



LEGISLATIVE ASSEMBLY FOR THE AUSTRALIAN CAPITAL TERRITORY

SELECT COMMITTEE ON ESTIMATES 2010-2011

(Reference: [Appropriation Bill 2010-2011](#))

Members:

MS M HUNTER (The Chair)
MR Z SESELJA (The Deputy Chair)
MR J HARGREAVES
MS A BRESNAN
MR B SMYTH

TRANSCRIPT OF EVIDENCE

CANBERRA

TUESDAY, 18 MAY 2010

Secretary to the committee:
Dr S Lilburn (Ph: 6205 0199)

By authority of the Legislative Assembly for the Australian Capital Territory

Submissions, answers to questions on notice and other documents, including requests for clarification of the transcript of evidence, relevant to this inquiry that have been authorised for publication by the committee may be obtained from the Legislative Assembly website.

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Amended 21 January 2009

The committee met at 9.02 am.

Appearances:

Gallagher, Ms Katy, Deputy Chief Minister, Treasurer, Minister for Health and Minister for Industrial Relations

ACT Health

Brown, Dr Peggy, Chief Executive

Thompson, Mr Ian, Deputy Chief Executive, Clinical Operations

Norrie, Dr Peter, Acting Director, Chief Psychiatrist, Mental Health ACT

Guest, Dr Charles, Chief Health Officer, Population Health

Croome, Ms Veronica, Chief Nurse

Cahill, Ms Megan, Executive Director, Government Relations, Planning and Development

Childs, Ms Judi, Executive Director, Human Resource Management Branch

Foster, Mr Ron, Chief Finance Officer, Financial Management Branch

O'Donoghue, Mr Ross, Executive Director, Policy Division

Bracher, Ms Katrina, Acting General Manager, Community Health

Croome, Ms Veronica, Chief Nurse, Nursing and Midwifery Office

McGlynn, Ms Lisa, Executive Director, Capital Region Cancer Service

Gehrig, Ms Therese, Manager, Aged and Community Care Policy

Department of Treasury

Ahmed, Mr Khalid, Executive Director, Policy Coordination and Development Division

THE CHAIR: Welcome to this public hearing of the Select Committee on Estimates. The Legislative Assembly has referred to the committee for examination the expenditure proposals in the 2010-11 appropriation bill and the revenue estimates in the 2010-11 budget. The committee is due to report to the Assembly on 22 June 2010 and has fixed a time frame of five working days for the return of answers to questions taken on notice.

The proceedings today will continue with an examination of the Department of Health which began yesterday afternoon.

Can I remind witnesses of the protections and obligations afforded by parliamentary privilege and draw your attention to the yellow coloured privilege statement before you on the table. Could you confirm for the record that you understand the privilege implications of the statement?

Ms Gallagher: Yes.

THE CHAIR: Can I also remind witnesses to keep their responses to questions concise and directly relevant to the subject matter of the question. We have a great deal of ground to cover during the hearing and I would like to maximise the opportunity for members in attendance to put their questions directly today rather than on notice.

Before we proceed to questions from the committee, minister, would you like to make any brief statement?

Ms Gallagher: No, thanks. We just have a few items from yesterday that we undertook to get back or to table. We have the phase-in of the commonwealth funding estimates, the timetable and the access block figures for older persons from Canberra Hospital and Calvary hospital.

THE CHAIR: Thank you.

MR SMYTH: On page 211 of budget paper 4, under strategic indicator 1, there is one of my favourite subjects: bed block. Let me read it for you. The target for 2009-10 for bed block would be 25 per cent. The estimated outcome for 2009-10 is now 29 per cent. Can you explain why we are not meeting the target?

Ms Gallagher: We have never met the target of 25 per cent. It was a target we set a couple of years ago when our access block figures were in the 40 per cent range. We included it as a strategic indicator. Ian would probably be able to answer that. We have never reached the target. It is a target we continue to work towards. Five years ago, the access block was at 43 per cent. We are heading in the right direction. I think it may have gone up slightly from last year, from about 28 per cent to 29 per cent. It is really a reflection of how busy our hospitals are.

MR SMYTH: If we are heading in the right direction, why is it going up?

Ms Gallagher: Overall, if you look at it over the past five years, it has gone from 43 per cent—it has gone to 28 per cent. It is slightly up this year, but we have a range of measures in place that we think will continue to work back towards 25 per cent. Access block is one of the indicators. If you look at our bed occupancy figures, you will see that they are going in the right direction too. Overall, we will reach that target, but it is a target that I do not think has ever been met in the ACT.

MR HANSON: What is the story with the CDU? Yesterday evening we were finishing up on that.

Ms Gallagher: We have just tabled the figures there. Essentially there has been an anomaly in the data collection at Calvary around their access block figures which did involve the use of the CDU. You can see the impact of that from the access block figures I have just tabled. That anomaly in data collection has had an impact on the access block figure overall.

MR HANSON: Has that been looked at? Was that a deliberate intent to skew the figures?

Ms Gallagher: We cannot answer that. I would like to think that it is not, but it is under Calvary management. I would like to think that it is not; I would like to think that it was a genuine mistake. But it is a mistake that has been identified and rectified.

MR HANSON: I have not got those figures in front of me.

Ms Gallagher: I have just tabled them. They will be coming.

MR HANSON: Is there a percentage difference if you calculate it with the CDU or without? I am just trying to establish an order of magnitude.

Mr Thompson: We are in the process of an audit, which is still not complete, to look at exactly what the effect of the change would be. As you will see in the figures, the reported Calvary access block on the corrected counting method this year is significantly higher than it has been in previous years. However, as the minister explained, there is always a combination of factors that influence access block, not least that it has been a very busy year in emergency departments, Calvary included. Therefore, at this point we cannot conclude if the difference is simply the difference between what was reported last year and this year—hence the audit process that we are now undertaking.

MR HANSON: How long has the CDU been operational there at Calvary?

Mr Thompson: Since about 2002. Its role has changed over time, which is one of the reasons why the effect on the access block was not automatically apparent.

MR SMYTH: The issue of getting patients out of the waiting room and into a bed—what is the number of incidents this year where patients have not been able to be received from ambulance officers because of bed block and we have had ambulance officers minding gurneys?

Ms Gallagher: Ambulance off-stretcher times are excellent. The last figure I saw was 95 per cent offloaded within 20 minutes.

MR SMYTH: That may be so, but how many times have we had incidents where ambulance officers are minding gurneys in the corridor?

Ms Gallagher: I am sure we can get that for you. I do not think it is a number that we count and have in our brief here. The ambulance off-stretcher time is excellent, probably one of the best in Australia, and we have worked very hard at it. I am sure we can get you the individual numbers of cases where that is exceeded.

MR SMYTH: What is the time if it is excellent?

Ms Gallagher: Ninety-five per cent offloaded within 20 minutes. That is how we count it.

THE CHAIR: Ms Bresnan.

MS BRESNAN: Were there any other questions on indicator 1?

MR SESELJA: Not on indicator 1, no.

MS BRESNAN: On strategic indicator 2, looking at the rate of unplanned return to the operating theatre, I note that the rate for TCH is quite a bit higher than for Calvary. Is this because TCH does deal with more complex and acute cases and that

contributes to that? Is that the primary reason for that?

Dr Brown: Exactly right. It is the type of patient and the complexity of the care that is required in relation to the operating theatre and the nature of the surgery performed.

Ms Gallagher: More emergency procedures are performed.

Dr Brown: More emergency procedures also.

MR HANSON: The percentage has been adjusted to cope for that, as I understand it.

Dr Brown: That is why they have different targets.

MR HANSON: There are different targets and it still indicates that Calvary is achieving their target and the Canberra Hospital is not. Is there a reason for that?

Ms Gallagher: I think you will find that the small numbers involved in this do allow for fluctuations in those numbers over time but—

MR HANSON: That has been a consistent measure now I think certainly since I have been in the Assembly. Even with the adjusted targets, Calvary does achieve and Canberra Hospital does not. Are the targets wrong? I assume that they are established as targets for peer hospitals, are they?

Dr Brown: The target is set to be consistent with the Australian Council on Healthcare standards for our peer benchmark services. I think we are within that range for our peer services.

MR HANSON: So there is no explanation why Calvary can actually get below the target and the Canberra Hospital gets above it.

Dr Brown: Calvary belongs to a different peer group. It is not the same level of hospital. It deals with a lower degree of emergency and complex surgery.

MR HANSON: I understand that but the targets are adjusted for that. My question is: once you have adjusted those targets—

Dr Brown: But you will see that the target for 2010-11 has been adjusted upwards from 0.85 to one. That reflects the peer benchmark through ACHS.

MR HANSON: Thank you.

MR SESELJA: Sorry, minister, it is not clear to me. We have gone around the fact that they are different targets and that they will be adjusted in 2010-11. But the 2009-10 target has not been met again and I think that this has happened in previous years. It has been met at Calvary even though it is a different measure but it is a lower measure to account for that. What are the differences? Why is it that we are not meeting that target?

Ms Gallagher: Mr Seselja, I think you go on this point every year. These are targets.

If you look at the 2010-11 target, the estimated outcome for 2009-10 is within that target, which has been adjusted based on the complexity of care and the work performed at tertiary referral hospitals. There is no issue, I believe. I have looked at this very closely in relation to the rate of unplanned return to the operating theatre at either of our hospitals and I think we should be very thankful about that.

MR SESELJA: So what is being done to bring down the rate of unplanned returns?

Ms Gallagher: I think there is a level of expectation that there will be a rate of unplanned return to the operating theatre. What we try to do is keep it within the target. But the small numbers involved can distort the outcome. As I said, I am very confident that everything is done to reduce the risk of an unplanned return to the operating theatre. But when 53 per cent of your work is emergency work, there will be cases that have to return to the operating theatre.

MR SESELJA: You said “small numbers”. What are those in raw numbers?

Ms Gallagher: I am sure we will be able to get them.

Dr Brown: We do not actually have those here.

Ms Gallagher: But we will be able to get them.

MR SESELJA: That is taken on notice.

THE CHAIR: We will move on to strategic indicator 3.

MR HANSON: Are we doing all the strategic indicator services at the moment? Can we move on to other areas?

THE CHAIR: We are doing the strategic indicators. That was agreed to yesterday afternoon.

MR HANSON: I thought we were considering acute services. I did not know we were just considering the strategic indicators.

MR SESELJA: I did not think we were going to do the strategic indicators. I wanted to look at some of the strategic indicators as they apply particularly to acute care.

MS BRESNAN: I have other questions on strategic indicators as well.

MR SESELJA: I might defer to Ms Bresnan then.

MS BRESNAN: I have a question on strategic indicator 7, mental health—return to hospital, a new indicator. It is good to see that in there. Has this come out of feedback on the mental health plan and I guess trying to move towards some more outcome-based measurements?

Dr Brown: Yes, in part it is related to the fourth national mental health plan, but it has been an indicator that has been reported previously through the COAG national

mental health plan and I think from memory that it is in the ROGS, *Report on Government Services*, data set as well. We are just wanting to make it transparent here.

MS BRESNAN: So is it planned that this will continue to be a part of the budget process?

Dr Brown: Yes.

MS BRESNAN: And in terms of the rates of remission that is the figure that has come out of COAG as a good practice figure?

Dr Brown: Nationally, the agreed figure is that it is desirable to be less than 10 per cent. You can see, as indicated there, that the national rate in 2008-09 is actually 13 per cent.

MS BRESNAN: Has there been feedback from carers and consumers on this particular target as well in terms of getting there? I guess you can set a level through COAG, but also getting that input from carers and consumers. I guess probably no readmission is good, but what sort of target do you aim for?

Dr Brown: Carers and consumers would obviously prefer to see the lowest number possible. At the national level where those discussions have occurred, there has been consumer and carer input into all of those deliberations.

MS BRESNAN: I know it is not necessarily reported but there have been discussions, I think through the national mental health plan, about trying to have some more outcome-based measures. Are there any plans to do that? I guess this is probably moving a bit more towards an outcome-based measurement if it is feeding that into this process when looking at people returning, why they are returning and what happens to them when they leave. Are there any plans to start looking at that?

Dr Brown: Yes. We participate in all of those national discussions. We have an ACT representative on the mental health information strategy committee as well as on the committees around the fourth plan. We already undertake outcome measures and the next move is to start to use that data to look at the improvement between admission and discharge outcome measures. But there is a range of other measures that we want to start looking at as well in relation to housing, education, services in prisons—that sort of thing. That is what is being considered at the national level. Some of that is already being reported as part of the COAG data set and we are looking to adopt that as an outcome report for the fourth national mental health plan as well.

MR HARGREAVES: As I understand it, we are almost half the group A percentage and considerably under what COAG believe to be best practice, good practice. Can you tell us what it is you are doing better than the other jurisdictions which is affecting that 50 per cent reduction?

Dr Brown: I think the feature that the ACT has that stands out from other jurisdictions is the level of services in the community. Over 80 per cent of our funded mental health services exist in the community; that is, both public sector and community organisation services. We have also programs to support people post

discharge—again some through community organisations and some through the public sector—and we have supports for people in the more urgent situations as well so that if there is an event post discharge they do not necessarily need to return to hospital; we have the capacity to treat them in their own home. We have also in the last two years opened the two step-up, step-down facilities which offer an additional option for support in the community.

MR HARGREAVES: What sort of relationship do you have with the community organisations? I am getting a sense that you are regarding this as a partnership providing services to an individual. Can you give us an idea of the range of community organisations and what sort of formal arrangements exist?

Dr Brown: We provide to a range of funding organisations and work closely with them. We, of course, have the Mental Health Community Coalition as well as the Mental Health Consumer Network and Carers ACT that we work with very closely. So we have organisations like the Mental Health Foundation, the Richmond Fellowship, Centacare, Mental Illness Fellowship of Victoria and a wide range of others that we are working with closely. They also sit on the executive committees for Mental Health ACT. They are part of the strategic oversight group for the implementation of the mental health services plan.

MR HANSON: What is the funding for those organisations as a percentage of the mental health budget?

Dr Brown: It is currently approximating 13 per cent, which we believe is still the highest in the country.

MR HANSON: Minister, my understanding is that the Greens-Labor agreement establishes 30 per cent as a target for funding for community mental health. Is that right?

MR HARGREAVES: You will have to go back and have another look, won't you?

MS BRESNAN: Are you asking me a question or the minister a question?

MR HANSON: She does not seem to know, so—

Ms Gallagher: We are working towards our targets in mental health under the parliamentary agreement. Can I say that our record on it has taken us from the lowest per capita spend on mental health in the country, under the last Liberal government, to one of the highest spends on mental health in the country.

MR HANSON: Sure, but the question I have is—

Ms Gallagher: You don't want to talk about that, do you? The lowest in the country—

MR HANSON: I want to talk about the question that I have asked.

Ms Gallagher: And what it means is a gradual increase.

MR HANSON: When will you meet that target?

Ms Gallagher: Of the \$4 million allocated in this budget, and that is aside from the opportunities in the subacute money received under the national health agreement, \$2 million will go to the community sector.

MR HANSON: When will you meet that target, minister, of 30 per cent? That is the question.

Ms Gallagher: We will meet it over time, Mr Hanson

MR HANSON: So you do not have a date for meeting it.

Ms Gallagher: You will be informed when it is reached.

MR HANSON: Do you have a date?

Ms Gallagher: It is subject to further budget considerations—so, no, we do not have a date.

MR HANSON: You do not have a date. Can we look at strategic indicator 6, which is mental health also? That is the access block for mental health clients. We have not met that target again. There is a two per cent decline from last year. Can you explain what is going on there?

Ms Gallagher: You will know that the mental health assessment unit, which has been specifically designed to deal with the issues around access block in the emergency department, is now open. It has been open for a short amount of time, probably two weeks, and is seeing patients. That is a six-bed unit within the emergency department and people who present to the emergency department with a mental illness will be able to proceed to that unit. We believe that will significantly improve not just our figures—because it is not just about improving our figures—but the care that is provided to people with a mental illness. We are very confident that that will ensure that we work hard to reach that target of 15 per cent.

MR HANSON: If they are moved to the mental health assessment unit then that is treated as an admission to hospital in terms of that access block? I am trying to see the CDU-type issues. That is not a CDU-type establishment; that is an admission to hospital, is it?

Dr Brown: Not necessarily. In the first instance, those who present to ED will be deemed to be an ED presentation. They are actually under the care of the ED admitting officer, with services provided to mental health. If and when a decision is made that they need to be admitted for inpatient care then they will be deemed to be an admission. I should note that in terms of that particular rate there is an issue about the smaller numbers again affecting the variation—a variation of one or two per cent when you have got a small denominator. You need to take that into account.

MR HANSON: What is the number?

Dr Brown: I do not have it in front of me. Again, we can—

MR HANSON: Do you know approximately what it is?

Dr Brown: We have around 60 to 70 admissions to PSU per month. Not all of those come through the emergency department.

THE CHAIR: I want to go back to strategic indicator 2. Page 212 talks about the hospital-acquired infection rate. I note that in 2009-10 the target will be met. I am trying to get an understanding of why there is a different target for Canberra Hospital than Calvary hospital.

Dr Brown: Again, that reflects the nature of the work undertaken at Canberra Hospital. There is a higher level of complex and emergency surgery and, therefore, a greater risk associated with the care there. It is also to do with the type of patients cared for in other parts of the hospital.

Ms Gallagher: You use your benchmark for the type of hospital you have rated. Over time, though, we expect that both the target will reduce and the incidence as we move towards a greater increase of single-bed rooms within wards, which is the single biggest thing you can do to reduce your hospital-acquired infections.

Dr Brown: Canberra Hospital has a much greater rate of acute trauma, and it is also a tertiary referral hospital. That is where you get the greater level of complexity and the higher risk of infection that goes with the trauma and tertiary referrals.

MR HANSON: I want to go to strategic indicator 9, urgent radiotherapy patients. In terms of urgent radiotherapy patients, I am just trying to find out exactly how that gets classified. We had the media reports of Vesna Nedic, who was a radiotherapy—

Ms Gallagher: The category is based on clinical decision making—whether you are urgent, semi-urgent or non-urgent category A or B. That is based on your doctor's advice.

MR HANSON: And there is a time frame for what is determined as urgent and—

Ms Gallagher: That is outlined in strategic indicator 9.

MR HANSON: How are we going in terms of meeting the targets? Are you comfortable that we are improving?

Ms McGlynn: This service is doing very well, with an increasing demand that continues within the ACT for radiotherapy services. For urgent treatment where the target is 100 per cent, at March this year we were at 97.9 per cent. That means that one person did not get seen within that time frame; they were seen the next day. For semi-urgent patients, the 2009-10 target was 85 per cent, and at March we were at 91 per cent. For non-urgent category A, the target was 65 per cent and at the end of March it was 73 per cent. And for non-urgent category Bs, the target was 65 per cent and at the end of March we were up at 87.7 per cent.

MR HANSON: Have we resolved the problem where there was a breakdown in communication in radiation oncology where—obviously you are aware of the situation.

Ms McGlynn: Sure.

MR HANSON: Has that been resolved now? How have we resolved that?

Ms McGlynn: There were some very unusual circumstances during that period. We had a significant increase in the number of referrals during that period. As well as that, we had a number of unanticipated vacancies occur. We had a couple of people leave—young radiation therapists—

MR HANSON: Six left within a very short time frame, I think.

Ms McGlynn: But some of those were planned retirements. During that period we also had started recruitment before those people left, quite rightly. Then we had another couple of people who resigned unexpectedly. It is a very mobile workforce. We have a lot of young radiation therapists, and they do move around. During the December-January-February period, a number of those people left with short notice to take up other opportunities.

MR HANSON: Do you know what the reason was, the underlying reason? I have heard a couple of anecdotal reasons—that other jurisdictions pay more and suggestions that it was to do with staff culture issues. Are you across any particular reasons? Is there a trend?

Ms McGlynn: I am not aware of any individual circumstances. These are mostly young therapists who move around, and they often go back to where their families are. They take an opportunity to start their training and then they will sometimes go back to Sydney or Melbourne where their families are. I am not aware of any individual circumstances, no.

MR HARGREAVES: Thanks for the update to March on this strategic indicator. I notice that, with the urgent one, it is only two per cent under-achievement. When you have got 100 per cent, it is a pretty tough target anyway. I imagine that the critical mass of patient numbers might have contributed a bit to that.

Ms McGlynn: Certainly.

MR HARGREAVES: I am interested also to see that the semi-urgent is 10 per cent above your target. You have got 20 per cent above target on the non-urgent category As and 30 per cent above target on category Bs. I also congratulate the department for picking up those new targets and putting them forward into 2010-11. We have seen some agencies drop back: even though they have done well in this current financial year just passed, they have gone back to the other target, I suppose so that they can make themselves look good next year. Notwithstanding that, firstly, congratulations on those achievements. Mr Hanson has indicated that there has been the odd issue or two that you have faced during the year. Could you tell me whether or not the reason

for what I consider to be the over-achievement here is due to management practice, management approach or systemic changes that you have done and how you actually tackled that?

Ms McGlynn: There is nobody who is more ambitious to reach these targets than our staff. They are incredibly diligent and take it hard when things do not go right or when there is demand that they feel does put them under pressure. I think they have also done incredibly well when, as happens sometimes, we have machinery issues or technical issues. That involves the staff having to reschedule all the patients that need to be seen while that is addressed and then they have to work overtime. They have done that willingly and under great duress sometimes.

We continue to look at our processes. The staff, on their own initiative, have looked at the way that they book clients and the way that they utilise the machinery so that they can maximise the throughput for patients and so that they can make sure that we do overachieve. I think the ambition continues to be that we see people as quickly and as clinically appropriately as we can.

MR HARGREAVES: I am hearing you talk about the willingness of the people working in the area to work together. It seems to me that you have a greater sense of team players—teamship, for lack of a better word—applying themselves through basic service delivery. That is something new, isn't it, that you get this absolute commitment to working together as a team?

Ms McGlynn: I think that a lot of the people who choose to work in cancer see it as a particular calling. I really see that in the commitment of the staff. In saying that, we have some way to go. We have a young, mobile workforce. But we are putting in place a number of things. We are going to have some staff focus groups around what makes it a good place to work and how we make sure that there is a career structure, particularly for radiation therapists coming through, because it is a very competitive workforce right across Australia. It is hard to get people; it is hard to keep good people. So we have a number of things in place to support people to work here and to attract people.

I have very positive news on that front. During the difficulties we had earlier in the year, we sought approval to have an additional five radiation therapy positions, to actually look at that load levelling, so that we could anticipate more sick leave, annual leave, so that people could take their leave, and any unanticipated vacancies. With the ads that we already had in place, we managed to attract people, and we are now fully staffed up to our original staff establishment. We then had an additional two and sometimes three temporary staff during that period. The recruitment has just been completed and recommendations are being made. We expect to fill those five vacancies and we had some very good applicants.

MR HANSON: Does this figure in the strategic indicator include those patients sent to New South Wales?

Ms McGlynn: Sorry?

MR HANSON: You have patients who are sent to New South Wales for treatment?

Ms McGlynn: Yes.

MR HANSON: Assuming that they are ACT Health clients and they are sent to New South Wales to start their treatment, is that figure included in this or is that excluded from this?

Ms McGlynn: They would be excluded. They would be within the unit that takes them on.

MR HANSON: What is the percentage of those patients as a percentage of the whole or what is the raw number of people who are going to New South Wales for treatment?

Ms McGlynn: I do not have that figure at the moment.

MR HANSON: Do you know what it is approximately? Is it 100 a year, 50 a year?

Ms Gallagher: No, nowhere near it.

MR HANSON: Twenty a year?

Ms McGlynn: We have not sent anybody interstate since, I believe, 2008, until this high demand period, and it was in the order of something like 20 that we are aware of. That covers the people that we know about from our own services and the figures that we keep.

MR HANSON: My understanding is that those patients get reimbursed—is it \$30 a day?

Ms McGlynn: Through the IPTAS scheme.

Ms Gallagher: That is over and above—the treatments, of course, are covered.

MR HANSON: I suppose my point is that we saw this play out and, if you are sent to New South Wales—to Sydney or somewhere like that—you cannot get accommodation for \$30 a night. That will not cover your meals. So those people are significantly out of pocket. Of course, there is an incredible amount of pressure put on them. This is a very stressful time—

Ms Gallagher: That is why we do not like to send anyone interstate, Mr Hanson. That is the whole point of—

MR HANSON: But we do, don't we, minister?

Ms Gallagher: building up a service so that you reduce—

MR HANSON: I am trying to understand what we do for these clients. I am not trying to get into those sorts of issues. Is there any more that we can do? Do we look to do any more for those patients who are both separated from their family and out of

pocket, and how is the selection made that patient A is going to New South Wales and patient B stays in Canberra? Is that made on clinical or social determinants? How do we make that decision?

Ms McGlynn: I think I can say, as I said in my opening remarks, that the most important thing here is the clinical decision making around that person being seen in a clinically appropriate time. That is the focus of our clinicians saying, “Where can this person go so that they get the best possible outcome?” That is the first decision.

Then, of course, we do need to consider people’s competing social and other supports. We certainly look at things like whether the patient has family there. One of our patients chose to go to Brisbane, for example, which seems like a very long way away. But they went there specifically because they had a family member there and they wished to stay with them and be supported by them. We would certainly look at those social issues as well.

MR HANSON: Moving forward with this extra staff that we have now got, would you anticipate we are going to be able to reduce or eliminate that need to send people interstate?

Ms McGlynn: Certainly since we have been staffed up, we have not sent any patients interstate. As I said, since 2008 it is a very unusual circumstance. I think we would be very hopeful that that continued.

But in saying that, we are never going to be self-sufficient. None of the Sydney hospitals are self-sufficient. They regularly close their books and refer to another hospital. It is a very common practice. It just so happens that we have only one hospital; so we cannot level the load between services. I think we have done very well to limit the number of patients we have sent. But I have to say that we cannot apologise for really giving the patients the opportunity to get those clinical targets met and get seen as quickly as possible.

Many patients—and we have some very positive feedback during that period, to the staff and to the service—commend the service for taking the steps to look for alternatives. We had patients saying that they were supporting the staff during the difficult times they had. I think that genuine support from the community has been a very good thing and is something that helped those staff that did do it tough during that period.

MR SESELJA: How many have been—

Ms Gallagher: Twenty-five patients.

MR SESELJA: Since 2008 or this year?

Ms Gallagher: As at the end of March 2010 but that was the first time since 2008. I should say, again, we are a regional provider. Twenty-five per cent of the work performed in radiation oncology are people travelling from New South Wales to Canberra for treatment and do not have, I guess, the treatment options available in that time. We can look at and try to minimise any Canberra patients having to move

interstate for treatment. But we take a lot from New South Wales.

MR HANSON: Are there any other strategic indicators where the ACT hospital system is unable to treat somebody, they get sent elsewhere and we do not incorporate them in our strategic indicators? If we basically say we are only counting the ones we actually see and we are sending a percentage somewhere else, they are not going to appear in our strategic indicators.

Ms Gallagher: I think there are a number of cases based on clinical need where a decision has been taken to move them interstate.

MR HANSON: But that is not a clinical need; this is a capacity issue. The reason they were sent interstate—

Ms Gallagher: No, it was clinical and capacity.

MR HANSON: I presume we could have done them here if we had the capacity. We simply did not have the capacity. They were not sent to New South Wales because New South Wales has more clinicians.

Ms Gallagher: In some instances, not necessarily in radiation oncology, it is about the service that is provided.

MR HANSON: I suppose what I am trying to see is whether there are other strategic indicators where—and I am just using this as an example—the capacity is not in the ACT system and we are sending people elsewhere, to Sydney or some other system—

Ms Gallagher: We are trying to make our numbers look good by not treating them here? Is that where you are going?

MR HANSON: It is not a matter of making the numbers look good; it is a matter of understanding the true picture.

Ms Gallagher: I think that is what you are accusing us of.

MR HANSON: It is not. It is a matter of trying to understand the picture.

Ms Gallagher: I cannot think of another strategic indicator where there would be—

MR HANSON: If we say we are treating 100 per cent of people on time but we find out that some could not be treated in our system and had to be sent elsewhere, I think that is relevant information to understand. If we are trying to look at where the capacity shortfalls are in our system—and I accept this was only for a limited period and so on—then that gives a true picture of what actually is happening in our service. If we say we want to get more staff in there, we want to provide additional regional assistance in that area and we see in a strategic indicator, on a piece of paper, that we are meeting it 100 per cent, it does not give the full picture. I suppose that is my point.

Ms Gallagher: Okay.

THE CHAIR: Ms Bresnan.

MS BRESNAN: This is on strategic indicator 21. It does note at the bottom of that paragraph that there will be an increase in the numbers of fractures and broken hips as the population ages. I am wondering if there has been any modelling done in terms of what the expected increased rate would be and what flow-on impact that may have on the hospital system.

Mr Thompson: The short answer is no; we have not modelled that. One of the issues with fractured neck of femur is that it is frequently caused by falls. We have a series of programs looking at fall prevention to try and reduce it. It is always very difficult to project into the future how the dynamic will be affected, because what we are looking for is going to stabilise the rate, as you see with our indicator, which is a combination of an ageing population, which would suggest an increased rate, and a fall prevention program, which is looking to reduce the rate. At this point, we cannot say with confidence where we are going to be, but we are very definitely focusing on the preventative side of things.

MS BRESNAN: My next question was going to be about fall prevention. If these numbers suggest a possible increase, or that there will be an increase, because of ageing, does that then get fed into the funding pool for fall prevention type programs?

Mr Thompson: There is no direct link, the point being that fall prevention programs are of value in and of themselves irrespective of whether somebody is going to break their hip when they fall. The sorts of indicators for falls are also indicators for a wide range of quality of life and personal capacity for independence. We do not tie fall prevention funding and activity specifically to the rate of fracture—

MS BRESNAN: I was not suggesting that you were tying it. As you said, we do know that with fall prevention those sorts of programs do significantly reduce the rates of fractures, where the fracture leads to admission to hospital, which often can start a downward decline in people's health. I was not suggesting that it is tied—but if that does get fed into the process for considering what funding is put in, particularly with the ageing population.

Dr Brown: Certainly in terms of identifying strategic priorities around promotion-prevention expenditure, fall prevention has been one of the top five that we have looked at over time, and it remains so. With the increasing demographic, it is certainly not going to be reduced as a priority.

MS BRESNAN: But there is likely to be an increase in that?

Dr Brown: Yes.

MS BRESNAN: Because it is one of those prevention programs.

Dr Brown: There was dedicated funding again this year, and in the promotion-prevention money, and of course we run two falls clinics in the communities as well.

MR HARGREAVES: Going to the point that Mr Hanson was making about patient

transfers to other hospitals, is there a hospital anywhere in Australia which accepts and treats 100 per cent of its patients presenting and which does not transfer any patients to any other hospital in the country?

Dr Brown: Not to my knowledge.

Ms Gallagher: I think it is very unlikely.

MR HARGREAVES: So we are not doing anything which is unusual.

MR HANSON: My point—

MR HARGREAVES: I do not want a conversation, Mr Hanson. This is 20 questions, not a conversation.

MR SMYTH: Minister, this morning you tabled a document with the breakdown of the commonwealth funding estimates in the 2010-11 budget and the outyears. The question that I cannot see an answer for was this. I actually asked for the breakdown of the GST percentage by year and a breakdown of the ratio as to when the commonwealth takes over the majority of the services.

Ms Gallagher: I think I answered that yesterday. The dedication of the GST revenue occurs on 1 July 2011. That is the dedication. The new arrangements will happen in 2014-15.

MR SMYTH: I was aware of that. The question I asked was: what percentage of the GST revenue at 1 July 2011 goes to the commonwealth?

