publicly on the forecasts or conclusions contained within AIHW releases, including not issuing any media statements/articles on the topic until after the AIHW release has been publicly released.

I agree to comply with any relevant requirements of the Australian Government Protective Security Policy Framework. I acknowledge that I can obtain further information in relation to the Australian Government Protective Security Policy Framework through the following link to the Commonwealth Attorney-General's Department Website: www.protectivesecurity.gov.au

If you would like any further information, please contact communications@aihw.gov.au or (02) 6249 5089.

Kind regards,

Communications & Engagement Unit

Australian Institute of Health and Welfare

Communications@aihw.gov.au | @aihw | aihw |

Lowe, Shannon

From: Gower, Tara on behalf of ACT Health DLO
Sent: Tuesday, 8 October 2024 12:44 PM
To: Elliffe, Martin
Subject: RE: VSC
Attachments: DG Letter - ACTHD Response to Dr Kerrie Aust - VSC.pdf

Hi Martin

For your awareness, please see attached the Directorate Response provided to Dr Aust.

Thank you
Tara

Tara Gower | Directorate Liaison Officer | ACT Health Directorate
Mob: Schedule 2.2(a)(ii) | Email: ACTHealthDLO@act.gov.au
Office of Rachel Stephen-Smith | Minister for Health
Office of Emma Davidson | Minister for Mental Health
Level 2, Legislative Assembly Building, Civic Square



From: Elliffe, Martin
Sent: Friday, 4 October 2024 11:32 AM
To: ACT Health DLO
Subject: RE: VSC
Importance: High

OFFICIAL

Thanks, Tara.

Cheers,
Martin

Martin Elliffe (he/him)
Adviser | Office of Minister Rachel Stephen-Smith MLA
Minister for Health | Minister for Children, Youth and Family Services | Minister for Disability | Minister for Aboriginal and Torres Strait Islander Affairs
Member for Kurrajong
M: Schedule 2.2(a)(ii) | Email: martin.elliffe@act.gov.au
ACT Legislative Assembly, 196 London Circuit, Canberra, ACT 2601



From: Gower, Tara <Tara.Gower@act.gov.au> **On Behalf Of** ACT Health DLO
Sent: Friday, October 4, 2024 9:19 AM
To: Elliffe, Martin <Martin.Elliffe@act.gov.au>
Subject: RE: VSC

OFFICIAL

Hi Martin

Thank you – I will send this out to the team for action.

The response to Dr Aust has not yet been delivered – back with the team for some further minor amendments.

I will provide a copy once finalised.

Thank you
Tara

Tara Gower | Directorate Liaison Officer | ACT Health Directorate
Mob: Schedule 2.2(a)(ii) | Email: ACTHealthDLO@act.gov.au
Office of Rachel Stephen-Smith | Minister for Health
Office of Emma Davidson | Minister for Mental Health
Level 2, Legislative Assembly Building, Civic Square



From: Elliffe, Martin <Martin.Elliffe@act.gov.au>
Sent: Thursday, 3 October 2024 5:28 PM
To: ACT Health DLO <ACTHealthDLO@act.gov.au>
Subject: RE: VSC
Importance: High

OFFICIAL

Hi Tara,

Further to the below, can we please get an update on the work underway to prepare for the implementation of VSC and providing training for practitioners?

The AMA has reached out to Meg again today to reiterate their concerns regarding lack of training and no GTPs having been approved.

Has there been any progress on these issues? And what discussions has the team had with the AMA since the last update?

I believe the team were going to send through a timeline and info on comms and training for non-GP specialists, but I don't think I've seen that come through yet.

And has the DG responded to Mr Somerville's letter yet? Is so, grateful if we could get a copy for our info.

Thanks,
Martin

Martin Elliffe (he/him)
Adviser | Office of Minister Rachel Stephen-Smith MLA
Minister for Health | Minister for Children, Youth and Family Services | Minister for Disability | Minister for Aboriginal and Torres Strait Islander Affairs
Member for Kurrajong
M: Schedule 2.2(a)(ii) | Email: martin.elliffe@act.gov.au
ACT Legislative Assembly, 196 London Circuit, Canberra, ACT 2601

From: Travers, Maria <Maria.Travers@act.gov.au>
Sent: Wednesday, September 11, 2024 9:44 PM
To: Bransgrove, Meagen <Meagen.Bransgrove@act.gov.au>; Smith, Kahlia <Kahlia.Smith@act.gov.au>
Cc: Cross, Rebecca <Rebecca.Cross@act.gov.au>; Hudson, Robyn <Robyn.Hudson@act.gov.au>; Elliffe, Martin <Martin.Elliffe@act.gov.au>
Subject: RE: VSC

OFFICIAL

Hi Meg, so sorry for the delay in responding.

We are not aware of any GTPs currently under development, and we will most probably only become aware of a GTP when it is submitted for consideration by the Board.

Maria

Maria Travers
A/g Executive Group Manager
Policy Partnerships and Programs Division
Mobile: Schedule 2.2(a)(ii) |Email: maria.travers@act.gov.au
2-6 Bowes Street Phillip ACT 2606| www.health.act.gov.au





I acknowledge the Ngunnawal people as traditional custodians of the ACT and recognise any other people or families with connection to the lands of

the ACT and region. I acknowledge and respect their continuing culture and the contribution they make to the life of this city and this region.
Please consider the environment before printing this email.

From: Bransgrove, Meagen <Meagen.Bransgrove@act.gov.au>
Sent: Monday, September 9, 2024 2:06 PM
To: Travers, Maria <Maria.Travers@act.gov.au>; Smith, Kahlia <Kahlia.Smith@act.gov.au>
Cc: Cross, Rebecca <Rebecca.Cross@act.gov.au>; Hudson, Robyn <Robyn.Hudson@act.gov.au>; Elliffe, Martin <Martin.Elliffe@act.gov.au>
Subject: RE: VSC

OFFICIAL

Thanks Maria, that's helpful. Is there further on the general treatment plans in terms of number of GTP's currently under development etc?

Thanks,

Meg

From: Travers, Maria <Maria.Travers@act.gov.au>
Sent: Monday, September 9, 2024 12:36 PM
To: Smith, Kahlia <Kahlia.Smith@act.gov.au>; Bransgrove, Meagen <Meagen.Bransgrove@act.gov.au>
Cc: Cross, Rebecca <Rebecca.Cross@act.gov.au>; Hudson, Robyn <Robyn.Hudson@act.gov.au>
Subject: VSC

OFFICIAL

Hi Kahlia and Meg

Things are actually better that I just advised the Minister (which is aways good). Please see the attached Advisory Note which is on its way to the MO, and sorry I didn't have all the detail on hand at the time.

We will also provide you with a timeline and info on comms and training for non-GP specialists.

Maria

Maria Travers
A/g Executive Group Manager
Policy Partnerships and Programs Division
Mobile: Schedule 2.2(a)(ii) |Email: maria.travers@act.gov.au
2-6 Bowes Street Phillip ACT 2606| www.health.act.gov.au





I acknowledge the Ngunnawal people as traditional custodians of the ACT and recognise any other people or families with connection to the lands of the ACT and region. I acknowledge and respect their continuing culture and the contribution they make to the life of this city and this region.

Please consider the environment before printing this email.

ACT Government
Health

Office of the Director-General

Dr Kerrie Aust
President, Australian Medical Association (ACT)
Australian Medical Association (ACT) Limited
reception@ama-act.com.au

Dear Dr Aust

Variation in Sex Characteristics (Restricted Medical Treatment) Act 2023 – Commencement of Criminal Penalty Provisions and Training

I refer to your letter of 11 September 2024 to Ms Rachel Stephen-Smith MLA, Minister for Health about the *Variation in Sex Characteristics (Restricted Medical Treatment) Act 2023* (the Act) and the commencement of criminal penalty provisions and training.
I am responding to you as the ACT Government is currently observing caretaker arrangements in the lead up to the ACT Election.

I note the concerns you have raised regarding General Treatment Plans (GTPs) and staff training. Thank you for your ongoing contact with the ACT Health Directorate (ACTHD) and Canberra Health Services (CHS) as we implement the Act.

Training
Two online training modules covering information on variations in sex characteristics (VSC) and relevant sections of the Act are available to all CHS staff. The training has been made compulsory for approximately 300 staff involved in maternal and children's healthcare as this is largely where a VSC will be identified. This includes all maternity services, maternal and child health nurses, neonatal care, genetic counselling, obstetrics, and midwifery.

The CHS Psychosocial Support Unit is delivering face-to-face training to CHS clinicians whose role brings them in close contact with the legislation. This training is compulsory for approximately 40 staff members. One session has been delivered and further sessions are planned for the coming weeks. Participants to date have included paediatric endocrinologists and paediatric surgeons.

While most people receive treatment for a VSC through services provided by CHS, some will be under the care of a general practitioner. A webinar will be delivered on 29 October 2024 to Capital Health Network (CHN) stakeholders. This webinar will be tailored to the needs of general practitioners. The webinar will be available for viewing after 29 October 2024 via

the CHN website. ACTHD welcomes advice from the Australian Medical Association (AMA) about any non-GP specialists whose work is impacted by the Act.

ACTHD is disseminating communications to support the timely delivery of information to stakeholders within and external to ACTHD and CHS. Communication materials are being distributed via health professional peak bodies and through the promotion of training. Specific communications will be disseminated regarding the requirement for Individual Treatment Plans (ITPs) for existing patients prior to 23 December 2024, to ensure continuity of treatment as appropriate.

General and Individual Treatment Plans

The Act, including the option to complete GTPs, has been voluntary since 23 December 2023. The offence provisions in the Act commence on 23 December 2024, 18 months after the Act's notification and 12 months after declared persons have had the option to complete GTPs.

ACTHD, including the Chief General Practitioner and Primary Care Advisor and the Chief Medical Officer are working with CHS to support the development of GTPs as appropriate, and ITPs for individuals currently on treatment who require it to continue beyond 23 December 2024. These GTPs and ITPs will be developed in collaboration with CHS, and form part of the ongoing business of government service delivery and administration.

Commencement of the Act

During development of the legislation, the ACT Government considered delaying the commencement of mandatory application of the Act including the criminal penalty provisions. This was why most of the legislation did not commence until six months after it passed the Legislative Assembly, and there was an additional 12 months delay of the offence provisions, which do not commence until 23 December 2024. In the 12 months between the Act commencing and the offence provisions coming into effect, it has been possible to submit both individual treatment plans and general treatment plans.

I look forward to continued engagement as we work toward the 23 December 2024 full implementation of legislation to protect rights and ensure the wellbeing of people with a variation in sex characteristics in relation to restricted medical treatment.

Yours sincerely



Rebecca Cross
Director-General

8 October 2024

From: Docker, Jake
Sent: Tuesday, 8 October 2024 13:49
To: ACT Health DLO
Subject: FW: Lung Foundation Australia concerns on Lung Cancer Screening readiness
Attachments: 240905L_ACT_LFA Lung Cancer Screening concerns_LFAn.pdf

Importance: High

Hi Tara,

For the Directorate's awareness.

Best wishes,

Jake Docker | Adviser, Population Health & Community Services
Office of Emma Davidson| ACT Greens Member for Murrumbidgee
E: jake.docker@act.gov.au

From: Davidson
Sent: Friday, 6 September 2024 9:48 AM
To: Docker, Jake
Subject: FW: Lung Foundation Australia concerns on Lung Cancer Screening readiness

Good Morning Jake,

One for your action.

Thanks,

Maxine Harris (She/Her)
Office Manager
Office of Emma Davidson | ACT Greens Member for Murrumbidgee
Minister for Community Services, Seniors and Veterans | Minister for Mental Health
Minister for Corrections and Justice Health | Minister for Population Health
GPO Box 1020, Canberra ACT 2601
02 6205 1941
Davidson@act.gov.au

From: Zoe Scovell [redacted]
Sent: Thursday, September 5, 2024 3:24 PM
To: STEPHEN-SMITH <STEPHEN-SMITH@act.gov.au>; Davidson <DAVIDSON@act.gov.au>
Subject: Lung Foundation Australia concerns on Lung Cancer Screening readiness

Some people who received this message don't often get email from [redacted] Learn why this is important

Caution: This email originated from outside of the ACT Government. Do not click links or open attachments unless you recognise the sender and know the content is safe.

Dear Ministers,

Please find attached a letter from Lung Foundation Australia CEO, Mark Brooke, detailing our organisation's concerns about state and territory preparedness for the National Lung Cancer Screening Program.

Kind regards,

Zoe Scovell

Health Policy Insights Officer

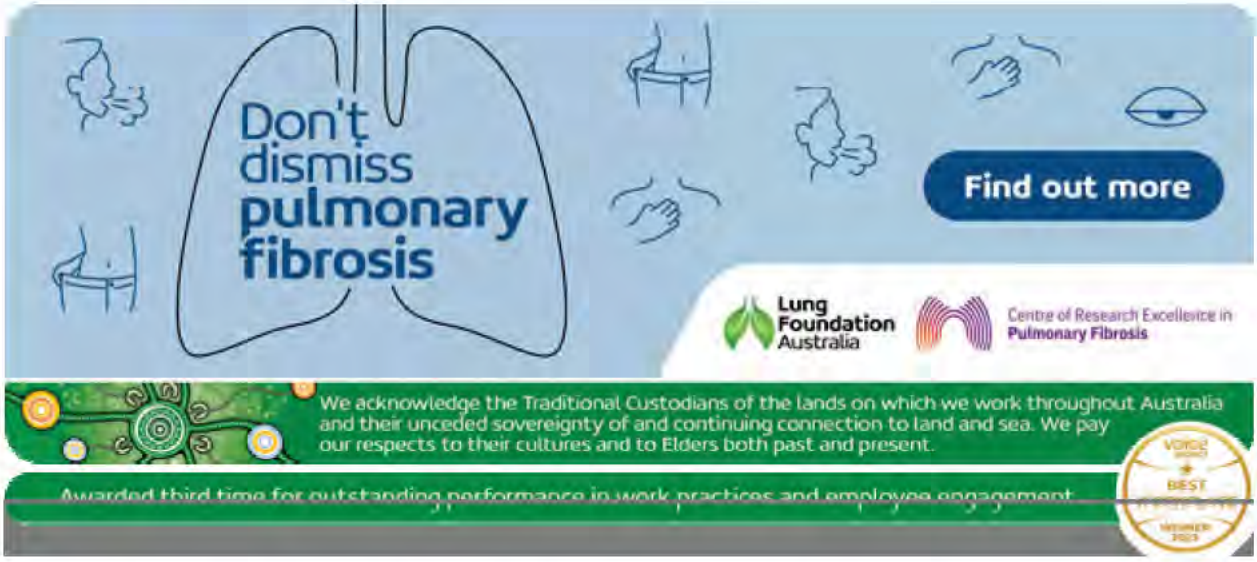
Policy, Advocacy and Prevention team

A Brisbane, Yuggera Country

T Schedule 2.2(a)(ii)

E

W lungfoundation.com.au



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Disclaimer: The information in this email is intended as a general guide only and is not intended or implied to be a substitute for professional medical advice or treatment. Any external links provided should not be taken as an endorsement or a recommendation by Lung Foundation Australia (ACN 160 505 671) of their content. While all care it taken to ensure accuracy, Lung Foundation Australia and its members exclude all liability for any injury, loss or damage incurred by use of or reliance on the information provided. The way we collect and manage your personal information is governed by the Privacy Act 1988 (Cth) (Privacy Act) and the Australian Privacy Principles (APPs) established under the Privacy Act. Please refer to our Privacy Policy for details.

From: Docker, Jake
Sent: Tuesday, 8 October 2024 1:50 PM
To: ACT Health DLO
Cc: Davidson
Subject: FW: Official Information Act Request Consultation - Responses due 12pm AEST Thursday 12 September 2024 [SEC=OFFICIAL]
Attachments: OIA request - P1028 Infant Formula - September 2024.pdf

Importance: High

Hi Tara,

For the Directorate's awareness.

Jake Docker | Adviser, Population Health & Community Services
Office of Emma Davidson| ACT Greens Member for Murrumbidgee
E: jake.docker@act.gov.au

From: Davidson
Sent: Friday, 6 September 2024 9:47 AM
To: Docker, Jake
Subject: FW: Official Information Act Request Consultation - Responses due 12pm AEST Thursday 12 September 2024 [SEC=OFFICIAL]

Good Morning Jake,

One for your action.

Thanks,

Maxine Harris (She/Her)
Office Manager
Office of Emma Davidson|ACT Greens Member for Murrumbidgee
Minister for Community Services, Seniors and Veterans | Minister for Mental Health
Minister for Corrections and Justice Health | Minister for Population Health
✉ GPO Box 1020, Canberra ACT 2601
☎ 02 6205 1941
Davidson@act.gov.au

From: FoodRegulationSecretariat <FoodRegulationSecretariat@health.gov.au>
Sent: Thursday, September 5, 2024 4:28 PM
Subject: Official Information Act Request Consultation - Responses due 12pm AEST Thursday 12 September 2024 [SEC=OFFICIAL]

Caution: This email originated from outside of the ACT Government. Do not click links or open attachments unless you recognise the sender and know the content is safe.

Dear Ministers
Cc Food Regulation Standing Committee contacts

The New Zealand Ministry for Primary Industries (MPI) is considering a request under the New Zealand *Official Information Act 1982* (OIA).

The request is for copies of all aides-mémoire, briefings, memos, notes, reports, or any other advice, if any, the (New Zealand) Minister or their Office holds concerning Proposal P1028 on Infant Formula.

In a couple of briefings, New Zealand copy and pasted the recommendations from FMM09 agenda paper Item 4 - *Proposal P1028 – Infant Formula* (FMM09/24.22) or summarised them as per the attachment. Please note it has been determined that the agenda paper itself does not fall within scope of this request.

Please advise the Food Regulation Secretariat of any objections to the release of the attached information or provide comments by **12pm AEST, Thursday 12 September 2024**. We apologise for the tight timeframe for response. If a response is not received by this date, it will be considered you have no objections to the release of the information.

Kind regards

Schedule 2.2(a)(ii)

food regulation

Website: www.foodregulation.gov.au | Email: secretariat@foodregulation.gov.au
Phone: +61 2 6289 5128 | Postal Address: MDP 707, GPO Box 9848, Canberra ACT 2601

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Official Information Act request – September 2024

Request is for copies of all aides-mémoire, briefings, memos, notes, reports, or any other advice, if any, the (New Zealand) Minister or their Office holds concerning Proposal P1028 on Infant Formula.

In a couple of briefings, New Zealand copy and pasted the recommendations from FMM09 agenda paper Item 4 - *Proposal P1028 – Infant Formula* (FMM09/24.22) or summarised them as per the attachment.

START

Name	**Decision**
Proposal P1028 – Infant Formula	**AGREE** to inform the Food Standards Australia New Zealand (FSANZ) Board, in relation to Proposal P1028 – Infant Formula, that the Food Ministers' Meeting (FMM) members will either: a) request that a review of the draft standard be undertaken; or b) not request a review of the draft standard. **NOTE** to enable the FMM to meet the 60-day legislative deadline required by the Food Standards Australia New Zealand Act 1991 (FSANZ Act), if a decision is not reached at the meeting, responses via an out-of-session process must be provided to the Food Regulation Secretariat by COB 5 August 2024.

Agenda item	**Anticipated decision(s) for Food Ministers**
Proposal P1028 – Infant formula decision	**Agree** to the draft variations to the Food Standards or request a review of these.

Proposal P1028 – Infant Formula
7. This item seeks the Australia New Zealand Food Ministers' (Food Ministers) agreement to either (a) request a review of the draft standard prepared under
Proposal P1028; or (b) not request a review of the draft standard.

END

From: STEPHEN-SMITH
Sent: Wednesday, 9 October 2024 10:15
To: ACT Health DLO
Cc: Smith, Kahlia; Bransgrove, Meagen
Subject: FW: ACT Local Hospital Network Directorate- Audit Management Report
Attachments: LHN24 Audit Management Report.pdf; LHN24 Covering Letter to the Minister.pdf

Importance: High

OFFICIAL

Hi Tara,

For appropriate action please.

Thank you,

Sally Cooke
Office Manager | Office of Rachel Stephen-Smith MLA
Minister for Health | Minister for Children, Youth and Family Services | Minister for Disability | Minister for Aboriginal and Torres Strait Islander Affairs
Member for Kurrajong
ACT Legislative Assembly, 196 London Circuit, Canberra ACT 2601 | P: (02) 6205 2661 | www.act.gov.au

From: Akram, Aamir
Sent: Wednesday, 9 October 2024 10:13 AM
To: STEPHEN-SMITH
Cc: Anjum, Rehan ; Mazhar, Tehmina
Subject: ACT Local Hospital Network Directorate- Audit Management Report

OFFICIAL

Dear Ms Stephen-Smith,

Please find attached Audit management report for ACT Local Hospital Network Directorate for year ended 30 June 2024.

If you have any questions, please do not hesitate to contact us.

Kind Regards,

Aamir Akram| ACCA, B.com | Acting Senior Auditor | Financial Services
Phone: (02) 6207 0955 | Email: Aamir.akram@act.gov.au
ACT Audit Office | Auditor-General An Officer of the ACT Legislative Assembly
Nara Centre, Level 4, 3 Constitution Avenue, Canberra | PO Box 158 Canberra ACT 2601 | www.audit.act.gov.au

Communications from the ACT Audit Office may contain protected information for the purposes of Part 5A of the Auditor-General Act 1996 (ACT).

ACT Audit Office

AUDITOR-GENERAL AN OFFICER OF THE ACT LEGISLATIVE ASSEMBLY

OFFICIAL: SENSITIVE

Ms Rebecca Cross
Director-General
ACT Health Directorate

rebecca.cross@act.gov.au

Dear Ms Cross

ACT LOCAL HOSPITAL NETWORK DIRECTORATE
AUDIT MANAGEMENT REPORT FOR THE YEAR ENDED 30 JUNE 2024

The ACT Audit Office (Audit Office) has completed the audit of the financial statements and limited assurance engagement on the statement of performance of the ACT Local Hospital Network Directorate (Directorate) for the year ended 30 June 2024.

The Audit Office is required by Australian Auditing Standards to communicate significant matters identified during an audit, including any deficiencies in internal controls, to those charged with the governance of an agency. I advise that no such matters have come to the attention of the Audit Office during the audit of the financial statements and limited assurance engagement on the statement of performance of the Directorate. A copy of this report has been provided to the Minister for Health, Ms Rachel Stephen-Smith MLA.

I acknowledge the assistance and cooperation received from representatives of the Directorate during the audit.

Please contact Mr Rehan Anjum (Acting Senior Director, Financial Audit) on 6207 3839 or myself on 6207 0830 if you require further information on this audit.

Yours sincerely

Ajay Sharma PSM
Assistant Auditor-General, Financial Audit
9 October 2024

c.c. Mr Geoff Knuckey, Chair, Audit and Risk Management Committee
Mr Shane Nielsen, Acting Executive Group Manager, Corporate and Governance
Mr Muku Ganeshalingam, Chief Finance Officer

ACT Audit Office

AUDITOR-GENERAL AN OFFICER OF THE ACT LEGISLATIVE ASSEMBLY

OFFICIAL: SENSITIVE

Ms Rachel Stephen-Smith MLA
Minister for Health
ACT Legislative Assembly

stephen-smith@act.gov.au

Dear Ms Stephen-Smith

ACT LOCAL HOSPITAL NETWORK DIRECTORATE
AUDIT MANAGEMENT REPORT FOR THE YEAR ENDED 30 JUNE 2024

Attached for your information is a copy of the Audit Management Report relating to the audit of the financial statements and limited assurance engagement on the statement of performance of the ACT Local Hospital Network Directorate for the year ended 30 June 2024.

Please contact Mr Rehan Anjum (Acting Senior Director, Financial Audit) on 6207 3839 or myself on 6207 0830 if you wish to discuss this report.

Yours sincerely

Ajay Sharma PSM
Assistant Auditor-General, Financial Audit
9 October 2024

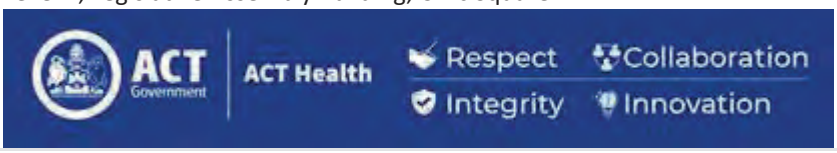
From: Gower, Tara on behalf of ACT Health DLO
Sent: Friday, 11 October 2024 10:31 AM
To: Bransgrove, Meagen; Elliffe, Martin
Cc: ACT Health DLO
Subject: RE: outstanding items

Hi Meg and Martin
Hope you both have been keeping well 😊
I was hoping to follow-up on my email below.
Ahead of the incoming government forming, we are required to close out all outstanding matters within our system whether they have been signed or not signed.

- MIN24-00167 - 00. Meg docs for review\Complete\Archive\COPY MIN24-00167 - Workplace Compensation at Calvary Schedule 2.2(a)(ii)
- MIN24-00139 - 00. Meg docs for review\Complete\Archive\20240329 MIN24-00139 - Maternity in Focus Project Update
- MIN24-00171 - 01. RSS - digital signing\03. Min docs for sig\Z HOLD - to read\20240409 MIN24-00171 - LGBTIQ+ Scoping Study Implementation Update
- MIN24-00075 - 01. RSS - digital signing\00. Martin docs for review\03. Health (LGBTQ + ATSI)\MIN24-00075 - VSC advisory materials

Grateful for your advice if I can close these matters with notification that they will not be formally signed by the Minister.
Thank you
Tara

Tara Gower | Directorate Liaison Officer | ACT Health Directorate
Mob: Schedule 2.2(a)(ii) | Email: ACTHealthDLO@act.gov.au
Office of Rachel Stephen-Smith | Minister for Health
Office of Emma Davidson | Minister for Mental Health
Level 2, Legislative Assembly Building, Civic Square



From: Gower, Tara **On Behalf Of** ACT Health DLO
Sent: Monday, 16 September 2024 4:04 PM
To: Bransgrove, Meagen ; Elliffe, Martin
Subject: outstanding items
Importance: High

OFFICIAL

Hi Meg and Martin
The below documents remain unsigned and are currently sitting in the below folders (the only copies I can find).

- MIN24-00167 - 00. Meg docs for review\Complete\Archive\COPY MIN24-00167 - Workplace Compensation at Calvary - Schedule 2.2(a)(ii)
- MIN24-00139 - 00. Meg docs for review\Complete\Archive\20240329 MIN24-00139 - Maternity in Focus Project Update
- MIN24-00171 - 01. RSS - digital signing\03. Min docs for sig\Z HOLD - to read\20240409 MIN24-00171 - LGBTIQ+ Scoping Study Implementation Update

I would be grateful for your advice if these items will be returned signed or shall I close them off on our end ?
Thank you
Tara

Tara Gower | Directorate Liaison Officer | ACT Health Directorate
Mob: Schedule 2.2(a)(ii) | Email: ACTHealthDLO@act.gov.au

Office of Rachel Stephen-Smith | Minister for Health
Office of Emma Davidson | Minister for Mental Health
Level 2, Legislative Assembly Building, Civic Square



From: STEPHEN-SMITH
Sent: Friday, 11 October 2024 12:23 PM
To: ACT Health DLO; CSDDLO
Cc: Smith, Kahlia; Goodwin, Jonathan
Subject: FW: New AIHW embargo release available: Young people under youth justice supervision and their interaction with the child protection system 2022–23

Importance: High

Hi Team,

For noting please.

Thank you,

Sally Cooke
Office Manager | Office of Rachel Stephen-Smith MLA
Minister for Health | Minister for Children, Youth and Family Services | Minister for Disability | Minister for Aboriginal and Torres Strait Islander Affairs
Member for Kurrajong
ACT Legislative Assembly, 196 London Circuit, Canberra ACT 2601 | P: (02) 6205 2661 | www.act.gov.au

From: communications@aihw.gov.au
Sent: Friday, 11 October 2024 10:34 AM
To: STEPHEN-SMITH
Subject: New AIHW embargo release available: Young people under youth justice supervision and their interaction with the child protection system 2022–23

Caution: This email originated from outside of the ACT Government. Do not click links or open attachments unless you recognise the sender and know the content is safe.

Dear all,

The latest AIHW release ***Young people under youth justice supervision and their interaction with the child protection system 2022–23*** is now available **under strict embargo** until its public release on **Friday, 25 October at 12:01am**.

About the release:

This report presents information on young people under youth justice supervision during 2022–23 who had an interaction with the child protection system in the 10 years from 1 July 2013 to 30 June 2023. Almost 2 in 3 (65%) young people under youth justice supervision in 2022–23 had an interaction with the child protection system in the 10-year period. About one half of young people in community-based supervision (45%) and detention (50%) were the subject of a substantiated notification for abuse or neglect.

The release **will not be** accompanied by a media release.

Please click on link and follow the instructions below:

- AIHW Stakeholder hub (https://pp.aihw.gov.au/login)
- Your username is your **email address**
- Please select '**Forgot your password'** link if required.

Embargo access conditions

By accessing the AIHW Stakeholder hub you agree to the following:

Access to the Stakeholder hub is provided to you for background and research purposes. It is conditional on your organisation not commenting publicly on the forecasts or conclusions contained within AIHW releases, including not issuing any media statements/articles on the topic until after the AIHW release has been publicly released.

I agree to comply with any relevant requirements of the Australian Government Protective Security Policy Framework. I acknowledge that I can obtain further information in relation to the Australian Government Protective Security Policy Framework through the following link to the Commonwealth Attorney-General's Department Website: www.protectivesecurity.gov.au

If you would like any further information, please contact communications@aihw.gov.au or (02) 6249 5089.

Kind regards,

Communications & Engagement Unit

Australian Institute of Health and Welfare

Communications@aihw.gov.au | @aihw | aihw |

From: STEPHEN-SMITH
Sent: Friday, 11 October 2024 14:01
To: ACT Health DLO
Cc: Elliffe, Martin; Smith, Kahlia; Bransgrove, Meagen
Subject: FW: Requesting your support to promote the growing suite of Safer Baby Bundle resources
Attachments: Stakeholder Promotion Kit_CRE Culturally Adapted Safer Baby Resources_Sept 2024_v2.pdf; Rachel Stephen-Smith- Minister for Aboriginal and Torres Strait Islander Affairs ACT.pdf

Importance: High

Hi Team,

For directorate response please.

Thank you,

Sally Cooke
Office Manager | Office of Rachel Stephen-Smith MLA
Minister for Health | Minister for Children, Youth and Family Services | Minister for Disability | Minister for Aboriginal and Torres Strait Islander Affairs
Member for Kurrajong
ACT Legislative Assembly, 196 London Circuit, Canberra ACT 2601 | P: (02) 6205 2661 | www.act.gov.au

From: Vicki Flenady
Sent: Friday, 11 October 2024 1:16 PM
To: STEPHEN-SMITH
Cc: Meghna Bhamidipati ; David Ellwood
Subject: Requesting your support to promote the growing suite of Safer Baby Bundle resources

You don't often get email from vicki.flenady@mater.uq.edu.au. Learn why this is important

Caution: This email originated from outside of the ACT Government. Do not click links or open attachments unless you recognise the sender and know the content is safe.

Dear Minister Stephen-Smith,
We're excited to share with you updated Safer Baby Bundle resources and information to help drive down stillbirth rates across Australia.
The Stronger Bubba Born resources for First Nations Communities, and the Growing a Healthy Baby resources for migrant and refugee communities, were developed over several years, and co-designed and tested with communities.

This work is in line with the National Stillbirth Action and Implementation Plan (NSAIP), which was launched by the Australian Government in 2020 with the goal of reducing stillbirth in Australia by 20 per cent, by December 2025.
These adapted resources demonstrate what can be achieved when we work together, and with sufficient funding, towards the common goal of ensuring all communities have care and resources that meet their needs.

Please find attached an explanatory letter and a Stakeholder Communications Kit which has links to all the assets for promoting the resources (social tiles, posters and newsletter copy).
As we know, stillbirth rates in Australia are significantly higher among First Nations and some migrant and refugee communities, compared to the general population. But, with your help, together we can work towards driving down these rates by promoting this culturally safe information into communities.

Please let us know if you have any questions.
Thank you for your continued partnership and support.

Kind regards,
Prof Vicki Flenady and Prof David Ellwood
Stillbirth Centre of Research Excellence

September 2024

Stakeholder Promotion Toolkit

culturally adapted resources to help reduce the risk of stillbirth.

- **Stronger Bubba Born** (First Nations)
- **Growing a Healthy Baby** (migrant & refugee, 4 languages)
- Plus healthcare professional eLearning and Safer Baby translations.

Safer Baby Bundle
WORKING TOGETHER TO REDUCE STILLBIRTH

Stillbirth
CENTRE OF RESEARCH EXCELLENCE

Purpose of this toolkit

The Stillbirth Centre of Research Excellence have been working hard with our partners and community groups to adapt our evidence-based and free Safer Baby Bundle resources for First Nations and migrant and refugee communities. This work is a priority action of the National Stillbirth Action and Implementation Plan, made possible with funding from the Australian Government.

This stakeholder promotion toolkit has been developed so it is easy for key stakeholders (peak bodies, NGOs, community groups, support networks, researchers and politicians) to promote and share these resources with women and families, and healthcare professionals.

We thank you for helping us reach more Australians with this vital information, via your communication channels.

We look forward to hearing from you about these resources and promotional assets.

Stillbirth CRE team
stillbirthcre@mater.uq.edu.au

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Overview

First Nations and some migrant and refugee communities are disproportionately impacted by stillbirth in Australia. After extensive consultation and co-design a suite of culturally adapted Safer Baby Bundle resources have been developed.

These resources, launched in October 2023 have received fantastic feedback from communities and healthcare professionals. They are an important way to reduce the risk of stillbirth in communities. **However, we need your help to ensure more women, families and healthcare professionals know about them.** This toolkit provides detail on the growing suite of resources, as well as links to social media assets, and suggested copy for social posts and newsletters to assist stakeholders promote them.

For First Nations women and their communities the **'Stronger Bubba Born'** resources include flyers, videos and a website.



In-language (and English) resources for Arabic, Dari, Dinka and Karen speaking communities. **'Growing a Healthy Baby'** includes - booklets (PDF and audio), videos and a website.





What is new?

- There are new posters for community/healthcare settings and an suite of social media assets, including some in-language) for use on your channels..
- Last month new elearning modules for healthcare professionals have been made available.
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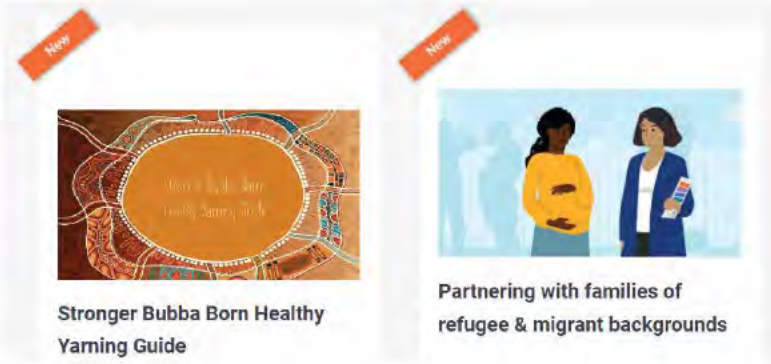
Examples of new content and promotional assets:











New eLearning modules for healthcare professionals on learn.stillbirth.org.au

- The Safer Baby master brochure is available in now available in 30 languages (saferbaby.org.au/translated-resources/ or learn.stillbirthcre.org.au/clinician-resources/

What is the Safer Baby Bundle?

The Safer Baby Bundle is a national initiative with five evidence-based elements to address key areas where improved practice can reduce the number of stillborn babies.

- Smoking Cessation
- Fetal Growth Restriction (FGR)
- Decreased Fetal Movement (DFM)
- Side sleeping
- Timing of birth

Since its launch in 2019, the Safer Baby Bundle has been implemented in all Australian jurisdictions.

Why have we culturally adapted the Safer Baby Bundle?

The rate of stillbirth in Australia is higher than other top-performing countries, with a rate of 7.7 per 1,000 births in 2020. First Nations Australians and women from migrant and refugee backgrounds experience relatively higher rates still.

Across Australia, the stillbirth rate amongst First Nations people in 2020 was 11.9 per 1,000 births. And this is even much higher in some communities.

For women born in South Asia, the stillbirth rate was 9.1 per 1,000 births in 2020 and the rate for Central and West African-born women was 14 per 1,000 births, which is why these have been identified as priority groups for stillbirth prevention as outlined in the National Stillbirth Action and Implementation Plan (NSAIP).

Stillbirth is preventable in many cases and research shows 20-30% of late gestation stillbirths could be avoided with better care.

The following document provides a reference for all the Safer Baby Bundle resources and collateral that has been developed to support the Safer Baby Bundle initiative for clinicians and women.

Key messages

- Stillbirth is a serious public health problem with far-reaching burdens on families and communities.
- The stillbirth rate is significantly higher for First Nations and some migrant and refugee communities compared to the general Australian population.
- In-language resources that outline preventative measures in culturally-sensitive ways and that can be easily understood by priority groups for stillbirth prevention are required to make a different to stillbirth rates.
- Healthcare workers need to be made aware of the sensitivities of discussing issues like stillbirth with multicultural and First Nations communities.
- Extensive consultation across First Nations and migrant and refugee communities has been undertaken to ensure these resources speak to those communities.
- The cultural adaptation of the Safer Baby Bundle has been funded by the Australian government under the National Stillbirth Action and Implementation Plan (NSAIP) to reduce stillbirth in target communities.

Stronger Bubba Born

First Nations resources and promotional assets



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Curtin University

NACCHO National Aboriginal Community Controlled Health Organisation

Waminda

Stronger Bubba Born

Overview



Website	strongerbubbaborn.org.au/ (includes all resources)
Description	Stronger Bubba Born resources include flyers and videos that can be discussed and watched with First Nations women, or shared via email, newsletter or social media. The aim is to reduce the rates of Sorry Business Babies (stillbirth), stigma and its impact on mothers, parents and communities. These resources were developed by the Stillbirth CRE Indigenous research team with the guidance of the Indigenous Advisory Group. Delivery partner Curtin University supported the extensive consultation and co-design process. The National Aboriginal Community Controlled Health Organisation (NACCHO) and the Waminda South Coast Women's Health and Wellbeing Aboriginal Corporation are also collaborators with the CRE on their Indigenous work.
Usage	Source of evidence to use as an internal reference for clinicians and as an information source for Aboriginal and Torres Strait Islander women.
Partners	Curtin University; NACCHO; Waminda

Stronger Bubba Born

Master brochure



Link to print ready master brochure	https://strongerbubbaborn.org.au/wp-content/uploads/2023/10/SBB_booklet_web_final.pdf
Description	The Stronger Bubba Born master brochure is a 12-page brochure containing information around the five evidence-based elements that address key areas where improved practice can reduce the number of Sorry Business Babies (stillbirth).
Usage	Source of evidence to use as an internal reference for clinicians and as an information source for Aboriginal and Torres Strait Islander women.

Stronger Bubba Born

Flyers



Links to print ready resources	Quit Smokes for Bubba Bubba's Growth Matters Bubba's Movements Matter Sleep on your side when Bubba's inside Let's Yarn Timing of Birth
Description	Five discrete, downloadable flyers provide information around the five evidence-based elements that address key areas where improved practice can reduce the number of Sorry Business Babies (stillbirth).
Usage	Source of evidence to use as an internal reference for clinicians and as an information source for Aboriginal and Torres Strait Islander women.

Stronger Bubba Born

Introduction video



Link to introduction video	https://strongerbubbaborn.org.au/resources/
Description	A two-minute and 50-second video that gives key information around how to decrease the risk of Sorry Business Baby (stillbirth) in culturally-appropriate and accessible language.
Usage	Source of evidence to use as an internal reference for clinicians and as an information source for Aboriginal and Torres Strait Islander women.

Stronger Bubba Born

short videos











Links to short videos	Quit Smokes for Bubba video Bubba's Growth Matter video Bubba's Movements Matter video Sleep on your side when Bubba's inside video Let's Yarn Timing of Birth video
Description	Five short videos that give key information about how to decrease the risk of Sorry Business Baby in culturally-appropriate and accessible language for each of the five identified areas of prevention.
Usage	Source of evidence to use as an internal reference for clinicians and as an information source for Aboriginal and Torres Strait Islander women.

Promoting Stronger Bubba Born

Poster, suite of social assets & newsletter copy

Safer Baby Bundle
WORKING TOGETHER TO REDUCE STILLBIRTH

Stillbirth
CENTRE OF RESEARCH EXCELLENCE

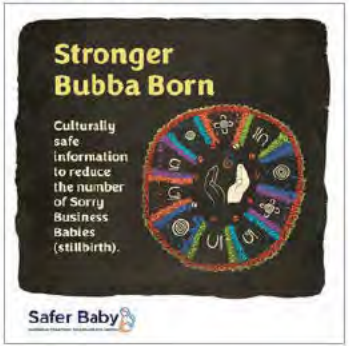
NEW Poster - Promoting Stronger Bubba Born



Link to poster	Stronger Bubba Born resources (dropbox folder) If your organisation cannot access dropbox please email stillbirthcre@mater.uq.edu.au to receive a zip file.
Description	An A3 poster with a QR code which links to strongerbubbaborn.org.au/ (includes all resources).
Usage	To be printed for community centres and health care settings to reach Aboriginal and Torres Strait Islander women, their families and healthcare professionals.

NEW Social media tiles - Promoting Stronger Bubba Born

Carousel







Single tiles







Link to social assets (see proposed posts on following pages)	Stronger Bubba Born resources (dropbox folder) If your organisation cannot access dropbox please email stillbirthcre@mater.uq.edu.au to receive a zip file.
Description	A series of single and carousel social posts (various sizes) to promote the new Stronger Bubba Born resources and the website where the flyers and videos are available. Proposed copy has been drafted to accompany the graphics on the following pages of example posts.
Usage	For social channels, that can reach Aboriginal and Torres Strait Islander women, their families and healthcare professionals working with First Nations women.

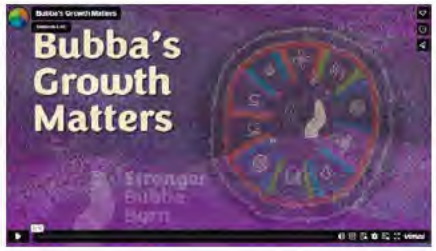
NEW social media graphics - Stronger Bubba Born

For General Awareness with women and families, healthcare teams and healthcare organisations	
Selection of graphics in various sizes	**Post copy (suggested only can be edited when posting)**
	The Stronger Bubba Born resources introduce five evidence-based elements that address key areas that can reduce the number of Sorry Business Babies (Stillbirths). Access the free resources and learn more at strongerbubbaborn.org.au #StrongerBubbaBorn #CulturallySafeResources #SaferBabyBundle #SaferBaby #StillbirthCRE #pregnancycare Facebook - @CentreofResearchExcellenceinStillbirth Twitter- @CREStillbirth LinkedIn - @StillbirthCRE
	Healthcare professionals are encouraged to download the free Stronger Bubba Born resources for First Nations women, their families and communities. Stronger Bubba Born addresses key areas that can reduce the number of Sorry Business Babies (Stillbirths) in a culturally safe way. Learn more and download the free resources at strongerbubbaborn.org.au #StrongerBubbaBorn #CulturallySafeResources #SaferBabyBundle #SaferBaby #StillbirthCRE #pregnancycare Facebook - @CentreofResearchExcellenceinStillbirth Twitter- @CREStillbirth LinkedIn - @StillbirthCRE
	Culturally safe videos and flyers for First Nations women and their families, to help reduce the number of Sorry Business Babies (Stillbirths). Access the free resources and learn more at strongerbubbaborn.org.au #StrongerBubbaBorn #CulturallySafeResources #SaferBabyBundle #SaferBaby #StillbirthCRE #pregnancycare Facebook - @CentreofResearchExcellenceinStillbirth Twitter- @CREStillbirth LinkedIn - @StillbirthCRE

Social media posts - Stronger Bubba Born

For General Awareness with women and families, healthcare teams and healthcare organisations	
Video content (embed link)	**Post copy (suggested only can be edited when posting)**
Summary Video - How to have a safer pregnancy https://vimeo.com/825684769 	WATCH AND SHARE WITH YOUR MOB Having a safer and healthy pregnancy is the aim for all families. While having Sorry Business Babies (stillbirth) is unlikely for most women, there are a few key things to do to keep bubba safe. This short video shares the key information around how to decrease the risk of Sorry Business Baby (stillbirth). Also download the master brochure here - strongerbubbaborn.org.au/resources/ #StrongerBubbaBorn #CulturallySafeResources #SaferBabyBundle #SaferBaby #StillbirthCRE #pregnancycare Facebook - @CentreofResearchExcellenceinStillbirth Twitter- @CREStillbirth LinkedIn - @StillbirthCRE
Video - Quit Smokes for Bubba https://vimeo.com/825685322 	QUIT SMOKES FOR BUBBA Watch this short video to learn more about the importance of quitting smokes for bubba. Stopping smoking as soon as possible in pregnancy is best for bubba and you. Also download the flyer - strongerbubbaborn.org.au/quit-smokes/ #StrongerBubbaBorn #CulturallySafeResources #SaferBabyBundle #SaferBaby #StillbirthCRE #pregnancycare Facebook - @CentreofResearchExcellenceinStillbirth Twitter- @CREStillbirth LinkedIn - @StillbirthCRE

Social media posts - Stronger Bubba Born

For General Awareness with women and families, healthcare teams and healthcare organisations	
Video content (embed link)	**Post copy (suggested only can be edited when posting)**
Video - Bubba's Growth Matters https://vimeo.com/825685481 	BUBBA'S GROWTH MATTERS You can help bubba be healthy by looking after yourself. Eating healthy, looking after your social and emotional wellbeing and keeping in touch with your midwife if you're worried about anything. Watch the short video to learn more about the importance of your bubba's growth. And then download the flyer - strongerbubbaborn.org.au/bubbas-growth/ #StrongerBubbaBorn #CulturallySafeResources #SaferBabyBundle #SaferBaby #StillbirthCRE #pregnancycare Facebook - @CentreofResearchExcellenceinStillbirth Twitter- @CREStillbirth LinkedIn - @StillbirthCRE
Video - Bubba's Movements Matter https://vimeo.com/825688130 	BUBBA'S MOVEMENTS MATTER Be aware of bubba's movements from 28 weeks onwards. It is a sign they are healthy. If bubba's movements stop or slow down, contact your health care team immediately. Watch the video below to learn more about the importance of your bubba's movements. Also download the flyer - strongerbubbaborn.org.au/bubbas-movements/ #StrongerBubbaBorn #CulturallySafeResources #SaferBabyBundle #SaferBaby #StillbirthCRE #pregnancycare Facebook - @CentreofResearchExcellenceinStillbirth Twitter- @CREStillbirth LinkedIn - @StillbirthCRE

Social media posts - Stronger Bubba Born

For General Awareness with women and families, healthcare teams and healthcare organisations	
Video content (embed link)	**Post copy (suggested only can be edited when posting)**
Video - Sleep on Your Side When Bubba's Inside https://vimeo.com/825685659 	SLEEP ON YOUR SIDE WHEN BUBBA'S INSIDE Going to sleep on your side from 28 weeks onwards is best for bubba. Either side is OK. Watch the video and download the flyer to learn why this is important for Bubba - strongerbubbaborn.org.au/sleep-side/ #StrongerBubbaBorn #CulturallySafeResources #SaferBabyBundle #SaferBaby #StillbirthCRE #pregnancycare Facebook - @CentreofResearchExcellenceinStillbirth Twitter- @CREStillbirth LinkedIn - @StillbirthCRE
Video - Let's Yarn Timing of Birth https://vimeo.com/825685712 	LET'S YARN TIMING OF BIRTH It is important to think about your own beliefs, cultural values and preferences when yarning about timing of birth. Watch the video to learn more about the importance of yarning about the timing of birth for bubba. Also download the flyer - strongerbubbaborn.org.au/timing/ #StrongerBubbaBorn #CulturallySafeResources #SaferBabyBundle #SaferBaby #StillbirthCRE #pregnancycare Facebook - @CentreofResearchExcellenceinStillbirth Twitter- @CREStillbirth LinkedIn - @StillbirthCRE

Newsletter/website copy - Promoting Stronger Bubba Born

Having a safer and healthy pregnancy is the aim for all families. While having Sorry Business Babies (stillbirth) is unlikely for most women, there are a few key things to do to keep bubba safe.

Two years of consultation across Australia with First Nations' communities, clinicians, Aboriginal and Torres Strait Islander health practitioners and support organisations has gone into making sure evidence-based practice is implemented in First Nations communities' own ways of "knowing, being and doing".

Resources have been created to take women through key prevention strategies in a culturally-sensitive way. There is a master brochure, an introduction video and five short flyers and videos to explain how to keep bubba safe.

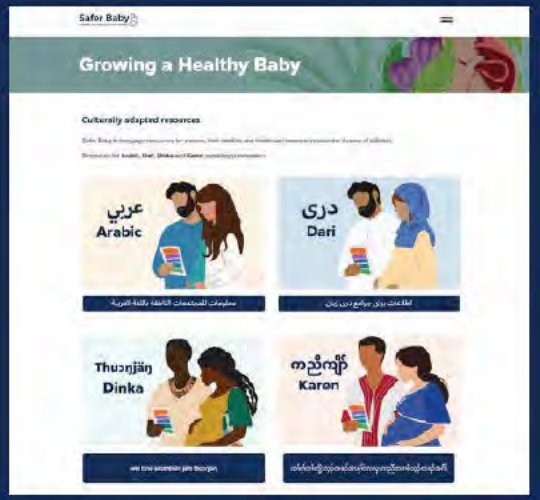
The Stillbirth CRE Indigenous Advisory Group guided the Stillbirth CRE Indigenous team for the Indigenous consultations and co-designing of resources, in partnership with Curtin University. The National Aboriginal Community Controlled Health Organisation (NACCHO) and the Waminda South Coast Women's Health and Wellbeing Aboriginal Corporation are also collaborators with the CRE on their Indigenous work.

Access the resources and learn more at strongerbubbaborn.org.au

Please note: The artwork in these resources has been produced by the Queensland Aboriginal and Islander Health Council (QAIHC) and QAIHC was engaged by the Mater Research Institute. An image that can be utilised in a newsletter is available here. Please ensure the Queensland Aboriginal and Islander Health Council are credited with image usage.

Growing a Healthy Baby

In-language resources and promotional assets



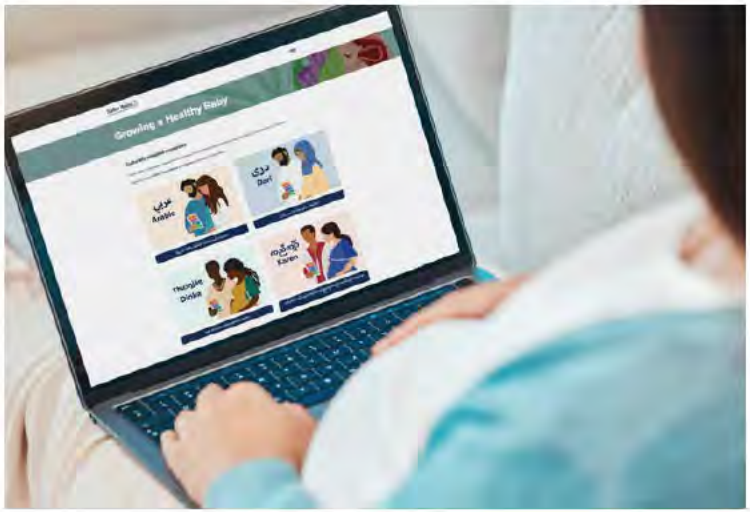
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MULTICULTURAL
CENTRE FOR
WOMEN'S HEALTH

STRONGER
FUTURES
Centre of
Research
Excellence

Growing a Healthy Baby

Culturally-adapted resources for four migrant and refugee communities



Website	growingahealthybaby.org.au/
Description	Safer Baby in-language resources for women, their families and healthcare teams to reduce the chance of stillbirth. **Resources are for Arabic, Dari, Dinka and Karen speaking communities co-designed with communities and healthcare professionals.** For each of the four community groups there are a summary animation video, digital audit booklet and a detailed PDF booklet. A network of community groups and healthcare educators from the Multicultural Centre for Women's Health and the Murdoch Children's Research Institute worked with the Stillbirth CRE to develop and translate these resources.
Usage	Source of evidence to use as an internal reference for clinicians and as an information source for Arabic, Dari, Dinka and Karen speaking communities.
Partners	MULTICULTURAL CENTRE FOR WOMEN'S HEALTH STRONGER FUTURES Centre of Research Excellence

Growing a Healthy Baby

Arabic



Arabic resources	https://growingahealthybaby.org.au/languages/arabic/
Description	All resources are designed using culturally-appropriate language providing information to women about ways to prevent stillbirth based on the latest research and clinical best practice. Resources on the website are: - A 20-page, printed booklet that clinicians can hand to women giving information about stillbirth prevention. - A 26-page digital booklet link with self turning pages and translated audio on each page that takes women through information about stillbirth prevention. - An animated and narrated in-language video giving information about stillbirth prevention, running for less than five minutes. - A3 poster in-language for health and community settings.
Usage	In-language information for clinicians to share with women in person and electronically.

Growing a Healthy Baby

Dari



Dari resources	https://growingahealthybaby.org.au/languages/dari/
Description	All resources are designed using culturally-appropriate language providing information to women about ways to prevent stillbirth based on the latest research and clinical best practice. Resources on the website are: - A 20-page, printed booklet that clinicians can hand to women giving information about stillbirth prevention. - A 26-page digital booklet link with self turning pages and translated audio on each page that takes women through information about stillbirth prevention. - An animated and narrated in-language video giving information about stillbirth prevention, running for less than five minutes. - A3 poster in-language for health and community settings.
Usage	In-language information for clinicians to share with women in person and electronically.

Growing a Healthy Baby

Karen



Karen resources	https://growingahealthybaby.org.au/languages/karen/
Description	All resources are designed using culturally-appropriate language providing information to women about ways to prevent stillbirth based on the latest research and clinical best practice. Resources on the website are: - A 28-page, printed booklet that clinicians can hand to women giving information about stillbirth prevention. - A 26-page digital booklet link with self turning pages that takes women through information about stillbirth prevention, with pages read out in language. - An animated and narrated in-language video giving information about stillbirth prevention, running for less than five minutes. - A3 poster in-language for health and community settings.
Usage	In-language information for clinicians to share with women in person and electronically.

Growing a Healthy Baby

Dinka



Dinka resources	https://growingahealthybaby.org.au/languages/dinka/
Description	All resources are designed using culturally-appropriate language providing information to women about ways to prevent stillbirth based on the latest research and clinical best practice. Resources on the website are: - A 20-page, printed booklet that clinicians can hand to women giving information about stillbirth prevention. - A 26-page digital booklet link with self turning pages that takes women through information about stillbirth prevention, with pages read out in language. - An animated and narrated in-language video giving information about stillbirth prevention, running for less than five minutes. - A3 poster in-language for health and community settings.
Usage	In-language information for clinicians to share with women in person and electronically.

Promoting Growing a Healthy Baby

Suite of social assets, posters & newsletter copy

Safer Baby Bundle
WORKING TOGETHER TO REDUCE STILLBIRTH

Stillbirth
CENTRE OF RESEARCH EXCELLENCE

NEW Posters - Growing a Healthy Baby





Link to posters	Growing a Healthy Baby resources (dropbox folder) If your organisation cannot access dropbox please email stillbirthcre@mater.uq.edu.au to receive a zip file.
Description	**Two English and four in-language A3 posters** with a QR code which links to pages on growingahealthybaby.org.au (includes all resources).
Usage	To be printed for community centres and health care settings to reach Aboriginal and Torres Strait Islander women, their families and healthcare professionals.

NEW Posters - Growing a Healthy Baby



Arabic poster



Dari poster



Dinka poster



Karen poster



English copy version for content reference

NEW Social media assets - In-language and English







Link to social assets and proposed copy	Growing a Healthy Baby resources (dropbox folder) If your organisation cannot access dropbox please email stillbirthcre@mater.uq.edu.au to receive a zip file.
Description	A suite of still and video social posts in various sizes have been developed to promote the new resources and promote the website where the PDF booklets, digital audio booklets and videos can be accessed. Proposed copy has been drafted to accompany the graphics, with some of the graphics and copy being in-language.
Usage	For social channels to reach women, their families and healthcare teams for Arabic, Dari, Dinka and Karen speaking communities.

Social media examples - Growing a Healthy Baby

General Awareness (ENGLISH) Audience = Healthcare teams and followers of healthcare organisations	
Graphic/ image content	**Post copy (suggested only can be edited when posting)**
Single image post (still and gif option) 	LET'S WORK TOGETHER TO MAKE YOUR PREGNANCY SAFER To help reduce the chance of stillbirth for Arabic, Dari, Dinka and Karen speaking communities, new resources have been co-designed with communities and healthcare professionals. Access the resources and learn more at growingahealthybaby.org.au #GrowingaHealthyBaby #SaferBabyBundle #SaferBaby #StillbirthCRE #TranslatedResources #pregnancycare Facebook - @CentreofResearchExcellenceinStillbirth Twitter- @CREStillbirth LinkedIn - @StillbirthCRE
Carousel (two images)  	LET'S WORK TOGETHER TO MAKE YOUR PREGNANCY SAFER To help reduce the chance of stillbirth for Arabic, Dari, Dinka and Karen speaking communities, new resources have been co-designed with communities and healthcare professionals. Access the resources and learn more at growingahealthybaby.org.au #GrowingaHealthyBaby #SaferBabyBundle #SaferBaby #StillbirthCRE #TranslatedResources #pregnancycare Facebook - @CentreofResearchExcellenceinStillbirth Twitter- @CREStillbirth LinkedIn - @StillbirthCRE

Growing a Healthy Baby - social media posts (English)

General Awareness (ENGLISH) Audience = Healthcare teams and followers of healthcare organisations	
Graphic/ image content	**Post copy (suggested only can be edited when posting)**
Images (5) - language groups focus carousel Swipe through of 5 images. Cover image animated (gif option of cover = plant grows) 	GROWING A HEALTHY BABY To help reduce the chance of stillbirth for Arabic, Dari, Dinka and Karen speaking communities, new resources have been co-designed with communities and healthcare professionals. Each of the four community groups have an in-language - summary animation video, digital audio booklet, detailed PDF booklet. So they can watch, listen, or read. Access the resources and learn more at growingahealthybaby.org.au Please share with women and families you know in these communities. #GrowingaHealthyBaby #SaferBabyBundle #SaferBaby #StillbirthCRE #TranslatedResources #pregnancycare Facebook - @CentreofResearchExcellenceinStillbirth Twitter- @CREStillbirth LinkedIn - @StillbirthCRE

Growing a Healthy Baby - social media posts (English)

General Awareness (ENGLISH) Audience = Healthcare teams and followers of healthcare organisations	
Graphic/ image content	**Post copy (suggested only can be edited when posting)**
Images (4) with resource focus (for carousel) 	LET'S WORK TOGETHER TO MAKE YOUR PREGNANCY SAFER To help reduce the chance of stillbirth for Arabic, Dari, Dinka and Karen speaking communities, new resources have been co-designed with communities and healthcare professionals. Each of the four community groups have an in-language - summary animation video, digital audio booklet, detailed PDF booklet. So they can watch, listen, or read. Access the resources and learn more at growingahealthybaby.org.au Please share with women and families you know in these communities. #GrowingaHealthyBaby #SaferBabyBundle #SaferBaby #StillbirthCRE #TranslatedResources #pregnancycare Facebook - @CentreofResearchExcellenceinStillbirth Twitter- @CREStillbirth LinkedIn - @StillbirthCRE

Growing a Healthy Baby - social media posts (English)

General Awareness (ENGLISH) Audience = Healthcare teams and followers of healthcare organisations	
Graphic/ image content	**Post copy (suggested only can be edited when posting)**
Safer baby elements focus – 3 images for carousel (animated option for cover where poster highlight 5 elements)   	WORKING TOGETHER FOR A SAFER PREGNANCY To help reduce the chance of stillbirth, new resources have been co-designed with communities and healthcare professionals to provide safer pregnancy information for Arabic, Dari, Dinka and Karen speaking communities. These resources are available in the four languages for women and their families to either watch, listen to, or read. Access the resources and learn more at growingahealthybaby.org.au #GrowingaHealthyBaby #SaferBabyBundle #SaferBaby #StillbirthCRE #TranslatedResources #pregnancycare Facebook - @CentreofResearchExcellenceinStillbirth Twitter- @CREStillbirth LinkedIn - @StillbirthCRE

Growing a Healthy Baby - social media posts (in-language)

ARABIC - Audience = Women, their families, communities and healthcare teams		
Graphic/ image content	**ENG text translated on graphic**	**Post copy - Translated text (ENG below for reference)**
Arabic Single image post 	**Let's work together to make your pregnancy safer** (on tablet) Information to help you and your baby have a safer pregnancy, with the support of your family and healthcare team.	نمو طفل صحي هذه المعلومات تتحدث عن طرق تقليل الاملاص. نتحدث مع الجميع عن طرق تقليل تلك المشاكل شاهد أو استمع أو اقرا growingahealthybaby.org.au --- Growing a healthy baby This information is about preventing stillbirth. We speak with everyone about these things. Watch, listen or read growingahealthybaby.org.au
NEW video edits 	**Arabic video and digital booklet can be posted via their links** https://vimeo.com/871330730 (video) https://simplebooklet.com/arabicdigitalbooklet (digital booklet with audio)	*Same text as above can be used when posting the video and/or digital booklet.*

Growing a Healthy Baby - social media posts (in-language)

ARABIC - Audience = Women, their families, communities and healthcare teams		
Graphic/ image content	**ENG text translated on graphic (reference)**	**Post copy - Translated text (ENG below for reference)**
Arabic carousel of 4 images 	Growing a Healthy Baby (on green) **Watch, listen or read** Information to help you and your baby have a safer pregnancy with the support of your family and healthcare team (image 2 translation) **Watch the summary video** Summary video with key information about things women and families can do with the support of their healthcare team to reduce their chance of stillbirth (image 3 translation) **listen to the long-form information in the interactive digital booklet.** This interactive booklet enables women and families to listen at their own pace, with images to support health information. (image 4 translation) **read the long-form information in the booklet** Booklet (PDF) with all the information in written format to support women and families to have a healthy pregnancy and reduce their chance of stillbirth.	لنعمل معًا لجعل الحمل أكثر أمانا معلومات تساعدك أنت وطفلك على التمتع بحمل أكثر أمانًا، بدعم من عائلتك وفريق الرعاية الصحية. شاهد أو استمع أو اقرا growingahealthybaby.org.au ——————— Let's work together to make your pregnancy safer Information to help you and your baby have a safer pregnancy, with the support of your family and healthcare team. Watch, listen or read growingahealthybaby.org.au

Growing a Healthy Baby - social media posts (in-language)

DARI - Audience = Women, their families, communities and healthcare teams		
Graphic/ image content	**ENG text translated on graphic**	**Post copy - Translated text (ENG below for reference)**
Dari Single image post 	**Let's work together to make your pregnancy safer** (on tablet) Information to help you and your baby have a safer pregnancy, with the support of your family and healthcare team.	رشد یک طفل سالم این جزوه معلوماتی در مورد پیش گیری از ولادت طفل مرده است. ما با همه در مورد این چیزها صحبت می کنیم. تماشا کنید، گوش بدهید یا بخوانید growingahealthybaby.org.au --- Growing a healthy baby This information is about preventing stillbirth. We speak with everyone about these things. Watch, listen or read growingahealthybaby.org.au
NEW video edits 	**Dari video and digital booklet can be posted via their links** https://vimeo.com/871331573 (video) https://simplebooklet.com/daridigitalbooklet (digital booklet with audio)	*Same text as above can be used when posting the video and/or digital booklet.*

Growing a Healthy Baby - social media posts (in-language)

DARI - Audience = Women, their families, communities and healthcare teams		
Graphic/ image content	**ENG text translated on graphic (reference)**	**Post copy - Translated text (ENG below for reference)**
Dari carousel of 4 images 	Growing a Healthy Baby (on green) **Watch, listen or read** Information to help you and your baby have a safer pregnancy with the support of your family and healthcare team (image 2 translation) **Watch the summary video** Summary video with key information about things women and families can do with the support of their healthcare team to reduce their chance of stillbirth (image 3 translation) **listen to the long-form information in the interactive digital booklet.** This interactive booklet enables women and families to listen at their own pace, with images to support health information. (image 4 translation) **read the long-form information in the booklet** Booklet (PDF) with all the information in written format to support women and families to have a healthy pregnancy and reduce their chance of stillbirth.	بیایید باهم کار کنیم تا بارداری شما را امن تر و سالم تر بسازیم معلوماتی که به شما و طفل تان کمک میکند تا بارداری محفوظ و سالم داشته باشید، با حمایت خانواده و تیم مراقبت های بهداشتی. تماشا کنید، گوش بدهید یا بخوانید growingahealthybaby.org.au ——————— Let's work together to make your pregnancy safer Information to help you and your baby have a safer pregnancy, with the support of your family and healthcare team. Watch, listen or read growingahealthybaby.org.au

Growing a Healthy Baby - social media posts (in-language)

DINKA - Audience = Women, their families, communities and healthcare teams		
Graphic/ image content	**ENG text translated on graphic**	**Post copy - Translated text (ENG below for reference)**
Dinka Single image post 	**Let's work together to make your pregnancy safer** (on tablet) Information to help you and your baby have a safer pregnancy, with the support of your family and healthcare team.	muök mɛnh puɔ̈lguöp Wël tɔ̈u athor kënë yic aci kek looi tɛ bi thɛɛrbei/määr riɛ̈m gël thïn. Ɣok a jäm kek kuat ë raan ë bën e rin wël käkä. Dääi, piëŋe wala kuen growingahealthybaby.org.au —---------- Growing a healthy baby This information is about preventing stillbirth. We speak with everyone about these things. Watch, listen or read growingahealthybaby.org.au
NEW video edits 	**Dinka video and digital booklet can be posted via their links** https://vimeo.com/871337304 (video) https://simplebooklet.com/dinkadigitalbooklet (digital booklet with audio)	*Same text as above can be used when posting the video and/or digital booklet.*

Growing a Healthy Baby - social media posts (in-language)

DINKA - Audience = Women, their families, communities and healthcare teams		
Graphic/ image content	**ENG text translated on graphic (reference)**	**Post copy - Translated text (ENG below for reference)**
Dinka carousel of 4 images    	Growing a Healthy Baby (on green) **Watch, listen or read** Information to help you and your baby have a safer pregnancy with the support of your family and healthcare team (image 2 translation) **Watch the summary video** Summary video with key information about things women and families can do with the support of their healthcare team to reduce their chance of stillbirth (image 3 translation) **listen to the long-form information in the interactive digital booklet.** This interactive booklet enables women and families to listen at their own pace, with images to support health information. (image 4 translation) **read the long-form information in the booklet** Booklet (PDF) with all the information in written format to support women and families to have a healthy pregnancy and reduce their chance of stillbirth.	Luiku e tok ku buk liëcdu cɔl aŋic bɛn bëi ke pɛth Wël bi yïn ku mɛnhdhu kony ba näŋ liëc pɛth, kek kuöny kääckun ku kööckun ŋiëc piälguöp. Dääi, piëŋe wala kuen growingahealthybaby.org.au ---------- Let's work together to make your pregnancy safer Information to help you and your baby have a safer pregnancy, with the support of your family and healthcare team. Watch, listen or read growingahealthybaby.org.au

Growing a Healthy Baby - social media posts (in-language)

KAREN - Audience = Women, their families, communities and healthcare teams		
Graphic/ image content	ENG text translated on graphic (reference)	**Post copy - Translated text (ENG below for reference)**
Karen Single image post 	Let's work together to make your pregnancy safer (on tablet) Information to help you and your baby have a safer pregnancy, with the support of your family and healthcare team.	ဖိသဉ်ဆံး ဒိဉ်ထီဉ် ဒီး အိဉ်ဆူဉ်အိဉ်ချ့ တၢ်ဂ့ၢ်တၢ်ကျိၤလၢလံာ်တဘဉ်အံၤ မ့ၢ်ဝဲတၢ်ဂ့ၢ်တၢ်ကျိၤလၢကဒီသဒၢ ဖိသဉ်အသးသမူလာ်လၢဒၢလီၢ်အပူၤ အဂီၢ်လီၤ. ပတဲသကိးတၢ်ဂ့ၢ်အံၤဒီးပှၤကိးဂၤဒဲးလီၤ. ကွၢ်, ကနၢ် မ့တမ့ၢ် ဖး growingahealthybaby.org.au —---------- Growing a healthy baby This information is about preventing stillbirth. We speak with everyone about these things. Watch, listen or read growingahealthybaby.org.au
NEW video edits 	Karen video and digital booklet can be posted via their links https://vimeo.com/871332533 (video) https://simplebooklet.com/karensaferbabybooklet (digital booklet with audio)	*Same text as above can be used when posting the video and/or digital booklet.*

Growing a Healthy Baby - social media posts (in-language)

KAREN - Audience = Women, their families, communities and healthcare teams		
Graphic/ image content	**ENG text translated on graphic (reference)**	**Post copy - Translated text (ENG below for reference)**
Karen carousel of 4 images    	Growing a Healthy Baby (on green) **Watch, listen or read** Information to help you and your baby have a safer pregnancy with the support of your family and healthcare team (image 2 translation) **Watch the summary video** Summary video with key information about things women and families can do with the support of their healthcare team to reduce their chance of stillbirth (image 3 translation) **listen to the long-form information in the interactive digital booklet.** This interactive booklet enables women and families to listen at their own pace, with images to support health information. (image 4 translation) **read the long-form information in the booklet** Booklet (PDF) with all the information in written format to support women and families to have a healthy pregnancy and reduce their chance of stillbirth.	မၤသကိးတၢ်ဒ်သိးနကဒၢဘဉ်နဖိမှာ်မှာ်အဂီၢ် တၢ်ဂ့ၢ်တၢ်ကျိုၤတဖဉ်အံၤလ၊ နဟံဉ်ဖိဃီဖိ ဒီး တၢ်အိဉ်ဆူဉ်အိဉ်ချ့တၢ်ကွၢ်ထွံမၤစ၊ၤအပှၤဘဉ်မူဘဉ်ဒါတဖဉ် ကမၤသကိးတၢ် လ၊နကဒၢဘဉ်နဖိမှာ်မှာ်အဂီၢ်. ကွၢ်, ကန်ၢ် မ့တမ့ၢ် ဖး growingahealthybaby.org.au ---------- Let's work together to make your pregnancy safer Information to help you and your baby have a safer pregnancy, with the support of your family and healthcare team. Watch, listen or read growingahealthybaby.org.au

Newsletter/website copy - Promoting Growing a Healthy Baby

Some migrant and refugee communities suffer from higher rates of stillbirth than other communities in Australia. To help reduce the chance of stillbirth in migrant and refugee women, new resources have been co-designed with community groups and health educators to produce culturally sensitive information for Arabic, Dari, Dinka and Karen speaking communities.

Each of the four community groups have three in-language resources with tailored information and illustrations, that provide culturally appropriate safer pregnancy information.

The animation video, digital audio booklet and a detailed PDF booklet enable women and their families to either watch, listen to, or read. These resources are available on the Growing a Health Baby website.

A network of community groups and healthcare educators from the Multicultural Centre for Women's Health and the Murdoch Children's Research Institute worked with the Stillbirth CRE to develop and translate these in-language resources.

This work has involved an extensive co-design and consultation process. Community members involved in the development of the resources also recorded the voiceovers for the videos and digital booklet audio.

Note: Imagery developed for the social media tiles can also be repurposed for use in newsletters or emails. These are available here.

Additional resources & Thank you

Safer Baby Bundle
WORKING TOGETHER TO REDUCE STILLBIRTH

Stillbirth
CENTRE OF RESEARCH EXCELLENCE

Additional Resources

NEW resources to assist healthcare professionals support women from migrant and refugee backgrounds, are now available on learn.stillbirthcre.org.au. These include:

- Learning from Women's Perspectives animation video
- eLearning module
- Top 10 Tips fact sheet
- Top 10 Tips animation video



The Safer Baby Booklet is also translated in 30 languages, available on saferbaby.org.au/translated-resources/ (woman facing) and **learn.stillbirthcre.org.au/clinician-resources/** (healthcare professionals site).

COMING SOON for interpreters working in maternity settings, (on learn.stillbirthcre.org.au) will be:

- Top 10 Tips fact sheet
- Top 10 tips animation video
- A new eLearning module

Thank you to our partners and contributors

The development of these culturally adapted resources would not have been possible without the expertise, commitment and support from our partners for these projects. And the time and commitment from community groups and individuals who participated in the co-design and consultations.

The cultural adaptation of the Safer Baby Bundle has been funded by the Australian Government.

For more information on these resources and any enquiries or feedback please contact the Stillbirth CRE at stillbirthcre@mater.uq.edu.au

Professor Vicki Flenady and Professor David Ellwood
Co-Directors, NHMRC Centre of Research Excellence in Stillbirth (Stillbirth CRE)
Mater Research Institute – The University of Queensland (MRI-UQ)
Mater Health Services, South Brisbane, QLD 4101
Phone: +61 7 3163 1592
Email: vicki.flenady@mater.uq.edu.au
d.ellwood@griffith.edu.au

10 October 2024

Hon Rachel Stephen-Smith,
Minister for Aboriginal and Torres Strait Islander Affairs and Minister of Health
Australian Capital Territory Parliament
Canberra ACT 2600

Requesting your support to promote Safer Baby Bundle resources to your constituents

Dear Hon Rachel Stephen-Smith,

The Stillbirth Centre of Research Excellence (Stillbirth CRE) continues to develop culturally adapted Safer Baby Bundle resources with our partners, thanks to vital funding from the Australian Government. We are seeking your support to share these free, culturally safe and evidence-based resources with your constituents.

Stillbirth rates in Australia are significantly higher among First Nations and some migrant and refugee communities, compared to the general population. We are working to address this with our partners by ensuring these communities have care and resources that meet their needs.

We need to work together to ensure that as many women and families, and their healthcare teams, are aware of these culturally safe and free resources. The information is tailored for priority populations in a range of formats and is part of our continuing work to reduce stillbirth rates in Australia.

This work is in line with the National Stillbirth Action and Implementation Plan (NSAIP), which was launched by the Australian Government in 2020 for the goal of reducing stillbirth in Australia by 20 per cent, by December 2025. This national commitment was the first of its kind in Australia and received bi-partisan support.

To make it simple for you and your team to promote these resources to your network we have developed new social media assets, posters and updated the Stakeholder Communication Kit (PDF attached to this email), which includes links to all assets for your use on social media, websites and newsletters.

What we've been working on

It is almost a year since we launched the Stronger Bubba Born resources for First Nations communities, along with the Growing a Healthy Baby resources for migrant and refugee communities. These resources were developed over several years and were co-designed and tested with communities. The Growing a Healthy Baby provides adapted information to watch, read and listen for Arabic, Dari, Dinka and Karen speaking communities.

We have recently published new videos, fact sheets and eLearning modules for healthcare professionals on learn.stillbirthcre.org.au. The Safer Baby Bundle eLearning course has been updated and new eLearning courses, titled Stronger Bubba Born Healthy Yarning Guide and Partnering with families of refugee & migrant backgrounds, are now live. A new eLearning course, videos and fact sheet will also be available soon for interpreters working in maternity settings.

We have also just completed five new translations of the Safer Baby information for Amharic, Farsi, Kirundi, Somali and Tami speaking communities. This takes our translated information to 30 languages, all of which are available at saferbaby.org.au/ and available with all resources for healthcare professionals at learn.stillbirthcre.org.au.

We have received fantastic feedback already from communities, health care professionals and peak bodies. We need to continue to ensure these resources are utilised in maternity settings and communities across Australia to reach the target set out in the NSAIP and drive down stillbirth rates across the country.

Let's keep working together

We are so grateful to all our project partners and the organisations and individuals who have contributed to the co-design and development of these important resources. This extends to federal and state governments, which are important partners on this journey. Raising awareness about the steps that can be taken to help reduce the risk of stillbirth in all population groups is vital. We rely on you to continue championing our work and providing ongoing funding to achieve our shared mission.

This work would not have been possible without Australian Government funding, and we are grateful for the support for these resources as we know they make a real difference. However, much more needs to be done to achieve the goals outlined in the NSAIP, which has bi-partisan support.

The Stillbirth CRE did not receive any funding in the last Federal Budget, and we do not receive any funding from States or Territories. Our lack of funding is now urgent and limiting our capacity to continue our work in improving maternity care to reduce stillbirth rates and ensure best outcomes for families who experience this loss. We will be providing another funding request for the Mid-Year Economic and Fiscal Outlook (MYEFO) process.

We would welcome the opportunity to speak with you about the other important work that the Stillbirth CRE needs to do to address inequality in stillbirth care, embed best practice care in all communities, and ensure programs and research are funded adequately to deliver the National Plan and reduce the devastating impact of stillbirth in Australia.

Yours sincerely,

Schedule 2.2(a)(ii) [redacted]

Prof Vicki Flenady and Prof David Ellwood

Co-Directors
NHMRC Centre of Research Excellence in Stillbirth

About Stronger Bubba Born

For First Nations women and their families to reduce the risk of Sorry Business Baby (stillbirth), the new Stronger Bubba Born resources include flyers and videos that are available at the Stronger Bubba Born website. These resources were developed by the Stillbirth CRE Indigenous research team with the guidance of the Indigenous Advisory Group. Delivery partner Curtin University supported the extensive consultation and co-design process. The National Aboriginal Community Controlled Health Organisation (NACCHO) and the Waminda South Coast Women's Health and Wellbeing Aboriginal Corporation are also collaborators with the CRE on their Indigenous work.

About Growing a Healthy Baby (migrant and refugee)

Arabic, Dari, Dinka and Karen-speaking communities now have access to important tailored information in the form of a written booklet, summary video and self-paced digital booklet with audio. These resources are now available at the Growing a Healthy Baby website. A network of community groups and healthcare educators from the Multicultural Centre for Women's Health (MCWH) and the Stronger Futures CRE at the Murdoch Children's Research Institute (MCRI) worked with the Stillbirth CRE to develop these in-language resources.

Lowes Shannon

From: Gower, Tara on behalf of ACT Health DLO
Sent: Friday, 11 October 2024 4:21 PM
To: Tomlinson, Benjamin; Smith, Kahlia
Subject: NOTING BRIEF : GBC2024/00321 - ACT Auditor-General Performance Audit Report on NTT Australia Invoicing and Payments for the Digital Health Record

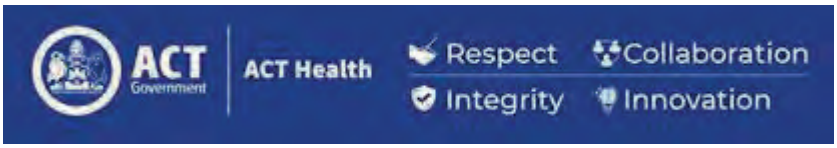
Hi Ben and Kahlia

This Noting Brief is placed in the Minister's folder here.

Please note the critical date of today, 11 October 2024.

Thank you
Tara

Tara Gower | Directorate Liaison Officer | ACT Health Directorate
Mob: Schedule 2.2(a)(ii) | Email: ACTHealthDLO@act.gov.au
Office of Rachel Stephen-Smith | Minister for Health
Office of Emma Davidson | Minister for Mental Health
Level 2, Legislative Assembly Building, Civic Square



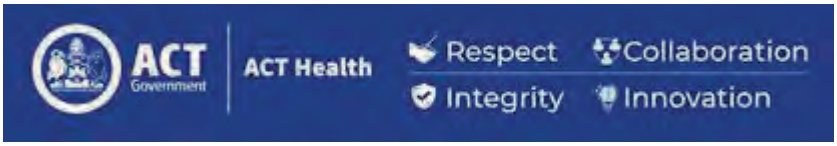
Lewis Shannon

From: Gower, Tara on behalf of ACT Health DLO
Sent: Monday, 14 October 2024 10:45 AM
To: Tomlinson, Benjamin; CSDDLO; iCBR, DLO; CHS DLO
Subject: RE: Cabinet documents

And sorry, Sam Tyler is actually the best contact.

Thank you
Tara

Tara Gower | Directorate Liaison Officer | ACT Health Directorate
Mob: Schedule 2.2(a)(ii) | Email: ACTHealthDLO@act.gov.au
Office of Rachel Stephen-Smith | Minister for Health
Office of Emma Davidson | Minister for Mental Health
Level 2, Legislative Assembly Building, Civic Square



From: Gower, Tara **On Behalf Of** ACT Health DLO
Sent: Monday, 14 October 2024 10:44 AM
To: Tomlinson, Benjamin ; CSDDLO ; MPC, DLO ; CHS DLO
Subject: RE: Cabinet documents

Hi Ben

I sought further clarification from the CM DLO.

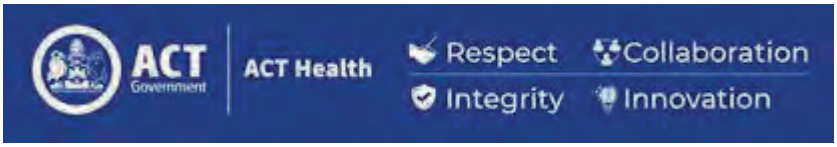
The DLO has noted that cabinet documents once removed from MO drives will not be restored, even if the Minister is re-elected.

The practice is that if the MO want access to previous Cabinet documents, the MO have to go through Cabinet Office. This applies to business cases also.

I believe Yersheena is the contact if you would like to discuss further.

Thank you
Tara

Tara Gower | Directorate Liaison Officer | ACT Health Directorate
Mob: Schedule 2.2(a)(ii) | Email: ACTHealthDLO@act.gov.au
Office of Rachel Stephen-Smith | Minister for Health
Office of Emma Davidson | Minister for Mental Health
Level 2, Legislative Assembly Building, Civic Square



From: Gower, Tara **On Behalf Of** ACT Health DLO
Sent: Monday, 14 October 2024 10:22 AM
To: Tomlinson, Benjamin <Benjamin.Tomlinson@act.gov.au>; CSDDLO <CSDDLO@act.gov.au>; MPC, DLO <MPCDLO@act.gov.au>; CHS DLO <CHSDLO@act.gov.au>
Subject: RE: Cabinet documents

Hi Ben

Hope you are well.

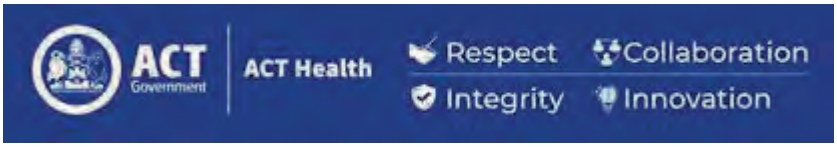
Just following up on the email below please.

Please let us know if you would like DLOs to remove business cases, CNRs and any other cabinet material in MO drives (Adviser to keep folders etc) ?

All other cabinet material in the signed archived folders have been identified.

Thank you
Tara

Tara Gower | Directorate Liaison Officer | ACT Health Directorate
Mob: Schedule 2.2(a)(ii) | Email: ACTHealthDLO@act.gov.au
Office of Rachel Stephen-Smith | Minister for Health
Office of Emma Davidson | Minister for Mental Health
Level 2, Legislative Assembly Building, Civic Square



From: Gower, Tara **On Behalf Of** ACT Health DLO
Sent: Tuesday, 24 September 2024 11:40 AM
To: Tomlinson, Benjamin <Benjamin.Tomlinson@act.gov.au>; CSDDLO <CSDDLO@act.gov.au>; MPC, DLO <MPCDLO@act.gov.au>; CHS DLO <CHSDLO@act.gov.au>
Subject: RE: Cabinet documents

Hi Ben

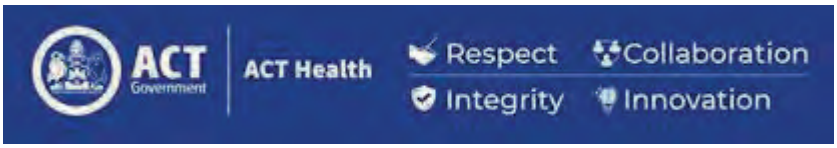
Thank you for the advice – we will ensure no cabinet documents are removed prior to these dates.

I understand that cabinet documents which include CNRs, ARFs and business cases also need to be removed.

Can you please advise if you would like DLOs to remove these also or would the MO prefer to remove these particular files?

Thank you
Tara

Tara Gower | Directorate Liaison Officer | ACT Health Directorate
Mob: Schedule 2.2(a)(ii) | Email: ACTHealthDLO@act.gov.au
Office of Rachel Stephen-Smith | Minister for Health
Office of Emma Davidson | Minister for Mental Health
Level 2, Legislative Assembly Building, Civic Square



From: Tomlinson, Benjamin <Benjamin.Tomlinson@act.gov.au>
Sent: Tuesday, September 24, 2024 9:59 AM
To: ACT Health DLO <ACTHealthDLO@act.gov.au>; CSDDLO <CSDDLO@act.gov.au>; MPC, DLO <MPCDLO@act.gov.au>; CHS DLO <CHSDLO@act.gov.au>
Subject: Cabinet documents
Importance: High

Hi all

I understand ahead of the election that all cabinet documents need to be removed from drives in line with caretaker conventions. Can I ask that this does not occur until Thursday 17 October or Friday 18 October. The Office and Minister may have need for the documents over the coming weeks. I understand that this is appropriate request in line with the convention.

Happy to discuss.
Ben

Ben Tomlinson
Chief of Staff
Office of Minister Rachel Stephen-Smith MLA
ACT Government
Ph: (02) 6205 9949 | Mob: Schedule 2.2(a)(ii) | Email: Benjamin.Tomlinson@act.gov.au
ACT Legislative Assembly, 196 London Circuit, Canberra, ACT 2600

From: Gower, Tara on behalf of ACT Health DLO
Sent: Monday, 14 October 2024 2:43 PM
To: STEPHEN-SMITH
Cc: Smith, Kahlia
Subject: RE: Correspondence from the Hon Mark Butler MP
Attachments: MS24-000647 - signed letter to Minister Stephen-Smith.pdf

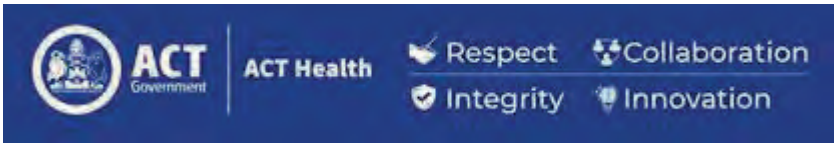
Hi Ben

Just hoping to follow-up on this one please.

Grateful for your confirmation so ACTHD can still meet the timeframe of 24 October with a DG Response.

Thank you
Tara

Tara Gower | Directorate Liaison Officer | ACT Health Directorate
Mob: Schedule 2.2(a)(ii) | Email: ACTHealthDLO@act.gov.au
Office of Rachel Stephen-Smith | Minister for Health
Office of Emma Davidson | Minister for Mental Health
Level 2, Legislative Assembly Building, Civic Square



From: Gower, Tara **On Behalf Of** ACT Health DLO
Sent: Friday, 11 October 2024 9:18 AM
To: STEPHEN-SMITH
Cc: Smith, Kahlia
Subject: RE: Correspondence from the Hon Mark Butler MP

Hi Ben

Please note the response from the Commonwealth below:

"Thank you for your email regarding state and territory nominations to the Board of the Australian Institute of Health and Welfare. While I understand the issue of the ACT Government being in caretaker, we are not in a position to provide an extension.
To maintain sound governance of the AIHW, we would like to finalise the appointments by the end of the year. This will necessitate seeking approval from the Prime Minister and/or consideration by Cabinet before the appointments can be finalised.
Please note that Minister Butler is only seeking nominations and has written to all state and territory health ministers. The Minister will then consider each nomination before making a final decision on the appointments. As the decision remains with the Commonwealth Health Minister, your nomination will not bind an incoming ACT Government. However, this is ultimately a matter for ACT Health."

Can you please confirm the office is comfortable with a Directorate response noting an extension is not granted?

Thank you
Tara

Tara Gower | Directorate Liaison Officer | ACT Health Directorate
Mob: Schedule 2.2(a)(ii) | Email: ACTHealthDLO@act.gov.au
Office of Rachel Stephen-Smith | Minister for Health
Office of Emma Davidson | Minister for Mental Health
Level 2, Legislative Assembly Building, Civic Square



From: STEPHEN-SMITH <STEPHEN-SMITH@act.gov.au>
Sent: Tuesday, 1 October 2024 12:28 PM
To: ACT Health DLO <ACTHealthDLO@act.gov.au>; STEPHEN-SMITH <STEPHEN-SMITH@act.gov.au>
Cc: Smith, Kahlia <Kahlia.Smith@act.gov.au>
Subject: RE: Correspondence from the Hon Mark Butler MP [SEC=OFFICIAL]
Importance: High

OFFICIAL

I think that is very sensible

From: Gower, Tara <Tara.Gower@act.gov.au> **On Behalf Of** ACT Health DLO
Sent: Tuesday, 1 October 2024 12:06 PM
To: STEPHEN-SMITH <STEPHEN-SMITH@act.gov.au>
Cc: Smith, Kahlia <Kahlia.Smith@act.gov.au>
Subject: RE: Correspondence from the Hon Mark Butler MP [SEC=OFFICIAL]

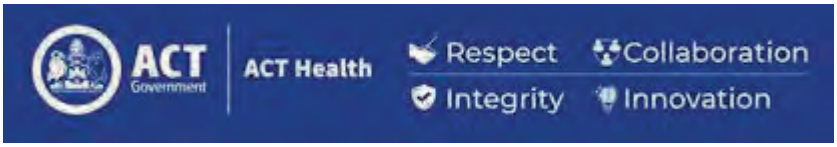
OFFICIAL

Hi Ben

Thank you – noting the letter requests a response by 24 October 2024, (and noting new government may not yet been formed), would you like ACTHD to request a short extension to note an incoming Minister response will be provided?

Thank you
Tara

Tara Gower | Directorate Liaison Officer | ACT Health Directorate
Mob: Schedule 2.2(a)(ii) | Email: ACTHealthDLO@act.gov.au
Office of Rachel Stephen-Smith | Minister for Health
Office of Emma Davidson | Minister for Mental Health
Level 2, Legislative Assembly Building, Civic Square



From: STEPHEN-SMITH <STEPHEN-SMITH@act.gov.au>
Sent: Tuesday, October 1, 2024 9:46 AM
To: ACT Health DLO <ACTHealthDLO@act.gov.au>
Cc: Smith, Kahlia <Kahlia.Smith@act.gov.au>
Subject: FW: Correspondence from the Hon Mark Butler MP [SEC=OFFICIAL]
Importance: High

Hi team

See attached. To prepare a response for an incoming minister please.

Ben

From: Schedule 2.2(a)(ii)
Sent: Tuesday, 24 September 2024 1:36 PM
To: STEPHEN-SMITH <STEPHEN-SMITH@act.gov.au>
Cc: AIHW MoU <AIHWMoUInbox@health.gov.au>
Subject: Correspondence from the Hon Mark Butler MP [SEC=OFFICIAL]

You don't often get email from Schedule 2.2(a)(ii) Learn why this is important

Caution: This email originated from outside of the ACT Government. Do not click links or open attachments unless you recognise the sender and know the content is safe.

Dear Minister
Please find attached a letter from the Minister for Health and Aged Care, the Hon Mark Butler MP, seeking nominations for the Board of the Australian Institute of Health and Welfare.
Kind regards

Schedule 2.2(a)(ii)
Assistant Director – Evaluation and Strategic Advice Section
Health Modelling, Partnerships and Evaluation Branch
Health Economics and Research Division
Australian Government Department of Health and Aged Care
T: Schedule 2.2(a)(ii)
E:
PO Box 9848, Canberra ACT 2601, Australia



The Department of Health and Aged Care acknowledges the traditional owners of country throughout Australia, and their continuing connection to land, sea and community. We pay our respects to them and their cultures, and to elders both past and present.

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From: Smith, Kahlia
Sent: Tuesday, 15 October 2024 11:33
To: ACT Health DLO; STEPHEN-SMITH
Cc: Tomlinson, Benjamin
Subject: Re: Correspondence from the Hon Mark Butler MP - MIN2024/00833

Importance: High

Follow Up Flag: Follow up
Flag Status: Flagged

OFFICIAL

Hi Tara - apologies for the delay! A DG response is fine, thank you.

Kahlia

Get Outlook for Android

From: Gower, Tara on behalf of ACT Health DLO
Sent: Friday, October 11, 2024 9:17:46 am
To: STEPHEN-SMITH
Cc: Smith, Kahlia
Subject: RE: Correspondence from the Hon Mark Butler MP

OFFICIAL

Hi Ben
Please note the response from the Commonwealth below:
"Thank you for your email regarding state and territory nominations to the Board of the Australian Institute of Health and Welfare. While I understand the issue of the ACT Government being in caretaker, we are not in a position to provide an extension.
To maintain sound governance of the AIHW, we would like to finalise the appointments by the end of the year. This will necessitate seeking approval from the Prime Minister and/or consideration by Cabinet before the appointments can be finalised.
Please note that Minister Butler is only seeking nominations and has written to all state and territory health ministers. The Minister will then consider each nomination before making a final decision on the appointments. As the decision remains with the Commonwealth Health Minister, your nomination will not bind an incoming ACT Government. However, this is ultimately a matter for ACT Health."
Can you please confirm the office is comfortable with a Directorate response noting an extension is not granted?
Thank you
Tara

Tara Gower | Directorate Liaison Officer | ACT Health Directorate
Mob: Schedule 2.2(a)(ii) | Email: ACTHealthDLO@act.gov.au
Office of Rachel Stephen-Smith | Minister for Health
Office of Emma Davidson | Minister for Mental Health
Level 2, Legislative Assembly Building, Civic Square



From: STEPHEN-SMITH
Sent: Tuesday, 1 October 2024 12:28 PM
To: ACT Health DLO ; STEPHEN-SMITH
Cc: Smith, Kahlia
Subject: RE: Correspondence from the Hon Mark Butler MP [SEC=OFFICIAL]
Importance: High

OFFICIAL

I think that is very sensible

From: Gower, Tara <Tara.Gower@act.gov.au> **On Behalf Of** ACT Health DLO
Sent: Tuesday, 1 October 2024 12:06 PM
To: STEPHEN-SMITH <STEPHEN-SMITH@act.gov.au>
Cc: Smith, Kahlia <Kahlia.Smith@act.gov.au>
Subject: RE: Correspondence from the Hon Mark Butler MP [SEC=OFFICIAL]

OFFICIAL

Hi Ben
Thank you – noting the letter requests a response by 24 October 2024, (and noting new government may not yet been formed), would you like ACTHD to request a short extension to note an incoming Minister response will be provided?
Thank you
Tara

Tara Gower | Directorate Liaison Officer | ACT Health Directorate
Mob: Schedule 2.2(a)(i) | Email: ACTHealthDLO@act.gov.au
Office of Rachel Stephen-Smith | Minister for Health
Office of Emma Davidson | Minister for Mental Health
Level 2, Legislative Assembly Building, Civic Square



From: STEPHEN-SMITH <STEPHEN-SMITH@act.gov.au>
Sent: Tuesday, October 1, 2024 9:46 AM
To: ACT Health DLO <ACTHealthDLO@act.gov.au>
Cc: Smith, Kahlia <Kahlia.Smith@act.gov.au>
Subject: FW: Correspondence from the Hon Mark Butler MP [SEC=OFFICIAL]
Importance: High

Hi team
See attached. To prepare a response for an incoming minister please.
Ben

From: Schedule 2.2(a)(ii)
Sent: Tuesday, 24 September 2024 1:36 PM
To: STEPHEN-SMITH <STEPHEN-SMITH@act.gov.au>
Cc: AIHW MoU Schedule 2.2(a)(ii)
Subject: Correspondence from the Hon Mark Butler MP [SEC=OFFICIAL]

You don't often get email from Schedule 2.2(a)(ii) Learn why this is important

Caution: This email originated from outside of the ACT Government. Do not click links or open attachments unless you recognise the sender and know the content is safe.

Dear Minister

Please find attached a letter from the Minister for Health and Aged Care, the Hon Mark Butler MP, seeking nominations for the Board of the Australian Institute of Health and Welfare.

Kind regards

Schedule 2.2(a)(ii)
Assistant Director – Evaluation and Strategic Advice Section
Health Modelling, Partnerships and Evaluation Branch
Health Economics and Research Division
Australian Government Department of Health and Aged Care
T Schedule 2.2(a)(ii)
E
PO Box 9848, Canberra ACT 2601, Australia



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SD MAGS Exchange with Ben Tomlinson – 16 October 2024

Wednesday, 16 October 2024

16/10/2024 4:05 pm

hello - I flagged the query i was unable to address with DDG office when i was speaking to them and understand Shane Nielsen may be your best go to for factual info on that matter.

From: Tomlinson, Benjamin
To: Ellis, Catherine
Cc: ACT Health DLO
Subject: Re: Outstanding ACTHD items
Date: Wednesday, 16 October 2024 3:38:35 PM

OFFICIAL

Hi Cathy

As discussed, please hold for now

B

Get Outlook for Android

From: Ellis, Catherine <Catherine.Ellis@act.gov.au>
Sent: Wednesday, October 16, 2024 3:28:11 PM
To: Tomlinson, Benjamin <Benjamin.Tomlinson@act.gov.au>
Cc: ACT Health DLO <ACTHealthDLO@act.gov.au>
Subject: FW: Outstanding ACTHD items

OFFICIAL

Hi Ben

Just following up on the below email from Tara.

My proposed approach at present will be for DLO to advise back to the Directorate on Friday that these matters are to be closed as they have not been actioned by MO during the term of Government and to make notes accordingly on the file.

This will just give us clarity on what occurred, especially if someone asked for a signed copy of a brief etc, and also leave us clear of any business going into the new term of government.

Happy to further discuss as required.

Thanks
Cath

Catherine Ellis | Senior Director
Ministerial and Government Services | ACT Health Directorate
Mob Schedule 2.2(a)(ii) Email: Catherine.Ellis@act.gov.au
Level 5, Bowes Street, Woden ACT



From: Gower, Tara <Tara.Gower@act.gov.au> **On Behalf Of** ACT Health DLO
Sent: Tuesday, 8 October 2024 9:56 AM
To: Tomlinson, Benjamin <Benjamin.Tomlinson@act.gov.au>
Cc: Bransgrove, Meagen <Meagen.Bransgrove@act.gov.au>; ACT Health DLO <ACTHealthDLO@act.gov.au>
Subject: Outstanding ACTHD items
Importance: High

OFFICIAL

Hi Ben

Please note the following ACTHD matters are with the MO for signing.

I would be grateful for advice if these matters will be signed prior to 18 October 2024, so we can appropriately close them in our system.

name	
MIN24/00796 – Min Response - ANMF ACT Branch	With Meg
MIN24/00372 – Min Brief - Progress Update on SOCI Funding	With Minister (Info briefs – non-urgent folder)
MIN24/00373 – Min Response - Howard Conkey	With Meg
MIN24/00708 – Advisory Note - 13SICK	With Minister (Info briefs – non-urgent folder)
MIN24/00671 – Min Brief - ACT Health Forum Report #2	With Minister (Info briefs – non-urgent folder)
MIN24/00442 – Advisory Note - NDIS and Palliative Care	With Minister (Info briefs – non-urgent folder)
GBC24/257 – Advisory Note - Annual Review of Fees and Charges	With Minister (Info briefs – non-urgent folder)
MIN24/00619 – Advisory Note - GP Single-Employer Model	With Minister (Info briefs – non-urgent folder)

Thank you
Tara

Tara Gower | Directorate Liaison Officer | ACT Health Directorate
Mob: Schedule 2.2(a)(ii) Email: ACTHealthDLO@act.gov.au
Office of Rachel Stephen-Smith | Minister for Health
Office of Emma Davidson | Minister for Mental Health
Level 2, Legislative Assembly Building, Civic Square



From: STEPHEN-SMITH
Sent: Thursday, 17 October 2024 8:48 AM
To: ACT Health DLO
Cc: Bransgrove, Meagen; Smith, Kahlia
Subject: FW: Response from the Royal Australian College of General Practitioners to letter regarding Expedited Specialist Pathway
Attachments: Letter to Federal and State Health Ministers and Dr Anne Tonkin re SIMG Pathway - 15 October 2024.pdf

Importance: High

FYI

From: RACGP President
Sent: Tuesday, 15 October 2024 5:09 PM
To: STEPHEN-SMITH ; Cross, Rebecca ; Coleman, Kerryn ; Schedule 2.2(a)(ii) [redacted]
Cc: Georgina van de Water
Subject: Response from the Royal Australian College of General Practitioners to letter regarding Expedited Specialist Pathway

Caution: This email originated from outside of the ACT Government. Do not click links or open attachments unless you recognise the sender and know the content is safe.

Dear Federal and State Health Ministers and Dr Anne Tonkin AO

Please find attached a response from the Royal Australian College of General Practitioners to the letter received from Dr Tonkin dated 14 October 2024, regarding the Expedited Specialist pathway for your consideration.

Yours sincerely

Dr Nicole Higgins

DrNicole Higgins
President
Council

RACGP

T +61 3 8699 0550
president@racgp.org.au|racgp.org.au

The Royal Australian College of General Practitioners Ltd

100 Wellington Parade, East Melbourne VIC 3002

The RACGP acknowledges Aboriginal and Torres Strait Islander peoples as the Traditional Custodians of the land and waterways in which we live and work. We recognise their continuing connection to land, water and culture and pay our respects to Elders past, present, and emerging.



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RACGP
Royal Australian College of General Practitioners

Healthy Profession. Healthy Australia.

15 October 2024

TO: Federal and State Health Ministers
Dr Anne Tonkin AO, Chair, Medical Board of Australia

Dear Ministers and Dr Tonkin

RE: Expedited Specialist pathway

I refer to Dr Tonkin's letter dated 14 October 2024 advising of the commencement of the Expedited Specialist pathway for General Practitioners on 21 October 2024 as approved by Australian health ministers.

We draw to your attention that the Royal Australian College of General Practitioners (RACGP) remains extremely concerned about the proposed implementation of this expedited pathway to specialist medical registration for Specialist International Medical Graduates (SIMGs) in Australia.

In concert with the College Presidents of Medical Colleges (CPMC), and on behalf of our members and the general practice profession requests:

- an immediate stay on implementing the expedited SIMG pathways as currently proposed
- revision of the pathways to value the expertise of specialist medical colleges in assessment of SIMG rather than bypassing it
- revision of pathways to address geographical maldistribution and specialty-specific shortages
- integration of the SIMG pathway with broader strategies to address medical workforce challenges
- A more precise implementation plan including qualification criteria and assessment, supervision and monitoring
- Full exemption for the RACGP from the expedited pathway so it can continue its current, safe, successful and fast assessment process that is processing SIMGs benchmarked and agreed timelines.

Despite its commencement in just 7 days, the Health Minister approved pathway still has significant unresolved issues including:

- how 'unsuitable' candidates are going to be identified in the expedited pathway (+-19% of applicants based on RACGP's experience)
- how the MBA/Ahpra will ensure SIMGs are placed in identified areas of greatest need
- how the MBA/Ahpra will ensure SIMGs are supervised to an appropriate standard by suitably qualified supervisors
- what the long-term retention strategies are – there is no comprehensive strategy in place to encourage SIMGs to remain in underserved areas or specialties
- there are no checks and balances in place to ensure the expedited pathway complements, rather than competes with efforts to train and retain domestically educated doctors
- Thers is still no clarity about other potential points of delay for SIMGs (including visas and issuing of Medicare provider numbers)
- The risk of confusion for SIMGs navigating multiple pathways of entry to Australia will be mitigated.

In good faith the RACGP has continued to create efficiencies in our processes to fast-track the assessment of SIMGs. **We note that the Kruk review recommended an expedited assessment process by Ahpra for SIMGs *only if the Colleges were unable to do so themselves*.** We have already responded to this recommendation, by making our processes more efficient when compared to other medical colleges. The Medical Board of Australia's own data shows this.

The RACGP already performs well above the benchmark on both approval time and numbers, **meeting all expectations within agreed timelines.** Despite these efforts to deliver outcomes articulated by Government, the general practice is still one of the first four specialities being forced to adopt the expedited pathway.

The Royal Australian College of General Practitioners Ltd
100 Wellington Parade, East Melbourne VIC 3002
Tel **1800 4RACGP** | 1800 472 247 Fax (03) 8699 0400 Email racgp@racgp.org.au
racgp.org.au ACN 000 223 807 ABN 34 000 223 807

RACGP
Royal Australian College of General Practitioners

Healthy Profession. Healthy Australia.

The RACGP is committed to working collaboratively with the MBA, Ahpra, and other stakeholders to refine our own pathways further. We aim to maintain high standards of safety for the Australian public while growing our medical workforce across all geographical areas.

Given Australian Health Ministers' have chosen to continue to progress the implementation of the general practice SIMG expediated pathway without the resolution of the above matters, **the RACGP re-iterates that it will accept no responsibility for adverse patient outcomes caused by the MBA's SIMG expedited pathway.**
If you would like to discuss our concerns further, please contact RACGP's Chief Executive Officer, Georgina van de Water on P: 03 8699 0078.

Yours sincerely,

Schedule 2.2(a)(ii)

Dr Nicole Higgins, FRACGP
President

Australian Capital Territory and Chair of the HMM:
Hon. Rachel Stephen-Smith — stephen-smith@act.gov.au
Ms Rebecca Cross, Director-General, ACT Health — rebecca.cross@act.gov.au
Dr Kerryn Coleman, Chief Health Officer — kerryn.coleman@act.gov.au

National Health Secretariat

Schedule 2.2(a)(ii)

Federal Minister for Health Australian Government:
Hon. Mark Butler
Prof Paul Kelly, Chief Medical Officer

Victoria:
Hon Mary-Anne Thomas MP, Minister for Health
Prof Euan Wallace AM, Secretary, Department of Health and Human Services
Clare Looker, Chief Health Officer

New South Wales:
Hon Ryan Park MP, Minister for Health
Ms Susan Pearce, Secretary, NSW Ministry of Health
Dr Kerry Chant, Chief Health Officer

Queensland:
Hon Shannon Fentiman MP,
Minister for Health and Ambulance Services
Mr Michael Walsh, Director-General, Queensland Health
Dr John Gerrard, Chief Health Officer

South Australia:
Hon Chris Picton MP,
Minister for Health and Wellbeing
Dr Robyn Lawrence, Chief Executive, Department of Health and Wellbeing
Dr Nicola Spurrier, Chief Public Health Officer

Western Australia:
Hon Amber-Jade Sanderson MLA, Minister for Health
Dr Shirley Bowen, Director General, Department of Health
Dr Simon Towler, Chief Medical Officer

Tasmania: Hon Guy Barnett MP, Minister for Health
Mr Dale Webster, Acting Secretary, Department of Health & Human Services
Dr Mark Veitch, Director of Public Health

Northern Territory:
Hon Steven Edgington, Minister for Health
Dr Marco Briceno, Chief Executive Officer, Department of Health
Dr Christine Connors, Chief Health Officer

Dr Anne Tonkin AO, Chair, Medical Board of Australia

From: Docker, Jake
Sent: Thursday, 17 October 2024 12:37
To: ACT Health DLO
Subject: FW: FMM Decision - A1247, A1284, P1063 [SEC=OFFICIAL]

Importance: High

FYI

From: Davidson
Sent: Thursday, 17 October 2024 11:12 AM
To: Docker, Jake
Subject: FW: FMM Decision - A1247, A1284, P1063 [SEC=OFFICIAL]

Good Morning Jake,

One for your information.

Thanks,

Maxine Harris (She/Her)
Office Manager
Office of Emma Davidson|ACT Greens Member for Murrumbidgee
Minister for Community Services, Seniors and Veterans | Minister for Mental Health
Minister for Corrections and Justice Health | Minister for Population Health
GPO Box 1020, Canberra ACT 2601
02 6205 1941
Davidson@act.gov.au

From: FoodRegulationSecretariat <FoodRegulationSecretariat@health.gov.au>
Sent: Thursday, 17 October 2024 10:50 AM
Subject: FMM Decision - A1247, A1284, P1063 [SEC=OFFICIAL]

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Dear Food Ministers' Meeting (FMM) members
cc Food Regulation Standing Committee contacts

On 7 October 2024 the FMM agreed to **not seek a review** in relation to the following:

- A1247 - D-allulose as a novel food
- A1284 - Triacylglycerol lipase from GM *Trichoderma reesei* as a processing
- P1063 - Code Revision (2024) - Added Sugar(s) Claims

Yours sincerely

Schedule 2.2(a)(ii)

A/g Director – Food Regulation and Governance



Website: www.foodregulation.gov.au | Email: secretariat@foodregulation.gov.au
Phone: +61 2 6289 5128 | Postal Address: MDP 570, GPO Box 9848, Canberra ACT 2601

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Lewis Shannon

From: Ellis, Catherine on behalf of ACT Health DLO
Sent: Thursday, 17 October 2024 1:19 PM
To: Wiggins, Taylor
Cc: ACT Health DLO
Subject: RE: Query regarding Mental Health Foundation

Hi Taylor

The advice is still currently being prepared and finalised.

I have just sent a prompt to the team so we can get the factual information back to you ASAP.

Thanks
Cath

From: Wiggins, Taylor
Sent: Wednesday, 16 October 2024 4:33 PM
To: ACT Health DLO
Subject: RE: Query regarding Mental Health Foundation
Importance: High

Hi team,

Just seeking to understand if you've had an opportunity to consider this one?

Thank you

Taylor Wiggins (she/her) | Adviser
Office of Emma Davidson| ACT Greens Member for Murrumbidgee
Ph: 6205 1941 E: davidson@act.gov.au

From: Wiggins, Taylor
Sent: Tuesday, 8 October 2024 1:51 PM
To: ACT Health DLO <ACTHealthDLO@act.gov.au>
Subject: Query regarding Mental Health Foundation

Hello!

Noting caretaker conventions, would it be possible for ACTHD to provide us with some factual dot points on whether the Mental Health Foundation's funding has been changed / decreased by the ACT Government?

If you're unable to provide us with anything as it sits outside of conventions, please let us know.

Kind regards,

Taylor Wiggins (she/her) | Adviser
Office of Emma Davidson| ACT Greens Member for Murrumbidgee
Ph: 6205 1941 E: davidson@act.gov.au

From: STEPHEN-SMITH
Sent: Friday, 18 October 2024 09:24
To: ACT Health DLO
Cc: Smith, Kahlia
Subject: FW: Canberra Health Services FY24 IT Audit Management Reports
Attachments: Covering letter to Minister for Health.pdf; CHS24 - IT Applications_Audit Management Report.pdf

Importance: High

OFFICIAL: Sensitive

Hi Tara,

For appropriate action please.

