# LEGISLATIVE ASSEMBLY FOR THE AUSTRALIAN CAPITAL TERRITORY

## SELECT COMMITTEE ON ESTIMATES

**(Reference: Appropriation Bill 2003-04)**

**Members:**
**MR B SMYTH (The Chair)**
**MRS H CROSS (The Deputy Chair)**
**MRS V DUNNE**
**MR J HARGREAVES**
**MS K MacDONALD**

## TRANSCRIPT OF EVIDENCE

**CANBERRA**

**THURSDAY, 22 MAY 2003**

**Secretary to the committee:**
**Mr Derek Abbott (Ph: 6205 0199)**

**By authority of the Legislative Assembly for the Australian Capital Territory**

**The committee met at 9.08 am.**

Appearances:

Mr S Corbell, Minister for Health and Minister for Planning
Department of Health and Community Care
Dr M Alexander, Chief Executive, ACT Health
Ms S Killion, Executive Director, Policy and Planning
Mr R Foster, Director, Financial Management
Dr W Ramsey, acting General Manager, Canberra Hospital
Ms L Yen, General Manager, Community Care
Mr B Jacobs, General Manager, Mental Health ACT
Mr R Cusack, Chief Executive, Calvary Hospital
Mr A Schmidt, Executive Director, Corporate Services
Mr I Thompson, Director, Health Policy and Reform
Dr P Dugdale, Chief Health Officer

**THE CHAIR**: Good morning, Minister. I thank you and your staff for attending this sitting day of the Estimates Committee hearing on the 2003-04 budget.

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.

It will also assist the committee's staff and departmental officers if witnesses state clearly when a question is being taken on notice. It will also greatly assist in the preparation of the transcript if witnesses state their full name and the capacity in which they are appearing on the first occasion that they give evidence. Thank you for your cooperation on that. Minister, would you like to make an opening statement on behalf of the department of health?

**Mr Corbell**: Yes, please, Mr Chair. I will make a few brief opening comments. I'd like to highlight to members organisational and structural changes in the department of health since the last estimates process and also some changes of key personnel. In the first place, the government has announced the appointment of Dr Tony Sherborn as Chief Executive of ACT Health, effective from 2 June this year. This is a very important appointment for the government and for ACT Health, and it will certainly assist us in further driving the reform agenda.

Dr Sherborn is yet to start his appointment, and I'd like to place on the record my thanks to Dr Max Alexander, who is acting as chief executive in this period of time. His leadership and his effective coordination across the department has been most welcomed by me. I also place on the record my thanks for the long-term service of Dr Penny Gregory, who has acted as or has been chief executive of the department over an extended period.

I'll also address the budget for health. The 2003-04 budget delivers record expenditure on health in the ACT: $546 million in planned expenditure and a 7 per cent increase in government payments for outputs on the forward estimates. The key areas of focus for this budget are mental health and elective surgery. The government is committed to addressing the long-term neglect of mental health in the ACT, a neglect that places it at the bottom in terms of expenditure per head of population of any jurisdiction in the country.

On that basis, the government has allocated an additional $1.45 million for additional initiatives and incentives, and this on top of $2 million recurrent allocated in last year's budget. In addition to this, $2 million per year has been allocated for elective surgery over the next four years which, it is estimated, will result in an additional 600 patients per year receiving vital elective surgery that will improve their quality of life.

The government has also moved in this budget to address the significant gap in salary that exists between the ACT public service and comparable agencies, a situation perpetuated by the previous government, which delivered real wage decreases over their period of time in office. This budget provides full funding for wages and indexation to ACT Health.

This current financial year, which is coming to a close, has been a year of significant change for ACT Health. There is not only a new minister but also a range of important changes in financial reporting. Until December 2000 the organisation was three separate entities, under the Financial Management Act. The government has managed its transition to the new arrangement smoothly. More importantly, ACT Health has made significant strides to implement the recommendations of the Reid review, which was released in June 2002. Purchaser/provider has been disbanded, and key corporate functions are being centralised to maximise efficiency and effectiveness.

This process involves considerable change and upheaval in a department the size of ACT Health, and I want to record my appreciation of all the officers in ACT Health who have worked hard to make these new arrangements successful and progressed them in the period of time since Reid was brought down. It has been an important period, but the focus for the government is to improve health service delivery in the ACT.

Health service delivery is always difficult to fund and achieve, and there is always unmet need. The question of expenditure in health is a bit like asking: how long is a piece of string? There can never be enough. Our government's focus is on improving health service delivery, particularly in key and vital areas, to improve the quality of life of people—whether that's through elective surgery or shorter waiting times for dental services or mental health services. I'll close my opening comments there and ask Dr Max Alexander to make a few brief comments.

**Dr Alexander**: First, I wish to deal with the issue of the so-called "leaked memo". I want to place on the record for the *Hansard* my apologies for this incident. I speak for myself and all the other ACT Health executives who will appear before you when I say that we understand both the role of this committee and our rights and responsibilities before it.

The memo that was leaked to you, Mr Smyth, was not prepared by a member of the ACT Health executive. The document was never part of our formal considerations of or preparations for today's hearings. I fully appreciate that the document contained several inappropriate comments. It was never put before the Health executive for approval or endorsement.

The document has no status or legitimacy. It in no way reflects the approach taken by the ACT Health executive to the estimates process. We're very much aware of our responsibilities and obligations with regard to estimates and intend to fulfil those in the proper manner. There is not, nor has there ever been, any intention to disrupt the proper business of estimates.

The officers responsible for the production and dissemination of the paper recognise what has been a serious lack of judgment and have been counselled. Their actions have made the news but should not be allowed to besmirch the professionalism of the officers who appear before you today. I wish to assure you, Mr Chairman and members, that the answers provided to you today will be given in the same good faith and with the same rigour as in previous estimates hearings.

I also wish to give you a sense, from a management perspective, of where ACT Health is up to in its reform process. The Reid review's recommendations were announced in June 2002, as mentioned by the minister, and the administrator was placed in charge of the old ACT Health and Community Care. This arrangement lasted until December 2002, when the legislative and financial reforms repealing purchaser/provider arrangements took effect.

In April 2003, the appointment of Dr Sherborn as the next chief executive was announced, and I'm acting as chief executive until he arrives in early June. Committee members will appreciate that I've been in this position since April and have been in the ACT only since February. It is for this reason that I may seek to involve my executive colleagues in providing answers more than my predecessor may have felt necessary. I seek your forbearance.

To start with, I'll ask Susan Killion to present an erratum in the budget papers concerning the cost weight targets for the acute sector. This is important because it bears on the outputs of by far the largest portion of the Health budget: acute hospital services. If that's okay, I'll ask Susan to talk about that.

**THE CHAIR**: Before we move on to the erratum, we might address the issue of the budget estimates document and welcome Sue to the table. Max, you've just said officers were responsible for preparing it. How many officers were involved?

**Mr Corbell**: I don't think it's appropriate to look at exactly how many officers were involved. Indeed, I don't know how many officers were involved. I don't think it's relevant. What is relevant is that the document has no formal status. It was neither sought nor endorsed by me; nor was it sought or endorsed by officers in ACT Health management. The officers involved have been counselled about the paper. It is inappropriate, does not reflect the policy of this government and certainly does not reflect the approach of the department.

