LEGISLATIVE ASSEMBLY FOR THE AUSTRALIAN CAPITAL TERRITORY

SELECT COMMITTEE ON ESTIMATES

(Reference: Appropriation Bill 2002-2003)

Members:

MR G HUMPHRIES (The Chair)
MR J HARGREAVES
MS R DUNDAS
MRS V DUNNE
MS K GALLAGHER

TRANSCRIPT OF EVIDENCE

CANBERRA

TUESDAY, 30 JULY 2002

Secretary to the committee:
Ms S Leyne (Ph: 620 50490)

By authority of the Legislative Assembly for the Australian Capital Territory

The committee met at 9.04 am.

Appearances:
Mr J Stanhope, Chief Minister, Attorney-General, Minister for Health, Minister for Community Services and Minister for Women
Department of Health and Community Care—
Dr P Gregory, Chief Executive
Dr D Dugdale, Chief Health Officer
Mr S Rosenberg, Manager, Mental Health and Correct Yourself Policy
Mr R Foster, Director, Financial Risk Management
Canberra Hospital—
Mr T Rayment, Chief Executive
Ms J Holt, Director, Medical Services
Calvary Hospital—
Mr R Cusack, Chief Executive Officer
Community and Health Services Complaints Commission—
Mr K Patterson, Commissioner

THE CHAIR: Welcome again, Minister and officials, to today's proceedings. Today we're examining the Department of Health and Community Care and the Attorney-General's Department.

I remind you that we asked for questions on notice to be answered within three full working days. To facilitate this, the transcript of proceedings is emailed each day to the minister and the departmental contact officer, for distribution to witnesses as soon as it is available. We ask witnesses to check the transcript to see if there's a particular issue that they're expected to take on notice. I'd ask members, therefore, when they're asking a question that they want taken on notice, to identify that clearly, so it's clearly indicated in the transcript.

Proceedings are being broadcast to specified government officers, and the media may record proceedings. We'll break for morning tea at about 10.30 and afternoon tea at about 3.30.

You should understand that these hearings are legal proceedings of the Legislative Assembly protected by parliamentary privilege. That gives you certain protections, but also certain responsibilities. It means that you are protected from certain legal action, such as being sued for defamation for what you say at this public hearing. It also means that you have a responsibility to tell the committee the truth. Giving false or misleading evidence will be treated by the Assembly as a serious matter.

I ask witnesses, as they come to the table, to state their name and the capacity in which they appear before the committee, for the purposes of the transcript.

As is our usual practice, we'll go through the agenda for the day and identify those areas where we expect questions to be asked. Ms Dundas is late, so it might be better if we leave that until she arrives, because she may have questions on areas that we don't

anticipate. We'll do that exercise a little bit later this morning, because we have overview questions about health to start with.

Minister, would you like to make an opening statement in this area before we commence?

Mr Stanhope: Thank you, Mr Chair. I am Jon Stanhope, Chief Minister of the ACT. I have nothing specific to say other than to say thank you for the invitation to attend these hearings. I, the head of the department and all officers look forward to assisting the committee in any way that we can.

THE CHAIR: Thank you, Minister. I'll start with a question about the productivity savings that the Treasurer has identified across government. We referred yesterday to that one-page document. I think you might have a copy of that now. It refers to savings in the Department of Health and Community Care of $1.6 million this financial year, rising to $2.4 million in the out years. Would you detail for the committee exactly where those savings will be made within the department, please?

Mr Stanhope: Thank you, Mr Chair. Dr Gregory will be happy to do that for the committee.

Dr Gregory: Thanks very much. I am Penny Gregory, Chief Executive of the ACT Department of Health and Community Care.

The savings that the portfolio as a whole offered up in the last budget totalled $1.6 million. I'll detail what those are comprised of. First of all, there was a reduction owing to the fact that the well babies program, which was about folate, did not proceed. That was a $90,000 reduction.

Health First is the consumer call centre. We reduced the allocation for Health First by $300,000 through continuing negotiation with those who run Health First. By combining the health promotion and healthy cities budgets, we've reduced them by $200,000.

In addition, $200,000 of those savings were forecast to come from portfolio changes as a result of the Reid review, in particular, because the board no longer requires payment. The information system that is being implement in community care provided $500,000 worth of savings, which was a considerable proportion of the total.

The remainder is made up of small amounts that relate to changing the way we order stationery, changing the way rostering takes place, changes to the fleet, and some other changes within the community health area that add up to the remainder of that total, $1.6 million.

THE CHAIR: Do you have a figure?

Dr Gregory: Just some changes in the way that services are delivered.

THE CHAIR: No, I mean what's the figure for that remainder?

Dr Gregory: $75,000.

THE CHAIR: $75,000. Okay. Had the well babies program been assessed as not being of value? Why was that discontinued?

Dr Gregory: If you're happy with this, I'd ask Dr Paul Dugdale to come and answer that question.

THE CHAIR: Sure.

Dr Dugdale: I am Paul Dugdale, the Chief Health Officer. When we were getting ready to commence that program, and had a look at the baseline folate intake of pregnant women and women who might be contemplating pregnancy, we found that the levels were very good, and that there wasn't really a justification for doing a folate promotion in the ACT.

It is a national issue, and that was why we'd originally contemplated it but, when we looked specifically at the ACT population, we found that its folate intake was better than the national average and there was no need for the program.

MRS DUNNE: Does that mean the program never ran?

THE CHAIR: It never happened?

Dr Dugdale: That's correct.

Dr Gregory: It was put up by the previous government, and the previous chief health officer, as something that, on the basis of evidence in other places, would be a sensible thing to do. When we then researched further to calculate whether it was needed, the evidence demonstrated that it was not needed, so the money was returned to the budget.

THE CHAIR: All right. Is it fair to see the $200,000 cut in the health promotion budget as a reduction in the amount spent on health promotion and healthy cities type issues in the ACT?

Dr Gregory: Again, I'll ask Dr Dugdale to answer.

Dr Dugdale: It is a reduction in the intended expenditure, but there is actually a considerable increase in the actual expenditure. In 2000-2001, total expenditure on health promotion and healthy cities was $338,500. In 2001-2002, the year just gone, the allocation was $951,500. In 2002-2003, taking into account the savings, the allocation is $1,112,100, so there is a continual growth in the health promotion allocation within the territory.

THE CHAIR: Okay. What's the source of those step-ups? Was that built into the budget for some reason?

Dr Gregory: That was actually the previous government's initiative in the 2001-2002 budget.

THE CHAIR: For health promotion generally?

Dr Dugdale: Yes. It's the health promotion strategies initiative of the 2001-2002 budget.

THE CHAIR: All right. You say that Health First can deliver a saving of $300,000. What's the total cost this year of Health First?

Dr Gregory: May I ask Susan Killion to take those questions?

THE CHAIR: You may, yes.

Ms Killion: I am Susan Killion from the Department of Health and Community Care. It's roughly $2.4 million. I don't have the figure in front of me. Certainly, the savings have come from having less advertising, and we're managing to do what was quite an expensive evaluation for less money.

MRS DUNNE: Are you advertising at all, or are you just cutting back?

Ms Killion: We're just cutting back.

MRS DUNNE: What sort of advertising are you doing?

Ms Killion: There is advertising in both the printed media and on television and radio.

MRS DUNNE: Just less of it.

Ms Killion: Yes.

Dr Gregory: The advertising campaign is actually run by McKessons, who run Health First. They do their own advertising, and we have reduced the amount of their budget for advertising.

MR HARGREAVES: Could I ask a question on Health First. What impact has it had on, say, the emergency part of the hospital?

Dr Gregory: That's been a question that part of the evaluation is aimed at answering, so we carefully ask people their intentions before a Health First call, and try to track the outcomes from those. Our understanding is—and Susan can say more about this—that it has not had a negative impact on the area in which the emergency department is having a problem, which is the growth in the category one emergency department attendances, those who need be treated in a very short time frame.

People who ring Health First are people who might otherwise be going to a GP. The difficulties with after-hours GPs, which we are working on at the moment, are part of that scenario. Our understanding is that the category fours and fives are not being substantially affected overall by Health First. Certainly, if we can improve the GP after-hours arrangements in the town, then things will be a lot better.

MS DUNDAS: Can I ask a question?

MR HARGREAVES: I'm just waiting for Ms Killion's response.

Dr Gregory: Did you want to add to that?

Ms Killion: I know that there are rumours that is a direct effect of Health First on the emergency department, but there is no evidence to prove that. We don't know that. We can't prove that. Certainly, the trend of increases in the emergency department visits began way before Health First came into place.

MR HARGREAVES: Right. You said you were evaluating it. When will that be finished, if I've missed it? Is it an ongoing thing?

Ms Killion: There have been two preliminary evaluations and those reports are out. There is also a full evaluation, the report of which isn't due until later on in the year.

MR HARGREAVES: When, roughly? Towards the end, at Christmas time?

Ms Killion: Yes.

MR HARGREAVES: Okay. Thank you.

THE CHAIR: Are there other questions on Health First?

MRS DUNNE: Yes. Dr Gregory, you said before—and I don't know whether I misheard you—that there wasn't an impact on category fours and fives as a result of Health First?

Ms Killion: There's no causative—

Dr Gregory: We can't see the relationship. The evidence for a relationship isn't appearing in the surveys we do. There's no relationship that we can track. As Susan says, the trend in fours and fives was already under way before Health First came along.

MRS DUNNE: Was the trend towards an increase in presentations of category four and five cases at accident and emergency?

Dr Gregory: Yes.

MRS DUNNE: Is that continuing?

Dr Gregory: I don't have those figures.

Ms Killion: Yes, that is continuing, and it is a national issue, not just an ACT issue.

MRS DUNNE: Yes. Is it continuing irrespective of whether people contact Health First?

Ms Killion: I don't know the answer to that.

MRS DUNNE: Or is it too soon to tell?

Dr Gregory: I think it's probably more related to the availability of forms of care that are alternatives to emergency departments, given the low numbers of bulk-billing GPs we have in the town, and also the expense of after-hours emergency services.

MRS DUNNE: The expense is considerable, yes.

THE CHAIR: Okay. Ms Tucker, do you have a question on Health First?

MS TUCKER: I'll just follow up on that, if you don't mind. It may be a question for Mr Stanhope, though. Given that there is a decline in the availability of bulk-billing for people on low incomes, and in regard to the discussion that we've just heard, what do you see as a possible solution to ensuring access to primary health care for people who don't have the money to pay up front?

Mr Stanhope: I know the AMA's response to a disinclination to provide the bulk-billing service is, in the first instance, to express concern at the lack of GPs within the community. There is the suggestion that, on a per capita basis, we are 40 or 50 GPs short in the ACT, so certainly there is a major work force issue that is perhaps relevant to the availability of services, and particularly to bulk-billing services. However, I note from this morning's paper that the latest information from the federal government is that 52 per cent of GPs in the ACT continue to provide bulk-billing. There has been a significant decline, but not as great as in other areas. It was interesting to see.

However, I'm sure there are work force issues that do affect the access to GPs, and do affect the willingness of GPs to provide bulk-billing. I think the initial indications are that the Health First initiative is providing very significant services. I note the discussion that has just been had. It is a discussion that perhaps would be more fruitfully concluded at the time of the final assessment of Health First. It would be interesting to have the chief executives of our hospitals engaged in that debate. They are here and are quite happy to enter the debate today, if members of the committee want that.

In relation to access to GPs, the problem is something that we are acutely aware of, with regard to which the department is pursuing a number of initiatives. I would be happy for Dr Gregory to expand on some of the work that has been done in relation to that, and that might be helpful.

Dr Gregory: Thanks. First of all, in relation to the work force issues that the minister mentioned, we did approach the Commonwealth, which holds the money and the key to the solution to this problem, to a large extent. We approached the Commonwealth arguing that, owing to the shortage of GPs in the town, we be given what is similar to an area of need status, so that we could recruit additional GPs.

Unfortunately, the Commonwealth rejected that application, not regarding Canberra as one of the areas experiencing critical shortages of GPs. In recent budget initiatives, the Commonwealth targeted its GP initiatives to outer metropolitan areas, and unfortunately Canberra doesn't come within that category. So, at the moment, work force questions are very difficult.

What we are doing is working very closely with the division of GPs, with a joint steering committee, and with our GP adviser in the department, to come up with some more innovative ways of arranging services after hours. We are looking for some seed funding from the Commonwealth to try to cover that access issue, which is related both to the numbers of GPs and also the expense. If you wanted some further background on that, I could ask Ian Thompson to provide that information.

MS TUCKER: I am interested to know how much work you have done in terms of identifying need in the ACT, for a start. Do you have a sense of whether there is any capacity for a person to access a bulk-billing doctor? I know that, when the city doctors closed their bulk-billing facility, that created an immediate crisis in that particular area.

You referred before to the trend towards using the hospital accident and emergency units, which started some time ago. That was when the bulk-billing 24-hour facility—I think it was—closed in Belconnen somewhere, and there was a spike in the graph after that. It is pretty obvious that it does have an impact on accident and emergency but, from what people are saying in the community, it is also obvious that you're not going to see some people on any graph because they are just not going to a doctor. Obviously, that is a public health problem.

I would like to know if you have a plan. You said that you are working with the GPs and the AMA, but are there other ways that you can look at this, and how far has that plan progressed? Some people talk about the potential for having independent practising nurses to deal with some of the primary care issues. What's your view of that? Are you pursuing that? I think it is a very serious situation because, in a way, the people who are most in need of access to primary health care are the ones who can't access it.

Dr Gregory: We would agree with you that it is a very serious situation. The issue is that, in this federal system, in which responsibility for health is divided between the state and territory governments—which are responsible for hospital and community health services—and the Commonwealth—which is responsible for the GPs and primary health to that extent—this problem becomes very difficult to solve because it requires both levels of government and the GPs to sit down together to work out the responsibilities.

It is very difficult because the territory already faces difficulties in providing enough funding to the sectors for which it is responsible, and therefore we are constantly calling on the Commonwealth to sit down with us and better plan the GP end, the primary health end. We don't have the resources to direct into that area because it is something that, under the federal system, is the responsibility of the Commonwealth government.

We are well aware that there are a lot of areas of need, as you rightly outline. That was part of the basis of our submission to the Commonwealth about requiring extra GPs, and it's the reason that we are providing a submission to the Commonwealth for seed funding for a more innovative arrangement to cover this issue. We are well aware of those

problems. It is a very difficult problem for the territory government as it has to decide to what extent it wants to step in and take over the responsibility of the Commonwealth government, which funds the GPs.

MR HARGREAVES: Dr Gregory, you did mention Ian Thompson a minute ago. I know he has been working very hard with us on the Lanyon Valley issue. I think that would be a very good contribution to Ms Tucker's question. It is something that I had in my mind and you raised it earlier, Kerrie. I would like to know what point the discussions have reached.

MRS DUNNE: Dr Gregory, you were saying that you are making innovative approaches to the Commonwealth. Are you in a position to say what those innovative approaches are at the moment?

Dr Gregory: I'll hand over to Ian.

Mr Thompson: I am Ian Thompson from the Department of Health and Community Care. The innovative approaches at the moment are specifically concerned with after-hours care. We hope to get Commonwealth support for funding for an after-hours care initiative. They are considering our application at the moment, and we hope to get an answer later this calendar year.

MRS DUNNE: You said you are looking at an after-hours care model, but can you describe what the model might be?

Mr Thompson: There are a couple of issues with after-hours care. We don't have universal access to the Canberra after-hours locum medical service at the moment, and so one of—

MRS DUNNE: You need to pay $55. Is that the impediment?

Mr Thompson: Yes, it's both an up-front cost issue and also that Canberra after-hours locum medical service only provides care to patients of the GPs who are members of CAHLMS. What we're looking at is working with CAHLMS. I must stress that, for all the solutions that we're working on, we have to work very closely with the medical profession and the locum medical profession, because they are the providers, and their agreement and support is essential for this.

So we are working with CAHLMS at looking at options to increase coverage of CAHLMS, and increase the number of GPs who are members of CAHLMS. One of the potential solutions is a better arrangement for what's called the graveyard shift, the midnight to 6 am shift. Having to work that shift is a major disincentive for doctors to be members.

MRS DUNNE: Has it always been the case, Mr Thompson, that CAHLMS was only available to patients of CAHLMS members?

Mr Thompson: Yes, that's correct.

MR HARGREAVES: We have discussed at length with yourself, the minister's office, Laurann Yen and quite a number of people, the issue of the Lanyon Valley having no doctor at all at the moment. I think the only surgery—and Mr Smyth would know this—is at Gordon, and that has closed its books now. Are we further down the track than we were the last time we spoke?

Mr Thompson: We are further down the track. We've had discussions with a number of doctors' organisations about potential solutions. I don't want to be definitive about that because, as I stressed earlier, we need agreement from the local medical organisations and the medical profession on what we're developing. However, the sort of solution that we're looking for is an option that would enable GPs to work part time, building on existing services.

As you know, the maternal and child health service is down there at the moment. We have spoken to them and they have clearly indicated that it would be an advantage to have a part-time doctor available to supplement their service. So we are looking at the extent to which we can expand that service with a part-time doctor.

The other area of particular concern is the youth service. As you know, there is a particular model for providing care for youth services available at the moment called the Junction. We are looking at the possibility of expanding that service as well, to provide better care at Lanyon.

MR HARGREAVES: Okay. I understand the sensitivity of the negotiations as well, so I'm not going to press you for too much detail. However, I am rather anxious to know whether there is a time line for providing a solution. These folks have needed the services there for a donkey's age and I'm rather anxious to find something down there rather quickly. Do you have anything encouraging to tell me?

Mr Thompson: Yes. Unfortunately, I hesitate to be definitive about a time line.

MR HARGREAVES: Well, do try.

Mr Thompson: Yes.

Dr Gregory: Perhaps I can add to that. One of the difficulties is that, traditionally, GPs are small business people. They are not employees. They are funded by the Commonwealth to run small businesses, and the solutions we're looking for don't necessarily fit with the small business approach. There are some interesting and difficult threshold issues that GPs must deal with in order to provide more flexible and responsive services.

MR HARGREAVES: I also understand—and I don't know much about the detail of this, not being in the medical profession—that other innovative models are either being trialled or are operating in other places, such as Sydney, with a different type of nurse practitioner service. Is investigation of that option still on the table?

Mr Thompson: Yes, we've just about completed a trial of nurse practitioner services. We expect the final report of that to be available within the next month or so. We are getting final comments from the steering committee on that. To date, none of those nurse

practitioner positions have been specifically for community-based nurse practitioners. However, a community-based nurse practitioner is something we definitely want to consider for the next round.

In terms of what that model would look like, nurse practitioners are independent practitioners, but in the model they work as part of a team, so we have to establish a team environment in which they can work. Again, this model has the potential to link with the maternal and child health service in Lanyon. We would look at a model, if there is support from that service, and we can develop an appropriate model for nurse practitioners.

MR HARGREAVES: It's advancing the role of nurses in medicine quite significantly, from my understanding. Does the concept, which is quite new, have the support of the medical practitioner profession?

Dr Gregory: We actually did a trial of nurse practitioners and the evaluation report of that will be released fairly soon. The amount of GP support for the various nurse practitioners we trialled varied.

MR HARGREAVES: I'll bet it varied.

Dr Gregory: When it's in an area that doesn't directly, shall we say, threaten their traditional work areas, then we did receive support. This is clearly an area that would have a significant impact on GPs. It relates back to what I said before about a process of ensuring that the GPs are not entirely threatened, but see these practitioners as part of a team.

MR HARGREAVES: Good luck. Thank you.

MR SMYTH: Mr Thompson, is the promise of the two GP clinics in your area?

Mr Thompson: Yes, it's in my area.

MR SMYTH: What point has that reached?

Mr Thompson: At the moment, we're looking at that in the after-hours options. At this stage, we're not specifically talking about establishing a clinic. We are talking about strengthening the CAHLMS clinics that are currently at the two hospitals. The reason we are approaching it from this perspective is that this is the model of which the medical profession, the GPs themselves, are most supportive. We're looking to strengthen what they're currently doing, rather than stepping in and establishing something new.

Dr Gregory: What we faced with that was that, if we step in with something new and lose the goodwill of those doctors who are currently doing the graveyard shift, then the whole capacity to have any sort of after-hours service would probably collapse. We need to work with the goodwill that is there and strengthen what we have, rather than saying, "Let's start again and do something different", and alienate them all.

I wonder whether it would be also useful for Ian to advise the committee about the two-week study we did in the emergency department of category fours and fives, which he oversaw and which I think is of particular interest.

Mr Thompson: As part of the development of our model for after-hours care, we conducted a two-week study of all category four and five patients who attended the emergency department. Category fours and fives are the less urgent patients, the people for whom care is not required in a short period of time.

I think a number of significant issues emerged from that. The first—and this is particularly relevant in the context of bulk-billing—is that 85 per cent of people said they would prefer to have gone to a GP, and would have been prepared to pay for it if they could access a GP. That suggests that the major issue that we face is access in general, rather than access to bulk-billing in particular.

The next issue, which is equally significant, is that 46 per cent of people weren't aware that there were other alternatives. Again, this gives us something to work on. As part of our after-hours proposal, we are looking at making the information about alternative forms of care, and access to those, more readily available to people.

The final issue involved looking at people who attended emergency departments and whether or not it would be appropriate for them to see a GP. The directors of the emergency departments had a look at the results of the attendance, after the patients had seen a doctor, and concluded that about 60 per cent of category four and five patients could have been cared for appropriately by a GP.

MR SMYTH: What are the alternatives: visit a GP, ring Health First? What else?

Mr Thompson: Essentially for primary medical care, yes, it's visit a GP or ring Health First.

MR SMYTH: But you've just told us you've dropped the promotional budget of Health First by $300,000. Is that not illogical?

Dr Gregory: We're actually not concerned about the degree to which people are aware of Health First. It came out with a very big advertising campaign and the usage rate of Health First is good. Therefore we are concentrating much more on the GP side.

MR SMYTH: All right, but would it not be better if we constantly reminded people that Health First was there, and would that therefore not take pressure off the clinic?

Mr Thompson: The advertising hasn't been stopped.

Dr Gregory: Cut altogether.

Mr Thompson: It is more targeted advertising, because something that's come through clearly is that people's awareness of Health First is very good. We don't think it's an awareness issue with Health First per se. It is actually an awareness issue about how to access GP services after hours.

MR SMYTH: Okay. To go back to the first question, you ran through a list of where the cuts or the savings had occurred. That adds up to 1.4—

THE CHAIR: Before we leave after-hours health care, are there any other questions about after-hours GP care? I might do that so we keep these in discrete bundles. Do you want to ask him a question about that? Kerrie?

MS TUCKER: Yes, I have a couple of questions. I wasn't quite clear: when you said that 85 per cent of people you surveyed said they would have used a GP and paid for it if they'd known, are you only talking about after-hours services?

Mr Thompson: Yes, this is after hours.

MS TUCKER: What percentage of people are using the hospital all the time for basic category four or five cases, as you've described it, because they can't get free medical care.

Mr Thompson: We actually did conduct the survey 24 hours a day. We haven't done the analysis yet of the in-hours component, but we're doing that at the moment. Unfortunately, I can't answer your question at the moment, but I should be able to within about a month or so.

MS TUCKER: Okay. I'd also like to know what the cost of servicing a category four or five patient in the hospital would be compared to that of looking after that person in, say, a health centre with a salaried doctor.

Dr Gregory: That is a very difficult question to answer because, as I'm sure the hospitals will tell you, emergency departments have a lot of very fixed costs. Emergency departments have to be staffed to a level that will allow them to cater for whatever emergency comes in the door, off the helicopter or off the ambulance, within the correct time frames, and we're talking minutes here. The level of staffing that has to be available in an emergency department is aimed at that high level. At times, category fours and fives can be treated within that without a lot of additional resources, because those people have to be there anyway.

A lot of studies have been done that have tried to come up with a cost that relates to categories four and five, but again it's very hard to find a true variable cost. If you wanted further information, I'm sure Peter or Robert would be happy to help.

MS TUCKER: I'm just trying to understand how you work out what is feasible. You are saying that it is a Commonwealth issue, and there is cost shifting and so on, and I understand all that. I don't know if categories four and five are the only categories that a general practitioner would handle. Is that correct, or would they also handle categories three or two, so that the issue is broader?

Mr Thompson: Generally speaking, if patients are in categories one, two and three, it's not considered that a general practitioner would be an appropriate alternative form of care. It is also worth stressing the 60 per cent figure that I mentioned earlier. It is not automatically the case that, if you're in categories four and five, a general practitioner would be the appropriate form of care. A significant percentage of both category four

and five patients are actually admitted to the hospital as a result of their attendance in the emergency department.

MS TUCKER: Thanks. I'm interested to know how you make the decisions that it is better to leave these people accessing the hospital at this point in time. You would think that, even if it is difficult—and you're telling me it is—to give a clear cost comparison, there are other benefits of having the availability of primary health care in the community linked to a health centre of some kind, which has the capacity for broader referral into support services, and so on.

We are talking strictly medical stuff here, with Health First as well. You don't have a service there to refer patients to broader support services. I would be interested to know if picking up the social context of health in Health First has ever been considered, because that's obviously something that comes up every year. People don't know where the services are for the broader social issues related to health.

In your plan for delivering good public health services, how do you decide, "We can't do this because it's too complicated or because it's a Commonwealth issue", and so on. This has been going on for years. In my short time here I've become familiar with that.

Mr Stanhope: I think, Ms Tucker, that a tremendous effort is being made and there is a tremendous commitment to resolving some of these issues. There are some very complicated factors. There was an interesting trial that I supported, which was conducted by Mr Moore at the Canberra Hospital, in relation to the co-location of a GP. I think that particular trial, which, as I say, I supported, sounded like a really good idea to me. It would be interesting to have Mr Rayment provide an explanation of the outcomes of that trial.

The trial certainly added to the sum of our knowledge about how to deal with this issue of providing primary care and after-hour access to GPs. I think it was an interesting experiment. However, I think Mr Rayment can give you some indication of what happened. We've moved on from that, but it certainly has informed our thinking. The processes that we have in place now for addressing this issue are the ones that have been described. That is the point we have reached. Mr Rayment, if you could explain? It is an interesting illustration of what we've tried, what we think hasn't worked, and the things that we continue to trial in relation to this very difficult issue.

Mr Rayment: I am Ted Rayment, the Chief Executive of the Canberra Hospital. Just to put this in context, in the emergency department there are times when we're absolutely full to the gunwales and have patients waiting to go into a ward. It is at those times that category four and five patients become problematic. In times when we're not under great pressure—we seem to be, more often than not—the category fours and fives can be picked up in the normal course of business.

The trial to which the minister referred was a four-month trial that was conducted. At the time, we had a GP-type service at the Canberra Hospital. The evaluation of the clinic that was run there was measured by the number of patients triaged to the low-acuity clinic, the waiting times for the low-acuity clinic and the waiting times in the ED department.

The low-acuity service was available on 55 weekdays out of a possible 69, and 27 weekdays out of a possible 28, so for approximately 707 hours of operation. The service treated 711 patients, which is approximately one patient per hour. This is about 5.3 per cent of the total ED presentations.

The mean time that patients waited to be seen by a doctor in the service was 59 minutes for category four patients and 63 minutes in ED, and 52 minutes for category five patients and 71 in ED. That's the comparison there. The service saw 61 per cent of category four patients within the recommended time of one hour, which is identical to the emergency department. The service saw 93 per cent of category 5 patients within the recommended two hours, compared to 75 per cent in ED. To conclude, while there was a slight improvement in the waiting times on some shifts, there was no obvious pattern of effect on the ED waiting times at that particular trial.

There was an improvement of about 2 per cent in waiting times for a five-hour shift, which is in the order of that which would be expected if another doctor were to be employed in the emergency department. Even if we had not run the trial, we believe that, if we had employed that person in the emergency department, we could have just dealt with those patients there.

The people I've been speaking to at the hospital feel that the fundamental issue is that, if we had an after-hours service in the community for the people who come to the emergency department, get frustrated and go away because they haven't been treated when we're very busy, we'd have an alternative.

MS TUCKER: That's interesting, but I have a broader question: if you agree that it's good for people to have access to a doctor when they need it as a preventative response, then you have to say that you're interested in looking at access. At the moment, the hospital carries the load of people who don't have the up-front money. I am not just talking about after hours. This involves people in the community, particularly people at risk who are vulnerable and impoverished or disadvantaged.

If they don't have access to a local doctor, the hospital is a long way away for a start, and transport and access are issues, according to people I talk to who work with this group in our community. If you agree that prevention is good, and that it stops more serious illnesses which would be in the other categories once they get to hospital, then my questions go back to where I started: what's your analysis of access to basic preventative primary health care for people in the ACT who can't pay, and all day, not just after hours?

Then, after that, you have that picture, and you know what the groups are. Then you have to look at the cost, in the long run, of providing, say, a salaried medical doctor in a health centre with access to other services and support, who will see health in a holistic way. These surveys are interesting, but they're not coming back to those basic questions that my limited reading of public health leads me to believe are fundamental.

Dr Gregory: I don't think anyone would disagree with you that a comprehensive primary health care service within the community is very fundamental to those issues. The difficulty is how we actually deliver that. In relation to the after-hours issues, community health centres with salaried doctors, when we had them, were not open after

hours. They don't necessarily relate to the after-hours issue, because creating the after-hours infrastructure is a very difficult and expensive thing, which you don't necessarily want to do in too many places.

Regarding a much more comprehensive primary health care service, yes, absolutely. A lot of the Commonwealth-state joint work is trying to deliver services where, with this big funding divide and incentives that aren't necessarily in the right place, we can actually work together.

Laurann Yen might want to talk a bit further about what we're doing in preventative community health to try to strengthen that approach, if you are happy.

MS TUCKER: I've asked a question about people's access to the GPs. If the committee wants to hear the broader community health responses that is fine, but I think I have received the answers to my questions regarding the planning stage.

MR HARGREAVES: This is related to that question I asked about the Lanyon Valley. I'm interested in the provision of daytime GP services in areas that don't have them as well.

Dr Gregory: I think it does come back to what Ian was talking about—innovative models. Innovative models is code, in some ways, for GPs being employed in different ways to the traditional small businessman way in which they have been employed in the past. That's absolutely what we're working on in those proposals. We are concentrating particularly on Lanyon. We believe that the Junction youth service is a good example that we're trying to translate into other places as well.

MS TUCKER: Can I ask about the Junction then?

MR HARGREAVES: Go for it. Knock yourself out.

MS TUCKER: You mentioned the Junction. I can ask about the Junction.

THE CHAIR: Well, hang on, that's a daytime service.

Dr Gregory: Yes.

THE CHAIR: Yes, let's just finish with after-hours care.

MS TUCKER: Well, it's primary health care.

THE CHAIR: Fine, okay.

MS TUCKER: But no, fine.

THE CHAIR: No, let's try to keep this in bite-sized chunks.

MS TUCKER: Whatever you say, Chair.

THE CHAIR: I wanted to ask a couple of questions about the after-hours service. A member of the AMA suggested to me about a year ago that the problem with the after-hours GP, with the CAHLMS service at the moment, is that doctors have to pay to be part of it. The administrative cost means that they're working for much the same, late at night, as they would be during the day. There's no particular incentive to work at 3 o'clock in the morning, if you might get the same amount of money for working at 3 o'clock in the afternoon.

MRS DUNNE: And you may have to turn up and work at 3 o'clock in the afternoon as well.

THE CHAIR: Indeed. That person asked whether the government would contribute to the administrative costs of running that service. Has the government considered that idea?

Dr Gregory: That's certainly part of what we're looking at with the division of GPs. Another related issue is their safety after hours, and how safe it is for a lone GP to go into somebody's house after hours. There is a whole range of issues that Ian might want to give us some further detail on. When we say innovative models, we're talking about an increase in funding that might come from the territory in order to trial a model to get over some of these barriers.

Mr Thompson: We actually raised with CAHLMS the issue of payment for membership. CAHLMS is reluctant to drop it because there is a risk that, if it doesn't charge up front, then its capacity to provide administrative support will be considerably lessened. It's very important for the service to have that administrative support.

Regarding the proposal that we've put to the Commonwealth, we're talking about the ACT government putting up $140,000 a year to assist with this matter. That won't remove the need to provide the payment for membership of CAHLMS, but it will greatly assist to provide the graveyard shift cover, and to remove some of the disincentives for membership of CAHLMS and make it a little bit more attractive for doctors to join.

The other thing that's worth mentioning is that the Commonwealth government actually does give what's called a practice incentive payment to GPs to provide after-hours care, so it does contribute to the cost of that. While membership of CAHLMS costs, the Commonwealth does provide compensation for some of that cost.

THE CHAIR: Where does that leave the government's promise to build at least two after-hours clinics staffed by GPs, preferably at Calvary and Canberra hospitals?

Mr Stanhope: It leaves it in the mix of options that are currently being considered, Mr Chair.

THE CHAIR: This wasn't put forward as an option. Labor actually promised that it would establish at least two after-hours clinics. Are you saying that it might not happen now?

Mr Stanhope: That's possible. Yes, it might not happen, but the clinics would certainly be replaced with what, on the basis of further investigation and study, is a better way forward or a better model of ensuring after-hours care and primary care.

THE CHAIR: Do you mean that it would be an enhancement of the existing service?

Mr Stanhope: Whatever it is that we, at the end of the day, can negotiate with the Commonwealth and decide to do. That's quite right. It is certainly now in a mix of the options that the government is considering, but it's probably not our primary focus, at this point.

MRS DUNNE: So does that mean, Minister, that your policy proposals before the last election weren't properly thought out?

Mr Stanhope: I'm sorry, Mrs Dunne, I didn't hear you.

MRS DUNNE: Does that mean that the policy proposal you put forward for two after-hours clinics based at Calvary and Woden were not properly thought out?

Mr Stanhope: No. As I said, I was encouraging and very supportive of the possibility of after-hours clinics at Calvary and at the Canberra Hospital. I think it was after I first indicated that this was the Labor Party's intention that the previous minister, Mr Moore, initiated a trial of a GP service at the Canberra Hospital.

THE CHAIR: No, actually it wasn't. It predated that. It was already in train.

Mr Stanhope: I don't think it was, but certainly, Mrs Dunne, my thinking in relation to co-located GP clinics is very much affected by the sort of information that Mr Rayment has just given the committee. Certainly, I'm more than happy to adjust my thinking in relation to options on these difficult issues on the basis of the evidence and experience.