Thank you,

Sally Cooke
Office Manager | Office of Rachel Stephen-Smith MLA
Minister for Health | Minister for Children, Youth and Family Services | Minister for Disability | Minister for Aboriginal and Torres Strait Islander Affairs
Member for Kurrajong
ACT Legislative Assembly, 196 London Circuit, Canberra ACT 2601 | P: (02) 6205 2661 | www.act.gov.au

From: Wong, Joe
Sent: Thursday, 17 October 2024 3:58 PM
To: STEPHEN-SMITH
Cc: Anjum, Rehan
Subject: Canberra Health Services FY24 IT Audit Management Reports

OFFICIAL: Sensitive

Dear Ms Stephen-Smith,

Please find attached our covering letter and the Audit Management Report relating to the review of controls over Digital Health Record System, Powerbilling & Revenue Collection System, CHRIS21 (NCH) and KRONOS (NCH) for the financial year ended 30 June 2024.

Yours sincerely,
Joe

Joe Wong, CA | Director | Financial Audit

Phone: (02) 6205 0688 | Email: joe.wong@act.gov.au
ACT Audit Office | Auditor-General an Officer of the ACT Legislative Assembly
Nara Centre, Level 4, 3 Constitution Avenue, Canberra | PO Box 158 Canberra ACT 2601 | www.audit.act.gov.au

I acknowledge the Ngunnawal people as traditional custodians of the ACT and recognise any other people or families with connection to the lands of the ACT and region. I acknowledge and respect their continuing culture and the contribution they make to the life of this city and this region.

My employer supports me working flexibly, so I may write to you outside of normal office hours. I don't expect you to read or respond outside of yours.



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ACT Audit Office

AUDITOR-GENERAL AN OFFICER OF THE ACT LEGISLATIVE ASSEMBLY

OFFICIAL: SENSITIVE

Ms Rachel Stephen-Smith MLA
Minister for Health
ACT Legislative Assembly

Stephen-Smith@act.gov.au

Dear Ms Stephen-Smith

CANBERRA HEALTH SERVICES – DHR, PBRC, CHRIS21 (NCH) AND KRONOS (NCH) AUDIT MANAGEMENT REPORT FOR THE YEAR ENDED 30 JUNE 2024

Attached is a copy of the Audit Management Report relating to controls over the Digital Health Record System (DHR), Powerbilling & Revenue Collection System (PBRC), CHRIS21 (NCH) and KRONOS (NCH) reviewed as part of the audit of the financial statements of Canberra Health Services for the year ended 30 June 2024.

Please contact Ms Rosa San Miguel (Audit Principal, Financial Audit) on 6207 0905 or myself on 6207 0830 if you wish to discuss this report.

Yours sincerely

Ajay Sharma PSM
Assistant Auditor-General, Financial Audit
17 October 2024

Level 4, Nara Centre, 3 Constitution Avenue, Canberra 2601 PO Box 158 Canberra ACT 2601
T 02 6207 0833 E actauditorgeneral@act.gov.au W www.audit.act.gov.au

ACT Audit Office

AUDITOR-GENERAL AN OFFICER OF THE ACT LEGISLATIVE ASSEMBLY

OFFICIAL: SENSITIVE

Mr Dave Peffer
Chief Executive Officer
Canberra Health Services

Dave.Peffer@act.gov.au

Dear Mr Peffer

CANBERRA HEALTH SERVICES
DHR, PBRC, CHRIS21 (NCH) AND KRONOS (NCH)
AUDIT MANAGEMENT REPORT FOR THE YEAR ENDED 30 JUNE 2024

1. Completion of the Review

The ACT Audit Office (Audit Office) has completed the review of controls over Digital Health Record System (DHR), Powerbilling & Revenue Collection System (PBRC), CHRIS21 (NCH) and KRONOS (NCH) as part of the audit of the financial statements of the Canberra Health Services for the year ended 30 June 2024.

DHR and PBRC are used across Canberra Health Services, whilst the versions of CHRIS21 and KRONOS used by North Canberra Hospital (NCH) are versions of the applications exclusively used by NCH following the acquisition of the former Calvary Public Hospital Bruce in July 2023.

Canberra Health Services relies on the controls implemented by the ACT Health Directorate's Digital Solutions Division for DHR and PBRC, as well as the internal controls implemented by ACT Government Digital, Data and Technology Solutions for CHRIS21 (NCH) and KRONOS (NCH), when using these applications to record transactions included in its financial statements. Therefore, whilst the recommendations in this report suggest actions for Canberra Health Services, the responsibility for addressing control weaknesses should be clearly defined and coordinated between Canberra Health Services, the ACT Health Directorate's Digital Solutions Division, and ACT Government Digital, Data and Technology Solutions.

These applications are as follows.

- DHR – used to record patients' interactions with ACT public health services; and to interface with other key systems such as PBRC.

- PBRC – used to process and record healthcare revenue, bill processing and collection.

- CHRIS21 (NCH) – human resource information management system used to process and record salary payments and leave entitlements of NCH staff.
- KRONOS (NCH) – used to record timesheet and leave data for NCH staff, including the transfer of time information to CHRIS21 (NCH) to support payroll processing.

2. Purpose and Scope of the Audit Management Report

The Audit Office is required by Australian Auditing Standards to communicate significant matters identified during an audit, including any deficiencies in internal controls, to those charged with the governance of Canberra Health Services.

Under the *Financial Management Act 1996*, the Chief Executive Officer is responsible under the Minister for Health and the Minister for Mental Health, for maintaining adequate internal controls, safeguarding Canberra Health Services' assets, compliance with applicable legislation and the proper reporting of the financial and operating results of Canberra Health Services. The Audit Office has therefore provided this Audit Management Report to you. A copy of this report has been provided to the Minister for Health and the Minister for Mental Health.

This report only raises matters that have come to the attention of the Audit Office during the review and should not be regarded as a comprehensive report of all matters that may exist.

3. Audit Findings

3.1 Classification of Audit Findings

Audit findings are classified as follows.

Category	Description
Reporting	• Matters that resulted in, or could result in, a modified auditor's report if not addressed. • Matters where reporting practices should be improved.
Governance	• Matters which pose an operational or financial risk. • Matters which have been previously reported to the management but have not been satisfactorily addressed.
Internal controls	• Key controls which are ineffective or non-existent. • Control weaknesses which are systemic or undermine the control environment.
Fraud	• Matters that resulted in, or could result in, theft or other fraudulent activities.

The Audit Office has included a suggested timeframe for resolving each finding.

3.2 Status of Audit Findings

The status of audit findings is summarised in the following table.

Application	Previously Reported	Resolved	Partially Resolved	New	Balance
DHR	1	-	1	3	4
PBRC	1	(1)	-	5	5
CHRIS21 (NCH)	-	-	-	4	4
KRONOS (NCH)	-	-	-	1	1
Total	**2**	**(1)**	**1**	**13**	**14**

3.3 Previously Reported Audit Findings

The status of the two previously reported audit findings is summarised in the following table.

2022-23 Audit Management Report Finding	Year first reported	2023-24 Status	2023-24 Audit Management Report Reference
Review of Audit Logs - DHR	2022-23	Partially Resolved	**Appendix B**
Review of Password Parameters - PBRC	2022-23	Resolved	Section 3.3.1

3.3.1 Review of Password Parameters - PBRC (Resolved)

In 2022-23 the Audit Office reported that parameters such as minimum length, re-use restrictions and complexity settings were not defined in PBRC's ICT Security Plan.

In 2023-24, Canberra Health Services resolved this weakness by updating PBRC's ICT Security Plan and enforcing system password settings that comply with the ACT Government Password Standard. This reduces the risk of unauthorised and possibly fraudulent access to the application.

3.4 New Audit Findings

Thirteen new audit findings were identified during the review of controls over DHR (3), PBRC (5), CHRIS21 (NCH) (4) and KRONOS (NCH) (1). Information on these audit findings is provided in **Appendix A**.

4. Management Comments

Management comments included in this report were coordinated by Mr David Morgan, Acting Deputy Chief Financial Officer.

5. Acknowledgement

The Audit Office would like to acknowledge the assistance and cooperation received from representatives of Canberra Health Services, ACT Health Directorate's Digital Solutions Division, and ACT Government Digital, Data and Technology Solutions during the review.

6. Contacts

Please contact Ms Rosa San Miguel (Audit Principal, Financial Audit) on 6207 0905 or myself on 6207 0830 if you wish to discuss this report.

Yours sincerely



Ajay Sharma PSM
Assistant Auditor-General, Financial Audit
17 October 2024

c.c. Mr Geoff Knuckey, Chair, Audit and Risk Management Committee
Mr Holger Kaufmann, Chief Information Officer, ACT Health Directorate
Ms Sandra Cook, Chair, Executive Branch Manager, Application Support, AHD
Mr Colin MacDonald, Executive Branch Manager, Technology Operations, AHD
Ms Natalie Watson, Executive Branch Manager, DDTS Major Programs, CMTEDD
Mr Luke Cartwright, Senior Director, Patient Administration Services Hub, AHD
Mr Bruce James, Senior Director, DDTS Major Programs, CMTEDD
Ms Florence Young, Acting Chief Financial Officer
Mr David Morgan, Acting Deputy Chief Financial Officer
Ms Mea Van Der Ploeg, Senior Director, Head of Internal Audit

Appendix A

New Audit Findings

Year Ended 30 June 2024

1. Security Documentation

Applicable to: DHR, PBRC, CHRIS21 (NCH) and KRONOS (NCH)

Audit finding category: Internal controls

Recommended implementation timeframe: Within six months

Observation

The ACT Government 'Cyber Security Policy' (January 2024), applicable to all ICT systems including those outsourced to IT service providers and vendors such as CHRIS21 (NCH), establishes the ACT Government framework for cyber security for official territory records, information, or data being processed or stored in electronic form.

A System Security Plan (SSP), part of the Cyber Security Policy, ensures consistent management of security risks and compliance with policies. It identifies security contexts, describes controls, assesses risk levels, and recommends treatment strategies. According to this policy, system owners are responsible for the development and maintenance of a Security Plan and performing risk treatments to secure their critical and sensitive business systems.

The Cyber Security Policy refers to the 'ACT Government Cyber Security Risk Management Standard' (April 2024) which states:

> The Security Plan is a tool developed by ACT Cyber Security Centre to assist directorates to manage security risk for ICT systems. It is a mandatory requirement of the ACT Government Cyber Security Policy for qualifying ICT system including cloud services and systems hosted by outsourced service providers.

Further, the 'ACT Government Cyber Security Risk Management Standard' states:

> The Chief Information Security Officer (CISO) reviews and endorses the security assessment. Endorsement of a security assessment demonstrates that it identifies all known security risks and recommends appropriate controls to bring risk to an acceptable level.
>
> The System Owner approves the security assessment after endorsement. Approval constitutes acceptance of residual risk levels and commitment to implement the documented security controls and advised risk treatments. The security assessment should be approved before Territory information is transferred to an ICT system or cloud service

The Audit Office identified that several security and process documents in relation to DHR, PBRC, CHRIS21 (NCH) and KRONOS (NCH) were not developed, appropriately approved, or properly maintained.

For example:

- DHR and PBRC System Security Plans (SSPs) remain in draft form following their reviews in October 2022 and November 2023, respectively. Further PBRC's SSP appears incomplete.

- SSP for CHRIS21 (NCH) does not outline the vendor's responsibilities regarding IT security and related processes, nor is there any guidance providing detailed information on these responsibilities.

- PBRC User Access Procedure (2021) and CHRIS21 New User Process (2022) lack evidence of approval, and no reviews have been scheduled to date. Further, neither outline procedures for terminating user access.

- User Access Procedures for KRONOS (NCH) do not exist.

Implication

Where system security documentation has not been developed, appropriately approved, or properly maintained, there is a higher risk that the policies and procedures may become ineffective, leading to resources being deployed on less effective or outdated cyber security measures.

Further, the absence of current guidance outlining the responsibilities of CHRIS21 (NCH)'s vendor regarding IT security may compromise the application's availability when security vulnerabilities or system performance issues arise.

Recommendations

Canberra Health Services should:

(i) ensure that security and process documentation in relation to DHR and PBRC is updated and properly evidenced as 'approved' and regularly reviewed to reflect accurate information regarding the system and control environment; and updated in a timely manner;

(ii) incorporate into the relevant security documentation a clear outline of vendor's responsibilities concerning IT security and related processes for CHRIS21 (NCH);

(iii) ensure access procedures for PBRC and CHRIS21 (NCH) outline the process for termination of user access; and

(iv) develop User Access Procedures for KRONOS (NCH).

Management comments

DHR: Agreed. The DHR security plan has been regularly reviewed and is next scheduled for review in October 2025. It will be formally approved and documented.

PBRC: Agreed. All PBRC Systems documentation will be developed, reviewed and updated to include review dates. Jira tasks have been created to ensure regular reviews are completed.

CHRIS21 (NCH): Agreed. The System Security Plan (SSP) will be appended to clearly state the vendor's responsibilities concerning IT security and related processes. Further changes to the SSP will be recorded that outline the User Access Management process following the onboarding and offboarding of staff. Any changes to the SSP will be approved by the appropriate CHS/NCH delegate.

KRONOS (NCH): Agreed. The SSP will be appended to clearly state how User Access Procedures are managed within the application. Any changes to the SSP will be approved by the appropriate CHS/NCH delegate.

Action officer:

DHR: Ms Sandra Cook, Executive Branch Manager, Application Support

PBRC: Ms Catherine Swift, Director, Billing, Patient and Administration Support Hub

CHRIS21 (NCH) and KRONOS (NCH): Mr Bruce James, Senior Director HR Systems

Due date:

DHR and PBRC: 30 April 2025

CHRIS21 (NCH) and KRONOS (NCH): 31 March 2025

2. User Access Granting, Maintenance and Termination

Applicable to: DHR and PBRC

Audit finding category: Internal controls

Recommended implementation timeframe: Within six months

Observation

User access management controls are implemented to prevent unauthorised access to applications and systems and commonly support the granting, maintenance and termination of user access. User access management is generally owned and operated by a specific team and often involves system administrators.

Given their critical importance, user access management controls should be documented, describing the processes for granting, maintaining, and terminating user access for each specific application. The Patient Administration Services Hub within the ACT Health Directorate provides IT support for both DHR and PBRC.

As part of the review of controls over PBRC and DHR, the Audit Office conducted user access testing to assess whether the granting and termination of access for PBRC and DHR was in accordance with the respective System Security Plan (SSP) requirements and relevant User Access procedures.

The Audit Office identified the following control weaknesses:

- DHR Business System team does not perform regular reviews of DHR user access to ensure it remains appropriate, although this risk is partially mitigated by a system-enforced control that locks a user's account after 90 days of inactivity.

- Despite being identified for removal during the PBRC Business System team's quarterly reviews, users continued to have access for over 90 days beyond the designated removal date.

Implication

Without regular reviews of user access by the DHR Business System team and the timely removal of users identified during the PBRC Business System team's quarterly reviews, there is an increased risk of security vulnerabilities, which may result in unauthorised access to applications and data.

Recommendations

Canberra Health Services should implement processes for PBRC and DHR to ensure that regular reviews of user access are conducted, and that users identified for termination are promptly and appropriately removed.

Management comments

DHR: Partially Agreed. Since DHR access is linked to the whole-of-government identity and access management system via Lightweight Directory Access Protocol (LDAP), a DHR user who loses network access after employment termination will automatically lose DHR access. For temporary employees with end-dated access, network and DHR access is terminated automatically at their contract end date, but this might be delayed for permanent employees with open-ended network access.

The DHR Security and Provider Administration team will investigate options to terminate DHR access as soon as possible after employment termination date.

PBRC: Partially Agreed. PBRC Access Standard Operating Procedure will be written (with review dates etc.) and referenced in the Security Plan. This will be maintained outside of the Security Plan to enable independent updating.

Action officer:

DHR: Mr Luke Cartwright, Senior Director, Patient and Administration Support Hub

PBRC: Ms Catherine Swift, Director, Billing, Patient and Administration Support Hub

Due date:

DHR and PBRC: 30 April 2025

3. Change Management

Applicable to: CHRIS21 (NCH) and DHR

Audit finding category: Internal controls

Recommended implementation timeframe: Within six months

Observation

An ICT change is any modification to applications or systems, which generally involves updating code or installing software.

The ACT Government 'ICT Change and Release Management Policy' (April 2024), the authoritative policy on the management of ICT changes states that:

> All Digital, Data and Technology Solutions (DDTS) staff, directorate staff and external vendors involved in changing any Configuration Item (CI) that supports ACT Government business applications, are required to follow the Change and Release Management process when introducing changes to the ACT Government ICT environment.

The Audit Office identified the following control weaknesses:

- The ICT Change and Release Management Policy requires the vendor to notify the ACT Government of any changes that could affect other systems. However, there is no specific ICT change management framework for CHRIS21 (NCH) that clearly defines the system change approval process. Currently, this process is managed by the vendor through their ticketing system, as CHRIS21 (NCH) is fully hosted within the vendor's IT infrastructure. This control weakness raises concerns about the vendor's compliance with the ACT Government's ICT Change and Release Management Policy.

- A sample of CHRIS21 (NCH) change requests showed no evidence of assessment, testing, or approval before being implemented into the operating environment. As a result, the Audit Office could not verify whether the changes were properly tested in a test environment or if segregation of duties was enforced when requesting and approving the change. Segregating the roles of change requesters and approvers, ensuring they are not the same individuals, is required.

- DHR's System Security Plans (SSP) states that:

  > …to comply with the ICT Change Management process, the Business System manager must comply with the ICT Change Management Policy and Change Management Process.

  This reference appears outdated and does not align with the current DHR Change Approval Process document.

Implication

The lack of clearly defined change management processes increases the risk of applications not operating as intended because erroneous or fraudulent changes have been made to them. This may occur, for example, where the impact of the change on other processes, changes and controls implemented in the system or application or broader information technology environment has not been identified and addressed.

Recommendations

Canberra Health Services should ensure that:

(i) change management documentation for CHRIS21 (NCH) is finalised, approved and includes a review schedule that is adhered to;

(ii) changes to CHRIS21 (NCH) are appropriately managed and approved in accordance with ACT Government 'ICT Change and Release Management Policy'; and

(iii) DHR SSP is updated to include updated references to relevant DHR Change Approval Process documentation.

Management comments

CHRIS21 (NCH):

Recommendation (i), Agreed. Change Management Documentation will be finalised and approved by the appropriate CHS/NHS delegate. This will include an annual review of the documentation to accommodate refinement and changes where applicable.

Recommendation (ii), Agreed. Once recommendation (i) is finalised, the Change Management Documentation will be aligned to the ACT Government ICT Change and Management Policy to clearly state the process for all system changes and software releases.

DHR: Recommendation (iii), Agreed. The current SSP will be updated with the required approval changes.

Action officer:

CHRIS21 (NCH): Mr Bruce James, Senior Director HR Systems.

DHR: Ms Sandra Cook, Executive Branch Manager, Application Support

Due date:

CHRIS21 (NCH) and DHR: 30 April 2025

4. Segregation of Duties

Applicable to: PBRC

Audit finding category: Internal controls

Recommended implementation timeframe: Within six months

Observation

Segregation of incompatible duties among users is a key preventative control to mitigate the risks of unauthorised and potentially fraudulent activities in computer information systems. For example, duties assigned to users should be appropriately segregated so a single user cannot initiate and complete a transaction.

The Audit Office identified that no Segregation of Duties policy exists that defines incompatible access role assignments within PBRC. Further, eight users have multiple accounts related to receivables processing, which could potentially bypass system-enforced approval controls

This is exacerbated by the fact that there is no formal review of key transaction logs, as noted in the audit finding 'Monitoring of Privileged User Audit Logs'.

Implication

Where segregation of duties is not defined or enforced, there is a higher risk that erroneous or fraudulent transactions conducted by a single user account may go undetected and unaddressed.

Recommendations

Canberra Health Services should:

(i) ensure that all users have only one user access account within PBRC; and

(ii) implement system-based preventative controls over high-risk segregation of duties functions, following the completion of a risk assessment.

Management comments

PBRC: Agreed. PBRC will be upgraded to better manage and control segregation of duties. Due to system limitations, PBRC does not currently enable a technological solution to address this recommendation until new version update, scheduled 30 March 2025.

Action officer: Ms Cathrine Swift, Director, Billing, Patient and Administration Support Hub

Due date: 30 April 2025

5. Business Continuity and Disaster Recovery

Applicable to: PBRC and CHRIS21 (NCH)

Audit finding category: Governance

Recommended implementation timeframe: Within six months

Observation

A Business Continuity Plan (BCP) helps ensure an organisation's operations continue in the event of an unexpected incident or disaster that adversely affects critical systems, including the ability to use software or hardware and process data.

An ICT Disaster Recovery Plan (DRP) focuses on information technology and technology systems supporting critical business functions and contains procedures developed to restore critical systems with minimal (or no) loss of data or functionality.

Testing the backup and recovery of data and systems is an essential process to ensure the availability of data and systems as a result of a continuity event or disaster. Further, better practice standards such as ISO/IEC 27031:2011 [1] and ISO 22301:2019 [2] require testing of business continuity and disaster recovery arrangements to occur at least annually.

The Audit Office identified the following control weaknesses:

- The effectiveness of PBRC's BCP has not been tested since September 2022. Further, there is a DRP for PBRC in place, however it is not clear when this document was last reviewed.

- The effectiveness of CHRIS21 (NCH)'s BCP and DRP has not been tested in accordance with the testing requirements under these documents.

Implication

Where business continuity and disaster recovery plans have not been appropriately maintained or tested, there is a higher risk that Canberra Health Services will not be able to resume operations, without the loss of information, in a timely manner in the event of major disruption or disaster.

[1] ISO/IEC 27031:2011 Information technology - Guidelines for information and communication technology readiness for business continuity

[2] ISO 22301:2019 Security and resilience - Business continuity management systems

Recommendations

Canberra Health Services should:

(i) ensure PBRC's DRP is properly evidenced as approved;

(ii) schedule and test the BCP and DRP for PBRC and CHRIS21 (NCH); and

(iii) make any necessary updates to the relevant BCPs and DRPs based on the testing results should any deficiencies be identified.

Management comments

PBRC: Agreed. DRP and BCP will be reviewed and formally approved with review dates. A testing schedule will be included in the BCP document.

CHRIS21 (NCH): Agreed. As CHRIS21 is vendor hosted, CHS/NCH will consult with the vendor to develop an annual schedule for the undertaking of BCP and DRP testing. Results will be reviewed and saved for guidance and to ensure compliance with ISO standards.

Action officer:

PBRC: Ms Cathrine Swift, Director, Billing, Patient and Administration Support Hub

CHRIS21 (NCH): Mr Bruce James, Senior Director HR Systems

Due date:

PBRC and CHRIS21 (NCH): 30 April 2025

6. Monitoring of Privileged User Audit Logs

Applicable to: PBRC and CHRIS21 (NCH)

Audit finding category: Internal controls

Recommended implementation timeframe: Within six months

Observation

The ACT Government's 'Cyber Security Policy' (January 2024) refers to the 'Monitoring and Logging Standard' (May 2024) which defines expectations for system logging such as the ability to be able to track key actions such as the access, creation and deletion of data at the system and individual record levels, including the logging and monitoring of privileged user activity. It also states that:

> Monitoring is necessary to ensure that users are only performing activities that they have been explicitly authorised to undertake. Monitoring includes active, ongoing surveillance and monitoring of audit logs for specified events.
>
> The level of monitoring required for individual facilities will be determined by a risk assessment and documented in the System Security Plan. The results of monitoring should be reviewed regularly by a business system security administrator. The frequency of the review will be indicated by the risk assessment and documented in the System Security Plan.

The Audit Office identified the following control weaknesses:

- Although PBRC audit logs are reviewed on an 'as needed' basis, there is no formal logging strategy informed by a risk assessment, as required by the ACT Government's 'Monitoring and Logging Standard'. Further, the outcomes of these reviews are not documented.
- There is no logging strategy for CHRIS21 (NCH) informed by a risk assessment, as required by the ACT Government's 'Monitoring and Logging Standard,' and no monitoring of privileged user access and activities in CHRIS21 (NCH).

Implication

There is a higher risk of undetected erroneous and fraudulent changes to PBRC and CHRIS21 (NCH), and their data not being detected and promptly addressed, when regular monitoring and review of user activity, including vendor activity, do not follow and approved logging strategy.

Recommendations

Canberra Health Services should:

(i) implement an event logging strategy for PBRC and CHRIS21 (NCH), respectively, based on a risk assessment, and formalise the responsibilities for monitoring audit logs of activities performed by privileged users, including vendor activity; and

(ii) ensure that the review of audit logs is performed periodically by an independent officer, documented, and reported to appropriately authorised individuals responsible for PBRC and CHRIS21 (NCH) and their data, respectively.

Management comments

PBRC: Agreed. PBRC logging strategy will be documented, including the review process and escalation steps for inappropriate access.

CHRIS21 (NCH): Agreed. As a vendor hosted business application, the process for monitoring the actions of privileged users cannot replicate that used for the CHRIS21 system managed by Shared Services. CHS/NCH will work with the vendor to achieve an appropriate monitoring solution of privileged user accounts.

Action officer:

PBRC: Ms Cathrine Swift, Director, Billing, Patient and Administration Support Hub

CHRIS21 (NCH): Mr Bruce James, Senior Director HR Systems

Due date:

PBRC and CHRIS21 (NCH): 30 April 2025

OFFICIAL: SENSITIVE

Appendix B

Previously Reported Audit Finding

Year Ended 30 June 2024

1. Review of Audit Logs

Applicable to: DHR

Audit finding category: Internal controls

Recommended implementation timeframe: Within twelve months

First reported: 2022-23

2023-24 Status update: Partially Resolved

Observation

The ACT Government's 'Cyber Security Policy' (January 2024) refers to the 'Monitoring and Logging Standard' (May 2024) which requires audit logs that record exceptions and other security-relevant events be produced and kept for an agreed period to assist in future investigations and access control monitoring. This Standard also states that audit log monitoring is necessary to ensure that users are only performing activities that have been explicitly authorised.

The Audit Office first reported in 2022-23, that Canberra Health Services did not have a documented logging strategy for DHR to formalise responsibilities for monitoring audit logs over activities performed by privileged users.

Whilst this weakness continues to exist in 2023-24, the Audit Office notes that some improvements have been made. Canberra Health Services implemented controls that actively monitor privileged user assignments for the DHR. This includes weekly audits of privileged users undertaken by the Security & Provider Administration (SPA) team.

Implication

There is an increased risk that erroneous or fraudulent changes made by privileged users to DHR and its data will not be promptly detected and addressed.

Recommendations

Canberra Health Services should:

(i) document a logging strategy for DHR and formalise responsibilities for monitoring audit logs of activities performed by privileged users; and

(ii) formally report audit logging outcomes to appropriately authorised individuals with responsibility over the DHR and its data.

Management comments

Agreed. There is a privileged user auditing policy that has been operationalised via two reports (privileged user audit report and Chronicles items auditing report). These reports are automatically exported and delivered into a dedicated securitised folder on Kiteworks network every week. DHR Security team reviews the reports and follows up on suspicious cases involving 'administrator level' users.

The auditing policy will be updated to formalise responsibilities for monitoring audit logs, including activity and reporting audit outcomes, including identifying the appropriate reporting line.

Action officer: Mr Luke Cartwright, Senior Director, Patient and Administration Support Hub

Due date: 31 October 2025

From: Gower, Tara on behalf of ACT Health DLO
Sent: Friday, 18 October 2024 11:34 AM
To: Wiggins, Taylor
Subject: RE: Query regarding Mental Health Foundation

Hi Taylor

Apologies for the delay.

Please see ACTHD response below.

SFA 2020.13985.004	Funding GST exclusive	GST	Funding GST inclusive
Mental Health Discharge Accommodation Program – Core Agreement	$1,000,000.00	$100,000.00	$1,100,000.00*
Mental Health Discharge Accommodation Program – Letter of Variation July 2022	$300,000.00	$30,000.00	$330,000.00*
Mental Health Discharge Accommodation Program – Letter of Variation August 2023	$300,000.00	$30,000.00	$330,000.00*
Mental Health Discharge Accommodation Program – 1 September 2023 to 30 September 2024	$684,125.00	$68,412.50	$752,537.50
Total of original SFA	**$2,284,125.00**	**$228,412.50**	**$2,512,537.50**
DoG 20240.025.041	**Funding GST exclusive**	**GST**	**Funding GST Inclusive**
1 October 2024 to 30 June 2025	$278,000	$27,800	$305,800
1 July 2025 to 31 December 2025	$200,000	$20,000	$220,000
Total of DoG	**$478,000**	**$47,800**	**$525,800**
Total funding for MHF over agreements	**$2,762,125.00**	**$276,212.50**	**$3,038,337.50**

- In terms of the latest funding, that has been provided to Discharge Accommodation Program (DAP) through a Deed of Grant. The funding for the Deed of Grant was provided through the Budget item "Better care for our community – Housing for Vulnerable People", available here: https://www.treasury.act.gov.au/__data/assets/pdf_file/0019/2513521/2024-25-Budget-Outlook.pdf.
- Specifically, this Budget item provided $478,000 over 2024-25 and 2025-26 financial years to support the transition out of the current DAP to the new contemporary, evidence-based Housing Assistance Support Initiative (HASI) model.
- ACT Health negotiated a new Deed of Grant with Mental Health Foundation to support the transition out of the DAP program and in alignment with the Budget item of $478,000. This Deed of Grant provided funding over 18 months as follows: $278,000 for the period of 1 October 2024 to 30 June 2025, and $200,000 for the period 1 July 2025 to 31 December 2025, which aligns with the Commissioning of other NGO services.
- The funding for the DAP program has decreased in line with the above budget item.

Thank you

Tara

Tara Gower | Directorate Liaison Officer | ACT Health Directorate
Mob: Schedule 2.2(a)(ii) Email: ACTHealthDLO@act.gov.au
Office of Rachel Stephen-Smith | Minister for Health
Office of Emma Davidson | Minister for Mental Health
Level 2, Legislative Assembly Building, Civic Square



From: Wiggins, Taylor
Sent: Tuesday, 8 October 2024 1:51 PM
To: ACT Health DLO
Subject: Query regarding Mental Health Foundation
Importance: High

Hello!

Noting caretaker conventions, would it be possible for ACTHD to provide us with some factual dot points on whether the Mental Health Foundation's funding has been changed / decreased by the ACT Government?

If you're unable to provide us with anything as it sits outside of conventions, please let us know.

Kind regards,

Taylor Wiggins (she/her) | Adviser
Office of Emma Davidson| ACT Greens Member for Murrumbidgee
Ph: 6205 1941 E: davidson@act.gov.au

From: STEPHEN-SMITH
Sent: Monday, 21 October 2024 09:50
To: ACT Health DLO
Cc: Bransgrove, Meagen
Subject: FW: Ahpra: ACT MBA recommendations for appointment (2024 R4) - Email 2 of 2
Attachments: 2024-10 ACT Letter to Minister recruitment campaign 2025 Round 3.pdf; Attachments.zip

Importance: High

For appropriate action.

Ben

From: Tracey Chick
Sent: Friday, 18 October 2024 4:11 PM
To: Statutory Appointments ; STEPHEN-SMITH
Cc: Osman, Nadia ; Krister Partel ; AHM-ACT
Subject: Ahpra: ACT MBA recommendations for appointment (2024 R4) - Email 2 of 2

Caution: This email originated from outside of the ACT Government. Do not click links or open attachments unless you recognise the sender and know the content is safe.

Dear Minister

Please find attached documentation outlining the Australian Capital Territory Board of the Medical Board of Australia member vacancies arising in 2025 and the strategy to fill the vacancies.

Should you have any questions, please contact Krister Partel, Territory Manager, ACT on 02 6195 2623 and Schedule 2.2(a)(ii)

Kind regards
Tracey Chick

Tracey Chick
Senior Adviser, Statutory Appointments
Government Relations
Phone | (03) 8708 9184
Email Schedule 2.2(a)(ii)
Web | www.ahpra.gov.au

Australian Health Practitioner Regulation Agency
G.P.O. Box 9958 | Melbourne VIC 3001 | www.ahpra.gov.au

Ahpra acknowledges the Traditional Owners of Country throughout Australia and the continuing connection to lands, waters and communities. We pay our respect to Aboriginal and Torres Strait Islander cultures and Elders past and present.



18 October 2024

Hon. Rachel Stephen-Smith MLA
Minister for Health
GPO Box 1020
CANBERRA ACT 2601

Via email: stephen-smith@act.gov.au

Dear Minister

Vacancies on the Australian Capital Territory Board of the Medical Board of Australia (ACT MBA)

I write in relation to the proposed recruitment arrangements to fill the following vacancies on the ACT MBA arising in 2025:

- two practitioner members and one community member (including Chair) of the ACT MBA.

Members' terms expire on 13 October 2025. The vacancies above include the recent resignation of practitioner member Dr Jason Yosar, who is no longer sitting on the Board.

The position of Chair, currently held by community member Ms Gulnara Abbasova is also included in the upcoming round and it is proposed that the whole Board is invited to express interest in the position of Chair (as opposed to only practitioner members, which is customary). As the Board has recently experienced some turnover of members, it would be beneficial if the incumbent Ms Abbasova had the opportunity to reapply for the position.

A table of the current composition of the ACT MBA with the identified vacancies is Attachment 1.

Recruitment process

The Health Practitioner Regulation National Law, as in force in each state and territory (the National Law) provides that the Australian Health Practitioner Regulation Agency (Ahpra) may assist the responsible Minister in the process of appointing members of a state or territory board including the advertising of vacancies.

In line with the guidelines (Attachment 2), Ahpra's approach to the recruitment process to fill the vacancies is as follows:

1. On 11 January 2025, advertisements will be placed in major metropolitan newspapers, online search engines, on Ahpra's and the MBA's websites; on LinkedIn, Facebook, Twitter and the *Koori Mail*, *The Australian* and the National Indigenous Times. The positions will also be mentioned in the MBA's newsletter. Ahpra will call for expressions of interest to current members.
2. Ahpra will facilitate selection processes whereby candidates are assessed against agreed selection criteria by selection advisory panels (SAP).
3. The SAPs will shortlist and interview applicants (most likely during the period 10 March to 23 May 2025.)
4. Ahpra will conduct probity checks on shortlisted candidates.
5. At the conclusion of the SAP's selection processes, recommendation reports outlining the recommended and suitable candidates will be provided by 18 July 2025 with appointments commencing in October 2025

A timeline of the recruitment process is Attachment 3.

Extension of board member terms

The date to appoint board members may bypass the expiry date in unexpected instances. Ahpra seeks your approval in writing to extend all board members whose terms expire in 2025 for six months beyond their expiry date or until appointments are made, whichever is sooner.

Composition of the Board

The size and composition of the ACT MBA is nine members, five of whom are practitioners and four of whom are community members.

To enable the recruitment to progress, your assistance would be appreciated in the:

1. acknowledgement of the recruitment process
2. approval of Ahpra inviting both practitioner and community members of the Board to express interest in the position of Chair.
3. approval of the extension of all members whose terms expire in 2025 for six months beyond their expiry date or until appointments have been made
4. nomination of departmental or a ministerial staff member to participate in the selection advisory panel for these vacancies.

SAP nominations

Ahpra is working to ensure that the recruitment process occurs in a timely fashion to ensure the continuity of the Boards and certainty for its members. To assist, we request that your nominees be available during the following periods to participate in the SAPs. This will help us to plan processes and reduce the likelihood of late submission of reports.

Campaign stage	**Preparation**	**Shortlisting**	**Interviews**	**Reporting finalisation**
Period in which nominees are requested to be available	10 March to 4 April 2025		28 April to 23 May 2025	18 July 2025
What is required of the nominees	Participate in a briefing on the recruitment process	Review applications and then participate in a meeting to shortlist candidates	Participate in interviews of shortlisted candidates	Review and finalise recommendation report
The expected time commitment	Approximately one hour.	Dependent on number of applications but a typical process will require approximately eight hours	Dependent on number of applications but a typical process will require approximately eight hours	Approximately three hours.

As per standard process, all SAPs comprise a nominee of the National Board, a senior Ahpra representative and the nominated departmental or ministerial staff member.

I am available to provide further information to you if required and can be reached by phone on 02 6195 2623 or via email at Schedule 2.2(a)(ii)

Thank you for your consideration of this matter and I look forward to a response at your earliest convenience.

Yours sincerely

Schedule 2.2(a)(ii)

Krister Partel
Territory Manager, Australian Capital Territory
Australian Health Practitioner Regulation Agency

Encl.:

1. Current composition with identified vacancies to the Board
2. Guidelines for recruitment, appointment and separation of members to National Boards and State and Territory Boards of National Boards
3. Timeline of the recruitment campaign

Australian Capital Territory Board of the Medical Board of Australia board composition
Nine members 5 x Health Practitioners (HP) and 4 x Community Members (CM)) – 2025 Vacancies (Round 3): 2 HP and 1 CM (incl Chair)

Title	First Name	Last Name	Gender	CM/ HP	Specialty /Qualifications/ Skills	Commencement Date	Completion Date	No of Terms
1 vacant practitioner member and 1 vacant community member position under consideration by the Minister								
1 vacant practitioner member position (resignation)								
Ms	Gulnara	Abbasova	Female	CM – Chair	Public policy and strategy, governance, community services	01-06-2024	13-Oct-2025	Chair – 1 CM – 2 terms
Dr	Ramila	Varendran	Female	HP	Physician	14-Oct-2022	13-Oct-2025	1
Ms	Catherine (Kate)	Gauthier	Female	CM	Masters of International Social Development	01-06-2024	31-05-2027	4
Mr	Aasish	Ponna	Male	CM	Solicitor	01-06-2024	31-05-2027	2
Dr	Stephen	Moulding	Male	HP	General Practitioner	01-04-2024	31-03-2027	1
Dr	Morgan	Sheridan	Male	HP	General Practitioner	01-04-2024	31-03-2027	1

Shaded area indicates vacancies which will be managed in the 2025 Round 3 campaign.

Guidelines for the recruitment, appointment and separation of members to National Boards and State and Territory boards of National Boards

August 2022

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1. Introduction

These Guidelines have been developed by the Australian Health Practitioner Regulation Agency (Ahpra) in accordance with the *Health Practitioner Regulation National Law Act* (National Law) as in force in each state and territory, to set out the procedure for supporting:

a) the Ministerial Council recruitment and appointment of members to National Boards
b) Ministerial recruitment and appointments for State, Territory and Regional Boards, and
c) the separation of members from National, State, Territory and Regional Boards.

The Guidelines outline the best practice principles and procedures for the recruitment and appointment of board members and are intended to provide a degree of national consistency, while allowing for some individual variation by each National Board and jurisdiction.

The Guidelines apply to all new appointments and reappointments.

2. The National Law

2.1 Ministerial responsibility for appointments

Members of National Boards are appointed by the Ministerial Council and members of State and Territory Boards of a National Board are appointed by the responsible Minister in the jurisdiction of the State, or Territory Board.

For National Board appointments, Ahpra's role is to assist the Ministerial Council in the process of appointing members, including in the advertising of vacancies (see section 5, Schedule 4 of the National Law). The relevant sections of the National Law are also included in **Attachment A** to these guidelines.

2.2 National Board members

The National Law provides for the appointment and reappointment of National Board members by the Ministerial Council. There is also power for the Ministerial Council to appoint acting board members.

2.3 Size and composition of the National Boards

On 31 August 2009, the Ministerial Council announced the appointment of the inaugural members of the ten National Boards that were joining the national scheme on 1 July 2010. The members were appointed for three years from 10 August 2009.

Currently, the Ministerial Council has appointed members to the following size and composition (for health practitioner members (HP) and community members (CM)) for each of the 15 National Boards:

- Aboriginal and Torres Strait Islander Health Practice Board of Australia - 9 members (6 HP; 3 CM)
- Chinese Medicine Board of Australia – 9 members (6 HP; 3 CM)
- Chiropractic Board of Australia - 9 members (6 HP; 3 CM)
- Dental Board of Australia - 12 members (8 HP; 4 CM)
- Medical Board of Australia - 12 members (8 HP; 4 CM)
- Medical Radiation Practice Board of Australia - 12 members (8 HP; 4 CM)
- Nursing and Midwifery Board of Australia - 12 members (8 HP; 4 CM)
- Occupational Therapy Board of Australia - 9 members (6 HP; 3 CM)
- Optometry Board of Australia – 9 members (6 HP; 3 CM)
- Osteopathy Board of Australia - 9 members (6 HP; 3 CM)
- Paramedicine Board of Australia - 9 members (6 HP; 3 CM)

- Pharmacy Board of Australia - 12 members (8 HP; 4 CM)
- Physiotherapy Board of Australia - 12 members (8 HP; 4 CM)
- Podiatry Board of Australia - Nine members (6 HP; 3 CM), and
- Psychology Board of Australia - 12 members (8 HP; 4 CM).

2.4 State and Territory Boards

The National Law provides for National Boards to establish State and Territory Boards. Some National Boards have decided to establish State or Territory Boards in each jurisdiction and others do not have State or Territory Boards.

A summary of National Boards who have appointed State and Territory Boards are below:

	State / Territory Boards							
Board	ACT	NT	NSW	QLD	SA	TAS	VIC	WA
Medical	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Nursing and Midwifery	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

Members of a State or Territory Board are appointed by the responsible Minister for the participating jurisdiction.

3. Vacancy in office of a board member

3.1 National Board vacancies

The National Law provides that the office of a National Board member becomes vacant in the following circumstances:

- a member completes a term of office (Note: for a period of up to six months after the board member's term expires, the board member may continue in the office during that vacancy until the date on which the vacancy is filled)
- resignation of the board member
  - the board member may elect to resign from the position prior to the expiry of the period of appointment. The board member resigns by instrument in writing addressed to the Chairperson of the Ministerial Council.
- the board member is absent, without leave first being granted by the Chairperson of the Board, from three or more consecutive meetings of the relevant board of which reasonable notice has been given to the member personally or by post
- the board member dies
- the Chairperson of the Ministerial Council or responsible Minister removes the board member from the position.
  - the Chairperson of the Ministerial Council may remove a board member from office if:
    - the board member has been found guilty of an offence (whether in a participating jurisdiction or elsewhere) that, in the opinion of the Ministerial Council or responsible Minister, renders the board member unfit to continue to hold the office
    - the board member ceases to be a registered health practitioner as a result of their misconduct, impairment or incompetence, or

- the board member ceases to be eligible for appointment to the office that they hold on the board, or
- the board member becomes bankrupt, applies to take the benefit of any law for the relief of bankrupt or insolvent debtors, compounds with his or her creditors or makes an assignment of their remuneration for their benefit, or
- the National Board recommends the removal of the board member, on the basis that the board member has engaged in misconduct or has failed or is unable to properly exercise their functions as a board member.

3.2 State and Territory Board vacancies

The office of a member of a State or Territory Board becomes vacant in the following circumstances:

- the period of appointment expires
- resignation of the board member prior to the expiry of the period of appointment, or
- the board member dies.

The National Law does not prescribe arrangements for terminating the appointment of a member of a State or Territory Board.

It is therefore important that the letter of appointment contains reference to the term of each appointment and appropriate termination arrangements.

3.3 Board member resignation

National Board members who choose to resign are to tender their resignation to the Chair of the Ministerial Council while State or Territory Board members are to provide their resignation to the respective jurisdictional Minister. Resigning Board members are also encouraged to notify the respective National Board Chair and if applicable, the Chair of the State or Territory Board and Ahpra personnel to assist with timely communication and appropriate cessation activities to be commenced.

The following table provides a summary:

Member resigning	Written resignation to	Advice to
National Board member	Hon Yvette D'Ath MP Ministers' Meeting (HMM)	• National Board Chair • Executive Officer • Director, National Board Services
State or Territory Board member	Minister of the relevant jurisdiction	• National Board Chair • State / Territory Board Chair • Executive Officer • State/Territory Manager

4. Timelines for the appointment process

4.1 Recommended timeframe

Upcoming vacancies should be identified well in advance and most selection or reappointment processes will commence at least six months before the anticipated date of appointment.

4.2 Considerations that impact on timelines

As National Board appointments are made by the Ministerial Council, sufficient time must be allocated to

navigate the approval process through the Health Chief Executives Forum (HCEF). The timing of elections can have a significant impact on proposed timeframes for decisions to be made.

State and Territory Ministers have busy and often unpredictable schedules. Elections also have an added impact on timelines. As a result, the proposed timeline for all recruitment action will provide for liaison with state and territory agencies and ministerial offices.

5. Consultation with Ministerial Council or responsible Minister

The Ministerial Council (via a briefing paper) or relevant Minister (via Ministerial staff) should be advised on an upcoming vacancy for a board member and the proposed process for filling that vacancy, including advertising and other processes to canvas nominations or expressions of interest that are consistent with these Guidelines.

5.1 Determining the recruitment process to be used

In general, the process is:

National Board	**State or Territory Board**
Following consultation with National Boards, Ahpra to advise the Ministerial Council of vacancies and proposed advertising and recruitment.	Following consultation with the National Board and State or Territory Board, Ahpra to advise the relevant State or Territory Ministers of vacancies and the proposed advertising and recruitment process.
Receive advice from HMM on how to proceed	Receive advice from Minister(s) or representative(s) on how to proceed
Advertise using HMM logo	Advertise using Ahpra logo
Establish Selection Advisory Panels	
Ahpra to receive nominations and expressions of interest	
Selection Advisory Panels will determine and execute the appropriate short listing process and formulate recommendations for consideration by the HMM	Selection Advisory Panels will determine and execute the appropriate short listing process and formulate recommendations for consideration by the Ministers
Referee reports and probity checks to be completed	
Appointment letters issued	
All applicants advised of the decision of the Ministerial Council	All applicants advised of the decision of the Minister

The composition of the panel is to be decided as part of the recruitment process. The proposed panel and selection process are to be agreed by the Ministerial Council / individual Minister for their delegates.

The composition of the panel is outlined in Section 10 - Selection Process.

Depending on the requirements in each jurisdiction, it may be possible to streamline the process by conducting two appointment ‘rounds’ per year. For example, anticipated vacancies that fall mid-year could be advertised in February; while anticipated vacancies falling around the end of the year could be advertised in June.

6. Board member requirements

6.1 Board Member Skills. Experience and Attributes

The National Law provides that when deciding whether to appoint a person as a member of a National Board or a State or Territory Board, the Ministerial Council or the responsible Minister is to have regard to 'the skills and experience of the person that are relevant to the Board's functions'.

The board member attributes in **Attachment B** articulates the requirements of National Board member and is used to inform selection criteria and performance appraisal.

6.2 National Board Succession Planning Principles

Whether establishing a new National Board or filling a vacancy on an established board, a number of factors need to be considered before starting the recruitment process, including the succession and sustainability of the National Board.

The National Board Succession Planning Principles are:

- **Principle 1:** The standard length of term for national board members appointed by the Ministerial Council will be three years.
- **Principle 2:** The frequency of new board member appointments will be every three years.
- **Principle 3:** National Board members may serve a maximum of up to three terms.
- **Principle 4:** An exception to the maximum continuous terms of National Board chairs may be considered if needed.

6.3 Principles to guide Ahpra in assisting with the recruitment process

All recruitment and selection processes conducted by Ahpra on behalf of the Ministerial Council and Ministers will be based on principles that support the National Law requirements for each candidate to have skills and experience relevant to the functions of the board and for the necessary board compositional requirements to be met.

The principles that guide Ahpra in this process are:

- all vacancies will be publicly advertised
- all candidates will be provided with an information pack about the role including selection criteria
- all persons who meet the eligibility provisions set out in the National Law are eligible to apply or be nominated for consideration
- the merits of each candidate in fulfilling the skills and experience relevant to a board's functions
- the board compositional requirements as specified in the National Law are the key factors to be considered in the making of recommendations for appointment
- compositional requirements of boards as specified in the National Law must be met, and
- all applicants will be advised of the outcome of the recruitment process.

6.4 Board composition

The compositional requirements of the National Boards are set out in Section 33 of the National Law.

- At least half, but not more than two-thirds, of the members of a National Board must be persons appointed as practitioner members.
- The practitioner members of a National Board must consist of:
    - at least one member from each large participating jurisdiction (being either New South Wales, Queensland, South Australia, Victoria and Western Australia), and
    - at least one member from a small participating jurisdiction (being Tasmania, Northern Territory and the Australian Capital Territory).
- At least two of the members of a National Board must be persons appointed as community members
- At least one of the members of a National Board must live in a regional or rural area

- A person cannot be appointed as a member of a National Board if the person is a member of the Agency Management Committee.

One of the practitioner members of the National Boards is to be appointed as Chairperson of the Board by the Ministerial Council. The compositional requirements of State or Territory Boards are set out in Section 36 of the National Law as follows:

- at least half, but not more than two-thirds, of the members of a State or Territory Board must be persons appointed as practitioner members
- at least two of the members of a State or Territory Board must be persons appointed as community members.

In assisting the Ministerial Council and Ministers, Ahpra will also ensure information is collected from candidates to allow consideration of:

- gender balance
- cultural diversity
- equal opportunity for disadvantaged groups, and
- a mix of membership drawn from metropolitan, rural and remote areas.

6.5 Availability and commitment

Candidates are to be informed about the nature of the work and commitment that is required to fulfil the requirements of a board member. The information pack available to all prospective candidates at the time of advertising a vacancy is to provide an overview of the role of a board member, the purpose and function of the board(s) and give an indication of the type and nature of work plus the time required for preparing and attending meetings and other related activities.

There is a general expectation that members attend meetings and that they make a significant contribution to the board and more generally to the objectives of the National Registration and Accreditation Scheme.

6.6 Reappointment

Board members can be reappointed, subject to continuing eligibility under the National Law and guided by the National Board Succession Planning Principles. Principle No. 3 states that National Board members may serve a maximum of up to three terms which means that ideally a board member should not be serving more than nine years or three consecutive terms on the same board.

All the board membership requirements and the performance of the member in their previous term on the board should be available for consideration by the Selection Advisory Panel. This may include, but is not limited to, compliance with attendance requirements for meetings and level of effective contribution.

National Board Succession Planning Principle No. 2 states that the frequency of new board member appointments will be every three years. Principle No. 4 provides an exception to the principle of serving no more than three consecutive terms in order for National Board Chairs to serve an additional term if needed. Ministers will therefore take account the need to ensure a regular turnover of members and injection of fresh ideas and enthusiasm balanced against the need to retain a proportion of board members with the necessary skills and experience; and the need for succession planning or management of a board through a period of transition or considerable change.

7. Consultation

The Ahpra officer responsible for the administration of the recruitment and appointment process will liaise with the following key stakeholders in relation to the recruitment and appointment process:

7.1 Consultation with relevant National Board

The relevant National Board should be consulted via the Executive Officer in relation to the upcoming vacancy, to determine if there are any specific criteria that the National Board would like taken into consideration.

7.2 Consultation with State or Territory Board

If the upcoming vacancy is for a member of a State or Territory Board of a National Board, the Chair of

that State or Territory Board may be consulted to determine if there are any specific criteria that the State or Territory Board would like taken into consideration.

7.3 Contact with the incumbent

If a member whose term of office has expired is eligible to serve a further term of office, the member should be asked to indicate whether they would like to express their interest for re-appointment.

8. Recruitment

8.1 Goals

The goals of the recruitment process are to assist the Ministerial Council (or individual Minister) in the process of appointing members, including the advertising of vacancies:

- to attract suitable candidates with relevant skills and knowledge and encourage them to nominate by promoting the positive aspects of involvement, and
- to encourage suitable candidates to apply by clearly communicating the requirements of the position and the relevant selection criteria.

8.2 Documentation about the appointment

Potential candidates should be provided with documentation about the vacant appointment.

The documentation about the vacancy to be provided to potential candidates aims to meet the goals outlined above and should include the following information as a minimum:

- information about the role of the particular National Board and/or the State and Territory Board under the National Law
- the duties and responsibilities associated with the role
- mandatory and desirable selection criteria, including specific applicant requirements
- duties and responsibilities of the particular position and the likely time commitment for the role
- the terms and conditions of appointment - noting that in accordance with the National Boards Succession Planning Principles, the standard length of appointment will be three years
- an explanation of the selection process
- application form
- information about police and probity checks, and
- the requirement to complete a Declaration of Private Interests and to be aware of conflict of interest concerns.

8.3 Calls for nominations and expressions of interest

The National Law provides that:

- before the Ministerial Council appoints a member of a National Board or the responsible Minister appoints a member of a State or Territory Board, the vacancy to be filled is to be publicly advertised
- the National Agency may assist the Ministerial Council or the responsible Minister in the process of appointing members of a National Board or State or Territory Board, including in the advertising of vacancies, and
- it is not necessary to advertise a vacancy in the membership of a National Board or a State or Territory Board before appointing a person to act in the office of a member.

Advertising may include advertisements:

- on the website of Ahpra and the National Board and/or other appropriate professional bodies
- in major metropolitan, community and regional newspapers (see the next section for more detailed advertising guidelines)
- in major indigenous publications, and
- in a professional body publication.

Other options for calling for nominations or expressions of interest may include:

- informal approaches to current and former board members; panel members; senior Ahpra staff; and relevant Ministerial department staff seeking names of potential candidates
- contacting community associations or groups; and professional bodies and colleges inviting nominations, and
- the names of respondents to advertisements for expressions of interest for board appointments can be placed in a 'pool' that may provide candidates for subsequent vacancies. This pool should be refreshed regularly, e.g. every 12 to 18 months.

8.4 Acting appointments

The National Law provides for the appointment of acting members of a National Board or a State or Territory Board of a National Board. The maximum period of acting is 12 months. It is not necessary to advertise before appointing a person to act in the office of a board member. Acting members may be selected from the 'pool' of previous applicants. The applicants' interest in being appointed as an acting member should be sought.

9. Guidelines for the advertising of vacancies

Relevant factors to consider in relation to the advertising of vacancies include:

- the particular requirements for the appointment (i.e. practitioner or community member, jurisdictional requirement, regional or rural requirements or diversity considerations), with advertising to be targeted accordingly;
- attracting a broad range of applicants or nominees who might not otherwise have been considered
- specify the number of vacancies, the particular vacancy to be filled, the duties and responsibilities of the role and the criteria, both specific and general, required for selection. It is important that the selection criteria are clearly articulated and relevant, to assist in targeting suitable candidates and reduce the likelihood of attracting large numbers of candidates with inappropriate skills and experience;
- include a contact person for enquiries about the advertised vacancy, and
- sufficient time should be allowed between the date the advertisement appears and the closing date for applications. As a general guide, advertisements should be published at least 10 working days before the closing date for applications.

10. Selection Process

10.1 Ongoing dialogue with the Minister

The initial briefing process is outlined above at Section 5. Consultation with Ministerial Council or responsible Minister on the vacancy and selection process will be established and maintained during the process.

10.2 Database on appointments

The Ahpra officer responsible for the administration of the recruitment and appointment process will develop and maintain a central database on board appointments to track appointments; forecast upcoming vacancies; monitor trends in appointments; and monitor the composition of boards. It is important that the information held on this database is accurate and up to date, and that practices are consistent with the requirements of relevant privacy legislation which applies to personal information being collected and stored on the database.

Ahpra is required to take reasonable steps to make sure that the personal information that it collects, uses, or discloses is accurate, complete and kept confidential.

10.3 Selection Advisory Panel

A Selection Advisory Panel will be used as part of recruitment and appointment processes. The composition of the panel may vary, i.e. bulk selections for a number of National Board vacancies may require a panel of nominated HCEF members to be established. However, in general the usual arrangements for Selection Advisory Panels are as follows:

National Board Selection Advisory Panel	State, Territory and Regional Board Selection Advisory Panel
Ministerial Council representative(s)	Determined after consultation with: 1. the relevant National Board via the Executive Officer 2. relevant Ministerial staff 3. relevant senior Ahpra Executive

It is beneficial to utilise the expertise and knowledge of current or former members of the National Board or State or Territory Board and Ministerial staff in the panel.

The role of the selection advisory panel is to determine the most suitable candidates for consideration by Ministers. Part of this process will include the preparation of a report outlining the process, providing a list of preferred candidates (and at least one alternative), and reasons for recommending a preferred candidate or candidates for the consideration of the Ministerial Council or the relevant Minister.

The panel should:

- assess each application against the selection criteria
- determine if interviews are required to gather additional information and if so, how and when these are to occur and by whom
- determine which referees, nominated or additional referees, need to be contacted and if referee reports are to be collected by phone or written report, and
- determine if any other process to aid the selection is required.

The appointed Ahpra officer will co-ordinate the selection process with the panel and will be responsible for administrative matters including undertaking the probity checks (screening) of candidates, checking the registration details of candidates (for practitioner members), forwarding forms to applicants, contacting panel members, arranging interviews where necessary, and liaising with relevant senior Ahpra staff during the process.

11. Screening

11.1 Applications and nominations

Ahpra will check all applications and nominations as they are received to ensure they are complete.

The Selection Advisory Panel will consider each application and nomination to determine the extent to which each applicant or nominee meets the requirements as set out in the selection criteria and whether to include them in the shortlist for further consideration.

11.2 Interview

It is a matter for the Selection Advisory Panel to determine if applicants are to be interviewed and how this best occur. Issues to be considered many include the number of applicants, the time required, the location of applicants and the panel members involved.

11.3 Probity checks

Candidates for board appointments will be subject to probity checks prior to their appointment to ensure personal, professional and commercial integrity.

The application forms for expressions of interest/nomination for appointment as a board member must seek consent from the applicant each time a probity check is conducted.

The minimum probity checks consist of:

- a nationally coordinated criminal history check
- a check of the Australian Securities and Investment Commission (ASIC) register of persons prohibited/disqualified by ASIC under the provisions of *the Corporations Act 2001* (Cth)

- a check of the Australian Financial Security Authority (AFSA) which contains information about proceedings and administrations under the *Bankruptcy Act 1966* (Cth).

Where the candidate is applying as a practitioner member, a check of the public national register and board records is also undertaken to ensure the practitioner is registered and of good standing. The officer appointed to administer the recruitment and appointment process will coordinate the safety screening process.

Where the criminal history check has returned criminal history information, Ahpra is required to advise the candidate of the result and Ahpra must promptly provide results to an applicant upon request. Ahpra has a dispute resolution process in place if an applicant wishes to dispute a result. The Selection Advisory Panel will be provided with a copy of any results that have been assessed by Ahpra as warranting referral to the appointing entity.

AFSA checks are undertaken on-line for a fee through the bankruptcy register on the AFSA website.

Declarations of Private Interest should be scrutinised for potential conflicts of interest.

The criminal history check and other probity check documents and Declarations of Private Interest will be securely stored by Ahpra.

11.4 Referee reports

Referee reports should be obtained for shortlisted applicants (as required) to clarify, confirm or counterbalance information already before the panel.

It may also be necessary for selection advisory panels to extend their enquiries beyond nominated referees to ensure a comprehensive and accurate appraisal against selection criteria.

Ahpra will assist as required by compiling complete and accurate reports of referees' comments for consideration by the Selection Advisory Panel.

12. Appointment and reappointment process

12.1 Appointment process

The Selection Advisory Panel will provide the Ministerial Council (via HCEF) or responsible Minister with a report detailing the recommendations and reasons for a preferred candidate or candidates.

For National Board member appointments, approval is by the Ministerial Council. Therefore, the process of taking recommendations to the Ministerial Council will occur via the usual government process.

For state or territory board appointments, Ministerial Staff will be the conduit for the provision of information to the Minister. Ideally this should occur at least three months before the expiry date of the appointment period.

12.2 Appointment of Chair

The Chair of a National Board is appointed by the Ministerial Council, as provided for under the National Law.

The Chair of a State or Territory Board are appointed by Ministers, unless the decision to appoint the Chair is delegated by the Minister to the relevant National Board.

Ministers will be provided with advice as to suitable candidates for these positions and sufficient information to enable the Minister/s to make a decision.

12.3 Instrument of appointment

For the Ministerial Council to make the appointments, the paper brought to the meeting includes draft letters of appointment and terms and conditions of appointment.

If the responsible Minister for a State or Territory Board has made the appointment, the Ahpra officer will liaise with the Ministerial staff and co-ordinate the sending of the letter of appointment.

Where the appointment is to a Regional Board, the letter of appointment will be signed by the responsible Minister for the jurisdiction where the appointee is based.

The terms of the appointment are decided by the Minister however, the appointment letter should include the information provided in the relevant jurisdictional template in as a minimum.

New appointees will be added to the database of board appointments maintained by the Ahpra officer responsible for the administration of the recruitment and appointment process.

The term of appointment for board and committee members will be consistent with the National Boards Succession Planning Principles.

12.4 Induction

As part of an Induction program, persons appointed as board and committee members will be provided with the *Manual for National Boards and their committees* and training by senior Ahpra staff.

13. Privacy requirements

Personal information relating to candidates for board appointments, including its collection, use, disclosure and storage is to be handled in accordance with the provisions of the Privacy Act 1988 (Cth) as outlined in Ahpra'S privacy policy.

14. Related sources of reference

The Guidelines are supported by the following reference documents:

- All Boards Governance Charter
- Board Members Manual
- National Board Succession Planning Principles
- Ahpra Policy Framework

14. Attachments

Attachment A - relevant sections of the National Law

Attachment B - board member attributes

Attachment A

The National Law

National Board members

The following sections of the National Law set out the legislative requirements for appointment of National Board members:

33 Membership of National Boards

(1) A National Board is to consist of members appointed in writing by the Ministerial Council.

(2) Members of a National Board are to be appointed as practitioner members or community members.

(3) Subject to this section, the Ministerial Council may decide the size and composition of a National Board.

(4) At least half, but not more than two-thirds, of the members of a National Board must be persons appointed as practitioner members.

(5) The practitioner members of a National Board must consist of—

(a) at least one member from each large participating jurisdiction; and

(b) at least one member from a small participating jurisdiction.

(6) At least 2 of the members of a National Board must be persons appointed as community members.

(7) At least one of the members of a National Board must live in a regional or rural area.

(8) A person cannot be appointed as a member of a National Board if the person is a member of the Agency Management Committee.

(9) One of the practitioner members of the National Board is to be appointed as Chairperson of the Board by the Ministerial Council.

(10) Schedule 4 sets out provisions relating to a National Board.

(11) In this section—

large participating jurisdiction means any of the following States that is a participating jurisdiction—

(a) New South Wales;

(b) Queensland;

(c) South Australia;

(d) Victoria;

(e) Western Australia.

small participating jurisdiction means any of the following States or Territories that is a participating jurisdiction—

(a) the Australian Capital Territory;

(b) the Northern Territory;

(c) Tasmania.

34 Eligibility for appointment

(1) In deciding whether to appoint a person as a member of a National Board, the Ministerial Council is to have regard to the skills and experience of the person that are relevant to the Board's functions.

(2) A person is eligible to be appointed as a practitioner member only if the person is a registered health practitioner in the health profession for which the Board is established.

(3) A person is eligible to be appointed as a community member of a National Board only if the person—

(a) is not a registered health practitioner in the health profession for which the Board is established; and

(b) has not at any time been registered as a health practitioner in the health profession under this Law or a corresponding prior Act.

(4) A person is not eligible to be appointed as a member of a National Board if—

(a) in the case of appointment as a practitioner member, the person has ceased to be registered as a health practitioner in the health profession for which the Board is established, whether before or after the commencement of this Law, as a result of the person's misconduct, impairment or incompetence; or

(b) in any case, the person has, at any time, been found guilty of an offence (whether in a participating jurisdiction or elsewhere) that, in the opinion of the Ministerial Council, renders the person unfit to hold the office of member.

The following clauses in Schedule 4 of the National Law are also relevant to the appointment of National Board members:

2 Terms of office of members

Subject to this Schedule, a member holds office for the period (not exceeding 3 years) specified in the member's instrument of appointment, but is eligible (if otherwise qualified) for reappointment.

3 Remuneration

A member is entitled to be paid such remuneration (including travelling and subsistence allowances) as the Ministerial Council may from time to time determine with respect to the member.

4 Vacancy in office of member

(1) The office of a member becomes vacant if the member—

(a) completes a term of office; or

(b) resigns the office by instrument in writing addressed to the Chairperson of the Ministerial Council; or

(c) is removed from office by the Chairperson of the Ministerial Council under this clause; or

(d) is absent, without leave first being granted by the Chairperson of the Board, from 3 or more consecutive meetings of the National Board of which reasonable notice has been given to the member personally or by post; or

(e) dies.

(2) The Chairperson of the Ministerial Council may remove a member from office if—

(a) the member has been found guilty of an offence (whether in a participating jurisdiction or elsewhere) that, in the opinion of the Chairperson of the Ministerial Council, renders the member unfit to continue to hold the office of member; or

(b) the member ceases to be a registered health practitioner as a result of the member's misconduct, impairment or incompetence; or

(c) the member ceases to be eligible for appointment to the office that the member holds on the National Board; or

(d) the member becomes bankrupt, applies to take the benefit of any law for the relief of bankrupt or insolvent debtors, compounds with member's creditors or makes an assignment of the member's remuneration for their benefit; or

(e) the National Board recommends the removal of the member, on the basis that the member has engaged in misconduct or has failed or is unable to properly exercise the member's functions as a member.

5 Vacancies to be advertised

(1) Before the Ministerial Council appoints a member of a National Board, the vacancy to be filled is to be publicly advertised.

(2) The National Agency may assist the Ministerial Council in the process of appointing members of a National Board, including in the advertising of vacancies.

(3) It is not necessary to advertise a vacancy in the membership of a National Board before appointing a person to act in the office of a member.

Note.

The general interpretation provisions applicable to this Law under section 6 confer power to appoint acting members of a National Board.

6 Extension of term of office during vacancy in membership

(1) If the office of a member becomes vacant because the member has completed the member's term of office, the member is taken to continue to be a member during that vacancy until the date on which the vacancy is filled (whether by reappointment of the member or appointment of a successor to the member).

(2) However, this clause ceases to apply to the member if—

(a) the member resigns the member's office by instrument in writing addressed to the Chairperson of the Ministerial Council; or

(b) the Chairperson of the Ministerial Council determines that the services of the member are no longer required.

(3) The maximum period for which a member is taken to continue to be a member under this clause after completion of the member's term of office is 6 months.

State and Territory Boards

The relevant sections of the National Law relating to State and Territory Boards are:

36 State and Territory Boards

(1) A National Board may establish a committee (a State or Territory Board) for a participating jurisdiction to enable the Board to exercise its functions in the jurisdiction in a way that

provides an effective and timely local response to health practitioners and other persons in the jurisdiction.

(2) A State or Territory Board is to be known as the "[Name of participating jurisdiction for which it is established] Board" of the National Board.

(3) The members of a State or Territory Board are to be appointed by the responsible Minister for the participating jurisdiction.

Example.

(a) The Nursing and Midwifery Board of Australia decides to establish a State or Territory Board for New South Wales. The State or Territory Board will be known as the New South Wales Board of the Nursing and Midwifery Board of Australia. The members of the State or Territory Board will be appointed by the responsible Minister for New South Wales.

(4) In deciding whether to appoint a person as a member of a State or Territory Board, the responsible Minister is to have regard to the skills and experience of the person that are relevant to the Board's functions.

(5) At least half, but not more than two-thirds, of the members of a State or Territory Board must be persons appointed as practitioner members.

(6) At least 2 of the members of a State or Territory Board must be persons appointed as community members.

(7) Before a responsible Minister appoints a member of a State or Territory Board the vacancy to be filled is to be publicly advertised.

(8) The National Agency may assist a responsible Minister in the process of appointing members of a State or Territory Board, including in the advertising of vacancies.

(9) It is not necessary to advertise a vacancy in the membership of a State or Territory Board before appointing a person to act in the office of a member.

Note.

The general interpretation provisions applicable to this Law under section 6 confer power to appoint acting members of a State or Territory Board.

The following clauses in Schedule 7 of the National Law are relevant to the appointment of all board members:

27 Acting appointments

(1) If this Law authorises a person or body to appoint a person to act in an office, the person or body may, in accordance with this Law, appoint—

(a) a person by name; or

(b) a particular officer, or the holder of a particular office, by reference to the title of the office concerned;

to act in the office.

(2) The appointment may be expressed to have effect only in the circumstances specified in the instrument of appointment.

(3) The appointer may—

(a) determine the terms and conditions of the appointment, including remuneration and allowances; and

(b) terminate the appointment at any time.

(4) The appointment, or the termination of the appointment, must be in, or evidenced by, writing signed by the appointer.

(5) The appointee must not act for more than 1 year during a vacancy in the office.

(6) If the appointee is acting in the office otherwise than because of a vacancy in the office and the office becomes vacant, then, subject to subclause (2), the appointee may continue to act until—

(a) the appointer otherwise directs; or

(b) the vacancy is filled; or

(c) the end of a year from the day of the vacancy;

whichever happens first.

(7) The appointment ceases to have effect if the appointee resigns by writing signed and delivered to the appointer.

(8) While the appointee is acting in the office—

(a) the appointee has all the powers and functions of the holder of the office; and

(b) this Law and other laws apply to the appointee as if the appointee were the holder of the office.

(9) Anything done by or in relation to a person purporting to act in the office is not invalid merely because—

(a) the occasion for the appointment had not arisen; or

(b) the appointment had ceased to have effect; or

(c) the occasion for the person to act had not arisen or had ceased.

(10) If this Law authorises the appointer to appoint a person to act during a vacancy in the office, an appointment to act in the office may be made by the appointer whether or not an appointment has previously been made to the office.

28 Powers of appointment imply certain incidental powers

(1) If this Law authorises or requires a person or body to appoint a person to an office—

(a) the power may be exercised from time to time as occasion requires; and

(b) the power includes—

(i) power to remove or suspend, at any time, a person appointed to the office; and

(ii) power to appoint another person to act in the office if a person appointed to the office is removed or suspended; and

(iii) power to reinstate or reappoint a person removed or suspended; and

(iv) power to appoint a person to act in the office if it is vacant (whether or not the office has ever been filled); and

(v) power to appoint a person to act in the office if the person appointed to the office is absent or is unable to discharge the functions of the office (whether because of illness or otherwise).

(2) The power to remove or suspend a person under subclause (1)(b) may be exercised even if this Law provides that the holder of the office to which the person was appointed is to hold office for a specified period.

(3) The power to make an appointment under subclause (1)(b) may be exercised from time to time as occasion requires.

(4) An appointment under subclause (1)(b) may be expressed to have effect only in the circumstances specified in the instrument of appointment.

National Registration and Accreditation Scheme

Board member attributes



Aboriginal and Torres Strait Islander Health Practice
Chinese Medicine
Chiropractic
Dental
Medical
Medical Radiation Practice
Nursing and Midwifery
Occupational Therapy
Optometry
Osteopathy
Pharmacy
Physiotherapy
Podiatry
Psychology

Australian Health Practitioner Regulation Agency

member attributes

Core attributes for all Board members

All Board and committee members will demonstrate the following attributes:

- **Displays integrity**: is ethical, committed, diligent, prepared, organised, professional, principles-based and respectful, values diversity, and shows courage and independence.
- **Thinks critically**: is objective and impartial, uses logical and analytical processes, distils the core of complex issues and weighs up options.
- **Applies expertise**: actively applies relevant knowledge, skills and experience to contribute to decision-making
- **Communicates constructively**: is articulate, persuasive and diplomatic, is self-aware and reflects on personal impact and effectiveness, listens and responds constructively to contributions from others.
- **Focuses strategically**: takes a broad perspective, can see the big picture, and considers long term impacts.
- **Collaborates in the interests of the scheme**: is a team player, flexible and cooperative, creates partnerships within and between boards and the Australian Health Practitioner Regulation Agency.

Attributes for Chairs of National Boards

In addition to the core attributes for all Board members, National Board Chairs will possess the following attributes:

- **Demonstrates leadership**: is confident, decisive and acts without fear or favour, is at the forefront of professional regulation, drives reform and facilitates change.
- **Engages externally**: is the spokesperson for the National Board and advocate for the National Scheme, defines the nature and tone of engagement, builds and sustains stakeholder relationships.
- **Chairs effectively**: establishes and follows well-organised agendas, facilitates input from all members, builds consensus, distils core issues, summarises discussion and confirms decisions ensuring they are accurately recorded.

2025 State and Territory Boards Campaign Timelines

2025 STB ACT MBA campaign – key milestones: Round 3

Campaign Milestone	Round 3
Applications open: Online media goes live	11 January 2025
Applications close	23 February 2025
Ahpra processing and checking applications	24 February to 7 March 2025
Selection Advisory Panel process	10 March to 17 July 2025
SAP short listing and interviews	10 March to 23 May 2025
Probity checks on shortlisted candidates	7 to 24 April 2025
Reference checks (if required) on recommended candidates	26 May to 13 June 2025
SAP recommendations to Health Ministers	18 July 2025
Commencement of members	14 October 2025

Note: These timelines are a guide only. While the statutory appointments team aims to progress campaigns as quickly as possible, variations in timings may occur as campaigns progress. Timing alterations for each Board campaign may be made to take into account the end date of members whose terms expire and the outcome of the expression of interest process.

From: STEPHEN-SMITH
Sent: Monday, 21 October 2024 09:51
To: ACT Health DLO
Cc: Bransgrove, Meagen
Subject: FW: Ahpra: ACT MBA recommendations for appointment (2024 R4) - Email 1 of 2
Attachments: 2024 -10 ACT MBA Letter to Minister - Recommendations for appointment.pdf; Attachments.zip

Importance: High

For appropriate action.

Ben

From: Statutory Appointments
Sent: Friday, 18 October 2024 4:02 PM
To: STEPHEN-SMITH
Cc: Statutory Appointments ; Osman, Nadia ; Krister Partel ; AHM-ACT
Subject: Ahpra: ACT MBA recommendations for appointment (2024 R4) - Email 1 of 2

Some people who received this message don't often get email from statutoryappointments@ahpra.gov.au. Learn why this is important

Caution: This email originated from outside of the ACT Government. Do not click links or open attachments unless you recognise the sender and know the content is safe.

Dear Minister

Please find attached documentation recommending appointments to the Australian Capital Territory Board of the Medical Board of Australia. Recommendations will be forthcoming over the coming weeks for the ACT Board of the Nursing and Midwifery Board of Australia.

Should you have any questions, please contact Krister Partel, Territory Manager, ACT on 02 6195 2623 and Schedule 2.2(a)(ii)

Kind regards
Tracey Chick

Tracey Chick
Senior Adviser, Statutory Appointments
Government Relations
Phone | (03) 8708 9184
Email Schedule 2.2(a)(ii)
Web | www.ahpra.gov.au

Australian Health Practitioner Regulation Agency
G.P.O. Box 9958 | Melbourne VIC 3001 | www.ahpra.gov.au

Ahpra acknowledges the Traditional Owners of Country throughout Australia and the continuing connection to lands, waters and communities. We pay our respect to Aboriginal and Torres Strait Islander cultures and Elders past and present.



Ahpra & National Boards

18 October 2024

Rachel Stephen-Smith, MLA
GPO Box 1020,
CANBERRA ACT 2601

Via e-mail: stephen-smith@act.gov.au

Dear Minister

Appointments to the ACT Board of the Medical Board of Australia (ACT MBA)

The Australian Health Practitioner Regulation Agency (Ahpra) wrote to you on 9 January 2024 and outlined the arrangements for recruitment processes to appoint members to fill two vacancies arising on the ACT MBA, that were not filled in the previous recruitment round.

Ahpra, with the assistance of the nominated Ministerial representative, has undertaken a selection process for the vacant positions. Please find enclosed a report proposing candidates suitable for appointment.

The selection advisory panel seeks your approval of the recommended candidates for appointment under section 36(3) of the Health Practitioner Regulation National Law, as in force in each state and territory (the National Law).

To enable the continued effective functioning of the ACT MBA, it is recommended that the appointments be made at your earliest convenience. Recommendations are forthcoming for the ACT Board of the Nursing and Midwifery Board of Australia.

I am available to provide further information to you should you require it and can be reached by telephone on 02 6195 2623 or alternatively by email at Schedule 2.2(a)(ii)

Thank you for your consideration of this matter.

Yours sincerely

Schedule 2.2(a)(ii)

Krister Partel
Territory Manager, Australian Capital Territory
Australian Health Practitioner Regulation Agency

Attachments:

1. 2024 Recommendations for appointment – ACT MBA (R4)
2. Summary of applicants
3. Applications of recommended and alternative candidates
4. Resumes of recommended and alternative candidates
5. Interview assessment reports of interviewed candidates

From: Docker, Jake
Sent: Tuesday, 22 October 2024 12:31
To: ACT Health DLO
Cc: Davidson
Subject: RE: Critical event outcome analysis

Importance: High

For the information of the ACTHD.

Best wishes,

Jake Docker | Adviser, Population Health & Community Services
Office of Emma Davidson| ACT Greens Member for Murrumbidgee
E: jake.docker@act.gov.au

From: Davidson
Sent: Tuesday, 22 October 2024 10:37 AM
To: Docker, Jake
Subject: FW: Critical event outcome analysis

Hi Jake,

For your information.

Maxine Harris (She/Her)
Office Manager
Office of Emma Davidson|ACT Greens Member for Murrumbidgee
Minister for Community Services, Seniors and Veterans | Minister for Mental Health
Minister for Corrections and Justice Health | Minister for Population Health
✉ GPO Box 1020, Canberra ACT 2601
☏ 02 6205 1941
💻 Davidson@act.gov.au

From: STEPHEN-SMITH <STEPHEN-SMITH@act.gov.au>
Sent: Monday, 21 October 2024 11:22 AM
To: Davidson <DAVIDSON@act.gov.au>; ACT Health DLO <ACTHealthDLO@act.gov.au>
Cc: Smith, Kahlia <Kahlia.Smith@act.gov.au>
Subject: FW: Critical event outcome analysis

For Davidson office and ACTHD info.

Thanks
Ben

From: Schedule 2.2(a)(ii)
Sent: Monday, 21 October 2024 11:11 AM
To: STEPHEN-SMITH <STEPHEN-SMITH@act.gov.au>
Subject: Critical event outcome analysis

You don't often get email from Schedule 2.2(a)(ii) Learn why this is important

Caution: This email originated from outside of the ACT Government. Do not click links or open attachments unless you recognise the sender and know the content is safe.

Dear Rachel,

I am writing to share the outcomes of the Critical Event Analysis undertaken by Schedule 2.2(a)(ii) on behalf of Sexual Health and Family Planning (SHFPACT) in regard to the probe cover incident identified in August this year.

Please find attached a letter detailing the identified cause of the issue, opportunities for improvement in our process, and an explanation regarding how these recommendations will be implemented in our organisation.

If you have any questions or would like to discuss further, please contact Schedule 2.2(a)(ii) on 6247 3077 or Schedule 2.2(a)(ii)

As a key stakeholder of SHFPACT, we value your support, trust and confidence, and look forward to working with you in the future.

Kind regards,

Schedule 2.2(a)(ii)

Sexual Health and Family Planning ACT Inc

Level One, 28 University Avenue, Canberra ACT 2601
Reception 02 6247 3077
www.shfpact.org.au

We're committed to reconciliation! SHFPACT acknowledges the Aboriginal people are the traditional custodians of the land we live and work on. We recognise their ongoing contribution to Australian culture and pay our respect to Elders, past and present. We respectfully acknowledge the distinct rights and perspectives of Aboriginal and Torres Strait Islander peoples.



SEXUAL HEALTH & FAMILY PLANNING ACT

Rachel Stephen-Smith MLA

Monday, 21 October

Dear Rachel,

Across 7 and 8 August 2024, Sexual Health and Family Planning ACT (SHFPACT) issued a product withdrawal for products distributed as condoms by SHFPACT.

We took this step after becoming aware that instead of condoms, lubricated probe covers for medical ultrasound were inadvertently distributed to community health organisations and members of the public at events in the ACT. The products have similar packaging and the appearance of condoms but do not provide the same level of protection against pregnancy and sexually transmitted infections.

SHFPACT is grateful for the way that the Canberra health, education, and community sectors responded to this issue. Our priority is the health and well-being of Canberrans, and we are aware of the additional burden this issue placed on our partners.

As we talked with our partners and the Canberra community to issue the withdrawal and provide advice to impacted organisations and individuals, I committed to resolving this issue with transparency and diligence. As part of that commitment, SHFPACT engaged Schedule 2.2(a)(ii) to undertake an independent critical event analysis to determine the cause and extent of the issue and to provide recommendations to prevent such occurrences in the future.

I write to share with you the review's outcomes and an overview of SHFPACT's commitments as a result.

The probe covers were distributed through various community outreach events conducted by SHFPACT between 19 January and 7 August 2024. SHFPACT's stocktake identified approximately 4,200 probe covers that may have been distributed to the community.

[redacted] analysis identified the following as key contributing factors:

Schedule 2.2(a)(xi)

[redacted]

Level One, 28 University Avenue, Canberra GPO Box 1317, Canberra ACT 2601 ABN: 89 389 381 869

Phone 02 6247 3077 Fax 02 6257 5710

Email shfpact@shfpact.org.au Web www.shfpact.org.au

SEXUAL HEALTH & FAMILY PLANNING ACT

[redacted] made a number of recommendations to improve SHFPACT's procurement and inventory controls. These include:

Schedule 2.2(a)(xi)

[redacted]

SHFPACT is committed to fully implementing the recommendations made by [redacted] and have formed an internal working group to imbed these suggestions into our procurement process. Strategic oversight will be provided by the Governance subcommittee of the SHFPACT Board.

SHFPACT staff and board are grateful for the professional advice provided by [redacted] to improve our procurement and inventory processes. We remain committed to providing sexual and reproductive health education and clinical services to the Canberra community, and these enhanced processes will support our ability to continue to distribute condoms to prevent sexually transmissible infections and as a contraceptive method to prevent pregnancy as part of our approach.

As one of SHFPACT's partners, we know that your trust and confidence are prerequisites for the successful delivery of our health promotion, workforce development, and clinical services. If you have further questions about the incident or our response, I would welcome the opportunity to meet with you and offer you a further briefing.

Yours sincerely,

Schedule 2.2(a)(ii)

[redacted]

Level One, 28 University Avenue, Canberra GPO Box 1317, Canberra ACT 2601 ABN: 89 389 381 869

Phone 02 6247 3077 Fax 02 6257 5710

Email shfpact@shfpact.org.au Web www.shfpact.org.au

From: Gower, Tara on behalf of ACT Health DLO
Sent: Tuesday, 22 October 2024 1:37 PM
To: STEPHEN-SMITH
Cc: Bransgrove, Meagen
Subject: RE: Ahpra: ACT MBA recommendations for appointment (2024 R4) - Email 2 of 2
Attachments: 2024-10 ACT Letter to Minister recruitment campaign 2025 Round 3.pdf

Hi Ben

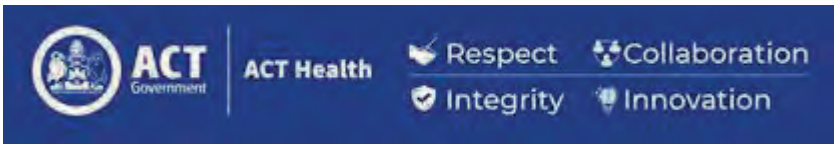
In accordance with section 36 (3) of the Health Practitioner regulation National Law (ACT), the members of a State or Territory Board are to be appointed by the responsible Minister for the participating jurisdiction.

Noting this, an incoming Minister response will be prepared.

I will ask the team to notify Ahpra that an incoming Minister response will be prepared but noting we are still in Caretaker period, a Ministerial response will be provided in late November.

Thank you
Tara

Tara Gower | Directorate Liaison Officer | ACT Health Directorate
Mob: Schedule 2.2(a)(ii) Email: ACTHealthDLO@act.gov.au
Office of Rachel Stephen-Smith | Minister for Health
Office of Emma Davidson | Minister for Mental Health
Level 2, Legislative Assembly Building, Civic Square



From: STEPHEN-SMITH
Sent: Monday, 21 October 2024 9:50 AM
To: ACT Health DLO
Cc: Bransgrove, Meagen
Subject: FW: Ahpra: ACT MBA recommendations for appointment (2024 R4) - Email 2 of 2
Importance: High

For appropriate action.

Ben

From: Tracey Chick Schedule 2.2(a)(ii)
Sent: Friday, 18 October 2024 4:11 PM
To: Statutory Appointments <statutoryappointments@ahpra.gov.au>; STEPHEN-SMITH <STEPHEN-SMITH@act.gov.au>
Cc: Osman, Nadia <Nadia.Osman@act.gov.au>; Krister Partel Schedule 2.2(a)(ii) >; AHM-ACT <AHM-ACT@act.gov.au>
Subject: Ahpra: ACT MBA recommendations for appointment (2024 R4) - Email 2 of 2

Caution: This email originated from outside of the ACT Government. Do not click links or open attachments unless you recognise the sender and know the content is safe.

Dear Minister

Please find attached documentation outlining the Australian Capital Territory Board of the Medical Board of Australia member vacancies arising in 2025 and the strategy to fill the vacancies.

Should you have any questions, please contact Krister Partel, Territory Manager, ACT on 02 6195 2623 and Schedule 2.2(a)(ii)

Kind regards
Tracey Chick

Tracey Chick
Senior Adviser, Statutory Appointments
Government Relations
Phone | (03) 8708 9184
Email Schedule 2.2(a)(ii)
Web | www.ahpra.gov.au

Australian Health Practitioner Regulation Agency
G.P.O. Box 9958 | Melbourne VIC 3001 | www.ahpra.gov.au

Ahpra acknowledges the Traditional Owners of Country throughout Australia and the continuing connection to lands, waters and communities. We pay our respect to Aboriginal and Torres Strait Islander cultures and Elders past and present.



18 October 2024

Hon. Rachel Stephen-Smith MLA
Minister for Health
GPO Box 1020
CANBERRA ACT 2601

Via email: stephen-smith@act.gov.au

Dear Minister

Vacancies on the Australian Capital Territory Board of the Medical Board of Australia (ACT MBA)

I write in relation to the proposed recruitment arrangements to fill the following vacancies on the ACT MBA arising in 2025:

- two practitioner members and one community member (including Chair) of the ACT MBA.

Members' terms expire on 13 October 2025. The vacancies above include the recent resignation of practitioner member Dr Jason Yosar, who is no longer sitting on the Board.

The position of Chair, currently held by community member Ms Gulnara Abbasova is also included in the upcoming round and it is proposed that the whole Board is invited to express interest in the position of Chair (as opposed to only practitioner members, which is customary). As the Board has recently experienced some turnover of members, it would be beneficial if the incumbent Ms Abbasova had the opportunity to reapply for the position.

A table of the current composition of the ACT MBA with the identified vacancies is Attachment 1.

Recruitment process

The Health Practitioner Regulation National Law, as in force in each state and territory (the National Law) provides that the Australian Health Practitioner Regulation Agency (Ahpra) may assist the responsible Minister in the process of appointing members of a state or territory board including the advertising of vacancies.

In line with the guidelines (Attachment 2), Ahpra's approach to the recruitment process to fill the vacancies is as follows:

1. On 11 January 2025, advertisements will be placed in major metropolitan newspapers, online search engines, on Ahpra's and the MBA's websites; on LinkedIn, Facebook, Twitter and the *Koori Mail*, *The Australian* and the National Indigenous Times. The positions will also be mentioned in the MBA's newsletter. Ahpra will call for expressions of interest to current members.
2. Ahpra will facilitate selection processes whereby candidates are assessed against agreed selection criteria by selection advisory panels (SAP).
3. The SAPs will shortlist and interview applicants (most likely during the period 10 March to 23 May 2025.)
4. Ahpra will conduct probity checks on shortlisted candidates.
5. At the conclusion of the SAP's selection processes, recommendation reports outlining the recommended and suitable candidates will be provided by 18 July 2025 with appointments commencing in October 2025

A timeline of the recruitment process is Attachment 3.

Extension of board member terms

The date to appoint board members may bypass the expiry date in unexpected instances. Ahpra seeks your approval in writing to extend all board members whose terms expire in 2025 for six months beyond their expiry date or until appointments are made, whichever is sooner.

Composition of the Board

The size and composition of the ACT MBA is nine members, five of whom are practitioners and four of whom are community members.

To enable the recruitment to progress, your assistance would be appreciated in the:

1. acknowledgement of the recruitment process
2. approval of Ahpra inviting both practitioner and community members of the Board to express interest in the position of Chair.
3. approval of the extension of all members whose terms expire in 2025 for six months beyond their expiry date or until appointments have been made
4. nomination of departmental or a ministerial staff member to participate in the selection advisory panel for these vacancies.

SAP nominations

Ahpra is working to ensure that the recruitment process occurs in a timely fashion to ensure the continuity of the Boards and certainty for its members. To assist, we request that your nominees be available during the following periods to participate in the SAPs. This will help us to plan processes and reduce the likelihood of late submission of reports.

Campaign stage	**Preparation**	**Shortlisting**	**Interviews**	**Reporting finalisation**
Period in which nominees are requested to be available	10 March to 4 April 2025		28 April to 23 May 2025	18 July 2025
What is required of the nominees	Participate in a briefing on the recruitment process	Review applications and then participate in a meeting to shortlist candidates	Participate in interviews of shortlisted candidates	Review and finalise recommendation report
The expected time commitment	Approximately one hour.	Dependent on number of applications but a typical process will require approximately eight hours	Dependent on number of applications but a typical process will require approximately eight hours	Approximately three hours.

As per standard process, all SAPs comprise a nominee of the National Board, a senior Ahpra representative and the nominated departmental or ministerial staff member.

I am available to provide further information to you if required and can be reached by phone on 02 6195 2623 or via email at Schedule 2.2(a)(ii) .

Thank you for your consideration of this matter and I look forward to a response at your earliest convenience.

Yours sincerely

Schedule 2.2(a)(ii)

Krister Partel
Territory Manager, Australian Capital Territory
Australian Health Practitioner Regulation Agency

Encl.:

1. Current composition with identified vacancies to the Board
2. Guidelines for recruitment, appointment and separation of members to National Boards and State and Territory Boards of National Boards
3. Timeline of the recruitment campaign

Lowe, Shannon

From: Gower, Tara on behalf of ACT Health DLO
Sent: Wednesday, 23 October 2024 3:42 PM
To: Tomlinson, Benjamin; Smith, Kahlia
Subject: NOTING BRIEF : MIN2024/00864 - Consultation on National Water Guidelines

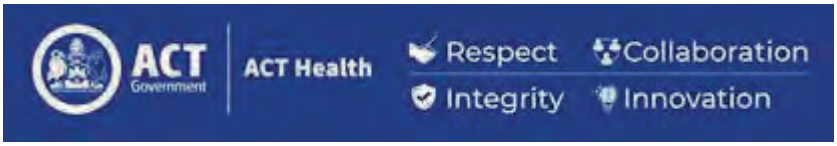
Hi Ben and Kahlia

This Noting Brief is placed in the Minister's folder here.

Please note there is no formal critical date.

Thank you
Tara

Tara Gower | Directorate Liaison Officer | ACT Health Directorate
Mob: Schedule 2.2(a)(ii) Email: ACTHealthDLO@act.gov.au
Office of Rachel Stephen-Smith | Minister for Health
Office of Emma Davidson | Minister for Mental Health
Level 2, Legislative Assembly Building, Civic Square



From: STEPHEN-SMITH
Sent: Wednesday, 23 October 2024 16:13
To: ACT Health DLO
Cc: Smith, Kahlia; Bransgrove, Meagen
Subject: FW: New AIHW embargo release available: First hospitalised falls among people living with dementia: risk factors and outcomes

Importance: High

Hi Tara,

For noting please.

Thank you,

Sally Cooke
Office Manager | Office of Rachel Stephen-Smith MLA
Minister for Health | Minister for Children, Youth and Family Services | Minister for Disability | Minister for Aboriginal and Torres Strait Islander Affairs
Member for Kurrajong
ACT Legislative Assembly, 196 London Circuit, Canberra ACT 2601 | P: (02) 6205 2661 | www.act.gov.au

From: communications@aihw.gov.au
Sent: Wednesday, 23 October 2024 1:08 PM
To: STEPHEN-SMITH
Subject: New AIHW embargo release available: First hospitalised falls among people living with dementia: risk factors and outcomes

Caution: This email originated from outside of the ACT Government. Do not click links or open attachments unless you recognise the sender and know the content is safe.

Dear all,

The latest AIHW release ***First hospitalised falls among people living with dementia: risk factors and outcomes*** is now available **under strict embargo** until public release on **Wednesday, 6 November at 12:01am**.

About the release:

People living with dementia are more likely to experience falls and severe outcomes following a fall than people without dementia.

This study focused on almost 19,600 people living with dementia who were hospitalised for a fall in 2019, and 113,000 people living with dementia who had no record of a hospitalised fall.

The study explored the presence of health-related risk factors before a hospitalised fall and health outcomes following that fall.

The release **will not be** accompanied by a media release.

Please click on the link and follow the instructions below:

- AIHW Stakeholder hub (https://pp.aihw.gov.au/login)
- Your user name is your **email address**
- Please select '**Forgot your password**' link if required.

The following Ministerial Offices are receiving access to the embargoed material:

- Office of the Prime Minister
- Senator the Hon. Katy Gallagher - Minister for Finance, Minister for the Public Service, Minister for Women
- The Hon. Mark Butler MP - Minister for Health and Aged Care
- Senator the Hon Malarndirri McCarthy - Minister for Indigenous Australians
- The Hon Ged Kearney MP - Assistant Minister for Indigenous Health
- The Hon. Amanda Rishworth MP - Minister for Social Services
- The Hon. Bill Shorten MP - Minister for the National Disability Insurance Scheme Minister for Government Services
- The Hon. Julie Collins MP - Minister for Housing, Minister for Homelessness, Minister for Small Business
- The Hon. Anne Aly MP - Minister for Early Childhood Education, Minister for Youth
- The Hon. Anika Wells MP - Minister for Aged Care, Minister for Sport
- The Hon. Justine Elliot MP - Assistant Minister for Social Services, Assistant Minister for the Prevention of Family Violence
- The Hon. Ged Kearney MP - Assistant Minister for Health and Aged Care
- The Hon. Emma McBride MP - Assistant Minister for Mental Health, Assistant Minister for Rural and Regional Health

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- ACT Health
- QLD Health
- NSW Ministry of Health
- NT Department of Health
- TAS Department of Health
- WA Department of Health
- SA Department of Health and Wellbeing

- VIC Department of Health and Human Services

If you would like any further information, please contact communications@aihw.gov.au or (02) 6249 5089.

Kind Regards,

Communications & Engagement Unit

Australian Institute of Health and Welfare

communications@aihw.gov.au | @aihw | aihw



From: Ellis, Catherine
To: Tomlinson, Benjamin
Cc: ACT Health DLO
Subject: ACTHD FOI Released Today - 23 October 2024
Date: Wednesday, 23 October 2024 5:24:00 PM
Attachments: ACTHDFOI24-25.07 Response.pdf

Hi Ben

Please find attached FOI response that was released today under the FOI Act to Schedule 2.2(a)(ii) following a request made on 10 September.

This will be publicly available on the disclosure log in 3-10 business days.

Thanks
Cath

Catherine Ellis | Senior Director
Ministerial and Government Services | ACT Health Directorate
Mob Schedule 2.2(a)(ii) Email: Catherine.Ellis@act.gov.au
Level 5, Bowes Street, Woden ACT



ACT Government | ACT Health

Our reference: **ACTHDFOI24-25.07**

Schedule 2.2(a)(ii)

Dear Schedule 2.2(a)(ii)

DECISION ON YOUR ACCESS APPLICATION

I refer to your application under section 30 of the *Freedom of Information Act 2016* (FOI Act), received by the ACT Health Directorate (ACTHD) on **Tuesday 10 September**.

This application requested access to:

'Under the FOI ACT I would like to be supplied with all papers related to the following briefings (a copy of the briefing paper):

MIN2024/00290 – Ongoing alleged coercive control;
MIN2024/Burrangiri – future options;
MIN2024/00406 – Update on Hydrotherapy Pool project and targeted engagement of creche closure ahead of construction;
MIN2024/00444 – Ministerial Brief – Birth Centre feasibility study;
MIN2024/00384 – Ministerial Brief – options relating to illicit drug overdose prevention and supervised drug consumption services in the ACT;
MIN2024/00494 – Ministerial Brief - Formal Designation of transfer of assets as a contribution by owner;
MIN2024/00372 - Ministerial Brief - Progress updates on the on the security of critical infrastructure requirements for ACT health Directorate and CHS;
MIN2024/00562 – Ministerial Brief – ACT Voluntary Assisted Dying Implementation - communications approach;
MIN2024/00580 - Ministerial Brief – West Belconnen Health Centre Update;
MIN2024/00575 – Ministerial Brief – Next steps with IVF Australia;
GBC2024/00079 – Ministerial Brief – Letter of offer from the Hon. Mark Butler MP; and
COR24/13985 – Question time brief: PopH #7 – Australian CDC Establishment.'

I am an Information Officer appointed by the Director-General of ACTHD under section 18 of the FOI Act to deal with access applications made under Part 5 of the Act. ACTHD was required to provide a decision on your access application by **Wednesday 23 October 2024**.

I have identified 13 documents holding the information within scope of your access application. These are outlined in the schedule of documents included at Attachment A to this decision letter.

Decisions
I have decided to:

- grant full access to four documents; and
- grant partial access to seven documents; and
- refuse access to one document.

My access decisions are detailed further in the following statement of reasons and the documents released to you are provided as Attachment B to this letter.

In reaching my access decision, I have taken the following into account:

- The FOI Act;
- The contents of the documents that fall within the scope of your request;
- The *Human Rights Act 2004*.

Full Access
I have decided to grant full access to the documents at references: 3-4 and 10-11.

Partial Access
I have decided to grant partial access to the documents at references: 1-2 and 5-9. These documents contain information that I consider, on balance, to be contrary to the public interest to disclose under the test set out in Section 17 of the FOI Act. These documents also include information that is taken to be contrary to the public interest to release under Schedule 1 of the FOI Act.

Refuse Access
I have decided to refuse access to the documents at reference 12. This document is comprised of information that would reveal deliberations of Cabinet and is therefore taken to be contrary to the public interest to release, under Schedule 1.6 (1)(d) the disclosure of which would reveal any deliberation of Cabinet.

Public Interest Factors Favouring Disclosure
The following factors were considered relevant in favour of the disclosure of the documents:

- Schedule 2, 2.1 (a)(i) promote open discussion of public affairs and enhance the government's accountability; and
- Schedule 2, 2.1 (a)(ii) contribute to positive and informed debate on important issues or matters of public interest.

Public Interest Factors Favouring Non-Disclosure
The following factors were considered relevant in favour of the non-disclosure of the documents:

- Schedule 2, 2.2 (a)(ii) prejudice the protection of an individual's right to privacy or any other right under the Human Rights Act 2004; and
- Schedule 2, 2.2 (a)(iii) prejudice security, law enforcement or public safety; and
- Schedule 2, 2.2 (a)(ix) prejudice the flow of information to the police or another law enforcement or regulatory agency; and
- Schedule 2, 2.2 (a)(x) prejudice intergovernmental relations; and
- Schedule 2, 2.2(a)(xi) prejudice trade secrets, business affairs or research of an agency or person; and
- Schedule 2, 2.2 (a)(xiii) prejudice the competitive commercial activities of an agency; and
- Schedule 2, 2.2 (a)(xv) prejudice the management function of an agency or the conduct of industrial relations by an agency.

Documents at references 1, 5, and 6 are partially comprised of personal information such as mobile numbers of ACT-Government employees and the names of Non-ACT Government Employees in accordance with Schedule 2, 2.2 (a)(ii) prejudice the protection of an individual's right to privacy or any other right under the Human Rights Act 2004.

Documents at references 2 and 7 are partially comprised of information classified as information that would be contrary to the public interest in accordance with Schedule 2, 2.2 (a)(xi) prejudice the business affairs of an agency.

Documents at references 2 and 8 are partially comprised of information classified as information that would be contrary to the public interest in accordance with Schedule 2, 2.2 (a)(xiii) prejudice the competitive commercial activities of an agency.

Documents at references 7 are partially comprised of information classified as information that would be contrary to the public interest in accordance with Schedule 2, 2.2 (a)(iii) prejudice security, law enforcement or public safety, Schedule 2, 2.2 (a)(ix) prejudice the flow of information to a regulatory agency and Schedule 2, 2.2 (a)(x) prejudice intergovernmental relations.

Documents at references 2 and 9 are partially comprised of cabinet information under Schedule 1.6, and under Schedule 1.6 (1) Cabinet Information, it is taken to be contrary to the public interest to release. Schedule 1.6 (1)(d) the disclosure of which would reveal any deliberation of Cabinet (other than through the official publication of a Cabinet decision).

Explanatory Note

The Infrastructure, Communications & Engagement Division has noted that in relation to the document at reference 9 (MIN2024/00580), that this particular brief was developed and provided reflective of a moment in time.

Charges

Processing charges are not applicable to this request.

Disclosure Log

Under section 28 of the FOI Act, ACTHD maintains an online record of access applications called a disclosure log. The scope of your access application, my decision and documents released to you will be published in the disclosure log not less than three days but not more than 10 days after the date of this decision. Your personal contact details will not be published.
https://www.health.act.gov.au/about-our-health-system/freedom-information/disclosure-log.

Ombudsman review

My decision on your access request is a reviewable decision as identified in Schedule 3 of the FOI Act. You have the right to seek Ombudsman review of this outcome under section 73 of the Act within 20 working days from the day that my decision is published in ACT Health's disclosure log, or a longer period allowed by the Ombudsman.

If you wish to request a review of my decision you may write to the Ombudsman at:

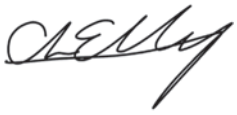
The ACT Ombudsman
GPO Box 442
CANBERRA ACT 2601
Via email: ACTFOI@ombudsman.gov.au
Website: ombudsman.act.gov.au

ACT Civil and Administrative Tribunal (ACAT) review
Under section 84 of the Act, if a decision is made under section 82(1) on an Ombudsman review, you may apply to the ACAT for review of the Ombudsman decision. Further information may be obtained from the ACAT at:

ACT Civil and Administrative Tribunal
Allara House
15 Constitution Avenue
GPO Box 370
Canberra City ACT 2601
Telephone: (02) 6207 1740
http://www.acat.act.gov.au/

Further assistance
Should you have any queries in relation to your request, please do not hesitate to contact the FOI Coordinator on (02) 5124 9831 or email HealthFOI@act.gov.au.

Yours sincerely



Catherine Ellis
Senior Director
Ministerial and Government Services

23 October 2024

ACT Government | ACT Health

FREEDOM OF INFORMATION SCHEDULE OF DOCUMENTS

Please be aware that under the *Freedom of Information Act 2016*, some of the information provided to you will be released to the public through the ACT Government's Open Access Scheme. The Open Access release status column of the table below indicates what documents are intended for release online through open access.
Personal information or business affairs information will not be made available under this policy. If you think the content of your request would contain such information, please inform the contact officer immediately.
Information about what is published on open access is available online at: http://www.health.act.gov.au/public-information/consumers/freedom-information

APPLICANT NAME	WHAT ARE THE PARAMETERS OF THE REQUEST	FILE NUMBER
Schedule 2.2(a)(ii) [redacted]	*'Under the FOI ACT I would like to be supplied with all papers related to the following briefings (a copy of the briefing paper):* *MIN2024/00290 – Ongoing alleged coercive control;* *MIN2024/Burrangiri – future options;* *MIN2024/00406 – Update on Hydrotherapy Pool project and targeted engagement of creche closure ahead of construction;* *MIN2024/00444 – Ministerial Brief – Birth Centre feasibility study;* *MIN2024/00384 – Ministerial Brief – options relating to illicit drug overdose prevention and supervised drug consumption services in the ACT;* *MIN2024/00494 – Ministerial Brief - Formal Designation of transfer of assets as a contribution by owner;* *MIN2024/00372 - Ministerial Brief - Progress updates on the on the security of critical infrastructure requirements for ACT health Directorate and CHS;* *MIN2024/00562 – Ministerial Brief – ACT Voluntary Assisted Dying Implementation - communications approach;* *MIN2024/00580 - Ministerial Brief – West Belconnen Health Centre Update;* *MIN2024/00575 – Ministerial Brief – Next steps with IVF Australia;* *GBC2024/00079 – Ministerial Brief – Letter of offer from the Hon. Mark Butler MP; and* *COR24/13985 – Question time brief: PopH #7 – Australian CDC Establishment.'*	**ACTHDFOI24-25.07**

Ref Number	Page Number	Description	Date	Status Decision	Factor	Open Access release status
1.	01 - 03	MIN2024/00290 - Response to Mr Peter Cain MLA - Ongoing alleged coercive control [REDACTED]	17 May 2024	Partial Release	Schedule 2.2(a)(ii) Privacy	YES
2.	04 - 11	MIN2024/294 - Burrangiri Aged Care Respite Centre – Future options for service and facility	22 May 2024	Partial Release	Schedule 1.6 Cabinet Schedule 2.2(a)(xi) Business affairs Schedule 2.2(a)(xiii) Commercial activities Section 2.2(a)(xv) Management functions	YES
3.	12 - 16	MIN2024/00406 - MIN2024/00406 - To provide an update on the Hydrotherapy pool project and targeted engagement for creche closure ahead of construction	04 June 2024	Full Release		YES
4.	17 - 22	MIN2024/00444 - Freestanding Birth Centre Feasibility Study	12 June 2024	Full Release		YES
5.	23 - 27	MIN2024/00384 - Illicit drug overdose harm reduction and considerations for a supervised drug consumption service	13 June 2024	Partial Release	Schedule 2.2(a)(ii) Privacy	YES
6.	28 - 31	MIN2024/00494 - Formal designation of transfer of assets as a contribution by owners	18 June 2024	Partial Release	Schedule 2.2(a)(ii) Privacy	YES

7.	32 – 39	MIN2024/00372 - Progress update on the Security of Critical Infrastructure requirements for ACT Health Directorate and Canberra Health Services	21 June 2024	Partial Release	Schedule 2.2(a)(iii) Security Schedule 2.2(a)(ix) Information to regulatory agency Schedule 2.2(a)(x) Intergovernmental relations Schedule 2.2(a)(xi) Business Affairs	YES
8.	40 - 44	MIN2024/00562 - ACT Voluntary Assisted Dying Implementation – Communications Approach	05 July 2024	Partial Release	Schedule 2.2(a)(xi) Business affairs	YES
9.	45 - 50	MIN2024/00580 - West Belconnen Health Centre Site Selection	10 July 2024	Partial Release	Schedule 1.6 Cabinet	YES
10.	51 - 57	MIN2024/00575 - Assisted Reproductive Technology (ART) Communications Strategy	16 July 2024	Full Release		YES
11.	58 - 59	COR24/13985 - GBC24/262 - Australian Centre for Disease Control establishment	30 May 2024	Full Release		YES
12.	N/A	GBC2024/00079 - Letter of offer from the Hon. Mark Butler MP – [REDACTED]	10 July 2024	Refuse Release	Schedule 1.6 Cabinet	NO
Total Number of Documents						
12						

OFFICIAL

MINISTERIAL BRIEF

ACT Health Directorate

To:	Minister for Mental Health	**Tracking No.: MIN2024/00290**
From:	Prof Anthony Cidoni, A/g Chief Psychiatrist	
Through:	Robyn Hudson, Deputy Director-General, Policy and Transformation	
Subject:	Response to Mr Peter Cain MLA - Ongoing alleged coercive control [redacted]	
Critical Date:	Not applicable	
Critical Reason:	Not applicable	

Recommendation

That you:

1. Sign the attached letter of response to Mr Peter Cain MLA at Attachment A.

Signed / Not Signed / Please Discuss

Emma Davidson MLA ..../...../.....

Minister's Office Feedback

Background

1. On 5 April 2024, Mr Peter Cain MLA wrote to you to provide information about an alleged case of domestic violence and coercive control. Mr Cain advised that the previous Chief Psychiatrist had reviewed the matter in 2018 and cited concerns that an incorrect decision was made. It was requested that the Chief Psychiatrist engage in a new review of the matter.

Issues

2. Due to health privacy constraints, the ACT Health Directorate are not to comment on or share information about the specific case.

3. Since the initial review of the matter in 2018, the Chief Psychiatrist has since been separated from the Director of Clinical Services role, with the latter holding responsibility for the provision of services.

4. The Chief Psychiatrist does not have the power under the *Mental Health Act 2015* to investigate and manage complaints.

5. The Chief Psychiatrist is therefore unable to assist any further in relation to this matter.

Financial Implications

6. Not applicable.

Consultation

Internal

7. Not applicable.

Cross Directorate

8. Canberra Health Services (CHS) was consulted in preparation of this response.

External

9. Nil

Work Health and Safety

10. Not applicable.

Benefits/Sensitivities

11. The response letter outlines services who are more appropriately placed to respond to the concerns, including CHS and ACT Human Rights Commission.

Communications, media and engagement implications

12. Not applicable.

Signatory Name:	Associate Professor Anthony Cidoni, A/g Chief Psychiatrist	Phone:	[redacted]
Action Officer:	Camille Falkiner	Phone:	5124 6137

Attachments

Attachment	Title
Attachment A	MIN2024/00290 - Letter of Response to Mr Peter Cain MLA

OFFICIAL SENSITIVE

MINISTERIAL BRIEF

ACT Health Directorate

To:	Minister for Health	**Tracking No.: MIN2024/00294**
From:	Rebecca Cross, Director-General	
Through:	Robyn Hudson, Deputy Director-General, Policy and Transformation Liz Lopa, Deputy Director-General, Corporate, Communications and Delivery	
Subject:	Burrangiri Aged Care Respite Centre – Future options for service and facility	
Critical Date:	06/06/2024	
Critical Reason:	To seek agreement to and provide information on current provider of Burrangiri and future options for the ACT respite services.	

Recommendations

That you:

1. [redacted]

   a. [redacted]

   Agreed / Not Agreed / Please Discuss

   b. [redacted].

   Agreed / Not Agreed / Please Discuss

2. Note that further policy work needs to be undertaken to determine the long-term options for ACT respite services; and

   Noted / Please Discuss

3. [redacted]

   Noted / Please Discuss

Rachel Stephen-Smith MLA ..../...../.....

Minister's Office Feedback

Background

1. A brief was recently prepared for you regarding future options for the Burrangiri Aged Care Respite Centre ('Burrangiri') (MIN2023/00918 refers). You requested additional information which is addressed in (Attachment A) and further below.

2. Since 1989 the ACT Health Directorate (ACTHD) has contracted the Salvation Army (TSA) to operate a 15-bed aged care respite centre, Burrangiri Aged Care Respite Centre ('Burrangiri'), which provides overnight planned and emergency respite, post-hospital convalescent care, and a day centre program.

Arcadia House

3. Located in Bruce, Arcadia House is operated by Directions ACT under a contract with the ACT Health Directorate. It is a 12-bed unit that provides withdrawal, residential and day treatments for adults with severe alcohol and other drug (AOD) problems, treatments including:

    a. one-two week withdrawal program;

    b. 12 week day program;

    c. 12 week residential program with additional 'step-down' four week day program. Those living in NSW can complete the four week 'step-down' stage of the program online; and

    d. continuum of care is provided to clients prior to admission and on discharge.

4. Demand projections indicate that the service offering provided by Directions at Arcadia House will remain steady until 2033 with current capacity of 12 patients (ten from ACT and two from NSW).

5. The facility operates 24 hours a day, seven days a week. It is a residential style setting that is defined under the Territory Plan 2023 as Supportive Housing in that it is residential accommodation for persons in need of support, provides a range of support services, counselling, domestic assistance and personal care for residents as required.