**THE CHAIR**: You might choose to answer in that way, but the question still stands. Dr Alexander, how many officers were involved in the preparation of the document?

**Mr Corbell**: Mr Smyth, it's not relevant, and I haven't sought that information. I don't see how it could be relevant to the Estimates Committee. The officers have been counselled. It does not reflect the views of this government or the department.

**THE CHAIR**: The question would then be: why don't you think it's relevant, Mr Corbell?

**Mr Corbell**: Because it was not produced in any formal policy sense. It was not a request from either me, as the minister, or Dr Alexander and his executive colleagues, in preparation for this Estimates Committee. It is a document produced by an officer without request. It is an inappropriate document which does not reflect the views of this department or of the government, and the officers involved have been counselled.

**THE CHAIR**: The question still stands: how many officers were involved?

**Mr Corbell**: It does not reflect the—

**THE CHAIR**: If there is to be any confidence in this process, let's get this whole question out of the way early and then we'll get on with looking at the numbers. How many officers were involved in it and, if they weren't members of the executive, at what level were they? I'm not interested in names. I'd like to know at what level the officers who prepared it were and how many were involved.

**Mr Corbell**: The officers involved have been counselled. The document does not represent the views of the government or of the department.

**MS MacDONALD**: Mr Smyth, I don't see that this needs to be turned into a witch-hunt, and I feel that's what you are trying to do now. I think it's totally inappropriate. I think we should be getting on with the process of reviewing the budget, which is our task.

**THE CHAIR**: Thank you for your comment, Ms MacDonald. Mr Corbell, the reason I pursue this is that this is page 1 of the document; it's numbered page 1. I want to put to rest any fears that still exist, and I have some doubts myself. I would like to know how many officers were involved and at what level they were. Indeed, can the committee be provided with page 2 or any subsequent pages of the document?

**Mr Corbell**: The document does not represent the views of the government or the department. The officers involved have been counselled.

**THE CHAIR**: Mr Corbell, the *Canberra Times* mentioned that official instructions were involved, and I would like you to clear this matter up. What were they? Who wrote them, and who authorised them?

**Mr Corbell**: There were no official instructions for these documents. The documents do not represent the views of the government or the department, and the officers have been counselled.

**THE CHAIR**: Minister, I find it curious that you haven't even asked how many people were involved. This is a very political document. One could even suggest that, if it wasn't the executive of the department, perhaps officers in your office assisted in the preparation of such a document. Was it prepared in your office?

**Mr Corbell**: No.

**THE CHAIR**: And you know that because you checked?

**Mr Corbell**: Yes.

**THE CHAIR**: You asked all the members of your staff whether they had a hand in this?

**Mr Corbell**: I know what my staff do, Mr Smyth. You may not, but I do.

**THE CHAIR**: So you haven't checked?

**Mr Corbell**: It's clear from discussions I have had with my staff that it was not produced in my office.

**THE CHAIR**: All right, if it wasn't produced in your office and you bothered to discuss it with your staff, why didn't you bother to ask the department how many officers were involved and at what level they were?

**Mr Corbell**: Responsibility for the management of the department is the responsibility of the chief executive. I have discussed the matter with the chief executive. The chief executive has assured me that the relevant officers have been counselled and that the document does not represent the views of the department—nor was it sought by the management of the department. I am satisfied of that. I have confidence in my chief executive, and the officers involved have been counselled.

**THE CHAIR**: Will you table subsequent pages of the document that aren't available?

**Mr Corbell**: I'm not aware that there are additional pages, and I don't believe that's relevant. The bottom line is that the document does not represent the views of the government or the department, and the officers involved have been counselled for their inappropriate behaviour.

**THE CHAIR**: Why didn't you find out if there were subsequent pages and what was contained in them?

**Mr Corbell**: Because it is not an official document. It does not represent the views of the government or the department.

**MR HARGREAVES**: Mr Chair, we've got that answer now about eight times and I really think—

**THE CHAIR**: I'm happy to keep going, Mr Hargreaves. I appreciate that you're protecting your Labor colleague, and that's fine.

**MR HARGREAVES**: We're not doing that at all, Mr Smyth. You've had ample time to explore this, and the minister has quite clearly said this is not a document which is owned or authorised by the government or is even part of its psyche—or that of the department. The executive has said exactly the same thing. It's a case of which part of no you don't understand. Can we please move on to the reason we're here? If you want to be political, go out there and do a press release on it.

**THE CHAIR**: Thank you for your input, Mr Hargreaves.

**MR HARGREAVES**: And the input hasn't finished yet, Mr Chair.

**THE CHAIR**: Mr Hargreaves, come to order. Mr Corbell, how can we have any confidence in the fact that it's not an official document when we don't know who produced it or at what level it was produced. The fact that you've asked no questions about it would indicate that either you're not interested or you don't care. Several members of the committee are quite interested in where the document came from and what's on the subsequent pages, and I would ask you to table any subsequent pages that might be available.

**Mr Corbell**: The document does not represent the views of the government or the department. It was not sought by me or the executive of the department; it was certainly not endorsed by me or the executive of the department. It does not represent the views of the government, and the officers involved have been counselled.

**MR HARGREAVES**: Perhaps, Mr Smyth, you could name the officer who gave it to you, or does that officer have coverage under whistleblower legislation?

**THE CHAIR**: Mrs Dunne has the floor.

**MR HARGREAVES**: Yes—you won't give it.

**MRS DUNNE**: My question is to Dr Alexander. It's been said here this morning that this document was not solicited by anyone in the executive. Having considerable experience in preparing for estimates in the Commonwealth and knowing what goes on in preparing departmental submissions for estimates, I ask how it came about that officers, or an officer, on their own initiative decided to come up with such a document?

**Mr Corbell**: The document, Mrs Dunne, was not sought by the executive of ACT Health or by me as minister. It does not have and will never have the endorsement of me as minister or of the senior executive of the department. It does not represent the views of the government or the department, and the officers involved have been counselled for their inappropriate behaviour.

**MRS DUNNE**: My question was to Dr Alexander.

**Mr Corbell**: I'm the responsible minister, and I'll answer questions on this matter.

**MRS DUNNE**: But you just said, Minister, that the administration of the department was the responsibility of the chief executive.

**Mr Corbell**: Indeed. I have to be satisfied that that administration has been conducted in a proper matter, and I am.

**MRS DUNNE**: I'd like to know how many man-hours went into the preparation of this document and what might accompany it. Given that the amount of time and effort that goes into the preparation of estimates briefs—

**MS MacDONALD**: Which is being wasted at the moment.

**MRS DUNNE**: Well, it was certainly wasted in the department by the creation of a document—

**MS MacDONALD**: It's being wasted at the moment by spending time on this.

**THE CHAIR**: No argument. Keep going, Mrs Dunne.

**MRS DUNNE**: There's a document here that some thought has gone into—perhaps not nearly enough. A large amount of work goes on in departments in the preparation of estimates briefs. How much time and effort was diverted from the preparation of estimates briefs for the preparation of this document?