Ms Gallagher: On our estimates—these are estimates—it is 48.9 per cent, based on the commonwealth estimate.

MR SMYTH: I thought you said 47 yesterday.

Ms Gallagher: Yesterday I said around, in the 40s. I have said around 47 per cent. Using the commonwealth budget figure, it is 48.9 per cent. By 2013-14 it grows to 51.6 per cent. Again, they are estimates based on the commonwealth budget.

MR SESELJA: So we started at a third and we are now at 51 per cent.

Ms Gallagher: No. We never started at a third.

MR SESELJA: We did.

Ms Gallagher: We never started at a third. That is wrong, and the record should not allow you to continue to say that.

MR SESELJA: Could you talk us through when you told people that. The day after this was negotiated the Chief Minister put out a press statement which was silent on the number: it was only recorded as a third. He said in the release “a proportion of the ACT’s GST revenue”, and it was reported in the *Canberra Times* and all those other

outlets that day that it would be a third. Why was that not corrected? Did you not know at the time when you signed up that it would be 49 and now 51?

Ms Gallagher: Yes, we did know, and I have said it a number of times.

MR SESELJA: When?

Ms Gallagher: I have said it on ABC radio. I have said it to journalists in the *Canberra Times*. I did a 15-minute interview—

MR SESELJA: It has not been reported in the *Canberra Times*.

Ms Gallagher: about three or four weeks ago on this subject. It has been clear to me. I have been clear in my public communications where I can. If that is not reported, that is outside my control where I have explained—

MR SESELJA: Why didn't you put out a press release then?

Ms Gallagher: I have explained—

MR SESELJA: if you wanted the information out there.

Ms Gallagher: that in order for the commonwealth to get to 60 per cent, which is what they need to be at in 2015-16 when the additional growth money comes through, they would have to take a larger dedication of our GST money. But again, when you look at the whole package, the ACT health system significantly benefits from this deal.

MR SESELJA: But we pay a lot more than the other states.

Ms Gallagher: We are not paying more than the other states.

MR SESELJA: We are.

Ms Gallagher: No state is worse off under this arrangement.

MR SESELJA: All the other states are better off.

MR SMYTH: That is a different proposition.

MR HARGREAVES: Madam Chair, on a point of order, can we have one speaker at a time?

THE CHAIR: Certainly.

Ms Gallagher: We are not paying more. It depends on your current expenditure on health and the proportion of the commonwealth spend on health in that jurisdiction. That varies across the states.

MR SESELJA: If you look at the other states, in 2012-13 we have got New South Wales paying 30 per cent, Victoria 24 per cent, Queensland 42 per cent, South

Australia 27 per cent, Tasmania 20 per cent and the Northern Territory 14 per cent—ACT 49 per cent. How did these negotiations go? Was that the first offer from the commonwealth? Did they say “You’ll pay around about 50 per cent of your GST” and we just accepted it? Or did we actually argue, as New South Wales and Victoria apparently did, for a better deal for the territory? How did the negotiation go? Jon was off at the bar. You were negotiating on our behalf. How did it work out?

Ms Gallagher: I am glad you find it so hilarious.

MR SESELJA: I do not find it hilarious.

MR HARGREAVES: Madam Chair, this is getting beyond the pale.

Ms Gallagher: This is serious reform—

MR HARGREAVES: He is talking over. Let her answer the question.

Ms Gallagher: and serious injections of cash from the commonwealth into our health system.

MR SESELJA: We pay more than the other states.

Ms Gallagher: No, we do not pay more than the other states. The dedication—

MR SESELJA: New South Wales negotiated a better deal.

Ms Gallagher: No. We do not pay more. What it means is that we are dedicating a share of our current GST from the commonwealth to go into health—in the order of \$400-odd million. Our health budget is more than our GST revenue. We are already putting that money into health.

MR SESELJA: You are giving up control of the GST.

Ms Gallagher: As a part of that, we are now getting additional money, including 60 per cent of the growth cost, which is going to benefit this community to the order of \$248 million outside the forward estimates period.

MR SESELJA: But every other jurisdiction is getting that.

Ms Gallagher: It is a good deal for the ACT.

MR SESELJA: Every other jurisdiction is getting that and some jurisdictions are—

Ms Gallagher: Perhaps Mr Ahmed can explain it.

MR SESELJA: If I can ask—

MR HARGREAVES: Madam Chair, this is getting beyond the pale.

MR SESELJA: No, it is not.

MR HARGREAVES: Stop talking over her, will you?

MR SESELJA: I am not talking over her.

MR HARGREAVES: How about you give her a chance to answer the question and behave yourself and stop being a bully.

THE CHAIR: Thank you, Mr Hargreaves.

MR SESELJA: She has finished her answer. You are a joke.

MR HARGREAVES: You are being a bully.

Ms Gallagher: Everyone knows Mr Seselja is a bully.

MR SESELJA: The question Mr Ahmed is going to take is why—at 60 per cent growth that the commonwealth is going to take—has New South Wales only dedicated 30 per cent of its GST, Victoria 24 per cent and so it goes?

Mr Ahmed: Perhaps I should clarify for the committee that we are not paying this money to the commonwealth. The money goes into a fund. This is expenditure the ACT is already making. Under the reform model, that funding goes into a state-specific fund. In our case, that fund already exists, which is our health budget. But we need to discuss the formal arrangements with the commonwealth, how the funding model will be implemented. Indeed, for all states and territories, GST-dedicated funding will go into a central, state-specific fund, topped up by further state funding.

As the Treasurer said, our total expenditure on health is more than our total GST funding. So we have to top it up as well—this 48 per cent or 49 per cent, whatever the percentage comes out for other states. That fund will get a couple of other sources of funding. It will get dedicated GST funding, further top-up from states and territories, health SPP funding will go into that fund, and commonwealth top-up. That is the benefit that the states will start getting beyond 2014-15. To clarify the arrangement, we are not giving this money away to the commonwealth.

In terms of your question about why we have, say, 48.9 per cent and other states and territories have a smaller amount, perhaps I should first clarify that these are just estimates. The GST dedication will be fixed in 2013-14. At that time, the GST pool cycle might be different. At that time, our health costs might be different from what we estimate now.

There is a bit of work that needs to be done, and that has been planned within the health reform working group. That relates to the definitional issues of what is in scope and what is out of scope. That ratio will change. I can assure you that that ratio will change.

The other aspect that is very significant for us is the cross-border patient activity. This is the number that the commonwealth has estimated in their budget and this is the

commonwealth's estimate. It is not our estimate. They have estimated it based on AIHW data. AIHW data would pick up the cross-border patient costs as ACT costs. They have assumed a dedication amount which includes the New South Wales patient activity. That is all right for monitoring purposes. All that means is that, if that arrangement goes ahead, we will get paid from New South Wales on an activity funding basis.

The alternative treatment would be that that dedication happens in the New South Wales pool. If that happens, our ratio will drop. So there are a fair few things that drive our ratio.

The other aspect that I could perhaps draw the committee's attention to—and these ratios will vary and I think the communication from the commonwealth has already been that it is around that figure—is that it depends on the amount of primary care expenditure that each state and territory has and what is in that scope. So that is another variable within this calculation.

The total expenditure that a state or territory makes on health is another variable. The largest states that you mentioned do have economies of scale. Health expenditure relative to the GST would vary, on that basis. The other side, of course, is their GST relativity. There are a whole range of factors that would determine this ratio. This is just an indicative estimate, as the commonwealth states itself.

MR SESELJA: It could well be more or it could be a little less; we do not know what the final numbers will be. As we move down the track to what the federal government has said that they want, which is for it to operate, presumably, across borders—and they have particularly cited the example of the ACT and the region—will we retain control of that funding which is dedicated from our GST or will we potentially be in the position of subsidising Yass or Queanbeyan or any of the other hospitals in our region?

Ms Gallagher: That is all hypothetical because it is not the model we have signed up to.

MR SESELJA: It is not hypothetical because the Prime Minister has already put it out there as what he wants from the agreement. It was one of the examples he used.

Ms Gallagher: That is not what the agreement delivers. We have certainly discussed the opportunities—

MR SESELJA: But you have not ruled it out in the future.

Ms Gallagher: No, we have not, because it makes some sense. But we are not going to do it if it is a financial disadvantage to the territory, and that will be a decision that government of the future will have to make about how you move, or whether you move, to a regional local hospital network.

Mr Ahmed: Perhaps I should clarify: under the reform model, states and territories remain the owners of their hospitals. It is a very clear principle that has been agreed under the reform model and under the funding model. States and territories retain the

ownership of their hospitals. The payments that relate to the ownership costs are made directly to states and territories. So we retain control of our hospitals to the extent that we have now.

In relation to the cross-border activity, there is no denying the fact that the ACT is a regional centre. The reform model sort of invokes a principle that is well and truly in place here already. In fact, what it does is give us an opportunity to perhaps entrench it or implement it a bit more properly. We do have cross-border activity and I understand our health system works very closely with the regional health service.

THE CHAIR: Can I just clarify something there. You were saying that based on this figure—say it was around 48 per cent at the moment—25 per cent of the delivery is for patients, people, who come in over the border and that we would then be reimbursed back. Does that mean that really we would be looking at about 36 per cent at the end of the day by the time—you are paying the money but then you are getting the people in and you are getting payment back again?

Mr Ahmed: I have not got the maths right in front of me but the ratio will drop and I think it dropped to in the vicinity of 40 per cent. It depends on how you implement the model. That piece of work has been recognised—it needed to be done—how cross-border patient activity gets treated. The way this has been calculated, if this model goes ahead, 50 per cent of the New South Wales patient activity would be on activity-based funding coming out of that fund. We will get reimbursed by New South Wales for the remaining 40 per cent. If the model you described—that would be our preference but we can work with either—is implemented, the dedicated amount comes out of New South Wales GST and the commonwealth would be paying us 60 per cent. They would take money from New South Wales, pay it to us and then New South Wales would pay the remaining 40 per cent. So it is the mechanisms and how they work. Our dedicated GST amount would become smaller; that is true. I do not have the numbers in front of me; I apologise.

MR SMYTH: But in the local hospital network, who controls the spending?

Mr Ahmed: The model as described is that states and territories would have contracts or agreements with the local hospital networks around the level of activity, around the quality of service et cetera. I need to understand what you are asking when you say “control”. The control can be at various levels. If the contractual arrangement is between the state and territory government or the health department and the local hospital network, the network itself has got a governing council which are responsible for running the network and they are the ones who have control of the network as well. So control is at various levels, in various places.

Ms Gallagher: The commonwealth money follows the state money—

Mr Ahmed: That is true.

Ms Gallagher: if that is where you are going, if you are talking about controlling the purse and decisions about how much goes into the local hospital networks. It is probably not a huge issue for us, because there is only going to be one, but perhaps it would be in a larger state where there are numerous local hospital networks; if there

was one that was underperforming or the state government had concerns about, decisions around the flow of the commonwealth funds would be linked to the flow of the state funds.

Mr Ahmed: That is true.

MR SMYTH: So there is an agreement between the ACT government and the hospital that the hospital, being the local area network—

Ms Gallagher: Yes, the local hospital network.

MR SMYTH: I am sorry, the local hospital network. And the GST revenue that is held back by the federal government goes into a different fund?

Mr Ahmed: Can I just clarify? It is not held back.

Ms Gallagher: It is not held back. It is just a re-labelling. It is the labelling of an amount of GST that is coming to us. It is the same funding that comes to us. Part of it is labelled “health”. It is not held back. That funding goes into a health fund, that is correct—

MR SMYTH: Who controls that fund?

Mr Ahmed: The ACT government would control that fund. That is the fund that gets the money from all the different sources. Funding comes from the commonwealth in perhaps two or three streams—three streams, actually—and one stream would be from the ACT government.

MR HANSON: If it is exactly the same money doing exactly the same thing, what is the reform?

Ms Gallagher: It is actually more money that is coming as part of this.

Mr Ahmed: Yes.

MR HANSON: You can give more money without going through this process. What you are saying is that we get, as it is now, 48.9 per cent of our GST, we put it into a pool and then we use it for what we are getting it for.

Mr Ahmed: Yes. It goes without saying that health systems are complex. Different economic agents in this complex health system need, and respond, to different kinds of levers. These are the levers and mechanisms that the commonwealth thinks are important to them—and they do think that governance and mechanisms are important to them. If I were sitting in the commonwealth I would figure that it does make sense. The governing councils of the local hospital networks do make sense, at least for states which are very large. In our case, it will be different. I understand this issue has been recognised for the ACT—that we have a unique circumstance where we have a city state and just two hospitals.

It has also been recognised that we do service the region. Our situation will be

different, but for other places it makes sense that there is a funding stream from different sources. For the first time—and that is a most important point—the commonwealth get a stake, and the stake is through that mechanism. That might appear to be just a superficial mechanism at this time, but that brings them in as a funding partner and a larger share funding partner—60 per cent of the growth in health costs will be picked up by them.

I should point out to the committee that health costs across the nation have been growing at well in excess of the GST growth rate. That is the benefit that the states and territories get. That is the \$15.6 billion that the commonwealth has estimated over the period 2014-15 to 2019-20. Over a five-year period that is the amount of benefit that comes out of the differential in the growth rate between the GST pool, which is the dedicated amount source, and the actual growth in health costs.

MR SMYTH: What form will the agreement between the ACT government and the local hospital network take? Will that be in the form of a purchaser-provider agreement? Do we specify certain activity and they will honour to give that?

Dr Brown: The actual form of that is still to be determined, but there will be a service agreement.

MR SMYTH: It will be a service-level agreement. So in effect it will be purchaser-provider. We will pay for services provided.

Dr Brown: We will essentially identify what services and activities are to occur through that local hospital network and to be funded through the funds.

MS BRESNAN: It is a fee for service?

Dr Brown: Not strictly.

MR SMYTH: It is more purchase-provider than fee for service. We are getting back a board for the hospital. In effect, we are going back to 2001, when we had a purchase-provider model where government would purchase services off the local hospital network, and they were run by a board. After 10 years of reform, we have gone back to 2001.

Mr Ahmed: Certainly in our case—

Ms Gallagher: So you think it is a good deal, then?

MR SESELJA: Is it?

MR SMYTH: I am exploring the model. The model we had in 2001 delivered the lowest elective surgery waiting lists. Since your government's reform following the Reid review, it seemed to blow out.

THE CHAIR: Do we have a question there, Mr Smyth?

MR SESELJA: There was a question.

THE CHAIR: I just wanted to clarify that there was a question.

MR HANSON: The minister answered it.

Mr Ahmed: In our case, the commonwealth has recognised that our circumstances are different. We do not have in place that model that other places do. In our case, because of our past experiences, we might have a different model. But that is something to be discussed and negotiated on at a bilateral level.

MR SMYTH: Until this point, the commonwealth has contributed to health costs. We have had agreements with the commonwealth. The Chief Minister said that in the past the commonwealth share has been negotiated by states and territories going cap in hand to the Prime Minister. We have negotiated. There has been a federal contribution to it.

Ms Gallagher: Yes.

Mr Ahmed: The federal contribution has been in the form of, largely, the healthcare grant. A large number of SPPs got rolled in as well. For the ACT, it is of the order of \$140 million this year—of that order. The total health cost in our system would be around \$970 million or \$980 million—close to a billion dollars this year.

Ms Gallagher: It is a billion this year.

MR SMYTH: Treasurer, perhaps you could, on notice—again, I thought I would ask for this yesterday—give us a reconciliation of the health funding and the arrangements between, say, this budget and the budget in 2019 so that we know what is coming in in terms of the additional hospital payments, the revenue that is dedicated from the GST and the federal contribution?

Ms Gallagher: We can be as helpful as we can, based on estimates—

MR SMYTH: That is fine. You have got a figure of \$248 million. It has got to come from somewhere.

Mr Ahmed: The \$248 million is not our modelling. This is commonwealth modelling.

MR HANSON: Surely you verified that?

Mr Ahmed: Different models will give you different methods.

MR HANSON: Are you saying that we did not do any modelling to verify it?

Mr Ahmed: We did. Our modelling would give us slightly different numbers and larger numbers.

MR SMYTH: The Chief Minister, in his press release, quotes at least \$248 million.

Ms Gallagher: We used the commonwealth number.

Mr Ahmed: That is the number in the commonwealth publications. We can certainly give you references to those publications. The modelling that we did was primarily based on—and I am distressed at their modelling—our projections of a world that we are yet to encounter. There are a range of assumptions. I think it is important for me to point out to the committee those assumptions and the basis of that modelling.

They assume that the percentage growth in our healthcare costs is 9½ per cent per annum. They assume the growth in the GST pool, which would be counterproductive, would be in the order of 6.5 to 6.8 per cent per annum. That is the long-run average that they see. They do make a number of other assumptions as well. These are simply modelling based on projections. The differential between the GST growth rate and the growth in healthcare costs and the 60 per cent of that which is to be funded by the commonwealth means that that commonwealth top-up, on our modelling, starts at \$19 million in 2014-15 and it grows.

A lot could happen between now and those four or five years hence. There could be some new technology which reduces the growth in healthcare costs. If that happens, that is a good thing. The model of care might change.

MR SMYTH: Except we are paying 51 per cent.

Mr Ahmed: We are not paying, Mr Smyth—we are not paying—

Ms Gallagher: We are paying more than that at the moment into the health system. That is what you do not understand. We do not lose one cent out of this. We get money into the health system.

MR SESELJA: But you lose a level of control over that money.

Ms Gallagher: We do not lose any control. The health budget is over a billion dollars. We are going to dedicate over \$400 million into health and then we are going to pay another \$600 million into health.

MR SESELJA: So again you are confirming that the whole deal as struck by the Prime Minister, that aspect of it that was so trumpeted, actually in your opinion makes absolutely no difference because you are just spending money that you were going to spend anyway.

Ms Gallagher: It does make a difference.

MR SESELJA: Because they fund more. But that is a totally separate argument. They should have said, “We are going to give more money to the states to run health.”

Ms Gallagher: I do not even know why I bother showing—

MR HANSON: Can I ask a question on the 60 per cent?

Ms Gallagher: It does make a difference. It makes a difference outside the forward estimates when they pick up the growth costs. That is the difference and we have

always been clear about that. That is what is extremely attractive to all state and territory budgets—they are at the table, they have 60 per cent stake in the funding of the local hospital network and they pick up 60 per cent of the growth. They do not do that at the moment. Under the healthcare agreement, it is fixed. Their contribution is fixed and they do not take a share of the risk on the growth of the health budget, and that is what is attractive and that is what is good for the ACT community.

MR SESELJA: And that efficient price that they take up: how far off are we from that efficient price at the moment?

Ms Gallagher: It depends on what the nationally efficient price is determined at. At the moment, if you look at it across our national benchmarks, I think we are about 106, down from 130 when the Liberals were last in government.

MR SESELJA: How much does that put the numbers out?

Mr Thompson: The other factor to bear in mind, and drawing attention back to what the minister said yesterday, is that as part of the negotiations some of the structural higher costs that the ACT inevitably faces are going to be taken into account when it comes to establishing what the ACT efficient price would be. So as a consequence it is not possible to answer the question as to the differential between our current and what is finally struck as the ACT efficient price under this new deal.

MR SESELJA: So, just to finish, what is the \$248 million based on? Is that based on us reaching the efficient price? The \$248 million in benefits that was quoted by the Chief Minister and the commonwealth: is that based on us meeting the efficient price?

Mr Ahmed: No. We did clarify with the commonwealth—it is not based on implementing the efficient price. Perhaps I should outline the process for setting up the efficient prices. I think that is an important piece of the reform model. There would be an independent hospital pricing authority set up. It would be independent of all the states and territories—just a statutory body that would be asked to establish an efficient price.

The language might be different but it would have a range of prices, not just one price at the national level. It would have different prices for different regions—possibly different prices for different metropolitan cities as well. So efficient price is not just one price and I think it is important to point out that we should not use the six per cent and take it off and say that that is the money we lose. That is not right. In all probability we will have an efficient price for the ACT. There will be a different efficient price for perhaps New South Wales far west and so on. There is work to be done.

MR HARGREAVES: Mr Ahmed was talking about the growth in GST at 6½ per cent, if my memory serves me correctly. Then he talked about the growth in healthcare costs at nine per cent. If I read it correctly, he was saying that essentially the commonwealth would pick up 60 per cent of that 2½ per cent difference. Am I correct there at that point?

Mr Ahmed: About three, 3½, yes.

MR HARGREAVES: Give or take a bit. I am happy with that. But you also mentioned a figure of, I think it was, 19½ million. Am I right? In the smoke I missed exactly what that \$19½ million was applicable to. I wonder if you would be able to say that again for me, please.

Mr Ahmed: Sure. The 19 million is our estimate of the additional commonwealth funding we would get that we would otherwise not have got. I think that is the point we made. That is our estimate of the funding that we will get in 2014-15 under this reform model, because the commonwealth starts picking up the growth risk—50 per cent of the activity in cost.

MR HARGREAVES: Is that in the year 2014-15?

Mr Ahmed: That is correct.

MR HARGREAVES: For the years going forward beyond that, is there any calculation about whether there is an escalator or anything that may apply to that?

Mr Ahmed: Yes. We do have a range of scenarios modelled. As I mentioned earlier, that 19 million under one scenario would grow to in the order of 150 million by the end of 2019-20.

MR HARGREAVES: Sorry.

Mr Ahmed: It is in the order of 150 million. It is not exactly that number but it is in that order. This is the loss compounding—that growth continuing. Perhaps I should point out that there are other benefits. The financial benefit is one point. The reform sort of creates a partnership between the commonwealth, states and territories. That is a very important element of the reform model.

The other thing that it does in clarifying the roles and responsibilities is that it sets up mechanisms. They are subtle but they are very important. It sets up mechanisms where the commonwealth has an interest to actually do something in its area of responsibility. We see that as being very important—the responsibility for primary care—and then tying it to an adjusted target. It is a very important and subtle link. But they are linked. So the whole model—the principles are really good. We need to do further work on it in operationalising it.

THE CHAIR: So is part of the reform you are talking about the importance of that partnership with the commonwealth? In a way, it is about the commonwealth now being part of providing health care across Australia and understanding the complexities of it, the needs and so forth. That is what you see as an important step forward rather than just being able to point the finger at the states and blame the states for what could be seen as not being optimal delivery. It is bringing the two levels of government together so there is a common understanding of where we need to go and what needs to be provided.

Ms Gallagher: In the past the healthcare agreement has been, I think, a five-year agreement. So by the time you get to that end year you are still locked in to what you

agreed five years before. The healthcare agreement that is operational now is indexing health growth at about 7.3 per cent, I think, on average. The one we were locked into before that was indexed at, I think, 4.8 or 5.1 per cent. Health costs grew every year at 10 per cent, but that agreement was locked in. It was unresponsive. We still had to respond to the targets—what the commonwealth were demanding as part of that agreement, but they did not take any share or any risk at all in the growth in health costs.

So the state and territory budgets were dealing with that. Every year, as the health costs grew by 10 per cent, that differential between the state and the commonwealth grew bigger and bigger. What went from a 50-50 partnership ended up as 60-40 for the big states and 70-30 here. That is what is so attractive about moving to this model, where the commonwealth are fairly and squarely at the table and taking a share of that growth in costs every year and having to respond as the states and territories have had to respond.

THE CHAIR: So previously it was a five-year agreement and you are saying that under this arrangement it is more flexible and you can address issues in a more timely way. The amount will be growing as growth funds come through.

Ms Gallagher: And it is not capped. Their involvement is not capped. It has always been capped. It is a big risk for the commonwealth. I think all state and territory ministers were sitting there going, “Are you sure you want to do this?” They were in a very luxurious position. It is an acknowledgement, I think, of the fact that it is an unsustainable system. It is a public acknowledgement that by 2040 our budget will be totally consumed by health and the commonwealth have to respond to that. It would happen at different stages in different state and territory budgets, but it was an unsustainable system.

MR HANSON: Madam Chair, in the—

THE CHAIR: I just wanted to go over one other point, Mr Hanson. When the agreement first came down there was not a lot of detail out. I do not even know if those who were in the room negotiating it had a lot of detail at various points. We have heard today a lot more than I have heard previously. What are you doing about communicating the reform—how it is going to work, the dollars and so forth—to the public? It is easy to grab a figure and toss it out there without the context and the understanding. It is very complex. How do you think you can communicate this to the people of the ACT?

Ms Gallagher: There is a level in the community that just want their hospital funded. The extent of the implementation issues and the tied issues around that is of absolutely no interest at all. I guess a simple message about more money going into health is very attractive to people. In terms of the people who are actively involved in health, our stakeholder groups, there is a lot of discussion at the moment around how we move to implement this system and the opportunities that that provides.

I have met with a range of stakeholders in the last month or so to talk to them about using this as an opportunity to look at how we do all aspects of our work to make sure that we are aligning with the new reform program, even down to structures around

advisory councils. As they sit now, are they going to be relevant? Do we need to look at how we align them better with the local hospital network or the primary healthcare organisation to better reflect the system as we go forward? We are doing a lot of work on that. When we get to finalising all the details of the governing council and how the local hospital network will be established, I think that will be the community information exercise. There will be a part of the community, though, that will remain uninterested.

THE CHAIR: They just want to walk through a door and get a service, obviously.

Ms Gallagher: Exactly.

MR SMYTH: Of course they do. I have just a few final questions. The funding that is retained by the commonwealth and then allocated: what control will the ACT government have over that?

Ms Gallagher: It is not retained; it is quarantined into a health fund and it will go into the hospital.

MR SMYTH: You have control over our funds at all times?

Ms Gallagher: All the funds come to the ACT and then they are channelled. There is a portion of the GST that is dedicated to health that will go into the fund that funds the local hospital network.

MR SESELJA: You say it is not retained. The communique says that it is and that the commonwealth and all states, apart from Western Australia, agree that from 1 July 2011 an agreed amount of GST revenue will be retained and allocated by the commonwealth to health and hospital services. That does not seem to match up with what you are saying, that it is not retained by the commonwealth. The communique actually makes it clear that it is.

Ms Gallagher: It goes in. It comes to the ACT, to the local hospital network, to be put into our hospitals. We would argue that we are already doing that and more. In that sense, there is no change. As I have said a number of times, we pay more than our GST into the health system.

MR SMYTH: The communique that you guys signed up to says that it will be retained and allocated by the commonwealth. The money does pass out of our control, therefore.

MR SESELJA: That is what the communique says. What you have been telling us this morning is that that is not the case, that it is not retained, that you actually still get it; it is just labelled differently.

Ms Gallagher: It goes into the state fund.

MR SESELJA: That is not what the communique says.

Ms Gallagher: It goes into the state fund for the local hospital network. In my view,

if we want to use the word “retained”, it is retained for health purposes but it comes to the ACT, which is the argument. You are trying to say that it does not come to the ACT, that we lose control over it—

MR SMYTH: No. We have been saying all morning—

Ms Gallagher: in the sense that we lose control over a decision. That money is definitely going into health. That is what we already do.

MR SMYTH: The communique says that it is retained and allocated by the federal government. That does say to me that the money will always remain under our control. Yes, it will come to our local health network but not through your budget.

Ms Gallagher: And the commonwealth funding will follow the state funding into that local hospital network.

Mr Ahmed: Perhaps I could clarify the mechanism in the fund. By the way, we still need to work with the commonwealth on the final detail of the fund. The money will be retained in a state or territory’s specific fund. The notion is the commonwealth will distribute the money that comes from the payments that are to be made on an activity basis. The way it will work is that the independent hospital pricing authority will set a price for state debts. The funding pool exists for that state. The commonwealth will say, “Our 60 per cent share, based on that price, will be allocated from that fund and go into the hospital network.”

If there is a shortfall in the fund, the commonwealth will top it up. That is the mechanism whereby the commonwealth is coming in and having a stake in the fund and in the funding of the system. The notion of the commonwealth paying is specifically because of the basis of the activity-based funding.

MR SMYTH: Which appropriation bill will the money appear in? Will we appropriate the money for the hospital network or will the commonwealth appropriate the money?

Mr Ahmed: That is something we need to work on. As I said, the governance of the fund itself is subject to discussion.

MR SMYTH: We do not know at this stage what the financial governance arrangements will be for this money?

Mr Ahmed: It will be operational in 2014-15, as I understand it. We need to work it out.

MR SMYTH: If it is only worked out in 2014-15 but we are handing the money over from 1 July next year—

Ms Gallagher: We are not handing over the money.

MR SMYTH: The money will be retained and allocated by the commonwealth from 1 July next year.

Ms Gallagher: No.

MR SESELJA: That is what the communique says. Is the communique wrong?

Ms Gallagher: My understanding is that the dedication shows from 2011—

Mr Ahmed: Yes. From 2011-12 it is simply a labelling of the funds that come to ACT—

MR SMYTH: So it will still be appropriated in the ACT budget?

THE CHAIR: The funds are still going to be appropriated in the ACT budget and they will be allocated to health?

Mr Ahmed: That is our understanding at this time. We have one year, the whole of next year, to actually work through the operational aspects of the fund and the implementation details.

MR SESELJA: It says in the communique specifically that from 1 July 2011 that will be retained and allocated by the commonwealth.

Ms Gallagher: So what is your issue, Mr Seselja?

MR SESELJA: It is the lack of clarity. You have been claiming—

Ms Gallagher: No, I think it is the use of the word “retained” and how we—

MR SESELJA: You have denied that they are retaining it and allocating it. You have said it will simply be labelled differently. The communique directly contradicts that. I am trying to get to the bottom of it, given you do not know what the financial governance arrangements are because they have still to be worked out. You have been very unclear as to how this money will be retained or allocated or labelled.

Ms Gallagher: I don't think we have been. I disagree with you on that.

MR SESELJA: The communique directly contradicts what you are saying. They are retaining it and allocating it. Therefore, presumably, they are going to want some control. That is completely contrary to what you have been claiming, which is that it is simply a labelling issue and really nothing changes.

MS BRESNAN: Can I just—

THE CHAIR: Yes. Ms Bresnan.

MS BRESNAN: When information came out about this arrangement, I understand the commonwealth government originally stated that they did want to have control over the funding. That seemed to be the key sticking point, particularly with Victoria—that they wanted to have control of that funding for the GST. Basically, the agreement that came out was that the states will control the funding. I am probably

getting this wrong as well, but essentially—

Ms Gallagher: There is another step in the process.

MS BRESNAN: You are handing them the GST and they are giving it back to you, basically, so the states are having control over the funding. It was my understanding that that was one of the issues in terms of regional bodies. That cannot happen now because the states will have the money. There will not be those regional bodies, as was originally put, as well as, for example, the ACT with Queanbeyan and other areas.

MR SMYTH: But we may have that in the local hospital network.

MS BRESNAN: But we do not have that now. In the agreement we do not actually have that.

Ms Gallagher: Exactly.

MR SESELJA: We don't know.

Ms Gallagher: We do know, Mr Seselja. You have just got something shoved in your ears and you cannot hear the answer to it.

MR SESELJA: You do not even know the financial governance arrangements. You do not know whether the money will be retained.

MR HARGREAVES: Madam Chair, this is getting really hard.

Ms Gallagher: We are in negotiations with the commonwealth about how those arrangements are to be implemented here locally. While we are negotiating those I do not think it is useful to air them publicly. We will be clear once those negotiations are finalised. The agreement we have with the commonwealth is that we may not have to set up an independent statutory authority as a local hospital network. But what they would want to see is that the national arrangements are reflected in whatever governance arrangements are established here. That may mean that the commonwealth money will come to the ACT and then we, through our budget papers, will be very clear with how that money is going to the local hospital network. But that is still being negotiated. When those negotiations are complete, we will be able to provide you with all of that information.