6. Admissions are voluntary and admissions and discharge are typically conducted during regular business hours.

Issues

Current contract with TSA for Burrangiri

7. The current contract with TSA for operation of services at Burrangiri expires 30 June 2024. The contract provides for a four-month transition out clause (schedule 6), which automatically commences four-months prior (1 March 2024) to the agreement expiry.

8. To allow adequate time and consideration of other feasible options for the provision of respite care in the ACT, ACTHD will extend the TSA's contract until 30 June 2025.

9. [redacted]

10. Burrangiri's target group is older people in the ACT (aged 65 years and over), including people with dementia and their carers. However, Burrangiri is not an Australian Government approved provider of aged care services, thus, patients do not require an aged care assessment to be admitted to the facility.

11. Burrangiri is a 30-year-old facility owned by the ACT Government. The condition of the building is lower than the expected standard for this type of facility.

12. [redacted]

Difficulties in accessing respite care in the ACT

13. The provision of respite aged care is a Commonwealth responsibility, with the Commonwealth funding respite and other short-term aged care for eligible people in Residential Aged Care Facilities (RACFs).

14. RACFs require clients to have an aged care assessment prior to being provided a place, including those accessing respite care.

15. In principle this should allow hospitals to rapidly discharge patients to Burrangiri (as it does not require an aged care assessment to access), including after hours and on weekends.

- [redacted]
- [redacted]

- There is a demand to support people of all ages to transition from hospital to home, particularly long-stay patients who medically ready for discharge.

16. There has been an increase in the number of inquiries from clients with complex needs for Burrangiri, including bariatric patients, those with substance abuse, and clients with complex mental health conditions. Providing services for these patients exceeds the service capacity and capability of the facility, and therefore TSA has been unable to accept these patients, who may then be admitted to hospitals unnecessarily.

Burrangiri asset assessment

17. Burrangiri is a 15-bedroom facility with five toilets and 4 shower and toilet rooms.

18. [redacted]

19. [redacted]

20. Minor repairs and maintenance can continue to keep the facility safe for operation to cover the extension of the contract (i.e., to 30 June 2025).

21. The definition of respite care under the Territory Plan 2023 is captured as "Supportive Housing" which is defined as: "the use of land for residential accommodation for persons in need of support, that provides a range of support services such as counselling, domestic assistance and personal care for residents as required. Although such services must be able to be delivered on site, management and preparation may be carried out on site or elsewhere." (Territory Plan 2023). A facility for the treatment of adults with alcohol and other drug dependencies is likely to be captured under this same definition, however legal advice is required before undertaking detailed planning to confirm this assumption.

Relationship to Northside Hospital

22. [redacted]

23. [redacted]

24. Given the importance and uptake of the existing services, there is a need to maintain service delivery, this means we need to deliver new accommodation, and commission it before the site can be cleared for use by the hospital redevelopment.

25. ACTHD has been exploring options for the permanent relocation of these services to provide certainty to consumers and operators. To date, no suitable permanent option for Directions has been identified. ACTHD is now exploring temporary options.

26. [redacted]

27. [redacted]

28. [redacted]

29. [redacted]

30. [redacted]

31. [redacted]

Timing

32. [redacted]

Next steps

33. Infrastructure, Communications and Engagement (ICED) will determine any necessary, immediate works required at Burrangiri associated with the contract extension.

34. [redacted]

35. [redacted]

Consultation

Internal

36. The brief was jointly developed by Ageing and End of Life Branch and the Northside Hospital Project Teams.

Cross Directorate

37. The Environment, Planning and Sustainable Development Directorate (EPSDD) has been consulted on land use questions.

External

38. Carers ACT provided feedback on their view of respite services in the ACT.

39. [redacted]

Work Health and Safety

40. Not applicable.

Benefits/Sensitivities

41. [redacted]

to Burrangiri on Friday 10 May 2024; at the time of this brief, the contract had not yet been executed.

42. The TSA General Manager, Fiona Sanders has requested a meeting with the Executive Branch Manager Ageing & End of Life in June 2024, to discuss:
    a. [redacted]
    b. [redacted]
    c. [redacted]
    d. [redacted]
    e. [redacted]

43. You will be briefed on the outcome of this meeting.

44. [redacted]

Financial Implications

45. [redacted]

46. [redacted]

47. [redacted]

Communications, media and engagement implications

48. [redacted]

49. [redacted]

50. [redacted]

[redacted]

Signatory Name:	Rebecca Cross, Director-General	Phone:	5124 9400
Action Officer:	Michael Culhane, Executive Group Manager, Policy, Partnerships & Programs Catherine Loft, Executive Group Manager, Infrastructure Communication and Engagement	Phone	MS Teams

Attachments

Attachment	Title
Attachment A	Further information requested on Burrangiri

ACT Health Directorate

To:	Minister for Health	**Tracking No.: MIN2024/00406**
CC:	Rebecca Cross, Director-General, ACT Health Directorate	
From:	Catherine Loft, Executive Group Manager, Infrastructure, Communication and Engagement Division	
Through:	Liz Lopa, Deputy Director-General, Corporate, Communications and Delivery	
Subject:	To provide an update on the Hydrotherapy pool project and targeted engagement for creche closure ahead of construction	
Critical Date:	Not applicable	
Critical Reason:	Not applicable	

Recommendations

That you:

1. Note the Communication on a Page at Attachment A; and

Noted / Please Discuss

2. Note the start of targeted engagement at Tuggeranong Lakeside Leisure Centre.

Noted / Please Discuss

Rachel Stephen-Smith MLA ..../...../.....

Minister's Office Feedback

Background

1. The ACT Government is building a new southside hydrotherapy pool next to the Tuggeranong Lakeside Leisure Centre. The 2022-23 ACT Budget provided funding for the detailed design and construction of a Southside Hydrotherapy pool (project) at this site.

2. During the concept and preliminary design of the new facility, ACT Health Directorate (ACTHD) undertook significant community engagement and took on board a range of feedback and lessons learnt from other hydrotherapy pools around Australia, including the University of Canberra Public Hospital.

3. The Development Application (DA) was officially lodged for assessment on 29 August 2023. The conditional Notice of Decision was received on 2 November 2023. The DA stamped plans were released in March 2024.

4. To facilitate the delivery of this project, ACTHD sought a suitably qualified and experienced Head Contractor to undertake the final design (Building Approval design) and construction of the pool and associated works.

5. The Head Contractor tender evaluation was completed in early 2024. Monarch Building Solutions was awarded the tender for this work.

6. The leisure centre is currently managed by Belgravia Leisure on behalf of the ACT Government. This contract is managed by ACT Property Group (ACTPG).

7. The scope of works for the project includes both the hydrotherapy pool, and relocation of the existing creche facility which has been identified as the preferred location for the pool.

8. You completed a sod turn media event on site on 26 February 2024. This opportunity also announced the successful Head Contractor.

Issues

9. Construction of the new hydrotherapy pool is due for completion in May 2025 and a new creche is required as the site of the current creche is in the chosen location of the new pool. The new facility will include a new creche that has been upgraded to be a multipurpose room including a space for additional community uses.

10. To enable this, the existing creche is required to be temporarily closed (no creche services offered) for a period of up to 16 weeks (Mid June 2024 - mid October 2024). The creche on site currently operates Mondays, Tuesdays and Thursdays 9am-12pm.

11. On 1 May 2024, ACTPG advised ACTHD via email that the Minister for Education and Youth Affairs supported the approach to close the creche service at the leisure centre for 16 weeks, to allow for construction to proceed (Attachment B).

12. It is estimated that the creche is used less than ten times a week, following feedback from a recent survey of its users undertaken by Belgravia Leisure, the operator of the Lakeside Leisure Centre.

13. ACTHD is working with ACTPG and Belgravia, to deliver a series of pop-up engagements on the site over three days to inform the users of the leisure centre about the temporary closure of the creche and understand how it could affect them.

14. The pop-ups are proposed to occur 9am-12pm on:

    a. Monday, 3 June 2024;

    b. Tuesday, 4 June 2024; and

    c. Thursday, 6 June 2024.

15. These pop-ups would involve casual but meaningful conversations with people using the leisure centre and the creche during those days it is open.

16. This would be an informal, small and highly targeted in-person engagement activity for the current users of the creche.

17. The pop-ups will provide ACTHD representatives the opportunity to highlight the investments being made to the new hydrotherapy pool and other health infrastructure in the area, such as the South Tuggeranong Health Centre and the Canberra Hospital Master Plan.

18. This engagement would be notified via the Built for Canberra website and through letters to users.

19. It has been planned so that it targets visitors to the centre while they use the facilities in times where the creche is available. Therefore, it is recommended that wider communications, the YourSay platform or an end-of-engagement listening report are not needed.

20. ACTHD will continue to use its social media channels to provide the community with construction updates and information on the new hydrotherapy pool as the project progresses.

21. ACTHD will send a letter to community members who have participated in previous consultation in the coming weeks with an update on the project and the handover to the Head Contractor.

Financial Implications

22. The 2022-23 ACT Budget provided $8.5m funding for the detailed design and construction of the Southside Hydrotherapy Pool.

23. ACTHD are working with ACTPG on the development of the Operational Expenditure business case for reoccurring maintenance cost. The submission is forecasted for mid-year cabinet review.

24. There is no financial cost to undertaking this community engagement.

Consultation

Internal

25. Not applicable.

Cross directorate

26. There have been discussions with ACTPG about this proposed engagement, and they are supportive of ACTHD informing the users about these temporary changes.

External

27. Belgravia Leisure have been consulted on the development of the engagement activities and are supportive of the approach.

Work Health and Safety

28. Not applicable.

Benefits/Sensitivities

29. Usage of the creche is low, but will still be a disruption for users. This is being managed by the in-person engagement and updates provided to users.

30. The in-person engagement provides the opportunity to also highlight the significant investment that is being made to health infrastructure in the Tuggeranong area and across Canberra.

Communications, media and engagement implications

31. Closure of the creche may gain the attention of media outlets. This will be managed with talking points.

Signatory Name:	Catherine Loft, Executive Group Manager, Infrastructure, Communication and Engagement Division	Phone:	Via Teams
Action Officer:	Matthew Drennan, Director, Communications and Engagement	Phone:	Via Teams

Attachment

Attachment	Title
Attachment A	Communication on a Page
Attachment B	Email confirmation of Creche closure from Property Group

OFFICIAL

OFFICIAL SENSITIVE

MINISTERIAL BRIEF

ACT Health Directorate

To:	Minister for Health	**Tracking No.: MIN20204/00444**
From:	Liz Lopa, Deputy Director-General, Corporate, Communications and Delivery	
cc:	Rebecca Cross, Director-General	
Subject:	Freestanding Birth Centre Feasibility Study	
Critical Date:	18/06/2024	
Critical Reason:	To provide an update on the freestanding birth centre feasibility study and progress the study to stakeholder engagement.	

Recommendations

That you:

1. Note the scope of the (freestanding) birth centre feasibility study Attachment A; and

Noted / Please Discuss

2. Agree to the communications plan detailing the stakeholder engagement strategy for the (freestanding) birth centre feasibility study Attachment B.

Agreed / Not Agreed / Please Discuss

Rachel Stephen-Smith MLA ..../...../.....

Minister's Office Feedback

Background

1. On 7 February 2023, a letter with a copy of the terms of Petition 042-222 and 001-23 was lodged by Ms Jo Clay MLA, calling on the ACT Government to invest in building a freestanding birth centre in the north side of Canberra.

2. On 28 March 2023, in recognition of the significance of Petition 042-222 and 001-23, a letter was issued to the Clerk of the ACT Legislative Assembly, affirming the Government's commitment to consider the early design and feasibility of establishing a co-designed freestanding birth centre in the context of the current health service planning for a new northside hospital.

3. As a result of the ACT Government committing to consider the freestanding birth centre, the ACT Health Directorate (ACTHD) has undertaken to deliver the feasibility study as part of the planning and development of the Northside Hospital Project (NHP). The feasibility study is being delivered in collaboration with the Maternity in Focus team who are committed to delivering the ACT Public Maternity System Plan 2022-2032 to improve maternity services to women or pregnant person and their family.

4. In January 2024, ACT Health issued a Request for Quote and approached three suitable consultants. From the evaluation process, the evaluation team selected a preferred supplier: HealthConsult. HealthConsult commenced the project in April 2024 and will undertake the study over four months. They will review and analyse available maternity data, and engage stakeholders such as ACT Government employees, a working group of subject matter experts, and community representatives.

5. Definitions of birth centre options are defined in Figure 1.

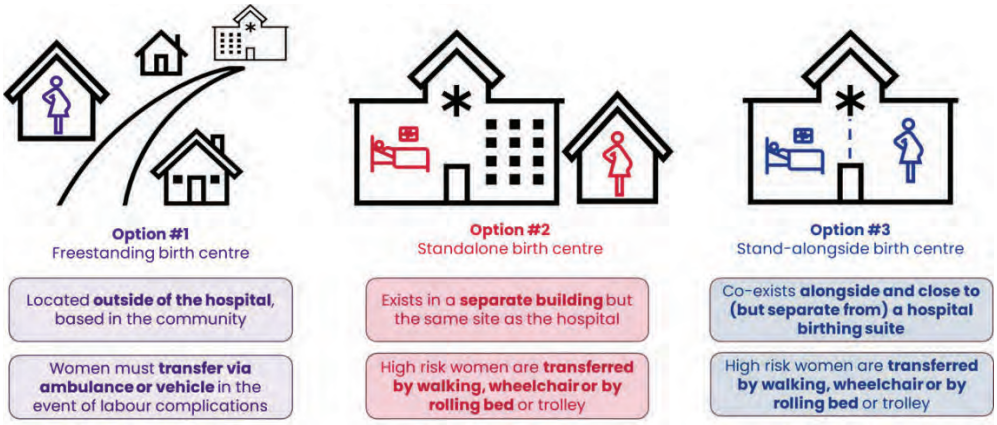


Figure 1- Birth Cente Definitions

Issues

Statement of Requirements (SOR)

6. A codesign approach was undertaken to build the project scope and SOR for the freestanding birth centre feasibility study.

7. To achieve this, a working group of subject matter experts from Canberra's maternity hospitals, Maternity in Focus, and the Office of the Chief Nursing and Midwifery was established to guide and recommend desired outcomes to be achieved from the feasibility study. The resulting SOR is available at Attachment A.

8. The study will provide recommendations on whether a freestanding within the community or a standalone (freestanding) as part of the northside hospital redevelopment is or isn't feasible based on the methodology in the SOR.

9. If feasible the study will make recommendations about the scope, size and possible workforce models, and advise on the impact of these options on the current planned birth suites in the new northside hospital.

10. Should the study recommend that a freestanding or standalone (freestanding) isn't feasible, the consultant will provide recommendations on an stand-alongside birth centre that co-exists alongside a hospital birthing suite and other maternity services to meet maternity services now and into the future.

11. Other recommendations for the birth centre will include clinical capacity, eligibility/exclusion criteria, and culturally safe spaces for women or persons.

Methodology and timeframes

12. The feasibility study officially started in early April 2024 and will run until mid-September. The first stage requires the consultant to fully understand the background, purpose, key stakeholders, and project outputs. This stage also includes developing stakeholder engagement, risk, and project plans.

13. The study is currently in stage two, with the consultant undertaking the internal ACT Government engagement to understand the current ACT maternity system, reviewing, and analysing the available data on population and birthing trends and maternity service utilisation, and developing the situation analysis summary report. Also, in this stage, the first workshop with the working group (subject expert matters) to seek their input commences.

14. Stage three of the project continues the stakeholder engagement with internal ACT Government stakeholders. At this stage, the consultant will develop a feasibility assessment report, identify options, and create the options assessment criteria for presenting to the working group for feedback.

15. In stage four, the consultant will undertake targeted stakeholder engagement with peak bodies, targeted focus groups, and clinical engagement focus groups. At this stage, the consultant will start to define the service scope, size, patient eligibility criteria, model of care, and workforce requirements for a birth centre and continue to engage with the working group. ACTHD will also be looking at land studies and indicative costings.

16. At stage five, the consultant will analyse expected costs and benefits associated with the relevant options, develop an options evaluation paper against the agreed criteria, and present it to ACTHD and the working group. At this stage, the consultant will deliver a draft of the final options assessment report for feedback and finalisation by mid-September.

Stakeholder engagement and consultation

17. Stakeholder engagement and consultation is a key component of the feasibility study, and a communication strategy for stakeholder engagement has been created to capture the activities to be undertaken by HealthConsult as part of the feasibility study. This is for your agreement at Attachment B. The study will focus on engaging targeted audiences to understand the current ACT maternity service, current workforce requirements, models of care and population growth analysis. The consultant will also conduct focus groups to understand perspectives on the role and feasibility of a standalone birth centre located in the community. This will include stakeholders invited from the Maternity in Focus stakeholder pool, community advocates and e-petition participants, local Aboriginal and Torres Strait Islander representatives, cultural groups, and consumers arranged in partnership with Health Care Consumers Association.

18. Approximately 70 stakeholders, including allied health, non-government organisations (NGOs), general practice, Aboriginal and Torres Strait Islander peoples, academic and university partners, midwives, and obstetricians are registered as part of the Maternity in Focus consultation pool. The Maternity in Focus team recently contacted these stakeholders to seek their continuing engagement on the Maternity in Focus YourSay private page where opportunities to participate in a range of research projects will be advertised. The current work will use this private page to encourage participation in a focus group, facilitated by the consultant, to understand the role and feasibility of a freestanding birth centre located in the community or standalone on a hospital campus.

19. The consultant will also conduct a focus group for local Aboriginal and Torres Strait Islander peoples and cultural groups, using the established focus group that currently provides input to Maternity in Focus for the Birthing on Country. The consultant will also reach out to local culturally and linguistically diverse groups for their viewpoint and provide context on what is a birth centre and how stakeholders would use the centre; this approach will provide the groundwork to establish relationships for further discussion once a recommendation is endorsed and when further consultation is required.

20. The final strategy for stakeholder consultation is a focus group with the e-petition participants via the Friends of the Birth Centres Canberra Facebook page.

Future design with the new northside hospital

21. ACTHD is leading the delivery of a masterplan and precinct strategy for the North Canberra Hospital campus in synergy with the new northside hospital project.

22. Should the study's recommendation indicate that the preferred location of a birth centre is a standalone on the new hospital campus, ACTHD will ensure the North Canberra Hospital campus masterplan reflect this with an appropriate footprint identified, noting that a separate business case and appropriate delegate approval will be required to progress the project beyond the feasibility study and further develop the design and construction of the centre.

Next steps

23. ACTHD will provide a further briefing when the outcomes of the feasibility study are understood.

Consultation

Internal

24. The Infrastructure Policy and Planning branch has continuously consulted with the Maternity in Focus team throughout the process and acknowledges that this study will support the delivery of the Maternity in Focus System from 2022 to 2032 and the commitment to increase the continuity of care model to 50 per cent by 2028.

Cross Directorate

25. To support the project, Canberra Health Services (CHS) has been consulted to obtain maternity data and site visits to the Canberra and Northside hospitals.

26. Executive staff from CHS are members of the working group.

External

27. The Maternity in Focus Advisory Group, which consists of members who represent a wide range of consumers and the maternity sector from allied health, NGOs, general practices, Aboriginal and Torres Strait Islander peoples, academic and university partners, midwives, and obstetricians. ACTHD and HealthConsult presented to the group on 2 May 2024 to seek their feedback on the project and advice on the best approach for the stakeholder engagement stages.

Benefits/sensitivities

28. The birth centre feasibility study was initiated from an e-partition from the local community wanting a freestanding birth centre within the community, and depending on the outcome, this may cause public sensitivities.

29. The birth centre feasibility study will support the Maternity in Focus System from 2022 to 2032 through a broader understanding of the need and demand for a birth centre and how this may increase the continuity of care model and support Birthing on Country.

Financial implications

30. ACTHD will fund the consultant's engagement from the approved 2023/2024 and 2024/25 financial year budget for the NHP.

Communications, media and engagement implications

31. The ACTHD Communications and Engagement team has supported the project and developed a communications plan for stakeholder engagement included at Attachment B. They will also provide advice to the consultants to ensure the birth centre feasibility study consults with the right people at the right time.

Signatory Name:	Liz Lopa, Deputy Director-General, Corporate, Communications and Delivery	Phone:	5124 9400
Action Officer:	Justeen Stapleton, Infrastructure Policy, and Planning Catherine Loft, Executive Group Manager, Infrastructure Communication and Engagement	Phone	MS Teams

Attachments

Attachment	Title
Attachment A	Statement of Requirements
Attachment B	Communications plan

OFFICIAL

MINISTERIAL BRIEF

ACT Health Directorate

To:	Minister for Population Health	**Tracking No.: MIN2024/00384**
Through:	Rebecca Cross, Director General	
From:	Maria Travers, A/g Executive Group Manager, Population Health Division	
Subject:	Illicit drug overdose harm reduction and considerations for a supervised drug consumption service	
Critical Date:	17/06/2024	
Critical Reason:	To ensure that ACTHD can include any Ministerial input into contract negotiations with the successful provider for the Harm Reduction Review	

Recommendation

That you:

1. Note the information contained in this brief and attachments.

Noted / Please Discuss

Emma Davidson MLA …….. …../…../…..

Minister's Office Feedback

Background

1. You requested this brief following your visit in April to the East Richmond Medically Supervised Injecting Room and the recent increased detection of Nitazenes, a type of highly potent synthetic opioid, both nationally and in the ACT.

2. In 2020, ACT Health Directorate (ACTHD) commissioned the Burnet Institute to undertake a feasibility study for a potential ACT medically supervised injecting facility (MSIF) (the Burnet Report). This addressed one of the actions in the ACT Drug Strategy Action Plan 2018-2021. The Burnet Report recommended that it would be feasible to establish an MSIF in the ACT. The Burnet project was not required to comment on whether an MSIF should be a high priority option for the ACT.

3. Funding was allocated in the 2021-22 Budget to 'explore options for a Medically Supervised Injecting Facility, including a suitable service model and a potential location'. The ACT Drug Strategy Action Plan 2022-2026 also includes a commitment to 'work towards establishing a supervised injecting service tailored to the ACT'.

Issues

4. While the Burnet Report recommended that it would be feasible to establish an MSIF in the ACT, it did not consider whether a Drug Consumption Room (DCR) or MSIF would be the most impactful and cost-effective harm reduction intervention.

5. The ACT's harm reduction landscape has also changed since the feasibility study. This includes the introduction of nation-leading harm reduction initiatives, such as the establishment of a fixed-site drug checking service and amendments to the *Drugs of Dependence Act 1989* (ACT).

6. Commissioning in the Alcohol, Tobacco and Other Drugs (ATOD) sector, which is currently underway, will also impact the current mix of support services being delivered by Non-Government Organisations (NGOs).

7. Another emerging issue is the potential for an increase in the use of potent synthetic opioids (e.g. Fentanyl and Nitazenes) in the ACT. Synthetic opioids are more potent and cheaper than other opioids (e.g. heroin). Both the United States and Canada have experienced ballooning rates of overdose deaths from deliberate and unintentional synthetic opioid use, with 107,000 overdose deaths in the US in 2021, representing 1 death per 3,100 people.

8. The illicit drug market is vulnerable to contamination by synthetic opioids where the substance is sold as heroin or another drug including to people who are intending to buy stimulants or hallucinogens. In January, for example, three people were hospitalised in Sydney after they ingested pills sold as MDMA.

9. Further information on the considerations for a DCR and the ACT's current harm reduction landscape is contained in the policy paper at Attachment A.

Harm Reduction Review

10. Given these changes and the limitations of the Burnet Report, ACTHD is procuring expertise to undertake an independent Harm Reduction Review (the Review). The Review is required to determine the strengths, gaps and opportunities for harm reduction in the ACT. This will include consideration of whether a DCR would meet the needs of the ACT community and if so, what specific model would be most appropriate. It will also consider whether any alternative interventions or adjustments to existing services are better suited for the local context.

11. A Request for Quotation (RFQ) was issued to academics with alcohol and other drug expertise on 14 May 2024. The RFQ contains the proposed Statement of Requirements for the Review Attachment B, which includes consideration of:

    a. What harm reduction services are currently working well in the ACT, what needs improvement and where the gaps are in the system?

    b. Whether a DCR is required in the ACT?

    c. The ACT's readiness to respond to changes in the illicit drug market, including a potential rise in potent synthetic opioids.

12. The review will include a brief literature review as well as stakeholder engagement. Additionally, ACTHD will provide the Supplier with any relevant qualitative and quantitative data it has access to. This may include, for example, information from the ATOD commissioning process, development of the ACT Drug Strategy Action Plan 2022-2026, and the evaluation of the fixed-site drug checking service pilot.

13. Subject to contract negotiations, a final report is expected to be delivered in December 2024. The report is expected to summarise the Review's findings and include recommendations for practical options to improve and future-proof the ACT's ATOD harm reduction services, especially if there is an increase in potent synthetic opioids.

14. While the scope of the Review is broadly constrained by the Statement of Requirements and funding limitations, ACTHD will seek to address any Ministerial feedback on the Review through contract negotiations with the successful Supplier.

Financial Implications

15. The funding available for the Review is limited to $165,000 remaining from the 2021-22 MSIF Budget measure. The RFQ for the Review has been scoped to ensure that it can be delivered within that funding envelope.

Consultation

Internal

16. Not applicable.

Cross Directorate

17. The Review will provide opportunity for cross-government consultation, particularly with Canberra Health Services, Community Services Directorate and the Justice and Community Safety Directorate.

External

18. ACTHD has engaged with key staff from the MSIFs in Kings Cross and Richmond, as well as with ATOD academics regarding considerations for establishing and operating a DCR.

Work Health and Safety

19. Some DCR models are associated with various Work, Health and Safety risks. The nature of the model (for example the presence of drug inhalation versus only injection) will affect risk. A risk assessment will be undertaken as part of considerations of any DCR model(s) that could be appropriate for the ACT.

Benefits/Sensitivities

20. The Review will improve understanding of the ACT harm reduction landscape, now and into the future, which can in turn inform Government decision making.

21. Development of the ACT Drug Strategy Action Plan 2022-2026 and ATOD commissioning involved considerable stakeholder engagement and a review of the current ATOD sector. Rather than duplicating this work, the Review will leverage the data and insights from these processes and will focus on discrete gaps and areas for improvement, including for a DCR.

22. Harm reduction policy, and DCRs specifically, can attract significant community and media interest. Any proposal for a DCR may attract geographically localised sectionalist concerns (especially if a location is proposed), and media attention.

Communications, media and engagement implications

23. ACTHD will work with your office regarding any future public communications relating to the Review and DCRs.

Signatory Name:	Maria Travers, A/g Executive Group Manager, Population Health Division	Phone:	[redacted]
Action Officer:	Megan Arnold, Senior Director, ATOD Policy	Phone:	MS Teams

Attachments

Attachment	Title
Attachment A	Policy Paper: Considerations for supervised drug consumption and harm reduction in the ACT
Attachment B	Request for Quotation Statement of Requirements

OFFICIAL

MINISTERIAL BRIEF

ACT Health Directorate

To:	Minister for Health	**Tracking No.: MIN2024/00494**
CC:	Janet Wilson, A/g EGM, Corporate & Governance, ACT Health Directorate	
From:	Muku Ganeshalingam, Chief Finance Officer, ACT Health Directorate	
Subject:	Formal designation of transfer of assets as a contribution by owners	
Critical Date:	20/06/2024	
Critical Reason:	Formal designation required prior to transfer of assets scheduled for 30/6/2024	

Recommendation

That you:

1. Agree that this brief will act as the formal designation for the transfer to be considered a contribution by owner in equity, as required in Australian Accounting Standards.

Agreed / Not Agreed / Please Discuss

Rachel Stephen-Smith MLA ……..…….. …../…../…..

Minister's Office Feedback

Background

1. The ACT Health Directorate (ACTHD) owns land and building assets comprising:
    a. multi-storey public carpark at North Canberra Hospital, and
    b. Clare Holland House.

ACTHD intends to transfer these assets to Canberra Health Services (CHS) following the execution of the Health Infrastructure Enabling Act 2023, which brought North Canberra Hospital and Clare Holland House under the control of CHS.

2. The transfer of these assets has been approved by the relevant parties, refer to Attachment A.

3. The transfer will occur on 30 June 2024.

4. As per Australian Accounting Standards, as this is not a Restructure of Administrative Arrangements, in order for the transfer of assets to be considered an equity contribution by owners, a formal designation is required to be approved by the owners.

5. A Whole of Government (WhoG) ACT Accounting Policy Paper for the treatment of Contribution by Owners (AASB 1004 and Interpretation 1038) has been issued, which outlines the requirements of the Designation.

Issues

6. In order to recognise the transfer of the assets as an equity 'contribution by owners' to CHS and a 'distribution to owners' by ACTHD, there must be a formal designation by the 'owners' of the transferring agency.

7. As per WhoG ACT Accounting Policy Paper 116 – Contributions by Owners (AASB 1004 and Interpretation 1038), an 'owner' can include either the Cabinet or the Portfolio Minister of the transferring agency (i.e. the transferor).

   Your agreement to this brief will act as a formal designation by the owners of the asset that the transfer is an equity contribution to be recognised as a 'Contribution by owners' against 'Accumulated Funds' for CHS and a 'Distribution to owners' against 'Accumulated Funds' for ACTHD.

8. Without a formal designation, ACTHD will be required to recognise the transfer as a loss arising from contribution of assets and CHS would recognise a revenue for the gain arising from contribution of assets.

Financial Implications

9. It is calculated that at the transfer date of 30 June 2024 the land and buildings will have a fair value of $36,153,061, which is consistent with the carrying value recorded by ACTHD at the transfer date. As already agreed by the relevant parties, they will be transferred to CHS for nil consideration.

10. Regardless of whether the transfer is treated as equity or recognised in the Operating Statement, the transfer will be recognised at fair value, which will be $36,153,061.

11. With a designation as a contribution by/distribution to owners, this will be recognised within equity and the transfer itself will have nil impact on the Headline Net Operating Balance or Operating result of either Directorate. It will result in an increase in assets and total equity in CHS, and a corresponding reduction in assets and total equity of ACTHD.

12. The financial impact on the consolidated ACT Government Financial Statements will be nil as the transaction would be eliminated.

Consultation

Internal

13. Consultation on the requirement for a formal designation has been sought with ACT Health Strategic Finance. The requirement was endorsed, and on 10 April 2024 Muku Ganeshalingam, Chief Financial Officer, ACTHD, sought in-principle agreement from CHS to progress towards a formal designation.

Cross Directorate

14. Consultation on the requirement for a formal designation has been sought with Paul Ogden, Chief Financial Officer (5124 9683). CHS' in-principle agreement to the transfer of assets outlined in this Brief was confirmed on 11 April 2024.

External

15. Nil

Work Health and Safety

16. Not applicable

Benefits/Sensitivities

17. The benefit is compliance with the relevant Australian Accounting Standard and appropriate reporting of the transfer of assets.

Communications, media and engagement implications

18. Not applicable

Signatory Name:	Muku Ganeshalingam, Chief Financial Officer	Phone:	5124 6825
Action Officer:	Dean Naude	Phone:	[redacted]

Attachments

Attachment	Title
Attachment A	Agreement in principle to transfer land and buildings from ACT Health to Canberra Health Services.

OFFICIAL

MINISTERIAL BRIEF

ACT Health Directorate

To:	Minister for Health	**Tracking No.: MIN2024/00372**
From:	Rebecca Cross, Director General, ACT Health Directorate & Dave Peffer, Chief Executive Officer, Canberra Health Services	
Through	Liz Lopa, Deputy Director General, ACT Health Directorate	
Subject:	Progress update on the Security of Critical Infrastructure requirements for ACT Health Directorate and Canberra Health Services	
Critical Date:	5/07/2024	
Critical Reason:	To update you on the progress of the Critical Infrastructure Risk Management Program	

Recommendations

That you:

1. Note the information contained in this brief.

Noted / Please Discuss

Rachel Stephen-Smith MLA ..../...../.....

Minister's Office Feedback

Background

1. The Commonwealth Security of Critical Infrastructure (SOCI) Act 2018 provides a framework for managing risk related to Critical Infrastructure, with applicable rules in place since 17 February 2023. The SOCI Act 2018 gives the Commonwealth powers to step in and control critical infrastructure assets, in the event the local government responsible entities are not able to demonstrate their ability to ensure continued functioning of the critical infrastructure.

There are three primary security obligations which apply to most critical infrastructure assets, which include:

a. Provide operational and ownership information to the Register of Critical Infrastructure assets (RCIA).

b. Report cyber incidents which impact the delivery of essential services.

c. Adopt, maintain and comply with a written risk management program, which requires the establishment, maintenance and compliance with a written Critical Infrastructure Risk Management Program (CIRMP) for critical assets.

2. Under the SOCI Act 2018, the Canberra Hospital (TCH) has been classified as a critical infrastructure asset as a critical public hospital with a tertiary Intensive Care Unit (ICU). At the time, the ACT Health Directorate (ACTHD) was identified as the responsible entity and the ACTHD Chief Information Office (CIO) registered TCH and provided operational and ownership information to the RCIA.

3. In collaboration with ACTHD, the ACT Government Cyber team updated its Whole of Government (WhoG) incident response plan to include the requirement to report cyber security incidents to the Australian Cyber Security Centre.

4. In February 2023, the Minister for Home Affairs introduced the Risk Management Program Rules that prescribes that responsible entities of critical infrastructure assets under the Act must establish and maintain a CIRMP by 17 August 2023.

5. Subsequently, ACTHD, in collaboration with Canberra Health Services (CHS) developed a CIRMP Attachment A, which describes how ACTHD and CHS manage material risks associated with TCH for the following four hazard categories:

a. Cyber and Information Security

b. Personnel Security

c. Supply Chain

d. Physical Security and Natural Hazards

6. In February 2024, the Chief Executive Officer of CHS approved the CIRMP, and the CIRMP was also endorsed by the Director-General of ACTHD in March 2024.

7. The SOCI Act has the following objectives:

a. Improving the transparency of the ownership and operational control of critical infrastructure in Australia to better understand those risks.

b. Facilitating cooperation and collaboration between all levels of government, and regulators, owners, and operators of critical infrastructure, to identify and manage those risks.

c. Requiring responsible entities for critical infrastructure assets to identify and manage risks relating to those assets including risks associated with buildings, staff, and technology.

d. Imposing enhanced cyber security obligations on relevant entities for systems of national significance to improve their preparedness for, and ability to respond to, cyber security incidents. This does not apply to health.

e. Providing a regime for the Commonwealth to respond to serious cyber security incidents.

8. To ensure that SOCI risk management is conducted at an appropriate level and coordinated across the business, ACTHD and CHS have implemented the following arrangement to comply with CIRMP obligations:

f. established a SOCI implementation working group, which includes membership across ACTHD, CHS and ACT Government stakeholders to deliver the RMP.

g. begun discussions with ACTHD and CHS governance and risk departments to further improve and maintain the RMP post August 2023.

Entity Accountabilities

9. ACTHD took accountability for TCH achieving compliance with the SOCI Act initially. While there has been a collaborative approach to developing the CIRMP, the ACTHD cannot complete the CIRMP as it is not accountable for managing all risks associated with TCH, nor for reporting to Territory and national bodies in relation to security matters. As such, the roles associated with managing the SOCI Act compliance have been reviewed and the Risk Management Plan updated accordingly to reflect all entity responsibilities aligned with SOCI Act definitions:

a. Under the SOCI Act, CHS is considered a Responsible Entity as it operates TCH. In Western Australia and Victoria, Responsible Entities are Health Service Providers as they are custodians and operate the critical infrastructure. Similarly in New South Wales the Local Health Districts are the Responsible Entities.

b. ACTHD is considered both a Direct Interest Holder and a Managed Service Provider in terms of providing digital services including cybersecurity services.

c. The Chief Minister, Treasury and Economic Development Directorate (CMTEDD) is considered a Managed Service Provider in terms of providing digital services including cybersecurity services; and

d. The Justice and Community Safety Directorate (JACS) is considered a Reporting Entity and reports on security matters to ACT Government.

Annual Reporting

10. Section 30AG of the SOCI Act requires responsible entities to provide an annual report beginning 18 August 2024. The report is to be in the approved form, which includes the following:

a. A declaration that the CIRMP was up to date at the end of the Australian financial year.

b. Whether a hazard occurred that has a significant relevant impact on an asset during the year.

c. Whether any variations to the CIRMP were made during the year.

d. Whether the program was effective in mitigating any relevant impacts that hazards may have had on that asset during that year.

e. An attestation that the information contained within the annual report was approved by the board or governing body of the entity. The annual report does not need to contain the CIRMP. However, it must be sufficient to assure the CISC or relevant Commonwealth regulator that the program remains up to date and appropriate.

Issues

Cyber and Information Security Hazards

11. Cyber and Information Security SOCI legislation sets minimum standards for cyber security for in-scope systems that could cause a material hazard to the functioning of the hospital. [redacted]

12. [redacted]

13. [redacted]

    a. [redacted]

    b. [redacted]

    c. [redacted]

    d. [redacted]

14. [redacted].

15. [redacted]

16. [redacted]

17. [redacted]

Personnel Security Hazards

18. ACTHD and CHS have committed to aligning with the elements of personnel security as outlined in the ACT Government's ACT Protective Security Framework (PSF). These include controls in the following elements:

    a. Eligibility and suitability of personnel – ensuring appropriate pre-employment screening functions and vetting practices are undertaken that provide assurance that employees and contractors are suitable to access ACT Government resources and meet an appropriate standard of integrity, and drive consistency and conformity across the ACT Government.

    b. Ongoing assessment of personnel – assessing and managing the ongoing suitability of personnel and sharing relevant information of security concern, where appropriate.

    c. Separating personnel – ensuring separating personnel have access to relevant ACT Government sites and resources withdrawn; and are informed of any ongoing security obligations related to their role.

19. Within the PSF context, when engaging personnel in certain positions who may require a security clearance to access particular ACT or Australian Government resources relevant to their position, CHS will ensure appropriate audits and monitoring are in place such that personnel in these Positions of Trust and Designated Security Assessment Positions meet the criteria set out in the Security Clearance Policy.

20. Additionally, CHS employs specific essential requirements for contractors working at CHS sites. [redacted]

21. [redacted]

Supply Chain Hazards

22. [redacted]

23. Physical security of inventory has been assessed and installed as recommended under guidance of an independent security consultant.

24. Provision for bulk storage of critical clinical inventory (including Personal Protective Equipment (PPE) for pandemic) has been considered in the risk plan.

25. Alternate supply chain arrangements for critical clinical inventory have been considered as part of the business continuity planning.

Physical and Natural Hazards

26. [redacted]

27. CHS commissioned an independent security risk assessment in late 2023, with the engagement of a specialist consultant, IPP, to undertake a review of CHS properties across the Territory.

28. As part of this security risk assessment the new Building 5, which will house the intensive care unit later in 2024, has been considered from a SOCI perspective [redacted]

29. [redacted]

Amendments to the SOCI Act 2018: Draft Impact analysis

30. The Department of Home Affairs conducted a draft impact assessment (IA) to [redacted] the Department of Home Affairs consulted with the following industry sectors to advise on appropriate steps moving forward. The sectors include:

- Healthcare & Medical
- Energy
- Communications
- Data & Storage systems
- Financial services & markets
- Water & sewerage
- Higher education & research
- Foos & grocery
- Transport
- Space technology
- Defence industry.

31. [redacted]:

32 [redacted]

33 [redacted]

Financial Implications

34. [redacted]

35. [redacted]

36. The financial impact of these updated specifications is not known at present, however, [redacted] will ensure that compliance cost is minimised by capturing requirements early at planning and design stage rather than at construction or post completion stages.

37. [redacted]

Consultation

Internal

38. Various internal teams within ACTHD and CHS were consulted to prepare this briefing.

Cross Directorate

39. JACS has been consulted in relation to its security reporting role and has commenced reporting SOCI compliance status to ACT Government.

40. CMTEDD Digital and Data Technology Solutions has been consulted in respect of its role as Managed Service Provider.

External

41. Not applicable

Work Health and Safety

42. Not applicable

Benefits/Sensitivities

43. The alignment of accountabilities with the SOCI Act requirements between ACTHD and CHS will ensure that all risks associated with Canberra Hospital as a critical infrastructure are managed in accordance with the requirements of the SOCI Act.

Communications, media and engagement implications

44. Not applicable

Signatory Name:	Rebecca Cross Director-General, ACT Health Directorate; and Dave Peffer, Chief Executive Officer Canberra Health Services	Phone: Ms Teams
Action Officer:	Holger Kaufmann, Chief Information Officer ACT Health Directorate; and Colm Mooney, Executive Group Manager, Canberra Health Services	Phone: Ms Teams

Attachments

Attachment	Title
Attachment A	Critical Infrastructure Risk Management Plan

OFFICIAL

MINISTERIAL BRIEF

ACT Health Directorate

To:	Minister for Health	**Tracking No.: MIN2024/00562**
CC:	Chief Minister Dave Peffer, Director-General Liz Lopa, Deputy Director General, Corporate, Communications and Delivery	
Through:	Robyn Hudson, Deputy Director-General, Policy and Transformation	
From:	Catherine Loft, Executive Group Manager, Infrastructure, Communications & Engagement	
Subject:	ACT Voluntary Assisted Dying Implementation – Communications Approach	
Critical Date:	10/07/2024	
Critical Reason:	Ministerial noting is required for papers to be lodged for the Strategic Communications Review Group meeting to be held on 18 July 2024. Papers are due on 11 July 2024.	

Recommendation

That you note the progression of the ACT Voluntary Assisted Dying Implementation– Communication Strategy Attachment A for consideration by the Strategic Communications Review Group on 18 July 2024.

Noted / Please Discuss

Rachel Stephen-Smith MLA ……..... …../…../…..

Minister's Office Feedback

Background

1. The ACT Health Directorate (ACTHD) Communications and Engagement Team has led the development of the ACT Voluntary Assisted Dying Implementation – Communication Strategy (the Strategy) provided at Attachment A.

2. This Strategy is a high-level document that presents a vision and direction to guide our communication and engagement approach during the implementation phase to provide information and resources about voluntary assisted dying, as one end-of-life choice.

3. The Strategy supports the Policy, Partnerships and Programs Division's priorities to ensure all Canberrans have access to end-of-life choices which align with their rights, preferences and values.

4. The Strategy forms one part of the approach to ensure the community have access to the right information when they need, so they can make informed choices about their end-of-life care, with support from health professionals who understand the voluntary assisted dying legislation and services.

5. In 2023 as part of the community consultation on the ACT's voluntary assisted dying framework, a YourSay survey of nearly 3,000 people found:

    a. 85 per cent of respondents had a high level of awareness and interest in voluntary assisted dying, and 75 per cent wanted to learn more;

    b. 62 per cent were interested in having input into a model for voluntary assisted dying;

    c. there was a high interest in understanding more about the criteria for a person to be eligible (84 per cent), the process for requesting and accessing voluntary assisted dying (76 per cent), the safeguards required to protect patient safety (64 per cent), the role of family, friends or carers (63 per cent) and the role of health professionals (58 per cent); and

    d. the preferred information channels were ACT Government website (50 per cent), fact sheets (44 per cent), email updates (42 per cent), explanations in plain English (34 per cent), social media (29 per cent) and frequently asked questions (29 per cent).

6. The Strategy will use an integrated communications approach to target the general community, health care consumers, health professionals and relevant stakeholder organisations/groups. It will consist of:

    a. Research – voluntary assisted dying survey questions will be included in the [redacted] in July 2024 to better understand the community's awareness and information preferences about voluntary assisted dying.

    b. Community engagement – key milestones and opportunities will be identified during the implementation of voluntary assisted dying for targeted stakeholder engagement and communication, including the development of monthly eNewsletters.

c. Workforce engagement – engagement opportunities will be identified to ensure provision of information directly to healthcare professionals/facilities and other stakeholder organisations/groups to raise awareness and encourage participation in the voluntary assisted dying model and community of practice.

d. Public relations – increasing broad community awareness of voluntary assisted dying as one end-of-life option. Encouraging conversations with family and friends about wishes for end-of-life.

e. Media placement – increasing awareness amongst community stakeholders and workforce about engagement opportunities and information events, through digital, social, and notices in printed and online newspapers and local publications.

f. Website – will house information, updates and resources as voluntary assisted dying implementation progresses.

g. Conference – a one-day implementation conference will be held as a major engagement piece for the health workforce and relevant stakeholders. Conference will be in-person and streamed online.

7. Supporting engagement and implementation plans will be developed to promote clinician and workforce engagement (both public and private sectors), to ensure that this audience:

   a. understands their obligations under the *Act*, including those who conscientiously object to voluntary assisted dying;

   b. feels empowered to respond to enquiries from consumers about voluntary assisted dying;

   c. is willing to take part in the mandatory training to become an authorised practitioner; and

   d. knows how to access support for their wellbeing during their involvement in a person's voluntary assisted dying process.

8. To effectively execute the Strategy several suppliers will be required to be engaged. This includes accessing the services of the ACT Government's media buyer Universal McCann, [redacted], and a conference centre with events support.

Issues

9. The Strategy has been defined by the Whole of Government Communications and Engagement Framework as a Tier 1 project. As such, the Strategy is required to undergo peer review via the Strategic Communications Review Group (SCRG). This has been scheduled for the meeting on 18 July 2024.

10. The SCRG requires projects to present for discussion through a staged approach, first presenting the Strategy and then returning to present the creative concepts, media plan and engagement design. At the completion of the project the evaluation report is to be presented.

11. There is a requirement for formal endorsement of the communication approach by the responsible Minister prior to presenting at the meeting.

12. ACTHD will explore collaborative engagement opportunities across directorates such as Canberra Health Services and Community Service Directorate, to ensure a one government approach to any further stakeholder engagement.

13. Implementation of the Strategy occurs in July 2024, commencing with research to develop the targeted engagement approach.

14. Within the Strategy, engagement will focus on targeted consultation with specific stakeholders and community groups using connections through the voluntary assisted dying communications and engagement consultation group. This consultation group will have broad representation from the general community, health care workforce and health care consumers including First Nation and Culturally and Linguistically Diverse people.

15. Paid and non-paid media placement would commence from January 2025, noting that paid media will only be used to promote education and information events about voluntary assisted dying in the ACT. No paid promotional campaign will occur as part of the implementation of voluntary assisted dying in the ACT.

Financial Implications

16. $100,000 has been allocated for the Strategy from the voluntary assisted dying taskforce 2024/25 budget.

Consultation

Internal

17. Policy, Partnerships and Programs Division has been consulted on the development of the Strategy.

Cross Directorate

18. Canberra Health Services has been consulted on the development of the Strategy.

External

19. Not applicable.

Work Health and Safety

20. Not applicable.

Communications, media and engagement implications

21. The Strategy is being presented to the SCRG on 18 July 2024.

22. We will work with your office on ongoing media and engagement opportunities as part of the Strategy.

Signatory Name:	Catherine Loft, Executive Group Manager, Infrastructure, Communications & Engagement	Phone:	Via Teams
Action Officer:	Alana Devine	Phone:	Via Teams

Attachment

Attachment	Title
Attachment A	ACT Voluntary Assisted Dying Implementation – Communication Strategy

MINISTERIAL BRIEF

ACT Health Directorate

To:	Minister for Health	**Tracking No.: MIN2024/00580**
From:	Catherine Loft, A/g Executive Group Manager, Infrastructure, Communication and Engagement	
CC:	Dave Peffer, Director-General, ACT Health Directorate	
Through:	Liz Lopa, Deputy Director-General, Corporate, Communications and Delivery	
Subject:	West Belconnen Health Centre Site Selection	
Critical Date:	18/07/2024	
Critical Reason:	To approve the site location for the West Belconnen Health Centre	

Recommendations

That you:

1. Agree to the identified site for West Belconnen Health Centre at the Macnamara Local Centre; and

Agreed / Not Agreed / Please Discuss

2. Note that, following you indicating your agreement, ACTHD will pursue in-principal agreement to acquisition of the site from the SLA.

Noted / Please Discuss

Rachel Stephen-Smith MLA ..../...../.....

Minister's Office Feedback

Background

1. In the Parliamentary and Governing Agreement of the 10th Legislative Assembly for the Australian Capital Territory, the Government committed to the delivery of five new local walk-in-health centres in South Tuggeranong, Molonglo, Inner South, North Gungahlin and West Belconnen between 2021-22 and the middle of the decade.

2. In the 2023-24 Budget, the ACT Government committed $16.6 million over four years to design and construct the new health centre in South Tuggeranong, and to progress site planning and preliminary design for additional facilities in North Gungahlin and the Inner South.

3. In the 2024-25 Budget, the ACT Government committed $52.8 million over four years to design and construct the new health centres in North Gungahlin and the Inner South, and to progress site planning and preliminary design for the new health centre in West Belconnen.

Issues

4. The ACT Health Directorate (ACTHD) has been working in collaboration with the Environment, Planning and Sustainable Development Directorate (EPSDD) and the Suburban Land Agency (SLA), to identify suitable locations within the West Belconnen area for the new health centre.

5. The Ginninderry Development was identified as an appropriate setting for the new West Belconnen health centre. Ginninderry was established in 2016 and is a joint venture between ACT Government (60 per cent) and Riverview Developments Pty Limited (40 per cent). The future Ginninderry development will compromise more than 11,500 dwellings and population of over 30,000, over the next 25-30 years.

6. Ginninderry Joint Venture are proposing to develop their first local centre in Macnamara, it is anticipated to be operational in 2027. A health centre would provide key health services to the local community and drive economic activity to the Local Centre.

7. The Ginninderry development currently has a population of 2,200 (850 dwellings), it is expected that by 2028 the population will have grown to approximately 10,000 (almost 3,700 dwellings).

8. Ginninderry and SLA propose to work with ACTHD on the local centre site to ensure it is developed collaboratively and meets both stakeholder objectives.

9. Initial requirements for the site included:

    a. Large enough to accommodate a building gross floor area of approximately 2,300 square metres, either at level or with the ability for a multi-storey design;

    b. sufficient space to allow for parking to meet the ACT Parking and Vehicular Access General Code;

    c. proximity to transport options (public and private), including easy access for emergency vehicles from major roads;

d. land owned by ACT Government or nominal land purchase requirements; and

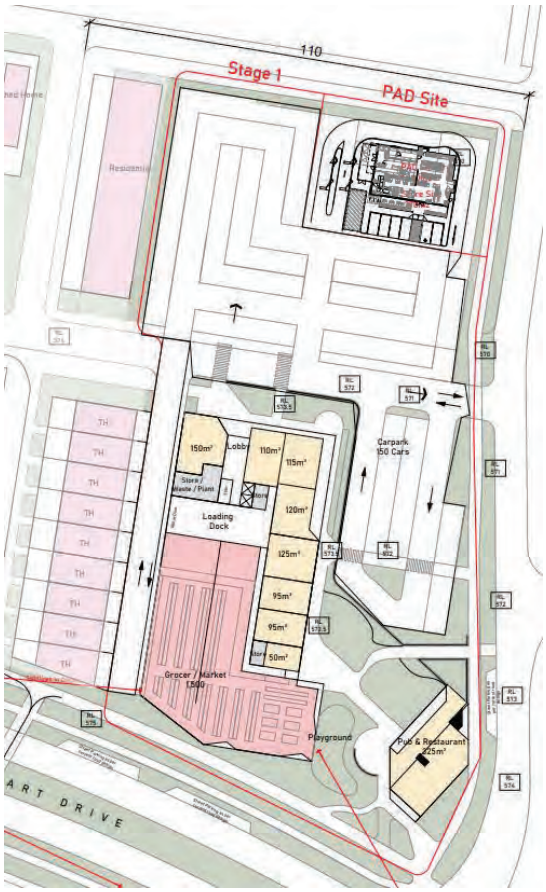
e. a site that could potentially allow for construction to commence in the second half of 2025-26 [redacted]

10. A block has been identified on the northern end of the Macnamara Local Centre site. This block is 1,250 square metres and allows for the health centre to be designed as a standalone building. The site is in a Commercial Zone 5 Mixed Use area.

11. This site is the location identified for the health centre in West Belconnen, with the advantages and disadvantages of the proposed site outlined below.

Advantages	**Disadvantages**
• The site is available for ACTHD to purchase and utilise for a health centre. • The site is appropriately zoned for a health facility. • The site is an appropriate size for ACTHD's requirements. • The site is part of the Macnamara Local Centre, so will be co-located with other community facilities. • The site is located close to public transport. • There will be additional car parking available at the local centre. • The site will allow ACTHD to proceed with the health centre design and construction separately to the Local Centre. • The site will allow for a three-level health centre, if required, to accommodate an appropriate sized facility and parking.	• The Local Centre carpark will be located between the health centre and the closest bus stops, so pedestrian access will need to be carefully considered during the development of the site. • The site will not be construction ready until early 2026, as it still requires services and road infrastructure. However this timeline aligns with the anticipated program for the design and Development Application process. • A large portion of the site will be surrounded by carparks, so access for ambulances, people with a disability and vulnerable road users will need to be considered in the design of the health facility and Local Centre.

The "PAD site" is the proposed West Belconnen Health Centre Site:



12. Should you endorse the use of this site, agreement will be sought from the Ginninderry Joint Venture Board, before the site can be announced and work can commence. A formal in-principle agreement will also need to be established between ACTHD, SLA and Ginninderry Joint Venture to secure the site. ACTHD will pursue these agreements once you have indicated your agreement to the site.

13. A consultant has not yet been appointed for the preliminary design work. ACTHD is working with Major Projects Canberra to determine the best mechanism for the tender and appointment of a Principal Consultant.

Financial Implications

14. Out of the $52.8 million committed in the 2024-25 ACT Budget, approximately $500,000 will be utilised for the design development of the West Belconnen Health Centre.

15. [redacted]

16. SLA have indicated that the acquisition process would not occur until the land is ready, which is anticipated to occur in early 2026.

17. [redacted]

Consultation

Internal

18. Health System Innovation and Performance Division have been heavily involved on this project and the Infrastructure Policy and Planning Branch are continuing to engage with them.

Cross Directorate

19. ACTHD is working with Canberra Health Services to confirm the clinical scope of each of the Health Centres.

20. ACTHD will continue to collaborate with the Community Services Directorate to ensure provision of aligned community-based services is considered in the planning for the centres.

21. ACTHD is working closely with EPSDD and SLA to progress the acquisition of this site and to ensure the delivery program for the West Belconnen Health Centre aligns with the planning and development works for the Macnamara Local Centre.

External

22. The SLA are keeping the Ginninderry Joint Venture informed about a potential site announcement for the health centre.

23. While no formal community engagement has commenced for the West Belconnen Health Centre, reference to the government's plans to build a health centre in the local area has featured as part of both the broad health infrastructure and health centre specific community consultation in 2024.

Work Health and Safety

24. Not applicable.

Benefits/Sensitivities

25. The proposed site allows ACTHD to progress the design, development application and construction separately to the local centre, whilst working closely with the Joint Venture Partner to ensure the design is cohesive and public amenity such as carparking can be shared across the site.

Communications, media and engagement implications

26. Ongoing communications and engagement will be led by the Infrastructure Communication and Engagement team.

27. The team will work with your office on the timing for an announcement of the preferred site, including supporting collateral for the announcement.

28. It is anticipated that once a site is selected and secured for the West Belconnen Health Centre, community engagement will commence on what services could be located there. This would be in a similar style to the engagement undertaken for the South Tuggeranong Health Centre, and the current engagement program underway for the North Gungahlin and Inner South Health Centres.

Signatory Name:	Catherine Loft, A/g Executive Group Manager, Infrastructure Communication and Engagement	Phone:	MS Teams
Action Officer:	Andrew Crichton, A/g Senior Director, Infrastructure Policy and Planning	Phone:	MS Teams

MINISTERIAL BRIEF

ACT Health Directorate

To:	Minister for Health	**Tracking No.: MIN2024/00575**
CC:	Liz Lopa, Deputy Director-General, Corporate, Communications and Delivery Dave Peffer, Director-General	
From:	Robyn Hudson, Deputy Director-General, Policy & Transformation	
Subject:	Assisted Reproductive Technology (ART) Communications Strategy	
Critical Date:	16/07/2024	
Critical Reason:	To ensure you are informed about the response to the community concerns about the ART legislation and transition provisions.	

Recommendation

That you:

1. Note the communications strategy to allay community concerns about the ART legislation, including continued use of gametes for ART treatment in the ACT by ART providers.

Noted / Please Discuss

Rachel Stephen-Smith MLA ..../...../.....

Minister's Office Feedback

Background

1. On 29 March 2024, the *Assisted Reproductive Technology Act 2024* (the Act) commenced in the ACT. The introduction of legislation is the first part of a two-staged approach.

   Stage 1 introduces regulatory requirements for the clinical practice of ART by ART providers and establishes a prospective donor register. The donor register will contain

identifying information in relation to donated gametes and/or embryos, donors, the donor's own children, intended parent(s), and the donor-conceived person.

2. A donor-conceived person will be able to access information on the donor register at age 16 (with younger people granted access through the support of a parent or guardian), for the benefit of their health and wellbeing, understanding of genetic heritage, and formation of identity. The protection of the donor-conceived person's right to information were considered to outweigh the donor's preference for anonymity.

3. The Act is largely modelled on similar legislation across Australia. In particular, it was designed to be as interoperable as possible with the equivalent NSW legislation *(Assisted Reproductive Technology Act 2007)*, to harmonise health care access across the border.

4. The regulatory requirements of the Act have commenced. However, transitional provisions in the Act allow ART consumers who have already begun ART treatments to complete their families using gametes from the same donor without being subject to many of the new obligations under the Act. The transitional provisions were designed to limit disruption for those accessing ART.

    a. Under section 131, an individual or couple that have already birthed a child using gametes from a donor may continue to use gametes from the same donor and will not be subject to many of the new obligations under the Act. This also applies if an individual has no previous child born using gametes from a donor but is currently pregnant with a child created using gametes from that same donor. These protections will extend for 15 years from commencement of the ACT (until 29 March 2039) to provide time for these people to complete their families.

    b. Similarly, under section 132, an individual or couple that already have formed embryos in storage prior to the commencement of the Act, may continue to use those embryos and not be subject to many of the new obligations under the Act. Again, these protections will extend for 15 years until 29 March 2039.

    c. In addition, a six-month transitional period has been included to allow for individuals or couples that have been allocated and/or purchased gametes prior to the commencement of the legislation (29 March 2024) but who do not yet have any embryos formed and in storage. Those individuals or couples will have until 28 September 2024 to create embryos using those gametes, at which point they will be included in the provisions under Section 132. However, if an embryo is not created prior to 28 September 2024, then the additional requirements under the Act would apply to the use of the gamete, and extra information related to the donor would need to be collected prior to continuing the use of those gametes.

Issues

5. During April and May 2024, following the introduction of the legislation, the ACT Health Directorate (ACTHD) met with each of the three ART providers in the

ACT: Genea Canberra, IVF Australia (IVFA) Canberra, and Compass Fertility Canberra to discuss the implications and obligations of the new legislation.

6. In April to June 2024, ART providers in the ACT expressed concerns through email correspondence to ACTHD about the possibility that the new requirements for information on donors would reduce availability of donor sperm, which could impact their businesses and current business models.

7. In June and July 2024, correspondence from concerned constituents was received by your office. ACTHD has received information that in early June, IVFA informed consumers that due to the ACT's new legislation, the clinic was halting all/most treatments in order to review compliance. IVFA also encouraged clients to express concerns to you as Minister for Health.

8. The halting of treatments and misinformation have been stressors for ART consumers currently undergoing treatment. Consumers fear they can no longer continue planned ART cycles or access gametes to produce genetic siblings of their children. The main source of concern appears to be a lack of understanding about the transitional periods, as well as a general lack of understanding of the intent of the Act, which is to ensure that ART providers operate to a high clinical and ethical standard.

9. Many concerned constituents are from the LGBTIQA+ community who wish to, or have already, started their families through ART treatment. LGBTIQA+ families are usually dependant on donated gametes in order to have a child.

10. On 24 June 2024, ABC's Four Corners program released an episode titled, 'When IVF Goes Wrong.' The episode alleged wrongdoing in the ART industry in Australia, including an incident where the incorrect sperm was used to conceive children. The Four Corners episode helped publicise issues in the ART industry to a wide audience, including in the ACT.

11. The multinational ART company at the centre of the Four Corners episode was Virtus Health. Virtus Health is an umbrella company for several large ART providers, including IVFA Canberra in the ACT.

12. The Health Services Commissioner has not received any complaints from the community. We will continue to liaise with their office in coming weeks.

Communications Strategy

13. In order to allay community concerns and limit misinformation about the Act, ACTHD is implementing a communications strategy involving direct community outreach, individual phone calls, written responses to queries, meetings with ART providers, website updates, and factsheet communications to be circulated to key stakeholders.

Direct communications

14. Letters providing clarification about the legislation and advice to the three ART providers in the ACT and IVFA head office, were sent on Friday 5 July 2024. These letters also urged providers to ensure that they are providing accurate information to clients and care consistent with the legislation, including swiftly moving to reassure clients who are covered by transitional provisions under sections 131 and 132 of the Act that their treatment can continue.

15. A face-to-face meeting has been scheduled with representatives from IVFA Head Office including Virtus Australia's A/g General Counsel (legal counsel) and IVFA Canberra, to take place on 16 July 2024. This was the earliest date representatives from IVFA and Virtus Health were available to meet with ACTHD. On 3 July 2024 IVFA provided correspondence confirming that it is currently providing ART treatment to ACT patients through the Canberra clinic, and in these circumstances, we are satisfied an earlier meeting date is not essential.

16. ACTHD continues to draft individualised Ministerial responses to constituent emails. These include an ACTHD contact email address for people with further queries or concerns: ART.healthpolicy@act.gov.au.

17. A number of constituents were telephoned to have their concerns heard and to clarify transitional arrangements.

Information campaign

18. Once finalised, two factsheets will be circulated widely to the ACT ART community. These are expected to be finalised in the week commencing 8 July, following advice from ACTHD Legal Policy. Accessible information is being designed for two audiences:

    a. ART consumers and the general public

    b. ART providers in the ACT.

    This content will be provided to your office prior to public distribution.

19. A public-facing webpage is in development for ART, with input from the Strategic Communications team.

    a. The webpage will include a page for consumers, and a page for providers.

    b. The webpage will be designed with accessibility needs in mind, including a flowchart and will simply detail the new requirements and transitional arrangements for ART.

20. ACTHD is liaising with the Office of LGBTIQA+ (CMTEDD) to seek advice and networks to connect with LGBTIQA+ community members.

    a. The factsheet and other relevant communications will be circulated through the Office's various channels.

b. On 30 July 2024, the Office of LGBTIQA+ will host a forum for LGBTIQA+ community members. ACTHD will give a presentation at the forum on the new requirements and transitional arrangements for ART.

Consultation

Internal

21. ACTHD Legal Policy

a. Legal Policy were consulted during the preparation of this brief and in the planning of the communication strategy on the ART legislation.

b. Legal Policy have also reviewed all public facing documents for legal accuracy.

Cross Directorate

22. Office of LGBTQIA+ Affairs

a. The Office was immediately contacted when it became evident that misinformation was being shared with ART clients in the ACT and that this was causing distress and anger. The communications plan was discussed with the Office, and it was agreed that all public facing documents will be shared through the Office's various channels. The Office also invited a member of the ART policy team to present at an upcoming LGBTQIA+ roundtable.

External

23. IVFA Canberra

a. A face-to-face meeting was held on 16 April 2024 between representatives of IVFA Canberra and ACTHD officers. The meeting was an opportunity for IVFA to seek clarification about the legislation and to ask questions. No medical officers were present at this meeting. Following that meeting, IVFA sent an email indicating concern about the potential effects of some aspects of the donor register. That message gave no indication of any issues with the delivery of treatments.

b. ACTHD received an email from Dr David O'Rourke, IVFA Canberra, on 16 June 2024 seeking further clarification about the legislation, including the transitional arrangements. Due to the time critical nature of certain ART procedures, ACTHD officers met Dr O'Rourke on Friday 21 June 2024 to discuss the new legislative requirements. Dr O'Rourke was assured that, for clients to whom the 'completion of family' provisions apply, there was no need to halt ART treatments that may utilise donated gametes. An official response to Dr O'Rourke's email has been drafted and is going through clearance processes.

24. IVFA Head Office, Sydney

a. ACTHD exchanged several emails and phone calls with IVFA Head Office to ascertain why IVFA had requested a halt for all ART procedures utilising donated gametes in the ACT.

b. Tuanh Nguyen Legal Counsel for Virtus Health (IVFA's parent company), has stated that no directive came from IVFA to halt ART treatments.

c. A face-to-face meeting with IVFA Head Office, the Canberra clinic and ACTHD representatives has been scheduled for Tuesday 16 July 2024 at the Bowes Street Offices. This was the soonest date that invitees were available.

25. Compass Fertility Canberra

a. A face-to-face meeting was held on 15 May 2024 between representatives of Compass Fertility and ACTHD officers. The meeting was an opportunity for Compass Fertility to seek clarification about the legislation and to ask questions. No medical officers were present at this meeting.

26. Genea Canberra

a. A face-to-face meeting was held on 16 May 2024 between representatives of Genea Canberra and ACTHD officers. The meeting was an opportunity for Genea Canberra to seek clarification about the legislation and to ask questions. Genea Canberra's Clinical Director, Doctor Felicity Brims was present at this meeting.

Benefits/Sensitivities

27. ART can be a sensitive and personal topic for people undergoing treatment, or people wanting to start or expand their families. The planned communications may assist in dispelling the misinformation and fears being expressed in correspondence from consumers.

28. There will be continuing sensitivities around access to donor gametes, as it is anticipated that the reforms will (as they are expected to in other jurisdictions) reduce the supply of donor materials because of potential donor unwillingness to meet the information requirements of these reforms.

Communications, media and engagement implications

29. The communications strategy will allow ACTHD to clarify requirements, limit misinformation in the ACT, and promote the ART legislation to help prevent the clinical wrongdoing identified in other jurisdictions.

30. The Four Corners episode has drawn attention to ART issues and may spark further media interest in the ACT.

31. IVFA may draw media interest if it does not communicate effectively with its clients and quickly resume ART treatments to those completing their families.

32. Stage 2 of the ART Project, to be introduced in 2025 following consultation, will enable retrospective access to the register. This means that any donor-conceived individual, irrespective of when they were conceived or born, will be able to gain information about the donor from the donor register, should those records exist.

33. Anyone who is impacted by donor conception, including past donors who donated under the condition of anonymity, will be encouraged to participate in the consultation and provide feedback. The ACTHD Strategic Communications team is currently developing a 2025 communications plan and information campaign about the retrospective legislation.

Signatory Name:	Robyn Hudson, Deputy Director-General, Policy & Transformation	Phone:	MS Teams
Action Officer:	Simone Woods, Assistant Director; Family and Inclusion Policy	Phone:	MS Teams

QUESTION TIME BRIEF

GBC24/262**Portfolio:** Population Health

Australian Centre for Disease Control establishment

Talking points:

- The Australian Government is establishing an Australian Centre for Disease Control (CDC). The interim Australian CDC was established on 1 January 2024, within the Department of Health and Ageing.
- The primary goal is to improve Australia's national coordination, response and preparedness for public health emergencies. The interim Australian CDC has adopted a 'One Health' approach, to ensure greater consideration of the intersection between human health, animal health and environmental or planetary health.
- A post Federal budget announcement by Chief Medical Officer and Head of the Interim CDC, Professor Paul Kelly, has advised that the Australian Government has deferred final decisions on the scope, role and function of the Australian CDC until after the Commonwealth's COVID-19 Response Inquiry has concluded, with the report due in September 2024. The extended timeframes will enable the Government to ensure any recommendations from the Inquiry are reflected in the establishment of the Australian CDC, where appropriate.
- It is reassuring that the Australian Government remains committed to ongoing consultation with states and territories and key stakeholders to finalise scope and governance arrangements for the Australian CDC. The ACT is represented on key multilateral national forums, including an interjurisdictional senior officials group and working group to support the establishment of the Australian CDC, although these groups have been placed on hold for the last few months.
- The Commonwealth is expected to commence bilateral meetings in the second half of 2024 to work through continuing Australian CDC establishment matters, prior to returning to multilateral forums. The ACT remains committed to participating in these forums.
- In March 2024, the ACT Government provided their support to the Australian National University's proposal to the Department of Health

and Aged Care to locate the future proposed standalone Australian CDC within the ACT.

Background Information

- In the 2023-24 Federal Budget, $90.9 million over two years was committed to support establishing an Australian CDC and an interim Australian CDC was established within the Department of Health and Aged Care on 1 January 2024. There was no additional dedicated funding in the 2024-2025 budget to support the establishment of a future standalone CDC.
- A Statement of Intent was signed by Health Ministers in November 2023. While not legally binding, the Statement of Intent outlines the shared commitment to support the establishment of the Australian CDC and commits states and territories to participating in future negotiations.

Lewis Shannon

From: Gower, Tara on behalf of ACT Health DLO
Sent: Thursday, 24 October 2024 9:18 AM
To: Tomlinson, Benjamin; Smith, Kahlia; Bransgrove, Meagen
Subject: ACTHD FOI - Released 23 October 2024

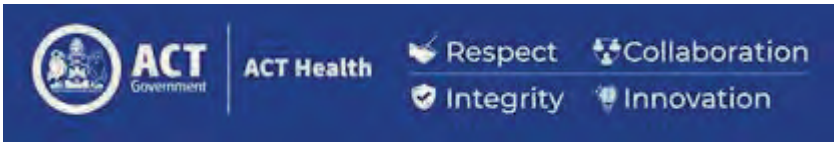
Good morning all

I have placed this FOI response in the Minister's folder here.

There is no covering brief and the response was delivered to the applicant yesterday, 23 October 2024.

Thank you
Tara

Tara Gower | Directorate Liaison Officer | ACT Health Directorate
Mob: Schedule 2.2(a)(ii) Email: ACTHealthDLO@act.gov.au
Office of Rachel Stephen-Smith | Minister for Health
Office of Emma Davidson | Minister for Mental Health
Level 2, Legislative Assembly Building, Civic Square



From: Tomlinson, Benjamin
Sent: Wednesday, 23 October 2024 5:28 PM
To: Ellis, Catherine
Cc: ACT Health DLO
Subject: Re: ACTHD FOI Released Today - 23 October 2024
Importance: High

OFFICIAL

Hi

Can you please put it in the mins folder as per normal process and advise kahlia/meg.

Thank you!

B

Get Outlook for Android

From: Ellis, Catherine <Catherine.Ellis@act.gov.au>
Sent: Wednesday, October 23, 2024 5:24:57 PM
To: Tomlinson, Benjamin <Benjamin.Tomlinson@act.gov.au>

Cc: ACT Health DLO <ACTHealthDLO@act.gov.au>
Subject: ACTHD FOI Released Today - 23 October 2024

OFFICIAL

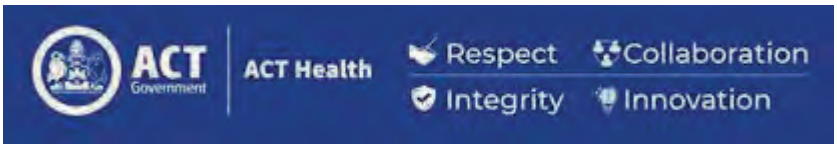
Hi Ben

Please find attached FOI response that was released today under the FOI Act to Schedule 2.2(a)(ii) following a request made on 10 September.

This will be publicly available on the disclosure log in 3-10 business days.

Thanks
Cath

Catherine Ellis | Senior Director
Ministerial and Government Services | ACT Health Directorate
Mob: Schedule 2.2(a)(ii) Email: Catherine.Ellis@act.gov.au
Level 5, Bowes Street, Woden ACT



From: Docker, Jake
Sent: Thursday, 24 October 2024 13:07
To: ACT Health DLO
Cc: Ord, Jon
Subject: RE: NOTING BRIEF : MIN2024/00864 - Consultation on National Water Guidelines

Importance: High

OFFICIAL

Hi Tara,

Minister Davidson has asked that this brief be sent to the incoming Population Health Minister.

Many thanks,

Jake Docker | Adviser, Population Health & Community Services
Office of Emma Davidson| ACT Greens Member for Murrumbidgee
E: jake.docker@act.gov.au

From: Gower, Tara **On Behalf Of** ACT Health DLO
Sent: Wednesday, 23 October 2024 3:40 PM
To: Docker, Jake
Subject: NOTING BRIEF : MIN2024/00864 - Consultation on National Water Guidelines

OFFICIAL

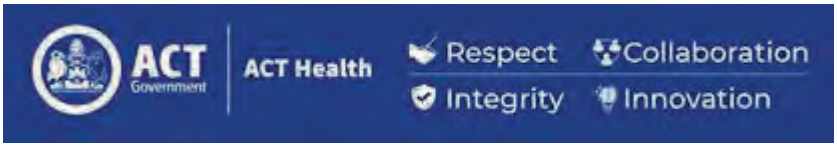
Hi Jake

This Noting Brief is placed in your folder here.

Please note there is no formal critical date.

Thank you
Tara

Tara Gower | Directorate Liaison Officer | ACT Health Directorate
Mob: Schedule 2.2(a)(ii) Email: ACTHealthDLO@act.gov.au
Office of Rachel Stephen-Smith | Minister for Health
Office of Emma Davidson | Minister for Mental Health
Level 2, Legislative Assembly Building, Civic Square


ACT
Government
ACT Health
Respect
Collaboration
Integrity
Innovation

From: STEPHEN-SMITH
Sent: Thursday, 24 October 2024 16:43
To: ACT Health DLO
Cc: Smith, Kahlia
Subject: FW: AIHW forthcoming releases list

Importance: High

Hi Tara,

For noting please.

Thank you,

Sally Cooke
Office Manager | Office of Rachel Stephen-Smith MLA
Minister for Health | Minister for Children, Youth and Family Services | Minister for Disability | Minister for Aboriginal and Torres Strait Islander Affairs
Member for Kurrajong
ACT Legislative Assembly, 196 London Circuit, Canberra ACT 2601 | P: (02) 6205 2661 | www.act.gov.au

From: communications@aihw.gov.au
Sent: Thursday, 24 October 2024 4:02 PM
To: STEPHEN-SMITH
Subject: AIHW forthcoming releases list

Caution: This email originated from outside of the ACT Government. Do not click links or open attachments unless you recognise the sender and know the content is safe.

Dear all,

The AIHW's list of forthcoming releases has been updated.

Please note the following delays/reschedules since the last forthcoming release list was distributed, in early October. Such as:

- *Health of Veterans – update* will now be released 31 October
- *Alcohol available for consumption in Australia: 1944–45 to 2022–23* has been renamed to *Alcohol available for consumption in Australia*
- *Suicide & self-harm monitoring: cause of death 2023 – update* has been renamed to *Suicide & self-harm monitoring update: Causes of death 2023 and suicide registers*
- *First Nations users of primary health care* has been moved from 14 November to early December
- *Chronic respiratory conditions: National asthma indicators - update* has been renamed to *Chronic respiratory conditions: National asthma indicators and Asthma – updates*
- *National Dementia Action Plan indicators dashboard* and *National Dementia Data Improvement Plan 2023-2034* have been moved from late November to early December
- *Australia's mothers and babies update (Stillbirths and neonatal deaths, Maternal deaths)* has been renamed to *Australia's mothers and babies: maternal deaths - update*

- *Closing the Gap targets – drivers of change* will now be released in early December
- *GEN Aged Care Data: Unmet needs in aged care: How long did Australians wait for aged care services? (update)* has been renamed to *Timeliness of access to aged care services in Australia*

****Please note, all release dates are subject to change****

Kind regards,

Communications & Engagement Unit

Australian Institute of Health and Welfare

Communications@aihw.gov.au | @aihw | aihw |

From: STEPHEN-SMITH
Sent: Friday, 25 October 2024 10:27
To: ACT Health DLO; CHS DLO
Cc: Bransgrove, Meagen
Subject: FW: Midwifery Futures: Building the Australian midwifery workforce | Final report published

Importance: High

Hi Team,

For noting please.

Thank you,

Sally Cooke
Office Manager | Office of Rachel Stephen-Smith MLA
Minister for Health | Minister for Children, Youth and Family Services | Minister for Disability | Minister for Aboriginal and Torres Strait Islander Affairs
Member for Kurrajong
ACT Legislative Assembly, 196 London Circuit, Canberra ACT 2601 | P: (02) 6205 2661 | www.act.gov.au

From: Nursing & Midwifery Board
Sent: Friday, 25 October 2024 10:05 AM
Subject: Midwifery Futures: Building the Australian midwifery workforce | Final report published

Some people who received this message don't often get email from nmbacalendar@ahpra.gov.au. Learn why this is important

Caution: This email originated from outside of the ACT Government. Do not click links or open attachments unless you recognise the sender and know the content is safe.

Dear stakeholder,

On Wednesday 23 October 2024, the Nursing and Midwifery Board of Australia (NMBA) published Midwifery Futures: Building the Australian Midwifery Workforce.

The final report takes in the views of more than 3,000 midwives, 300 students and 70 educators as well as focus groups across the country to accurately predict future Australian midwifery workforce trends and grow our midwifery workforce.

Commissioned by the NMBA to help safeguard the profession and the women and babies who rely on it, the Burnet Institute-led research includes more than 30 recommendations to address a midwifery crisis.

Action to deliver the report's recommendations will grow the midwifery workforce, support greater workforce flexibility, develop leadership capacity and improve outcomes for the people our midwives serve.

We encourage you to read and share the report with your network as we take a major step toward the long-term planning for the birth of future generations.

Kind regards
Nursing and Midwifery Board of Australia

Australian Health Practitioner Regulation Agency
G.P.O. Box 9958 | Melbourne VIC 3001 | www.ahpra.gov.au
Web | www.ahpra.gov.au

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From: STEPHEN-SMITH
Sent: Friday, 25 October 2024 13:14
To: ACT Health DLO; CHS DLO
Cc: Bransgrove, Meagen; Smith, Kahlia
Subject: FW: New AIHW embargo release available: Medicare Benefits Scheme funded services: monthly data

Importance: High

Hi Team,

For noting please.

Thank you,

Sally Cooke
Office Manager | Office of Rachel Stephen-Smith MLA
Minister for Health | Minister for Children, Youth and Family Services | Minister for Disability | Minister for Aboriginal and Torres Strait Islander Affairs
Member for Kurrajong
ACT Legislative Assembly, 196 London Circuit, Canberra ACT 2601 | P: (02) 6205 2661 | www.act.gov.au

From: communications@aihw.gov.au
Sent: Friday, 25 October 2024 12:29 PM
To: STEPHEN-SMITH
Subject: New AIHW embargo release available: Medicare Benefits Scheme funded services: monthly data

Caution: This email originated from outside of the ACT Government. Do not click links or open attachments unless you recognise the sender and know the content is safe.

Dear all,

The latest AIHW release ***Medicare Benefits Scheme funded services: monthly data*** is now available **under strict embargo** until its public release on **30, October at 12:01am AEST**.

About the release:

The Australian Government subsidises the cost of health services covered by the Medicare Benefits Scheme (MBS) for all Australians since 1984. This report presents monthly data on the usage rates of these health services as well as the MBS subsidy rate (that is, the proportion of the cost of these services funded through the MBS, as opposed to via patient contributions and other arrangements such as private health insurance).

Data in this report is updated monthly.

The release **will not be** accompanied by a media release.

Please click on link and follow the instructions below:

- AIHW Stakeholder hub (https://pp.aihw.gov.au/login)
- Your username is your **email address**
- Please select '**Forgot your password'** link if required.

Embargo access conditions

By accessing the AIHW Stakeholder hub you agree to the following:

Access to the Stakeholder hub is provided to you for background and research purposes. It is conditional on your organisation not commenting publicly on the forecasts or conclusions contained within AIHW releases, including not issuing any media statements/articles on the topic until after the AIHW release has been publicly released.

I agree to comply with any relevant requirements of the Australian Government Protective Security Policy Framework. I acknowledge that I can obtain further information in relation to the Australian Government Protective Security Policy Framework through the following link to the Commonwealth Attorney-General's Department Website: www.protectivesecurity.gov.au

If you would like any further information, please contact communications@aihw.gov.au or (02) 6249 5089.

Kind regards,

Communications & Engagement Unit

Australian Institute of Health and Welfare

Communications@aihw.gov.au | @aihw | aihw |



From: STEPHEN-SMITH
Sent: Friday, 25 October 2024 16:44
To: ACT Health DLO
Cc: Smith, Kahlia
Subject: FW: New AIHW embargo release available: Alcohol available for consumption in Australia

Importance: High

Hi Tara,

For noting please.

Thank you,

Sally Cooke
Office Manager | Office of Rachel Stephen-Smith MLA
Minister for Health | Minister for Children, Youth and Family Services | Minister for Disability | Minister for Aboriginal and Torres Strait Islander Affairs
Member for Kurrajong
ACT Legislative Assembly, 196 London Circuit, Canberra ACT 2601 | P: (02) 6205 2661 | www.act.gov.au

From: communications@aihw.gov.au
Sent: Friday, 25 October 2024 1:44 PM
To: STEPHEN-SMITH
Subject: New AIHW embargo release available: Alcohol available for consumption in Australia

Caution: This email originated from outside of the ACT Government. Do not click links or open attachments unless you recognise the sender and know the content is safe.

Dear all,

The latest AIHW release ***Alcohol available for consumption in Australia*** is now available **under strict embargo** until its public release on **8, November at 12:01am AEST**.

About the release:

The Alcohol available for consumption in Australia report, previously referred to as 'Apparent consumption of alcohol in Australia' uses data from a range of sources. These sources include excise data, import clearance records, financial information, and sales data to estimate the total amount of alcohol made available to people living in Australia every financial year. Estimates are also available for the total amount of alcohol in the forms of beer, wine, spirits, and cider.

The release **will not be** accompanied by a media release.

Please click on the link and follow the instructions below:

- AIHW Stakeholder hub (https://pp.aihw.gov.au/login)
- Your user name is your **email address**
- Please select '**Forgot your password**' link if required.

The following Ministerial Offices are receiving access to the embargoed material:

- Office of the Prime Minister
- Senator the Hon. Katy Gallagher - Minister for Finance, Minister for the Public Service, Minister for Women
- The Hon. Mark Butler MP - Minister for Health and Aged Care
- Senator the Hon Malarndirri McCarthy - Minister for Indigenous Australians
- The Hon Ged Kearney MP - Assistant Minister for Indigenous Health
- The Hon. Amanda Rishworth MP - Minister for Social Services
- The Hon. Bill Shorten MP - Minister for the National Disability Insurance Scheme Minister for Government Services
- The Hon. Julie Collins MP - Minister for Housing, Minister for Homelessness, Minister for Small Business
- The Hon. Anne Aly MP - Minister for Early Childhood Education, Minister for Youth
- The Hon. Anika Wells MP - Minister for Aged Care, Minister for Sport
- The Hon. Justine Elliot MP - Assistant Minister for Social Services, Assistant Minister for the Prevention of Family Violence
- The Hon. Ged Kearney MP - Assistant Minister for Health and Aged Care
- The Hon. Emma McBride MP - Assistant Minister for Mental Health, Assistant Minister for Rural and Regional Health

The following federal departments receive access to the embargoed material:

- Department of the Prime Minister and Cabinet
- Department of Health and Aged Care
- Department of Social Services
- National Indigenous Australians Agency

The following state and territory health departments receive access to the embargoed material:

- ACT Health
- QLD Health
- NSW Ministry of Health
- NT Department of Health
- TAS Department of Health
- WA Department of Health
- SA Department of Health and Wellbeing
- VIC Department of Health and Human Services

If you would like any further information, please contact communications@aihw.gov.au or (02) 6249 5089.

Kind Regards,

Communications & Engagement Unit

Australian Institute of Health and Welfare

Communications@aihw.gov.au | @aihw | aihw |



From: Davidson
Sent: Monday, 28 October 2024 09:57
To: ACT Health DLO
Subject: FW: FMM10 - agenda papers available [SEC=OFFICIAL]

Importance: High

Good Morning Tara,

Passing this one on for the Directorate's awareness.

Thank you,

Maxine Harris (She/Her)
Office Manager
Office of Emma Davidson|ACT Greens Member for Murrumbidgee
Minister for Community Services, Seniors and Veterans | Minister for Mental Health
Minister for Corrections and Justice Health | Minister for Population Health
GPO Box 1020, Canberra ACT 2601
02 6205 1941
Davidson@act.gov.au

From: FoodRegulationSecretariat
Sent: Friday, 25 October 2024 2:08 PM
Subject: FMM10 - agenda papers available [SEC=OFFICIAL]

Caution: This email originated from outside of the ACT Government. Do not click links or open attachments unless you recognise the sender and know the content is safe.

Dear Ministers
Cc Food Regulation Standing Committee contacts

Agenda papers for FMM10 to be held on 15 November 2024 can now be accessed on SharePoint.

Item 7 - *Companion animals in indoor settings* may be a late paper. This has been approved by the FMM Chair.

Yours sincerely

Schedule 2.2(a)(ii)

A/g Director, Food Regulation and Governance

Website: www.foodregulation.gov.au | Email: secretariat@foodregulation.gov.au
Phone: +61 2 6289 5128 | Postal Address: MDP 570, GPO Box 9848, Canberra ACT 2601

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From: Cross, Rebecca
Sent: Tuesday, 29 October 2024 09:34
To: Tomlinson, Benjamin
Subject: COVID Inquiry

Item 2: COVID Inquiry

- Aust did very well comparatively, but need to pay regard to lessons learnt in order to prepare for future pandemics
- Are we better prepared than 4 years ago?
- Focus on what we need at national level for a health response. How to link health response to broader government crisis management framework
- Need to focus better on preparedness. Responded as series of jurisdictions that came together, not as a nation. Need measures that focus on coordination and coherence. National Cabinet needs to be different eg secrecy and information sharing provisions
- CDC – primary focus on additional benefits eg national data set, interoperable systems, pre-agreement on data sharing, provision of real-time information. Won't cut across operational responsibilities in an emergency situation. Work hand in glove with S/Ts to ensure technical expertise is shared, and focus on national response. Focus on pandemic preparedness. Phased approach to establishment. Not a research body – but look at gaps.
- AHPC – understand strictures and limitations on who it could talk to were difficult - shouldn't cut across statutory responsibilities. CDC to be ex-officio member of AHPC.
- ATAGI – potentially adopt a broader remit
- Greater clarity on primary health care response in an emergency situation – potential role of UCCs in future, greater clarity on role of PHNs
- Expectation that rather than restrictions on movement and trade should avoid border closures. Avoid closing education and ECEC facilities (requires proactive approaches)
- Leverage existing structures. Role clarity. Models for priority cohorts (priority in data collection, understand transmission patterns). Areas of shared responsibility were areas of greatest challenges. Pandemic plans in these areas should have greater element of shaping.
- Transparency - level of restrictions people will bear is unknown but unlikely to be as high. More proactive commitments eg in Victoria about what will be made public will be needed so rationale is understood. Behavioural insights – was different at time of fear and panic.
- Don't plan for past pandemics
- Communication is key
- Local govt – different views on how they can assist and varied role in different jurisdictions. Issue is how to make best use of them. Where there were flexible funding arrangements to get $ to community orgs there were real benefits. Get $ to the local level as quickly as possible

Rebecca Cross, Director General
Pronouns: She/her
ACT Health Directorate | ACT Government
Phone: 02 5124 9400| Email: rebecca.cross@act.gov.au
health.act.gov.au

From: Davidson
Sent: Tuesday, 29 October 2024 09:47
To: ACT Health DLO
Subject: FW: FMM - Correspondence - Australian Breastfeeding Association [SEC=OFFICIAL]

Importance: High

Good Morning Tara,

Passing this one to the Directorate for consideration.

Thank you,

Maxine Harris (She/Her)
Office Manager
Office of Emma Davidson | ACT Greens Member for Murrumbidgee
Minister for Community Services, Seniors and Veterans | Minister for Mental Health
Minister for Corrections and Justice Health | Minister for Population Health
GPO Box 1020, Canberra ACT 2601
02 6205 1941
Davidson@act.gov.au

From: FoodRegulationSecretariat
Sent: Monday, 28 October 2024 4:44 PM
Subject: FMM - Correspondence - Australian Breastfeeding Association [SEC=OFFICIAL]

Caution: This email originated from outside of the ACT Government. Do not click links or open attachments unless you recognise the sender and know the content is safe.

Dear Ministers
Cc Food Regulation Standing Committee contacts

Please note the following correspondence is now available on SharePoint:

- Australian Breastfeeding Association

Yours sincerely

Schedule 2.2(a)(ii)

A/g Director, Food Regulation and Governance

Website: www.foodregulation.gov.au | Email: secretariat@foodregulation.gov.au
Phone: +61 2 6289 5128 | Postal Address: MDP 570, GPO Box 9848, Canberra ACT 2601

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From: Tomlinson, Benjamin
Sent: Tuesday, 29 October 2024 10:09
To: ACT Health DLO
Cc: Smith, Kahlia; Stephen-Smith, Rachel; STEPHEN-SMITH
Subject: FW: Important Healthscope Announcement
Attachments: 291024 Healthscope Letter to ACT Health Minister, Ms Rachel Stephen-Smith MLA.pdf

Importance: High

DLO Note – Sent to PPP initially, now with HSIP for advice.
Note this has not been formally tasked through Objective yet – I was awaiting for advice initially.

Hi team

For information and advice if appropriate for an incoming Minister.

Ben

From: Schedule 2.2(a)(ii) **On Behalf Of** Greg Horan
Sent: Tuesday, 29 October 2024 10:02 AM
To: Stephen-Smith, Rachel <Rachel.Stephen-Smith@act.gov.au>
Cc: Tomlinson, Benjamin <Benjamin.Tomlinson@act.gov.au>
Subject: Important Healthscope Announcement

Some people who received this message don't often get email from Schedule 2.2(a)(ii) Learn why this is important

Caution: This email originated from outside of the ACT Government. Do not click links or open attachments unless you recognise the sender and know the content is safe.

Dear Ms Rachel Stephen-Smith MLA,

Please find attached a letter from Healthscope CEO, Mr Greg Horan. Please do not hesitate to contact us should you have any queries regarding the contents of this letter.

Yours faithfully,

On behalf of Greg Horan,

Schedule 2.2(a)(ii)

Healthscope Operations Pty Ltd.
Level 1 / 312 St Kilda Rd, Melbourne VIC 3004
Schedule 2.2(a)(ii)



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Healthscope

Level 1, 312 St. Kilda Road,
Melbourne VIC 3004
P (03) 9926 7500
F (03) 9926 7599
healthscope.com.au

29 October 2024

Ms Rachel Stephen-Smith MLA
ACT Minister for Health
GPO Box 1020,
Canberra, ACT 2601
E: Rachel.Stephen-Smith@act.gov.au
C
C: Chief of Staff, benjamin.tomlinson@act.gov.au

Dear Minister

I wish to take this opportunity to congratulate you and your team on your reelection.

I am writing to advise you of a significant upcoming change at Healthscope hospitals. In the Australian Capital Territory, we operate National Capital Private Hospital.

Since the pandemic, over 70 private hospitals have closed, and more are at risk due to the rising costs of hospital care.

Private hospitals play a crucial role in Australia's healthcare system, providing nearly 40% of all hospital admissions and performing 66% of elective surgeries. Despite this vital contribution, the financial sustainability of private hospitals has deteriorated and is continuing to do so.

While premiums get more expensive, private health insurers are paying out proportionally less to cover hospital care – just 83 cents in the dollar on average, compared with 88 cents before COVID. This is despite spending millions on executive bonuses and marketing.

This underfunding from insurers, coupled with rising health costs, is pushing private hospitals to the brink of collapse.

Despite lengthy negotiations with Bupa and the insurers that comprise the Australian Health Service Alliance, we have not been able to reach agreements with these funds to sustainably cover the costs of the care we provide to patients.

As a result, we are now forced to introduce a Hospital Facility Fee to members of these funds from 26 November 2024. The Hospital Facility Fee is $100 for overnight patients per admission and $50 for same day patients per admission. The Fee will sit alongside other hospital out of pocket fees patients are already required to pay, which may include insurer excesses and co-payments.

Level 1, 312 St. Kilda Road,
Melbourne VIC 3004
P (03) 9926 7500
F (03) 9926 7599
healthscope.com.au

This is an outcome Healthscope has been trying to avoid, and not a decision we wanted to make. However, these insurers have left us with no choice. We will not compromise on patient care.

Members of other insurers we have discussed funding with will be exempt from the Fee because their funds have agreed to provide fairer funding for hospital care.

Exemptions to the Fee will apply to patients undergoing day treatment for chronic conditions (such as day chemotherapy, and day renal dialysis), mental health day programs and day rehabilitation programs. Palliative care patients will also be exempt.

Patients who are members of these funds can avoid the new fee by switching their cover to a comparable product with another fund.

If you would like further information on the challenges facing the private hospital sector, I invite you to contact Schedule 2.2(a)(ii) on Schedule 2.2(a)(ii) to arrange a briefing, or a visit to National Capital Hospital. You can also visit our website healthscope.com.au/newfee.

I look forward to your continued support in ensuring all Australians have access to the high-quality healthcare they deserve.

Yours faithfully,

Schedule 2.2(a)(ii)

Greg Horan
Chief Executive Officer
Healthscope

From: Cross, Rebecca
Sent: Tuesday, 29 October 2024 13:33
To: Tomlinson, Benjamin
Subject: RE: EMBARGOED: Strictly Confidential [SEC=OFFICIAL]

Thank you!

From: Tomlinson, Benjamin
Sent: Tuesday, 29 October 2024 1:30 PM
To: Cross, Rebecca
Subject: FW: EMBARGOED: Strictly Confidential [SEC=OFFICIAL]
Importance: High

From: MARTIN, Nick Schedule 2.2(a)(ii)
Sent: Tuesday, 29 October 2024 1:15 PM
To: Tomlinson, Benjamin <Benjamin.Tomlinson@act.gov.au>; Schedule 2.2(a)(ii)
Subject: EMBARGOED: Strictly Confidential [SEC=OFFICIAL]
Importance: High

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Embargoed and Strictly Confidential Until Public Release

Dear Chiefs of Staff,

Attached are two documents prepared by the COVID 19 Response Inquiry.

- COVID 19 Response Inquiry Summary Report
- COVID 19 Response Inquiry Full Report

The summary response is drafted specifically to provide clear lessons for future pandemic preparedness.

The Inquiry Panel has examined what worked well, the longer-term repercussions of some of the policies enacted, and, most importantly, where Australia can make improvements to prepare and protect our country for future infectious disease crises.

The report includes 9 guiding recommendations and 26 actions for change to improve Australia's preparedness and response systems to manage public health emergencies. 19 of these are immediate actions for implementation (in the next 12 to 18 months), and 18 actions directly impact the Commonwealth Health and Aged Care portfolio.

- The nine recommendations highlight what the Panel considered are the nine pillars of a successful pandemic response: minimising harm, planning and preparedness, leadership, evidence and evaluation, agility, relationships, trust, equity, and communications.

The report's recommendations are for the Commonwealth to implement or lead, but there are a number that will require consultation and agreement from states and territories. This recognises the important role states and territories play in the health response but also the contentious areas where responsibilities were unclear or overlapped. Key actions relate to:

- updating health emergency planning and response arrangements, including escalation and de-escalation points and options for real-time review
- national governance including providing additional expertise to National Cabinet
- the need to agree and document responsibilities of all key parties in a national health emergency including escalation triggers
- a national strategy for trust in vaccines and improving vaccination rates
- clarity in communications during national health emergencies.

In releasing the report today, the Commonwealth Government will indicate the findings will require careful consideration and consultation across the Commonwealth and with states and territories over the coming months.

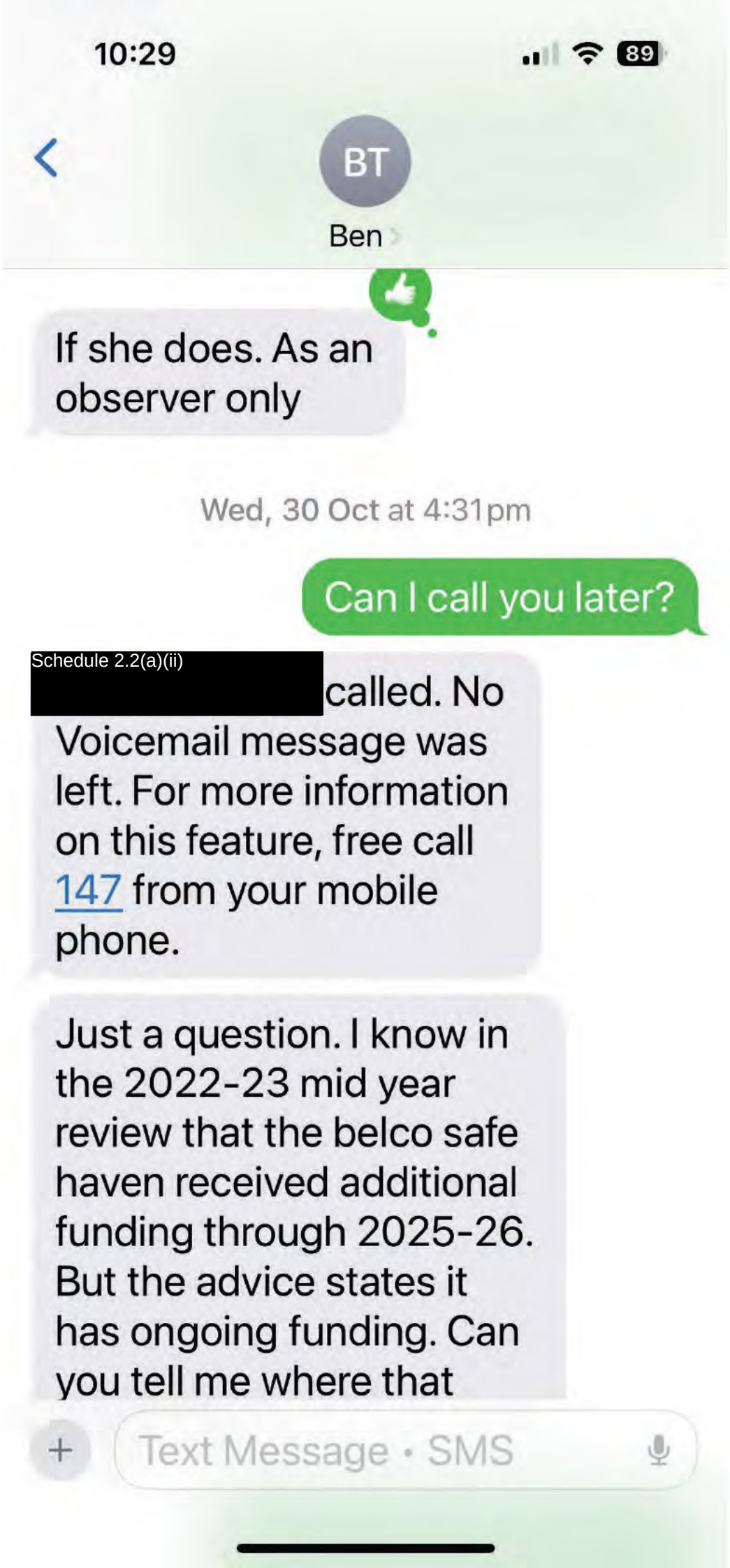
The Commonwealth Government will also announce its plans for an Australian CDC today.

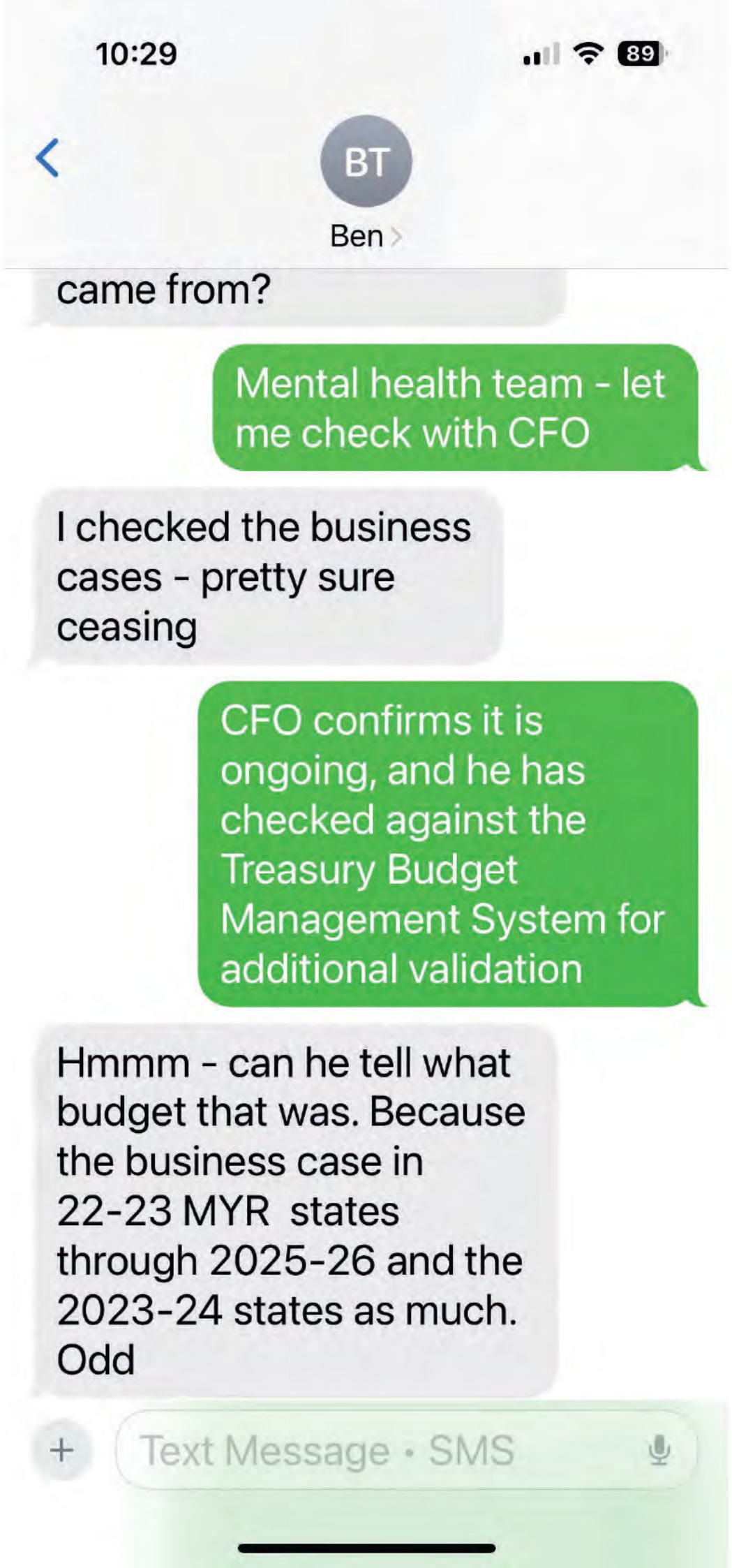
Regards

Nick Martin
Chief of Staff
Office of the Minister for Health and Aged Care
M: Schedule 2.2(a)(ii)

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10:28
89
BT
Ben
Sorry.
I'll see what we can do
R
Thank you!
It has been removed and will be fixed for tomorrow
👍 to 'It has been removed and will be fixed for tomorrow'
Tue, 29 Oct at 4:56 pm
Is the minister going to HMM tomorrow?
Maybe
It shouldn't matter but technically the govt is still in caretaker
Text Message • SMS


10:29
89
BT
Ben
If she does. As an observer only
Wed, 30 Oct at 4:31pm
Can I call you later?
Schedule 2.2(a)(ii)
called. No Voicemail message was left. For more information on this feature, free call 147 from your mobile phone.
Just a question. I know in the 2022-23 mid year review that the belco safe haven received additional funding through 2025-26. But the advice states it has ongoing funding. Can you tell me where that
Text Message • SMS

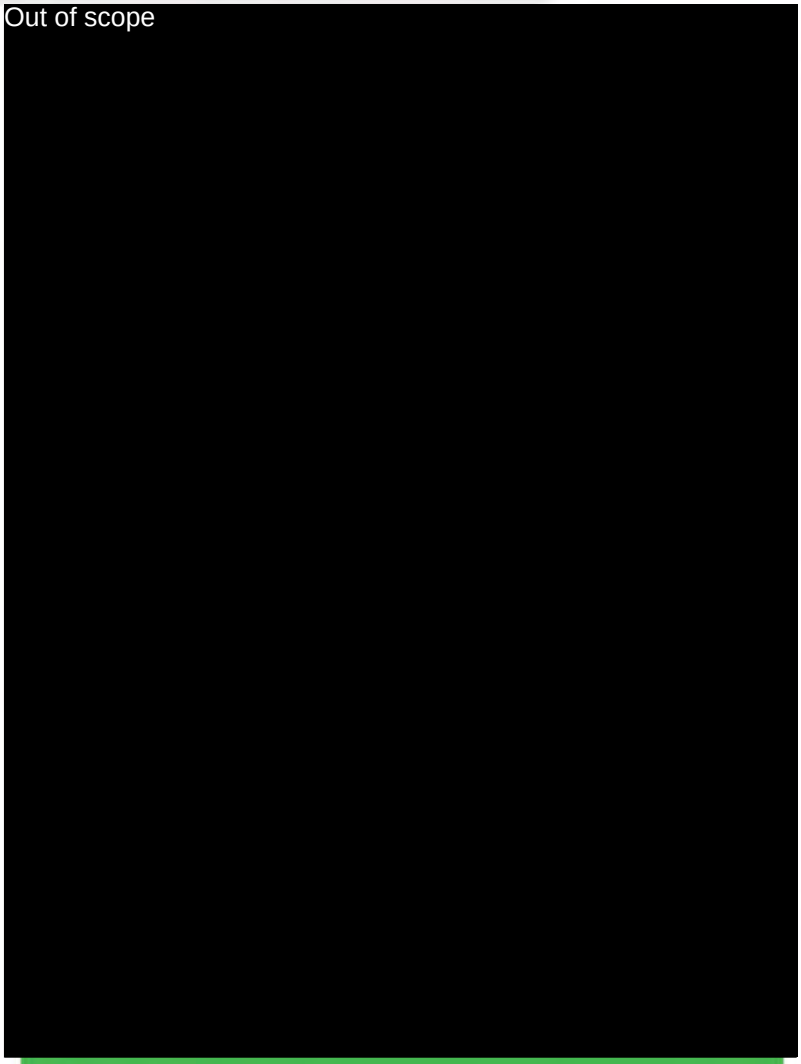

10:29
89
BT
Ben
came from?
Mental health team - let me check with CFO
I checked the business cases - pretty sure ceasing
CFO confirms it is ongoing, and he has checked against the Treasury Budget Management System for additional validation
Hmmm - can he tell what budget that was. Because the business case in 22-23 MYR states through 2025-26 and the 2023-24 states as much. Odd
Text Message • SMS

10:29

BT

Ben

Odd



I'll see if Muku can answer your question

It must be very satisfying to always be right. Muku has rechecked and

Text Message • SMS

Lowe, Shannon

From: Gower, Tara on behalf of ACT Health DLO
Sent: Wednesday, 30 October 2024 9:05 AM
To: Smith, Kahlia; STEPHEN-SMITH; CHS DLO
Cc: Bransgrove, Meagen
Subject: RE: DUE 30/10 : New AIHW embargo release available: Medicare Benefits Scheme funded services: monthly data

Hi Kahlia

Apologies for the delay.

Please see ACTHD response below.

GP attendances

- Over the past 10 years, the average number of Medicare services per person has been slowly increasing in the ACT and nationally, and the average number of services per person in the ACT has been consistently lower than the Australian average for GP services.
    - The average number of services per person in the rolling 12 months to September 2024 was 22% lower than the national average (4.89 per person for the ACT and 6.30 nationally)
- The percentage of provider fees paid by Medicare for GP services in the ACT has been consistently lower than the national average over the past 10 years. The average number of services per person has been stable with the exception of a spike in attendances between 2021 and 2022 that returned to pre-2021 levels in 2023.
    - The percentage of provider fees paid for by Medicare in the ACT was 69% in the 12 months to September 2024 compared to 84% nationally

Specialist attendances

- Over the past 10 years, the average number of Medicare services per person in the ACT has been consistently lower than the Australian average for Specialist attendances.
    - The average number of services per person in the rolling 12 months to September 2024 was 20% lower than the national average (1.02 per person for the ACT and 1.28 nationally)
- The percentage of provider fees paid by Medicare for Specialist attendances in the ACT has been consistently lower than the national average over the past 10 years.
    - The percentage of provider fees for Specialist attendances paid for by Medicare was 51% in the 12 months to September 2024 compared to 55% nationally

Obstetric services

- Over the past 10 years, the average number of Obstetric services per female in the ACT has been consistently decreasing in the ACT and nationally. The number of services per female in the ACT is consistently lower than the Australian average for Obstetric services.
    - The average number of services per female in the rolling 12 months to September 2024 was 27% lower than the national average (0.08 per person for the ACT and 0.11 nationally)
- The percentage of provider fees paid by Medicare for Obstetric services in the ACT has been consistently lower than the national average over the past 10 years.
- The gap between the percentage of provider fees paid by Medicare in the ACT and nationally increased between 2022 and 2024
    - The percentage of provider fees paid for by Medicare was 29% in the 12 months to September 2024 compared to 38% nationally

Anaesthetic services

- Over the past 10 years, the average number of Anaesthetic services per person in the ACT has been consistently lower than the Australian average for Anaesthetic services.

  - The average number of services per person in the rolling 12 months to September 2024 was 20% lower than the national average (0.12 per person for the ACT and 0.15 nationally)

- The percentage of provider fees paid by Medicare for Anaesthetic services in the ACT has been steady, but consistently lower than the national average over the past 10 years.
  - The percentage of provider fees paid for by Medicare in the ACT was 31% in the 12 months to September 2024 compared to 38% nationally

Pathology services

- Over the past 10 years, the average number of Pathology services per person in the ACT has been consistently lower than the Australian average, with the exception of the period between April 2022 and November 2022.
  - The average number of services per person in the rolling 12 months to September 2024 was 18% lower than the national average (5.08 per person for the ACT and 6.18 nationally)
- The percentage of provider fees paid for by Medicare for Pathology services is on par with the national percentage over the last 10 years at around 93%.

Diagnostic imaging services

- Over the past 10 years, the average number of Diagnostic imaging services per person in the ACT has been consistently lower than the Australian average
  - The average number of Diagnostic imaging services per person in the rolling 12 months to September 2024 was 31% lower than the national average (0.8 per person for the ACT and 1.16 nationally)
- The percentage of provider fees paid by Medicare for Diagnostic imaging services in the ACT has been stable, but consistently lower than the national average over the past 10 years.
  - In the 12 months to September 2024, the percentage of provider fees paid for by Medicare in the ACT for Diagnostic imaging services was 75% compared to 86% nationally

Surgical operations

- Over the past 10 years, the average number of Surgical operations per person in the ACT has been stable, but consistently lower than the Australian average.
  - The average number of services per person in the rolling 12 months to September 2024 was 29% lower than the national average (0.32 per person for the ACT and 0.45 nationally)
- The percentage of provider fees paid by Medicare for Surgical operations has been slowly decreasing in the ACT and nationally. The ACT is consistently lower than the national average over the past 10 years.
  - The percentage of provider fees paid for by Medicare in the ACT was 36% in the 12 months to September 2024 compared to 47% nationally

Allied health services

- Over the past 10 years the number of Allied health services per person has been steadily increasing in the ACT and nationally.
- Over the past 10 years, the average number of Allied health services per person in the ACT has been consistently lower than the Australian average.
  - in the rolling 12 months to September 2024, the average number of Allied health services per person was 20% lower than the national average (0.8 per person for the ACT and 1.0 nationally)
- Nationally and in the ACT the percentage of provider fees paid by Medicare for Allied health services has been slowly decreasing.
- The percentage of provider fees paid by Medicare for Allied health services in the ACT has been consistently lower than the national average over the past 10 years.
  - In the 12 months to September 2024, the percentage of provider fees paid for by Medicare in the ACT was 66% compared to 75% nationally

Other MBS services

- These services include radiation oncology, and therapeutic nuclear medicine, diagnostic procedures and investigations, assisted reproductive services and other unreferred services.