**Mr Corbell**: The document does not represent the views of the government or the department. The document was not sought by or endorsed either by me, as minister, or the executive of the department, and the officers involved have been counselled for their inappropriate action.

**THE CHAIR**: Minister, if these aren't the official estimates preparations for the departments, were official instructions given for the preparation of guidelines for estimates by you or the department?

**Mr Corbell**: Officers in the department discussed, as officers always do, their preparation for estimates. They discussed that with me. This document was not sought by officers as part of that preparation; it was not sought by me as part of that preparation. The document does not represent the views of the government or the department, and the officers involved have been counselled for their actions.

**MR HARGREAVES**: It's going to be a long day.

**THE CHAIR**: I understand that; you've said it several times. Was a document that is the official preparation for estimates prepared?

**Mr Corbell**: The officers involved prepare working papers for their own reference. I have not sought or received any documents from the department for my own reference. I have my own working notes, and I have verbal briefings from the department to prepare me for hearings today.

**THE CHAIR**: All right. Minister, on page 130, BP 4, the expected outcome for the—

**Mr Corbell**: Mr Chair, with your forbearance, before that item Ms Killion wanted to provide for the record upfront an erratum to the budget papers. It is a formal erratum to the budget papers. I will ask her to table that so that we don't go into a line of questioning which is based on incorrect data.

**MRS DUNNE**: Mr Chairman, could I put on the record that this is the second day in a row that we've received an erratum at the time we're about to discuss the figures. This is an entirely unsatisfactory way of proceeding because we spend time preparing for estimates and going over things and then we're suddenly presented with changes.

**Mr Corbell**: I will ask Ms Killion to outline what the erratum is so that members understand its significance and then make judgments about whether it's had a big impact on preparation for the day.

**THE CHAIR**: I realise that. When did you first become aware that this erratum was needed, Minister?

**Mr Corbell**: Yesterday.

**THE CHAIR**: Only yesterday?

**Mr Corbell**: Yes.

**THE CHAIR**: When did the department become aware that the figures issued in the budget papers were incorrect?

**Mr Corbell**: Some time this week.

**THE CHAIR**: Why wasn't the erratum prepared earlier and distributed earlier so that we as a committee could have the full benefit of it?

**Mr Corbell**: It's a busy week for everyone. My apologies to the committee for not providing the data sooner. It's a relatively straightforward erratum. With your forbearance, I'll ask Ms Killion to outline what it is.

**Ms Killion**: My apologies for presenting this erratum. I draw your attention to Budget Paper 4, page 146. In output class 1 on the very top line under "measures", it gives numbers of inpatient cost- weighted separations. In the third column you need to replace 61,580 in the 2003-04 column with $63,714.

**THE CHAIR**: How did this erratum come about, and why were the figures published in the budget papers not correct?

**Mr Killion**: It was a mistake.

**THE CHAIR**: That is quite clear, but how did it come about?

**Ms Killion**: I believe it was a transforming mistake between what we provided and what actually got printed. That's my understanding of how it happened.

**THE CHAIR**: So the department provided the right figures, and the Treasurer's department or the printers got the wrong figures?

**Ms Killion**: I'm not quite sure where the mistake happened, Mr Smyth.

**MRS DUNNE**: Did you provide the figure of $63,714, Ms Killion? Did the health department provide this figure at any stage in the budget preparation?

**Ms Killion**: Yes.

**MRS DUNNE**: So this figure hasn't actually moved within the department of health since the budget was published?

**Ms Killion**: No.

**MRS DUNNE**: This is the figure that was there before the budget was published?

**Ms Killion**: This is the figure that was meant to be put in the budget papers.

**MRS DUNNE**: Okay. I would like an explanation as to how—

**Ms Killion**: I can actually explain. I'm happy to do that. I will continue because there is also a mistake in point (1) in the notes. The last sentence says that the target expressed as national public hospital weights is 61,700. That number should be 62,164. With your forbearance, I have another sheet of paper that can explain further why this mistake might have been made.

**MR HARGREAVES**: This actually improves the position, doesn't it?

**Mr Corbell**: It clarifies the position, Mr Hargreaves. It shows that there is an increase in the number of cost-weighted separations.

**MR HARGREAVES**: Greater throughput, you might want to say.

**Mr Corbell**: Yes, more throughput, Mr Hargreaves. That's correct.

**MR HARGREAVES**: Fancy that.

**THE CHAIR**: Ms Killion, did this come to light because of the question I put on notice?

**Ms Killion**: No, the chief executive picked up the discrepancy for us.

**THE CHAIR**: Chief executive, when did you pick up the discrepancy?

**Dr Alexander**: I can't name the exact time, but it was early this week when we were doing our preparation.

**THE CHAIR**: So, perhaps, when I put my question on notice, it prompted people to check what was happening inside the department.

**Dr Alexander**: I wasn't aware that you had a question on notice.

**Mr Corbell**: I think it occurred following a discussion I had with the chief executive as we prepared for budget earlier this week.

**MRS DUNNE**: Minister, you said that you found out about the need for the erratum yesterday.

**Mr Corbell**: Yes, I found out about the need for the erratum yesterday.

**MRS DUNNE**: What you said in the previous sentence indicated to me that you highlighted there was a problem with the budget papers earlier in the week.

**Mr Corbell**: No, I was discussing this output class and those figures with the chief executive earlier this week and it was raised in that discussion how they seemed not to be consistent with what we would normally expect.

**MRS DUNNE**: So you knew earlier in the week.

**Mr Corbell**: I'll just finish my answer. The department and the chief executive looked at that matter further and advised me yesterday that an erratum was required.

**THE CHAIR**: Given that there seem to be two sets of figures floating around, can we have the calculations on how this second set of figures was determined?

**Mr Corbell**: The explanatory note Ms Killion has circulated will assist in that, and I'll ask her to provide further detail.

**THE CHAIR**: I can see the explanatory notes. I'm asking how we now came to a figure of $63,714 instead of $62,230.

**Mr Corbell**: I'll ask Ms Killion to explain that to you.

**Ms Killion**: It's using different weights, Mr Smyth. What is explained here is that the ACT contract weights you see on the top line, which is what we used to use under purchaser/provider, have been changed to the national public weights, which is what other states and territories use. Each of those lines changes depending on the weight.

**THE CHAIR**: My question still stands. Can we have the breakdown of how the figure $63,714 was determined?

**Ms Killion**: Yes.

**THE CHAIR**: There are two figures floating around, and I'm tempted to go with the figures in the budget because that's issued by the Treasurer. Has this erratum been run past the Treasurer? Is this an official erratum issued by the Treasurer?

**Mr Corbell**: This is an official erratum issued by the department and will be issued for the purposes of audit.

**THE CHAIR**: Except that this is the Treasurer's document. Have you explained to the Treasurer why this is wrong?

**Mr Corbell**: I'm not sure what the process is. I don't know whether Mr Foster can clarify the situation. There would normally be a process to deal with this.