MR SESELJA: I am sure you will be very open about it, as you have been to date.

Ms Gallagher: But I can tell you, Mr Seselja, that there will be not one cent lost to the health system under this.

THE CHAIR: Thank you. As we are now—

MR SESELJA: I am sure you will be very open about the arrangements, on past form.

THE CHAIR: five minutes past the morning tea break, the committee will now break for morning tea.

Meeting adjourned from 10.33 to 10.57 am.

THE CHAIR: We will now resume the public hearing of the Select Committee on Estimates and move to 1.2, Mental Health Services, followed by 1.3, Community Health Services and 1.4, Public Health Services.

Ms Gallagher: Thank you, chair. I have a couple issues that this morning we undertook to get back to the committee on. The ambulance off-stretcher time to the end of April 2010, the percentage offloaded in 20 minutes, which is how we count it, at Canberra Hospital was 98.8 per cent and at Calvary hospital it was 99.2 per cent. The numbers of ambulance arrivals at TCH were 10,603 and at Calvary were 6,028. The numbers waiting 20 minutes or longer were 127 at Canberra Hospital and 48 at Calvary. In mental health—

MR SMYTH: Sorry, and that was at what time?

Ms Gallagher: That was the financial year to end April 2010.

MR SMYTH: The 12 months to April 2010?

Ms Gallagher: From 1 July to April.

MR SMYTH: Okay, 10 months.

Ms Gallagher: For the same time, from 1 July to end of April 2010, the number of individuals that have been mental health access blocked is 87. The number admitted by the ED is 499. The percentage access block is 17.4 per cent. The unplanned return to theatre, again for the same time frame—no, not the same time frame but from 1 July to end of February 2010—at Canberra Hospital, total operations is 8,773. Mr Smyth you are not writing this down. You are the—

MR SMYTH: No, I am memorising it. Do you want me to repeat the figures?

MR HANSON: Have you heard of *Hansard*?

Ms Gallagher: How many operations? Come on: how many operations just then?

MR SMYTH: I have got *Hansard* working for me.

Ms Gallagher: You have just told me you are memorising it. There were 8,773; returns to operating theatre, 77; and the percentage returned to theatre, 0.88 per cent.

MR SMYTH: I am not sure whether I asked the minister to take on notice the reconciliation of the funding arrangements between now and 2019-20?

Ms Gallagher: We can certainly provide you with the details that we have got from Treasury along those lines, but they will be estimates, particularly outside of the forward estimate period, because that is a long time.

MR SMYTH: Sure, and I am not sure if it was answered just at the end: when is it expected that the agreements will be reached and signed?

Ms Gallagher: Around the governance arrangements?

MR SMYTH: Yes.

Ms Gallagher: The timetable is to have a local hospital network established by July 2011.

MR HANSON: Can we finish off on the issue of the community being misled about the 30 per cent versus 51 per cent issue of GST?

THE CHAIR: I think we actually spent quite a bit of time in the last session. There was agreement of the committee that we would continue on from yesterday afternoon to this morning, up until morning tea time. There are a number of very important outputs that we do need to get to and I know that there are committee members who have questions on those outputs.

MR SESELJA: It does have to be just a little bit of flexibility.

THE CHAIR: No, because we have had an agreement and I am ready to go with the mental health questions.

MR SESELJA: We did agree to have some flexibility.

MR HANSON: Can I have it noted then that I still have outstanding questions in this area, be it for either the recall day or later?

THE CHAIR: As you attended the hearing, you are able to put those questions on notice. There is a template provided that your office would have been informed of.

Going to page 80 of budget paper 3 in regard to the mental health growth funding that is coming in, it is \$1 million per annum. What exactly is the ACT government planning to spend this money on?

Dr Brown: That will be split 50 per cent between community agencies and 50 per cent to the public sector. Dr Norrie may be able to speak to the details of the public sector and Mr O'Donoghue to the details of the community agency.

Dr Norrie: The \$2.092 million over the next four years is going to be allocated for a number of improvements: a quality improvement consumer consultant to support forensic mental health training and supervision; to establish a dialectical behaviour therapy coordinator, which is a special therapy looking at managing personality disorder and sort of working with our patients in psychotherapy; and also to fund the Mental Health ACT information system to ensure that our system continues to meet the needs of clients and clinicians, and that will be spread over the four-year period.

MS BRESNAN: Sorry, was that for the community-based funding or for the government—

Dr Norrie: That is for the government-based funding.

MS BRESNAN: I am sorry; what was the second item?

Dr Norrie: There is the consumer consultant—

MS BRESNAN: Yes, I have got that.

Dr Norrie: the forensic mental health training, the dialectical behaviour coordinator and the ACT information system called MHAGIC.

Mr O'Donoghue: The other half of the mental health growth from 2010-11 relates to funding for community organisations. The lion's share of it is devoted towards a service that will be delivered through a tender process and this is a short-term early intervention step-up, step-down in-home support service. So \$370,000 has been allocated towards the provision of this service. It is consistent with the mental health services plan and an identified need for increased outreach support, including during after-hours periods for people aged 18 to 64 and suffering from mental illness. The intention is to provide support for people who are at risk of hospitalisation, to try and keep them stably in the community, as well as to assist consumers to manage the transition back to the community following discharge from hospital. So it is akin to the residential step-up, step-down services but it is a more virtual service in the sense that it is delivered in people's own homes.

An element of our commitment through the national partnership agreement on bridging the gap will see \$150,000 allocated to Gugan Gulwan for delivery of a young Aboriginal and Torres Strait Islander mental health and wellbeing program. This was a commitment that was signed up to under that bridging the gap national partnership agreement, and this element was always scheduled to commence in this particular budget year. That is \$150,000 for that particular service.

Of the other three smaller elements, one relates to supplementing ADACAS for their advocacy services. ADACAS appear in the tribunal on behalf of or alongside a significant number of people with mental health issues in relation to the making of guardianship or financial management orders. This initiative will enable ADACAS to meet growing demand and provide an appropriately trained individual advocate to assist individuals appearing before the tribunal with information about the process, assisting them to speak before the tribunal or representing the person's wishes. That has been allocated \$25,000.

There is an additional 500 hours of family support being provided through Tandem for \$30,000. Over the past 12 months, Tandem's mental health respite program has shown a strong improvement in client outcomes and outputs and that has been reflected by a dramatic increase in referrals and client numbers. There is always a large unmet need within the ACT for mental health respite services, and this initiative will allow, as I said, an additional 500 hours of respite services to be provided through the program.

The last element relates to the Mental Illness Fellowship of the ACT where we

propose to fund \$25,000 to enable the development of a certificate II in horticulture. The current rehabilitation program is provided through North South Contractors where people do basically home care type gardening services for clients. This initiative will enable in-program training to enable those participants to achieve a certificate II in horticulture. It means that consumers exiting the rehabilitation program will have a formal qualification that is recognised throughout Australia to facilitate their opportunities to obtain employment in the open workplace. That actually totals a little bit more than the \$500,000 allocated to this, but that is taking advantage of the fact that the community sector review, which was a sort of one-off targeted initiative, will cease in this financial year.

MS BRESNAN: Can you just clarify about the step-up, step-down program to be based in people's homes? I understand that obviously step up, step down is a different sort of thing from crisis—it is trying to prevent the crisis happening—but one of the things that the community has been calling for, for quite some time, is an after-hours ACAT type of service. This is a different thing, but was that factored into the considerations at all? I appreciate that the step-up, step-down program is coming out of the mental health services plan as well and was identified in that.

Mr O'Donoghue: Yes. This is specific to the step-up, step-down sort of issues, supporting people in transition, either preventing their hospitalisation or enabling their transition back to the community. It is providing an after-hours component in the community for that. It is a separate issue from the after-hours ACAT issue that you raised.

MS BRESNAN: Have the Strategic Oversight Group had an input into the distribution of this funding?

Mr O'Donoghue: Not the specific allocations. The Strategic Oversight Group met very recently and we discussed a forward process for the next budget cycle, in which they will have much more active involvement, particularly following the outcomes of the community sector review for the next budget year. But these were needs that were either identified through the mental health services plan or through the community budget submission process or, in the case of the national partnership agreement one, there was an element that was under the bridging the gap initiative.

MS BRESNAN: And when you say “more active involvement”, what does that active involvement entail?

Mr O'Donoghue: The discussion we had with the strategic advisory group was that they would have an active role in establishing priorities for funding based on the mental health services plan and other emerging needs. They will not have an allocative role in that sense but they will provide advice to government, as will the ministerial advisory council, on strategic priorities that can be agreed in that forum.

MS BRESNAN: Okay. So the oversight group and the advisory council will be providing advice on the project.

Ms Gallagher: I think that is a good process to get in place. But the allocations have been made based on representations from the community sector, particularly that large

program component which I have had several meetings with several different organisations about—wanting some extra support going into that.

THE CHAIR: I am just wondering what sort of outcome measures are being put in place to ensure that the money achieves what it is setting out to do.

Mr O'Donoghue: Obviously these are early days in terms of finalising these allocations. In the case of each service that will be delivered, there would be a service level agreement with the provider. As part of that process we would always identify deliverables and evaluation strategies for each of the elements. Obviously, where services are yet to be established, we have not put those in place.

THE CHAIR: I think Ms Bresnan raised one service that some in the community sector have been calling for, the after-hours service. What other gaps have you identified, particularly in the community-based delivery area around mental health?

Mr O'Donoghue: I guess, in the totality of the mental health services plan—and there are a large number of elements that we are still working on in that context—it is a bit hard to identify any particular priority elements.

Ms Gallagher: Obviously there is always going to be more that you can invest. From my understanding of the area, I really think it is across the board. I think we have got supports there. Whether the supports are enough to deal with demand is the question. We could always do more in accommodation and supporting people to live in their community and recover in their community. I get certain representations about out-of-hours crisis assessment, for example, in out-of-hours time. I am not sure. There is a gap in our service system. I think it is more around capacity. One of the biggest gaps, I would say, is the secure mental health unit. That is a gap where we do not have something here in the ACT but that is not in the community-based sector.

Mr O'Donoghue: I think we anticipate some findings from the community sector review in terms of sector capacity and working towards quality standards of service delivery; so that will be one supplement to what we do. I guess we are always doing work. There is emerging work in the supported accommodation field, with the early days of the HASI project in partnership with Housing. So I think we will continue to see that build as a model, hopefully, because it has been pretty successful in the ACT.

MR SMYTH: In the output classes on page 223 of budget paper 4, there seems to be a lesser amount allocated for the total budget for this coming year against the outcome for this financial year. Can you explain that difference?

Dr Brown: Yes. Some of the funding has been allocated against output 1.7, to reflect the nature of the funding, which is around promotion, prevention, early intervention services.

MR SMYTH: At the bottom of output class 1.7, it says that a review of outputs has resulted in the transfer of funds from the outputs that are listed. Output 1.2, mental health, has lost \$4 million to early intervention?

Dr Brown: It is not a loss; it is just better reflecting the expenditure against that

output, which is early intervention and prevention.

Ms Gallagher: In mental health.

Dr Brown: In mental health.

MR SESELJA: So how much has shifted across?

Ms Gallagher: It is there.

Dr Brown: It is listed there, \$4.069 million.

MR HARGREAVES: On that basis, can I ask Dr Brown: if \$4 million has been transferred to early intervention and prevention from your estimated outcome—I do not see what the budget was for 2009-10, so I am assuming the \$4 million would come off the \$75 million, which is the estimated outcome for 2009-10—that means that there has, in fact, been a \$3 million increase in terms of netting that off, because you would take off the \$4 million from your \$75 million, which gets you down to \$71 million; then you have put it back up to \$74 million, have you not?

Dr Brown: That is right. There is mental health growth money in this budget.

MR HARGREAVES: So we need to be very careful when looking at these figures, because, in fact, whilst the figure at page 223 shows a reduction, it is actually an increase of about \$3 million.

Dr Brown: Yes, but I guess the purpose behind the reallocation was to highlight that, particularly in mental health but across all of health, prevention and early intervention services are quite key. Over time, we would like to see that allocation continue to grow.

MS BRESNAN: On that, I have a question.

MR HARGREAVES: Before we get off that one, I noticed that, in budget paper 3, mental health growth funds are, in fact, only \$1 million.

Ms Gallagher: A year?

MR HARGREAVES: Yes. If we take year one, for the sake of the argument, it only shows an increase of \$1 million. Basically, if this is true, I see an extra \$2 million going into mental health provision, which I would say is fantastic.

Dr Brown: Some of that reflects indexation for pay rises and other things. The growth in the budget as reflected is \$1 million this year, the \$4-point-whatever million over—

MR HARGREAVES: That is for indexation and all of that?

Dr Brown: Yes, wage rises.

MR HARGREAVES: Let us reconcile it. We have got \$75 million as your estimated

outcome. We take the \$4 million off it because you have quite rightly transferred that to early intervention and prevention. That drops it down to \$71 million. Add your \$1 million in, which is the growth funds, which takes it to \$72 million. Now what I am seeing, in fact, is \$74 million; so it is actually increasing by an extra \$2 million.

Dr Brown: My advice is that it is due to indexation factors.

MR SMYTH: It is about a four per cent growth. When you take in indexation and wage increases, what is the real growth year on year in mental health?

MS BRESNAN: In relation to that, my question was going to be based basically on what Mr Smyth and Mr Hargreaves said about the growth funds, that \$1 million being allocated rather than \$2 million. I know in the previous budget there was that \$2 million there. So I am wondering—

Dr Brown: Sorry, I missed that.

MS BRESNAN: Why the thinking for having \$1 million of growth instead of the \$2 million, as it was in the last budget?

Dr Brown: Part of the Greens-Labor agreement, I think, was an allocation over the four years of \$14 million-plus.

Ms Gallagher: No, that was in our election commitment. So we are keeping that. Essentially, the \$1 million this year is what has been allowable and affordable with the other competing interests within the growth envelope for Health. It is in line with the commitments we made at the election about an additional \$14 million over four years into mental health. I should say, though—

MS BRESNAN: That was not actually looking at what the need was in the community; it was actually based on cost considerations?

Ms Gallagher: Yes, what was affordable. Theoretically, you could put \$10 million into mental health but then you would not have any to deal with elective surgery or critical care. The growth envelope is only so big, and that is what we were working within for growth. So everybody got an allocation, essentially; plus, when we were finalising this, the knowledge that we had that subacute money coming through the commonwealth and that we would be providing a proportion of that to mental health gave us a little more flexibility.

Dr Brown: Mr Foster has further information in relation to the \$74 million that Mr Hargreaves was speaking about.

Mr Foster: You heard earlier about how the \$1 million is being spent. That is new activity and new cost. As well as price rises, pay rises and indexation, the growth between 2009-10 estimated outcome and 2010-11 has a factor in relation to a delayed expenditure in mental health this year associated with the mental health assessment unit. Therefore, that creates a larger percentage increase than we will be incurring, in fact, because the mental health assessment unit is now open and will be full cost in future. But the impact this year is that it shows a lesser amount spent on mental health

and, therefore, a larger percentage increase into next year, where the increase is the \$1 million new expenditure and the funding increases associated with pay rises and indexation on the base mental health.

MR HARGREAVES: Thank you. With Mr Smyth's help, I have reconciled it from \$75 million to \$74 million, with the 2.8 per cent cost increase factor, which is worth about \$2.1 million, give or take \$100,000. Thank you very much for the explanation.

MR SMYTH: As a percentage of the total health budget, how much are we spending on mental health this year?

Ms Gallagher: It is around eight per cent. We are just finalising that and we will get an exact figure once we have worked out the subacute money going into mental health. It does look like a significant proportion of that \$26 million-odd will go into mental health provision. That figure will change but it is around eight per cent.

MR SMYTH: And what was it in 2009-10?

Ms Gallagher: About 7.9 per cent. It will be over eight per cent.

THE CHAIR: Those subacute beds you are talking about, is that what you were talking about yesterday that may be targeted at the 18 to 25-year-olds?

Ms Gallagher: Yes.

Dr Brown: Yes, some of that will be going into 18 to 25s.

THE CHAIR: I have a question on page 223 of budget paper No 4. Mr Hargreaves has gone through the figures for us.

MR HARGREAVES: I can do it again, if it helps.

THE CHAIR: Thank you but no. There is \$71.5 million. I am just wondering about 2010-11 funding. I have got a breakdown here. We may not get to all of them today. Could you give us some idea of the breakdown of how much is hospital-based acute mental health service, how much is community based and how much is now being provided by the community sector?

Mr Foster: We will have to take that on notice.

Dr Brown: Just over 80 per cent of our funding is spent in the community. That includes community organisations and public sector services. The community is around the 13 per cent mark overall.

Ms Gallagher: That is the non-government organisations.

Dr Brown: The remainder is our inpatient sector, which, of course, includes our acute units plus Brian Hennessy rehabilitation.

MR HANSON: Could I ask a question. I suppose it goes to the health and wellbeing

of ACT Health staff. You have been conducting staff culture surveys, I believe. Can you advise how many you have now conducted, who has conducted them, what the results have been and how we can access those results, to have a look at the—

Ms Gallagher: To get a headline, yes.

MR HANSON: Well—

Ms Gallagher: Well, what?

MR HANSON: I think that is information that the public would want.

Ms Gallagher: No. We believe you, Mr Hanson. Your motives are genuine. We do, we believe you.

MR HANSON: There have been a lot of allegations about bullying.

MR HARGREAVES: Yes, I made the accusation about bullying this morning.

MR HANSON: There are a lot of allegations about bullying—

MR SMYTH: All right, let us have a discussion about bullying, then?

MR HARGREAVES: Yes, let us have a talk about bullying.

MR HANSON: There are a lot of allegations about bullying and problems with the staff culture in ACT Health. I think it is appropriate that, if a staff culture survey has been conducted, it would be provided. I have asked for it repeatedly.

Ms Gallagher: Yes, and shared with Mr Hanson to go and scaremonger around the city with it.

MR HANSON: If it says good things, what is the problem? What are you hiding, minister? What are you hiding?

MR SESELJA: What is in it that would allow scaremongering?

Ms Gallagher: It is always the little flavour that Mr Hanson puts on. We have looked at this. We have done a number of staff surveys, and we can certainly speak in general around them. There are always issues identified that you have to respond to. That is why you do them. Otherwise, why would you do them? You would not do them if you did not want to respond to the issues. There is an element of commercial-in-confidence around the surveys that are done; that is done by the contractor that does them for us. We have looked at this in the past—as to whether you can release them.

MR HANSON: You can release the results, surely?

MR SESELJA: The surveys are never published?

THE CHAIR: Mr Seselja, could we just wait for the answer to be finished and then we can come back with another question.

Ms Gallagher: I am sure Dr Brown can take you through it.

Dr Brown: We have, over the last five years, conducted three culture surveys. They have been conducted by an external organisation called Best Practice Australia and New Zealand. The results overall are a good news story. Over the course of the five years between the first and the last survey, we demonstrated a 20 per cent increase in engagement with staff in the organisation and particularly made gains around leadership and management and performance management. Staff said to us in the original surveys that they wanted to be very clear what was expected of them and to engage in regular dialogue and feedback about their performance. We responded to that by putting in place a formal process for performance management and performance agreements; staff have responded and said that they have appreciated that and we are doing well.

The survey has highlighted other areas where we need to continue to work. Working in teams is one of those areas. We do have in place an overall ACT Health approach to using the results from the culture survey. That is also taken down to individual operational divisions, which have in place a plan to address the response for their individual workplace areas. We do not, however, release the details of the individual areas. The staff engaged in this exercise with an undertaking from the organisation that it was a confidential process. We do not feel that we would be keeping true to the promise made to staff if we were to release the details of the information broken down.

MR HANSON: Were there any areas of concern around bullying within ACT Health?

Dr Brown: Bullying and harassment have been raised as an issue in the survey. I dare say that if you undertook a similar survey in just about any other public sector organisation, or even a private healthcare organisation, you may well find similar issues. There have been gains made in some of those areas over the five years. There are some areas there that we understand that we need to continue to work on.

MR HANSON: For those areas where you have identified a problem with harassment and bullying, what action have you taken?

Dr Brown: We have undertaken a range of training, and we are in the process of developing some further training. We have information given to staff at orientation. There have been training sessions within the workplace and within teams around how people communicate and work in teams better. We are developing further training for managers around bullying and harassment and how to respond to that. We have had information for senior executives around ethics and values and bullying and harassment. So we have got a range of strategies that we are using to address that.

MR HANSON: There has been some criticism of the complaints process as well. That certainly came to light with the problem we had at obstetrics. A number of the doctors there complained in the media that, when they made complaints to ACT Health and to the general manager of Canberra Hospital and others, those complaints

were ignored, and that went on for a protracted period, resulting in, I think, nine or more obstetricians leaving. What is it that means that a doctor can go and complain and those complaints, in their words, get ignored? Has that been identified as a problem? If so, has it been resolved?

Dr Brown: That is not the sort of information that we get specifically out of the culture survey, but yes, that issue has been raised with us. There are informal and formal mechanisms for raising complaints and responding to complaints. The expectations of staff sometimes vary, depending on the mechanism that is utilised. Sometimes staff have an expectation that they can raise something informally and yet get the results that a formal complaint might deliver. Sometimes they want to see nothing less than a dismissal, for example, and that is not necessarily the outcome that is ever going to come about as a result of a complaint.

But we have looked at our mechanisms in terms of how complaints can be made. They can be made through line managers; they can be made through other members of staff. We have been looking at whether we have designated other staff within the organisation to be receivers of complaints around bullying and harassment.

MR HANSON: I was trying to work out, though, in this particular case, why complaints were made over a protracted period of about 12 months, and nine obstetricians left, but we had a situation where we were told that there were no complaints made and the minister actually described it as these being complaints without substance, simple mud-slinging. It seems to be a complete breakdown in the communication process that, when bullying does occur or is alleged to have occurred, the investigating process had to get to a point where the doctors had to leave their place of employment and then go to the media, and then there was a considerable kickback from the department and from the minister to basically refute the allegations being made by the minister. What went wrong?

Dr Brown: I think you are making an assumption that nine doctors who left all raised complaints of bullying and harassment that were not responded to. That is not the case. We were advised that two doctors had raised issues. They were responded to. They were not responded to in the way necessarily that those two doctors felt they should have been, but it is not fair or true to say that there was no response.

MR HANSON: If I can go to the minister and ask the minister—

THE CHAIR: One more, Mr Hanson; then we do need to move on. I have a waiting list.

MR HANSON: Why is it that, when these allegations were first raised in the media, you discarded and discounted them as mud-slinging and doctor politics? It has turned out that there has been a formal investigation or process instigated. Why is it that your initial response was so dismissive and basically was a kickback at those doctors who were trying to raise complaints? I do not understand why you were so defensive rather than actually talking to the doctors and saying, “If there’s a problem, let’s investigate it further.” Why did you try and—I will not use the term “cover up”, it is probably too much, but that is certainly an impression that came out.

Ms Gallagher: There was certainly no attempt to cover up anything, Mr Hanson. As Minister for Health, I have never attempted to cover up anything. I stand by the comments I made around some of the ways that those issues were pursued in the media. There was a fair bit of mud-slinging going around; and obstetrics, public and private, has had a long and difficult history in this town. I stand by those comments. They were the comments I made in the media.

THE CHAIR: Mr Hargreaves.

MR SESELJA: When will that review—

MR HARGREAVES: Thanks very much, Madam Chair.

MR SESELJA: I have a supp on this. Is this a supplementary, Mr Hargreaves?

MR HARGREAVES: There are two issues. Firstly, I will respond to the chair, Mr Seselja, not to you; you are only the deputy chair. I have two questions; I just sit here quietly and wait for my turn.

THE CHAIR: Okay, Mr Hargreaves.

MR SESELJA: Is this a supp?

MR HARGREAVES: My understanding is that this issue flared in about February, which is about three months ago, maybe more. I would like to know whether you feel that the issue and the underlying culture issues have been resolved in that period of time and whether in fact the community concern need not be the case. Am I right or wrong?

Ms Gallagher: There are two processes underway. There has been a clinical review conducted, which we have not received the final report of. We have had some feedback from the reviewers, but nothing formal. That was specifically to look at the issues that were raised by doctors who did not work in the public system, alleging that there were safety risks with presenting and having your baby at the Canberra Hospital. We knew from our own internal data that we run a very safe obstetric unit, and I was very keen to have that independently examined by a team of reviewers. That review, in terms of them coming down and having a look at the service, has been done. Their final report has not been received. Secondly, they are around issues of workplace culture. That has been dealt with under a separate process, which I am not able to be briefed upon. I am not sure that Peggy, who is able to know more than I do, is in a position where she can give anything out today. Those processes are underway.

In terms of the unit itself, it has been under a fair bit of pressure. I think staff have been hurt through this process, particularly by the way it has been aired publicly. That is unfortunate, and I think it is going to take a fair bit of work to build that team up. There is a situation where there is the potential for camps to form, with supporters of some and opponents of others. I think we are going to have to do a fair bit of work to support the staff in that unit over the next few months or so.

THE CHAIR: Mr Hargreaves, your second question.

MR HARGREAVES: I have a follow-up on this one, but also I would like to ask a question on mental health services, which is what I understood you were here for.

THE CHAIR: Yes, most certainly, and I do take your point. I am allowing—

MR HARGREAVES: So I have got one on this last one, and then I would like to come back to mental health.

THE CHAIR: Certainly. We will be.

MR HARGREAVES: My last one on this is: from your perspective, and I do not want detail, do you think the continued conversation in the public arena around an issue which arose three months ago is likely to affect adversely the confidence that the community may have in the obstetrics services in the hospital?

Ms Gallagher: We run a very safe service at the Canberra Hospital—extremely safe, with some of the best outcomes in the country. I am very keen to ensure that women understand that. When these issues were aired in the way they were, with the comments that were made, we did have a number of women who were concerned about whether it was a safe service. We had to respond to that. I am very confident that the service offered at Canberra Hospital is very safe. Indeed, we are seeing more babies being delivered there than ever before.

There is a level of transparency and accountability that we have to provide to the community. Issues have been raised around the unit. We have to respond to those and we have to let the community know, as much as we can, what the outcomes of those issues are. However, I will not endorse a witch-hunt; I am not going to go and disadvantage particular individuals through this process. I am very keen to be dealing with this at a systemic level rather than an individual level.

THE CHAIR: Mr Smyth and Mr Seselja, a follow-up question on this; then we are moving to Ms Bresnan first and then Mr Hargreaves on mental health questions.

MR SMYTH: Just to follow up on what Mr Hargreaves asked, you said, in regard to the workplace culture, that you are not being briefed. Is there a reason for that?

Ms Gallagher: It is under the public interest disclosure laws. I am not allowed to be.

MR SMYTH: Okay. Dr Brown, when will the workplace culture review be completed?

Dr Brown: The review around the workplace environment?

MR SMYTH: Yes.

Dr Brown: We do not have a final time frame yet, but I anticipate that sometime towards the end of June we should have an outcome.

MR SMYTH: And the clinical review?

Dr Brown: Around the same time frame.

MR SMYTH: When you receive those reports, what will be the process for their release?

Ms Gallagher: I have given a commitment that we will release the clinical review as soon as possible. I do not see any problem with that. I think the public interest disclosure review—and this is speaking without knowing what that review has found or anything like that—may be more difficult to release to the public. If there are individual names raised in that, I imagine—and I am only trying to imagine—there will be views of those individuals about what information they would like to be made public.

MR SMYTH: Sure.

THE CHAIR: Mr Seselja.

MR SMYTH: Sorry, just to finish. On the issue of complaints, are statistics kept on the number of complaints?

Dr Brown: We keep statistics in our consumer engagement team around complaints, compliments and comments. That is not necessarily the same as a member of staff making a complaint around a workplace colleague. We keep statistics around formal processes, but we do not have mechanisms for reporting on informal discussions.

MR SMYTH: You said that there had been a change in the level of engagement—

THE CHAIR: Mr Smyth, we are going to move on to Mr Seselja.

MR SMYTH: Sure. If you have only kept a record of the formal ones, are there more or fewer formal complaints being received?

Ms Gallagher: Internally—staff?

MR SMYTH: Yes.

Dr Brown: I do not have those figures in front of me. Certainly, in the wake of events earlier this year we did experience a number of complaints coming in and being brought to our attention. I actually see that as a positive thing. It is a sign that people trust that the system is responding and will respond.

MR SMYTH: You might take that on notice and give us, say, the last two or three years numbers, if possible. Thank you.

Ms Gallagher: Yes.

THE CHAIR: Mr Seselja, and then we are moving back to Ms Bresnan and Mr Hargreaves.

MR SESELJA: Thank you, chair. I have a couple of things. One follows on from that answer and from an earlier answer. In relation to the workplace culture review which was done on the public interest disclosure, given it is done under that act, what information will eventually be communicated to the community at large about workplace culture issues at the hospital? What is being done to resolve those after the review is completed?

Ms Gallagher: I cannot answer that because I do not know what it will find. It may find that there is no problem. It may find that there are a few problems. It is a hypothetical question. I do not know how you can know what you would be able to release without knowing what is in it.

MR SESELJA: But without identifying individuals, will the findings of the review ever see the light of day?

Ms Gallagher: I am not sure, Mr Seselja. It is pre-empting a report that I have not seen. I do not know how other people involved in that process may pursue options around protecting reputations, for example. I cannot answer you. It is just impossible for me—

MR HANSON: Who makes that decision though?

Ms Gallagher: Individuals would be able to—

THE CHAIR: Okay. Back to—

MR SESELJA: I have not finished. I had two questions.

THE CHAIR: No, I think the answer has been that we do not know.

MR SESELJA: That is one. Chair, you are very keen to shut it down. I said I had two questions.

THE CHAIR: No, I want to move on to mental health, Mr Seselja.

MR SESELJA: And one was a follow-on from an earlier one. We are just finalising this, and Ms Gallagher was just finishing her question. I was allowing her to finish.

Ms Gallagher: Well, I have answered you. I cannot answer it without knowing what is in there. The content of that report will pretty much determine whether or not information can be made public. I cannot answer it.

MR SESELJA: Going back to Mr Hargreaves's point earlier that these things emerged in February, that is not quite right. You have said that this has been a 10-year war going on. Given you have been health minister for several years now and you are aware of these issues going on, what have you been doing to try and resolve some of these workplace issues, which you were obviously aware of—and you say that everyone was aware of or many people were aware of? What have you done to improve the situation over the last few years?

Ms Gallagher: Mr Seselja, the opposition array of verballing is just getting out of control.

MR SESELJA: You did use that terminology.

Ms Gallagher: All right. Just keep interjecting and continue your rude and arrogant behaviour, as everyone is a witness to in this place. The issues—

MR SESELJA: Are you going to answer the question—

Ms Gallagher: Yes, I will answer the question if you stop interjecting.

MR SESELJA: or just throw barbs?

Ms Gallagher: I have to say that your interjections and the manner in which you are conducting yourself this morning, Mr Seselja, are taking it to a new level, but that is up to you. If my mother had been here, you would have got a clip around the ear.

MR SESELJA: It is a classic Katy tactic, isn't it? Don't answer the question. Just try and divert. Are you going to answer the question or not?

Ms Gallagher: No, I can answer it.

THE CHAIR: We have a question. Minister, could you answer the question and then we will move back to Ms Bresnan.

MR HANSON: Don't you like the line of questioning, minister? What have you got to hide?

Ms Gallagher: I can answer it. I have nothing to hide. The issue—

THE CHAIR: Mr Hanson, one at a time. There is a question that the minister is about to answer.

MR HARGREAVES: Madam Chair, I will ask that this member be ejected if this continues.

THE CHAIR: Minister.