- Over the past 10 years, the average number of Other MBS services per person in the ACT has been consistently lower than the Australian average.
    - in the rolling 12 months to September 2024, the average number of Other MBS services per person was 14% lower than the national average (0.47 per person for the ACT and 0.55 nationally)
- Nationally and in the ACT the percentage of provider fees paid by Medicare for Other MBS services has been fairly stable.
    - In the 12 months to September 2024, the percentage of provider fees paid for by Medicare in the ACT was 77% compared to 86% nationally

Thank you
Tara

Tara Gower | Directorate Liaison Officer | ACT Health Directorate
Mob: Schedule 2.2(a)(ii) Email: ACTHealthDLO@act.gov.au
Office of Rachel Stephen-Smith | Minister for Health
Office of Emma Davidson | Minister for Mental Health
Level 2, Legislative Assembly Building, Civic Square



From: Smith, Kahlia
Sent: Saturday, 26 October 2024 4:03 AM
To: STEPHEN-SMITH ; ACT Health DLO ; CHS DLO
Cc: Bransgrove, Meagen
Subject: DUE 30/10 : New AIHW embargo release available: Medicare Benefits Scheme funded services: monthly data
Importance: High

Hi both - could we please get some dot points on any ACT specific content in here?

Thanks
Kahlia

Get Outlook for Android

From: STEPHEN-SMITH <STEPHEN-SMITH@act.gov.au>
Sent: Friday, October 25, 2024 1:13:43 PM
To: ACT Health DLO <ACTHealthDLO@act.gov.au>; CHS DLO <CHSDLO@act.gov.au>
Cc: Bransgrove, Meagen <Meagen.Bransgrove@act.gov.au>; Smith, Kahlia <Kahlia.Smith@act.gov.au>
Subject: FW: New AIHW embargo release available: Medicare Benefits Scheme funded services: monthly data

Hi Team,

For noting please.

Thank you,

Sally Cooke
Office Manager | Office of Rachel Stephen-Smith MLA
Minister for Health | Minister for Children, Youth and Family Services | Minister for Disability | Minister for Aboriginal and Torres Strait Islander Affairs
Member for Kurrajong
ACT Legislative Assembly, 196 London Circuit, Canberra ACT 2601 | P: (02) 6205 2661 | www.act.gov.au

From: communications@aihw.gov.au <communications@aihw.gov.au>
Sent: Friday, 25 October 2024 12:29 PM
To: STEPHEN-SMITH <STEPHEN-SMITH@act.gov.au>
Subject: New AIHW embargo release available: Medicare Benefits Scheme funded services: monthly data

Caution: This email originated from outside of the ACT Government. Do not click links or open attachments unless you recognise the sender and know the content is safe.

Dear all,

The latest AIHW release ***Medicare Benefits Scheme funded services: monthly data*** is now available **under strict embargo** until its public release on **30, October at 12:01am AEST**.

About the release:

The Australian Government subsidises the cost of health services covered by the Medicare Benefits Scheme (MBS) for all Australians since 1984. This report presents monthly data on the usage rates of these health services as well as the MBS subsidy rate (that is, the proportion of the cost of these services funded through the MBS, as opposed to via patient contributions and other arrangements such as private health insurance).

Data in this report is updated monthly.

The release **will not be** accompanied by a media release.

Please click on link and follow the instructions below:

- AIHW Stakeholder hub (https://pp.aihw.gov.au/login)
- Your username is your **email address**
- Please select '**Forgot your password'** link if required.

Embargo access conditions

By accessing the AIHW Stakeholder hub you agree to the following:

Access to the Stakeholder hub is provided to you for background and research purposes. It is conditional on your organisation not commenting publicly on the forecasts or conclusions contained within AIHW releases, including not issuing any media statements/articles on the topic until after the AIHW release has been publicly released.

I agree to comply with any relevant requirements of the Australian Government Protective Security Policy Framework. I acknowledge that I can obtain further information in relation to the Australian Government Protective Security Policy Framework through the following link to the Commonwealth Attorney-General's Department Website: www.protectivesecurity.gov.au

If you would like any further information, please contact communications@aihw.gov.au or (02) 6249 5089.

Kind regards,

Communications & Engagement Unit

Australian Institute of Health and Welfare

Communications@aihw.gov.au | @aihw | aihw |

From: Stephen-Smith, Rachel
Sent: Wednesday, 30 October 2024 21:56
To: ACT Health DLO
Cc: STEPHEN-SMITH; Tomlinson, Benjamin
Subject: Re: Information on Safe Havens

Importance: High

No worries - thanks Tara.

R

Rachel Stephen-Smith MLA
Member for Kurrajong
ph: 02 6205 2661

On 30 Oct 2024, at 9:03 PM, ACT Health DLO wrote:

OFFICIAL

Good evening Minister
Unfortunately, following some further queries, I have just been advised that the funding for Safe Haven Belconnen is not ongoing, it ceases in 2025-26.
Please see the updated information highlighted in yellow below.
Sincere apologies that the earlier information was incorrect.

Belconnen Safe Haven

1. In partnership with the Capital Health Network (CHN), ACT Health commissioned the Non-Government organisation (NGO) Stride to operate the Belconnen Safe Haven from November 2021.

2. The Belconnen Safe Haven site receives annual funding of $400,000 (GST exclusive), plus indexation. Budget funding for Safe Haven Belconnen ceases at the end of 2025-26.
3. ACT Health currently provides funding to Stride through a contract with CHN, which is due to expire on 31 December 2024. A new direct contract between Stride and ACT Health for the period 1 January 2025 to 30 June 2025 is currently being negotiated. This short extension is to allow the service to continue while an open grant process is undertaken to identify a provider to operate a Safe Haven network (ie. the Belconnen and TCH Safe Havens - see further information below on TCH Safe Haven).
    1. ACTHD has received Stride's grant response application, reviewed and evaluated the response, and subject to confirmation with the incoming Minister, will commence negotiations with Stride for the short contract extension.

4. According to the latest performance report, between January 2024 and June 2024 there was a total of 503 visits to the Belconnen Safe Haven, averaging 19 visits per week. During this same reporting period:
    1. 81 unique guests were supported, averaging to 6.2 visits per guest.
    2. In addition, 489 phone sessions were delivered.

5. The January 2024 to June 2024 reporting period indicated:
    1. 88% of guests had a positive experience in using the service.
    2. Average reduction of 24% in Subjective Unit of Distress Scale scores between the guests arrival and departure.
    3. Guests have been referred to a wide range of services:
        1. Stride Southside Community Step Up Step Down
        2. Head2Health Peer Social Group (and other Head2Health services)
        3. Dialectical Behaviour Therapy programs
        4. Care Financial
        5. CAMHA
        6. Directions Health Services
        7. Domestic Violence and Crisis Service (DVCS)
        8. Toora
        9. when necessary, directly to emergency services such as the PACER team.

6. Staff at the Belconnen Safe Haven and guests have participated in research activities associated with the Australian National University (ANU) Co-Creating Safe Spaces evaluation project, since its inception. This is a national research project reviewing six different safe spaces for people experiencing emotional distress, including the Belconnen Safe Haven service. This research project is primarily funded through grants from the Australian Government Department of Health. The project team is to produce a report on evaluating these Safe Spaces. ACTHD understands that this report will be completed in December 2024. ACTHD has not undertaken any formal evaluation of the Belconnen Safe Haven including the direct impact on ED diversions and cost benefit analysis of the service model.

New TCH Safe Haven

1. The ACT Government announced $2.316 million in funding over 2024-25 to 2026-27 for a second Safe Haven at the Canberra Hospital as part of the 2023-2024 ACT Budget. This included $700,000 in capital funding to ACTHD to support the establishment of the TCH Safe Haven, with the balance being ongoing operational funding for the Safe Haven TCH service.

1. It is intended for TCH Safe Haven to be operated by a non-government organisation to provide a non-clinical alternative to the Emergency Department.

2. Planning is currently underway for the process to determine a service provider. An open grant process is proposed for an NGO to operate the Belconnen and TCH sites as a network as indicated above. Subject to the incoming Minister's approval, ACT Health would need to begin the open grant process as soon as possible after Caretaker so that an NGO provider can be identified in the first half of 2025. The successful NGO provider would then be able to be included in the final design and construction work, and potentially recruit and train new staff, before operation begins.

2. ACT Health and CHS are working closely together for the architect design and construction of the hospital site. Work is progressing to allow CHS to be responsible for managing the capital works funding to enable effective delivery of the project with the broader Canberra Hospital re-developments.

3. ACT Health will continue to coordinate with CHS on the detailed design and its final acceptance. ACT Health will continue to manage the non-infrastructure elements of the project including the operationalisation of the Safe Haven Model of Care and contracting the NGO provider.

4. TCH Safe Haven is expected to begin operation in August 2025 following architect design in 2024, with construction at the hospital site likely to commence in 2025. CHS

has indicated that it is not expecting any major delays from other work planned on this site.

5. A Co-Design Group has been established by ACTHD to assist in the detailed implementation of the model of care. Membership includes ACTHD, CHS, people with lived experience and representatives from other linked services. The Co-Design group will provide advice and evidence to the Steering Group.

Thank you
Tara

Tara Gower | Directorate Liaison Officer | ACT Health Directorate
Mob: Schedule 2.2(a)(ii) Email: ACTHealthDLO@act.gov.au
Office of Rachel Stephen-Smith | Minister for Health
Office of Emma Davidson | Minister for Mental Health
Level 2, Legislative Assembly Building, Civic Square

From: Gower, Tara **On Behalf Of** ACT Health DLO
Sent: Wednesday, 30 October 2024 4:17 PM
To: Stephen-Smith, Rachel
Cc: STEPHEN-SMITH ; Tomlinson, Benjamin
Subject: Information on Safe Havens
Importance: High

Good afternoon Minister
Rebecca Cross, DG ACTHD has asked that I provide the below information direct to you.
I understand this information was requested by Ben this morning.

Belconnen Safe Haven

7. In partnership with the Capital Health Network (CHN), ACT Health commissioned the Non-Government organisation (NGO) Stride to operate the Belconnen Safe Haven from November 2021.

8. The Belconnen Safe Haven site receives annual funding of $400,000 (GST exclusive), plus indexation. There is ongoing funding in the Budget for Safe Haven Belconnen.
9. ACT Health currently provides funding to Stride through a contract with CHN, which is due to expire on 31 December 2024. A new direct contract between Stride and ACT Health for the period 1 January 2025 to 30 June 2025 is currently being negotiated. This short extension is to allow the service to continue while an open grant process is undertaken to identify a provider to operate a Safe Haven network (ie. the Belconnen and TCH Safe Havens - see further information below on TCH Safe Haven).
    1. ACTHD has received Stride's grant response application, reviewed and evaluated the response, and subject to confirmation with the incoming Minister, will commence negotiations with Stride for the short contract extension.

10. According to the latest performance report, between January 2024 and June 2024 there was a total of 503 visits to the Belconnen Safe Haven, averaging 19 visits per week. During this same reporting period:
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9. TCH Safe Haven is expected to begin operation in August 2025 following architect design in 2024, with construction at the hospital site likely to commence in 2025. CHS has indicated that it is not expecting any major delays from other work planned on this site.

10. A Co-Design Group has been established by ACTHD to assist in the detailed implementation of the model of care. Membership includes ACTHD, CHS, people with lived experience and representatives from other linked services. The Co-Design group will provide advice and evidence to the Steering Group.

Thank you
Tara

Tara Gower | Directorate Liaison Officer | ACT Health Directorate
Mob: Schedule 2.2(a)(ii) Email: ACTHealthDLO@act.gov.au
Office of Rachel Stephen-Smith | Minister for Health
Office of Emma Davidson | Minister for Mental Health
Level 2, Legislative Assembly Building, Civic Square

From: Cross, Rebecca
Sent: Friday, 1 November 2024 10:13
To: Tomlinson, Benjamin
Subject: FW: FINAL Cost Pressures Slide Deck
Attachments: CHS Structural Cost Pressures - ERC Slide pack 2_FINAL_3.6.24.pptx

From: Canberra Health Services CFO
Sent: Monday, 3 June 2024 2:05 PM
To: Peffer, Dave ; Cross, Rebecca ; Tomlinson, Benjamin ; Bransgrove, Meagen
Cc: Ogden, Paul ; Young, Florence ; Fulton, Duncan ; Canberra Health Services CFO ; Howard, Grant ; Zagari, Janet ; Culhane, Michael ; Ganeshalingam, Muku ; CHS DLO
Subject: FINAL Cost Pressures Slide Deck

OFFICIAL: Sensitive

Good afternoon All,

Please see attached the final/clean slide deck relating to CHS Structural Cost Pressures, ahead of this afternoon's ERC.

The version with Minister's commentary is still available at the link below, should you wish to review these:
20240528 CHS Structural Cost Pressures - ERC Slide pack 2_23.5.24 - RSS comments.pptx

Please get in touch if you have any issues.

Kind regards
Tasfia

Tasfia Khan | Business Manager
Phone: MS Teams | Email: CHSCFO@act.gov.au
CFO Division | Canberra Health Services | ACT Government
PO Box 11, WODEN ACT 2606 | canberrahealthservices.act.gov.au

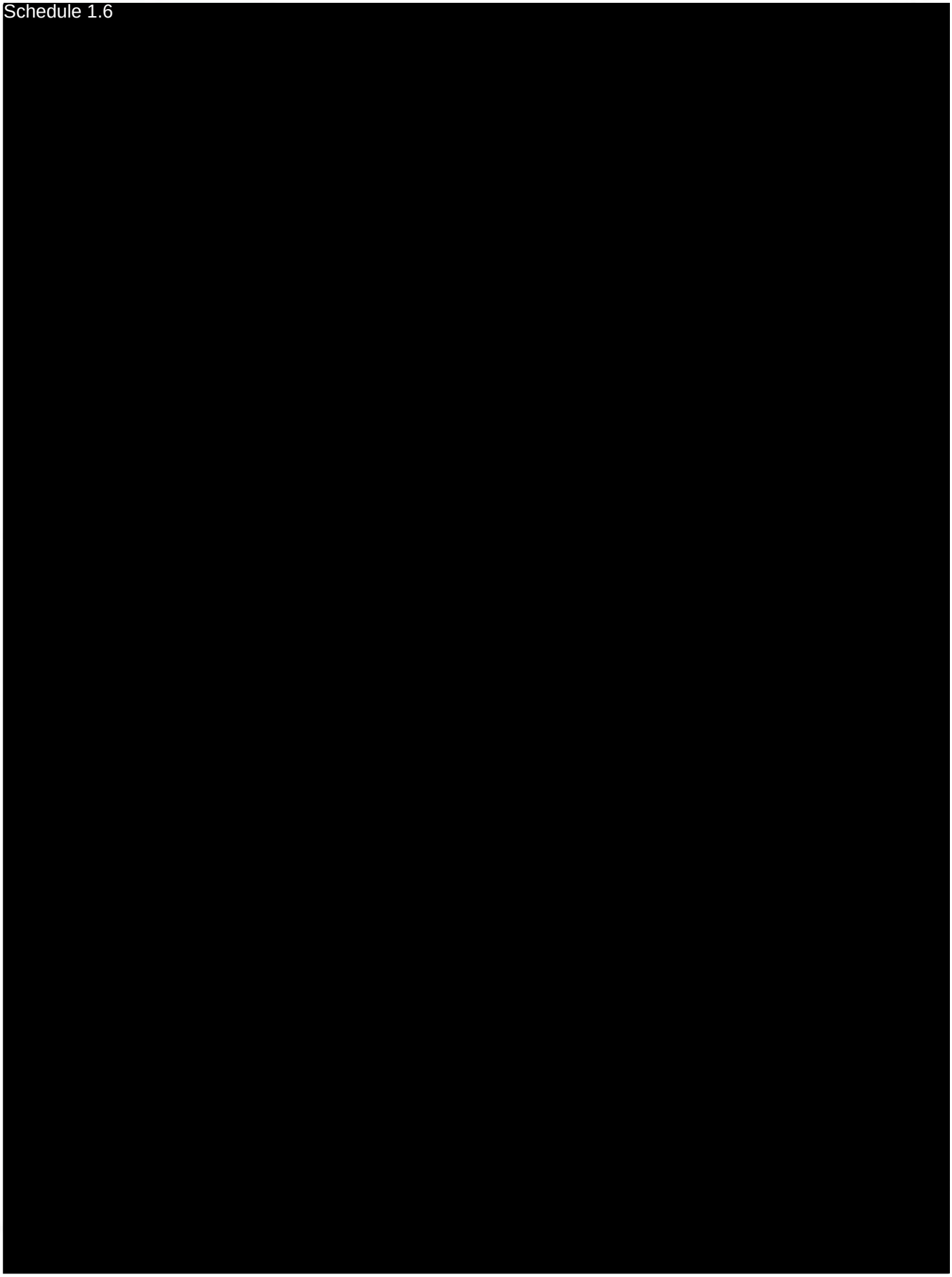
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'Creating exceptional health care together.'

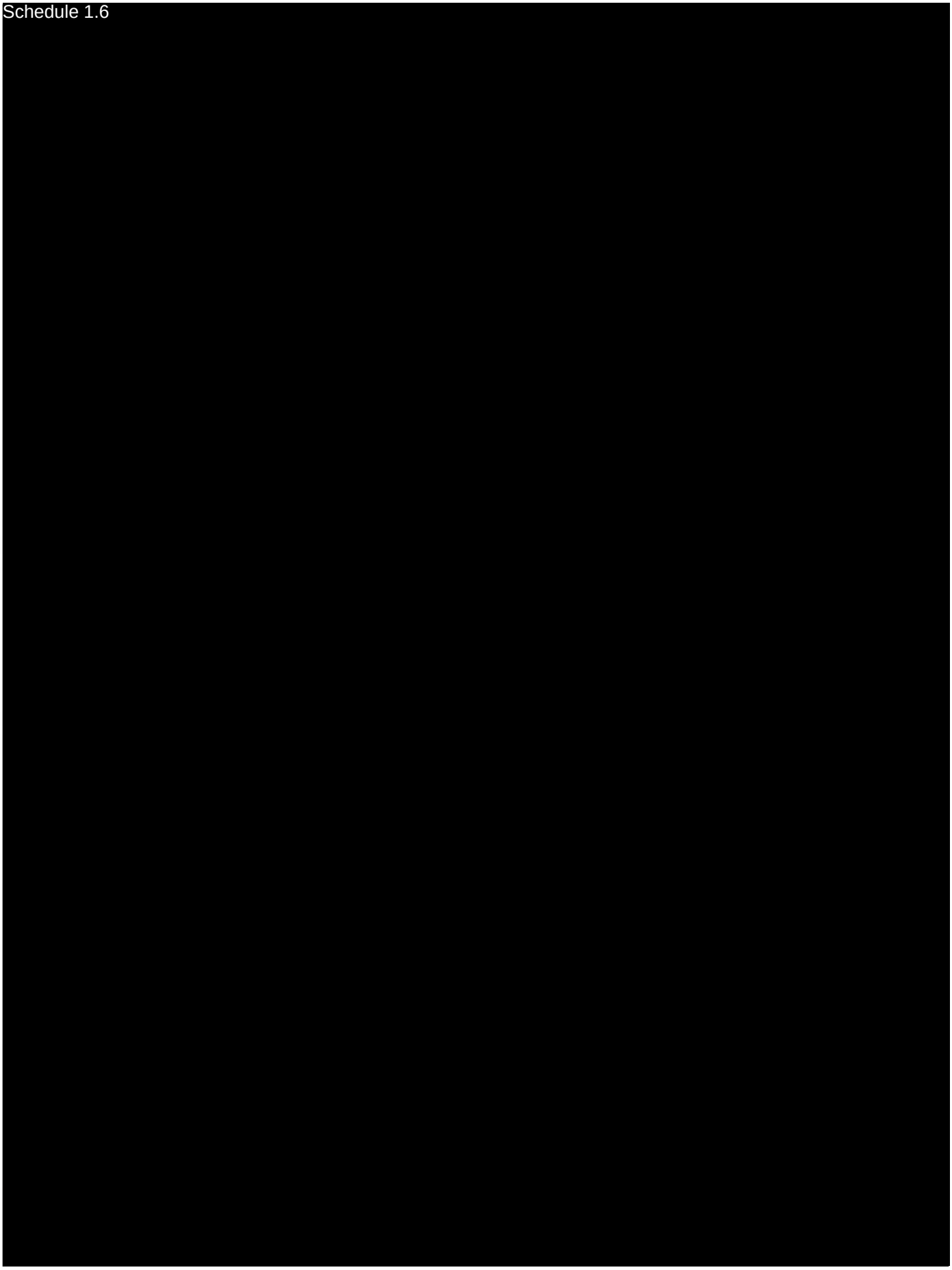
Canberra Health Services acknowledges the Ngunnawal people as traditional custodians of the ACT and recognises any other people or families with connection to the lands of the ACT and region.
We acknowledge and respect their continuing culture and contribution to the life of this region.



Schedule 1.6



Schedule 1.6



Schedule 1.6

[redacted]

Schedule 1.6

[redacted]

Schedule 1.6

[redacted]

Lowe, Shannon

From: Ellis, Catherine on behalf of ACT Health DLO
Sent: Friday, 1 November 2024 1:21 PM
To: Tomlinson, Benjamin
Cc: CHS DLO; ACT Health DLO
Subject: FW: ASMOF Letter : Correspondence to Chief minister and Minister for Health
Attachments: 241029 ASMOF to ACT Gov.pdf; RE: urgent advice please : Correspondence to Chief minister and Minister for Health

Importance: High

Hi Ben

For awareness and per the attached email CHS are now leading on this matter so the ASMOF letter has been redirected between the directorates.

Thanks
Cath

From: Tomlinson, Benjamin
Sent: Tuesday, 29 October 2024 1:37 PM
To: ACT Health DLO
Cc: Cross, Rebecca ; Peffer, Dave ; STEPHEN-SMITH
Subject: ASMOF Letter : Correspondence to Chief minister and Minister for Health
Importance: High

For appropriate action and advice please.

Thank you
Ben

From: STEPHEN-SMITH <STEPHEN-SMITH@act.gov.au>
Sent: Tuesday, 29 October 2024 1:33 PM
To: Tomlinson, Benjamin <Benjamin.Tomlinson@act.gov.au>
Subject: FW: Correspondence to Chief minister and Minister for Health

Hi Ben,

For your advice/action please.

Thank you,

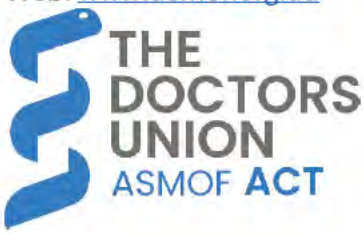
Sally Cooke
Office Manager | Office of Rachel Stephen-Smith MLA
Minister for Health | Minister for Children, Youth and Family Services | Minister for Disability | Minister for Aboriginal and Torres Strait Islander Affairs
Member for Kurrajong
ACT Legislative Assembly, 196 London Circuit, Canberra ACT 2601 | P: (02) 6205 2661 | www.act.gov.au

From: Steve Ross <stever@asmof.org.au>
Sent: Tuesday, 29 October 2024 1:22 PM
To: STEPHEN-SMITH <STEPHEN-SMITH@act.gov.au>; BARR <BARR@act.gov.au>
Subject: FW: Correspondence to Chief minister and Minister for Health

Caution: This email originated from outside of the ACT Government. Do not click links or open attachments unless you recognise the sender and know the content is safe.

Benjamin,
I had an 'on leave' bounceback from Meg. Please find correspondence attached.
Feel free to give me a call.
Regards

Steve Ross
Executive & Industrial Officer
ASMOF (ACT)
Part Time – available Tues, Wed, Thurs
Mobile: 0498 268 948
Email: stever@asmof.org.au
Web: www.asmof.org.au

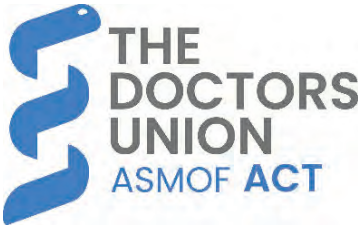


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From: Steve Ross
Sent: Tuesday, 29 October 2024 12:57 PM
To: Bransgrove, Meagen <Meagen.Bransgrove@act.gov.au>
Subject: Correspondence to Chief minister and Minister for Health

Hi Meg,
Please see correspondence attached.
Regards

Steve Ross
Executive & Industrial Officer
ASMOF (ACT)
Part Time – available Tues, Wed, Thurs
Mobile: 0498 268 948
Email: stever@asmof.org.au
Web: www.asmof.org.au



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THE DOCTORS UNION
ASMOF ACT

29 October, 2024

Andrew Barr **Rachel Stephen-Smith**
Chief Minister **Minister for Health**

BY EMAIL: Meagen.Bransgrove@act.gov.au

Dear Mr Barr and Ms Stephen-Smith,

Re: Medical Practitioner Enterprise Bargaining Wage Dispute

As you are aware ASMOF members are currently taking Protected Industrial Action in pursuit of an improved wages outcome to that rejected emphatically in the ballot for a proposed agreement.

During the course of the recent ACT election campaign, you replied to correspondence from ASMOF with the following proposition:

We are keen to see improved pay and conditions flowing for medical practitioners as soon as possible. To ensure the ACT public health service remains competitive in the short-term a re-elected Labor Government proposes to commence an arbitration process with MPEA bargaining parties to resolve the issue of the pay offer for the agreement currently under negotiation.
ACT Labor proposes that this process be undertaken through an independent arbitrator who would make a binding determination. In the interests of finalising the agreement and given the strong feedback from your members that pay was the key issue, we would propose that this is the only matter progressed to arbitration. This does not preclude further discussion on non-financial matters where agreement can be reached in a timely way.

ASMOF replied to this correspondence on 1 October seeking clarification of several aspects of the proposal and included the following question:

[T]he proposal for an arbitration process lacks detail. As you are aware employed medical practitioners don't have the legislative cushion afforded VMOs under s106 of the Health Act(ACT)1993. Rather, the employment relationship is governed by the Fair Work Act (Cwlth) 2009. How is it proposed that the outcome of any voluntary arbitration be codified?

In ASMOF's view the only pathway to an arbitrated outcome on the wages dispute being reflected in an enforceable industrial instrument is through a Protracted Bargaining Declaration being made pursuant to FWA section 235 which then leads to a Workplace Determination pursuant to FWA section 269.

(We note that in the two sets of proceedings brought by ASMOF pursuant to FWA s240, both of which occurred prior to the Caretaker period, no proposal for a voluntary arbitration was advanced by the ACT Govt.)

In pursuit of an arbitrated settlement ASMOF has filed an application for an Intractable Bargaining Declaration (Matter B2024-1319). The application has been listed before DP Dean who issued a Direction that the ACT Government indicate its position on the ASMOF application by 18 October, and if opposed, outline its arguments. A submission was filed on behalf of the Government opposing the ASMOF application.

The position taken on behalf of the ACT Government is extremely disappointing. Firstly, as stated above, ASMOF believes this to be the only legislative path available to settle the dispute through arbitration. If there's an alternative ASMOF members would be happy to consider it.

Secondly, the reasons advanced for opposing ASMOF's application are in our view spurious.

- The Respondent submission argues that the protected industrial action has been 'low key' and a Protracted Bargaining Declaration would end it prematurely (Respondent submissions para 14(1)(a)). In response ASMOF members will now necessarily escalate their action.
- The Respondent submission argues that the ASMOF position is not reflective of the broader view of the Medical Workforce (Respondent submissions para 14(1)(b)). ASMOF finds it extraordinary that after 23 years of Labor Government and the well-established Union Encouragement policy that public servants would still consider it appropriate to advance instructions to GSO based on that old trope.
- The Respondent submission argues that ASMOF submitted new claims on 17 July that reset the negotiations (Respondent submissions para 14(2)). This is not correct, and the issue was canvassed extensively in the FWA s240 conferences post ballot before DP Dean. At the 17 July meeting with Ms Stephen-Smith ASMOF set out what we considered the wages deficit to be and suggested several mechanisms for bridging that gap that in our view wouldn't compromise the Govt. politically by making a further wage offer to Medical Practitioners different to that offered to the rest of the ACTPS. ASMOF confirmed that approach in correspondence on 23 July and also invited proposals from the Govt.:

  …

  ASMOF set out that we believe the rejected ACT Govt wage offer left the remuneration package for Medical Practitioners approximately 10% short of what would be acceptable to members. Accordingly, we advanced a number of proposals that combined would bridge that gap. ASMOF is seeking the ACT Government's response on:

  a) Whether it is prepared to increase the funding available for Medical Practitioner remuneration in order to bridge the 10% gap; and

  b) *A preliminary view on the proposals in the ASMOF package (or indeed any other proposals).*

Deputy President Dean has now listed the ASMOF application for a Directions Conference on 12 November at which we anticipate the matter will be programmed as if for a contested Hearing. In the Respondent's submission referred to above, there is a suggestion that now the election is over that *it is not unreasonable to consider that the minister for health may want to revise the respondent's current position* (Respondent's submission para14(3)).

In ASMOF's view, the new ACT Government has an opportunity to settle this matter through either: a new, acceptable wages offer; or by consenting to the ASMOF application for a Protracted Bargaining Declaration which would then allow for the matter to be resolved by way of a Workplace Determination in which the wage outcome was the only issue under consideration.

ASMOF would welcome the opportunity for further discussions with you prior to the Directions Conference scheduled for 12 November.

Regards

Sent electronically

Steve Ross

Executive and Industrial Officer

ASMOF – ACT Branch

From: Murray, Ryan
To: Ellis, Catherine
Subject: RE: urgent advice please : Correspondence to Chief minister and Minister for Health
Date: Friday, 1 November 2024 11:18:16 AM
Attachments: image008.png
image009.jpg
image010.png
image011.jpg
image012.png
image013.png
image014.png
image001.png

OFFICIAL: Sensitive

Hi Cath,

Confirming that CHS is leading MPEA from now.

Regards,

Ryan Murray | Director - Government Relations

Phone: 02 5124 2452 | Mobile: Schedule 2.2(a)(ii) Email: ryan.murray@act.gov.au

Strategy and Governance | Canberra Health Services | ACT Government

Yamba Drive, Garran, ACT 2605 | canberrahealthservices.act.gov.au

Creating exceptional health care together.

Canberra Health Services acknowledges the Ngunnawal people as traditional custodians of the ACT and recognises any other people or families with connection to the lands of the ACT and region.

We acknowledge and respect their continuing culture and contribution to the life of this region.

From: Ellis, Catherine <Catherine.Ellis@act.gov.au>
Sent: Thursday, 31 October 2024 4:20 PM
To: Murray, Ryan <Ryan.Murray@act.gov.au>
Subject: FW: urgent advice please : Correspondence to Chief minister and Minister for Health

OFFICIAL: Sensitive

Hi Ryan

As discussed, seeking advice on MPEA and progression of both Cabinet packages on this matter and also responding to the attached letter which was also provided to Dave Peffer by MO.

Can you let me know what you are able to find out, and if you are comfortable pending advice received for ACTHD to redirect the attached letter through to CHS for preparation of a response.

Thanks

Cath

Catherine Ellis | Senior Director

Ministerial and Government Services | ACT Health Directorate

Mob: Schedule 2.2(a)(ii) Email: Catherine.Ellis@act.gov.au

Level 5, Bowes Street, Woden ACT

From: Tomlinson, Benjamin <Benjamin.Tomlinson@act.gov.au>
Sent: Tuesday, 29 October 2024 1:37 PM
To: ACT Health DLO <ACTHealthDLO@act.gov.au>
Cc: Cross, Rebecca <Rebecca.Cross@act.gov.au>; Peffer, Dave <Dave.Peffer@act.gov.au>; STEPHEN-SMITH <STEPHEN-SMITH@act.gov.au>
Subject: FW: Correspondence to Chief minister and Minister for Health
Importance: High

For appropriate action and advice please.

Thank you

Ben

From: STEPHEN-SMITH <STEPHEN-SMITH@act.gov.au>

Sent: Tuesday, 29 October 2024 1:33 PM
To: Tomlinson, Benjamin <Benjamin.Tomlinson@act.gov.au>
Subject: FW: Correspondence to Chief minister and Minister for Health

Hi Ben,

For your advice/action please.

Thank you,

Sally Cooke

Office Manager | Office of Rachel Stephen-Smith MLA

Minister for Health | Minister for Children, Youth and Family Services | Minister for Disability | Minister for Aboriginal and Torres Strait Islander Affairs

Member for Kurrajong

ACT Legislative Assembly, 196 London Circuit, Canberra ACT 2601 | P: (02) 6205 2661 | www.act.gov.au

From: Steve Ross <stever@asmof.org.au>
Sent: Tuesday, 29 October 2024 1:22 PM
To: STEPHEN-SMITH <STEPHEN-SMITH@act.gov.au>; BARR <BARR@act.gov.au>
Subject: FW: Correspondence to Chief minister and Minister for Health

Caution: This email originated from outside of the ACT Government. Do not click links or open attachments unless you recognise the sender and know the content is safe.

Benjamin,

I had an on leave bounceback from Meg. Please find correspondence attached.

Feel free to give me a call.

Regards

Steve Ross

Executive & Industrial Officer

ASMOF (ACT)

Part Time available Tues, Wed, Thurs

Mobile: 0498 268 948

Email: stever@asmof.org.au

Web: www.asmof.org.au

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From: Steve Ross
Sent: Tuesday, 29 October 2024 12:57 PM
To: Bransgrove, Meagen <Meagen.Bransgrove@act.gov.au>
Subject: Correspondence to Chief minister and Minister for Health

Hi Meg,

Please see correspondence attached.

Regards

Steve Ross

Executive & Industrial Officer

ASMOF (ACT)

Part Time available Tues, Wed, Thurs

Mobile: 0498 268 948

Email: stever@asmof.org.au

Web: www.asmof.org.au

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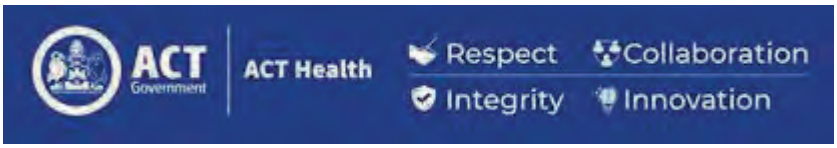
From: Ellis, Catherine on behalf of ACT Health DLO
Sent: Friday, 1 November 2024 3:26 PM
To: Elliffe, Martin
Subject: RE: MIN2024-00839 : RE: VSC

Hi Martin

A factual brief on the update on VSC has now been completed, and I have placed it in your folder, here.

Thanks
Cath

Catherine Ellis | Senior Director
Ministerial and Government Services | ACT Health Directorate
Mob: Schedule 2.2(a)(ii) Email: Catherine.Ellis@act.gov.au
Level 5, Bowes Street, Woden ACT



From: Elliffe, Martin
Sent: Thursday, 3 October 2024 5:28 PM
To: ACT Health DLO
Subject: MIN2024-00839 : RE: VSC
Importance: High

OFFICIAL

Hi Tara,

Further to the below, can we please get an update on the work underway to prepare for the implementation of VSC and providing training for practitioners?

The AMA has reached out to Meg again today to reiterate their concerns regarding lack of training and no GTPs having been approved.

Has there been any progress on these issues? And what discussions has the team had with the AMA since the last update?

I believe the team were going to send through a timeline and info on comms and training for non-GP specialists, but I don't think I've seen that come through yet.

And has the DG responded to Mr Somerville's letter yet? Is so, grateful if we could get a copy for our info.

Thanks,
Martin

Martin Elliffe (he/him)
Adviser | Office of Minister Rachel Stephen-Smith MLA
Minister for Health | Minister for Children, Youth and Family Services | Minister for Disability | Minister for Aboriginal and Torres Strait Islander Affairs
Member for Kurrajong
M: Schedule 2.2(a)(ii) Email: martin.elliffe@act.gov.au
ACT Legislative Assembly, 196 London Circuit, Canberra, ACT 2601

From: Travers, Maria <Maria.Travers@act.gov.au>
Sent: Wednesday, September 11, 2024 9:44 PM
To: Bransgrove, Meagen <Meagen.Bransgrove@act.gov.au>; Smith, Kahlia <Kahlia.Smith@act.gov.au>
Cc: Cross, Rebecca <Rebecca.Cross@act.gov.au>; Hudson, Robyn <Robyn.Hudson@act.gov.au>; Elliffe, Martin <Martin.Elliffe@act.gov.au>
Subject: RE: VSC

OFFICIAL

Hi Meg, so sorry for the delay in responding.

We are not aware of any GTPs currently under development, and we will most probably only become aware of a GTP when it is submitted for consideration by the Board.

Maria

Maria Travers
A/g Executive Group Manager
Policy Partnerships and Programs Division
Mobile: Schedule 2.2(a)(ii) Email: maria.travers@act.gov.au
2-6 Bowes Street Phillip ACT 2606| www.health.act.gov.au





I acknowledge the Ngunnawal people as traditional custodians of the ACT and recognise any other people or families with connection to the lands of the ACT and region. I acknowledge and respect their continuing culture and the contribution they make to the life of this city and this region.
Please consider the environment before printing this email.

From: Bransgrove, Meagen <Meagen.Bransgrove@act.gov.au>
Sent: Monday, September 9, 2024 2:06 PM
To: Travers, Maria <Maria.Travers@act.gov.au>; Smith, Kahlia <Kahlia.Smith@act.gov.au>

Cc: Cross, Rebecca <Rebecca.Cross@act.gov.au>; Hudson, Robyn <Robyn.Hudson@act.gov.au>; Elliffe, Martin <Martin.Elliffe@act.gov.au>
Subject: RE: VSC

OFFICIAL

Thanks Maria, that's helpful. Is there further on the general treatment plans in terms of number of GTP's currently under development etc?

Thanks,

Meg

From: Travers, Maria <Maria.Travers@act.gov.au>
Sent: Monday, September 9, 2024 12:36 PM
To: Smith, Kahlia <Kahlia.Smith@act.gov.au>; Bransgrove, Meagen <Meagen.Bransgrove@act.gov.au>
Cc: Cross, Rebecca <Rebecca.Cross@act.gov.au>; Hudson, Robyn <Robyn.Hudson@act.gov.au>
Subject: VSC

OFFICIAL

Hi Kahlia and Meg

Things are actually better that I just advised the Minister (which is aways good). Please see the attached Advisory Note which is on its way to the MO, and sorry I didn't have all the detail on hand at the time.

We will also provide you with a timeline and info on comms and training for non-GP specialists.

Maria

Maria Travers
A/g Executive Group Manager
Policy Partnerships and Programs Division
Mobile: Schedule 2.2(a)(ii) Email: maria.travers@act.gov.au
2-6 Bowes Street Phillip ACT 2606| www.health.act.gov.au





I acknowledge the Ngunnawal people as traditional custodians of the ACT and recognise any other people or families with connection to the lands of the ACT and region. I acknowledge and respect their continuing culture and the contribution they make to the life of this city and this region.
Please consider the environment before printing this email.

From: STEPHEN-SMITH
Sent: Monday, 4 November 2024 14:01
To: ACT Health DLO
Cc: Smith, Kahlia
Subject: FW: New AIHW embargo release available: GEN: Residential aged care quality indicators (annual report)

Importance: High

Hi Tara,

For noting please.

Thank you,

Sally Cooke
Office Manager | Office of Rachel Stephen-Smith MLA
Minister for Health | Minister for Children, Youth and Family Services | Minister for Disability | Minister for Aboriginal and Torres Strait Islander Affairs
Member for Kurrajong
ACT Legislative Assembly, 196 London Circuit, Canberra ACT 2601 | P: (02) 6205 2661 | www.act.gov.au

---

From: communications@aihw.gov.au
Sent: Monday, 4 November 2024 1:43 PM
To: STEPHEN-SMITH
Subject: New AIHW embargo release available: GEN: Residential aged care quality indicators (annual report)

Caution: This email originated from outside of the ACT Government. Do not click links or open attachments unless you recognise the sender and know the content is safe.

Dear all,

The latest AIHW release ***GEN: Residential aged care quality indicators (annual report)*** is now available **under strict embargo** until public release on **Monday, 18 November at 12:01am AEST**.

About the release:

Quality indicators measure important aspects of quality of care that affect the health and wellbeing of people living in residential aged care. This report presents quality indicators that have been recompiled for more complete data than were available at the cut-off dates for quarterly reporting in Q4 2022–23 and Q1-4 2023–24.

The release **will not be** accompanied by a media release.

Please click on the link and follow the instructions below:

- AIHW Stakeholder hub (https://pp.aihw.gov.au/login)
- Your user name is your **email address**

- Please select '**Forgot your password**' link if required.

The following Ministerial Offices are receiving access to the embargoed material:

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- Senator the Hon. Katy Gallagher - Minister for Finance, Minister for the Public Service, Minister for Women
- The Hon. Mark Butler MP - Minister for Health and Aged Care
- Senator the Hon Malarndirri McCarthy - Minister for Indigenous Australians
- The Hon Ged Kearney MP - Assistant Minister for Indigenous Health
- The Hon. Amanda Rishworth MP - Minister for Social Services
- The Hon. Bill Shorten MP - Minister for the National Disability Insurance Scheme Minister for Government Services
- The Hon. Julie Collins MP - Minister for Housing, Minister for Homelessness, Minister for Small Business
- The Hon. Anne Aly MP - Minister for Early Childhood Education, Minister for Youth
- The Hon. Anika Wells MP - Minister for Aged Care, Minister for Sport
- The Hon. Justine Elliot MP - Assistant Minister for Social Services, Assistant Minister for the Prevention of Family Violence
- The Hon. Ged Kearney MP - Assistant Minister for Health and Aged Care
- The Hon. Emma McBride MP - Assistant Minister for Mental Health, Assistant Minister for Rural and Regional Health

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- National Indigenous Australians Agency

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- QLD Health
- NSW Ministry of Health
- NT Department of Health
- TAS Department of Health
- WA Department of Health
- SA Department of Health and Wellbeing
- VIC Department of Health and Human Services

If you would like any further information, please contact communications@aihw.gov.au or (02) 6249 5089.

Kind Regards

Communications & Engagement Unit

Australian Institute of Health and Welfare

Communications@aihw.gov.au | @aihw | aihw |



From: STEPHEN-SMITH
Sent: Monday, 4 November 2024 14:01
To: ACT Health DLO
Cc: Smith, Kahlia
Subject: FW: New AIHW embargo release available: Pharmaceutical Benefits Scheme prescriptions: October data update

Importance: High

Hi Tara,

For noting please.

Thank you,

Sally Cooke
Office Manager | Office of Rachel Stephen-Smith MLA
Minister for Health | Minister for Children, Youth and Family Services | Minister for Disability | Minister for Aboriginal and Torres Strait Islander Affairs
Member for Kurrajong
ACT Legislative Assembly, 196 London Circuit, Canberra ACT 2601 | P: (02) 6205 2661 | www.act.gov.au

From: communications@aihw.gov.au
Sent: Monday, 4 November 2024 1:52 PM
To: STEPHEN-SMITH
Subject: New AIHW embargo release available: Pharmaceutical Benefits Scheme prescriptions: October data update

Caution: This email originated from outside of the ACT Government. Do not click links or open attachments unless you recognise the sender and know the content is safe.

Dear all,

The latest AIHW release ***Pharmaceutical Benefits Scheme prescriptions: October data update*** is now available **under strict embargo** until public release on **Thursday, 7 November at 12:01am AEST**.

About the release:

The Australian Government has subsidised prescription medicines covered by the Pharmaceutical Benefits Scheme (PBS) for all Australians, permanent residents and eligible foreign visitors since 1948. The Repatriation Pharmaceutical Benefits Scheme (RPBS) was established in 1919 for returning Australian service people who had served in previous wars. This report presents monthly data on the usage rates of numbers of dispensed prescriptions and Australian Government spending on combined PBS/RPBS medicines and is reported as PBS for simplicity.

Data in this report are updated monthly.

The release **will not be** accompanied by a media release.

Please click on the link and follow the instructions below:

- AIHW Stakeholder hub (https://pp.aihw.gov.au/login)
- Your user name is your **email address**
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- Senator the Hon Malarndirri McCarthy - Minister for Indigenous Australians
- The Hon Ged Kearney MP - Assistant Minister for Indigenous Health
- The Hon. Amanda Rishworth MP - Minister for Social Services
- The Hon. Bill Shorten MP - Minister for the National Disability Insurance Scheme Minister for Government Services
- The Hon. Julie Collins MP - Minister for Housing, Minister for Homelessness, Minister for Small Business
- The Hon. Anne Aly MP - Minister for Early Childhood Education, Minister for Youth
- The Hon. Anika Wells MP - Minister for Aged Care, Minister for Sport
- The Hon. Justine Elliot MP - Assistant Minister for Social Services, Assistant Minister for the Prevention of Family Violence
- The Hon. Ged Kearney MP - Assistant Minister for Health and Aged Care
- The Hon. Emma McBride MP - Assistant Minister for Mental Health, Assistant Minister for Rural and Regional Health

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- Department of Social Services
- National Indigenous Australians Agency

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- QLD Health
- NSW Ministry of Health
- NT Department of Health
- TAS Department of Health
- WA Department of Health
- SA Department of Health and Wellbeing
- VIC Department of Health and Human Services

If you would like any further information, please contact communications@aihw.gov.au or (02) 6249 5089.

Kind Regards

Communications & Engagement Unit

Australian Institute of Health and Welfare

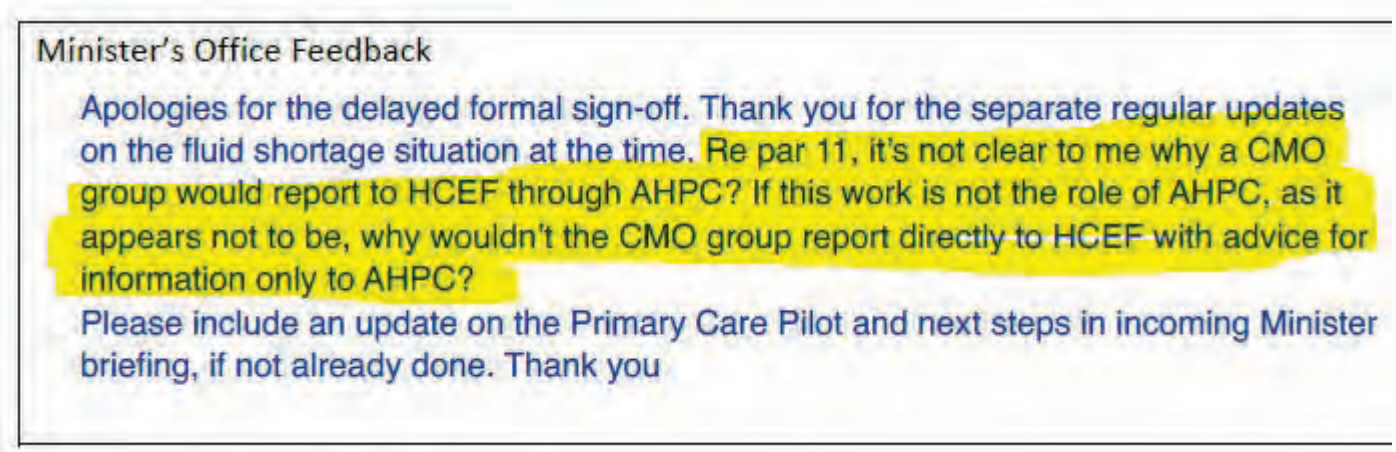
Communications@aihw.gov.au | @aihw | aihw |



From: Ellis, Catherine on behalf of ACT Health DLO
Sent: Monday, 4 November 2024 3:18 PM
To: Smith, Kahlia; Tomlinson, Benjamin
Cc: ACT Health DLO
Subject: FOR INFORMATION: Response to Comment - GBC2024/00215 - ACTHD Weekly Brief - 5 to 9 August 2024

Hi both

On review and signing of the ACTHD weekly brief – 5 to 9 August 2024 Minister made the following comments:


Minister's Office Feedback

Apologies for the delayed formal sign-off. Thank you for the separate regular updates on the fluid shortage situation at the time. Re par 11, it's not clear to me why a CMO group would report to HCEF through AHPC? If this work is not the role of AHPC, as it appears not to be, why wouldn't the CMO group report directly to HCEF with advice for information only to AHPC?

Please include an update on the Primary Care Pilot and next steps in incoming Minister briefing, if not already done. Thank you

In response to the highlighted query the Office of the Chief Medical Officer has provided the following advice:

It was initially thought that the CMO IV Fluid group would need to report to a subcommittee of HCEF noting it is not a group that has been established by HCEF and does not have authority. Noting IV Fluids are a critical medical therapeutic it was not clear how the CMO group remit would differ from the Australian Health Protection Committee's (AHPC) National Health Emergency Management Sub-committee (NHEMS) if it was to invite CMOs from the jurisdictions where they are subject matter experts on IV Fluid shortages.

Once it was determined that IV Fluids shortage did not need the level of response from NHEMS and that the Victorian HCEF member would table the CMO group's discussions and decisions on IV Fluids, the need for AHPC as the conduit was abandoned.

Further discussions at HCEF have since occurred and the CMO group was asked to focus on logistics and distribution of fluids, nationally aligned communication on management of IV Fluids and data and IV Fluid information sharing between jurisdictions. A paper was being prepared on what the role and function of a CMO group would look like beyond just the IV Fluid shortage. There has been no HCEF agreement on the group or its potential remit beyond the IV Fluid shortage issues, but the CMO group continue to present updates to HCEF on the topic of IV Fluids.

If further information is needed, please let me know and I will follow up further.

Thanks
Cath

Catherine Ellis | Senior Director
Ministerial and Government Services | ACT Health Directorate
Mob: Schedule 2.2(a)(ii) Email: Catherine.Ellis@act.gov.au
Level 5, Bowes Street, Woden ACT


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From: Tomlinson, Benjamin
Sent: Tuesday, 5 November 2024 12:05
To: ACT Health DLO
Cc: STEPHEN-SMITH
Subject: FW: ANMF 100 Years Anniversary

Importance: High

Hi team

Can the incoming minister please have a short script for a video to be filmed on this likely by the end of the week. Would be good for ACTHD to be in a position to have a short speech done ASAP for the incoming Minister (whether that be RSS or someone else).

Thanks
Ben

From: Carlyn Fidow Schedule 2.2(a)(ii)
Sent: Tuesday, October 15, 2024 11:03:15 AM
To: Bransgrove, Meagen <Meagen.Bransgrove@act.gov.au>
Subject: ANMF 100 Years Anniversary

Caution: This email originated from outside of the ACT Government. Do not click links or open attachments unless you recognise the sender and know the content is safe.

Hi Meg

Hope all is well.

As you might know, the ANMF is celebrating its 100 Year Anniversary next week and we have been putting together some bits and pieces for our socials channels.

I'm reaching out to see if the Minister would be interested in doing a spotlight/short vid to help us celebrate our 100 Years to feature on our socials pending if Labor is re-elected.

Happy to have a chat about it after election as I know you all would be flat chat in the last leg.

Thanks for the consideration,
Carlyn

Australian Nursing & Midwifery Federation
AUSTRALIAN CAPITAL TERRITORY

Carlyn Fidow
Secretary

02 6282 9455
anmfact@anmfact.org.au
www.anmfact.org.au

The ANMF ACT Branch acknowledges the Ngunnawal people as the Traditional Custodians of the land on which we meet, and we pay our respects to their Elders past and present.

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From: STEPHEN-SMITH
Sent: Tuesday, 5 November 2024 4:06 PM
To: ACT Health DLO; CHS DLO
Cc: Smith, Kahlia
Subject: FW: New AIHW embargo release available: Exploring how transitional aged care supports older people leaving hospital

Importance: High

Hi Team,

For noting please.

Thank you,

Sally Cooke
Office Manager | Office of Rachel Stephen-Smith MLA
Minister for Health | Minister for Children, Youth and Family Services | Minister for Disability | Minister for Aboriginal and Torres Strait Islander Affairs
Member for Kurrajong
ACT Legislative Assembly, 196 London Circuit, Canberra ACT 2601 | P: (02) 6205 2661 | www.act.gov.au

From: communications@aihw.gov.au
Sent: Tuesday, 5 November 2024 4:05 PM
To: STEPHEN-SMITH
Subject: New AIHW embargo release available: Exploring how transitional aged care supports older people leaving hospital

Caution: This email originated from outside of the ACT Government. Do not click links or open attachments unless you recognise the sender and know the content is safe.

Dear all,

The latest AIHW release ***Exploring how transitional aged care supports older people leaving hospital*** is now available **under strict embargo** until public release on **Thursday, 14 November at 12:01am AEST**.

About the release:

Older Australians are more likely to be admitted to hospital than younger Australians, and leaving hospital can be a particularly vulnerable time. The national Transition Care Programme (transition care) provides funding for short-term specialised support to help older people to regain their functional independence after a hospital stay. This In-focus report provides a snapshot of 20,500 people using transition care within a 1-year period. It explores who uses transition care, how it is used, and how the program fits into the broader aged care system.

The release **will not be** accompanied by a media release.

Please click on the link and follow the instructions below:

- AIHW Stakeholder hub (https://pp.aihw.gov.au/login)
- Your user name is your **email address**
- Please select '**Forgot your password**' link if required.

The following Ministerial Offices are receiving access to the embargoed material:

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- Senator the Hon. Katy Gallagher - Minister for Finance, Minister for the Public Service, Minister for Women
- The Hon. Mark Butler MP - Minister for Health and Aged Care
- Senator the Hon Malarndirri McCarthy - Minister for Indigenous Australians
- The Hon Ged Kearney MP - Assistant Minister for Indigenous Health
- The Hon. Amanda Rishworth MP - Minister for Social Services
- The Hon. Bill Shorten MP - Minister for the National Disability Insurance Scheme Minister for Government Services
- The Hon. Julie Collins MP - Minister for Housing, Minister for Homelessness, Minister for Small Business
- The Hon. Anne Aly MP - Minister for Early Childhood Education, Minister for Youth
- The Hon. Anika Wells MP - Minister for Aged Care, Minister for Sport
- The Hon. Justine Elliot MP - Assistant Minister for Social Services, Assistant Minister for the Prevention of Family Violence
- The Hon. Ged Kearney MP - Assistant Minister for Health and Aged Care
- The Hon. Emma McBride MP - Assistant Minister for Mental Health, Assistant Minister for Rural and Regional Health

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- Department of Health and Aged Care
- Department of Social Services
- National Indigenous Australians Agency

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- ACT Health
- QLD Health
- NSW Ministry of Health
- NT Department of Health
- TAS Department of Health
- WA Department of Health
- SA Department of Health and Wellbeing
- VIC Department of Health and Human Services

If you would like any further information, please contact communications@aihw.gov.au or (02) 6249 5089.

Kind Regards,

Communications & Engagement Unit

Australian Institute of Health and Welfare

Communications@aihw.gov.au | @aihw | aihw |



From: Ellis, Catherine on behalf of ACT Health DLO
Sent: Tuesday, 5 November 2024 5:09 PM
To: Tomlinson, Benjamin; Smith, Kahlia
Subject: FW: DG RESPONSE (CARETAKER) : Letter from ACT ART providers - ART legislation
Attachments: Letter to ACT Minister of Health - ACT ART Legislation (ART Providers - 13.9.2024).pdf

Importance: High

Hi both

ACTHD was requested to respond to this matter during Caretaker, which has occurred. Factual dot points were also requested to be provided back, these have been completed and are available in Kahlia's folder, here.

Thanks
Cath

From: STEPHEN-SMITH <STEPHEN-SMITH@act.gov.au>
Sent: Friday, September 13, 2024 5:38 PM
To: ACT Health DLO <ACTHealthDLO@act.gov.au>
Cc: Tomlinson, Benjamin <Benjamin.Tomlinson@act.gov.au>; Smith, Kahlia <Kahlia.Smith@act.gov.au>
Subject: FW: Letter from ACT ART providers - ART legislation
Importance: High

Hi Tara,

For directorate response please.

Thank you,

Sally Cooke
Office Manager | Office of Rachel Stephen-Smith MLA
Minister for Health | Minister for Children, Youth and Family Services | Minister for Disability | Minister for Aboriginal and Torres Strait Islander Affairs
Member for Kurrajong
ACT Legislative Assembly, 196 London Circuit, Canberra ACT 2601 | P: (02) 6205 2661 | www.act.gov.au

From: Schedule 2.2(a)(ii)
Sent: Friday, September 13, 2024 5:33 PM
To: STEPHEN-SMITH <STEPHEN-SMITH@act.gov.au>
Cc: Tomlinson, Benjamin <Benjamin.Tomlinson@act.gov.au>
Subject: Letter from ACT ART providers - ART legislation

Some people who received this message don't often get email from Schedule 2.2(a)(ii) Learn why this is important

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Dear Minister

Please see enclosed a joint letter from IVFAustralia, Genea and Compass Fertility for your consideration.

Regards

Schedule 2.2(a)(ii)

Schedule 2.2(a)(ii)

Virtus Health Pty Limited
Level 3, 154 Pacific Highway
GREENWICH NSW 2065
AUSTRALIA
M: Schedule 2.2(a)(ii)
E:
W: www.virtushealth.com.au

Fertility Services
Specialist Day Hospitals
Diagnostics & Advanced Science

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From: STEPHEN-SMITH
Sent: Wednesday, 6 November 2024 11:18 AM
To: ACT Health DLO
Cc: Smith, Kahlia; Tomlinson, Benjamin
Subject: FW: 3 new AIHW embargo releases available: Health expenditure Australia 2022–23, Health system spending on disease and injury in Australia 2022–23, & Health system spending on the response to COVID-19 in Australia 2019–20 to 2022–23

Importance: High

Hi Team,

For noting please.

Thank you,

Sally Cooke
Office Manager | Office of Rachel Stephen-Smith MLA
Minister for Health | Minister for Children, Youth and Family Services | Minister for Disability | Minister for Aboriginal and Torres Strait Islander Affairs
Member for Kurrajong
ACT Legislative Assembly, 196 London Circuit, Canberra ACT 2601 | P: (02) 6205 2661 | www.act.gov.au

From: communications@aihw.gov.au
Sent: Wednesday, 6 November 2024 11:11 AM
To: STEPHEN-SMITH
Subject: 3 new AIHW embargo releases available: Health expenditure Australia 2022–23, Health system spending on disease and injury in Australia 2022–23, & Health system spending on the response to COVID-19 in Australia 2019–20 to 2022–23

Caution: This email originated from outside of the ACT Government. Do not click links or open attachments unless you recognise the sender and know the content is safe.

Dear all,

There are 3 new AIHW releases available for viewing **under embargo** in the AIHW Stakeholder Hub until their public release on **Wednesday, 20 November at 12:01am AEST**.

- ***Health expenditure Australia 2022–23***
- ***Health system spending on disease and injury in Australia 2022–23***
- ***Health system spending on the response to COVID-19 in Australia 2019–20 to 2022–23***

About the releases:

Health expenditure Australia 2022–23: regular reporting of national health expenditure is vital to understanding the health system and its relationship to the economy as a whole.

- In 2022–23, total health spending has returned to the pre-pandemic trends, totalling $252.5 billion which equates to 9.9% of Gross Domestic Product.

- Health spending decreased by 0.3% in real terms, which was lower than the decade average growth of 3.3% per year.
- Government health spending decreased by 2.6% while non-government spending was estimated to increase by 5.8% in 2022–23.

Health system spending on disease and injury in Australia 2022–23: health system spending on disease and injury in Australia 2022–23, analyses Australia's national health spending to provide additional detail about the people receiving care and the conditions and diseases being treated.

In this report, 2022–23 data is presented for each of the 17 Australian Burden of Disease Study (ABDS) groups and 220 conditions within these groups. Spending for three additional groups, well care, the treatment of risk factors and examination and observation NEC are also included. Spending is reported by area of expenditure, age group and sex. This report also includes comparisons with historical data back to 2013–14.

Health system spending on the response to COVID-19 in Australia 2019–20 to 2022–23: this report examines Australia's health system spending in response to the COVID–19 pandemic from 2019–20 to 2022–23. It covers funding by the Australian Government, state and territory governments and individuals. It looks at spending by broad area: primary health care, hospitals, referred medical services, aged care services and other health services as well as detailed areas of expenditure within these broad areas. This report also compares Australia's additional health expenditure and excess mortality during COVID–19 to other countries.

The releases **will be** accompanied by a media release, **which will also be available at the link below usually three days prior to public release.**

Please click on the link and follow the instructions below:

- AIHW Stakeholder hub (https://pp.aihw.gov.au/login)
- Your user name is your **email address**
- Please select '**Forgot your password**' link if required.

The following Ministerial Offices are receiving access to the embargoed material:

- Office of the Prime Minister
- Senator the Hon. Katy Gallagher - Minister for Finance, Minister for the Public Service, Minister for Women
- The Hon. Mark Butler MP - Minister for Health and Aged Care
- Senator the Hon Malarndirri McCarthy - Minister for Indigenous Australians
- The Hon Ged Kearney MP - Assistant Minister for Indigenous Health
- The Hon. Amanda Rishworth MP - Minister for Social Services
- The Hon. Bill Shorten MP - Minister for the National Disability Insurance Scheme Minister for Government Services
- The Hon. Julie Collins MP - Minister for Housing, Minister for Homelessness, Minister for Small Business
- The Hon. Anne Aly MP - Minister for Early Childhood Education, Minister for Youth
- The Hon. Anika Wells MP - Minister for Aged Care, Minister for Sport
- The Hon. Justine Elliot MP - Assistant Minister for Social Services, Assistant Minister for the Prevention of Family Violence
- The Hon. Ged Kearney MP - Assistant Minister for Health and Aged Care
- The Hon. Emma McBride MP - Assistant Minister for Mental Health, Assistant Minister for Rural and Regional Health

The following federal departments receive access to the embargoed material:

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- Department of Health and Aged Care
- Department of Social Services
- National Indigenous Australians Agency

The following state and territory health departments receive access to the embargoed material:

- ACT Health
- QLD Health
- NSW Ministry of Health
- NT Department of Health
- TAS Department of Health
- WA Department of Health
- SA Department of Health and Wellbeing
- VIC Department of Health and Human Services

If you would like any further information, please contact communications@aihw.gov.au or (02) 6249 5089.

Kind Regards,

Communications & Engagement Unit

Australian Institute of Health and Welfare

Communications@aihw.gov.au | @aihw | aihw |



From: STEPHEN-SMITH
Sent: Wednesday, 6 November 2024 11:18
To: ACT Health DLO; CSDDLO
Cc: Elliffe, Martin
Subject: FW: ADVANCE ACCESS – Closing the Gap dashboard data update – Productivity Commission [SEC=OFFICIAL:Sensitive]

Importance: High

Hi Team,

For noting please.

Thank you,

Sally Cooke
Office Manager | Office of Rachel Stephen-Smith MLA
Minister for Health | Minister for Children, Youth and Family Services | Minister for Disability | Minister for Aboriginal and Torres Strait Islander Affairs
Member for Kurrajong
ACT Legislative Assembly, 196 London Circuit, Canberra ACT 2601 | P: (02) 6205 2661 | www.act.gov.au

From: Strategic Communications & Engagement (Productivity Commission)
Sent: Wednesday, 6 November 2024 11:11 AM
To: Strategic Communications & Engagement (Productivity Commission)
Cc: CTG Data
Subject: ADVANCE ACCESS – Closing the Gap dashboard data update – Productivity Commission [SEC=OFFICIAL:Sensitive]

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OFFICIAL // Sensitive

ADVANCE ACCESS – Closing the Gap dashboard data update

Under embargo until 10:30 pm AEDT, Wednesday 13 November 2024

As part of the National Agreement on Closing the Gap (the Agreement), the Productivity Commission publishes information that will inform reporting on progress against the Agreement. The Commission's Closing the Gap Information Repository includes a **dashboard** and **Annual Data Compilation Report**, for more information see: https://www.pc.gov.au/closing-the-gap-data.

The Commission will publish a data update for the Closing the Gap Dashboard on 13 November. The update includes a new year of data for three supporting indicators and will report for the first time on a further four supporting indicators.

Access to the embargoed dashboard is below. The data is available in different formats, including visual and data files. Advice on how to access and interpret the data is also provided.

The information is provided under strict embargo until release, and is subject to the following conditions:

- The material within the dashboard must be kept confidential until it is made publicly available on release.
- Any information in the dashboard should not be communicated to third parties until the embargo is lifted.
- You must ensure that anyone who accesses the dashboard fully understands and adheres to the embargo conditions.

To access the embargoed material, please use the username and password:

https://www.pc.gov.au/closing-the-gap-data/embargo/home

Username:
Password: Schedule 2.2(a)(ii) [redacted]

Advance embargoed access is being provided today to relevant federal, state and territory ministers, their respective departments and the Coalition of Aboriginal and Torres Strait Islander Peak Organisations.

The dashboard's data release will be made public **at 10:30 pm on Wednesday 13 November** and will be available from the Commission's Closing the Gap Information Repository at: https://www.pc.gov.au/closing-the-gap-data.

For information, the next dashboard update is scheduled for March 2025.

Regards,

Michelle Cross
Assistant Director | Strategic Communications and Engagement

Productivity Commission
Wurundjeri, Woi-wurrung Country
Level 8, 2MQ, 697 Collins Street, Docklands VIC 3008
p. 03 9653 2115 | m. Schedule 2.2(a)(ii) [redacted]
pc.gov.au

The Productivity Commission acknowledges the Traditional Owners of Country throughout Australia and their continuing connection to land, waters and community. We pay our respects to Aboriginal and Torres Strait Islander Cultures, Country and Elders past and present.

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From: STEPHEN-SMITH
Sent: Wednesday, 6 November 2024 11:59
To: ACT Health DLO
Cc: Smith, Kahlia
Subject: FW: New AIHW embargo release available: Perinatal mental health screening in Australia - update

Importance: High

Hi Team,

For noting please.

Thank you,

Sally Cooke
Office Manager | Office of Rachel Stephen-Smith MLA
Minister for Health | Minister for Children, Youth and Family Services | Minister for Disability | Minister for Aboriginal and Torres Strait Islander Affairs
Member for Kurrajong
ACT Legislative Assembly, 196 London Circuit, Canberra ACT 2601 | P: (02) 6205 2661 | www.act.gov.au

From: communications@aihw.gov.au
Sent: Wednesday, 6 November 2024 11:52 AM
To: STEPHEN-SMITH
Subject: New AIHW embargo release available: Perinatal mental health screening in Australia - update

Caution: This email originated from outside of the ACT Government. Do not click links or open attachments unless you recognise the sender and know the content is safe.

The latest AIHW release ***Perinatal mental health screening in Australia – update*** is now available **under strict embargo** until its public release on **Friday, 15 November at 12:01am AEST**.

About the release:

National guidelines recommend that all women are screened for signs and risk factors of mental health conditions during the perinatal period. This report brings together the latest perinatal mental health screening data in 2022 from 4 state and territory health authorities and how these vary by maternal characteristics and behaviours, birth settings, and birth outcomes. For the first time, analysis of models of care provided to women in Queensland and detailed antenatal mental health and family violence risk factor screening data from New South Wales public health services are presented. Further, it describes how efforts to improve reporting and targeted initiatives that improve outcomes for mothers and their families may be possible through data development and integration opportunities.

The releases **will NOT be** accompanied by a media release.

Please click on the link and follow the instructions below:

- AIHW Stakeholder hub (https://pp.aihw.gov.au/login)

- Your user name is your **email address**
- Please select '**Forgot your password**' link if required.

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- The Hon Ged Kearney MP - Assistant Minister for Indigenous Health
- The Hon. Amanda Rishworth MP - Minister for Social Services
- The Hon. Bill Shorten MP - Minister for the National Disability Insurance Scheme Minister for Government Services
- The Hon. Julie Collins MP - Minister for Housing, Minister for Homelessness, Minister for Small Business
- The Hon. Anne Aly MP - Minister for Early Childhood Education, Minister for Youth
- The Hon. Anika Wells MP - Minister for Aged Care, Minister for Sport
- The Hon. Justine Elliot MP - Assistant Minister for Social Services, Assistant Minister for the Prevention of Family Violence
- The Hon. Ged Kearney MP - Assistant Minister for Health and Aged Care
- The Hon. Emma McBride MP - Assistant Minister for Mental Health, Assistant Minister for Rural and Regional Health

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- Department of Health and Aged Care
- Department of Social Services
- National Indigenous Australians Agency

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- QLD Health
- NSW Ministry of Health
- NT Department of Health
- TAS Department of Health
- WA Department of Health
- SA Department of Health and Wellbeing
- VIC Department of Health and Human Services

If you would like any further information, please contact communications@aihw.gov.au or (02) 6249 5089.

Kind Regards,

Communications & Engagement Unit

Australian Institute of Health and Welfare

Communications@aihw.gov.au | @aihw | aihw |



From: STEPHEN-SMITH
Sent: Wednesday, 6 November 2024 12:08 PM
To: ACT Health DLO
Cc: Smith, Kahlia; Tomlinson, Benjamin
Subject: FW: Correspondence from Minister Butler - Senate Inquiry into treatments for rare and less common cancers - MS24-001256 [SEC=OFFICIAL]
Attachments: Letter from Minister Butler to ACT Minister Stephen-Smith - MS24-001256.pdf; MS24-001256 Att A - Senate Inquiry Final Report.pdf

Importance: High

Hi Team,

For response for the incoming minister please.

Thank you,

Sally Cooke
Office Manager | Office of Rachel Stephen-Smith MLA
Minister for Health | Minister for Children, Youth and Family Services | Minister for Disability | Minister for Aboriginal and Torres Strait Islander Affairs
Member for Kurrajong
ACT Legislative Assembly, 196 London Circuit, Canberra ACT 2601 | P: (02) 6205 2661 | www.act.gov.au

From: Minister Butler DLO
Sent: Tuesday, 5 November 2024 5:10 PM
To: STEPHEN-SMITH
Subject: Correspondence from Minister Butler - Senate Inquiry into treatments for rare and less common cancers - MS24-001256 [SEC=OFFICIAL]

Caution: This email originated from outside of the ACT Government. Do not click links or open attachments unless you recognise the sender and know the content is safe.

Good afternoon

Please see attached correspondence from Minister Butler seeking Minister Stephen-Smith's consideration of the final report from the Senate Community Affairs References Committee inquiry into *Equitable access to treatment for individuals with rare and less common cancers, including neuroendocrine cancer*.

No hard copy to follow.

Regards

Schedule 2.2(a)(ii)
Departmental Liaison Officer

Office of the Hon Mark Butler MP
Minister for Health and Aged Care
T: Schedule 2.2(a)(ii)
E: Schedule 2.2(a)(ii)
Suite MG.50 | PO Box 6022, Parliament House, Canberra ACT 2600

The Department of Health and Aged Care acknowledges First Nations peoples as the Traditional Owners of Country throughout Australia, and their continuing connection to land, sea and community. We pay our respects to them and their cultures, and to all Elders both past and present.

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The Hon Mark Butler MP
Minister for Health and Aged Care

Ref No: MS24-001256

Ms Rachel Stephen-Smith MLA
Minister for Health
GPO Box 1020
CANBERRA ACT 2601
stephen-smith@act.gov.au

Dear Minister Rachel

I am writing to seek your consideration of the final report from the Senate Community Affairs References Committee's inquiry into *Equitable access to diagnosis and treatment for individuals with rare and less common cancers, including neuroendocrine cancer*. The Inquiry report was tabled on 16 May 2024.

The Inquiry report makes 41 recommendations to the Australian Government to improve the outcomes for people with rare and less common cancers, spanning across genomics and treatment, research and clinical trials and supportive and palliative care. A copy of the Inquiry report is enclosed for ease of reference. The Commonwealth is considering the recommendations before providing a formal response to the report.

Improving cancer outcomes for individuals with rare and less common cancer requires coordinated action across levels of government and the cancer control sector. The Commonwealth has identified eight recommendations where state and territory governments have responsibility or require close collaboration with the Commonwealth.

These recommendations are:

- Recommendation 5: The Australian Government, in partnership with state and territory governments, undertake a review of the distribution and availability of MRI, PET and CT services and infrastructure across jurisdictions.
- Recommendation 13: The Australian Government work with state and territory governments to ensure the families of paediatric cancer patients are not financially disadvantaged for hospital stays.
- Recommendation 14: The Australian Government work with state and territory governments to identify the barriers faced by cancer patients requiring rehabilitation, prosthetics and implants as a result of their treatment, with a view to ensuring they have financial support for those services.
- Recommendation 16: The Australian Government work with state and territory governments to implement the One Stop Shop and National Clinical Trials Front Door platform as a matter of priority.

- Recommendation 24: The Australian Government work with state and territory governments, and palliative care services to support:
    - improved understanding amongst patients, families and clinicians of the potential benefits, and timely delivery of palliative care
    - increased awareness that palliative care is not just an end-of-life service
    - increased availability of tailored and appropriate palliative care services, for a range of population groups
    - where appropriate, greater dialogue upon diagnosis, or throughout treatment, between patients, families and clinicians on palliative care options.
- Recommendation 26: State and territory governments reform patient assisted travel schemes with a view to:
    - create more consistency in scheme offerings across all jurisdictions
    - increase financial assistance
    - expand schemes to include travel and accommodation costs for clinical trial participants.
- Recommendation 29: The Australian Government, in partnership with state and territory governments and the higher education sector, review the emerging educational and workforce skill needs in relation to precision oncology, genomics, molecular curation and theranostics.
- Recommendation 30: State and territory governments provide sustained funding and participation incentives for staffing positions and training opportunities for medical professionals and researchers interested in specialising in rare and less common cancers, including neuroendocrine cancers.

I seek your consideration of the recommendations and commitment to implement the recommendations where possible.

I have also asked the Department of Health and Aged Care to engage with jurisdictional officials through the Cancer and Population Screening Committee on these recommendations.

Thank you for your ongoing work to support individuals with rare and less common cancers.

Yours sincerely

Mark Butler

05 / 11 / 2024

Encl (1) Senate Community Affairs References Committee Inquiry report

The Senate

Community Affairs References Committee

Equitable access to diagnosis and treatment for individuals with rare and less common cancers, including neuroendocrine cancer

May 2024

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Members

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Senator Janet Rice *(until 27 March 2024)*	AG, VIC

Deputy Chair

Senator Marielle Smith	ALP, SA

Members

Senator Wendy Askew	LP, TAS
Senator Slade Brockman *(until 13 July 2023)*	LP, WA
Senator Hollie Hughes *(from 18 March 2024)*	LP, NSW
Senator Maria Kovacic *(from 13 July 2023)*	LP, NSW
Senator Kerrynne Liddle *(from 13 July 2023 until 4 December 2023)*	LP, SA
Senator Jacinta Nampijinpa Price *(until 13 July 2023)*	CLP, NT
Senator Louise Pratt	ALP, WA
Senator Dave Sharma *(from 4 December 2023 until 18 March 2024)*	LP, NSW

Participating Members

Senator Fatima Payman	ALP, WA

Secretariat

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Emily Nelson, Senior Research Officer
Grace Holt, A/g Senior Research Officer
Aadya Ramesh, Graduate
Flynn Benson, Research Officer
Ayrton Kiraly, Research Officer
Tara King, Administrative Officer
Angela Paulson, Administrative Officer

PO Box 6100
Parliament House
Canberra ACT 2600
Phone: 02 6277 2515
Email: community.affairs.sen@aph.gov.au
Internet:
www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs

Terms of reference

Equitable access to diagnosis and treatment for individuals with rare and less common cancers, including neuroendocrine cancer, with particular reference to:

(a) barriers to screening and diagnosis, including the impact of factors such as:

  (i) geographic location,
  (ii) cost,
  (iii) cultural and language barriers,
  (iv) type of cancer, and
  (v) availability of treating practitioners;

(b) barriers to accessing appropriate treatment;
(c) the adequacy of support services after diagnosis;
(d) the adequacy of Commonwealth funding for research into rare, less common and neuroendocrine cancer; and
(e) any other related matters.

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Abbreviations

ACCHO	Aboriginal Community Controlled Health Organisation
A-GLIMMER	Australian Genetics and Life Insurance Moratorium: Monitoring the Effectiveness and Response
AIHW	Australian Institute of Health and Welfare
ALK	anaplastic lymphoma kinase
ALLG	Australasian Leukaemia Lymphoma Group
CALD	Culturally and Linguistically Diverse
CDF	Cancer Drugs Fund
Closing the Gap	National Agreement on the Closing the Gap
CT	Computed Tomography
DIPG	Diffuse Intrinsic Pontine Glioma
GP	general practitioner
HTA	Health Technology Assessment
HTA Review	Health Technology Assessment Policy and Methods Review
MAP	Managed Access Program
MBS	Medicare Benefits Schedule
MoST	Molecular Screen and Therapeutics
MRFF	Medical Research Future Fund
MRI	Magnetic Resonance Imaging
MSAC	Medical Services Advisory Committee
MTOP	Medical Treatment Overseas Program
NACCHO	National Aboriginal Community Controlled Health Organisation
NED	No Evidence of Disease
NET	Neuroendocrine tumour
NHMRC	National Health and Medical Research Council
NIAA	National Indigenous Australians Agency

NICE	National Institute for Health and Care Excellence
NICE framework	National Institute for Health and Care Excellence real-world evidence framework
NOSS	National One Stop Shop
NRHA	National Rural Health Alliance
PATS	Patient Assisted Travel Schemes
PBAC	Pharmaceutical Benefit Advisory Committee
PBS	Pharmaceutical Benefits Scheme
PET	Positron Emission Tomography
PJCCFS	Parliamentary Joint Committee on Corporations and Financial Services
PLANET	PLAnning for optimal treatment of NETs
PrOSPeCT	Precision Oncology Screening Platform Enabling Clinical Trials program
R&D	research and development
RACGP	Royal Australian College of General Practitioners
the Atlas	Australian Cancer Atlas
the committee	Senate Community Affairs References Committee
the department	Department of Health and Aged Care
the Minister	The Hon Mark Butler MP
the Plan	Australian Cancer Plan
the Select Committee	Select Committee into Funding for Research into Cancers with Low Survival Rates
the Strategy	Medical Workforce Reform Advisory Committee's National Medical Workforce Strategy
VCCC	Victorian Comprehensive Cancer Centre
VHL	Von Hippel-Lindau disease
ZERO Childhood Cancer Program	Childhood Cancer National Precision Medicine Program

List of recommendations

Recommendation 1

2.128 The committee recommends that the Australian Government further develop clinical guidelines and local pathways for rare and less common cancers and ensure that they are accessible and available for general practitioners at the point-of-care.

Recommendation 2

2.131 The committee recommends that the Department of Health and Aged Care investigate the feasibility of a two-week urgent referral system for suspected cancer, such as the model offered in the United Kingdom.

Recommendation 3

2.134 The committee recommends that the Australian Government undertake a review of Medicare reimbursement settings for diagnostic tests and services, with a view of ensuring patients with, or with suspected rare or less common cancer, receive prompt, appropriate and affordable diagnostic testing.

Recommendation 4

2.141 The committee recommends that the Australian Government enable increased reimbursements for MRI, PET and CT services throughout the diagnosis, surveillance and restaging of rare cancers.

Recommendation 5

2.142 The committee recommends that the Australian Government, in partnership with state and territory governments, undertake a review of the distribution and availability of MRI, PET and CT services and infrastructure across jurisdictions, with a view of ensuring more equitable access to these services going forward.

Recommendation 6

2.149 The committee recommends that, as a matter of priority, the Australian Government legislate a complete ban on genetic discrimination in life insurance.

Recommendation 7

2.153 The committee recommends that the Australian Government investigate opportunities to increase equitable uptake and access to genomic screening and profiling for Australians.

Recommendation 8

2.157 The committee recommends that the Australian Government closely monitor the outcomes of the DNA Screen study, and the implications of the study for the future development of population wide, preventive genomic screening programs.

Recommendation 9

3.126 The committee recommends that the Australian Government, through the Medical Research Future Fund, extend funding for the ZERO Childhood Cancer Program beyond June 2025.

Recommendation 10

3.134 The committee recommends that the Australian Government utilise the Health Technology Assessment Policy and Methods Review to provide Australian rare and less common cancer patients with timely and affordable access to novel medicines.

Recommendation 11

3.135 The committee recommends that the Australian Government ensure that the Managed Access Program is more widely accessed where appropriate.

Recommendation 12

3.136 The committee recommends that the Australian Government adjust regulatory processes to broaden indication coverage for medicines that treat rare and less common cancers, including neuroendocrine cancer.

Recommendation 13

3.138 The committee recommends that the Australian Government work with state and territory governments to ensure the families of paediatric cancer patients are not financially disadvantaged for hospital stays.

Recommendation 14

3.141 The committee recommends that the Australian Government work with state and territory governments to identify the barriers faced by cancer patients requiring rehabilitation, prosthetics and implants as a result of their treatment, with a view to ensuring they have financial support for those services.

Recommendation 15

3.144 The committee recommends that the Australian Government review the eligibility criteria of the Medical Treatment Overseas Program, with a

particular focus on access to clinical trials and treatments for rare and less common cancer.

Recommendation 16

3.149 The committee recommends that the Australian Government work with state and territory governments to implement the One Stop Shop and National Clinical Trials Front Door platform as a matter of priority.

Recommendation 17

3.154 The committee recommends that the Australian Government ensure the Clinical Trials Activity initiative has an appropriate focus on funding clinical trials and research for people with cancer, including children, young people, and patients diagnosed with rare and less common cancers.

Recommendation 18

4.114 The committee recommends that the Australian Government provide appropriate funding to key cancer advocacy organisations supporting patients with rare and less common cancers by providing informative resources and support services that:

- **increase health literacy;**
- **empower patients to make informed decisions regarding their health; and**
- **are culturally appropriate and accessible in a variety of languages.**

Recommendation 19

4.116 The committee recommends that the Australian Government provide sufficient funding and resources to ensure that the supportive care aspirations of the Australian Cancer Plan are delivered on for all Australians, including for those affected by rare and less common cancers.

Recommendation 20

4.121 The committee recommends that the Department of Health and Aged Care monitor and report on progress for the delivery of the all-cancer nurse service.

Recommendation 21

4.122 The committee recommends that the Australian Government explore the provision of at least one specialised neuroendocrine tumour nurse, and paediatric cancer nurse, in each Australian jurisdiction.

Recommendation 22

4.127 The committee recommends that the Australian Government ensure that general practitioners are appropriately incentivised and remunerated for

patient care coordination and longer-term management of complex and chronic diseases, including rare and less common cancers.

Recommendation 23

4.130 The committee recommends that the Australian Government consider further investment to ensure the timely and affordable provision of psychological services to support patients and their families acutely impacted by rare and less common cancers.

Recommendation 24

4.134 The committee recommends that the Australian Government work with state and territory governments, and palliative care services to support:

- **improved understanding amongst patients, families and clinicians of the potential benefits, and timely delivery of palliative care;**
- **increased awareness that palliative care is not just an end-of-life service;**
- **increased availability of tailored and appropriate palliative care services, for a range of population groups; and**
- **where appropriate, greater dialogue upon diagnosis, or throughout treatment, between patients, families and clinicians on palliative care options.**

Recommendation 25

5.129 The committee recommends that the Australian Government consider a review of the eligibility criteria and adequacy of the Carer Payment and Carer Allowance with a view of ensuring that people caring for cancer patients have access to appropriate support.

Recommendation 26

5.132 The committee recommends that state and territory governments reform patient assisted travel schemes with a view to:

- **create more consistency in scheme offerings across all jurisdictions;**
- **increase financial assistance; and**
- **expand schemes to include travel and accommodation costs for clinical trial participants.**

Recommendation 27

5.135 The committee recommends that Australian health services continue to invest in, and extend the use of telehealth and teletrial technology and infrastructure, to ensure adequate and timely delivery of diagnostic, treatment and support services, particularly for people living outside metropolitan areas.

Recommendation 28

5.139 The committee recommends that the Australian Government prioritise and monitor the implementation of the recommendations from the National Medical Workforce Strategy 2021–2031, and ensure it addresses the needs of rare and less common cancer patients, including neuroendocrine cancer patients.

Recommendation 29

5.141 The committee recommends that the Australian Government, in partnership with state and territory governments and the higher education sector, review the emerging educational and workforce skill needs in relation to precision oncology, genomics, molecular curation and theranostics.

Recommendation 30

5.142 The committee recommends that state and territory governments provide sustained funding and participation incentives for staffing positions and training opportunities for medical professionals and researchers interested in specialising in rare and less common cancers, including neuroendocrine cancers.

Recommendation 31

5.145 The committee recommends that the Australian Government continue to engage with and support Aboriginal Community Controlled Health Organisations to ensure the ongoing and expanded delivery of culturally safe and appropriate and health and supportive care for First Nations people.

Recommendation 32

5.147 The committee recommends that the Australian Government, in collaboration with Aboriginal Community Controlled Health Organisations, develop initiatives to increase participation rates of First Nations people in cancer screening, research and clinical trials.

Recommendation 33

5.148 The committee recommends that the Australian Government partner with organisations representing culturally and linguistically diverse communities to develop initiatives to increase participation rates in cancer screening, research, and clinical trials.

Recommendation 34

6.67 The committee recommends that the Australian Government ensure continued funding for rare and less common cancer projects to reduce existing research and clinical trial disparities.

Recommendation 35

6.71 The committee recommends that the Australian Government fund biobanking initiatives to ensure the availability of quality cancer samples for research.

Recommendation 36

6.74 The committee recommends that the Australian Government explore options to provide incentives to expand genomic research in Australia.

Recommendation 37

6.78 The committee recommends that the Australian Government consider new mechanisms to encourage greater private sector investment in rare and less common cancer related research and clinical trial sponsorship in Australia.

Recommendation 38

6.83 The committee recommends that the Australian Government review its evidentiary standards specifically for rare and less common cancer clinical trials to consider accepting real-world evidence and greater uncertainty in data where appropriate.

Recommendation 39

7.86 The committee recommends that the Australian Government ensure the timely delivery of the national cancer data framework and minimum dataset, as per the timeframes set out in the Australian Cancer Plan.

Recommendation 40

7.95 The committee recommends that the Australian Government, in consultation with the cancer control sector, address the following key data-related issues in its delivery of the national cancer data framework and minimum dataset, under the Australian Cancer Plan:

- **ensure that data is collected and reported in a way that includes information on both tumour location and body part, as well as molecular level information on cancer type and subtype;**
- **ensure that information on the stage of cancer at diagnosis is consistently captured;**

- **where appropriate, ensure that researchers and academics have access to such data in an accessible and timely way; and**
- **ensure that patient privacy and consent is upheld throughout this work and in any future reforms.**

Recommendation 41

7.98 The committee recommends that any existing or future reforms to health and cancer data, must prioritise, and align with the National Agreement on Closing the Gap Priority Reform Four, to ensure:

- **commitment to the best practice collection, handling, and reporting of Aboriginal and Torres Strait Islander data; and**
- **that such information and data is available to Aboriginal and Torres Strait Islander people in a timely and accessible way.**

Chapter 1
Introduction

1.1 Whilst cancer outcomes in Australia are amongst the best in the world,[1] this inquiry has made clear that these outcomes are not felt equally amongst all Australian cancer patients.

1.2 Although each rare and less common cancer individually impacts a small number of Australians, collectively, a large number of people are affected, with approximately 52 000 Australians diagnosed with a rare or less common cancer each year.[2]

1.3 This means that 30 per cent of people diagnosed with cancer in Australia will have a rare or less common cancer. Yet these cancers disproportionately account for 42 per cent of all cancer deaths[3] – termed by Medicines Australia as the 'survival gap'.[4]

1.4 Those diagnosed with rare or less common cancers do not always receive the same level of support, or have access to the same diagnosis and treatment options, as those with more common cancers,[5] having, at times, deadly consequences.[6]

1.5 The purpose of this inquiry is to explore the factors contributing to the inequitable diagnosis, treatment, research and support for those affected by rare and less common cancers, and to consider measures to address these issues to ease patients' cancer journeys, improve their health outcomes, and close the survival gap.

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1 See, for example, Cancer Australia, *Submission 43,* p. 1; Cancer Australia, *Australian Cancer Plan Summary Report,* Additional information received 16 January 2024, pp. 2, 4, 6; Associate Professor Anna Boltong, Chief Executive Officer, Ovarian Cancer Australia, *Committee Hansard,* 1 February 2024, p. 63; Professor Dorothy Keefe, Chief Executive Officer, Cancer Australia, *Committee Hansard,* 1 March 2024, p. 26.

2 Rare Cancers Australia, *Submission 3,* [p. 1].

3 Department of Health and Aged Care, *Submission 1,* p. 4; Rare Cancers Australia, *Submission 3,* [p. 1]; Society of Hospital Pharmacists Australia, *Submission 17,* [p. 1].

4 Medicines Australia, *Submission 8,* [pp. 2 and 3].

5 See, for example, Rare Cancers Australia, *Submission 3,* [p. 1]; Medicines Australia, *Submission 8,* [p. 3]; Minderoo Foundation, *Submission 23,* [p. 1]; Queensland Health, *Submission 12*, p. 3; Emily, Private capacity, *Committee Hansard,* 1 February 2024, p. 28; Glen, Private capacity, *Committee Hansard,* 20 February 2024, p. 20.

6 Rare Cancers Australia, *Submission 3*, [pp. 1 and 2].

Referral of the inquiry

1.6 On 14 June 2023, the following matter was referred to the Senate Community Affairs References Committee (the committee) for inquiry and report by the first sitting Thursday in March 2024:

> Equitable access to diagnosis and treatment for individuals with rare and less common cancers, including neuroendocrine cancer, with particular reference to:
>
> (a) barriers to screening and diagnosis, including the impact of factors such as:
>
> (i) geographic location,
>
> (ii) cost,
>
> (iii) cultural and language barriers,
>
> (iv) type of cancer, and
>
> (v) availability of treating practitioners;
>
> (b) barriers to accessing appropriate treatment;
>
> (c) the adequacy of support services after diagnosis;
>
> (d) the adequacy of Commonwealth funding for research into rare, less common and neuroendocrine cancer; and
>
> (e) any other related matters.[7]

1.7 On the 26 February 2024 the Senate granted an extension of time to report until 16 May 2024.[8]

Conduct of the inquiry

1.8 Details of the inquiry were published on the committee's website and the committee invited a number of organisations and individuals to lodge submissions. The committee received 149 submissions which are listed at Appendix 1.

1.9 The committee also held five public hearings, and two site visits, across Australia:

- 31 January 2024 – Sydney, New South Wales;
- 1 February 2024 – Melbourne, Victoria;
- 20 February 2024 – Hobart, Tasmania (including a site visit);
- 1 March 2024 – Canberra, Australian Capital Territory; and
- 9 April 2024 – Adelaide, South Australia (including a site visit).

1.10 A list of witnesses who gave evidence at the public hearings is available at Appendix 2.

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7 *Journals of the Senate*, No. 50, 14 June 2023, p. 1450.

8 *Journals of the Senate,* No. 98, 26 February 2024, p. 2969.

1.11 In this report, references to *Committee Hansard* are to both proof and official transcripts. Page numbers may vary between proof and official transcripts.

Structure of this report

1.12 This chapter sets out general information outlining the conduct of the inquiry and provides background information relating to rare and less common cancers, and cancer control policy in Australia.

1.13 Chapter 2 discusses issues relating to the diagnosis and screening of rare and less common cancers. It examines the challenges in accurately and swiftly diagnosing these cancers, the implications of mis- and late diagnoses, as well as options to address diagnostic challenges. The chapter then considers screening options and issues, particularly in relation to genomic screening and testing.

1.14 Chapter 3 focuses on access to treatment and clinical trials for patients with rare and less common cancers. It provides an overview of Australia's treatment landscape, including the existing processes that regulate approval and access to treatment and clinical trials.

1.15 Chapter 4 discusses the need for a wide range of increased and improved supports for rare and less common cancer patients and their loved ones, following a diagnosis.

1.16 Chapter 5 explores structural barriers impacting the equitable access of diagnosis and treatment services for rare and less common cancer patients. In particular, it considers the impacts of health literacy, financial toxicity, geographic variation and health workforce challenges. It also explores access challenges pertaining to First Nations and culturally and linguistically diverse (CALD) communities.

1.17 Chapter 6 explores Australia's research and clinical trials landscape. It explores mechanisms to address gaps in funding for research and examines ways to increase clinical trial activity in Australia, with the view of improving patient outcomes.

1.18 Chapter 7 discusses cancer data in Australia, including the need for a national cancer data framework, and other key data issues such as the changing nature of cancer classification, the lack of data regarding cancer stage at diagnosis, accessibility of data, privacy considerations for First Nations communities, and views of the Australian Government's My Health Record system.

Acknowledgements

1.19 The committee thanks all those who contributed to the inquiry by making submissions, providing additional information, appearing at public hearings and facilitating site visits.

1.20 In particular, the committee would like to acknowledge the individuals who shared their lived experiences of rare and less common cancers, including those

experiencing these illnesses themselves, as well as those who shared how their loved ones have been affected.

1.21 These personal testimonies have been vital in deepening the committee's understanding of the impact of rare and less common cancers on the Australian community, and have helped inform the recommendations of this report which aim to improve outcomes for patients and their families, into the future.

What is cancer?

1.22 Cancer Australia, an Australian Government entity established in 2006 which aims to 'reduce the impact of cancer, address disparities and improve outcomes for people affected by cancer by leading and coordinating national, evidence-based interventions across the continuum of care',[9] explains that cancer is:

> … a disease of the cells, which are the body's basic building blocks. Cancer occurs when abnormal cells grow in an uncontrolled way. These abnormal cells can damage or invade the surrounding tissues, or spread to other parts of the body, causing further damage.[10]

1.23 It explained that most cancers start in a particular organ, which is known as the primary site or primary tumour. Tumours can be benign (not cancer) or malignant (cancerous). Cancer spreads when cancer cells break off the primary tumour, enter the bloodstream or lymphatic system, and travel to a new organ to form secondary tumours. This is called metastasis.[11]

1.24 According to Cancer Australia, there are several different types of cancer which can be broadly grouped into the following categories:

- **carcinoma:** cancer that begins in the skin or in tissues that line or cover internal organs for example, melanoma
- **sarcoma:** cancer that begins in bone, fat, muscle, blood vessel, or other supportive or connective tissue - for example, osteosarcoma
- **leukaemia:** cancer that begins in the tissues that make blood cells, such as the bone marrow - for example, acute myeloid leukaemia
- **lymphoma and myeloma:** cancers that start in cells of the immune system - for example, Hodgkin lymphoma and multiple myeloma
- **central nervous system cancer:** cancer that begins in the brain or spinal cord - for example, glioma.[12]

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9 Cancer Australia, *About us*, www.canceraustralia.gov.au/about-us (accessed 23 January 2024).

10 Cancer Australia, *What is cancer?*, www.canceraustralia.gov.au/impacted-by-cancer/what-cancer (accessed 23 January 2024).

11 Cancer Australia, *What is cancer?*, www.canceraustralia.gov.au/impacted-by-cancer/what-cancer (accessed 23 January 2024).

12 Cancer Australia, *What is cancer?*, www.canceraustralia.gov.au/impacted-by-cancer/what-cancer (accessed 23 January 2024).

The disease burden of cancer in the Australian community

1.25 According to the Department of Health and Aged Care (the department), cancer is responsible for Australia's largest disease burden and is a leading cause of death.[13]

1.26 Currently, there are over one million Australians who are living with, or who have lived with cancer. In 2022, it is estimated that about 162 000 new cases of cancers were diagnosed in Australia, and that around 55 000 people will have died from cancer.[14]

1.27 The department outlined that whilst cancer mortality rates in Australia have been steadily decreasing, incidence rates for all cancers, including rare and less common cancers, have been increasing. It explained that the reduction in mortality rates is partly due to increasing investment and participation in screening programs, as well as changes to personal and behavioural risk factors.[15]

1.28 Cancer Australia also recognised that whilst cancer outcomes in Australia are amongst the best in the world, this is not the story for all Australians, with significant disparities in cancer outcomes experienced by specific population groups including First Nations people.[16]

1.29 According to the National Aboriginal Community Controlled Health Organisation (NACCHO), cancer is the leading cause of death for Aboriginal and Torres Strait Islander people, and diagnosis rates are significantly higher in Aboriginal and Torres Strait Islander communities compared to other Australians.[17]

1.30 Data from the Australian Institute of Health and Welfare (AIHW) indicates that First Nations people have a slightly higher rate of cancer diagnosis but are approximately 40 per cent more likely to die from cancer than other Australians.[18]

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13 Department of Health and Aged Care, *Submission 1*, p. 4.

14 Department of Health and Aged Care, *Submission 1*, p. 4; Australian Institute of Health and Welfare (AIHW), *Cancer*, 7 July 2022, www.aihw.gov.au/reports/australias-health/cancer (accessed 22 January 2024).

15 Department of Health and Aged Care, *Submission 1*, p. 4.

16 Cancer Australia, *Submission 43*, p. 1.

17 National Aboriginal Community Controlled Health Organisation (NACCHO), *Submission 48*, p. 8.

18 Cancer Australia, *For Aboriginal and Torres Strait Islander people*, www.canceraustralia.gov.au/key-initiatives/aboriginal-and-torres-strait-islander-health (accessed 24 January 2024); AIHW and National Indigenous Australians Agency (NIAA), *Aboriginal and Torres Strait Islander Health Performance Framework: 1.08 Cancer*, 14 March 2023, www.indigenoushpf.gov.au/measures/1-08-cancer (accessed 24 January 2024).

1.31 Cancer Australia also outlined that disparities in cancer outcomes exist between other population groups in Australia, and that these differences are strongly associated with the determinants of health including ethnicity, language, location, socioeconomic group, education, health literacy and other factors.[19] These factors will be explored further throughout this report, particularly in Chapter 5 – Structural barriers to equitable care.

Rare and less common cancers

1.32 The AIHW defines rare cancers as those that have less than six incidents per 100 000 people per year, and less common cancers as those that have between six and 12 incidents per 100 000 people, per year.[20]

1.33 The department explained that examples of rare cancers include:

- gallbladder cancer (3 cases per 100 000 people per year);
- soft tissue sarcoma (6 incidents per 100 000 people per year); and
- penile cancer (0.38 incidents per 100 000 people per year).

1.34 This is compared to common cancers such as lung (44 incidents per 100 000 people per year) or breast cancer (67 incidents per 100 000 people per year).[21]

1.35 Other examples of rare and less common cancers were also outlined by submitters, noting that this list is not exhaustive:

- Adenoid cystic carcinoma
- Appendix cancer
- Ocular (eye) melanoma
- Pseudomyxoma peritonei tumour
- Small bowel cancer
- Upper tract urothelial cancer[22]
- Neuroendocrine cancer
- Mesothelioma
- Acute myeloid leukaemia
- Brain cancer
- Stomach cancer
- Ovarian cancer
- Pancreatic cancer[23]

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19 Cancer Australia, *Submission 43,* p. 5.

20 Department of Health and Aged Care, *Submission 1*, p. 4.

21 Department of Health and Aged Care, *Submission 1*, p. 4.

22 Cancer Council Australia, the Cancer Nurses Society of Australia, the Clinical Oncology Society of Australia, Private Cancer Physicians of Australia, the Medical Oncology Group of Australia and the Lung Foundation Australia, *Submission 4,* p. 3.

23 Cancer Australia, *Submission 43,* p. 2.

- Testicular cancer[24]
- Neuroblastoma[25]
- Head and neck cancers[26]
- Blood cancers[27]
- Diffuse Intrinsic Pontine Glioma (DIPG)[28]

1.36 Despite falling outside of the AIHW's definition of rare cancer, the department highlighted that all cancer diagnosed in children and teenagers is classified as rare.[29] This is discussed further in the childhood cancer section below.

A note on the changing classification of cancer

1.37 Some inquiry participants noted that with improved technology and increased understanding of cancer in recent decades, the way cancer is classified is changing – moving away from descriptions based on tumour location, to classification of subtypes at the genetic and molecular level.[30]

1.38 Whilst this issue will be discussed further throughout this report, Rare Cancers Australia explained that cancers that were previously considered common, are becoming increasingly rare through the discovery of multiple rare sub-types linked to the discovery of genetic mutations.[31] It provided the following example regarding lung cancer:

> People with lung cancer, for example, previously understood to be a common cancer, used to be diagnosed as one of two possibilities – small cell or non-small cell lung cancer. Now, we understand there are over 30 different sub-types associated with lung cancer – many of which are rare.[32]

Rates and statistics of rare and less common cancers

1.39 Rare Cancers Australia outlined that whilst each rare or less common cancer impacts a small number of people, approximately 52 000 Australians are

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24 Movember Foundation, *Submission 40,* p. 2.

25 Neuroblastoma Australia, *Submission 58,* [p. 1].

26 TROG Cancer Research, *Submission 25,* [p. 3]. See also, Head and Neck Cancer Australia, *Submission 19,* p. 1. Head and neck cancer is not one type of cancer, rather a diverse group of cancers that can affect a person's mouth tongue, throat, salivary glands, skin or voice box.

27 Leukaemia Foundation, *Submission 39*, pp. 2 and 3. The Leukaemia Foundation advised that there are over 120 discrete blood cancers.

28 Professor Matthew Dun, *Submission 125*, [p. 1].

29 Department of Health and Aged Care, *Submission 1*, p. 13.

30 See, for example, Rare Cancers Australia, *Submission 3,* [p. 2]; Ms Christine Cockburn, Chief Executive Officer, Rare Cancers Australia, *Committee Hansard,* 31 January 2024, p. 4; Ipsen, *Submission 30,* [p. 2]; Roche, *Submission 9*, p. 7.

31 Rare Cancers Australia, *Submission 3,* [p. 2].

32 Rare Cancers Australia, *Submission 3,* [p. 2].

diagnosed with a rare or less common cancer each year, making up 30 per cent of all cancer diagnoses in Australia.[33]

1.40 Further, several submitters highlighted that rare and less common cancers disproportionately account for approximately 42 per cent of all cancer deaths.[34]

1.41 In terms of survival rates, Cancer Australia reported that whilst five-year relative survival[35] for all cancers has improved over the past 30 years, increasing from 52.2 per cent in 1989–93, to 70.1 per cent in 2014–18, these improvements have not manifested consistently across all cancers.[36]

1.42 Cancer Australia also noted that for some rare and less common cancers, including mesothelioma and cancers of the lip, blood, and brain, there has been little improvement in survival, and pointed out that for rare cancers such as eye, urethral, and bladder cancers, survival may have actually decreased.[37]

1.43 Noting the sparsity of available data on rare and less common cancers, NACCHO submitted that data which is available indicates that Aboriginal and Torres Strait Islander people are disproportionately affected by rare and less common cancers when compared to other Australians.[38]

1.44 NACCHO also outlined that the disproportionate impacts of rare and less common cancers in Aboriginal and Torres Strait Islander communities are also observed in higher mortality rates. For example, it highlighted that between 2015 and 2019, the age-standardised mortality rate for liver cancer in Aboriginal and Torres Strait Islander people was 15.7 per 100 000 people, whilst for other Australians it was 6.7 per 100 000 people.[39]

1.45 NACCHO submitted that data indicates that what constitutes rare and less common cancers for non-Indigenous Australians, are common cancers for Aboriginal and Torres Strait Islander people.[40] It explained that Aboriginal and Torres Strait Islander cancer incidence data shows that only one type of cancer

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33 Rare Cancers Australia, *Submission 3*, [p. 1].

34 See, for example, Rare Cancers Australia, *Submission 3*, [p. 1]; Department of Health and Aged Care, *Submission 1*, p. 4; Medicines Australia, *Submission 8*, [p. 2]; Australian Genomics, *Submission 10*, [p. 1]; Society of Hospital Pharmacists of Australia, *Submission 17*, [p. 1]; Australian Rare Cancer Portal, *Submission 26*, p. 1; Bristol Myers Squibb Australia, *Submission 46*, [p. 2].

35 Cancer Australia, *Submission 43*, p. 3. According to Cancer Australia, relative survival compares the survival of a group of people diagnosed with cancer to the expected survival of similarly aged people in the general population.

36 Cancer Australia, *Submission 43*, p. 3.

37 Cancer Australia, *Submission 43*, p. 3.

38 NACCHO, *Submission 48*, p. 8.

39 NACCHO, *Submission 48*, p. 9.

40 NACCHO, *Submission 48*, p. 9.

(bladder cancer) meets the definition of a less common cancer, and none meet the definition of a rare cancer.[41]

Childhood cancers

1.46 According to the Sydney Children's Hospital Network, each type of childhood cancer is rare or uncommon cancer.[42]

1.47 The Children's Cancer Institute explained that childhood cancers are classified as rare diseases due to their low prevalence and diverse and unique characteristics, leading to even rarer sub-types that require distinct treatments.[43]

1.48 Children's cancers include, for example:

- Brain and central nervous system tumours (including gliomas)
- Neuroblastoma (develops from nerve tissue)
- Leukaemia (cancer of the blood)
- Lymphoma (affects the lymph nodes)
- Bone cancers (including osteosarcoma).[44]

1.49 The Children's Cancer Institute also outlined that despite improved survival rates due to medical research advances, cancer remains the primary cause of disease-related death amongst Australian children.[45]

1.50 In terms of rates of childhood cancers in Australia, the Sydney Children's Hospital Network reported:

- The incidence rate of individual childhood cancers ranges between 0.16 and 4.25 cases per 100 000 population per year.
- Acute lymphoblastic leukaemia is the most common childhood cancer with an incidence rate of 4.25 cases per 100 000 per year.
- Melanoma is the rarest childhood cancer with an incidence rate of 0.16 cases per 100 000 per year.
- Over the period 1983 to 2015 there was a mean of 770 new cancer cases per year in children under 15 years of age in Australia.[46]

Neuroendocrine cancer

1.51 As outlined in a joint submission from Cancer Council Australia, the Cancer Nurses Society of Australia, the Clinical Oncology Society of Australia, Private

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41 NACCHO, *Submission 48*, p. 8.

42 Sydney Children's Hospital Network, *Submission 14*, p. 3.

43 Children's Cancer Institute, *Submission 6*, [p. 1].

44 Cancer Council Australia, *Types of children's cancers*, www.cancer.org.au/cancer-information/types-of-cancer/childhood-cancers/types-of-childrens-cancers (accessed 18 January 2024).

45 Children's Cancer Institute, *Submission 6*, [p. 1].

46 Sydney Children's Hospital Network, *Submission 14*, p. 3.

Cancer Physicians of Australia, the Medical Oncology Group of Australia and the Lung Foundation Australia, the neuroendocrine system is a network of glands and cells that produce and release hormones throughout the body, and neuroendocrine tumours can form in these cells.[47]

1.52 NeuroEndocrine Cancer Australia explained that neuroendocrine cancers are:

> … a complex group of tumours that develop predominantly in the digestive or respiratory tracts, but can occur in other areas of the body. These tumours arise from neuroendocrine cells. The main function of neuroendocrine cells in the body is to create, store and secrete a variety of peptides (little proteins) and hormones for normal bodily functions.[48]

1.53 Cancer Australia outlined that neuroendocrine cancer comprises a grouping of rare cancers (or 'sub-types') which can be found at sites around the body such as the small and large bowel, pancreas, lung, skin and adrenal gland.[49]

1.54 It noted that individually, the incidence rate for each neuroendocrine cancer sub-type meets the definition of rare or less common cancer, although collectively the incidence rate is above 12 cases per 100 000 population.[50]

1.55 According to Cancer Australia, an estimated 3.4 per cent of all new cancer diagnoses in 2022 were neuroendocrine cancers (equating to 5437 total new cases).[51] Further, Cancer Australia reported that for the period of 2014 to 2018, there was a 51 per cent chance of survival for at least five years for individuals with neuroendocrine cancer.[52]

The Australian Government's role in cancer control

1.56 The department submitted that the government provides 'national leadership on cancer policy and research and recognises that improving outcomes for Australians living with cancer is a shared responsibility'. The department noted that this requires coordinated action including all levels of government, non-government organisations and the health and research sectors.[53]

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47 Cancer Council Australia, the Cancer Nurses Society of Australia, the Clinical Oncology Society of Australia, Private Cancer Physicians of Australia, the Medical Oncology Group of Australia and the Lung Foundation Australia, *Submission 4,* p. 5.

48 NeuroEndocrine Cancer Australia, *What are Neuroendocrine Cancers?*, October 2023, https://neuroendocrine.org.au/what-are-nets/ (accessed 24 January 2024).

49 Cancer Australia, *Submission 43,* p. 2.

50 Cancer Australia, *Submission 43,* p. 2.

51 Cancer Australia, *Submission 43*, p. 2.

52 Cancer Australia, *Neuroendocrine tumours,* 31 August 2022, www.canceraustralia.gov.au/cancer-types/neuroendocrine-tumours/statistics, (accessed 24 January 2024).

53 Department of Health and Aged Care, *Submission 1,* p. 5.

1.57 The department submitted that the Australian Government is 'determined to improve outcomes for people with the poorest cancer experiences and is exploring initiatives that will achieve equity in access for all Australians with cancer, regardless of cancer type'.[54]

Australian Cancer Plan

1.58 On 2 November 2023, the Australian Government released the Australian Cancer Plan (the Plan), a 10-year national framework that 'will accelerate world-class cancer outcomes, experiences, and equity across the continuum of cancer care for all cancers'.[55]

1.59 The Minister for Health and Aged Care, the Hon Mark Butler MP (the Minister), outlined that the Plan aims to 'improve prevention, screening, treatment, and management of all cancers for all people in Australia regardless of their background or where they live'.[56]

1.60 The Plan was developed by Cancer Australia, in consultation with states and territories, First Nations communities, clinicians, researchers, people affected by cancer and support organisations.

1.61 A key priority of the Plan is improving outcomes for groups with the poorest cancer experiences, having a particular focus on First Nations people, and it covers all cancer types across the whole cancer journey, from prevention and early detection to treatment, recovery and end of life care.[57]

1.62 The Plan has six 'strategic objectives':

(1) Maximising cancer prevention and early detection;
(2) Enhanced consumer experience;
(3) World-class health systems for optimal care;
(4) Strong and dynamic foundations;
(5) Workforce to transform the delivery of cancer care; and
(6) Achieving equity in cancer outcomes for Aboriginal and Torres Strait Islander people.[58]

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54 Department of Health and Aged Care, *Submission 1*, p. 4.

55 Cancer Australia, *Submission 43*, p. 1.

56 The Hon Mark Butler MP, Minster for Health and Aged Care, 'New era in cancer care for all Australians', *Media Release*, 2 November 2023.