**Mr Foster**: I agree that it's the Treasurer's document. The decision to make the erratum was made late yesterday afternoon, and Treasury haven't been advised yet. They will be. The issue here is that an error was made at officer level within the department and the correct figure has been provided today that shows a growth in cost weights, which reflects the fact that money has been provided in the budget to buy extra cost weights.

**THE CHAIR**: We might move on.

**MRS DUNNE**: I have another question. Ms Killion, could you explain the difference, in layperson's terms, between ACT contract weights and national public weights?

**Ms Killion**: Yes. In brief, the contract weights that we used to use in the ACT were the national weights with some alterations made. We took out emergency department, we took out intensive care and we took out various aspects of the weights and treated them differently in the contracts. Because we don't have contracts any more and we have service agreements with the hospitals, we decided that the national public weights are really what should be used.

**MRS DUNNE**: Would it be possible, for comparison's sake, to backcast the previous two budgets and replace the ACT contract weights with the national public weights?

**Ms Killion**: Yes, it's possible.

**MRS DUNNE**: Could we do that, please?

**Mr Corbell**: Yes, I'm happy to provide that. It's important to note that this change, as Ms Killion points out, has come about as a result of the removal of purchaser/provider within the health portfolio. Under purchaser/provider these figures did not include emergency department and intensive care activity and a number of other more minor categories. We are now including those in this measure.

**MRS DUNNE**: So it isn't the case, as Mr Hargreaves said, that we're seeing more throughput; we're just seeing the categories rearranged.

**Mr Corbell**: I'm advised that there is an additional level of activity of approximately 1,500 cost weights.

**MRS DUNNE**: We need to be able to compare apples with apples.

**Mr Corbell**: We're happy to provide that information to you, Mrs Dunne.

**MRS DUNNE**: We need to have the backcasting of the national public weights so that we know what we're comparing.

**Mr Corbell**: I'm happy to provide comparative figures for the committee.

**MRS DUNNE**: Thank you.

**THE CHAIR**: We'll move to general questions now. Minister, I'd like to start with the blow-out in the budget of the department by almost $20 million this financial year. I notice that the operating result was expected to be $1.9 million in the black but ends up as $18,175,000—

**Mr Corbell**: Which page are you referring to?

**THE CHAIR**: Page 130, BP 4. It appears that we now have a deficit of $18,175,000. How has that been allowed to happen?

**Mr Corbell**: It's interesting that you make the assertion of a cost blow-out and at the same time suggest that the government's not spending enough on health. You can't have it both ways. Either we're not spending enough on health or we're spending too much.

**THE CHAIR**: You can have it both ways, Minister, because what you're not delivering is more services.

**Mr Corbell**: Mr Chairman, the reality is we are spending more on health. As to this particular accounting issue, I'll ask Mr Foster to address that.

**THE CHAIR**: I'll make another point before Mr Foster goes ahead. Nobody has objected to the fact that you've spent more money on health. We acknowledge that you have spent more money; you have just achieved less for the community with that money.

**MR HARGREAVES**: That's a contention and for the committee to report on; it is not for you to make comment on us.

**MRS CROSS**: Yes, that's a matter of conjecture.

**THE CHAIR**: Check your numbers.

**MR HARGREAVES**: That's just not on. You do it in the context of the estimates report, Mr Chairman. Don't represent my views, because they're not those.

**Mr Corbell**: Mr Smyth, tell that to the 600 additional people and their families who'll get elective surgery next year.

**THE CHAIR**: We'll see if they do.

**Mr Foster**: I guess it's important to understand what this table represents. The first column represents the agreed budget for 2002-03 for the department under the purchaser/provider model, and it didn't include the elements of the Canberra Hospital on ACT Community Care that operated the statutory authority. So you're missing elements in this operating result here to do with depreciation and movement in provisions for those two entities. I could refer you to the budget paper for 2002-03, and you would find in those documents that there were planned deficits for the Canberra Hospital and ACT

Community Care that weren't represented in this budget for the department. That's the first issue.

The second column represents transactions in relation to the restructure, where for the first six months of the year the Canberra Hospital and Community Care financials were reported, in their responsibility as statutory authorities under the Financial Management Act, directly to Treasury. This column here represents the department's estimated financial transactions for the 12 months, plus six months of activity for the Canberra Hospital and Community Care from 1 January through to 30 June this year.

The movement to a deficit of $18 million reflects those deficits that were planned for those two entities for that year. It also reflects the fact that there's been an accounting standard change in relation to the way provisions are calculated, such that we now have to recognise the impact on provisions of pay rises that we know are coming up rather than just those that have occurred.

There's been a multimillion dollar adjustment to the provisions figure and the balance sheet, which has to come through the operating statement. There are technical reasons why it's gone out to a $19 million budget blow-out. It hasn't been a budget blow-out in the context of increased costs for services as such. There have been technical adjustments, plus the fact that the statement represents the Canberra Hospital and Community Care activities bringing depreciation, movement and provisions for their normal activity into this department's accounts.

**THE CHAIR**: When I first looked at it, I made the same assumption: the restructure did it. That's the normal excuse an estimates committee would get. The restructure is a wonderful thing. The combined operating loss of all the agencies was only forecast to be $6.994 million in the current year. That still doesn't explain $18 million. You're saying the other $12 million is accounting standards.

**Mr Foster**: I will confirm the exact figure for the accounting standards in relation to provisions. In relation to the way funds came into the operating statement through government payment for outputs to buy things like equipment, equipment doesn't go through the operating statement on the expense side. The Canberra Hospital, in the course of 2002-03, has deferred some equipment purchases and used that cash on operating expenses.

**THE CHAIR**: You've transferred equipment purchase money.

**Mr Foster**: We have deferred some equipment purchases from this year, and the Canberra Hospital has required the cash from that to cover increased costs this year.

**THE CHAIR**: How much was transferred from purchasing equipment to operational costs?

**Mr Foster**: $2 million.

**MRS DUNNE**: So what wasn't purchased?

**Mr Foster**: I'll have to get the Canberra Hospital to answer that.

**THE CHAIR**: We might explore that later because I'd like to continue through this. That still doesn't account for $13 million. Are you confident that the $13 million is accounted for in changes to accounting standards? I'm certainly not.

**Mr Foster**: I will provide the detail on that this morning. I haven't got the exact reconciliation of that deficit, but I will provide that information.

**Mr Corbell**: To assist the committee we'll provide a detailed breakdown, and then you can see how that works.

**THE CHAIR**: The Canberra Hospital budget itself deteriorated by $3.8 million for the year. When was that brought to your attention, Minister?

**Dr Alexander**: Where are you referring to, Mr Smyth?

**THE CHAIR**: I don't have the reference with me, but the full year reports show that TCH and Community Care blew out by a total of $4.8 million.

**Mr Foster**: I presume we are looking at page 147, which reflects the Canberra Hospital's accounts. There's your figure: the $4.8 million.

**THE CHAIR**: Yes, there it is.

**Mr Foster**: This table excludes Mental Health, if you were trying to compare that $4.6 million original budget to the budget that was in the 2002-03 year. Moving from $4.6 million to $8.4 million reflects the equipment deferrals I mentioned, and there would also be an element of the provisions issue around the accounting standard. They were unaudited figures at that stage.