Ms Gallagher: The issues that I referred to in terms of a long and protracted war—I think I did use the word “war”—were around the private and public obstetrics service in this town. I was not referring to individual staff grievances that may or may not have occurred in the obstetric unit. Indeed, when I first heard that there were concerns in the obstetric unit—and they were not raised by the doctors who went public; the concerns were coming from a doctor within that unit—I met with her, the director of the unit at the time, to speak with her. I questioned extensively ACT Health about whether there were concerns in that unit. The advice I got back was that there were not. There were no formal complaints lodged within that unit.

The comments I made around a long and difficult environment in obstetrics relate to a

decision that pre-dates this government—in fact, it might have been Michael Moore, or it might have been before his time—around appointing staff specialists at the Canberra Hospital and not having a private VMO lead service at the Canberra Hospital. That was the start of the concerns that have waged on and off over the last few years. What appeared to trigger some of the concerns from the private obstetricians in this town was some recruitment action that was undertaken, or advertised, in late 2009 for positions at the Canberra Hospital.

MR HANSON: Can I just ask another question?

THE CHAIR: We have spent 20 minutes on this matter. We are on mental health services and I am now going to move to Ms Bresnan.

MR HANSON: Where else will we discuss this, please, Madam Chair?

THE CHAIR: Mr Hanson!

MR HANSON: Where else will we discuss this issue?

THE CHAIR: Ms Bresnan.

MR SESELJA: You are very keen to shut down the scrutiny of government.

Ms Gallagher: We are very keen to try and keep rude boys in line.

THE CHAIR: No, Mr Seselja. I think we should get back to mental health services and the scrutiny of mental health services. Thank you. Ms Bresnan.

MR HANSON: You're trying to hide from something, Katy.

Ms Gallagher: I am not trying—

MR HARGREAVES: Madam Chair, can you remind the members of the standing order?

THE CHAIR: Order! We are going back to Ms Bresnan.

MR SESELJA: You've had a bad day, haven't you, Katy?

THE CHAIR: Mr Seselja!

Ms Gallagher: I'm terrified! I'm trying to hide from something! For God's sake.

MS BRESNAN: Can I ask a question on this one?

MR HANSON: Why do you attack on this one instead of answering the question?

THE CHAIR: Mr Hanson!

MS BRESNAN: Mr Hanson, I am trying to ask a question on the budget.

THE CHAIR: Ms Bresnan has the call.

MS BRESNAN: Thank you, chair. This may be something which has to be taken on notice, but I did want to ask this question. Ms Hunter asked earlier about the total mental health services budget and the various allocations that go to various things in the community sector. Has there been any work done—and can we get this information—about what money is coming from other agencies and going towards mental health services? HASI is probably a good example. There are other agencies where there is mental health funding. Is it possible to get those figures, if any work has been done on that?

Dr Brown: We will have to take that on notice.

MS BRESNAN: I quickly wanted to go back to something. I am sorry, I should have raised this earlier. It is a very quick one, hopefully. The strategic oversight group and the ministerial advisory council—you did say they will both have input into funding decisions. I am just wondering how they will work differently. It seems like there will be a different membership on those two groups but they may be performing a similar function. I am just wondering how they will actually work together and what level of input there will be.

Dr Brown: There is some crossover in the representation inasmuch as there is, for example, a consumer and carer representative on the ministerial advisory and strategic oversight groups—not necessarily the same person.

MS BRESNAN: I do recognise that.

Dr Brown: The ministerial advisory group is to look at strategic priorities and give advice to the minister. The strategic oversight group will give advice to the department and focus on the implementation of the plan. Both will, however, look at priorities for budget expenditure and provide advice. As Mr O'Donoughue said, it will not actually be allocating dollars.

MS BRESNAN: I am just wondering how that advice will be used—from both. One is providing input advice to the department; one is providing advice to the minister. How will that work together in terms of looking at what the priorities are coming out of the services plan?

Dr Brown: I guess it will be the basis for some robust discussion.

Ms Gallagher: It will shape the initiatives, for sure.

Dr Brown: The strategic plan outlines a number of initiatives that we hope to take forward over the next five years. There is an issue about deciding which ones to do in what order, particularly where new funding is required. That is the sort of discussion that will occur at the strategic oversight group. It is a question of how that lines up with what goes to the ministerial advisory council, but one would expect that there would be some overlap. The strategic oversight group is, however, looking at not just the ACT plan but also the fourth national mental health plan, the COAG national

mental health plan; and it has on it cross-government representation as well as commonwealth government representation. So it has a broader look at the other initiatives that are happening outside the ACT-funded services.

MS BRESNAN: Different advice might come because consumers and carers may have some different input in terms of what some of their priorities are. I am just wondering how those two will be reconciled together, with the two groups operating.

Dr Brown: What normally happens within the department? Mr O'Donoghue, do you want to speak to this in terms of looking at the priorities for the strategic oversight group and how that will happen? Did you discuss that in recent times?

Mr O'Donoghue: There are somewhat different roles between the two bodies. The strategic oversight group pretty much has carriage of the detail of the mental health services plan and the other strategic plans that Dr Brown has mentioned. In that sense, they already have a work plan, if you like, of identifying priorities, some of which will require additional funding beyond the growth envelope that currently exists in health. So they have the immediate task of an implementation task and a prioritising task in terms of what are the next steps to be progressed within the plan. The ministerial advisory council, as Dr Brown has suggested, has a broader strategic role. But there is cross-membership and there is good communication between the two groups and they are both working off the same song sheet in terms of the mental health services plan being the agreed blueprint that has been very thoroughly developed and consulted about in its evolution. So the ministerial advisory council is looking at a slightly broader remit in a strategic sense; the oversight group is more into the detail of the plan, but we would imagine that their advice would be reasonably congruent.

Ms Gallagher: The Ministerial Advisory Council on Mental Health gets an update about the strategic oversight group as part of the standing item at the Ministerial Advisory Council on Mental Health. A paper is provided. We look at what the strategic oversight group are doing and then have a discussion around that. So there are some strong links through that. I would see the ministerial council—I do not know whether this will offend anyone in the strategic oversight group—as the peak advisory body. It is definitely the peak advisory body to me, but it would probably sit just a bit above the strategic oversight group if we were to draw a hierarchy, which we are not.

MS BRESNAN: That is not what I suggested. You said there is cross-representation. Is that cross-representation from peak groups?

Mr O'Donoghue: The representation at the ministerial advisory committee level has been based on the expertise of the individual members rather than the organisations that they may be members of. But as it turns out, there are members of the ministerial advisory group who are involved in some of the peak bodies and there is common membership of those peaks in the strategic oversight group. So there is a harmony of membership, if you like. But the appointments to the ministerial advisory council are on an individual expertise basis.

MS BRESNAN: Did you say that there was consumer representation on the strategic oversight group?

Mr O'Donoghue: Yes, there is.

MS BRESNAN: And that is from the consumer network?

Mr O'Donoghue: Yes. I could run through the key stakeholders, if you like. There are the ACT departments of Education and Training, Justice and Community Safety, Disability, Housing and Community Services and Chief Minister's. There are representatives from mental health consumers, carers and community agencies. And the commonwealth departments of Health and Ageing, Families, Housing, Community Services and Indigenous Affairs and Education, Employment and Workplace Relations are also represented on the strategic advisory group.

MS BRESNAN: Thank you.

THE CHAIR: Mr Hargreaves.

MR HARGREAVES: Thanks very much. I wanted to talk about the mental health assessment unit. Are there people here who can do that? It was talked about briefly, but straight over the top. I want to get a bit more detail. It was opened recently. I would like to know where exactly physically it is and what sort of benefit this provides to patients who require urgent treatment or assessment. Could we go down there for a couple of questions?

Dr Brown: Yes. The mental health assessment unit is actually located within the emergency department of the Canberra Hospital. It is a six-bed unit that has been built to provide a safe and appropriate environment for the assessment of mental health consumers. There are individual rooms for clients to be assessed in. There is also an appropriate waiting area for them and their family and carers. We anticipate that some people may self-present to the hospital, some people will come with family members or friends or carers, and others may come in the company of police or ambulance. There is appropriate staffing to ensure that there is a safe environment for the staff within the unit.

MR HARGREAVES: Did you have to employ new staff to provide the service?

Dr Brown: Yes.

MR HARGREAVES: How many did you employ?

Dr Brown: There are additional staff. I do not have that detail. Dr Norrie may have that detail with him.

MR HARGREAVES: While we are at it, what classifications are they, please, Dr Norrie?

Dr Norrie: We have a full-time psychiatrist appointed to the unit, and we have used our existing psychiatric registrar staff to support the unit, both within and without hours. Previously, there were nursing staff and allied health staff provided under the access improvement project and also through the crisis assessment and triage team.

We have increased staff so that there are now three per shift during the day and two into the evening shift, and there continues to be one person in the night hours of 11 o'clock through to seven. The majority of staff are registered nurse 3 level, but we also have some health professional level 3 staff in the unit. We have known from experience that the overall staff mix is the most successful way to run those services.

MR HARGREAVES: Yes, I appreciate it. Thank you. I have some experience with that.

THE CHAIR: I just wanted to follow up—

MR HARGREAVES: I have not quite finished, thank you very much.

THE CHAIR: Keep going.

MR HARGREAVES: What is the relationship between the community crisis team, the outreach team that goes out—if someone is having an episode, they will go out there, sometimes in the company of police, sometimes not—and this assessment unit?

Dr Norrie: The mental health assessment unit and the crisis team are in fact one team. We have quite deliberately kept it that way so that the services can work together.

MR HARGREAVES: So if there is an episode in the community, that does not denude the service in the hospital?

Dr Norrie: Absolutely not, no.

MR HARGREAVES: Some years ago, there was criticism levelled at both the AFP and Mental Health that the relationship between those two bodies was not as wild as it could be. I understand that there was an MOU or something like that to be developed between the two organisations, and I know that did occur. Now that there is some distance down the track, you should be able to test whether that MOU and the relationship are actually working or whether you have still got some way to go in terms of the culture shift. From where I am sitting, the culture shift is the problem of the police, not Mental Health. Other people have a different view. Could I get your view on that?

Dr Norrie: Developing on from the MOU, what we set up about 18 months ago was an ED liaison meeting between Mental Health and ED which has comprised Mental Health members across both the in-patient and the CAT teams and also representatives from our other community teams; the emergency department at the Canberra Hospital—and invited from Calvary as well—but also representatives of the police; the Public Advocate if a representative is able to come; and the wardsmen of the hospital. That has been an astounding success in terms of essentially breaking down some of the barriers that existed. We have been able to have calls both within and out of hours between us if there have been some emerging problems so that, between the police and ourselves, we can speed up access. The most significant improvement now is essentially going to be that the mental health assessment unit will have the facility to cope with patients much better, so we foresee an ongoing improvement in those relationships.

MR HARGREAVES: That is another good news story. I really think it is fantastic; we have come an awful long way. What kind of response times have you got when you are outreaching into the community? When somebody rings in to the crisis line and says, “I’ve got an episode,” how quickly are you able to respond to that?

Dr Norrie: This is a difficult area. We looked at this particularly carefully earlier in the year when there were some concerns raised. I need to first of all cover the fact that, inevitably, a mental health response team cannot be the same as police, fire and ambulance. That is a difficult perception sometimes for consumers, carers and the community to bear in mind. Over the last couple of months, I think we have taken the responsibility to work harder to explain at the time of the call what Mental Health can do and what it cannot do. We have got a responsibility not only to the particular consumer who may be unwell at the time, but also to our staff in terms of safety and the appropriateness of one or two individuals going into the community.

MR HARGREAVES: Is there an understanding on the part of the community that, if we have got a really savage episode on foot, the team can actually turn up, take someone into custody and cart them away—when in fact you do not have the authority to do that? Is that one of the biggest issues?

Dr Norrie: No. Firstly, depending on the appropriate triage of the individual’s needs—clearly, it depends on the workload of the day, but we can have a response, often within the hour, from a team that will actually go out. The assessment of that is based on whether we know the consumer and whether we are assured that it is an appropriate response from Mental Health. If there are particular needs around aggression, agitation and possible risk, we will ask the Australian Federal Police to attend with us. Increasingly, we have had that combined cooperation rather than just having the police attending on their own.

MR HARGREAVES: Is there any involvement by your group in training police officers in their response?

Dr Norrie: Yes, there is. In fact, just recently, over the last couple of weeks, we have had the team leader of the crisis assessment and triage team and also the director of our acute and access team actually go and work with the new police recruits. That has been a system that we have had in operation for some years.

MR HARGREAVES: Fantastic; thank you very much.

MS BRESNAN: Just to follow up on that, it relates to a question I asked about having that after-hours assistance for people and that community proposal about having an after-hours assessment team. I guess the only alternative is the CAT team. Is that a proposal which will be examined in light of future budgets? How are you now dealing with those after-hour situations? Often it does happen to people on weekends and after hours in particular.

Dr Norrie: Very much so. I wonder if I could back-track because it is often what we do within hours that is most important. One of the other things that we have worked on, in looking at triage and our four community teams in the Canberra district, is

looking at increasing responsiveness from the community teams to the consumers and carers of that particular district in the ACT, but, more particularly, increasing the services of consultant psychiatrists into the community teams, and having the ability for general practitioners to ring in and speak to the psychiatrists about a particular problem.

We have often found that when those needs are not resolved adequately enough during business hours, the crisis emerges after hours. So it is a matter of being able to adequately deal with the emerging problem. Clearly, as you mentioned, problems do occur after hours and at weekends, and the significance probably of the mental health assessment unit and the resources that we have provided there is that they are going to increase the capacity for a more efficient response to those problems if they do need to come in for formal assessment.

MS BRESNAN: Has there been any assessment of whether that approach is working? You mentioned that having that knowledge and assistance provided to GPs is having an impact on preventing that crisis from occurring on the weekend.

Dr Norrie: Sure. Relatively speaking, it is a new initiative. We have worked progressively on that over the last three or four months. It is a little bit early to give you feedback at this stage.

MS BRESNAN: Will there be a review process of that?

Dr Norrie: Certainly. The initial response from the GPs has been very positive. I had a teaching session with six GPs on Monday of last week, and their response indicated that they were happy with that access happening.

MR HARGREAVES: Could I ask about these cross-border regional responsibilities for mental health? Is it the same as for the other elements of health service provision or are there any barriers?

Dr Norrie: We have very strongly worked with our staff on what we call both formally and informally a no-wrong-door policy. The important thing is that, if a consumer, either from the ACT or from surrounding New South Wales, comes into one of our facilities, they are given the appropriate assessment and treatment, and issues about where they return to are discussed at a later stage.

MR HARGREAVES: Does the CAT team go over the border?

Dr Norrie: No.

MR HARGREAVES: So what happens to people in Queanbeyan?

Dr Norrie: We have very good communication with our colleagues in New South Wales. There is a memorandum of understanding between ourselves and the Greater Southern Area Health Service about the mental health services that are provided both within the ACT and in surrounding New South Wales. There is continuing work. One of the ongoing initiatives is that one of our registrars spends some time at the Queanbeyan mental health service, so that we have a relationship-building exercise

going on and we can talk to each other.

MR HARGREAVES: My final question is for the minister or Dr Brown. Will the health reform package that is coming forward have any effect on this particular relationship?

Dr Brown: The relationship with—

MR HARGREAVES: Will the health reforms that are being done, particularly around funding and that sort of thing, impact on mental health provision or just the hospital services, given that mental health has a foot in both camps?

Dr Brown: The detail of how mental health is going to be dealt with under the national health reform is yet to be finalised. The commonwealth government have announced that they are going to take over funding and policy around mental health service provision in primary care settings for mild to moderate depression and anxiety. For the most part, that does not apply to our community mental health services. They have flagged that that is an area where they want to have some further discussion around how they deal with the specialised mental health services. Mental health in-patients are currently part of the Canberra Hospital, and we assume they will continue to be part of it. We also want to look at maintaining and enhancing the integration with the wide range of community services that may well come under some of the primary healthcare organisations as well. So there is a lot of work to be done in that space.

MR HARGREAVES: Thank you.

MR SMYTH: What is the FTE for the mental health unit or for this output class for mental health services?

Dr Brown: The total mental health full-time equivalent, from memory, is in the order of—

Dr Norrie: 345, with 390 head count.

MR SMYTH: So currently it is fully staffed?

Dr Norrie: We have obviously a progressive recruitment area. At times we will struggle with some of our community positions, but in the last 12 months we have been significantly more successful. There is about a five per cent recruitment lag for some of our community positions due to ongoing movements, retirements and so forth.

MR SMYTH: What is the percentage of turnover for staff inside the service?

Dr Brown: The turnover is usually—I have not seen the figures in the last month or so—less than 10 per cent for mental health.

MR SMYTH: And for the whole of ACT Health, what is the turnover?

Dr Brown: Nine per cent was the latest figure.

MR SMYTH: Okay.

Dr Brown: That is turnover for permanent staff.

MR SMYTH: Going to the mental health of all ACT mental health staff, mental health services does not provide internal counselling, does it?

Dr Brown: No. We have an employee assistance scheme to provide support for staff, which is independent of Health, so that staff feel assured about the confidentiality and privacy of that service.

MR SMYTH: Inside mental health services, are there many staff off on stress leave or other illness-related leave?

Dr Norrie: We have reduced those figures substantially over the last two years. I would have to take the exact figure on notice, but my understanding is that there are less than 10 off at this stage.

MR SMYTH: And broader, across the department, what is the level of stress leave?

Dr Brown: Again, I would have to take that on notice but it is not high by relative standards across the public sector.

MR SMYTH: It is not high?

Dr Brown: No.

MR SMYTH: And the causes of why people are off on stress leave?

Ms Gallagher: They will vary.

Dr Brown: Yes. I do not have that detail with me. We do not necessarily get a level of detail behind that in aggregated data.

MR SMYTH: Why wouldn't you get the level of detail—

Ms Gallagher: Are you talking about accepted compensation cases?

MR SMYTH: Yes. Either just off on leave or accepted compensation cases. Why wouldn't you be looking at the causes—if it is a physical health issue like it is a sick building or there is a cause or, at the other end, say, it is stress or bullying?

Dr Brown: It gets classified. When we get our workers compensation data, it comes as aggregated data with a range of categories. It might be due to stress-related illness or back disorders and musculoskeletal things et cetera. Where there is a number in the stress claims, the individual operational areas know the detail, but when it is aggregated up at the whole-of-organisation level, we do not get the details of individual cases. But the operational areas would.

THE CHAIR: While Dr Norrie is here I want to touch on child and adolescent mental health and get some idea about what sort of resources are being allocated to children and adolescents in the mental health system.

Dr Norrie: We have a northern and southern children and adolescent mental health service team. They also have a day program provided. We have services that are provided into the paediatric unit of the hospital liaison, and that is particularly now looking at a member of the nursing staff who has got a liaison role both with the paediatric team and with the crisis team, and some dedicated time of a child and adolescent psychiatrist to work with the paediatric team.

Whilst that has always been an ad hoc arrangement, in the last 2½ years particularly, with increasing the resources of child and adolescent psychiatrists, we have found that that has been a very successful way to manage, in the current absence of the adolescent and young adult unit which is planned.

In addition to that, we have, right across the service, appointed clinical directors, psychiatrists who work under my substantive position as director of clinical services, to work with the teams. Particularly within child and adolescent mental health, that has been a significant way of helping the service director to look at the clinical provision of those services.

THE CHAIR: So is there greater demand than you have the capacity to meet at this time?

Dr Norrie: No, I believe not. I think we have continued to look at the way that access is provided and, in the same way that we have looked at it for both adult and older person services, making sure that the appropriate response to the community and the appropriate response to GPs is there. So we have decreased our waiting times for people coming into child and adolescent mental health services.

THE CHAIR: Do you have a relationship with Calvary hospital?

Dr Norrie: Yes. There are no formal child and adolescent mental health services at the Calvary complex itself. They are actually provided at Belconnen.

MS BRESNAN: Do you also work with services like headspace, which are—

Dr Norrie: Absolutely.

MS BRESNAN: very much targeting that age group?

Dr Norrie: The ACT was very forward in making contact with the options for headspace, and we have a collaborative relationship with them in terms of their work in the ACT, but particularly looking at where they fit in with CAMHS as well.

Dr Brown: Just to expand on that, we have Mental Health ACT workers who go to headspace and work there. Where it is required, those clients can access the child and adolescent psychiatrists or adult psychiatrists, as is appropriate for their age, if that is required. So it is a very collaborative relationship with headspace.

THE CHAIR: Dr Brown, is that funding secure? I know we sat in a lot of meetings getting that service up, and I am wondering whether that funding has been secured into the future.

Dr Brown: Certainly, the Mental Health ACT component of it is secure.

THE CHAIR: Right.

Dr Brown: Some of it is funded through commonwealth. There was a reduction on the original envelope, I believe. We are yet to hear whether we get any allocation of additional headspace money from the commonwealth budget.

MS BRESNAN: So that money that has been allocated for headspace in the federal budget, you have not heard yet if the ACT will get any?

Dr Brown: I do not believe that we have yet.

Ms Gallagher: From what I saw, there is a pro rata allocation to the ACT.

Dr Norrie: At the latest meeting that I attended with headspace, they were waiting on formal announcement.

MR SESELJA: Dr Norrie, before I think you referred to the relationship with what goes on in Queanbeyan in relation to mental health. Are you able to just expand a little on that. I have obviously spoken to some providers of support both to homeless people and to people with mental health issues in Queanbeyan and the region. There are some challenges there. Obviously, there are some ACT residents who are more proximate to some of those services, particularly in Oaks Estate, for instance.

Dr Norrie: Yes.

MR SESELJA: How do we make sure they are looked after, for instance, because obviously we often talk about people coming over the border to our system. There are also people accessing the system in Queanbeyan.

Dr Norrie: Sure, particularly Queanbeyan, because I guess it is the nearest example, but also for the other surrounding areas of New South Wales. The issue for us in providing treatment is not where they live; it is where they access the service. Clearly, as we look at that and do the formal assessment or provision of care, there is also flexibility in terms of people who may, for example, live outside the ACT but work in the ACT where it is more logical to access services within the ACT.

Where ongoing care is needed and where, clearly, there is the issue around cross-border, there is continuing negotiation with our sister service in Queanbeyan, particularly making sure that those decisions do not affect the individual's care.

MR SESELJA: Is it your understanding that the home in Queanbeyan which is being built will be accessible to anyone in the region, or will it be only for those in Queanbeyan?

Dr Norrie: I would have to take that on notice.

MR SESELJA: Okay, thank you.

MR HANSON: Going back to the investigation of bullying at TCH, the AMA describes certain actions of the government as a thinly veiled threat and the president of the national college of obstetricians as an attempt to muzzle people from coming forward. I have a question specifically for the minister and one for Dr Brown.

Minister, have you received any further complaints or correspondence from doctors raising any concerns with your role in relation to the allegations of bullying at Canberra Hospital? Dr Brown, have you, yourself, received any verbal complaints or correspondence from doctors raising concerns with the minister's role in the allegations of bullying?

Ms Gallagher: Just in relation to the preamble to your question, when you said the AMA says that it is a thinly veiled threat, what is that in relation to?

MR HANSON: That was in relation to when you raised the issue of going back through 10 years of medical board reviews. The comments then came out from the AMA in relation to that and from the national college.

Ms Gallagher: Right; so that is a little bit—

MR HANSON: Well, it is to do with your dealing with the issue.

Ms Gallagher: That is a little bit different.

MR HANSON: No, it is not.

Ms Gallagher: Well, no—

MR HANSON: This is—

Ms Gallagher: The opposition is having an exercise in verballing. I have a right to put some context around this.

MR HANSON: I am very happy for you to do so.

Ms Gallagher: The thinly veiled threat was not about—

MR HANSON: It was—

Ms Gallagher: Sorry, Mr Hanson, let me finish. The “thinly veiled threat” was not around my handling of any allegations of complaints in the obstetrics unit. Let us just get that clear.

MR HANSON: Well, it was. It was in relation to—

Ms Gallagher: No, it was not.

MR HANSON: It was directly in relation to—

Ms Gallagher: No, it was not.

MR HANSON: your subsequent actions—

Ms Gallagher: It was around the comments—

THE CHAIR: Mr Hanson, can we have the answer?

Ms Gallagher: It was around the comments that the Chief Minister made around seeing whether there were issues that the medical board were concerned about. I think it is an entirely appropriate—

MR SMYTH: It was put out there as a blocker; let's face it.

THE CHAIR: Mr Smyth.

MR SMYTH: It was a tactic from the Chief Minister

Ms Gallagher: Well, no, you can have your own view on that. You can have your own view. We had doctors coming out saying that the service was not safe. Why would you not go to your medical board and ask them if they had any information around that that might support those allegations?

MR HANSON: Madam Chair, I am happy to just clarify this. This—

Ms Gallagher: No, no, I understand your issue.

MR HANSON: This goes to the point that doctors are significantly concerned.

Ms Gallagher: No.

MR HANSON: Have you received any correspondence or any further complaints with regard to—

Ms Gallagher: From when?

MR HANSON: From doctors?

Ms Gallagher: When you say “further”, what do you mean?

MR HANSON: Beyond the allegations that have been made in the media, have you received any verbal complaints or any correspondence in relation to your dealing with—

Ms Gallagher: My handling of it?

MR HANSON: the whole process and your role in this whole process?

Ms Gallagher: I received one letter from a doctor in Coogee, who was a registrar at the hospital, who raised the fact that I had both my babies as a public patient at the Canberra Hospital as a belief that I had a conflict of interest in this, Mr Hanson. That is the only one I recall.

MR HANSON: And Dr Brown, have you received any complaints or concerns?

Dr Brown: I have to say, I recall seeing—

Ms Gallagher: That doctor.

Dr Brown: that particular correspondence. I do not recall any other. We have had a range of correspondence. Where it has been relevant, we have fed that into the two reviews that have been undertaken. So where it has been relevant to the clinical outcomes of the unit and the standards, we have asked the clinical review to look at that particular correspondence.

Where there has been other correspondence that has looked at issues around the workplace environment and workplace culture, we fed that into that particular review. So we have been active in terms of ensuring that the correspondence that has come in has been looked at.

THE CHAIR: Okay, thank you, Dr Brown.

MR SMYTH: So do you—

MR HARGREAVES: Madam Chair, I have got a question on mental health. Can I have a go?

THE CHAIR: I have a question myself.

Ms Gallagher: Look, I mean—

THE CHAIR: Mr Hargreaves.

MR HARGREAVES: Okay.

Ms Gallagher: Just for the record, because I think the opposition are going to go out and mud-rake over this, as we expect, I have had all my three children at the Canberra Hospital. I had the same midwife deliver and assist with the delivery of two of my children, which I feel very lucky about. I do not feel that my fertility and my due date to deliver babies has impacted on my ability to respond to any concerns that have been raised and if the opposition have any evidence otherwise, I would suggest they come forward with it, Mr Hanson.

MR HANSON: I do not think that is the issue. I think the thinly-veiled threats and the attempt to muzzle doctors are the concern.

THE CHAIR: Mr Hanson!

Ms Gallagher: Just for the record—

THE CHAIR: Thank you, minister.

Ms Gallagher: I do not intend to have any more children; so any future potential conflicts of interest are eradicated—not that I believe they exist, anyway.

MR HARGREAVES: Are there any mental health questions?

THE CHAIR: Mr Hargreaves.

MR HARGREAVES: After you, Madam Chair.

THE CHAIR: I had a question. It was whether or not the ACT government monitored the number of deaths and injuries in the ACT that are attributable to the workplace and are related to mental illness. It might be harassment in the workplace. We are not talking about one particular workplace. We are talking about right across the ACT.

Ms Gallagher: It would be interesting to do a workplace culture survey here. I would like to deal with that now.

MR HARGREAVES: We could ask Bill Stefaniak and Greg Cornwell about that, couldn't we?

Ms Gallagher: Yes.

THE CHAIR: I am wondering whether there is somewhere that does collect that information or monitor whether those workplace incidents do lead to mental health issues or suicide.

Dr Brown: We have suicide data which is collected but I do not believe that we have other data relating specifically to mental health causes. Of course, there would be data available around any work-related deaths. It would be through Work Safety. But that is not data that ACT Health would specifically have for the whole of the ACT.

Ms Gallagher: Unless they died in the hospital. Data on a death in the hospital would be collected.

Dr Brown: Sorry, in the mental health in-patient unit. But you are talking more broadly?

Ms Gallagher: Yes, across the board.

Dr Brown: Across the board.

THE CHAIR: With the suicides, how many are we looking at each year that would be in that category?

Dr Brown: We have—and, again, I am stretching my memory here—I think it is in the order of 30 suicide deaths per annum in the ACT. It fluctuates somewhat.

THE CHAIR: And do you know how many of those may be related back to any sort of workplace incident?

Dr Brown: No, I do not.

THE CHAIR: So that information is not collected?

Ms Gallagher: You could probably go back and have a look at each of those individual cases.

Dr Brown: You would have to go to the coroners, to the inquest, to see whether there was any association with work-related factors, but we do not collate that information.

MR SMYTH: I would like to follow up on the question of suicide, if I can. Lifeline put out a press release after the budget and basically made the comparison that we are more interested in addressing the road toll than suicide. Both are important issues and are not to be trivialised. Is Lifeline right in their concerns that we do not do enough to address the incidence of suicide in the ACT?

Ms Gallagher: I think it is easy for a whole range of stakeholders to come and say we have not done enough in this budget. I think I have admitted several times that this budget is not going to be everything to everybody. You can always do more. However, I think our response to the community sector has been to shield them from the savings task that we have implemented across this year and indeed into the forward years. And where we have got extra money, we are putting extra money into the community service system. We have certainly not reduced our effort anywhere.

We have got two strategic plans that we released within the last year around suicide prevention and promotion and early intervention, which I think were widely supported by and heavily consulted on in the sector. So I would not agree that we are not doing enough. Any group can come and say we should do more.

Dr Brown: Suicide is a very complex event.

MR SMYTH: Is it possible to isolate in the budget the specific funding for the suicide prevention programs?

Dr Brown: Sorry?

Ms Gallagher: I am not sure how you would do that.

MR SMYTH: Is it possible to isolate the budget that has been apportioned to those two plans to assist in suicide prevention?

Dr Brown: Mr O'Donoghue might be able to speak to that. The suicide prevention strategy has a range of activities undertaken, some of which have been funded

previously, and that funding has continued.

MR SMYTH: Have all the actions been funded?

Dr Brown: Within that plan?

MR SMYTH: Yes.

Dr Brown: I think, historically, there has been funding allocated to many of them. There has been no new funding specifically allocated to the suicide prevention plan. For example, when you look at the funding going out into the community for supporting transition and out-of-hours care, you cannot say that does not support some element of suicide prevention.

Ms Gallagher: I am not sure how you could disaggregate it in a way that you could have an indication. I am open to it if you think there is a way to do it but I am not sure.

MR SMYTH: I am wondering whether the department can disaggregate it. You said you have funded many of them. Does that mean there are unfunded elements of the plan or are they just elements of the plan that are picked up even through general health funding or through the mental health services funding?

Dr Brown: We can take it on notice and provide you with information around the components of the suicide prevention strategy and what funding has been allocated.

THE CHAIR: We will note for the *Hansard* that that will be taken on notice.

MR SMYTH: So that we can have a comparison, if you are going to break that down, is it possible to break it down over a number of years so that we can see the trend in the funding?

Ms Gallagher: I do not know.

Dr Brown: I do not know that we would—

Ms Gallagher: I just do not know how you can do that. You would have to go into your mental health funding, your community services funding, some of your acute funding, and then work out how much. It would be very difficult.

MR SMYTH: Where it is possible?