57 The Hon Mark Butler MP, Minster for Health and Aged Care, 'New era in cancer care for all Australians', *Media Release*, 2 November 2023.

58 Cancer Australia, *Submission 43*, p. 1.

1.63 According to the Minister, the Australian Government has committed a total of $735.7 million from 2023–24, to support the implementation of the Plan.[59]

Aboriginal and Torres Strait Islander Cancer Plan

1.64 On 26 October 2023, the Aboriginal and Torres Strait Islander Cancer Plan was launched. According to the department, it was developed in co-design with the First Nations health sector and will be owned and delivered by NACCHO.[60]

1.65 The Aboriginal and Torres Strait Islander Cancer Plan states that it has been written to 'change cancer experiences and create a new foundation for partnership in Australia's national approach to cancer control'.[61] The shared vision for the plan is:

> Through collective community-led action and sustained partnerships, inequitable and avoidable differences between Aboriginal and Torres Strait Islander peoples and other Australians in cancer prevention, screening, treatment and supportive care will be addressed.[62]

1.66 The Aboriginal and Torres Strait Islander Cancer Plan notes that synergies exist between this plan and the broader Australian Cancer Plan. It states that 'by working together, these two plans will achieve better outcomes for more Aboriginal and Torres Strait Islander peoples, their families and communities at a faster pace'.[63]

Commonwealth funding for cancer control

1.67 According to the department, between 2013–14 and 2022–23, total Commonwealth expenditure for cancer control activities is estimated to be more than $32.0 billion, which includes funding for cancer related item numbers under Medicare and the Pharmaceutical Benefits Scheme (PBS), cancer prevention, detection and support programs, health infrastructure, health and medical research, and the provision of some cancer treatments.[64]

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59 The Hon Mark Butler MP, Minister for Health and Aged Care, 'Biggest investment in cancer nurses on record', *Media Release*, 17 November 2023.

60 Department of Health and Aged Care, *Launch of the Aboriginal and Torres Strait Islander Cancer Plan*, 26 October 2023, www.health.gov.au/news/launch-of-the-aboriginal-and-torres-strait-islander-cancer-plan (accessed 5 March 2024).

61 NACCHO, *Aboriginal and Torres Strait Islander Cancer Plan*, October 2023, p. 2.

62 NACCHO, *Aboriginal and Torres Strait Islander Cancer Plan*, October 2023, p. 3.

63 NACCHO, *Aboriginal and Torres Strait Islander Cancer Plan*, October 2023, p. 2.

64 Department of Health and Aged Care, *Submission 1*, p. 5.

1.68 The department also noted that the Australian Government provides funding to state and territories through the National Health Reform Agreement 'to assist with the cost of delivering public health and hospital services'.[65]

Commonwealth funding for cancer research

1.69 The Australian Government also provides funding for cancer research projects and programs in Australia, including through the National Health and Medical Research Council (NHMRC), the Medical Research Future Fund (MRFF), Cancer Australia, the Australian Research Council, and the Department of Health and Aged Care.[66] Commonwealth funding for cancer research is discussed further in Chapter 6 of this report.

National Health and Medical Research Council

1.70 Between 2018 and 2022, the NHMRC committed approximately $221.6 million for 186 new research grants relevant to rare and/or and less common cancers.[67]

1.71 This equates to approximately 5 per cent of total NHMRC funding commitments, and 25.9 per cent of all cancer research for this same period.[68]

Medical Research Future Fund

1.72 The department outlined that since the MRFF's inception in 2015, to 31 July 2023, the MRFF has invested $2.78 billion in 1145 health and medical research grants.[69]

1.73 This includes $454.70 million in 189 cancer-specific research grants, and $37.9 million in 25 research grants that focus on rare cancers in particular.[70]

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65 Department of Health and Aged Care, *Submission 1*, p. 5.

66 Cancer Australia, *Cancer Research in Australia: An overview of funding for cancer research projects and programs in Australia 2021 to 2020*, January 2023, pp. 15 and 16.

67 National Health and Medical Research Council (NHMRC), *Submission 2*, [p. 3].

68 NHMRC, *Submission 2*, [p. 3]; Dr Julie Glover, Research Foundations Branch, NHMRC, *Committee Hansard*, 1 March 2024, p. 34.

69 Department of Health and Aged Care, *Submission 1*, p. 14.

70 Department of Health and Aged Care, *Submission 1*, p. 14.

Cancer Australia

1.74 According to Cancer Australia, since 2007–08, Cancer Australia and its funding partners[71] have provided over $53 million to support 147 grants focussed on rare or less common cancers and neuroendocrine cancers.[72]

Previous and ongoing reviews and inquiries

1.75 There are a number of previous, as well as current inquiries and reviews that have been undertaken, which closely relate to this inquiry. A brief overview of each of these pieces of work is provided below.

Ongoing: Treasury Consultation on the use of genetic testing results in life insurance underwriting

1.76 In November 2023, the Hon Stephen Jones MP, Assistant Treasurer and Minister for Financial Services and Mr Josh Burns MP, announced the commencement of a consultation to consider options addressing the use of genetic testing by life insurers.[73]

1.77 According to a media release, it outlined that, 'the consultation process and any comments received in relation to this paper will help inform the development of future policy in this area'.[74]

1.78 The consultation closed on 31 January 2024.[75]

Ongoing: Health Technology Assessment Policy and Methods Review

1.79 In October 2022, Australian Government commenced the Health Technology Assessment Policy and Methods Review (HTA Review).[76]

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71 Cancer Australia, *Submission 43*, pp. 10 and 11. Cancer Australia's funding partners include Australia and New Zealand Sarcoma Association (formerly Australasian Sarcoma Study Group); Australian Lions Childhood Cancer Research Foundation; beyondblue; Cancer Council Australia; Cure Cancer; Leukaemia Foundation; My Room Children's Cancer Charity Ltd; National Breast Cancer Foundation; Radiation Oncology section of the Department of Health and Aged Care; The Kids' Cancer Project; World Cancer Research Fund International; and Worldwide Cancer Research.

72 Cancer Australia, *Submission 43*, pp. 10 and 11.

73 The Hon Stephen Jones MP, Assistant Treasurer and Minister for Financial Services and Mr Josh Burns MP, 'Consultation open on the use of genetic testing results in life insurance underwriting', *Media Release*, 27 November 2023.

74 The Hon Stephen Jones MP, Assistant Treasurer and Minister for Financial Services and Mr Josh Burns MP, 'Consultation open on the use of genetic testing results in life insurance underwriting', *Media Release*, 27 November 2023.

75 Department of the Treasury, *Use of genetic testing results in life insurance underwriting*, https://treasury.gov.au/consultation/c2023-467047 (accessed 5 March 2024).

76 The Hon Mark Butler MP, Minister for Health and Aged Care, 'HTA review and chair committee', *Media Release*, 27 October 2022.

1.80 According to the department, health technology assessments inform Australian Government decisions to fund and subsidise health technologies through subsidy schemes and funding programs, including:

- the Pharmaceutical Benefits Scheme;
- the Medicare Benefits Schedule;
- the National Immunisation Program; and
- the Life Saving Drugs Program.[77]

1.81 A health technology assessment involves a range of processes that use scientific evidence to assess health technologies for their quality, safety, efficacy, effectiveness and cost-effectiveness.[78]

1.82 According to the department, the goals of the review are:

- reducing time to access for Australians so that they can access new health technologies as early as possible
- maintaining the attractiveness of Australia as a first-launch country to build on Australia's status as a world leader in providing access to affordable healthcare
- ensuring that our assessment processes keep pace with rapidly advancing health technology and minimise barriers to access.[79]

1.83 At the time of writing, the first public consultation for the HTA Review was completed, and consultation two was underway, to consider an options paper which details options for reform.[80]

1.84 At the time of writing, the review had been extended until 4 May 2024.[81]

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77 Department of Health and Aged Care, *Health Technology Assessment Policy and Methods Review*, 29 January 2024, www.health.gov.au/our-work/health-technology-assessment-policy-and-methods-review (accessed 6 March 2024).

78 Department of Health and Aged Care, *Health Technology Assessment Policy and Methods Review*, 29 January 2024, www.health.gov.au/our-work/health-technology-assessment-policy-and-methods-review (accessed 6 March 2024).

79 Department of Health and Aged Care, *Health Technology Assessment Policy and Methods Review*, 29 January 2024, www.health.gov.au/our-work/health-technology-assessment-policy-and-methods-review (accessed 6 March 2024).

80 Department of Health and Aged Care, *Health Technology Assessment Policy and Methods Review*, 29 January 2024, www.health.gov.au/our-work/health-technology-assessment-policy-and-methods-review (accessed 6 March 2024).

81 Department of Health and Aged Care, *Health Technology Assessment Policy and Methods Review*, 29 January 2024, www.health.gov.au/our-work/health-technology-assessment-policy-and-methods-review (accessed 15 May 2024).

2021: House of Representatives Standing Committee on Health, Aged Care and Sport inquiry into approval processes for new drugs and novel medical technologies

1.85 The House of Representatives Standing Committee on Health, Aged Care and Sport, conducted an inquiry into approval processes for new drugs and novel medical technologies in 2021.[82]

1.86 The committee tabled its report titled 'The New Frontier – Delivering better health for all Australians' on 25 November 2021.[83]

1.87 The committee found the HTA process is designed primarily for more common diseases, which creates challenges for reimbursement decisions for rare disease medicines and technologies.[84] The final report made 31 recommendations, many of which focussed on the HTA system.[85]

1.88 The Australian Government tabled its response to this report in November 2023.[86]

2016–17: Senate Select Committee into Funding for Research into Cancers with Low Survival Rates

1.89 In November 2016, the Senate established the Select Committee into Funding for Research into Cancers with Low Survival Rates (the Select Committee), to inquire and report on the impact of health research funding models on the availability of funding for research into cancers with low survival rates.[87]

1.90 The Select Committee tabled its final report in on 28 November 2017.[88]

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82 Parliament of Australia, *Inquiry into approval processes for new drugs and novel medical technologies in Australia*, www.aph.gov.au/Parliamentary_Business/Committees/House/Health_Aged_Care_and_Sport/Newdrugs (accessed 6 March 2024).

83 Parliament of Australia, *Standing Committee on Health, Aged Care and Sport: Completed inquiries and reports*, www.aph.gov.au/Parliamentary_Business/Committees/House/Health_Aged_Care_and_Sport/Completed_inquiries#Tabcontent-tab-1 (accessed 6 March 2024).

84 House of Representatives Standing Committee on Health, Aged Care and Sport, *The New Frontier – Delivering better health for all Australia,* November 2021, p. 203.

85 House of Representatives Standing Committee on Health, Aged Care and Sport, *The New Frontier – Delivering better health for all Australia*, November 2021, pp. xxxi–xlvi.

86 The Hon Mark Butler MP, Minister for Health and Aged Care, 'New Frontier will lead to better health outcomes', *Media Release*, 30 November 2023.

87 Parliament of Australia, *Select Committee into Funding for Research into Cancers with Low Survival Rates*, www.aph.gov.au/Parliamentary_Business/Committees/Senate/Funding_for_Research_into_Cancers (accessed 6 March 2024).

88 Parliament of Australia, *Select Committee into Funding for Research into Cancers with Low Survival Rates: Report*, www.aph.gov.au/Parliamentary_Business/Committees/Senate/Funding_for_Research_into_Cancers/FundingResearchCancers/Report (accessed 6 March 2024).

1.91 The committee was chaired by Senator Catryna Bilyk and it received 326 submissions. The committee made 25 recommendations, which focussed on improving outcomes for cancer patients with low survival rates by addressing issues pertaining to diagnosis, treatment and support.[89]

2014–15: Senate Community Affairs References Committee inquiry into the Availability of new, innovative and specialist cancer drugs in Australia

1.92 From 2014–15, during the 44th Parliament, the Community Affairs References Committee inquired into the availability of new, innovative and specialist cancer drugs in Australia.[90]

1.93 The committee was chaired by former Senator Rachel Siewert and the inquiry received 205 submissions. The committee made three recommendations, which called for a review of how medicines are registered and subsidised, how data on cancer medicines is collected, and recommended that the government establish a steering committee to examine the feasibility of a national cancer medicines register.[91]

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89 Senate Select Committee into Funding for Research into Cancers with Low Survival Rates, *Report*, November 2017, pp. xiii–xvii, 161–170.

90 Parliament of Australia, *Availability of new, innovative and specialist cancer drugs in Australia*, www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/Cancer_Drugs (accessed 6 March 2024).

91 Senate Community Affairs References Committee, *Availability of new, innovative and specialist cancer drugs in Australia*, September 2015, pp. xi–xii and 113–120.

Chapter 2
Diagnosis and screening

> …[It is] well established that early diagnosis and screening programs very directly impact the outcomes of the cancer trajectory and people's survival. In the absence of those two mechanisms in rare cancers, people are typically diagnosed late, and the disease is often not well understood.[1]

2.1 This chapter discusses the evidence received by the committee in relation to:

- the challenges and issues in diagnosing rare and less common cancers accurately and swiftly;
- the implications of mis- and late diagnoses and the vast benefits of early diagnosis in terms of patient outcomes, treatment options and the impact on the Australian healthcare system; and
- options to address diagnostic challenges.

2.2 It also considers screening options and issues regarding rare and less common cancers, particularly in relation to genomic testing.

2.3 It concludes with the committee's views and recommendations on these matters.

Challenges in diagnosing rare and less common cancers

2.4 Considerable evidence to the committee highlighted the difficulties in accurately and swiftly diagnosing rare and less common cancers.[2]

2.5 For example, the committee heard that rare and less common cancers and neuroendocrine tumours are often diagnosed following 'a lengthy process of exclusion' and that eventual diagnosis can require complex and less-used

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1 Ms Christine Cockburn, Chief Executive Officer, Rare Cancers Australia, *Committee Hansard*, 31 January 2024, p. 3.

2 See, for example, Ms Christine Cockburn, Chief Executive Officer, Rare Cancers Australia, *Committee Hansard*, 31 January 2024, p. 3; Australian Genomics, *Submission 10*, [p. 6]; Pancare Foundation, *Submission 21*, [p. 4]; Royal College of Pathologists of Australasia, *Submission 144*, [p. 1]; Royal Australian College of General Practitioners (RACGP), *Submission 5*, p. 6; Ovarian Cancer Australia, *Submission 18*, [p. 2]; National Aboriginal Community Controlled Health Organisation (NACCHO), *Submission 48*, p. 15; Mr David Menzies, Head of PanSupport, Pancare Foundation, *Committee Hansard*, 1 February 2024, p. 59; Neuroblastoma Australia, *Submission 58*, [p. 2]; Dr Richard Stuckey, *Submission 97*, p. 2; PanKind, The Australian Pancreatic Cancer Foundation, *Submission 20*, p. 2; Omico, *Submission 44*, p. 4; Ms Meredith Cummins, Chief Executive Officer, NeuroEndocrine Cancer Australia, *Committee Hansard*, 1 February 2024, p. 2; Dr Melanie Wuttke, Head of Medical Oncology, Royal Hobart Hospital, *Committee Hansard*, 20 February 2024, p. 7; Mrs Tiffany Boughtwood, Managing Director, Australian Genomics, *Committee Hansard*, 1 February 2024, p. 22.

investigations and technology.[3] In a joint submission, Cancer Council Australia, the Cancer Nurses Society of Australia, the Clinical Oncology Society of Australia, Private Cancer Physicians of Australia, the Medical Oncology Group of Australia and the Lung Foundation Australia (Cancer Council Australia) noted that these diagnostic challenges are more pronounced than the difficulties in identifying more common cancers.[4]

2.6 The Royal Australian College of General Practitioners (RACGP) explained the diagnostic challenge of patients initially presenting with ambiguous symptoms:

> Patients who present to general practice early in their illness usually have ambiguous symptoms that will typically have more common benign explanations, with the connections between the symptoms not yet clear. Rare and less common cancers do not have clear symptom signatures...[5]

2.7 Cancer Australia also explained that clinicians may see very few patients with rare and less common cancers and may therefore be less familiar with signs and symptoms, which can be vague and non-specific. Cancer Australia stated that these factors can lead to misdiagnosis or delays in diagnosis and referral, and consequently a delay in treatment.[6]

2.8 AstraZeneca similarly summarised some of the factors that contribute to delayed and/or misdiagnoses of rare and less common cancers:

> Symptoms of rare and less common cancers can be unusual or unremarkable and as a result are less well known to doctors than symptoms of more common cancers. Doctors often investigate other causes for the symptoms first, leading to delayed diagnosis and/or misdiagnosis. A patient may need several tests and to see more than one specialist to confirm a diagnosis. For patients with cancer, the right test and the right treatment at the right time are critical to optimal patient outcomes.[7]

2.9 Ms Meredith Cummins, Chief Executive Officer of NeuroEndocrine Cancer Australia, highlighted how these issues can have serious health and financial implications for neuroendocrine cancer patients in particular:

> The symptoms are so vague: diarrhoea, bloating, flushing, wheezing—it could be anything. Because the diagnosis is delayed by an average of five to seven years, symptoms are often protracted. Sixty per cent of these patients

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3 Cancer Council Australia, the Cancer Nurses Society of Australia, the Clinical Oncology Society of Australia, Private Cancer Physicians of Australia, the Medical Oncology Group of Australia and the Lung Foundation Australia, *Submission 4,* p. 5.

4 Cancer Council Australia, the Cancer Nurses Society of Australia, the Clinical Oncology Society of Australia, Private Cancer Physicians of Australia, the Medical Oncology Group of Australia and the Lung Foundation Australia, *Submission 4,* p. 5.

5 RACGP, *Submission 5,* p. 6. Citation omitted.

6 Cancer Australia, *Submission 43,* p. 7.

7 AstraZeneca, *Submission 41*, p. 2.

> have stage 4 disease, which means it's spread to other organs, like the liver, and the chance of cure is often lost. The cost of unnecessary tests impacts patients and the public healthcare system, predominantly because of this misdiagnosis and prolonged time, and it costs patients about $1,700 over three months for out-of-pocket expenses.[8]

2.10 The committee also heard several accounts from individuals with lived experience of rare and less common cancers, and the difficulties they experienced in receiving an accurate and timely diagnosis, either for themselves or their loved ones.[9]

2.11 For example, David, who outlined his experience living with neuroendocrine cancer, told the committee he was misdiagnosed for 'three frustrating years'.[10]

2.12 Mrs Hannah Pringle, mother of Ruby, Kate, aunty of Emily, and Jelena, mother of Marko, also detailed the difficulties in getting a timely and accurate diagnosis for their loved ones who were each diagnosed with childhood cancer.[11]

2.13 Sarah, who lives with rare blood cancers Erdheim Chester Disease and Chronic Myelomonocytic Leukemia, also explained the difficult and stressful diagnostic process she encountered:

> It took almost eight months of testing, including four bone marrow biopsies, numerous types of medical imaging, blood and genetic testing before I was diagnosed. The challenge I faced was the rarity of these diseases produce symptoms that can be like a lot of other diseases. The tests were done more as a process of elimination for other diseases. I required time off work and people to accompany me which was at times a logistical nightmare. The stress involved with having the test done and then waiting for the results was immense.[12]

Importance of early diagnosis

2.14 Several inquiry participants outlined the implications of delayed and/or misdiagnoses, including delayed treatment, poorer patient outcomes and

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8 Ms Meredith Cummins, Chief Executive Officer, NeuroEndocrine Cancer Australia, *Committee Hansard,* 1 February 2024, p. 2.

9 See, for example, Leona, *Submission 65*, [p. 1]; Jean, *Submission 74,* [p. 1]; Christopher, *Submission 73,* [p. 1]; Shae, *Submission 82,* [p. 1]; Name Withheld, *Submission 91,* [p. 1]; Name Withheld, *Submission 99*, [p. 1]; Ada, *Submission 117*, [p. 1]; Elnaz, *Submission 133*, [p. 1]; Anita, *Submission 135,* [p. 1]; Name withheld, *Submission 138*, [p. 1]; Jacqui, Private capacity, *Committee Hansard,* 20 February 2024, p. 18; Mrs Susanne Manks, Patient, Peter MacCallum Cancer Centre, *Committee Hansard*, 1 February 2024, p. 3; Peter, Private capacity, *Committee Hansard,* 20 February 2024, p. 23; Yvonne, *Submission 100,* [p. 1]; Syd, *Submission 61*, [pp. 1 and 2]; Russell, *Submission 142,* p. 1.

10 David, *Submission 105,* p. 1.

11 Mrs Hannah Pringle, Australian DIPG Families, *Committee Hansard,* 31 January 2024, p. 35; Kate, Private capacity, *Committee Hansard,* 31 January 2024, p. 40; Jelena, Private capacity, *Committee Hansard,* 1 February 2024, p. 29.

12 Sarah, *Submission 113,* [p. 1].

increased costs to the health system.[13] The Royal College of Pathologists of Australasia summarised these issues:

> Rare cancers often present diagnostic dilemmas for the clinician, necessitating a long and complex journey for the patient. Delays in diagnosis subsequently lead to delays in treatment, where patients with rare and less common cancers frequently have limited therapeutic options to begin with.[14]

2.15 Many also emphasised the importance of early diagnosis.[15] For example, Head and Neck Cancer Australia explained that head and neck cancers are largely curable if detected early, but are often highly aggressive and a delay in diagnosis can have an 'enormous impact on what treatment a patient is offered and their subsequent quality of life'.[16]

2.16 Yvonne, who highlighted her child's experience of being diagnosed with the aggressive paediatric bone cancer Ewing Sarcoma at the age of 17, similarly outlined that the difficulty in getting an early diagnosis of a rare disease is 'a barrier to optimal care and may preclude curative cancer treatment'.[17]

2.17 Associate Professor Anna Boltong, Chief Executive Officer of Ovarian Cancer Australia made a similar point, and explained the serious implications of delayed diagnosis for women diagnosed with this rare form of cancer:

> Too many women are diagnosed with advanced disease by the time symptoms present, reducing the five-year survival rate to just 29 per cent.

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13 See, for example, Ms Christine Cockburn, Chief Executive Officer, Rare Cancers Australia, *Committee Hansard,* 31 January 2024, pp. 1 and 2; NeuroEndocrine Cancer Australia, *Submission 38*, pp. 8 and 9; Associate Professor Anna Boltong, Chief Executive Officer, Ovarian Cancer Australia, *Committee Hansard,* 1 February 2024, pp. 57 and 58; Pancare Foundation, *Submission 21,* [pp. 4 and 6]; Cure Our Ovarian Cancer, *Submission 114,* p. 6; Australian Genomics, *Submission 10,* [p. 6]; Australian Rare Cancer Portal, *Submission 26,* [p. 1]; Movember Foundation, *Submission 40*, [p. 3]; Yvonne, *Submission 100,* [p. 1]; Mr Ryan Patterson, *Submission 142*, p. 2; Michelle, Private capacity, *Committee Hansard,* 31 January 2024, p. 43; Leona, *Submission 65,* [p. 1]; Syd, *Submission 61*, [p. 1].

14 Royal College of Pathologists of Australasia, *Submission 144*, [p. 1].

15 See, for example, The Hospital Research Foundation Group, *Submission 146*, p. 6; Angel Flight, *Submission 147*, [p. 3]; Dr Peter Baade, Senior Manager, Descriptive Epidemiology, Cancer Council Queensland, *Committee Hansard,* 31 January 2024, pp. 22 and 23; Associate Professor Antoinette Anazodo, Paediatric and Adolescent Oncologist, Sydney Children's Hospital Randwick, Sydney Children's Hospitals Network, *Committee Hansard*, 31 January 2024, p. 50; Ms Christine Cockburn, Chief Executive Officer, Rare Cancers Australia, *Committee* Hansard, 31 January 2024, p. 3; Roche, *Submission 9,* p. 7; Head and Neck Cancer Australia, *Submission 19,* p. 2; Daffodil Centre and the University of Sydney Cancer Research Network, *Submission 32,* p. 6; NeuroEndocrine Cancer Australia, *Submission 38,* p. 8; Movember Australia, *Submission 40,* p. 3; Milton, *Submission 80*, p. 3; Mr Howard Hobbs, Chair, Angel Flight Australia, *Committee Hansard,* 9 April 2024, p. 10; Lynn, *Submission 66*, [p. 1].

16 Head and Neck Cancer Australia, *Submission 19*, p. 2.

17 Yvonne, *Submission 100,* [p. 1].

> They face an uphill battle even prior to diagnosis, with no effective screening test; no routine way of assessing elevated risk; vague symptoms, leading to delayed diagnosis, advanced disease and poor prognosis; plus difficulties sourcing specialist care. What follows is a series of treatment options that fast lead to the development of resistance.[18]

2.18 In the childhood cancer context, Associate Professor Antoinette Anazodo, Paediatric and Adolescent Oncologist representing the Sydney Children's Hospitals Network, explained that the time from first symptoms, to the time of diagnosis (known as the 'symptom interval') is 'often longer than we want it to be'. She emphasised the benefits of early and accurate diagnosis in terms of both cost and treatment effectiveness:

> For many rare cancers, while we're talking about all the costs, what we're not also talking about are the benefits. An early and accurate diagnosis when you've got a rare cancer—to be able to accurately say not only what the cancer is but how aggressive the cancer is, what the targets are and how likely those targets are to work—makes a significant difference.[19]

2.19 More broadly, Rare Cancers Australia submitted that early diagnosis is critical for improving survival outcomes for cancer patients, as well as reducing the burden on the Australian healthcare system and associated expenditure.[20] Roche, a pharmaceutical and biotechnology company, similarly observed that it is widely accepted that 'early diagnosis results in better health outcomes at lower costs, as less intensive interventions are required'.[21]

2.20 Further, Professor Rodney Hicks, former Director of the Neuroendocrine Service at Peter MacCallum Cancer Centre and Honorary Board Member of NeuroEndocrine Cancer Australia, reported that 96 cents in every dollar spent in health care is spent on therapies such as surgery, radiotherapy and drugs – whereas just 4 cents in that dollar is spent on diagnosis. He highlighted that this is despite the fact that 'every one of those 96 cents is determined by the accuracy of the diagnosis that we do'.[22]

2.21 Professor Hicks continued to emphasise the vast benefits of investing in early diagnosis in terms of both cost savings and patient outcomes:

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18 Associate Professor Anna Boltong, Chief Executive Officer, Ovarian Cancer Australia, *Committee Hansard,* 1 February 2024, pp. 57 and 58.

19 Associate Professor Antoinette Anazodo, Paediatric and Adolescent Oncologist, Sydney Children's Hospital Randwick, Sydney Children's Hospitals Network, *Committee Hansard*, 31 January 2024, p. 50.

20 Rare Cancers Australia, *Submission 3,* p. 3.

21 Roche, *Submission 9,* p. 7. Citation omitted.

22 Professor Rodney Hicks, Honorary Board Member, NeuroEndocrine Cancer Australia, *Committee Hansard,* 1 February 2024, p. 11.

> That's the payback for looking after patients. If you keep them well, you keep them productive, you keep them out of hospital and you diagnose them earlier, it actually saves you money. The money you spend for better diagnosis, earlier detection and better care of patients to improve their quality and duration of life can pay back massively. That has to be part of the discussion we have. It's not just about healthcare delivery. It's about economics.[23]

Role of general practitioners in diagnosis

2.22 The committee heard that general practitioners (GPs) are the first point-of-contact for initial investigations and referrals for most people with rare and less common cancers,[24] and the important role that GPs play in the diagnosis of these cancers.[25]

2.23 Cancer Australia recognised that GPs have a vital role in recognising symptoms and signs in patients with possible rare or less common cancer, as well as in initiating referral to specialists for early diagnosis and care.[26] The Royal Australian College of General Practitioners (RACGP) similarly outlined that GPs are critical in the diagnosis, holistic management and care coordination of patients diagnosed with a rare cancer.[27]

2.24 Noting this, many inquiry participants reported issues regarding GPs throughout their, or their loved ones, diagnostic journey,[28] with several witnesses calling for greater awareness about rare and less common cancers amongst GPs.[29]

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23 Professor Rodney Hicks, Honorary Board Member, NeuroEndocrine Cancer Australia, *Committee Hansard*, 1 February 2024, p. 10.

24 RACGP, *Submission 5,* p. 5.

25 See, for example, Cancer Australia, *Submission 43,* p. 7; Mr Tim Murphy, General Manager, Blood Cancer Partnerships, Leukaemia Foundation, *Committee Hansard,* 31 January 2024, p. 18; Ms Nadia Rosin, Chief Executive Officer, Head and Neck Cancer Australia, *Committee Hansard,* 31 January 2024, p. 19; RACGP, *Submission 5,* p. 5; TrialHub, *Submission 37,* p. 3; Head and Neck Cancer Australia, *Submission 19*, p. 2; Cancer Australia, *Submission* 43, p. 7; Christopher, *Submission 73*, [p. 1].

26 Cancer Australia, *Submission 43*, p. 7.

27 RACGP, *Submission 5,* pp. 3 and 4.

28 See, for example, Ada, *Submission 117,* [p. 1]; Anita, *Submission 135,* [p. 1]; Name withheld, *Submission 138*, [p. 1]; Jenaya, *Submission 115,* p. 2; Jessica, *Submission 108,* [p. 1]; Russell, *Submission 142,* p. 1; David, *Submission 105,* p. 1; Sandra, *Submission 84,* p. 2; Kate, Private capacity, *Committee Hansard*, 31 January 2024, p. 40; Jelana, Private capacity, *Committee Hansard,* 1 February 2024, p. 29; Mrs Beau Kemp, Australian DIPG Families, *Committee Hansard*, 31 January 2024, p. 37; Mrs Amanda Robertson, Information and Support Manager, Cancer Council South Australia, *Committee Hansard,* 9 April 2024, p. 1.

29 See, for example, Dr Matthew Magarey, Board Director, Head and Neck Cancer Australia, *Committee Hansard,* 31 January 2024, p. 21; NeuroEndocrine Cancer Australia, *Submission 38,* pp. 5,

2.25 In its submission to the inquiry, the RACGP noted that the process to diagnose a rare and less common cancer can be time-consuming and complex.[30] TrialHub, Mr David Menzies, Head of PanSupport at the Pancare Foundation, and Ms Christine Cockburn, Chief Executive Officer of Rare Cancers Australia, also recognised the difficult job that GPs have in diagnosing rare cancers.[31]

The need for point-of-care clinical information for GPs

2.26 The RACGP reported that currently, there is a lack of supportive and easily accessible clinical information and local pathways for rare and less common cancers available for GPs, at the point-of-care.[32] It added that enabling GPs to have access to such accurate information would assist them in making an early diagnosis and providing optimal management and support, for patients and their families living with a rare and less common cancer.[33]

2.27 RACGP noted that it would be impractical to provide comprehensive education on the ever-changing guidance for all rare and less common cancers, but suggested that a cost-effective option would be to expand the existing 'HealthPathways'[34] system, to 'include guidance on rare and less common cancers, with point-of-care information on assessment, diagnosis and local referral pathways'.[35]

2.28 Other inquiry participants also advocated for similar tools to support GPs to make prompt diagnoses and referrals.[36] For example, the Leukaemia Foundation made the following recommendations:

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6 and 9; Head and Neck Cancer Australia, *Submission 19*, pp. 2 and 4; Ms Meredith Cummins, Chief Executive Officer, NeuroEndocrine Cancer Australia, *Committee Hansard,* 1 February 2024, p. 3; Yvonne, *Submission 100*, [pp. 1 and 2]; Mrs Amanda Robertson, Information and Support Manager, Cancer Council South Australia, *Committee Hansard*, 9 April 2024, p. 5; Christopher, *Submission 73,* [p. 1].

30 RACGP, *Submission 5*, p. 5.

31 TrialHub, *Submission 37*, p. 3; Mr David Menzies, Head of PanSupport, Pancare Foundation, *Committee Hansard,* 1 February 2024, p. 59; Ms Christine Cockburn, Chief Executive Officer, Rare Cancers Australia, *Committee Hansard,* 31 January 2024, p. 10.

32 RACGP, *Submission 5*, p. 5.

33 RACGP, *Submission 5*, p. 5.

34 According to the RACGP, HealthPathways is a system developed through Primary Health Networks to be used during consultations, with links to clinical guidance for assessing and managing a patient with a particular symptom or condition. HealthPathways also provides locally relevant information on referrals to existing services and specialists. See, RACGP, *Submission 5,* p. 5.

35 RACGP, *Submission 5*, p. 5.

36 See, for example, Cancer Council Australia, the Cancer Nurses Society of Australia, the Clinical Oncology Society of Australia, Private Cancer Physicians of Australia, the Medical Oncology Group of Australia and the Lung Foundation Australia, *Submission 4*, p. 11; Leukaemia Foundation, *Submission 39,* pp. 4 and 8; Kate, Private capacity, *Committee Hansard,* 31 January 2024, p. 41;

- Develop symptom support tools for GPs aimed at improving prompt and accurate diagnosis and appropriate referral to specialists of low survival, non-screenable cancers, including blood cancers.
- … review existing international diagnostics guidelines in blood cancer and develop Australian-specific guidelines for minimum and recommended testing requirements for different types of blood cancer in Australian healthcare settings. These guidelines should be integrated with clinical guidelines.[37]

2.29 Cancer Council Australia explained that Optimal Care Pathways, guidelines which 'outline consistent, safe, high-quality and evidence-based care for people with cancer',[38] covering every step from prevention, early detection and recovery, should receive further investment.[39]

2.30 It noted that that Optimal Care Pathways for rare or less common cancers only exist for neuroendocrine tumours, some blood cancers, and soft tissue sarcoma. Cancer Council Australia urged for increased investment and support from all Australian governments 'to establish develop, implement and embed the Optimal Care Pathways for all rare and less common cancers'.[40]

2.31 The Daffodil Centre and the University of Sydney Cancer Research Network similarly recommended the development of Optimal Care Pathways for rare cancers, as well as 'robust mechanisms for their dissemination, implementation and reporting as best practice within all health systems'.[41]

2.32 Kate, who shared the story of her niece, Emily, who was diagnosed with neuroblastoma, advocated for further government investment in 'more effective symptom support tools for GPs, and clinical education'.[42]

2.33 At a public hearing of the inquiry in Melbourne, Professor Mark Morgan, Chair of the Expert Committee for Quality Care at the RACGP, reiterated the RACGP's

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Mrs Amanda Robertson, Information and Support Manager, Cancer Council South Australia, *Committee Hansard*, 9 April 2024; p. 5; The Daffodil Centre and the University of Sydney Cancer Research Network, *Submission 32*, p. 2; Ms Megan Varlow, Director, Cancer Control Policy, Cancer Council Australia, *Committee Hansard,* 31 January 2024, p. 10; Christopher, *Submission 73*, [p. 1].

37 Leukaemia Foundation, *Submission 39,* pp. 4 and 8.

38 Cancer Australia, *Optimal Care Pathways,* www.canceraustralia.gov.au/optimal-cancer-care-pathways (accessed 10 April 2024).

39 Cancer Council Australia, the Cancer Nurses Society of Australia, the Clinical Oncology Society of Australia, Private Cancer Physicians of Australia, the Medical Oncology Group of Australia and the Lung Foundation Australia, *Submission 4,* p. 11.

40 Cancer Council Australia, the Cancer Nurses Society of Australia, the Clinical Oncology Society of Australia, Private Cancer Physicians of Australia, the Medical Oncology Group of Australia and the Lung Foundation Australia, *Submission 4,* p. 11.

41 The Daffodil Centre and the University of Sydney Cancer Research Network, *Submission 32*, p. 2.

42 Kate, Private capacity, *Committee Hansard,* 31 January 2024, p. 41.

calls to expand the point-of-care information that is available to GPs regarding rare cancers:

> We … recommend increasing the support for point-of-care information available to GPs. That would be products such as HealthPathways, which are currently places where GPs can get information they need to help with referral pathways and clinical information and guidance. If that could be expanded for rare cancers, it would be very helpful.[43]

Improving referral pathways

2.34 Some inquiry participants including the Daffodil Centre and the University of Sydney Cancer Research Network, Cancer Australia and Ms Nadia Rosin, Chief Executive Officer of Head and Neck Cancer Australia, noted the importance of clear and prompt referrals for patients with rare and less common cancers.[44]

2.35 The Pancare Foundation, which represents and advocates for Australians impacted by upper gastrointestinal cancers, specifically recommended that systems be established for 'rapid and informed' specialist referral to improve diagnoses.[45]

2.36 The RACGP informed the committee that the United Kingdom has a two-week urgent referral system for suspected cancer, 'along with overall diagnostics, management plan and treatment (if required) within 16 weeks'.[46]

2.37 The RACGP recommended that further scoping and research should be undertaken to determine whether this model would be successful in an Australian context, and if so, that adequate resourcing and investment be provided.[47] It made the following recommendation:

> Provide funding to scope and research into the feasibility of an urgent cancer referral system in Australia that includes people with suspected rare and less common cancers.[48]

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43 Professor Mark Morgan, Chair, Expert Committee for Quality Care, RACGP, *Committee Hansard,* 1 February 2024, p. 51.

44 See, for example, The Daffodil Centre and the University of Sydney Cancer Research Network, *Submission 32,* p. 13; Cancer Australia, *Submission 43,* p. 8; Ms Nadia Rosin, Chief Executive Officer, Head and Neck Cancer Australia, *Committee Hansard,* 31 January 2024, p. 20.

45 Pancare Foundation, *Submission 21,* pp. 3 and 18.

46 RACGP, *Submission 5,* p. 6.

47 RACGP, *Submission 5,* p. 6; Professor Mark Morgan, Chair, Expert Committee for Quality Care, RACGP, *Committee Hansard,* 1 February 2024, p. 51.

48 RACGP, *Submission 5,* p. 6.

Issues around funding and availability of diagnostic tests

2.38 The committee heard that there are issues around the availability and funding of diagnostic tests and equipment.[49]

2.39 The Royal College of Pathologists of Australasia explained that there is 'variable access nationwide' to advanced technologies for diagnostic testing and treating specialists, both geographically and financially.[50]

2.40 Inquiry participants also raised concern about the out-of-pocket costs for diagnostic tests and the various implications of this, for example, Professor Hicks raised concern about the lack of Medicare funding for scans:

> There's an incredible financial disincentive to using scans that aren't funded by Medicare. It's both the beauty and the tragedy of the Medicare system that it has created a mindset amongst the community that our health care should be entirely free and 'If the government isn't prepared to pay for a test, then why should I?' That also feeds back to doctors being reluctant to refer patients for scans that aren't reimbursed by Medicare, and so sometimes they'll work around the edges and come up with an indication that might be almost fit for funding.[51]

2.41 Professor Hicks considered that the system is broken, and that a 'rethink' of the Medical Services Advisory Committee (MSAC) process as it applies to the reimbursement of scans is warranted, to achieve a more 'patient centred' approach to evaluating imaging and diagnostic technologies.[52]

2.42 The Peter MacCallum Cancer Centre also noted the implications of inadequate funding for diagnostics.[53] It submitted that current state-funded subsidies are 'vastly insufficient' to cover the full costs of diagnostic assessments, 'which may

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49 See, for example, Royal College of Pathologists of Australasia, *Submission 144*, [p. 1]; Professor Rodney Hicks, Honorary Board Member, NeuroEndocrine Cancer Australia, *Committee Hansard*, 1 February 2024, p. 11; Dr Melanie Wuttke, Head of Medical Oncology, Royal Hobart Hospital, *Committee Hansard*, 20 February 2024, p. 7; Angie, *Submission 76*, [p. 1]; Pancare Foundation, *Submission 21*, Attachment 1, p. 90; Professor John R Zalcberg AO, *Submission 50*, [p. 1]; National Rural Health Alliance, *Submission 7*, p. 7; NeuroEndocrine Cancer Australia, *Submission 38*, Attachment 3, [p. 3]; Peter, *Submission 131*, [p. 2]; Ms Margaret Deerain, Director of Policy and Strategy Development, National Rural Health Alliance, *Committee Hansard*, 1 March 2024, p. 17; Sydney Children's Hospitals Network, *Submission 14*, p. 5; Peter MacCallum Cancer Centre, *Submission 29*, p. 2; Yvonne, *Submission 100*, [p. 3]; Christopher, *Submission 73*, [p. 1].

50 Royal College of Pathologists of Australasia, *Submission 144*, [p. 1].

51 Professor Rodney Hicks, Honorary Board Member, NeuroEndocrine Cancer Australia, *Committee Hansard*, 1 February 2024, p. 11.

52 Professor Rodney Hicks, Honorary Board Member, NeuroEndocrine Cancer Australia, *Committee Hansard*, 1 February 2024, p. 11.

53 Peter MacCallum Cancer Centre, *Submission 29*, p. 2.

delay diagnosis and impact on subsequent disease treatment and management'.[54]

2.43 Ms Delaine Smith, Chief Executive Officer of the Australasian Leukaemia and Lymphoma Group noted similar concerns:

> Some diagnostics are not covered by private health insurance, are not covered through out-of-hospital costs and can lead to inconsistent use and variation in the minimum standards of the use of these diagnostic tests. It's important that we are providing the facilities, the technology, the education and the workforce in healthcare professionals to deliver timely and accurate diagnosis.[55]

2.44 Angie, whose daughter Eve has been diagnosed by the aggressive childhood cancer Diffuse Intrinsic Pontine Glioma (DIPG), told the committee that the cost associated with diagnostic procedures and imaging tests can pose a substantial burden for families, and hinder timely detection.[56]

2.45 Yvonne, whose child has been diagnosed with a rare paediatric bone cancer, also noted the significant out-of-pocket costs for diagnostic and monitoring scans, and advocated for a 'scheme to fund scan costs', including gap fees for paediatric cancers and other cancers with high risk of relapse.[57]

2.46 Another issue regarding access to diagnostic services was outlined by Dr Ian Kamerman, Secretary of the Rural Doctors Association NSW, and rural GP based in Tamworth, New South Wales. He reported that a 'major problem' he faces when dealing with patients with suspected cancer, is that as a GP, there are very few imaging tests he can order in his own right.[58]

2.47 Dr Kamerman argued that addressing this issue, and related Medicare limitations, would help fast-track patients to treatment:

> I can't order an MRI on someone I suspect has cancer for the patient to get a Medicare rebate unless they happen to have brain cancer and that's what I'm suspecting. The Medicare limitations are such that psychiatrists can order it or a rehabilitation specialist can order it, but a specialist GP can't order those sorts of tests. Similarly I'm totally prevented from getting a PET scan on a patient. The Medicare requirements for PET scans are essentially a patient with a known cancer where you suspect there is a spread going on. I don't understand why a rural GP—even specialist GPs from anywhere—can't

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54 Peter MacCallum Cancer Centre, *Submission 29*, p. 2.

55 Ms Delaine Smith, Chief Executive Officer, Australasian Leukaemia and Lymphoma Group, *Committee Hansard*, 1 February 2024, p. 13.

56 Angie, *Submission 76*, [p. 1].

57 Yvonne, *Submission 100*, [p. 3].

58 Dr Ian Kamerman, Secretary, Rural Doctors Association NSW, *Committee Hansard*, 1 March 2024, p. 19.

> order those sorts of tests. It would just cut weeks or a month or two off the patient getting definitive treatment.[59]

2.48 More specific barriers regarding access to particular diagnostic imaging services are discussed below, and Chapter 5 of this report discusses broader barriers to accurate and prompt diagnoses including high out of pocket costs, geographical factors and workforce shortages.

Magnetic Resonance Imaging (MRI) services

2.49 Evidence to the committee highlighted that funding and regulatory issues are impacting the accessibility of magnetic resonance imaging (MRI) services.[60]

2.50 Professor John R Zalcberg AO, a practicing medical oncologist who has worked in the field for almost 40 years, flagged that whilst Australia has a high number of MRI machines, the technology is disproportionately utilised, likely due to restricted funding and high out of pocket costs:

> According to data reported in 2018 … Australia has the highest number of magnetic resonance imaging (MRI) machines in the OECD (13.4/million people) but has the lowest number of MRI examinations per 1000 people (27.6 in Australia versus 51.7 examinations/1000 people in the OECD). Whilst these numbers are not confined to cancer, they are likely to be representative and reflect the restricted funding and substantive out of pocket costs required to have an MRI scan when clinically indicated.[61]

2.51 Bayer Australia also noted that the availability and access to cancer-detecting diagnostic technology such as MRI can be more restrictive for Australian patients than other OECD countries.[62]

2.52 The Australian Diagnostic Imaging Association noted the essential role that radiology plays in the diagnosis of rare cancers, and argued that changes must be made to the 'inflexibility' and 'unavailability' of Medicare items, and the MRI licensing system, as it would enable 'all Australian rare cancer patients to receive the best possible diagnosis and treatment'.[63]

2.53 Professor John Zalcberg explained he has 'regularly observed how much restricted access to MRI scans interferes with optimal cancer care',[64] and the Australian Diagnostic Imaging Association explained that Australia's current

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59 Dr Ian Kamerman, Secretary, Rural Doctors Association NSW, *Committee Hansard*, 1 March 2024, p. 19.

60 See, for example, Peter MacCallum Cancer Centre, *Submission 29*, pp. 2 and 4; Professor John R Zalcberg AO, *Submission 50,* [pp. 1 and 2]; Alison, *Submission 90*, [p. 1]; Australian Diagnostic Imaging Association, *Submission 16,* pp. 1 and 2.

61 Professor John R Zalcberg AO, *Submission 50,* [p. 1].

62 Bayer Australia, *Submission 42,* p. 3.

63 Australian Diagnostic Imaging Association, *Submission 16,* p. 2.

64 Professor John R Zalcberg AO, *Submission 50,* [p. 1].

MRI licensing system hinders equitable access to appropriate radiology services for rare cancer and other patients in several ways, including:

- licences are skewed towards high socio-economic areas;
- patients are referred for less appropriate examinations; and
- the system of full and partial licences is confusing for patients and referrers.[65]

2.54 The Australian Diagnostic Imaging Association made the following recommendations to address these issues:

- Create Medicare items for MRI for diagnosis, surveillance and restaging of rare cancers.[66]
- Remove the licencing requirement for specific paediatric and cancer MRI services. This initial increment could be conducted as a pilot, with evaluation to include the actual cost to the Budget of the measure; the impact on patient access to MRI; and a timetable for ultimately removing licence restrictions on all MRI items.[67]

PET/CT imaging services

2.55 Some submitters also outlined issues regarding the accessibility of Positron Emission Tomography (PET) and Computed Tomography (CT) imaging.[68]

2.56 Associate Professor Gabrielle Cehic AM, a medical oncologist and nuclear medicine physician noted the 'pressing issue' of restricted access to, and the inequitable funding model for PET investigations. She contended that these factors are continuing 'to hinder ongoing clinical improvements that we all know are possible but continues to be denied or deferred'.[69]

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65 Australian Diagnostic Imaging Association, *Submission 16*, p. 3.

66 Australian Diagnostic Imaging Association, *Submission 16*, p. 2.

67 Australian Diagnostic Imaging Association, *Submission 16*, p. 3.

68 See, for example, Peter MacCallum Cancer Centre, *Submission 29,* pp. 2 and 4; National Rural Health Alliance, *Submission 7*, pp. 4 and 7; NeuroEndocrine Cancer Australia, *Submission 38*, p. 6; NeuroEndocrine Cancer Australia, *Submission 38*, Attachment 3, [p. 3]; Dr S. Cox, *Submission 45*, [p. 1]; Telix Pharmaceuticals, *Submission 47*, [p. 1]; Peter, *Submission 131,* [p. 2]; Associate Professor Gabrielle Cehic AM, *Submission 140,* [pp. 1 and 2]; Associate Professor Grace Kong, Medical Consultant, Nuclear Medicine Physician and Co-Chair, Neuroendocrine Tumour Unit, Peter MacCallum Cancer Centre, *Committee Hansard,* 1 February 2024, p. 1; Christopher, *Submission 73*, [p. 1]; Mrs Miriam Cocking, Private capacity, *Committee Hansard,* 9 April 2024, p. 7; Mr Paul Flynn, Group Chief Executive Officer, The Hospital Research Foundation Group, *Committee Hansard,* 9 April 2024, p. 21; Dr Sally Cox, Private capacity, *Committee Hansard,* 9 April 2024, p. 25; Associate Professor Gabrielle Cehic AM, Clinical Lead, South Australian Peptide Receptor Radionuclide Therapy Service, and Chair, South Australian Gastroenteropancreatic Neuroendocrine Tumours Multidisciplinary Team, South Australia Medical Imaging, *Committee Hansard,* 9 April 2024, p. 26.

69 Associate Professor Gabrielle Cehic AM, *Submission 140,* [pp. 1 and 2].

2.57 The Australian Diagnostic Imaging Association outlined that for most rare cancers, PET scans are not currently funded other than for initial staging of rare cancers. It recommended that MSAC consideration of Medicare items for PET diagnosis and restaging of rare cancers be expedited, and that access to these items should not be subject to a lifetime cap.[70]

2.58 Michael, a submitter who outlined his experience living with pancreatic cancer, informed the committee that Medicare does not cover the PET scans he needs, and the high out-of-pocket costs he incurs as a result:

> PET scans for pancreatic cancer are not covered by Medicare and cost me $450.00 each time. I have now spent many thousands of dollars on PET scans, but I have no other choice if my doctors are to have the best information to continue my treatment. Many cancers do qualify for a Medicare rebate for PET scans, but pancreatic cancer does not.[71]

2.59 Similarly, Christopher, who was diagnosed with Merkyl Cell Carcinoma, a rare and aggressive neuroendocrine skin cancer in 2023, noted the significant costs he has incurred due to PET scans, and called for for additional Medicare rebates to subsidise PET and other scans.[72]

2.60 Dr S. Cox, a nuclear medicine specialist in South Australia, raised concern about the inequitable access for PET/CT medical imaging in South Australia in particular, reporting that the state has markedly lower PET/CT services per capita (nearly 50 per cent lower than the national average). Dr Cox also reported that South Australia has the lowest number of PET/CT scanners per capita in Australia.[73]

2.61 Dr Cox reiterated these concerns at a public hearing that the committee held in Adelaide:

> We've been advocating for PET/CT at Flinders Medical Centre for almost two decades at both local and government levels. We've failed to deliver equitable access of PET/CT over a 20-year period, and we're continuing to do so despite very clear evidence of the role that PET/CT has in management not only of the rare and less common cancers but actually of a large majority of cancers. Patients don't have equal access to standard of care in their cancer management if they live in South Australia, particularly if they live or are managed in the Southern Adelaide Local Health Network.[74]

2.62 Mrs Miriam Cocking, who has volunteered for over 20 years to advocate for, and assist community members navigating and accessing the health-and-ageing

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70 Australian Diagnostic Imaging Association, *Submission 16*, p. 3.

71 Michael, *Submission 71,* [p. 1].

72 Christopher, *Submission 73*, [p. 1].

73 Dr S. Cox, *Submission 45,* [pp. 1 and 2].

74 Dr Sally Cox, Private capacity, *Committee Hansard*, 9 April 2024, pp. 25 and 26.

system in South Australia, echoed Dr Cox's concerns about the lack of PET/CT machinery in South Australia:

> When you look at our counterpart states per population, they have more PET/CT scan machinery than we do. We have approximately 2.5 million people in South Australia, but we currently have one PET/CT scan machinery in the Royal Adelaide Hospital, which is the principal referral hospital. Our second principal referral hospital is Flinders, which is long overdue in having one of these machines because they're covering the southern Adelaide local health network, which has a massive population and is still increasing.[75]

2.63 Associate Professor Cehic expressed that PET should not be 'something seen as special', and also emphasised the to fund PET services in South Australia:

> At the South Australian level it is no longer just embarrassing; it's distressing and incredibly frustrating. I have personally tabulated nine separate trials which we cannot take part in because we don't have PET. …We have to get funding, and not just for one but for all of us; that is the take-home message.[76]

Box 2.1 Site visit – The Queen Elizabeth Hospital, Adelaide

The committee conducted a site visit at the Queen Elizabeth Hospital in Adelaide. The site visit included a tour of the hospital's Nuclear Medicine Department followed by several short presentations focused on the equity and access for South Australian patients with rare and uncommon cancers including progress to date, challenges, and future goals.

Committee members heard that the Nuclear Medicine Department adopts a strong patient-centred approach throughout diagnostic and treatment services for patients across South Australia and the Northern Territory.

Throughout the site visit, hospital staff further emphasised that one of their biggest challenges is the lack of PET/CT infrastructure to deliver quality diagnostic and treatment care to patients.

Staff told committee members that they are seeking to 'future-proof' the department, but that the lack of PET/CT machines is undermining this goal and their ability to offer more advanced treatment to patients.

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75 Mrs Miriam Cocking, Private capacity, *Committee Hansard*, 9 April 2024, p. 7.

76 Associate Professor Gabrielle Cehic AM, Clinical Lead, South Australian Peptide Receptor Radionuclide Therapy Service, and Chair, South Australian Gastroenteropancreatic Neuroendocrine Tumours Multidisciplinary Team, South Australia Medical Imaging, *Committee Hansard*, 9 April 2024, p. 26.

Screening

2.64 The committee understands that screening is different to diagnostic testing. Whilst diagnostic testing is used to confirm cancer when a person already has symptoms,[77] screening aims to detect cancers early, at an asymptomatic stage.[78]

2.65 According to the Department of Health and Aged Care (the department), screening is 'one of the most effective ways to detect the early signs of cancer' and can enable earlier management and treatment of disease and result in better health outcomes.[79]

2.66 Queensland Health similarly emphasised the importance of screening, echoing that screening is one of the most effective ways to detect the early signs of cancer, at an early stage, when treatment is likely to be more effective.[80]

2.67 Issues regarding screening for rare and less common cancers, and options to address these matters, will be canvassed in the following sections.

No national screening programs for rare and less common cancers

2.68 Amongst other submitters, Rare Cancer Australia, NACCHO and the department noted that currently, there are no national screening programs available for rare and less common cancers.[81]

2.69 Advocacy organisations including Ovarian Cancer Australia, Head and Neck Cancer Australia and the Pancare Foundation also noted that there are no screening tests for the respective cancer populations they represent.[82]

2.70 Inquiry participants noted Australia's existing national cancer screening programs for bowel, cervical and breast cancers,[83] however some explained that

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77 Queensland Health, *Submission 12,* p. 4.

78 See, for example, Cancer Australia, *Submission 43,* p. 6; The Daffodil Centre and the University of Sydney Cancer Research Network, *Submission 32,* p. 6.

79 Department of Health and Aged, *Submission 1*, p. 6.

80 Queensland Health, *Submission 12,* p. 4.

81 See, for example, Cancer Australia, *Submission 43,* p. 6; Rare Cancers Australia, *Submission 3,* pp. 3 and 7; Cancer Council Australia, the Cancer Nurses Society of Australia, the Clinical Oncology Society of Australia, Private Cancer Physicians of Australia, the Medical Oncology Group of Australia and the Lung Foundation Australia, *Submission 4,* p. 7; NACCHO, *Submission 48,* p. 15; Department of Health and Aged Care, *Submission 1,* p. 6; Queensland Health, *Submission 12,* pp. 3 and 4; The Daffodil Centre and the University of Sydney Cancer Research Network, *Submission 32*, p. 7; Sandra, *Submission 84,* p. 3; Milton, *Submission 80,* [p. 3].

82 Ovarian Cancer Australia, *Submission 18,* [p. 2]; Head and Neck Cancer Australia, *Submission 19,* p. 2; Ms Nadia Rosin, Chief Executive Officer, Head and Neck Cancer Australia, *Committee Hansard*, 31 January 2024, p. 19; Pancare Foundation, *Submission 21,* [p. 5].

83 See, for example, Cancer Australia, *Submission 43,* p. 6; Queensland Health, *Submission 12,* p. 4; NACCHO, *Submission 48,* p. 15; Australian Genomics, *Submission 10,* [p. 2]; Professor Dorothy Keefe, Chief Executive Officer, Cancer Australia, *Committee Hansard,* 1 March 2024, p. 33; The

such population level screening programs would likely not be feasible for rare and less common cancers.[84] Cancer Australia submitted that this is because many rare and less common cancers:

- do not have an identifiable early stage at which a screening intervention is possible;
- do not have an available, accurate and acceptable screening test; or
- do not have an evidence-based, cost-effective assessment and management pathway for patients with a positive screening test.[85]

2.71 Ms Megan Varlow, Director of Cancer Control Policy at Cancer Council Australia similarly outlined:

> The difficult thing with rare and less common cancers is the fact that they're rare and less common. Particularly in the Australian community, numbers in each of the different types of cancer are quite small. To be efficient and cost-effective and for them to be considered at a population level—they're never going to get to that level. We don't have the numbers of people in Australia with those cancers that would meet the criteria that, say, BreastScreen has had to meet to be able to get up and running.[86]

2.72 Ms Varlow noted that the challenge for rare and less common cancers is developing a screening test or regime that assists people to be diagnosed earlier, but that still ensures cost effectiveness, recognising the small patient populations.[87]

Calls for greater screening efforts

2.73 Several inquiry participants called for increased investment or efforts in terms of screening for rare and less common cancers.[88] For example, AstraZeneca submitted:

Daffodil Centre and the University of Sydney Cancer Research Network, *Submission 32*, pp. 7 and 9; Milton, *Submission 80,* [p. 3].

84 See, for example, Queensland Health, *Submission 12,* p. 4; Ms Megan Varlow, Director, Cancer Control Policy, Cancer Council Australia, *Committee Hansard,* 31 January 2024, p. 3; Ms Christine Cockburn, Chief Executive Officer, Rare Cancers Australia, *Committee Hansard,* 31 January 2024, p. 4; Cancer Australia, *Submission 43,* p. 6.

85 Cancer Australia, *Submission 43*, p. 6.

86 Ms Megan Varlow, Director, Cancer Control Policy, Cancer Council Australia, *Committee Hansard,* 31 January 2024, p. 3.

87 Ms Megan Varlow, Director, Cancer Control Policy, Cancer Council Australia, *Committee Hansard,* 31 January 2024, p. 3.

88 See, for example, Ovarian Cancer Australia, *Submission 18*, [p. 2]; The Daffodil Centre and the University of Sydney Cancer Research Network, *Submission 32,* pp. 1 and 7; Rare Cancers Australia, *Submission 3,* [p. 10]; Queensland Health, *Submission 12,* p. 4; National Rural Health Alliance, *Submission 7,* p. 6; Roche, *Submission 9,* p. 5; Melanoma Patients Australia, *Submission 22,* p. 4; Dr Minmin Li FRACP and Associate Professor Kathy Tucker AO FRACP, *Submission 36*, [p. 3];

> Access to screening and cancer genomics will enable faster and more accurate diagnosis, early intervention and identification of patients who may benefit from targeted therapies. This will ensure more efficient use of medicines by preventing ineffective use of therapies on patients in whom they do not work and overall, will improve outcomes for cancer patients, including those with rare and less common cancers.[89]

2.74 The Daffodil Centre and the University of Sydney Cancer Research Network recommended increased Australian Government investment in research into risk-based and personalised (as distinct from population-based) cancer screening and systematic approaches to early detection across the cancer spectrum.[90]

2.75 Options for improving and widening screening options for rare and less common cancers are explored in the sections below.

Genomic testing and screening

2.76 Roche, a pharmaceutical and biotechnology company, explained that in cancer, genomic technologies 'are able to identify genetic or biological markers that are driving cancer growth by analysing a tumour or blood sample'.[91]

2.77 Ms Christine Cockburn, Chief Executive Officer of Rare Cancers Australia noted the various terms used to describe genomic testing and precision medicine, and further explained these concepts:

> By undergoing genomic profiling, or precision medicine, or personalised medicine, or molecular screening—you would have read all of these phrases in the submissions—what we can understand is what the fingerprint of each of the cancers is, and we end up with a target, or a biomarker, that we can target to treat the cancer. So what we're looking at is each individual's fingerprint of their cancer and what really will effectively treat that cancer. That concept is precision, or personalised, medicine.[92]

2.78 Several inquiry participants outlined recent developments in relation to, as well as the potential benefits of genomics in cancer care.[93]

NeuroEndocrine Cancer Australia, *Submission 38*, p. 7; AstraZeneca, *Submission 41*, p. 2; Ms Meredith Cummins, Chief Executive Officer, NeuroEndocrine Cancer Australia, *Committee Hansard*, 1 February 2024, p. 4; Mr David Menzies, Head of PanSupport, Pancare Foundation, *Committee Hansard*, 1 February 2024, p. 62; Caitlin, *Submission 111*, [p. 2].

89 AstraZeneca, *Submission 41*, p. 2.

90 The Daffodil Centre and the University of Sydney Cancer Research Network, *Submission 32*, p. 1.

91 Roche, *Submission 9*, p. 7.

92 Ms Christine Cockburn, Chief Executive Officer, Rare Cancers Australia, *Committee Hansard*, 31 January 2024, p. 3.

93 See, for example, Minderoo Foundation, *Submission 23*, p. 3; Ms Megan Varlow, Director, Cancer Control Policy, Cancer Council Australia, *Committee Hansard*, 31 January 2024, p. 1; Ms Christine Cockburn, Chief Executive Officer, Rare Cancers Australia, *Committee Hansard*, 31 January 2024,

2.79 For example, a submission from Dr Jane Tiller and Associate Professor Paul Lacaze from the Public Health Genomics Program at Monash University outlined that 'the field of genomics has great potential to improve medicine and public health, through enabling diagnosis, prevention and early treatment of cancer (and other genetic disease)'.[94]

2.80 Cancer Australia similarly noted that the 'rapidly expanding' use of genomics in cancer control may particularly benefit patients with rare and less common cancers. It continued:

> There is an increasing knowledge base for genetic conditions potentially linked to rare and less common cancers including neuroendocrine cancer, and improvements in technology to allow for risk-stratified screening programs.[95]

2.81 The department explained that genomic medicine is already allowing clinicians to diagnose diseases more accurately, tailor treatments to an individual and better identify those at high genetic risk of inherited disease and a range of conditions. It also pointed out that patients affected by rare and less common cancers, as well as other complex conditions, are likely to be 'the major beneficiaries of future developments' in this space.[96]

2.82 Whilst the benefits of genomics in terms of the *treatment* of rare and less common cancers will be covered in Chapter 3 of this report, the following sections focus on addressing barriers in relation to genomic *screening*.

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p. 3; Melanoma Patients Australia, *Submission 22*, [p. 3]; Cancer Council Australia, the Cancer Nurses Society of Australia, the Clinical Oncology Society of Australia, Private Cancer Physicians of Australia, the Medical Oncology Group of Australia and the Lung Foundation Australia, *Submission 4*, p. 4; Dr Jane Tiller and Associate Professor Paul Lacaze, Public Health Genomics Program, Monash University, *Submission 35*, pp. 1 and 2; NeuroEndocrine Cancer Australia, *Submission 38*, p. 20; Bayer Australia, *Submission 42*, p. 2; Mr Tim Murphy, General Manager, Blood Cancer Partnerships, Leukemia Foundation, *Committee Hansard*, 31 January 2024, p. 21; Associate Professor Grace Kong, Medical Consultant, Nuclear Medicine Physician and Co-Chair, Neuroendocrine Tumour Unit, Peter MacCallum Cancer Centre, *Committee Hansard*, 1 February 2024, p. 5; Dr Kurt Lackovic, Chief Executive Officer, Cancer Trials Australia, *Committee Hansard*, 1 February 2024, p. 39; Dr Chloe Georgiou, Chair, Victorian Rare Cancer, Clinical Trial Alliance, TrialHub, Alfred Health, *Committee Hansard*, 1 February 2024, p. 40; Professor Joanne Dickinson, Lead, Cancer Genetics, Menzies Institute for Medical Research, University of Tasmania, *Committee Hansard*, 20 February 2024, p. 1; Associate Professor Vanessa Tyrrell, Program Director, Zero Childhood Cancer Program, Children's Cancer Research Institute, *Committee Hansard*, 1 March 2024, pp. 1 and 5.

94 Dr Jane Tiller and Associate Professor Paul Lacaze, Public Health Genomics Program, Monash University, *Submission 35*, p. 2.

95 Cancer Australia, *Submission 43*, p. 14.

96 Department of Health and Aged Care, *Submission 1*, p. 7.

The case for greater access to genomic testing and screening

2.83 The committee heard about the importance and potential of genomic screening and the benefits this could provide to rare and less common cancer patients.[97]

2.84 The department outlined that whilst there have been no advancements in identifying suitable screening tests for rare and less common cancers, in the future, 'it is likely genomics offers the potential to better understand the risk of rare cancers without the need for understanding the natural history of the disease'.[98]

2.85 Relatedly, Cancer Australia reported that there is an increasing interest, and growing evidence for, more risk-based, personalised approaches to population screening.[99] Cancer Australia explained that in the future, such approaches 'may provide an opportunity to address delays in diagnosis for people with rare and less common cancers'. It outlined the benefits of genetic screening in the following example:

> … a patient with known risk factors, such as a family history or a hereditary condition which predisposes a person to developing cancer (such as neuroendocrine cancer) could be identified by genetic screening, allowing for regular surveillance to enable early detection.[100]

2.86 Whilst several inquiry participants advocated for greater access to, and investment in genomic testing and screening,[101] the committee heard that factors including a regulatory issue regarding genetic discrimination in life insurance, as well as out-of-pocket costs and strict testing criteria are limiting patients access and use of such screening tests.[102]

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97 See, for example, Melanoma Patients Australia, *Submission 22*, [p. 3]; AstraZeneca, *Submission 41*, p. 2; Ms Megan Varlow, Director, Cancer Control Policy, Cancer Council Australia, *Committee Hansard*, 31 January 2024, p. 1; Professor Paul Lacaze, Head of Public Health Genomics, School of Public Health and Preventive Medicine, Monash University, *Committee Hansard*, 1 February 2024, p. 21.

98 Department of Health and Aged Care, *Submission 1*, p. 7.

99 Cancer Australia, *Submission 43*, p. 6.

100 Cancer Australia, *Submission 43*, p. 6.

101 See, for example, Minderoo Foundation, *Submission 23*, p. 4; Royal College of Pathologists of Australasia, *Submission 144*, [p. 1]; AstraZeneca, *Submission 41*, p. 2; Ms Megan Varlow, Director, Cancer Control Policy, Cancer Council Australia, *Committee Hansard*, 31 January 2024, p. 1; Roche, *Submission 9*, p. 15; Rare Cancers Australia, *Submission 3*, p. 8; Bayer Australia, *Submission 42*, p. 4; Associate Professor Grace Kong, Medical Consultant, Nuclear Medicine Physician and Co-Chair, Neuroendocrine Tumour Unit, Peter MacCallum Cancer Centre, *Committee Hansard*, 1 February 2024, p. 5.

102 See, for example, Menzies Institute for Medical Research, University of Tasmania, *Submission 148*, [pp. 4, 5 and 6]; WA Health, *Submission 11*, pp. 2 and 3; Children's Cancer Institute, *Submission 6*, [p. 6]; Australian Genomics, *Submission 10*, [p. 4]; Professor Paul Lacaze, Head of Public Health Genomics, School of Public Health and Preventive Medicine, Monash University, *Committee*

Genetic discrimination in life insurance

2.87 The committee was made aware that currently, the *Disability Discrimination Act 1992* provides an exemption for life insurers to use genomic or genetic test results when underwriting life insurance contracts.[103]

2.88 Submitters explained that this can lead to discrimination in the offer of insurance policies against people with genetic results, including denials of cover, increases in premiums, and exclusions on cover.[104]

2.89 A joint submission from Dr Jane Tiller and Associate Professor Paul Lacaze, from the Public Health Genomics Program at Monash University outlined that this has been an issue for some time, with a 2017–18 Parliamentary Joint Committee on Corporations and Financial Services (PJCCFS) inquiry into the life insurance industry, considering these issues in detail and recommending various reforms.[105]

2.90 In 2019, the life insurance industry peak body, the Financial Services Council introduced a partial moratorium (Financial Services Council moratorium) requiring applicants to disclose genetic test results only for policies above certain financial limits.[106] Dr Tiller and Associate Professor Lacaze outlined that this moratorium is industry self-regulated, with no government oversight, and still resulted in 'an overwhelming lack of confidence by Australian consumers and health professionals', particularly in regards to its self-regulated nature.[107]

2.91 Amongst other inquiry participants,[108] Dr Tiller raised concern that this issue is deterring people and families from accessing such testing:

Hansard, 1 February 2024, pp. 21 and 24; Royal College of Pathologists of Australasia, *Submission 144,* [p. 1]; Mrs Tiffany Boughtwood, Managing Director, Australian Genomics, *Committee Hansard,* 1 February 2024, p. 19; Leukaemia Foundation, *Submission 39,* p. 8. Citations omitted; Caitlin, Private capacity, *Committee Hansard,* 1 February 2024, p. 37.

103 Dr Jane Tiller and Associate Professor Paul Lacaze, *Submission 35*, p. 2; The Hon Stephen Jones MP, Assistant Treasurer and Minister for Financial Services and Mr Josh Burns MP, 'Consultation open on the use of genetic testing results in life insurance underwriting', *Media Release*, 27 November 2023.

104 Dr Jane Tiller and Associate Professor Paul Lacaze, *Submission 35*, p. 2; Australian Genomics, *Submission 10,* [p. 4].

105 Dr Jane Tiller and Associate Professor Paul Lacaze, *Submission 35*, p. 2. See, Parliamentary Joint Committee on Corporations and Financial Services, *Life Insurance Industry*, March 2018.

106 Dr Jane Tiller and Associate Professor Paul Lacaze, *Submission 35*, p. 2. Citation omitted.

107 Dr Jane Tiller and Associate Professor Paul Lacaze, *Submission 35*, p. 1.

108 See, for example, Menzies Institute for Medical Research, University of Tasmania, *Submission 148*, [pp. 5 and 6]; WA Health, *Submission 11*, pp. 2 and 3; Children's Cancer Institute, *Submission 6,* [p. 6]; Australian Genomics, *Submission 10,* [p. 4]; Professor Paul Lacaze, Head of Public Health Genomics, School of Public Health and Preventive Medicine, Monash University, *Committee Hansard,* 1 February 2024, p. 21.

> Oftentimes people decide that they would rather not have this information and not have the impact of that on their life insurance, so they choose not to have this testing. I don't need to tell you, in this committee and in this context, how important it is that people are able to access the genetic testing that's available to them. We've heard of a lot of challenges with people accessing clinical trials and treatments, but if people aren't accessing this kind of thing that is available to them, because they're worried about implications for their future life insurance or their children's life insurance, that is a significant tragedy.[109]

2.92 Professor Lacaze outlined that whilst the suite of applications for genomic testing is increasing, this issue with life insurance discrimination 'looms like a black cloud' over this progress and for the benefits of this technology to be felt by the population.[110]

2.93 Dr Tiller informed the committee that internationally, many countries have adopted bans and regulatory responses such as legislation to prohibit or restrict the use of genetic results by insurers and other industries. She outlined that jurisdictions including Canada, the UK and much of Europe have bans in place.[111] Professor Lacaze said 'it's fair to say that Australia is behind the eight ball and a bit of an outlier'.[112]

2.94 Specifically, Dr Tiller and Professor Lacaze submitted that Australia must consider a 'legislative prohibition' on genetic discrimination, 'to address this critical human rights issue, protect individuals, and remove barriers to screening and diagnosis of cancers'.[113]

Australian Genetics and Life Insurance Moratorium: Monitoring the Effectiveness and Response (A-GLIMMER) Project

2.95 The committee also heard that a comprehensive review to investigate the effectiveness of the Financial Services Council moratorium as a regulatory solution to genetic discrimination in Australian life insurance has been undertaken, with the Australian Government funding the Australian Genetics and Life Insurance Moratorium: Monitoring the Effectiveness and Response (A-GLIMMER) Project from 2020 to 2023. The funding was awarded through

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109 Dr Jane Tiller, Ethical, Legal and Social Adviser, Public Health Genomics, Monash University, *Committee Hansard*, 1 February 2024, p. 19.

110 Professor Paul Lacaze, Head of Public Health Genomics, School of Public Health and Preventive Medicine, Monash University, *Committee Hansard,* 1 February 2024, p. 21.

111 Dr Jane Tiller and Associate Professor Paul Lacaze, *Submission 35*, p. 1; Dr Jane Tiller, Ethical, Legal and Social Adviser, Public Health Genomics, Monash University, *Committee Hansard*, 1 February 2024, p. 20.

112 Professor Paul Lacaze, Head of Public Health Genomics, School of Public Health and Preventive Medicine, Monash University, *Committee Hansard,* 1 February 2024, p. 20.

113 Dr Jane Tiller and Associate Professor Paul Lacaze, *Submission 35*, p. 1.

the Genomics Mission of the Medical Research Future Fund and was led by Monash University.[114]

2.96 The project found that 'a very high proportion' of key stakeholders considered that legislation is required to regulate the use of genetic test results in life insurance underwriting. This included 93 per cent of health professionals, 88 per cent of patients with experience of genetic testing, 78 per cent of the general public, and 86 per cent of researchers involved with the project.[115]

2.97 The project concluded that its findings demonstrate that the Financial Services Council moratorium is inadequate to address and prevent genetic discrimination in life insurance, and that it should be replaced with a legislative model of prohibition. The specific recommendations of the project are outlined in the table below.[116]

Box 2.2 A-GLIMMER Project Recommendations

1. The Australian Government amend the *Disability Discrimination Act 1992* (Cth) ('the Act') to prohibit insurers from using genetic or genomic test results to discriminate between applicants for risk-rated insurance, and consider amendments to the regulation of financial services to ensure insurers are subject to a positive duty to not discriminate.
2. Australian Government allocate responsibility and appropriate resources to the Australian Human Rights Commission ('AHRC') to enforce, promote, educate and support individuals and all relevant stakeholders to understand and meet the new legal obligations under the Act. The AHRC should consult with a range of genetics and genomics experts and stakeholders to achieve this goal.

Source: Dr Jane Tiller and Associate Professor Paul Lacaze, Australian Genetics and Life Insurance Moratorium: Monitoring the Effectiveness and Response, Final Stakeholder Report, p. 4 (tabled 1 February 2024).

2.98 Evidence to the committee outlined that the RACGP supports the A-GLIMMER recommendations, concurring that the Australian Government should pass legislation to amend the *Disability Discrimination Act 1992* to prohibit insurers from using genetic or genomic test results to discriminate between applicants for risk-rated insurance.[117]

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114 Dr Jane Tiller and Associate Professor Paul Lacaze, *Submission 35*, p. 3.

115 Dr Jane Tiller and Associate Professor Paul Lacaze, *Submission 35*, p. 3.

116 Dr Jane Tiller and Associate Professor Paul Lacaze, *Australian Genetics and Life Insurance Moratorium: Monitoring the Effectiveness and Response, Final Stakeholder Report*, pp. 4 and 5 (tabled 1 February 2024).

117 Dr Jane Tiller and Associate Professor Paul Lacaze, *Submission 35*, [p. 15].

2.99 Several other inquiry participants also advocated for legislative change to address this issue.[118]

2.100 Australian Genomics agreed that legislation must change 'since the industry self-regulated moratorium currently in place does not provide confidence in appropriate protection' and therefore 'serves as a strong deterrent from having screening or predictive testing'.[119]

2.101 The Children's Cancer Institute further echoed these points:

> There is a legislative opportunity for the Australian Government to legislate a moratorium instead of leaving it self-regulated by the FSC [Financial Services Council], alleviating the anxiety in the community around genetic testing and therefore ensuring patients access the right testing and support services at the right time for their disease.[120]

2.102 Mrs Tiffany Boughtwood, Managing Director of Australian Genomics considered that 'anything less than a complete ban is just going to further stifle the outcome for patients with rare and less common cancers, as well as the broader Australian community'.[121]

Cost and funding factors

2.103 Some submitters outlined that out-of-pocket costs for genomic screening and profiling is limiting access for Australians.[122] For example, the Leukaemia Foundation submitted that most genomic testing is not publicly subsidised. It considered that this not only limits uptake for Australians, but also creates inequitable access across the population.[123]

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118 See, for example, Menzies Institute for Medical Research, University of Tasmania, *Submission 148*, [pp. 5 and 6]; Australian Genomics, *Submission 10*, [p. 4]; WA Health, *Submission 11*, pp. 2 and 3; Children's Cancer Institute, *Submission 6*, p. 6.

119 Australian Genomics, *Submission 10,* [p. 4].

120 Children's Cancer Institute, *Submission 6,* p. 6.

121 Mrs Tiffany Boughtwood, Managing Director, Australian Genomics, *Committee Hansard*, 1 February 2024, pp. 22 and 23.

122 See, for example, Menzies Institute for Medical Research, University of Tasmania, *Submission 148*, [p. 4]; Professor Paul Lacaze, Head of Public Health Genomics, School of Public Health and Preventive Medicine, Monash University, *Committee Hansard,* 1 February 2024, p. 24; Sydney Children's Hospitals Network, *Submission 14*, p. 5; Caitlin, Private capacity, *Committee Hansard*, 1 February 2024, p. 37.

123 Leukaemia Foundation, *Submission 39*, p. 8. Citations omitted.

2.104 The Royal College of Pathologists of Australasia and Mrs Tiffany Boughtwood, of Australian Genomics, also confirmed there is no reimbursement for comprehensive cancer genomic profiling in Australia.[124]

2.105 Mrs Boughtwood highlighted that this is in contrast with people in England who are facing a cancer diagnosis, who are able to receive reimbursements for comprehensive cancer genomic profiling through the National Health Service. Mrs Boughtwood observed that the inequity of access experienced by Australians who cannot afford such tests 'is a situation that should not exist in Australia'.[125]

2.106 Bayer Australia also drew international comparisons, outlining that individuals in countries such as the UK, United States, Belgium, Denmark, France, Germany and the Netherlands have advanced levels of access for patients to genomic testing. It also outlined that Korea encourages such testing as part of routine care and offers a 'flexible funding model' where co-payment contributions result in a 'significantly larger uptake in testing'.[126]

2.107 To address these issues, submitters advocated for increased government funding to subsidise genomic testing for patients and improve access.[127] The Royal College of Pathologists of Australasia considered that Commonwealth funding, for comprehensive tumour profiling via genetic testing, would best support equitable access to testing for individuals with rare and less common cancers.[128]

2.108 Omico, a national not-for-profit organisation focussed on delivering precision oncology to Australian cancer patients, proposed that development of a 'sustainable funding model' to ensure ongoing access to precision oncology, including free access to genomic profiling 'is a critical consideration for improving patient outcomes in Australia in the future'.[129] Roche similarly recommended that the Australian Government 'commit to a national funding framework for genomic screening that is sustainable in the long term'.[130]

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124 Royal College of Pathologists of Australasia, *Submission 144,* [p. 1]; Mrs Tiffany Boughtwood, Managing Director, Australian Genomics, *Committee Hansard,* 1 February 2024, p. 19.

125 Mrs Tiffany Boughtwood, Managing Director, Australian Genomics, *Committee Hansard*, 1 February 2024, p. 19.

126 Bayer Australia, *Submission 42*, p. 3.

127 See, for example, WA Health, *Submission 11,* p. 4; Menzies Institute for Medical Research, University of Tasmania, *Submission 148,* [pp. 3–5]; Royal College of Pathologists of Australasia, *Submission 144*, p. 1; Roche, *Submission 9,* p. 5; Bayer Australia, *Submission 42,* p. 4; Omico, *Submission 44*, p. 11.

128 Royal College of Pathologists of Australasia, *Submission 144*, p. 1.

129 Omico, *Submission 44*, p. 11.

130 Roche, *Submission 9*, p. 5.

2.109 Bayer Australia, a pharmaceutical company, recommended that genomic testing be offered routinely to all Australian patients as standard of care, and that 'universal access to genomic testing for all Australian patients' be aspired to.[131]

2.110 Caitlin, who outlined her experience living with a rare form of ovarian cancer, also advocated for more equitable and affordable access to genomic screening:

> As a rare-cancer patient, scientist and patient advocate I believe we need to do the following for all rare- and less-common-cancer patients. Firstly, we need to create equitable and affordable access to genetic screening of blood and tumour tissue, which should be a really standard of care and accessible to everyone.[132]

2.111 Cancer Australia outlined that it is developing a National Framework for Genomics in Cancer Control across the cancer continuum, and further explained the aims of this framework:

> The Framework aims to promote a common understanding of this technology, drive its safe and effective application in practice, foster collaboration and provide future direction for its integration and use within the cancer care system, for personalised, equitable cancer care, experiences and outcomes for all Australians.[133]

Genomic testing for preventive screening

2.112 Associate Professor Paul Lacaze outlined that there is a 'paradigm shift' happening in genomics, with growing potential to use genomic testing for cancer prevention:

> We want to live in a society where people can engage proactively in their health and in prevention to prevent cancer from happening in the first place. We've got a huge opportunity to be able to do that with genomics, and so we need to pave the way for the population to be able to engage in that kind of proactive health behaviour and realise the benefits of genomics.[134]

2.113 However, Professor Lacaze also flagged that strict testing criteria is preventing this from occurring. He told the committee that it is very difficult to get access to genetic testing 'if you don't have a very strong family history or a prior cancer diagnosis or both'. He noted that many people are missing out on such testing or are not even aware it may be available to them in the first place.[135]

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131 Bayer Australia, *Submission 42*, p. 4.

132 Caitlin, Private capacity, *Committee Hansard*, 1 February 2024, p. 37.

133 Cancer Australia, *Submission 43*, p. 14.

134 Professor Paul Lacaze, Head of Public Health Genomics, School of Public Health and Preventive Medicine, Monash University, *Committee Hansard*, 1 February 2024, p. 23.

135 Professor Paul Lacaze, Head of Public Health Genomics, School of Public Health and Preventive Medicine, Monash University, *Committee Hansard*, 1 February 2024, p. 24.

2.114 Australian Genomics also confirmed that predictive tests are only available to those who meet stringent inclusion criteria.[136]

2.115 Professor Lacaze outlined that a large pilot study, 'DNA Screen', is underway, which offers population-based testing to young people for cancer risk regardless of their family history, with most participants having never had cancer before. He explained that the study is:

- identifying people who carry very high-risk genetic variants;
- intervening to help them prevent cancer from happening; and
- notifying participants' family members who may also be at risk, if they want to know.[137]

2.116 Both Professor Lacaze and Australian Genomics noted the high level of interest and engagement with the study.[138] Professor Lacaze explained that the study's sample of 10 000 people between 18 and 40 across all Australian states and rural areas, has evidenced 'huge public interest and appetite to engage in this kind of preventative genetic testing for cancer risk and for other types of risk'.[139]

2.117 He noted that many people want to get access to such testing but can't because of 'the current system' and due to 'very strict criteria' surrounding genetic testing.[140]

2.118 Genomics Australia further explained that the program is 'determining feasibility, scalability, and public acceptance of the program to ultimately work towards a population screening program for Australia'.[141]

2.119 WA Health also outlined the DNA Screen program and suggested that widening population-based screening programs such as this, could help identify more at-risk individuals and improve outcomes from a public health genomics perspective.[142]

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136 Professor Paul Lacaze, Head of Public Health Genomics, School of Public Health and Preventive Medicine, Monash University, *Committee Hansard,* 1 February 2024, p. 24; Australian Genomics, *Submission 10,* [p. 4].

137 Professor Paul Lacaze, Head of Public Health Genomics, School of Public Health and Preventive Medicine, Monash University, *Committee Hansard,* 1 February 2024, p. 24.

138 Professor Paul Lacaze, Head of Public Health Genomics, School of Public Health and Preventive Medicine, Monash University, *Committee Hansard,* 1 February 2024, p. 24; Australian Genomics, *Submission 10,* [p. 4].

139 Professor Paul Lacaze, Head of Public Health Genomics, School of Public Health and Preventive Medicine, Monash University, *Committee Hansard,* 1 February 2024, p. 24.

140 Professor Paul Lacaze, Head of Public Health Genomics, School of Public Health and Preventive Medicine, Monash University, *Committee Hansard,* 1 February 2024, p. 24.

141 Australian Genomics, *Submission 10,* [p. 4].

142 WA Health, *Submission 11*, p. 2.

Committee view

2.120 The committee heard overwhelming evidence about the importance of early and accurate diagnosis when it comes to rare and less common cancers. The committee notes the difficult diagnostic journeys that too many patients with rare and less common cancers have, including multiple costly, invasive, and unnecessary investigations, and the added anxiety that mis- and delayed diagnoses can cause during an already stressful time for patients and their families.

2.121 The committee understands that early detection is critical, not only to enable improved prognoses, survival rates, and quality of life for patients, but it also reemphasises evidence highlighted by multiple inquiry participants that earlier diagnoses can also deliver savings for patients, and reduce the burden on the Australian healthcare system, and taxpayer more broadly.

2.122 It is for these reasons the committee considers it essential that the Australian Government prioritises investment and reforms that remove and reduce existing barriers to swift and accurate diagnoses of rare and less common cancers.

Point-of-care information and improved referral pathways

2.123 GPs are often the first point-of-contact that rare and less common cancer patients have with the health system when symptoms arise. The committee recognises the key role that GPs play in initiating diagnostic investigations and referrals and acknowledges the extremely difficult job that GPs have at this point in a rare cancer patient's journey.

2.124 Noting this, and the existing, well-established challenges of the GP workforce, the committee accepts that it would be impractical to require extra training or education for GPs on all rare and less common cancers. Rather, the committee considers that ensuring GPs have access to accurate and up to date point-of-care information regarding rare cancers, is vital.

2.125 The committee notes that existing clinical guidelines such as HealthPathways and Optimal Care Pathways are used across the country, which provide practitioners with point-of-care, best-practice guidance for the assessment, diagnosis and referral pathways for many conditions, including cancers. However, the committee was concerned to hear that such resources are not available for most rare and less common cancers.

2.126 The committee is of the view that GPs should have access to easily accessible clinical information and local pathways for rare and less common cancers at the point-of-care. This will help enable more swift and accurate diagnoses, as well as improve patient experiences in the early stages of their cancer journey.

2.127 The committee considers that the Government should engage with key non-government stakeholders to ensure these resources are made available.

Recommendation 1

2.128 The committee recommends that the Australian Government further develop clinical guidelines and local pathways for rare and less common cancers and ensure that they are accessible and available for general practitioners at the point-of-care.

2.129 Inquiry participants also highlighted how important prompt referrals are during the diagnostic phase of a patient's journey. The committee notes the success of the UK's two-week urgent referral system for suspected cancer, which also aims for overall diagnostics, a management plan and treatment (when required) to occur within 16 weeks.

2.130 The committee sees merit in further scoping and research to determine the feasibility of this model in the Australian context, to further enable earlier diagnoses for all cancers, including rare and less common cancers.

Recommendation 2

2.131 The committee recommends that the Department of Health and Aged Care investigate the feasibility of a two-week urgent referral system for suspected cancer, such as the model offered in the United Kingdom.

Diagnostic services

2.132 The committee was concerned to hear that cost is presenting a barrier to certain diagnostic tests and services for patients and their families. Further, it was particularly concerned that this can result in practitioners being reluctant to refer patients for scans that aren't reimbursed under Medicare, which can delay diagnoses and interfere with optimal cancer care.

2.133 The committee believes that the Australian Government should review these settings, to ensure that all patients with suspected cancer can receive prompt, appropriate and affordable diagnostic testing.

Recommendation 3

2.134 The committee recommends that the Australian Government undertake a review of Medicare reimbursement settings for diagnostic tests and services, with a view of ensuring patients with, or with suspected rare or less common cancer, receive prompt, appropriate and affordable diagnostic testing.

2.135 The committee also heard more specific evidence around issues regarding the accessibility of both MRI and PET/CT services. Regarding MRI services, the committee was concerned to hear that the availability and access to cancer detecting technology such as MRI can be more restrictive in Australia, than in our OECD counterparts. The committee also notes that that despite Australia having the highest number of MRI machines in the OECD, it has the lowest number of MRI examinations per 1000 people.

2.136 The committee understands that limited and inflexible Medicare items for MRI, as well as the maldistribution of MRI machines and services across the country, continues to hinder equitable access to appropriate radiology in several ways, including variable access for patients based on socioeconomic area and rurality, and patients being referred for less appropriate examinations.

2.137 Similarly, the committee heard that a lack of infrastructure, restrictive access to, and inequitable funding for PET and CT investigations continues to hinder ongoing clinical improvements, and results in high out-of-pocket costs for patients accessing the scans that they need.

2.138 The committee was alarmed to hear that discrepancies exist in eligibility for Medicare reimbursements for PET scans based on cancer type – where patients with certain types of cancers are eligible for reimbursements, whilst others with different forms of cancer, are not.

2.139 The committee also holds concerns about the inequitable distribution of PET/CT machinery across the country, which was highlighted in particular by inquiry participants who appeared at the committee's hearing in Adelaide.

2.140 The committee also agrees that Medicare items for PET diagnosis and restaging of rare cancers should be reviewed as a matter of priority.

Recommendation 4

2.141 The committee recommends that the Australian Government enable increased reimbursements for MRI, PET and CT services throughout the diagnosis, surveillance and restaging of rare cancers.

Recommendation 5

2.142 The committee recommends that the Australian Government, in partnership with state and territory governments, undertake a review of the distribution and availability of MRI, PET and CT services and infrastructure across jurisdictions, with a view of ensuring more equitable access to these services going forward.

Genomic testing and screening

2.143 The committee understands the importance of screening in improving cancer outcomes, in that it helps to detect cancers early, at an asymptomatic stage, when treatment is more likely to be effective.

2.144 The committee received a substantive amount of evidence advocating for greater access to, and investment in genomic testing and screening. The committee agrees that further investment and reforms in this area have the potential to provide significant benefits for all cancer patients, particularly those with rarer forms.

2.145 The committee holds concerns that the current regulatory environment permits life insurers to use genomic test results when underwriting life insurance contracts, which can result in denials of cover, or increased premiums for life insurance and some other insurance products.

2.146 Whilst an industry self-regulated, partial moratorium on these practices has been in place since 2019, the committee received compelling evidence that this moratorium has not provided sufficient assurance to patients and their families, who continue to refuse genomic testing in fear of the implications for their, or their children's future life insurance.

2.147 The committee also notes that Australia lags behind several jurisdictions internationally, who have already adopted bans and regulatory responses to prohibit this practice. It also notes that a comprehensive review to investigate solutions to these matters has already occurred, with Monash University's led A-GLIMMER Project concluding that the Australian Government must legislate a complete ban on insurers using genetic test results to discriminate between applicants for risk-rated insurance.

2.148 The committee notes that the Department of the Treasury is currently consulting on and considering policy solutions for this issue, however the committee firmly believes sufficient work has already been undertaken to confirm that the Australian Government must legislate a complete ban on this practice.

Recommendation 6

2.149 The committee recommends that, as a matter of priority, the Australian Government legislate a complete ban on genetic discrimination in life insurance.

2.150 The committee also understands that out-of-pocket costs for genomic screening and profiling is limiting uptake for Australian patients, and also creating inequitable access across the country.

2.151 Again, the committee draws on international comparisons, and notes that patients in England facing a cancer diagnosis have access to reimbursement for comprehensive cancer genomic profiling through the National Health Service, and that other jurisdictions including France, Germany, Denmark, Belgium and Korea have more advance levels of access to genomic testing for patients.

2.152 Given the significant benefits that genomic testing and screening can offer patients, the committee believes that the Commonwealth should consider the potential of further developing genomic testing and screening for Australian patients.

Recommendation 7

2.153 The committee recommends that the Australian Government investigate opportunities to increase equitable uptake and access to genomic screening and profiling for Australians.

2.154 The committee also heard about the potential of using genomic testing for preventive purposes, to allow people to engage proactively with their health and prevent cancer from occurring in the first place.

2.155 The committee notes the high level of public interest and engagement in the 'DNA Screen' study, which is determining the feasibility, scalability and public acceptance of this type of population-based screening in Australia.

2.156 The committee is encouraged by the possibility of such a population-wide genomic screening program in Australia, and the vast public health benefits this could deliver, particularly for those with rare and less common cancer. The committee considers that the outcomes of the study should be monitored closely, and that further investment to gauge the effectiveness and appropriateness of such screening programs should be explored further.

Recommendation 8

2.157 The committee recommends that the Australian Government closely monitor the outcomes of the DNA Screen study, and the implications of the study for the future development of population wide, preventive genomic screening programs.

Chapter 3
Treatment and clinical trials

> You don't have to look far to see that the healthcare system discriminates against rare cancer patients … We are often not candidates for many clinical trials or the PBS listed drugs which could prolong life … This inequity in access to genetic testing and PBS listed medicines and trials is not just unfair but also grossly unethical, in my mind.[1]

Introduction

3.1 Inequitable access to medicines and clinical trials are two of the major barriers to treatment for people with rare and less common cancers, including neuroendocrine cancers, in Australia. This chapter examines Australia's current and emerging cancer treatments, Australia's policies on subsidising medicines, and patient access to clinical trials.

3.2 Firstly, this chapter examines Australia's shifting landscape from a traditional, one-size-fits-all approach to cancer treatment, to personalised forms of medicines and treatment that are guided by genomic screening and precision oncology.

3.3 The chapter then explores Australia's Health Technology Assessment (HTA) processes, which regulate what medicines are subsidised under the Pharmaceutical Benefits Scheme (PBS). It also outlines the current and past reviews of HTA processes to improve patient access to treatments and considers issues relating to indication coverage of medicines and challenges with reimbursement for specific cohorts.

3.4 Finally, the chapter examines clinical trials in Australia and discusses the barriers that patients often encounter when attempting to receive treatment through these trials. It then explores existing initiatives that are designed to improve patient access to clinical trials.

3.5 The chapter concludes with the committee's view and recommendations to improve treatment outcomes for patients with rare and less common cancer.

Treatment

3.6 Queensland Health explained that typically, there are three main types of cancer treatment that are available to patients in Australia. These treatments can be used in conjunction with one another to treat a patient's cancer:

- Surgery:
  - Removes the tumour or repairs part of the body impacted by cancer.

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1 Caitlin, Private Capacity, *Committee Hansard*, 1 February 2024, p. 36.

- Radiation therapy/radiotherapy:
  - A localised, controlled dose of radiation that that kills or damages cancer cells so that they cannot grow, spread or multiply.
- Chemotherapy:
  - Uses cytotoxic (toxic to cells)[2] drugs to stop or slow cancer cells that are dividing rapidly. Chemotherapy can also impact non-cancer cells, causing serious side effects.[3]

3.7 In their submission, Queensland Health also indicated that there are other drug therapies available to patients, including targeted therapy, hormone therapy and immunotherapy. However, it noted that these treatments may not work for every person who has been diagnosed with cancer.[4]

3.8 Many submitters indicated that cancer care is usually delivered in metropolitan centres, which can force patients who live outside these areas to travel to receive treatment.[5] The geographic barriers that patients experience and existing schemes that are designed to assist patients to receive care are also discussed further in Chapter 5 of this report.

3.9 Omico, a national not-for-profit organisation focussed on delivering precision oncology to Australian cancer patients, and Roche, a pharmaceutical and biotechnology company, submitted that the typical treatments (surgery, radiotherapy and chemotherapy) are usually used as a one-size-fits-all approach.[6] Roche elaborated that cancer medicines were historically developed to treat large patient populations, and as a result, most treatments have been developed to treat a cancer type that has developed within a specific organ or tissue, for example breast cancer.[7]

3.10 Relatedly, Omico explained patients with the same type and stage of cancer are receiving similar treatments, and as a result, patients 'can experience debilitating side effects that can limit the treatment journey.'[8]

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2 Cancer Council, *Understanding Chemotherapy: A guide for people with cancer, their families and friends*, May 2002, p. 9.

3 Queensland Health, *Submission 12,* p. 5.

4 Queensland Health, *Submission 12,* pp. 4–5.

5 See, for example, Rare Cancers Australia, *Submission 3,* [p. 7]; Roche, *Submission 9,* p. 18; WA Health, *Submission 11,* [p. 1]; Queensland Health, *Submission 12,* pp. 3–4; The Society of Hospital Pharmacists of Australia, *Submission 17,* [p. 4]; Melanoma Patients Australia, *Submission 22,* p. 3.

6 Omico, *Submission 44,* p. 2; Roche, *Submission 9,* p. 8.

7 Roche, *Submission 9,* p. 8.

8 Omico, *Submission 44,* p. 2.

3.11 Inquiry participants also told the committee about the negative side effects that they, or their loved ones, have experienced from traditional cancer treatments.[9] For instance, Michelle told the committee of her life partner's, Mark, battle with stage 4 pancreatic cancer, and the severe chemotherapy side effects he suffered:

> We were only offered standard of care (one of 2 available chemotherapy regimes) – both of which were completely brutal and apparently unsustainable. It soon became obvious that if the cancer didn't kill him, the chemotherapy would. The landslide of side effects that come with such intense therapy, also come with a barrage of medications.[10]

3.12 Similarly, Emily, who was diagnosed with a rare cancer known as NUT Midline Carcinoma at age 27, detailed her own experiences receiving traditional cancer treatments. Emily originally received chemotherapy and radiotherapy, with concurrent immunotherapy, then switched to targeted treatments.[11] Emily told the committee that the chemotherapy and radiotherapy resulted in:

> … permanent vision loss, permanent damage to my pituitary gland (resulting in ongoing hormone imbalances), infertility, post traumatic stress disorder, as well as a medically induced opioid addiction. It could be argued that, if access to targeted treatment was allowed at an earlier point in my treatment, that my condition would not have deteriorated as far as it has. In addition, a number of the side effects previously mentioned, as well as those experienced during chemotherapy and radiotherapy, could well have been avoided.[12]

A shifting treatment landscape

3.13 Pharmaceutical company Bayer Australia identified a shifting cancer treatment paradigm, in which treatment is moving away from the one-size-fits-all approach, towards precision oncology.[13]

3.14 Omico submitted that precision oncology and therapies are sometimes called 'next-generation treatments' and commented that 'cancer patients can now be treated based on the genetics of their disease, rather than where in the body the cancer has occurred.'[14]

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9 See, for example, NeuroEndocrine Cancer Australia, *Submission 38,* Attachment 5, 'Bryce's story,' p. 2; Michelle, *Submission 62,* [p. 1]; Emily, *Submission 64,* [pp. 1–2]; Jenaya, *Submission 115,* p. 3; Katherine, Private capacity, *Committee Hansard,* 1 February 2024, p. 32; Kristina, Private capacity, *Committee Hansard,* 1 February 2024, p. 36.

10 Michelle, *Submission 62,* [p. 1].

11 Emily, *Submission 64,* [pp. 1–2].

12 Emily, *Submission 64,* [p. 3].

13 Bayer Australia, *Submission 42,* p. 2.

14 Omico, *Submission 44,* p. 4.

3.15 Chief Executive Officer of Rare Cancers Australia, Ms Christine Cockburn, echoed similar sentiments when she explained the concept and advantages of precision oncology:

> Lung cancer, at some point, was regarded as a single cancer or as a single disease … Now we're starting to lean toward a more precise understanding, which is where the word 'precision' comes from, and now we understand lung cancer is 30 different diseases … what we can understand is what the fingerprint of each of the cancers is, and we end up with a target, or a biomarker, that we can target to treat the cancer. So what we're looking at is each individual's fingerprint of their cancer and what really will effectively treat that cancer. That concept is precision, or personalised, medicine.[15]

Accessibility of genomic testing and precision oncology

3.16 Roche explained that genomic testing is an essential component of precision oncology, as it identifies the specific molecular abnormalities that drive a patient's tumour. Once abnormalities are identified, precision medicines can be matched to the patient to specifically inhibit what is causing the tumour to grow.[16]

3.17 Cancer Council Australia highlighted that a comprehensive profile of a patient's tumour at the DNA level can result in greater diagnostic accuracy, targeted treatment options, and improved patient outcomes.[17]

3.18 However, Australian Genomics raised that a barrier preceding the selection of appropriate precision treatment is getting a molecular test in the first place, because if a person with cancer can get a test, 'they have the chance to be matched to an existing or novel therapy'.[18]

3.19 Relatedly, inquiry participants have detailed that genetic testing and screening can be costly, thus acting as a barrier to accessible treatment.[19] For example, Jon raised that genetic screening is not covered by the PBS and costs more than $5000. He also told the committee that genetic screening is often required more than once as his type of lung cancer, ALK+, frequently mutates. Jon raised

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15 Ms Christine Cockburn, Chief Executive Officer, Rare Cancers Australia, *Committee Hansard,* 31 January 2024, p. 3.

16 Roche, *Submission 9,* pp. 8–9.

17 Cancer Council Australia, the Cancer Nurses Society of Australia, the Clinical Oncology Society of Australia, Private Cancer Physicians of Australia, the Medical Oncology Group of Australia and the Lung Foundation Australia, *Submission 4,* p. 8.

18 Australian Genomics, *Submission 10,* [p. 8].

19 See, for example, Leukaemia Foundation, *Submission 39*, p. 8. Citations omitted; Jon, *Submission 67,* [p. 1]; Judi, Private capacity, *Committee Hansard,* 20 February 2024, p. 28.

concerns that 'this is existing technology which has significant life extending benefits and may be out of reach of many patients.'[20]

3.20 Judi, who has been diagnosed with pancreatic cancer, expressed similar concerns when she told the committee that she could not afford a $6000 fee to have a genetic test that would have told her:

> … what drugs would have killed that cancer and what drugs I could have taken in lesser quantities that wouldn't then have ravished my body, ravished my brain, ravished what's left of the organs that they didn't remove.[21]

3.21 Associate Professor Christopher Steer, President of Private Cancer Physicians of Australia reinforced concerns around the lack of government funding to provide wider access to genomics for more Australians:

> It's an unfair irony that the arrival of genomics or precision medicine is the first real opportunity to close the gap of patient disadvantage. However, without government funding or regulatory reform, genomics will also remain out of reach for those who need it most.[22]

Existing genomic screening programs

3.22 The Department of Health and Aged Care (the department) drew the committee's attention to two major genetic screening programs that the government has provided funding to: the Childhood Cancer National Precision Medicine Program (ZERO Childhood Cancer program or the ZERO program), and Omico's Precision Oncology Screening Platform Enabling Clinical Trials program (PrOSPeCT).[23]

ZERO Childhood Cancer program

3.23 The Children's Cancer Institute and the Kids Cancer Centre at Sydney Children's Hospital Randwick developed the ZERO program – the largest research initiative for children's cancer in Australia and one of the most advanced precision medicine programs globally.[24]

3.24 The Children's Cancer Institute told the committee that they have delivered their program to children with aggressive, high-risk, relapsed or rare cancers

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20 Jon, *Submission 67,* [p. 1].

21 Judi, Private capacity, *Committee Hansard,* 20 February 2024, p. 28.

22 Associate Professor Christopher Steer, President, Private Cancer Physicians of Australia, *Committee Hansard*, 31 January 2024, p. 24.

23 Department of Health and Aged Care, *Submission 1,* p. 7.

24 Children's Cancer Institute, *Submission 6,* [p. 1].

since 2017, by providing them with genomic testing and recommended personalised treatment options.[25]

3.25 Associate Professor Vanessa Tyrrell, Program Director of ZERO at the Children's Cancer Institute, explained that of the first 250 children that participated in the program, the molecular basis of cancer in more than 90 per cent of cases was identified, and a precision guided treatment recommendation was made 70 per cent of the time.[26]

3.26 Associate Professor Antoinette Anazodo, a paediatric and adolescent oncologist, provided the committee with an example of the impact that the ZERO program has had on children with cancer and their families:

> An example that I am able to share, with the family's permission, is a child with a liver tumour that I have been looking after. Liver tumours are very rare anyway, but this liver tumour had some features of an adult tumour and some features of a paediatric tumour. It's been sequenced on ZERO and we know it's a more aggressive tumour. We would never have had that new data earlier. But now, last week, we had a conference with the surgeons. Rather than having an upfront resection, this child will have a liver transplant. That's important because we know, based on the data, that this patient has a more aggressive tumour and has no molecular targets, so we know that the chance of cure is going to be based on the surgery that can be done upfront. It's information like this, upfront, that is really having a significant impact on what we as clinicians can offer.[27]

3.27 While the ZERO program received $61.3 million in funding via the Medical Research Future Fund (MRFF),[28] the Children's Cancer Institute drew to the committee's attention that funding is only guaranteed until June 2025.[29]

Precision Oncology Screening Platform Enabling Clinical Trials (PrOSPeCT) program

3.28 Omico launched the PrOSPeCT initiative with the intention of using genomics to save or extend the lives of Australians who have incurable or advanced cancers, including rare cancers.[30]

3.29 PrOSPeCT builds on Omico's Molecular Screen and Therapeutics (MoST) program – which focusses on specific populations with rare and uncommon

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25 Children's Cancer Institute, *Submission 6*, [p. 1].

26 Associate Professor Vanessa Tyrrell, Program Director, ZERO Childhood Cancer Program, Children's Cancer Research Institute, *Committee Hansard*, 1 March 2024, p. 1.

27 Associate Professor Antoinette Anazodo, Paediatric and Adolescent Oncologist, Sydney Children's Hospital Network, *Committee Hansard*, 31 January 2024, p. 50.

28 Department of Health and Aged Care, *Submission 1*, p. 7.

29 Children's Cancer Institute, *Submission 6*, [p. 2].

30 Omico, *Submission 44*, p. 1 and p. 7.

cancers, or unmet need. The MoST program provides patients with genomic screening and then depending on eligibility, matches them with a clinical trial or other targeted therapy.[31]

3.30 Omico told the committee that it will provide 23 000 Australian patients with free access to genomic profiling and a clinical assessment of their results. Omico will also match patients to advanced precision treatments, including through linking patients to clinical trials.[32]

3.31 In its submission, Omico detailed that it received funding from both private and public funds, with the government providing $61.2 million in funding. The organisation anticipates that the PrOSPeCT program will lead to a $525 million investment in local clinical trials and $135 million in savings to the health system by providing access to innovative therapies via clinical trials.[33]

3.32 Many submitters called for an increase in genomic testing for cancer patients due to the positive treatment outcomes that it can generate.[34]

Access to medicines

3.33 The Minderoo Foundation told the committee that whilst exploring targeted therapies based on genomic abnormalities is key, it is equally important to create pathways that make it easier to access drugs and repurpose drugs, to ensure patients can receive the treatments for their unique genetic makeup.[35]

3.34 Similarly, speaking on precision oncology and childhood cancers, Professor Matthew Dun, Founder and Director of RUN DIPG and Professor of Paediatric Haematology/Oncology Research at the University of Newcastle, commented that:

> drug access remains the largest challenge in the realisation of the full potential of precision medicine, and it is here that we see the largest inequities affecting the health outcomes of our Australian children with this disease.[36]

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31 Omico, *Submission 44,* pp. 6 and 7.

32 Omico, *Submission 44,* p. 7.

33 Omico, *Submission 44,* pp. 7 and 8.

34 See, for example, Rare Cancers Australia, *Submission 3,* [p. 10]; Children's Cancer Institute, *Submission 6,* [p. 2]; Australian Genomics, *Submission 10,* [p. 12]; Minderoo Foundation, *Submission 23,* p. 3; Leukaemia Foundation, *Submission 39,* p. 4; AstraZeneca, *Submission 41,* p. 2; Bayer Australia, *Submission 42,* p. 4; Omico, *Submission 44,* p. 11; Caitlin, *Submission 111,* [p. 2].

35 Minderoo Foundation, *Submission 23,* p. 4.

36 Professor Matthew Dun, Professor of Paediatric Haematology and Oncology Research, Founder and Director of RUN DIPG, *Committee Hansard,* 31 January 2024, p. 45.

Australia's Health Technology Assessment (HTA) processes

3.35 Many submitters highlighted that Australia's current Health Technology Assessment (HTA) processes, which inform whether a medicine will be listed on the PBS, are a major barrier to ensuring that patients can access subsidised treatments in a timely manner.[37]

3.36 Rare Cancers Australia explained that Australia, like many other countries, uses HTA processes to inform decisions about what health technologies can be sold in Australia, and which will be subsidised by the government.[38] It elaborated that:

> HTA provides a pathway to achieving subsidised access to a new medical technology, but it is a time-consuming process. For cancer treatments, the time between submission to the [Therapeutic Goods Administration] for regulatory approval, which makes a drug available to people in Australia, and PBS listing, which makes it subsidised by the public healthcare system, may be long, and some medicines may take several attempts to achieve a successful listing.[39]

3.37 Medicines Australia, a representative body for research-based pharmaceutical companies, drew the committee's attention to the timeframe between regulatory approval and subsidisation of innovative medicines in comparative countries. In Australia, the delay is 466 days across all medicines, compared to Japan where it takes 102 days, 136 days in Germany, and 156 days in the United Kingdom. However, Medicines Australia also pointed out that for medicines that treat rare diseases, including rare cancers, this timeframe is two to four years longer in Australia than in other comparable countries.[40]

3.38 Drawing on the findings of the House of Representatives Standing Committee on Health, Aged Care and Sport's 'The New Frontier Report', Ipsen explained that Australia's HTA processes are designed primarily for more common diseases.[41]

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37 See, for example, Medicines Australia, *Submission 8,* [pp. 2–3]; Roche, *Submission 9,* p. 4; Australian Genomics, *Submission 10,* [p. 9]; Minderoo Foundation, *Submission 23,* [p. 2]; Ipsen, *Submission 30,* [p. 2]; Leukaemia Foundation, *Submission 39,* p. 12; AstraZeneca, *Submission 41,* p. 3; Bristol Myers Squibb Australia, *Submission 46,* [pp. 2 and 3]; IQVIA Australia, *Submission 49,* pp. 1 and 2; Professor John R Zalcberg AO, *Submission 50,* [p. 1]; MSD Australia, *Submission 53,* [p. 1].

38 Rare Cancers Australia, *Submission 3,* [p. 4].

39 Rare Cancers Australia, *Submission 3,* [p. 5].

40 Medicines Australia, *Submission 8,* [p. 4].

41 Ipsen, *Submission 30,* [p. 2].

3.39 Bristol Myers Squibb Australia considered that the lack of evidence for rare cancer treatments, and the challenges of demonstrating cost-effectiveness of those treatments, makes the HTA evaluation processes very challenging.[42]

3.40 Consequently, Bristol Myers Squibb Australia called for the HTA processes to accommodate the limitations and challenges associated with rare cancer treatments when considering whether to list a treatment on the PBS.[43]

3.41 Relatedly, Medicines Australia concluded:

> In some cases, Australian patients miss out entirely on treatments where other countries have established HTA processes tailored to evaluate treatments for rare diseases, including rare cancers.[44]

3.42 More specifically highlighting these issues, Dr Minmin Li, Fellow of the Royal Australasian College of Physicians, and Associate Professor Kathy Tucker AO, highlighted the impact of Australia's HTA evidentiary barriers on patients with Von Hippel-Lindau disease (VHL). They explained that VHL is a rare syndrome caused by a germline heterozygous mutation in the VHL gene and is associated with a high lifetime risk of multisystem rare tumours. They informed the committee that a treatment exists for VHL patients known as belzutifan, an oral therapy which 'has shown to be highly efficacious'. Belzutifan has been available to patients in the United States since 2021, however, access in Australia is severely limited since it is TGA approved but not listed on the PBS.[45]

3.43 NeuroEndocrine Cancer Australia reported that Australian VHL patients are 'forced into a cost share model of $12 000 AUD per month' and noted that this is a cost that very few Australians can afford.[46] Lana, a submitter who detailed her experiences after being diagnosed with VHL, echoed these sentiments:

> It [belzutifan] is TGA-approved and it is HERE in Australia. But because it is beyond unaffordable, it is therefore inaccessible. Belzutifan shrinks VHL tumours, simple as that. It is the only drug treatment available to those suffering from VHL.