**THE CHAIR**: If that is the case, what is the logic in transferring cash for equipment into operational moneys, given that you don't have that as recurrent?

**Mr Corbell**: The government has sought to address a cost shortfall in the Canberra Hospital budget this year. The budget the Canberra Hospital has been running has put us under constant pressure for an extended number of years. It is one of the key issues the government has sought to address through its reform.

By removing purchaser/provider we are able as an agency and as a government to directly drill into the budget of the Canberra Hospital. The Canberra Hospital no longer reports to a board; it no longer has different accountability lines; it is part of the single agency. This gives the central area of the department much greater access to understanding what is going on in the finances of the Canberra Hospital.

I have been in ongoing dialogue with my officers about the cost of the operation of the Canberra Hospital. One of the steps taken by the previous minister was to defer the purchase of some equipment to address the cost shortfalls this year in the Canberra Hospital and keep the overall health budget within the appropriation provided by the Assembly.

**THE CHAIR**: At the same time, your revenues have gone up by something like $30 million and your expenses have blown out by $50 million. Is not the $20 million blow-out explained by the fact that you haven't been controlling your spending?

**Mr Corbell**: The management and finances of the Canberra Hospital are very complex. One of the reasons the government sought to implement the reforms and the removal of purchaser/provider was to allow the government to get much better control of expenditure at the Canberra Hospital. The Canberra Hospital is the single largest spender of the ACT Health budget and we need to address that, and we need to make sure the Canberra Hospital works within the budget it is provided.

It has been an unfortunate legacy of governments of all political persuasions that additional appropriations have gone the Canberra Hospital's way whenever there has been additional cost. We are seeking to establish a new framework where the hospital will work within its appropriation. As part of managing the issue this year, the previous minister took the decision to defer some equipment purchases to deal with the cost overruns this financial year. That will allow us to work within the budget as much as we can this financial year and ensure that for the coming financial year we will be working from a better base in terms of overall funding for the Canberra Hospital.

**THE CHAIR**: You mentioned cost overruns. How much were the overruns?

**Mr Corbell**: I'll ask Mr Foster or perhaps Dr Ramsey to clarify that.

**Mr Foster**: I'll make a comment on your statement of revenues going up $30 million. A lot of that is in relation to the restructure of the organisation, where we're now reflecting the Canberra Hospital's patient revenues, facility fees and meals and accommodation. That increase in revenue, represented on page 130, is largely related to budgeted revenue that appeared in the 2002-03 budget papers for those entities.

The Canberra Hospital has had overruns in this financial year. These have been addressed by increased revenues collected by the Canberra Hospital—they'd expected to get a certain level of user charges and they're collecting a higher level; the equipment adjustments, as I mentioned; and the fact that we were able in the department to provide them with additional funding, which was the balance of the growth funds identified in last year's budget process.

**THE CHAIR**: So all the growth funds are now committed?

**Mr Foster**: In 2002-03 we identified to the estimates committee how the growth funds were spent. We identified that there was a $620,000 figure, which we hadn't distributed at that time, for acute services. All those funds were provided to Canberra Hospital subsequent to the production of last year's budget papers, as we've identified in this last process.

All the growth funds for last year were allocated through 2002-03 where they hadn't already been allocated. The quantum of the Canberra Hospital's projected overspend is not yet finalised—as the year's not completed—but issues were raised through the year that required certain actions, which included the decision to defer equipment and the

need for the Canberra Hospital to look at cost-cutting measures. Dr Ramsey might be able to advise on the actual level of the overspend.

**THE CHAIR**: You don't have that answer?

**Mr Foster**: I don't.

**Dr Ramsey**: Wayne Ramsey, Acting General Manager, the Canberra Hospital. As the minister indicated, the Canberra Hospital is under budget pressure, but there's also a very clear expectation that the hospital will manage within budget and also manage the demand of activity that's been occurring. That, from a hospital management perspective, is always a very fine and difficult balancing act.

There have been some unexpected pressures on our activity, which have been reflected in the budget this financial year. There are two clear areas of adverse impact, which the government has addressed by way of additional allocation for the financial year 2003-04: growth in requirement for orthopaedic and neurosurgical implants.

Implants are one-off items and are very expensive, and there's been an unexpected and an unusual growth in demand for those particular implants for urgent and non-elective procedures. We identified this problem early in the budget year just gone, but it was a matter of managing that demand and living within a budget. Within a six-month period, demand for these implants caused us a budget blow-out of nearly $1 million. We then had to consider how to manage the other component of implants—the elective component. TCH did that by reducing the throughput of elective procedures and working within the existing guidelines on urgency so that urgent procedures were still performed.

It's important for us to understand, as we talk about that particular issue, what services the Canberra Hospital should be providing and what's more appropriately provided in other hospitals, in particular Calvary Hospital. I see Canberra Hospital as being the acute care tertiary level facility. Its responsibility is to look after the most urgent, serious and complex patients, and it's more appropriate that elective procedures are provided where it's better for those procedures to be provided.

**THE CHAIR**: Doctor Ramsey, the question was: what are the overruns this year—what's the blow-out on the hospital this financial year?

**Dr Ramsey**: Where cost pressures occurred previously, and did occur again, was in the area of pharmaceuticals. Pharmaceutical demand is always a significant driver of cost and that pressure occurred again. The pharmaceutical drugs that are required for medical oncology are very expensive, and the cost drive on those drugs, because of the unexpected increase in demand in that particular area, wasn't factored into our budget. So a second area was in pharmaceuticals.

**THE CHAIR**: Thank you for the reason why. How much did you blow out?

**Dr Ramsey**: I'll take the exact figure on notice.

**THE CHAIR**: You don't have that number with you now?

**Mr Corbell**: We'll endeavour to get it to you later in the hearing this morning.

**THE CHAIR**: The question was whether Dr Ramsey has the number with him.

**Mr Corbell**: He just doesn't have it to hand; he'll take it on notice and give it to the committee shortly.

**MRS CROSS**: Minister, I have some questions for you, but I want to welcome Dr Alexander to Canberra. I congratulate you on your appointment and hope your transition is smooth.

**Mr Corbell**: He's having a great time this morning.

**MRS CROSS**: I wish you well.

**Dr Alexander**: Thank you.

**MRS CROSS**: Minister, I refer to your explanation in the statement of financial performance on page 134, BP 4. Could you explain for me why you say in the first paragraph that nurses' wage increases were "fully funded" and in the second paragraph that there were nursing wage increases of $1.292 million. You can't have it fully funded and then say you've got nursing wage increases. There's a contradiction there, so could someone explain that to me?

**Mr Foster**: The first paragraph refers to the movement from the original budget to the outcome for 2002-03. There was no requirement for more money in the course of 2002-03 because of the timing of pay rises. Based on the pay outcomes of the nursing agreements, there's a financial impact in 2003-04, which is represented there. It's in relation to two different financial years. The statement in the first one about "fully funded" relates to 2002-03.