Ms Gallagher: It would be very difficult. But we can see how we can be helpful in our answer, within reason

THE CHAIR: Ms Bresnan.

MS BRESNAN: My question was going to be the same as Mr Smyth's question. Have there been any specific allocations? I know there has been a review of the suicide prevention plan. I think there has been—

Dr Brown: Yes, we launched the new three-year plan.

MS BRESNAN: I was wondering whether there had been any specific funding. But I take your point that there are a lot of other funding areas that go towards that. Have there been any specific allocations for that plan or will there be any in the next budget?

THE CHAIR: Thank you. We might now adjourn the hearing for lunch.

Meeting adjourned from 12.28 to 2 pm.

THE CHAIR: Welcome back to this public hearing of the Select Committee on Estimates. We will start with output class 1.3, community health services.

MR SMYTH: Did we finish with mental health?

THE CHAIR: Yes. Ms Bresnan, would you like to start?

MS BRESNAN: The first thing I would like to ask some questions about is mentioned in BP4. It is about Corrections Health.

MR HARGREAVES: Corrections Health?

MS BRESNAN: Yes. There are a few questions under that that I would like to ask and I imagine other committee members will as well. First off, how is Health working with corrections and community groups to address the through-care and after-care issues, which includes difficulty in accessing GPs and community health care upon a prisoner's release from prison? And, I guess, what work is going on in the through-care and after-care area as well?

Dr Brown: I will ask Katrina Bracher, who is the General Manager of Community Health, to respond to that.

Ms Bracher: Can you please repeat the question?

MS BRESNAN: Yes. It was just how Health is working with corrections and community groups to address through-care and after-care issues. That includes accessing GPs and community health care once people are released from prison. Is there any other work that you are doing in that general area?

Ms Bracher: In terms of through-care, we are working at intake or induction to the program to establish who the treating team is for the particular person in the community, which includes understanding who the general practitioner is or if they are involved in any other services in the community—alcohol and drug services, mental health services, dental health program services. So we are talking about public services in the community. Once the person is inducted into the health service in the AMC, the person receives a care plan and care is provided according to that care plan from both Corrections Health and Mental Health, and the tertiary sector if that is required.

There are a lot of non-government agencies that also operate in the AMC. Ross O'Donoghue can speak to the non-government sector probably better than I can. But there is certainly a collegiate approach to working together with the non-government sector in the AMC to look at through-care, particularly for alcohol and drug program support. I think I will have to take on notice or ask somebody to answer in respect of the non-government sector with regard to the mental health services because I do not actually manage those services.

In terms of discharge or release from the AMC, we are in the process of establishing the electronic discharge form for our transfer of care back to the treating general practitioner in the community. But as you are probably aware, many of our detainees in the corrections facility do not have a regular GP. So while we can facilitate a structural arrangement like an electronic discharge, sometimes it means more of a personal connection, trying to connect people with GPs in the community. It is not a structural connection like the electronic discharge.

THE CHAIR: I will just also clarify for the *Hansard* that this will be taken on notice. Is that right? Did you take on notice the question on non-government organisations involved in drugs and alcohol? Did you take that question on notice or were you referring that to someone else?

Ms Bracher: Ross, come up—

MS BRESNAN: Sorry, I just want to clarify that too. You referred to access to GPs. I was not quite sure what you said—something about structural. Are you actually—

Ms Bracher: What we provide the detainee with is a discharge letter. If the detainee actually has a GP on induction into the AMC then the discharge letter goes directly back to the GP. We are in the process of making that electronic. If the person does not have a GP then we provide the detainee with a letter and information about their care that they were provided with in the AMC so that when they approach GPs in the community on their own behalf, they actually have an accurate picture of the care that was provided to them in the AMC.

MS BRESNAN: Is there any assistance provided specifically for people in the transitional cottages to actually assist them with that access to GPs? Obviously, if they do not have a GP—we know that in Canberra it is quite difficult for someone that has not been to a GP before to access one—and they are just being released from prison, there is an added difficulty there. Is there any assistance provided in terms of that?

Ms Bracher: Specifically, to the transitional cottages, the Corrections Health program provides medical services into the transitional cottages from both medical and nursing. Is that what you—

MS BRESNAN: Yes, but I said in terms of other prisoners who might be—they are not in the transitional cottages. I understand that assistance is provided there for them but I am referring to prisoners who might be released, because there are a lot of prisoners who are just direct-released as well—

Ms Bracher: Yes.

MS BRESNAN: This might be provided through the community groups, but I am referring to that assistance to actually access GPs and not, I guess, just giving them the letter and sending them out to do it themselves.

Ms Bracher: Yes.

Mr O'Donoghue: Corrective Services medical staff recently met with the executive of the division of general practice, who meet with the portfolio executive members. These issues around difficulty of accessing general practitioners were discussed. What was offered was access to the GP liaison officers, who are based at TCH and Calvary hospital. They maintain a good network of GPs and their availability as a referral point for the AMC medical staff to access GPs who may be willing to accept referrals from prisoners who are transiting from the AMC was discussed. That is one way of addressing the issue that you raised.

MS BRESNAN: Is that something which is happening now?

Mr O'Donoghue: Yes, that arrangement has been put in place. So AMC medical staff and nursing staff for that matter are urged to contact the GPLOs. They try to facilitate those referrals. There are some GP practices that, I guess, almost as a sort of pro bono aspect of their work, accept referrals from some of the non-government organisations such as Karralika and see their group of clients as a special arrangement.

MR HANSON: What is the cost of the GP program?

MS BRESNAN: Sorry, there were just a couple more questions I had on that.

THE CHAIR: And then we go to Mr Smyth.

MS BRESNAN: You mentioned mental health and you said that this might be something that you take on notice. In relation to the number of prisoners—because we know there is a fairly high number with mental health issues in the prison—

Ms Bracher: Yes.

MS BRESNAN: I am asking about the rate of follow-up that happens to them from Mental Health ACT?

Ms Bracher: I am sure Peter Norrie can answer that question. Dr Norrie could answer that question specifically, because Mental Health ACT does very carefully connect with the community through either the forensic team or the community health teams. Perhaps Peter can provide the detail.

MR HANSON: I have a supplementary around—

THE CHAIR: Mr Smyth, you had your hand up for a supplementary.

MS BRESNAN: I have one—

THE CHAIR: You have more, do you, Ms Bresnan?

MS BRESNAN: I just have one other question.

THE CHAIR: Yes, certainly.

MS BRESNAN: It was just about release packs that are given to prisoners.

Dr Norrie: In the 2008-09 year, there were 169 consumers seen in the prison. In the 2009-10 year so far there were 453 consumers. Our forensic community team actually tries to make contact with all of those consumers within a seven-day period following release from the Alexander Maconochie Centre. Our take-up rate for that at the moment is over 90 per cent. Then the consumers who need ongoing mental health care are linked into either the forensic team or, in fact, are being referred on to one of our other full community teams for active follow-up.

MS BRESNAN: How long has that seven-day follow-up been in place?

Dr Norrie: Since the opening of the Alexander Maconochie Centre we have moved to actually achieve that.

MS BRESNAN: And you said it was a 90 per cent—

Dr Norrie: It is a 90 per cent follow-up at the moment.

MS BRESNAN: And that 90 per cent, is that when direct contact has been made or when they have actually gone and seen the person?

Dr Norrie: Yes, it would be either. It is direct contact where possible and it would also cover initial phone calls and so forth where there may have been some difficulty accessing the individual. But it relates to where the actual contact has been successful.

MS BRESNAN: I know that is a fairly good rate, but with the 10 per cent, what is actually happening to that?

Dr Norrie: We pursue that wherever we can. There are some consumers who will not receive contact and do not want it but we will continue to pursue it wherever possible to actually work with those people.

MS BRESNAN: Thank you.

THE CHAIR: I am wondering—

MS BRESNAN: Sorry, I have one—

THE CHAIR: You have one more?

MR SMYTH: Do you promise?

MS BRESNAN: Then I will be quiet. You had quite a good say this morning; so

perhaps I can ask several questions. Just on release packs, we have had some concerns expressed to us by community groups that not all prisoners in the ACT were receiving the release packs with their medication when they were being released. I am just wondering if this is something you were aware of or—

Ms Bracher: The process for planned release is that the detainees or the remandees do receive their medications through the release area when that is planned. When the detainee might be going to court and then is released from court, we actually have a process in place where the medications go to the court with the custodial officers. If the person is released directly from court and then has no further access to Corrections Health staff, the custodial officers provide the detainee with, I am pretty sure, two days of medication.

MS BRESNAN: We have had concerns expressed to us by a couple of community groups that that was not always happening, that prisoners were not actually in all instances receiving their release packs. Has that been something which you were aware of or had heard about?

Ms Bracher: It certainly has not been flagged with me.

MS BRESNAN: Is it possible that it is something that you will be able to look into and just—

Dr Brown: It is certainly something that we would be happy to look into but it is not something that has been brought to our awareness.

MS BRESNAN: In relation to that, could you take this on notice about actually what percentage of prisoners are receiving those release packs and their medications when they are released?

Ms Bracher: Is that what percentage—

MS BRESNAN: What percentage is actually receiving their—

Ms Bracher: are on medications or—

MS BRESNAN: Receiving their release packs, yes.

Ms Bracher: of those receiving medications, do they all receive them—is that—

MS BRESNAN: Well, those that require release packs, yes. Are they receiving them?

Dr Brown: We may not be able to provide that within the time frame of the usual questions on notice. It may be that we actually need to do an audit if we do not have that information immediately to hand.

MS BRESNAN: Sure, even if you can let us know if an audit is going to be done, that would be good. Thank you.

THE CHAIR: I just want to go to the issue of prisoners and detainees contracting

blood-borne viruses while at AMC and how you collect that data. I understand people are tested on the way in but not tested on the way out. What program have you got in place to, I guess, oversight this particular issue?

Ms Bracher: The blood-borne virus screening is voluntary. It is consent driven, so people are offered blood-borne virus screening on intake or on induction, and they are offered it at release, for planned release, but our anecdotal information suggests that many people are more interested in finding out what their status is on induction than they are at release, so we get a higher consent rate on induction than at release. Then the process is for the pathology to be undertaken for people who consent, and any results are then individually fed back to the particular person. That is the screening program.

In terms of collating the data that relates to that, we have a quarterly process where we audit all of the clinical records for all of the detainees in the AMC at a particular point in time and at that point in time we establish the rates of the viruses that we test for.

THE CHAIR: Are you looking at ways, understanding that it is voluntary, that you might be able to encourage more to have a voluntary test, not just on the way in but on the way out?

Ms Bracher: It certainly is part of the primary healthcare relationship that the doctors and the nurses establish with the detainees through their stay in the AMC. There is a very active public health push for people to understand their blood-borne virus status and to have the appropriate treatment while in there if that is appropriate. So it is a one on one relationship really that tries to encourage more people to consent to screening and therefore access the care.

MR HANSON: Could you tell me what the cost is for a GP to visit the AMC or what you pay a GP if they pay a visit? Do they do it on a client to client basis or do they turn up for a day? How is that managed?

Ms Bracher: We have a clinical director, who is a staff specialist employed by ACT Health. His salary is part of the certified agreement salary and I do not know what that is.

MR HANSON: No, that is fine. It is more the sort of GPs that you get in from the community.

Ms Bracher: Yes, and the rest of the roster is established through a visiting medical officer roster. They all have contracts with ACT Health.

Ms Gallagher: And they are in the annual report.

Ms Bracher: Yes, they are in the annual reports. They have a roster arrangement where they cover—usually it is a session—and then they are also on call for the on-call roster.

MR HANSON: Do you know what the amount is that they are paid per session and how long a session is, or you do not have that information?

Ms Bracher: Not off the top of my head—but I can find it out and provide that by the end of the afternoon.

Dr Brown: It is an established and published rate. I do not know it off the top of my head, but we certainly can provide it.

MR HANSON: That is fine. I am sure it is available. And how much is the entire cost of corrections health? Has that been broken down? By the time you add the VMOs and all of the staff specialists, the director and so on, what is the cost of running corrections health?

Ms Bracher: The corrections health program is one of the programs within community health. I can provide you with the actual budget for that. Likewise, I do not have the dollar figure in my head as the budget.

MR HANSON: All right. Thank you.

MR HARGREAVES: Getting away from the prison for a while, I just thought I would give the delightful guests some light relief.

THE CHAIR: Mr Hargreaves, are we able to go to another question on the prison before we need to change the personnel at the table?

MR HARGREAVES: Yes, sure. I will ask a question on the prison if that is the way you are going to be. I thought we were here to do general community health.

THE CHAIR: We are, but I just thought while we had certain personnel up at the table it might be a good thing to run through some questions in this area. Mr Hargreaves, would you like to ask a question?

MR HARGREAVES: Absolutely, absolutely. I would like to know, if I can, please, at some point, what the patient numbers are that went through the dental suite at the AMC—not now, over the period of time—and also whether there are any specific women's health programs coming out of the health centre, at the health centre. If you have got something you can tell us now about that, that would be helpful. I am aware that the economy of scale is an issue with the female prisoners at the AMC, and I am aware that the nature of the remand classification versus sentence classification is also an issue.

With respect to those people who come into the AMC, regardless of gender, almost all of them have either a drug and alcohol issue or a mental health issue. Do you have access to the ACT's mental health medical records and alcohol and drug medical records when a person presents to the AMC, and under what authority do you have to get that?

Ms Bracher: Can I answer the second question first?

MR HARGREAVES: You can answer whichever one you like.

Ms Bracher: With regard to the access to clinical records, the mental health clinical record, the MHAGIC system, is available as a network system whether the person is in the AMC or not, or in the community.

MR HARGREAVES: Can I stop you there for a second. If a person presents to the AMC, would they have to do a health screen?

Ms Bracher: Yes.

MR HARGREAVES: When they do that health screen, do you automatically access or try to access any medical records within the ACT health system or do you just wait for the patient or client to actually tell you about it?

Ms Bracher: The health screen that we do on induction is a health screen. It is done within 24 hours of the person arriving, so it is an overview screen—it is not a full health assessment—to establish what services are required. It is undertaken by nursing staff in the first instance, with an escalation process to our medical staff, mental health or any other services that may be required—even into the tertiary healthcare system if that is required.

So our nurses ask the client whether they are a patient or a client of any of the community-based services—mental health, alcohol and drug. That is noted. And then the process for finding out what care the person received in the community, so that that can be continued in the AMC, starts. If the person was a client of Mental Health ACT, there is a referral specifically to Mental Health. At the moment, in fact, it is a dual induction assessment; the Mental Health staff are actually there on induction.

With regard to the alcohol and drug program, we have a formal system in place, but it is not reliant on, at this point in time, an electronic system for sharing clinical records. We have established funding through the policy unit, the living list, which is a list of all the people in the alcohol and drug programs, methadone replacement program, and their current prescriber, their current dosages, so that that information is then available into the corrections health program, at induction, so that that care can also be continued. Things like dental and less urgent care are then picked up over the next days and weeks of the person staying at the AMC.

MR HARGREAVES: One of the issues that we discussed, when I was on both sides of this fence, in fact, was the need for rehabilitation within the prison setting. I had in my mind cardiac rehabilitation, because I know there was one prisoner who had a cardiac episode and that was advancing the cause or the justification for a medical gymnasium—not a body-building gymnasium but a medical one. I wonder what arrangements are in place for people who may suffer a cardiac episode in the present. Once they are discharged from the hospital, are there any processes that can take place within the AMC setting, or do they need to go back to the hospital for their rehab there?

Ms Bracher: To date, we have not had a person that has had a cardiac event as a detainee within the AMC. Our plan, though, when—

MR HANSON: Sorry, so no-one has had a cardiac arrest in the AMC?

Ms Bracher: Nobody has to date.

MR HANSON: I thought the coronial inquest said that the death in custody was as a result of cardiac arrest.

Dr Brown: No, it was a result of an aortic dissection, which is a different matter.

MR HANSON: Fair enough then.

Dr Brown: The lining of the aorta splits.

MR HANSON: I will take your word for that.

MR HARGREAVES: You have got to have a heart to understand how it works.

MR SMYTH: I will explain it to you later then, John.

MR HARGREAVES: I have had my heart attack, and they took it out.

MR HANSON: It has got a heart. It is the mind that has gone missing.

Ms Bracher: Our plan, when and if such a cardiac arrest does occur, is that the person would receive care in the tertiary sector. If part of that care, after they are discharged from the coronary care unit or whichever ward they are in, is around cardiac rehabilitation in the gym, that would be organised for the detainee. But it would be as part of the community-based services that are already available to the community.

MR HARGREAVES: I am aware that there is a minimum six-week cardiac rehabilitation program. The patient needs that cardiac rehabilitation—there is no question about that—but it would be very resource intensive for the person to be brought at 7 o'clock in the morning from the AMC to the hospital to do it. When you talk about a community setting, what sort of process would that be?

Ms Bracher: The community setting I am talking about is the community outside of the AMC. So that might be actually on the Canberra Hospital campus as part of your cardiac rehabilitation six-week program that is there or follow on into the community after that program, if that is appropriate.

The dilemma that we have with regard to—and you have already touched on that—the economies of scale, establishing a cardiac rehab program within the walls of the AMC, is not necessarily going to be efficient, given the number of people that do not have cardiac arrests in the AMC; likewise, the skill set for the staff that would be required specifically to provide cardiac rehab. That is, while it might not be tertiary level inpatient care, it is certainly secondary level, more specialised care than we can provide in a primary healthcare model that we currently staff the health centre with.

MR HARGREAVES: Okay. Thank you.

MR SMYTH: I want to follow up on a couple of things Mr Hargreaves said. What

percentage of the inmates at the AMC have drug-related problems or are drug dependent?

Ms Bracher: About 60 per cent. At any one time, about 60 per cent of our detainees are receiving methadone.

MR SMYTH: And the other 40 per cent are?

Ms Bracher: Sorry, that is incorrect. It is about 60 detainees; so it is 30 per cent. Sorry, 60 detainees is the number that are on the methadone program, and there are currently about 200 detainees.

MR SMYTH: And what percentage have mental health issues?

Ms Bracher: Can I defer to Peter?

Ms Gallagher: I think Dr Norrie can give you the figures of the contacts that we are having. It changes.

MS BRESNAN: It is about three-quarters, I think, isn't it?

Ms Bracher: Yes. It is certainly higher than the alcohol and drug.

Dr Brown: It depends on how you define mental health issues.

MR SMYTH: What percentage would it be?

Ms Gallagher: Dr Norrie gave you the number of contacts that Mental Health ACT has with prisoners at the AMC just previously.

MR SMYTH: But the number of contacts is not necessarily the percentage of the inmates.

Dr Brown: It depends on what exactly you are talking about, whether you are talking about a diagnosed major mental illness, whether you are talking about an adjustment disorder, for example, which is not uncommon in circumstances where people are subjected to recent change and stress; that is, court proceedings and being detained.

MR SMYTH: We will call it diagnosed mental illness then.

Dr Brown: Dr Norrie does not have those figures. We can provide them.

MR SMYTH: Will you take that one on notice?

THE CHAIR: I note for the record, Mr Smyth, we are taking that question on notice.

MR SMYTH: I know the Corrections New South Wales website actually claim that a percentage of the people in their care have mental health problems. I was interested in what it was here. With regard to hep C—I know we had a small discussion about this a bit earlier—do we know what percentage have hep C when they enter the

system?

Ms Bracher: I can provide the figures on it as at the end of March.

Dr Brown: Of the detainees tested?

Ms Bracher: Yes.

Ms Gallagher: This is through the voluntary screening?

MR SMYTH: No, that is—

Dr Brown: Sixty-five per cent in the last—

MR HARGREAVES: Can I follow up on that?

Ms Gallagher: Sixty-five per cent in the last survey, of those who were screened. Of the 82 detainees screened, 65 per cent had hepatitis.

MR SMYTH: What percentage is that—it is about 40 per cent?

MR HANSON: Fifty-nine males, 71 females.

MR SESELJA: That is 65 per cent of the 82.

MR SMYTH: No, 65 per cent of the 82, but the 82 represents 40 per cent of the total population?

MR HARGREAVES: Less, actually; about 30 per cent.

Ms Gallagher: Of that, 64 per cent were males and 36 per cent were females.

MR SMYTH: What liability attaches to the government if somebody contracts hep C in the AMC?

Ms Gallagher: That remains to be tested.

MR SMYTH: Is there any testing of that underway at the moment?

Ms Gallagher: The fourth survey has been completed, and we have done a quarterly survey. Through that fourth-quarter result to the end of March this year, it appears that one detainee has evidence of the transmission of hepatitis C whilst at AMC. But this is our first case where there is evidence to support transmission of hepatitis C while in the AMC.

MS BRESNAN: What date was that, sorry?

Ms Gallagher: That is to the end of March.

MR HARGREAVES: One of the things that were going to be important about the

AMC regimes was that all prisoners were coming from New South Wales. The percentage of people who had contracted hep C was significantly high, particularly around the culture that has existed in the New South Wales prison system. One of the hopes was that the incidence of blood-borne disease would shrink if, in fact, the experience of the prison culture in New South Wales was not repeated in the ACT.

I would be interested to see 12 months down the track whether or not there has been a reduction in people actually having that condition as they go into the prison. I understood it to be the aim that, if we could prevent people going into the prison with the condition, sooner or later we could reduce the incidence down to just a couple rather than the wholesale thing which we inherited when the people came from New South Wales. Is there any evidence that you can point to that there has been a shrinkage in this, or would you not know yet?

Dr Brown: We have had three quarterly reports. We actually have not had the 12-month report. We are doing quarterly reviews; so we should be able to provide that after the next quarterly report.

MR HARGREAVES: What are the indications on those three quarters?

Dr Brown: I do not—

Ms Bracher: Sorry, what was the—

Dr Brown: The trend over those three quarterly reports in terms of the blood-borne viruses. It has remained stable.

Ms Bracher: It is fairly stable.

Ms Gallagher: I think the important thing, though, that what we have been able to do, which we have never been able to do, is link those prisoners into the liver clinic at Canberra Hospital. The senior nurse from the liver clinic works some of her week out at the AMC and we have been able to offer those people treatment, if they choose to have treatment. Indeed, some of them have. We have not had very good success in curing hepatitis C.

The issue in the past has been that we have not been able to offer them that service. Whilst we could have started it while they were in Belconnen remand, they may have been sent to Goulburn or wherever and their treatment could not continue. They were not eligible for and they did not receive that treatment in New South Wales.

I think there are some really good success stories in corrections health. The dental program is one of them, where we have a dentist really clearing a backlog of long-overdue dental work that is required for prisoners. Again, when I spoke to the Medical Director, Corrections Health, he talked about a reduction in the need for pain relief, long-term pain relief, because people were having their teeth fixed after years of inaction when they were not under the control of our health system.

I think the liver clinic and the opportunities to offer long-lasting treatment through that program are a real benefit to those prisoners, not only while they were in the jail

but also on their release.

MR HANSON: As a supplementary on hep C, is the one case that you refer to the case where someone was released during the period of the testing—so there is some ambiguity about where they contracted it—or is this a separate, different case?

Mr Thompson: This is a different case.

Ms Gallagher: But again, because there is one case, I do not think we can go any further than that in speculating around that incident, because it will be disclosing, I think—

MR HANSON: That is fine. I was wanting to find out—

Ms Gallagher:—what is potentially private information.

MR SMYTH: But you did make a comment, minister, on the one yet to be tested. Has this person started?

Ms Gallagher: I do not know whether formal legal proceedings have started. I have heard that there is a view that, if there was a needle and syringe exchange program, this may not have occurred. I do not know whether that is going to eventuate into legal action. I cannot tell you.

MR SMYTH: Is the department aware whether somebody is taking legal action?

Dr Brown: No. We have been advised that he may but, to the best of my knowledge, there have been no actual, formal proceedings initiated at this point in time.

MR HANSON: Do you think there should be a needle exchange program there, minister, to prevent this sort of thing?

Ms Gallagher: No. That is what has been put to me about this individual's case.

MR HANSON: What is your view on that?

Ms Gallagher: From a health point of view, it is a no-brainer; you have a needle and syringe program in the jail as soon as you can. From a corrections staff point of view—I have said this in these forums a number of times—it is more complex than that. Corrections staff have mixed and strongly held views around the commencement of a needle and syringe program. It would be a brave new step. We would be the first jail in the country to head this way—not the first jail in the world but the first jail in the country.

But I have to say that, from a health point of view, I do not think you would find anyone interested in public health who would oppose it. But it is always more complicated than that. The review that we are doing into that is due to report at the end of December, which is using information that we have collected through our own data but some independent experts as well; plus we have a broad section of the Department of Justice and Community Safety and Health on that reference group that

is leading that work.

MR SMYTH: Has ACT Health had any issues with access or service provision in the prison?

Ms Gallagher: In terms of cooperation between—

MR SMYTH: Either in terms of cooperation or straight up access? Can you always get in to deliver your programs?

Dr Brown: There are times when there are issues with the lockdown of the facility and our staff need the corrections staff to bring prisoners up to the clinic. That is not always available.

MR HANSON: How often is that happening?

Dr Brown: I do not have the detail on how often. It has occurred.

Ms Bracher: We actually have a very good relationship with the custodial staff there. More often than not, the custodial staff are very readily available. Corrections ACT provides a custodial officer to be in the health centre at the time when clinics are underway, whether they be mental health or the liver clinic or whatever, and they provide custodial officers to be part of our medication rounds when we take the medications out to the residential areas in the AMC. I cannot think of the word but they bring the detainees up to the health centre.

MR SMYTH: Escort.

Ms Bracher: “Escort”, that is it. I better be careful how I word that. They provide an escort service.

MR HARGREAVES: It is an agency, though—an escort agency.

Ms Bracher: They escort the detainees up to the health centre when there are booked appointments.

MR SMYTH: “Escort” is the correct word. Could you take on notice how often the lockdowns have affected the delivery of service?

Dr Brown: I do not believe we would have that data.

MR SMYTH: Could we check?

MR HANSON: It seems that DIRECTIONS ACT did not get into the AMC because of lockdowns. Is that a Corrections Health program, for example, or is it corrections?

Dr Brown: That is a non-government agency—DIRECTIONS ACT.

MR HANSON: Indeed, but I assume that it was supporting a program in the AMC being run by either corrections or Corrections Health. I am just wondering whether it

was corrections or Corrections Health.

Dr Brown: Corrections.

Ms Bracher: As to the feedback that I get from the Corrections Health staff that I manage, in the last year I cannot remember a time when they have not been able to get in to provide their services due to lockdown. There have been occasions when they have not been able to get out.

MR HARGREAVES: Just one last question on that particular one. I am curious about the model. If my memory serves me correctly, it is the first time we have had an independent health centre set up within a corrections institution. Most of them are embedded into the process right around the country. I am wondering how, from a health professional perspective, you feel the efficacy of that particular model is working and whether you think it would be better that way or this way—how you feel it is going.

Ms Bracher: We believe very strongly that the separation of the two services is beneficial to the health care of the detainees both in terms of providing primary health care and in terms of access to tertiary level care.

MR HARGREAVES: So the vision of the current health minister was spot on the money then. A simple “yes” will do.

Ms Bracher: Of course.

MR HARGREAVES: I know it is. I am just telling everybody else.

Ms Gallagher: I have visited the AMC and have spent a bit of time there talking with Corrections Health staff. I think the decision we took around ensuring that the health programs were under the control of the health system and not under the control of corrections has certainly had some pretty tangible outcomes in terms of the willingness of prisoners to share information with their health provider. It is very clear that the information will not be handed on to corrections necessarily—that a person’s health record is their private health record. There are instances where information may be shared for particular reasons. I think it helps enormously when people are willing to engage in education or potential treatment or support while they are in the AMC. I think it is something that is already showing positive signs.

When you talk to Dr Levy, who has worked extensively in prisons around Australia, he speaks very highly of the services being offered at the AMC—extremely highly. For example, if you come in and you need methadone, at the AMC you can get onto the methadone program within a day of your intake. That would never happen in one of the New South Wales jails. You go into a queue for that program and maybe you will get it, which can have a serious impact on people’s health. There are some really good, positive health outcomes that will come from having our own jail and having our own control of the health system.

MR HANSON: What is the impact on someone’s health if they are not receiving methadone, minister?

Ms Gallagher: I think they can have some significant health impacts from withdrawing from a drug that they are dependent on. If they want to get on methadone it is very important that we get them onto methadone quickly. No-one is forced to go onto methadone.

MR SMYTH: How quickly does a non-AMC resident get onto the methadone program delivered by ACT Health?

Ms Bracher: If they refer themselves or they are referred?

MR SMYTH: Yes.

Ms Bracher: Those clients are seen within 24 to 48 hours. They are actually inducted onto the program if it is clinically appropriate.

Ms Gallagher: In fact, the nurse who runs the opioid treatment service at the Canberra Hospital won nurse of the year last week for the excellent work that she does, and that team.

MR HARGREAVES: And her name was, minister?

Ms Gallagher: Amy Faden.

MR HARGREAVES: Let the record show this committee congratulates Amy Faden.

THE CHAIR: Thank you. I would like to move on. I am just hoping it is in this area, minister. I want to know about the status of the gender disaggregated data trial and where that is up to.

Ms Gallagher: It is not under community health. It will be under Megan or Ross, I imagine.

MR HARGREAVES: Moving right along, then.

MR HANSON: We will have to wait till then, won't we? That is the way it works, Madam Chair.

MR HARGREAVES: Don't let a chance go by. Can I ask a community health question while we are waiting?

THE CHAIR: We do not have detail on that—

Ms Gallagher: I do not know whether we have the officer responsible for the women's health plan here, which is where it is happening. If you do have a question, Ms Hunter, I will aim to assist you.

THE CHAIR: It was really where that trial was up to. I am not sure if you need to take it on notice. It was just getting some more detail on what was happening with the trial and when it was planned to be completed.

Ms Gallagher: We will find that out this afternoon.

THE CHAIR: And also about being able to run that out across government.

Ms Gallagher: We will get that for you this afternoon.

THE CHAIR: Referring to page 220 of budget paper 4, I want to talk about the health of people of Aboriginal and Torres Strait Islander background. The local elected body has raised concerns about the lack of data for Aboriginal and Torres Strait Islander people. That came out in their first report that was tabled in the Assembly recently. On page 220 of budget paper 4 there is a strategic indicator around life expectancy. There is also strategic indicator 20, which is around the prevalence of diabetes.

The life expectancy one is broken down into gender—not the other one—but it does not seem to be telling us anything about the life expectancy of Aboriginal and Torres Strait Islander people. We are not being told about the incidence of diabetes in this population, even though we know that life expectancy is far lower and that the incidence of diabetes is, unfortunately, alarmingly high. I was just wondering whether ACT Health is considering collecting this data, or whether we collect it somewhere else. It is just not in this indicator.

Mr O'Donoghue: I guess we have got a problem with data ascertainment and also a problem with small numbers in the ACT. Historically, there has been difficulty in collecting accurate data on Aboriginal and Torres Strait Islander people. There are a number of projects currently underway that are trying to improve the data ascertainment, one of which involves using the pathology request forms that are used to include a field for Aboriginality, which we think will have a positive effect. That was proposed as a national approach some years ago, but the ACT has basically forged ahead with that ahead of other jurisdictions.

Another process that we have underway is a training program that uses the ABS standard questions so that reception and clinical staff in particular are encouraged to ask all clients if they identify as an Aboriginal or Torres Strait Islander person. It is known that trying to guess who might or might not be an Aboriginal or Torres Strait Islander person is not a reliable way of gaining information. Although we obviously need to support our staff in what may sometimes seem an awkward or a confrontational question, we think it is important that that question be asked in order to improve data ascertainment.