3.44 Lana also noted the delays in PBS funding for belzutifan:

> … the process is agonisingly slow. This is due to the number of affected individuals in the trial being lower (thanks to their disease rarity) than other trials which are conducted against a placebo (proving that the drug works when compared to this). As such, the results from the Belzutifan trial, which would be used to make an application for it to go on the Pharmaceutical

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42 Bristol Myers Squibb Australia, *Submission 46,* [p. 3].

43 Bristol Myers Squibb Australia, *Submission 46,* [p. 3].

44 Medicines Australia, *Submission 8,* [p. 4].

45 Dr Minmin Li FRACP and Associate Professor Kathy Tucker AO FRACP, *Submission 36,* [p. 1].

46 NeuroEndocrine Cancer Australia, *Submission 38,* p. 9.

> Benefits Scheme (PBS), are limited … inappropriate evidence standards are applied to drugs for rare conditions when they shouldn't be.[47]

Findings of the House of Representatives Standing Committee on Health, Aged Care and Sport's 'The New Frontier – Delivery better health for all Australians' report

3.45 When considering approaches to reforming HTA processes, many submitters echoed the recommendations made in the 'New Frontier Report'.[48] For instance, Bristol Myers Squibb Australia reinforced the need for HTA evidentiary requirements for rare and less common cancers to be developed, which would include a greater acceptance of real-world evidence.[49] Additionally, pharmaceutical companies AstraZeneca, Bayer, Telix and Roche highlighted the recommendation of establishing a Centre for Precision Medicine and Rare Diseases within the department,[50] with the view of ensuring that the department's capacity is enhanced to provide Australians with timely access to new medicines and technologies.[51]

Managed Access Program

3.46 Some submitters also highlighted the specific findings in the 'New Frontier Report' regarding Australia's Managed Access Program (MAP).[52] For context, Bristol Myers Squibb Australia explained that the MAP is a mechanism that enables products to be listed on the PBS where there is a special circumstance of high unmet clinical need, or to allow for the resolution of otherwise unacceptable clinical or economic uncertainty.[53]

3.47 However, IQVIA Australia pointed to the findings within the 'New Frontier Report' that the MAP is underutilised.[54] MSD Australia corroborated this

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47 Lana, *Submission 54,* [p. 3].

48 See, for example, Medicines Australia, *Submission 8,* [pp. 2 and 4], Roche, *Submission 9,* pp. 5 and 17; Australian Genomics, *Submission 10,* p. 12; NeuroEndocrine Cancer Australia, *Submission 38,* p. 12; AstraZeneca, *Submission 41,* p. 2; Bayer Australia, *Submission 42,* p. 5; Omico, *Submission 44,* pp. 11–12; Bristol Myers Squibb Australia, *Submission 46,* p. 2; Telix Pharmaceuticals, *Submission 47,* [pp. 3–4]; MSD Australia, *Submission 53,* [p. 2].

49 Bristol Myers Squibb Australia, *Submission 46,* [pp. 3 and 4].

50 Roche, *Submission 9,* p. 5; AstraZeneca, *Submission 41,* p. 2; Bayer, *Submission 42,* p. 5; Telix Pharmaceuticals, *Submission 47,* [p. 7].

51 Roche, *Submission 9,* p. 5.

52 See, for example, NeuroEndocrine Cancer Australia, *Submission 38,* p. 12; Bristol Myers Squibb Australia, *Submission 46,* [p. 4]; IQVIA Australia, *Submission 49,* p. 2.

53 Bristol Myers Squibb Australia, *Submission 46,* [p. 4].

54 IQVIA Australia, *Submission 49,* p. 2.

finding, and raised that from 2010 to 2017, the MAP was used for only 11 drugs and resulted in the implementation of only three drugs.[55]

3.48 Consequently, some submitters recommended increasing the use of the MAP to improve access to treatments.[56] NeuroEndocrine Cancer Australia specifically stated that this avenue could assist patients with VHL to access belzutifan.[57]

3.49 IQVIA Australia suggested that the MAP could be guided by England's Cancer Drugs Fund (CDF) as an example model. The CDF provisionally funds cancer therapies for two years, which allows the sponsor to gather evidence to manage uncertainties and support the routine use of the drug.[58] An example is the funding of a therapy called Yescarta via the CDF:

> Yescarta is one of those therapies that in the UK have been funded through that program. It meant that, from the regulatory submission to patient access, there was only 15 months. In Australia is has been 32 months, so there is a huge difference, and I think that it highlights that there is a huge need for that type of program in Australia.[59]

3.50 AstraZeneca was also supportive of Australia introducing a model similar to the CDF.[60]

HTA Policy and Methods Review

3.51 Submitters drew the committee's attention to the department's HTA Policy and Methods Review (HTA Review), which was due to report on 4 May 2024 but at the time of writing has not yet been published.[61] For instance, Rare Cancers Australia argued that:

> Through the HTA Review, currently underway, we need to seize the opportunity to adapt our HTA system to consider different levels of evidence, as well as novel trial designs, such as basket trials or umbrella trials, that consider multiple targeted therapies across multiple cancers. There is an increasing number of precision oncology therapies that are

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55 MSD Australia, *Submission 53*, [p. 8].

56 See, for example, NeuroEndocrine Cancer Australia, *Submission 38*, p. 12; Bristol Myers Squibb Australia, *Submission 46*, [p. 1]; IQVIA Australia, *Submission 49*, p. 2; MSD Australia, *Submission 53*, [p. 8].

57 NeuroEndocrine Cancer Australia, *Submission 38*, p. 12.

58 IQVIA Australia, *Submission 49*, p. 2.

59 Mr Quentin Bracquart, Head of Payer, Provide and Government Services and Principal Strategic Insights and Analytics, IQVIA, *Committee Hansard*, 31 January 2024, p. 65.

60 AstraZeneca, *Submission 41*, pp. 3–4.

61 Department of Health and Aged Care, *Health Technology Assessment Policy and Methods Review*, 24 April 2024, www.health.gov.au/our-work/health-technology-assessment-policy-and-methods-review (accessed 15 May 2024).

coming to market with phase II data, and as such, a greater reliance on real world evidence for ongoing evaluation is needed.[62]

3.52 Additionally, IQVIA raised that HTA review provides an opportunity to streamline access for rare cancer therapeutics.[63] Similarly, Ms Penny George, Director of Corporate Affairs for AstraZeneca, called for the HTA review to reduce wait times between TGA approval of a treatment and PBS listing to three months.[64]

3.53 Ipsen echoed this sentiment and considered that the committee's inquiry was timely as it coincides with the HTA Review. It expressed hope that the inquiry would lead to a meaningful reduction in wait times.[65]

3.54 MSD Australia was also of the view that the HTA Review provided an opportunity to address delays in the system.[66]

Indication coverage

3.55 Rare Cancers Australia told the committee that once a treatment is subsidised on the PBS, people with rare and less common cancers continue to face challenges in accessing affordable medicines.[67] In Australia, medicines are TGA registered and PBS listed based on specific medical conditions, known as indications. Consequently, a new TGA registration and PBS listing is required for each indication where a cancer medication could be used.[68]

3.56 Rare Cancers Australia also informed the committee that doctors can prescribe medicines for another indication once it has been approved for an original indication. However, Rare Cancers Australia flagged that this can lead to inequitable access, as only a small proportion of people can afford the non-subsidised medicines, which can cost many thousands of dollars.[69]

3.57 In a joint submission, Cancer Council Australia raised that it has previously reported the confusion and frustration that people with cancer experience when

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62 Rare Cancers Australia, *Submission 3*, [p. 5].

63 IQVIA Australia, *Submission 49*, p. 2.

64 Ms Penny George, Director of Corporate Affairs, AstraZeneca, *Committee Hansard*, 31 January 2024, p. 68.

65 Ipsen, *Submission 30*, [p. 2].

66 MSD Australia, *Submission 53*, [p. 3].

67 Rare Cancers Australia, *Submission 3*, [p. 5].

68 Rare Cancers Australia, *Submission 3*, [p. 5].

69 Rare Cancers Australia, *Submission 3*, [p. 5].

they discover that their medication is approved for reimbursement for one purpose, but not for their own condition.[70]

3.58 For example, The Sydney Children's Hospital Network explained that crizontinib, an anaplastic lymphoma kinase (ALK) inhibitor, is TGA registered and subsidised by the PBS to treat high stage ALK-and/or reactive oxygen species-rearranged lung cancer. However, despite its approval for the treatment of other cancers in the United States, the Sydney Children's Hospital Network reported that:

> … in Australia, there is no mechanism for crizotinib to be funded for cancers other than lung cancer, unless the sponsoring pharmaceutical company is willing to reapply to the TGA to extend the registered treatment indications of crizotinib to include other rare cancers.[71]

3.59 Telix Pharmaceuticals and the Children's Cancer Institute suggested that indication coverage could be improved by adjusting regulatory and reimbursement processes for treatments to be registered by molecular indication, as well as by disease indication.[72] This recommendation was also made in the 'New Frontier Report,' supported by evidence in the United States where a treatment was approved for a molecular indication, where the treatment was not listed for a specific type of cancer, such as breast cancer, but instead was listed for every cancer where an NTRK fusion was found.[73]

3.60 Cancer Trials Australia told the committee that clinical trials are the 'only way to improve the evidence base' to help ensure the availability of new, potentially life-prolonging treatments that may 'have an excellent rationale, but not yet be reimbursed for rare cancer indications.'[74]

3.61 TrialHub echoed this sentiment when it told the committee that it remains difficult to achieve PBS reimbursement for rare cancer novel targeted therapies without Phase 3 clinical trials (explored below), which are commonly reimbursed for multiple common cancer indications, as there is a lack of evidence that is 'too difficult' to generate for many rare cancers. It stressed that this needs to change for the 'third of Australians that are dying of a RC [rare cancer]'.[75]

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70 Cancer Council Australia, the Cancer Nurses Society of Australia, the Clinical Oncology Society of Australia, Private Cancer Physicians of Australia, the Medical Oncology Group of Australia and the Lung Foundation Australia, *Submission 4*, p. 11.

71 Sydney Children's Hospital Network, *Submission 14*, p. 10.

72 See, Telix Pharmaceuticals, *Submission 47*, [pp. 3–4]; Children's Cancer Institute, *Submission 6*, [p. 4].

73 House of Representatives Standing Committee on Health, Aged Care and Sport, *The New Frontier – Delivering better health for all Australia*, November 2021, pp. 96–97 and p. 325.

74 Cancer Trials Australia, *Submission 34*, [p. 1].

75 TrialHub, *Submission 37*, p. 2.

Reimbursement challenges

3.62 Submitters drew the committee's attention to other reimbursement challenges that rare and less common cancer patients can encounter on their treatment journey.[76]

Cover for paediatric inpatients

3.63 The Sydney Children's Hospital Network pointed to gaps in patient coverage under the Medicare Benefits Schedule (MBS) and PBS. It explained that the state governments fund inpatient care in public hospitals and that the federal government covers outpatient health care costs via the MBS, and outpatient medications via the PBS.[77]

3.64 The Sydney Children's Hospital Network explained that as a result, patients are not eligible for MBS funding when they are inpatients at public hospitals. Consequently, any tests for inpatients in public hospitals must be paid by the hospital itself, the oncology department, or the patient and their family. It stressed to the committee that almost every child with cancer has their 'diagnostic work-up, including tumour biopsies and treatment' performed whilst they are inpatients at a public hospital.[78]

3.65 Further, the Sydney Children's Hospital Network argued that:

> Whilst the intent of Australian health care funding is to provide equitable access to appropriate tests for all eligible patients, in practice admitted inpatients in public hospitals are disadvantaged …[79]

3.66 Dr Richard Mitchell, the Director of the Kids Cancer Centre, Sydney Children's Hospital Randwick, further stressed that:

> When it comes to paying for treatments, all of the expensive cancer therapies do not fall under the PBS when you're a child stuck in a hospital.[80]

Support for patients who require dental and maxillofacial rehabilitation

3.67 Head and Neck Cancer Australia flagged their concerns with the committee regarding reimbursement for oral and maxillofacial rehabilitation.[81]

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76 See, for example, Sydney Children's Hospital Network, *Submission 14,* pp. 4–5; Head and Neck Cancer Australia, *Submission 19,* p. 4; Michael, Private capacity, *Committee Hansard,* 1 February 2024, pp. 34 and 35.

77 Sydney Children's Hospital Network, *Submission 14,* p. 4.

78 Sydney Children's Hospital Network, *Submission 14,* pp. 4–5.

79 Sydney Children's Hospital Network, *Submission 14,* p. 5.

80 Dr Richard Mitchell, Director, Kids Cancer Centre, Sydney Childrens Hospital Randwick, Sydney Childrens Hospitals Network, *Committee Hansard,* 31 January 2024, p. 46.

81 Head and Neck Cancer Australia, *Submission 19,* p. 4.

3.68 It told the committee that patients with head and neck cancers are offered 'the most complex and involved surgery covered by Medicare' but highlighted there is no affordable route for patients to access dental and maxillofacial rehabilitation afterwards. Head and Neck Cancer Australia also noted that this includes dental implants and facial prosthetics to replace parts of the mouth or face, including the eye, ear, nose or cheek.[82]

3.69 At a public hearing of the inquiry, Ms Nadia Rosin, Chief Executive Officer of Head and Neck Cancer Australia, explained that dental implants could cost anywhere between $20 000 and $30 000, and that a facial prosthetic can cost up to $6000, which also needs to be replaced every few years.[83]

3.70 Relatedly, Michael who was diagnosed with throat cancer and is a member of the support group 'the Larykins,' told the committee of his experience with throat cancer and the resulting dental costs:

> The other downside is that I've now got eight cracked teeth, a crook tendon in the jaw and a broken muscle in the jaw thanks to radiation. So, if you think the first quote to get my 2½ teeth fixed was $13,600, you don't want to know what it is for that amount of work. I'm like, 'What do you do?'—and there's no dental cover.[84]

3.71 Ms Rosin also told the committee that not having access to facial prosthetics after receiving treatment can severely lessen a patient's quality of life:

> We've been told stories of people not leaving the house, avoiding their grandchildren or using a tissue with tape to cover their face when they go out. For some people, wearing a mask during COVID gave a sense of freedom they hadn't experienced since surgery.[85]

Clinical trials

3.72 The committee received overwhelming evidence from submitters on the important role that clinical trials play in providing treatment to people with rare and less common cancers.[86]

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82 Head and Neck Cancer Australia, *Submission 19,* p. 4.

83 Ms Nadia Rosin, Chief Executive Officer, Head and Neck Cancer Australia, *Committee Hansard*, 31 January 2024, p. 12.

84 Michael, Private capacity, *Committee Hansard,* 1 February 2024, pp. 34 and 35.

85 Ms Nadia Rosin, Chief Executive Officer, Head and Neck Cancer Australia, *Committee Hansard*, 31 January 2024, p. 13.

86 See, for example, Rare Cancers Australia, *Submission 3,* [p. 4]; Cancer Council Australia, the Cancer Nurses Society of Australia, the Clinical Oncology Society of Australia, Private Cancer Physicians of Australia, the Medical Oncology Group of Australia and the Lung Foundation Australia, *Submission 4,* pp. 6–7; Medicines Australia, *Submission 8,* [p. 9]; Roche, *Submission 9,* pp. 17–18; Australian Genomics, *Submission 10,* [pp. 8–9]; Minderoo Foundation, *Submission 23,* [p. 1]; Cancer Trials Australia, *Submission 34,* [p. 2]; TrialHub, *Submission 37,* p. 1; Leukaemia Foundation,

3.73 Queensland Health explained that clinical trials are conducted to investigate the safety and efficacy of new cancer treatments and drug combinations, with results being used to identify new treatment options or complement existing treatments.[87]

3.74 Emphasising the importance of clinical trials, Rare Cancers Australia informed the committee that clinical trials have 'become the new standard of care' for many people with rare and less common cancers where they have exhausted other options, or where there are no other effective treatments available.[88]

3.75 Cancer Trials Australia echoed that clinical trials are frequently the only 'viable treatment option' for people with rare and less common cancers but indicated that they are often difficult to initiate and conduct, and to access for patients.[89]

Clinical trial activity in Australia and overseas

3.76 TrialHub informed the committee of the various phases of clinical trials that a treatment must undergo in Australia for it to become standard and widely accessible for use:

- Phase 1: establishes the safety of the treatment;
- Phase 2: evaluates dosing administration, including frequency and some signal of efficacy; and
- Phase 3: involves a larger study which compares the new treatment against the existing treatment standard.[90]

3.77 Pharmaceutical company MSD Australia submitted that compared to more common cancer clinical trials, there are fewer clinical trials for rare and less common cancer treatments due to the difficulty in recruiting sufficient patient numbers to conduct Phase 3, randomised controlled trials.[91] Evidentiary standards and clinical trials are further discussed in Chapter 6.

3.78 TrialHub provided statistics in their submission that compared open clinical trials for all cancers with open rare cancer trials:

Submission 39, p. 27; Bristol Myers Squibb Australia, *Submission 46,* [p. 5]; Cure Our Ovarian Cancer, *Submission 114,* p. 3.

87 Queensland Health, *Submission 12,* p. 5.

88 Rare Cancers Australia, *Submission 3,* [p. 4].

89 Cancer Trials Australia, *Submission 34,* [p. 2].

90 TrialHub, *Submission 37,* p. 2.

91 MSD Australia, *Submission 53,* [p. 1].

Table 3.1 Clinical trial activity in Australia

Cancer Trials Australia – all open trials		**Rare Cancers Australia – open rare cancer trials**	
Phase I	101	**Phase I**	39
Phase I/II	72	**Phase I/II**	29
Phase II	100	**Phase II**	32
Phase II/III	11	**Phase II/III**	3
Phase III	118	**Phase III**	32
Phase IV	6	**Phase IIIb/IV**	2
Other	96	**Other**	33
Total:	504	**Total:**	170

Source: TrialHub, Submission 37, p. 2.

3.79 Some inquiry participants flagged that pharmaceutical companies do not view Australia as an economically attractive destination to conduct research or clinical trials due to Australia's relatively small population.[92] Cancer Council Australia drew on anecdotal evidence to explain that these types of clinical trials 'are not attractive to research sites/sponsors, as they are less financially viable than trials for more common cancers, with larger patient pools to draw from.'[93]

3.80 TrialHub and Cancer Trials Australia pointed out that consequently, rare cancer clinical trials can be difficult to initiate, as funding tends to be based on per-patient enrolments. They explained that for low incidence diseases, it may be insufficient to prioritise trial unit resource allocations over common cancer trials. TrialHub and Cancer Trials Australia advised that this results in higher running costs to the participating unit with lower reimbursement.[94]

3.81 Relatedly, Elsa spoke of her sister, Kristen's, battle with low-grade serous ovarian cancer, and their experience relating to clinical trials:

> We came to understand that clinical trials are typically not funded or resourced for rare-cancers. This is economically understandable, however it felt incredibly unfair that Kristen potentially could have benefited from

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92 See, for example, Roche, *Submission 9,* p. 18; Melanoma Patients Australia, *Submission 22,* p. 6; MSD Australia, *Submission 53,* [p. 2]; Ms Lucy Jones, Chief Executive Officer, Neuroblastoma Australia, *Committee Hansard,* 31 January, p. 18; Associate Professor Vanessa Tyrrell, Program Director, Zero Childhood Cancer Program, Children's Cancer Institute, *Committee Hansard,* 1 March 2024, p. 3.

93 Cancer Council Australia, the Cancer Nurses Society of Australia, the Clinical Oncology Society of Australia, Private Cancer Physicians of Australia, the Medical Oncology Group of Australia and the Lung Foundation Australia, *Submission 4,* p. 9.

94 TrialHub, *Submission 37,* p. 1; Cancer Trials Australia, *Submission 34,* [p. 2].

> these promising new drugs or new drug combinations being tested in cancers that have similar profiles to hers.[95]

3.82 Dr Kurt Lackovic, Chief Executive Officer of Cancer Trials Australia did raise that Australia ranks third in the world, behind the United States and China, for the initiation of phase 1 clinical trials. Dr Lackovic also highlighted that 'later-stage trials are more likely to include Australia if the phase 1 trials are undertaken here.'[96]

3.83 The department advised that the Australian Government has committed $750 million from 2022–23 under the MRFF's Clinical Trials Activity Initiative to increase clinical trial activity in Australia.[97]

Access to international clinical trials

3.84 The committee received evidence from inquiry participants who have had to consider travelling overseas to access clinical trials for themselves or their loved ones. For example, Megan, whose daughter Kira is now in a surveillance phase after being declared NED (No Evidence of Disease) following her neuroblastoma battle,[98] stressed to the committee that:

> The only thing scarier for a Neuroblastoma parent than receiving that initial cancer diagnosis, is the threat of relapse. Relapse for an Australian child with Neuroblastoma is almost certainly a death sentence with no access to curative therapies on home soil. Families are forced to fundraise and/or self-fund travel to access treatment overseas, where clinical trials are more readily available …[99]

3.85 Megan also submitted that there is 'very little hope for neuroblastoma families' that 'meaningful research and clinical trials on home soil will be forthcoming' which 'provides a very bleak view of what the future might hold for our child should she relapse.'[100]

3.86 Additionally, Elnaz, who was diagnosed with a rare type of lung cancer called ALK Positive in her late 30s, told the committee of her own experience relating to treatment and the possibility of overseas travel to access clinical trials:

> Advanced ALK Positive lung cancer usually gets treated with targeted therapy using oral medication. Unfortunately, I have progressed on the two medications available for treatment and have to wait for my oncologist to advise if any clinical trials are available for me. Unfortunately, not so many

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95 Cure Our Ovarian Cancer, *Submission 114,* p. 8.

96 Dr Kurt Lackovic, Chief Executive Officer, Cancer Trials Australia, *Committee Hansard,* 1 February 2024, p. 39.

97 Department of Health and Aged Care, *Submission 1,* p. 15.

98 Megan, *Submission 107,* p. 2.

99 Megan, *Submission 107,* p. 3.

100 Megan, *Submission 107,* p. 3.

> clinical trials are recruiting in Australia, and I may have to travel overseas to save my life.[101]

3.87 The department highlighted that the Australian Government funds the Medical Treatment Overseas Program (MTOP) to 'assist eligible Australians with a life-threatening medical condition to access life-saving medical treatment overseas where treatment is not available in Australia.'[102] However, some submitters informed the committee that the MTOP excludes travel for clinical trials.[103]

3.88 Kristina and Brett, parents of seven-year-old Oscar who has been diagnosed with neuroblastoma, implored the government to provide further funding to assist families like theirs:

> Additionally, we need government support and financial assistance to access overseas clinical trials. Despite what we've been told by our local medical experts, there are cures for relapsed neuroblastoma internationally and there are more treatment options available overseas. So we ask you, why should families be forced to choose between their child's life and selling everything they own to afford treatments abroad? What would you do if it were your child? How can you make a difference today, to help support paediatric cancer patients in the future?[104]

Australian clinical trials - barriers to patient access

3.89 Australian Genomics and Omico told the committee that it is currently estimated that only 8 per cent of all cancer patients in Australia access clinical trials.[105]

3.90 Submitters outlined various barriers that inhibit patient access to Australian clinical trials, as explored below.

Australia's fragmented health system

3.91 Bristol Myers Squibb Australia informed the committee that there is a disparity in accessing clinical trials in Australia, which is exacerbated for patients with rare and less common cancers. Both Medicines Australia and Bristol Myers Squibb Australia raised that one of the main causes of disparity is Australia's federated health system:

> The current landscape of clinical trials in Australia is marked by fragmentation due to a federated system. There is variability in trial

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101 Elnaz, *Submission 133,* [p. 1].

102 Department of Health and Aged Care, *Submission 1,* p. 10.

103 See, for example, Neuroblastoma Australia, *Submission 58,* p. 3; Natalie, *Submission 122,* p. 4; Professor Dorothy Keefe, Chief Executive Officer, Cancer Australia, *Committee Hansard,* 1 March 2024, p. 30.

104 Kristina and Brett, *Submission 92,* p. 3.

105 Australian Genomics, *Submission 10,* [p. 10]; Omico, *Submission 44,* p. 4.

> protocols and regulatory processes between each jurisdiction. [Citation omitted] Rare cancer trials suffer from disparities in access to cutting-edge treatments due to these inconsistencies, leaving patients and researchers struggling to navigate a complex and inefficient system.[106]

3.92 Dr Chloe Georgiou, Chair of the Victorian Rare Cancer, Clinical Trial Alliance, also told the committee about the difficulties that a fragmented health service system presents in terms of clinical trials:

> In Victoria we've got a very fragmented health service system in terms of jurisdiction and oversight. New South Wales has got its seven districts, and Queensland has a statewide system. Victoria has 54 health services, I think, and every single of those would need to go through its own governance process to start a trial.[107]

Navigating information systems and websites

3.93 Rare Cancers Australia submitted that access to clinical trials is often limited due to the high level of health literacy required by patients to identify trials that are relevant to them.[108] Health literacy is more broadly discussed in Chapter 5 of the report.

3.94 Similarly, the VCCC Alliance also identified that clinical trial databases are not well maintained and are often difficult to navigate,[109] and the Pancare Foundation highlighted that there is a limited patient awareness of trials and how to find them, particularly for those who cannot use clinical trial websites.[110]

3.95 This sentiment was echoed by Cancer Trials Australia, who submitted that databases are not easily searchable for rare cancers, as they are often included in subgroups or within tumour agnostic trials. Cancer Trials Australia concluded that for both patients and practitioners, this is a barrier to understanding what clinical trials are available.[111]

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106 Bristol Myers Squibb Australia, *Submission 46,* [p. 5]; Medicines Australia, *Submission 8,* [p. 9].

107 Dr Chloe Georgiou, Chair, Victorian Rare Cancer, Clinical Trial Alliance, TrialHub, Alfred Health, *Committee Hansard,* 1 February 2024, p. 44.

108 Rare Cancers Australia, *Submission 3,* [p. 4].

109 VCCC Alliance, *Submission 24,* [p. 3].

110 Pancare Foundation, *Submission 21,* [p. 9].

111 Cancer Trials Australia, *Submission 34,* [p. 2].

Rural and regional patients

3.96 The committee received evidence that rural and regional patients with rare and less common cancers may encounter additional barriers when attempting to access clinical trials.[112]

3.97 The Leukaemia Foundation submitted that many newer treatments or therapies may only be available through clinical trials, 'which are mostly available at select major metropolitan treatment centres.'[113]

3.98 Some inquiry participants were supportive of teletrials when considering how to overcome geographic barriers to clinical trials.[114] Queensland Health explained that the Australian Teletrial Program, funded by the MRFF, intends to create a network of clinical trials which can enable regional, rural, remote, and Aboriginal and Torres Strait Island communities to access trials closer to home.[115]

3.99 Dr Wei-Sen Lam, Teletrials Medical Lead at the Western Australian Country Health Service, told the committee that:

> You can imagine the patient who is dying from cancer but wants to be close to home or needs to stay in the region because of income and they have to work at home. They often say, 'I can't afford to go to your clinical trial; I can't afford to be away from home.' This program really helps country patients have access closer to home.[116]

3.100 Similarly, the Minderoo Foundation submitted that it believes investment to improve tele-trials would 'support equitable access to clinical trials regardless of geographical location' and that the Australian Teletrial Program will 'improve access to, and participation in, clinical trials for rural, regional and remote Australians.'[117]

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112 See, for example, Rare Cancers Australia, *Submission 3,* [p. 4]; Medicines Australia, *Submission 8,* [p. 9]; Pancare Foundation, *Submission 21,* [p. 9]; Bristol Myers Squibb Australia, *Submission 46,* [p. 5].

113 Leukaemia Foundation, *Submission 39,* p. 11.

114 See, for example, WA Health, *Submission 11,* p. 8; Queensland Health, *Submission 12,* p. 5; Minderoo Foundation, *Submission 23,* p. 3; TrialHub, *Submission 37,* p. 1; Omico, *Submission 44,* p. 10; Dr Kurt Lackovic, Chief Executive Officer, Cancer Trials Australia, *Committee Hansard,* 1 February 2024, p. 39; Ms Kaye Hewson, Director, Australian Teletrial Program, Australian Teletrial Program National Office, Queensland Health, *Committee Hansard,* 1 March 2024, p. 9; Dr Wei-Sen Lam, Medical Lead, Teletrials, WA Country Health Service, *Committee Hansard,* 1 March 2024, p. 12.

115 Queensland Health, *Submission 12,* p. 5.

116 Dr Wei-Sen Lam, Medical Lead, Teletrials, WA Country Health Service, *Committee Hansard,* 1 March 2024, p. 12.

117 See, Minderoo Foundation, *Submission 23,* p. 3; TrialHub, *Submission 37,* p. 3.

3.101 Issues related to regional and rural workforces and their impacts on diagnosis and treatment for patients with rare and less common cancers, including neuroendocrine cancer, are further discussed in Chapter 5.

Funding of paediatric clinical trials

3.102 Some submitters drew the committee's attention to the particular importance of clinical trials for children with cancer.[118] The Children's Cancer Institute explained that enrolment in clinical trials is the standard of care for paediatric cancers due to the lack of medicines available.[119]

3.103 However, Neuroblastoma Australia raised that due to the small patient populations, drug companies have no incentive to invest in clinical trials for children until a treatment has been proven to be safe and effective in treating adults. Neuroblastoma Australia raised that this is a significant problem, as neuroblastoma 'almost never affects adults.'[120]

3.104 Similarly, the Children's Cancer Institute raised that this is particularly challenging, as there is 'a lack of industry support' to supply drugs or establish clinical trials, meaning that paediatric clinical trials largely rely on philanthropic or government funding.[121] The Sydney Children's Hospital Network echoed that:

> … funding mechanisms for children's cancer clinical trials units is highly variable across Australia with many cancer clinical trials units relying on philanthropic funding to fund staff positions. Unlike adult oncology services, the majority of clinical trials that are conducted for children with cancer are investigator-initiated trials sponsored by large international academic trials consortia such as the Children's Oncology Group (COG) and the International Society for Paediatric Oncology (SIOP).[122]

3.105 Angie and Tamer, parents of Eve,[123] Beau and Terry, parents of Ryley,[124] and Alan and Truc, parents of Madeline,[125] all told the committee of their children's battles with Diffuse Intrinsic Pontine Glioma (DIPG). When discussing clinical trials for DIPG in Australia, all three sets of parents highlighted that since 2018:

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118 See, for example, Children's Cancer Institute, *Submission 6,* [p. 4]; Sydney Children's Hospital Network, *Submission 14,* pp. 7–8; The Society of Hospital Pharmacists of Australia, *Submission 17,* [p. 5].

119 Children's Cancer Institute, *Submission 6,* [p. 4].

120 Neuroblastoma Australia, *Submission 58,* [p. 3].

121 Children's Cancer Institute, *Submission 6,* [p. 4].

122 Sydney Children's Hospital Network, *Submission 14,* p. 8.

123 Angie, *Submission 76,* [p. 1].

124 Beau, *Submission 93,* [p. 1].

125 Alan, *Submission 137,* [p. 1].

> only three new [DIPG] clinical trials have opened in Australia (which have all only been in the last 12 months). The United States and Europe have a significant number of available clinical trials to give families some hope and yet once again bureaucratic red tape prevents Australian families from applying and accessing these medications and trials. When a clinical trial is available in Australia, positions are limited, and patients may not be able to access the trial. Biopsies are prerequisites for families to access a position on a clinical trial for their child. However, due to the diffuse intrinsic nature of a DIPG tumour, a biopsy is often not feasible or safe for children to partake in thus, forcing families to relinquish positions in a clinical trial.[126]

3.106 Angie and Tamer also indicated that there is no centralised hub for DIPG families and medical staff, making it difficult for parents to access current and reliable information on developments, treatment options, and clinical trials. They raised that as a result, 'parents of children with DIPG are placed in the distressing position of having to shoulder the burden of finding relevant clinical trials.'[127]

Existing initiatives to improve access to clinical trials

3.107 Submitters drew the committee's attention to various initiatives that could enhance clinical trial activity in Australia for patients with rare and less common cancer. These are explored below.

Omico's PrOSPeCT program

3.108 In addition to providing Australians with access to genomic profiling, as discussed earlier in this chapter, Omico illuminated that the PrOSPeCT program will also generate an estimated $52 million investment in local clinical trials.[128]

3.109 Further, Omico outlined that the program will facilitate the completion of clinical trials for both adults and children with cancer, which they stated is a 'massive drawcard for new international investment in the Australian medical research sector.'[129]

3.110 Some submitters were supportive of the program. For instance, the Children's Cancer Institute noted:

> This initiative intends to attract pharma and biotech companies to our shores to undertake clinical trials, and therefore increase early access to new medicines for cancer patients …[130]

3.111 Roche echoed these sentiments and told the committee that it believes programs like PrOSPeCT are vitally important in raising Australia's profile as an attractive

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126 Angie, *Submission 76,* [p. 2]; Beau, *Submission 93,* [p. 2]; Alan, *Submission 137,* [p. 2].

127 Angie, *Submission 76,* [p. 3].

128 Omico, *Submission 44,* p. 8.

129 Omico, *Submission 44,* p. 8.

130 Children's Cancer Institute, *Submission 6,* [p. 4].

destination for clinical trials. They explained that ensuring Australia has the infrastructure to link genomic analysis to clinical trial therapies 'increases international confidence that Australia can make significant patient recruitment contributions and deliver on these trials.'[131]

Clinical Trials Activity initiative

3.112 As discussed earlier in this chapter, the government has committed $750 million over 10 years from 2022–23 to increase clinical trial activity in Australia under the Clinical Trials Activity initiative. The department submitted that this initiative would improve the evidence base that supports clinical care and help patients access relevant treatment, while also enabling researchers to bring international trials to Australia.[132] The department outlined that the MRFF has invested $25.53 million in 14 grants with a research focus on rare cancer under the initiative.[133]

3.113 Some submitters were supportive of the Clinical Trials Activity initiative.[134] Yet, the Cancer Council Australia raised concerns regarding the broadened scope of initiative. They outlined that the initiative's original focus was on clinical trials for rare cancers, rare diseases, and unmet needs. However, it explained that the focus has since been expanded to any disease or condition that meets the objective specified in each grant opportunity.[135] It added that:

> We are concerned that the Clinical Trial Activity Initiative's expansion of focus could inevitably result in less priority and funding investment towards rare and less common cancer research.[136]

National One Stop Shop and the National Clinical Trials Front Door

3.114 In June 2023, the Australian Government released a consultation report on the National One Stop Shop (NOSS) platform.[137] In October 2023, the government announced that all Australian health ministers agreed to establish the

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131 Roche, *Submission 9*, p. 18.

132 Department of Health and Aged Care, *Submission 1*, p. 15.

133 Department of Health and Aged Care, *Submission 1*, p. 15.

134 See, for example, Roche, *Submission 9*, p. 17; The Society of Hospital Pharmacists of Australia, *Submission 17*, [p. 10].

135 Cancer Council Australia, the Cancer Nurses Society of Australia, the Clinical Oncology Society of Australia, Private Cancer Physicians of Australia, the Medical Oncology Group of Australia and the Lung Foundation Australia, *Submission 4*, pp. 9–10.

136 Cancer Council Australia, the Cancer Nurses Society of Australia, the Clinical Oncology Society of Australia, Private Cancer Physicians of Australia, the Medical Oncology Group of Australia and the Lung Foundation Australia, *Submission 4*, p. 10.

137 The Hon Mark Butler MP, Minister for Health and Aged Care, 'Next step towards a health and medical research one-stop shop', *Media Release*, 1 June 2023.

Inter-Governmental Policy Reform Group, which will provide policy and operational oversight over the NOSS.[138]

3.115 Bristol Myers Squibb Australia explained that the NOSS aims to harmonise clinical trial systems in Australia, which will:

> … transform the ability of patients to access clinical trials and therapeutic interventions, and make it easier for industry, sponsors, and researchers, to find, invest and conduct research in Australia.[139]

3.116 Throughout the consultation process, the government found that stakeholders broadly supported a public facing website, known as the National Clinical Trials Front Door, that would be the central point of access point for a range of groups, including researchers, sponsors, industry and carers.[140]

3.117 Medicines Australia argued that a nationally consistent and harmonised clinical trials systems 'would encourage multinational innovator companies to bring their trials to Australia' and would provide Australian rare and less common cancer patients with more opportunities to access treatment.[141]

Research processes

3.118 Australian Genomics flagged that Australia's research processes need to be 'more agile and receive timely approval' to ensure that Australia is an attractive place to conduct clinical trials. Evidence relating to research and clinical trials is further discussed in Chapter 6 of the report.

Committee view

3.119 Evidence to the committee highlighted clear inequities in access to treatments and clinical trials for people with rare and less common cancers, including neuroendocrine cancer.

3.120 The committee firmly believes these issues and inequities must be addressed to ensure that patients receive the most appropriate treatment to support them throughout their cancer journey.

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138 The Hon Mark Butler MP, Minister for Health and Aged Care, 'Eminent Australian to lead one stop clinical trials reform group', *Media Release*, 31 October 2023.

139 Bristol Myers Squibb Australia, *Submission 46*, [p. 5].

140 Australian Commission on Safety and Quality in Health Care, *The National One Stop Shop – a national cross government platform for health-related human research*, www.safetyandquality.gov.au/our-work/health-and-human-research/national-one-stop-shop-national-platform-health-related-human-research (accessed 22 March 2024).

141 Medicines Australia, *Submission 8*, [p. 9].

Access to genomic screening and precision oncology

3.121 The committee received compelling evidence that genomic screening can link rare and less common cancer patients with targeted treatment options, via precision oncology, that may improve treatment outcomes.

3.122 The committee is of the view that precision oncology treatments hold the potential to provide cancer patients with improved treatment outcomes, particularly when compared to traditional forms of treatment, such as radiotherapy and chemotherapy. However, the committee holds concerns that precision oncology may remain out of reach for patients if they cannot access genomic screening, particularly due to financial factors.

3.123 Therefore, the committee reiterates its call to ensure that people with cancer have access to genomic screening, as recommended in Chapter 2, to enable rare and less common cancer patients to access precision oncology therapies where appropriate.

3.124 The committee notes the work of the ZERO Childhood Cancer program. The committee is encouraged that this program can identify the molecular basis of cancer in children and provide their families with precision guided treatment recommendations.

3.125 However, the committee is concerned that funding for the ZERO Childhood Cancer Program is only guaranteed until June 2025. The committee considers it vital that this program continues to be funded beyond June 2025.

Recommendation 9

3.126 The committee recommends that the Australian Government, through the Medical Research Future Fund, extend funding for the ZERO Childhood Cancer Program beyond June 2025.

Health Technology Assessment processes

3.127 The committee notes the considerable evidence received in relation to the need to reform Australia's Health Technology Assessment (HTA) processes to provide rare and less common cancer patients faster access to relevant treatments.

3.128 The committee was concerned to learn of the lengthy timeframe between regulatory approval and the subsidisation of novel medicines on the Pharmaceutical Benefits Scheme (PBS) that exist in Australia, especially when comparing these timelines to other countries, such as Japan, Germany, and the United Kingdom. The committee is also mindful that the Managed Access Program is underutilised, therefore further limiting patients from receiving access to novel medicines.

3.129 The committee firmly considers that HTA reform is needed to ensure that Australian patients can access affordable treatments. Accordingly, the

committee echoes calls from submitters that HTA processes should be adjusted to account for rare and less common diseases, including cancers.

3.130 Further, the committee is cognisant of the comprehensive recommendations made in the House of Representatives Standing Committee on Health, Aged Care and Sport's 'The New Frontier – Delivering better health for all Australians' report. The committee notes the specific recommendation on areas for consideration and reform during the HTA Review, such as increasing the use of Managed Access Programs to facilitate earlier access to innovative medicines.

3.131 The committee believes that the recommendations of both reviews have the potential to improve patient access to treatment, with a particular consideration on how to increase use of the Managed Access Program.

3.132 The committee is also aware of patient frustrations upon discovering that medicines are not listed for their specific indication. The committee sees value in further exploring how to adjust regulatory processes to ensure equitable access to treatments for rare and less common cancer patients.

3.133 Specifically, the committee notes the recommendation made in the 'New Frontier – Delivering better health for all Australians' report for the Department of Health to reform its regulatory and reimbursement processes to enable therapeutic goods to be registered and reimbursed by molecular indication, in addition to by disease indication.

Recommendation 10

3.134 The committee recommends that the Australian Government utilise the Health Technology Assessment Policy and Methods Review to provide Australian rare and less common cancer patients with timely and affordable access to novel medicines.

Recommendation 11

3.135 The committee recommends that the Australian Government ensure that the Managed Access Program is more widely accessed where appropriate.

Recommendation 12

3.136 The committee recommends that the Australian Government adjust regulatory processes to broaden indication coverage for medicines that treat rare and less common cancers, including neuroendocrine cancer.

Reimbursement gaps

3.137 Throughout the inquiry, the committee was made aware of concerning gaps in the reimbursement of therapies for some cohorts. The committee was troubled to learn of the particular impacts that the state and federal funding split for

inpatient and outpatient care can have on paediatric cancer inpatients, specifically when families attempt to access reimbursement for testing and treatment.

Recommendation 13

3.138 The committee recommends that the Australian Government work with state and territory governments to ensure the families of paediatric cancer patients are not financially disadvantaged for hospital stays.

3.139 The committee is concerned that cancer patients who require oral and maxillofacial rehabilitation, including prosthetics, following treatment for head and neck cancers, must fully pay for these procedures.

3.140 The committee is of the view that people who require essential oral and maxillofacial rehabilitation because of their cancer treatment should not be financially penalised.

Recommendation 14

3.141 The committee recommends that the Australian Government work with state and territory governments to identify the barriers faced by cancer patients requiring rehabilitation, prosthetics and implants as a result of their treatment, with a view to ensuring they have financial support for those services.

Access to clinical trials

3.142 The committee is concerned by the low number of rare and less common cancer clinical trials in Australia, particularly when considering that clinical trials are often the only treatment option available to rare and less common cancer patients who have exhausted other options.

3.143 In particular, the committee notes that patients and families are not covered by the Medical Treatment Overseas Program (MTOP) if they need to travel overseas to access treatment via clinical trials. The committee is of the strong view that Australian patients and their families should not be faced with exorbitant out-of-pocket costs to access potentially lifesaving treatment.

Recommendation 15

3.144 The committee recommends that the Australian Government review the eligibility criteria of the Medical Treatment Overseas Program, with a particular focus on access to clinical trials and treatments for rare and less common cancer.

3.145 The committee notes the concerns raised by submitters that rural and regional cancer patients may be at a disadvantage when attempting to access clinical trials. However, the committee is supportive of the Australian Teletrial Program

and believes that continued investment in teletrials will continue to improve access to clinical trials for rural and regional cancer patients. The committee discusses its views and makes its recommendation on teletrials in Chapter 5 of this report.

3.146 The committee is also aware of the various barriers that patients face when attempting to access the limited number of rare and less common cancer clinical trials within Australia, including the fragmentation of the health system, the difficulty of navigating complicated websites and databases, the high levels of health literacy required, and reliance on practitioner awareness of existing clinical trials.

3.147 However, the committee is encouraged by existing initiatives aimed at improving access to clinical trials and it believes that these stand to greatly benefit rare and less common cancer patients. The committee is optimistic that Omico's Precision Oncology Screening Program enabling Clinical Trials (PrOSPeCT) program will lead to increased clinical trial activity in Australia for people with rare and less common cancers.

3.148 Furthermore, the committee considers that the National One Stop Shop and National Clinical Trials Front Door platform is an initiative that would assist patients, practitioners, and family members to navigate Australia's complex health system, as well as providing Australians with a simplified website to assist them navigate the clinical trials landscape. As such, the committee believes this platform should be implemented as a matter of priority.

Recommendation 16

3.149 The committee recommends that the Australian Government work with state and territory governments to implement the One Stop Shop and National Clinical Trials Front Door platform as a matter of priority.

3.150 The committee notes the concerns raised by inquiry participants that pharmaceutical companies have limited incentives to establish clinical trials for children with rare and less common cancers in Australia.

3.151 The committee is concerned that as a result, Australian children with rare and less common cancers may not be receiving the same access to treatments and trials that are available overseas.

3.152 The committee considers that there is merit in leveraging the Clinical Trials Activity initiative to have a specific focus on generating clinical trial activity in Australia for children and young people with cancer.

3.153 Noting the concerns raised regarding the broadened scope of the Clinical Trials Activity initiative, the committee encourages the Australian Government to ensure that clinical trials and research opportunities for rare and less common cancers in particular are not overlooked under the initiative.

Recommendation 17

3.154 The committee recommends that the Australian Government ensure the Clinical Trials Activity initiative has an appropriate focus on funding clinical trials and research for people with cancer, including children, young people, and patients diagnosed with rare and less common cancers.

Chapter 4
Support for patients and families after diagnosis

4.1 This chapter discusses the evidence the committee received regarding the significant impact of a rare cancer diagnosis, and the importance of increased and improved supports for rare and less common cancer patients, and their loved ones. In particular, it discusses the need for:

- supporting key non-government organisations to provide essential supports and informative resources;
- additional specialised cancer care nurses;
- improving funding frameworks to support general practitioners to provide supportive cancer care and coordination;
- increasing access and improving psychological supports; and
- the need for more timely, equitable and appropriate palliative care services.

4.2 It concludes with the committee's views and recommendations on these matters.

The impact of a rare cancer diagnosis

4.3 The committee heard extensive evidence about the wide-ranging, devastating personal impacts that a rare and less common cancer diagnosis can have on individuals and their loved ones.[1]

4.4 For example, 32-year-old Emily who was diagnosed with rare cancer NUT carcinoma in 2019, told the committee that the emotional and psychological impacts of a rare cancer diagnosis are 'substantial', yet there are limited supports which leave patients and their families feeling isolated. She continued:

> Limited awareness and information about rare cancers hinder patients like me from making well-informed decisions regarding treatment… Lastly, advocacy for rare cancers is often overshadowed by more common cancers, resulting in insufficient attention from policymakers and limited funding for research and support services... I have, like many others, felt alone, with

[1] See, for example, Michelle, Private capacity, *Committee Hansard*, 31 January 2024, pp. 43 and 44; Katherine, Private capacity, *Committee Hansard,* 1 February 2024, p. 31; Jelena, Private capacity, *Committee Hansard,* 1 February 2024, pp. 29 and 30; Kristina, Private capacity, *Committee Hansard,* 1 February 2024, p. 35; Jacqui, Private capacity, *Committee Hansard,* 20 February 2024, p. 19; Ms Angie Sari-Daher, Australian DIPG Families, *Committee Hansard,* 31 January 2024, pp. 34 and 35; Movember Foundation, *Submission 40*, [pp. 2 and 3]; Eleni, *Submission 126,* [pp. 1 and 2]; Sandra, *Submission 84,* p. 2; Kate, Private capacity, *Committee Hansard,* 31 January 2024, pp. 40 and 41; Alison, *Submission 90,* [p. 1]; Mrs Amanda Robertson, Information and Support Manager, Cancer Council South Australia, *Committee Hansard,* 9 April 2024, p. 1; Associate Professor Gabrielle Cehic AM, *Submission 140*, [p. 1]; Glen, *Submission 101,* p. 1; Lesley, Private capacity, *Committee Hansard,* 21 February 2024, p. 27; Jon, *Submission 67*, [p. 1]; Professor Matthew Dun, Professor of Paediatric Haematology and Oncology Research, Founder and Director of RUN DIPG, *Committee Hansard*, 31 January 2024, p. 29.

> limited access to support organisations, combined with a lack of commitment to government funding.[2]

4.5 Milton outlined his personal experiences and perspectives to the committee – having had cancer twice himself, experienced the loss of two siblings and both parents due to cancer, as well as caring for and losing his first wife to brain cancer, and more recently, his second wife Frances, to pancreatic cancer. He similarly reflected that a cancer diagnosis is a 'life-changing' experience, which can often make people feel 'powerless, out of control, and isolated'. He also observed that parents and carers don't usually know what questions to ask, or where they can get support.[3]

4.6 Further, Mrs Beau Kemp, who lost her son Ryley at the age of eight in March 2023, following a battle with Diffuse Intrinsic Pontine Glioma (DIPG), outlined the life changing impacts of such a diagnosis on families:

> Our son's diagnosis was swift, disorientating and filled with uncertainty... The day before our lives had seemed blissfully perfect. Now we knew, from the whispers and stares of nurses and doctors, that our lives were about to change. We were completely ignorant and unaware that such a diagnosis could exist for such a young child and that in a first-world nation we were soon to be offered no help at all to save our son's life.[4]

4.7 The sections that follow highlight that more must be done to better support individuals with rare or less common cancers, and their families, throughout this incredibly tough time.

The need for more support

4.8 A significant number of inquiry participants, including individuals with lived experience, advocacy organisations, medical professionals and researchers, outlined the need for greater, and improved supports for rare and less common cancer patients and their families, after diagnosis.[5]

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2 Emily, Private capacity, *Committee Hansard,* 1 February 2024, p. 28.

3 Milton, *Submission 80,* [pp. 1 and 2].

4 Mrs Beau Kemp, Australian DIPG Families, *Committee Hansard,* 31 January 2024, p. 37.

5 See, for example, Milton, *Submission 80,* [p. 1]; Sandra, *Submission 84,* p. 5; Professor Matthew Dun, Professor of Paediatric Haematology and Oncology Research, Founder and Director of RUN DIPG, *Committee Hansard*, 31 January 2024, p. 31; Mrs Hannah Pringle, Australian DIPG Families, *Committee Hansard,* 31 January 2024, pp. 36 and 37; Mrs Beau Kemp, Australian DIPG Families, *Committee Hansard,* 31 January 2024, p. 38; Judi, *Submission 116*, [pp. 8–10]; Kate, Private capacity, *Committee Hansard,* 31 January 2024, p. 42; Michelle, Private capacity, *Committee Hansard,* 31 January 2024, pp. 42 and 44; Katherine, Private capacity, *Committee Hansard,* 1 February 2024, p. 32; Michael, Private capacity, *Committee Hansard,* 1 February 2024, p. 34; Robert, Private capacity, *Committee Hansard,* 20 February 2024, p. 25; Lesley, Private capacity, *Committee Hansard,* 20 February 2024, pp. 27 and 28; Dr Richard Stuckey, *Submission 97,* p. 5; Associate Professor Kathy Tucker, Private capacity, *Committee Hansard,* 31 January 2024, p. 55; Associate Professor Grace Kong, Medical Consultant, Nuclear Medicine Physician and Co-Chair, Neuroendocrine Tumour Unit, Peter

4.9 For example, the Minderoo Foundation strongly considered that more must be done to improve the access and availability of support services after diagnosis. It noted that treatment for any cancer is difficult, but that people with rare cancers have 'an added burden of uncertainty because they are usually presented with limited treatment options, or none at all' as well as minimum information about their cancer type.[6] It added that patients should have access to 'the same quality of care and ease of access regardless of complexity'.[7]

4.10 Geneticists, Dr Minmin Li and Associate Professor Kathy Tucker similarly outlined that unlike more common cancers, there are little supports available following the diagnosis of a rare cancer. They also noted that there are fewer psychosocial supports available, less patient advocacy groups and less reliable information to support patients and their families.[8]

4.11 Lived experience inquiry participants also outlined the need for greater supports for those with rare cancers. For instance, Glen – who outlined his experiences following his wife Masumi's diagnosis of a rare form of lung cancer in 2022, and his own diagnosis of renal cell carcinoma, a rare kidney cancer in 2023 – observed support inequities dependent on cancer type:

> Our experience with the public hospital system in Australia has been that support very much depends on what kind of cancer you are afflicted with - like some cancers are more important than others.[9]

4.12 Judi, who was diagnosed with pancreatic cancer in 2021, also echoed these concerns. She told the committee that through her experience, she observed that 'the type of cancer you have impacts the support available' and that some cancers have major gaps in knowledge, treatment options and support available.[10]

Cancer care navigation and coordination needs

4.13 Submitters and witnesses made clear that physical and emotional impacts of a rare and less common cancer diagnosis can also be compounded by challenges

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MacCallum Cancer Centre, *Committee Hansard*, 1 February 2024, pp. 1 and 2; Mr Doug Hawkins, Chief Executive Officer, Pancare Foundation, *Committee Hansard*, 1 February 2024, p. 57; Associate Professor Anna Boltong, Chief Executive Officer, Ovarian Cancer Australia, *Committee Hansard*, 1 February 2024, p. 58; Minderoo Foundation, *Submission 23*, p. 3. Citations omitted; Rare Cancers Australia, *Submission 3*, [pp. 7 and 8]; Queensland Health, *Submission 12*, pp. 14 and 15; Melanoma Patients Australia, *Submission 22*, p. 5; Leona, *Submission 65*, [p. 1]; Christopher, *Submission 73*, [p. 1]; Jelena, Private capacity, *Committee Hansard*, 1 February 2024, p. 30.

6 Minderoo Foundation, *Submission 23*, p. 3. Citations omitted.

7 Minderoo Foundation, *Submission 23*, p. 2. Citations omitted.

8 Dr Minmin Li FRACP and Associate Professor Kathy Tucker AO FRACP, *Submission 36*, p. 2.

9 Glen, *Submission 101*, p. 1; Glen, Private capacity, *Committee Hansard*, 20 February 2024, p. 20.

10 Judi, *Submission 116*, [p. 9].

presented by having to navigate the complex health system, make difficult decisions about treatment and care, manage the financial impacts of your diagnosis, and juggle a multitude of medical appointments.[11]

4.14 Robert, who lives with neuroendocrine cancer, told that committee that he lives 'every day with the challenge of navigating a complex health system and a complex disease, with no support from the government'.[12]

4.15 Michelle, who lost her life partner Mark after a 28-month battle with stage 4 pancreatic cancer, told the committee that being Mark's primary carer as he underwent intense treatment, 'was a jarring lesson in project management'. She added that they were left to navigate a 'wildly new, complex and terrifying world with no realistic support of anyone with in-house knowledge or lived experience'.[13]

4.16 Kate, who lost her niece Emily, at age four in 2023, after a battle with neuroblastoma, similarly explained the difficulties in cancer care navigation that families can experience whilst trying to care for their sick child:

> More support is needed during treatment and at the post-treatment stage, including emotional support for families who, at the same time as trying to care for their sick child, must research clinical trials, investigate alternative treatments, chase test results, interpret test results, source second opinions and desperately try to understand what all this means for their child.[14]

4.17 Various other submitters also noted these issues, including NeuroEndocrine Cancer Australia which outlined that navigating the healthcare system is extremely challenging, but especially for a cancer that is little known or understood.[15]

Best practice patient-centred, supportive care and survivorship services

4.18 According to the Victorian Department of Health, supportive care in cancer is 'an umbrella term used to describe services that may be required by those affected by cancer'. It includes self-help and support, information, psychological

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11 See, for example, Mrs Hannah Pringle, Australian DIPG Families, *Committee Hansard,* 31 January 2024, p. 36; Milton, *Submission 80,* [p. 1]; Megan, *Submission 107,* pp. 3 and 4; Mrs Amanda Robertson, Information and Support Manager, Cancer Council South Australia, *Committee Hansard,* 9 April 2024, pp. 1 and 2; Danielle, *Submission 109*, p. 2; Rare Cancers Australia, *Submission 3,* [pp. 7 and 8]; Mr Owen Smith, Managing Director, Bristol-Myers Squibb Australia, *Committee Hansard,* 1 February 2024, p. 67; Roche, *Submission 9,* p. 19; Bristol Myers Squibb Australia, *Submission 46,* p. 6.

12 Robert, Private capacity, *Committee Hansard,* 20 February 2024, p. 26.

13 Michelle, Private capacity, *Committee Hansard,* 31 January 2024, p. 42.

14 Kate, Private capacity, *Committee Hansard,* 31 January 2024, p. 42.

15 See, for example, NeuroEndocrine Cancer Australia, *Submission 38,* p. 5; Roche, *Submission 9,* p. 19; Mrs Hannah Pringle, Australian DIPG Families, *Committee Hansard*, 31 January 2024, p. 36.

support, symptom control, social support, rehabilitation, spiritual support, palliative care, and bereavement care.[16]

4.19 Several inquiry participants noted the importance of supportive care,[17] including Cancer Australia which recognised that patient-centred, supportive care is a vital part of cancer treatment and care.[18]

4.20 The Daffodil Centre and the University of Sydney Cancer Research Network similarly explained that access to evidence-based supportive care is crucial for improving patients' quality of life, prognoses, and for reducing inequities between patient groups.[19]

4.21 In a joint submission, Cancer Council Australia, the Cancer Nurses Society of Australia, the Clinical Oncology Society of Australia, Private Cancer Physicians of Australia, the Medical Oncology Group of Australia and the Lung Foundation Australia (Cancer Council Australia) noted that ensuring the delivery of adequate supportive care services is a challenge given constrained resources in the health system, and due to the fact that the health system generally prioritises the delivery of treatment instead. Cancer Council Australia advised that this can result in the supportive care needs of people with cancer being overlooked and emphasised the economic benefits of investing in supportive care:

> This is despite evidence to suggest that for every dollar invested in supportive care, patients and the system can benefit from up to $9 in social return.[20]

Survivorship services

4.22 The Department of Health and Aged Care (the department) outlined that historically, follow-up care has focused on monitoring for cancer recurrence and second primary cancers. However, it explained that as people live longer

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16 Victorian Department of Health, *Supportive cancer care*, 15 June 2023, www.health.vic.gov.au/health-strategies/supportive-care (accessed 22 April 2024).

17 See, for example, Pancare Foundation, *Submission 21*, p. 12; Leukaemia Foundation, *Submission 39*, pp. 19 and 20; Melanoma Patients Australia, *Submission 22*, [pp. 8, 11 and 15]; Cancer Council Australia, the Cancer Nurses Society of Australia, the Clinical Oncology Society of Australia, Private Cancer Physicians of Australia, the Medical Oncology Group of Australia and the Lung Foundation Australia, *Submission 4*, p. 9; Head and Neck Cancer Australia, *Submission 19*, p. 4; Pankind, the Australian Pancreatic Cancer Foundation, *Submission 20*, p. 2; Pancare Foundation, *Submission 21*, [pp. 3, 4 and 12]; Cancer Australia, *Submission 42*, p. 10; Leukaemia Foundation, *Submission 39*, p. 19.

18 Cancer Australia, *Submission 42*, p. 10.

19 The Daffodil Centre and the University of Sydney Cancer Research Network, *Submission 32*, p. 14.

20 Cancer Council Australia, the Cancer Nurses Society of Australia, the Clinical Oncology Society of Australia, Private Cancer Physicians of Australia, the Medical Oncology Group of Australia and the Lung Foundation Australia, *Submission 4*, p. 9. Citation omitted.

following their cancer diagnosis, care following cancer treatment is becoming 'a fundamental part of the cancer control continuum'.[21]

4.23 Dr Matthew Magarey, Board Director of Head and Neck Cancer Australia told the committee that this concept is known as 'survivorship':

> This concept of survivorship—which is relatively new in terms of the cancer world—is one where people are looking at the idea that if we're keeping people with cancer alive, then we want to keep them alive well. We need to allow them to survive and to enjoy their lives.[22]

4.24 Cailtin, who was diagnosed with stage 4 clear cell ovarian cancer in 2017, reflected on her own cancer journey and noted the importance of survivorship care:

> … cancer is lonely - there is a lack of support for advanced cancer patients, who can now live for many years. Especially those aged 25 - 55 with advanced and rare disease. Survivorship involves a multidisciplinary approach, integrative oncology has been essential for me to not just survive, but really thrive too.[23]

Existing supports for patients and their families

4.25 The committee heard that currently, those affected by rare and less common cancer can access supports through the following avenues, which are explored further below:

- non-government organisations, charities, and peer support initiatives;[24]
- Aboriginal community controlled health organisations;[25] and
- government funded services.[26]

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21 Department of Health and Aged Care, *Submission 1*, p. 12.

22 Dr Matthew Magarey, Board Director, Head and Neck Cancer Australia, *Committee Hansard,* 31 January 2024, p. 19.

23 Caitlin, *Submission 111,* [p. 1].

24 See, for example, Rare Cancers Australia, *Submission 3*, p. 8; Ovarian Cancer Australia, *Submission 18,* [p. 1]; Head and Neck Cancer, *Submission 19,* pp. 1, 4–5; PanKind, the Australian Pancreatic Cancer Foundation, *Submission 20,* p. 1; Pancare Foundation, *Submission 21,* [p. 2]; NeuroEndocrine Cancer Australia, *Submission 38,* pp. 1–2; Leukaemia Foundation, *Submission 39*, p. 2; Neuroblastoma Australia, *Submission 58*, [p. 1]; WMozzies, *Submission 119*; [p. 1]; Cancer Council Australia, the Cancer Nurses Society of Australia, the Clinical Oncology Society of Australia, Private Cancer Physicians of Australia, the Medical Oncology Group of Australia and the Lung Foundation Australia, *Submission 4,* p. 9.

25 National Aboriginal Community Controlled Health Organisation (NACCHO), *Submission 48*, pp. 10 and 13.

26 See, for example, Department of Health and Aged Care, *Submission 1,* pp. 13–14; WA Health, *Submission 11*, p. 5; Queensland Health, *Submission 12*, pp. 16–17.

Non-government organisations, charities, and peer support initiatives

4.26 Several witnesses and submitters outlined that charities and cancer advocacy organisations often fill the gap in supports that are available to rare and less common cancer patients, and their loved ones.[27]

4.27 The committee also heard that many Australians affected by rare and less common cancers lean on each other, through various peer support groups and other online and local initiatives, established by individuals with lived experience to help others navigating similar journeys.[28]

4.28 Judi, who is living with pancreatic cancer, outlined the invaluable supports that she accessed through both non-government advocacy organisations and peer support groups throughout her cancer journey:

> The biggest thing that gave me support was finding an informal support group, just by accident. With their lived experience, they have been able to help me in this journey … you go to the Cancer Council—and they're fantastic—and they just have an all cancer group, and you're lumped into that. There's no expert dealing with people with pancreatic cancer … I have been really lucky to have been able to access support through groups like Pancare, PanKind and through my informal support group. These organisations are filling a gap. They shouldn't necessarily have to be.[29]

4.29 Megan, mother of Kira who was diagnosed with neuroblastoma in 2022, outlined how she has leant on a variety of charities throughout her family's cancer journey, lamenting that these important services were not embedded in the health system or funded by government:

> Currently, my family and others rely on the support available via charities to fill this gap. Charities provide emotional support, counselling, and access to safe playgroup/kindergarten programs. These were not as forthcoming via the hospital system or government funded programs… Oncology Units, School Liaison Nurse, a role critical in ensuring schools know how to keep children with ports, central lines, feeding tubes and immunocompromised

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27 See, for example, Megan, *Submission 107,* p. 4; Yvonne, *Submission 100,* [p. 4]; Melanoma Patients Australia, *Submission 22*, p. 5; Ron, *Submission 110,* [p. 4]; Megan, *Submission 128,* [p. 3]; Mrs Emma Phillips, Executive Director, Can Assist (Cancer Assistance Network), *Committee Hansard,* 31 January 2024, p. 25; Professor Matthew Dun, Professor of Paediatric Haematology and Oncology Research, Founder and Director of RUN DIPG, *Committee Hansard,* 31 January 2024, p. 31; Judi, Private capacity, *Committee Hansard*, 20 February 2024, pp. 28–29; Mrs Patricia Marjorie O'Hara OAM, Committee Member, Rotary Outreach Myeloma Program, Rotary Club of Camberwell, *Committee Hansard,* 1 February 2024, p. 14.

28 See, for example, Dr Ian Kamerman, Secretary, Rural Doctors Association NSW, *Committee Hansard*, 1 March 2024, p. 23; David, *Submission 105,* p. 2; Michael, Private capacity, *Committee Hansard,* 1 February 2024, pp. 34–35; The Larykins, *About,* https://larykins.com.au/about/ (accessed 22 April 2024); Megan, *Submission 128,* [p. 3]; Milton, *Submission 80,* [p. 1]; Lesley, Private capacity, *Committee Hansard,* 20 February 2024, p. 27; Cure Our Ovarian Cancer, *Submission 114,* p. 1; WMozzies, *Submission 119,* [p. 1]; Claudia, *Submission 81,* [p. 3].

29 Judi, Private capacity, *Committee Hansard*, 20 February 2024, pp. 28–29.

> systems safe, is also funded by charities, not by the hospital, not by government.[30]

4.30 Queensland Health flagged that often patients do not know that these non-government support organisations exist, and that their lack of funding hinders the capacity of these 'fundamental community and patient [services]'.[31]

4.31 Rare Cancers Australia told the committee 'in the absence of nationally available and accessible support services for people with [rare and less common] cancers' it has taken a lead role in creating and delivering such services to 'to alleviate some of the stress, complexity and hardship experienced by patients, carers and families'.[32]

Aboriginal Community Controlled Health Organisations

4.32 National Aboriginal Community Controlled Health Organisation (NACCHO) explained that the Aboriginal Community Controlled Health Organisation (ACCHO) sector is 'a significant component of the cancer ecosystem' playing an essential role in providing holistic, culturally safe comprehensive care for Aboriginal and Torres Strait Islander people and their families.[33]

4.33 NACHHO outlined that providing culturally safe follow up care and support is crucial in helping Aboriginal and Torres Strait Islander community members to 'survive and thrive with cancer' and that culturally tailored, community based survivorship programs can strengthen cancer care for Aboriginal and Torres Strait Islander people.[34]

4.34 NACCHO also recognised the importance of Aboriginal and Torres Strait Islander communities being able to share their lived experience with others via support groups, and further explained that spiritual care and connections to other Aboriginal and Torres Strait Islander cancer survivors, are key components to survivorship programs.[35]

4.35 NACCHO specifically recommended that funding be allocated to ACCHOs to provide survivorship programs to enable community members to connect, share their lived experience, and receive ongoing post treatment care as needed.[36]

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30 Megan, *Submission 107*, p. 4.

31 Queensland Health, *Submission 12*, p. 14.

32 Rare Cancers Australia, *Submission 3*, [p. 7].

33 NACCHO, *Submission 48*, p. 10.

34 NACCHO, *Submission 48*, p. 16.

35 NACCHO, *Submission 48*, p. 16.

36 NACCHO, *Submission 48*, p. 16.

4.36 Overall, the committee heard about the amazing work of a multitude of non-government organisations, charities, advocacy groups and individuals, that are striving to improve, and increase supports for Australians with rare and less common cancers across the country. A number of these inquiry participants are listed in the following table:

Table 4.1 Non-government organisations, charities, and peer support advocacy groups and initiatives

Rare Cancers Australia	Cancer Council Australia
Ovarian Cancer Australia	Cancer Council Tasmania
Head and Neck Cancer Australia	Cancer Council South Australia
PanKind, The Australian Pancreatic Cancer Foundation	RUN DIPG
Pancare Foundation	Cure Our Ovarian Cancer
Melanoma Patients Australia	WMozzies
Leukaemia Foundation	Angel Flight
Movember Foundation	NeuroEndocrine Cancer Australia
Neuroblastoma Australia	Can Assist – Cancer Assistance Network
National Rural Health Alliance	Lymphoma Australia
The Hospital Research Foundation Group	Rotary Outreach Myeloma Program
Michael – Larykins	Rob – Flinders Island Cup
NACCHO	Multicultural Communities South Australia

Government funded supports

4.37 Patients and their families can also access both federally and state-funded support services.[37]

4.38 The department outlined that it has invested in a range of initiatives to 'ensure all people diagnosed with cancer, regardless of their cancer type' have access to supports after diagnosis. This includes:

[37] See, for example, Department of Health and Aged Care, *Submission 1*, pp. 12–14; WA Health, *Submission 11*, p. 6; Queensland Health, *Submission 12*, pp. 15–17.

- **Information and advocacy**: funding to rare cancer advocacy organisations to increase awareness, expand information resources, and educate medical professionals.[38]
- **Emotional and wellbeing support**: such as launching the Cancer Hub, a digital tool that provides cancer navigation, counselling and support for people under 25 and their parents. The department also outlined its investments in mental health and suicide prevention through various programs, and the Better Access initiative, under which people with rare and less common cancers may be able to access up to 10 Medicare-subsidised mental health services per calendar year.[39]
- **Cancer care navigation and coordination**: supporting tumour-specific nurses for people diagnosed with breast, prostate, lung, ovarian cancer and melanoma.[40]

Australian Cancer Plan and supportive care

4.39 Under Strategic Directive Two, 'Enhanced Consumer Experience', of the Australian Cancer Plan (the Plan), Cancer Australia recognises that supportive care is priority area for action.[41]

4.40 Cancer Australia highlighted that to deliver nationally equitable outcomes and experiences in cancer control, Australia's health systems 'must provide tailored, appropriate, and adequately resourced services to all Australians in need—when, where, and how they need them'.[42]

4.41 Further details on Strategic Directive Two of the Plan, and the relevant goals and timelines for this work, are outlined in the following figure.[43]

38 Department of Health and Aged Care, *Submission 1*, pp. 12 and 13.

39 Department of Health and Aged Care, *Submission 1*, pp. 13 and 14.

40 Department of Health and Aged Care, *Submission 1*, p. 14.

41 Cancer Australia, *Australian Cancer Plan, Strategic Objective 2: Enhanced Consumer Experience,* www.australiancancerplan.gov.au/so/enhanced-consumer-experience (accessed 22 April 2024).

42 Cancer Australia, *Submission 43,* p. 9.

43 Cancer Australia, *Australian Cancer Plan, Strategic Objective 2: Enhanced Consumer Experience,* www.australiancancerplan.gov.au/so/enhanced-consumer-experience (accessed 22 April 2024).

Box 4.1 Australian Cancer Plan, Strategic Objective 2: Enhanced Consumer Experience

2-year goal: Person-centred models of integrated navigation in cancer care are nationally defined, co-designed, developed and tested with consumers, to incorporate culturally safe cancer care.

5-year goal: Personalised models of navigation in cancer care are widely available to all Australians affected by cancer — engaging consumers in culturally safe, equitable and responsive cancer care, and driving re-orientation of health service systems, including training and distribution of cancer health workforce.

10-year ambition: People affected by cancer are partners in culturally safe, equitable and responsive cancer care, and health services and systems are trusted and supported for optimal experience, quality of life and cancer outcomes.

Source: Cancer Australia, Australian Cancer Plan, Strategic Objective 2: Enhanced Consumer Experience, www.australiancancerplan.gov.au/so/enhanced-consumer-experience (accessed 22 April 2024).

4.42 Cancer Council Australia noted that the Plan recognises the need to 'directly identify and address the supportive care and cancer navigation needs of people with all kinds of cancers in a person-centred way'.[44] However, it emphasised that to achieve equity in cancer care, 'particular focus, attention and resources' must also be allocated to deliver on these aspirations of the Australian Cancer Plan for rare and less common cancers, including neuroendocrine tumours.[45]

4.43 Particular support issues and gaps, as well as options to address these matters, are outlined in the sections below.

Availability of information for patients

4.44 Several inquiry participants outlined the need for greater access and availability of information to patients and their families, throughout their cancer journey.[46]

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[44] Cancer Council Australia, the Cancer Nurses Society of Australia, the Clinical Oncology Society of Australia, Private Cancer Physicians of Australia, the Medical Oncology Group of Australia and the Lung Foundation Australia, *Submission 4*, p. 9.

[45] Cancer Council Australia, the Cancer Nurses Society of Australia, the Clinical Oncology Society of Australia, Private Cancer Physicians of Australia, the Medical Oncology Group of Australia and the Lung Foundation Australia, *Submission 4*, p. 9.

[46] See, for example, Judi, *Submission 116*, [p. 9]; Ms Sharon Winton, Chief Executive Officer, Lymphoma Australia, *Committee Hansard*, 1 February 2024, pp. 15 and 16; Movember Foundation, *Submission 40*, p. 5, Katherine, Private capacity, *Committee Hansard*, 1 February 2024, p. 31; Rare Cancers Australia, *Submission 3*, [pp. 7 and 8]; Lesley, Private capacity, *Committee Hansard*,

4.45 For example, Rare Cancers Australia submitted that Australians affected by rare and less common cancers, require information to assist them in making decisions about their treatment and in understanding their disease.[47]

4.46 However, Rare Cancers Australia explained that due to the number of rare cancers, small patient populations and a paucity of experts in these cancers, there is less information and support available to patients, their support networks and clinicians. Further, it explained how this lack of information can impact on the wellbeing of patients, and their access to support services:

> It can be difficult to find the most knowledgeable local expert or support services to help a patient with a rare cancer to best manage their illness. This brings significantly higher unmet needs in the domains of psychological well being, the provision of reliable information and access to supportive services.[48]

4.47 Judi, who was diagnosed with pancreatic cancer in 2021, submitted that it is 'vital to empower people affected by cancer diagnosis' and explained why access to such information is so important:

> Access to information enables patients like me to make informed choices about every aspect of the cancer journey and enables them to take the driver's seat, assisting them to feel empowered to complete that journey knowing more about their direction, the destination, and their choices and options.[49]

4.48 Milton similarly outlined the need for 'easy access to reliable information, from trusted sources' and echoed that people must be able to make informed decisions at every stage of their cancer journey.[50]

4.49 The department noted that it has 'made targeted investments', to the following organisations, to provide patients with rare and less common cancers information and resources:

- NeuroEndocrine Cancer Australia;
- Pancare Australia;
- Head and Neck Cancer Australia;
- Canteen Australia;[51] and

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21 February 2024, p. 27; Head and Neck Cancer Australia, *Submission 19,* p. 3; Leona, *Submission 65,* [p. 1]; Claudia, *Submission 81,* [p. 3].

47 Rare Cancers Australia, *Submission 3,* [p. 7].

48 Rare Cancers Australia, *Submission 3,* [p. 7].

49 Judi, *Submission 116*, [p. 9].

50 Milton, *Submission 80,* [p. 1].

51 Department of Health and Aged Care, *Submission 1*, pp. 12 and 13.

- Cancer Council Australia.[52]

4.50 The department also acknowledged the work of Rare Cancers Australia and Cancer Council Australia in providing information, factsheets and resources for specific cancer types, including rare and less common cancers.[53] The committee also understands that several non-government cancer advocacy organisations provide information and guidance resources,[54] as well as helpline services[55] to their respective patient groups.

4.51 However, Rare Cancers Australia noted that in recent years, it has observed growing demand to support people to navigate the everyday challenges their cancer diagnosis presents.[56] It also indicated that as more and more people are impacted by rare and less common cancers, initiatives such as these will need to be expanded and further resourced, 'so the ever-growing needs of Australians living with cancer can continue to be met, and better experiences and outcomes can be achieved'.[57]

Calls for additional investment in cancer care nurses

4.52 A significant number of inquiry participants outlined the need for wider provision of cancer care nurses to support patients and their families affected by rare and less common cancers.[58]

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52 Mrs Ariane Hermann, Acting First Assistant Secretary, Department of Health and Aged Care, *Committee Hansard,* 1 March 2024, pp. 28 and 29.

53 Department of Health and Aged Care, *Submission 1*, p. 13.

54 See, for example, Head and Neck Cancer Australia, *Submission 19*, p. 4; PanKind, The Australian Pancreatic Cancer Foundation, *Submission 20*, p. 1; Pancare Foundation, *Submission 21*, [p. 2]; Leukemia Foundation, *Submission 39*, [p. 2]; Movember Foundation, *Submission 40*, pp. 4–5.

55 See, for example, Head and Neck Cancer Australia, *Submission 19*, p. 4; Melanoma Patients Australia, *Submission 22*, p. 4; Rare Cancers Australia, *Submission 3*, [p. 8].

56 Rare Cancers Australia, *Submission 3*, [p. 7].

57 Rare Cancers Australia, *Submission 3*, [p. 8].

58 See, for example, Anita, *Submission 135*, [p. 1]; Ms Meredith Cummins, Chief Executive Officer, NeuroEndocrine Cancer Australia, *Committee Hansard,* 1 February 2024, pp. 2, 7 and 8; Mrs Kate Wakelin, Neuroendocrine Tumour Clinical Nurse Consultant, Peter MacCallum Cancer Centre, *Committee Hansard,* 1 February 2024, p. 8; Mrs Patricia Marjorie O'Hara OAM, Committee Member, Rotary Outreach Myeloma Program, Rotary Club of Camberwell, *Committee Hansard,* 1 February 2024, p. 14; Associate Professor Anna Boltong, Chief Executive Officer, Ovarian Cancer Australia, *Committee Hansard,* 1 February 2024, p. 60; Mrs Bridget Bradhurst, Acting Chief of Support and Advocacy, Ovarian Cancer Australia, *Committee Hansard,* 1 February 2024, p. 60; Professor Matthew Dun, Professor of Paediatric Haematology and Oncology Research, Founder and Director of RUN DIPG, *Committee Hansard,* 31 January 2024, p. 31; Dr Melanie Wuttke, Head of Medical Oncology, Royal Hobart Hospital, *Committee Hansard,* 20 February 2024, pp. 7 and 12; Mrs Amanda Robertson, Information and Support Manager, Cancer Council South Australia, *Committee Hansard*, 9 April 2024, p. 5; Dr Wei-Sen Lam, Medical Lead, Teletrials, WA Country Health Service, *Committee Hansard,* 1 March 2024, p. 13; Associate Professor Gabrielle Checic AM, Clinical Lead, South

4.53 Dr Melanie Wutkke, Head of Medical Oncology, and Dr Tom Walwyn, Staff Specialist in Paediatric, Adolescent and Young Adult Oncology at the Royal Hobart Hospital both described the important role of specialist cancer nurses and explained that these staff often have expert knowledge about the diagnosed disease, or disease area, as well as the usual pathways, treatments and side effects, to help patients navigate their cancer journey.[59]

4.54 Dr Wuttke, along with her colleagues Dr Walwyn and Dr Anna Johnston, outlined the invaluable range of supports that cancer nurses can provide to patients, including:

- sitting in on consultations with patients and providing further explanation afterwards to reiterate key information;
- coordinating medical investigations;
- arranging transport to hospital and assisting patients to applying for patient travel and accommodation scheme funding;
- facilitating links with outpatient health services;
- taking calls from patients and families if they're worried about symptoms, or if they need someone to listen to them;
- provide advice to carers about supportive care needs;
- providing advice to patients and their carers about what should be brought to the attention of oncologist or other specialists, or what is less important;
- attending appointments with patients if they don't have family member supports; and
- providing follow-up support to families of patients who have passed away.[60]

4.55 Anita, who outlined her own experiences and perspectives to the committee, after being diagnosed with a rare form of lung cancer in 2014, broadly advocated for more specialist cancer nurses to be available across the country:

> I would like to see more specialist cancer nurses spread throughout Australia. Nurses that can be educated about the specific rare cancer of the patients living in their communities. Instead of the families having to spend

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Australian Peptide Receptor Radionuclide Therapy Service, and Chair, South Australian Gastroenteropancreatic Neuroendocrine Tumours Multidisciplinary Team, South Australia Medical Imaging, *Committee Hansard*, 9 April 2024, p. 26; Yvonne, *Submission 100*, [p. 4]; Caitlin, *Submission 111,* [p. 1].

59 Dr Melanie Wuttke, Head of Medical Oncology, Royal Hobart Hospital, *Committee Hansard*, 20 February 2024, p. 12; Dr Thomas Walwyn, Staff Specialist, Paediatric, Adolescent and Young Adult Oncology, Royal Hobart Hospital, *Committee Hansard*, 20 February 2024, p. 12.

60 Dr Anna Johnston, Director of Clinical Haematology, Royal Hobart Hospital, *Committee Hansard*, 21 February 2024, p. 12; Dr Melanie Wuttke, Head of Medical Oncology, Royal Hobart Hospital, *Committee Hansard*, 20 February 2024, pp. 12 and 13; Dr Thomas Walwyn, Staff Specialist, Paediatric, Adolescent and Young Adult Oncology, Royal Hobart Hospital, *Committee Hansard*, 20 February 2024, p. 12.

> hours researching the rare cancer their loved one has, the specialist nurse helps them research and navigate... This way the loved one has more time and energy to spend with the patient. The support for the family in navigating the system and having a medical background, would smooth the process for the patient and provide invaluable support.[61]

4.56 Other inquiry participants with lived experience of rare cancers, either directly themselves, or through a loved one, also advocated for expanded cancer nurse supports.[62] Pharmaceutical companies Ipsen, Bristol Myers Squibb Australia, and Novartis further outlined the critical role of these nurses supporting patients in the community.[63]

4.57 Novartis specifically recommended that the Australian Government increase investment in specialist cancer nurses for Australian's diagnosed with rare and less common and neuroendocrine cancers, to support optimised patient care and improve outcomes:

> Dedicated cancer nurses can make a positive difference on patients navigating a cancer diagnosis. Dedicated cancer nurses are ideally placed and skilled to optimise patient care while minimising risk to patients, and to work within systems and with patients, carers, and families to improve patient safety and the patient experience as a routine part of their role.[64]

4.58 Some inquiry participants, including Dr Melanie Wuttke, Ipsen and the National Rural Health Association, noted the success of the McGrath Foundation's breast cancer nurse program.[65] The National Rural Health Association considered this model could be explored for other cancers:

> The McGrath Breast Care Nurse model of care, supported by the Royal Flying Doctor Service, provides good support for people living in remote

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61 Anita, *Submission 135,* [p. 1].

62 See, for example, Yvonne, *Submission 100*, [p. 4]; WMozzies, *Submission 119,* p. 2; Glen, Private capacity, *Committee Hansard,* 20 February 2024, p. 20; Robert, Private capacity, *Committee Hansard,* 20 February 2024, p. 25; Caitlin, *Submission 111,* [p. 1]; David, *Submission 105*, p. 2; Claudia, *Submission 81,* [p. 4]; Ms Angie Sari-Daher, Australian DIPG Families, *Committee Hansard,* 31 January 2024, p. 33; Mrs Beau Kemp, Australian DIPG Families, *Committee Hansard,* 31 January 2024, p. 38.

63 Ipsen, *Submission 30,* pp. 4 and 5; Bristol Myers Squibb Australia, *Submission 46,* p. 6; Novartis, *Submission 52*, pp. 5 and 6.

64 Novartis, *Submission 52,* pp. 5 and 6. Citations omitted.

65 See, for example, Dr Melanie Wuttke, Head of Medical Oncology, Royal Hobart Hospital, *Committee Hansard*, 20 February 2024, pp. 7 and 12; National Rural Health Association, *Submission 7*, p. 8; Associate Professor Gabrielle Checic AM, Clinical Lead, South Australian Peptide Receptor Radionuclide Therapy Service, and Chair, South Australian Gastroenteropancreatic Neuroendocrine Tumours Multidisciplinary Team, South Australia Medical Imaging, *Committee Hansard,* 9 April 2024, p. 26; Robert, Private capacity, *Committee Hansard,* 20 February 2024, p. 25; Pancare Foundation, *Submission 21*, Attachment 1, p. 181; Caitlin, *Submission 111,* [p. 1].

areas. Our membership suggests this model be enhanced in rural Australia, with similar models explored for other cancers.[66]

4.59 Caitlin, who lives with stage 4 clear cell ovarian cancer, also advocated for an expansion of this model:

> I would love to see all cancer patients have dedicated informed nurses (such as in the breast cancer model). This should be standard best practise [sic] for high quality person centred care to ensure that no patient is left behind.[67]

The Australian Government 'All-cancer nurse service'

4.60 Mrs Arianne Hermann, Acting First Assistant Secretary at the department, outlined that a key component under the government's Australia Cancer Nursing and Navigation Program, which provides a total of $186.2 million over four years from 2023–24, is the 'All-cancer nurse service'.[68]

4.61 Mrs Hermann noted previous government investments in breast care, prostate cancer, lung cancer and melanoma nurses, but informed the committee that this new initiative is 'designed to be an all-cancer nurse service', which aims to provide a similar level of service across the country, no matter what type of tumour patients have.[69]

4.62 According to the Minister for Health and Aged Care, the Hon Mark Butler MP (the Minister), total government funding for this all-cancer nurse service is $74.5 million. The Minister outlined that through this program, the McGrath Foundation will build on its 'well-established model' to recruit 100 new all-cancer nurses.[70] He outlined the total number of Commonwealth funded cancer care nurses and expected implementation timeframes:

> These nurses will be in addition to the existing 148 Commonwealth-funded melanoma, breast and lung cancer nurses who will work together to support all cancers by 2026-27, resulting in almost 250 Commonwealth funded all cancer care nurses by 2027, delivered through the McGrath Foundation.[71]

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66 National Rural Health Association, *Submission 7*, p. 8.

67 Caitlin, *Submission 111*, [p. 1].

68 Mrs Arianne Hermann, Acting First Assistant Secretary, Department of Health and Aged Care, *Committee Hansard*, 1 March 2024, pp. 27 and 28.

69 Mrs Arianne Hermann, Acting First Assistant Secretary, Department of Health and Aged Care, *Committee Hansard*, 1 March 2024, p. 28.

70 The Hon Mark Butler MP, Minister for Health and Aged Care, 'Biggest investment in cancer nurses on record', *Media Release*, 17 November 2023.

71 The Hon Mark Butler MP, Minister for Health and Aged Care, 'Biggest investment in cancer nurses on record', *Media Release*, 17 November 2023.

Calls for specific cancer care nurses

4.63 Some inquiry participants advocated for more cancer-specific nurses, including specialist pancreatic cancer nurses,[72] upper gastrointestinal cancer nurses;[73] neuroendocrine tumour (NET) nurses;[74] and DIPG nurses.[75]

4.64 For instance, Yvonne, who outlined her story following her child's diagnosis of an aggressive paediatric bone cancer, Ewing Sarcoma, at the age of 17, outlined the advantages of 'condition specific' nurses:

> Condition specific Clinical Nurse Coordinators are a wonderful resource as they are easy to approach/contact and they have time assigned to problem solve, often saving money and time and optimising care. There is a risk in relying on charities to fill existing gaps in support.[76]

DIPG and paediatric cancer nurses

4.65 Some inquiry participants whose children were affected by the rare and aggressive childhood cancer, DIPG, emphasised the need for DIPG nurse navigators.[77] Alan, whose daughter Madeline was diagnosed with DIPG at age six in November 2023, submitted:

> …the absence of a DIPG nurse navigator further hinders families in accessing comprehensive guidance and assistance throughout their journey, leaving them feeling lost and overwhelmed amidst the complexities of the disease.[78]

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72 Claudia, *Submission 81,* [p. 4].

73 Pancare Foundation, *Submission 21,* Attachment 1, pp. 141, 176, 181, and 182.

74 See, for example, Ms Meredith Cummins, Chief Executive Officer, NeuroEndocrine Cancer Australia, *Committee Hansard,* 1 February 2024, p. 2; Robert, Private capacity, *Committee Hansard,* 20 February 2024, p. 25; NeuroEndocrine Cancer Australia, *Submission 38,* pp. 14 and 15; Ipsen, *Submission 30,* [p. 5]; Associate Professor Gabrielle Cehic AM, Clinical Lead, South Australian Peptide Receptor Radionuclide Therapy Service, and Chair, South Australian Gastroenteropancreatic Neuroendocrine Tumours Multidisciplinary Team, South Australia Medical Imaging, *Committee Hansard*, 9 April 2024, p. 26; Associate Professor Grace Kong, Medical Consultant, Nuclear Medicine Physician and Co-Chair, Neuroendocrine Tumour Unit, Peter MacCallum Cancer Centre, *Committee Hansard,* 1 February 2024, p. 1.

75 See, for example, Ms Angie Sari-Daher, Australian DIPG Families, *Committee Hansard,* 31 January 2024, p. 33; Mrs Beau Kemp, Australian DIPG Families, *Committee Hansard,* 31 January 2024, p. 38; Alan, *Submission 137,* p. 3.

76 Yvonne, *Submission 100*, [p. 4].

77 See, for example, Alan, *Submission 137*, p. 3; Ms Angie Sari-Daher, Australian DIPG Families, *Committee Hansard,* 31 January 2024, p. 33; Mrs Beau Kemp, Australian DIPG Families, *Committee Hansard,* 31 January 2024, p. 38,

78 Alan, *Submission 137,* p. 3.

4.66 More broadly, Professor Matthew Dun, called for all paediatric oncology centres in the country to have a dedicated nurse available to assist children and their families:

> It is our firm belief that every paediatric oncology treatment centre in Australia should have a dedicated nurse to assist children and their families in navigating the hardest of all journeys. This essential support should ideally be a standard part of the healthcare system and supported by government.[79]

Specialised neuroendocrine tumour nurses

4.67 Robert, who is battling neuroendocrine cancer, amongst several other members of his family, passionately advocated for government funding for a dedicated NET nurse in Tasmania.[80] He considered that having access to a NET nurse 'would alleviate the anxiety associated with navigating the healthcare system and constant rotation of healthcare professionals'.[81]

4.68 Robert also expressed frustration about the inequitable availability of cancer care nurses throughout Australia:

> In Tasmania, through McGrath Foundation funding, breast cancer patients have one nurse for every 100 patients. We had over 100 patients diagnosed with NETs in 2023. As well as newly diagnosed patients, it is estimated we have 500 patients living with NETs in Tassie. If all were equal, we should have five NET nurses in Tasmania. I only asked the government for one.[82]

4.69 NeuroEndocrine Cancer Australia similarly advocated for wider availability of specialised NET nurses in Australia.[83] It considered there is 'a huge inequity in accessing support services for Australian NET patients and their families when compared to the majority of other cancer patients'.[84]

4.70 NeuroEndocrine Cancer Australia outlined that currently, the only support available to the approximately 24 000 Australians affected by neuroendocrine tumours, is the one full-time specialist NET nurse, which is funded through NeuroEndocrine Cancer Australia via donations.[85]

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79 Professor Matthew Dun, Professor of Paediatric Haematology and Oncology Research, Founder and Director of RUN DIPG, *Committee Hansard,* 31 January 2024, p. 31.

80 Robert, Private capacity, *Committee Hansard,* 20 February 2024, pp. 24–26.

81 Robert, Private capacity, *Committee Hansard,* 20 February 2024, p. 26.

82 Robert, Private capacity, *Committee Hansard*, 20 February 2024, pp. 24.

83 Ms Meredith Cummins Chief Executive Officer, NeuroEndocrine Cancer Australia, *Committee Hansard,* 1 February 2024, pp. 7 and 8.

84 NeuroEndocrine Cancer Australia, *Submission 38*, p. 14.

85 NeuroEndocrine Cancer Australia, *Submission 38*, p. 14.

4.71 Ms Meredith Cummins, Chief Executive Officer of NeuroEndocrine Cancer Australia, considered this 'unsustainable and inequitable' and advocated for at least one NET nurse in each Australian jurisdiction.[86]

4.72 NeuroEndocrine Cancer Australia also expressed hesitancy regarding the Australian Cancer Plan's 'cancer agnostic' approach to supportive care. It considered that this model this would not provide sufficiently specialised support to NET patients:

> The Australian Cancer Plan recommends cancer "agnostic" navigation in the delivery of supportive care, which is highly likely to not be a nurse navigators. This is not going to be suitable for NET patients as they require high expertise in NETs due to the incredible complexity of their disease and varying treatments... NECA fears that this "navigation" approach will cause more issues than it solves for NET patients, and in the end, patients will still rely on the NECA specialist service...[87]

The role of general practitioners after diagnosis

4.73 Some inquiry participants highlighted that general practitioners (GPs) play an important role in supporting rare and less common cancer patients after their diagnosis.[88] For instance, Lesley, who has been managing recurrent adrenal cancer for the last 13 years, described how crucial her GP has been in supporting her throughout her cancer journey:

> On a very positive note, one other thing I would like to mention that has been incredibly important for me is the supporting role of my GP in overseeing everything medical and looking after me as a person. The importance of having a GP who knows me, who can tell how I am just by looking at me and who understands and is familiar with my complex medical history and circumstances, should not be underestimated. I also have appreciated the respectful and timely collaboration between my GP, oncologist and surgeon and their multidisciplinary team.[89]

4.74 Professor Mark Morgan, Chair of the Expert Committee for Quality Care at the Royal Australian College of General Practitioners (RACGP) advised that the role of GPs extends beyond the point of the patient's diagnosis:

> I also think that the GP role doesn't end with diagnosis and referral. I think the management of ongoing risk factors and chronic diseases, supporting a patient and their carers, and managing and helping people through

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86 Ms Meredith Cummins, Chief Executive Officer, NeuroEndocrine Cancer Australia, *Committee Hansard*, 1 February 2024, pp. 2, 7 and 8.

87 NeuroEndocrine Cancer Australia, *Submission 38*, p. 14.

88 See, for example, Lesley, Private capacity, *Committee Hansard,* 20 February 2024, p. 28; Professor Mark Morgan, Chair, Expert Committee for Quality Care, Royal Australian College of General Practitioners (RACGP), *Committee Hansard,* 1 February 2024, p. 52; Claudia, *Submission 81,* [p. 4].

89 Lesley, Private capacity, *Committee Hansard,* 20 February 2024, p. 28.

> survivorship or end-of-life care all fall to general practice. I think there's a lot more that can be done for rare cancers on those sides after the diagnosis.[90]

4.75 The RACGP flagged that cancer care and coordination requires 'complex discussions' and a shared decision-making approach with patients of varying levels of health literacy – particularly if patients have a rare cancer where other supports are lacking.[91]

4.76 The RACGP noted that this work is currently unfunded, despite its complexities, with consultations often involving a multidisciplinary team and including:

- discussion of the potential benefits and harms of treatments;
- management of other complex chronic conditions for people with a rare cancer diagnosis;
- management of the mental health of the patient, family and carers; and
- discussion of Advance Care Directives with the patient, family and carers.[92]

4.77 The RACGP also advised that patient care coordination is not funded under current settings. It highlighted that for instance, when GPs receive test results from pathology providers, time is required to review reports, and compare and update screening records. It outlined that for rare cancers, this coordination work requires further research, analysis and liaison with other health professionals involved in the patient's care.[93]

4.78 It stressed that whilst the Medicare Benefits Schedule (MBS) fee-for service structures work well for an individual patient's face-to-face care, current MBS funding levels 'reward short, episodic care, rather than long-term management of complex and chronic diseases'.[94]

4.79 It specifically called for MBS investment and reforms, and the introduction of 'blended payment models' to better support longer, and more complex consultations and collaborative shared care models:

> Recommendation 1 – GPs are supported and funded to deliver evidence-based and coordinated care to patients with complex health issues and shared-care models are supported.[95]

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90 Professor Mark Morgan, Chair, Expert Committee for Quality Care, RACGP, *Committee Hansard*, 1 February 2024, p. 52.

91 RACGP, *Submission 5*, p. 7.

92 RACGP, *Submission 5*, p. 7.

93 RACGP, *Submission 5*, p. 4.

94 RACGP, *Submission 5*, p. 4.

95 RACGP, *Submission 5*, p. 5.

The need for further psychological supports

4.80 Several witnesses and submitters explained the significant social, emotional and psychological impacts that a rare cancer diagnosis, and the complex treatment journey thereafter, can have on patients and their families.[96]

4.81 Mrs Amanda Robertson, Information and Support Manager at Cancer Council South Australia, described the psychological and social impacts that one of her clients, a woman in her late 40s, experienced following a neuroendocrine tumour diagnosis in 2019:

> I can't not mention the emotional toll. As I said, she was very isolated and overwhelmed. There were lots of practical and emotional challenges, which certainly took a toll on her mental health and often strained family relationships, owing to her needing to rely on family members for support.[97]

4.82 Jon, who outlined his perspectives and experiences after being diagnosed with a rare form of lung cancer, ALK+, in April 2022, stressed the value of psychological supports to help patients like himself to process the implications of their diagnoses:

> Psychological support can not be underestimated with a diagnosis of a rare cancer [like] ALK+ lung cancer… we are still diagnosed with a terminal cancer and are dealing with the psychological implications of his while we are still trying to live our best lives with our families. [This] is a challenging position for anyone to be in. [Psychological] support should be considered standard first line treatment.[98]

4.83 Further, Head and Neck Cancer Australia explained that treatments for these cancers, especially in relation to radiation therapy, can have a detrimental effects on quality of life and the psychological wellbeing of patients. It advised that issues such as low self-esteem, changes to intimacy and sexual health impacting mental health and wellbeing, may arise during treatment, or develop later and persist throughout a patient's life.[99]

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96 See, for example, Emily, Private capacity, *Committee Hansard,* 1 February 2024, p. 28; Mrs Amanda Robertson, Information and Support Manager, Cancer Council South Australia, *Committee Hansard,* 9 April 2024, p. 2; Head and Neck Cancer Australia, *Submission 19,* p. 3; Melanoma Patients Australia, *Submission 22*, pp. 4 and 8; NeuroEndocrine Cancer Australia, *Submission 38,* pp. 6 and 15; Movember Foundation, *Submission 40*, p. 2; Alison, *Submission 90*, [p. 1]; Mrs Bridget Bradhurst, Acting Chief of Support and Advocacy, Ovarian Cancer Australia, *Committee Hansard,* 1 February 2024, p. 60; Ms Angie Sari-Daher, Australian DIPG Families, *Committee Hansard,* 31 January 2024, p. 34; Jon, *Submission 67*, [p. 1].

97 Mrs Amanda Robertson, Information and Support Manager, Cancer Council South Australia, *Committee Hansard,* 9 April 2024, p. 1.

98 Jon, *Submission 67*, [p. 1].

99 Head and Neck Cancer Australia, *Submission 19*, p. 3

4.84 Several inquiry participants called for additional investment in psychological, or mental health services to support patients and their loved ones throughout their cancer journey.[100]

4.85 The Minderoo Foundation, specifically recommended investment in 'robust psychosocial support services' including counselling, support groups and survivorship programs, to effectively address the unique challenges faced by patients with rare cancer diagnoses and their families.[101]

4.86 Specific issues to be addressed regarding psychological services are outlined below.

Timeliness of psychological supports

4.87 The committee heard of the importance of timely psychological supports for those affected by rare and less common cancers.[102]

4.88 For example, Mrs Amanda Robertson, Information and Support Manager at Cancer Council South Australia, emphasised the need for more timely provision of psychological services. She posited 'one would hope we could intervene earlier to lower those distress levels and not get to the point where someone is desperately unwell'.[103]

4.89 Lived experience accounts also emphasised the need for more timely provision of these services.[104] For example, Eleni, whose mother Miro was diagnosed with pancreatic cancer in October 2021, told the committee that the offer of psychological support came far too late in her mother's cancer journey:

> During Mum's short time in [hospital], she became more and more medicated in an effort to manage the pain. During this time, she became more and more distant, drowsy and eventually got to the point where she struggled to stay awake or communicate, as her body rapidly shut down. It wasn't until this point that we were first offered the support of a psychologist or counsellor, but it was far too late by this stage. I wish Mum

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[100] See, for example, Alison, *Submission 90*, [p. 1]; Queensland Health, *Submission 12*, p. 15; NeuroEndocrine Cancer Australia, *Submission 38*, pp. 15 and 16; Dr Richard Mitchell, Director, Kids Cancer Centre, Sydney Childrens Hospital Randwick, Sydney Childrens Hospitals Network, *Committee Hansard*, 31 January 2024, p. 52; Associate Professor Kathy Tucker, Private capacity, *Committee Hansard*, 1 February 2024, p. 55; Mrs Amanda Robertson, Information and Support Manager, Cancer Council South Australia, *Committee Hansard*, 9 April, p. 2; Christopher, *Submission 73*, [p. 1].

[101] Minderoo Foundation, *Submission 23*, pp. 3 and 4.

[102] See, for example, Glen, *Submission 101*, [p. 1]; Eleni, *Submission 126*, [p. 2]; Mrs Amanda Robertson, Information and Support Manager, Cancer Council South Australia, *Committee Hansard*, 9 April 2024, p. 6.

[103] Mrs Amanda Robertson, Information and Support Manager, Cancer Council South Australia, *Committee Hansard*, 9 April 2024, p. 6.

[104] See, for example, Glen, *Submission 101*, [p. 1]; Eleni, *Submission 126*, [p. 2].

> had this support earlier, when she was still lucid, to help her work through the thoughts, emotions and fear of knowing she would ultimately lose her life to cancer and leave her family behind.[105]

Dedicated psychological supports for children and young people

4.90 The committee also heard specific calls for more psychosocial supports to support children and young people affected by rare and less common cancer.[106]

4.91 Jelena, whose youngest son Marko was diagnosed with neuroblastoma when he was 16 months old, outlined the need for such services:

> Also, with rare cancers, I think investing in psychosocial support is extremely important, especially in childhood cancers. As an adult, you kind of have those coping mechanisms. Children have their whole lives ahead of them. Even though he's feeling okay now, we don't know what the long-term effects of his treatment are going to be, and, now that the treatment is done, we are left to our own devices.[107]

4.92 Similarly, Yvonne advocated for the provision of psychological support for children, adolescents and young adults, and their families when they are diagnosed with a rare disease or cancer, within the first week of diagnosis.[108]

4.93 The department advised the Australian Government has recently launched the 'Cancer Hub', a digital platform providing immediate online, consolidated, and tailored cancer navigation, counselling and support service for people under 25 years and their parents. According to the department, this initiative will help over 70 000 Australians navigate the cancer journey and a further 20 000 with mental health support.[109]

4.94 The department also outlined that the government has supported Canteen Australia to establish and deliver the Youth Cancer Service program for young people with cancer. It further detailed:

> This provides patients with services, social and emotional support, access to clinical trials and developing and implementing national and local strategies to support the delivery of high-quality youth cancer services. The Government provided Canteen $22.0 million over four years from 2020-21 to support this activity, which is available to all young people with cancer.[110]

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105 Eleni, *Submission 126*, [p. 2].

106 See, for example, Dr Richard Mitchell, Director, Kids Cancer Centre, Sydney Childrens Hospital Randwick, Sydney Childrens Hospitals Network, *Committee Hansard,* 31 January 2024, p. 52; Jelena, Private capacity, *Committee Hansard,* 1 February 2024, p. 30; Yvonne, *Submission 100,* [p. 4].

107 Jelena, Private capacity, *Committee Hansard,* 1 February 2024, p. 30.

108 Yvonne, *Submission 100,* [p. 4].

109 Department of Health and Aged Care, *Submission 1*, p. 13.

110 Department of Health and Aged Care, *Submission 1*, p. 13.

Bereavement care

4.95 Evidence to the committee also highlighted the importance of bereavement care and supports following the death of a patient.[111]

4.96 Evidence provided by the Pancare Foundation highlighted the 'sad reality' that many patients diagnosed with pancreatic cancer will pass away from this disease, which leaves loved ones grappling with their loss and in need of bereavement support:

> Furthermore, with five-year survival rates less than 35 per cent, the sad reality is that 65 percent of patients will be lost within five years of diagnosis (absent developments in treatment). It follows that many carers and family members will deal with the loss of their loved ones, and therefore, bereavement and available social support are critical for carers.[112]

4.97 Ms Lucy Jones, Chief Executive Officer of Neuroblastoma Australia, echoed these sentiments at a public hearing, where she described the lack of bereavement supports available to families affected by neuroblastoma. Ms Jones noted that a neuroblastoma diagnosis results in the 'death of the child in 50 per cent of cases', and that families are expected to 'get back, in theory, to the real world with very little support'.[113] She appealed for government to fund additional supports for these families:

> It really would be recommended for the government to fund more support in hospitals and afterwards, after the actual treatment journey has finished, because the overall journey certainly hasn't.[114]

4.98 Kate, whose young niece Emily, passed away following complications after undergoing treatment for neuroblastoma, also noted the lack of bereavement supports that were extended to her and her family following Emily's passing:

> Emily would have started prep last week. My mum, Emily's grandmother, had to call St Benedict's to tell them that Emily died and that we needed to unenrol her. Emily died cancer free. In the months that followed, we received one follow-up phone call from Emily's oncologist. We never heard from bereavement services. We found out via Facebook that, every year, our hospital holds a memorial service for children who have died. We did not know about the service, and Emily was not included. When we asked why, we were simply told that Emily's social worker had moved on, and her paperwork had been lost in the system. Because Emily died on a Thursday afternoon, and her social worker finished early on Friday, I had to call White

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111 See, for example, Ms Lucy Jones, Chief Executive Officer, Neuroblastoma Australia, *Committee Hansard*, 31 January 2024, p. 17; Pancare Foundation, *Submission 21,* Attachment 1, p. 129; Kate, Private capacity, *Committee Hansard,* 31 January 2024, p. 41.

112 Pancare Foundation, *Submission 21,* Attachment 1, p. 129.

113 Ms Lucy Jones, Chief Executive Officer, Neuroblastoma Australia, *Committee Hansard*, 31 January 2024, p. 17.

114 Ms Lucy Jones, Chief Executive Officer, Neuroblastoma Australia, *Committee Hansard*, 31 January 2024, p. 17.

> Lady to organise the transfer of Emily's body from the hospital morgue to the funeral home.[115]

Palliative care services

4.99 The committee heard of the importance of palliative care in providing support to patients diagnosed with rare and less common cancers, including neuroendocrine cancer.[116]

4.100 Queensland Health noted that whilst cancer remains one of the leading causes of death across all ages, the availability of timely and equitable access to palliative care is essential.[117] Further, it explained:

> Palliative care is 'person and family-centred care provided for a person with an active, progressive, advanced disease, who has little or no prospect of cure and who is expected to die, and for whom the primary goal is to optimise the quality of life'. Palliative care treats physical, emotional, spiritual, or social symptoms because of a condition or disease.[118]

4.101 Queensland Health informed the committee that a patient may enter and exit palliative care throughout their cancer journey, particularly if their prognosis is years from their diagnosis.[119]

4.102 Some submitters flagged that palliative care is not always provided appropriately, or early enough during a patient's cancer journey. For example, Mrs Hannah Pringle, mother of Ruby who passed away in March 2023 following a battle with DIPG, outlined issues that Ruby experienced in the delivery end of life care:

> Even in Ruby's death, she was unable to access the critical medication to comfort her in her passing. The palliative care institute ran out of medication they were administrating via a continuous pump. For four hours Ruby was actively dying without the adequate medication. An on-call doctor was called out of hours to write a script. The medication then had to be retrieved from off site. This resulted in further suffering for Ruby and ingrained memories of the sound of her death rattle for four hours that was not needed.[120]

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115 Kate, Private capacity, *Committee Hansard,* 31 January 2024, p. 41.

116 See, for example, Queensland Health, *Submission 12,* p. 15; Mrs Hannah Pringle, Australian DIPG Families, Committee Hansard, 31 January 2024, p. 36; Ms Angie Sari-Daher, Australian DIPG Families, *Committee Hansard,* 31 January 2024, p. 35.

117 Queensland Health, *Submission 12,* p. 15.

118 Queensland Health, *Submission 12,* p. 15. Citation omitted.

119 Queensland Health, *Submission 12,* p. 15.

120 Mrs Hannah Pringle, Australian DIPG Families, *Committee Hansard*, 31 January 2024, p. 36.

4.103 The Pancare Foundation submitted that access to supportive and palliative care services is 'limited, late and varied across Australia'.[121] It also noted that patients living with upper gastrointestinal cancers are only referred when they are actively deteriorating, it continued:

> …the median time before death at which a patient access palliative care is about 20 days. In this sense, palliative care services are underutilised in Australia.[122]

4.104 Similarly, Ms Angie Sari-Daher, whose daughter, Eve, was diagnosed with DIPG, told the committee that 'palliative care services offer limited supports until the child is actively dying' for DIPG families.[123]

4.105 Queensland Health explained that there are many reasons as to why palliative care may not be discussed with the patient or their loved ones at the time of diagnosis. It explained that reasons for this could include:

- that clinicians and patients alike are unaware that palliative care 'is more than just making a patient comfortable at end-of-life';
- a lack of knowledge of palliative care supports and services;
- a lack of knowledge or recognition of what palliative care can offer; and
- a lack of regional, rural and remote palliative care services.[124]

The importance of culturally safe palliative care for First Nations people

4.106 The committee heard that First Nations individuals and communities do not have access to culturally safe palliation services, despite their disproportionally high cancer mortality rates.[125]

4.107 NACCHO outlined that there is a need for palliative care services for First Nations people in residential aged care and hospital settings that accommodate cultural needs, which could include supporting the patient to return to country.[126]

4.108 To achieve this, NACCHO recommended provided funding to the ACCHO sector so that they can provide holistic and culturally safe palliation and end-of-life services, stressing that there is a significant need for investment so that First Nations people can 'die with dignity'.[127]

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121 Pancare Foundation, *Submission 21*, p. 4.

122 Pancare Foundation, *Submission 21*, p. 13.

123 Ms Angie Sari-Daher, Australian DIPG Families, *Committee Hansard*, 31 January 2024, p. 35.

124 Queensland Health, *Submission 12*, p. 15.

125 NACCHO, *Submission 48*, p. 17.

126 NACCHO, *Submission 48*, p. 17.

127 NACCHO, *Submission 48*, p. 17.

Committee view

4.109 The committee was moved by the multitude of lived experience accounts which outlined the devastating and life-changing impacts that a rare or less common cancer diagnosis can have on Australian individuals, their loved ones, and their communities.

4.110 The committee notes that beyond the significant physical, social and psychological tolls that a such a diagnosis can have on individuals, these factors are often compounded by further cancer navigation and coordination challenges such as navigating the complex health system, making difficult decisions about treatment and care, and juggling numerous medical appointments.

4.111 This evidence made clear that there is an overwhelming need for increased and improved, patient-centred, supportive care and survivorship services for Australians with rare and less common cancers.

Funding for support services and information

4.112 The committee is aware that there are many generous, innovative, and hard-working non-government organisations, charities and lived experience advocates in the community which work to fill these crucial support gaps for those affected by rare cancers. However, the committee considers that Australians should not be forced to rely upon the goodwill or fundraising capacity of other Australians or charities to ensure the ongoing provision of such essential supports.

4.113 The committee believes that if the Commonwealth is not providing these essential supports itself, then it must play a larger role in ensuring cancer advocacy and other relevant community organisations have sufficient and secure funding to keep up with the demand for supports. The committee considers it crucial that community organisations are supported to continue delivering services such as helplines and providing other rare cancer information and guidance materials, for their clients and patient groups, long into the future.

Recommendation 18

4.114 The committee recommends that the Australian Government provide appropriate funding to key cancer advocacy organisations supporting patients with rare and less common cancers by providing informative resources and support services that:

- **increase health literacy;**
- **empower patients to make informed decisions regarding their health; and**
- **are culturally appropriate and accessible in a variety of languages.**

4.115 Further, whilst the committee welcomes the Australian Cancer Plan's ambitions in relation to the provision of supportive care, it reemphasises that to achieve equity in cancer care, sufficient focus, attention and resources must also be provided to deliver on these for rare and less common cancers.

Recommendation 19

4.116 The committee recommends that the Australian Government provide sufficient funding and resources to ensure that the supportive care aspirations of the Australian Cancer Plan are delivered on for all Australians, including for those affected by rare and less common cancers.

Cancer care nurses

4.117 The committee heard a substantive amount of evidence which outlined the need for further investment in, and provision of cancer care nurses across Australia.

4.118 The committee was encouraged to hear that the Australian Government has recently committed to establishing the 'all-cancer nurse service' which strives to provide approximately 250 Commonwealth funded all-cancer care nurses by 2027, to provide a similar level of service across the country, no matter what type of tumour patients have.