**MRS CROSS**: Okay. I'll direct this through the minister. Could you explain what you mean by indexation in the second paragraph? You've got $6.685 million, which is a lot of money. Why was it not allowed for in the previous budget? Have you allowed for it in the upcoming budget, and would you show me where in the budget papers you have allowed for it?

**Mr Corbell**: I'll ask Mr Foster to answer that.

**Mr Foster**: Indexation relates to the non-labour costs of the organisation, and the $6.6 million represents the 2.25 per cent that was agreed by Treasury. This explanation here is moving from the estimated outcome to the 2003-04 budget. That money was allowed for in the forward estimates. That would be an explanation of forward estimates to the 2003-04 budget, whereas this is an explanation of moving from an estimated outcome for 2002-03 to the level of expenditure in 2003-04, so it's a valid explanation for that movement.

**MRS CROSS**: Minister, I hope you can answer this one. Could you explain what you mean by "growth funds"? $7.963 million is a large amount of money. Isn't this the term for the same thing your leader, Mr Stanhope, described as a "slush fund" when it was used by the previous government?

**Mr Corbell**: No. All departments usually receive a level of appropriation for growth in activity in areas of demand, whether it's disability, health or other government services. These growth funds are to meet increased levels of activity, which can be a natural consequence of providing the service. These are growth funds, which are identified to be spent in particular ways. Mr Foster may be able to provide further information on that.

The issue for the government is that we have to make sure there is provision for growth, because we know growth will occur, taking account of where we believe it's most likely to occur and therefore how much it will cost. That was the process for this budget.

**MRS CROSS**: Could you then explain to me why you have "new budget initiatives" that include mental health growth of $1.45 million, renal growth of $300,000 and price pressures of $980,000. Aren't these just specific examples of where you failed to budget properly and allowed overexpenditure?

**Mr Corbell**: No, they are not. As Dr Ramsey said earlier, some price pressures are extremely difficult to anticipate. For example, this year we've had a significant increase in the amount of unplanned but urgent surgery as a result of trauma cases. We can't predict how many road accidents or other serious incidents will occur and therefore how many people will need surgery. But we have seen an increase in trauma cases and in the amount of emergency and unscheduled surgery, and that brings a cost.

Equally, demand for services such as medical oncology and the drugs that go with that cannot necessarily be anticipated. It wasn't able to be anticipated this year. We didn't know there was going to be a significant increase in the number of people seeking that service and therefore the drugs that go with that service.

**MRS CROSS**: There are lots of unanticipated things here, aren't there?

**Mr Corbell**: If you can tell me, Mrs Cross, how we can anticipate and plan for how many people will need cancer services this year, you'll do very well outside this place.

**THE CHAIR**: Minister, the growth funds were allocated last year. Are the programs that were funded in the current financial year recurrent?

**Mr Corbell**: Sorry, I missed your question, Mr Smyth.

**THE CHAIR**: You had a figure for growth funds in this year's budget that is similar to the one in the coming year. They were all allocated. Are the programs that were allocated in last year's growth funds recurrent?

**Mr Corbell**: Yes.

**THE CHAIR**: So is the money noted as growth funds in this year's budget new money or the same money?

**Mr Foster**: New money.

**THE CHAIR**: There's additional money. It's another pot of money called growth funds?

**Mr Foster**: Yes.

**MR HARGREAVES**: I think we'll give the hospitals a bit of a breather for a second.

**Mr Corbell**: They thrive under pressure.

**MR HARGREAVES**: I'd like to ask some questions about adult dental services. I'm aware, from my connection with health in the past, how difficult the dental services division is. I detect here not only an allocation of a fair amount of money but also a significant change in the way service is going to be delivered. I'd be interested in knowing what sort of throughput changes you anticipate for that and what fundamental change to service delivery will be made. Also, is there any involvement of Commonwealth funds in this issue?

**Ms Yen**: Are you talking, Mr Hargreaves, about what we're hoping to do in the next year or in this current year?

**MR HARGREAVES**: I'm talking about the extra $500,000 that is there but, if you want to tell me about how we're going to be doing it, we have to relate it back. There seems to be a shift. In the explanation it says that the idea is to go away from the concentration on emergency services and into long-term checking—a bit more prevention and that kind of thing. I don't have a full handle on how you can do that.

**Ms Yen**: Which page are you on, Mr Hargreaves?

**MR HARGREAVES**: Page 150, Budget Paper 3. That's just a good starting point.

**Ms Yen**: In the current calendar year an additional $150,000 has been put into dental services, over and above last year's targeted budget.

**MR HARGREAVES**: Was that ACT funded or Commonwealth funded?

**Ms Yen**: It was ACT funded. Those funds were expended in two ways. The first was reducing the waiting list for dentures, particularly for people needing full dentures as a matter of urgency. With the reduction in funding in the previous year the waiting list for people needing new dentures had actually expanded.

In the current financial year we have been able to bring that waiting list back down to something which the dental officer is confident meets best practice around Australia and is certainly a good benchmark against any other service. People who are in urgent need of dentures will be able to book into that so that an appointment can be made for them. People requiring replacement dentures over a period of time may still need to wait, but we don't think this is an unreasonable bench.

We were also able to pursue a change in the way that we ask private dental services to provide some of the dental care for people on the adult waiting list—the restorative waiting list. We agreed that we would contract out an additional hundred full cases of care to private dental practitioners in Canberra. You may be aware that private dental practitioners had to a large extent withdrawn from providing services to our clients, and we've spent quite a lot of time renegotiating the relationships and changing the way we're providing that contract to private dental services.

The major change there is that, instead of the dental program doing the first assessment and then referring out, we're doing a pilot of referring straight out to those dentists and the dentists then providing a plan for the program of care, which we would then approve. The dentist would carry it out and we would then fund the dentist for the work that was actually done.

We've put a cap on that so that we're not just letting the funds run unmanageably into the other services. So far, we've contracted out 50 people, and we've got 50 more who will come in this calendar year. This will give us the information we need about whether the appropriateness of care that's been provided is what we're expecting and whether the quality of care is right and the funding for that care is right.

**MR HARGREAVES**: Are the access points for people receiving adult dental care in all town centres or just in the city?

**Ms Yen**: No, the two public dental services for adults are at Civic, in the Moore Street building, and at Phillip. Children receive care at Tuggeranong and Belconnen. The private dental practitioners are wherever clients have a private dental practitioner.

**MR HARGREAVES**: The poor old Tuggeranong people have to travel all the way—yet again.

**Ms Yen**: No, the Tuggeranong children are in brand new premises.

**MR HARGREAVES**: It's a shame. We'll lobby the minister on that a little later.

**Mr Corbell**: As you know, there are excellent children's dental services in Tuggeranong.

**MR HARGREAVES**: There was at one stage a fairly significant involvement of Commonwealth funds in the adult dental service. That disappeared some time ago. Is it still the case that there is little contribution from the Commonwealth to these services?

**Mr Corbell**: I'll stand corrected by my officers but, as I understand it, the Commonwealth no longer provides support. Without being too partisan, the previous Labor federal government did provide important funding. That was cut by the Howard government in its first budget and it has remained singularly lacking since then.