We now have the benefit of a four-month trial, which was rigorously assessed at the Canberra Hospital, and which—while it was useful in itself—we would have to say didn't prove to be particularly efficacious in resolving issues about after-hours care or access. Our judgments are informed by that. We learn from that and we move on, to try to find appropriate responses. That's what the department is doing, and doing rigorously.

MRS DUNNE: Mr Thompson, does the department have any feel for where there are pockets of need? We know that there is a general need for GP services in the Lanyon Valley but, in relation to after-hours services, do you have a feel for whether they're best addressed on site at hospitals? For instance, CAHLMS operates essentially off the Calvary campus or the Canberra Hospital campus. Would there be more benefit to the community as a whole if there were CAHLMS-type services available, say, in Gungahlin and Kambah as well?

Mr Thompson: Yes. CAHLMS also has a weekend clinic that it operates at Erindale. One of the issues to bear in mind in terms of the location of the clinics is that having them at the hospital is good for the transfer of patients if an emergency arises. However, something that the GPs themselves are quite concerned about is security. It concerns a GP sitting with a receptionist late at night—someone could think they have money or

drugs. GPs are very concerned about their security, and one of the things that attracts them to being located on the campuses of hospitals is that they would actually have the security infrastructure of the hospital around them.

MRS DUNNE: Rather than being the one light burning in the shopping centres?

Mr Thompson: Exactly.

MRS DUNNE: Okay, I see the point.

MR SMYTH: Was the trial at the hospital bulk-billing or did people pay for the service?

Dr Gregory: Because it was at the hospital, it had to be free. It's not even bulk-billed. Under the health care agreement with the Commonwealth, any services at the hospital have to be free of charge. It is one of the very strange incentives in the system that, if you go to the hospital, the service must be free, and if the same service is provided anywhere else, it is paid for, with a co-payment.

THE CHAIR: Questions about after-hours services, Ms Tucker?

MS TUCKER: I am right. I have a different subject.

THE CHAIR: If we've finished with after-hours service, are there any questions about the list of savings?

MR SMYTH: Yes, if we can go back to the savings. Unless I've missed one, I add that up to be $1.365 million of savings. Did I miss something? You had $90,000 for well babies, a $300,000 saving on Health First, $200,000 on health promotion and healthy cities—or was that $200,000 each?

Dr Gregory: No, that's correct.

MR SMYTH: $200,000 for folio changes, $500,000 on the computer system and $75,000 on minor changes. That leaves a shortfall of $263,000, if I can add up.

Dr Gregory: Yes, I think that's because I didn't give you a figure for the fleet rostering and stationery. I mentioned them, but I didn't give you a figure.

THE CHAIR: Yes, you said that was $75,000. That's what you said was $75,000.

Dr Gregory: No, minor charges in delivering community health services and the way they were delivered was $75,000. The bit I didn't give you a figure for was fleet rostering and stationery, which is a total of $160,000.

MR SMYTH: 160?

Dr Gregory: 160: 65 fleet, 45 rostering, and 50 stationery.

MR SMYTH: That would leave then $100,000 unaccounted for.

Dr Gregory: No, I think that covers the lot, according to my maths.

MR SMYTH: So fleet, rostering and stationery is $100,000?

Dr Gregory: 160 altogether.

THE CHAIR: Any further questions about the savings targets? All right, let's move on. We're dealing with an overview of Health and Community Care, including capital works. Any questions?

MS TUCKER: What has happened with the action plan for health that was meant to have been developed out of the health summit?

Mr Stanhope: It is being developed, Ms Tucker. I have to say that our timing on it has slipped a month or so as a result of a major restructuring of the portfolio, to which we gave a higher priority than the action plan. However, work is very well advanced. I'll ask Dr Gregory to update you on the work that's being done on that, Ms Tucker.

Dr Gregory: Thank you. I'm pleased to say there is a draft in existence and very shortly—I'm hoping later this week or early next week—that will be available to community organisations and medical professionals across the board. We will then be holding four public meetings to give a presentation on the content of that health action plan, and to seek feedback from the community and medical professionals about whether they think the plan encapsulates what came out of the summit.

The health action plan has been put together from what came out of the health summit, and also from what came out of the consultations and work that Mick Reid did in the Reid review and the government's response to that. We anticipate that it will be available as a consultation draft very shortly. We've spoken to health care consumers and ACTCOSS about assisting us in hosting some of those consultation sessions, and there'll be one at each at the hospitals as well.

MR SMYTH: Is there a costing attached to the implementation of the health action plan?

Dr Gregory: It's aimed to be delivered within the existing forward estimates.

THE CHAIR: Other general questions. Ms Tucker?

MS TUCKER: Yes. I understand that the ACT health quality and safety forum is tasked with developing ACT-wide standards for consumer input. What's happening with that?

Dr Gregory: If Jenny Berrill was here, I'd ask her to speak but, as she's not, I'll ask Paul Dugdale.

Dr Dugdale: I am also chair of the quality and safety forum. For that project you referred to, we've employed officers to work with consumers at both Canberra and Calvary hospitals, and ACT Community Care. They have assembled reference groups involving consumers at each of those sites, and are working on the development of the standards. Work is also going on in the ACT Health Care Consumers Association on that project.

MS TUCKER: What's the time frame for that?

Dr Dugdale: I can't recall the agreed time frame for the project, but I understand it will go on for around 12 months.

Dr Gregory: We could bring that information back to you after lunch if you are interested.

MS TUCKER: Okay. I have another general question about Winnunga Nimmityjah. They're in a physically difficult facility. What do you intend to do about that, if anything?

Mr Stanhope: Yes, they certainly are, Ms Tucker. Winnunga Nimmityjah has expanded way beyond the capacity of its current accommodation. We, as you know, are jointly funding a strategic planning exercise with the Commonwealth. The ACT government and the Commonwealth government are jointly funding consultants to develop a strategic plan for Winnunga Nimmityjah. I believe the date for completion of that must be drawing nigh. In the context of that, we've delayed decisions on Winnunga Nimmityjah. I have written to the Commonwealth. I'm sure I wrote.

Dr Gregory: Yes, you did.

Mr Stanhope: I wrote to the Commonwealth, indicating to them the ACT government's concern about the physical situation of Winnunga Nimmityjah. I understand there are now 27 employees of Winnunga Nimmityjah and they operate out of a three or four-bedroomed house. There just isn't room within the facility for the people who are employed now by the organisation. Of course, Winnunga Nimmityjah, as we all know, is fundamental to the delivery of health services to indigenous people in the community.

I've written to the Commonwealth indicating that the ACT government would wish to pursue with the Commonwealth arrangements for providing appropriate accommodation for an indigenous health centre in the ACT. I would be prepared to negotiate with the Commonwealth about our capacity to provide land for the development of a new facility, but we would be looking to the Commonwealth to meet the costs of the development of that facility.

Having said that, we've also agreed with the Commonwealth that we'll await the outcomes of the strategic plan, which I think is fundamental to the future direction of the health service. It's something we're aware of and concerned about.

MS TUCKER: When's that due to be completed?

Dr Gregory: The end of August.

Mr Stanhope: The end of the August.

MS TUCKER: Right, okay. Can I continue? The dual diagnosis project is related to that matter to a degree, but not just in relation to indigenous people. What's happened with that?

Dr Gregory: My understanding is that that project is well under way, and I'll ask Laurann Yen or perhaps Simon Rosenberg to fill you in.

Mr Rosenberg: I am Simon Rosenberg, Manager of Mental Health and Correct Yourself Policy, Department of Health and Community Care. The dual diagnosis project has been under way for about three years now, since the *Dual diagnosis: stopping the merry-go-round* report came out. Both ACT Mental Health Services and the alcohol and drug program of ACT Community Care, as they were, have been working together on joint training and education arrangements, and on such things as common assessment protocols.

More recently, the non-government sector and consumers and carers have been involved as well. There have been additional resources for that project but, increasingly, that has been mainstreamed into the core business of each service.

MS TUCKER: Is that it? Okay. Are you training people at the moment?

Mr Rosenberg: There is a combination of training and development for the clinicians in the services, but also the development of things such as common assessment protocols and, increasingly, team approaches and multidisciplinary approaches to working with the clients.

MS TUCKER: What does this mean in terms of facilities being available, because obviously there's unmet need in the area of mental health and people who are suffering from substance abuse. We have one facility at Watson and a new facility in the last few years, but what is the plan for meeting need? Do you have a sense of the unmet need and what should happen?

Mr Rosenberg: There's unmet need in both areas, and I think we'll have a better sense of that after some policy and service development work is done in both areas. As you probably know, we have a mental health strategy and action plan that is about to get under way, and also work for the drugs task force.

Because of the importance of dual diagnosis as an issue, there'll be a lot of work that crosses over between those activities to ensure that that target group is addressed. One thing to say about unmet need is that it's not just about the fact that there are people who aren't accessing the services, because the need is great: it is also that the nature of the service can be a barrier to access in itself. Improving the way services work together—giving people one access point at which they can have their needs met, rather than having to go around through different referrals—should improve access and, we hope, outcomes for consumers.

MS TUCKER: Yes. I totally agree and understand that. That's the barrier that has been talked about for years now. That's why you have a dual diagnosis project. The problem was that people were falling through the gaps. However, my understanding of the situation is that there does need to be, and there will need to be, more beds, more responses on the ground for people who are at the point in their lives where they do want to seek help.

They get in: there's not a barrier, they're not going to fall through the cracks, but then something that has to happen. The community sector can't carry the load, when you have more people accessing the service and getting help—which of course we want—because it is already under such pressure. I would have thought that you would have to be looking at what services need to be increased: facilities, staff or people on the ground.

Mr Rosenberg: Yes. An important point there, Ms Tucker, is that it's the point at which access is gained which can be critical. You mentioned more beds earlier. There's increasing evidence to say—and this isn't just in the ACT, but internationally—that if you can intervene earlier and arrest people's co-morbidity issues before they get to the point of needing an acute admission, then you can—

MS TUCKER: I said beds figuratively. Forget beds. The beds, yes, too, but, I understand what you're saying. Consider the whole spectrum of service response.

Mr Rosenberg: Yes, okay. As I said earlier, there is some policy and service development work about to happen in both areas which will look at exactly what you're talking about: the needs that aren't being met and, within the resources available, the best way to target additional resources.

MS TUCKER: You mentioned the substance abuse task force. This is a question for Mr Stanhope. As I'm sure you're aware, the people in the community who initiated this idea as a result of the forum held in this building are very disappointed. They're disappointed in the model that you've come up with, because they were very, very keen to see this work as the poverty task force worked, being fully engaged working with the community to do this work, to develop the terms of reference and so on.

We've ended up with a situation in which the terms of reference are exactly the same—except for about five words—as what came out of the department initially. People in the community who came up with this proposal because they felt—and their experience would have to be given a lot of credibility—that it was the best way it could be done, have been left out of the loop.

I'm concerned that this has happened and I want to understand, as much as I can from you, why you've taken this position. One of the arguments that I understand has been used is cost, but my question has to be, then, how much are you going to spend on this?

If it's going from within budget, how much research are you going to do? What's that going to be worth? The poverty task force came up with very strong research documents, which the previous government paid for. It was also owned by the community. This model that you've produced now is disappointing, to say the least.

Mr Stanhope: I disagree with you, Ms Tucker. I think you're being unduly harsh on the model and, if I may so, on the public sector and the department. The drugs task force model that has been developed, with which we're proceeding, is very much a partnership between the public and the private sector, and the public and private service providers.

I don't think it's appropriate to suggest that a task force, 50 per cent of whose membership is comprised of members of the community and private sector service providers, is not reflective in any way of the community's interest in or ownership of drug issues, drug strategies and the development of a strategic plan for the territory. I think that you undermine and undervalue the role of the department of health, and of all of those within the public sector involved in the development and delivery of services in this area.

There is enormous expertise within the public sector, and of course the public sector provides much of the support and many of the services in relation to alcohol, tobacco and other drugs, about which that particular task force is developing a plan for the future. I don't accept your criticisms in relation to the task force. I don't accept that this is not an appropriate model. I don't accept that it in any way discriminates against the community. I don't accept that it's not an appropriate partnership, relationship or arrangement for developing an ongoing strategic plan.

The plan that we had in relation to these particular issues has expired. It is time for us to look again at the issues. It is time for us to concentrate again on the issue of tobacco consumption, as well as the consumption of alcohol and other drugs.

I see, in all the national surveys that are undertaken on smoking and the position of the ACT in relation to it, that we're slipping, in the assessment of many around Australia, including the Heart Foundation, in our determination to address, for instance, tobacco consumption. It's certainly timely that we provide a whole new focus on alcohol, tobacco and other drugs, and I think this task force provides us with an excellent opportunity to do that. You and I might disagree—and we obviously do on this matter—but I'm not conceding that, in relation to its membership or its terms of reference, that the task force is in any way deficient. Of course, you would insist that it is.

MS TUCKER: Why didn't you consult with the community on the terms of reference?

Mr Stanhope: We consult all the time on a whole range of issues. I think the issues related to tobacco, alcohol and other drugs and developing a new way forward are probably fairly self-evident, Ms Tucker.

I don't have terms of reference in front of me, but I'd be happy to go through them point by point. I'd be happy to debate with you what it is that this task force won't be able to do, and what it's excluded from doing as a consequence of its terms of reference. It would be an interesting exercise to go through. I've yet to see terms of reference—almost in relation to anything—that didn't have the capacity to meet a specific interest or a specific possibility of any of its members.

I'd be quite happy to have a debate with you, or with anybody, on a point-by-point analysis of the terms of reference, about what it is that members of the community and ACTCOSS think won't be pursued, won't be discussed or won't be investigated as

a result of deficiencies in the terms of reference. What are the limiting factors in the terms of reference that so concern you or ACTCOSS?

MS TUCKER: That's exactly my point. You don't need to debate it with me. You don't need to ask me what is it that ACTCOSS would like. Ask ACTCOSS what they would like. Ask the people on the task force now—

Mr Stanhope: No. The criticisms coming from you and from ACTCOSS

MS TUCKER: Can I finish, please?

THE CHAIR: Minister, I think the question wasn't finished.

MS TUCKER: I would like to finish the question, thank you. Ask the people who are on the task force, who are also concerned that you didn't ask them. I'm asking you why you didn't ask them. You obviously haven't asked them, and asking me to debate it with you is really not the point. I'm trying to understand why you haven't engaged with the community more fully. Maybe I should ask the question of Dr Gregory, but the point is that the community wants to have a chance to work with you on the terms of reference.

Maybe I wouldn't have a huge problem with the terms of reference. I'm asking the community what the issues are with the terms of reference. I haven't looked at them properly this week either, because I've been away. The point is why didn't you work with the community to do this?

The other question I asked that I would like you to answer was what cost are you putting on this? How can you do this as well as the poverty task force was done without it costing anything except in-house resources? I would like to know how much you think it will cost and I would also like to know what was wrong with the poverty task group structure? I would like to know why you chose this structure and not the one the community asked for. I want to understand why you think it's different. If it's just cost, okay, say that. However, if there's some other reason for it, if you didn't like the structure of the poverty task force, for instance, I'd like to know why, and why this is better, to allay the community's concerns.

Mr Stanhope: I'll get in touch with ACTCOSS and arrange a meeting with them about this. They were in touch with the department about the terms of reference. I understood that we'd met their concerns in relation to them. I'll get on to them and find out exactly what their continuing gripe is.

In relation to the methodology, the terms of reference or the structure, I think it's appropriate for the development of a strategic plan for the territory on alcohol, tobacco and other drugs that the head of the Department of Health and Community Care chairs that particular working party. I think it's more than appropriate that the most senior health official in the territory, the person with direct responsibility for the administration of our programs on alcohol, tobacco and drugs, should have that primary role of chairing such a committee.

I think it's appropriate that those public officials with direct responsibility across the board for alcohol, tobacco and other drugs—and I say responsibility in all its emanations, for instance, the justice issues that are so much a part and parcel of the consumption of illicit substances—be part of the task force.

I believe it appropriate that those senior officers of government, who are at the coalface delivering services in this area, are part of that task force, just as I believe in the need to nurture the partnerships which we have with private sector providers and the community, so that they are also involved significantly, as they are on this committee. Fifty per cent, half the members of this committee, are community members, and represent community organisations involved in the delivery of services in these areas.

Now, we might have a different philosophical position on this, Ms Tucker. You might be more inclined to actually farm out to the community responsibility for developing the government's strategic plan on alcohol, tobacco and other drugs. I think it appropriate that the chief and most senior health official in the territory has primary responsibility for the development of that, in consultation, in an equal partnership with the community. That's the decision I took. That's the model that was developed at my direction. That's the model that I approved. That's the model we're proceeding with.

Yes, there are resource issues and implications in relation to this. It's a tight budget. There's a whole range of things we would love to have done that we didn't. We made a range of painful cuts. These are matters for judgment, always. There are a million things I would like to have done if I had more money.

MS TUCKER: Will you be collecting the quantitative data that was collected for the poverty task group?

Mr Stanhope: I'll ask Dr Gregory to respond to that, Ms Tucker.

Dr Gregory: Can I just respond by saying that the department is strongly committed to this work, and we have internally rearranged some resources to ensure that there is resourcing available for a full secretariat for the drug task force. Part of that will certainly be providing all the data and statistics that we can possibly find, and whatever surveys can be done, to add to the database, because we're very committed to it being an evidence-based approach.

MS TUCKER: What's the value of that work? How much money are you putting into it? What resources are you providing?

Dr Gregory: I can't tell you offhand what that amount is, but I can get back to you, if you want to know.

MR HARGREAVES: I have number 46.

THE CHAIR: Yes, Ms Gallagher is next.

MS GALLAGHER: I had a question on radiotherapy services in the hospital. I don't know to whom it's best addressed. It's in Budget Paper 3 on page 147. You will have to forgive me, as this is my first estimates, but there's a reference saying that the initiative

in radiotherapy support services is funded from internal growth funds. Would someone could tell me what an internal growth fund is? It's probably very easy. Would someone also update the committee on the current situation for patients needing to access radiotherapy services at the hospital? Also, what is the allocation for the initiative going to be used for?

Dr Gregory: Thanks for that, Katy. I'll take the first part and then call Joanna back to answer the second part. First of all, the issue about growth funding is that the previous government did recognise the need for growth in the health sector, in response to population growth, the ageing of the population, and also what's called utilisation demand, which is a technical term that comes out of the health care agreement funding we receive and refers to the fact that, as technology increases, so the cost of services will increase.

In the forward estimates, an amount was already built in for growth in services. At the start of each year, we look at how we allocate that amount. That funding was already available to us and at the start of the year we considered that this was a particular area into which we should put some additional funding. That's where it comes from. I'll hand over to Joanna to talk about services.

Ms Holt: I am Joanna Holt, the Director of Medical Services at the Canberra Hospital. Can I ask you to repeat the second part of your question?

MS GALLAGHER: We have been reading about problems, and certainly constituents have spoken to me about access to radiotherapy—availability may be a better word. Would you update us on the current situation, and whether you've been able to address some of those problems? The second part of that question concerned the money that has been allocated for growth in support services: how is that going to be used? Is it going to be used to fund additional positions or technology?

Ms Holt: We have been struggling to maintain full delivery of radiation therapy services for almost 18 months now. However, unlike the way it affected other states and territories, the problem really hit us earlier this year. It wasn't too bad: we were managing to cope, but we did not have enough radiation therapists, and we could not recruit radiation therapists, although we tried on numerous occasions.

We had lost a number of staff earlier this year, all for different reasons and all for very good reasons, and we have not been able to replace many of those. From a staffing level of about 20 radiation therapists, we are now down to a staffing level of about 13. We're still running both our two linear accelerators, although one of them we're not able to run eight hours a day, which we would prefer to do.

We also have some difficulties with radiation oncologists. We had three full-time positions in radiation oncology. With some of the additional funding, we'll be bringing that up to four, which is the level that we need to cope with the number of new patients seen in the ACT. We are in a position where we only have two radiation oncologists at the moment, and that may drop down to one towards the end of this year. We've been working with the ACT registration board to declare radiation oncology an area of need, and that's been successful.

We have also been actively recruiting overseas. We've advertised a number of times in the *British Medical Journal*. We've offered a position to one radiation oncologist, who is still trying to find a locum to replace him in the UK, and we're still hopeful he will come. There is also the possibility of an employee to come from Canada, and one from New Zealand, so we're hoping we will be in a better position by the end of the year.

Regarding radiation therapists, we are now able to provide a more competitive salary compared to our colleagues in New South Wales and Victoria. We're also hoping that we will attract a number of radiation therapists to the ACT to bring us up to full capacity again. We're not there yet, but we have plans in place to achieve that.

MS GALLAGHER: Are there recruitment problems outside of salary that make Canberra less desirable as a place to work?

Ms Holt: The problem with radiation therapists and radiation oncologists is national. The problem with radiation therapists is international as well. We have a shortfall in the number of people who want to undertake studies in radiation therapy, and therefore we have a shortfall in supply. Everyone is competing for a dwindling supply of radiation therapists. In fact, the college anticipates that there may be a shortfall of up to 500 therapists in Australia by 2004. It doesn't actually look good.

Mr Stanhope: Ms Gallagher was asking whether there is any difference between us and other jurisdictions. On the basis of your research, is there anything that makes this a less desirable destination for radiation therapists than, say, Sydney?

Ms Holt: I guess we are a smaller facility in some respects than, say, the Peter McCallum Institute in Victoria, or Westmead in New South Wales, and some therapists would prefer a broader range of work and some subspecialisation in particular areas. In monetary terms, we now compete fairly well with New South Wales and, in some grades, also with Victoria. So, not really, and of course the ACT is an attractive place to live.

MR SMYTH: On that issue, does New South Wales employ AWAs and are we still using AWAs for these positions?

Ms Holt: In New South Wales, no. They have made a fairly radical change to the structure of their radiation therapy staff, and they've separated them from other groups of allied health staff. That occurred earlier this year. They have a plan in place to increase salaries again next year. We will have AWAs with our radiation therapy staff until the EBA is renegotiated towards the end of this year.

MR SMYTH: So currently it's AWAs and you're going to an EBA?

Ms Holt: The EBA for that whole group of allied health professionals is coming up for renewal towards the end of the year, so that will be dealt with in negotiations at that time.

MR SMYTH: The supporting paragraphs for this in Budget Paper 3 say the program will support a comprehensive cancer service in the ACT. What were we lacking before or what will you be offering now with this money?

Ms Holt: Is this particularly in relation to radiation oncology or all cancer?

MR SMYTH: No, it says growth in radiotherapy support services. The third paragraph underneath that says the program will support a comprehensive cancer service in the ACT. It's on page 147 of Budget Paper 3. What wasn't here before or how will this be more comprehensive than it was?

MS GALLAGHER: It doesn't say it wasn't there. It just says it will support a comprehensive cancer service.

Ms Holt: We've only two radiation oncologists, or even three. It's hard to get the range of specialty skills that you might find in another facility of a similar size. For example, you need a sufficient skill base to maintain specialty skills in brachytherapy and other types of superficial and deep X-ray. If we can have four radiation oncologists, we'll be able to provide a broader range of services than we do now.

MR SMYTH: So the target with this money is to bring the staff back up to the 20 level?

Ms Holt: That's what we want to do. We want to be able to run our machines even more than eight hours a day. We actually want to run them for nine to 10 hours a day, and we want to ensure that we have sufficient radiation oncologists to provide on-call cover at the subspecialty level.

You also asked about equipment and I think that's an area which has been a great morale booster to the staff of the radiation oncology department. We hope that by the end of this year we will have state-of-the-art equipment in most of the areas of radiation oncology. In particular, we now have a planning system that is one of the best you can get. It's a three-dimensional system and it enormously improves our ability to plan the radiation therapy for our patients.

We will have a new CT simulator by the end of the year. We're in the process of tendering for that at the present. That will be a CT that is custom designed for radiation therapy. We currently have a CT from an imaging department that was simply adapted for use in the radiation therapy department.

We will have two important pieces of equipment from our staff's perspective and those are called multileaf collimators. They sit on top of the linear accelerators and allow staff to avoid having to lift very heavy lead weights every time they treat a patient. These also increase the accuracy and speed with which patients can be treated. Thank you.

MS GALLAGHER: Thank you.

Dr Gregory: Can I add, further to your question about comprehensive services, I believe that that reference was in relation to there being additional psychosocial support, which is also a key part of the cancer spectrum. This has been funded in this last budget, as has

the expanded haematology service. That's part of the comprehensive increase in cancer services.

Short adjournment

THE CHAIR: We'll now resume the hearing. We deferred going through the list of things that we were going to do today to tick off any areas that weren't required, however, we now know that the committee has questions about all output areas. We're still doing overview questions about the Department of Health and Community Care. Mr Smyth, you had a question?

MR SMYTH: Mr Chair, can I follow up on what Ms Gallagher was talking about? There are a number of initiatives here in this year's budget that are actually funded from internal growth funds and, as you run through them, it's radiotherapy, haematology, midwifery, the hospice, growth at Calvary, throughput at Canberra, the expansion of older persons mental services and psychosocial support.

Over the four years, if my maths is right, that's about $13 million of money that's been diverted from internal growth funds to new initiatives. Dr Gregory, does that mean your budget is unsustainable, given that you've taken away money from expected growth?

Dr Gregory: Can you repeat the question, please, Mr Smyth?

MR SMYTH: You've diverted about $13 million worth of internal growth funds. I assumed, when the question about growth was put to the previous government, that it was based on a case that said services grow at something like 7 per cent a year, and we need funding in the out years. However, that funding in the out years has now been diverted to new projects. The question would be where has that money come from, so what existing programs have been cut or defunded, and how do you intend to cope with that growth in the future?

Dr Gregory: First, let me make it clear that this is new money added to the forward estimates. It was added on the basis of a submission that we put together about the future growth, a 2.1 per cent utilisation factor, the ageing of the population and population growth in general. That money is available to be spent on areas where demand grows as a result of those various factors.

There are two ways of dealing with that. One is that we could sit back and say, "Here you are. Here's a whole lot of money, Canberra Hospital. Here's a whole lot of money, Community Care. Spend it as you like and we'll all go home happy." The alternative to that is to say, "Here are our highest priority targeted areas of need, which we believe the government is particularly interested in meeting", and put that growth money towards those specific targeted areas. That is, in fact, what we've done.

The difference between a new initiative and an expanded service—or using resources in a slightly different way to meet the growth and demand that exists there—is sometimes a very fine one. It's not a case of diverting growth funds to anything: it's a case of using growth funds well by working up proposals that are responsive to growing needs and demands. These funds have been allocated for specific purposes as a means of meeting that growth.

MR SMYTH: What programs have they been diverted from?

Dr Gregory: From nowhere at all. It's new money from government, so it's new money that—

THE CHAIR: In this budget?

Dr Gregory: In this budget. It is money that was added to the forward estimates. The previous government had agreed with the department's submission that it was important to build in growth. We all know that growth in the health centre is something that we are faced with every year and, with some foresight, the previous government agreed to allow funds for growth, which could then be spent.

This is money that was not allocated to anything at all. It was sitting in the forward estimates waiting to be spent in that future year on growth, and what we have done is targeted the areas where we believe that growth is most needed, and where we can be most responsive to the increased demands.

MR SMYTH: My memory is that, where we put the internal growth funds into last year's budget, there was a charge against what was called Michael Moore's slush fund, and those funds were all allocated. Mr Moore came to the Assembly and explained where all that money was going and how it was being spent. Is that the same money?

Dr Gregory: That was the last or whichever financial year that was.

MR SMYTH: 1-2.

Dr Gregory: It was 2000-2001. Then, in the following year, there was again an increase and that was allocated. I think the difference in that first year was that a lot of that money remained unallocated at the start of the year, whereas we are now allocating it right at the start of the year and in the budget process.

MR SMYTH: How big is the internal growth fund?

Dr Gregory: This year, $5.7 million.

Mr Foster: I am Ron Foster, Director of Financial and Risk Management, Department of Health and Community Care. That figure is for acute services. It's actually $7.5 million for the system in total.

THE CHAIR: Isn't that money required, though, to meet increases in demand for general services across the hospital—growth in demand in the emergency department, growth in demand for oncology services and across the board? Isn't that what you use for the general increase in demand?

Dr Gregory: That is the aim of the money. However, all areas do not require the same amount of growth, so we try to target that money. Some of it is going into general growth and throughput at both hospitals, but some of it is going into targeted areas of growth. For example, we know that cancer is a particular area where there is a growing demand.

That's due to the ageing of the population. That's also due to what I'm calling utilisation demand, because technology improves and the ways of dealing with that demand change. Some of this funding is allocated across the board, but some of it is targeted at the very highest needs.

THE CHAIR: How much is targeted at general growth in throughput?

Dr Gregory: I think it's a figure of $3 million for general growth.

THE CHAIR: $3 million for general growth.

Dr Gregory: Yes, growth in throughput.

THE CHAIR: So you anticipate that, in the total hospital budget this year, if you spend $3 million more, you'll meet the growing demand for services across the board? We've heard that the expected growth in demand for emergency departments is about 7.5 per cent. Even if it's less in other areas, are you still going to be able to match and meet that growth with $3 million?

Dr Gregory: The level of demand that we've experienced over the last few years is around 2.5 per cent overall, and this funding is consistent with that.

THE CHAIR: So we shouldn't expect to see a crisis in a department because there are not enough funds.

Dr Gregory: I think there will always be the problem of matching the community's preparedness to pay its taxes with the kind of services it would like to see available in the health sector.

MR SMYTH: You said there was $7.5 million in this fund. About $3 million will be spent on the new services. That leaves about $4.5 million. How will that be spent?

Dr Gregory: We can provide you with a listing of that. A lot of that is in the budget papers under specific programs. Do you want me to—there are a number of them.

MR SMYTH: What page would that be?

Dr Gregory: They're spread throughout. They're not specifically mentioned in there.

Mr Stanhope: Go through them, Penny.

MRS DUNNE: Perhaps a general exposition would be useful, because it's not very transparent the way it is.

Dr Gregory: Okay. For the growth in oncology-haematology services, which we've already referred to briefly, the page reference is 147. At the top of page 147 you'll find the expanded haematology services.

MR SMYTH: Yes.

MRS DUNNE: Yes.

Dr Gregory: The next one is the growth in radiotherapy support services, about which Joanna has already spoken to you. It's the next one on page 147.

MR SMYTH: Look, I have all of those in BP 3. Many of the initiatives that the government has announced are funded from internal growth funds. At my reckoning, that comes to about $3 million. I have those in the initiatives. Where is the other $4.5 million or, to use the words of the previous opposition, is that in a slush fund somewhere?

Dr Gregory: No, it certainly is not. Part of the amount that I refer to that was general growth is listed on page 148 as well. There's demand growth at Calvary emergency department, and growth in throughput at the Canberra Hospital.

MR SMYTH: Yes, but that's also in the $3 million that I added up. It's the $4.5 million that I can't account for. There are about a dozen programs in the initiatives between pages 143 and 148 that add up to about $3 million a year. Where is the other $4.5 million?

THE CHAIR: You say these initiatives, Mr Smyth, were described as being funded from internal growth funds?

MR SMYTH: Yes. In Budget Paper 3, between pages 143 and 148, are the initiatives in the budget. If we go through them, there is $300,000 for psychogeriatric care and $85,000 for mental illness: if you add them all up, that's about $3 million.

Dr Gregory: Yes.

MR SMYTH: For this year. The other 4.5 doesn't seem to be mentioned anywhere in the budget papers.

Dr Gregory: The major component of that, which isn't mentioned in there, is additional growth and throughput at Calvary Hospital, which is a figure of $3 million.

THE CHAIR: That's mentioned on page 148.

Dr Gregory: Not the $3 million.

MS DUNDAS: The mean growth at Calvary emergency?

MR SMYTH: Sorry, how much at Calvary? $3 million?

Dr Gregory: $3 million, yes.

MRS DUNNE: It says 1.264 on page 148.

Dr Gregory: There's an additional $3 million, which is specifically aimed at keeping the anaesthetic service and the intensive care service running to standard at Calvary Hospital.

MRS DUNNE: Sorry, where is that in the budget paper?

Dr Gregory: It's not in the budget papers.

MRS DUNNE: Why isn't it in the budget paper?

Dr Gregory: Because we're not required to list every single way in which what was internal money was being spent. It could well have been in the budget papers. It just isn't because it was already allocated into Calvary Hospital's base for—

MRS DUNNE: So is it new money or is it a reallocation?

Dr Gregory: It's part of that forward estimates money that—

MRS DUNNE: Is that new money? It becomes increasingly unclear.

Dr Gregory: Yes, it hasn't been allocated anywhere before, that's correct. It's new money.

THE CHAIR: That would be the second largest item on the list, if it was there.

Dr Gregory: Yes, it would be. The reason that it wasn't put in there was that it's a continuation of some funding that was within Calvary's allocation previously. You've probably heard reference to the Commonwealth CUTS money, the $16 million bucket that the previous government received from the Commonwealth, which was the critical urgent treatment money. That funding was drying up. We had tried to allocate that funding over a five-year period, so that we weren't using it all in one year and then having to cope with the question of how to wind our services down after that.

There is only a little bit of that funding left for next financial year and this was put into the base of Calvary's services in advance, so that that funding would be replaced. It wasn't specifically referred to in the budget papers for that reason.

MR SMYTH: Okay, that then leaves $1.5 million and where is that?

Mr Foster: It might be best if we give you a list of all the items.

Dr Gregory: Yes.

Mr Foster: It hasn't all been allocated. For example, mental health gets about $.9 million, made up from older persons mental health expansion, mental illness ACT and education ACT.

MR SMYTH: Yes. Those are in the initiatives which are transparent and you can see them.

Dr Gregory: Yes.

MR SMYTH: It's the 1.5 that I now can't find and that I want to locate.

Dr Gregory: If you wouldn't mind just—

MR HARGREAVES: We've had an offer from the department to supply a list. That might be a good idea, I think.

Dr Gregory: We just need a little bit of time to reconcile the items in the other document with those in my list here.

MR SMYTH: Okay.

THE CHAIR: On that point, I'm a bit concerned that we have different lists here, and I would argue that such lists should appear in the budget papers, rather than be sitting on your table, as it were.

Mr Stanhope: I think it's a moot point that you raise, Mr Chair, and I understand the point, but the practice that was adopted this year is consistent with that of the budget that you delivered last year. Nevertheless, I take the point that you make.

THE CHAIR: Well, it's not really, because some of the things that have been funded from these growth funds are listed here and some are not. If that was the case in previous years, the question is why. Why list some of them and not others?