4.119 However, the committee notes there was some hesitancy amongst inquiry participants about the 'cancer-agnostic' nature of this service, with some calling for the provision of cancer-specific nurses.

4.120 The committee is of the strong view that the government's all-cancer nurse service will be effective in providing additional, much needed supports for rare and less common cancer patients and it looks forward to monitoring the roll out of these nurses in the community in the coming years. However, the committee recognises the additional need for dedicated paediatric cancer and neuroendocrine tumour nurses, noting the complex and unique characteristics of these cancers and these patients.

Recommendation 20

4.121 The committee recommends that the Department of Health and Aged Care monitor and report on progress for the delivery of the all-cancer nurse service.

Recommendation 21

4.122 The committee recommends that the Australian Government explore the provision of at least one specialised neuroendocrine tumour nurse, and paediatric cancer nurse, in each Australian jurisdiction.

General practitioners

4.123 The committee is aware of the important role that general practitioners (GPs) continue to play in supporting rare and less common cancer patients, far beyond the point of diagnosis, or their referral to other specialist services.

4.124 The committee understands that GPs provide crucial supports such as patient care coordination, providing advice regarding the potential benefits and harms of treatments, managing comorbidities and risk factors, and helping people navigate survivorship or end-of-life care.

4.125 However, the committee notes evidence which highlighted that current Medicare Benefits Schedule (MBS) settings do not sufficiently remunerate or incentivise GPs to provide this more complex, intensive care and coordination support, which is often required for patients affected by rare and less common cancers, or other rare diseases.

4.126 Noting the substantive amount of evidence received from patients and families affected by rare and less common cancers which observed the overall lack of supportive care following diagnosis, the committee believes that there is an opportunity to ensure that GPs are better enabled to fill these critical support gaps.

Recommendation 22

4.127 The committee recommends that the Australian Government ensure that general practitioners are appropriately incentivised and remunerated for patient care coordination and longer-term management of complex and chronic diseases, including rare and less common cancers.

Psychological services

4.128 The committee heard that additional, more affordable, and more timely psychological services are needed to adequately support rare and less common cancer patients and their loved ones, through this incredibly challenging time.

4.129 The committee also notes particular calls for dedicated psychological supports for children and young people affected by these cancers, as well as the need for improved and increased bereavement services.

Recommendation 23

4.130 The committee recommends that the Australian Government consider further investment to ensure the timely and affordable provision of psychological services to support patients and their families acutely impacted by rare and less common cancers.

Palliative care

4.131 The committee heard that palliative care is an essential form of support for several Australians affected by rare and less common cancers, including neuroendocrine cancer.

4.132 However, the committee was concerned to hear that too often, palliation services are not always provided in a timely manner, and that patients, families and medical professions alike can misunderstand, or lack awareness of the purpose of these services. The committee was also alarmed to learn about the inequities in access to palliation services across the country, particularly in rural and remote regions.

4.133 There is a need for more timely, equitable and appropriate access to palliation services for rare and less common cancer patients. Particular consideration should also be given to the provision of culturally safe and appropriate palliative care for First Nations people and communities.

Recommendation 24

4.134 The committee recommends that the Australian Government work with state and territory governments, and palliative care services to support:

- **improved understanding amongst patients, families and clinicians of the potential benefits, and timely delivery of palliative care;**
- **increased awareness that palliative care is not just an end-of-life service;**
- **increased availability of tailored and appropriate palliative care services, for a range of population groups; and**
- **where appropriate, greater dialogue upon diagnosis, or throughout treatment, between patients, families and clinicians on palliative care options.**

Chapter 5
Structural barriers to equitable care

> Access to these life-saving tests and treatments should be a choice for patients, not a privilege or postcode or tumour stream lottery.[1]

5.1 The committee received substantial evidence in relation to structural barriers which can contribute to, and exacerbate inequitable access to diagnostic, treatment and support services for rare and less common cancer patients, and their loved ones.

5.2 This chapter discusses how the following factors can impact patient experiences and outcomes, throughout their cancer journey:

- health literacy;
- financial 'toxicity' including direct out-of-pocket costs, indirect out-of-pocket costs, and changes in financial circumstances following a rare cancer diagnosis;
- geographical challenges – particularly for those in regional, rural and remote Australia;
- health workforce issues; and
- cultural factors – particularly in relation to First Nations people and communities, as well as culturally and linguistically diverse (CALD) communities.

5.3 This chapter concludes with the committee's views and recommendations relating to these matters.

Health literacy

5.4 The committee heard that health literacy is an important factor which can influence diagnostic and treatment outcomes and experiences for cancer patients.[2] For instance, Professor Mark Morgan, Chair of the Expert Committee for Quality Care at the Royal College of General Practitioners (RACGP) told the

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1 Caitlin, Private capacity, *Committee Hansard*, 1 February 2024, p. 37.

2 See, for example, Rare Cancers Australia, *Submission 3,* [p. 4]; Queensland Health, *Submission 12*, p. 7; Pancare Foundation, *Submission 21*, p. 12; Movember Foundation, *Submission 40*, pp. 3 and 7; National Aboriginal Community Controlled Health Organisation (NACCHO), *Submission 48*, p. 15; Jelena, Private capacity, *Committee Hansard,* 1 February 2024, p. 30; Associate Professor Anna Boltong, Chief Executive Officer, Ovarian Cancer Australia, *Committee Hansard,* 1 February 2024, p. 64.

committee that people's level of health literacy and self-advocacy can influence their ability to seek answers and appropriately manage symptoms.[3]

5.5 The broad implications of poor health literacy were explained by both Queensland Health and the Pancare Foundation.[4] Queensland Health advised that patients with low health literacy are more likely to have worse health outcomes overall due to:

- lower engagement with health services and preventive services such as cancer screening;
- higher hospital readmission rates;
- poorer understanding of medication instructions; and
- a lower ability to recognise potential cancer symptoms and/or self-manage their care.[5]

5.6 Lived experience inquiry participants outlined the particular challenges regarding health literacy and navigating the management of a rare or less common cancer. For example, Lesley emphasised the 'life saving' role health literacy has played in her recurrent adrenal cancer journey. She explained:

> Knowing how to access research papers, to read and process those papers, and having access to and attending virtual conferences for adrenal cancer has helped me to stay alive and provides for informed discussions with my oncologist and surgeon ... By reading these papers and contacting a PhD student, I was referred on to my current surgeon, which has been a life-saving experience. [6]

5.7 Similarly, Caitilin, who was diagnosed with ovarian cancer, reflected that as a clinical scientist herself, she feels 'lucky to be health-literate' throughout her journey, but acknowledged that not all are so fortunate.[7] She added:

> It has been my ability to self-advocate for the right genetic tests and personalised treatments at the right time that has really kept me alive this long, making those sliding-door moments open in my favour.[8]

5.8 Judi, who lives with pancreatic cancer, also echoed the importance of health literacy. She reflected that 'you go from being a layperson to suddenly becoming

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3 Professor Mark Morgan, Chair, Expert Committee for Quality Care, Royal Australian College of General Practitioners (RACGP), *Committee Hansard*, 1 February 2024, p. 53.

4 Queensland Health, *Submission 12,* p. 7; Pancare Foundation, *Submission 21,* p. 12.

5 Queensland Health, *Submission 12,* p. 7.

6 Lesley, Private capacity, *Committee Hansard,* 20 February 2024, p. 27.

7 Cailtin, Private capacity, *Committee Hansard,* 1 February 2024, p. 36.

8 Cailtin, Private capacity, *Committee Hansard,* 1 February 2024, p. 37.

someone who, unless you get health literate and advocate for yourself, could sink or swim'.[9]

5.9 The Hospital Research Foundation Group reflected that individuals diagnosed with more common cancers such as breast or prostate cancer, 'have far easier health literacy pathways than those diagnosed with rare cancers and neuroendocrine cancers'.[10] Paul Flynn, Chief Executive Officer of the Hospital Research Foundation Group, expanded on this matter:

> Having recently transversed the prostate cancer pathway myself … access to information to make informed choices once I was past the initial shock was very good. My good experience is often not the experience a patient from a rural and remote area or those diagnosed with rare cancers have.[11]

5.10 These issues closely relate to the broader concerns discussed in Chapter 4 of this report, regarding calls for better overarching availability and accessibility of information and guidance for patients, throughout their cancer journey.[12]

5.11 As discussed in Chapter 4, the Australian Cancer Plan has identified a two-year ambition, as part of their 'Enhanced Consumer Experience' strategic objective, to 'improve availability of co-designed, tailored information and care for consumers to improve health literacy and reduce cancer-related stigma'.[13]

Financial toxicity

5.12 Inquiry participants provided significant evidence outlining experiences of financial hardship encountered whilst seeking diagnostic or treatment services for rare and less common cancers.[14]

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9 Judi, Private capacity, *Committee Hansard,* 20 February 2024, p. 28.

10 The Hospital Research Foundation Group, *Submission 146*, p. 4.

11 The Hospital Research Foundation Group, *Submission 146*, p. 4.

12 See, for example, Judi, *Submission 116*, [p. 9]; Ms Winton, Lymphoma Australia, *Committee Hansard*, 1 February 2024, pp. 15 and 16; Movember Foundation, *Submission 40*, p. 5; Katherine, Private capacity, *Committee Hansard*, 1 February 2024, p. 31; Rare Cancers Australia, *Submission 3,* [pp. 7 and 8]; Lesley, Private capacity, *Committee Hansard*, 21 February 2024, p. 27; Head and Neck Cancer Australia, *Submission 19*, p. 3; Leona, *Submission 65*, [p. 1]; Claudia, *Submission 81*, [p. 3].

13 Cancer Australia, *Australian Cancer Plan Summary Report*, Additional information received 16 January 2024, p. 18.

14 See, for example, Associate Professor Christopher Steer, President, Private Cancer Physicians of Australia, *Committee Hansard,* 31 January 2024, p. 24; Associate Professor Kathy Tucker, Private capacity, *Committee Hansard*, 31 January 2024, p. 56; Michael, Private capacity, *Committee Hansard*, 1 February 2024, p. 34; Mrs Julia Sammut, Private capacity, 31 January 2024, pp. 15–16; David, *Submission 105,* [p. 1]; Sarah, *Submission 112*, [p. 2].

5.13 Inquiry participants were of the view that these hardships were a result of cancer-related financial toxicity[15], which Ms Megan Varlow, Director of Cancer Control Policy at Cancer Council Australia explained includes:

- costs associated with receiving cancer:
  - direct out-of-pocket costs
  - indirect costs
  - change in someone's financial circumstances; and
- stressing about one's financial situation.[16]

5.14 Ms Varlow explained that rare and less common cancer patients are more likely to experience financial toxicity because:

> …a lot of the other treatments that they might have to access or seek out for themselves are additional costs that are not necessarily covered by the way the health system is currently funded.[17]

5.15 From a patient's perspective, Caitlin, who lives with stage 4 clear cell ovarian cancer asserted that 'any cancer is financially toxic - but to be further financially penalised due to a rare pathology seems unethical'.[18]

5.16 This can result in financially distressing situations for patients and their families, as evidenced by Associate Professor Christopher Steer, President of Private Cancer Physicians Australia, who has directly observed the 'extreme choices patients feel they must make'[19]. He outlined a recent, firsthand example:

> Last week, for example, I experienced the anguish of a patient who is a young father of school aged children who was facing the choice of drawing on his super to pay the mortgage or selling his house whilst he was

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15 See, for example, Michelle, Private capacity, *Committee Hansard,* 31 January 2024, p. 44; Ms Megan Varlow, Director, Cancer Control Policy, Cancer Council Australia, *Committee Hansard,* 31 January 2024, p. 1; Associate Professor Christopher Steer, President, Private Cancer Physicians of Australia, *Committee Hansard*, 31 January 2024, p. 24; Ms Meredith Cummins, Chief Executive Officer, NeuroEndocrine Cancer Australia, *Committee Hansard*, 1 February 2024, pp. 2 and 4; Pancare Foundation, *Submission 21*, [p. 10]; Menzies Institute for Medical Research, University of Tasmania, *Submission 148*, [p. 3].

16 Ms Megan Varlow, Director, Cancer Control Policy, Cancer Council Australia, *Committee Hansard,* 31 January 2024, p. 2.

17 Ms Megan Varlow, Director, Cancer Control Policy, Cancer Council Australia, *Committee Hansard,* 31 January 2024, p. 2.

18 Cailtin, *Submission 111,* [p. 1].

19 Associate Professor Christoper Steer, President, Private Cancer Physicians of Australia, *Committee Hansard,* 31 January 2024, p. 24.

> undergoing treatment for a curable condition. The rising cost of living hurts all Australian families, but for those with cancer the costs can be crippling.[20]

Direct out-of-pocket costs

5.17 Inquiry participants expressed concern over high out-of-pocket costs incurred when accessing diagnostic and treatment services.[21] The different types of out-of-pocket expenses incurred across the rare and less common cancer journey, and their impacts on patients and families, are discussed in the following sections.

The costs of diagnosis

5.18 As discussed in Chapter 2, inquiry participants told the committee that the diagnostic process for rare or less common cancers is often long, logistically burdensome and costly.[22] This section discusses the financial aspects of accessing these services.

5.19 The Leukaemia Foundation outlined that delayed diagnosis can increase costs for patients and provided the following example:

> The patient took over 3 years before a diagnosis was made despite presenting with enlarged lymph nodes (ultrasound but no biopsy). So those medical costs, all the CT and biopsies and testing, and medical visits pre-diagnosis was borne out of pocket.[23]

5.20 Ms Meredith Cummins, Chief Executive Officer of NeuroEndocrine Cancer Australia also outlined that unnecessary tests and mis-diagnoses, can have financial consequences, for both patients and the health system:

> The cost of unnecessary tests impacts patients and the public healthcare system, predominantly because of this misdiagnosis and prolonged time,

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20 Associate Professor Christoper Steer, President, Private Cancer Physicians of Australia, *Committee Hansard,* 31 January 2024, p. 24.

21 See, for example, Sarah, *Submission 112,* [p. 2]; Judi, *Submission 116,* [p. 12]; Ms Christine Cockburn, Chief Executive Officer, Rare Cancers Australia, *Committee Hansard,* 31 January 2024, p. 6; Pancare Foundation, *Submission 21*, [p. 10]; NeuroEndocrine Cancer Australia, *Submission* 38, pp. 9–10; Professor John R Zalcberg AO, *Submission* 50, [pp. 1–2]; Yvonne, *Submission* 100, [pp. 3–4]; Associate Professor Christoper Steer, President, Private Cancer Physicians Australia, *Committee Hansard,* 31 January 2024, pp. 23–24; AbbVie, *Submission 120,* [p. 3]; Name Withheld, *Submission 123,* pp. 1–2.

22 See, for example, Emily, Private capacity, *Committee Hansard,* 1 February 2024, p. 27; Peter, Private capacity, *Committee Hansard,* 20 February 2024, p. 23; David, *Submission 105,* p. 1; Jessica, *Submission 108,* [p. 1]; Doreen, *Submission 118,* [p. 1]; Leukemia Foundation, *Submission 39,* p. 6; Sarah, *Submission 113*, [p. 1]; Cancer Council Australia, the Cancer Nurses Society of Australia, the Clinical Oncology Society of Australia, Private Cancer Physicians of Australia, the Medical Oncology Group of Australia and the Lung Foundation Australia, *Submission 4,* p. 5; Mrs Hannah Pringle, Australian DIPG Families, *Committee Hansard,* 31 January 2024, p. 35; Kate, Private capacity, *Committee Hansard,* 31 January 2024, p. 40; Jelena, Private capacity, *Committee Hansard,* 1 February 2024, p. 29.

23 Leukemia Foundation, *Submission 39*, p. 8.

> and it costs patients about $1,700 over three months for out-of-pocket expenses.[24]

Treatment costs

5.21 As discussed in Chapter 3 of this report, many treatments for rare and less common cancers are not government funded, compounding direct out-of-pocket expenses[25], which can make them 'prohibitive' to access.[26]

5.22 For instance, Jim, who lives with a rare salivary duct cancer, described investigating clinical trials for treatment because his class of drug (BRAF V600E drugs), while available in Australia, is not listed on the Pharmaceutical Benefits Scheme and therefore would cost him between $10 000 to $15 000 a month. This led him to choose a less genetically targeted treatment method which scans later showed as being ineffective. He highlighted that due to these financial barriers, the 'BRAF V600E pathway still remains blocked' for him.[27]

5.23 Relatedly, Claudia, who was diagnosed with pancreatic cancer in 2022, identified that even in cases where treatment costs are covered by Medicare, an initial payment is required before a treatment begins.[28] She observed that this can be prohibitive and unfair, stating:

> … my treatment for the pancreatic cancer and a nodule cost $6230.00, and another nodule treated later cost $3950. These are expenses not everyone would be able to pay in advance. It indicates an unfair and unequitable access to treatment, based on a patient's financial situation …[29]

5.24 The emotional toll this can place on patients due to the vast cost differences in treatment compared to other cancers was articulated by Sarah, who emphasised feeling frustrated and less valued as a rare cancer patient.[30] She explained that despite her son's school fundraising thousands of dollars 'the depressing thing

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24 Ms Meredith Cummins, Chief Executive Officer, NeuroEndocrine Cancer Australia, *Committee Hansard*, 1 February 2024, p. 2.

25 See, for example, Ms Megan Varlow, Director, Cancer Control Policy, Cancer Council Australia, *Committee Hansard*, 31 January 2024, p. 1; Ms Christine Cockburn, Chief Executive Officer, Rare Cancers Australia, *Committee Hansard,* 31 January 2024, p. 2; Pancare Foundation, *Submission 21*, [p. 10]; Minderoo Foundation, *Submission 23*, [p. 2]; Dr Minmin Li FRACP and Associate Professor Kathy Tucker AO FRACP, *Submission 36*, [p. 2]; Melanoma Patients Australia, *Submission 22*, p. 4; NeuroEndocrine Cancer Australia, *Submission 38*, pp. 9–10.

26 Associate Professor Christopher Steer, President, Private Cancer Physicians of Australia, *Committee Hansard,* 31 January 2024, p. 24.

27 Jim, *Submission 55,* [pp. 1–2].

28 Claudia, *Submission 81,* p. 3.

29 Claudia, *Submission 81,* p. 3.

30 Sarah, *Submission 112,* [p. 2].

is … it only covered about a week of treatment. Having a rare cancer is expensive'.[31]

5.25 The committee also heard that monitoring cancer progression and treatment effectiveness can require regular scans and testing, which often incur out-of-pocket expenses to patients.[32] For example, NeuroEndocrine Cancer Australia explained that there is a specific type of blood test (Chromogranin A) used in the diagnosis, monitoring and management of neuroendocrine tumours.[33] This test is Medicare non-rebatable and sometimes occurs every three to six months, which 'over many years can add up to thousands of dollars'.[34]

Overseas treatment costs and crowdfunding

5.26 As discussed in Chapter 3, clinical trials are often the only treatment avenue for patients with rare or less common cancers[35], which can result, in patients and families self-funding travel costs to participate in trials overseas where they are more 'readily available'.[36]

5.27 Also outlined in Chapter 3, patients and their families do not have coverage for clinical trials under the Medical Treatment Overseas Program.[37] This can result in out-of-pocket expenses upwards of $300 000 to participate in international trials.[38]

5.28 Families often resort to crowdfunding to pay these high costs, which Ms Lucy Jones, Chief Executive Officer of Neuroblastoma Australia expressed concern over:

> Leaving families to rely on fundraising to save their child is to sanction survival disparities and inequities in the most serious of stakes … Whilst

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31 Sarah, *Submission 112,* [pp. 1–2].

32 See, for example, Professor John R Zalcberg AO, *Submission 50*, [p. 2]; NeuroEndocrine Cancer Australia, *Submission 38,* p. 10; WMozzies, *Submission 119*, [p. 2]; Sandra, *Submission 84,* p. 3; Peter, *Submission 131,* [p. 2].

33 NeuroEndocrine Cancer Australia, *Submission 38,* p. 10.

34 NeuroEndocrine Cancer Australia, *Submission 38,* p. 10.

35 See, Rare Cancers Australia, *Submission 3,* [p. 4]; Cancer Trials Australia, *Submission 34,* [p. 2].

36 Megan, *Submission 107,* p. 3.

37 Natalie, *Submission 122,* p. 4.

38 See, for example, Jelena, Private capacity, *Committee Hansard,* 1 February 2024, p. 29; Danielle, *Submission 109,* p. 3; Neuroblastoma Australia, *Submission 58*, [p. 3]; Katherine, Private capacity, *Committee Hansard,* 1 February 2024, p. 31; Jacqui, Private capacity, *Committee Hansard*, 20 February 2024, p. 19.

> some families do manage to raise the many hundreds of thousands of dollars often needed, it comes at a huge emotional and financial cost.[39]

5.29 Kate, whose niece, Emily, was diagnosed with neuroblastoma also echoed concern over crowdfunding, which she undertook for 6 months to access 'promising' overseas treatment for Emily. She asserted that 'no family should have to fundraise for their child's future'.[40]

5.30 Katherine, whose three-year-old child was diagnosed with neuroblastoma, illustrated to the committee the emotional burden of crowdfunding, as it 'entails putting your whole life and trauma out into the public domain' and was told that 'the more personal, upsetting photos will raise more money'.[41]

Indirect costs

5.31 Further to the expenses outlined above, considerable evidence to the committee highlighted that additional indirect costs associated with a rare and less common cancer diagnosis, can magnify experiences of financial toxicity.[42]

5.32 Several inquiry participants described the out-of-pocket expenses and burden associated with travel and relocation for diagnostics and treatment.[43] For instance, Associate Professor Antoinette Anazodo, Paediatric and Adolescent Oncologist from Sydney Childrens Hospital Randwick, described the financial implications patients can experience due to travel and relocation:

> … we have data from our centre that shows that the average distance between home and the cancer centre in Sydney is 327 kilometres … it means that many of these patients … have to relocate for the time of their treatment. On average, cancer treatment for a child is between six and 12 months. So,

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39 Ms Lucy Jones, Chief Executive Officer, Neuroblastoma Australia, *Committee Hansard*, 31 January 2024, pp. 13-14.

40 Kate, Private capacity, *Committee Hansard*, 31 January 2024, p. 42.

41 Katherine, Private capacity, *Committee Hansard*, 1 February 2024, p. 31.

42 See, for example, Mrs Beau Kemp, Australian DIPG Families, *Committee Hansard*, 31 January 2024, p. 38; Name Withheld, *Submission 123*, pp. 1–2; Cancer Council Australia, the Cancer Nurses Society of Australia, the Clinical Oncology Society of Australia, Private Cancer Physicians of Australia, the Medical Oncology Group of Australia and the Lung Foundation Australia, *Submission 4*, p. 6; NeuroEndocrine Cancer Australia, *Submission 38*, pp. 6, 9-11; Peter, *Submission 131*, [p. 2]; Queensland Health, *Submission 12*, p. 8; Pancare Foundation, *Submission 21*, Attachment 1, pp. 121–122; AbbVie, *Submission 120*, pp. 3–4; Yvonne, *Submission 100*, [p. 4].

43 See, for example, Rare Cancers Australia, *Submission 3*, [p. 7]; National Rural Health Alliance, *Submission 7*, pp. 4 and 7; Australian Genomics, *Submission 10*, [p. 2]; The Society of Hospital Pharmacists of Australia, *Submission 17*, [p. 4]; Melanoma Patients Australia, *Submission 22*, p. 3; Ovarian Cancer Research Foundation, *Submission 27*, [p. 6]; AbbVie, *Submission 120*, [p. 3]; Mrs Susanne Manks, Patient, Peter MacCallum Cancer Centre, *Committee Hansard*, 1 February 2024, p. 3; Dr Anna Johnston, Director of Clinical Haematology, Royal Hobart Hospital, *Committee Hansard*, 20 February 2024, pp. 7–8; Leukaemia Foundation, *Submission 39*, p. 12.

> again, we're already talking about a point of financial embarrassment for patients who have to be in one of these centres...[44]

5.33 The committee was also informed of other incidental expenses patients must cover throughout their cancer journey, including food, parking, support equipment and other health services.[45]

5.34 For example, a mother reported paying over $7000 for meals (450 total) during her son's 10-month hospital stay for osteosarcoma treatment.[46]

5.35 Beau, who tragically lost her son Ryley to DIPG at just eight-years-old in March 2023, also indicated that essential equipment to support children with DIGP may not be supplied, with some families having to purchase their own wheelchairs, recliners, toiletries and bathing aids.[47] She drew the committee's attention to one example where a family was unable to afford a wheelchair-accessible car to help transport their sick daughter to appointments:

> As there was no financial support to enable this family to access a wheelchair-accessible car, they swallowed their pride and begged on social media for the public to help source a car for their hospital appointments. Their daughter died stuck in her home, her parents unable to borrow a car or fundraise enough money to purchase a new one in time. How is this acceptable? It isn't. It's disgraceful.[48]

5.36 Angie, whose daughter Eve was diagnosed with DIPG in 2021, expressed similar concerns about the potential costs of support equipment to assist her daughter:

> Had we not been so persistent with the therapies through the allied team, we would have had to pay out of pocket for these treatments or she would be completely immobile. If she were to become immobile, we would need access to wheelchairs, house adjustments to help her mobilise in the home, different therapies to assist with her life quality and numerous other factors based on her specific needs.[49]

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44 Associate Professor Antoinette Anazodo, Paediatric and Adolescent Oncologist, Sydney Childrens Hospital Randwick, Sydney Childrens Hospitals Network, *Committee Hansard*, 31 January 2024, p. 47.

45 See, for example, Name Withheld, *Submission 123*, pp. 1–2; Peter, *Submission 131*, [p. 2]; Megan, *Submission 107*, p. 4; WA Health, *Submission 11*, p. 5; Queensland Health, *Submission 12*, p. 8; Pancare Foundation, *Submission 21*, [pp. 10–11]; Mrs Susanne Mans, Patient, Peter MacCallum Cancer Centre, *Committee Hansard*, 1 February 2024, p. 3.

46 Name Withheld, *Submission 123*, pp. 1–2.

47 Mrs Beau Kemp, Australian DIPG Families, *Committee Hansard*, 31 January 2024, p. 38.

48 Mrs Beau Kemp, Australian DIPG Families, *Committee Hansard*, 31 January 2024, p. 38.

49 Ms Angie Sari-Daher, Australian DIPG Families, *Committee Hansard*, 31 January 2024, p. 34.

Change in financial circumstances for both patients and carers

5.37 The committee heard several accounts from individuals with lived experience and their families, regarding the adverse financial changes that can accompany the diagnosis and treatment of a rare and less common cancer.[50]

5.38 Some inquiry participants emphasised the loss in earning potential for patients due to time away from work.[51] For instance, some submitters explained that maintaining work can be especially challenging for rare cancer patients and their families due to lengthy diagnostic processes, a multitude of appointments and scans, symptom management, and caring responsibilities.[52]

5.39 Michelle described to the committee the financial stress her life partner, Mark, experienced during his battle with stage 4 pancreatic cancer. Michelle outlined that it became a 'full-time job to survive' for Mark:

> You're mostly unable to work, and yet you're expected to be able to make your monthly life payments—rent, mortgage, food, utilities—and factor in a myriad of meds, herbs, multiple visits to specialists, treatments, et cetera.[53]

5.40 Michelle also explained that becoming Mark's primary caregiver was 'financially crippling' as she had to sell her business to take on caregiving responsibilities and Mark had to draw on his superannuation.[54]

5.41 Inquiry participants also made clear that the involved level of care for rare and less common cancer patients often results in carers either having to give up full time work or significantly reduce their hours, and therefore earning potential.[55]

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50 See, for example, Michelle, Private capacity, *Committee Hansard*, 31 January 2024, p. 44; Lana, *Submission 54,* p. 2; Name Withheld, *Submission 106,* [p. 1]; Michael, *Submission 57*, p. 1; Yvonne, *Submission 100*, [p. 4]; Jamie, *Submission 121*, p. 2; Megan, *Submission 128*, [p. 2]; Mrs Beau Kemp, Australian DIPG Families, *Committee Hansard,* 31 January 2024, p. 38; Gay, *Submission 96*, [p. 1].

51 See, for example, Lana, *Submission 54,* [p. 2]; Name Withheld, *Submission 106,* [p. 1]; Rare Cancers Australia, *Submission 3*, [p. 7]; Ann, *Submission 68*, [p. 1]; Sarah, *Submission 113*, [p. 1]; Cure Our Ovarian Cancer, *Submission 114*, p. 7; Le-Anne, *Submission 141*, [p. 1].

52 See, for example, Sarah, Submission 113, [p. 1]; Cure Our Ovarian Cancer, *Submission 114*, [p. 7]; Rare Cancers Australia, *Submission 3,* [p. 7]; Michelle, Private capacity, *Committee Hansard*, 31 January 2024, p. 44; Megan, Submission 107, [pp. 3 and 4]; Angie, Submission 76, [p. 3]; Jamie, Submission 121, p. 1.

53 Michelle, Private capacity, *Committee Hansard*, 31 January 2024, p. 44.

54 Michelle, Private capacity, *Committee Hansard,* 31 January 2024, p. 44.

55 See, for example, Michael, *Submission 57*, p. 1; Mr Tim Murphy, General Manager, Blood Cancer Partnerships, Leukaemia Foundation, *Committee Hansard*, 31 January 2024, p. 16; Ms Angie Sari-Daher, Australian DIPG Families, *Committee Hansard,* 31 January 2024, p. 35; Mrs Beau Kemp, Australian DIPG Families, *Committee Hansard,* 31 January 2024, p. 38; Michelle, Private capacity, *Committee Hansard,* 31 January 2024, p. 44; Katherine, Private capacity, *Committee Hansard*, 1 February 2024, pp. 31–32; Megan, *Submission 107,* p. 3; Name Withheld, *Submission 123,* p. 2;

5.42 For example, Michael, whose daughter was diagnosed with neuroblastoma, told the committee that his family has gone from 'thriving to basically living off the good will of others'. He described the significant financial and emotional impact of his family going from two incomes to one, after his wife became a full-time carer for their child:

> We have suffered extreme financial hardship. We have gone from two wages to one. My wife is now a full-time carer to a dying child. I work 6 days a week, nearly 60 hrs a week, [to] support a mortgage and bills. I am being robbed of time away from my child when it is needed most![56]

Adequacy of the Australian Government Carer Payment and Carer Allowance

5.43 Despite the availability of income support payments for carers, many inquiry participants considered these payments inadequate and difficult to access.[57] For example, Megan, whose daughter Kira was diagnosed with stage 4 high risk neuroblastoma, expressed frustration over the eligibility of the Australian Government Carer Payment and the severe inadequacy of the Carer Allowance:

> Centrelink deemed that Kira did not attract enough points for me to qualify for the Carers Payment. In short, she was not "sick enough" because her illness was not permanently disabling. So instead, I was offered the Carers Allowance, an amount so measly it didn't cover the cost of her medications (even after the health care concession was applied) or her tube feeds. It didn't cover the cost of petrol to shuttle her back and forth to hospital, or for parking at the hospital and it definitely didn't make a dent in supporting us to cover our other household expenses.[58]

5.44 Megan, whose husband, Ken, was diagnosed with stage 4 inoperable pancreatic metastatic cancer in February 2022, also explained being initially rejected for the Carer Payment and Allowance because Ken was deemed to 'not require sufficient care'.[59] While she now receives the Carer Payment which helps supplement her part-time salary, their financial stability relies on this source of income.[60]

5.45 Beau, representing Australian DIPG Families, similarly conveyed the inadequacy of the Carer Allowance, and advocated for the payment to increase and eligibility to be widened:

Megan, *Submission 128,* p. 2; Jenaya, *Submission 115*, p. 4; Mr Ryan Paterson, *Submission 143*, p. 2; Beau, *Submission 93*, [p. 3].

56 Michael, *Submission 57*, p. 1.

57 See, for example, Megan, *Submission 107,* p. 4; Ms Angie Sari-Daher, Australian DIPG Families, *Committee Hansard,* 31 January 2024, p. 35; Name Withheld, *Submission 123,* p. 2; Megan, *Submission 128,* p. 2; Katherine, Private capacity, *Committee Hansard,* 1 February 2024, p. 32.

58 Megan, *Submission 107,* p. 4.

59 Megan, *Submission 128,* [p. 2].

60 Megan, *Submission 128,* [p. 2].

> Carer's allowance of $70 a week for one parent is a joke. When two parents quit their jobs to care for and be with their dying child, this small amount of government funding is unsustainable to survive on. Such an amount should be increased and automatically awarded to the sole carers of terminally ill children upon diagnosis.[61]

Geographical barriers

5.46 The committee heard that outside of major metropolitan centres such as Sydney or Melbourne, and particularly in regional, rural or remote Australia, patients faced extra logistical and financial burdens, exacerbating challenges to accessing diagnostic and treatment services.[62]

5.47 Several inquiry participants emphasised to the committee that people living in regional, rural and remote areas of Australia experience disproportionately worse cancer outcomes compared to their metropolitan counterparts.[63] For example, spatial analysis data submitted to the committee found 'substantial evidence' of geographical variation in incidence and survival of rare cancer types between 2007 and 2016.[64] In particular, the data showed that 'more disadvantaged, and rural/remote areas had higher incidence and poorer survival'.[65]

5.48 In addition, evidence to the committee outlined that Australians living in remote areas are 1.3 times more likely to die from cancer and have a lower 5-year relative survival rate compared to Australians in major cities.[66]

Access to health care services

5.49 Inquiry participants drew the committee's attention to the exacerbated difficulties in accessing diagnostic and treatment services in regional, rural and

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61 Mrs Beau Kemp, Australian DIPG Families, *Committee Hansard,* 31 January 2024, p. 38.

62 See, for example, WA Health, *Submission 11,* p. 5; Cancer Council Australia, the Cancer Nurses Society of Australia, the Clinical Oncology Society of Australia, Private Cancer Physicians of Australia, the Medical Oncology Group of Australia and the Lung Foundation Australia, *Submission 4,* p. 5; Yvonne, *Submission 100,* [p. 1]; NeuroEndocrine Cancer Australia, *Submission 38,* p. 6; Ms Majella Gallagher, Advocacy and External Relations, Can Assist (Cancer Assistance Network), *Committee Hansard*, 31 January 2024, p. 23; National Rural Health Alliance, *Submission 7*, p. 4.

63 See, for example, Rotary Outreach Myeloma Project, Opening Statement, [p. 1] (tabled 1 February 2024); Department of Health and Aged Care, *Submission 1*, p. 10; Rare Cancers Australia, *Submission 3*, [p. 6]; National Rural Health Alliance, *Submission 7*, p. 3; Mrs Tiffany Boughtwood, Managing Director, Australian Genomics, *Committee Hansard,* 1 February 2024, p. 19; Mr David Menzies, Head of PanSupport, Pancare Foundation, *Committee Hansard,* 1 February 2024, p. 58.

64 Australian Cancer Atlas, Journal article regarding geographical and spatial disparities in the incidence and survival of rare cancers in Australia, November 2022, p. 7 (tabled 31 January 2024).

65 Australian Cancer Atlas, Journal article regarding geographical and spatial disparities in the incidence and survival of rare cancers in Australia, November 2022, p. 7 (tabled 31 January 2024).

66 Cancer Australia, *Submission 43,* p. 5.

remote Australia due to a maldistribution of health care services, specialists and relevant equipment.[67]

5.50 For example, the National Rural Health Alliance (NRHA) submitted that regional and remote areas struggle with GP access.[68] Research in their submission suggested that 44 930 people residing in remote and very remote Australia cannot access primary healthcare services 'within a 60-minute drive time of their home'.[69] In addition, it noted that outer regional, remote and very remote residents utilise Medicare '50 per cent less' and experience 'longer waiting periods to see a GP' compared to residents in major cities and inner regional areas.[70]

5.51 Relatedly, the committee heard that specialist access in regional, rural and remote Australia can be limited as oncology specialists predominantly work in metropolitan regions.[71] The Society of Hospital Pharmacists of Australia indicated that this can affect detection rates in areas without specialists or referral centres that can adequately screen and diagnose rare cancers.[72]

5.52 Further, Mr Shaun O'Connor, Co-Chair of Oncology and Haematology Leadership Committee from the Society of Hospital Pharmacists of Australia raised that a shortage in expertise, administering nurses and outsourcing pathways in regional or rural hospitals also limit access to treatment for patients in these areas.[73]

5.53 Regarding clinical trials, Cancer Trials Australia explained that participation can be limited due to the number of trials available and their location, causing travel

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67 See, for example, Department of Health and Aged Care, *Submission 1*, p. 10; Rare Cancers Australia, *Submission 3*, [p. 3]; Cancer Council Australia, the Cancer Nurses Society of Australia, the Clinical Oncology Society of Australia, Private Cancer Physicians of Australia, the Medical Oncology Group of Australia and the Lung Foundation of Australia, *Submission 4*, p. 5; Melanoma Patients Australia, *Submission 22*, p. 3; Ovarian Cancer Research Foundation, *Submission 27*, [p. 6]; Leukaemia Foundation, *Submission 39*, pp. 12 and 15; Telix Pharmaceuticals, *Submission 47*, p. 3; NACCHO, *Submission 48*, p. 13; WA Health, *Submission 11,* [p. 1]; Lesley, Private capacity, *Committee Hansard,* 20 February 2024, p. 27; National Rural Health Alliance, *Submission 7*, p. 6.

68 National Rural Health Alliance, *Submission 7,* p. 4.

69 National Rural Health Alliance, *Submission 7,* p. 4.

70 National Rural Health Alliance, *Submission 7,* p. 4.

71 See, for example, The Society of Hospital Pharmacists of Australia, *Submission 17,* [p. 3]; Roche, *Submission 9*, p. 18; WA Health, *Submission 11*, p. 1; Queensland Health, *Submission 12*, p. 5; Australian Rare Cancer Portal, *Submission 26*, p. 2.

72 The Society of Hospital Pharmacists of Australia, *Submission 17,* [p. 3].

73 Mr Shaun O'Connor, Co-Chair, Oncology and Haematology Leadership Committee, Society of Hospital Pharmacists of Australia, *Committee Hansard,* 1 February 2024, p. 54.

burdens and 'disproportionately affecting those who live outside of major cities'.[74]

Travel, relocation and its costs

5.54 Limited access to relevant oncology services for rare or less common cancers can force regional, rural and remote patients to travel and/or relocate.[75] For example, Danielle and Tony, who are based in Taree made 132 trips and travelled 24,000 kilometres for their seven-year-old daughter, Halley, to receive treatment over a two-year period.[76]

5.55 The ramifications of travelling were clearly articulated by the NRHA, indicating its adverse impacts on patients because it causes:

> … the need to take time off work, the inability to meet caring responsibilities for children or others, and the cost of the travel itself and associated accommodation. Travel also takes people away from their support networks and into potentially culturally unsafe environments. Hence, travel is associated with personal and financial burdens and these are felt disproportionately by rural people.[77]

5.56 These logistical and financial burdens were reflected by Mary who lives with borderline ovarian cancer.[78] She submitted:

> I travel over an hour (100 kms away) for local oncologist appointments, scans and chemo so can go this distance weekly … We can be away from home and friends for 2 to 3 months, we have had to shut our business down and rely on own funds plus disability allowance etc …[79]

Patient travel and accommodation schemes

5.57 Patient Assisted Travel Schemes (PATS) are operated at the jurisdictional level and are available in every Australian state and territory for the purpose of providing financial assistance for treatment related travel and accommodation.[80]

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74 Cancer Trials Australia, *Submission 34*, [p. 2].

75 See, for example, Mrs Patricia Marjorie O'Hara, OAM, Committee Member, Rotary Outreach Myeloma Program, Rotary Club of Camberwell, *Committee Hansard*, 1 February 2024, p. 14; Name Withheld, *Submission 106*, [p. 1]; Jamie, *Submission 121*, p. 2; Leukaemia Foundation, *Submission 39*, p. 12; National Rural Health Alliance, *Submission 7*, pp. 5–6.

76 Ms Majella Gallagher, Advocacy and External Relations, Can Assist (Cancer Assistance Network), *Committee Hansard*, 31 January 2024, p. 23.

77 National Rural Health Alliance, *Submission 7*, p. 4.

78 Mary, *Submission 87*, [p. 1].

79 Mary, *Submission 87*, [p. 1].

80 NACCHO, *Submission 48*, p. 12.

5.58 Ms Clare Crawford, Senior Director of Revenue and Hospital Financial Services from Canberra Health Services, explained that schemes can vary amongst states and territories as each have their own 'eligibility, funding support and rates'.[81]

5.59 Cancer Council Australia provided valuable information to the committee in relation to state and territory PATS.[82] The example below illustrates the discrepancies between schemes.

Table 5.1 PATS comparison between New South Wales and Victoria based on cents per kilometre and accommodation

State or territory	Private vehicle	Accommodation
New South Wales	40 cents per km, no restriction on km travelled or maximum claim. No ability to claim tolls or parking.	Not-for-profit or Commercial $75 per night first 7 nights, $120 per night from day 8. Private $40 per night, includes Airbnb bookings and staying with family/friends
Victoria	21 cents per km, irrespective of engine capacity or number of people in the vehicle. No restrictions on km travelled or maximum claim. Community transport services reimbursed at the rate charged or 20 cents per km. No ability to claim tolls or parking.	Commercial $45 per night each for patient and approved escort (over 18 years). Private No subsidy.

Source: Cancer Council Australia, Answers to questions taken on notice, 31 January 2024, pp. 1 and 2 (received 9 February 2024)

81 Ms Clare Crawford, Senior Director, Revenue and Hospital Financial Services, Canberra Health Services, *Committee Hansard*, 1 March 2024, p. 10.

82 For more detailed information that includes all states and territories, see, Cancer Council Australia, Answers to questions taken on notice, 31 January 2024, pp. 1–8 (received 9 February 2024).

5.60 Despite the existence of these PATS, many inquiry participants emphasised to the committee that they are inadequate in helping alleviate travel and accommodation costs.[83]

5.61 An issue raised by Cancer Council Australia was how these schemes, in most cases, function as a subsidy and therefore are not designed to cover care expenses.[84] Ms Megan Varlow, Director of Cancer Control Policy at Cancer Council Australia explained the adverse consequences that can arise from this:

> … lots of people with rare and less common cancers—and, in fact, people in regional areas with common cancers—don't end up receiving the treatment that's been recommended, because they can't afford to travel and to stay somewhere and to receive that care.[85]

5.62 Some inquiry participants also highlighted that the majority of schemes do not cover travel and accommodation costs associated with accessing clinical trials.[86] A patient reflected that 'PATS does not cover trials so I can't afford transport accommodation and rest of bills'.[87]

5.63 The importance of accommodation in accessing treatment, particularly for rural patients was underscored by Emma Phillips, the Executive Director of Can Assist, who considered accommodation the 'gateway' for rural residents to seek treatment and care.[88]

5.64 To address inconsistencies between schemes, Ms Varlow suggested:

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83 See, for example, Rare Cancers Australia, *Submission 3,* [p. 7]; Peter MacCallum Cancer Centre, *Submission 29,* p. 2; Leukaemia Foundation, *Submission 39,* pp. 21–22 and 24; NACCHO, *Submission 48,* p. 12; NeuroEndocrine Cancer Australia, *Submission 38*, pp. 11–12; Ms Meredith Cummins, Chief Executive Officer, NeuroEndocrine Cancer Australia, *Committee Hansard*, 1 February 2024, p. 2; Dr Peter Diamond, General Manager Support and Research, Cancer Council SA, *Committee Hansard*, 9 April 2024, p. 2; Dr Anna Johnston, Director of Clinical Haematology, Royal Hobart Hospital, *Committee Hansard*, 20 February 2024, p. 11; Associate Professor Gabrielle Cehic AM, Clinical Lead, South Australian Peptide Receptor Radionuclide Therapy Service, and Chair, South Australian Gastroenteropancreatic Neuroendocrine Tumours Multidisciplinary Team, South Australia Medical Imaging, *Committee Hansard,* 9 April 2024, p. 24.

84 Ms Megan Varlow, Director, Cancer Control Policy, Cancer Council Australia, *Committee Hansard,* 31 January 2024, p. 6.

85 Ms Megan Varlow, Director, Cancer Control Policy, Cancer Council Australia, *Committee Hansard,* 31 January 2024, p. 6.

86 See, for example, Ms Kaye Hewson, Director, Australian Teletrial Program, Australian Teletrial Program National Office, Queensland Health, *Committee Hansard,* 1 March 2024, p. 12; Leukaemia Foundation, *Submission 39,* p. 22; Cancer Council Australia, Answers to questions on notice, 31 January 2024, p. 1 (received 9 February 2024).

87 Leukaemia Foundation, *Submission 39,* p. 22.

88 Mrs Emma Phillips, Executive Director, Can Assist (Cancer Assistance Network), *Committee Hansard,* 31 January 2024, p. 25.

> From my perspective, there is a role for the federal government in supporting the states and territories to think about how the programs could be implemented in a more consistent way and to improve the level of support that they provide to people ...[89]

Potential opportunities from utilising telehealth technology

5.65 Many inquiry participants highlighted the potential benefits of utilising telehealth technology for regional, rural and remote patients, particularly in:

- increasing access to GPs, pharmacy and oncology specialists;
- increasing access to remote trials; and
- upskilling regional, rural and remote workforces.[90]

5.66 Margaret Deerain from the National Rural Health Alliance commented that in-person consults are the 'gold standard', but where they are not possible, telehealth can help 'augment' in person services.[91]

5.67 For instance, The Society of Hospital Pharmacists of Australia submitted that 'TeleChemotherapy' would allow patients to access chemotherapy treatment and 'comprehensive pharmacy care' without the burden of travelling.[92] It cited the Western Australia Country Health Service TeleChemotherapy Pharmacy Service as a current and nationally recognised example of delivering lower-risk chemotherapy treatment to regional, rural and remote patients using the 'support of specialist metropolitan-based clinicians via telehealth services'.[93]

5.68 The Minderoo Foundation also indicated that telehealth technology enables better clinical trial access, regardless of geographic location, by linking hospitals

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89 Ms Megan Varlow, Director, Cancer Control Policy, Cancer Council Australia, *Committee Hansard,* 31 January 2024, p. 6.

90 See, for example, The Society of Hospital Pharmacists of Australia, *Submission 17,* [p. 9]; National Rural Health Alliance, *Submission 7,* p. 2; TrialHub, *Submission 37*, p. 3; Dr Richard Stuckey, *Submission 97,* p. 5; Dr Kurt Lackovic, Chief Executive Officer, Cancer Trials Australia, *Committee Hansard,* 1 February 2024, p. 39; Dr Chloe Georgiou, Chair, Victorian Rare Cancer, Clinical Trial Alliance, TrialHub, Alfred Health, *Committee Hansard,* 1 February 2024, p. 40; Associate Professor Gabrielle Cehic AM, Clinical Lead, South Australian Peptide Receptor Radionuclide Therapy Service, and Chair, South Australian Gastroenteropancreatic Neuroendocrine Tumours Multidisciplinary Team, South Australian Medical Imaging, *Committee Hansard,* 9 April 2024, pp. 27–28; Dr Wei-Sen Lam, Medical Lead, Teletrials, WA Country Health Service, *Committee Hansard,* 1 March 2024, p. 13.

91 Ms Margaret Deerain, Director of Policy and Strategy Development, National Rural Health Alliance, *Committee Hansard,* 1 March 2024, p. 23.

92 The Society of Hospital Pharmacists of Australia, *Submission 17,* [p. 9].

93 The Society of Hospital Pharmacists of Australia, *Submission 17,* [p.9].

and sites in non-metropolitan regions to larger hospitals in city areas.[94] Kaye Hewson from the Australian Teletrial Program described their model's impact:

> Let me tell you about one patient: an anaesthetist living in Cairns who was diagnosed with a rare form of Hodgkin's lymphoma. A clinical trial was his best treatment option, but it was only accessible thousands of kilometers away. The teletrial model connected the clinical trial site to the Cairns Hospital so he could access the trial locally. He is now at the end of his maintenance phase and in full remission and has been able to work throughout his treatment.[95]

5.69 Dr Wei-Sen Lam, the Medical Lead of Teletrials in WA Country Heath Service, also noted how their teletrial model offers upskilling and job generation to health workers via knowledge dissemination, education and support provided by regional clinical trial coordinators.[96] He explained:

> What we hope to do is have medical oncologists who are very passionate about delivering clinical trials to regional areas and have the RCCCs, the regional clinical trial coordinating centres, support those regional areas, upskill coordinators, find nursing staff that are passionate about clinical trials and upskill clinicians in that area so that we can have clinical trials in those regional areas.[97]

5.70 Mrs Ariane Hermann, Acting First Assistance Secretary from the Department of Health and Aged Care (the department) told the committee the department has invested $36.4 million towards specialist telehealth services and their delivery via non-government cancer organisations.[98]

5.71 While telehealth technology can provide benefits to patients outside of metropolitan areas, as evidenced above, Queensland Health raised in its submission that people in rural and remote locations may not have the equipment or skills to utilise this technology in addition to 'reliable internet' and cost.[99]

Health workforce challenges

5.72 Inquiry participants outlined the need to address health workforce shortages, funding issues and the emerging health workforce needs and skill requirements

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94 Minderoo Foundation, *Submission 23*, p. 3.

95 Ms Kaye Hewson, Director, Australian Teletrial Program, Australian Teletrial Program National Office, Queensland Health, *Committee Hansard*, 1 March 2024, p. 9.

96 Dr Wei-Sen Lam, Medical Lead, Teletrials, WA Country Health Service, *Committee Hansard*, 1 March 2024, p. 13.

97 Dr Wei-Sen Lam, Medical Lead, Teletrials, WA Country Health Service, *Committee Hansard*, 1 March 2024, p. 13.

98 Mrs Ariane Hermann, Acting First Assistant Secretary, Department of Health and Aged Care, *Committee Hansard*, 1 March 2024, p. 28.

99 Queensland Health, *Submission 12*, p. 7.

of the future – particularly to ensure equitable and quality care for rare and less common cancers are provided to patients.[100]

Workforce shortage and funding issues

5.73 As identified from previous inquiries, Australia's health workforce faces several challenges, which can adversely influence the provision of quality care to patients.[101] In the context of rare cancers, inquiry participants specifically highlighted two major workforce barriers to staffing levels and their subsequent impact on accessing diagnostic and treatment services:

- workforce shortages across various specialist disciplines; and
- short-term and unreliable funding of workforce and research positions.[102]

5.74 Cancer Australia explained that there is a 'limited number of health professionals with specialist expertise in rare and less common cancers' and the growing incidence of cancer cases and complexity of cancer care, amongst other factors, is placing heightened demands on the cancer care workforce.[103]

5.75 This sentiment was reflected by Mr Tim Murphy, General Manager of Blood Cancer Partnerships from the Leukaemia Foundation. He told the committee that the current workforce consists of 'highly specialised, highly skilled people' but there is an impending supply challenge, with a growing population and

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100 See, for example, Children's Cancer Institute, *Submission 6*, [p. 3]; Roche, *Submission 9*, p. 8; WA Health, *Submission 11*, pp. 4 and 6; Queensland Health, *Submission 12*, p. 14; Melanoma Patients Australia, *Submission 22*, p. 4; Ovarian Cancer Research Foundation, *Submission 27*, [p. 9]; Telix Pharmaceuticals, *Submission 47*, [p. 4]; NACCHO, *Submission 48*, p. 13; RACGP, Answers to questions on notice 1 February 2024, [p. 1] (received 16 February 2024); Dr Anna Johnston, Director of Clinical Haematology, Royal Hobart Hospital, *Committee Hansard,* 20 February 2024, p. 16.

101 See, for example, Senate Standing Committee on Community Affairs, *Provision of general practitioner and related primary health services to outer metropolitan, rural and regional Australians – Interim Report*, April 2022, pp. 71, 73, 77 and 83–84 ; Senate Standing Committee on Community Affairs, *Ending the postcode lottery: Addressing barriers to sexual, maternity and reproductive healthcare in Australia*, May 2023, pp. 53–55 and 75; Senate Standing Committee on Community Affairs, *Accessibility and quality of mental health services in rural and remote Australia*, December 2018, pp. 135, 139–143 and 148–149.

102 See, for example, Neuroblastoma Australia, *Submission 58,* [p. 4]; Sydney Children's Hospitals Network, *Submission 14,* p. 7; Professor Matthew Dun, Professor of Paediatric Haematology and Oncology Research, Founder and Director of RUN DIPG, *Committee Hansard,* 31 January 2024, p. 32; Professor Nick Gottardo, Head, Department of Paediatric Oncology and Haematology, Perth Childrens Hospital and Chair, Australian and New Zealand Children's Haematology and Oncology Group, *Committee Hansard,* 1 March 2024, p. 3; Dr Peter Wejbora, Director Research Development and Partnerships, Childrens Cancer Institute, *Committee Hansard,* 31 January 2024, p. 45; RACGP, Answers to questions on notice, 1 February 2024, [p. 1] (received 16 February 2024).

103 Cancer Australia, *Submission 43,* p. 8.

cancer incidence.[104] He further noted that 'at some point, there aren't going to be enough clinicians to serve the population that we have'.[105]

5.76 In particular, multiple inquiry participants flagged staffing shortages amongst pathologists in Australia and their associated consequences on rare and less common cancers.[106] Dr Thomas Walwyn, Staff Specialist in Paediatric Adolescent and Young Adult Oncology from the Royal Hobart Hospital, explained that rare cancers need adequate pathology staffing in terms of 'expertise and also headspace' in particular.[107]

5.77 Dr Melanie Wuttke, Head of Medical Oncology at the Royal Hobart Hospital reflected on the downstream impact of pathologist shortages on patients at her hospital.[108] She explained:

> We've got four full-time equivalents at the Royal Hobart Hospital ... they've had some leave over Christmas, as everyone does, and they now have 600 cases which they need to process ... The flow-on effect from that is that it's taking three, four or five weeks to get pathology results back … The pathology department is actually starting to get calls from patients who are begging them to get their reports through.[109]

5.78 In addition, many inquiry participants identified unreliable funding of workforce positions as a major challenge to staffing levels.[110] For example, in the context of childhood cancers, the Sydney Children's Hospitals Network

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104 Mr Tim Murphy, General Manager, Blood Cancer Partnerships, Leukaemia Foundation, *Committee Hansard,* 31 January 2024, p. 20.

105 Mr Tim Murphy, General Manager, Blood Cancer Partnerships, Leukaemia Foundation, *Committee Hansard,* 31 January 2024, p. 20.

106 See, for example, Children's Cancer Institute, *Submission 6*, [p. 3]; Roche, *Submission 9,* p. 8; WA Health, *Submission 11,* p. 4; Dr Melanie Wuttke, Head of Medical Oncology, Royal Hobart Hospital, *Committee Hansard,* 20 February 2024, p. 7; Dr Anna Johnston, Director of Clinical Haematology, Royal Hobart Hospital, *Committee Hansard,* 20 February 2024, p. 15.

107 Dr Thomas Walwyn, Staff Specialist, Paediatric, Adolescent and Young Adult Oncology, Royal Hobart Hospital, *Committee Hansard,* 20 February 2024, p. 16.

108 Dr Melanie Wuttke, Head of Medical Oncology, Royal Hobart Hospital, *Committee Hansard,* 20 February 2024, pp. 15–16.

109 Dr Melanie Wuttke, Head of Medical Oncology, Royal Hobart Hospital, *Committee Hansard,* 20 February 2024, pp. 15–16.

110 See, for example, Neuroblastoma Australia, *Submission 58,* [p. 4]; Sydney Children's Hospitals Network, *Submission 14,* p. 7; Professor Matthew Dun, Professor of Paediatric Haematology and Oncology Research, Founder and Director of RUN DIPG, *Committee Hansard,* 31 January 2024, p. 32; Professor Nick Gottardo, Head, Department of Paediatric Oncology and Haematology, Perth Children's Hospital and Chair, Australian and New Zealand Children's Haematology and Oncology Group, *Committee Hansard,* 1 March 2024, p. 3; Dr Peter Wejbora, Director Research Development and Partnerships, Childrens Cancer Institute, *Committee Hansard,* 31 January 2024, p. 45.

explained that 'a significant issue facing all children's cancer services is that only a proportion of staff members are funded by permanent, recurrent funding'.[111] As discussed in Chapter 6, this leaves a significant proportion of staff with positions funded by 'soft funds' such as philanthropic donations and other short term funding mechanisms such as grants.[112]

5.79 It detailed the range of serious consequences this has on the workforce, as well as patient outcomes and care:

> This has a negative impact on staff retention, staff satisfaction, service planning and staff turnover. This reduces the availability of treating practitioners required across the health care disciplines (eg oncology pharmacists, pharmacy technicians, specialist nurses etc) required for paediatric oncology and particularly has a negative impact on being able to provide supportive care (eg social work, psychology, allied health, care navigators etc) to children with cancer and their families.[113]

5.80 From a patient's perspective, an inquiry participant described the adverse impacts of high staff turnover throughout their father's cancer treatment, indicating:

> … there were several interfaces with, and inputs from, the oncologist, general practitioner, hospital / emergency staff, palliative care staff and others, coupled with high staff turnover which made it almost impossible to maintain consistency in treatment and resulted in wasted time / effort in re-briefing new staff everyday (if not multiple times per day from the different organisations).[114]

5.81 Similarly, as outlined in Chapter 6, in the context of research, Professor Matthew Dun outlined that research teams operate on soft funding grants, which he suggests can often lead to:

> … the loss of talented researchers either to overseas positions or, alternatively, to industry, emphasising the importance of stable and sustained funding mechanisms.[115]

5.82 To address some of the challenges discussed above, a few inquiry participants emphasised the importance of sustained funding to critical specialist and research positions to ensure patients have access to diagnostic and treatment services.[116]

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111 Sydney Children's Hospitals Network, *Submission 14,* p. 7.

112 Sydney Children's Hospitals Network, *Submission 14,* p. 7.

113 Sydney Children's Hospitals Network, *Submission 14,* p. 7.

114 Name Withheld, *Submission 91,* [p. 1].

115 Professor Matthew Dun, Professor of Paediatric Haematology and Oncology Research, Founder and Director of RUN DIPG, *Committee Hansard,* 31 January 2024, p. 32.

116 See, for example, WA Health, *Submission 11,* pp. 3–4; Sydney Children's Hospitals Network, *Submission 14,* p. 7; Professor Matthew Dun, Professor of Paediatric Haematology and Oncology

5.83 The department referenced the government's $810 million funding towards future health education and training programs which aim to 'alleviate current workforce shortages' and make them future-proof to service Australia's long-term health needs.[117]

5.84 The Medical Workforce Reform Advisory Committee's National Medical Workforce Strategy (the Strategy) 2021-2031 has identified concerns in Australia's medical workforce, including an 'imbalance between specialist disciplines' and 'subspecialisation and generalism'. The Strategy seeks to address these concerns by providing a number of detailed actions.[118]

Emerging specialties and skill requirements

5.85 Evidence to the committee made clear that the skill and speciality needs of the health workforce for rare and less common cancers is rapidly changing, with the emergence of advancements in genomics and molecular science.[119]

5.86 For example, the committee heard that molecular biology, which does not traditionally feature in oncology training, is beginning to play a substantial role within the diagnosis and treatment of rare and less common cancers as specific cells are targeted rather than a whole-body approach, as discussed further in Chapters 2 and 3 of this report.[120]

5.87 Dr Richard Mitchell, from the Sydney Children's Hospitals Network, observed that the Zero Childhood Cancer Program is fostering an emergence of new specialities,[121] and Dr Emily Mould from the Children's Cancer Institute, similarly reflected that the program is fostering a new workforce including curation scientists.[122] Dr Mould elaborated that:

> From a Zero and a Children's Cancer Institute perspective, we have also produced a new workforce to support the diagnostics delivery of the Zero

Research, Founder and Director of RUN DIPG, *Committee Hansard,* 31 January 2024, p. 32; Omico, *Submission 44*, p. 11.

117 Department of Health and Aged Care, *Submission 1,* p. 11.

118 Department of Health and Aged Care, *About the National Medical Workforce Strategy 2021-2031*, 5 March 2024, www.health.gov.au/our-work/national-medical-workforce-strategy-2021-2031/about (accessed 2 April 2024).

119 See, for example, Department of Health and Aged Care, *Submission 1*, pp. 7–8; Roche, *Submission 9*, p. 13; Australian Genomics, *Submission 10*, p. 8; VCCC Alliance, *Submission 24*, p. 3; Cancer Australia, *Submission 43*, p. 14; Telix Pharmaceuticals, *Submission 47*, pp. 7–8.

120 Ms Anastasia Glushko, Stakeholder Engagement Manager, Childrens Cancer Institute, *Committee Hansard,* 31 January 2024, p. 49.

121 Dr Richard Mitchell, Director, Kids Cancer Centre, Sydney Childrens Hospital Randwick, Sydney Childrens Hospitals Network, *Committee Hansard,* 31 January 2024, p. 49.

122 Dr Emily Mould, Head of Business Development, Childrens Cancer Institute, *Committee Hansard,* 31 January 2024, p. 50.

> program. We now have a whole team of curation scientists, which we didn't have before, to help interpret this data. We've got computational biologists and engineers who have built systems to be able to cope with the data that we're creating.[123]

5.88 Telix Pharmaceuticals underlined that whilst advancements in cancer treatment and management, such as radiopharmaceuticals, are exciting, it is important that investments are made into the health workforce to meet these demands.[124] For instance, it elaborated that Australia has over 500 nuclear medicine specialists, but not all have theranostic (a combination of diagnostics and therapy to produce targeted and personalised treatments) training.[125]

5.89 In the context of childhood cancers, Ms Anastasia Glushko, Stakeholder Engagement Manager from the Childrens Cancer Institute, outlined that advancements from programs like the Zero Childhood Cancer Program highlight the need for further educating the clinical workforce regarding changing treatment approaches and molecular biology.[126]

5.90 To address these advancements and skill requirements, the VCCC Alliance have advocated for genomic education to be embedded in medical training programs and ongoing professional development.[127]

5.91 Under the Australian Cancer Plan, a key ambition is to produce an 'engaged, capable and future-focused cancer workforce', with a specific five-year goal to 'assist the sector to support all cancer care practitioners to work at the top of their scope of practice, increase retention and ensure ongoing access to continuing professional development'.[128]

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123 Dr Emily Mould, Head of Business Development, Childrens Cancer Institute, *Committee Hansard*, 31 January 2024, p. 50.

124 Telix Pharmaceuticals, *Submission 47*, [pp. 1–2 and 7].

125 Telix Pharmaceuticals, *Submission 47*, [p. 7].

126 Ms Anastasia Glushko, Stakeholder Engagement Manager, Childrens Cancer Institute, *Committee Hansard*, 31 January 2024, p. 49.

127 VCCC Alliance, *Submission 24*, [p. 3].

128 Cancer Australia, *Australian Cancer Plan Summary*, Additional information received 16 January 2024, p. 24.

Priority Populations

5.92 For population groups such as First Nations or CALD communities, barriers to diagnostic and treatment services for rare and less common cancers can be more greatly pronounced[129] affecting the quality in care they receive.[130]

5.93 The committee acknowledges that CALD and First Nations communities are diverse population groups and therefore have varied experiences. The evidence presented in the section below does not reflect all CALD or First Nations experiences and is limited to the evidence received over the course of this inquiry pertaining to these population groups.

First Nations people and communities

5.94 The committee was made aware that First Nations people experience inequity of outcomes for rare and less common cancers, and cancers more broadly, compared to non-Indigenous Australians.[131] As outlined in Chapter 1, First Nations people are disproportionately impacted by rare and less common cancers compared to their non-Indigenous counterparts.[132]

5.95 Cancer Australia outlined these disparate outcomes:

- cancer is the leading cause of death amongst Aboriginal and Torres Strait Islander people;
- Aboriginal and Torres Strait Islander people have a lower relative survival rate for cancer overall; and
- Aboriginal and Torres Strait Islander people have a lower relative survival for specific rare and less common cancers such as stomach and oesophageal cancer.[133]

5.96 To address First Nations cancer outcomes, the Australian Government has funded the development of the First Nations Cancer Package which invests

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129 See, for example, Omico, *Submission 44,* p. 5; Pancare Foundation, *Submission 21,* p. [11]; Pancare Foundation, *Submission* 21, Attachment 1, p. xiii; Movember Foundation, *Submission 40*, p. 4; RACGP, *Submission* 5, p. 6; Ovarian Cancer Research Foundation, *Submission* 27, pp. 5–6; Associate Professor Anna Boltong, Chief Executive Officer, Ovarian Cancer Australia, *Committee Hansard,* 1 February 2024, p. 61; Mrs Tiffany Boughtwood, Managing Director, Australian Genomics, *Committee Hansard,* 1 February 2024, p. 19.

130 Pancare Foundation, *Submission 21,* [p. 11].

131 See, for example, Australian Genomics, *Submission 10,* [p. 1]; WA Health, *Submission 11*, p. 8; The Society of Hospital Pharmacists of Australia, *Submission 17*, [p. 7]; Head and Neck Cancer Australia, *Submission 19*, p. 4; Ovarian Cancer Research Foundation, *Submission 27*, [pp. 3 and 5]; Movember Foundation, *Submission 40*, pp. 3–4; Cancer Australia, *Submission 43*, pp. 5–6; NACCHO, *Submission 48*, pp. 8–9; Associate Professor Anna Boltong, Chief Executive Officer, Ovarian Cancer Australia, *Committee Hansard,* 1 February 2024, p. 58.

132 NACCHO, *Submission 48,* p. 8.

133 Cancer Australia, *Submission 43,* p. 5.

$197.9 million to the Aboriginal Community Controlled Health Organisations (ACCHOs) sector.[134] NACCHO explained that the program will 'lay the foundation for scalable, national solutions to improve cancer related outcomes for all Aboriginal and Torres Strait Islander people'.[135]

Racism and discrimination

5.97 Systemic and institutional racism can impact the level of appropriate, timely and respectful cancer care to First Nations people, including their willingness to seek out healthcare.[136]

5.98 Australian Genomics drew the committee's attention to data from the Australian Reconciliation Barometer which indicated that the proportion of Indigenous Australians reporting racial discrimination by doctors, nurses and/or medical staff has increased since 2014 (11 per cent in 2014 to 20 per cent in 2022).[137]

5.99 NACCHO cited that racism and discrimination within mainstream health services 'creates a culturally unsafe environment' and discourages 'accessing or completing cancer treatment'.[138] They pointed out that not completing care can contribute to increased morbidity and mortality rates.[139] For example, it submitted that:

> … compared to other Australians who require hospitalisation, Aboriginal and Torres Strait Islander people are four times more likely to leave hospital before completing treatment. The rates of self-discharge are highest in very remote regions in Australia, where Aboriginal and Torres Strait Islander people self-discharge from hospital, against medical advice, at 9.1 times the rate when compared with other Australians.[140]

The importance of culturally safe health services

5.100 Several inquiry participants underscored the critical importance of culturally appropriate care for First Nations people and its impact on health service

134 NACCHO, *Submission 48*, p. 9.

135 NACCHO, *Submission 48*, p. 9.

136 See, for example, RACGP, *Submission 5*, p. 6; NACCHO, *Submission 48*, pp. 10 and 12; RACGP, Answers to questions on notice, 1 February 2024, [p. 3] (received 16 February 2024); Australian Genomics, *Submission 10*, [p. 5]; Pancare Foundation, *Submission 21*, Attachment 1, p. xxi.

137 Australian Genomics, *Submission 10*, [p. 5]. Citation Omitted.

138 NACCHO, *Submission 48*, p. 12.

139 NACCHO, *Submission 48*, p. 13.

140 NACCHO, *Submission 48*, p. 13.

engagement.[141] Culturally safe care, regarding support after diagnosis, for First Nations patients is also discussed in Chapter 4.

5.101 NACCHO submitted that Aboriginal and Torres Strait Islander people have shown preference for accessing care via ACCHOs.[142] It explained that more than 50 per cent of its members prefer ACCHO services and will often 'bypass mainstream services to access an ACCHO, where they are confident that their cultural safety is guaranteed'.[143]

5.102 To ensure continuity of care for Aboriginal and Torres Strait Islander patients with a cancer diagnosis, NACCHO identified the need for:

> … collaborative arrangements with and between treatment facilities, governments, localised primary healthcare networks, external support agencies, and the ACCHO sector. This includes available funding to employ an Aboriginal and Torres Strait Islander workforce into cancer support officer or care coordinator positions within the ACCHO sector.[144]

5.103 Consequently, NACCHO recommended collaboration and partnerships between ACCHOs and cancer facilities to ensure culturally safe continuity of care, and that the Australian Government introduce an agreement with state and territory governments to ensure culturally safe care is provided across all levels of the healthcare system.[145]

5.104 The Australian Cancer Plan includes embedding cultural safety as a priority and focus across its strategic objectives and shorter-term ambitions.[146]

5.105 However, NACCHO raised concern over the current workforce shortage within the ACCHO sector as data they cited has indicated:

- a 20-30 per cent decrease in full time employment in ACCHO clinical staff per 1,000 population; and
- a 50 per cent increase in the number of unfilled positions since the start of 2020. They further elaborated that:

> Many ACCHOs in rural and remote locations rely on transient general practitioners to provide primary health care which means Community

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141 See, for example, NACCHO, *Submission 48,* pp. 13–14; Ms Margaret Deerain, Director of Policy and Strategy Development, National Rural Health Alliance, *Committee Hansard,* 1 March 2024, p. 22; Movember Foundation, *Submission 40*, p. 4; Cancer Australia, *Submission 43*, pp. 8; Ms Clare Fitzmaurice, Policy and Data Analytics Officer, National Rural Health Alliance, *Committee Hansard,* 1 March 2024, p. 22; WA Health, *Submission 11*, p. 2.

142 NACCHO, *Submission 48,* p. 10.

143 NACCHO, *Submission 48,* p. 10.

144 NACCHO, *Submission 48,* p. 14.

145 NACCHO, *Submission 48,* p. 14.

146 Cancer Australia, *Australian Cancer Plan Summary Report*, Additional information received 16 January 2024, pp. 24 and 26.

> members often find it difficult to build trust and rapport with visiting general practitioners.[147]

5.106 According to NACCHO, whilst the First Nations Cancer Package 'provides a foundation' to developing and delivering culturally safe services, it advocated for additional funding to alleviate gaps in areas of accessing early diagnostic and treatment services, Aboriginal and Torres Strait Islander health workforces, survivorship support and culturally safe palliation services.[148]

Language literacy

5.107 In addition to health literacy challenges discussed earlier in this chapter, language barriers can further undermine access to diagnostic and treatment care.[149] For example, Queensland Health submitted that people with language barriers may lack the confidence to seek health information in their own language, which can, amongst other factors, lead to a 'delayed cancer diagnosis'.[150]

5.108 Sandra, who was diagnosed with a midgut neuroendocrine tumour, reflected on the impact language literacy has on making informed health decisions, submitting:

> I have never seen NETS education materials available in a language other than English … I have never heard of any in-hospital support workers or translators who could interpret NET information or help with doctor consults … I have three university degrees and struggled to make sense of NET language. How do people of low literacy or ESL background acquire any meaningful information? ... Lack of understanding of your medical condition makes a mockery of the notion of informed consent …[151]

5.109 Regarding treatment, The Society of Hospital Pharmacists of Australia explained that CALD information resources for chemotherapy and supportive non-chemotherapy medications are not currently available. It suggested that the development of these resources would support 'important conversations and help improve cultural perspectives on hospitals and cancer treatment options'.[152]

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147 NACCHO, *Submission 48,* pp. 12–13. Citation Omitted.

148 NACCHO, *Submission 48,* p. 9.

149 See, for example, Queensland Health, *Submission 12*, p. 10; National Rural Health Alliance, *Submission 7*, p. 5; Australian Genomics, *Submission 10*, [pp. 5–6]; Cancer Australia, *Submission 43*, pp. 5 and 7; Department of Health and Aged Care, *Submission 1*, p. 12; Ms Delanie Smith, Chief Executive Officer, Australasian Leukaemia and Lymphoma Group, *Committee Hansard*, 1 February 2024, p. 18.

150 Queensland Health, *Submission 12,* p. 10.

151 Sandra, *Submission 84*, p. 4.

152 The Society of Hospital Pharmacists of Australia, *Submission 17,* [p. 7].

5.110 The Children's Cancer Institute indicated that there is limited funding available for the research and development of appropriate tools and resources for CALD and Indigenous populations to improve equity of access.[153] It flagged that responsibility for the development of such resources currently lies with hospitals and district level services rather than having a 'national approach'.[154]

5.111 The department noted that the government provides 'Free Interpreting Services' for patients with limited English language proficiencies while Cancer Australia and Cancer Council Australia have published resources in multiple languages.[155]

5.112 NeuroEndocrine Cancer Australia also indicated that they provide 'Explainer Videos' of neuroendocrine cancer in Arabic and Mandarin, but advocated that ongoing government funding is needed to produce more culturally and linguistically diverse resources.[156]

Lower participation in diagnostic and treatment services

5.113 CALD and First Nations communities were recognised as underrepresented in cancer screening, clinical trials and research initiatives.[157]

Screening

5.114 CALD and First Nations communities were reported as being under screened and exhibited lower rates of engagement in cancer screening initiatives, respectively.[158]

5.115 The VCCC Alliance raised to the committee that 'there have been no substantial efforts' to address barriers in accessing 'molecular testing' and 'targeted therapies' for Aboriginal and Torres Strait Islander and CALD communities.[159]

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153 Children's Cancer Institute, *Submission 6*, [p. 3].

154 Children's Cancer Institute, *Submission 6*, [p. 3].

155 Department of Health and Aged Care, *Submission 1*, p. 12.

156 NeuroEndocrine Cancer Australia, *Submission 38*, p. 17.

157 See, for example, Cancer Australia, *Submission 43*, p. 6; National Rural Health Alliance, *Submission 7*, p. 4; Associate Professor Anna Boltong, Chief Executive Officer, Ovarian Cancer Australia, *Committee Hansard*, 1 February 2024, p. 61; Mrs Tiffany Boughtwood, Managing Director, Australian Genomics, *Committee Hansard*, 1 February 2024, p. 21.

158 See, for example, Cancer Australia, *Submission 43*, p. 6; National Rural Health Alliance, *Submission 7*, p. 4; Australian Genomics, *Submission 10*, [p. 2].

159 VCCC Alliance, *Submission 24*, [p. 2].

5.116 Australian Genomics submitted that 'Indigenous-led, developed or co-developed cancer screening and service pathway models' will help to address access and equity barriers to health services.[160]

Clinical trials

5.117 Associate Professor Anna Boltong, Chief Executive Officer of Ovarian Cancer Australia commented that barriers to participating in clinical trials can be pronounced in priority populations like Aboriginal and Torres Strait Islander people. She further noted that English reading and speaking requirements of a trial can prevent participation.[161]

5.118 Another barrier to participation raised by Mrs Tiffany Boughtwood, Managing Director of Australian Genomics, is the availability and granularity of data to help indicate the number of Indigenous Australians accessing interventions and their outcomes. She reflected that this leads to inequity in opportunities for Indigenous Australians 'to benefit from advancements in genomics and in therapies'.[162]

5.119 In their submission, Australian Genomics explained that clinical trials in Australia are not required to collect and report data on numbers related to screening, enrolment and clinical trial completion of Aboriginal and Torres Strait Islander people.[163] Of the data that is captured, it submitted that between 2006 to 2020, under 0.8 per cent of registered clinical trials focused on Aboriginal and Torres Strait Islander people.[164] This issue is further discussed in Chapter 7 of this report.

5.120 The Trans Tasman Radiation Oncology Group advocated for more research initiatives focused on increasing clinical trial diversity, as they see this as a mechanism to participation inequity.[165]

5.121 Mrs Boughtwood also commented on the importance of incorporating governance frameworks for clinical trials and considering issues related to 'data

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160 Australian Genomics, *Submission 10,* [p. 2].

161 Associate Professor Anna Boltong, Chief Executive Officer, Ovarian Cancer Australia, *Committee Hansard,* 1 February 2024, p. 61.

162 Mrs Tiffany Boughtwood, Managing Director, Australian Genomics, *Committee Hansard,* 1 February 2024, p. 21.

163 Australian Genomics, *Submission 10,* [p. 9].

164 Australian Genomics, *Submission 10,* [p. 9].

165 Trans Tasman Radiation Oncology Group, *Submission 25,* [p. 2].

sovereignty, Indigenous knowledge and benefit sharing with trials', particularly with genomics.[166]

Committee view

5.122 The committee was presented with substantial evidence outlining the myriad of barriers that can undermine equitable access to diagnostic, treatment and other cancer care services amongst rare and less common cancer patients. The committee considers that reducing these inequities must be prioritised to alleviate adverse impacts on a patient's cancer care journey and their subsequent outcomes.

Health literacy

5.123 The committee recognises that health literacy is crucial to a patient's ability to self-advocate and make informed and empowered decisions about their own health, and rare and less common cancer journey. It also notes that the lack of information regarding rare cancers, as discussed in Chapter 4 of this report, can further reduce a patient's ability to self-advocate and make decisions.

5.124 The committee acknowledges that health literacy pathways and information for rare and less common cancers, including neuroendocrine cancers are limited due to their complexity and non-standard nature. The committee believes that improving the health literacy of patients is paramount to achieving equity in access to diagnostic and treatment services for rare and less common cancers.

5.125 The committee welcomes the objectives of the Australian Cancer Plan, particularly its goals to strengthen health literacy for cancer patients and consumers. The committee urges the Australian government to appropriately prioritise and deliver on these key actions. In particular, developing appropriate resources relevant to rare and less common cancers should be prioritised.

Financial toxicity

5.126 The committee heard a considerable amount of evidence regarding the significant out-of-pocket expenses associated with the diagnosis and treatment of a rare or less common cancer. The committee understands these expenses, coupled with changing financial circumstances of a patient and/or their family, can cause notable distress amongst affected individuals. The committee considers it unacceptable that some patients forgo potentially life-saving treatments due to exorbitant costs.

5.127 As discussed in Chapters 2 and 3, the committee is of the view that the Australian Government should ensure rare cancer patients and families are not faced with prohibitive out-of-pocket diagnostic and treatment costs.

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166 Mrs Tiffany Boughtwood, Managing Director, Australian Genomics, *Committee Hansard*, 1 February 2024, p. 21.

5.128 The committee is also cognisant of the various indirect costs patients and families are often burdened with. The committee particularly notes the significant financial impacts on families when carers, particularly parents of children diagnosed with rare cancers, have to abandon their paid work to become full-time carers of their sick loved one. The committee notes the evidence it received from patients and families about their experience of the current payment levels and eligibility criteria for the Carer Payment and Carer Allowance.

Recommendation 25

5.129 The committee recommends that the Australian Government consider a review of the eligibility criteria and adequacy of the Carer Payment and Carer Allowance with a view of ensuring that people caring for cancer patients have access to appropriate support.

Tyranny of distance

5.130 The issue of access to health services, particularly specialised health services in regional, rural and remote Australia has been a longstanding problem. The committee understands that the uneven distribution of clinicians and healthcare providers pose increased logistical and financial burdens on rare and less common cancer patients located outside major metropolitan centres. The committee is concerned that cancer outcomes remain far worse for communities living outside major metropolitan areas.

5.131 The committee acknowledges that patient assisted travel schemes are available in each state and territory for the purpose of providing financial and accommodation assistance. Yet, the committee remains alarmed by the evidence inquiry participants raised, particularly pertaining to variations between state and territory schemes, inadequate subsidy amounts and the exclusion of most schemes to support patients participating in clinical trials. The committee urges Australian, state and territory governments to prioritise greater consistency, and review subsidy amounts under these schemes to help further address geographical variations.

Recommendation 26

5.132 The committee recommends that state and territory governments reform patient assisted travel schemes with a view to:

- **create more consistency in scheme offerings across all jurisdictions;**
- **increase financial assistance; and**
- **expand schemes to include travel and accommodation costs for clinical trial participants.**

Telehealth

5.133 The committee notes that telehealth technology cannot eliminate travel for diagnostic testing or treatment delivery, nor can it replace in-person healthcare delivery altogether. However, the committee believes that the strategic and appropriate use of telehealth technology in health care service delivery can significantly benefit rare and less common cancer patients residing outside of metropolitan areas. The committee is convinced that this would increase access to multidisciplinary teams while enabling patients to remain close to home and their support networks.

5.134 The committee welcomes the Australian Government's $36.4 million investment in specialist telehealth support services, which includes $4.4 million in funding to Rare Cancers Australia.

Recommendation 27

5.135 The committee recommends that Australian health services continue to invest in, and extend the use of telehealth and teletrial technology and infrastructure, to ensure adequate and timely delivery of diagnostic, treatment and support services, particularly for people living outside metropolitan areas.

Building sustainable healthcare workforces

5.136 The committee recognises that structural workforce issues in the Australian health sector have remained a persistent challenge for some time now, and building a sustainable healthcare workforce is a complex problem. Based on the evidence received, the committee understands that unsustainable funding models undermine current and future healthcare and researcher workforces from delivering timely and quality health services. Problems with staff retention, turnover, demand, and shortages must also be addressed.

5.137 The committee is aware of the National Medical Workforce Strategy 2021-2031 (the Strategy) which seeks to ensure equitable access to healthcare services, improve workforce distribution, enhance training pathways, and promote diversity within the medical workforce.[167]

5.138 The committee believes it is important that the actions recommended by the Strategy are monitored and implemented, as equitable access to rare and less common cancer diagnosis and treatment cannot be achieved with an under resourced and ill-equipped health workforce.

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[167] Department of Health and Aged Care, National Medical Workforce Strategy 2021-2031, 2021, 2021, pp. 1–6.

Recommendation 28

5.139 The committee recommends that the Australian Government prioritise and monitor the implementation of the recommendations from the National Medical Workforce Strategy 2021–2031, and ensure it addresses the needs of rare and less common cancer patients, including neuroendocrine cancer patients.

5.140 The committee is also cognisant that the professional healthcare landscape is changing, with many new specialisations and fields emerging such as molecular curation. To accommodate this, and to ensure rare and less common cancer patients receive the best care and treatment into the future, the committee agrees that targeted training and education opportunities, and sustained funding models, are required to retain skilled staff, foster knowledge awareness and up-skill professionals working in these spaces.

Recommendation 29

5.141 The committee recommends that the Australian Government, in partnership with state and territory governments and the higher education sector, review the emerging educational and workforce skill needs in relation to precision oncology, genomics, molecular curation and theranostics.

Recommendation 30

5.142 The committee recommends that state and territory governments provide sustained funding and participation incentives for staffing positions and training opportunities for medical professionals and researchers interested in specialising in rare and less common cancers, including neuroendocrine cancers.

Culturally appropriate care

5.143 The committee is concerned that First Nations people encounter additional barriers when accessing and engaging with healthcare services. The committee considers it unacceptable that First Nations communities are disproportionately impacted by rare and less common cancers compared to non-Indigenous Australians.

5.144 The committee welcomes the Australian Government's $239 million investment towards capacity and capability building of ACCHOs and ensuring cancer care is culturally safe and accessible to First Nations people within mainstream healthcare. The committee believes it is paramount this investment appropriately addresses gaps within First Nations cancer care, particularly regarding access to early diagnosis and treatment, shortages in First Nations health workers, survivorship support and culturally safe palliation services.

Recommendation 31

5.145 The committee recommends that the Australian Government continue to engage with and support Aboriginal Community Controlled Health Organisations to ensure the ongoing and expanded delivery of culturally safe and appropriate and health and supportive care for First Nations people.

Increasing participation of First Nations and CALD communities

5.146 Evidence presented to the committee highlighted disparities in participation among First Nation and CALD communities for screening, research and clinical trials. To ensure equity of access to diagnostic and treatment services for these priority populations, the committee acknowledges the importance of increasing engagement and participation rates.

Recommendation 32

5.147 The committee recommends that the Australian Government, in collaboration with Aboriginal Community Controlled Health Organisations, develop initiatives to increase participation rates of First Nations people in cancer screening, research and clinical trials.

Recommendation 33

5.148 The committee recommends that the Australian Government partner with organisations representing culturally and linguistically diverse communities to develop initiatives to increase participation rates in cancer screening, research, and clinical trials.

Language and literacy

5.149 The committee believes that inclusive health and language information related to rare and less common cancers will facilitate better health outcomes within the Australian community, particularly amongst CALD communities. Therefore, providing accessible and tailored information to overcome literacy and language barriers is paramount.

5.150 The committee believes it is important that health and language resources for CALD communities need to be guided, driven and implemented by CALD and rare cancer organisations to create trust, increase literacy and empower patients.

Chapter 6
Research

> We've got amazing researchers in Australia; we're world leading. Some people with rare and less common cancers have exceptional outcomes—world's best. Other people … pay with their lives[1]

6.1 This chapter explores Australia's research landscape and examines ways to improve research and clinical trial activity in Australia, in aim of improving outcomes for people with rare and less common cancers, including neuroendocrine cancer.

6.2 Firstly, this chapter outlines the Australian landscape of research and clinical trials by exploring the existing levels of funding, as well as funding gaps based on tumour types.

6.3 It then considers options to address research gaps for rare and less common cancers, including:

- financially supporting researchers;
- funding biobanks;
- encouraging genomic research; and
- attracting pharmaceutical company investment in Australia.

6.4 Finally, it examines how encouraging collaborative trials and adjusting evidence standards could generate increased clinical trial activity in Australia.

6.5 The chapter concludes with the committee's view and recommendations on providing better outcomes for rare and less common cancer patients through research and clinical trials.

Existing funding environment for Australian research and clinical trials

6.6 The Department of Health and Aged Care (the department) outlined that the Medical Research Future Fund (MRFF) has invested $2.78 billion across 1145 health and medical research grants from 2015 to 2023, which includes $37.9 million in 25 research grants that focus on rare cancers.[2]

6.7 Rare Cancers Australia drew the committee's attention to the findings of the 2023 National Audit of Cancer Research Funding in Australia, which identified 419 cancer trials with a total of $315 million in funding from 2012 to 2020. Rare Cancers Australia also highlighted that the Australian Government provided

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1 Ms Megan Varlow, Director, Cancer Control Policy, Cancer Council Australia, *Committee Hansard*, 31 January 2024, p. 4.

2 Department of Health and Aged Care, *Submission 1*, p. 14.

$147 million in funding for these trials, and that the state and territory governments provided $77 million.[3]

6.8 Subsequently, on 2 May 2024, the Australian Government announced its new 'Health Research for a Future Made in Australia' package, which includes a new 10-Year Low Survival Cancers Mission, focused on improving outcomes for people with a cancer where the 5-year survival rate is less than percent.[4]

6.9 The National Health and Medical Research Council (NHMRC) identified itself as the single largest funder of health and medical research in Australia.[5] In its submission, the NHMRC explained that:

> Most NHMRC funding is awarded in response to investigator-initiated applications in which the research is proposed by the researchers in the application to NHMRC, based on the expertise and research interests of the applicants.[6]

6.10 The NHMRC advised that a smaller proportion of funding is allocated to specific areas of unmet need, which can be through Targeted Calls for Research[7] and international collaborative schemes.[8]

6.11 For example, the department highlighted the MRFF 2021 Rare Cancers, Rare Diseases and Unmet Need grant opportunity, which awarded $2.3 million to Flinders University for the 'Implementing a Nurse-Enabled, Shared-Care Model to Address Unmet Needs of People with Neuroendocrine Tumours: the AUS-NET Trial.' The department elaborated that this project intends to improve the quality of life and reduce the unmet needs of people with neuroendocrine tumours.[9]

6.12 However, the department acknowledged that proportional funding for research and clinical trials for many cancers 'is low compared with the burden on the Australian population.'[10]

6.13 Rare Cancers Australia also noted that Australia is a leader in cancer research and that funding for rare and less common cancers has increased in recent years.

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3 Rare Cancers Australia, *Submission 3*, [p. 9].

4 The Hon Mark Butler MP, Minister for Health and Aged Care, 'Transforming health and medical research in Australia', *Media Release*, 2 May 2024.

5 National Health and Medical Research Council (NHMRC), *Submission 2*, [p. 2].

6 NHMRC, *Submission 2*, [p. 3].

7 The NHMRC provides that a Targeted Call for Research is a one-time request for grant applications to address a specific health issue where there is a significant research knowledge gap or unmet need, see /www.nhmrc.gov.au/funding/targeted-calls-research.

8 NHMRC, *Submission 2*, [p. 3].

9 Department of Health and Aged Care, *Submission 1*, p. 14.

10 Department of Health and Aged Care, *Submission 1*, p. 14.

Yet, it raised that the total funding required to close the gap between funding and the burden of disease and mortality caused by rare and less common cancers compared to common cancers 'remains significant.'[11]

6.14 Professor David Chan, Chair of the Neuroendocrine Tumours Group, also raised concerns about the framework used by the NHMRC. Dr Chan contended the framework structurally disadvantages rare and less common cancer projects:

> … one of the newest things I've noticed in the NHMRC framework is an instruction to the referees to evaluate feasibility, and that's defined as 'the ability to have enough patients for what you propose'. And the statistics are the same, whether you do a common or less common cancer. Unfortunately, that means less common cancers, rare cancers, are, by definition, almost structurally disadvantaged when it comes to the NHMRC framework.[12]

6.15 In a joint submission, Cancer Council Australia, the Cancer Nurses Society of Australia, the Clinical Oncology Society of Australia, Private Cancer Physicians of Australia, the Medical Oncology Group of Australia and the Lung Foundation Australia flagged that lower levels of funding for rare and less common cancers impacts on diagnosis:

> the lack of investment to better understand rare and less common cancers limit the development of specific diagnostic criteria and appropriate diagnostic tools to identify those cancers that are already classified as rare and less common as well as cancers that are not sufficiently understood and remain 'undiscovered' yet still numerically rare and less common.[13]

6.16 In addition to improving diagnosis, Dr Chloe Georgiou, Chair of the Victorian Rare Cancer Alliance, Clinical Trial Alliance, emphasised the importance of research and trials for improving a patient's quality of life:

> We need more research and trials in rare cancers to provide information to assist patients and funders to make value based decisions on management options, and to know what treatments improve survival and quality of life, also avoiding unnecessary expenditure of money and time on treatments that do not have benefit …[14]

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11 Rare Cancers Australia, *Submission 3*, [p. 9].

12 Professor David Chan, Neuroendocrine Tumours Group, Clinical Oncology Society of Australia, *Committee Hansard*, 31 January 2024, p. 59.

13 Cancer Council Australia, the Cancer Nurses Society of Australia, the Clinical Oncology Society of Australia, Private Cancer Physicians of Australia, the Medical Oncology Group of Australia and the Lung Foundation Australia, *Submission 4*, p. 3.

14 Dr Chloe Georgiou, Chair, Victorian Rare Cancer Alliance, Clinical Trial Alliance, TrialHub, Alfred Health, *Committee Hansard*, 1 February 2024, p. 40.

Gaps in research funding by tumour type

6.17 The Australian Rare Cancer Portal contended that current funding models favour cancers where breakthroughs have already been made, and further argued that 'success begets success, with more challenging areas being left behind … Yet those rare cancer types require more research, not less.'[15]

6.18 The Daffodil Centre and the University of Sydney Cancer Research Network similarly told the committee:

> Disparities in cancer research funding by tumour type are complex and multifaceted. A history of investigator-driven research and a tendency to build on success has led to underfunding of complex, rare and low-survival cancers. In addition, cancer research funding generated by large, tumour-specific nongovernment organisations further skews the investment towards comparatively well-served cancer types often with large survivor populations …[16]

6.19 In addition to gaps in research funding for rare cancers overall, inquiry participants also drew the committee's attention to specific gaps by tumour type. For example, the Ovarian Cancer Research Foundation identified a 'shortfall' that 'has persisted for two decades' for funding allocated to ovarian cancer medical research and clinical trials.[17] It reported that from 2016–2022, 0.7 per cent of all Commonwealth research funding was directed to ovarian cancer research.[18]

6.20 NeuroEndocrine Cancer Australia similarly stated that neuroendocrine tumours (NETs) have been traditionally underrepresented in research and stressed that targeted funding is needed through the MRFF for NETs research.[19]

6.21 The Pancare Foundation also pointed to low levels of funding for upper gastrointestinal cancers. They provided research funding figures from 2018 to 2020, which they stressed are 'significantly less' than 'other low-survival or high-survival rate cancers:'[20]

- Pancreas – $17 million
- Liver – $11.4 million
- Stomach – $7.2 million
- Oesophagus – $2.8 million

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15 Australian Rare Cancer Portal, *Submission 26,* p. 4.

16 Daffodil Centre and the University of Sydney Cancer Research Network, *Submission 32,* p. 5.

17 Ovarian Cancer Research Foundation, *Submission 27,* [p. 7].

18 Ovarian Cancer Research Foundation, *Submission 27,* [p. 7].

19 NeuroEndocrine Cancer Australia, *Submission 38,* p. 17 and p. 20.

20 Pancare Foundation, *Submission 21,* [p. 16].

- Biliary/gallbladder – $0.[21]

6.22 Relatedly, Emma, whose mother passed away from pancreatic cancer, stressed the importance of even funding across all tumour types:

> Why can there not be an overall even distribution of government funding to ALL cancers. What makes one cancer more important than the other? It's like telling a family with a member with pancreatic cancer, 'you're not as important' as another family whose member has breast cancer. How do you compare 92% survival rate for breast cancer to 12% for pancreatic? Money = research. Research = cure. Cure = having my mum with me still.[22]

6.23 Grace, Angie and Tamer, Beau and Terry, and Alan and Truc also identified gaps in Diffuse Intrinsic Pontine Glioma (DIPG) research. They submitted that:

> DIPG has been plagued by a lack of progress in treatments and cures since the 1960s, leaving families and researchers grappling with frustration and heartbreak. Regrettably, DIPG stands out as the deadliest childhood cancer, inflicting immense suffering on young patients and their loved ones. What exacerbates the distress is the profound absence of answers concerning the disease's origin, prevention, and cure, leaving families grappling with the haunting uncertainties surrounding DIPG.[23]

Improving levels of rare and less common cancer research

6.24 In addition to increasing funding for underfunded tumour types, submitters also highlighted various mechanisms and options to address gaps in rare and less common cancer research.[24] These are explored below.

Supporting researchers

6.25 The Ovarian Cancer Research Foundation stressed that the research sector needs to be able to attract long-term funds and resources, since research projects are not short-term endeavours.[25]

6.26 Professor Matthew Dun, Founder and Director of RUN DIPG and Professor of Paediatric Haematology/Oncology Research at the University of Newcastle, echoed this sentiment, yet he noted that most research teams operate on research

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21 Pancare Foundation, *Submission 21,* [p. 16].

22 Emma, *Submission 63,* [p. 3].

23 Grace, *Submission 59,* [p. 2]; Angie, *Submission 76,* [p. 4]; Beau, *Submission 93,* [p. 4]; Alan, *Submission 137,* [p. 5].

24 See, for example, Cancer Council Australia, the Cancer Nurses Society of Australia, the Clinical Oncology Society of Australia, Private Cancer Physicians of Australia, the Medical Oncology Group of Australia and the Lung Foundation Australia, *Submission 4,* p. 9; Melanoma Patients Australia, *Submission 22,* p. 6; Ovarian Cancer Research Foundation, *Submission 27,* [p. 9]; Victorian Cancer Biobank, *Submission 28,* [p. 1].

25 Ovarian Cancer Research Foundation, *Submission 27,* [p. 9].

grants, which he referred to as 'soft funding'.[26] The Sydney Children's Hospitals Network similarly noted that soft funding tends to be awarded to children's cancer services via short term mechanisms, like philanthropic donations or grants.[27]

6.27 Professor Dun contended that soft funding fosters a 'lack of job security' which 'promotes the loss of talented research minds to overseas positions or alternate industries.'[28] Relatedly, Dr Peter Wejbora, Director of Research Development and Partnerships at the Children's Cancer Institute, told the committee that soft funding:

> … introduces a great deal of uncertainty not only for our staff funded through those sources but, most importantly, for the kind of innovation and research based clinical services we can provide patients access to …[29]

6.28 Sandra, who was diagnosed with a midgut neuroendocrine tumour in 2016, emphasised that:

> There is no personal income security for our researchers and no guarantee that funding for ongoing work will be forthcoming. Many research projects are abandoned as money streams dry up. Frustration levels escalate for researchers, doctors, patients and advocates as years pass with little improvement in treatment options and life expectancy … Who would want to spend their career chasing money and writing proposals for research which has virtually no chance of success in becoming realized? … How can we be "the clever country" with lacklustre support for our best and brightest?[30]

6.29 Ovarian Cancer Australia stressed that 'we must provide researchers with ongoing funding to see the breakthroughs we have in other cancer types, as opposed to one off funding injections' and that 'it cannot continue to be so hard for [researchers] to persist in their work.'[31] Soft funding is further discussed in Chapter 5 of the report when examining broader health workforce challenges.

The role and funding of Australian biobanks

6.30 The Victorian Cancer Biobank explained that biobanks ethically procure, manage and distribute human biomaterials, which are 'critical for translation of

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26 Professor Matthew Dun, *Submission 125*, p. 3.

27 Sydney Children's Hospitals Network, *Submission 14*, p. 7.

28 Professor Matthew Dun, *Submission 125*, p. 3.

29 Dr Peter Wejbora, Director Research Development and Partnerships, Childrens Cancer Institute, *Committee Hansard*, 31 January 2024, p. 45.

30 Sandra, *Submission 84*, p. 6.

31 Ovarian Cancer Australia, *Submission 18*, [p. 6].

research into new treatment, detection and prevention approaches, leading to improved cancer outcomes.'[32]

6.31 Professor Matthew Dun also highlighted the importance of collecting and assessing rare and less common cancer biospecimens, as 'we cannot understand the biological drivers of diseases or find/develop therapies that address such [diseases] without material for study.'[33]

6.32 The Ovarian Cancer Research Foundation also identified biobanks as a component of a sustainable research sector, submitting that enhanced biobanking systems would allow sufficient clinical tissue access for researchers, who can then achieve 'relevant, translatable research'.[34]

6.33 The Victorian Cancer Biobank considered that while all cancer research can benefit from biobanking, long term support towards collecting specimens for rare and less common cancers is specifically required, as the 'accrual of a significant cohort size that is meaningful for research may take years due to the rarity'.[35]

6.34 Dr Wayne Ng, General Manager of the Victorian Cancer Biobank, also raised the importance of coordination between biobanks to achieve sufficient cohort sizes for research:

> The whole industry is starting to work quite closely in coordinating how biobanks could work with each other. Currently, it's quite an uncoordinated way, especially interstate because there are often different jurisdictions and so on … In our case, we're doing it at Victoria [sic] level, but hopefully this can expand. I think this is very valuable, especially in rare and less common cancers, because it's very hard to capture a sufficient cohort to even do something meaningful for research and training.[36]

6.35 However, Professor Dun claimed that biobanks are 'critically underfunded', which he argued impacts recruitment, participation, ease of access, as well as the quality and availability of samples. He further stressed that:

> Add to this the sheer number of samples that need to be collected to provide adequate sample sizes for many studies (the low incidence of rare/less common cancers a confounding factor in this regard), the support of active and functional biobanks should be prioritised in our efforts to enhance equity of diagnosis and treatment availability.[37]

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32 Victorian Cancer Biobank, *Submission 28,* [p. 1].

33 Professor Matthew Dun, *Submission 125,* p. 4.

34 Ovarian Cancer Research Foundation, *Submission 27,* [p. 9].

35 Victorian Cancer Biobank, *Submission 28,* [p. 1].

36 Dr Wayne Ng, General Manager, Victorian Cancer Biobank, *Committee Hansard,* 1 February 2024, p. 41.

37 Professor Matthew Dun, *Submission 125,* p. 4.

6.36 The Victorian Cancer Biobank also submitted that 'investment in biobanking research infrastructure remains as a gap necessary to successful research of rare and less common cancers' and called for the lack of ongoing funding for the collection of rare and less common cancers to be addressed. Further, it submitted that funding should consider leveraging existing biobanking infrastructure, which already have established patient access pathways.[38]

Genomic research

6.37 As detailed in Chapters 2 and 3 of this report, submitters highlighted the potential of genomics to improve patient outcomes.[39]

6.38 When speaking about genomic research, The Menzies Institute for Medical Research told the committee about the work they do to translate 'genetic/genomics testing' and in 'accelerating the implantation of health innovation in Tasmania.'[40] It noted the success of their research in achieving outcomes for one patient in particular:

> Our team recently identified a rare inherited clinically actionable mutation in a participant diagnosed with a high-grade prostate cancer. This participant will now be offered clinical genetics services through our research program and would qualify for access to a new targeted therapy. In the absence of our research program, this person would not have qualified for genetic testing at this time.[41]

6.39 The Leukaemia Foundation also highlighted that 'raising our genomics capability in turn provides a powerful tool to drive further research,' and noted that the Department of Industry, Science and Resources identified genomics as a 'critical technology'.[42]

Attracting and incentivising further investment from pharmaceutical companies

6.40 Submitters also noted the importance of attracting pharmaceuticals to conduct research and clinical trials in Australia.[43] Cancer Trials Australia identified

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38 Victorian Cancer Biobank, *Submission 28,* [p. 2].

39 See, for example, Department of Health and Aged Care, *Submission 1,* p. 7; Cancer Council Australia, the Cancer Nurses Society of Australia, the Clinical Oncology Society of Australia, Private Cancer Physicians of Australia, the Medical Oncology Group of Australia and the Lung Foundation Australia, *Submission 4,* p. 4; Roche, *Submission 9,* p. 7; Minderoo Foundation, *Submission 23,* p. 3; NeuroEndocrine Cancer Australia, *Submission 38,* p. 20; Leukaemia Foundation, *Submission 39,* p. 9; AstraZeneca, *Submission 41,* p. 2; Bayer Australia, *Submission 42,* pp. 2–3; Cancer Australia, *Submission 43,* p. 14; Omico, *Submission 44,* pp. 2–3.

40 Menzies Institute for Medical Research, University of Tasmania, *Submission 148,* [p. 2].

41 Menzies Institute for Medical Research, University of Tasmania, *Submission 148,* [p. 2].

42 Leukaemia Foundation, *Submission 39,* p. 25.

43 See, for example, Cancer Council Australia, the Cancer Nurses Society of Australia, the Clinical Oncology Society of Australia, Private Cancer Physicians of Australia, the Medical Oncology Group

Australia's 'research and development' (R&D) tax incentive as a 'key driver' of international biotech companies choosing to conduct their clinical activities in Australia.[44]

6.41 However, Melanoma Patients Australia submitted that 'there a number of issues' regarding funding for rare cancers, including a 'lack of financial incentives' for companies to develop and bring to market new treatments or innovative technologies.

6.42 Pharmaceutical company UCB Australia similarly contended that 'there are currently no specific incentives for pharmaceutical manufacturers to prioritise Australia over other countries for new and novel therapies.'[45]

6.43 Melanoma Patients Australia signalled its support for the government to continue to provide tax incentives, as well as other financial incentives, to encourage research and the development of new technologies in Australia.[46]

6.44 As discussed in Chapter 3, the Cancer Council Australia also stressed that anecdotally, rare and less common cancer clinical trials are not attractive to research sponsors. Consequently, it reinforced the need for greater investment and incentives to undertake research and clinical trials to improve access and outcomes for people with rare and less common cancers.[47]

6.45 Professor David Thomas, Chief Executive Officer of Omico, also stressed the need for the government to work with the private sector to make Australia an attractive destination for the development of new treatments:

> I would advocate, in essence, that we need an infrastructure that enables government and the private sector to work together collectively to make Australia a preferred destination for this era of drug development.[48]

6.46 Pharmaceutical companies AstraZeneca, IQVIA and Bristol-Myers Squibb Australia drew the committee's attention to the United Kingdom's Cancer

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of Australia and the Lung Foundation Australia, *Submission 4*, p. 9; Medicines Australia, *Submission 8*, [p. 9]; Bristol Myers Squibb Australia, *Submission 46*, [p. 5]; Melanoma Patients Australia, *Submission 22*, p. 6.

44 Cancer Trials Australia, *Submission 34*, [p. 1].

45 UCB Australia, *Submission 51*, [p. 2].

46 Melanoma Patients Australia, *Submission 22*, p. 6.

47 Cancer Council Australia, the Cancer Nurses Society of Australia, the Clinical Oncology Society of Australia, Private Cancer Physicians of Australia, the Medical Oncology Group of Australia and the Lung Foundation Australia, *Submission 4*, p. 9.

48 Professor David Thomas, Chief Executive Officer, Omico, *Committee Hansard*, 1 February 2024, p. 65.

Drugs Fund,[49] which as discussed in Chapter 3, funds cancer therapies to assist sponsors in gathering evidence.[50] Mr Owen Smith, Bristol-Myers Squibb Australia's Managing Director, noted that the Cancer Drugs Fund:

> … is not a perfect system, but it is a system that has … afforded a greater degree of risk sharing between the developers of the medicines and the payers in the healthcare system, and that's a positive.[51]

Importance of further investment in clinical trial research

6.47 Whilst clinical trials were discussed in Chapter 3 in terms of access to treatment for patients, these sections will examine clinical trials in the context of future research.

6.48 Cancer Australia explained that clinical trials are 'fundamental to establishing whether new cancer treatments or new ways of using existing therapies, diagnostic tests, preventative or supportive interventions are effective.'[52]

6.49 Further, both Cancer Trials Australia and TrialHub contended that clinical trials are a critical step in the research and development of new drugs, vaccines, medical devices and diagnostics. They added:

> Patients in clinical trials get early access to potentially life-saving treatments or medical interventions, while at the same time advancing medical knowledge. More broadly, clinical trial activity contributes to the development of a thriving research culture and promotes Australia's international research profile.[53]

6.50 However, Cancer Australia reported that conventional, randomised clinical trials require large patient populations to 'detect significant effects on health outcomes.' It stated that there are smaller patient populations to participate in trials for rare and less common cancers, which raises 'unit costs per patient due to longer recruitment times' and increases 'difficulty in achieving statistically significant outcomes.'[54] Cancer Australia also noted that industry-led trials tend

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49 See, AstraZeneca, *Submission 41,* pp. 3–4; Mr Andrew Sutton, Vice President and General Manager, IQVIA, *Committee Hansard,* 31 January, p. 62; Mr Owen Smith, Managing Director, Bristol-Myers Squibb Australia, *Committee Hansard,* 1 February 2024, p. 69.

50 IQVIA Australia, *Submission 49,* p. 2.

51 Mr Owen Smith, Managing Director, Bristol-Myers Squibb Australia, *Committee Hansard,* 1 February 2024, p. 71.

52 Cancer Australia, *Submission 43,* p. 11.

53 See, Cancer Trials Australia, *Submission 34,* [p. 2]; TrialHub, *Submission 37,* p. 1.

54 Cancer Australia, *Submission 43,* p. 13.

to prioritise cancers with larger population, which leads to 'reduced volumes of cancer-specific research available in rare and less common cancers.'[55]

6.51 The mechanisms that submitters raised to address this issue around small patient populations in clinical trials are explored below.

Encouraging collaborative trials

6.52 Numerous submitters identified a need for collaborative research and clinical trials to improve both future research and patient outcomes.[56] The NHMRC called for collaborative research between national and international parties to 'increase the critical mass needed for research progression.'[57]

6.53 Cancer Australia also noted that patient numbers in clinical trials for rare and less common cancers can be improved via national and international collaboration, thereby improving the cost-benefit ratio for trials, as well as statistical power.[58]

6.54 Melanoma Patients Australia similarly noted that Australia's small population base, which contributes to low clinical trial activity, can be overcome by international clinical trial collaboration.[59]

6.55 This was echoed by Ms Delaine Smith, Chief Executive Officer of the Australasian Leukaemia and Lymphoma Group (ALLG), who also outline the importance of international collaboration for clinical trials:

> We have welcomed through our ALLG collaborations with major global drug companies and smaller biotech companies instances where there might be only five or six cases a year diagnosed with a particular type of cancer, a rare form of blood cancer. We can operate the sites. We can work with our member network to find those patients and give them the opportunity to be a part of those trials. This is a challenge for us generally because our numbers in Australia are so small population-wise … We need to work with international partners on those clinical trials, bringing them to Australia for the benefit of patients to get those opportunities in Australia.[60]

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55 Cancer Australia, *Submission 43,* p. 13.

56 See, for example, NHMRC, *Submission 2,* [p. 2]; Rare Cancers Australia, *Submission 3,* [p. 9]; Children's Cancer Institute, *Submission 6,* [p. 5]; Melanoma Patients Australia, *Submission 22,* p. 6; Peter MacCallum Cancer Centre, *Submission 29,* p. 3; Noxopharm, *Submission 33,* p. 4; Leukaemia Foundation, *Submission 39,* p. 27; Cancer Australia, *Submission 43,* p. 13.

57 NHMRC, *Submission 2,* [p. 2].

58 Cancer Australia, *Submission 43,* p. 13.

59 Melanoma Patients Australia, *Submission 22,* p. 6.

60 Ms Delaine Smith, Chief Executive Officer of the Australasian Leukaemia and Lymphoma Group, *Committee Hansard,* 1 February 2024, p. 17.

6.56 However, Ms Smith also considered that 'we are not supported in building those international collaborations as well as we possibly could be' when working to bring clinical trials to the region.[61]

Adjusting evidence standards

6.57 Bristol Myers Squibb Australia submitted that studies for rare and less common cancers are usually small, single-arm or non-comparative due to the small patient populations.[62] Yet, it noted that phase 3 clinical trials[63] are seen as 'the gold standard of clinical evidence' for the Pharmaceutical Benefits Advisory Committee (PBAC).[64]

6.58 Pharmaceutical company MSD Australia similarly raised that:

> Due to the challenges associated with conducting Phase III randomised control trials (RCTs) for rare cancers, often the best available evidence often comes from early phase, single arm trials. The key challenge with single arm trials is that there is less evidence upon which the PBAC can base their assessment of comparative health gains and comparative cost-effectiveness.[65]

6.59 Noting the inherent limitations in rare and less common cancer clinical trial evidence, Bristol Myers Squibb Australia called for a 'more pragmatic approach' to Australia's Health Technology Assessment (HTA) processes, which 'places equivalent weight and value of all available evidence used to treat rare and less common cancers.'[66]

6.60 Several submitters pointed to the United Kingdom's National Institute for Health and Care Excellence (NICE) 'Real-world evidence framework' (NICE framework) as a relevant example of such an approach.[67] For example, the Leukaemia Foundation submitted that the NICE framework:

> accepts that "real-world data can improve our understanding of health and social care delivery, patient health and experiences, and the effects of

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61 Ms Delaine Smith, Chief Executive Officer of the Australasian Leukaemia and Lymphoma Group, *Committee Hansard*, 1 February 2024, p. 16.

62 Bristol Myers Squibb Australia, *Submission 46*, [p. 3].

63 Phase 2 clinical trials determine efficacy and further evaluate safety, whereas phase 3 clinical trials compare the intervention to other standard interventions, experimental interventions, standard care or a placebo, monitor adverse effects, and collect information that will allow the intervention to be used safely. See, Australian Clinical Trials, *What is a clinical trial?* 8 November 2023, www.australianclinicaltrials.gov.au/about/what-is-a-clinical-trial (accessed 16 May 2024).