**MR HARGREAVES**: Has that subject ever been raised in health ministers' discussions?

**Mr Corbell**: It has been raised from time to time. The difficulty we have at the moment, as all members will appreciate, is that the Commonwealth ain't in a negotiating mood. To follow up on that, Mr Hargreaves, I'm also advised that a national oral health strategy is being prepared at this time at officer level in all jurisdictions.

**MRS DUNNE**: I would like to go back to the initiatives, particularly two initiatives that appear on page 151. The need for them has already been touched on this morning by Dr Ramsey. These initiatives—I might be prepared to say "supposed" initiatives—are to cover the cost of pharmaceutical growth. I presume that's mainly oncology and pharmaceuticals.

**Dr Ramsey**: Yes, it is.

**MRS DUNNE**: And the cost of surgical implants. Minister, can you to explain to the committee how upping the budget appropriation for these items is an initiative rather than just continued funding?

**Mr Corbell**: It's new money from the government, so it's a new initiative.

**MRS DUNNE**: But you aren't suddenly funding pharmaceutics or surgical implants. We have been providing pharmaceuticals and surgical implants since Adam was a boy. So what's the added initiative?

**Mr Corbell**: It's new money.

**MRS DUNNE**: You're saying that, because you've increased the money, that makes it an initiative?

**Mr Corbell**: Well, we can have an argument about semantics if you like, Mrs Dunne.

**MRS DUNNE**: No, I don't like, actually.

**Mr Corbell**: The bottom line is that the government is spending more in these areas.

**MRS DUNNE**: It seems you are creating a virtue of necessity. Dr Ramsey said before that in the first six months of this financial year there was a million dollar blow-out in the implants budget.

**MS MacDONALD**: Is that right, Dr Ramsey?

**Dr Ramsey**: It was of that order.

**MRS DUNNE**: It was of that order, but in this initiative you are providing a quarter of that amount for the next year, so you are still actually not meeting demand. It would seem that you are not meeting demand.

**Mr Corbell**: That's not strictly the case. There is a range of measures that the hospital can take to better manage the cost of surgical implants.

**MRS DUNNE**: Like rationing?

**Mr Corbell**: A waiting list is a ration, Mrs Dunne. The reality is that all health services are rationed based on need. Otherwise, you'd never have enough money to provide health services, which is a general philosophy we all need to understand. I'll ask Dr Ramsey to address how costs and surgical implants can and will be addressed this coming year.

**Dr Ramsey**: There are other methods of dealing with this problem—and we have dealt with it. Because of the increase in demand for these somewhat unique instruments, we undertook a more formal and rigid structured tender process because we now see this is going to be an ongoing issue for us. We went to the market through a tender process so that we can better manage the purchase and the maintenance of these implants.

**MRS DUNNE**: Are you saying that you got a better purchasing regime so are actually getting more implants for your money?

**Dr Ramsey**: That's right.

**MRS DUNNE**: That's one of the measures. You said, when you spoke before, that there had been a blow-out of about $1 million in the first six months and that you were managing that with a range of means, including elective surgery. Does that mean that there were people needing, for instance, hip replacements who weren't getting them?

**Dr Ramsey**: That's right.

**MRS DUNNE**: How many?

**Dr Ramsey**: I can't tell you the exact number.

**MRS DUNNE**: I'd like to know.

**Mr Corbell**: You can take that on notice, Mrs Dunne.

**MRS DUNNE**: I'll take that on notice, thank you.

**Mr Corbell**: This is not a new issue, though. You'll be aware of the planned closure of surgeries at the Calvary Hospital. Mr Smyth has commented on this on a number of occasions. That did indeed result in more people waiting longer. That's one of the reasons the government is injecting additional money into elective surgery and improving elective surgery provision by an additional 600 or so people per year.

**MRS DUNNE**: Because you ran it down by more than that last year.

**Mr Corbell**: It will spend $8 million extra over the next four years on elective surgery.

**THE CHAIR**: But that won't go anywhere near covering what was taken out of the Calvary budget, will it?

**Mr Corbell**: I will refute the point that it was taken out of it, and I am happy to do it now, Mr Smyth. The reality is that there was a one-off payment from the Commonwealth to the ACT for signing up early to the previous Australian Health Care Agreement. That funding was a one-off payment, which ran out last financial year. The previous government made no provision for that in its forward estimates; it simply relied on the fact that it was going to run out after the next election and made no additional provision.

This government has had to step in and make additional provision, but our pockets are not as deep as the Commonwealth's, and we have made the significant provision of an additional $8 million over the next four years, which will see an extra 600 Canberrans receive elective surgery on average every year for the next four years.

The focus is on category 2 and category 3 patients, where we do not perform as well as I would like to see the territory perform. We perform extremely well in category 1—people who should wait no more than 30 days for surgery. Hardly ever does someone who has to wait no more than 30 days for surgery wait more than 30 days for surgery. But there are issues for category 2 and category 3, and the government is addressing them—in a sustainable way rather than relying on the one-off largesse of the Commonwealth. The territory did not take any money out of the budget; the money that ran out was part of a one-off Commonwealth grant.

**THE CHAIR**: I'm sure we'll get to the waiting lists in a minute.

**MRS DUNNE**: I still want to pursue the issue that was in 11a and in 11b for a document that has no status in the department. Dr Ramsey, was the blow-out of about $1 million in the first six months of this financial year the result of the cutback in elective surgery in Calvary, where a lot of orthopaedic surgery that had been done in the past wasn't done this year? Were you experiencing cost blow-outs in implants because the people who would normally have it done in Calvary needed to go to Canberra?

**Dr Ramsey**: No, we weren't.

**MRS DUNNE**: So there was no relationship between—

**Dr Ramsey**: There was absolutely no relationship between the waiting list for elective surgery at Calvary and elective surgery at the Canberra Hospital.

**MRS DUNNE**: With your indulgence, Mr Chair, I will go on to the other item of a similar nature, which is the cost of pharmaceuticals. When you spoke before about this, you said at one stage that it wasn't unforeseen. Later you said the amount of the blow-out in oncology pharmaceuticals was unforeseen.

**Dr Ramsey**: The quantum was unforeseen.

**MRS DUNNE**: What was the quantum that made it so unforeseen?

**Dr Ramsey**: We were expecting an increase in drug cost for this financial year of $3.71 million. In fact, it was $0.742 million in a six-month period. We had budgeted for growth in expenditure in that area, but the quantum of growth was unforecast. In

percentage terms it was greater than what we had expected and what we had experienced in previous years. There are a small number of particular drugs that are driving this.

**MRS DUNNE**: What were the factors—an increase in the cost of the drugs or an increase in the amount of demand?

**Dr Ramsey**: It's both an increase in the costs of the drugs—and there have been significant increases in those costs—and an increase in demand for particular drugs.

**MRS DUNNE**: Is this a change in practice? Is there a suite of drugs that are becoming more popularly used by oncologists for the treatment of conditions?