Mr Stanhope: Well, I think that's the moot point. I just make the point that I don't think there's anything different in the practice that we've used this year.

THE CHAIR: I make the point that, whether it was done in previous years or not, it shouldn't be the case.

Mr Stanhope: Fine.

THE CHAIR: We should have all of them consistently on the table. You were asking a question, Mr Smyth.

MR SMYTH: Is it then possible to find out how much growth fund there is in the next two years budgets?

Dr Gregory: Yes, that's already built into the forward estimates.

MR SMYTH: And how much is there?

Dr Gregory: Can you tell me off the top of your head?

Mr Foster: Well, no. I'll include that in the reconciliation for you. However, you will note that the budget papers do recognise the growth amount being provided for the last out year, and that's $8.6 million, so we've received 7.5 in the 2002-2003 year and there's

8.6 of new money available in 2005-2006. That means that, for those two years in between, it increases by between 7.5 and 8.6, but I'll confirm those figures for you.

MRS DUNNE: So you have $8.7 million in growth money this year?

Mr Foster: No, $7.5 million.

MRS DUNNE: 7.5, sorry. 7.5 in growth funds this year. Then, next year, those funds become part of the base funding for the hospitals, is that right?

Mr Foster: If you allocate that 7.5 recurrently, which we have, then that's ongoing.

MRS DUNNE: It is being allocated recurrently.

Mr Foster: Then, next year there'll be another between 7.5 and 8.5—whatever the figure is that I'll confirm—of new money that will be allocated through a process of determining the areas of growth with which we should deal.

MRS DUNNE: So that what's new money this year becomes recurrent money next year, and in the out years.

Mr Foster: That's right.

MR SMYTH: You mentioned $3 million of this has gone to Calvary. Is that to cover the expected $3.5 million shortfall, or is the shortfall above that, as well?

Dr Gregory: The amount allocated to Calvary is just part of the base funding to Calvary that's built into the budget.

MRS DUNNE: But you said before that it was for a specific purpose, for anaesthetic services and intensive care. How can it be base funding and for a specific purpose at the same time?

Dr Gregory: Because Calvary was in a position—and Robert Cusack might want to say more about this—where its anaesthetic service and its intensive care service needed some major surgery, should we say, in order to ensure that it they were viable and ongoing services, and could support the elective surgery going on at Calvary.

THE CHAIR: But if it's base funding, then it's not specifically allocated, unless it's an informal arrangement whereby the funding is actually used specifically for that purpose.

Dr Gregory: That's correct. When I say base funding, I mean it's built into the base, but for that specific purpose: it is being used for that purpose of anaesthetics and ICU.

MRS DUNNE: So what are the problems there, Robert?

Mr Cusack: I am Robert Cusack, the Chief Executive Officer, Calvary Hospital. If I will explain the situation with intensive care. The situation we had was that we had one part-time intensivist, covering intensive care 24 hours a day, 7 days a week, 365 days of the

year. Just on the very issue of safety alone, that wasn't viable. We did not have a problem, but that was, I suspect, only as a result of good fortune.

What we had to do was invest to ensure we had adequate intensivist cover and also registrar cover. To adequately cover that with the staffing profile, we'd need to cover it 24 hours a day, 7 days a week. We've now entered into a network arrangement with the Canberra Hospital, where the intensivists rotate through the two facilities to provide that service. However, we needed some additional funding to make sure we had both a safe and a viable service.

MRS DUNNE: And anaesthetics?

Mr Cusack: For anaesthetic services, essentially we had very little in the way of registrar cover and emergency cover. We were running a lot of lists that were going over time because of the additional emergency load. The consultant anaesthetists who were working on those lists were often finishing very late at night, and were then required to be on duty again first thing in the morning at 7 o'clock. They were burning out, for one thing, but it wasn't safe as well, if they didn't have enough sleep, so I've had to supplement the service.

I also had to match that service with those in other hospitals throughout Australia, to make sure we had appropriate registrar cover to back up the consultants, and also dedicated emergency lists that ran after hours.

MRS DUNNE: So that if you started at 7 o'clock in the morning and you were still on your feet at 9 at night because the emergency list was going on, you would be able to find somebody to take over the rest.

Mr Cusack: That's true. In some extremes, people were finishing at 2 o'clock in the morning and then being expected to start again at 7 that morning. Obviously, in those cases, the lists were cancelled or we got a replacement anaesthetist, but it wasn't a good thing to even put the anaesthetist in that position.

MR SMYTH: How are negotiations going with the government to get extra funds to cover the 14-week closure of elective surgery you announced?

Mr Cusack: I think the situation is that we've had discussions with the government. There aren't any more funds available in this current budget in relation to that, and so we've put in place the strategies we now have to work within the existing funding allocation.

MRS DUNNE: Is that elective surgery in the public hospital?

Mr Cusack: This is just about the public hospital.

MRS DUNNE: So that, if I have private health insurance, I can still go to Calvary to have my elective surgery done.

Mr Cusack: You can still go to a private hospital. The situation is twofold. It's not just about the finite amount of funding that's available. We've had fairly significant growth in our emergency department, and particularly in medical admissions. That's where the bulk of our medical admissions come from. There's been significant growth there, in the order of 18 per cent. We have growth in emergency admissions and we have growth in emergency surgery, and so the area that we have some discretion about is elective surgery. That's the area that we've had to target to bring things down to available funding.

THE CHAIR: Are you still looking at a 14-week reduction in the availability of elective surgery during the year?

Mr Cusack: We are. The situation is that we had some options about trying to reduce sessions here, there and everywhere throughout the year, but it was more efficient for us to actually close down elective surgery over those periods that coincide with school holidays. It is easier for staff to be able to take annual leave around that time, and also doctors and, for that matter, by and large our patients actually prefer to be able to take the school holidays. It's more efficient for us to close down the theatres almost totally during that time. We leave them open for emergency surgery, and we also leave them open for any private hospital work.

THE CHAIR: What does your elective surgery waiting list stand at now?

Mr Cusack: Just bear with me for a moment. As at the end of June—I'll just go through the numbers—ENT had about 20 on that list, orthopaedics has 288, ophthalmology has 98 and general surgery has 83.

THE CHAIR: About 500 and something on the list. How does that compare with, say, this time last year and how will it compare, do you think, with this time next year, if that 14-week hiatus has to be put in place?

Mr Cusack: Sorry, those numbers that I gave you were actually the long wait figures. The numbers actually on the waiting list for elective surgery were 1,363, and 509 of those were actually long waits. It's 37 per cent of that list.

THE CHAIR: Is that number higher than it was this time last year?

Mr Cusack: At this particular point in time, the numbers have increased in relation to the waiting list. With the levels of service we're providing this year in comparison to last year, that will grow by the time we reach June of this current financial year.

THE CHAIR: How much do you reckon it will grow by?

Mr Cusack: I actually don't have a firm figure on that. The areas that we've had to target to reduce services vary across the different specialities. We've had to target those based on existing waiting times. The areas for which, with particular doctors, there are the longest waiting times are the ones whose surgical lists have been least reduced, because we want to make sure we move through those waiting times.

Those doctors whose patients have the shortest waiting times are the ones who have probably had the biggest cuts to their theatre time. It's difficult to tell. The reduction in cost-weighed separations for which we're funded this year is approximately 600. If all things remain equal with the volume of demand in our emergency department, we would expect that it would increase by something in the order of that number of cost-weighted separations for the year. However, it depends on the demand for emergency.

THE CHAIR: So what number?

Mr Cusack: 600.

THE CHAIR: 600, okay.

MRS DUNNE: That means that, in a year's time, you would expect that the waiting list would be 600 more than the current one?

THE CHAIR: About 2,000.

Mr Cusack: About 2,000. That's what we'd expect, but the situation we have is significantly increased demand on the emergency department. You touched on some of those issues this morning. We'd based our estimates on the emergency department on population growth figures we knew at that time, but I noted that the ABS figures during the week about growth in Gungahlin were higher than expected. Clearly, that's a catchment area for us, particularly in relation to the emergency department.

The problem in our emergency department is not just about growth in numbers. It's also about the flow-on admissions that are occurring. We have had increases in our category ones, category twos and category threes. We have had increases right across the board of around 7 per cent, but a higher increase in those category ones, twos and threes, which are the higher acuity levels. That has turned into more admissions.

THE CHAIR: Can I ask the minister and Dr Gregory what the strategy is at the Canberra Hospital to cope with what would have to be some displacement of elective surgery? The same specialists have lists at both Calvary and Canberra, don't they?

Mr Cusack: That's true.

THE CHAIR: So presumably a person who couldn't get in at Calvary might want to go over to Canberra, and try to have surgery there.

Mr Cusack: In the last year, I think about 400 patients from the Canberra Hospital waiting list were treated at Calvary.

THE CHAIR: All right. What's the strategy for handling what's obviously going to be pressure on the waiting list as a result?

Mr Stanhope: There certainly will be pressure, Mr Chair. I think it needs to be said at the outset, though, that the waiting lists overall are down at the moment, I think at their lowest point. Mr Cusack has just indicated that they've risen at Calvary at this point in

comparison with this time last year. However, taking the hospitals together, I understand that the waiting list at the moment is perhaps the lowest it's been for some years.

THE CHAIR: What is the overall waiting list at the moment?

Mr Stanhope: We need to just put this in some perspective, Mr Chair. I'm just providing perspective. We are in a situation now where I think we have the waiting list as low as we have had it. I'll have to get the numbers out, and perhaps it would be useful to do this for the committee. My understanding is—I haven't seen the numbers, but I've been advised of this—that at the moment the figures are probably as low as they've been for some years. Certainly, the fact that the numbers are down is a reflection of the fact that significant additional funding was provided to Calvary over the course of the last seven or eight months.

Calvary received an additional $4.5 million in CUTS funding, I think, since last Christmas or thereabouts, essentially to reduce elective surgery waiting lists. It was on that basis that Calvary was able to take a significant load. $2.7 million of the additional money that the government has provided to Calvary in that time was directed to that additional throughput, which has been achieved. It is reflected in the very high growth that we see in throughput at Calvary.

There is a chicken-and-egg situation here. Calvary was able to achieve the results it achieved last year because this government provided it with an additional $4-5 million for that very purpose. Those funds are no longer available. This is one of the classic difficulties that governments face. The money was available, it was used, and it produced an excellent result for the community insofar as Calvary has been going gangbusters for the last year, and came in with a number well above that budgeted for or projected a year or so ago.

However, the money is not there now, so we're now faced with this situation of Calvary having to manage demand through its emergency department. The demand has been stimulated to the extent that Calvary has been able to produce some absolutely excellent results for the community.

It's difficult. Governments always hesitate to do this. You create an expectation and it's expected that you'll keep it going. We can't keep funding Calvary at that rate, just as we can't keep funding Canberra at the rates that you might like, to knock off your elective lists altogether. This is the conundrum that we face.

Certainly, regarding the overall question, it would be worth asking Mr Rayment to talk about throughput at Canberra. It's interesting to compare the performances of the two hospitals in that regard. It's interesting, and I think important, that we take note of what Mr Cusack has said about the enormous increase in demand at Calvary, essentially as a result of the growth of Gungahlin over this last year, and the result that's been produced with the significant additional funds, an 8.4 per cent increase in funding for Calvary since the last budget. Those were the additional funds that we provided over and above the budgeted funds for Calvary a year ago.

We increased the funding for Calvary by 8.4 per cent, as a result of which, as I say, Calvary has produced the most staggering throughput. However, the money's not there now, and demand will be controlled in the way that Mr Cusack has indicated. Yes, the waiting list will blow out again but, as I say, from a position where it's as low as it's been across the hospitals, as I understand it, for some years. If you want to pursue the issue further in terms of Canberra—

MRS DUNNE: I want to pursue the issue in relation to Calvary.

THE CHAIR: Hang on. Sorry, I have some questions first. I note the points you make about pressure on the hospital. Indeed, I think the former minister for health made precisely the same points in the last few years, so your points are well made.

I appreciate the context in which you placed your answer, but the answer I'm seeking is to this question: what is the waiting list at the moment and how does that compare with this time last year? I understand that, at this time last year, we also had historically low waiting list numbers. That's what my minister for health told me, so what does it stand at today?

Mr Stanhope: I'm sorry, I'll have to get that for you, Mr Chair. I don't have it in front of me, but I'm sure we could obtain it for you.

MR SMYTH: I have some numbers if you want them. In August last year, the waiting list was at a low period. It was 3,565.

MRS DUNNE: Is that across both hospitals?

MR SMYTH: I assume that is across both hospitals. According to the *Canberra Times* in mid-July this year, the hospital waiting lists were at 3,894, which is actually a 9 per cent increase over 12 months, in effect. The question is will the list come down? In your rebuilding the ACT health services statement before the election, you said,

> A crisis injection by Labor of $6 million to The Canberra Hospital will ensure its viability and operation at improved standards. With this additional $6 million, the Hospital would be able to employ more nurses—

which it has, and well done—

> and, for example, admit another 1,300 in-patients, and handle another 2,500 patients in Emergency.

The answer that I received on notice to a question about how the money was spent said that, in fact, only $.82 million was spent for extra surgery, and all we got was an additional 300 cost-weighted separations. How can you put an extra $8.7 million into the hospitals and only receive 300 cost-weighted separations when you said your stated aim was to provide more surgery?

Mr Stanhope: I'd be happy to ask Mr Rayment to discuss how the money has been expended. However, going back and forwards again, Mr Smyth, the basis of the proposition you put assumes, to some extent, that the money that was put into the Canberra Hospital wasn't needed, or wasn't appropriately utilised. The question that I'll

ask Mr Rayment to answer is what would the situation be at the Canberra Hospital if they hadn't received that money. I think it's a much better question.

MR SMYTH: No, you may think it's a better question, but that's not the question that has been asked. I'm sure you don't want to answer questions about what you've done.

Mr Stanhope: It is a better question, and I welcome Mr Rayment's answer to the question of what the consequences of not providing that—

MRS DUNNE: Mr Chair, the minister doesn't control the agenda.

THE CHAIR: Yes, I'm sorry, Minister. With great respect, it's the members of the committee who ask the questions.

Mr Stanhope: Do you not want that question answered? I'm sure Mr Rayment is happy to answer both questions.

MRS DUNNE: I haven't asked the question because we're talking about Calvary Hospital.

MS GALLAGHER: Well, Brendan asked a question that wasn't on Calvary.

Mr Stanhope: No, that's not right, Mrs Dunne. The chair asked about—

THE CHAIR: I'd like to ask the question that I asked first, please, and have an answer to that. I asked you what the waiting list stood at and Mr Smyth is—

Mr Stanhope: And I took that on notice.

MS GALLAGHER: He answered it.

THE CHAIR: Well, Mr Smyth—

Mr Stanhope: Mr Smyth asked a question and I took it on notice, Mr Chair.

THE CHAIR: However, it's a contradiction. You said that the waiting list is at an historical low, and Mr Smyth said that the figures published in the *Canberra Times* suggest that the waiting list is higher than it was this time last year. They can't be compatible.

Mr Stanhope: Absolutely, and I indicated at some length that, on the basis of advice—and I said quite specifically that I hadn't seen the numbers myself, but I'd been advised—I believed that they're low at the moment, and at a low point in terms of the last two years. I said that I didn't have the numbers, and that that's what I'd been advised, and I'm now telling you I don't have the numbers and I'll take the question on notice. Mr Smyth has some numbers and we're grateful for his advice.

THE CHAIR: Dr Gregory, do you think the figures published in the *Canberra Times* in the last few weeks are inaccurate?

Dr Gregory: I'm sorry, I can't comment on the *Canberra Times* figures. However, we will have the figures for you. We have a graph showing how elective surgery, as a whole, has gone over the last two years or more. We'll provide that for you as soon as we can today.

THE CHAIR: Do you believe it's at a low point in the cycle of the last few years, at the moment?

Dr Gregory: It might not be the lowest end-of-month figure, but it certainly has been cycling down over the last little while.

MR SMYTH: Has there been a cleanup of the list?

MRS DUNNE: Yes.

Dr Gregory: In response to a Legislative Assembly standing committee report on elective waiting lists some years ago, the department has undertaken a whole range of work to try to ensure that the lists are well managed. It is also part of being in touch with patients and being in touch with their GPs, to provide a better service with the lists.

MR SMYTH: The Chief Minister said earlier that he'd provided an extra $4.7 million to Calvary since he'd come to government. Was that ACT money or was that the federal CUTS money to which you were referring? In the $8.7 million extra appropriation, I can't find $4.7 million that was sent to Calvary at all.

Dr Gregory: I'm sorry, I missed the question.

MR SMYTH: The Chief Minister said, "You have to remember, we've provided an extra $4.7 million to Calvary since we came to government." Where did that money come from? It's certainly not in the $8.7 million that was in the second appropriation. Is that CUTS money? Is it Commonwealth money that was provided to Calvary, rather than ACT money?

Dr Gregory: Are you talking about the additional 4.7 since the budget?

THE CHAIR: "$4.7 million since this government came to office", is what the minister actually said.

MR SMYTH: Or is that in this year's budget?

Mr Stanhope: 4.5.

Dr Gregory: That's a different figure. Sorry, would you just clarify the question?

MR SMYTH: The health minister said that, last financial year, his government provided $4.7 million additional dollars to Calvary Hospital.

Dr Gregory: Subsequent to the budget. Is that what you're talking about?

MR SMYTH: No, the Chief Minister didn't say "subsequent". He said they provided $4.7 million last financial year.

Dr Gregory: But he's talking about this government. Therefore it's subsequent to the budget because—

THE CHAIR: Last year's budget.

Dr Gregory: Last year's budget, yes. Subsequent to last year's. You are talking about last financial year and this government?

MR SMYTH: Yes.

Dr Gregory: Therefore you're talking about money that was additional to what was in the original budget.

THE CHAIR: In a second appropriation, for example.

Dr Gregory: Yes. Some of the additional $4.7 million, $1.1 million, came from New South Wales as part of a back pay arrangement for some cross-border funding, but it was only a one-off amount. It was an adjustment to the back pay they owed us for previous years.

THE CHAIR: The New South Wales government, all right.

Dr Gregory: But well negotiated by this government. A further part of that $4.7 million came from the funding that had been set aside to build a facility, but which was transferred into throughput at Calvary Hospital.

THE CHAIR: Which facility was this?

Dr Gregory: The funding was to do the capital works on the convalescent care facility, and because we—

MR SMYTH: So you transferred capital to recurrent—

Dr Gregory: It wasn't actually capital money: it was one-off money that the previous government had put in, but it wasn't capital works money.

MR SMYTH: Okay.

Dr Gregory: It was one-off money, and that money was translated into a one-off assistance for Calvary Hospital.

MRS DUNNE: Sorry, assistance to do what?

Dr Gregory: To improve its throughput. As was the 1.1.

MRS DUNNE: Throughput. So it was convalescent throughput money that became—

Mr Stanhope: Convalescent capital.

THE CHAIR: No, she said it wasn't capital.

Dr Gregory: It wasn't throughput. It was for refurbishment, for building. It wasn't actually allocated by the previous government as capital works money, but that was the intention of that allocation.

MR SMYTH: It was certainly the intention, though?

Dr Gregory: Yes. Instead of it being spent on a building, it was spent on service delivery at Calvary Hospital.

MR SMYTH: Okay.

MRS DUNNE: So we haven't done the service delivery on the convalescent unit, but that's not the story.

Mr Stanhope: Well, yes, because you spent it at Morling Lodge.

Dr Gregory: Because Calvary—

Mr Stanhope: That is another story and let's talk about it.

MR SMYTH: We'll get to that other story later today, I'm quite sure. That's 2.1. Where's the other 2.5?

Mr Foster: Could I just add some further information about the money provided to Calvary? In addition to the $1.1 million that was referred to, out of cross-border money, New South Wales was able to pay the ACT about $3 million more than we'd estimated. In fact, we gave Calvary $2 million of that. $900,000 of that went towards the nursing pay rise at Calvary associated with catch-up clauses linked to the pay rise granted to the TCH nurses. Then there was the $1.1 million for throughput.

Through the second appropriation, Calvary received $200,000 of the nursing component of the second appropriation, which is not related to the $8.7 million you refer to. There were several items in the second appropriation, being the $8.7 million for TCH, the $6.6 million for nursing across the system, and the SACS funding.

We directed some money from nursing scholarships out to Calvary. We had held some money centrally for scholarships, so we directed $200,000 to Calvary for that.

MRS DUNNE: That's not part of the 4.7 for throughput?

Mr Foster: It is. It was part of the—

MRS DUNNE: The scholarship money?

Mr Foster: 4.7 that went to Calvary for overall costs.

Dr Gregory: It was money left over from the scholarship scheme, which was then redirected into service provision.

MRS DUNNE: So the scholarship scheme wasn't taken up?

Dr Gregory: There was some spare money from it.

Mr Foster: That money has returned to the centre for this financial year, so we have the full amount available for scholarships in 2002-03.

MR SMYTH: That is about 3.4?

Mr Foster: Well, there are some other amounts of throughput money we did provide because of delayed spending on programs within the health portfolio in 2001-2002.

MRS DUNNE: So what you're saying, Mr Foster, is that there are a lot of little buckets of unexpended money and, rather than just hand it back, you've quite rightly put it into—

Mr Foster: Pressure points.

MRS DUNNE: Throughput in the hospital. Mr Cusack might need to answer this question. Did that provide an extra 400 services out of the—

Mr Foster: You're right, he'll have to answer that question. The $4.7 million doesn't necessarily buy throughput. As I said, there were elements associated with the nursing pay rise and elements associated with—

MRS DUNNE: Okay, so it wasn't all put into throughput. Okay, that's fair enough.

Mr Foster: The overall funding increase at Calvary from the original budget to the end of the year was the $4.7 million. There was a variety of uses for those funds. However, you're right, it came from unexpected sources, from New South Wales, which weren't budgeted for at the time, and opportunities that presented themselves throughout the year.

MRS DUNNE: That was $2 million—

Mr Foster: From New South Wales.

MRS DUNNE: Out of $3-odd million that came out of New South Wales.

Mr Foster: That's a one-off funding source.

MRS DUNNE: It really isn't the ACT government or the ACT Minister for Health giving that money to Calvary.

Mr Foster: Well, it had to make the decision to allow it.

MS GALLAGHER: It did, in allocating the funds.

MRS DUNNE: Unless, of course, he was just the messenger.

Mr Stanhope: It had to be put somewhere and the government chose to give it to Calvary.

MR SMYTH: Okay, but that leaves Calvary in the position now that it's $3.5 million short this year on what it had last year. How will you make that up or will Canberrans, as Mr Wood says, just have to adapt?

Mr Stanhope: Well, we're not making it up. The money's not there and Mr Cusack has outlined what the Calvary Hospital's response to that is.

MR SMYTH: Are you happy with that response, that the waiting lists will blow out?

Mr Stanhope: I'm not happy with it at all. It's a pity.

MR SMYTH: You are the Health Minister, so what will you do to rectify it?

Mr Stanhope: To rectify what, Mr Smyth?

MR SMYTH: The blow-out in the hospitals. You pilloried us for three years for the hospital list, for lack of throughput—

MR HARGREAVES: That's because it was really easy.

MR SMYTH: In the hospital and for not having a plan. You talked about crisis injections. Yet we see that, in both of the hospitals for which you're responsible, you have not made provisions for adequate funding into the future for a sustainable hospital system.

Mr Stanhope: Garbage.

MR SMYTH: How are you going to address that?

Mr Stanhope: Mr Smyth, we've addressed it in the first instance, this year, by the largest increase in funding for public health in the ACT for years.

MR SMYTH: Which has resulted in reduced services.

MRS DUNNE: We've just closed down Calvary's elective surgery for 14 weeks.

Mr Stanhope: It has not resulted in reduced services. We've provided significant increases across the board. We've provided significant increases to Canberra Hospital—$8.7 million in a second appropriation bill. That's been repeated in this budget. As I've just said, and as we've just been discussing, since we came to government, we've provided an additional $4.7 million to Calvary over and above what you were prepared to give them. We gave the Canberra Hospital $8.7 million over and above what you were prepared to give the Canberra Hospital.

We've provided an additional $2.5 million for disability services over and above what you were prepared to provide for disability services—

MR SMYTH: And the waiting lists are going up.

Mr Stanhope: Let me finish, Mr Smyth. We've provided an additional $4-point-something-or-other million for mental health over and above what you were prepared to provide for mental health. We've provided that additional $3.5 million plus for respite services over and above what you were prepared to provide for respite services. Don't come here and belabour me about a lack of commitment by this government to public health and health service delivery in this territory, Mr Smyth, because the record shows the reverse. We've provided—

MR SMYTH: No, the record shows that you've put extra money into it—

Mr Stanhope: Let me finish, Mr Smyth.

MR SMYTH: But we do not have extra services in the hospital system.

Mr Stanhope: Let me finish, Mr Smyth.

THE CHAIR: Mr Smyth, let the minister finish his answer.

Mr Stanhope: I don't have the percentages in front of me, but we have provided percentage increases in funding to Calvary Hospital, to Canberra Hospital and to community services in this last budget that put your efforts in relation to health to shame.

The response of this community to that will be evident. We have provided, as I said, an additional $4.7 million to Calvary over and above what you were prepared to provide to it.

That has led to an additional $2.7 million of funding being made available for throughput. That has had a significant impact over this last year. It's resulted in Calvary Hospital producing absolutely outstanding results in relation to service to the community. However, that rate of growth is simply not sustainable. This government can't go around finding an extra $4.7 million plus every year.

MR SMYTH: But you found $7 million for land development. Wouldn't that be better spent in health?

Mr Stanhope: We'll get greater returns from that. The returns that we will ultimately achieve from land development, Mr Smyth, will allow us at the end of the day, perhaps, to provide those additional dollars for health. That's the whole point.

MRS DUNNE: That's a big perhaps.

Mr Stanhope: I have no doubt about it. That's what we will do. We will respond to this community's major aspirations and demands. We will put those additional dollars into health, just as we'll spend community funds on education. We will respond to the community's priorities, as we've done throughout this budget.

MR SMYTH: I don't doubt that you have put extra money into the health service, and you're to be congratulated for that. It's not resulted in any extra services that I can see, through the hospital system. Your own target for 2001-2002 for cost-weighted occasions of outpatient services was $210,350, and the actual estimated outcome for 2001-2002 was $210,350. The target for 2002-2003 is $210,350. Your own press release says emergency services at Calvary go up by 7 per cent, but there are no extra outpatient services. Are you shifting services from TCH to Calvary to cope with Calvary? Where's the cut coming in? If Calvary's performance is improving, by what percentage has Canberra Hospital's decreased?

Mr Stanhope: Actually, significantly, but I think it'd be helpful for the committee if Mr Rayment explained exactly what's happened there.

MRS DUNNE: Sorry, I really need to know about the cut in elective surgery. Then we can put that to bed.

THE CHAIR: Yes, I think we are branching off a bit.

MS GALLAGHER: Mr Chair, I have a question on Calvary too.

MS DUNDAS: Mr Humphries, I have some questions as well.

THE CHAIR: Okay. All right.

MS DUNDAS: I have some questions under overview, but on a different topic.

THE CHAIR: Okay. We have a fair bit to do in this. I think it'll be a while before we get to it, unfortunately.

MS GALLAGHER: However, committee members have priority over visiting members, don't they?

THE CHAIR: Well, that's true. We've tended to take issues as they come. If you want to enforce that rule strictly, we can do that.

MS GALLAGHER: All right. Okay. It might be fair, though, to look at that considering the time we have today.

THE CHAIR: If you want to suggest that we cut it short then I'm happy to take that suggestion, but I wouldn't support it.

MS GALLAGHER: I'm not. I'm just saying that committee members should have the opportunity to ask questions if they have them.

THE CHAIR: Okay. That means we'll jump around a bit, but I don't mind. It is Mrs Dunne's turn.

MRS DUNNE: Mr Cusack, in relation to your announcement about the 14 weeks of elective surgery, can you actually tell me how many procedures that might be?

Mr Cusack: We work on the basis of cost-weighted separations, so it's about a 20 per cent reduction in the amount of services.

MRS DUNNE: Did I hear you say 600 or something previously?

Mr Cusack: Yes. With the funding levels that we have, we'll be able to provide 600 less cost-weighted separations this year than we provided last year, with the funding that was available last year.

MRS DUNNE: Sorry, and you said 600 less than last year. Last year you received money for taking some of the waiting list from Canberra, and there were about 400. Does that includes that extra 400?

Mr Cusack: Yes.

MRS DUNNE: You had a base amount for cost-weighted separations last year and then you had 400 added to that. Now you're saying that this year is going to be 600 less than that total number from last year.

Mr Cusack: That's true. It will include that amount.

MRS DUNNE: So, in a sense, it might it be as few as a net 200, seeing that that 400 was a one-off aberration.

Mr Cusack: Assuming those other cases are delivered at the Canberra Hospital.

MRS DUNNE: Regarding the 400 separations that you delivered on behalf of Canberra Hospital last year, if you weren't delivering those, would you have been delivering 400 extra cost-weighted separations at Calvary? Or didn't you have funding for those? Sorry, that's very dense.

Mr Cusack: No. Basically, we delivered in relation to the amount of funding that was available for those services. We had capacity because of a range of issues that would be better explained by Ted Rayment but, being the trauma hospital, it had other demands on its services. We were able to take those patients from the long wait list. That was negotiated with the Department of Health. Appropriate funding came with that as well, which allowed us to perform that work.

MRS DUNNE: Right. You don't have any expectation of getting that sort of funding this year?

Mr Cusack: Well, we already know what our funding levels are this year. The discussions we've had to date indicate that there is no other funding available.

MRS DUNNE: Are you saying that, this year, there'll be 600 less cost-weighted separations. They are not all surgical? Will some of those be medical? Or are you shifting the emphasis away and ensuring that, in fact, they will be 600 elective surgical—

Mr Cusack: Essentially, our growth has been mostly in the emergency department, and that has been predominantly in medical admissions and emergency surgery. Because we actually can't change those, the area that we do have some discretion about is elective surgery. The net effect of the surgery cases is that there will be about a 20 per cent reduction in our total levels of surgery. We actually have an increase there, because of the emergency surgery, of 7 per cent, but a total reduction in elective surgery of 27, so a net reduction of about 20 per cent.

MRS DUNNE: This is a little bit of crystal ball gazing, but at the moment, in addition to looking at the waiting list, you have clinical advice about the periods that patients should have to wait. In addition to the waiting list, if there are 600 procedures that you're not going to do this year, and therefore they're going to be added to your waiting list, how is it going to blow out the optimal clinical waiting times?

Mr Cusack: We'll always deal with those who need to be seen urgently first up.

MRS DUNNE: The category ones and twos.

Mr Cusack: Yes. What is likely to happen if someone else emerges—for example, if a cancer patient is due for urgent surgery—is that the surgery of somebody on the existing waiting list with a lower priority would be deferred.

MRS DUNNE: Where are the pressure points? There'll still be a reasonable flow through oncology, because oncology goes into category one, basically.

Mr Cusack: By and large, yes.

MRS DUNNE: So what this means is that patients of orthopaedics—

Mr Cusack: Orthopaedics, ophthalmology, urology and ENT.

MRS DUNNE: Sorry, what was the second-last one, neurology?

Mr Cusack: Urology.

MRS DUNNE: Urology. They're the things that will wait.

Mr Cusack: It could affect other areas of general surgery as well, such as gynaecology elective surgery. We've tried to target it based on where the demand and waiting times were, and the cuts that we've made have been determined on the basis of those priorities.

MRS DUNNE: Okay. The message is that, short of Calvary winning the lottery, you're not going to be able to make any inroads into your waiting list this year, so the people of Gungahlin and West Belconnen who don't have private health insurance can look forward to significant waits, especially in areas such as orthopaedics.

Mr Cusack: Certainly, the waiting times will grow in those areas. We actually provide elective surgery to the entire area of Canberra—

MRS DUNNE: Yes.

Mr Cusack: However, obviously our predominant catchment area is to the north. A thing I did mention is that the predicted amount of demand on our emergency department, and population growth in Gungahlin, have increased to higher levels than expected. That will increase demand and pressure on our emergency department.

MRS DUNNE: You might provide elective surgery across the ACT—that might be your catchment—but when it comes to A and E your catchment is principally Belconnen and Gungahlin?

Mr Cusack: Yes, it's predominantly that area. It's driven by the availability of GPs, the issue that we talked about this morning. There really aren't enough GPs in the work force. We have lots of anecdotal evidence about people being told there will be two or three weeks' wait for a GP, who ring around to other GPs and get the same response. Ultimately, they end up in emergency departments. That's not restricted to the north of Canberra.

Mr Stanhope: Mr Cusack, would you just tell the committee whether, if you'd been required to operate under the budget which the Liberals gave you last year, there would be an increase in throughput this year or a decrease in throughput this year?

THE CHAIR: Minister, I'm sorry, I have to come back to the protocol of this committee.

Mr Stanhope: Just a quick yes or no would suffice, Mr Cusack.

THE CHAIR: I appreciate that but you can—

Mr Stanhope: In fact, Mr Cusack, if you'd been—

THE CHAIR: You could always resign and become a member of the committee.

MR SMYTH: I think he'd be more comfortable as a member of the committee than he is now, Mr Chair.

MR HARGREAVES: I want an answer to the question that the Chief Minister has put—

Mr Stanhope: I can answer it. In fact, if Calvary Hospital had been required to operate under the budget which the Liberals gave it last year, there would have been an increase in throughput only if it had received the additional funding that the Labor government provided to Calvary. Rather than the decrease next year of 600, there would have been an increase of 300. I think we need to keep that in perspective.

We're talking here—

MR SMYTH: That, of course, is conjecture, based on predictions about what shape our budget would have taken?

Mr Stanhope: No, your budget was delivered, mate. The money that you provided to Calvary was supplemented by an additional $4.7 million by the Labor government, by this government. If Calvary had been stuck with your budget—

MRS DUNNE: Because you had windfall money from New South Wales.

Mr Stanhope: It would have produced between 600 and 900 fewer cost-weighted separations in this last financial year than it did. It's only as a result of that that we're talking about the decline that now has to be suffered and faced.

MR SMYTH: Again, that's conjecture.

Mr Stanhope: No, it's not.

THE CHAIR: Minister, isn't it the case—

Mr Stanhope: It's not, it is a fact. Your budget—

MR SMYTH: Well, that's assuming we would not have put extra money in the budget, Chief Minister.