64 Bristol Myers Squibb Australia, *Submission 46*, [p. 3].

65 MSD Australia, *Submission 53*, [p. 5].

66 Bristol Myers Squibb Australia, *Submission 46*, [p. 3].

67 See, for example, Leukaemia Foundation, *Submission 39*, p. 17; Bristol Myers Squibb Australia, *Submission 46*, [p. 3]; Novartis, *Submission 52*, p. 4; MSD Australia, *Submission 53*, [p. 6].

> interventions on patient and system outcomes in routine settings." In acknowledgment of the challenges with generating evidence for some treatments – particularly those regarding children, rare diseases and innovative treatments - NICE's committees will now be able to better manage and consider uncertainty.[68]

6.61 Relatedly, AbbVie told the committee that the United Kingdom, France and Germany have adjusted their regulatory approaches to rare disease therapies to allow for greater uncertainty in clinical evidence and broader acceptance of real-world evidence.[69]

6.62 Rare Cancers Australia argued that as more therapies 'come to market' with phase 2 data, there will be the need for a greater reliance on real world evidence:

> We need to act and ensure systems are put in place to make this the norm, not the exception. The health system must develop and adapt so that evidence-based knowledge can be translated quickly and seamlessly into the real-world clinical setting … [70]

Committee view

6.63 The committee received compelling evidence regarding the importance of boosting research and clinical trial activity to improve outcomes for people with rare and less common cancers, including neuroendocrine cancer.

Addressing gaps in funding for research and clinical trials

6.64 Evidence shows that whilst funding for research into rare and less common cancers has increased in recent years, it remains insufficient. Throughout the inquiry, the committee heard that the lack of investment in research contributes to lower survival rates for people with rare and less common cancers. The committee understands that some of the criteria to grant research funding are currently disadvantaging research applications pertaining to rare and less common cancers. The committee believes that it is paramount to address these disparities in research funding with the view to close the gap between funding and the burden of disease and mortality caused by rare and less common cancers.

~~6.65~~ The committee also notes the gaps in funding for specific tumour types and understands that this leads to inequitable outcomes across diagnosis, treatment, and the survivability of these rare and less common cancers.

6.66 Committee members acknowledge the recent government announcement of the 10-Year Low Survival Cancers Mission for additional research funding, however the committee also notes evidence received that gaps remain and

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68 Leukaemia Foundation, *Submission 39,* p. 17.

69 AbbVie, *Submission 120,* [p. 6].

70 Rare Cancers Australia, *Submission 3,* [pp. 5–6].

recommends that the Australian Government ensure funding continues as a priority for research into rare and less common cancers.

Recommendation 34

6.67 The committee recommends that the Australian Government ensure continued funding for rare and less common cancer projects to reduce existing research and clinical trial disparities.

Funding biobanks

6.68 The committee is encouraged to hear that various existing models can be leveraged to increase research into rare and less common cancers.

6.69 In particular, the committee is persuaded that research into rare and less common cancers will increase if Australia's researchers are provided with access to stable funding. The committee discusses funding models for researchers in Chapter 5 of the report.

6.70 Based on the evidence received, the committee understands that biobanks could generate sufficient cohort sizes for meaningful rare and less common cancer research and is greatly supportive of collaborative efforts to coordinate the work of biobanks across the nation. However, the committee remains concerned that biobanks are underfunded, thereby impacting the quality and availability of samples, and limiting the potential to improve diagnosis and treatment outcomes into the future.

Recommendation 35

6.71 The committee recommends that the Australian Government fund biobanking initiatives to ensure the availability of quality cancer samples for research.

Genomic research

6.72 The committee is encouraged to see that advances in genomic research are leading to more precise diagnoses of cancers, which includes the increased identification of rare sub-types in common cancers and the broadening of treatment options for patients. The committee notes that this is particularly important for rare and less common patients, who often have very limited treatment options available to them.

6.73 Increasing funding for genomic research in Australia is paramount so patients continue to have improved and increased treatment options into the future.

Recommendation 36

6.74 The committee recommends that the Australian Government explore options to provide incentives to expand genomic research in Australia.

Pharmaceutical companies

6.75 The committee also notes the concerns raised by some submitters that Australia does not have enough incentives to sufficiently attract pharmaceutical companies to conduct research, innovation and clinical trials in our country.

6.76 To this end, the committee believes it would be valuable for the Australian Government to consider implementing new reforms or financial incentives to attract these international companies to Australia, to stoke research and clinical trial activity in our region.

6.77 The committee sees value in exploring mechanisms that have successfully attracted new investment from pharmaceutical companies in comparable jurisdictions, including models such as the United Kingdom's Cancer Drugs Fund.

Recommendation 37

6.78 The committee recommends that the Australian Government consider new mechanisms to encourage greater private sector investment in rare and less common cancer related research and clinical trial sponsorship in Australia.

Generating clinical trial activity

6.79 There is a need to increase rare and less common cancer clinical trial activity in Australia to facilitate not only improved patient outcomes, but also improved research outcomes.

6.80 However, the committee is cognisant of the difficulties in obtaining sufficient cohort sizes for rare and less common cancer clinical trials. For this reason, the committee is supportive of the collaboration between international and national bodies to obtain the sample sizes needed for research progression.

6.81 Further, noting the inherent challenge of generating large sample sizes of patients with rare and less common cancers, the committee is convinced by the need to explore adjustments to the trial evidence standards that the Pharmaceutical Benefits Advisory Committee currently upholds when it comes to rare cancers in particular.

6.82 As such, the committee believes that the Australian Government should consider adjusting its evidentiary standards, where appropriate, to account for real-world evidence and acceptance of greater uncertainty arising from rare and less common cancer clinical trials. The committee notes that comparable jurisdictions, including the United Kingdom, have implemented similar changes to their Health Technology Assessment processes.

Recommendation 38

6.83 The committee recommends that the Australian Government review its evidentiary standards specifically for rare and less common cancer clinical

trials to consider accepting real-world evidence and greater uncertainty in data where appropriate.

Chapter 7
Data issues, gaps and opportunities

7.1 This chapter discusses the evidence received by the committee in relation to cancer data in Australia.

7.2 Firstly, it outlines the complex landscape of cancer control data in Australia and the key challenges this presents. It then discusses wide-ranging calls from submitters and witnesses to broadly improve how this data is collected, linked, analysed and made available, particularly in relation to rare and less common cancers.

7.3 It also sets out evidence received by the committee in relation to key cancer data-related issues, including:

- calls for a centralised, national cancer data framework;
- the changing nature of how cancer types are classified;
- the lack of data regarding the stage of cancer at diagnosis;
- the accessibility of data for research purposes;
- key considerations for data and First Nations communities; and
- views on the value of My Health Record.

7.4 It concludes with the committee's views and recommendations on these issues.

The complex landscape of cancer control data in Australia

7.5 Evidence to the committee made clear that the systems and infrastructure for the collection, collation, and reporting of cancer data in Australia are vast and complex.[1]

7.6 According to the Australian Institute of Health and Welfare (AIHW), cancer is a notifiable disease in all Australian states and territories, with legislation requiring certain individuals and organisations to notify all new cases of cancer to jurisdictional cancer registries.[2]

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1 See, for example, The The Daffodil Centre, Sydney Cancer Partners, Answers to questions on notice, 31 January 2024 (received 6 February 2024), p. 1; Ms Megan Varlow, Director, Cancer Control Policy, Cancer Council Australia, *Committee Hansard,* 31 January 2024, pp. 8 and 9; Minderoo Foundation, *Submission 23,* pp. 4 and 5; Leukaemia Foundation. *Submission 39*, p. 25; Associate Professor Kathy Tucker, Private capacity, *Committee Hansard,* 31 January 2024, p. 58; Professor Anna DeFazio, Convenor, University of Sydney Cancer Research Network, *Committee Hansard,* 31 January 2024, p. 58; Dr Chloe Georgiou, Chair, Victorian Rare Cancer, Clinical Trial Alliance, TrialHub, Alfred Health, *Committee Hansard,* 1 February 2024, p. 47.

2 Australian Institute of Health and Welfare (AIHW), *Australian Cancer Database,* 14 March 2024, www.aihw.gov.au/about-our-data/our-data-collections/australian-cancer-database (accessed 11 April 2024).

7.7 The Australian Cancer Plan, developed by Cancer Australia, highlights that data across the cancer control continuum is captured differently across various institutions and organisations, including:

- cancer services;
- primary care services (including Aboriginal Community Controlled Health Services);
- the National Cancer Screening Register;
- the Australian Cancer Database; and
- other jurisdictional cancer registries.[3]

7.8 The Australian Cancer Plan also notes that factors such as the segmented structure of the Australian health system, the delivery of cancer care across public and private systems, as well as other structural and legislative factors, including multiple data custodians responsible for different datasets (often with individual jurisdictional ethics requirements), challenge the ability to create a nationally consistent view of cancer control.[4]

7.9 The Daffodil Centre, a research partnership between Cancer Council NSW and the University of Sydney focussed on cancer control and policy,[5] similarly advised that the challenges of data linkage and utilisation to improve both clinical decision making and policy, are multifaceted, and 'compounded by the complex mesh of federal, state/territory, regional/local, public and private healthcare services and databases'.[6]

7.10 Likewise, Ms Megan Varlow, Director of Cancer Control Policy at Cancer Council Australia noted the complex nature of the various cancer data collections across the country, and pointed out that data is 'a really big issue for all cancers, but particularly for rare and less common cancers'.[7]

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3 Cancer Australia, *Australian Cancer Plan, Strategic Objective 4: Strong and Dynamic Foundations, 2-year goal action 4.2.1: Develop an agreed national cancer data framework to improve accessibility, consistency and comprehensiveness of integrated data assets*, www.australiancancerplan.gov.au/actions/4.2.1 (accessed 10 April 2024).

4 Cancer Australia, *Australian Cancer Plan, Strategic Objective 4: Strong and Dynamic Foundations, 2-year goal action 4.2.1: Develop an agreed national cancer data framework to improve accessibility, consistency and comprehensiveness of integrated data assets*, www.australiancancerplan.gov.au/actions/4.2.1 (accessed 10 April 2024).

5 The Daffodil Centre, *About*, https://daffodilcentre.org/about/ (accessed 10 April 2024).

6 The Daffodil Centre, Sydney Cancer Partners, Answers to questions on notice, 31 January 2024 (received 6 February 2024), p. 1.

7 Ms Megan Varlow, Director, Cancer Control Policy, Cancer Council Australia, *Committee Hansard*, 31 January 2024, p. 8.

7.11 The Daffodil Centre advised that data-driven solutions in the context of this inquiry, should recognise that improvements in the management of rare cancers 'can provide unique opportunities to enhance learning relevant to all cancers'.[8]

7.12 Relatedly, the committee notes that much of the evidence it received about data, referred to broader health data challenges, and cancer data in general, rather than specific matters regarding data for rare and less common cancers. The committee considers that these broader health and cancer data matters are still pertinent to the inquiry, but notes that wherever possible, it will discuss the evidence received that specifically relates to rare cancer data.

Overarching calls for data improvements and reforms

7.13 The committee heard broad calls and suggestions from inquiry participants to improve and reform cancer data in Australia.[9]

7.14 The Department of Health and Aged Care (the department) noted that improving cancer data will provide further insight into patterns and trends of diagnoses, and enable policy makers to better target initiatives and improve outcomes for people affected by cancer, including those with rare and less common cancer types.[10]

7.15 Similarly, the National Aboriginal Community Controlled Health Organisation (NACCHO) submitted that accurate data collection and reporting are critical to understanding the prevalence, incidence, and outcomes of all cancers. It also outlined that improvements to data collection and reporting will facilitate evidence-based policy development and inform targeted interventions to improve overall health outcomes.[11]

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8 The Daffodil Centre, Sydney Cancer Partners, Answers to questions on notice, 31 January 2024 (received 6 February 2024), p. 3.

9 See, for example, Dr Richard Stuckey, *Submission 97,* p. 5; Cancer Australia, *Submission 43,* p. 13; The Daffodil Centre, Sydney Cancer Partners, Answers to questions on notice, 31 January 2024 (received 6 February 2024), pp. 1–3; Minderoo Foundation, *Submission 23,* pp. 4 and 5; National Aboriginal Community Controlled Health Organisation (NACCHO), *Submission 48,* p. 17; Professor Hamish Scott, Head of Department, Genetics and Molecular Pathology, SA Pathology, *Committee Hansard*, 9 April 2024, p. 16; Leukaemia Foundation, *Submission 39,* p. 28; Minderoo Foundation, *Submission 23*, pp. 4 and 5; Caitlin, Private capacity, *Committee Hansard,* 1 February 2024, p. 40; Professor Mark Morgan, Chair, Expert Committee for Quality Care, Royal Australian College of General Practitioners (RACGP), *Committee Hansard,* 1 February 2024, p. 55; Australian Rare Cancer Portal, *Submission 26,* p. 4; Professor Clare Scott, Board Member, Cancer Trials Australia and Co-Chair, Victorian Rare Cancer, Clinical Trial Alliance, *Committee Hansard*, 1 February 2024, p. 48; The Daffodil Centre and the University of Sydney Cancer Research Network, *Submission 32,* p. 2; AbbVie, *Submission 120*, [p. 6]; Professor Hamish Scott, Head of Genetics and Molecular Pathology, SA Pathology, *Committee Hansard*, 9 April 2024, pp. 22 and 23.

10 Department of Health and Aged Care, *Submission 1,* p. 15.

11 NACCHO, *Submission 48*, p. 17.

7.16 Cancer Australia told the committee that there is a need for better and more comprehensive cancer data in Australia to improve patient outcomes and health system performance.[12] Cancer Australia's website also notes that improving the collection, access, analysis and reporting of national cancer data will help to better understand unwarranted variations in cancer outcomes across the Australian population.[13]

7.17 The Daffodil Centre similarly emphasised that up-to-date, accessible and linked datasets are 'increasingly important for improved patient outcomes', in terms of delivering optimal care for individual patients now, and for research to inform treatment technologies and approaches into the future.[14]

7.18 The Daffodil Centre acknowledged that substantial work has been undertaken over the past 20 years to address many of these well-established health data challenges, such as the introduction of Australia's My Health Record, the Australian Digital Health Agency, and several other government consultations and strategies. However, they considered that in their experiences as clinicians, researchers and advocates working with consumers, these initiatives 'only scratch the surface of what could be achieved if there were fundamental changes in how patient data is collected, managed and accessed'.[15]

7.19 The Daffodil Centre recognised that these are large challenges, but cautioned that without action, many existing data issues will continue to worsen due to increased fragmentation and an inability for data systems to keep pace with technological developments.[16]

Calls for a national cancer data framework

7.20 Several inquiry participants advocated for a centralised, national cancer data registry, framework, or ecosystem.[17]

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12 Cancer Australia, *Submission 43,* p. 13.

13 Cancer Australia, *Cancer Data,* www.canceraustralia.gov.au/research/data-and-statistics/cancer-data (accessed 10 April 2024).

14 The Daffodil Centre, Sydney Cancer Partners, Answers to questions on notice, 31 January 2024 (received 6 February 2024), p. 1.

15 The Daffodil Centre, Sydney Cancer Partners, Answers to questions on notice, 31 January 2024 (received 6 February 2024), p. 1.

16 The Daffodil Centre, Sydney Cancer Partners, Answers to questions on notice, 31 January 2024 (received 6 February 2024), p. 3.

17 See, for example, VCCC Alliance, *Submission 24,* [p. 4]; Peter MacCallum Cancer Centre, *Submission 29*, [p. 3]; Cancer Council Australia, Answers to questions taken on notice by Cancer Council Australia at a public hearing on 31 January 2024; received 9 February 2024, [p. 1]; Roche, *Submission 9*, p. 5; Professor Karen Veronica Canfell, Director, The Daffodil Centre, *Committee Hansard,* 31 January 2024, p. 55; Dr Mark Morgan, Chair, Expert Committee for Quality Care, RACGP, *Committee Hansard,* 1 February 2024, p. 51.

7.21 The VCCC Alliance, a partnership of 10 cancer research, academic and clinical institutions in Victoria, considered that data collected on a central registry with matched patient outcomes 'will be an invaluable resource' for clinicians and researchers alike, and may also lead to increased investment from pharmaceutical companies.[18] It noted that a centralised data registry will require significant investment from the Commonwealth, and that legislation would also be required to 'ensure a standardised health data sharing model that facilitates secure data exchange'.[19]

7.22 Ms Megan Varlow, Director of Cancer Control Policy at Cancer Council Australia similarly advocated for a national data framework:

> I might be extremely optimistic, but the idea of a national data framework which brings all of the different data collections together, implements a national minimum dataset across the country and then thinks about bringing in genomic and other collections—which we know are there at an individual level but are not collected at the level of the population—is what we want to see...[20]

7.23 In further evidence to the committee, Cancer Council Australia noted it has long advocated for a 'national-deidentified linked health dataset that brings together all cancer datasets and links to datasets, including data from electronic medical records'. Cancer Council Australia stated that the ability to link this data 'will provide a complete picture of the factors that influence cancer care and outcomes'.[21]

7.24 Roche, a pharmaceutical and biotechnology company, specifically recommended that the Australian Government 'set up a central registry with minimum data collection standard for rare cancers in line with the recommendations from other key stakeholders'.[22]

7.25 The department outlined that a priority area for action under the Australian Cancer Plan (the Plan), is the development and implementation of the National Data Framework and minimum dataset. The department submitted that the National Data Framework will provide a pathway for 'improving the collection and reporting of comprehensive data across the cancer control continuum'.[23]

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18 VCCC Alliance, *Submission 24*, [p. 4].

19 VCCC Alliance, *Submission 24*, [p. 4].

20 Ms Megan Varlow, Director, Cancer Control Policy, Cancer Council Australia, *Committee Hansard*, 31 January 2024, pp. 8 and 9.

21 Cancer Council Australia, Answers to questions taken on notice at a public hearing on 31 January 2024; received 9 February 2024, [p. 1].

22 Roche, *Submission 9*, p. 5.

23 Department of Health and Aged Care, *Submission 1*, p. 15.

7.26 According to the Plan, which was launched in November 2023, the national cancer data framework is expected to be developed within two years.[24]

7.27 Further detail on Strategic Directive Four 'Strong and Dynamic Foundations' of the Plan, and the relevant goals and timelines for this work, is outlined in the figure below.[25]

Box 7.1 Australian Cancer Plan, Strategic Objective 4: Strong and Dynamic Foundations,

2-year goal: Nationally agreed frameworks for collection and reporting of comprehensive cancer data, and implementation of new technologies into routine cancer care, with a focus on research priorities that drive innovation and fast-track opening of cancer clinical trials in Australia.

5-year goal: A national cancer data ecosystem supporting evidence-based, innovative models of care which incorporate national uptake of advanced technology and infrastructure, underpinned by world-class research and a clinical trials landscape in which all Australians have equal access.

10-year ambition: A modern, fit for purpose cancer control infrastructure, advanced by the innovative application of technology, research and data to improve Australia's cancer outcomes.

Source: Cancer Australia, Australian Cancer Plan, Strategic Objective 4: Strong and Dynamic Foundations, www.australiancancerplan.gov.au/so/strong-and-dynamic-foundations (accessed 10 April 2024).

7.28 The department explained that Cancer Australia will lead the development of the National Data Framework, in partnership with the department, the AIHW, state and territory governments, and the cancer control sector.[26]

7.29 Professor Dorothy Keefe, Chief Executive Officer of Cancer Australia elaborated on this key action of the Plan at a public hearing:

> … one of the foundational pieces of the implementation of the Australian Cancer Plan is the cancer data framework. We need a cancer data framework for Australia, and we need a minimum data set for collection. The data needs to be end to end, not just the bit where you're in the mainstream health system. A group at Cancer Australia is working on that now, in partnership

[24] See, Department of Health and Aged Care, 'Launch of the Australian Cancer Plan', *Media Release*, 2 November 2023; Cancer Australia, *Australian Cancer Plan, Strategic Objective 4: Strong and Dynamic Foundations*, www.australiancancerplan.gov.au/actions/4.2.1 (accessed 30 April 2024).

[25] Cancer Australia, *Australian Cancer Plan, Strategic Objective 4: Strong and Dynamic Foundations*, www.australiancancerplan.gov.au/so/strong-and-dynamic-foundations (accessed 30 April 2024).

[26] Department of Health and Aged Care, *Submission 1*, p. 15.

> with the AIHW and the cancer councils, because Cancer Council Australia had done some work in that area too.[27]

7.30 Some inquiry participants acknowledged these commitments of the Australian Cancer Plan,[28] for example, Professor Karen Canfell, Director of The Daffodil Centre, expressed support for the national cancer data framework as a key priority under the Plan. She considered it important to include genomic and genetic information, as well as information on patient's care pathways, in the minimum capture of the dataset.[29]

7.31 Associate Professor Christopher Steer, President of Private Cancer Physicians of Australia, told the committee that everyone associated with the management of cancer in Australia is 'crying out for systematised, standardised data collection' to inform appropriate treatment decisions, and expressed his hope this comes to fruition through actions under the Plan.[30]

Calls for a national neuroendocrine tumour registry

7.32 The committee also heard more specific calls for a national neuroendocrine tumour registry. Peter MacCallum Cancer Centre called for 'sustainable and targeted funding' to support a national neuroendocrine tumour registry,[31] and added:

> Resources to support a national registry database is also critical for enabling quality research to enhance our understanding of the disease and to address gap in knowledge of survival care for patients with NET in Australia.[32]

7.33 NeuroEndocrine Cancer Australia noted that it sponsors the only national neuroendocrine tumour registry, called PLANET (PLAnning for optimal treatment of NETs) which aims to 'fill the data gap that exists due to a lack of randomized clinical trials in neuroendocrine cancers and the inefficiencies in the state cancer registries'. NeuroEndocrine Cancer Australia submitted that

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27 Professor Dorothy Keefe, Chief Executive Officer, Cancer Australia, *Committee Hansard,* 1 March 2024, p. 33.

28 See, for example, Ms Megan Varlow, Director, Cancer Control Policy, Cancer Council Australia, *Committee Hansard,* 31 January 2024, p. 9; Associate Professor Christopher Steer, President, Private Cancer Physicians of Australia, *Committee Hansard,* 31 January 2024, p. 28; Cancer Council Australia, Answers to questions taken on notice at a public hearing on 31 January 2024; received 9 February 2024, [p. 1].

29 Professor Karen Veronica Canfell, Director, The Daffodil Centre, *Committee Hansard*, 31 January 2024, p. 57.

30 Associate Professor Christopher Steer, President, Private Cancer Physicians of Australia, *Committee Hansard,* 31 January 2024, p. 28.

31 Peter MacCallum Cancer Centre, *Submission 29*, p. 4.

32 Peter MacCallum Cancer Centre, *Submission 29*, p. 3.

funding is vital for the 'sustainability and progression of the PLANET registry' to ensure the registry is maintained.[33]

Addressing the changing nature of how cancer types are classified

7.34 As noted in Chapter 1 of this report, the committee was made aware that the way cancer is classified is changing, with inquiry participants explaining that with improved technology and understanding of cancer in recent decades, the classification of cancer is moving away from descriptions based on tumour location (body part), to classification of subtypes at the genetic and molecular level.[34]

7.35 Associate Professor Benjamin Loveday, Surgical Oncologist at the Peter MacCallum Cancer Centre considered that the practice of classifying cancers by body part 'is convenient but minimally helpful'. He explained that each body part can have many different types of cancer, which can all behave differently – so categorising things by body part makes such information 'murky' and 'meaningless' for clinicians.[35]

7.36 Associate Professor Loveday emphasised that having a precise understanding the exact type of cancer is crucial:

> We really need to know what is the type of cancer we're dealing with. That's the key part of information. That's more difficult but it's much more relevant. If we're going to put effort into something, we should put effort into the right thing.[36]

7.37 Along with his colleague Associate Professor Grace Kong, a Medical Consultant, Nuclear Medicine Physician and the Co-Chair of the Neuroendocrine Tumour Unit at Peter MacCallum Cancer Centre, Associate Professor Loveday proposed that after subtype, 'body part' should then be captured as a subset in cancer data.[37]

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33 NeuroEndocrine Cancer Australia, *Submission 38,* pp. 19–21.

34 See, for example, Rare Cancers Australia, *Submission 3,* p. 2; Children's Cancer Institute, *Submission 6*, [p. 5]; Ms Christine Cockburn, Chief Executive Officer, Rare Cancers Australia, *Committee Hansard,* 31 January 2024, p. 4; Ipsen, *Submission 30,* [p. 2]; Roche, *Submission 9*, p. 7; Australian Genomics, *Submission 10,* [p. 12].

35 Associate Professor Benjamin Loveday, Surgical Oncologist, Peter MacCallum Cancer Centre, *Committee Hansard,* 1 February 2024, p. 7.

36 Associate Professor Benjamin Loveday, Surgical Oncologist, Peter MacCallum Cancer Centre, *Committee Hansard,* 1 February 2024, p. 7.

37 Associate Professor Benjamin Loveday, Surgical Oncologist, Peter MacCallum Cancer Centre, *Committee Hansard,* 1 February 2024, p. 7; Associate Professor Grace Kong, Medical Consultant, Nuclear Medicine Physician and Co-Chair, Neuroendocrine Tumour Unit, Peter MacCallum Cancer Centre, *Committee Hansard,* 1 February 2024, p. 7.

7.38 Dr Anna Johnston, Director of Clinical Haematology at the Royal Hobart Hospital, also considered that both type and site should be captured by databases, which would enable data to be analysed either way.[38]

7.39 Mrs Kate Wakelin, Neuroendocrine Tumour Clinical Nurse Consultant at the Peter MacCallum Cancer Centre, noted that in addition to neuroendocrine and lung cancers, other cancers would also benefit from this lens. She emphasised that the specific subtype of cancer has 'far more implications on the treatment, the prognosis and the wellbeing of the patient than the body part it's grown from'.[39]

7.40 Rare Cancers Australia flagged that the rare molecular sub-types of cancers are not yet included in the statistics collated by the AIHW. It considered that as a result of this, estimates for the proportion of all rare and less common cancer cases in Australia are 'significantly underestimated'.[40]

7.41 Rare Cancers Australia specifically stated that action is required to improve AIHW data collection for rare and less common cancers, to include rare sub-type level information.[41]

7.42 Ms Meredith Cummins, Chief Executive Officer of NeuroEndocrine Cancer Australia also raised concern that the AIHW reports cancer data by body part, and explained the challenges this creates in the neuroendocrine cancer context:

> One problem that we do have with the Australian Institute of Health and Welfare data is that they're now reporting all cancers by body part. As we know, neuroendocrine cancer can happen anywhere in the body, so it makes it very difficult for us to get true data, unless we really dig down to the histology of the disease. If it's in the pancreas, we have to look to see whether it's an adenocarcinoma or a neuroendocrine tumour, so it makes it very difficult to see what the numbers are and to get an accurate amount.[42]

7.43 Ms Cummins proposed that there be a review of how cancer is classified, she specifically suggested:

> Rather than just having breast cancer, ovarian cancer and brain cancer, it should be put down as neuroendocrine, neoplasia or neuroendocrine cancer. Then there should be subsets of that so that we can actually collect the appropriate data. I think it's up to the individual cancer registries around

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38 Dr Anna Johnston, Director of Clinical Haematology, Royal Hobart Hospital, *Committee Hansard*, 20 February 2024, p. 14.

39 Mrs Kate Wakelin, Neuroendocrine Tumour Clinical Nurse Consultant, Peter MacCallum Cancer Centre, *Committee Hansard*, 1 February 2024, p. 8.

40 Rare Cancers Australia, *Submission 3*, [p. 2].

41 Rare Cancers Australia, *Submission 3*, [p. 10].

42 Ms Meredith Cummins, Chief Executive Officer, NeuroEndocrine Cancer Australia, *Committee Hansard*, 1 February 2024, p. 2.

the states as well to actually incorporate that so that then it can be nationally recorded and available.[43]

7.44 The Daffodil Centre and the University of Sydney Cancer Research Network also considered that improved data collection, organised by rare cancer and subtypes will be key to both informing and predicting responses to tailored treatments. In particular, it recommended that there be 'greater recognition of the increasing number of rare cancers classified as subtypes of more common cancers'.[44]

A lack of data regarding cancer stage at diagnosis

7.45 The committee heard from representatives of the Australian Cancer Atlas (the Atlas), an initiative which aims to quantify the geographical variations of the impact of cancer across the Australian community, by bringing data together from all states and registries, into an interactive, digital platform.[45]

7.46 Representing the Atlas, Dr Kerrie Mengersen, Distinguished Professor at the Centre for Data Science at Queensland University of Technology, told the committee that its research has found substantial evidence that incidence and survival of rare cancers, including neuroendocrine tumours, varies markedly across geographic areas in Australia. Dr Mengersen advised that areas with higher incidence, tend to have lower survival rates, and that a larger proportion of areas in more remote or socioeconomically disadvantaged regions have higher incidence of rare cancers and poorer survival outcomes, when compared to major cities.[46]

7.47 However, Dr Peter Baade, Senior Manager of Descriptive Epidemiology at Cancer Council Queensland, also representing the Atlas told the committee that it is difficult to determine the reasons why this variability occurs.[47]

7.48 Dr Baade told the committee that not all detail around the clinical characteristics of cancers are routinely collected at a population level. Dr Baade specifically

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43 Ms Meredith Cummins, Chief Executive Officer, NeuroEndocrine Cancer Australia, *Committee Hansard*, 1 February 2024, p. 6.

44 The Daffodil Centre and the University of Sydney Cancer Research Network, *Submission 32*, pp. 1 and 13.

45 Dr Peter Baade, Senior Manager, Descriptive Epidemiology, Cancer Council Queensland, *Committee Hansard*, 31 January 2024, p. 22; Dr Kerrie Mengersen, Distinguished Professor, Centre for Data Science, Queensland University of Technology, *Committee Hansard*, 31 January 2024, p. 22.

46 Dr Kerrie Mengersen, Distinguished Professor, Centre for Data Science, Queensland University of Technology, *Committee Hansard*, 31 January 2024, p. 22.

47 Dr Peter Baade, Senior Manager, Descriptive Epidemiology, Cancer Council Queensland, *Committee Hansard*, 31 January 2024, p. 22.

pointed out that detail around the stage of disease and the spread of the cancer, at the time of diagnosis, is not captured.[48]

7.49 Dr Baade explained that this makes it difficult to determine whether geographical variability in cancer outcomes are 'predominantly driven by better and earlier diagnosis or if it's predominantly driven by the details about better treatment or use and management afterwards'.[49]

7.50 He added that until the drivers of outcomes are able to be quantified, the goal of reducing the significant amount of geographical variability in cancer outcomes across the country will be compromised.[50]

7.51 Cancer Australia also recognises the need for high quality, comprehensive national data on the stage (including tumour, node, and metastasis) of cancer at diagnosis.[51] It notes that 'the lack of information on cancer stage at diagnosis is a fundamental gap in Australia's national cancer data', and that such data would add 'significant value' to existing data on incidence and mortality for 'monitoring service needs, patterns of care and outcomes across the population'.[52]

7.52 According to Cancer Australia, it is working in conjunction with the AIHW to explore ways to transfer tumour, node, and metastasis stage data into a national database on an ongoing basis.[53]

The accessibility of data for research purposes

7.53 The committee heard that current health data systems and structures can make it difficult for health and medical researchers to carry out their work.[54]

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48 Dr Peter Baade, Senior Manager, Descriptive Epidemiology, Cancer Council Queensland, *Committee Hansard*, 31 January 2024, p. 22.

49 Dr Peter Baade, Senior Manager, Descriptive Epidemiology, Cancer Council Queensland, *Committee Hansard*, 31 January 2024, p. 23.

50 Dr Peter Baade, Senior Manager, Descriptive Epidemiology, Cancer Council Queensland, *Committee Hansard*, 31 January 2024, p. 23.

51 Cancer Australia, *Improving Cancer Data*: *Stage, Treatment and Recurrence (STaR)*, www.canceraustralia.gov.au/research/data-and-statistics/cancer-data/improving-cancer-data (accessed 10 April 2024).

52 Cancer Australia, *Improving Cancer Data*: *Stage, Treatment and Recurrence (STaR)*, www.canceraustralia.gov.au/research/data-and-statistics/cancer-data/improving-cancer-data (accessed 10 April 2024).

53 Cancer Australia, *Improving Cancer Data*: *Stage, Treatment and Recurrence (STaR)*, www.canceraustralia.gov.au/research/data-and-statistics/cancer-data/improving-cancer-data (accessed 10 April 2024).

54 See, for example, Associate Professor Kathy Tucker, Private capacity, *Committee Hansard*, 31 January 2024, p. 58; Professor Anna DeFazio, Convenor, University of Sydney Cancer Research Network, Committee Hansard, 31 January 2024, p. 58; Mr Paul Flynn, Group Chief Executive Officer, The

7.54 For example, Mr Paul Flynn, Group Chief Executive Officer of the Hospital Research Foundation Group explained that even though existing, comprehensive datasets may be available, such as through major hospitals, accessing this data can often be challenging for researchers. He elaborated on these matters and advocated for this issue to be addressed:

> … One [issue] is the data that can inform future research. For example, any major quaternary hospital has decades of data. It's access to that data that is difficult. If you are a university and you're not clinically aligned to that hospital, you're going to have trouble getting access to that data even if it's de identified data. There is work going on all over Australia to try and find a legal pathway to that. That would be a very useful outcome if we could find a legal pathway for accredited researchers to be able to access de-identified clinical data.[55]

7.55 Associate Professor Kathy Tucker, a clinical cancer geneticist with over 30 years of experience working with people with rare genetic syndromes, expressed similar concerns. She provided a firsthand example that illustrated some of the challenges researchers can have when attempting to access data:

> We were doing a study on adults who have a rare cancer predisposition syndrome where they're at risk of getting lots and lots of tumours. For us to access their data, we had to contact each of the public health services and private health services. It actually takes a lot of time and effort, but all of that information is already there. In the end, we were able to get that information, but it took a lot of cost we could have otherwise used some other way.[56]

7.56 Associate Professor Tucker considered that solutions are urgently needed to ensure data can be accessed in a more streamlined way, whilst also being mindful of patient consent.[57]

7.57 Professor Anna DeFazio, Convenor of the University of Sydney Cancer Research Network, also discussed these issues. She outlined the 'challenging and costly' process researchers undertake when gathering data from a wide range of sources, including various jurisdictional, public and private hospitals, as well as different pathology laboratories.[58]

Hospital Research Foundation Group, *Committee Hansard,* 9 April 2024, p. 20; Dr Chloe Georgiou, Chair, Victorian Rare Cancer, Clinical Trial Alliance, TrialHub, Alfred Health, *Committee Hansard,* 1 February 2024, p. 47.

55 Mr Paul Flynn, Group Chief Executive Officer, The Hospital Research Foundation Group, *Committee Hansard,* 9 April 2024, p. 20.

56 Associate Professor Kathy Tucker, Private capacity, *Committee Hansard*, 31 January 2024, p. 58.

57 Associate Professor Kathy Tucker, Private capacity, *Committee Hansard*, 31 January 2024, p. 58.

58 Professor Anna DeFazio, Convenor, University of Sydney Cancer Research Network, *Committee Hansard*, 31 January 2024, p. 58.

7.58 Professor DeFazio considered that having better access to data 'can help research overall', however, she also recognised privacy considerations and the importance of patient consent in this context.[59]

7.59 Professor Hamish Scott, Head of Genetics and Molecular Pathology at SA Pathology also noted the variety of ethical, legal, infrastructural and technical considerations, whilst calling for improved data sharing in the context of rare cancers:

> Clinical laboratory data from standard care and research needs to be available in what we call federated databases nationally, and even internationally, so we can actually understand what's happening with patients with rare tumours. That poses significant legal, technical and infrastructure challenges as well as ethical and social considerations, including health and life insurance.[60]

7.60 Finally, Professor Karen Canfell, Director of the Daffodil Centre noted the need for timely access to such data for research, particularly in the context of the Australian Cancer Plan:

> In terms of research, I think the challenge has been comprehensive, nationally linked datasets; an enduring resource; and timely access to such data, so we very much support the relevant recommendations in the Australian Cancer Plan, because there's some way to go in achieving all of those aspects.[61]

Data considerations for First Nations communities

7.61 Particular considerations regarding data and First Nations individuals and communities were highlighted by some inquiry participants.[62]

7.62 NACCHO noted that Aboriginal and Torres Strait Islander communities have rights to the collection, ownership, and application of their data.[63]

7.63 Further, at a public hearing of the inquiry, Mr Paul Flynn, Group Chief Executive Officer of the Hospital Research Foundation Group, recognised the key principle of 'nothing about us without us' when it comes to First Nations

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59 Professor Anna DeFazio, Convenor, University of Sydney Cancer Research Network, *Committee Hansard*, 31 January 2024, p. 58.

60 Professor Hamish Scott, Head of Genetics and Molecular Pathology, SA Pathology, *Committee Hansard*, 9 April 2024, p. 16.

61 Professor Karen Veronica Canfell, Director, The Daffodil Centre, *Committee Hansard*, 31 January 2024, p. 57.

62 See, for example, NACCHO, *Submission 48*, pp. 5, 6 and 17; Mrs Tiffany Boughtwood, Managing Director, Australian Genomics, *Committee Hansard*, 1 February 2024, p. 21, Mr Paul Flynn, Group Chief Executive Officer, The Hospital Research Foundation Group, *Committee Hansard*, 9 April 2024, p. 20.

63 NACCHO, *Submission 48*, p. 17.

communities, and pointed out that the wishes of First Nations communities in terms of the use of their data, must be considered.[64]

7.64 NACCHO raised concern that whilst data for all cancer types for Aboriginal and Torres Strait Islander people should be easily accessible, this is currently not the case. It recommended that the National Agreement on the Closing the Gap (Closing the Gap) Priority Reform Four (which relates to the shared access of data and information) should be implemented to ensure 'commitment to the collection, handling, and reporting of data at sufficient levels of disaggregation, and in an accessible and timely way'.[65]

7.65 NACCHO also outlined that Closing the Gap Priority Reform Four recognises that access to data and information is crucial for Aboriginal and Torres Strait Islander people, communities and organisations to set priorities and drive positive change.[66]

7.66 Mrs Tiffany Boughtwood, Managing Director of Australian Genomics noted that a range of matters must be addressed in terms of data which captures the experiences and outcomes of First Nations people with rare and less common cancers. She told the committee:

> There's a real challenge with not only capturing the access and outcomes of Indigenous Australians with rare or less common cancers but we also know that rates of participation in clinical trials is vastly less than for non-Indigenous Australians, which is such a challenge. That data is just not captured, so the opportunities to benefit from advancements in genomics and in therapies is not equitably available … A lot of it is resourcing, as per usual, but there are a lot more nuanced elements around visibility of the experience, understanding cultural safety and the experience of racism within health care, which has been increasing over recent years.[67]

7.67 Further, as discussed in Chapter 5 of this report, Australian Genomics' submission to the inquiry, noted that in Australia, there is no mandatory requirement to collect or report on the number of Aboriginal and Torres Strait Islander people who are screened, enrolled, complete or withdraw from a clinical trial.[68]

7.68 The committee understands that as noted in the Australian Cancer Plan, under Strategic Directive 4, the following key actions have been committed to:

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64 Mr Paul Flynn, Group Chief Executive Officer, The Hospital Research Foundation Group, *Committee Hansard,* 9 April 2024, p. 20.

65 NACCHO, *Submission 48,* p. 17. Citation omitted.

66 NACCHO, *Submission 48,* p. 17.

67 Mrs Tiffany Boughtwood, Managing Director, Australian Genomics, *Committee Hansard,* 1 February 2024, p. 21.

68 Australian Genomics, *Submission 10*, [p. 9].

> Action 4.2.4: Establish Aboriginal and Torres Strait Islander-led initiatives which strengthen Indigenous Data Sovereignty and governance of cancer data.[69]

My Health Record

7.69 The Australian Digital Health Agency administers the My Health Record system, and explains that it is 'a safe and secure place to keep your key health information, available to you and your healthcare providers anytime, including in an emergency'.[70] It notes that information such as immunisations, pathology and diagnostic imaging reports, prescription and dispensing information, hospital discharge summaries and more, can be kept inside the system.[71]

7.70 Broadly speaking, witnesses had reservations about the value of My Health Record in the context of improving data for rare and less common cancers.[72]

7.71 Ms Varlow, Director of Cancer Control Policy at Cancer Council Australia told the committee that 'My Health Record isn't the place that we get data from for people who are living with and affected by cancer'. She explained that as cancer is a notifiable disease in Australia, medical data comes from state and territory cancer registries, as well as clinical trial data and electronic medical health records across the country.[73]

7.72 Ms Varlow advised that most organisations, clinicians, hospitals and services are not using My Health Record in the way that it is designed. She considered that it is currently not useful, but may have some potential:

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69 Cancer Australia, *Australian Cancer Plan, Strategic Objective 4: Strong and Dynamic Foundations, 2-year goal action 4.2.4: Establish Aboriginal and Torres Strait Islander-led initiatives which strengthen Indigenous Data Sovereignty and governance of cancer data*, www.australiancancerplan.gov.au/actions/4.2.4 (accessed 30 April 2024).

70 Australian Digital Health Agency, *My Health Record*, www.digitalhealth.gov.au/initiatives-and-programs/my-health-record (accessed 12 April 2024).

71 Australian Digital Health Agency, *My Health Record*, www.digitalhealth.gov.au/initiatives-and-programs/my-health-record (accessed 12 April 2024).

72 See, for example, Professor Mark Morgan, Chair, Expert Committee for Quality Care, RACGP, *Committee Hansard,* 1 February 2024, p. 53; Dr Ian Kamerman, Secretary, Rural Doctors Association NSW, *Committee Hansard,* 1 March 2024, p. 20; Associate Professor Gabrielle Cehic AM, Clinical Lead, South Australian Peptide Receptor Radionuclide Therapy Service, and Chair, South Australian Gastroenteropancreatic Neuroendocrine Tumours Multidisciplinary Team, South Australia Medical Imaging, *Committee Hansard*, 9 April 2024, p. 27; Ms Sharon Winton, Chief Executive Officer, Lymphoma Australia, *Committee Hansard,* 1 February 2024, p. 18; Ms Meredith Cummins, Chief Executive Officer, NeuroEndocrine Cancer Australia, *Committee Hansard,* 1 February 2024, pp. 8 and 9; Associate Professor Christopher Steer, President, Private Cancer Physicians of Australia, *Committee Hansard*, 31 January 2024, p. 28.

73 Ms Megan Varlow, Director, Cancer Control Policy, Cancer Council Australia, *Committee Hansard,* 31 January 2024, p. 8.

> The use of My Health Record in the way that it was intended would make a big difference. Seeing that playing out in real life is continuing to be a challenge.[74]

7.73 In the childhood cancer context, the Sydney Children's Hospital Network similarly explained that the My Health Record system is not regularly utilised for patients in public hospitals, and it considered that the platform 'does not contain very much useful information for our patient cohorts'. It continued:

> It is difficult to see how My Health Record may be of benefit when trying to access new trials or evidence for childhood cancer…
>
> For children with cancer in Australia, there are many avenues by which data is captured, including the Australian Childhood Cancer Registry, which provides appropriate data to identify the incidence and prevalence of cancer occurring in children in this country. This means there is already a national resource that can be accessed by academia and industry to consider new research.[75]

7.74 Associate Professor Christopher Steer, medical oncologist and President of Private Cancer Physicians of Australia, considered that 'My Health Record is a tool, but certainly not a perfect one'. He suggested that the work underway through the Australian Cancer Plan may be better placed to create 'a more standardised data collection platform'.[76]

7.75 Noting these existing challenges and concerns, some inquiry participants expressed optimism about the future role and potential of My Health Record.[77]

7.76 For example, Ms Rachael Anderson, Market Access Director at AstraZeneca noted that currently, there is not enough data in the My Health Record system, however she was hopeful about its future potential:

> In an ideal world the My Health Record could be enormously helpful, particularly when we're doing cost-effectiveness analyses. We need so much data, as you were talking about, on prior treatments or diagnostic outcomes, so the My Health Record ideally could be enormously helpful.[78]

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74 Ms Megan Varlow, Director, Cancer Control Policy, Cancer Council Australia, *Committee Hansard,* 31 January 2024, p. 9.

75 Sydney Children's Hospital Network, Answers to question on notice, 31 January 2024, received 6 February 2024, [p. 1].

76 Associate Professor Christopher Steer, President, Private Cancer Physicians of Australia, *Committee Hansard,* 31 January 2024, p. 28.

77 See, for example, Cancer Council Australia, Answers to question on notice, 31 January 2024, received 9 February 2024, [p. 1]; Mr Ben Robinson, Head, Access and Innovation, Roche, *Committee Hansard,* 31 January 2024, p. 67; Professor Karen Veronica Canfell, Director, The Daffodil Centre, *Committee Hansard,* 31 January 2024, p. 59; Ms Rachael Anderson, Market Access Director, AstraZeneca, *Committee Hansard,* 31 January 2024, p. 67.

78 Ms Rachael Anderson, Market Access Director, AstraZeneca, *Committee Hansard,* 31 January 2024, p. 67.

7.77 Professor Karen Canfell, Director of the Daffodil Centre, also considered that there would undoubtedly 'be a role for My Health Record in major data linkages of the future'.[79]

7.78 Supplementary evidence from Cancer Council Australia was also optimistic about the future of My Health Record, but cautioned that until greater levels of participation with the platform are reached across the whole healthcare system, and all patient-level healthcare data is inputted, it 'will not reach its full potential':

> [My Health Record] has the potential to be a valuable source of population, individual, and service and system level information about healthcare utilisation and outcomes in Australia. This could provide access to population-wide cancer data which could be used by researchers and service providers to identify where improvements to care and service provision can be made and enable greater insights into the factors that contribute to the development of cancer. This could lead to improved use of health data informing the delivery of programs and services to reduce the impact of cancer in Australia and deliver more equitable cancer outcomes.[80]

Committee view

7.79 The committee notes the vast complexities in how cancer data (and health data more broadly) is collected, analysed and made available in Australia, particularly due to the varying number of datasets, data custodians and reporting requirements across Australia's public and private health sector, and across all states and territories.

7.80 However, the committee is of the view that many components of this cancer and health data landscape must be urgently addressed to provide a more accurate picture of cancer diagnoses and trends (including rare and less common types) across the country, and to enable medical practitioners, researchers and policymakers alike, to develop and implement interventions to improve overall health outcomes for patients into the future.

7.81 The committee acknowledges that these are significant challenges, but agrees that reforms in this space must be prioritised, noting that technological advancements, and the growing emergence of genomic data will likely deepen data complexities and exacerbate existing issues.

7.82 The committee also believes that the data issues it has heard in relation to rare and less common cancers, have illuminated broader cancer and health data challenges. The committee considers that addressing the issues in this space will

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[79] Professor Karen Veronica Canfell, Director, The Daffodil Centre, *Committee Hansard,* 31 January 2024, p. 59.

[80] Cancer Council Australia, Answers to question on notice, 31 January 2024, received 9 February 2024, [p. 1].

result in wider learnings and improvements for other cancers and health data more broadly.

National cancer data framework

7.83 The committee agrees with inquiry participants that a national cancer data framework is required to bring the disparate data collections across the country together; implement a nationally consistent minimum dataset; and facilitate a standardised, secure data sharing model where information is made available in a timely and accessible way.

7.84 The committee understands that work, is already underway under the Australian Cancer Plan, as led by Cancer Australia, to develop and implement a national cancer data framework and minimum data set in the next two years.

7.85 The committee considers it vital that this national cancer data framework and minimum dataset is prioritised and delivered to this timeframe. Further, the committee urges Cancer Australia to work closely with key cancer control sector stakeholders including medical professionals, researchers and patients, to ensure that key data issues are addressed in the new framework's design and implementation.

Recommendation 39

7.86 The committee recommends that the Australian Government ensure the timely delivery of the national cancer data framework and minimum dataset, as per the timeframes set out in the Australian Cancer Plan.

Existing data gaps and challenges

7.87 Over the course of this inquiry, the committee heard a range of other data-related gaps and issues that require reform, and that committee considers that these matters should be addressed throughout the delivery of the Australian Cancer Plan and its data-related actions and goals.

7.88 For example, inquiry participants highlighted that the way we understand cancer has rapidly evolved in recent years, moving from classification of cancer by tumour or body part, to more precise, molecular or genomic classifications by subtypes. The committee heard compelling evidence that moving towards this more precise level of classification in cancer data sets would be more helpful for clinicians and patients, and agrees that databases and cancer registries should be collecting and reporting cancer information in this way wherever possible.

7.89 The committee understands that AIHW does not currently report cancer data by molecular or genetic subtype, but notes that it draws on data from state and territory clinical registries for its analysis and publication of data. Noting this, the committee encourages the Australian Government to work with states and territories, as well as public and private health services, to shift the way this

cancer data is collected and reported – to have a greater focus on molecular cancer types and subtypes.

7.90 Further, the committee also recognises that there is a 'fundamental gap' in Australia's cancer data, with information regarding the stage of cancer at diagnosis, not consistently or systematically collected across the country.

7.91 The committee recognises that Cancer Australia has made some progress to address this issue, however the committee strongly considers that this work be progressed as a matter of priority, particularly as reforms are implemented via the introduction of the national cancer data framework under the Australian Cancer Plan.

7.92 The committee considers the capture of cancer staging data is crucial to increasing our understanding of reasons for geographical variability in cancer outcomes across the country, as well as to better understand the extent to which earlier diagnosis, or treatments are affecting health and survival outcomes.

7.93 Finally, the committee was concerned to hear that current data structures and frameworks in Australia can make it challenging for health and medical researchers to carry out their work, with the disparate number of datasets and data custodians across the country is making this information difficult and laborious to access.

7.94 The committee notes that patient privacy and consent should always be paramount when it comes to public accessibility and academic use of such data, but it believes that where appropriate, researchers should have easy and timely access to this data to support their work. This is in recognition that timely access to data is vital for individual rare and less common cancer patients as they go through treatment now, but also for improving health outcomes and reducing the impact of rare cancers in the long-term – through future research and treatment breakthroughs.

Recommendation 40

7.95 The committee recommends that the Australian Government, in consultation with the cancer control sector, address the following key data-related issues in its delivery of the national cancer data framework and minimum dataset, under the Australian Cancer Plan:

- **ensure that data is collected and reported in a way that includes information on both tumour location and body part, as well as molecular level information on cancer type and subtype;**
- **ensure that information on the stage of cancer at diagnosis is consistently captured;**
- **where appropriate, ensure that researchers and academics have access to such data in an accessible and timely way; and**

- **ensure that patient privacy and consent is upheld throughout this work and in any future reforms.**

7.96 The committee firmly understands that First Nations individuals and communities have rights to the collection, ownership, and application of their data and it emphasises that these rights must be upheld, and remain at the forefront throughout any health and cancer data reforms.

7.97 The committee considers that in the context of this inquiry, the Australian Government must prioritise commitments under the National Agreement on Closing the Gap, particularly in relation to Priority Reform Four, which recognises that access to data and information is crucial for Aboriginal and Torres Strait Islander people, communities, and organisations to set priorities and drive positive change.

Recommendation 41

7.98 The committee recommends that any existing or future reforms to health and cancer data, must prioritise, and align with the National Agreement on Closing the Gap Priority Reform Four, to ensure:

- **commitment to the best practice collection, handling, and reporting of Aboriginal and Torres Strait Islander data; and**
- **that such information and data is available to Aboriginal and Torres Strait Islander people in a timely and accessible way.**

Senator Penny Allman-Payne
Chair

Additional comments from Labor Senators

Introductory remarks

1.1 Labor Senators thank those who have given evidence to the committee for their contributions throughout the inquiry.

1.2 We give our particular thanks to those witnesses who shared their personal experiences with rare cancers. The value of this evidence cannot be overstated, and we acknowledge where it has required courage and generosity to share.

1.3 As cancer treatment has developed in Australia and internationally, greater awareness of rare and less common cancers has increased. Whilst increased awareness is welcome, the evidence to the inquiry is clear that this has not translated to equity in outcomes for patients with these cancers compared to patients with more common cancers.

1.4 Labor Senators note the significant role of state and territory governments in providing and allocating funding for treatment and support for patients with rare and less common cancers, alongside the leadership of the Commonwealth Government.

Investment in improving cancer outcomes

1.5 Through the Australian Cancer Plan, the Albanese Labor Government has made a major commitment to improve cancer care in Australia – for patients of all cancer types. The Albanese Labor Government committed more than $700 million to the plan's implementation in the 2023-24 Budget.

1.6 Crucial to this plan is an investment in support services for patients, including for patients of rare and less common cancers.

1.7 As evidence to the committee has made clear, these support services are vital in assisting patients and their families to navigate complex care pathways, and to deal with the life-changing news of a diagnosis, and the treatment, of these cancers.

1.8 The Albanese Labor Government also recognises the importance of investment in research focussing on these cancers to improve treatment of rare and less common cancers. Further, the Albanese Labor Government is committed to reform of health technology assessment policies and methods so that Australians have access to the best medicines.

1.9 To this end, the Albanese Labor Government recently announced a new 10-year Low Survival Cancers Mission as part of a $1.89 billion investment in health and medical research, including $1.4 billion for the Medical Research Future Fund, as part of its "Health Research for a Future Made in Australia" package. This makes a total commitment to the Medical Research Future Fund of $6.4 billion over 13 years in research funding.

1.10 In the 2024-25 Budget, the Albanese Labor Government will also provide $18.8 million over two years from 2024–25 to continue the development of the National One Stop Shop for Clinical Trials and Human Research and support current systems. The National One Stop Shop will make it much easier for patients to access clinical trials and therapeutic interventions, and improve the ability of industry, sponsors, and researchers to find, invest and conduct research in Australia.

1.11 Further, the Albanese Labor Government is acting on community concerns that people are being dissuaded from taking genetic tests for fear of discrimination in accessing life insurance. The Albanese Labor Government has released a consultation paper considering options to address the use of genetic testing results in life insurance underwriting, which aims to ensure that consumers can continue to access affordable life insurance while maximising the significant health benefits provided by genetic testing.

1.12 Labor Senators note the evidence to the inquiry regarding barriers to My Health Record enabling quality care and more timely diagnosis and treatment. Labor Senators see value in mandating the upload of clinical records to My Health Record, subject to patient opt in, to enable patient and doctor access to patient records across different clinical institutions.

Conclusion

1.13 Labor Senators again acknowledge all those who made submissions, appeared at the hearings, and shared their lived experiences with our committee.

1.14 Labor Senators support the recommendations of the Committee Report and reaffirm our commitment to improve outcomes and equity for patients with rare and less common cancers.

Senator Marielle Smith **Senator Louise Pratt**

Appendix 1
Submissions and Additional Information

Submissions

1 Department of Health and Aged Care

2 National Health and Medical Research Council
- Attachment

3 Rare Cancers Australia

4 Cancer Council Australia, the Cancer Nurses Society of Australia, the Clinical Oncology Society of Australia, Private Cancer Physicians of Australia, the Medical Oncology Group of Australia and the Lung Foundation Australia

5 Royal Australian College of General Practitioners

6 Children's Cancer Institute

7 National Rural Health Alliance

8 Medicines Australia

9 Roche

10 Australian Genomics

11 WA Health

12 Queensland Health

13 Tasmanian Government

14 Sydney Children's Hospitals Network

15 Australian Nuclear Science and Technology Organisation

16 Australian Diagnostic Imaging Association

17 The Society of Hospital Pharmacists of Australia

18 Ovarian Cancer Australia

19 Head and Neck Cancer Australia

20 PanKind, The Australian Pancreatic Cancer Foundation

21 Pancare Foundation
- Attachment

22 Melanoma Patients Australia

23 Minderoo Foundation

24 VCCC Alliance

25 TROG Cancer Research

26 Australian Rare Cancer Portal

27 Ovarian Cancer Research Foundation

28 Victorian Cancer Biobank

29 Peter MacCallum Cancer Centre

30 Ipsen

31 The Australian Bragg Centre for Proton Therapy and Research

32 The Daffodil Centre and the University of Sydney Cancer Research Network

33 Noxopharm

34 Cancer Trials Australia
35 Dr Jane Tiller and Associate Professor Paul Lacaze, Public Health Genomics Program, Monash University
36 Dr Minmin Li FRACP and Associate Professor Kathy Tucker AO FRACP
37 TrialHub
38 NeuroEndocrine Cancer Australia
- 5 Attachments

39 Leukaemia Foundation
40 Movember Foundation
41 AstraZeneca
42 Bayer Australia
43 Cancer Australia
44 Omico
- Attachment

45 Dr S. Cox
- 45.1 Supplementary submission

46 Bristol Myers Squibb Australia
47 Telix Pharmaceuticals
48 National Aboriginal Community Controlled Health Organisation
49 IQVIA Australia
- Attachment

50 Professor John R Zalcberg AO
51 UCB Australia
52 Novartis
53 MSD Australia
54 Lana
55 Jim
56 Kim
57 Michael
58 Neuroblastoma Australia
59 Grace
60 Tanya
61 Syd
62 Michelle
63 Emma
64 Emily
65 Leona
66 Lynn
67 Jon
68 Ann
69 Brittany
70 Kathryn

71 Michael
72 Belinda
73 Christopher
74 Jean
75 Jenny
76 Angie
77 Kerryn
78 Jan
79 Susan
80 Milton
81 Claudia
82 Shae
83 Kim
84 Sandra
85 Jaimee
86 Mary
87 Mary
88 Peter
89 Ailsa
90 Alison
91 Name Withheld
92 Kristina and Brett
93 Beau
94 Name Withheld
95 Christine
96 Gay
97 Dr Richard Stuckey
98 Name Withheld
99 Name Withheld
100 Yvonne
101 Glen
102 Name Withheld
103 Keanna and Fiore
104 Name Withheld
105 David
106 Name Withheld
107 Megan
108 Jessica
109 Danielle
110 Ron
111 Caitlin
112 Sarah
113 Sarah

114 Cure Our Ovarian Cancer
115 Jenaya
116 Judi
117 Ada
118 Doreen
119 WMozzies
120 AbbVie
121 Jamie
122 Natalie
123 Name Withheld
124 Name Withheld
125 Professor Matthew Dun
126 Eleni
127 Lorraine, Heath, Frith & Daniel, Dominic, Elannise
128 Megan
129 Kaye
130 Dr Robert Thornton
131 Peter
132 Joyce
133 Elnaz
134 Andrea
135 Anita
136 Robin
137 Alan
138 Name Withheld
139 Megan
140 Associate Professor Gabrielle Cehic AM
141 Le-Anne
142 Russell
143 Mr Ryan Paterson
144 Royal College of Pathologists of Australasia
145 Cancer Council Tasmania
146 The Hospital Research Foundation Group
147 Angel Flight
148 Menzies Institute for Medical Research, University of Tasmania
149 The Kinghorn Cancer Centre and St Vincent's Hospital Sydney

Additional Information

1 Additional information provided by Cancer Australia, Australian Cancer Plan Summary Report; received 16 January 2024

2 Additional information provided by Victoria Rare Cancer Trials Alliance, Addendum; received 9 February 2024

3 Additional information provided by Neuroendocrine Clinical Nurse Consultant Kate Wakelin, Improving rates of diagnosis of neuroendocrine cancers; received 15 February 2024

4 Additional information provided by Glen, Private Capacity, Additional comments to public hearing appearance; received 20 February 2024

5 Additional information provided by Professor Peter Baade and Distinguished Professor Kerrie Mengersen, Latest trends in rare cancer diagnoses (counts), diagnoses rates and survival for all Australia; received 7 February 2024

Answer to Question on Notice

1 Answers to questions taken on notice by Cancer Council Australia at a public hearing on 31 January 2024; received 9 February 2024.

2 Answers to questions taken on notice by Private Cancer Physicians of Australia at a public hearing on 31 January 2024; received 7 February 2024.

3 Answers to questions taken on notice by Sydney Children's Hospital Network at a public hearing on 31 January 2024; received 6 February 2024.

4 Answers to questions taken on notice by Roche at a public hearing on 31 January 2024; received 5 February 2024.

5 Answers to questions taken on notice by Australasian Leukaemia and Lymphoma Group at a public hearing on 1 February 2024; received 9 February 2024.

6 Answers to questions taken on notice by NeuroEndocrine Cancer Australia at a public hearing on 1 February 2024; received 9 February 2024.

7 Answers to questions taken on notice by Cancer Trials Australia at a public hearing on 1 February 2024; received 6 February 2024.

8 Answers to questions taken on notice by Ipsen at a public hearing on 1 February 2024; received 13 February 2024.

9 Answers to questions taken on notice by Ovarian Cancer Australia at a public hearing on 1 February 2024; received 9 February 2024.

10 Answers to questions taken on notice by The Royal Australian College of General Practitioners at a public hearing on 1 February 2024; received 16 February 2024.

11 Answers to questions taken on notice by The Daffodil Centre, Sydney Cancer Partners at a public hearing on 31 January 2024; received 19 February 2024.

12 Answers to questions taken on notice by the Department of Health and Aged Care at a public hearing on 1 March 2024; received 27 March 2024

13 Answers to questions taken on notice by Dr Melanie Wuttke and Dr Anna Johnston at a public hearing on 20 February 2024; received 26 April 2024

14 Answers to questions taken on notice by Cancer Australia at a public hearing on 1 March 2024; received 13 March 2024.
15 Answers to questions taken on notice by National Rural Health Alliance at a public hearing on 1 March 2024; received 15 March 2024.
16 Answers to questions taken on notice by Australian Teletrial Program at a public hearing on 1 March 2024; received 15 March 2024.
17 Answers to questions taken on notice by Rare Cancers Australia at a public hearing on 31 January 2024; received 15 February and 11 March 2024.
18 Answers to questions taken on notice by Professor Jane Tiller at a public hearing on 1 February 2024; received 16 March 2024.

Tabled Documents

1 Australian Cancer Atlas, Slide deck, tabled at public hearing on 31 January 2024
2 Australian Cancer Atlas, Journal article regarding geographical and spatial disparities in the incidence and survival of rare cancers in Australia, tabled at public hearing on 31 January 2024
3 Dr Richard Mitchell, Opening statement, tabled at public hearing on 31 January 2024
4 IQVIA, Information regarding cancer treatment timelines and case studies, tabled at public hearing on 31 January 2024
5 Professor Matthew Dun, Opening statement, tabled at public hearing on 31 January 2024
6 Rotary Outreach Myeloma Project, Opening statement, tabled at public hearing on 1 February 2024
7 Dr Jane Tiller and Associate Professor Paul Lacaze, Australian Genetics and Life Insurance Moratorium: Monitoring the Effectiveness and Response, Final Stakeholder Report, tabled at public hearing on 1 February 2024

Appendix 2
Public Hearings

Wednesday, 31 January 2024
Corinthian Room, Sydney Masonic Centre
66 Goulburn St
Sydney

Cancer Council Australia
- Ms Megan Varlow, Director, Cancer Control Policy

Rare Cancers Australia
- Ms Christine Cockburn, Chief Executive Officer

Head and Neck Cancer Australia
- Ms Nadia Rosin, Chief Executive Officer
- Ms Carolyn Smith, Board Director
- Mr Matthew Magarey, Board Director

Neuroblastoma Australia
- Ms Lucy Jones, Chief Executive Officer

Leukaemia Foundation
- Mr Tim Murphy, General Manager, Blood Cancer Partnerships

Mrs Julia Sammut, Private capacity

Cancer Assistance Network
- Mrs Emma Phillips, Executive Director
- Ms Majella Gallagher, Advocacy and External Relations

Australian Cancer Atlas
- Dr Kerrie Mengersen, Distinguished Professor, Centre for Data Science, Queensland University of Technology
- Dr Peter Baade, Senior Manager, Descriptive Epidemiology, Cancer Council Queensland

Private Cancer Physicians of Australia
- Associate Professor Christopher Steer, President

Professor Matthew Dun, Professor of Paediatric Haematology and Oncology Research, Founder and Director of RUN DIPG

Australian DIPG families

- Mrs Beau Kemp
- Mrs Hannah Pringle
- Ms Angie Sari-Daher

Kate, Private capacity

Michelle, Private capacity

Children's Cancer Institute

- Dr Peter Wejbora, Director Research Development and Partnerships
- Dr Emily Mould, Head of Business Development
- Ms Anastasia Glushko, Stakeholder Engagement Manager

Sydney Children's Hospitals Network

- Dr Richard Mitchell, Director, Kids Cancer Centre, Sydney Childrens Hospital Randwick
- Dr Luciano Dalla-Pozza, Senior Staff Specialist and Director, Cancer Centre for Children, The Childrens Hospital at Westmead
- Associate Professor Antoinette Anazodo, Paediatric and Adolescent Oncologist, Sydney Childrens Hospital Randwick

Clinical Oncology Society of Australia

- Dr David Chan, Chair, Neuroendocrine Tumours Group

The Daffodil Centre

- Professor Karen Veronica Canfell, Director

The Daffodil Centre and the University of Sydney Cancer Research Network

- Professor Stephen Clarke

University of Sydney Cancer Research Network

- Professor Anna Defazio, Convenor

Associate Professor Kathy Tucker, Private capacity

IQVIA

- Mr Andrew Sutton, Vice President and General Manger
- Mr Quentin Bracquart, Head of Payer, Provider and Government Services and Principal, Strategic Insights and Analytics

Roche

- Mr Ben Robinson, Head, Access and Innovation
- Dr Richard Woodfield, Country Medical Director

AstraZeneca

- Ms Penny George, Director of Corporate Affairs
- Ms Rachael Anderson, Market Access Director

Thursday, 1 February 2024

Edinburgh Room, Stamford Plaza Melbourne
111 Little Collins St
Melbourne

NeuroEndocrine Cancer Australia

- Ms Meredith Cummins, Chief Executive Officer
- Professor Rodney Hicks, Honorary Board Member

Peter MacCallum Cancer Centre

- Associate Professor Grace Kong, Medical Consultant, Nuclear Medicine Physician and Co-Chair, Neuroendocrine Tumour Unit
- Mrs Kate Wakelin, Neuroendocrine Tumour Clinical Nurse Consultant
- Associate Professor Benjamin Loveday, Surgical Oncologist
- Mrs Susanne Manks, Patient

Lymphoma Australia

- Ms Sharon Winton, Chief Executive Officer

Australasian Leukaemia and Lymphoma Group

- Ms Delaine Smith, Chief Executive Officer

Rotary Outreach Myeloma Program

- Mr Peter Allen OAM, Secretary
- Mrs Patricia Marjorie O'Hara OAM, Committee Member

Australian Genomics

- Mrs Tiffany Boughtwood, Managing Director

Dr Jane Tiller, Ethical, Legal and Social Adviser, Public Health Genomics, Monash University

Professor Paul Lacaze, Head of Public Health Genomics, School of Public Health and Preventative Medicine, Monash University

Emily, Private capacity

Jelena, Private capacity

Katherine, Private capacity

Kristina, Private capacity

Michael, Private capacity

Caitlin, Private capacity

Cancer Trials Australia

- Dr Kurt Lackovic, Chief Executive Officer
- Professor Clare Scott, Board Member

TrialHub

- Ms Anne Woollett, Director
- Dr Chloe Georgiou, Chair, Victorian Rare Cancer, Clinical Trial Alliance
- Professor Clare Scott, Co-Chair, Victorian Rare Cancer, Clinical Trial Alliance

Victorian Cancer Biobank

- Dr Wayne Ng, General Manager

Royal Australian College of General Practitioners

- Professor Mark Morgan, Chair, Expert Committee for Quality Care

Society of Hospital Pharmacists of Australia

- Mr Jerry Yik, Head, Policy and Advocacy
- Mr Shaun O'Connor, Co-Chair, Oncology and Haematology Leadership Committee

Ovarian Cancer Australia

- Associate Professor Anna Boltong, Chief Executive Officer
- Mrs Bridget Bradhurst, Acting Chief of Support and Advocacy
- Ms Claire MacDonald, Governance Manager

Pancare Foundation

- Mr Doug Hawkins, Chief Executive Officer
- Mr David Menzies, Head of PanSupport

Omico

- Professor David Thomas, Chief Executive Officer

Bristol-Myers Squibb Australia

- Mr Owen Smith, Managing Director

Ipsen

- Mr Julien Dagher, General Manager Australia & New Zealand
- Mr Simon Higgins, Director, Public Affairs and Market Access

Tuesday, 20 February 2024

Centurion 1, Crowne Plaza Hobart
110 Liverpool St
Hobart

Menzies Institute for Medical Research, University of Tasmania

- Professor Joanne Dickinson, Lead, Cancer Genetics

Royal Hobart Hospital

- Dr Thomas (Tom) Walwyn, Staff Specialist, Paediatric, Adolescent and Young Adult Oncology
- Dr Anna Johnston, Director of Clinical Haematology
- Dr Melanie (Mel) Wuttke, Head of Medical Oncology

Glen, Private capacity

Jacqui, Private capacity

Jenaya, Private capacity

Judi, Private capacity

Lesley, Private capacity

Peter, Private capacity

Robert, Private capacity

Friday, 1 March 2024

Committee Room 1S3, Parliament House
Parliament Dr
Canberra

ZERO Childhood Cancer Program

- Associate Professor Vanessa Tyrrell, Director
- Ms Anastasia Glushko, Stakeholder Engagement Manager, Children's Cancer Institute

- Professor Nick Gottardo, Head, Department of Paediatric Oncology and Haematology, Perth Children's Hospital; and Chair, Australian and New Zealand Children's Haematology and Oncology Group

Australian Teletrial Program

- Ms Kaye Hewson, Director, Australian Teletrial Program, National Office, Queensland Health
- Dr Julie White, Executive Director, Office of Research and Innovation
- Dr Wei-Sen Lam, Medical Lead, Teletrials, WA Country Health Service

Canberra Health Services

- Ms Clare Crawford, Senior Director, Revenue and Hospital Financial Services
- Mrs Florence Young, Executive Branch Manager and Deputy Chief Financial Officer

National Rural Health Alliance

- Ms Clare Fitzmaurice, Policy and Data Analytics Officer
- Ms Margaret Deerain, Director of Policy and Strategy Development
- Dr Ian Kamerman, Secretary, Rural Doctors Association NSW

Cancer Australia

- Professor Dorothy Keefe, Chief Executive Officer
- Ms Claire Howlett, Deputy Chief Executive Officer

Department of Health and Aged Care

- Ms Adriana Platona, First Assistant Secretary, Technology Assessment and Access Division
- Ms Renaye Lucchese, Assistant Secretary, Genomics and Health
- Mrs Ariane Hermann, Acting First Assistant Secretary
- Dr Masha Somi, Assistant Secretary, Health and Medical Research Office
- Ms Natasha Ploenges, Chief Executive Officer, Health and Medical Research Office

National Health and Medical Research Council

- Dr Nicholas Johnson, Executive Director, Research Partnerships Branch
- Dr Julie Glover, Research Foundations Branch

Tuesday, 9 April 2024

Banqueting Room, Adelaide Town Hall
Adelaide

Cancer Council South Australia

- Dr Peter Diamond, General Manager Support and Research
- Mrs Amanda Robertson, Information and Support Manager

Mrs Miriam Cocking, Private capacity

Angel Flight Australia

- Mr Howard Hobbs, Chair

Royal Adelaide Hospital

- Professor Hamish Scott, Head of Department, Genetics and Molecular Pathology, SA Pathology
- Dr Anna Brown, Head, Molecular Oncology, SA Pathology

The Hospital Research Foundation Group

- Mr Paul Flynn, Group Chief Executive Officer

Associate Professor Gabby Cehic AM, Clinical Lead, South Australian Peptide Receptor Radionuclide Therapy Service, and Chair, South Australian Gastroenteropancreatic Neuroendocrine Tumours Multidisciplinary Team, South Australia Medical Imaging

Dr Sally Cox, Private capacity

From: STEPHEN-SMITH
Sent: Wednesday, 6 November 2024 2:37 PM
To: ACT Health DLO; CHS DLO
Cc: Tomlinson, Benjamin; Smith, Kahlia
Subject: FW: Australian Commission on Safey and Quality in Health Care's draft 2025-28 Work Plan and budget [SEC=OFFICIAL]
Attachments: DRAFT ACSQHC 2025-28 Work Plan - 29 Oct 2024.pdf; MS24-001114 - signed letter - ACT.pdf

Importance: High

Hi Team,

For appropriate action please.

Thank you,

Sally Cooke
Office Manager | Office of Rachel Stephen-Smith MLA
Minister for Health | Minister for Children, Youth and Family Services | Minister for Disability | Minister for Aboriginal and Torres Strait Islander Affairs
Member for Kurrajong
ACT Legislative Assembly, 196 London Circuit, Canberra ACT 2601 | P: (02) 6205 2661 | www.act.gov.au

From: ACSQHCSecretariat
Sent: Wednesday, 6 November 2024 2:13 PM
To: STEPHEN-SMITH
Cc: ACSQHCSecretariat ; ACSQHC IGR
Subject: Australian Commission on Safey and Quality in Health Care's draft 2025-28 Work Plan and budget [SEC=OFFICIAL]

Caution: This email originated from outside of the ACT Government. Do not click links or open attachments unless you recognise the sender and know the content is safe.

Dear Minister,

Please find attached correspondence from Minister Butler regarding the Australian Commission on Safey and Quality in Health Care's draft 2025-28 Work Plan and budget.

Kind regards,

Schedule 2.2(a)(ii)
Manager, Secretariat and Corporate Governance
Australian Commission on Safety and Quality in Health Care
GPO Box 5480 Sydney NSW 2001 | Level 5, 255 Elizabeth Street, Sydney NSW 2000
T Schedule 2.2(a)(ii) www.safetyandquality.gov.au

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NSQHS STANDARDS
A better way to care

The Australian Commission on Safety and Quality in Health Care acknowledges the traditional owners of country throughout Australia, and their continuing connection to land, sea and community. We pay our respects to them and their cultures, and to elders both past and present.

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AUSTRALIAN COMMISSION
ON SAFETY AND QUALITY IN HEALTH CARE

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Draft
Work Plan 2025-28

October 2024

We, the Australian Commission on Safety and Quality in Health Care, acknowledge the Traditional Custodians of Country throughout Australia and pay respect to those who have preserved and cared for the lands on which we live and work, and from which we benefit each day. We recognise the strength and resilience of First Nations people and acknowledge and respect their continuing connections and relationships with country, rivers, land and sea.

We acknowledge the ongoing contribution First Nations people make across the health system and wider community. We also pay our respects to Elders past, present and future, and extend that respect to all Traditional Custodians of this land.

We acknowledge and respect the Traditional Custodians on whose ancestral lands our office is located, the Gadigal people.

We are committed to the National Agreement on Closing the Gap and taking action to give effect to the four priority reform areas for joint national action: Formal partnerships and shared decision-making; Building the Community-controlled Sector; Transforming Government Organisations; and Shared access to data and information at a regional level.

The Commission's vision for reconciliation in Australia is to ensure First Nations people are physically, mentally, and culturally safe when they receive health care, enabled by equity of access and appropriate health care that meets their needs.

1. Introduction

The Australian Commission on Safety and Quality in Health Care (the Commission) works to create a sustainable, safe, high-quality healthcare system for all Australians.

The Commission is a national independent statutory authority, funded jointly by the Australian Government and state and territory governments.

The Commission contributes to better health outcomes and experiences for people, and improved value and sustainability in the Australian health system. We do this by leading and coordinating improvements to the delivery of health care that, nationally, ensure the safety of the health system, and contribute to its increased quality. We support the delivery of health care that, regardless of where it is delivered, is:

- Safe
- Appropriate
- Sustainable
- Integrated
- Person-centred
- Equitable
- Evidence-based
- Efficient.

This includes the delivery of health care across public and private services, in metropolitan, rural and remote areas, and across primary and community care, acute care, aged care, and at home.

2. Our legislative function

The Commission's role and responsibilities are specified in the *National Health Reform Act 2011*. Section 9(1) of the *National Health Reform Act 2011* describes the Commission's functions. In summary, these functions are to:

- Promote, support and encourage the implementation of arrangements, programs and initiatives relating to the safety and quality of the healthcare system.
- Collect, analyse, interpret and disseminate information relating to healthcare safety and quality matters.
- Formulate standards, guidelines and indicators relating to healthcare safety and quality matters.
- Formulate model national schemes relating to healthcare safety and quality, which support the accreditation of organisations providing healthcare services.
- Monitor the implementation and impact of the standards.
- Advise health ministers on national clinical standards.
- Promote, support, encourage, conduct and evaluate research relating to the performance of any of the Commission's functions.
- Publish reports and papers relating to healthcare safety and quality.

Schedule 2.2(a)(xvi)

[redacted]

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Schedule 2.2(a)(xvi)

[redacted]

2. Our priorities

The Commission's Strategic Intent 2020-2025 outlines four strategic priorities and the Commission's overarching strategic direction. These strategic priorities are connected and integral to each other:

1. Safe delivery of health care
   Clinical governance, systems, processes and standards ensure patients, consumers and all staff are safe from harm in all places where health care is delivered.

2. Partnering with consumers
   Patients, consumers, carers and the community are engaged in understanding and improving health care for all.

3. Partnering with healthcare professionals
   Healthcare professionals, organisations and providers are engaged and supported to deliver safe and high-quality care.

4. Quality, value and outcomes
   Evidence-based tools, guidance and technology are used to inform delivery of safe and high-quality care that is integrated, coordinated and person-centred.

3. Our approach

The Commission designs systems and structures to improve the quality of health care. Our focus is on innovation and system change by encouraging the implementation of frameworks and foundations for high reliability health service organisations, and measurement and monitoring to make sure improvements are effective, appropriate and sustainable.

We employ levers across the health system, including legislative reform, health service agreements, and national, state and territory initiatives. We connect, engage and work alongside people, communities and organisations across the health, social and education sectors.

The Commission identifies new and emerging issues and opportunities, which affect the safety and quality of the healthcare system and reviews its programs and priorities to ensure that they are responsive to the evolving needs of people, the health system and sector. The Commission's work plan is shaped by a broad range of national strategies (**Appendix C**) and consideration of the constraints and pressures health service organisations work under in today's complex and fast-moving environment. These include workforce shortages and increasing demand for health services.

The Commission's work is underpinned by proven processes (**Appendix D**).

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The Commission actively partners with and works with patients, their carers and families and communities to ensure that care is safe, of high quality, and meets people's needs. The Commission treats people with dignity and respect, sharing information and encouraging participation, collaboration and engagement.

The Commission aims to work collaboratively and in partnership with leading First Nations individuals, organisations and communities, and with other health organisations, as an ally and change-maker in improving First Nations health outcomes and experiences of health care. The Commission is committed to leading the health system to re-orient the delivery of health care and build the capability and capacity of its staff to act and engage in culturally safe and responsive ways. The Commission's Innovate Reconciliation Action Plan is an important part of the Commission's commitment to reconciliation and improving the safety and quality of health care for First Nations people in Australia.

The Commission supports collaboration across jurisdictions and consults extensively with the health sector, professions, academic experts, people and communities, and state and territory health departments. The Commission, as the lead organisation in Australia with expertise in strategies to improve the safety and quality of healthcare delivery, also takes part in, and gives input and advice to, international forums and initiatives.

To ensure projects are fit for purpose and learnings are shared and built upon, the Commission discusses key projects with the states and territories throughout their development and completion – including at the start of projects, when seeking nominations for jurisdictional representatives on working groups, during consultation and before publication. Where there are existing state or territory resources and they are discoverable or provided, the Commission works to avoid duplication and incorporate them into its national work (and align where possible) for their efficient and effective use.

The Commission progresses issues to the Health Chief Executives Forum and Health Ministers and gives updates to the Health Chief Executives Forum on progress against the work plan priorities, emerging issues and other matters of national importance.

4. Our work plan and budget

The Commission's work plan is funded jointly by the Australian Government and state and territory governments under a multi-party funding agreement. All items on the Commission's work plan are within its legislative functions under the *National Health Reform Act 2011*, and the NHRA Addendum. Under the *National Health Reform Act 2011* Part 2.1(s54):

1. The Commission must prepare a work plan during each financial year and give it to the [Australian Government] Minister [for Health].
2. The Commission must give the draft of the work plan to the Minister during the period that starts at the beginning of the financial year and ends at the end of 31 October.
3. The work plan must set out the Commission's priorities for work to be undertaken during the next three financial years.
4. As soon as practical after receiving the work plan, the Minister must give a copy of the work plan to each participating State/Territory Health Minister.

The multi-party funding agreement between the Commonwealth and state and territory governments and the Commission requires the Commission to provide a draft budget to the Australian Government Minister for Health and Aged Care, for a 3-year term, at the same time as it provides the work plan **(Appendix A).**

The Commission's work plan activities are categorised into six strategic objectives:

1. Clinical governance
2. Partnerships with patients, their carers and families, and communities
3. Appropriate and sustainable health care
4. Safe clinical processes
5. Integrated systems
6. Measurement for improvement.

Each strategic objective encompasses several areas of focus. There will be overlap and interconnections between these areas, and programs of work may fit into and across several objectives. This shows the synergies across the work plan, and the opportunity to work across these objectives to achieve safe, high-quality health care.

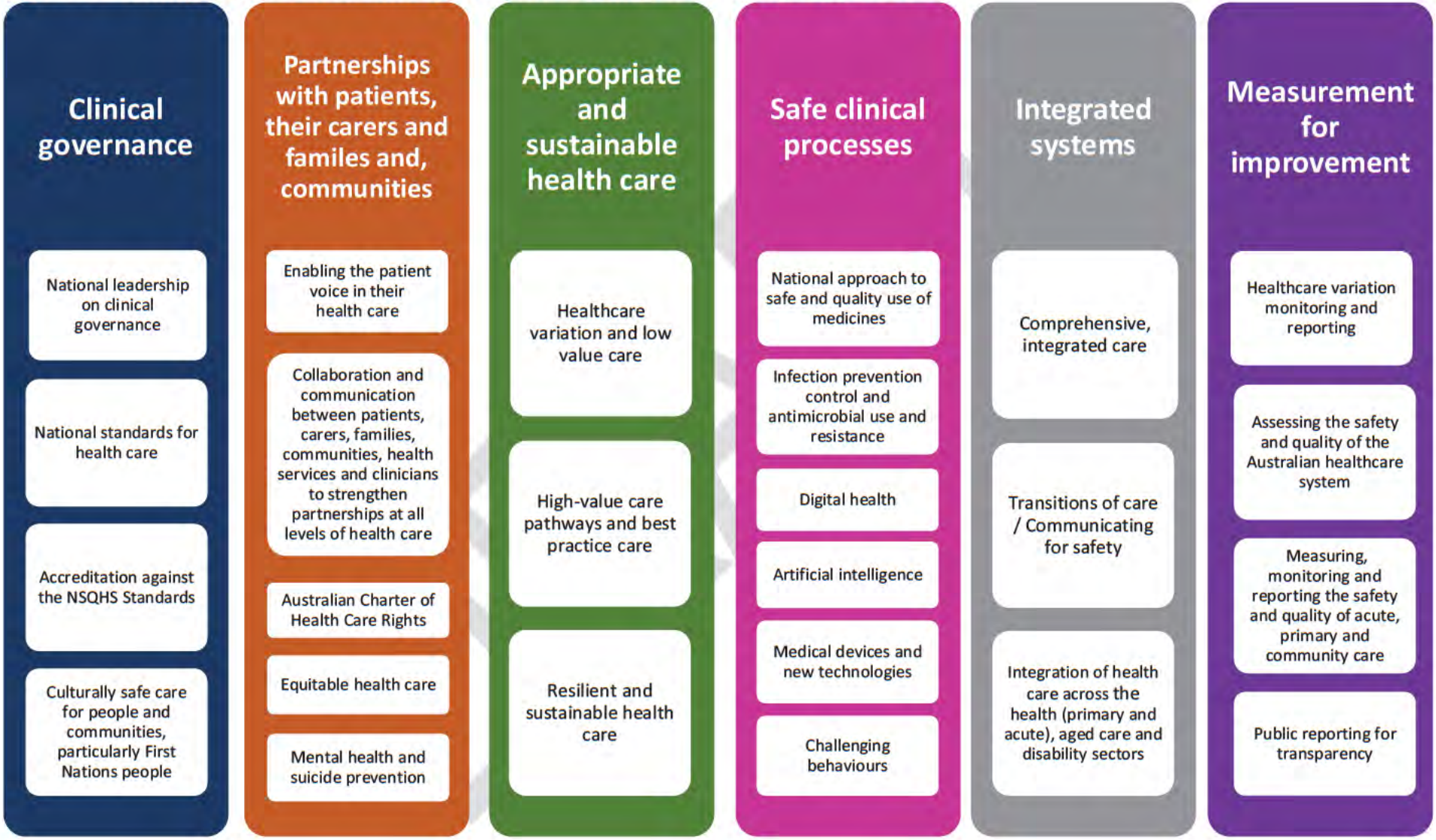
An overview of the work plan strategic objectives and focus areas is at **Figure 1**. The areas of focus are not ordered by priority but represent key activities that the Commission is undertaking to progress work in each strategic objective.

The Commission recognises the need to respond and adapt to emerging issues, challenges and opportunities influencing the health system. These include the changing national health profile, where the Australian health system needs to support the population ageing and the rise of chronic conditions; the impacts of climate change, pandemics and natural disasters, which have introduced pressures on the sustainability of the health system; and the acceleration of digital health. The work plan is structured to allow for innovation, flexibility and changes to priorities, to incorporate lessons learned in risk management systems and strategic planning.

The Commission delivers funded projects in addition to this cost-shared work plan. These projects complement and align with the Commission's work plan strategic objectives and focus areas. A list of the Commission's current funded projects for 2024-25 are set out in **Appendix B**.

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Figure 1 - Work plan overview: strategic objectives and areas of focus for 2025-28



Clinical governance

Clinical governance describes the systems and culture that are required to improve and maintain the reliability, safety and quality of health care, and improve healthcare outcomes for patients and communities.

Clinical governance remains a challenge within some health service organisations. This is evidenced by the themes and issues arising from safety reviews and inquiries, and the most common "not met" actions when health service organisations are surveyed independently against the National Safety and Quality Health Service (NSQHS) Standards. National leadership on clinical governance is a priority area of focus for the Commission.

It is recognised that if care is to be clinically safe, it must be culturally safe. Work to embed cultural safety and equity into the Australian health care system is therefore critical to achieving care that is safe, appropriate, accessible and free of racism.

In 2025, the Commission will begin the development of the third edition of the NSQHS Standards in collaboration with the Australian Government, states and territories, private sector providers, clinical experts, patients, carers, and the community. The NSQHS Standards provide a nationally consistent statement of the level of care people can expect from Australian health service organisations, providing a framework to protect the public from harm and to improve the quality of care.

The Commission has developed several national safety and quality standards for the health care system and works through appropriate governance arrangements and in partnership with the Commonwealth, state and territory health departments to support implementation. For example the Commission, in partnership with the Australian Government Department of Health and Aged Care and the Inter-Governmental Policy Reform Group, supports implementation of the national clinical trials reform agenda.

Table 1 describes key areas of focus and related activities that the Commission will undertake for Clinical governance.

Table 1: Key areas of focus and activities for Clinical governance

Clinical Governance		
Area of focus	Key activities	Estimated timeframe
National leadership on clinical governance	Collaborate with jurisdictions to: • Finalise the national clinical governance framework • Produce implementation and quality improvement guidance and resources	2025 2025-2028
National standards for health care	Develop the third edition of the NSQHS Standards including evidence review, drafting, piloting, consultation, impact assessment, refinement and Ministerial endorsement.	2025-2027
	Develop guidance and resources to support implementation of the third edition of the NSQHS Standards and improve the quality of health services under the NSQHS Standards.	From 2027

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Clinical Governance		
Area of focus	**Key activities**	**Estimated timeframe**
	Provide advisory services, training and education, and resources and guidance to support implementation and maintenance of national safety and quality standards for: • Acute and sub-acute health services • Digital health services • National clinical trials • Primary and community health services • Mental health services • Cosmetic surgery • Ambulance services.	Ongoing
Accreditation against the NSQHS Standards	Review of the accreditation process to support the assessment to the third edition of NSQHS Standards.	2025-2027
	Ongoing management, oversight and regular review of the Australian Health Service Safety and Quality Accreditation (AHSSQA) Scheme including: • Oversight, review and approval of accreditation agencies assessing against standards under the AHSSQA Scheme • Management of expansion and adaptation of the AHSSQA Scheme to accommodate new national safety and quality standards.	Ongoing
	National reporting on outcomes of accreditation of health services, including reports to the Australian Government Department of Health and Aged Care and state and territory regulators.	Ongoing
	Education, training and resources to support accreditation to the NSQHS Standards.	Ongoing
	Mediation resources to manage and resolve differences between assessors and facilities in relation to accreditation processes.	Ongoing
Culturally safe care for people and communities, particularly First Nations people	Schedule 2.2(a)(xvi)	
	Support self-determined design and release of tailored resources for First Nations people and communities.	

Partnerships with patients, their carers and families, and communities

All parts of the health system need to work together to deliver person-centred care. Integral to this, are the partnerships with patients, their carers and families, and communities to improve health service delivery and health care for all.

Care that respects and responds to the preferences, needs and values of the patient, and improved communication and collaboration between patients and their healthcare professionals, is associated with improvements in clinical and patient-reported outcomes, patient satisfaction, enablement, effective self-management and treatment understanding. It is also associated with improvements in clinical governance, patient safety and health care services utilisation.

Equitable health care requires a health care system and culture that addresses and recognises the intersecting identities of people most at risk of discrimination and unequal care; and the complex environmental, cultural and socio-economic factors that may influence their health care. The work to improve equitable care is closely tied to clinical governance.

Health literacy plays a significant role in enabling effective partnerships. With the increased use of digital health, it is also important to consider digital health literacy and how this may impact on the safety and quality of care.

Table 2 describes key areas of focus and related activities to which the Commission will undertake for Partnerships with patients, their carers and families, and communities.

Table 2: Key areas of focus and activities for Partnerships with patients, their carers and families, and communities

Partnerships with patients, their carers and families, and communities		
Area of focus	Key activities	Estimated timeframe
Enabling the patient voice in their health care	Strengthen guidance on informed consent for patients and clinicians to support improvements to the validity, and patient experience, of consent processes.	2025-2028
	Provide resources to support clinicians and patients to share decision-making about clinical care.	2025-2028
	Provide guidance on the use and integration of patient reported measures in clinical practice in different health settings, to support shared decision-making and measure patient outcomes and experience.	Ongoing
Collaboration and communication between patients, their carers and families, communities, health services and clinicians to strengthen partnerships at all levels of health care	Maintain a network or community of practice to share learnings and information about best practice approaches to person-centred care and partnering with patients, carers, families and communities, including in design and governance.	Ongoing
	Review, consult and develop resources, where needed, for partnering with people and	2025-2028

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Partnerships with patients, their carers and families, and communities		
Area of focus	Key activities	Estimated timeframe
	communities in face to face and virtual acute, primary and community health services.	
Australian Charter of Health Care Rights	Raise the profile of the Australian Charter of Health Care Rights.	Ongoing
Health literacy	Identify, develop, maintain and share tools and resources to support people's health literacy, including digital health literacy.	2025-2028
Equitable health care	Identify, design and develop resources to improve the safety and quality of health care for people most at risk of discrimination and unequal care.	2025-2028
	Identify, design and develop resources to improve the safety and quality of health care for people who live in rural and remote communities	2025-2028
Mental health and suicide prevention	Collaborate with governments and other agencies to support mental health and suicide prevention national priorities.	Ongoing

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Appropriate and sustainable health care

Health care is appropriate when it responds to patients' clinical needs across the continuum of care wherever they live; is based on the best available evidence; and is equitable. This requires a strong health system and culture focused on the provision of appropriate, equitable and sustainable health care, and individuals and a community that are health literate. This will help to reduce low-value care and increase high-value care; reduce waste and increase efficiency and cut unnecessary carbon emissions from the health system.

Identifying and reducing unwarranted variation - or unnecessary or low value care - as well as providing care that aligns with high-value care pathways and best practice, improves the appropriateness and sustainability of health care. A robust clinical governance framework provides the scaffold for sustainable and appropriate health care.

Clinical care standards play a key role in reducing unwarranted variation in clinical areas which have known gaps in delivering appropriate care. Clinical care standards identify and define the care people should expect to be offered or receive, regardless of where they live and are treated in Australia.

Schedule 2.2(a)(xvi) [redacted]

Table 3 describes key areas of focus and related activities that the Commission will undertake for Appropriate and sustainable health care.

Table 3: Key areas of focus and activities for Appropriate and sustainable health care

Appropriate and sustainable health care		
Area of focus	Key activities	Estimated timeframe
Healthcare variation and low value care	Collaborate with, and review levers available and action taken by, states and territories, the Australian Government and other organisations to reduce unwarranted variation and low value care.	Ongoing
	Provide guidance and tools for measuring and monitoring healthcare variation and improving appropriateness of care.	Ongoing
High-value care pathways and best practice care	Schedule 2.2(a)(xvi) [redacted]	
	Develop new clinical care standards, associated guidance and indicators, and strategies to support implementation, according to an agreed prioritisation process.	Ongoing

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Appropriate and sustainable health care		
Area of focus	Key activities	Estimated timeframe
	Disseminate, evaluate and review clinical care standards and monitor and assess their implementation.	Ongoing
	Revise existing clinical care standards and/or indicators according to the agreed review cycle process.	Ongoing
	Identify opportunities to improve the use of robust clinical guidance at a national level, in collaboration with states and territories. This will include considering options for a national approach to coordinating clinical guidance across jurisdictions.	2025-2027
Resilient and sustainable health care	Development of resources to support the NSQHS Standards *Environmental Sustainability and Climate Resilience Healthcare Module.*	2025-2027
	Participate in advisory groups and support the implementation plan for the National Health and Climate Strategy.	2025-2028

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Safe clinical processes

The Commission coordinates collaborative national action and develops national guidance and policy to inform the implementation of safe clinical processes.

This includes action and guidance to support safe and quality use of medicines and medical technology; address antimicrobial resistance; reduce healthcare associated infections; improve the appropriate and safe delivery of digital health care and support safe clinical communication.

Quality use of medicines and medicines safety is the 10th National Health Priority Area for Australia, recognising the importance of medicines in healthcare. While medicines can contribute to significant health improvement, medication errors can cause serious harm, accidents and communication issues.

Antimicrobial resistance (AMR) is a safety priority due to its serious and growing impact. AMR continues to be one of the biggest challenges to the provision of safe, high-quality health services both in Australia and internationally.

Healthcare-associated infections are the most common and significant hospital-acquired complications, with around 80,000 healthcare-associated infections occurring in Australia per year. As well as causing unnecessary pain and suffering for patients and their families, a healthcare-associated infection can prolong a patient's hospital stay and add to the cost of delivering health care.

Digital health solutions can help improve the quality of care and support integration of care across the health system. However, digital health solutions that are poorly integrated into service delivery, are not easy to use, and do not adhere to standards result in adverse events and unintended consequences that hinder good clinical care. Ongoing efforts to achieve functional and interoperable digital health systems is an essential pillar of patient safety.

The Commission will work in collaboration with relevant national agencies, the Commonwealth and state and territory governments about digital health technology, particularly artificial intelligence to ensure patients and communities continue to receive safe health care.

The mandatory reporting of medical device adverse events by public and private hospitals, and other health care facilities and subsequent action taken, mitigate the risk of harm. The Commission will work with the Therapeutic Goods Administration to find emerging signs of medical device adverse events more systematically and take earlier actions to inform people and health professionals about areas of concern.

Table 4 describes key areas of focus and related activities that the Commission will undertake for Safe clinical processes.

Table 4: Key areas of focus and activities for Safe clinical processes

Safe clinical processes		
Area of focus	Examples of activities	Estimated timeframe
National approach to safe and quality use of medicines	Undertake ongoing work in response to the third WHO Global Patient Safety Challenge: Medication without harm.	2025-2026

Safe clinical processes		
Area of focus	Examples of activities	Estimated timeframe
	Develop and maintain medicines education resources including for high-risk medicines, and other quality use of medicines topics.	2025-2027
	Provide stewardship of safe and quality use of medicines resources and materials including development of new policy and guidance.	2025-2027
Infection prevention control and antimicrobial use and resistance	Support the implementation of prevention and control of infection in health care settings and the community.	2025-2027
	Review and enhance the range of guidance on Healthcare-Associated Infection surveillance.	2025-2027
Digital health	Monitor and assess emerging risks and benefits to the safety and quality of digital health provision.	2025-2028
	Develop, review and revise national guidelines and resources for the safe and appropriate use of digital health aligned with work undertaken by states and territories (including Chief Information Officers) and the Australian Digital Health Agency.	2025-2028
Artificial intelligence	Prioritise and develop resources and guidance required at a national level to support the evaluation and safe implementation of artificial intelligence into clinical practice.	2025-2026
Medical devices and new technologies	Implement a framework for use of a national unique device identifier database, in collaboration with the Therapeutic Goods Administration.	2025-2028
	Implement mandatory reporting of medical device adverse events, in collaboration with the Therapeutic Goods Administration.	2025-2028
Challenging behaviours	Identify areas of focus and develop strategies to support health services and clinicians to safely manage patients with challenging behaviours, in collaboration with states and territories.	2025-2028

Integrated systems

Integrated and coordinated care is key to ensuring safe and high-quality care within and across all healthcare settings. If care is integrated, all parts of the health system work together to deliver health care that is person-centred, seamless, comprehensive, coordinated, and efficient across the continuum of care. Integrated care is a multidisciplinary collaboration, where each healthcare professional, service organisation and sector takes responsibility for the patient wherever the person needs or receives their health care.

Enablers of integrated care include safe clinical processes, highly interoperable digital health systems, teamwork and routine use of structured communication methods (such as ISBAR) at all levels of service delivery.

Communication is integral to all aspects of patient care. Poor communication and poor information sharing across healthcare settings puts patient safety at risk at transitions of care. This can lead to higher rates of preventable hospitalisations and readmissions and higher rates of medication errors and other adverse events.

Table 5 describes key areas of focus and related activities that the Commission will undertake for Integrated systems.

Table 5: Key areas of focus and activities for Integrated systems

Integrated systems		
Area of focus	Key activities	Estimated timeframe
Comprehensive, integrated care	Resources and guidance on safe and high-quality integrated, comprehensive care and recognition and response to the deteriorating patient.	2025-2028
Transitions of care / Communicating for safety	Resources to support a national approach to transitions of care, with a focus on discharge. This includes transition of aged care patients between hospitals and to community settings (including residential care).	2025-2028
	Guidance to support communication at transitions of care, aligned with work undertaken by states and territories. Develop, revise and improve the uptake of structured written and verbal communication tools between • Clinicians (for example, ISBAR) • Clinicians and patients (for example, treatment plans)	2025-2027
	Schedule 2.2(a)(xvi) [redacted]	

Integrated systems		
Area of focus	Key activities	Estimated timeframe
	Develop guidance for the safe and high-quality use of virtual care	2025-2028
Integration of health care across the health (primary and acute), aged care and disability sectors	Analysis and advice about the implementation of learnings from the OECD Patient-Reported Indicators Surveys (PaRIS) Initiative.	Ongoing
	Support and advice on older persons receiving high quality clinical care across the health and aged care sectors	Ongoing
	Engagement with the primary health care sector on priorities for the improved integration of health care nationally, including peak bodies and Primary Health Networks.	Ongoing

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Measurement for improvement

Measurement and feedback are key to monitoring and improving the quality of health care. Data can be used to find areas where clinicians, the services they provide and the health system are doing well, and areas where improvement is needed.

The Commission publishes national reports on healthcare variation, and continues to monitor, revise and enhance clinical and patient-reported measurement to support the meaningful use of data.

The Commission supports the system in making evidence-based decisions, sharing examples of best practice care and by measuring and monitoring patient outcomes and system performance. The Commission's role in monitoring safety and quality in health care also helps reduces the significant human and financial burden of harm caused by inefficient or ineffective system processes, preventable hospitalisations, readmissions, and hospital-acquired complications.

Additionally, measurement encourages a culture of continuous learning and innovation. As new evidence and insights appear, the Commission collaborates with its stakeholders to adjust strategies and prompt corrective actions to ensure ongoing improvement.

To ensure the appropriate management and use of data, the Commission has in place a Data Governance Framework, which is supported by a Data Plan, data management policies, guidelines, procedures and the Commissions' Privacy Policy.

Table 6 describes key areas of focus and related activities that the Commission will undertake for Measurement for improvement.

Table 6: Key areas of focus and activities for Measurement for improvement

Measurement for improvement		
Areas of focus	Key activities	Estimated timeframe
Healthcare variation monitoring and reporting	Focus reports as part of the Australian Atlas of Healthcare Variation series to examine healthcare variation and identify and monitor key safety and quality issues.	Ongoing
	Analysis of available data to identify priority areas to improve the safety and quality of health care.	Ongoing
Assessing the safety and quality of the Australian healthcare system	Develop and refine a measurement framework for assessing the safety and quality of the healthcare system in Australia.	2025-2028
	Work to increase the capacity of the system to provide additional information on the safety and quality of the healthcare system, including through supporting and advising on	2025-2028

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Measurement for improvement		
Areas of focus	Key activities	Estimated timeframe
	the Australian Government Department of Health and Aged Care's national Clinical Quality Registry strategy.	
Measuring, monitoring and reporting the safety and quality of acute, primary and community care Schedule 2.2(a)(xvi)	Develop, review and promote the use of: • Indicators and indicator sets (including those to measure clinical care standards) • National benchmarks for safety and quality using existing indicators to help with existing state-wide benchmarking, in collaboration with the Australian Institute of Health and Welfare • Tools to support measurement for improving the safety and quality of health care, including guides and training.	Ongoing
	Maintain, manage and promote the use of: • Hospital-Acquired Complications (HACs) list • Australian Sentinel Event list • Avoidable hospital readmissions list • Patient reported measures.	Ongoing
	Review international and local models and evidence for contemporary best practice incident management systems across health care settings, in partnership with academic institutions and other key stakeholders.	2025-2028
	Review the use of patient safety culture measures to improve the quality of health care and refine the patient safety culture measurement toolkit.	2025-2026
	First Nations cultural safety measurement.	
	Schedule 2.2(a)(xvi)	

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Measurement for improvement		
Areas of focus	Key activities	Estimated timeframe
	Schedule 2.2(a)(xvi)	
Public reporting for transparency	Publish national reports, information and papers relating to health care safety and quality.	Ongoing
	Refine and finalise additional indicators for public reporting through the *Safety in Health Care* web tool.	Ongoing
	Periodically review the *Safety in Health Care* webtool.	2025

5. Corporate reports

As an Australian Government entity, the Commission publishes reports describing the Commission's deliverables and performance as required by the *National Health Reform Act 2011,* the *Public Governance, Performance and Accountability Act 2011,* and other relevant legislation and general policy orders.

This includes an Annual Report and Corporate Plan. These corporate reports are available at: www.safetyandquality.gov.au/about-us/corporate-reports

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Appendix A: Draft budget

A draft budget for 2025-28 is provided at **Table A.** The draft budget includes agreed funding under the Multi-Party Funding Agreement for 2025-26 and projected funds for 2026-28. Projected funding includes consideration of minimum real-term costs required to perform the work plan and meet its objectives, at the time when this work plan was developed.

Funds for work allocated to the Commission under the next National Health Reform Agreement Addendum are not included in the draft budget and will be considered separately.

Schedule 2.2(a)(xvi), Schedule 2.2(a)(xi)

[redacted]

Appendix B: Current funded projects (2024-2025)

The Commission is separately funded to deliver projects that align with the Commission's core cost-shared work plan. These projects provide opportunities for the Commission to respond to emerging safety and quality issues and enhance greater collaboration across the health system. For some projects (*) the Commission provides in-kind support where there are opportunities to create synergies with elements of the cost-shared work plan, and where it supports the strategic intent of the work plan.

Table B describes the current funded projects for 2024-2025 that the Commission has been engaged to undertake in addition to the cost-shared workplan activities. Some projects continue into future budget years, and there may be more projects that are funded.

Table B: Current funded projects (2024-2025)

Project	Related strategic objective
Schedule 2.2(a)(xvi), Schedule 2.2(a)(xi) [redacted]	Integrated systems / Clinical governance
	Safe clinical processes
	Safe clinical processes
	Safe clinical processes
	Measurement for improvement / Partnering with patients, their carers and families and communities
	Clinical governance

Schedule 2.2(a)(xvi), Schedule 2.2(a)(xi) [redacted]	Clinical governance
	Safe clinical processes
	Measurement for improvement / Clinical governance
	Safe clinical processes
	Safe clinical processes
	Clinical governance
	Integrated systems
	Clinical governance / Safe clinical processes

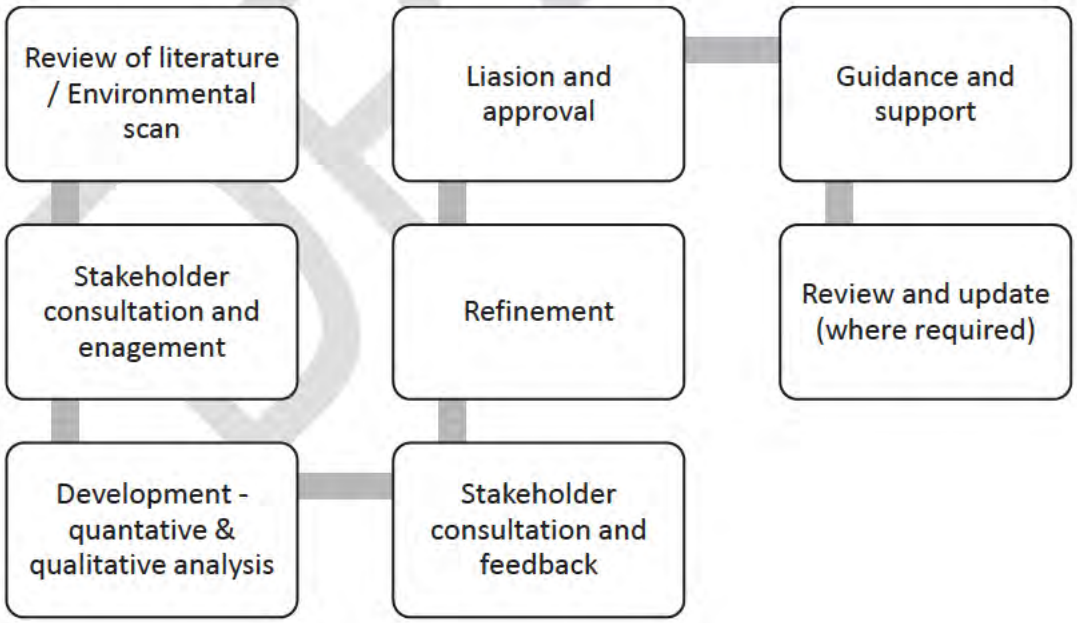
Appendix C: Examples of national strategies

- Australia's Long Term National Health Plan
- The National Health Reform Agreement Addendum 2020-2025 and its successor
- The Digital Health Blueprint 2023-2033 and Action Plan for the Digital Health Blueprint 2023-2033
- National Digital Health Strategy 2023-2028 and Strategy Delivery Roadmap
- The Cultural Respect Framework 2016-2026: For Aboriginal and Torres Strait Islander Health
- The National Agreement on Closing the Gap and health related targets
- The National Mental Health and Suicide Prevention Agreement (2022-2026)
- Australia's National Health and Climate Strategy
- Future focused primary health care: Australia's Primary Health Care 10-Year Plan 2022-2032 - and the work of the Strengthening Medicare Taskforce

- The work of the Aged Care Quality and Safety Commission and the outcomes of the Royal Commission into Aged Care Quality and Safety
- The outcomes of the Disability Royal Commission
- The National Aboriginal and Torres Strait Islander Health Plan 2021-2031
- National Strategic Framework for Chronic Conditions (2017-2025)
- National Strategy for the Quality Use of Medicines (NSQUM)
- National Action Plan for the Health of Children and Young People 2020–2030
- National Women's Health Strategy 2020-2030 (Women's Strategy)
- National Men's Health Strategy 2020-2030 (Men's Strategy)
- The National Medicines Policy
- The National Strategy for Quality Use of Medicines
- National Health Literacy Strategy Framework
- Maximising the Value of Australia's Clinical Quality Outcomes Data. A National Strategy for Clinical Quality Registries and Virtual Registries 2020-2030.

Appendix D: Overview of Commission processes

The figure below provides an overview of the key processes used to inform, develop and implement the Commission's work:



The Hon Mark Butler MP
Minister for Health and Aged Care

Ref No: MS24-001114

Ms Rachel Stephen-Smith MLA
Minister for Health
GPO Box 1020
CANBERRA ACT 2601
stephen-smith@act.gov.au

Dear Minister Rachel

The *National Health Reform Act 2011* (NHR Act) established the Australian Commission on Safety and Quality in Health Care (ACSQHC) as a permanent body on 1 July 2011, to lead and coordinate national improvements in the safety and quality of care.

Section 54 of the NHR Act requires the ACSQHC to provide a draft three-year work plan to me on 31 October each year, which I then provide to all Health Ministers for consideration.

The attached draft Work Plan and proposed budget for 2025-28 has been developed collaboratively with, and endorsed by, the ACSQHC's Inter-Jurisdictional Committee and other advisory committees including the Primary Care and Private Hospital Sector Committees.

This Work Plan presents the ACSQHC's proposed deliverables under six key areas of focus: clinical governance; partnering with patients, their families and carers and communities; appropriate and sustainable health care; safe clinical processes; integrated systems and measurement for improvement.

Key updates to the Work Plan this year include:

- Refined descriptions for each of the six strategic objectives
- Reviewed and updated areas of focus and key activities
- Expanded description about the ACSQHC's approach, including its processes, consultation, engagement, and partnerships
- Strengthened language to recognise the complexity and fast-paced nature of health service environments, and the challenges, risks and opportunities that may arise
- Increased emphasis on the Commission's commitment to improve the safety and quality of health for First Nations people
- Flagged potential work from the National Health Reform Agreement Addendum negotiations
- Inclusion of a draft three-year budget, which includes projected funds for 2026-28.

It is noted that the draft Work Plan and Budget may need to be adjusted in response to the outcomes agreed to in the next National Health Reform Agreement Addendum. The draft Work Plan and Budget reflects this need for flexibility by highlighting potential tasks that may be allocated to the ACSQHC as 'to be confirmed' (TBC).

The ACSQHC's Work Plan is funded jointly by the Commonwealth Government and all states and territories, through a Multi-Party Funding Agreement (MPFA). Under the MPFA the states and territories collectively match the Commonwealth Government's funding contribution based on population share. The 2023-26 MPFA, agreed to by all jurisdictions, provides funding for the first year of this Work Plan, that being 2025-26. The indicative budget presented for 2026-27 and 2027-28 will need to be further considered by all governments as part of the development of the 2026-2029 MPFA.

I invite you to make a written submission on the draft Work Plan, by 21 February 2025, to:

Conjoint Professor Anne Duggan
Chief Executive Officer
Australian Commission on Safety and Quality in Health Care
GPO Box 5480
SYDNEY NSW 2001
Email: Schedule 2.2(a)(ii)

Your submission will be considered by the ACSQHC, along with those from other jurisdictions.

Thank you for your consideration. Should you have any questions, please contact Conjoint Professor Duggan, by phone on Schedule 2.2(a)(ii) or email at Schedule 2.2(a)(ii)

Yours sincerely

Mark Butler

04 / 11 / 2024

Encl (1) ACSQHC draft Work Plan and budget 2025-28