Having said all of that, when there is in the ACT population, say, 3,000 or perhaps 5,000 Aboriginal people and that with a disease like diabetes it is known that for every person who has been diagnosed there is another person who remains undiagnosed, having the statistical significance that would be required to make a difference in Aboriginal data will always be challenging for us.

The same could be said for life expectancy. As to some of the things that we will be asked to report on as national indicators, the ACT and other small territories have consistently indicated to the commonwealth, for example, that we will always struggle

in some of these fields of data simply because of the significant statistical issues that we are confronted with with small numbers.

MR HARGREAVES: Just on that, does the Institute of Health and Welfare not do work on morbidity around Indigenous people state by state?

Mr O'Donoghue: They do, but they face the same statistical barriers in a small jurisdiction as the ACT does.

MR HARGREAVES: Do they have publications which would give indications of the sort of thing that we are talking about here—prevalence of diabetes by state? I do not know.

Mr O'Donoghue: Historically, they put caveats on the data reported in jurisdictions like the ACT because of the significance problem.

MR HARGREAVES: We will check that. Thank you.

MS BRESNAN: When you look at it at a national level, we have statistically small numbers—this is the answer we consistently get about that—nevertheless, it is important to collect the data. I appreciate it is a difficult question to ask and it can be confrontational sometimes for people. In many areas Aboriginal and Torres Strait Islander people are overrepresented. I guess we are using a statistical reason and I appreciate that is an issue, but it still has to be addressed as an issue because in a lot of areas—

Mr O'Donoghue: I agree; you are right. I think we know enough about the disparate rates of diseases like diabetes in disadvantaged communities to put programs in place to respond to that. I thought the question was more specifically about reporting the data around the prevalence and incidence of those diseases by Aboriginal and Torres Strait Islanders. That is where we have difficulty.

MS BRESNAN: Yes. I know it is, but—

Mr O'Donoghue: The evidence from the literature would suggest that there is a real problem in those communities and we should be putting programs in place to address it.

MS BRESNAN: That was the question, I guess. Often we hear that the reason is that, statistically, they are small numbers, but we do know that in a lot of areas—health in particular—Indigenous people are overrepresented in the ACT.

Mr O'Donoghue: Absolutely.

MS BRESNAN: It still has to be addressed as a key issue.

Mr O'Donoghue: You are absolutely right.

MR HANSON: Could I ask a question on—

THE CHAIR: Could I just follow on from that before I get to you, Mr Hanson? On page 228, under the accountability indicators, there are not any ATSI-related indicators. Is that why—because of the small statistical sample or the small size? I am just wondering why we do not have indicators there.

Mr O'Donoghue: It is an endemic problem in any reporting field involving Aboriginal and Torres Strait Islander people in this community. We are always going to struggle against that statistical power problem.

MS BRESNAN: ABS data is collected, though, for the ACT in terms of the ATSI population, isn't it?

Mr O'Donoghue: Yes, but I think that I am right in saying, and my epidemiology colleagues might correct me, that many of these reports are qualified in the context of the ACT—and the territory even, but especially in the ACT, because of this significance problem. So even while there is a laudable attempt to report all this data nationally, it is simply not possible to accurately quantify these data in the ACT. And it is then further exacerbated because small shifts in numbers would mean large shifts in percentages, so it is very difficult to interpret.

Mr Thompson: Yes. I will just add to that. Generally speaking, the national reports, where they make statements about ACT numbers, are extrapolations of national figures applied to the ACT general population rather than specific research and/or survey results for the ACT, because of the small numbers. Just to put it in perspective, as Ross was saying earlier, we are talking about up to 5,000 people in the ACT. Trying to get a sample that would be meaningful on that would involve trying to survey a very large proportion of the Aboriginal community.

MR HANSON: The Aboriginal and Torres Strait Islander drug and alcohol rehabilitation facility, the bush healing farm, I understand has been delayed by over a year. Is that correct?

Ms Gallagher: A year? It may be up to a year. We have taken a bit longer than expected to finalise and consult over the model of care for the bush healing farm. That has reached a point now where it has had approval from the Aboriginal and Torres Strait Islander advisory board that we established to govern this—and the project control group involved. So now it is really moving to the next stage. You cannot design a facility until you get your model of care agreed to. We have now got to that stage and we can now move to the design of the facility.

MR HANSON: That is the only cause for the delay?

Ms Gallagher: It has just taken longer than expected to agree on a model of care.

Mr O'Donoghue: We have also been doing some site-specific studies relating to the preferred location for the service, environmental impacts on flora and fauna and looking at water access, so various other site survey type work in parallel to the model of care. But the model of care has been quite an extensive piece of work, and that has only just been completed—

MR HANSON: And that environmental work that you have done still validates the position that you have taken to put it in that location?

Mr O'Donoghue: Yes. It is essentially looking at any possible negative impacts on endangered species or things like that. Nothing to date has come to light that causes us any undue concern.

MR HANSON: And access to water and things like that are okay?

Mr O'Donoghue: Yes.

MR SMYTH: And the treatment of, for instance, sewage from the site will not affect the local watertable or watercourses?

Mr O'Donoghue: No. All those matters of environmental sustainability will need to be taken into account in the design. We are very mindful of that, but we are not quite at that phase yet. As the minister indicated, we will move now from the model of care to the design phase; then that detailed design will form the basis of the approval process documentation that we will be putting forward.

MR SESELJA: What is the model of care that has been resolved?

Mr O'Donoghue: Sorry?

MR SESELJA: What is the model of care that has been agreed to?

Mr O'Donoghue: It is not dissimilar to—when the project feasibility study was done back in 2004, there was an initial model of care scoping document done. This is really another iteration of that, again looking at learning since that time and other services that the advisory board and the experts have visited. It sets out a set of principles and protocols around how the actual services are being delivered. It begins to sort of articulate things like the kind of program that would be run, the number of staff that might be required, and the sorts of facilities that might be needed in terms of recreation or teaching rooms and the like. And then, essentially, that enables the architects and the designers to sit down and start physically designing the building itself, the facility itself.

MR SMYTH: So the project is on schedule for opening in September 2012?

Mr O'Donoghue: I would be confident in saying that. Obviously, we still have to go through the design and approval process before we can meet those deadlines.

MR SMYTH: Is a territory plan variation required to put the facility out there?

Mr O'Donoghue: That is not our present understanding.

MR SMYTH: The current year's budget papers said that the facility was to be opened in June 2011, so it is a 15-month delay. Yet the budget for the project is exactly the same. Does that mean that something will be cut from the project?

Mr O'Donoghue: The phasing of the budget has been set back, as you would notice in the papers.

MR SMYTH: Yes.

Mr O'Donoghue: But once the detailed design work has been completed, we will need to look back at the costing of the project. Clearly, there has been a period of time since the original scoping of the budget. No doubt building costs have moved on; and now we are looking at a site-specific facility, and we did not have that information before. There may be unforeseen costs related to the particular site. We will need to have another look at the budget when we have got a detailed design.

MR SMYTH: Will that lead to a cutback in facilities or will you be seeking supplementation to cover the costs?

Mr O'Donoghue: I cannot speculate until we see the actual costing of the design.

MR SMYTH: All right. The figure is \$5,883,000. That has not shifted in the 12 months since it was put into this year's budget. Building costs have not stood still.

Ms Gallagher: I think it really relates to the fact that until the detailed design is done, if there is going to be extra appropriation required, that detail needs to be resolved before it can come back to government if further appropriation is required. I certainly would not rule out further appropriation if it is necessary. We are committed to this project. We do not want to cut back just because it has taken a year longer to develop. And the fact that we have taken a year longer to develop really has been to get agreement with the Aboriginal and Torres Strait Islander community about what type of service they would like. It is just that I cannot go and ask for a blank cheque either. I need the work to be done in order to inform the decision.

MR SMYTH: But that might prompt the question of why the work was not done before you actually went ahead with nominating a figure in this year's budget.

Ms Gallagher: You can always have the benefit of hindsight. We believed the work was done to get it to inform the budget. We were not going to do it without the sign-off of the Aboriginal and Torres Strait Islander advisory board. I have been to one of their meetings, and I know there have been many meetings held in finalising and getting them to agree or sign off on the model of care. It has taken longer than expected. The only alternative was to ignore what they were saying and press along with what we had scoped in the original budget.

MRS DUNNE: On the subject of the property, Miowera—is it occupied or managed in any way at the moment?

Mr O'Donoghue: Yes. We employ a resident caretaker, who was actually resident on the property when we acquired it. He was the caretaker for the previous owner. He has remained in situ for the entire period of time.

MRS DUNNE: So the property is being managed according to its property management agreement?

Mr O'Donoghue: Absolutely. In fact, we have done extensive improvements to the property in line with the land management agreement, including comprehensive refencing of the property, obligatory weed spraying and all the other things that you would expect. But yes, there is a resident caretaker on the property.

MR SESELJA: What has been the total cost of managing that property to date since purchase?

Mr O'Donoghue: I do not have those figures in front of me, Mr Seselja. I could take that on notice.

MR SESELJA: Thank you.

Ms Gallagher: It is an asset of the territory, though.

MR SESELJA: Sorry?

Ms Gallagher: It is an asset of the territory, so it is not just a cost. We actually have something for the money we spent on it.

MR SESELJA: But it is in terms of the delay. Given that it is a territory asset, that money is still funded from the money in the appropriation for the bush healing farm rather than from another part of TAMS or something, is it?

Mr O'Donoghue: That is correct; it comes from the appropriation. It was an obligation of the land management agreement that we maintain the property in terms of the required fencing, weed control and feral animal control, and they are the costs that we have incurred.

MR SESELJA: When you take that on notice, or when you come back, perhaps you could provide a bit of a breakdown of the costs—not just a total, please.

Mr O'Donoghue: Sure.

MRS DUNNE: Are there any cattle or stock agisted on it at the moment?

Mr O'Donoghue: Yes. We have entered into an agistment agreement with one of the neighbouring landholders. That is also consistent with the terms of the land management agreement.

MRS DUNNE: Good.

THE CHAIR: Who will be managing the bush healing farm at the end of the day? How will that work?

Mr O'Donoghue: The proposal is that, as the budget holder, the ACT government, through ACT Health, will manage the service in its initial iteration. Over time, the proposal is to transition, hopefully, towards a community-based management structure. But it has been acknowledged by the advisory board and by government that that

needs careful planning and stewardship. We are not rushing to that end point, but that is the working model. Over time, most of these therapeutic community type services are operated in the non-government sector historically; it is unusual to have a government-offered service. But given the sensitivity around this particular service, we thought that was the correct way to transition, if we can, towards a community management model.

Ms Gallagher: That was, perhaps, one of the lengthy discussions that was held with the advisory committee. Certainly, my long-term hope is that we can establish a governance of this facility by Aboriginal and Torres Strait Islander people for themselves. But because of the complex relationships in our rather small population here—the most established Indigenous health service is Winnunga, and there were different views in the community about whether they were the appropriate service. In the first instance, as I said, we will manage it, but with a very strong involvement of the local Indigenous community as part of that. I hope to be able to establish something very genuine in terms of not just an advisory capacity—having them very much involved in the management of it, but with some safeguards, and then moving towards being managed by an Indigenous service for themselves.

THE CHAIR: I have got a final question around Aboriginal and Torres Strait Islander health. Then we can go to any remainder questions and then move on to other areas. Mine was around this. Just recently at Winnunga Nimmityjah there was a ceremony or a celebration around signing on to closing the gap. The Chief Minister signed on. I am wondering what that means for the ACT. How will we see that reflected in budgets or in delivery?

Mr O'Donoghue: That is, in a sense, a parallel process going on. There is the statement of intent that the ACT has just signed, which had its precursor some years ago now when the Prime Minister signed the original statement of intent document. That was followed by the Prime Minister initiating the bridging the gap national partnership agreement. The ACT's commitment to bridging the gap is really through that national partnership agreement. That is where the ACT has committed some \$15 million over five years—I think the agreement is—on a range of measures to address the disparity in life expectancy and health outcomes for Aboriginal and Torres Strait Islander people. In a sense, one process is a community-driven one—the statement of intent sort of process. Then government came in behind that federally, and through states and territories, to support it with the national partnership agreement process.

THE CHAIR: Thank you. Are there any more questions on that area? Mr Smyth.

MR SMYTH: Given that the majority of members of the committee are from Brindabella, I was wondering whether we could find out a little more about the Tuggeranong Health Centre stage 2.

MR HARGREAVES: That was my question, Brendan.

MR SMYTH: John, you have got to be fast. I notice on page 157, budget paper 3, it says “services which may be relocated”. When will we know what services will be relocated to Tuggeranong?

Ms Gallagher: Part of that will be consultation with stakeholders about those services. The Tuggeranong Health Centre originally in our thinking was—and that is why it is stage 1 and stage 2—under stage 1, correct me if I am wrong, \$5 million. Megan, was it \$5 million for an upgrade of the facility?

Ms Cahill: Yes.

Ms Gallagher: When we were doing that work, it became clear that there were opportunities to relocate other services there if we invested more into that redevelopment. So this allows an extra \$14 million to progress that work. Some of the areas are renal and potentially a walk-in centre. As I said yesterday, that would be perhaps more controversial than the walk-in centre which, can I say, is open and doing very well and has seen a number of patients, 17 patients today, and we have had—sorry, Mrs Dunne, I did not hear that.

MRS DUNNE: Nothing.

Ms Gallagher: I did not hear that rather rude snipe from the corner. You should be celebrating a new way of doing things.

MS BRESNAN: One of my staff is going there today.

MR SMYTH: If you did not hear it, how did you know it was a rude snipe?

MRS DUNNE: How do you know it was a rude snipe if you did not hear it?

Ms Gallagher: It came from Mrs Dunne; so I took a punt.

MR SESELJA: You are into the personal attacks today, aren't you, Katy? Fair dinkum!

Ms Gallagher: Saint Seselja is sitting there.

MR SESELJA: Chair, why don't you take a bit of time and call the minister to order? Call the minister to order and ask her to answer questions.

MRS DUNNE: That is completely out of order.

Ms Gallagher: Sorry—

THE CHAIR: Can we get back to the—

Ms Gallagher: Sorry, I do apologise if I have offended Mrs Dunne. It is most unlike her to be ungracious in her comments. I will be fair about it.

MR HANSON: Madam Chair, I think you need to take control of the minister here. We have not abused the minister personally once, and she has made personal attacks on each of us.

THE CHAIR: Mr Hanson, thank you very much. I have heard the interchange. Minister, could you please answer the question that Mr Smyth has put to you and could you answer that question directly. I believe Mr Smyth was asking about a health centre in Tuggeranong.

MR SESELJA: Nothing like bringing Katy to order!

Ms Cahill: The additional services that we are planning to provide at the Tuggeranong Health Centre are renal dialysis, antenatal care. We would also like to provide a range of specialty clinics that are currently provided in the hospital settings, including aged care and rehabilitation, mental health and child health.

In terms of some of the specifics around the outpatient clinics, that is a matter still for some ongoing negotiation with staff at the hospitals in terms of deciding which services we can actually provide in a safe way in a community health centre. But we are reasonably confident that we can move a significant number of outpatient clinics off our hospital campus.

MR SMYTH: Are you saying that the decision has now been made that it will be renal, antenatal, aged care, mental and child?

Ms Cahill: That is certainly the range of services at this point in time that we will be offering in that health centre. There is a possibility of providing some additional, what I would call, more specialist-type outpatient clinics. Orthopaedics clinics might be one such example. If it is possible to be provided on a non-hospital campus setting, I think the community health centres are well placed to deliver those services.

MR SMYTH: If the decision has not been made on what services will be offered, how do you know how large the budget has to be? Are we just fitting what services we can within the \$14 million and the \$14 million is a cap, or have we determined what each of the services is worth, they have been factored in and that equals \$14 million?

Ms Cahill: What we have done is certainly look at a range of services that we already have agreement, with the staff that currently provide them, that they can be provided in a community health centre. Renal dialysis is one example of that. We have also done a desktop exercise looking at what services we believe can be provided or can be shifted from a hospital setting into a community-based setting. Those negotiations are still going on with those staff in terms of which ones can be shifted. But we have made an assumption that approximately 80 per cent of those services can be provided. We have looked at the projected activity for those services, and, on that basis, calculated how many clinics we would need to provide over a year and, on that basis, then calculated back to the number of consult rooms that we would need to provide in the health centre.

MR SMYTH: I am not sure whether you can answer this. Somebody who likes the numbers might like to come forward. There are two projects on page 157 of budget paper 3. The depreciation rate on the healthcare centres looks to be about 2.5 per cent per annum when it is all built; yet the clinical services redevelopment seems to have a four per cent depreciation. Is there a reason for the difference?

Ms Cahill : I am not able to answer that question. I do not know whether Mr Foster can.

Mr Foster: Which projects were you thinking of in particular?

MR SMYTH: They are on page 147, the clinical services redevelopment; the depreciation that kicks in at the completion of the program is about \$600,000 against the \$15 million, which is about four per cent; whereas when Tuggeranong is completed, at \$14 million, the full year depreciation in the first year after is only \$350,000, which is about 2½ per cent. Is there a reason?

Mr Foster: When you look at depreciating facilities, you take a longer time to depreciate a physical building like a health centre, for example, as opposed to some of the costs around the clinical services redevelopment. There are more ancillary costs around capital works. You might have to depreciate those more quickly, because you will be replacing them again more quickly, for instance. Refurbishments, for example, happen more quickly than a construction.

MR SMYTH: Is the clinical services redevelopment more internal work; it is machines and furniture?

Mr Foster: Yes. It is not going to be a large building, necessarily. It is works associated with construction of major facilities rather than the buildings themselves. I can take on notice and provide tomorrow morning the actual way we calculated those things. But generally, you have to recognise that, for IT, it is five years through to 10; for some construction works, 20 years through to 70 years, depending on the facility or the type of work.

MR SMYTH: If we go to the third project on that page, the capital asset development plan change management and communication support, what are you depreciating there?

Mr Foster: We are assigning the costs of implementing change management across the—I think there are two projects in particular there—the car parking and women's and children's hospital. Recognising the timing of when those projects are complete invokes different percentages, different amounts of money for depreciation. Again, we can provide you the detail on those calculations tomorrow as well. But the change management is, from our point of view, as significant as having fees or design work where we can attribute those costs to construction as well as facilities.

MR SMYTH: But you are not delivering a physical thing there, are you?

Mr Foster: No, but we are able to attribute the costs associated with implementing that change against the capital works project, the same way that fees and design are. Change management is—

MR SMYTH: I will be intrigued to see the numbers.

MRS DUNNE: Mr Foster, with these figures for change management, what is it that

the ACT taxpayer is getting for \$1.7 million and \$2.3 million?

Mr Foster: I will pass that answer up.

MR SMYTH: And the communication program in that, what does that involve? Is that telling people what is happening?

Ms Gallagher: Yes.

Dr Brown: Or is it signage?

Ms Gallagher: Yes, both.

Ms Cahill: In terms of the change management budget, we have incorporated a range of initiatives in that. A number are project officers. As you would appreciate, we are trying to achieve this change whilst staff are carrying on business as usual; so it is to put some project officer resources into clinical areas to assist them to develop things like new models of care, to assist them when they actually come to operationalising these new models of care, to help them to develop new standard operating procedures and things like that. It will be to provide some specialist internal expertise in terms of change management.

I do not think we should underestimate the significant changes that we are going to be making to the way that we deliver care, and that is going to be quite different to how we are doing things today, for example, introducing new workforce roles. We have got a well-planned change management process in place to accompany that change.

In addition, another component of that funding is for communication. That specifically will be targeted at not only staff, so that they are well aware of what is going on, but also the broader community. We think this offers us an opportunity to engage with the community, to get them involved, to get their ideas on how they would like health services to be delivered in the future. This will give us some capacity to hold forums and, I guess, implement strategies like that.

MR SMYTH: But it must be very hard to depreciate a forum. That is not a physical outcome that deteriorates over time.

MRS DUNNE: Or a standard operating procedure.

Ms Gallagher: I think Mr Foster said he will get you back the details on the depreciation.

MR SMYTH: The depreciation rate on that is actually 4.3 per cent, which means we are depreciating at a higher rate than we are buildings—

MRS DUNNE: I am sorry, minister; I was wondering if you could—

THE CHAIR: Could I just go to Mr Hargreaves, because he has been waiting for some time.

MRS DUNNE: Sorry; I just want to follow up on this particular matter.

MR HARGREAVES: I am a member of the committee, Mrs Dunne, and when you become a member of the committee you can get priority. Madam Chair, thank you for the call. I would like—

MRS DUNNE: Sorry, Madam Chair. I thought I had the call.

MR HARGREAVES: I would like to ask the minister and officials about the Tuggeranong health centre. I have not seen a floor plan, so please forgive me about that, but I am interested to know about two things, and they will not take very long to respond to. Firstly, I would assume that with the extent of this redevelopment you are going to be increasing the footprint of that building that is sitting on the corner of Pitman and Anketell Street. So to what extent will that footprint be increased, and will you be going out, up or both?

Ms Cahill: The plan at this point in time—and we have had discussions with other ACT government agencies, including ACTPLA, TAMS and LAPS—is to extend the footprint of the building to the east, so towards, I think, Cowlshaw Street. So the intention is to extend out on two levels towards Cowlshaw Street.

MR HARGREAVES: I understand—in fact, I know—there are staff or at least government car parks outside there, particularly for community nurse travel, medical officers—that sort of thing. Will that provision be underground or will that be just taking up further car parks as you are going towards the college?

Ms Cahill: The design concepts at this stage incorporate some additional basement car parking to provide that staff car parking, and as part of our discussions with those other ACT government agencies we are in the process of undertaking a car parking study to see what impact, if any, the increased activity in the centre will have on car parking demand. And on that basis we will look at whether there needs to be any increased provision of car parking as part of the project.

MR HARGREAVES: Fine. Thank you. My last question on this—

MR SMYTH: Sorry. Before we go off that, how big an area is it?

Ms Cahill: I would have to take that on notice.

MR HARGREAVES: Could we perhaps get a copy of the proposed floor plan in relation to the car park?

Ms Cahill: Yes, it is a concept design at this point.

MR HARGREAVES: That will probably answer nine-tenths of our questions in one go. The last question I have relates to services within the centre. If my understanding is correct, where you are going to expand the building out towards the college, part of the building includes the private medical practice which sits in there. What consultation processes have gone on with that medical practice, and will they still be accommodated in the redevelopment? And what involvement have they had in that

process?

Ms Cahill: In terms of the medical practice, we have had discussions with the medical practitioners who operate that service. They are well aware of our plans. We certainly have encouraged them to have input into the design. The design at this point in time does include provision for the ongoing general practice service.

MR HARGREAVES: So there will be no change to the size of service that that particular practice provides for that particular catchment area? I think they have got something like four or five practitioners and a practice nurse in there. I cannot remember the exact number. I presume that the health centre that you are going to have at the end of the day will also include the provision of medical services provided by the private practice sector. Is that true?

Ms Cahill: Yes. As I have indicated, the intention in the design concept that has been developed is to allow that general practice to continue. Whether it remains in the physical location where it currently is in the centre I think is something that remains to be tested as we go into the more detailed design process. It may change location, but obviously we need to be cognisant of the operating hours of that particular practice and ensure that the design facilitates, for example, after-hours access if that is appropriate.

MR HARGREAVES: Okay. And will they be catered for in terms of disruption to their practice whilst the redevelopment is going on?

Ms Cahill: We have certainly advised them that there is likely to be some level of disruption while the construction is going on. Again, we are probably at too early a stage to be able to define that clearly. Obviously, recognising that they are a private business, we will work as closely as we can to ensure that they can continue to provide that service with as little disruption as possible.

MR HARGREAVES: Were they involved in the contemplative stage of the redesign of the centre?

Ms Cahill: Yes.

MR HARGREAVES: Okay. Thank you.

THE CHAIR: Mrs Dunne.

MRS DUNNE: I would like to go back to the questions that Mr Smyth was asking in relation to the capital asset management plan change management. I was wondering if officials or the minister could give an explanation as to why the things that were described by Ms Cahill as things like standard operating procedures, change management facilitators et cetera could be considered capital for the purposes of the budget.

Ms Gallagher: My understanding is that these are costs associated with the capital projects and therefore they can be capitalised. I think Mr Foster said that in his earlier answer.

MRS DUNNE: But the things that were described are not in any way capital in their nature.

Ms Gallagher: No, they are related to. That is what we are saying—that you can capitalise costs that are related to the costs of the CADP. The construction of new buildings involves significant investment. This is an area I have identified as a gap. I have had many stakeholders over the past year come and speak with me—and these are people that are holding down full-time jobs, particularly at the Canberra Hospital, and saying, “We do not understand what is going on. We are involved in some meetings. We have not had time to attend them all. We don’t know what the timing of these plans is. We don’t know where our car park is going to be.” There is a whole range of issues that have been identified.

What the government has been asking is for ACT Health to manage that, with no additional resources, through Megan Cahill’s area. So they have been trying to manage the ACT government’s most significant infrastructure program, where all the money has been going into the infrastructure itself, and we have not allowed for an increased capacity to deal with the issues of change management.

When I went overseas and visited the hospitals in Denmark and Norway, this was identified, from both of those hospitals, as a major problem that they had not addressed early and they urged us to ensure that we were on top of the change management issues because, unless you have got the staff to buy in, unless you have got them to understand the journey you are going on, it creates more and more problems down the track.

MRS DUNNE: I accept your explanation. I would still like an explanation as to how you can depreciate this.

Ms Gallagher: I think the depreciation may be a component of the program. Ron Foster did say he would take it on notice, but is there anything further you can add?

Mr Foster: We consider it is legitimate to incorporate these sorts of costs in the initial creation of the projects. We see it as no different to a design. We see it as no different to fees. We see it as no different to the resources associated with helping to deliver a project. We employ people to assist in a project. I think it is quite legitimate to include these in the capital costs of a facility at the time of building it. We would not do it five years after building it if we were doing change management. We would see that as an operating cost. We see it as a legitimate cost associated with the implementation of these projects and we feel it is appropriate to capitalise that.

MRS DUNNE: But would you depreciate, Mr Foster, the designs of a building, the up-front process?

Mr Foster: You depreciate the final cost and that includes these charges.

MRS DUNNE: Just for clarification, these figures, the 1.7 and 2.3, are new money or are they being taken out of the—

Mr Foster: They are new funding.

Ms Gallagher: They are new money, and it is only for two years because I want to see how it is going before we agree to any other longer-term change management allocation.

MRS DUNNE: Thanks.

THE CHAIR: That seems like a good time to take the afternoon break.

Meeting adjourned from 3.26 to 3.46 pm.

THE CHAIR: We will resume this hearing. Minister, I wanted to ask a question about maternal and child health nurses.

Ms Gallagher: Yes.

THE CHAIR: I understand that a number are retiring or moving out of this service. Is that the case? If it is, do we have some sort of recruitment strategy underway to ensure that we do have the right number?

Ms Gallagher: I am sure you are right in terms of the number of nurses who will be reaching retirement age, because we are seeing that right across the board; so maternal and child health would be no different.

Ms Bracher: The maternal and child health nurses are in the same age profile as many of the community health nurses and many of the nurses across ACT Health. Yes, moving into the next five-year period, there will be a considerable retirement of a number of staff.

We have training programs in place for developing the skill sets specific to maternal and child health nursing, which are in addition to general nursing. We have a transition-to-community-nursing program which is around supporting the development of nursing staff to operate autonomously in the community.

THE CHAIR: So you are confident that you will be able to recruit the number of nurses in a timely manner into these positions?

Ms Bracher: We are certainly aiming towards that. We are working towards that. We are planning towards that with our training strategies with new graduates and training strategies that take on students through the Canberra University and Signadou, who have nursing programs, nursing student programs.

THE CHAIR: Have you also had any concerns about what might be seen as sort of lack of career pathway for those who might go into this area of nursing?

Ms Bracher: The chief nurse may add to my answer. The feedback that I get from our maternal and child health nurses is that they love the work that they do and that there are a number of opportunities within the child, youth and women's health program for

them to progress into clinical nurse consultant positions and then into a range of areas within the child, youth and women's health program looking specifically at maternal and child health nursing. There is the generalist aspect of the work that they do and also their being involved with more vulnerable groups in the community.

Ms Croombe: We have just set up a maternal and child healthcare network in the ACT, which the minister is launching in July. That is aimed at improving the acknowledgement and recognition of maternal and child healthcare nurses. Not only is that available for maternal and child healthcare nurses, but it is also available for nurses who might be interested in that specialty as a career in their nursing progression. So I think that is going to go a long way towards raising the profile and improving the sustainability of that particular nursing specialty.

THE CHAIR: At the moment, where are those nurses providing their services? Is it through the child and family centres?

Ms Croombe: That is right.

THE CHAIR: Are they also still at the junction youth health service?

Ms Bracher: I can answer that question. Our nursing staff were transferred across to the management of the junction a couple of years ago. I am not exactly sure of the date, but we no longer manage those staff.

THE CHAIR: Going back to other places that they are delivering services, what are those other locations?

Ms Croombe: They work out of community health centres. They work out of Belconnen.

Ms Bracher: Our maternal and child health nurses operate from the child and family centres where they currently exist through the current community health centres. They see people in their homes and we have a number of outreach clinic spaces that the nurses also operate out of. There are 13 of those dotted around that offer sessional services closer to where people actually live.

THE CHAIR: Thank you.

MR SESELJA: I have some questions around staffing. This is across the board; there is no particular area. Minister, BP4, page 210, shows the staffing profile across ACT Health. It shows a planned increase of 173 across the agency. What areas does this relate to? Can a breakdown be provided in terms of medical and administrative staff?

Ms Gallagher: Yes, certainly, we can do that. I do have the breakdown across areas, but that is not broken down into clinical and admin, although that should be relatively easy to do. The majority will be in clinical staff. So mental health growth, there is four; critical care capacity, 14.3; acute capacity, 11.4; elective surgery, 48; cancer growth, six; older persons growth, seven; chronic disease management, four; neurosurgery operating theatre, 16; emergency access, 15; flexible funding, 17; obstetrics and gynaecology, 10; and subacute, 20.

MR SESELJA: Okay, so—

Ms Gallagher: That equals 172.7.

MR SESELJA: Okay, so that is the growth. Were you taking on notice the part where you provide a breakdown of clinical and admin staff across the various areas?

Ms Gallagher: Yes, can I just say, though, because this comes up every year, that admin staff are essential to enable clinical staff to do their jobs. In fact, this year I have had more clinicians come and tell me that they need more admin staff than I have ever had before. It all goes to things such as the operating theatres and booking clerks to book procedures; so there will be an element of admin support, but I do not want it to translate into “evil health bureaucracy grows larger”. Admin staff are an integral part of delivering all of the programs across ACT Health.

MR SESELJA: Sure. So when you provide that breakdown, could you also provide a breakdown, obviously on notice, probably of the 5,034 along those lines as well in the different areas? As we were talking about the growth—

Ms Gallagher: Yes.

MR SESELJA: The 173, and then an in-total breakdown of those numbers. In the notes—

Dr Brown: We do publish that data in the annual report, but I can give you the approximate percentages.

MR SESELJA: Indeed, and up to date would be good. Obviously, the annual report goes to the end of last financial year; so an update on that would be great.

Dr Brown: Medical staff are 11 per cent, nursing staff are 40 per cent, allied health staff are 15 per cent, admin staff are around 20 per cent.

MR SESELJA: Okay. If we could get those exact numbers from you in addition to what is in the annual report, that would be great. The notes on page 210 also talk about the increase from the 2009-10 budget. It refers to an increase of 93 FTE in 2008-09 and it states:

... not known at the time of the 2009-10 Budget, and further increases ...