Mr Stanhope: Your budget provided—

MR SMYTH: You're actually not here to comment on our budgets and what might have happened.

Mr Stanhope: No, but I don't want anybody to be misled.

MR SMYTH: You're actually here to comment on how you've created an unsustainable hospital system.

Mr Stanhope: I don't want the committee to be misled. I want you all to understand. I need you all to understand that if the Labor Party had not provided that additional $4.7 million to Calvary—

MR SMYTH: It is quite clearly a smokescreen.

MRS DUNNE: Which Bob Carr gave you, yes.

Mr Stanhope: If the Labor government—

THE CHAIR: Okay, Minister, we take the point.

Mr Stanhope: You need to take it. You need to put this in perspective so we have a balanced discussion.

THE CHAIR: Yes, we've put it in perspective and, in fact, we've commended you for putting extra money into the hospital system. Well done. Congratulations. I'll send you a gold star later on.

Mr Stanhope: The community has already done that. You're too late.

THE CHAIR: Well, we'll see. Isn't it the case that people are looking not for inputs into the system, but outcomes? If there is an increase of from 1,000 to 2,000 in the space of two years in the waiting list at Calvary under your government, people won't be thanking you for the inputs, they'll be asking you, "When are we going to reduce the waiting list at Calvary." I come back to the question: what are you doing about that?

MS GALLAGHER: The nurses are pretty happy, though, I think. There's an outcome.

MR HARGREAVES: Before you address the question of waiting lists, can I also ask a question at the same time? This is supplementary to your question, Mr Chair.

THE CHAIR: Right.

MR HARGREAVES: I'm also interested in the issue of waiting times. I believe—and I've heard this in the last couple of estimates committees—that in fact waiting times are more meaningful than waiting lists. The number of people is neither here nor there. Could I ask you to think about that?

MRS DUNNE: That's what I was just asking Mr Cusack, yes.

MR HARGREAVES: Well, Mrs Dunne, if you have a difficulty understanding the difference between waiting lists and waiting times, that's probably the same as the difference between blocks and leases, so I think you should just sit there and listen to the answer. I'd like to know what the story is about these waiting times, and with yours.

THE CHAIR: Well, the question I asked was to the minister. We've been told today that there's going to be, in all likelihood, an increase in the waiting lists and times at Calvary Hospital. The first question is, what's your strategy—

Mr Stanhope: Over the lows that we've managed to achieve, certainly.

THE CHAIR: Well, the low is a matter of debate. We've heard that different figures have been published about whether it is a low or not. However, putting that to one side for a moment, what's your strategy for dealing with spill over from Calvary? As the lists rise in Calvary, aren't they going to spill over into Canberra? What's your strategy for dealing with that, and what is your strategy for reducing the waiting lists at Calvary?

Mr Stanhope: I think that, to pursue this particular issue, the committee will require some input from Mr Rayment in relation to Canberra Hospital's performance over the last year, and the growth or otherwise that might have been experienced there. It is part of this whole equation. I did offer to ask Mr Rayment to explain the Canberra Hospital's performance over the last year. As I indicated before, it is interesting to compare the Canberra Hospital with Calvary Hospital.

THE CHAIR: Yes, it's fascinating, but can we have an answer to the question, please?

MS DUNDAS: Could we also have an answer to Mr Hargreaves' questions about waiting times? We still haven't heard that.

MRS DUNNE: I thought Mr Cusack had already said that they would increase.

Mr Stanhope: I don't think we have.

THE CHAIR: I asked my question first. As soon as my question is answered, I'm happy to take Mr Hargreaves'.

Mr Stanhope: If I could just take that question of—

THE CHAIR: Roll the two answers in together, but I want an answer, please.

Mr Stanhope: On the question of waiting lists and waiting times, could we take those questions on notice?

THE CHAIR: With respect, that was second. May I have the answer to my question first? What is the strategy for dealing with the overflow from Calvary to Canberra, and what is the strategy for dealing with the rising waiting list at Calvary?

Mr Stanhope: As I've indicated, we have already provided this year significant additional funds to the Canberra Hospital, to Calvary Hospital and to the community sector. In fact, I'll get the percentage increases in funding for health in the ACT from your budget to this one for you, so that we can all be apprised of the significant additional support and input, and the significant additional resources provided. The allocation of those resources—

THE CHAIR: Which will lead to an increase in the waiting lists, according to the update.

Mr Stanhope: The allocation of those resources does reflect our response to a range of priorities across the board. There is a range of issues that it's important we deal with, for instance, the government's decision to provide an additional $2.5 million for disability services did, of course, affect other areas of health service funding. It has to be acknowledged that there are pressures.

MRS DUNNE: So you're saying you're robbing Peter to pay Paul?

THE CHAIR: I do acknowledge that, Minister.

Mr Stanhope: What I'm saying is that we've made a range of decisions, and you're now investigating them, you're looking into them and you're questioning the basis of that funding. My answer to your question is we've made our decisions, we've prepared our budget, we've delivered our budget. You're now having a look at it and exploring the detail of it, the nuts and the bolts. I can say to you, and I'm saying to you that, as a government, as a minister—

MRS DUNNE: That I'll obfuscate all day and not answer the question. That's what you're saying.

Mr Stanhope: The government and the minister have set out, in that budget, our expenditure intentions and our spending priorities as we see them at this time. You can argue about them. You can say to me that we, as the government, don't have a strategy for dealing with this or that, but through our—

THE CHAIR: Tell us what it is.

MR SMYTH: He doesn't have one.

Mr Stanhope: It is that we have funded health at a level over and above that at which you were ever prepared to fund it.

MR SMYTH: That has caused a blow-out in the waiting lists.

Mr Stanhope: You might say it's done that. You might say whatever you want, but that's just conjecture. That's what you expect to happen. Certainly, there's going to be some pain, there's no doubt about that. There always is. Certainly, we never have enough money available to ensure that nobody has to wait. It's a feature of every hospital in every jurisdiction in Australia and the world. It's something that we live with and something we have to manage. Mr Cusack has indicated today what his intentions are in relation to the moneys that have been allocated to Calvary.

THE CHAIR: As you've said, he has no choice but to allow elective surgery to increase, because there isn't the money there to do anything else.

Mr Stanhope: But elective surgery is only increasing there because this government provided an additional $4.7 million over the last eight or nine months, which allowed him to make such enormous inroads into the elective surgery that—

MR SMYTH: I thought it was the CUTS money.

Mr Stanhope: It was money which we, as a government, allocated to Calvary. We could have sent the money anywhere. We chose to give it to Calvary.

THE CHAIR: Okay, Minister, can I try to come to the point here. Let me finish my question.

Mr Stanhope: The point is that the cuts to the elective surgery waiting list which will be experienced this year, particularly at Calvary, have been delayed by 12 months. They would have occurred 12 months earlier had we not intervened and provided the additional $4.7 million to Calvary and $2.7 million for extra throughput. So what has happened—

THE CHAIR: Congratulations, Minister, fantastic job. Well done. However, I want to know about the future now. Notwithstanding these amounts you're putting into the hospital, there are people in the ACT who are going to miss out on elective surgery in the next 12 months because the waiting list is going to double. The question to you is very simple: do you have a strategy to address the rise in the waiting lists at either Calvary or Canberra Hospital?

Mr Stanhope: These, of course, are fundamental issues. That's why we've done the work we've done in relation to holding the first ever health summit for the ACT. It's why we're actually developing a health action plan. It's why we've completely restructured the portfolio to provide a far greater capacity for us to address these issues. We have, as you know, provided many more opportunities for cooperation in health service delivery in the ACT.

We have now centralised a new structure under the direction of Dr Gregory. It might be appropriate for me to ask Dr Gregory to talk about how we propose to address these particular issues through the work that we have done—the major portfolio restructuring and realigning.

MRS DUNNE: Can Dr Gregory give a straight answer as to whether there is a strategy to address the expected increase in the waiting list over the next 12 months?

THE CHAIR: I think that's why the minister is going to ask Dr Gregory to answer.

Mr Stanhope: We only ever give straight answers to everything.

MRS DUNNE: Is Dr Gregory actually going to be able to answer this question?

Mr Stanhope: Certainly.

THE CHAIR: Okay, Dr Gregory.

Dr Gregory: Thank you very much. There is funding within the Canberra and Calvary hospitals' budgets to sustain the level of elective surgery that we believe is reasonable. We have been fortunate in the past in being able to put extra money in and, unfortunately, the gains we hoped to make across the board in elective surgery have, to some extent, to be used to defray medical admissions. That will always be the case. There is continuing money in the Canberra and Calvary hospital budgets to meet the need for elective surgery to the highest extent possible.

However, in the health system, when somebody has a medical emergency and needs admission and immediate help, that has to be the first priority. Therefore, the level of elective surgery will fluctuate to the extent that the community is prepared to put in the additional money. We are hopeful that, in the next health care agreement with the Commonwealth, the amount of funds for this area will grow. You're probably all well aware that there's been a lot of discussion about whether or not the public hospital system is adequately funded by the Commonwealth, through the health care agreements, to allow sufficient levels of elective surgery to be done.

We are also hoping to be able to increase the amount of elective surgery that's done in the private sector through a complimentary approach with the private sector. Canberra has the highest level of those with private health insurance and still a very low level of usage. That's one of the things that we'll be targeting through the health action plan, through working with the private hospitals, but particularly through working with our own hospitals.

I'm sure Ted could tell you more about this. We are doing this to put in place the mechanisms that will ensure that people who do have private health insurance do go to the private hospital system, so that work that must be done for those who can't afford it, or don't have the insurance, can be done to a greater extent in the public hospital system. That is one of the ways that we'll be trying to address that need.

We can't print money, and elective surgery does have to be a lower priority than other medical emergencies. However, to the extent it is possible, we will be continuing to put money into that area and, if we are able to elicit any further funds from New South Wales with some arguments that we still have up our sleeves, then that certainly will be going into elective surgery. Any windfalls through the year we hope will be targeted at elective surgery. No, we can't have an overall strategy, because an overall strategy requires more funding as a percentage of GDP than the community is prepared to put into health in general.

THE CHAIR: Well, it's a question for the government as to what percentage of GDP goes in, isn't it? You are saying that, if extra money comes from New South Wales, the Commonwealth, or there is a windfall because something is underspent elsewhere in the system here, then you will consider putting that into increasing throughput and reducing the waiting list for elective surgery?

Dr Gregory: That will be one of our first ports of call, as it was for this government, with that extra 4.7 that went into Calvary.

THE CHAIR: That applies to both Calvary and Canberra hospitals? If there's money in those categories it will be considered for both Calvary and Canberra hospitals?

Mr Stanhope: Well, it will be applied where it could be most efficiently utilised.

MRS DUNNE: Minister, when you were putting together the health budget, were you advised that, if the funding for Calvary remained as it was, that the hospital would be forced to close down public elective surgery for 14 weeks, or for any period? Were you advised that this would result in—

Mr Stanhope: I was not advised specifically that Calvary would be proposing to close for 14 weeks. I must say I was certainly aware, in developing the health budget, that it would impose a strain, particularly on Calvary's capacity to meet the throughput levels that it met in this past year. Of course, in arriving at that conclusion, I was mindful of the fact that this government had already provided an additional $2.7 million to Calvary, as a result of the—to some extent—serendipitous availability of those funds. I knew that it would allow Calvary to increase throughput in the substantial way that it did, but also that that level of funding simply wasn't sustainable.

Of course I knew there would be pressures. I knew those pressures would have to be handled, and that the enormous demand that surfaced as a result of Calvary's capacity and its efficiency would create a circumstance in which the community would have to accept that, while this government produced a year of significant additional funding for Calvary, it was a position that wasn't sustainable into the future. I'm sure the community understands this.

However, regarding the very significant additional funds that we've provided for health, for the committee's benefit I'll get the percentage increase in funding that we've provided to health, over and above the funds that you provided in your last budget. I don't know whether you've worked them out yourselves.

THE CHAIR: Okay. The other component of that question before was waiting times. How did waiting times change as a result of the increase in the size of the waiting list?

Mr Cusack: Category one cases, where patients need to be operated on within 30 days, will always have priority, and we'll aim to have no blow-out on those times. Of course, prioritising that area will mean that there will probably be growth in category two and three waiting times.

MR HARGREAVES: To what extent is the availability of surgeons within the various disciplines contributory to a lengthening of waiting times?

Mr Cusack: It depends. Waiting times in a lot of cases are calculated by individual doctor. The department had to try to even that out, so that there were not long waiting lists for one surgeon in a particular specialty, and short ones for others. That's been reasonably successful.

MR HARGREAVES: Could you give us some examples of that please, Mr Cusack?

Mr Cusack: If you have an orthopaedic surgeon who is particularly popular, some people are prepared to wait a longer period of time to see that particular surgeon, and therefore there are longer waiting times. However, when the information is actually put to the patients that there are other options, that they can be seen in a shorter period of time by other available surgeons, some of them take up that option.

MR HARGREAVES: So it's within the discipline itself? Okay. I was thinking that perhaps what you were saying was that there was some way you were able to shovel around the surgeons, or patients accessing surgeons, within different disciplines to compensate.

Mr Cusack: No.

MR HARGREAVES: When we talk about the waiting lists—the number of people waiting—and the amount of waiting time, the actual resources available to the hospital allocated to these are, I agree, significant. However, these are only two of the relevant factors, are they not? The availability of the surgeons is also a factor.

Mr Cusack: It certainly is. It's a combination of both. What we didn't want to do was have disproportionately long waiting times for some surgeons within a particular discipline, when the others had very short waiting times. We have attempted to smooth those out.

MR HARGREAVES: Right. Do you have the same range of disciplines within elective surgery at Calvary as at the Canberra Hospital?

Mr Cusack: By and large we do, across the areas of elective surgery. However, the Canberra Hospital is also the trauma centre and so does specific trauma surgery. The areas of plastics and orthopaedics, and some elements of general surgery are done there too but, across elective surgery categories, by and large they are the same.

MR HARGREAVES: What ratio does your hospital have between ACT patients and, say, patients from surrounding New South Wales for elective surgery? I think it was Mrs Dunne who was mentioning something about the New South Wales—

Mr Cusack: It varies according to various disciplines, but overall almost 20 per cent of our patients come from the surrounding region. In areas such as orthopaedics, because there is a real dearth of availability of such services in Southern Area Health Service, it has been somewhere around the 40 per cent mark. That is changing to a degree, because Southern Area Health Service is looking to provide those sorts of services close to where people live. It has had some success with that, but it really hasn't had a big impact on the numbers of patients coming from Southern at this stage.

MR HARGREAVES: If New South Wales is being a bit recalcitrant about coughing up for its own payments, have you considered actually giving ACT residents priority over the regional people?

Dr Gregory: That regularly comes up as an option. Unfortunately, under the health care agreement, one of the principles that we sign up to in return for the Commonwealth's money is that state of residence will not be a factor in deciding whether or not care will be provided. That decision must be made on the basis of clinical need.

MR HARGREAVES: But when we're talking about elective surgery and, let's say, some elective maxillo-surgery or surgery for an ingrown toenail, presumably, then, there is some room to move in terms of the medical need?

Dr Gregory: It's not a threshold that we've crossed by regarding New South Wales patients as less deserving. However, it is true that, depending on the kind of surgery, when we talk about cost-weighted separations, for example, one orthopaedic case is probably around about four cost-weighted separations. So 600 cost-weighted separations doesn't equate to 600 people not receiving treatment. It depends on whether it's an ingrown toenail or a faciomaxillary, which might be up to 10 or so, as to how many people it affects.

MR HARGREAVES: So it's a really dangerous thing to say the magic number is 600, therefore that's 1,200 eyes out there not getting the surgery. That's a very misleading approach or a misunderstanding of the way the process works.

Dr Gregory: Yes.

MR HARGREAVES: Right. When you talk about that 600, is there any way you can indicate, as a snapshot at one time, how many people that would equate to?

Dr Gregory: Probably somewhere between 300 and 500.

MR HARGREAVES: So around about half, or just over half?

Dr Gregory: That depends on the kind of surgery that's required, as I say. Calvary had been doing an increased level of orthopaedic work, which is expensive and—

Mr Cusack: Which is a higher weight. Conversely, ophthalmology has a lower than one cost weighting, so it really is swings and roundabouts to get the numbers. However, we could work out what the exact numbers are, because we have actually had to target that on specialists' contracts—the amount of work that they've done or propose to do in this coming year.

MR HARGREAVES: All right. Thank you very much for that.

THE CHAIR: Could I ask for some sort of benchmark about the political treatment of waiting lists? You'd be aware, Minister, that in the past, when waiting lists go up, governments tend to downplay the importance of them and oppositions make a big thing of them. When they go down, governments say this is a great achievement and oppositions say there are other more important things, and so on. At the outset of your term as Minister for Health, can you say to us what you see as the value of using waiting lists for elective surgery as a measure of the health of the health system?

Mr Stanhope: Waiting lists are one measure, Mr Chair. I think they're—

THE CHAIR: Are they an important measure or a relatively unimportant issue.

Mr Stanhope: They are a significant measure of hospital capacity. I probably couldn't list them now, but I think there are a dozen other measures that are equally important. Of course, you and I both know that waiting lists and waiting times, and the debate about waiting lists and waiting times, in a public or perceptual sense, are issues that easily gain a political profile. In terms of my—

THE CHAIR: Answer my question. How high a profile should it have?

Mr Stanhope: Not as high as it has.

THE CHAIR: Okay.

Mr Stanhope: There's no doubt about that. I think there are a whole range of other measures of how a health system is performing, and I think that perhaps all of them are as legitimate. Certainly, I think it's unfortunate—and perhaps it's a reflection of a weakness in the political processes—that there is an undue emphasis on them, and there always has been. I accept that. My time in opposition has shown me that there is an undue focus on waiting times and waiting lists, and it will always be thus. I think we accept it as part of the process.

However, there are a whole range of other measures and other aspects of health service delivery that are very important and probably don't get the level of attention they deserve as a result of the focus by oppositions, in particular, and governments, on waiting lists. Perhaps it is a diversion of attention from these other issues.

THE CHAIR: Okay.

MRS DUNNE: Minister, you said that there probably were other measures, but you couldn't tell us what they were. In pursuit of a mature political discussion on the health of the health system, do you think that you might be able to provide us, in the course of

the day, with those measures that might go up independently next to waiting lists and clinical waiting times? Because you said—

MS TUCKER: They're in the budget outputs.

MRS DUNNE: —it will always be waiting lists, it will ever be thus. However, if you're saying that that's not a mature way to approach it, perhaps we might use this forum as a means of starting off the process of determining what is a mature way of doing it, rather than saying, "Oh, it will ever be thus." Without having to do it now, do you think you could perhaps provide us with a list of other measures that we should be looking at?

Mr Stanhope: I think to some extent the budget does that, and it does that in terms of—

MRS DUNNE: But you couldn't tell us what they were.

Mr Stanhope: I'm happy to sit here and go through the budget page by page, Mrs Dunne. I was actually saying that I'm not sure it's particularly profitable or helpful for me to actually sit here and say, "Yes, a satisfactory measure would be, rather than just concentrating on waiting lists, talking about attendances at emergency departments or waiting times at emergency departments." I could talk about anything.

I could go through the budget paper starting at output class 1 and say, "Here's a measure in relation to number of inpatient cost-weighted separations." Let's talk about the work that we do do, rather than concentrating on the work that's not done. That is a good measure: exactly what is the throughput in our hospitals? I'm happy to turn the page and say, "Here's another good measure."

THE CHAIR: Minister, can I butt in?

Mr Stanhope: Number of raw inpatient separations—there's a good measure.

MRS DUNNE: Do you know what they are? Do you know what it is? Do you know what it means?

Mr Stanhope: Yes, they're in the budget.

THE CHAIR: Minister, before you go on—

MRS DUNNE: Do you know what it means, though?

THE CHAIR: Hang on. Minister, the point that I think Mrs Dunne is making is a reasonable one. There are thousands of such measures in these documents. There must be some that are more important than others.

I think it's a reasonable offer to make. We talked about this at the health summit. Those of us who were present talked about what indicators we should use to decide what are the best ways of measuring the health of the health system. I'm not aware of any decided outcome from that part of the summit and I think Mrs Dunne's invitation is a fair one. Do you want to suggest to the committee the measures that ought to be used—maybe

a dozen or half a dozen or so measures that could be used—so we can all measure the health of the health system?

Mr Stanhope: I'm sure that's work we'd be more than happy to do and, of course, through the health summit process and the health action plan that we're developing, we're doing precisely that. However, if this committee would like to be informed about the ways of testing not only the health of the system, but the way we measure the health of the community—which, of course, is related to the extent to which the health system in the ACT addresses those issues—then I'm more than happy to respond to that.

MRS DUNNE: Thank you, Minister.

Mr Stanhope: If you want another dozen or so measures, certainly, I'd be happy to give you the government's response to that. There might be a range of views on that issue, but I'd be happy to present—

MR HARGREAVES: You can bet on that, I think, Minister.

Mr Stanhope: Yes, I think you could bet on that.

THE CHAIR: We're inviting the government to put its views on the table, Minister.

Mr Stanhope: Sure. Okay. Well, thank you for that, Mr Chair.

THE CHAIR: All right. I think that we can move off waiting lists and go to a question Ms Dundas wants to ask.

Mr Stanhope: Could I just, if I may, interrupt. Sorry, Ms Dundas. Mr Patterson, the Community and Health Services Complaints Commissioner, is here. I don't know whether there are questions for him or how many questions there are, but it would be convenient for Mr Patterson if questions were asked of him before we break for lunch. It's a question of how many there are. We are in the hands of the committee.

MS GALLAGHER: I have one on Calvary that I wanted to ask.

Mr Stanhope: Right.

THE CHAIR: For Mr Patterson?

MS GALLAGHER: I don't know if it's for Mr Patterson.

THE CHAIR: A question about Calvary generally?

Mr Stanhope: Right.

THE CHAIR: Unfortunately, the committee wants to ask questions of members first. Are members happy to go to Mr Patterson first?

MS DUNDAS: I do have a question for Mr Patterson as well.

THE CHAIR: Okay, then I think we'll accept that invitation. Mr Patterson, would you come to the table, please? Welcome. Questions, Ms Dundas?

MS DUNDAS: Thank you, Mr Humphries. Minister and Mr Patterson, you might remember in February this year I called on the Assembly—and the Assembly agreed—to initiate a review into the work of the Community and Health Services Complaints Commissioner and the advisory council, particularly into the methods used to process complaints and ensure accountability.

During that debate, Mr Stanhope, you indicated that the government wanted to refer the issue to the Community and Health Rights Advisory Council, rather than make any immediate changes. Now, five months later, can you tell me what has been done, what has been referred to the advisory council, what processes are under way, and what is the time frame for providing an appeals mechanism for people who are dissatisfied with the way their complaints have been handled?

Mr Stanhope: Thank you, Ms Dundas. Yes, I do recall that, and the government has responded by asking the advisory committee to provide advice about the operations of the office.

MS DUNDAS: When did you ask the council to do that?

Mr Stanhope: I'm not quite sure when the request was made, Ms Dundas, but I'd be more than happy to advise you of that. I have had a response from the committee. I had proposed to make the response public, but the committee asked me not to do that. It wished the report to be treated as confidential, and I respected that request. That came from the chair, Ms Tito. It is a useful report about that committee's existence and operations.

I might just say that questions have been raised by the committee itself about a its formal role in the scheme of consumer access and a consumer complaints process. Indeed, we're looking at adjusting the terms of reference of the committee.

You're also aware that, in his report, Justice Gallop made reference to particular concerns and the need for us to assess or investigate those—complaints generally, complaints mechanisms, and how best to deal with complaints that might be made about the operations of the Health Services Complaints Commissioner himself.

We're continuing to look at those issues and we'll be responding to that specific recommendation of Justice Gallop. Mr Patterson can respond on his own behalf in relation to this, but the issue that you raised was one that Mr Patterson had himself raised with me.

MS DUNDAS: Yes, it's been raised in his annual report repeatedly.

Mr Stanhope: Yes. There is a need for these particular issues to be investigated. We're doing that. What time frame do we have for the response? Dr Gregory might just explain the process and where we're up to. Mr Patterson might want to respond too.

I'll conclude my comments by saying that I accept the legitimacy of the issue. I'm committed to pursuing it. I believe there is an issue to be dealt with in relation to the Health Complaints Commissioner himself, and the capacity for appeals against his operations, just as I believe that there is a need for us to look broadly at how we as a community, a government or an administration handle complaints generally.

We have a discrimination commissioner, we have an ombudsman, and we have a health complaints commissioner. There are a number of avenues for complaint on a number of fronts, and there has been discussion from time to time, for instance, about whether or not our current structures and processes are efficient. I believe there is a debate to be had about that, and to some extent I'm happy to catch that up in a consideration of Mr Patterson's statute and operations.

Dr Gregory: There are a number of pieces of work that are coming together which will result in some proposals to reform the current Community and Health Services Complaints Act. The minister has made available to the department the report of the Health Rights Advisory Council, and we are examining what has been recommended in that, together with a small group from both the justice and health departments. That will involve the new disability department now as well. We will examine the recommendations made by Justice Gallop as a result of the disability inquiry.

Those processes are coming together and are being considered as the one piece of policy work towards revision of that act. However, I can't quite give you the time frames for that, because the justice department is leading part of that work and I'll have to go back and check the time frames with them.

MS DUNDAS: Are you taking that on notice?

Dr Gregory: Yes.

MS DUNDAS: This issue was raised in the Assembly five months ago and, as I'm sure Mr Patterson will tell us, it has been raised over a number of years, specifically about the Community and Health Services Complaints Commissioner?

Dr Gregory: Yes. We already have a number of recommendations about some fairly straightforward improvements to the operation of the act. However, there are other more complex issues. The justice department, in particular, is quite concerned that boundaries have to be drawn somewhere. We need to make sure that, when we do draw new boundaries, we aren't creating just as many difficulties as we had before, but simply in new areas. That work is proceeding and we'll take on notice the question about the time frame for that.

Mr Patterson: I am Ken Patterson, the Community and Health Services Complaints Commissioner. There are two very different issues here. One is the very specific one about the accountability of my office: that is, if somebody is unhappy with a decision I have made, where do they go? There is also a more general issue about how complaints mechanisms are managed in the ACT.

In relation to the first, you're quite right, this is an issue that I've been raising for some time. It was one of a number of issues which I raised with the previous government and they, at the time, accepted the suggestions I made and, as a consequence, a lot of work has been done on a bill which would in effect replace the current Community and Health Services Complaints Act. However, that bill has not been considered by the current government.

The bill is interesting and I'd like to mention it mainly because I've spent a lot of time on it and tried to make as many contributions as I can to it. A number of the changes to the current act that we were considering as part of that exercise were fairly straightforward tidyings up, if you like, as a result of a number of years of experience with the previous act. Some of them were specific things that were discussed in relation to the Gallop inquiry, and Justice Gallop accepted them as well, so we've also incorporated a number of those things into the bill.

Another major area relates to how we deal with the registration of professionals. The new legislation in relation to registered professionals is very important and that has been considered by the current government first. However, there are a number of changes to our act that mirror the changes in policy that are likely to be introduced as part of that act.

Since this general issue of what to do about complaints bodies has been mentioned, there is one thing I want to say. There are certain advantages in what we have at the moment, and I want to make sure that we don't lose sight of them. What we have in my office at the moment is a considerable degree of expertise in dealing with health issues. We also have considerable links to other parts of the health system and I think it's important that, if we make any changes, we don't lose those.

For example, we've been able to do some work in relation to personal privacy in the health area, which we were able to initiate in the ACT and which will subsequently be picked up by the Commonwealth and other states. Having the specialised understanding of those issues is important. It's enabled us to do that sort of work, which we may not otherwise do if we get to be part of a body that is a little bit too big.

We also work with other organisations in other states that have a similar purpose. What we find is that we will often take the lead in one year—as we did with health services privacy, and also in relation to information systems for health complaints—while other states have taken the lead in others, for example, in developing training in investigations in this area, which has been done by the people in New South Wales.

I wanted to make the point that we should be wary of assuming that all complaints, in all areas, can easily be dealt with by the same people in the same way. I think that it is important that we do not lose the links with particular industries and particular fields, and the appropriate expertise.

MS DUNDAS: Thank you. Just to follow up, Dr Gregory, is the committee that you've discussed, that's looking into the whole complaints issue, is that just being funded through the normal departmental appropriations?

Dr Gregory: It's not actually a committee. The Health Rights Advisory Council is one set up under the legislation.

MS DUNDAS: No, the group of people from JACS and the new department.

Dr Gregory: Yes. It is a priority piece of work to which resources from JACS and from our area have been devoted.

MS DUNDAS: Okay, and I will just ask a quick question on the output. A health service improvement project and consumer rights projects have been completed, and the aim, according to the budget papers, is to do two a year. The notes refer to the fact that the projects concluded during the 2000-2001 financial year were not those nominated at the beginning of the year. Can you tell me what the two completed projects were, and whether this review of the council and complaints specifically within your area is one of the projects that you are looking at for this financial year?

Mr Patterson: The answer to the second question is no.

MS DUNDAS: No, okay.

Mr Patterson: I can't remember exactly what the others were now, but I recall that one of the things that we had intended to deal with in the previous year was the code of health rights, and that was not completed, partly because, during that year, the Health Rights Advisory Council expressed a desire to become much more closely involved in that, and therefore I put that to one side.

MS DUNDAS: Is that one that was going to be picked up again this year?

Mr Patterson: It's actually being picked up at the moment in another way, so I think it is likely to be completed during the financial year that's just started. The work we did in relation to the development of new legislation for health professionals, for example, is one which, as I recall, we finished last year, or in the year that's in the budget papers.

MS DUNDAS: What was the other one? Do you want to take the question on notice?

Mr Patterson: Yes, thanks.

MS DUNDAS: Okay, thank you. Dr Gregory, you said the budget is coming from internal resources in the departments. Does the advisory council have its own budget under which it is sponsored to carry out its investigations?

Dr Gregory: That is one of the difficult issues. The Health Rights Advisory Council has actually been in the legislation for some time, but it didn't really start to exist and operate as a body with some influence until recently, when Ms Tito took over chairing that group, and it was never funded to do any work. I've agreed to a small allocation of funding to that group to allow it to have a secretariat function and to do some work, but it is an ongoing issue to be considered. The kind of resourcing that the committee will need to do its job effectively will depend on what its role becomes.

MS DUNDAS: Will it receive continuing support and resources throughout this review of the complaints mechanisms?

Dr Gregory: Yes, we've provided it with some secretariat funding. It's only a small amount, but that will continue until we establish the way forward.

MS DUNDAS: Okay, and what is that amount?

Dr Gregory: I can't tell you off the top of my head. It's quite small. I think it's under $10,000.

MR HARGREAVES: Mr Chair, I move that we go to lunch.

THE CHAIR: Do you have further questions for the commissioner for health complaints, Ms Dundas?

MS DUNDAS: No.

THE CHAIR: Does anybody else have questions? In that case, thank you very much. We'll resume at 2 o'clock.

Luncheon adjournment

THE CHAIR: We will resume the public hearing. Thank you, Minister and officials, for returning.

Mr Stanhope: Mr Chair, could I interrupt? Before we proceed with today's program, I wonder if I might be availed of an opportunity to correct something I said yesterday in estimates. Is that acceptable?

THE CHAIR: Yes, it is.

Mr Stanhope: Thank you, Mr Chair. Yesterday I advised the committee that the Clerk had agreed to manage a program to allow all 17 members of the Assembly access to rented space in public facilities to meet with their constituents. I might just say by way of explanation that that was the advice that was provided to me by my chief of staff following discussions that he had held with the Clerk. Both my chief of staff and the Clerk are absent today, but I've been advised by the acting clerk that it's not the understanding of his office that the Clerk had formally agreed to that proposal—that discussions had been held but there was no formal agreement from the Clerk that the secretariat would manage that process or that they would find the resources for it.

I must say there was an unfortunate breakdown in communications to that extent between my office and the Clerk's office. I regret that. I regret that, as a result of that, I provided that misleading advice to the committee. I will add, however, that the commitment is one that will be maintained. We will have further discussions with the Clerk's office and the secretariat in relation to this program. I have also, since receiving the letter from the Clerk at lunchtime today, had discussions with the head of the Chief Minister's Department to arrange a fallback position should that be necessary, and I wish to rush to assure members that this scheme will be implemented as soon as possible, and

I hope within the next couple of weeks—if not by the Assembly, then by the Chief Minister's Department. But I regret the confusion, Mr Chairman.

THE CHAIR: Thank you for that explanation. Unless there are any questions about that I propose we resume on health and the health department.

Mr Stanhope: I beg your pardon, Mr Chair. Mr Cusack has indicated to me that he made a statement this morning which he would like to clarify.

THE CHAIR: Yes.

Mr Cusack: Thank you. This morning I gave a figure in relation to our overall reduction in cost-weighted separations, whereas I believe the question that was asked was in relation to the reductions that are estimated in relation to elective surgery in particular and the impact on the waiting list. Rather than put it in terms of cost-weighted separations, which aren't meaningful, it equates to 970 patients that were on the waiting list. That reduction is 970 patients, so it increases the waiting list from 1,363 to about 2,333.

THE CHAIR: I see.

Mr Cusack: The reason is that there has been a significant increase in medicine, and to a lesser degree in maternity services. That, coupled with the emergency surgery, meant that there had to be an increased reduction in elective surgery. And so that's equated to 970 patients.

THE CHAIR: Okay. So are you saying this is the expected increase over the course of this financial year or that that increase has already occurred and the waiting list is now two thousand and whatever you said? What was the figure you mentioned?

Dr Gregory: Can I just clarify that? Sorry. I think Robert's talking about the decrease in the number of patients who'll be able to be treated. So it doesn't translate into a waiting list issue necessarily.

THE CHAIR: This is in the elective surgery area?

Dr Gregory: Yes, yes.

THE CHAIR: Well, I suppose it was an extrapolation—that if you have the same number of people on the waiting list at the moment and you extrapolate the same number to next year and then you add another 970 that you get an increase in the number of people on the waiting list.

Mr Cusack: It may or may not happen. Some of those people may in fact be taken up in the increase in emergency surgery that occurs.

Dr Gregory: And waiting lists are very fluid in terms of people going on and off all the time, so—

THE CHAIR: Yes.

MR HARGREAVES: Mr Chairman, I've got a question about that—something I meant to ask before.