What does that mean? Why was it not known at the time of the budget?

Ms Gallagher: You deal with the activity on a day-to-day basis. If activity grows faster than you expect, you have to put on staff to deal with that activity.

MR SESELJA: So this is growth that occurred in the part of the financial year post the framing of the 2009-10 budget; is that right?

Ms Gallagher: Yes.

MR SESELJA: Okay.

MR SMYTH: It seems an extraordinarily large number for that period. You are talking six weeks or eight weeks to the end of the year.

Ms Gallagher: For the last financial year?

MR SMYTH: No, for the previous financial year.

Ms Gallagher: Yes, for 2009-10.

MR SMYTH: No, for 2008-09.

Ms Gallagher: 2008-09.

MR SESELJA: The growth is in—the 93 FTE in the note refers to the 2008-09 financial year—

Ms Gallagher: Yes.

MR SESELJA: which was not known.

Ms Gallagher: I just do not understand Mr Smyth's question. It is growth in six weeks, did you say?

MR SMYTH: If you read note 1 there on page 210, it says that the increase from the 2009-10 budget for the estimated outcome relates to the increase of 93 FTE that were actually in the 2008-09 financial year that were not known at the time of the framing of the 2009-10 budget.

MR SESELJA: So your answer seemed to be indicating—

Ms Gallagher: Sorry, I am getting further information.

Mr Thompson: It is a question of the preparation of the budget papers, and obviously it is not a six-week figure, because the six weeks is from the point in the budget to the end of the financial year. I cannot remember off the top of my head when we actually closed off these staffing numbers, but it is obviously prior to the actual budget day to enable preparation of these estimates.

In every financial year, there is growth. The growth pattern is inconsistent across years. One of the particular problems we have always faced with these sorts of estimates is that the period immediately prior to the point at which we will prepare these estimates is the quietest time of the year—the January-February into the early March time of year. Activity increases as we get closer to the middle of the year, particularly May and June. It is always a difficult task striking an estimate, given the inconsistent pattern of growth over the year. As the minister was saying, this reflects the fact that when the estimates were made, we were not aware of the full impact of the growth at the end of the 2008-09 financial year.

MR SESELJA: But the point Mr Smyth makes—he has stepped out—I think is a reasonable one: the 93 is roughly about two per cent of the work force. That seems a lot to add in just a fairly short space of time at the end of the financial year. Is there a particular reason in that financial year where there was a rapid surge in numbers or has that been a pattern in other financial years as well?

Mr Thompson: It varies from year to year. The end of that financial year was a busy end of financial year. As I said, it is a relatively short period of time, but the particular thing to note is the seasonality of health service delivery. The period from December through to March is a quiet period. If we are preparing estimates in March, as we tend to do, then it is hard to extrapolate from the previous experience over the months of the financial year exactly what the growth activity will be in the last quarter of the year.

MR SESELJA: Could we get a breakdown, on notice, as well on those 93?

Ms Gallagher: Yes, I think there might be another technical reason, which I will just check and provide back on notice. In terms of what is counted in the full-time equivalent count, I think there has been a minor change to that. I am just looking at it.

MR HANSON: With regard to staffing generally, can you tell me how we are going with recruitment and retention and any specific areas where we are finding it difficult to recruit and retain staff?

Dr Brown: As I said earlier, in terms of retention, our turnover rate is currently around nine per cent, which is considered to be very good for healthcare agencies. In terms of nursing staff, we have had a lot of success in attracting new nursing staff, and we have been able to reduce the use of agency and overtime staff.

MR HANSON: How much is that now, do you know?

Dr Brown: What are you referring to?

MR HANSON: The use of agency nurses. Do you know what the amount of that is?

Dr Brown: We have got some figures, and I will have to find them, but we can certainly provide those for you. But it has come down something like 60 FTE.

MR HANSON: Right.

Dr Brown: We have been successful in recruiting around 60 graduate nurses this year who commenced in February-March. We have not had as many doctors starting this year as we have had in previous years, but that is because we have not had as many positions to offer. But we have actually been quite successful in terms of attracting nursing and medical staff.

MR HANSON: In terms of doctor training, is there some concern that there is going to be a blockage in terms of the ability to train doctors? With doctors coming out of ANU, do we have all the training positions for them in ACT Health?

Ms Gallagher: At the moment—

MR HANSON: And the doctors to actually train them?

Ms Gallagher: At the moment we are okay. There is a lot of anxiety around the future in terms of clinical training and places. That really goes to the huge increase in doctors in medical school at the moment—undergraduates who will be finishing and the demand that will place in terms of clinical training places. Health Workforce Australia has been established as the national agency to coordinate issues around clinical training across the country. At this point in time, we are all right. There may be an issue if, for example, we take about 60-odd interns out of a class of 80 graduates. We have got about 65 places at the hospital. We are filling large portions of that from our own graduates from ANU. I guess the pressure will come if there are excess graduates outside the ACT who cannot get a spot in one of the hospitals in New South Wales.

MR HANSON: As I understand it, the students that graduate from ANU are now guaranteed an internship in ACT Health.

Ms Gallagher: Pretty much, yes.

MR HANSON: But that is not the case for foreign students?

Ms Gallagher: That is right.

MR HANSON: Is that a decision that is under review at all? Are you comfortable with that?

Ms Gallagher: We were involved with IMET.

Dr Brown: And we still are.

Ms Gallagher: And we still are, in terms of an arrangement for the placement of graduate students. It was with some fear and trepidation that we branched out on our own—I think this is our second year of doing that—because IMET did offer us the opportunity, if we were not able to fill our positions locally, to get graduate students from other jurisdictions, through New South Wales. Our priority is ANU graduates who meet the criteria, but we usually go out and attract other interns to fill the required numbers if we do not get all of the applicants from the ANU wanting to come to the ACT and stay.

Dr Brown: I can provide the agency nursing numbers. As of the end of March 2010, the agency FTE had reduced from 106.2 to 39.

MR HANSON: From 106 to 39?

Dr Brown: Yes, so it is a reduction of 67 FTE in agency costs. That was in part because of the graduate nurses that we have taken on—but additional recruitment. We have initiatives across allied health as well, so it is focusing not just on the doctors

and nurses but across all of our staffing disciplines.

MR HANSON: If I could just go back to the original question, I asked in more detail in specific areas where there are still some recruitment problems. You may not have that.

Ms Gallagher: We can certainly provide that. There are areas—

MR HANSON: Areas like dentists, I think, were a concern.

Dr Brown: Sorry?

MR HANSON: Dentists, I think, were an area. Psych nurses were a problem.

Ms Gallagher: It is a shifting feast.

MR HANSON: Just where those problem areas are.

Dr Brown: Sure; we can provide that information to you.

Ms Gallagher: It does change month by month.

Dr Brown: It does.

Ms Gallagher: For example, if one doctor in a three-doctor team leaves, it shows up as a 33 per cent vacancy against that position even though it is only one position you are looking for. But there are certainly a number of areas where we continue to experience workforce shortage, and a number of medical staff, particularly, that work long hours for the public system—not only long hours, necessarily, but with intense rosters to deal with that.

THE CHAIR: Mr Seselja.

Ms Gallagher: Which we are immensely grateful for.

MR SESELJA: On the flip side of workforce shortages, are there areas of ACT Health where there has been a spike this financial year in turnover or resignations? For instance, it has been put to me by a constituent that in paediatrics we have seen a particular spike. I do not know if that is correct or not?

Dr Brown: I am not aware of that. I do not know if the executive director of HR is able to help.

Ms Childs: I am not aware of it either.

MR SESELJA: So you are not aware of paediatrics—any sort of spike? There are no other particular areas where—

Ms Gallagher: In terms of medical staff or just across the board?

MR SESELJA: Medical staff, it was put to me, I think, but it was not clear. So we have not seen that in paediatrics? That is incorrect?

Dr Brown: I am certainly not aware of it.

MR SESELJA: Are there any other areas in ACT Health where there has been a spike in either resignations or turnover?

Dr Brown: Not that I am aware of. Each of our operational divisions gets an HR report on a monthly basis and they do monitor and track that separation rate for permanent staff. It is not broken down by individual staff disciplines for each individual area because the numbers get very small to try and give a percentage. But I am not aware of any particular spikes. We can again take that on notice and provide you with information if there is a spike, but I am not aware of one.

MR SESELJA: Okay.

MRS DUNNE: I want to follow up something that follows neatly on from that. There is currently a temporary vacancy for a staff respiratory paediatrician. We know about staff respiratory paediatricians. I know that the hospital has made a sort of stopgap arrangement by bringing specialists down for clinics from Westmead. But it seems to me, from the conversations I have had—I was, for instance, rung by a VMO paediatrician last night at 9 o'clock, following up on records—that there are problems there because one person has gone on maternity leave. Is there any prospect of more appropriately filling that position, especially coming into the winter?

Dr Brown: Again, I will defer to the operational areas.

Mr Thompson: I am not aware of that area specifically, but the advice I have is that we are recruiting; we are attempting to find someone. Obviously it is always a problem for us in particularly specialised areas. Subspecialty paediatrics is, unfortunately, one of those specialty areas where from time to time it is difficult to find someone. We are actively recruiting, and as soon as we can find someone we will bring them on.

MRS DUNNE: What does “actively recruiting” mean?

Mr Thompson: It means, in the first instance—

MRS DUNNE: Are you looking or have you actually got somebody in mind?

Mr Thompson: No; looking.

THE CHAIR: Mr Smyth.

MR SMYTH: Minister, on page 346 of budget paper 3, we have got the GGS expenses by function. In class 05, Health, for instance, it breaks down the areas by expenses. The greatest increase in expense is health administration, which goes up more than 11 per cent. Is there a reason that health administration goes up by so much when acute care goes up about seven, patients in acute care goes up about seven,

community health goes up seven and public health goes up nine per cent? Why is there such a great concentration in administration?

Dr Brown: I think there is a combination of factors that contribute to that. Some of it relates to, for example, the capital asset development program and the need to have officers contributing to that who fit within the administrative stream. Last year, there was a deliberate move in some areas—for example, one of the allied health areas—to actually bring on admin staff who were then able to free the clinical staff of admin duties, so they were able to do more direct client contact through the use of less expensive admin staff. There is a range of factors that contribute to that. There have also been commonwealth-funded projects that bring additional admin staff into the program.

MR SMYTH: What percentage of the increase is related to commonwealth projects?

Dr Brown: Again, we would have to take that on notice. I do not have that.

THE CHAIR: I just note that that question has been taken on notice. I also wanted to—

Ms Gallagher: I was just checking. This also did come up in the Treasury estimates about fitting output classes into national break-ups. It is not the way we would structure or allocate functions. This is done by Treasury; we need to work with them and provide an answer on notice about how that break-up is done and what it means. It is not the total allocation for health.

MR SMYTH: It is just a significant increase.

Ms Gallagher: Yes.

MR SMYTH: Last year it went up 6.7 per cent.

Ms Gallagher: I am sure there is a very rational explanation for it.

MR SMYTH: This year it is 11.3.

THE CHAIR: We have taken that on notice?

Ms Gallagher: Yes.

THE CHAIR: I want to go to another matter. In budget paper 4 on page 228 under the accountability indicators, (b) is around the dental services and waiting times. My understanding is that the waiting time dropped down to about nine months in years like 2008-09.

Ms Gallagher: Yes.

THE CHAIR: Now we are back up to 12 months. Is that related, again, to an issue around recruitment or is there some other reason for that?

Dr Brown: No. My understanding is that the reduction down to 2008-09 was associated with some commonwealth funding and access to referrals to private dental services. Whilst we still have some of those referrals in place, we had a bit of a burst, I guess, and this is back to more business as usual.

Ms Bracher: That is absolutely right. We had a burst of referrals out to private providers in the beginning of the previous financial year, which dropped the wait time down significantly in anticipation of the commonwealth money. We have now gone back to business as usual.

THE CHAIR: So the commonwealth money is no longer available?

MRS DUNNE: It is held up in the Senate.

Dr Brown: It has not come through. But 12 months is still the best waiting time in the country.

Ms Gallagher: It was at 16 months, from memory, when we put in the extra resources through our budget, and that was with the intention of getting it to 12 months.

MS BRESNAN: Was the commonwealth money for a specific purpose?

Ms Gallagher: Yes.

MRS DUNNE: It is the teenage check-up.

Ms Gallagher: Yes; it is for the adolescents.

Ms Bracher: Yes, the teenage dental health program.

MS BRESNAN: There have not been particular increases in waiting times over that period which have affected it? It is primarily related to that funding?

Ms Bracher: Yes, that is right. It dropped down abnormally low at the beginning of the last financial year. It has now come up to our target of 12 months. With regard to the question that was raised earlier, that staff vacancies may be contributing to that, we are actually in a better place now this financial year than we were a year ago with regard to dentists.

MRS DUNNE: Can I just follow on from that, Madam Chair? Elsewhere in the indicators it talks about 100 per cent of people on the emergency list getting in—or 99 per cent.

Ms Gallagher: Within 24 hours.

MRS DUNNE: Within 24 hours. What is an emergency and what is not?

Ms Bracher: We define an emergency as an acute episode where the triage tool that we use that has been validated by the dental staff suggests that the patient needs to be treated immediately.

MRS DUNNE: Can you give me an example of what might be an emergency?

Ms Bracher: An infection.

MRS DUNNE: An abscess on a tooth?

Ms Bracher: An infection requiring antibiotics, significant pain relief that is required for people, a broken tooth.

MRS DUNNE: So a broken tooth would come into the emergency category?

Ms Bracher: Yes.

MRS DUNNE: Thank you.

THE CHAIR: We might now move on to public health.

MRS DUNNE: Can I just ask some questions about HACC first? Is community health the place to ask about HACC?

Ms Bracher: Community health receives some HACC funding. The policy area administers the HACC program.

MRS DUNNE: Thanks.

THE CHAIR: We will cover those HACC questions and then move on.

Ms Gallagher: HACC goes across a number of output classes, but we are here.

MRS DUNNE: I thought it might have fallen into—

Ms Gallagher: It does have community care in its title.

MRS DUNNE: I just wanted to get an update. Ms Bresnan and I had cause to make representations last year about delays in HACC funding, which were eventually made. There were some changes made and there are more changes anticipated. In the meantime, what will community providers expect this financial year in terms of the regularity with which they receive funding and the reliability of that funding?

Ms Gallagher: I think there were some problems which you and Ms Bresnan identified, and we have worked hard to fix those. Some of them are related to intergovernmental agreements or agreement between two governments. We expect to get an additional \$2.2 million through HACC growth, which keeps that share largely fifty-fifty. We will get a letter from the federal minister. I do not recall seeing it yet. Have we seen it?

Mr O'Donoghue: It is usually in July.

Ms Gallagher: Yes, she will write to us. We will reach agreement on the growth

allocation, which is expected to be \$2.2 million, and we expect that the money will flow to the community sector by September. Is that right?

Mr O'Donoghue: That is correct. What is happening this year is that we have conducted an open tender process for the HACC growth funds. That was advertised in February and it closed in March. The evaluation of the tender has now been completed. Basically, as soon as the letter of offer is received and we submit our plan to the federal minister and it is agreed, we are in a position to allow the moneys to flow to the community sector organisations who have been successful through the tender.

MRS DUNNE: So this year there has been a tender and in past years there was not a tender?

Ms Gallagher: Yes, there has been.

MRS DUNNE: What is the priority for the growth funding in HACC this year? Is there a priority?

Ms Gallagher: It might be difficult to—

Mr O'Donoghue: I might get Therese Gehrig to assist me with that one. She was directly involved in the crafting of the tender specifications. I would just stress that it will still require that intergovernmental agreement process to take place.

Ms Gehrig: Thank you for the question. The HACC growth tender this year was consistent with the priorities determined within the ACT triennial plan. That was to focus additional growth funds on the expansion of basic HACC services. The tender that was recently closed contained two elements. The largest component, which we estimate to be around \$1½ million, was across all of the 18 HACC eligible services—so across respite care, domestic assistance, personal care. There was also a second project that quarantined \$100,000 to expand services to the Indigenous community.

MRS DUNNE: Thank you very much, Ms Gehrig. Overall, the priority is just the expansion in meeting growth in demand?

Ms Gehrig: That is right. Part of the tender documentation asked organisations to provide evidence of unmet need to identify where there were service gaps and where those individual organisations deemed the highest priority for expansion of their existing programs. While I have said “expansion of programs”, under the ACT procurement guidelines the tender was open to new potential clients.

MS BRESNAN: I am sorry if this has already been answered. With the indexations and those previous issues, is there an expected time that organisations funded under HACC can expect to get that this year?

Ms Gehrig: As we noted, there was a delay in the release of funds in 2008-09. For last year, 2009-10, the full 100 per cent allocation of growth funding and the full allocation of indexation were delivered to the community sector by September. The allocation of indexation is an element in developing the HACC annual plan which is

agreed by the federal minister for ageing. We are on track to repeat the time lines that we delivered to organisations last year with indexation, both in contract variation and in cash payment—to be delivered by September.

MS BRESNAN: So it will be September this year.

Ms Gehrig: Those time frames were clearly indicated within the request for proposal and have been again communicated at the annual HACC sector planning day which was held only last Thursday.

MRS DUNNE: But the growth funding and the indexation money are still dependent upon the commonwealth meeting your expected time line.

Ms Gehrig: Yes.

MRS DUNNE: Mr O'Donoghue, you said you would expect a letter from the commonwealth in July which would allow you to release the money by September.

Ms Gehrig: That is correct.

MRS DUNNE: Thanks.

Mr O'Donoghue: We have been successful in negotiating the indexation level with the commonwealth government, so that is part of the equation as well.

MRS DUNNE: There are moves mooted for changes in the administration of HACC, with more responsibility going to the commonwealth; is that correct?

Ms Gallagher: Yes, that is right. Under the national health reform agenda—again, this is part of some ongoing work—there are expected to be changes in terms of responsibilities for the delivery of community health and HACC-related services. I think the timetable is June. I am sorry, we did table that timetable—I just do not have it in front of me.

Mr O'Donoghue: From July 2011.

Ms Gallagher: Yes.

Ms Gehrig: The current triennium continues until June 2011, with changes anticipated to commence in July 2012.

Ms Gallagher: Yes. People who are under the age of 65 and are within the HACC program remain with the states and territories. The commonwealth will take responsibility for the over 65s.

MRS DUNNE: What is the rationale for that?

Ms Gallagher: I think it is related to the fact that for people under the age of 65 the states and territories manage the disability services.

MS BRESNAN: So you do not have any details where the funding sits with community organisations? Would there be another process where that money goes from those community organisations and they would have to reapply for it? Would responsibility just be taken over by the commonwealth?

Ms Gallagher: It is just the responsibility. There has certainly been no discussion about upheavals to the program.

MS BRESNAN: So would it affect existing contracts and people accessing services that continue on?

MRS DUNNE: But who is going to pay for that? Is the commonwealth going to take full responsibility for the full funding of HACC?

Ms Gallagher: Yes, for the 65s and above.

MRS DUNNE: For the 65s and above.

MS BRESNAN: For all HACC—

Ms Gallagher: Yes, and then we would maintain our responsibilities.

MRS DUNNE: What is the breakdown?

Ms Gallagher: We can provide you with that.

MRS DUNNE: Thanks.

MS BRESNAN: I just wanted to clarify something. There was around \$9½ million for HACC in the ACT budget. Is that additional funding or is it just part of growth funding?

Ms Gallagher: It is the growth.

MS BRESNAN: So it is the growth funding. It was something that the ACT government were required to put into HACC?

Ms Gallagher: Yes.

MRS DUNNE: It is 2.2, 2.3, 2.4 and 2.4.

MS BRESNAN: I just wanted to check because in the budget papers it was heralded as being some sort of new money.

MRS DUNNE: An initiative.

Ms Gallagher: I do not think we have traditionally shown it, have we? This is the first year. I do not think it is heralding anything other than it is an allocation.

MRS DUNNE: It is not really an initiative.

MS BRESNAN: It is growth funding.

MRS DUNNE: Growth funding has been there as part of the HACC program for years.

MS BRESNAN: Yes, that is what I thought it was. I just wanted to clarify that.

THE CHAIR: I want to move on to the issue of air quality. So we have now moved into public health, 1.4. In budget paper No 4, on page 224, there is mention of air quality. The minister might recall that recently in the Assembly we debated a motion regarding air quality and wood smoke, and through that motion it was agreed that ACT Health, subject to resourcing and some technical implications, would make the PM10 and PM2.5 levels publicly available on a daily or a weekly basis. I think it sort of depended on the outcome of the budget. So can we be provided with an update of where that is up to?

Dr Guest: The two air pollutants to which you refer have been measured of course under the national environment protection measure for many years. Making those data available on a daily basis does require additional resources and it is something under consideration by the government at present.

THE CHAIR: Do we expect to see some sort of result there? What sort of consideration is it under, minister?

Ms Gallagher: It is under a budget consideration. It did not make this budget round but it will require extra resourcing, so a budget will be scoped along those lines.

THE CHAIR: For next year's budget?

Ms Gallagher: Yes.

THE CHAIR: While we have you here, Dr Guest, at last year's estimates you were telling us about the work being done on the feasibility study for developing a centre for adolescent health. I am wondering where that is up to.

Dr Guest: We rolled that project over last year because of the H1N1 pandemic. But I can tell you now that the project will be underway in the coming financial year. It has, of course, started in the quieter summer months and I think it will be a very interesting and important study that we do and I look forward to presenting it in due course to the minister.

THE CHAIR: So what work has been done so far? Is it just designing the study or scoping it?

Dr Guest: Designing the study, scoping it, getting the procurement started, consultation in a preliminary way with a wide range of people both here in the ACT and in other jurisdictions and overseas, actually. It is a very important matter that is going to be done in the coming financial year and is only rolled over because of the more urgent matter that faced us last year.

THE CHAIR: So is it envisaged that this will be a sort of staged thing? I suppose you are going out to tender to get someone in to have a look at what sort of model. What are the tender specs?

Dr Guest: The tender will invite a consultant or a group of consultants to look at models for centres for health and wellbeing for young people. It will look at the models that might be appropriate, the staff that might be appropriate, the gaps that need to be filled here in the ACT. We have heard in the last day about a variety of services for young people. The question is: what is missing? So it is an important study of what is missing and what opportunities are there to improve the life chances of young people when they are likely to benefit most from preventive programs.

THE CHAIR: So it will have a focus on preventative type programs?

Dr Guest: Absolutely.

THE CHAIR: And are you speaking to or have you included in these consultations the Junction Youth Health Service, headspace—some of the youth health programs and services?

Dr Guest: The feasibility study proper has not yet begun but I went to both of those places last week because I see those as very important centres here in the ACT to build on and to complement. So, yes, we will certainly be including both of those institutions in the design of the feasibility study and then the recommendations that are eventually made will of course complement what is already here and going well. Those are two key parts.

THE CHAIR: And also the adolescent step-up, step-down facility too?

Dr Guest: Correct. They will all be consulted. As I say, we have not got a preconceived idea of what the outcome of this feasibility study should be. It is really a study of gaps and needs with due reference to things that are going well and should continue.

MR SMYTH: Dr Guest, what is the prevalence of tuberculosis in the ACT?

Dr Guest: The prevalence of tuberculosis infection, as opposed to active tuberculosis disease, is quite common in the whole population of a developed country like Australia. It might be 20 per cent of the population that has been infected at some time with the tuberculosis bacillus. Very, very few of those people go on to develop active tuberculosis disease.

The answer to your question of how many people actually have active tuberculosis disease at any time is numbered on the fingers of one hand. At the present—I have not checked the hospital in-patient register in the last 24 hours—I do not think anybody is under active treatment in hospital. There will be a very small number being managed in thoracic medicine as usual. So the prevalence, if you want a percentage, will probably be much less than one in a thousand.

MR SMYTH: Is that static? Is it getting better, deteriorating or is it just so small that it is hard to measure?

Dr Guest: As we have heard repeatedly, measurement in the ACT, particularly for rare diseases, is always a problem and it is unwise to speculate on whether it is getting better or worse. But I can tell you that over the last 20 years and over the last decade the incidence of active tuberculosis, which is more important than the prevalence of tuberculosis infection, is going down in Australia. Australia is one of the best countries in the world at managing this problem. So the issue of tuberculosis infection, I think, in the ACT is optimally controlled.

MR SMYTH: Can you outline what the procedures are when a case is identified? What would normally happen?

Dr Guest: Yes. A clinician will make a suspected diagnosis and order tests and then tests will confirm the infection. There will be a referral in rapid time to the Department of Thoracic Medicine and then the Department of Thoracic Medicine will carry out both a treatment regime for the person infected and a contact tracing operation for those who may need contact tracing and prophylactic antibiotic treatment. The disease is notifiable in this jurisdiction, as it is elsewhere in Australia, so the public health unit is aware and we work closely with thoracic medicine to manage the contact tracing operation.

MR SMYTH: Minister, given the incident that occurred at the maternity unit at TCH, has anything changed in regard to the handling of TB inside the hospital?

Ms Gallagher: The issue at the maternity unit was that nobody knew the individual had tuberculosis.

MR SMYTH: All right. And as a consequence of that has it been seen that there is a need to change the procedures?

Ms Gallagher: No.

MR SMYTH: No?

Ms Gallagher: We reviewed the procedures and the procedures were appropriately applied with the information that was available to the clinical staff in the maternity unit at the time.

MR HANSON: Were there breaches of those procedures that night?

Ms Gallagher: No. There were no breaches of the procedures.

MR HANSON: Can you outline for us why or on what grounds the individual who was infected with TB was permitted to stay in a shared room, because there are certain—

Ms Gallagher: Those are decisions that are taken in consultation with the families and the clinical staff. It was not known at that time that the individual had tuberculosis.

If it was known—

MR HANSON: Of course not but—

Ms Gallagher: Sorry, Mr Hanson; if it was known, the individual would have been offered treatment and would not have been spending that time in that room with his partner.

MR HANSON: Certainly. My question was, though, why was he permitted to stay in the room, because there are certain guidelines—

Ms Gallagher: I am not going into an individual patient's situation in this forum, Mr Hanson.

MR HANSON: All right. Can you tell us when the investigation into the death of DJ Gill will be completed? Is that a—

Ms Gallagher: It is a coronial matter.

MR HANSON: It is a coronial matter. Do you know when that is due to report?

Ms Gallagher: You can direct your questions to the coroner's office.

THE CHAIR: Ms Bresnan?

MS BRESNAN: I will just check that I am asking this question at the right place. Does licensing and registration sit within public health?

Ms Gallagher: Of the national boards?

MS BRESNAN: Of activities such as infection control licences?

Ms Gallagher: Yes.

MS BRESNAN: How many staff does this section have going out to check businesses to ensure they are complying with licence and registration conditions?

Dr Guest: May I ask to which particular licences you refer?

MS BRESNAN: For example, businesses, whether it is health related, whether it is in terms of food or in terms of—

Dr Guest: Okay, food regulation?

MS BRESNAN: For example, one issue that has been brought to our attention is in beauty parlours, the beauty industry—any business, I guess, where infection control licences apply.

Dr Guest: Infection control licensing?

MS BRESNAN: Yes, in particular.

Dr Guest: I cannot give you an exact figure, but it would be of the order of 10 people.

MS BRESNAN: Is it possible to get an exact figure on that?

Dr Guest: Yes, it is.

MS BRESNAN: So it is about 10 people. Do you know how many businesses would be licensed under the scheme?

Dr Guest: I will take that on notice also.

MS BRESNAN: Probably a lot of these questions will need to be. I just wanted to check, too, how often businesses are checked for compliance.

Dr Guest: I will take that on notice as well. I will just add, though, that there is both a random checking activity and a responsive checking activity. So if there is a complaint, of course, we go straight there.

MS BRESNAN: Yes. But every two years or so people go out and check?

Dr Guest: It depends on the activity. I am just pointing out that there is an initiative that we take to make everyone who is in this business aware that they are subject to inspection and that it does actually happen.

MS BRESNAN: And is it something which is notified so they would be told that an inspection would be occurring and then they would come out and check the premises?

Dr Guest: They are told that when they take out the licence and renew it, but we do not actually make a business of warning people that we are coming.

MS BRESNAN: So you do not actually give them a date. And that is the regular checks?

Dr Guest: I should say that for some licences—that is, for the licensing of healthcare facilities and so on—yes, appointments are made, because it is necessary to take up staff time.

MS BRESNAN: But businesses where there might be an infection control licence applied?

Dr Guest: When it is a random check, it is a random check; and it is done without announcement generally.

MS BRESNAN: Yes, but if it is not a random check, if it is a regular check that is taking place—as you said, if they are renewing the licence—is that something that happens every two years?

Dr Guest: I can get you details on those issues.

MS BRESNAN: Okay.

MR SMYTH: Just to follow up on that, at page 228 of budget paper 4, accountability indicators, output class 1.4(b), what does that mean, therefore? It says “Inspection compliance of licensable, registrable and non-licensable activities”, with 90 per cent compliance. Ninety per cent compliance with what? It says inspection compliance, 90 per cent. What does that mean? What are we actually measuring?

Dr Guest: We are measuring the compliance of the activity with the standards that are required of it.

MR SMYTH: Okay.

THE CHAIR: So what you mean is that you go out and do a random check or a regular check, whatever it is, and this percentage reflects the number of those businesses that are complying with the licence they have been issued?

Dr Guest: Yes. And then there is, of course, an engagement with all those businesses to get them up to compliance. This is showing you, when you do those checks, what are your findings in terms of the satisfaction with the—

MS BRESNAN: Does it apply specifically to the random checks or the regular checks that would occur?

Dr Guest: This applies to the inspections that we take in a random way.

MS BRESNAN: Okay.

MR SMYTH: What activities would that cover? Perhaps you might take it on notice.

Dr Guest: It would cover such things as infection control matters. There are a variety of regulations about adequacy of, for example, hand towels in toilets; running water in toilets; running water in sinks near food preparation; and so on. There is a whole code of requirements for businesses in the food industry, for example, that we monitor.

MR SMYTH: With the outcome, what does the 90 per cent represent? That we visited 90 per cent of the businesses?

Dr Guest: No.

MR SMYTH: That we have checked against 90 per cent of the regulations?

Dr Guest: No. Of those visited, what proportion were compliant?

MR SMYTH: Of the number that are either licensed or registered, what percentage are visited in any given year?

Dr Guest: That I would have to take on notice.

THE CHAIR: I think that was Ms Bresnan's question.

MR SMYTH: Yes, but in some ways it is an interesting measurement but it does not particularly mean anything if you pick this up and just read it. The question that comes out of it is this. We achieved 90 per cent as the estimated outcome for 2009-10, but we are dropping back as a target for 2010-11 to 85 per cent. Having achieved 90 per cent this year, why would we move to a lower standard or remain at a lower standard?

Dr Guest: The outcome is better than the target. Those have been the findings. These are the findings from surveys. We know that a lot of businesses need assistance, advice and engagement from the health department to maintain their standards.

MR SMYTH: Sure.

Dr Guest: The target has not changed. That is true.

MS BRESNAN: Can I just ask about the complaint system? What sort of complaint system is available to the public or anyone in the community who wants to make a complaint about a particular service? Do they just make complaints to—

Dr Guest: On the inside of the *White Pages*, there is a panel which advises the public which phone number to ring with which problem. They are also free to call Canberra Correct healthdirect or contact the Health Protection Service 24 hours a day and notify such issues.

MS BRESNAN: And that is for any business?

Dr Guest: Yes.

THE CHAIR: So as part of the licensing for these businesses, they are not required to publicly display information about making a complaint or what they might feel is a breach of these licences? Is that what you are saying?

Dr Guest: I have not said that, no.

THE CHAIR: Right.

Dr Guest: What is your question? Whether businesses are required—

THE CHAIR: As part of the licensing requirements, are businesses required to publicly display—

Dr Guest: That a complaint has been made against them?

THE CHAIR: No; I am not going that far. About how, if they want to make a complaint, they can make a complaint.

Dr Guest: I see. No, that is not required.

THE CHAIR: That is not part of the licensing requirements?

Dr Guest: No.

MRS DUNNE: Nor is it with, say, liquor licensing or anything like that.

MS BRESNAN: One particular area that has been brought to our attention is, as I said, the beauty industry.

Dr Guest: The meat industry?

MS BRESNAN: The beauty industry. I know it is not normally—

MR SMYTH: The words are often interchangeable. Beauty industry and meat—I can see where you are coming from.

Dr Guest: We can discuss them together.

MS BRESNAN: It is the same thing; it is interchangeable. Have there been any emerging issues in that area? Could they also have infection control licences applied to them?

Dr Guest: Emerging issues in the beauty industry? I think not.

MS BRESNAN: No?

MR SMYTH: How closely do you monitor emerging issues in the beauty industry, Dr Guest?

Dr Guest: I am delighted to receive briefs on that from staff who run those areas, but I have not in the last 12 months, so I think we can say that there are not any great emerging infection control or other issues there.

MS BRESNAN: Thank you.

THE CHAIR: I want to go to page 231 of budget paper 4. I was wondering about the commonwealth grants to the ACT for preventative health and for Indigenous early childhood development. Has money been taken out of this area or am I just not reading this area properly?

MRS DUNNE: It is a technical adjustment?

THE CHAIR: It is in the adjustments? Mr Smyth, is that what you are saying?

MR SESELJA: I think he is asking—

THE CHAIR: Whether it is an adjustment. Yes, thank you.

MR SESELJA: Output class 1.7.

MR HANSON: Which output class are we on to now? Are we into output 1.7 now?

MS BRESNAN: No, we are still here. It is commonwealth grants, page 231. It is in relation to preventative health and early childhood development.

MR HANSON: I thought we were doing public health.

MS BRESNAN: It is within this.

Mr Foster: You are referring to the negative adjustment of \$1.1 million in 2011-12?

THE CHAIR: Yes, that is right.

Mr Foster: These adjustments here follow on from adjustments the previous year going into 2009-10 when the commonwealth advised a number of adjustments to SPPs and subsequently advised that there will be a change to those figures. This information comes from the commonwealth to Treasury, and Treasury asks us to load these adjustments in. So yes, there has been a reduction in the level of funding advised in the previous year for those initiatives.

THE CHAIR: What is the justification for the reduction in funding?

Mr Foster: I do not have that information.

Dr Brown: I do not have that information either; I am sorry. I will have to take that on notice and get back to you.

THE CHAIR: So you will take that one on notice, about preventative health and Indigenous early childhood development. Thank you. Mr Smyth, and then Mr Hanson.

MR SMYTH: Again, it is perhaps a staffing issue, maybe across all of the output classes. In relation to the special employment arrangements—the SEAs, I think they are called—how many staff within ACT Health are employed under SEAs?

Dr Brown: Again, I could not give you the number here and now, but we can provide that.

MR SMYTH: All right. What are the conditions where one would get an SEA offered to oneself?

Ms Gallagher: It is usually around pay.

MR SMYTH: It is usually around pay?

Ms Gallagher: Yes, so what we have to pay—

MR SMYTH: What are the special circumstances?

Ms Gallagher: What we would pay in order to attract to that particular workforce.

Dr Brown: Where there is a challenge in recruiting to a particular workforce—where we have a workforce shortage or it is hard to compete against the private sector, for example—in order to recruit, we may need to go some way towards matching a salary. That is the sort of circumstance where we would consider the use of an SEA.

MR SMYTH: How does an SEA differ from an AWA?

Ms Gallagher: The conditions are largely—I think in all circumstances—met through the certified agreement; then there is capacity to adjust around pay in special circumstances.

MR HANSON: So that is pay—and, I assume, conditions and things like that as well?

Dr Brown: There are some SEAs that have non-salary components to them, but they are not the majority.

MR HANSON: Because my understanding is that there are about 300 SEAs in operation in ACT Health or 300 people who are affected by an SEA.

Dr Brown: There are some SEAs that pertain to specific groups—

MR HANSON: There are 15 groups or something?

Dr Brown: I do not have the exact number. Where it relates to individuals, it is a much smaller number, but certainly—

MR HANSON: What would be the justification then for people who are administrative staff? They might not be a clinical specialist. If you have got administrative staff on SEAs, what would be the justification for that?

Dr Brown: Again, it comes to an issue of a particular skill base that you are seeking to recruit or to retain. If there is a challenge in recruiting or retaining staff with that particular skill base, if you are competing against a market—and we do compete against the commonwealth here in Canberra—then at times when we have a need for that skill base we have to meet the market.

Ms Gallagher: But it is looked at on a case-by-case basis.

MR HANSON: Who makes that level of decision? Is that at ministerial level?

Ms Gallagher: No.

Dr Brown: Chief executive level.

MRS DUNNE: What would be the circumstances in which you would have a group of people who were the subject of an SEA?

Dr Brown: A recent example would be the psychologists in Mental Health. We are competing against the New South Wales award. The New South Wales award

provides for a distinction between clinical psychologists and psychologists, with the clinical psychologists being paid an additional sum. Our rate for the health professionals was not able to come near the rate for a clinical psychologist. We have lost a substantial number of psychologists to New South Wales, so we needed to—

MRS DUNNE: Let me understand what you are doing. Where the EBA does not give you the flexibility to pay what the market is demanding, essentially, you have this other mechanism that—

Ms Gallagher: That is available.

MRS DUNNE: That is available, and it may be—

Dr Brown: To ensure that we retain a workforce to meet the needs.

MRS DUNNE: To retain or recruit. That may be in terms of salary, so you are not bound by what the pay scales and the EBA would necessarily demand. What other sorts of conditions might be in an SEA?

Dr Brown: There are some SEAs—a small number—where there is provision of a vehicle to an individual.

MR HANSON: Do we have a situation where we have got people who are of the same rank or position within ACT Health and one is on an SEA and one is not, where there is no specific recruiting or attention required for that? What I have heard anecdotally is that you have got people in a work environment and someone is on an SEA because they have been able to negotiate that whereas other people in the area who do similar work are not on an SEA. Are you aware of circumstances such as that?

Dr Brown: No, I am not aware of circumstances such as that. We do monitor the use of SEAs quite closely. It is very much around a specific skill need. If there is a range of people available, there is not necessarily any reason to offer one a bonus over the other. It is very much around the need that we have for the skill base. Not all specialists get it, but we have a particular need for some specialists who are very hard to recruit, and we may not have any in the private sector, for example, here in the ACT, so we may need to offer an SEA to attract someone to come to the ACT. But that does not mean that the next specialist gets the same deal.

MR HANSON: If I can move from there to industrial disputes, have you got any industrial disputes at the moment within ACT Health or have you been notified of any?

Dr Brown: No.

MR HANSON: I have got a document here that is from the AMA, from their workplace and industrial relations manager. It says:

AMA-ACT has notified a dispute to ACT Health in accordance with the Dispute Avoidance & Settlement Procedures of the Collective Agreement. The dispute is over the interpretation and implementation of the following Collective

Agreement clauses ...

And so on. You have not received that?

Dr Brown: No. We would be pleased—

Ms Gallagher: The AMA are not party to any certified agreement; they are not a registered industrial employee association. But tell me what it is in relation to. Is it from Andy Ozolins?

MR HANSON: Yes, it is.

Ms Gallagher: What is it in relation to?

MR HANSON: It is in relation to hours of work for medical officers, meal breaks, rostering practice for medical officers—

Ms Gallagher: Junior doctors?

MR HANSON: And overtime for medical officers. Yes, for JMOs. It says:

The response to our representations by HR ...

Ms Gallagher: There are certainly ongoing discussions with the AMA around junior doctors, but they are not a party to the agreement we have with our medical staff. They will be in the future, but they are not. To my knowledge—I do not know if Judi wants to come up and correct me—this has been an ongoing issue. The AMA and the salaried medical officers association, ASMOF, are in dispute about who should cover junior doctors. At the moment ASMOF covers them; the AMA want to cover them. Under Fair Work Australia, when the next agreement is negotiated, the AMA will be able to cover them or be a party to that agreement. But our question stands in relation to industrial disputes, in terms of those who are party to the agreements with us. The AMA has taken on board coverage of the junior doctors. They cover some junior doctors in terms of their own membership, but not all of them, and they are advocating strongly on junior doctors' behalf.

MR HANSON: Their comment is:

The response to our representations by HR—

I assume they mean ACT Health HR—

in some cases the lack of response, has to date been totally unsatisfactory.

And so on. How are you dealing with the AMA and the junior doctors on this? Is it a legitimate concern that they have? Have you addressed the AMA's concerns?

Dr Brown: The advice we have is that that is a discussion that has been had with the Fair Work Ombudsman, but it is not a registered dispute at this point in time. Judi Childs will be able to speak more fully on the issue of what discussions have occurred

with the AMA.

Ms Childs: We have been in discussion with the Fair Work Ombudsman on the matters that the AMA have raised, and to this date I believe we have supplied all the information that has been required of us and we are awaiting advice from the Fair Work Ombudsman as to what further information or discussions we will be having on the matters.

I do need to just correct one thing: we were notified of a dispute last week. The ANF have lodged a dispute with Fair Work Australia regarding our interpretation of payment for non-standard shift penalties. We are expecting to be advised of a date where we will talk about that.

MR HANSON: Okay, so if the ANF lodge a dispute, it is registered; if the AMA do, it is not? Is that right, because they are not—

Ms Gallagher: It is a different process in terms of the coverage, I think. The ANF and the ACT government are party to an agreement. The AMA is not currently. You said “industrial dispute”. In terms of industrial disputes, under our agreements the AMA have a list of concerns about the workplace conditions of JMOs but they are not conditions that are being—they are not a party to the agreement around our medical staff. But they are still being pursued. We work very closely with the AMA. I meet with them monthly. ACT Health meets with them as required. There is a little push and shove going on between the professional medical unions about who does what with whom and who represents whom, and I think you can see that in the work from the AMA.

THE CHAIR: I want to quickly go to the epidemiology branch and get some idea about what the branch is doing and what it plans to do in the coming year.

Dr Guest: The epidemiology branch has a portfolio-wide function and particularly focuses on the population health aspects of a wide range of diseases, notifiable and some non-notifiable. A key activity right now is the finalising of the Chief Health Officer’s report, which will provide information over a wide range of issues as required by the Public Health Act.

There are a variety of other reports in preparation at any given time. The epidemiology branch, for example, is assisting with the assembling of data related to the health and wellbeing of young people relevant to the feasibility study we were discussing earlier. I do not have in my head a complete list of every report it is working on, but possibly if you ask me about one, about your favourite topic, I might be able to say yes or no.

THE CHAIR: My favourite topics might be as long as the list of works that you are undertaking at the moment. It was more about how the findings from the work that you are doing, the various research projects, feed into health policy. There has to be some connect. I am trying to get an understanding of how your work then feeds in to shape programs and service delivery and so forth.

Dr Guest: We believe that the work of the epidemiology branch is critical to the

development of a wide range of policies and programs throughout the portfolio. To stay with the young people's health initiative, when we were preparing the Chief Health Officer's report two years ago, it was a few findings in that report that led to the budget bids leading to the feasibility study that may lead to the development of some initiatives in a year or so. The results of epidemiology research undertaken in the branch, and elsewhere in the portfolio, are intimately connected with the development of new policy and programs.

THE CHAIR: Are you able to provide, on notice, a list of the research and publications you are working on at the moment and some idea about when they will be finalised?

Dr Guest: Yes.

THE CHAIR: Thank you.

MR SMYTH: I have a couple of questions, first perhaps to Dr Guest. We spoke about this at the break. On the issue of immunising young people against the flu and the events of WA, can you update the committee on what has happened in the ACT and what advice you would give the parents of young people in the ACT in regard to flu injections?

Dr Guest: Yes. Just before Anzac Day the Western Australian government decided to pause the program for seasonal trivalent influenza vaccine for children under six. This was done because there had been reports, or apparent increases in reports, of adverse effects following immunisation in children over there. Many of you will be aware that after the 2000 series of deaths that occurred in children who had influenza who were not immunised against influenza, the Western Australian government had introduced a program of free universal vaccine for this age group. It was therefore not surprising that we have seen an increase in the number of reports of adverse effects.

The question was: is the increasing number of adverse effects reported in Western Australia above what would be expected if you extended the immunisation programs as they have? That is what the commonwealth Chief Medical Officer announced, on, I think, 23 April—that we would pause the program there. And of course other jurisdictions would follow suit, not because we have had an increase in adverse effects here in the ACT but because it would not be acceptable to continue vaccinating that young age group while this question was being investigated in one jurisdiction. So we have got a national pause of this program.

The chief health officers are meeting by teleconference with the Therapeutic Goods Administration regularly to discuss the findings. All jurisdictions are ensuring that the adverse effects following immunisation are all reported to a central place. We have tried to avoid speculation by a jurisdiction as to "you've got more than I've got", particularly for a place like the ACT where there have not been many adverse effects. But of course there have not been many adverse effects because, unfortunately here in the ACT and elsewhere, for private prescription it has actually been quite hard to get hold of the seasonal influenza vaccination. So, while people who have got priority group status—those with chronic disease, Aborigines and Torres Strait Islanders over 50, and so on—are getting their seasonal vaccine as they should, we have not actually

had a lot of immunisation of young children here in the ACT, so we would not know if it was a big problem.

The advice at the moment is to wait until the country decides whether in fact it is safe to resume immunising those under six. There has been no evidence here in the ACT that anything is seriously amiss. But, in view of the report in Western Australia, the pause continues. I would expect in a week or so there should be news. This has been quite an extensive investigation, not only into the adverse effects that get reported but also into the number of vaccines that have actually been administered. So at the moment the pause is in place. Parents of children under six should withhold the vaccine at the moment from their children. Everyone else, however, is being encouraged to proceed with it as before.

MR SMYTH: Okay. Thanks for that.

MRS DUNNE: On the subject of seasonal flu vaccine, what is the arrangement in the ACT? You adverted, Dr Guest, to private prescription immunisation being down? What are the criteria for free dispensing of seasonal flu vaccine?

Dr Guest: It is possible for people to ring our clinics and make arrangements. But, basically, the policy setting is to move immunisation for adults to general practice, where people can get the free vaccine if they are eligible—

MRS DUNNE: I want to know what the eligible groups are.

Dr Guest: The eligible groups are all Australians aged 65 and over; all Aboriginal and Torres Strait Islander people aged 50 and over; pregnant women, all three trimesters of pregnancy; and children aged, at present, six and over with chronic conditions.

MRS DUNNE: What about adults with chronic conditions?

Dr Guest: Yes. I should restate that. There is no change in this and these details are set out on the commonwealth website and elsewhere and in the immunisation handbook.

MRS DUNNE: And that is a free immunisation, or if you go to your doctor you do not need a prescription? He just pulls out a file and away he goes.

Dr Guest: That is ideal. I think somebody who wants to be immunised for seasonal flu vaccine would do well to ring forward to their GP and make sure they have got it.

MS BRESNAN: Would that include respiratory conditions, like anyone with a respiratory condition?

Dr Guest: The chronic conditions that make you eligible certainly include chronic respiratory conditions, chronic circulatory conditions and a wide variety of uncommon immune defects, and they are all listed in the immunisation handbook, which is on the web.

MS BRESNAN: And you said that is all people with chronic conditions covering all age groups?

Dr Guest: Yes, that is right.

MRS DUNNE: And anyone else who does not fit that has to go to their doctor, get a script, go and have it filled and take it back to their doctor?

Ms Gallagher: There are a range of workplace programs for many workplaces.

MRS DUNNE: Yes, we had one here, but what makes us qualify, just by way of interest—

Ms Gallagher: Because it is a public health measure by the employers. They want you to stay at work through winter. They do not want you to get sick with the flu—

Dr Guest: We encourage employers to—

Ms Gallagher: although maybe no-one would miss us in the workplace.

MRS DUNNE: What about people who are carers for people who might fit some of the other criteria—people with chronic respiratory conditions or chronic immune conditions?

Dr Guest: At the moment, carers of people who themselves are not unwell are not eligible for free vaccine unless they are in the other—

MRS DUNNE: Yes. I understand that. But there was a letter in the paper the other day from someone who said: “I am a 60-odd-year-old carer of somebody. How come I don’t get the free vaccine?” Is that a national policy or is that an ACT policy?

Dr Guest: That is the national immunisation policy, the national immunisation program.

Dr Brown: We should point out, however, that we do offer immunisation at community health clinics and that is available to all persons, including carers, free of charge.

MRS DUNNE: So if that person could be directed to his or her local clinic, that could happen.

Dr Brown: That is right; yes.

MS BRESNAN: I have a question about the health promotion grants program. I have asked a question without notice on this, but I want to get some more information about it. The government undertook a strategic review of the grants program last year, I believe. I am just wondering if we could get some information on the results of the review and where that is up to.

Dr Guest: The Health Promotion Branch engaged healthcare management advisers to

perform a systematic and strategic review of the ACT health promotion grants program. The outcomes of the review process were to provide advice on the appropriate strategic direction and funding format of the 2009-12 triennium for the health promotion grants program, to provide advice regarding the effectiveness of the program, to make recommendations to improve the efficiency and effectiveness of the grants management process, and to make recommendations to strengthen the processes used to evaluate individual projects and the effectiveness of the program.

The review commenced in April 2009. There were wide consultations with community stakeholders, government officers and the community as part of the review process. The views of the ACT community on the structure and operation of grants were sought through written submissions. In addition, two public meetings were held to provide information to stakeholders about the review and to discuss the key issues identified in the submission process. There was an analysis of the literature, local and national policy frameworks and grant programs in other jurisdictions. Finally, there was a report to the health department in October last year, with 43 recommendations. The response to this review is expected to be completed in the near future.

MS BRESNAN: Is there a time frame on when the response to the recommendations will be made?

Dr Guest: It is coming soon.

MS BRESNAN: It is coming soon. So it could be anywhere from six months to a year?

Dr Guest: It could.

MR SMYTH: He is not Ted Quinlan.

MS BRESNAN: No, he is not. Are measurements of outcomes taken within the grants program?

Dr Guest: There certainly are.

MS BRESNAN: What are some of these outcomes and the achievements from them?

Dr Guest: There is a wide variety of grants, and some of them have more easily measured outcomes than others. Let us just take sponsorship of sporting teams with, for example, the promotion of smoking cessation. There is a program that is measurable. You can see if there are signs up and leaflets distributed and if people are notified and informed by a program. But the point about health promotion grants—I would want to give the message that we embark on those with as much rigour as anything else in the healthcare system. Measurement is sometimes more difficult, but that does not make it less important. All of the programs that we fund in health promotion get as much evaluation as is feasible.

MS BRESNAN: Is part of the consideration about targeting particular vulnerable groups or is it, as you said, targeting particular areas where you want to achieve

certain outcomes such as a smoking cessation type of program? Are they both considerations that you take into account?

Dr Guest: The priorities of the health promotion grants?

MS BRESNAN: Yes. Are there priorities identified?

Dr Guest: There certainly are. There are different funding rounds advertised and the criteria for success are announced in advance to try and actually encourage people to hit the target. The health promotion grants staff do a lot of work with applicants to improve the quality of application. This is part of what we consider an important aspect of community engagement. And yes, the grants, of course, line up with government and portfolio priorities.

MS BRESNAN: In terms of the prevention programs, are there similar programs run by government that target vulnerable groups?

Dr Guest: There certainly are. For example, in the budget from last year, \$11 million was devoted to a series of programs for prevention at different stages of life. They complement the grants programs. We try to avoid overlap funding, of course.

MS BRESNAN: So it is about complementing what is already—

Dr Guest: Absolutely.

MS BRESNAN: Thank you.

Ms Gallagher: Ms Hunter, I would like to put some info into *Hansard*. I do not want to bring up the most contentious issue of the day, but I just want to read into *Hansard* a short excerpt of a media interview I did on 14 April, which was five days before COAG. I know that the Liberal Party listen very closely to everything I say on radio. This is the quote that I gave from Ross Solly's program:

... the GST component that we would I guess have hypothecated into health is probably about 40, upwards of 40 per cent of our GST revenue. It's 30 per cent across the board nationally, but because we're a small jurisdiction, it would essentially take almost half of our GST revenue, and ... maybe we can manage that.

But we have to just work through the detail.

We've only got the Commonwealth's final proposal two days ago ... And we've just got to work through all the detail, because it's too high risk to just say, oh well, the Federal Government wants it this way. So let's sign everything over.

That is a quote from two days after we got the draft arrangements from the federal government and five days before COAG.

MR HANSON: Can I follow up on that? That was a discussion you had on the radio. I must admit that I did not hear that before COAG.

Ms Gallagher: What a shame, Mr Hanson!

MR HANSON: What did you—

Ms Gallagher: I am so hurt.

MR HANSON: What did you do to outline what that was after COAG? That was an estimate you made before COAG.

Ms Gallagher: I can—

MR HANSON: Your press releases do not contain it.

Ms Gallagher: I spoke extensively in media interviews around this.

MR HANSON: From the front page of the *Canberra Times* today, they thought it was a surprise. Why, if it was so well publicised—

Ms Gallagher: The journalist from the *Canberra Times* who I gave an extensive interview specifically around this matter to was Danielle Cronin.

MR HANSON: So what you are saying is that you have given this information and it has not been reported?

Ms Gallagher: Yes. I have given the information, and I am just indicating for the purposes of *Hansard*—

MR HANSON: That was pre COAG, and it was not the figure we are talking about, which is 48.6 per cent, going to 51.6.

Ms Gallagher: The interview I gave afterwards was an extensive interview with Danielle Cronin. You will have to direct questions to the *Canberra Times* as to why they did not run that interview.

MR HANSON: Why is that figure not in any of the press releases that were released after COAG?

MR SESELJA: Or before?

Ms Gallagher: I cannot recall issuing a press release myself about that.

MR HANSON: There was a press release released from the Chief Minister directly after COAG.

MR SMYTH: It speaks of a proportion—

MR HANSON: And it does not mention that figure.

Ms Gallagher: It does not mention 30 per cent either.

MR HANSON: No, it does not. It says that from that time a proportion of GST—

Ms Gallagher: Anyway; here we go. That is the issue. I have addressed it.

MR HANSON: No, you have not addressed it—

Ms Gallagher: And my comments line up. Sorry to have raised it, Ms Hunter, but I just needed to—

MR HANSON: You raised this, minister; you cannot back away from it now.

Ms Gallagher: I know you are embarrassed, Mr Hanson, that you failed in your job, yet again, to actually understand the issues when they are raised, and publicly raised. You failed to respond at that time.

MR HANSON: They were not publicly raised.

Ms Gallagher: Probably because you were asleep, but there we go. I have raised it. It was raised on the 14th—raised publicly. It was raised prior to COAG and it has been raised after COAG.

THE CHAIR: Mr Smyth.

MR SMYTH: Perhaps, minister, you could provide that in writing so that we might actually read it. I have heard you read it once, but I would be interested in what you have said. I would like to flag that we might return to this in the morning, because it is a very important issue.

Ms Gallagher: It is not.

THE CHAIR: We can go through it this afternoon.

MR HANSON: Okay.

MR SMYTH: I have not got it in front of me. What I heard the minister say—

Ms Gallagher: Go and find it. You have got a media monitoring budget. Go and find it.

MR SMYTH: I am asking you, out of courtesy, to table it.

Ms Gallagher: It is from 14 April, the Ross Solly show. I presume it was after 8.30.

MR HANSON: This is pre COAG.

Ms Gallagher: You can even go to the ACT library and find it there. I am not going to do your job for you, Mr Smyth. I have done my job.

MR HANSON: Pre COAG.

Ms Gallagher: I have put it back on the record. I apologise to the chair for raising it again, but I felt that it was important that I back up the claim I made earlier.

MR HANSON: There was a lot of speculation about what happened pre COAG. We thought that we were going to get a local hospital network which included Cooma, Yass and Queanbeyan. We thought there were a lot of things in the mix. Now, because you happened to mention that the GST component might be somewhere around 40 per cent, as I recall you saying, on a radio program, and that is the only time that this has been mentioned, the community has been misled, minister. This is the point: you have misled the community.

Ms Gallagher: You have not done your job.

MR HANSON: You go out there and ask anybody on the street right now what percentage of GST we are giving up, and they will not say 48.6 per cent. They will tell you it is 30 per cent. That is a failure of this government, and that is a failure of you—

THE CHAIR: Mr Hanson, a question?

MR HANSON: She has thrown this in here. She has made a statement.

THE CHAIR: I know you are making a statement. What is your question to the minister about this issue?

MR HANSON: Why has she misled the community and can she point to evidence where she has actually addressed this issue and provided the information to the community about how much GST we will be giving up?

Ms Gallagher: I have just given you the evidence of how I have not misled the community, but slant it the way you want to, Mr Hanson. I would be embarrassed if I were you as well.

MR SMYTH: We will read it overnight and we will see who is embarrassed in the morning.

MR HANSON: If that is your defence—

Dr Brown: Can I provide information in relation to two other questions that we have taken on notice?

MR HANSON: Five days prior—

THE CHAIR: Mr Hanson, Dr Brown is providing an answer.

Dr Brown: One is in relation to the house at Queanbeyan. I am advised that we are able to refer ACT clients to the house. The second is in relation to Comcare claims around psychological stress. The numbers I can give you are for across ACT Health. In 2004, it was 26; in 2005, it was 18; in 2006, it was 17; in 2007, it was 10; in 2008, it was 10; in 2009, it was four, with two cases still undetermined; and in 2010, it is

zero, with two cases undetermined.

MR SMYTH: Thank you for that. I have a question. Minister, on page 242 of budget paper 4, under “Payables”, the note says that the increase of \$6.75 million in 2009-10 estimated outcome from the original budget relates to the timing of invoices received by ACT Health. What is so special about the timing of these invoices?

Dr Brown: We might ask the chief finance officer to provide that advice.

Mr Foster: If we have not received them, we cannot pay them. This relates to the fact that we have not received them in a certain time frame; so they are logged in the system for payment, when Shared Services actually pays, which is on a weekly basis.

MR SMYTH: So this is the allocation for anticipated invoices that have not been received?

Mr Foster: This is just a recognition of the timing. Yes, we accrue and then you actually spend when you receive the invoice.

MR SMYTH: So ACT Health pays all their invoices on time?

Mr Foster: Shared Services makes the payments. We are responsible for providing information to Shared Services to enable them to pay on time. There are reasons why not all invoices are paid on time. They can extend to disputed invoices, they can extend to the fact that we receive invoices with dates on and receive them some considerable days later than the actual date on the invoice. But in a monitoring system, that shows up as being a late payment but we physically receive them later than the date on the invoice. So there are reasons. I think we have put that information into a question on notice recently.

MR SMYTH: Minister, on the issue of litigation, over the last number of years—for instance, in 2008-09, there was \$14 million in damages of litigation, \$9.81 million in 2007-08, \$9.45 million in 2006-07—what has ACT Health actively been pursuing to reduce the amount of damages that have to be paid?

Ms Gallagher: We do not like to have to pay any damages but running a health system means that, from time to time, you will have to pay damages. We look to minimise our exposure to damages in everything we do. It is part of our core business. Nobody goes with the intention of doing any damage to anybody.

MR SMYTH: Sure, but what have you learned and what programs are in place to reduce the risk?

Dr Brown: We have a couple of ways in which we approach that. One is obviously learning from mistakes. So we have a very rigorous program for reporting incidents, then reviewing those, looking for the system’s learnings and then ensuring that we implement those learnings. That is a continuing process right across the health system.

One of the things we know about litigation is that it often does relate to the communication between the patient and the treating staff member. So we have got

some focus on improving communication, particularly around communication around incidents. We have an open disclosure policy which serves to have early communication with patients around any incident, how it happened, what has contributed to it and what we are going to do about it.

Ms Gallagher: We have the patient safety and quality unit; we have RiskMan, which is where incidents are logged; we have a policy of open disclosure when incidents have occurred where there were faults, to acknowledge that and; and we have a process about how we manage that forwards. So an enormous amount of work has gone into this area, particularly, I think, in terms of our processes since the neurosurgery issues at the hospital some years ago where we reviewed everything. Our clinical processes, our clinical review processes, credentialing and the privileges processes are very rigorous.

MR SMYTH: ACT Health get their advice from the Government Solicitor's Office?

Ms Gallagher: Yes.

MR SMYTH: Could we have saved on those costs if we had admitted liability earlier, rather than defending them?

Ms Gallagher: I do not know how you can answer that question. What makes up those liabilities would be a number of different cases for a number of different reasons, of which admitting liability may not have been relevant.

MR SMYTH: Are any of the legal claims solely from staff or industrial-related matters?

Ms Gallagher: Some of them are.

MR SMYTH: Could we get a breakdown of the proportion of which are medical and which are staff/industrial?

Ms Gallagher: Yes, I think we could look at that. As long as it does not breach any confidentiality requirements that may have been part of those agreements or settlements.

MS BRESNAN: This is slightly off the topic but, in terms of contracts or services that are contracted out to community groups or other organisations, are they required to report on any incidents that might occur within their activities?

Dr Brown: Are you able to speak to whether that is actually part of the contract with the non-government organisations? I do not believe there is a formal requirement to report to us. But Mr O'Donoghue may correct me on that.

Mr O'Donoghue: We use a standard deed of contract to service an agreement. I am just trying to scour my memory. I know there are requirements for complaints mechanisms placed on community organisations. I am not sure what other reporting obligations are placed on them in respect of incidents. But clearly, in terms of good practice, we would expect organisations to report any serious incident to us as

a matter of course. But we could look at the detail of the contract and see what—

MS BRESNAN: Just to know whether there is something which is formalised through the contractual processes that they have to report on.

Mr O'Donoghue: They are required as a matter of course to carry appropriate liability insurances and other insurances that mitigate risks. Depending on the nature of the service they provide, they may be asked to provide a risk mitigation plan. That may be part of the procurement process. But I can look at the detail of the contracts.

MS BRESNAN: It could be part of the procurement process that is incorporated in it, instead of having a risk management plan, whether or not it is formalised—

Mr O'Donoghue: A risk management plan is usually part of the procurement process, especially for a large procurement.

MS BRESNAN: I see they have liability insurance. Of course they have that.

Mr O'Donoghue: Indeed.

MS BRESNAN: And they would have to have police checks and all the usual things that go with that?

Mr O'Donoghue: Correct.

MS BRESNAN: Yes, but it would be good to check that.

Mr O'Donoghue: Sure.

MS BRESNAN: If it is dependent on what sort of service it is, as I understand it, that could be part of it too.

THE CHAIR: To clarify that, there was a question taken on notice. That is for *Hansard*. Thank you. I think that is the finish for today. As mentioned at the commencement of the hearing today, there is a time frame of five working days for the return of answers to questions taken on notice at this hearing. In relation to questions given on notice, these will be accepted for three working days following this public hearing for ACT Health. Members, please provide any questions on notice pertaining to acute services, mental health and community and public health services to the secretariat by close of business Friday, 21 May 2010.

On behalf of the committee, I would like to thank the Minister for Health and officials for attending today and, in advance, for responding promptly to questions taken on notice and given on notice. Tomorrow we will continue with Health. We will continue with cancer services, aged care and rehabilitation services and early intervention and prevention. That will be followed tomorrow morning by industrial relations. This public hearing is now adjourned.

The committee adjourned at 5.30 pm.