THE CHAIR: I want to just make sure we understand what's being said. That's why I'm going to clarify this. So the figure 1,360 was the present number of people on the waiting list for elective surgery at Calvary Hospital?

Mr Cusack: That's right, at the end of June.

THE CHAIR: Okay. And do you have an anticipated number of people who'll be waiting as of this time next year, 30 June next year? Have you extrapolated or—

Mr Cusack: Essentially, what I'm saying is that the amount of elective surgery that will be done this year compared to last year—we will have 970 less patients going through, so you expect some correlation to the waiting times.

THE CHAIR: It's reasonable to assume then that there'd be a waiting list this time next year, unless there's an infusion of funds, of well over 2,000 people.

Mr Cusack: In all likelihood.

MR HARGREAVES: My question on this is: is there any account taken of people who are possibly using the same surgeon but on waiting lists of both hospitals?

Mr Cusack: Yes, and I think I did touch on that this morning. There is a process in place to actually look at the waiting times by surgeon and by hospital for the various disciplines, and there are opportunities given to patients—and it's ultimately their decision about whether they're prepared to actually change where they have their surgery done, or who provides that surgery, based on the waiting times that are there. And ultimately that's the choice they make. A number of patients have taken up that option though.

MR HARGREAVES: So would it be fair to say that there are significant numbers on the lists of both institutions?

Mr Cusack: There certainly are. There are waiting lists for both Canberra Hospital and Calvary Public Hospital.

THE CHAIR: I think what you mean is that they are the same people waiting for the same procedure on both lists.

Mr Cusack: No—well, I don't believe there's as much of that as there has been in the past because of the centralisation of the waiting list management program. It's not something we manage through the department, but that certainly sorts out to make sure that we're not double counting in relation to that.

MR HARGREAVES: So the practice of surgeons optimistically putting their patients on both lists has reduced quite a bit, has it?

Mr Cusack: I think it's certainly streamlined. It's not totally eliminated though.

MR HARGREAVES: Thanks.

THE CHAIR: Before you leave the table, Mr Cusack, I thought while we're on Calvary I might ask another question—really mainly to the Minister. I just wanted to ask you about the public interpretation of the events or the problems that Calvary is facing. Your colleague Bill Wood, as acting Health Minister—what was it, two weeks ago?—made some comments about how these sorts of increases were expected. I think he made a comment to the effect that the hospital has had it good for some time and it can't continue to have it good. Dr Gavaghan, consulting doctor at the hospital, is reported in the *Canberra Times* in the following terms:

> … Dr Gavaghan said Calvary Hospital "was seriously underfunded which had forced management to close about 60 beds in the past six months.
>
> "They are glib, arrogant statements—just ridiculous," Dr Gavaghan said yesterday.
>
> He said Mr Wood's comments were irresponsible and demonstrated a lack of understanding about the community's health needs.

Do you want to in any way qualify what Mr Wood said as acting Health Minister about the problem at Calvary? Would you, for example, adopt his view that the hospital's had it good for too long and it can't expect to have it good in the same way in the future?

Mr Stanhope: Well, Mr Chair, I wasn't here at the time. I'm not aware of the context in which Mr Wood was speaking, or the extent to which his comments were edited. I would assume—and this is the difficulty in me responding to your offer—that Mr Wood was referring, in the way I have this morning, to the fact that over the last year an additional $4.7 million, in fact an 8.4 per cent increase in funding, was provided to Calvary by the government, $2.7 million of which was applied to increasing throughput. I think $2.7 million roughly equates to about 900 separations.

I can only assume that Mr Wood was making the same point that I've made—that we provided an additional $4.7 million to Calvary last year, $2.7 million of which was applied to increased throughput. As a result of that funding, Calvary has performed outstandingly over this last year. It can't be denied. Its activity levels have just been superb.

But we've made the point, and I've made it again today, that that level of funding is not available this year. In that context—and I've just had the sums done by the Department—in fact this government in this budget has increased funding to health by 13.5 per cent over that included in the forward estimates in your last budget for this year. There's a 13.5 per cent increase in funding in this budget for health. That's an amazing increase in funding. I'd bet that's not matched anywhere in Australia. A 13.5 per cent increase in funding is what we've achieved in this budget.

Now, of course, Calvary would love it all to go to Calvary. I would like Calvary to have more money. I would like the Canberra Hospital to have more money. But in the context of preparing budgets we make some decisions. We exercise judgment. You did it for a number of years, Mr Humphries, and it was tough for you, just as it's tough for us.

We've made our decisions and we're hopeful, in the context of the range of decisions we've made, the resourcing that we will apply across the board in the context of this 13.5 per cent increase in funding, that there will be health outcomes that will to a greater extent than previously accord with what this community wants.

This community does want reduced waiting times. There's no doubt about that. This community does want reduced waiting lists but they also want a range of other things to be delivered by their health services. They want reduced times in radiation oncology, they want better equipment and better treatment for people with cancer, they want far better services for people with disabilities, they want better services for mental health, and they want our Indigenous people looked after to a greater extent than possible. These are the decisions in the mix that we've taken.

But at the end of the day there's a 13.5 per cent increase in funding for health in this budget as against the forward estimates. You and I can argue, as we are, about whether or not greater attention should have been paid to the waiting lists at Calvary Hospital. Be that as it may, they're the decisions we've made—but in the context of a 13.5 per cent increase in funding for health.

THE CHAIR: Okay. I think people would say that nearly a doubling of the waiting list at Calvary was also pretty amazing in the space of one year.

Mr Stanhope: Well, let's see what happens, will we?

MR SMYTH: Well, I'm pleased that the Chief Minister acknowledges the great state that you left the economy of the ACT in, so that he's able to fund a 13 per cent increase in health funding, Mr Chair.

Mr Stanhope: It's a question of priorities. We weren't disposed to provide $27 million for free bus travel. We weren't disposed to organise a car race that actually was set to consume $30 million. We didn't expend $80 million on a football stadium, Mr Smyth. It's a question of priorities and a question of good government and management.

MR SMYTH: It is curious that when you're under pressure, Chief Minister, you can't tell us what you will do. You resort to the age-old trick, which will become well known as the Stanhope defence, of attacking the previous government. We're actually talking about your budget, not ours.

Mr Stanhope: I'm talking about my budget, too, Mr Smyth. Let's talk about a 13.5 per cent increase in health, over and above what you were prepared to expend on health. I'm happy to talk about that.

MR SMYTH: And reduced outcomes.

THE CHAIR: Order, gentlemen, order.

Mr Stanhope: Talk about the 13.5 per cent in health and then let's talk about the car race—

THE CHAIR: Order, Minister.

Mr Stanhope: Then let's talk about Bruce Stadium, then let's talk about a free bus scheme and let's talk about priorities.

THE CHAIR: Minister, thank you very much. I'm sorry that this has diverted us. We have a lot to get through this afternoon, and I'm sure you don't want to be recalled tomorrow.

Mr Stanhope: Well, if Mr Smyth wants to play politics with me, Mr Chairman, I'll go all afternoon.

THE CHAIR: I think we're all playing a bit of politics at the moment. Perhaps we should get back to questioning on the budget. Ms Dundas has a question.

MS DUNDAS: Thank you. This is a question that stretches over a number of years, but I'd like to ask about the hepatitis C financial assistance scheme. From my research, I believe that the scheme was initiated in the 1999-2000 budget, and was allocated $5.8 million for two years.

In the next budget, it is stated that only $62,000 had been spent of that $5.8 million, and the remaining money was to be deferred—and, Minister, I think, in your response to the 2000-2001 budget you actually raised this issue about the hepatitis C scheme. The 2001-2002 budget lists a negative figure for the estimated outcome of expenditure for the scheme, stating that the $3.5 million of funding had been delayed and no allocations were made for previous years. It's also listed in this budget, with an estimated outcome for 2001-2002 as a negative of $700,000 with no further funding for subsequent years.

Minister, can you please explain the financial management of this scheme? What happened to it? Where has the money that was allocated to it gone? Has it been deferred? Will the scheme continue?

Mr Stanhope: Sure, thanks, Ms Dundas. As you say, that's an issue that I've taken a significant interest in in the past—the issue around hepatitis C and the Hepatitis C Lookback Project. It is a difficult and complex issue. At the time that it was discovered that ACT residents may have been infected with the hepatitis C virus through blood donations, there was real concern, in the initial consideration of how extensive the problem might be, that up to 60 people may have been infected with hepatitis C. The Hepatitis C Lookback Project has been going now, I think, for three years and I think in that time, to date, 16 people have been identified as having contracted hepatitis C. So, in the context of the provision that was made, the provision that was initially made was made on the basis of the potential that up to 60 people may have been hepatitis C positive as a result of blood transfusions.

In relation to the management and operation of the scheme, it would perhaps be more informative if I asked Dr Dugdale to respond, and Mr Foster would also be happy to contribute in relation to the financial management.

Mr Foster: If I could just explain the $700,000 reduction in the 2001-2002 year, that's money being returned to the Territory budget because clearly we weren't in a position to pay out any settlements during 2001-2002. So we returned the allocation to the budget,

and that was a decision taken around March and that's why it figures in this outcome. We've also taken a decision that, for future settlements, we'll deal with those on an emerging cost basis. In other words, we'll pay for those out of our legal budget that we have, and if they are in excess of our legal budget we'll seek recourse to Treasurer's Advance, for example.

So that's then a decision of government that, rather than keep appropriating funds when we clearly haven't been able to line up an estimate against the timing of payments, we'll just now deal with the matters as they emerge.

MS DUNDAS: That doesn't necessarily answer my question about what happened to the money that's been allocated to the scheme over the last three years. We're talking in excess of $5 million here. And I can only see bits of it rolled back to the territory in the budget papers.

Mr Foster: Well, I haven't got a reconciliation here but we can certainly produce that. We have returned money to the budget in previous years as well. And there was $1 million in payments in the 001 year, for example. But certainly we can demonstrate how the funding has been returned to the budget where it hasn't been spent by us.

MS DUNDAS: I'd appreciate that information, if you could take that on notice.

Dr Gregory: Can I just clarify. The government remains committed to fulfilling everything under that scheme. It's just that it wasn't working to appropriate the money and then not spend it, and we didn't want to spend it on some other purpose instead, so it's been diverted back to government rather than being diverted to something or other else.

MS DUNDAS: And so that's just been diverted back to general revenue?

Dr Gregory: Yes, on the understanding that it will be brought back—that we will still be funded for that scheme as needed.

Mr Foster: Dr Dugdale could indicate where the Lookback Project's up to.

Dr Dugdale: In terms of doing the look-backs, the initial estimate, as Mr Stanhope said, was there might be around 60 people, but we've only found 25 possible cases. We've contacted 16 of those and settled with half of those. And with the other half it's under negotiation—and we're at various stages in the process of getting to a settlement with them. So it's considerably less people than we thought we were dealing with. The original numbers were just an estimate, and it was an overestimate, which was prudent at the time, so that we made sure that there was sufficient provision. But as it's turned out, thankfully, it's less people than we thought.

MS DUNDAS: You said that you thought the revised estimate was now 25 and you've contacted 16. Are the other nine no longer in the territory or unable to be contacted? What's going on with them?

Dr Dugdale: A number of them turned out not to be eligible. There were 25 who might have been eligible but it's turned out that they haven't acquired hepatitis C through blood transfusions.

MS DUNDAS: Well, lucky them.

Dr Dugdale: That's right.

MS DUNDAS: Okay. So will you take it on notice to give me the full information on the reconciliation?

Dr Dugdale: Yes.

MS DUNDAS: Because it was a substantial amount of money over a number years that just seems to have, in terms of the budget papers, disappeared. So I'd appreciate that information.

Dr Dugdale: We do have a regular reporting process to the Assembly and that's coming through shortly, indeed the next report.

MS DUNDAS: Yes. I've been getting it, but they don't actually tell us where the money has gone, because of the small number involved.

Dr Dugdale: Sure, sure.

MR HARGREAVES: Could I ask a question about the convalescent care facility, the step-down facility. Money's been provided, roughly $600,000 a year, as mentioned on page 144, Budget Paper 3. I can recall it being mooted in the 1990s and I'm really pleased to see it finally getting a mention in the budget. What I'd like—

MR SMYTH: It was mentioned in last year's budget too—money.

MR HARGREAVES: Yes, well it could have been mentioned but it didn't appear in bricks and mortar—that's one of the questions. What I'd like to know, if it's possible, is when it will actually appear. I note the $600,000 allocated for it for the first year. It's not already up and running so I presume that part of that money is for set-up costs and kicking it off. What I'd like to know is: when is it likely to actually appear, how many patients will it provide services for, do we know where it's going to be, and what sort of staffing model will be applied to it?

Mr Stanhope: Thanks, Mr Hargreaves. There's a range of initiatives that have been pursued in relation to this particular matter. And I think perhaps it would be most appropriate if I ask Dr Gregory to go through where we're up to with what the budget provides and what's been done over this last year in relation to the issues around care for people that require convalescence or care post-hospital.

As you're aware, there was funding in the budget last year. There was some funding provided of a capital nature for furnishing and refitting. There were some recurrent moneys made available. Mr Moore utilised half of those funds to match Commonwealth funding for a trial of a service at Morling Lodge, which has been extended now by

another year. And I think early indications are that the Morling Lodge experiment perhaps is producing some very worthwhile results in terms of its capacity to take particularly older people who have required acute care but require further convalescence or care before returning home.

As a consequence of that decision by Mr Moore—and in retrospect, and all things being equal, it was certainly a worthwhile trial and a very worthwhile thing to do, but it certainly didn't leave sufficient of the recurrent funds that were applied in the last budget to run a convalescence facility. It simply couldn't be done with the $250,000 or thereabouts that remained. That money has nevertheless been utilised in the provision of some aged care packages, but Dr Gregory could give more details in relation to that. But we are committed, and we're adding to the commitment which the previous government exhibited through the last budget. We've now negotiated with Calvary Hospital for the establishment of a nine-bed facility at Calvary. We'll continue the experiment at Morling Lodge and we've also committed to the establishment of a purpose-built facility and have provided funds in the budget for a feasibility study in relation to the construction.

Dr Gregory could actually flesh out some of the detail of that, but that's essentially what we're doing and it is our intention—and this is being negotiated with Calvary—that the convalescent facility will be open and operational, I think, within the next couple of months.

Dr Gregory: Thank you. I think that just about comprehensively covers it all actually. I'm sure Mr Cusack could talk further about the facility at Calvary if he wanted.

MR HARGREAVES: Okay. From my memory, it was going to have a beneficial effect on what we call the geriatric ward at the Canberra Hospital. People are staying in there for quite some time after breaking legs or femurs, not needing the acute hospital service necessarily, and they were actually going to go to such a facility. I'd be interested in whether there is any sort of idea on the effect it might have on that ward and on the rehabilitation ward.

Mr Stanhope: I'm bedlocked.

MR HARGREAVES: Will it assist? I know that the length of stay for people in that condition is considerably higher than in any other ward, and I would assume it will have a beneficial effect there, but I wondered if there's been any work done.

Mr Stanhope: Well, perhaps Ms Killion could answer that.

Ms Killion: Yes. There are a range of initiatives that are happening at the moment. Certainly the 11 beds that the minister spoke about at Morling Lodge are taking some of the pressure off those nursing home type patients that are currently within the hospitals. Also, the opening of the new Calvary transitional care/convalescent care nine beds will assist in that regard. Certainly with Morling Lodge, the people who go there are staying longer but there will be a faster throughput in the Calvary beds so that we'll be able to move more of those people through so that they're ready to go home, and that will free up some of the beds in the acute care system.

There's also $240,000 going into Community Options, which is supporting people at home, and sometimes 24 hours a day at home. So they are available to provide care overnight. Also, in the department, along with everybody in the portfolio, there is a feasibility study which is looking at four different aspects of care which greatly overlap, and those are rehabilitation, post-hospitalisation transitional care, psycho-geriatrics, both acute and residential, and dementia respite care. And there's funding in this year's budget to do a feasibility program. We've done some needs analysis, and indeed we do need extra beds across the system for these types of facilities and there's a working group that is going to be putting up recommendations through the capital works program to have those additional beds built.

MR HARGREAVES: Thank you.

MR SMYTH: One of the reasons in March for not going ahead with the project in the last year was that you wanted to conduct further consultation with the public. Was that consultation carried out, and what was the outcome of it?

Mr Stanhope: There was consultation. I'll ask Dr Gregory perhaps to explain that, Mr Smyth.

Dr Gregory: Yes, there was further consultation with the community. There was a working group set up with a number of community members on it. Those community members were particularly keen on a model of care that was a standalone model within the community, preferably close to shops, the idea being that people could spend two or three days there with some assistance and then move back into their own homes.

The research that the department did based on various models of care that are being put in place in Victoria demonstrated that it is an expensive and difficult model of care to sustain, even though the community find it more amenable in lots of ways. But the whole issue is around security, 24-hour backup, access to facilities, whether they're needed, the extra costs of bringing food in from outside et cetera. These all add to a model of care that was not demonstrated to be cost-effective or particularly effective in Victoria. And we took that research on board, so the consultation that we did had to be balanced by research from elsewhere. That was why the model of care at Calvary has been decided on by government.

Mr Stanhope: I think, Mr Smyth, you're probably aware that there was some significant community support for the prospect of a convalescent facility being established at Chapman in the facility there. We looked very closely at that. We're aware and we're mindful of the level of support within sections of the community for that particular facility to be converted to use as a convalescent facility. The investigations which the department undertook in relation to that were that the costs of upgrade and conversion probably at the end of the day would match the construction of a new facility, or be in the same ballpark, and that, similarly, the recurrent costs to run the facility there would far exceed the cost of a co-located facility. In the context of that advice, we're pursuing the current model and proposal. But I am aware of the level of support there was for that facility, but it was felt to be not cost-effective.

MR HARGREAVES: I also wanted to know what sort of staffing model will be applied?

Mr Stanhope: Mr Cusack could answer that.

Mr Cusack: Essentially, what we're talking about is nine beds, and it's co-located in a ward where we currently have capacity. And so three four-bed rooms will be converted to have three beds in there and also a lounge facility in each one. Essentially, we will be able to start with either assistants in nursing or enrolled nurses under the supervision of a registered nurse—almost certainly a clinical nurse consultant—because on that same ward on the other side we'll be running eight orthopaedic beds and so they'll be able to have the cross-supervision of those two areas. And so that's why we can do it as such a sort of cost-efficient set-up in relation to the staffing profile.

MR HARGREAVES: Will you be having occupational therapy and physiotherapy services dedicated to that facility?

Mr Cusack: I actually don't have the answer to that in front of me. As part of the model there are some limited services that are available for people, but I didn't—

Dr Gregory: People are telling me yes.

Mr Cusack: Okay. There will be, but that will come from a staffing base from our existing staff. And so it's not as if we're having to employ separate people to do that; it will be able to be done at a marginal rate.

MRS DUNNE: Can I assume, Mr Cusack, because it's closely located with the orthopaedic ward, that you would actually see that most of the clients would be orthopaedic patients on the way home, or is that just a coincidence?

Mr Cusack: That's just a coincidence.

MS TUCKER: I've got a Calvary question. I was interested in the CALCAM service. Has that service been running already?

Mr Cusack: It has been running. It's been running as a pilot, I think, for the best part of about 18 months on our site. The longer term plans are, as part of the Nurcombe review that was done into adolescent mental health services, that there would be an adolescent day facility built in an appropriate—yet to be determined in the ACT. But certainly the early findings of the pilot have indicated that this is an area of need and it has been successful.

MS TUCKER: So it's been evaluated, has it?

Mr Cusack: At this particular point in time we're effectively the landlords for this project, and it's actually being run by ACT Mental Health Service.

MS TUCKER: Right. So maybe that question's for them.

Mr Cusack: Mr Jager has just advised me that it has been evaluated as part of that review by Professor Nurcombe.

MS TUCKER: What, the original report?

Mr Stanhope: The pilot program. The pilot program was evaluated by Professor Nurcombe in February this year, as a consequence of which the program has received half a million dollars of recurrent funding in this budget.

MS TUCKER: Okay. And does that serve the same purpose as an early psychosis intervention centre?

Mr Stanhope: Well, we do this now or as a mental health issue—

MS TUCKER: All right, sorry. Well, if it's mental health and it isn't for Calvary, then I'm happy to wait.

Mr Stanhope: Yes, I think it is. Just on that, Mr Chair, could I just ask if there are any more questions for Mr Cusack? He's sort of been up and down for a number of hours. But could we conclude questioning in relation to Calvary. And I don't wish to impose on the committee, but Professor Owen has some other obligations and it would be convenient if perhaps mental health could be dealt with next, if that's convenient to—

THE CHAIR: I'm happy if the committee's comfortable with that approach. All right, questions of Calvary now, we'll try to conclude those.

MR SMYTH: My question for Mr Cusack, or perhaps for Dr Gregory, is: what's the recurrent funding for Calvary? It's hard to find it in the papers because you purchase services rather than give a lump sum allocation. How much did Calvary receive, say, last year, and how much is budgeted for this year, and perhaps next year, if that's available as a single figure?

Mr Foster: Yes. Calvary doesn't appear in the budget papers because of the unique situation of being a non-government organisation providing an important hospital service. The budget for Calvary in 2001-02 was around 60—

Dr Gregory: $61.3 million in 2001-02 was the final budget figure.

Mr Foster: And the figure for 2002-03 is $62.2 million.

MRS DUNNE: And what was it for last year?

Mr Foster: It was $61.3 million.

MR SMYTH: And do we have a projected figure for next year?

Mr Foster: For 2003-04?

MR SMYTH: Yes.

Mr Foster: No. We can project in relation to price issues existing in the forward estimates. Issues around the growth funding distribution would be determined later in this financial year. And obviously we don't know what other issues would come through in the budget.

MRS DUNNE: So did that $61.3 million in 2001-02 include the $4.7 million?

Mr Foster: Yes. That was the final outcome. We started that year at $56 million.

MRS DUNNE: Right, that's the final figure. So is the $62.2 million based on the $56 million or the $61 million?

Mr Foster: It's based on the $56 million because the majority of the issues that went on during the last year were from a one-off funding source.

MRS DUNNE: So that's CPI on top of 56?

Mr Foster: Impact of the nursing, other price pressures, the growth funding that we've talked about earlier for medical, surgical and ED.

MR HARGREAVES: Is that the amount that the ACT government provides Calvary? That's not the total operating costs of Calvary, or is it?

Mr Foster: No, no. This is the amount that we provide. Obviously Calvary would attract revenues from other sources.

MR SMYTH: So that's to fund public activity at Calvary Hospital?

Mr Foster: That's right.

Mr Cusack: That's true. We get other revenue resources through things like the Department of Veterans Affairs and other patient fees. But that's far and away the majority of the public hospital funding.

Mr Stanhope: It's a budget-to-budget increase of around 9 per cent.

MR HARGREAVES: And does that include capital works for the hospital as well?

Mr Foster: No, capital works is separately dealt with.

MR SMYTH: The final public question simply is: what's the expected growth in activity in Calvary this year?

Mr Cusack: If you'll just bear with me, there's a range of different areas. With the emergency department we expect a growth in the order of about 5 per cent. For medical patients, we expect a growth in the order of 5 per cent, bearing in mind that about 83 per cent of those patients originate from the emergency department. For obstetrics and paediatrics, we expect an increase of about 6 per cent. The corresponding reduction that's required in elective surgery, gynaecology and endoscopy is a decrease of approximately 20 per cent. And for psychiatry services, there's a decrease of 8 per cent.

MR HARGREAVES: So that's an average increase of between 5 and 6 per cent across a range of things, excluding the drop of 20. And did you say, Minister, that it had a resource increase of nine point something?

Mr Stanhope: Well, just on those numbers, I must admit that mental arithmetic's not one of my strengths, but 56 to 62 sounds like about 9 per cent to me.

MR SMYTH: Mr Cusack, is there an overall figure for the increase in activity, an overall percentage against last year?

Mr Stanhope: I think about a 9 per cent increase in funding, budget to budget.

Mr Cusack: I can probably give you the figures about our activity levels for last financial year compared to the previous financial year, and that was in the order of 12 per cent in relation to total admissions. There was a 12 per cent increase. As well, in our emergency department we had an increase in attendances there of about 7 per cent so that increased from 41,000 to close to 44,000. So they're the major—

Mr Stanhope: Look, I might just say that Dr Gregory has just upbraided me for how appalling my maths is. Dr Gregory thinks it's an 11 per cent increase in the budget.

THE CHAIR: And Mr Foster does.

MS DUNDAS: Does anybody want to borrow my calculator?

MR HARGREAVES: It was nice knowing you, Mr Foster.

MR SMYTH: Of course it's less than a 2 per cent increase on outcome over projection, isn't it?

Mr Foster: I wish I'd brought my calculator.

THE CHAIR: Feel free to correct the Chief Minister any time you want. That's fine by us.

MS DUNDAS: You might have done this this morning in the mental health discussion, but can you explain why there's a decrease of 8 per cent in psychiatry services?

Mr Stanhope: Perhaps we could do that in mental health.

MS DUNDAS: That's part of the mental health question. But in relation to Calvary, is it because services are being transferred out of Calvary or they've been—

Mr Cusack: That reduction is in relation to the level of service that was provided in the last year compared to the available funding that's available in this current year. So demand was greater than the available funding that was provided. We actually provided to that level but we're going to have to bring that availability of resources back to match the funding levels this year.

MR SMYTH: Rather than take up your time, could that detail about percentage increases over the years as totals be provided to the committee?

Mr Cusack: Sorry, would you mind repeating that?

MR SMYTH: Could the information about the growth of this year over last year, as just an all-up percentage, be provided to the committee?

Dr Gregory: Growth in relation to throughput, do you mean?

MR SMYTH: Yes.

Mr Cusack: Certainly we could provide the details of the summary of patient activity for the last financial year, which has a comparison to the previous year.

Mr Stanhope: We'd be happy to provide that, Mr Chair.

THE CHAIR: Okay. Well, are there any further questions of Calvary Hospital? Okay. In that case we'll thank Mr Cusack for his time today and assume that we don't need his attendance any further. Thank you. We will now call Canberra Community Mental Health Services.

MR HARGREAVES: Can I have something clarified? Is the Child and Adolescent Mental Health Service part of the mental health group?

Dr Gregory: Yes.

MR HARGREAVES: Okay, I'll ask my question now then. I thank Ms Yen for the briefing that I received on the Child and Adolescent Mental Health Service; it was very helpful. We spoke about the outreach parts of the service, addressing my concerns about the moving of it from the Tuggeranong area into Callam offices. Could you give me some sort of an indication of how the outreach services are going? I know there's been contact with the Lanyon (Mura) Youth Centre. I'd be interested to know what sort of contact has been made with that centre and how that service is actually going to manifest itself in the outreach.

Professor Owen: The CAMHS move to Woden is relatively recent, so you'll understand that these are fairly new arrangements in place. My understanding is that negotiations have taken place with Lanyon and service delivery has commenced through the Lanyon program. There also has always been the plan—and this has also commenced—of providing services still at the Tuggeranong Health Centre, albeit that the body of staff are more centrally located at Woden together. There has always been the intention to continue local service provision in each of the major health centre regions around the territory.

MR HARGREAVES: Can you give me an idea of the nature of the service being provided at Lanyon? What form does it take?

Professor Owen: A combination of direct consulting—so consulting by booked appointment—liaison work with the staff that are there, and the provision of home visiting services like anywhere else in the territory. So, in summary, the same broad range of services that were available when smaller fragments of the team were located in more locations.

MR HARGREAVES: Thank you. I just suggest that not too many of us know what those former services were, but thank you.

THE CHAIR: Can I just ask a couple of quick information questions before I go to Ms Dundas and then Ms Tucker. This year you're spending $322,000 on the expansion of the Older Persons Mental Health Service. How many raw in-patient separations would you achieve with that money—or how many extra raw in-patient separations would you achieve with that money?

Mr Jacobs: Basically, the funding will actually be going into the Older Persons Mental Health Service team, and the way they operate they'll be looking at in-reaching into beds in various facilities around Canberra, plus also extending the case management function for those people that are resident in the community.

THE CHAIR: Okay. So you don't measure those in terms of RISs?

Mr Jacobs: Well, essentially the person needs to be admitted. Then they'll actually manage their admission. If they're cared for in the community it would be an occasional service for each contact.

THE CHAIR: Okay. There are a number of things there where extra money is going, mainly on that page and the previous couple of pages. I'm just trying to get an idea of how many extra occasions of service this money will buy in the area of mental health. I'm looking at the CAMHS funding of $466,000 which is mentioned on page 143—yes, the enhancement package on page 143; that's $466,000. CALCAM gets $500,000, on page 144, and MIEACT, mentioned on the next page, gets $85,000. There are no measures or performance targets next to those, so I'm just wondering how much we get in terms of extra services for that—and, incidentally, how much that offsets the argument that the ACT is underfunded in the area of mental health services on a national scale. You may want to take those questions on notice. Do you understand the question I'm asking?

Dr Gregory: If the question is how much it will increase us from our lower percentage at the moment of funding, the difficulty with answering that question is that it depends on how much the other states increase their funding by, because it's a fairly fluid arrangement.

THE CHAIR: Yes, I appreciate that—perhaps measured against the previous position. If we were five percentage points behind—

Dr Gregory: Well, it will certainly add to the combined total of those amounts, which is well over a million dollars, into the mental health budget. In addition to that, I should say that in the growth-funded initiatives that Mr Smyth asked for earlier there is another $200,000 that's actually targeted at the Older Persons Mental Health Service, which is

for the psycho-geriatric clinical academic position. So, all in all, it is approximately $1½ million, so yes, it will make a considerable difference to our level of funding, but, again, it depends on how much other states are putting into the area as well.

THE CHAIR: On the assumption that other states didn't change, could someone do the figures on where that brings us up to—obviously you'd take this question on notice—or how far behind other states we would be?

Dr Gregory: Well, we could, except that the latest figures we have available that have been published are for, I think, the 1999-2000 financial year, so we're always a couple of years out of date. It's difficult to—

THE CHAIR: I don't mind; they are the best we can do. I'm happy to take those as an indication.

Dr Gregory: We'll have a go at something, yes.

THE CHAIR: And the other question was how much those items I suggested translate into extra occasions of service. I don't know whether you can measure that or whether you've got any targets in that respect but, if you have, can I have those on notice please?

MS DUNDAS: I know you were having a conversation this morning about dual diagnosis that I regret not being here for. You were discussing, Mr Stanhope, what I think you called your new health alliance—I guess your stamp on the ACT dual diagnosis project. Can you tell me what is the new project? Are you picking up where the old project left off, which I understand was about to commence targeting non-government organisations?

Mr Stanhope: That discussion was with Mr Rosenberg, I believe, Ms Dundas.

Ms Barry: Is this about the second stage of the dual diagnosis project?

MS DUNDAS: Yes, and whether or not that's going to go ahead with the new health alliance stamp on it.

Ms Barry: Well, the second stage of the dual diagnosis project is, as you say, targeted at outreach into the non-government sector, and the way that the project is managing that at the moment is by identifying a dual diagnosis project officer—one each in Mental Health Services and within the Alcohol and Drug Program—who is responsible for outreaching to the non-government sector, to do either capacity building and training of staff or to actually assist them with individual clients that come into the service.

MS DUNDAS: So the old ACT dual diagnosis project is just working continuously underneath.

Ms Barry: Yes. It's really just an extension of the previous service. At the beginning of the project, there was just one position that was looking after the project for the ACT, and that was the coordinator position, who was responsible for coordinating the training for government and non-government service providers and also for advertising the availability of the project to consumers. That position still exists, but it's been extended

to involve specialist people in each of the two services now. And that's really the NGO support role.

MS DUNDAS: So there isn't actually any new funding in the budget to go with the new health alliance. You're just relying on continuing funding through the mental health service stream and the Alcohol and Drug Program?

Ms Barry: That's right. They're funding them individually, yes.

MS DUNDAS: So there's no new funding for this?

Ms Barry: No.

MS DUNDAS: Will we have any way of measuring the success of this project in future budgets?

Ms Barry: The Alcohol and Drug Program, who are coordinating the project at the moment, are conducting ongoing evaluation of its progress and they've certainly had some preliminary very good feedback from the non-government sector, both mental health and alcohol and drug, that the current model for the second stage is working well. We could expect to get reasonably regular feedback from the project on how it's going.

MS DUNDAS: But will the Assembly see that feedback? How will we know that the project's running well?

Mr Stanhope: I must say that this stage, Ms Dundas, I haven't discussed with the department reporting arrangements in relation to the evaluation, or the evaluation approach for the work that's been done. I'm more than aware of the acute interest within the Assembly and within the community that each of us have in relation to the particular problems around dual diagnosis. There's been much community debate around and about this issue over this last year. I'm very aware of that. Mr Smyth, I acknowledge, has been very active in relation to the issue. And I'm more than happy to report to the Assembly, to the extent that I'm able, as the project progresses in relation to issues of dual diagnosis.

MS DUNDAS: But you're not yet sure what form that will take or when it will happen?

Mr Stanhope: Well, it's not a discussion that I've had, no. But I'm more than happy to talk through the issue with the department, having regard to your interest and the committee's interest, and to report to you. Ms Yen is happy to add to my answer.

Ms Yen: Thanks, Mr Stanhope. Ms Dundas, I think that probably two of the key indicators that we'd be looking for for success out of dual diagnosis would be the range of alcohol and drug staff and the range of mental health staff and the range of people working in community sectors and government sectors in both those areas who were able to do the initial triage, I guess, to identify mental health and/or alcohol and drug programs, because one of the biggest difficulties for people is negotiating a pathway when they feel as though they've been thrown between mental health services and drug and alcohol services.

So one of our key success areas would be around the staff in both government and non-government sectors who were trained and were using the assessment techniques that have been developed by mental health services and alcohol and drug services to identify those issues early and to take appropriate action, whether that's a brief intervention in a counselling sense or whether it's actually an appropriate referral into another service. I guess then the other thing that we would probably want to look for would be the number of clients who had actually had both a mental health and alcohol and drug assessment, a brief assessment, which we would hope would have increased from times gone by.

MS DUNDAS: Just to go back a step, a person was just talking about the next stage of the project and identifying two positions in mental health services and alcohol/drugs to begin the outreach to NGOs. Is there a time frame on when the bridging with NGOs will actually commence? Has it started? I just wanted to know what the time frame for the start of the second stage is.

Ms Barry: It's commenced. The outreach to the NGOs has commenced.

MS DUNDAS: Can you tell me when it commenced?

Ms Barry: About six or eight weeks ago.

MS DUNDAS: Thank you. On mental health services, Minister, is the government doing anything to ensure that mentally ill people who are capable of living independently are able to access affordable housing that provides a supportive environment and prevents relapses?

Mr Stanhope: Perhaps, Mr Jacobs, you could answer?

Mr Jacobs: Currently with our community-based program, as well as the case management programs which exist across the board, we do run a number of group homes that are mental health specific where we hold the head lease. There are nine of those. We also work with a number of NGO agencies and provide support to their programs through a case management approach. Is that roughly answering it?

MS DUNDAS: So you're providing group homes and case management?

Mr Jacobs: Into NGO-run houses.

MS DUNDAS: Case management to NGOs. Okay.

Mr Jacobs: We can provide a listing of those with the number of places that each one of those has.

MS DUNDAS: That would be appreciated. Thank you.

MS TUCKER: Thank you. I'd like to follow up on that question. You used to have a protocol with ACT Housing so that people who were in public housing who had a mental health issue were able to get support. Is that still the case?

Mr Jacobs: Yes.

MS TUCKER: And has there been any evaluation of how well that's actually working? I know with the change of government there has been a greater focus on other than the bricks and mortar aspect of public housing if you like. Although there always was a protocol there, it was certainly a matter of concern how well it was actually working. I wondered if there'd been any new work done since the change of government to actually make sure and evaluate whether or not people who may have mental health problems are able to sustain tenancies in public housing.

Professor Owen: The outcome measures that are used in that setting are pretty much the same as those that are used in any clinical encounter within the service, in that we have a set of outcome tools that we're increasingly implementing right across the service that try to take stock of where a person is in a number of domains in their life at the time of entering the service, and then at the times of review during their care, and at the time of exiting the service. There's not been a particular focus on assessing the clinical management support of clients who are residing in ACT Housing in a stand-alone fashion.

MS TUCKER: No, I think maybe you didn't understand my question. I'm more interested to know how you work with Housing when there are issues about—you know, they're not well for a while, they don't pay their rent, then they get threatened with eviction, and so there needs to be consideration taken of the fact that this person has a fairly severe disadvantage in terms of sustaining a tenancy in the way that people normally would be expected to.

Professor Owen: Certainly—my apologies for the confusion. There are partnerships, I think, at two levels. The clinical managers in the community tend to have very good working relationships, particularly with social workers and the like, within the housing department sector and use those relationships to ensure the necessary support and understanding from a housing perspective. The other two places where we dovetail well firstly is at the comprehensive management plan forum that we chair monthly within the service. We use that as a forum to try and work through particularly challenging, difficult clinical problems and invite appropriate players along to those meetings. And when necessary that has included the district representative from Housing who perhaps is considering the potential eviction of the person that we're working with.

The third venue is a similar one, but kind of a step up, at the management assessment panel, where Housing have often been attendees at case conferences around clinical problems that have really come to the fore in the housing sector. So they're the partnership levels.

MS TUCKER: Has how that's working been evaluated, because as a member I do get complaints from people in the community? We ring up Mental Health—this person gives us permission to do it—and we try to follow up, and no-one seems to be quite sure whether they're someone that's a client or not and it just seems to be not working really well. I wonder if you've looked at it; that's all—if you've evaluated it at all.

Professor Owen: Not in a formal project-specific sense. We've also been involved in the work that's recently been done on squalor, and looking at a partnership arrangement between the management assessment panel, Housing, Mental Health Services and any other appropriate government or non-government services that might be involved in trying to restore someone's housing and maintaining them in a reasonable way within the community.

MS TUCKER: You call that squalor?

Professor Owen: Squalor.

MS TUCKER: Right. Okay. Did you want to continue?

Dr Gregory: It might be useful for Simon to add something on the non-government sector side of things.

Mr Rosenberg: Ms Tucker, this might go to your question to some extent, but obviously, apart from tenants of public housing, there are mentally ill people who find themselves in unstable housing. And one of the things that the department's been doing recently is trying to look at a number of innovative solutions to ensure that people can maintain their housing when they're mentally ill, whatever it might be. Just one example of that is a current project that Centacare has in place, which is Youth Housing Outreach Support. And the supports attach not to the housing but to the person, so if they move from SAAP accommodation to Housing to some informal arrangement, the support can go with them and can rise or fall according to their needs. There's a range of outcome measures that have been piloted with that particular project, so we're hoping that in probably another six months or so we'll have a bit of a handle on how that's working and also what are the key things to measure.

MS TUCKER: Thanks for that. One of the things that is said to me—and it's only anecdotal, but I have reasonable confidence in its veracity—by people who work with homeless people in Canberra, and in fact around Australia, is that people with mental illness are highly represented in the homeless population. So it just leaves questions about how well society is managing to support people—you know, if they get to the point of being homeless, then obviously we're failing. Does anyone go and sit around with the free food night and work out what's going on? Whenever I've been there, it's pretty clear; you've just got to talk to people who provide the food and they'll give you the info if you want it. I know the argument is put that sometimes some people choose to be homeless, they choose to live on the streets, and that may well be the case, but my understanding is that a lot of them would prefer not to be, probably most of them, especially in winter in Canberra. So what do we do about that?

Mr Rosenberg: It's probably no news to say that homelessness is a very complex problem, and the recent report that was auspiced by ACTCOSS shows that quite starkly. I guess one thing that we're trying to do across government is to coordinate services better, given that often the issues people face are not just mental illness but their substance abuse, their employment, their poverty, their housing—and in fact it could be a range of physical performance issues as well. So, insofar as we get better at partnerships across programs, in particular some of the government and non-government programs

that Professor Owen was alluding to, I think we can help respond to that area of need much better.

MS TUCKER: So is the solution right now more crisis accommodation? We still haven't got the shelter, have we?

Mr Rosenberg: Crisis accommodation is a part of the picture, and I guess people running those services would say they're overloaded. But if you look at the causal factors that get people to the point of crisis, it's ensuring that they have the supports that prevent them from falling to that point as far as possible.

MS TUCKER: No, I totally understand that, but meanwhile it's cold. I understand that we need to be looking at supports and prevention, but it is concerning, the stories that we hear about who is out on our streets. Can I ask one more question of this group?

I started to ask this question before but it was the wrong person; it was a Calvary person. I'm interested in knowing a little bit more about this program for adolescents at Calvary, and whether it is like an early psychosis intervention centre or whether it's different from that.

Professor Owen: It overlaps in many ways and it's different in some ways. Early psychosis intervention programs usually run about over the, say, 15 to 30 age group, across that kind of profile. CALCAM is targeting a younger group than that. It is targeted at complex mental illness problems and moderate to serious mental illness problems, particularly compounded with difficulties in continuing education and with attending school. The aim of the CALCAM program is that a person can attend for assistance with health, reconnection with a school program that initially is an educational program on site, and eventually a re-feeding back into your established school program in your local area from wherever you've come

An early intervention program targets psychotic illnesses alone, usually over that older age group, and merges sometimes onto adult mental health services. Early intervention programs are somewhat contentious. It does depend a little on who you speak to and the evidence that you read. It goes through from glowing endorsement—and there are programs around the country that are held up as great examples of early intervention initiatives—to the other end of the spectrum, particularly amongst child and adolescent psychiatrists, who fear that early intervention can actually end up in the early labelling of what is actually an adolescent identity confusion, the more normal role crisis of someone moving through adolescence, rather than the major personality inroads of a major mental illness, and that we're at risk of labelling young people inappropriately in the attempt to get them to access treatment early.

So there is some controversy around early intervention programs. But young people with psychotic illnesses are certainly part of the business of CALCAM, and it's in a dovetailed setting with family support, individual treatment, attention to health needs and education.

MS DUNDAS: Calvary has said that it will have an 8 per cent decrease in psychiatric services, and I assume that's despite the CALCAM adolescent day program. What is going to happen to address the decrease in services from Calvary across the rest of the sector?

Dr Gregory: Can I first of all comment just to say that it's not despite CALCAM. CALCAM is actually separate to the mental health in-patient decrease.

MS DUNDAS: Okay.

Dr Gregory: So that's on top of. I'll leave Kathy then to answer.

MS DUNDAS: Thank you for that clarification.

Professor Owen: The psychiatric services unit at the Canberra Hospital has had a slight drop-off in in-patient separations in the last year where we're anticipating something in the order of 880. We're at present running at about 780. We've had a corresponding increase in community occasions of service, and I think that's where the difference lies—that more treatment is actually being provided to people earlier and in the community rather than later and in hospital.

If there is a—I don't know if you'd call it a planned reduction, but if there is an inevitable reduction in in-patient psychiatry, public psychiatry services at Calvary, there is some capacity at TCH to pick up some of that work if that's needed, at least on this year's projections.

MS DUNDAS: They've explained it as that they were running over budget in the services they were providing last year and cannot maintain that this year. So it is a planned reduction, in a sense, to keep to budget for them. But you're saying that there is space at the Canberra Hospital to pick them up?

Professor Owen: At present, yes.

MS DUNDAS: At present, for the next year?

Professor Owen: It depends on the patterns of care for the next year but, looking at the projections at this stage, yes.

MS DUNDAS: So this is possibly something that we're going to need to address in next year's budget?

Dr Gregory: Can I say that one of the consequences of the recent reorganisation that the government announced of the health portfolio is that, with the move away from purchaser/provider, we've now taken the step of creating a territory-wide mental health service, which is just in the throes of being created. One of the aims of that is that the services at Calvary Hospital, the services at Canberra Hospital and the policy/planning—which were previously three separate pieces—will now operate as a whole, with Brian and Kathy's leadership in particular and reporting to Laurann Yen in that process.

This provides the ability, then, to take the one bucket of money and work out where the need is, and to move patients to where they can best be dealt with in the system rather than being subject to wherever a particular psychiatrist might want to admit them. There will be a lot more flexibility and ability for the service to respond.

MS DUNDAS: Is that happening this financial year?

Dr Gregory: Yes, that's very recent. The start of that is certainly in place, and Brian, Kathy and Laurann are working very hard on achieving that.

MS DUNDAS: So we might actually have the outcome where Calvary doesn't see a reduction in services and where the funding does actually come through with the bodies, as it were, to Calvary as maybe the best place to deal with them.

Dr Gregory: Depending on, I guess, whether in-patient or community-based services are best needed—

MS DUNDAS: Potentially it's there, because the funding will be managed from a central pool.

Dr Gregory: Yes. Brian might want to comment on that further.

Mr Jacobs: I guess the main focus of how mental health services will be, and should be, provided is that we try and focus on caring for people in the least restrictive environment while still providing adequate treatment and care. So the focus will actually be on community provision of mental health services, backed up by a bed-based service. And that bed-based service can range from—well, we actually have sort of a cat flap mechanism: if someone is in urgent need of accommodation but doesn't need to be admitted through to our acute beds, both at PSU and at Calvary, then we have the rehab beds at Hennessy House, the secure extended care unit beds there as well, plus also our group home program. So we're trying to offer a spectrum or a range of different bed-based options. But the focus will be on trying to provide the community care focus first, backed up by the beds.

MS DUNDAS: So we can see an increase in spending in community care?

Mr Jacobs: Over the last four or five years there has been a significant shift in how the funding has been applied to mental health services. The community has grown quite significantly and that's been seen in things like the occasions of service. Actually, I've got the figures here. For 1999-2000 we did just under 120,000 occasions of service. This year just gone, we've done 158,000 occasions of service for ACT Mental Health Services, as it was then.

MS DUNDAS: So is that the number of occasions of service for public community-based extended care services?

Mr Jacobs: What I'm referring to here is particularly ACT Mental Health Services. There would also be some that have been pursued through Calvary.

Dr Gregory: In the future you'll see the one set of figures for the ACT whereas at the moment it's in two lots.

MS DUNDAS: And the figure was 158,000?

Mr Jacobs: That ACT Mental Health Services has done.

Dr Gregory: In those papers that excludes Calvary.

Mr Jacobs: Yes. So we're way over what we actually contracted to do in community.

MS DUNDAS: Yes, because I think, if we're looking at the same numbers, it was a target of 135,000. So you've gone to 158,000. I guess what I'm trying to find out is whether or not there was money to support that level of service.

Mr Jacobs: There were some new initiative moneys that came into mental health last year.

MS DUNDAS: That will continue into future years?

Mr Jacobs: Those moneys are ongoing, as I understand.

Mr Rosenberg: Ms Dundas, one of the points of doing the mental health strategy in the next few months is that we'll hopefully have a quite clear resource allocation formula. Out of that will come a clearer service mix that we require for future planning. So although there'll probably still be plenty of unmet need, we'll hopefully be able to target the services much better, both geographically and to particular population groups.

MS DUNDAS: Thank you.

MS TUCKER: You said Nurcombe evaluated the CALCAM. Could the committee get a copy of the report?

Dr Gregory: Certainly.

MS TUCKER: Thanks.

MR SMYTH: Without wanting to prejudice any of the coroner's inquiries, is there anything you can tell us about what Mental Health ACT has done to improve the way they care for people in their care so that we don't have a repeat of the three deaths?

Professor Owen: I can't tell you anything that will guarantee that we won't have a repeat of the three deaths. I can tell you, however, that we've looked very closely at those events, as we do at any untoward event within the service, and that we have a comprehensive method for doing that. The time frame on coronial inquiries is quite extended and if one was waiting for the handed down findings you'd be well behind the eight-ball in implementing necessary changes, so of course we don't do that. The changes that have flowed recently have included how staff are physically deployed around the unit, methods of observation around the unit, and, if you like, the science and application of the tools for rating risk and ensuring a universal understanding of those,

and for recording the observations of clients around the unit. And it's my view that this will go some way towards providing the best quality care in the face of the risk of self-harm that we can.

Mr Jacobs: Can I just make two comments. The other thing is that we have actually put in place a system of support for the relatives, should a death occur. We have actually made an offer to relatives that might be affected that assistance will be provided. The second thing is that, while we hate to see any suicide death, we just need to keep it in perspective that we are a jurisdiction that has, usually, a lower per-capita risk compared to the national average.

MS TUCKER: I have a follow-up question. If you've made these changes, what have you done to let people in the community who have a mental illness of some kind know that you've made these changes? I'm sure you're aware that people are actually frightened to go into the unit, and one of the people who told me she was frightened to go into the unit actually is not alive now. Now, if you've made these changes, obviously that's been a crisis for confidence of people, rightly or wrongly, and I'm sure you're aware of that. What have you done to let people know about these changes and try and let people feel comfortable, and know yourselves that they can be comfortable, to go in there and not be fearful?

Professor Owen: Thank you for that. We've done a number of things. PSU for some time now has had a community consultation forum on a monthly basis which has been a come-one come-all, share your views, hear about progress in the unit, give us feedback, whether it's your own feedback or that of those close to you. But it's very much been an open door policy about come and both give and receive information. And I think that's been central to trying to deal with the concerns that you rightly raise. We've also taken opportunities to work with the consumer network in the territory—whether that's been in formal meetings or in a more spreading the word method—and, as you know, we employ a number of consumer consultants who have been quite central in spreading the word about positive changes in the unit environment.

MS TUCKER: So have you done a survey to see if people feel better about it, or do you know if that's working?

Professor Owen: I think it would actually be too early to do that at this stage. We do do feedback surveys on about an annual basis, and I think, given that they're fairly new implementations, perhaps towards the end of the year might be an appropriate time to survey in a more steady environment.

MS TUCKER: But surely you don't want to wait that long. If these events have happened not very long ago—although it seems like a long time in some ways, especially if you're waiting for an inquest to finish, which is a question for another session that I wasn't here for but hopefully someone asked it—this is something that is a problem now for people in the community. So surely you don't wait for a year to find out if your attempts to reassure them are working or not, because these are the people who right now are making decisions about whether they'll admit themselves or not. Surely it requires more urgent response.

Professor Owen: Well, yes, you can see it in that light, and then you can also see that you'd be sampling your data in a time that's not representative perhaps of a broader period of time—that you'd be sampling within a crisis. You could argue it, I think, either way.

Mr Jacobs: Immediately when there was a fair bit of media around the three deaths, our occupancy rates dropped down to as low as 15 in the acute in-patient unit, PSU. They've now returned to roughly their normal levels, so—

MR SMYTH: Which is what?

Mr Jacobs: Well, it comes up to around 26 usually, and sort of oscillates between 24 and 26 as the number on the unit. So occasionally it'll spike above the 26 and at that time we do put in some extra resources as well to cater for the extra workload on the PSU at that time.

MS TUCKER: I thought you were saying to the committee earlier that more people were located in the ward, or are you just locating them differently—staff are positioned differently, or do you have more staff?

Professor Owen: Both, in fact.

MS TUCKER: So you have increased the resources.

Professor Owen: Increased numbers, wider diversity of staff backgrounds and a change in duties and deployment.

MS TUCKER: You've got the social worker in there now?

Professor Owen: Yes, and a psychologist and a welfare worker.

MS TUCKER: Okay, thanks.

THE CHAIR: Are there any further questions about mental health services? No? We'll end that there. Thank you for your attendance. We'll take a 15-minute break and I note that we have given the Director of Public Prosecutions a marking at 4 o'clock. We'll return briefly to health, but we'll cut in at 4 o'clock for that.

Mr Stanhope: Mr Chair, are there any other areas of the department that could be excused now that you're aware of? Perhaps there's not.

THE CHAIR: We've gone through the list already and there are none that people have no questions about, so unfortunately not.

Short adjournment

THE CHAIR: We will resume with the health overview, knowing that we will have to break it off at four o'clock.

MRS DUNNE: My question goes back to this morning when Dr Gregory was talking about strategies for approaching the public hospital waiting lists and it goes to private hospital uptake. In my limited experience as a patient entering the hospital system through accident and emergency or having family do so, I have marvelled at the number of times that I have been confronted with, "Look, you don't really need to use your private health insurance." Seeing that I have paid for it and have reasons for doing so, I always do. At the same time, I constantly marvel at this example of one part of the hospital system working against another. How do you overcome that happening where a lot of the pointy end stuff goes on, where you get lots of admissions through accident and emergency and people are saying, "You don't need to do this. You've already seen a doctor and you will see that doctor when you get in there?" How do you overcome this?

Dr Gregory: I think that is an issue that Ted Rayment has been working on quite considerably and he will come and talk to us about it.

MRS DUNNE: Are you going to beat your staff until they stop?

Mr Stanhope: You might be aware, Mrs Dunne, that the statistics at the Canberra Hospital in terms of the uptake of private health insurance are, I think, the lowest of any of the major hospitals in Australia. It really is a very significant issue for the Canberra Hospital, one of the major issues.

Mr Rayment: It is certainly a major issue for us. It think we are at around 7 per cent, whereas in other states it can be as high as 20 per cent or above, yet we have got the highest number of people holding private health insurance. What we are trying to do is not attract more private patients. We are trying to get those private patients declaring themselves public or, in your case, being persuaded to be public, not to do that. We have gone as far as providing a script for people coming into our hospital and following that process of asking people if they have private health insurance. I have asked our medical staff and others to let me know when that is not happening so that I can then go and address the issues and ensure that it does happen. How long ago was it that you had your interface with our hospital?

MRS DUNNE: March.

Mr Rayment: That is fairly recent, so I am concerned. It is something that we are trying to avoid. We have also had a number of our doctors in the hospital approach me—our employed doctors, rather than our contract doctors—over concerns that we are not converting the people who are really private but are declaring themselves public. Some declare themselves public because they don't want a gap. We are looking at ways of trying to get rid of the gap or reduce it.

MRS DUNNE: So there is less incentive to do so?

Mr Rayment: Yes.

MRS DUNNE: In fairness, Mr Rayment, it was actually at Calvary that this happened to me. It has happened at the Canberra Hospital as well, but not quite so recently.

Mr Rayment: I am sure that it does happen at our hospital, too, but we are working hard to try to stop that happening.

MRS DUNNE: It is one experience for me but it has been replicated hundreds of times. From the circle of people that you move in you find this experience often. I suspect that the answer is that people sit there and say, "I am going to see this bloke anyhow, so why should I pay the gap for the privilege?" Perhaps the issue is to address the gap.

Mr Rayment: I think that that is correct and then our facilities fees would increase and we would have more money to provide for public health.

THE CHAIR: I have a question about medical indemnity insurance. You may have seen comments recently by Dr Phelps, the federal president of the AMA, that if law reform is not achieved and legislated by, say, the end of October, we will all be in big trouble and there will be chaos, referring to the problem of doctors in the system generally not being able to access affordable medical indemnity insurance. What is your government's particular response to that issue?

Mr Stanhope: This certainly is a most important issue, along with issues around public liability insurance, and one of the major issues facing all jurisdictions in Australia. The ACT government, particularly through Dr Gregory, I acknowledge, has been at the forefront of the national move to seek some nationally consistent response to the issues we face in relation to medical indemnity insurance. Dr Gregory chaired a working group established by AHMAC, the Australian Health Ministers Advisory Council. The work that Dr Gregory did as chair of that AHMAC working group is acknowledged by all jurisdictions as having been vital to the position that we have now reached, which was progressed through a major national forum on medical indemnity insurance which was convened by Senator Patterson at Parliament House in Canberra in April.

As a response, that major seminar or forum, which included all Australian health ministers, health professionals and, indeed, a broad range of organisations with a major stake in the particular issue of medical indemnity insurance, tasked the establishment of a major national task force chaired by Professor Marcia Neave, professor of law at the University of Melbourne, to look specifically at a broad range of issues relating to medical indemnity insurance and its availability. The ACT is represented on that committee through an officer of the department of justice. The committee, I understand, will be providing a first or initial report on its views or findings in relation to a range of issues that should be addressed in relation to medical indemnity insurance, hopefully, next week. That particular committee will be providing a two-stage response to its terms of reference.

As I say, the terms of reference were quite specific but broad in the sense that they covered the broad range of issues that you would anticipate or expect to be covered. They go essentially to issues around, in the first place, how to avoid legal action. Of course, the issue we are focusing on is a reduction of premiums and an availability of medical indemnity insurance to medical professionals, to doctors essentially. But the issues that are being addressed by that particular committee go in the first instance to issues of how to avoid legal action.

There is real consideration being given to how one might avoid action, to the extent to which open disclosure following an incident will ameliorate the concerns of people who believe they have been adversely affected by an incident in a medical procedure—by open disclosure, I mean the prospect of a doctor apologising without the apology being considered to be in any way an admission of responsibility or culpability—and to a range of issues which I know we as communities have dealt with over the years in relation how to better mediate or to process issues through a court if those initial issues don't satisfy a potential plaintiff.

Another major issue being considered, perhaps the most difficult and significant of the issues of concern, is the potential to remove long-term care costs from a damages award. A case that is oft quoted in the debate around medical indemnity insurance and its difficulties is the record damages payment that was awarded to essentially a child that was catastrophically affected by an incident at birth. That particular award, as we know, was around $15 million, $6.2 or $6.8 million of which, I believe, was awarded for long-term care costs.

There is a belief, which this committee is pursuing, that if the long-term care cost component could be removed from a damages claim it would, quite obviously, have a significant impact on premiums. That, of course, has other implications, however, for the care of a particular person that is catastrophically injured or disabled as a result of, say, a procedure, using that as an example, which throws that responsibility straight onto the public purse. Of course, that is what would happen now to a person who wasn't insured or who couldn't claim insurance through such an incident in any event. It is the public, community services, that would care for that person, as we do now through our disability programs, but, of course, this would involve a major shift in cost.

There is a range of other initiatives, Mr Chairman. I would be happy to provide the committee with the terms of reference that the committee is pursuing. I would be more than happy to do that just to get the full range. They don't all spring immediately to mind.

THE CHAIR: I thank you for that. The question I was wanting to get at, though, was what timetable you were working to.

Mr Stanhope: Sorry, Mr Chair.

THE CHAIR: Hearing Dr Phelps' view that this matter is critical and will need to be, she says, actioned by October, is there any chance of that being the case?

Mr Stanhope: Yes. Certainly, we would have every intention of introducing a first raft of legislative change across-the-board before then and within that timeframe. There is a determination amongst all jurisdictions to seek to achieve, to the extent that we can, a national response to issues around medical indemnity insurance, public liability insurance and, of course, tort law reform to the extent that tort law reform is caught up as an essential part of reforms that all jurisdictions are pursuing.

I know that a number of jurisdictions have already legislated around the edges. New South Wales and Queensland certainly have introduced and passed legislation. Other jurisdictions have introduced some legislation. I have to say that I think some of what

has been done, and I will say it acknowledging that these other jurisdictions are Labor states, has been done for quite crass political purposes and I don't believe at the end of the day will achieve anything at all.

I am looking for a skerrick of evidence, for instance, that inhibiting the right of lawyers to advertise would have any impact on insurance premiums. I am one of those that would like to see just a tad of evidence that suggests that there is some causal link between lawyers advertising and insurance premiums. I am also mightily concerned that what I regard as a fairly effective campaign being run by insurance companies and, to a lesser extent, by some professionals around the nation to shift responsibility and costs from the private sector to the public sector and, along the way, impact fairly severely on the rights of individuals to pursue a right that currently exists to just compensation when they have been adversely affected by negligence or incompetence isn't the end result in a scenario where premiums don't come down and the insurance companies simply feather their pockets.

I think there are some real competing pressures that we are facing here. I have been holding my fire and keeping my powder dry until the work that is being done nationally, all of it sourced or chaired through Commonwealth leadership in relation to the AHMAC proposals and in relation to the expert group which Senator Coonan, the Assistant Commonwealth Treasurer, has instituted in relation to the public liability issues, and an interest which SCAG is now taking in relation to tort law reform, is allowed to come to some fruition. Let's look at the work of these expert groups which each and every jurisdiction is involved in before we go rushing off doing some things that we think might be all right, but which haven't been subjected to any scrutiny.

Yes, it is a major issue. The ACT has led the issue in relation to medical indemnity insurance, particularly through the initial work of Dr Gregory Gitters, convenor of the AHMAC working group. That work is now being carried on by Professor Neave. The first report, I understand, will be available next week, and I understand that it will be a report that we will certainly circulate for discussion and consultation. We will move quickly on the basis of that work and the work that Justice Ipp is doing at the behest essentially of the treasurers and Senator Coonan.

THE CHAIR: Okay. Those are all the questions I have on that subject.

Appearances:
Mr J Stanhope, Chief Minister, Attorney-General, Minister for Health, Minister for Community Services and Minister for Women
Department of Justice and Community Safety—
Mr T Keady, Chief Executive
Mr B Lenihan, Director, Resource Management
Director of Public Prosecutions—
Mr R Refshauge, Director

THE CHAIR: As promised, we will now hear from the Director of Public Prosecutions. I welcome the Director of Public Prosecutions to today's proceedings and invite Ms Dundas to ask the first question.

MS DUNDAS: Firstly, I understand that through Appropriation Bill (No 3), we provided for more expenditure by the DPP, due to an increased workload. I am actually interested in hearing what that increased workload was, but I also want to clarify something. Page 283 of Budget Paper No 4 talks about the increase in the JACS budget relating to the Director of Public Prosecutions' increased workload being at $165,000, whereas the changes to the appropriations actually talk about $737,000 on page 290. Is that a typo and which one is correct?

Mr Refshauge: My name is Richard Refshauge. I am the Director of Public Prosecutions. I am going to flick pass that one to someone else.

Mr Lenihan: My name is Brian Lenihan. I am director of resource management. The $737,000 relates to the additional appropriation which was provided in 2001-02, and the $165,000 is the additional appropriation provided in 2002-03; the $165,000 is for the ongoing additional workloads faced by the DPP and the $737,000 was a special appropriation.

MS DUNDAS: Can you tell me what your increased workload is?

Mr Refshauge: I think you can break it down into three parts. There has been overall a general increase in workload in the sense that there are more cases coming before the courts. That, in part, results from better police resources, more police, better investigative techniques and so on. In particular, there have been a number of programs, the one I want to specifically mention is the family violence intervention program, which have resulted in increases of the order of 300 per cent in the number of cases actually being prosecuted, so that there are substantially increased workloads. The other issue is that the work is becoming more complex and, in particular, we are finding that we are getting an increase in municipal or regulatory prosecutions and those prosecutions are inevitably extremely complex. It is a combination of, in effect, more cases and more complex cases.

MS DUNDAS: In that case, is $165,000, compared to over $700,000 extra last year, going to be enough? What was the peak of work last year that isn't going to recur?

Mr Refshauge: I am not quite sure about the $700,000.

MS DUNDAS: Sorry, in Appropriation Bill (No 3), the Director of Public Prosecutions was given an extra $700,000 for last financial year, whereas you have only had an increase for ongoing funding of $165,000.

Mr Refshauge: I am sorry, that $700,000 was a special appropriation which related to special cases. There were three cases involved there. The cases involved an appeal to the High Court in relation to the conviction of John Conway for the murder of his wife. Secondly, there were the continuing cases involving the death of the Saudi diplomat, Mr Abdullah Al-Ghandi, for which there were additional trial complications which could not be met from within our ordinary budget.

But the major issue was the then proposed inquiry in relation to Mr Eastman and the estimate at that stage, knowing his litigious capacity, was that we would have to have full-time legal staff, including senior counsel, for at least six months of the year. The

appropriation was a special appropriation for those purposes. It wasn't an ordinary appropriation and it didn't go to the ordinary workload additions.

MRS DUNNE: Does that mean that you will actually offer up some savings out of that $700,000?

Mr Refshauge: Yes. It hasn't all been drawn on but, as you would be aware, the Eastman saga has not concluded. We are hopeful that the Saudi diplomat case will be resolved. As you may be aware, we have already secured a conviction in relation to one of the participants, who has now agreed to assist the crown with evidence, and we are expecting that that might have an effect flow through on the others. But with Mr Eastman, I am not optimistic.

THE CHAIR: Could you provide us with an update on where the litigation of Mr Eastman stands?

Mr Refshauge: Yes. In the Federal Court, where I appealed the decision of Justice Gray, the court by a 2:1 majority upheld my appeal and declared that the decision of the Chief Justice to institute an inquiry was made without jurisdiction. Mr Eastman has commenced an application for special leave to appeal to the High Court on various grounds, including alleged bias in the Federal Court and that the decision was wrong in law. That process is continuing. My understanding from the High Court is that the special leave application will not be able to be heard until October at the earliest and then, if special leave is granted, some time next year, probably towards the end of next year.

THE CHAIR: If leave is not granted or the appeal is heard but then not acceded to by the High Court, is there then further litigation on that question or potential for a further inquiry of the kind that the Chief Justice was talking about?

Mr Refshauge: Yes. I am sorry, I should have made it clear that Mr Eastman has raised two issues with the Supreme Court in relation to the inquiry. The first was in relation to its conduct and, in effect, I counterargued that there was no jurisdiction, and that is the issue that has been resolved. He also raised the issue of the widening of the inquiry to include the issues that might be generally regarded as forensic issues; in particular, the evidence of a Mr Robert Barnes, who was one of a number of forensic experts that my office used. That issue is still before the courts. In fact, my recollection is that it has been listed for hearing by Justice Gray on 17 and 18 September.

That challenge is on the basis that the Chief Justice should have ordered an inquiry into the issues of the forensic evidence. If Justice Gray holds that his honour should have done so, then there will be an inquiry into that. If not, then no doubt Mr Eastman will challenge that decision through the courts. It is only the fitness to plead issue that has been resolved finally at this stage, so there is likely to other litigation.

In relation to the fitness to plead issue, if the High Court, by either of the mechanisms to which you referred, decides that the case cannot be taken any further, then that is the end of the issue. There is a question about whether Mr Eastman can make further application under the new part 20 of the Crimes Act. There are some difficulties about fitting fitness to plead within that, quite apart from the issue of whether guilty in the new part means

the same as guilt in 475, which is the old section. There are some issues about the scope of the section and to whether it fits into that, but it may be that he will try and, if he is unsuccessful, then he may use the courts to try to force some inquiry through that process. I don't expect that we've heard the last of him for a long, long time.

THE CHAIR: To whom is an application made under that new part 20 or section 20?

Mr Refshauge: Under the new part? I am told the executive or a judge of the court, but what the new part does is to regulate the process and, in particular, bring it into line with every other jurisdiction in Australia, whereby the inquiry, in effect, is conducted as an appeal by the courts, so that brings it into a reasonable scope, and then the remedies are those of an appellate court, which means that the executive doesn't have to use the extraordinary measures that would have to be used in the case of the present inquiry.

MS DUNDAS: In last year's annual report on the DPP, you said that there was no complex statistical information available about participants in the criminal justice system. Has this situation improved and are you looking at any way to help improve the situation?

Mr Refshauge: The situation hasn't immediately improved but there are within the department processes that are being undertaken to improve the statistical capacity of the department. That is really a question that, I think, Mr Keady might wish to comment on further if you want further information.

Mr Keady: My name is Tim Keady. I am chief executive of the Department of Justice and Community Safety. It is one of the major issues facing us, I think. There is a constant demand for more information about the people who go through the criminal justice system and the demand over time, depending on what the policy requirement is, is for finer and finer detail. With our current systems, we struggle to answer those kinds of questions.

In order to try to develop a better infrastructure which will provide that information, we recently conducted a review of data needs. The criminal justice system is made up of a number of agencies. As people progress through the system, the information that accumulates about an individual becomes both more complex and more diverse, so that in order to develop a proper data set it is essential not just to identify what we want to know, but to identify the source. Having done that, we need to have in place systems, and these days we're talking about computer systems, which are sufficiently capable of generating that information without having to resort to manual searching.

What we are basically designing is a criminal justice system, a computerised system, which will not only provide for the business needs of each of those agencies but also provide management reports, if you like, which would see the kind of data you are talking about being able to be produced easily and as a matter of course. But we haven't got there yet, because the kind of investment we have to make is very large indeed. We are in the process of designing or identifying the kinds of systems which we would need to replace our current systems to provide that information.

MS DUNDAS: What is your time frame for having the system up and running? Will we have to wait for the next budget or have a further appropriation to give you the funds to make the system work or is the money available within the departmental resources?

Mr Keady: No, it's not. The sort of money we are talking about ultimately is fairly large and that will be a matter for government to consider as part of its normal—

MS DUNDAS: What do you mean by fairly large?

Mr Keady: I can't give you a figure at the moment because I am talking about the replacing of whole systems in places like the courts—we are currently going through the process of doing that—and corrective services. It also means the designing of a system which will be appropriate for custodial as well as the community corrections components and the DPP, possibly Legal Aid as well. All up, we are probably talking about well in excess of $1 million. We are not just talking about software; we are also looking at hardware needs. The kind of system I am talking about is a system that caters for the whole needs of those agencies. For example, for the courts it would be a registry system which caters for the judicial needs and which is capable of producing all this information plus much more as a by-product.

MS DUNDAS: When do you think you will have the design complete?

Mr Keady: We know what we want. We are just going through a process of putting in place the component parts. I can't really give you a date when the whole thing will be done. We are doing the courts, for example, at the moment because we have the Court of Appeal about to commence. We have got a project under way which is seeing software both developed and now being implemented. That will be trialled. If it succeeds, that same package will be used then to provide for the rest of the Supreme Court's needs. Again, subject to experience, we will then seek to use the same package with customisation and adaptions in the Magistrates Court and tribunals. Inevitably, that kind of implementation is not only resource intensive but also it takes time merely to replace one system with another and have people getting used to it. If I had my druthers and the money was available, it would probably take at least two years.

MS DUNDAS: Two years if the money was there.

Mr Keady: If the money was there.

MS DUNDAS: You seem to be doing it in a piece by piece process.

Mr Keady: Yes. We are doing it incrementally and, with our current funds availability, we will do what we can with what we have got.

MS DUNDAS: Richard, during the Dangerous Goods Act debate, I remember hearing you talking about WorkCover leading you to believe that there was evidence when there was not in cases they were asking you to pursue. Can you give us some examples of what was going on there and perhaps tell us how much time and money you think you spent on the Dangerous Goods Act specifically over the last financial year?

Mr Refshauge: The case that springs specifically to mind is one where we were led to believe that the defendant that we had been prosecuting was, in fact, the occupier of premises and licensee and when we actually came to get the documentation—I can't remember the precise details—it was either a different company or it wasn't the company, it was the individual or something like that. It was that kind of thing, a technical issue but an important one and one where we had been told that we had the right defendant. It probably was someone who was involved in the processes but not the licensee or the occupier or something like that.

That kind of stuff has been resolved, as I indicated, and had been resolved well before the committee inquiry. You only get one or two of those kinds of cases and you will say, "I'm not going to prosecute until I've got all the materials." It was a case of a learning curve and we have increased that. I can't give you the issue in relation to costs because it is not possible in my office to break down the costs that are incurred. Principally, they are incurred by individual prosecutors, but individual prosecutors have other cases to run and it would be difficult to identify how many hours they spent on a particular case and so on.

In relation to the costs that were ordered in that case where we withdrew the prosecution and therefore costs were ordered against WorkCover, I would have to take that on notice. I can give you an indication. I did supply to the committee, of which I think you were a member—

MS DUNDAS: No.

Mr Refshauge: I did supply to the committee some details about costs that had been ordered, but I am happy to look up the costs in that particular case or give you a general view about costs in relation to dangerous goods material.

MS DUNDAS: That would be good, especially in relation to the Dangerous Goods Act specifically, because I remember also hearing you speak about the Ridgeway decision of the High Court and its casting doubt over the policing of systems such as the Dangerous Goods Act. The government has allocated in this budget $400,000 for the next three years, totalling $1.6 million, for the regulation of the Dangerous Goods Act. In your view, is this money well spent, or should we be spending money possibly on updating the Dangerous Goods Act so that we do not fall into the trap of the Ridgeway case?

Mr Stanhope: With respect, Mr Chair, that is probably a tough question to ask the Director of Public Prosecutions. I do not wish to avoid answering the question, but it is not a question that is really within Mr Refshauge's responsibilities. I am sure he has a view, but I am not sure that it is really fair to ask him to comment on a matter of administration of a division in another department.

MS DUNDAS: Sure. Maybe I can rephrase it. Given, I guess, the doubt that the Ridgeway decision does put over our current system, what is needed, in your view, to ensure that we can police our laws, enforce them in a sense?

Mr Refshauge: The Ridgeway decision was a decision that said, in effect, the discretion to exclude evidence should be exercised in favour of excluding the evidence where that evidence has been obtained by illegal activity that has been participated in by the law

enforcement agencies. What happened in Ridgeway was that the Australian Federal Police imported heroin from Malaysia and then supplied it to Mr Ridgeway, who was then to on-supply, and then they arrested him for supplying the heroin.

MS DUNDAS: And it was a form of entrapment.

Mr Refshauge: So it was a kind of entrapment. The kind of problem that you get with regulatory agencies is, to take a neutral one, there is a prohibition against selling cigarettes to minors. It is very difficult to find out whether that is happening, unless you get a child to go in and buy cigarettes and that child is then part of the process of doing that, has been put up to it by the regulatory agency, otherwise the child will deny it because kids shouldn't smoke and so on. So it is that kind of enforcement.

Having said that, it is clear that there is a possibility of enforcing the Dangerous Goods Act, because we are currently prosecuting and we have recently secured a conviction and expect some more, so it is possible. I think the evidence uniformly to the select committee was that the act is, however, a very complex technical act. One only has to try to work through the definition of "depot" in the act. If you look at that through the dictionary to the regulations, you will find that "depot" is defined as a depot and may include a magazine and a magazine is a depot which is in a depot and a depot is a building or a place and includes a magazine. It is a very complex act and a very technical act and that is what makes it difficult.

The whole question of the Ridegway issue is, if you are going to make it illegal to purchase fireworks and you are going to make it illegal to sell fireworks, then the likelihood of securing a conviction is going to be remote, because the two parties who can give evidence about that transaction can only give evidence at risk to themselves of prosecution of themselves. That was the kind of situation that regulatory agencies were looking for something over and above the Ridgeway position. That is the position currently under the Dangerous Goods Act. There is absolutely no doubt that, if we could allow inspectors to purchase fireworks with impunity and that evidence then wasn't excluded, you would be able to use those mechanisms to effectively use prosecution, so far as that is relevant to regulation, to regulate the industry.

MS DUNDAS: Do you see this as being an issue of concern in other areas? You mentioned specifically the sale of tobacco to minors and the Dangerous Goods Act. What other areas do you think that we will need perhaps to review in light of the Ridgeway decision?

Mr Refshauge: I haven't given any particular thought to that. Those are the two that have come up recently. But the test is that, where a transaction occurs and all parties to the transaction commit an offence, then it is difficult to get any evidence of that because all the parties are at risk if they give evidence of the offence.

MS DUNDAS: Perhaps prostitutes in Braddon would be?

Mr Refshauge: Yes, although that is a bit more difficult. That is the same kind of thing, I suppose, although one hopes that we will not go back to those days. Of course, we currently don't prosecute the customers of prostitutes. So, while the transaction is not illegal, there is an embarrassment factor which would probably mean that the customers

wouldn't be rushing off to the police station to give evidence in order to assist the prosecution. But that is the kind of thing, yes.

MS DUNDAS: Thank you very much for that information. The Chief Minister can take it on notice that I will be asking him, in his role as Attorney-General, about the money that we are allocating for the enforcement of the Dangerous Goods Act.

Mr Stanhope: I am happy to take it on notice, Ms Dundas.

MS DUNDAS: I will ask it tomorrow when you are here as Attorney-General.

Mr Stanhope: Actually, it is for Simon Corbell as it is a WorkCover issue.

MS DUNDAS: I spoke to Simon and WorkCover about this issue, but I would also like to speak to you about it tomorrow as Attorney-General. I am giving you a bit of a head start, I guess.

Mr Stanhope: Thanks. Actually, Simon administers the act and WorkCover is responsible for it, but I will get briefed on it by tomorrow.

MS DUNDAS: That is why I am giving you a big head start, Jon, and a free kick in a sense.

THE CHAIR: There being no further questions of the Director of Public Prosecutions, I thank him for his attendance today.

Mr Refshauge: I thank the committee. I am sorry to have mucked it up in terms of planning, but the meeting that I will be attending tomorrow is to be on child sexual assault reform and is an important issue. I am grateful for the committee's assistance in being able to attend.

THE CHAIR: Minister, going back to that correction you made earlier today about the MLA access scheme, you mentioned that you had written to the Clerk inviting him to take part in the scheme. Is it possible for the committee to have a copy of the letter?

Mr Stanhope: Yes, sure. I might just say by way of explanation, Mr Chair, that the letter followed on what I understood to be an agreement that had been reached between, as I said before, my chief of staff and the Clerk. My chief of staff, in company with another chief of staff, met with the Clerk some months ago and the advice that I had received was as I explained yesterday. To that extent, actually, I didn't provide it through the budget process for a specific item for this matter on an understanding I had that it would be incorporated within the Assembly's budget. As I said, I am happy to provide you, indeed, with the letter that I received from the Clerk's office today just for completeness of information.

THE CHAIR: As well.

Mr Stanhope: Yes. I would be more than happy to do that.

THE CHAIR: Thank you.

Mr Stanhope: As a result of the issues that were raised there and some question mark about this scheme, which I know every member is just desperate to have launched. I know of the eagerness with which everybody is awaiting this particular scheme and, as I said, I have arranged for Mr Tonkin to ensure that the scheme is up and away within the next couple of weeks.

THE CHAIR: Thank you for that.

Appearances:
Mr J Stanhope, Chief Minister, Attorney-General, Minister for Health, Minister for Community Services and Minister for Women
Department of Health and Community Care—
Dr P Gregory, Chief Executive
Dr D Dugdale, Chief Health Officer
Ms S Killion
Mr I Thompson
Mr S Rosenberg, Manager, Mental Health and Correct Yourself Policy
Mr R Foster, Director, Financial Risk Management
Canberra Hospital—
Mr T Rayment, Chief Executive
Mr J Holt, Director, Medical Services
Calvary Hospital—
Mr R Cusack, Chief Executive Officer
Community and Health Services Complaints Commission—
Mr K Patterson, Commissioner

THE CHAIR: We will resume on health.

MS DUNDAS: I understand that the Gene Technology Bill is before the Health Committee and I hope that I will not cross over any lines there, but I cannot see any funding in the budget specifically for anything to do with gene technology or the Office of the Gene Technology Regulator. Is this because you don't expect it to be set up this financial year?

Mr Stanhope: I will ask Dr Gregory to answer that question.

Dr Gregory: The Office of the Gene Technology Regulator has been set up within the federal government at this point in time. It is located in the Therapeutic Goods Administration and it will be operating from there on a cost recovery basis. The ACT does pay some costs for its participation in that, but they are, in the overall terms of the budget, fairly minor and they are just met within our general admin costs. Yes, we are contributing.

MS DUNDAS: You are paying a participation cost.

Dr Gregory: Yes.

MS DUNDAS: I know that you are going to tell me that it is a very small figure, but can you tell me what that figure is?

Dr Gregory: Not offhand, but we could take that on notice.

Dr Dugdale: We have assigned an officer to it, Dr Charles Guest, and it has become part of his duties. It is not onerous.

MS DUNDAS: Are you actually paying a lump sum of money to the federal Office of the Gene Technology Regulator as well as providing a person?

Dr Gregory: We will take that on notice and clarify it.

MS DUNDAS: You have said that the federal Office of the Gene Technology Regulator is going to be working on a full cost recovery basis. I am working off my memory of the legislation. Are you expecting the ACT component and the regulation of gene technology in the ACT to be on a cost recovery basis, that either your staff member or your funding will be met through enforcement in the ACT?

Dr Dugdale: As you will be aware from reading the legislation, the ACT is joining in with an intergovernmental effort nationally. The Office of the Gene Technology Regulator has been established. It is housed within the Therapeutic Goods Administration. The Therapeutic Goods Administration overall works on a cost recovery basis and the Office of the Gene Technology Regulator will be also, within that, operating on a cost recovery basis. People who are applying for licences or commissions of different kinds will need to fund the consideration of their applications. The process of regulating gene technology activity will be done on a cost recovery basis.

MS DUNDAS: On a federal level.

Dr Dugdale: At the national level. That is done by that office for things within the ACT and for things in other states. We are participating in that intergovernmental agreement.

MS DUNDAS: So you will be possibly paying a lump sum, no matter how much work is actually being done with gene technology in the ACT.

Dr Dugdale: On the lump sum, we would need to check.

MS DUNDAS: Can you tell me what the ACT office is doing in terms of gene technology?

Dr Dugdale: It is probably best if I come back with exactly what the request from the Gene Technology Regulator is on that. It is participating in the oversight of the Office of the Gene Technology Regulator.

MS DUNDAS: The other thing that I want clarified and added to the notice is dependent on what the ACT money is actually doing and whether the ACT, in its unit, is working on a cost recovery basis. Perhaps any conflict of interest in terms of gene technology regulation could be if the people who are enforcing the law are being funded by applications to be part of the system. If it is specifically working in the ACT on a cost recovery basis, which we haven't yet established because you have taken that on notice, do you see it as a conflict of interest in the ACT?

Dr Dugdale: I don't need to take the cost of assessing applications on notice, that's clear. The Office of the Gene Technology Regulator is a national office to which the ACT government has agreed to the establishment and has agreed to complementary legislation to give it proper powers. That office will operate on a cost recovery basis. I don't think that there is a conflict of interest. There is a user charge for the processing of applications. There is no incentive for the Office of the Gene Technology Regulator to try to drum up business, to overcharge or to undercharge; it has just got to recover its costs, and that is the way that it is set up as part of the Therapeutic Goods Administration. The same model is used for assessing applications for pharmaceutical products to be allowed to be marketed in Australia. It is a well established system and I can't see where there would be a conflict of interests, in that they are not a profit-making institute, so they can't go out and try to make a profit.

MS DUNDAS: Do you think that the officer who is working in the ACT will remain in Health into the future or do you think that there might be a move to another department?

Dr Gregory: There has been a government decision that that function would sit within Health.

MS DUNDAS: So there are no plans on moving out.

Dr Gregory: Of course, it will have to work across other departments as well, but that is where it will stay until there is any other decision to the contrary for any other reason.

MS DUNDAS: Thank you. I look forward to reading the information that you provide.

Mr Stanhope: Ms Dundas, just to clarify that, I believe it is the position in all jurisdictions throughout Australia that the minister for health is the lead minister in relation to gene technology issues. I think that on that position here we are consistent with all the other states and territories.

MRS DUNNE: Mr Chairman, do you think it might be time to move onto output classes?

THE CHAIR: I will make a brave decision and say that we will move to output class 1.1, which relates to acute services. I have a question about the output targets for Calvary and Canberra hospitals of 210,350 patient visits. You anticipate that the demand at Calvary will increase by about 7 per cent this year, as has been stated already. Why has that figure been constructed in that way? Why is the same number of people expected to be dealt with this financial year as were dealt with last financial year, given the rates of increase?

Dr Gregory: Can I just clarify, first of all, that the measures that are in the budget papers are a sample of measures. You referred before to the need to decide on a small sample of measures that will be effective for the health system. One of the measures that isn't included in output class 1 is the number of occasions of emergency department admissions. The occasions of outpatient services that are there, the 210,350, do not include emergency department admissions. That is another target that simply hasn't been included in the past in the budget papers.

MRS DUNNE: Does this mean that that 210,350 doesn't include people who are admitted out of A&E?

Dr Gregory: It doesn't even include people who go into A&E.

MRS DUNNE: Sorry, that's outpatients, excuse me.

Dr Gregory: It refers to the whole range of outpatient clinics across the service. The reason that that figure is static is that at this stage we are not expecting growth in those outpatient services. My understanding of the estimated outcome for this year is that probably it will be lower than the figure that was there, but we didn't have an up-to-date estimate at the time the budget papers were put together as to where that might be. It is a very difficult area and one that is under review at the moment by the Canberra Hospital, Calvary Hospital and ourselves to get a better handle on exactly what is going with the outpatient services. There has been some agreement amongst ourselves that, until that happens, there won't be a conscious effort to grow outpatient services.

THE CHAIR: Given the rate of increase in other services around the hospital, why would outpatient services, excluding the emergency department, be static?

Dr Gregory: Again, it comes back down to what we are trying to achieve with the outpatient services. In many cases, it makes sense for patients to be treated as an outpatient rather than as an inpatient where that is possible, and that does cause some growth. You will be aware that in many other states and territories, outpatient services are not growing within the public sector; there is more of a move to have them accommodated through bulk-billing arrangements in the private sector. Part of the review that we are looking at is to get a good handle on exactly what does go on within hospitals at the moment. There is a big survey exercise going on within the hospital at the moment just to get a better handle on that, so that we can plan much better for outpatient services in the future.

THE CHAIR: The question has not been answered. Why would the services be static in this area? Does it include day procedures, for example?

Dr Gregory: No. I am not sure of the definition—Susan might be able to help me there—but, if they are over a certain number of hours, they are a day patient, which is an inpatient.

THE CHAIR: If they are pushing for some procedures from being inpatient to being outpatient, you would assume that there would be some increase in the number of outpatient services below that certain number of hours.

Dr Gregory: Yes.

THE CHAIR: Given the increase in services across the board, because of the ageing of the population, the growth of population, et cetera, it is still just hard to imagine that there would be a static number of outpatient services being offered to the ACT. I can't understand why. Can you give me any reason as to why that would be the case?

Dr Gregory: It essentially goes back to being quite clear about what we are providing and, because we are not yet confident enough about what we are providing, we think that the estimated outcome for this year will only be around 202,000 rather than 210,000. So it is a fairly moveable feast and not one in which we are confident about planning growth because we need to get a much better handle on what we are doing and why we are doing it.

MR SMYTH: Could you tell us what you would classify as an outpatient service? It's rehabilitation, it's the fracture clinic, it's physio—

Dr Gregory: It is the whole range of clinics within the hospital which might be happening after an inpatient admission or might be some separate arrangement whereby somebody comes into the hospital, so both linked to the inpatient services but also separate to that.

MR SMYTH: The revised estimated outcome is now not 210,000 but 202,000, is that what you just said?

Dr Gregory: Yes.

MR SMYTH: How many accident and emergency services were provided last financial year and how many do you estimate this financial year?

Dr Gregory: Approximately 100,000 cost-weighted occasions of service. Approximately 45,000 of those are at Calvary and about 50,000 at Canberra. I haven't got the exact figures in front me, but I'm sure somebody here has.

MRS DUNNE: That is, roughly 45:55?

Dr Gregory: Yes. But Susan has probably got the exact figures there.

Ms Killion: Sorry, are we talking about the current year?

MR SMYTH: A comparison, if I could have last year's cost-weighted occasions of service for Calvary and TCH and then the estimates for this year?

Ms Killion: In 2000-01; is that the last year you are talking about?

MR SMYTH: No, 2001-02.

Ms Killion: For Calvary Hospital, there were 69,155 cost-weighted presentations to the emergency department.

THE CHAIR: That is for the emergency department?

Ms Killion: Yes, the emergency department, and then the Canberra Hospital, 84,577.

Dr Gregory: I was talking about raw numbers and Susan has the cost-weighted numbers.

Ms Killion: I've got them both, if you would like them both. Would you like the raw numbers as well?

MR SMYTH: Yes.

Ms Killion: For Calvary Hospital, the raw numbers in 2001-02 were 44,215 and in the Canberra Hospital in that same year the raw presentations were 50,740.

MS DUNDAS: Were the figures you were giving us cost-weighted with just emergency figures?

Ms Killion: Just emergency presentations.

MS DUNDAS: So the raw numbers are also just emergency presentations?

Ms Killion: That is right. The raw numbers are the people and the cost weights are the relative acuity.

MR SMYTH: And the estimate for this year?

Ms Killion: I don't have it right here. I will have to get back to you on that.

THE CHAIR: Sorry to be cynical, but I still can't see how, given the rising demand for services across the board and without any other factor being postulated, there would be a static amount of demand for outpatient services?

Ms Killion: There certainly isn't a static rate of demand for the emergency department. In the last financial year we did fund Calvary a growth of 7 per cent and they achieved almost that amount and at TCH we funded a growth of 5 per cent in the emergency department and they did not achieve that amount.

Dr Gregory: Just to go back to the outpatients issue, the review that I referred to before, I need to stress, is a piece of work that is going on to try to work out what is the most appropriate setting for outpatient services. Until we have done that and until we have completed the surveys that allow us to understand exactly what is going on, we are really not in a position to do some planning about what kind of growth we are looking for. I am sure if we provided a whole heap of professionals who were able to staff outpatient clinics there would be plenty of people coming in and using those, but we don't want to create a demand before we are quite sure where that demand can be most appropriately met.

There is a piece of work that the hospitals and the department are cooperating on that is quite critical to working out planning in these areas, because it is not just responding to loose demand that might be out there that could be met in a range of ways; it is actually trying to plan what is the most efficient way that we want to provide those services. That is why we were not planning for any growth in outpatients at this point until that work is completed.

MR SMYTH: Going to note 4 at the bottom of output 1.1, the population has actually gone up 3 per cent. It has gone from 313,000 to 322,000. If the number of services went up proportionately, you would expect it to go to 216,000, without taking into account the changing demographic and the increase in aged care that we all know is coming. Yet, instead of going up by 3 per cent, you are saying that it is actually going down by 4 per cent.

Dr Gregory: That is assuming that it is a model of care that is appropriate, that all outpatient services are being provided in an appropriate way. It is our job to review the way services are provided and to make sure that they are being provided in a way that is both consumer friendly but also good use of the territory's resources. That is a piece of work we haven't completed yet and that is why that target is being held static.

MR SMYTH: Again, it seems that we are paying more money and getting less service, but I guess we will all have to await the outcome of the review. If I may ask about the line above, the number of inpatient cost-weighted separations. At first blush, the 56,300 of last year goes to 60,700 and it looks like there will be about 4,000 extra cost-weighted separations, but the figures have actually changed and you can't compare them directly, can you?

Dr Gregory: That is correct.

MR SMYTH: I have to say to the committee that Dr Gregory gave me this information at lunchtime. On the 56,300, it doesn't include the DVAs, the compensables and the ineligibles, which you said came to 3,160.

Dr Gregory: That is correct.

MR SMYTH: If we took that off the 60,700 to compare apples with apples, the actual number of cost-weighted separations this year will be 57,540.

Dr Gregory: That is correct.

MR SMYTH: From that, given what Mr Cusack said earlier today, should we remove another 900 operations that are expected?

Dr Gregory: No, that is within the amount that is funded there. Can I say that those targets have been achieved by the overall expectation of a 2.5 per cent growth, so that when you add in the DVA and compensables figure, approximately 1,400 new cost-weighted separations will be provided across-the-board by the additional money that the government is providing in the 2002-03 financial year. That equates to around 2.5 per cent. It equates to around the $4 million to $5 million in additional money that has gone in, including growth and some of the new initiatives money to come up with that growth and throughput. That is funded and that is expected to be delivered and that includes the overall target at Calvary Hospital. I point out that that is both medical and surgical. It is not just surgical. The issue at Calvary Hospital is particularly one in relation to surgery, but it is both medical and surgical.

MRS DUNNE: Until the current financial year you didn't count DVA services and a few other bits and pieces in the number of inpatient services. Why was that?

Dr Gregory: We didn't count them because we don't actually fund them and we were on a purchaser/provider arrangement whereby we were passing on to the hospitals government money. We were purchasing from the hospitals. The DVAs are funded directly by the DVA and the compensables are funded by the compensation companies, whether it is motor vehicle accidents or whatever. The ineligibles are out of people's own pockets when they are not eligible for Medicare. Whilst those were reflected within each hospital's overall budget and the revenue coming in was reflected, we weren't actually purchasing them with ACT taxpayers' money or ACT government money. But, in view of the change to look more comprehensively at what we do, the full throughput at the hospitals has been added.

THE CHAIR: You are providing growth of about 2½ per cent in services across-the-board at the Canberra Hospital, at least?

Dr Gregory: Across-the-board is the expectation, yes.

THE CHAIR: We have established that the general growth in demand is somewhere between 6 and 7 per cent, haven't we?

Dr Gregory: No, the figure I referred to earlier was 2½ per cent. That has been the trend over the last few years, about 2½ per cent. It is 3 per cent sometimes. I haven't got those figures with me, but that is about the normal growth that we have funded in the past.

THE CHAIR: Minister, in a media release just before the last election, not quite a year ago, you said, "In this year's budget, the hospital is funded to treat an increased throughput of 2 per cent, despite the fact that last year's throughput increased by 7 per cent and the average increase over the last decade was 6 per cent a year." If it is between 6 and 7 per cent, as you have suggested—

Mr Stanhope: I will have to go back and check my sources, Mr Chair.

THE CHAIR: I am happy to give you your source right now.

Mr Stanhope: No, my sources for that information. I am happy to do that if it is of assistance to the committee.

MR SMYTH: I am happy to quote "Rebuilding the ACT health service", page 3 of 12, which says exactly that. It says, "The government has not factored into the hospital budget the increased activity achieved last year, that is, an increase of 7 per cent over the previous year."

Mr Stanhope: Where was that from, Mr Smyth?

MR SMYTH: From your document called "Rebuilding the ACT health service". Perhaps you have forgotten about it. It is on page 3 in the second last paragraph.

Mr Stanhope: I am happy for you to utilise it, Mr Smyth. It is a good document.

MRS DUNNE: Also, the figures that Mr Cusack quoted this morning for Calvary Hospital would indicate general increases of between 5 and 7 per cent for services at Calvary.

Ms Killion: But that is because they had the extra funding to do the additional surgical work.

Mr Stanhope: They were funded to do that, yes, but the demand met the funding.

MRS DUNNE: He was talking about what they were budgeting for this year, increases of between 5 and 7 per cent.

Dr Gregory: In emergency department admissions, he was looking at another 5 per cent, but he had around a 20 per cent increase in medical admissions in the 2001-02 financial year. So that is part of the extraordinary growth in medical admissions at Calvary that none of us expected to happen.

Mr Killion: But that is a percentage of a part, not the percentage of the whole.

MRS DUNNE: Yes, I realise that, but most of the figures that he was looking at for each of the categories were between 5 and 7 per cent.

Dr Gregory: Yes, but there were some big decreases in there, too. Some of them were going up and some of them were going down.

THE CHAIR: We funded the growth in the system by a 2 per cent throughput a year. You said, "For too long, the hospital has been underfunded by a government determined to run down the territory's health care system."

Mr Stanhope: True.

THE CHAIR: If you are funding at the same level approximately, why aren't you running down the territory's health care system as well?

Mr Stanhope: I am happy to go through the percentage increases in funding for Canberra, Calvary and the health system generally.

THE CHAIR: We have heard that the throughput is being funded, specifically the throughput.

Mr Stanhope: We are talking about throughput.

THE CHAIR: Yes, that is what the release was about.

Mr Stanhope: Mr Chair, I think we established earlier today that this government has increased the funding budget to budget for Calvary Hospital by 11 per cent. I understand it is about the same for the Canberra Hospital, but I don't have the numbers in front of me.

THE CHAIR: But that is not what Dr Gregory has told us. She said that the funding for the throughput has been—

Mr Stanhope: I am talking about funding for the hospital. We have had this debate three or four times today, Mr Humphries, and I am happy to engage in it again. I am happy to talk to you about the basis on which the 13.5 per cent increase in funding for the health portfolio has been distributed and the basis on which we did it. Certainly, we didn't focus just on throughput, we didn't focus just on the waiting list.

THE CHAIR: That is what the committee is focusing on now.

Mr Stanhope: Absolutely.

THE CHAIR: It is focusing on throughput.

Mr Stanhope: Sure. We have been through this three or four times today and it is getting to the stage now that it is just becoming repetitive and you are repeating the point ad nauseam. You think we should have put more money into throughput and into the waiting list. I am telling you that we have increased funding for the department of health, for the portfolio, by 13.5 per cent, more than you ever did.

THE CHAIR: No, Minister, I am saying to you that you said that the hospital should be funded for more throughput. You said so in your own media releases as shadow minister for health before the last election. You are not, in this budget, providing that increased funding for throughput. You have broken a promise.

Mr Stanhope: No, I am not conceding that at all. We have made this enormous commitment to health and to the health portfolio. You have a 13.5 per cent increase. Just look at the raw numbers, Mr Humphries—a 13.5 per cent increase in funding for health.

THE CHAIR: We have heard those numbers, but they don't go to the question of throughput.

Mr Stanhope: Yes, they are very significant numbers, lots of dollars, and we have met through the increased funding a whole range of pressures that were left to us.

THE CHAIR: In the right places, do you think?

Mr Stanhope: On wages for nurses—

MR SMYTH: And we also left you a very low waiting list.

Mr Stanhope: Let me just answer this. "In the right places," Mr Humphries says. Certainly, we were left to pick up a significant bill in relation to the successful nurse EBA negotiations, moneys that weren't in the budget, Mr Humphries, as you know.

MR SMYTH: Mr Quinlan doesn't agree with that. There was actually a *Canberra Times* article in which Mr Quinlan gave us credit for having made that allowance in the budget. I will get you the *Canberra Times* article.

Mr Stanhope: Did the previous government make allowance for the full amount of the nurses' payment, Dr Gregory. Mr Smyth seems to be under some—

THE CHAIR: He didn't say the full amount.

MR SMYTH: No, I didn't say that.

Mr Stanhope: Let's get the record straight.

MR SMYTH: I am just quoting the *Canberra Times*.

Mr Stanhope: No, the previous government did not. There was a significant shortfall. We picked it up and funded it. There was a whole range of pressures that were simply unavoidable. There was a whole range of mandatory pressures which we were faced with and which we didn't know about. The fact is that we have just had to pay an additional $6 million for insurance in the portfolio. These were payments we didn't know about. These are payments we have made.

MRS DUNNE: Mr Chairman, can I actually ask a question about inpatient cost-weighted separations?

THE CHAIR: If we branch into other areas, we are going to be here certainly until tomorrow.

Mr Stanhope: If you lay down those challenges to me, Mr Chair, I am going to respond. I am not going to leave those statements of yours and Mr Smyth's on the table unanswered. If you throw down those challenges to me and you continue to do it about what this government has done, then I will answer them and I will answer them completely because I am not going to leave them lying.

THE CHAIR: Okay, Minister, but the point is we are talking about specific components.

Mr Stanhope: So don't ask a question or throw down a challenge to me and then try to move on to another issue.

MRS DUNNE: No, I am still trying to get the answer to the question that I started.

THE CHAIR: We are not moving on to other issues; we are talking about throughput. You are the one, with respect, who is moving on to other issues.

MRS DUNNE: Dr Gregory, in BP4 there are estimated outcomes for 2001-02. Can you actually tell us what the outcomes were, or is it still too early to tell?

Dr Gregory: I think that figure is one of our better early estimations and I think it is almost line ball for the outcome. Can I also clarify that I was talking about growth in throughput, growth in cost-weighted separations, as distinct from growth in funding.

MRS DUNNE: Yes, I understand that. I want to talk about throughput, that is, cost-weighted separations. The estimate of 53,700 cost-weighted separations for inpatients does not include DVAs, compensables, ineligibles, Uncle Tom Cobleigh, and all?

Dr Gregory: No.

MRS DUNNE: Can you explain why there is a failure to meet the target by nearly 3,000?

Dr Gregory: It is probably best if I ask Ted Rayment to talk about that.

Mr Rayment: Within contacts, the Canberra Hospital deals with, as you know, inpatients, outpatients and a range of other challenges, like teaching and research, but our main area of shortfall in the target was in women's and children's, which is a significant issue for us, but I'll go through a number of them. On our viability, I think we are at about 1,800—I will give you the exact number—cost-weights in the women's and children's area. For a viable service, we need in the order of, I think, 2,500.

MRS DUNNE: What do you mean by "women's and children's"?

Mr Stanhope: Maternity.

MRS DUNNE: Is that maternity, or is it maternity and paediatrics?

Mr Rayment: The optimal size of a territory unit is 2,500 to 3,000 and our birth rate is declining. It has decreased to 1,852, so we are down 14.7 per cent in our maternity services.

MRS DUNNE: So you predicted more maternity services than you achieved?

Mr Rayment: There were more purchased than we achieved. It has dropped significantly. Basically, it calls into question the accreditation of that particular service, whether we can still have an accredited service, and there are fixed costs in providing nurses and doctors for on call which remain even though those cost-weights have dropped. That is one element.

Another important feature that is a problem for us is that we have had an increase of over 100 per cent in occupied bed days for our nursing home-type patients. The average length of stay for a nursing home-type patient is at least three months. Those beds otherwise could be available to patients who are spending on average three days. When we are running the hospital at 95 to 100 per cent occupancy it doesn't give us much leeway to deal with the surges coming through the emergency department that you read about from time to time.

Just to put this further in perspective, within the emergency department we have had an increase of 21 per cent in our category 1 patients. Those are the patients that are at the highest trauma end of the spectrum. When they come through the emergency department, because we are running the hospital at 95 to 100 per cent and we have that increase in nursing home-type patients, we are unable to move those patients into the wards, which then causes problems with category 5s in terms of getting through the usual

numbers within emergency, which is why we are down in the emergency department in the order of 6 per cent.

There are some other influences. Within our critical care area, we would have shorter lengths of stay for ICU, so they have improved their services and are getting about the same number of patients through but our occupied bed days overall have dropped. There are some other changes. Within our outpatients, raw numbers are up by 7 per cent, raw numbers, and the outpatients service can, in some cases, substitute for an inpatient service. There are services provided also in terms of our cancer patients, services provided both in hospital and in their own residences which can reduce your actual cost weights because you are not putting them in overnight but still delivering the outcome.

There are a number of factors that have affected our reduction in cost weights. One of the big ones is having two maternity services in a fairly small geographical area. Ours—I can speak for mine—is certainly not viable financially.

MRS DUNNE: Do you mean TCH and John James?

Mr Rayment: Calvary. Public facilities. I could call Rosemary O'Donnell here to provide more expert advice to you, but we could provide all of those services in our hospital, probably without having to increase the staffing level, for both hospitals, because we are coming down from the level we were at and are still having to provide that on-call, basic service. That is some of the background as to why our cost weights have fallen.

MS DUNDAS: Mr Rayment, you said that there had been an increase of 21 per cent in category 1 emergencies. Do you have any explanation for that?

Mr Rayment: Helicopter or aeromedical retrievals, the types of patients we are getting from New South Wales.

MS DUNDAS: The SouthCare region.

Mr Rayment: Yes. We get the extreme end of patients. We have been called the place of last resort. The major trauma comes to our hospital, which is what we are. We are an emergency hospital and we deal with major trauma. We put through elective surgery when we are not too busy with the major trauma.

MRS DUNNE: Is that 21 per cent year-on-year in category 1?

Mr Rayment: A 21 per cent increase in category 1 patients coming through the emergency department.

MRS DUNNE: That is from one year to the next.

Mr Rayment: Yes.

MR SMYTH: Is that expected to continue this year? I assume that you were comparing 2001-02 with 2000-01 when you spoke of a 21 per cent increase. Is a 21 per cent increase expected this year, in 2002-03?

Mr Rayment: I don't think so. Dr Gregory may be able to answer this question better than I, but I am aware that New South Wales is, in fact, providing some services on the coast, but whether that would take the pressure off in terms of the number of referrals is difficult to predict.

MRS DUNNE: On the subject of meeting targets, your targets for 2002-03 are, for the sake of comparison, 57,540. Do you think that you are going to meet those and are you going to be able to address the question of bed blockage of various sorts? Sorry, the 57,540 is without the DVA and things like that. Do you think that you will be able to address those issues and actually meet that target, seeing that you didn't meet the target for the last financial year? You had a whole lot of reasons for that.

Mr Rayment: Your figure is for across the ACT, I have just been advised.

MRS DUNNE: Yes, it is.

Mr Rayment: In terms of the Canberra Hospital, there are some areas where we predict that we would be able to increase activity coming through the hospital. One area that has been predicted, but I would need to have a close look at it, is in general surgery. We think we will be able to increase the number this coming year. Neurosurgery is continuing to trend upwards and we are expecting a neurosurgeon to join us, commencing this financial year. Orthopaedics are routinely over target. An additional urologist has been employed. Therefore, that impact has not been truly felt, but we think that that will go up. If the nursing home-type patients go up even further, then we would reduce the amount of beds that are available for the rest of the population. Susan Killion has given some information about what is being done to try to alleviate that. I would hope that that will have some effect, but we are also in the hands of the Commonwealth.

MRS DUNNE: Yes, indeed. You said before that the section for women and children wasn't viable. Does that mean paediatrics or do you just mean maternal?

Mr Rayment: Maternal.

MRS DUNNE: Just the maternity unit.

Mr Rayment: Yes.

MR SMYTH: Mr Rayment, you just said outpatients were up 7 per cent.

Mr Rayment: In raw numbers.

MR SMYTH: What is the relationship between raw numbers and the number of cost-weighted occasions of output services?

Mr Rayment: It depends on the types of patients being seen. One thing that is important is that some people latch on to cost weights as being the measure to determine productivity or throughput. There is a counter argument to that. A lot of work has been done on understanding hospital costs and submissions are being prepared for the Commonwealth Grants Commission. But it is quite clear that, if you are able to deal with

patients in another way which has a much lower cost weight or increase your day surgery and avoid an overnight stay, you can actually reduce your cost weights.

MR SMYTH: But that would be separations for inpatients, not occasions of service for outpatients?

Mr Rayment: That is right. In terms of outpatients, that sometimes can substitute for inpatients, the same as hospital in the home can. Another area I forgot to mention was cardiac surgery. We had a cardiac surgeon who had an accident and was unable to work and we had one doing one-on-one. He is now back, I am pleased to say, and has commenced work, so I would imagine that there will be an increase in that area, too. I predict that there will be an increase in cardiac surgery.

MR SMYTH: Getting back to the 7 per cent increase in outpatients, is that expected to continue this financial year?

Mr Rayment: There is a review that Dr Gregory referred to and we would work and cooperate with the department to see exactly where that may or may not need to be varied.

MR SMYTH: The outpatients figure that is up 7 per cent is for 2001-02 over 2000-01?

Mr Rayment: Yes, the year ending 30 June 2002 compared to 30 June 2001. Raw separations.

Dr Gregory: That is raw, not cost weighted.

THE CHAIR: I have a question about acute care services. A report was presented to the health ministers meeting in Darwin, which you may not have seen, Minister, but I assume is available to you, from the Australian Council for Safety and Quality in Health Care, which showed that between 2 and 3 per cent of annual admissions were the result of adverse reactions to prescribed medication. Do you think that there is a problem of the same dimension in the ACT? Do we have any programs in place to address that problem?

Mr Stanhope: I must say that I wasn't aware of that paper, Mr Chair, but perhaps Dr Gregory could answer the question. I'm afraid I am not aware of it.

Dr Gregory: The report was presented as part of the work of the national forum on safety and quality. It had been doing work over a number of years to try to identify the quality issues. I think it was shocking to people when the report came out with those figures, but, if we don't start counting them, then we don't know what the problem is that we are dealing with and we can't address it properly.

We have a number of projects in place under a comprehensive framework, which is the quality first framework, within the territory which is addressing a whole range of quality initiatives. Some are addressing that issue as well. The minister recently launched the awards for quality and safety that are another way to try to ensure that we have incentives in place for people to be doing the sort of work in the quality arena that means

that hospitals become a safer place to go to. If you want further information on that, Dr Dugdale could provide it.

THE CHAIR: You are telling me that there is a program in place to get better information and, in turn, to address that problem?

Dr Gregory: Yes. A substantial amount of money, $9 million, is being given by the Commonwealth to the ACT over the five-year period of the health care agreement to spend for that purpose, and we are well under way with spending that money.

THE CHAIR: There being no further questions on output 1.1, I have one on output 1.2. If you have not got anybody here who can answer the question, you can take it on notice. It is in regard to the initiative for psychogeriatric care, $300,000. Has there been an attempt to seek matching Commonwealth funding for that initiative?

Dr Gregory: Are you talking about the $300,000 in this year's budget?

THE CHAIR: Yes.

Dr Gregory: The purpose of that funding is actually to jointly work with the Commonwealth so that existing nursing home places can be made more, shall we say, dementia friendly or more accessible to people with psychogeriatric issues that cannot normally be dealt with in nursing homes. Some nursing homes are geared up specifically to deal with dementia patients, but the majority are not, so this is some funding that we will be supplementing into nursing homes to ensure that one-on-one care can be required and people can be dealt with in the ACT rather than having to go externally to other facilities. It is a cooperative arrangement with the Commonwealth.

THE CHAIR: Are they putting money in or just providing advice?

Dr Gregory: They are providing their existing nursing home places, but there is agreement that they will take more dementia patients, and more very difficult dementia patients, by putting further money in from the ACT to supplement it.

MR SMYTH: On page 144 of BP3 it is listed as $300,000 for this year, and it says that it will be partly funded from internal growth funds, so the change is actually to list it as $100,000, so $200,000 is from growth and $100,000 is new.

THE CHAIR: We will move on to output 1.3, which is about community health services.

MS GALLAGHER: I have a question about breast screening clients. I know that it is a target, but the estimated outcome is about 5 per cent down on the target. I am just wondering whether there is any explanation for that. Is it just a continuation of the normal numbers, considering that it is a target to begin with, and maybe you will never achieve it?

Ms Yen: My name is Laurann Yen. I am from Community Care. That is actually a higher target than we thought we were going to achieve. In fact, the end of the year outcome has been just slightly, I think, better than that at 11,800 women screened. There

are two issues that we have been dealing with in terms of breast screening numbers. One has been, as Joanna Holt referred to this morning, the difficulty in recruiting people to radiography and radiology positions in the territory and we have worked on looking at overseas recruitment of radiologists as well as looking at how we can actually manage some of our radiography services by way of women returning to work on a part-time basis and in ways that actually give us some more capacity in the service.

At the time, we were also in quite substantial negotiations with radiologists about how we actually cover the radiology services attached to breast screening, because there were a series of changes that required us to put in additional clinical oversight for radiologists at the time so that we could actually meet the national accreditation standards. I am pleased to say that just very recently we had the accreditors in and we think we have done well again in terms of the quality of the service in the ACT, which, as you know, provides a service to women in southern New South Wales as well as in the ACT.

Another thing that we are doing to try to make sure that we are actually getting the target number of women through is working with southern New South Wales on thinking about how we could better provide the service to women in New South Wales. We are looking, with the Southern Area Health Service, at a range of initiatives where we could actually provide services in Queanbeyan, for example, where they are wanting to set up some of their own services and we would work with them to provide some services attached to that.

The third thing that we are looking at doing is concentrating on the target group of women who are the sort of group who need to be screened in order for us to meet our accreditation standards. We have come through the year a great deal better than we thought at the beginning of the year we were going to. I think it is a credit to the management in breast screening that they really have managed to pull what looked as though it was going to be probably 2,000 activities down into something which is very close to our target.

MS DUNDAS: Are those services provided by both the ACT government and community organisations?

Ms Yen: Breast Screen ACT is a government-provided service done under the national breast screen initiatives.

MS GALLAGHER: At the moment, people who live outside the ACT travel in to use the service, if they want to, and you are thinking that that might discourage people from outside Canberra?

Ms Yen: No, we do both. Women from southern New South Wales, where we provide that service as well to New South Wales Health, can travel into Canberra for that. But just in the last year we set up a site at Batemans Bay and we screen down there. We have a mobile service that goes out to a number of communities around Canberra. But we are looking at how we can manage those services more efficiently so that the surrounding areas have not only a breast screening service but access to other radiography services, which some of the smaller areas want.

MS GALLAGHER: So you are setting yourself the same target.

Ms Yen: Yes, I think so.

THE CHAIR: I wish to ask about dental services. I know that there has been previous discussion about what the figures for the numbers of occasions of service mean, but should I understand it to be the case that there was, effectively, some privatisation of dental services going on?

Ms Yen: The additional funding for last year's budget, the additional $500,000 that went into public dental services, was used, as we have used funding before, to purchase services from private dental practitioners in Canberra and we have continued to use that as a source of dental service for people who have their service paid for by the government.

THE CHAIR: The additional services are not recorded in these targets, these measures?

Ms Yen: They are reported in the outcomes, yes, because we agreed to purchase additional services related to the additional funding at the beginning of the purchasing year. We agreed to the additional outcomes as part of that additional funding.

THE CHAIR: Can you explain why, if that is included, the outcome is lower than the target, given the extra amount of money which was put into the system?

Ms Yen: Again, as with radiography, we have been able to purchase some services from private dental practitioners, but we have found real difficulty in recruiting to our dental services through the period of the year. Part of the reason that our targets are above what we would expect for the children's service is that most of those services are provided by dental therapists. Those are the services which go into schools and then provide clinical services for children in dental clinics and we don't have the same recruitment difficulty around dental therapy.

Fairly recently, we just got up to our full complement of dental services, and we are hoping to increase the target. Despite the fact that we haven't met the target on that, the outcome for the year has been very good. We have reduced the waiting time for dental services for adults from almost three years to 21 months which, even though it is still far longer than anyone would want to have to wait, is a substantial improvement, and we have reduced the waiting list for dental services to just under 2,000, I think—no, slightly more than that.

THE CHAIR: But there will be an effective reduction on these figures for the number of child and youth dental services provided this year over last year.

Ms Yen: Sorry?

THE CHAIR: There will be an effective reduction in the number of child and youth dental services provided this year over last year.

Ms Yen: No, I think we can probably meet those targets again in the coming year.

THE CHAIR: The target for 2002-03 is out of date; is that what you are saying?

Ms Yen: Yes.

MS DUNDAS: Do you have revised targets for 2002-03?

Ms Yen: I haven't here with me, but I can certainly provide those if you would like for both adults and children.

MS DUNDAS: Yes, I would like those. You said that the waiting list was about—

Ms Yen: Down to 21 months.

MS DUNDAS: No, how many people are on the waiting list?

Ms Yen: I think it is 2,400.

MS DUNDAS: Do you think that having the minimum charge of $20 on non-urgent dental problems through Community Care might be deterring people from accessing dental services, especially when they have to wait 21 months to get that service?

Ms Yen: I don't think so. I think we are actually fairly careful to make sure that we are providing emergency services where those are required, so that if people are in pain there is not a 21-month wait to have an emergency seen to, thank God. I think that people do feel that making a contribution is not a disincentive. I think that where that contribution is difficult for them to make, then we would waive that. We have a system of being able to waive that if people present to us and say that they are in hardship and aren't able to meet that cost.

MS DUNDAS: I was going to ask you out about the targets, but I will wait for your revised figures.

Ms Yen: I am happy to give you updated numbers on those. Alan has just said to me that, as at 1 July, 2,776 people were on the waiting list. Those are adults waiting for dentistry. The final achievement, I think, is that we are probably the only state in Australia that doesn't have a waiting list for dentures at the moment. If you want dentures, then you know where to go!

THE CHAIR: I want to ask about multicultural liaison officers. We were told yesterday that there was funding in the budget for two aged care liaison officers for the multicultural community. Where will I find reference to that in the budget?

Ms Yen: I can give you the information about them, but I don't know where you will find it in the budget. Can I just tell you where they are and that will probably help?

THE CHAIR: If you can tell me how it is going to work.

Ms Yen: One post has actually been in place for some time and is placed at the Canberra Institute of Technology, and is working alongside the carers programs at the Institute of Technology.

THE CHAIR: For how long?

Ms Yen: That post has been in place since December 2000.

THE CHAIR: There was a promise to provide two officers. I think the implication was that they would be additional officers. We have only got one additional officer, have we?

Ms Yen: The funding for both of the multicultural officers has come through the HACC program. That, as you know, is a Commonwealth-funded program. Both officers are funded through that source. The second officer is a select tender which ACT Community Care won the bid for just recently and that post has not yet been appointed to. We were just in the last few weeks informed of that successful bid.

THE CHAIR: There was a promise to provide two aged care liaison officers for the multicultural community, Minister. Since one was already in place, you have only actually provided one more, haven't you?

Mr Stanhope: I would have to investigate that, Mr Humphries. I'm happy to get back to you on it.

THE CHAIR: Will you take that on notice?

Mr Stanhope: I will take that on notice.

MS DUNDAS: Can you explain what has happened to the home and community care services targets?

Dr Gregory: Yes, as I explained before, we tried to do a selection of appropriate targets within these budget papers and we were actually tasked previously to come up with some more meaningful measures and to reduce the overall number of measures. There was quite some debate, I must say, within the department as to whether counting 113 meals delivered was a meaningful target and something that was sensible to report in the budget papers. So what has happened is that those targets are no longer reported in the budget papers. They are still collected and the information is still available, but they were not considered to be terribly meaningful targets of any outcomes being achieved and that is why they are no longer appearing.

MS DUNDAS: Have you thought of a replacement quantity for home and community care services?

Dr Gregory: We certainly are trying, but we haven't come up with anything yet that is both measurable and meaningful in terms of talking about the kind of support provided. As I say, we still collect these.

MS DUNDAS: So they would be in your annual report?

Dr Gregory: Yes.

MR SMYTH: If I could piggyback on that, the indigenous services also do not have a target. Is that why you are looking for client contacts?

Dr Gregory: Yes, because that one for indigenous services client contacts wasn't measuring all indigenous client contacts by any means. It was just measuring some specific, easily measurable ones, so we felt it best not to include that as a measure because, again, it is not a meaningful indicator of what the system is doing.

MS DUNDAS: Is that also an explanation of why the outcome is half of what the target was for 2001 and 2002 in terms of indigenous client contacts?

Dr Gregory: Yes, although partly the explanation for why that is down is that there were some delays experienced in getting the new sexual assault service set up and that meant that we didn't actually have the number contact that we would otherwise have had. That was due to ensuring that the service that was to be set up was well consulted on and was going to be used and accepted by the clients whose needs it was trying to meet.

MS DUNDAS: You said that the indigenous client contact quantity measure is of a quite specific form of indigenous client contact. Can you explain what that is? Is that for services provided by Winnunga Nimmityjah?

Dr Gregory: No, it is not for Winnunga Nimmityjah. I think it is for specific indigenous workers that we had in place, which is why we didn't think it was a meaningful measure any further. We can get you a breakdown of what was in it. I would have to take that on notice. We think it was for things like rape crisis workers and some indigenous workers in Gugan Gulwan that we funded, but it doesn't include Winnunga Nimmityjah. As I say, it is not a measure for the current year's budget because we were not comfortable with it as a measure.

MS DUNDAS: I have a question about alcohol and drugs services. The estimated outcomes are consistently below the targets and the targets have been set at the same as they were last year. Can you explain why we didn't meet those targets? Was that due to a lack of demand or a lack of provision? What was going on?

Ms Yen: What we understand from speaking to the alcohol and drug workers, both in the government and the non-government sector, is that with the pattern of heroin availability through part of this year there has been a change in demand for services.

MS DUNDAS: But you would expect that demand to increase this financial year.

Ms Yen: The reason I haven't really changed the targets is because we don't know and we are certainly able to cope with that capacity. I think the other thing is that we would be thinking that probably the introduction of bupramorphine and the other pharmacotherapies may change the profile of the way that we actually provide alcohol and drug services. So, while this target is here as the next year's target, I would like to have some leeway really to come back part way through the year to talk about what the pattern has actually been through the first part of the year.

MS DUNDAS: The number of supervised alcohol and other drug withdrawal clients fell short by 18 per cent. Jacqui Pearce from Toora appeared before the committee yesterday and spoke about long waiting lists and the lack of availability of detox beds. Can you explain what is going on to address that shortage?

Ms Yen: I would ask Fran Barry to respond to that.

Ms Barry: I don't know precisely what Jacqui Pearce said, but the demand for any of the three ACT detoxes goes up and down throughout the year. Certainly, we have periods where there is quite a bit of capacity and then at other times, sometimes for reasons that just aren't that apparent, demand will increase and it can be hard to get a place. But in terms of access to services through ACT Community Care at the moment, it may be that she was referring to the fact that there have been some delays in seeing doctors at the alcohol and drug program, which has been through a difficulty in recruiting staff.

MS DUNDAS: Is that being rectified?

Ms Barry: It is being attempted to be rectified. Certainly, doctors have been advertised for both locally and interstate on a number of occasions and all the general practitioners in the ACT who currently do drug and alcohol work have been approached and asked if they would be prepared to do some work for the public program. It has improved a bit, I think.

Ms Yen: The area where that is of a particular worry is for people wanting to start on the methadone program, so it doesn't prevent people coming into withdrawal services generally. As Fran said, we are trying actively to recruit among general practitioners in the ACT as well as to keep the recruitment up for staff in other areas.

MS DUNDAS: Can you explain why the numbers went down on the target for last year, why you only had 925 units or people versus the target of 1,130?

Ms Barry: We think that that was also to do with the heroin shortage, just less people accessing treatment. In particular, I think Arcadia House, the non-government withdrawal unit, had a very quiet time at one stage during the year.

MS DUNDAS: Do we have the capacity to meet the target that we have set?

Ms Barry: I believe so, yes.

MS DUNDAS: You don't think there is a need for more detox beds in the ACT?

Ms Barry: As I said, it really does vary. I think we probably have sufficient detox beds, overall, but occasionally you will get a surge in demand or there will be a variation in the sort of demand, for the sort of detox, that people might be seeking. For example, we have at the moment four youth detox beds at the Ted Noffs Foundation and, so far, that has been about right, but if we had a surge of young people for some reason then that might not be enough briefly, but I think, overall, it is not too bad.

MS DUNDAS: You mentioned the methadone program, and I have a few questions about that. I understand that there are 800 registered clients at this point in time?

Ms Barry: There are 800 funded places.

MS DUNDAS: Are they all being utilised?

Ms Barry: No, they are not.

MS DUNDAS: Can you tell me a figure?

Ms Barry: It is just under 700, I think. It would be close to that.

MS DUNDAS: According to the documents, there is a target of 800 and the estimated outcome is 645, sorry.

Ms Yen: That, Ms Dundas, is a combination of the public methadone program and the GP and pharmacy supported places.

MS DUNDAS: Do you think both the GP program and the other program are successful? Are you having a high success rate?

Ms Barry: Do you mean in—

MS DUNDAS: In terms of people maintaining a drug-free status.

Ms Barry: What success is defined as varies quite significantly from client to client. Certainly, the fact that quite a large number of people in the ACT access the methadone program is a good sign. Certainly, you could say that for everybody who is currently on the methadone program, their other drug use would be significantly reduced. But you can't be certain that every individual will remain drug free throughout the course of their treatment and, because heroin dependency is a relapsing condition, sometimes people will go through different stages of capacity to adhere to the program.

Ms Yen: I think it would be well worth our while thinking about how we measure the effectiveness of the program, now that we have introduced bupramorphine as one of the pharmacotherapies, because that may create a different outcome for clients, it may be a more successful drug replacement for some clients and it may suit some people better. I think, at the same time, we also need to evaluate how effective it has been to make sure that all clients who are coming through the methadone program have access to case management so that they can begin to get access to counselling services and life rearranging services, I guess, to start getting people back into employment, back into good relationships with their families and so on.

MS DUNDAS: So you are starting to think about applying these forms of access?

Ms Yen: No, we are doing that now. I think it is a good research project and we need to think about how we do that. And we need to add to that, I think, the effectiveness of the diversion schemes from courts as well, which will also be affected by the availability of methadone or other opiate substitutes, I guess, as well as the higher level of counselling support for clients.

MS DUNDAS: Are evaluations undertaken at the moment?

Ms Yen: Evaluations are being undertaken. I think we probably could be doing better.

Ms Barry: There is also a great deal of national and international evidence about the benefits of methadone treatment for opiate dependent people. There is a lot of evidence to indicate that, from the time people actually commence on a pharmacotherapy program, the likelihood of a range of health and social problems occurring for them is greatly reduced. But, as Laurann says, it is most useful combined with a more holistic approach to people's lives. There is definitely also a suggestion that bupramorphine may be more suitable for some people who don't like methadone. Also, there may need to be less frequent dosing, which will enable people to have a better control over their lives.

MS DUNDAS: I want to go back to the evaluation. You currently do an evaluation, but you are looking at refining your evaluation program for a range of factors, as you have explained. What does your current evaluation tell you? Does it tell you that the program is successful? It is obviously telling you that you need to broaden what you are looking at in terms of success, but what is it telling you at the moment?

Ms Barry: Insofar as people can be followed up, and it is not always feasible to do that, it tells us that people who access the methadone program have better health, better stability and a lesser likelihood of getting a blood-borne virus, for example, or overdosing, than people who are using street heroin. But probably one of the most useful things that we are going to have over the next couple of years is we have recently had a national minimum data set for alcohol and drug services introduced in the ACT. At this point, it doesn't include methadone clients. The program started off fairly small, but it will expand and that will give us a much better way of tracking clients through the system and seeing how they go.

MS DUNDAS: Do you keep demographic data of those who are on the methadone program?

Ms Yen: I don't know, actually.

Ms Barry: We do keep basic, minimum data set information which would be around their residential address and their age and gender, and we would also keep clinical information on every client who came through, which would include specific health issues.

MS DUNDAS: I was wondering whether you had an analysis of who is using the program in a broad, non-private detail, kind of way.

Ms Yen: We have some and I could arrange to have what we are able to give you.

MS DUNDAS: That would be fantastic, thank you very much.

MR SMYTH: I wish to ask about the indigenous youth alcohol and drug project, which sounds wonderful. How many beds will there be and how many youths do you expect to assist?

Ms Barry: I think that we would be looking at probably a maximum of four beds for that figure, but that has not been finalised yet. We still have some negotiations to do with the indigenous community about the model.

MR SMYTH: Who will be providing that service?

Ms Barry: That is not finalised yet. It will be some sort of partnership between indigenous services and mainstream services.

MR SMYTH: At the end of class 1.3, I notice that the cost per 100,000 has gone down quite significantly. Has something been transferred or have you just worked out a better way of doing it? Have I missed something? Why has it dropped from $118 million to $95 million?

Dr Gregory: I'm sorry, Brendan, I just missed it. What was the question?

MR SMYTH: In the revised votes on page 160, the figure has dropped from $118 million a year to $95 million a year. What has moved out?

Dr Gregory: The disability program, I would suspect.

MR SMYTH: Although disabilities are still listed.

MS DUNDAS: But the footnote notes that it has gone to the new department.

THE CHAIR: They are last year's indicators.

MR SMYTH: They are last year's figures and disability has gone out to its own category.

Dr Gregory: Yes.

MS DUNDAS: All the other departments have footnoted when those administrative changes have taken place at the financial end as well as in the service end so that the poor plebs who are flipping through the budget papers have it quite clearly indicated to them where all the money has gone. It is not in the footnotes in this instance.

Dr Gregory: Yes, we footnoted it under 2, but not at that place. We will take that on board.

MR SMYTH: Are you game to talk in the last couple of minutes about respite care and what we will get for the extra $1 million? If you look at the measures for aged care and respite care, the number of bed nights seems to be the same. In terms of respite for disability it seems to be the same, and for mental health. Where do we find out what we will get for the $1 million?

Dr Gregory: It is not yet built into the targets here because the government's decision was $1 million across-the-board for respite services. Some of those will be in the disability area, some of them will be in mental health, some of them will be in aged care, and there is a needs-based process going on to determine where the greatest need is and whether it is institution-based respite care or home-based respite care. It won't be until the results of that are through that there will be a tender process to allocate those funds, so they aren't yet built in.

MR SMYTH: When would you expect that knowledge to be available?

Dr Gregory: At the end of the calendar year.

MS DUNDAS: I asked a similar question of Minister Wood under the new disability department; so, when the *Hansard* is available on that, there will be information there.

MR SMYTH: If it is to be done only by the end of the year, does that mean you probably wouldn't expect to spend the full $1 million this year?

Dr Gregory: Respite care is something that is a bit flexible and there may be extra this year than is able to be provided in an ongoing sense, but the aim would be not to have to carry any money over.

MR SMYTH: If you spend, say, $1 million in the second half of this year, does that mean then that you will need to increase the outyears by doubling them?

Dr Gregory: What I am saying is that it is flexible. It could be adjusted back down again. That is something that we would have to take on board when the results of that work are available.

MR SMYTH: I will put the rest on notice.

THE CHAIR: If there are no other questions on 1.3, we will move on to 1.4.

MS DUNDAS: The total cost in the public health service area came in at about $1.5 million under budget. Can you explain what happened to that money? Has it been rolled over, and why didn't you meet the target?

Mr Foster: Hepatitis C was $700,000 of it which has been returned to the budget. We have also deferred around $1 million in relation to immunisation money, vaccine money, that comes through the public health funding agreement, PHOFA. We have not had the need to buy those vaccines yet. However, we retained the money because it was provided for those purposes and it will be used next year for that. We have had an increase in SPPs in that group, specific purpose payments from the Commonwealth for the PHOFA agreement or other ones, a slight increase for that. While we went down by $1.7 million in deferrals or non-spending on hep C, we have actually had an increase in other SPPs and that explains the $1.5 million difference.

MS DUNDAS: There have been announcements over the last year about trying to curb the spread of chlamydia and STIs. What resources have been allocated to this and how is it going?

Dr Dugdale: There was an allocation to a chlamydia information campaign made in last year's budget. I don't have the actual figures with me, but it was in last year's budget papers. There has been a commencement of that campaign and there are posters up as we speak around various venues, including public toilets in the TAFE and shopping centres, that are just a preliminary to the chlamydia campaign. The problem we found was that nobody had actually heard of chlamydia, or very few people. I can have a poster sent to your office; you are welcome to display it for us.

MS DUNDAS: I would love to.

Dr Dugdale: It just shows people how to spell it, so it is "chlamydia", spelt three different ways with two of them crossed out, saying, "Chlamydia, hard to spell, easy to get."

MR SMYTH: Perhaps you should send one to every office in the Assembly.

Dr Dugdale: We will do that. This phase is just starting to raise awareness and people are thinking, "What's chlamydia?" The main phase of the campaign is being planned and a particular thing that we are looking at is screening of women for chlamydia when they have their pap smear, which is a logical time to get a sample.

With the incidence of chlamydia being possibly around 10 per cent and its usually being a silent infection, the traditional advice is to screen for it just in high risk people, that is, people who have symptoms or people who have had sex with a number of partners, but the thinking between myself and Professor Bowden, the professor of medicine, is that we should go for a general population screening amongst women up to the age of 40 who are sexually active and try to find that 10 per cent that we expect are out there.

As I say, we are in the planning phases of that campaign at the moment. We are just doing a prevalence survey at the moment. We are working with the GPs because this is, obviously, something that has to be coordinated between the public health people, the hospital people and the GPs. We expect to launch it later in the year.

MS DUNDAS: The money allocated in the last budget has just been rolled over to continue the campaign or to implement the campaign in this financial year?

Dr Dugdale: We have spent money this year in the preliminary phases, in research and the initial production of the posters. We had money allocated for the 2002-03 financial year for it within our general sexual health budget, so we are not short of resources for it.

MS DUNDAS: Fantastic. I want to ask about both breast screening and pap smears run by the department and contracted community organisations. How is the pathology service paid for? Who pays for the pathology services in both cases?

Dr Dugdale: For pap smears and for breast screening?

MS DUNDAS: And for those conducted, I guess, by both departmental health officers and community or contracted non-government health services.

Dr Dugdale: Okay. For the pap smears, it is paid for through the Medicare benefits scheme, where generally GPs take samples and they are sent usually to private providers but also ACT Pathology and it is paid for by the Commonwealth Medicare benefits scheme.

MS DUNDAS: That is if GPs do it, but what happens at community clinics where there might be nurses doing it as opposed to doctors?

Dr Dugdale: The numbers are quite small. I might ask ACT Community Care to answer that one.

MS DUNDAS: Sorry, I wasn't sure to ask it under public health or community health.

Ms Yen: The women's health doctors, the women's health service and some of the nursing staff do it in the women's health service. There are also the family planning services.

Mr Stanhope: Who does the pathology?

Ms Yen: ACT Pathology does the pathology for all pap smears in the ACT.

MS DUNDAS: With regard to the contracts with the community health clinics, do they include payment for pathology services if they are being done by nurses as opposed to doctors?

Dr Dugdale: If they are done by a nurse where there is a doctor on the premises, they are done under the supervision of the doctor and they attract a Medicare benefit, even if they are sent to ACT Pathology. If they are done by a nurse and it is not under the supervision of a doctor, it would just be paid for by ACT Pathology, but the numbers are very low where they are not done under medical supervision. Usually, we arrange medical supervision so we can claim the commonwealth benefit.

MR SMYTH: As you should.

Dr Dugdale: There are a few—for example, ones done in hospital—where they are part of the public hospital treatment. They are done by ACT Pathology and there is no Medicare benefit claimed. As I say, there are a few but they are quite small in number.

MS DUNDAS: And ACT Pathology just takes them on in their budget?

Dr Dugdale: Of those ones done in the public hospital or not done under medical supervision.

MS DUNDAS: And breast screening, again, is in a similar situation?

Dr Dugdale: No, breast screening is done through a breast screening program paid for through the PHOFA agreements done on contract between the department and ACT Community Care, so they are paid for through that government service.

MR SMYTH: Back to chlamydia, the health committee heard from, I think, The Junction that as a disease it is virtually unknown, particularly among young men. What will we do to spread the message that chlamydia is there, if it is affecting 10 per cent of women?

Dr Dugdale: First of all, it is a notifiable disease and, of the diseases that are notifiable in the ACT, it is the most common one. There were 427 notifications in 2001-02. That is only the tip of the iceberg.

MR SMYTH: How many of those were female?

Dr Dugdale: I don't have that breakdown with me, but the majority will be female. We have found low recognition, low understanding, about the disease. Of course, for young men it produces urethritis and they may get burning when they urinate, which often resolves, so it is not that serious for young men except that they will spread it. For young women, or for any women, it is probably the major cause of pelvic inflammatory disease and the major cause of infertility. We are planning the awareness campaign as well as a campaign to actually identify people who have got it and treat them.

We do have a contact tracing program at the moment so that if any cases are identified, and most of these are identified in women, we then trace their sexual partners and treat them. The treatment is dead simple. It is either a single dose of one antibiotic or a short course of another antibiotic. It is really a tragedy that people are walking around with untreated chlamydia.

MR SMYTH: I have seen some reports that say that STDs are on the rise, particularly among young women. Is that the experience of the ACT?

Dr Dugdale: I don't think so. We are seeing an increase in the reporting of chlamydia infections. I think that is because there is better case finding. The GPs and the gynaecologists are looking for it more and people themselves are going in and saying, "I am not just fronting for a PAP smear. I want to front for a sexual health check. Can you check me for STDs?" There is better case finding.

We use gonorrhoea as a bit of a marker of STD activity in the community and we had 16 notifications last financial year, 14 the year before, 20, 22 and 30 previously. We did have a bit of a special effort on gonorrhoea amongst the gay community in the ACT in response to a higher than expected number of notifications the year before last and we think that that has dropped back down now.

MR SMYTH: The immunisation rate has 90 per cent as the target. Where is the rest of Australia?

Dr Dugdale: Immunisation rates are a kind of science in themselves. We track about 10 different immunisation rates and we regularly put out press releases of the ones that we are the best on. I am being very frank here. I probably should play a bit more politics. Whenever my team says, "We're the best in the two-year-old scheduled completion rate and we want to put out a press release," I always check that we are looking pretty good across-the-board and in my experience in the ACT, which goes back five months last year plus six months this year, we have consistently been in the top third of Australia on any of the immunisation indicators.

MR SMYTH: On the timeliness of the response to outbreaks of communicable diseases, how many cases of meningococcal have we had in the ACT?

Dr Dugdale: We haven't had any outbreaks, we haven't had any clusters, so they have all been single cases as far as we can tell. The number was nine in 2001-02, compared to seven and five in the previous two years.

MS DUNDAS: In the health protection service, the number of samples analysed was about 1,000 below target for 2001-02 and the target has been revised to quite lower than the target set for last year. What is going on there?

Dr Dugdale: We analyse all samples that come to the lab. It is a demand driven service and we get samples. You can think of them in two main types, those that come in one by one and those that we get on contract. The target of 8,500 set for 2001-02, I suspect, was an optimistic assessment of contracts that they were going for. We compete with private labs for work, the main one being the analysis of cooling tower samples for Legionnaires and other water samples. I think that they were set with a reasonably optimistic contract tendering outcome. That kind of demand where we go out for and compete is user pays and, if we do less work, we bring in less money and it partly reflects the reduction in the total cost. It is not funded through government payment for outputs when we go for those contracts.

MS DUNDAS: The inspection of premises was also down by just under a thousand last financial year, but you have set the target at the same level as it was.

Dr Dugdale: Yes. That is driven by us where we license premises, food preparation businesses, air quality in places with smoking exemptions and so on. Basically, the outcome for 2001-02 is unacceptable to me as a manager. It is down. There are a number of reasons for that, particularly revolving around staffing difficulties, but we are aiming to do better next year.

THE CHAIR: If there are no further questions on public health services, we will draw down the curtain on today's proceedings.

Resolved:

> That the committee receive the documents presented so far this day and that, pursuant to standing order 243, the oral evidence and documents received at public hearing so far this day be authorised for publication.

The committee adjourned at 6.18 pm.