**Dr Ramsey**: That's correct.

**MRS DUNNE**: Do you have an upswing in the number of oncology patients?

**Dr Ramsey**: There is growth in medical oncology services.

**MRS DUNNE**: I would never have said that myself. By what numbers?

**Mr Corbell**: I'm advised, Mrs Dunne, that this figure does mostly relate to the cost of the service rather than growth in the number of patients. There is, nevertheless, some movement in the number of patients, but it's mostly, I'm advised, about cost. Another factor the committee should bear in mind is that a lot of these drugs have to be purchased from overseas, so there is the exchange rate issue. As members will be aware, the exchange rate has varied quite a bit this year due to international circumstances and that has had an impact also on cost.

**MRS DUNNE**: Could you take on notice then, Dr Ramsey, to provide the committee with some indication of how the costs have moved in those drugs?

**Dr Ramsey**: I can provide that advice now, if you like. In 1998-99 we dispensed 96,777 of the cytotoxic drugs and the expenditure was $1.024 million. In 2001-02 we dispensed 195,000. So there's a more than 100 per cent increase in the number of these drugs dispensed and an expenditure of $1.9 million. Our estimation is that in 2002-03 that will increase by another $400,000.

It's the order of magnitude that I can demonstrate of the number of drugs that are dispensed for these particular services. It reflects the complex nature of managing medical oncology patients and of that particular service, where it's now been identified that it's not just one drug that's the golden bullet; it's a combination of drugs that can provide incremental improvement in the management of cancer patients.

**MRS DUNNE**: What was that figure you were anticipating the demand for these drugs will increase by?

**Dr Ramsey**: $400,000.

**MRS DUNNE**: But there's only $250,000 in the budget, so where does the rest of the money come from?

**Dr Ramsey**: The $250,000 is additional. We factor growth in this area into our own internal budget anyway.

**MRS DUNNE**: Is that part of the growth fund?

**Dr Ramsey**: No.

**MRS DUNNE**: Sorry, I hate to labour this, but where are you getting the extra $400,000 from if not from the initiatives that are outlined on page 151?

**Dr Ramsey**: Part of the budget process in the hospital is internal re-allocation as well. Some services are contracting, some services are growing and in some areas we're more productive. It's a matter of how we manage the money that's been allocated to us as well. There are different ways in our budget process of internally managing resources.

**MS MacDONALD**: Minister, I'd like to congratulate you on the number of initiatives that you've taken within Mental Health, which is where I'd like to direct my attention now. It is important to note that these initiatives have been undertaken. Mental Health is a black hole area, and I believe it always will be, but it is important that this area has been addressed. I congratulate the government on taking the initiative to do so. Any criticism in future about there not being enough money will, of course, have to be taken on the chin as well.

As one of the members of the Health Committee of the Assembly, I had a briefing from Mental Health last year and, as a result of that, the Health Committee went on a tour of mental health services. I'm interested to see what things have been added onto from that and how things have changed.

I'd like to start by turning to page 148 in Budget Paper 3, where we're talking about the Calvary link. I don't know if Mr Robert Cusack needs to be at the table as well to talk about this, but can you outline what will be involved with that early link program?

**Mr Jacobs**: This position has been put in place as a result of previous recommendations for accreditation of the mental health service at Calvary. The position provides a link between the rest of the hospital and 2N, the public psychiatry beds, and facilitates client movements in an out of those beds as well as a link between 2N and other areas of Calvary Hospital providing mental health advice. It also links with the crisis assessment treatment team where needed.

**MS MacDONALD**: Is that the team that's based over in Woden?

**Mr Jacobs**: Yes, that's right.

**MS MacDONALD**: I noted that it's the early assessments. Will those be done on people who are presenting with symptoms?

**Mr Jacobs**: At Calvary ED—that type of thing.

**MS MacDONALD**: So, they'd be first time, not ongoing.

**Mr Jacobs**: Some of them may actually be previous clients of the service, and some may be new to the service.

**Mr Corbell**: There's certainly an increase, Ms MacDonald, in the number of presentations through ED, the emergency department at Calvary. That's probably the result of the increasing level of service being sought by residents on the north side through the emergency department at Calvary. Mr Cusack might have more detail.

**Mr Cusack**: There has been significant growth in the emergency department at Calvary. It's a combination of things: growth in the population, limited access to GPs, virtually no after-hours service and, being price sensitive, limited or no access to bulk-billing.

It is certainly the emergency department where the bulk of these presentations are but, as Mr Jacobs indicated, there may also be patients in the hospital for other conditions who became co-morbidities. It serves to fill that need as well as dealing with the specific mental health unit in the hospital. It's a combination of those three.

**THE CHAIR**: What do you expect that to grow by this year? Do I remember you saying last year that emergency services were growing by 17 per cent?

**Mr Cusack**: No, not at that rate. We expected it to grow by about 7 per cent.

**THE CHAIR**: Seven?

**Mr Cusack**: The $420,000 funding that's been provided by government this year is predicated on the 7 per cent growth of emergency services.

**MS MacDONALD**: On page 148, it says, "The program will support provision of a 'seamless' service for mental health clients at Calvary." Can you explain that statement?

**Mr Cusack**: We didn't want to have a disjointed arrangement. Previously, people might have needed to access the crisis assessment team or another mental health practitioner, whereas these services, if they are on the ground, can be facilitated by someone who can make sure that people don't have to wait to see another practitioner. We've had somebody in that role, with funding that's been temporarily allocated to it, for some time, and it's been enormously successful. This is to make sure that there's ongoing recurrent funding for that position. Do you have anything to add?

**Mr Jacobs**: No.

**MS MacDONALD**: I look forward to seeing the results of that. That's good. I'm also interested in the supported accommodation, on page 149. I take it that's specifically for people with mental health issues.

**Mr Jacobs**: Yes, it is. As a result of the Patterson review and a suggestion from Kerrie La Roche and Rod Mann, it was clear that some beds were being tied up in the acute psychiatry unit at TCH—the PSU—by people who could, with appropriate support, be out in less restrictive accommodation in the community.

It was recommended to provide a range of step-down beds where people can be discharged and supported. It was also suggested that it might stop some people from coming into the PSU because it would be a less restrictive option for them. We're presently negotiating with a few bed place providers about how to provide that coverage.

**MS MacDONALD**: You might want to explain "PSU" for the hearing today.

**Mr Jacobs**: The Psychiatry Services Unit. It's the acute psychiatry unit. It takes the involuntary admissions for the territory.

**MS MacDONALD**: It seems to me that, from everything I've been hearing and from my own experience, it's an area that will continue to grow in terms of the possibility of keeping people out of the PSU. Do you envisage that this will be an area of growth? I note there is provision for growth within the budget allocations in the outyears.

**Mr Jacobs**: It's been estimated that at any one time three to five people could be in this type of accommodation in the PSU. I do expect that their numbers will grow. To estimate the numbers will depend on the success of this type of program, but we're anticipating it'll be very useful in other jurisdictions. When I speak to Bev Raphael about this type of thing, she thinks these programs are quite effective around New South Wales.

**MS MacDONALD**: How will it operate in practice?

**Mr Jacobs**: At this point in time we're negotiating with a couple of people who provide services for us at present. How it will operate will depend on what we can do in terms of the deals with those providers. I need to say at this point that they're looking fruitful, but how it ends up being will depend on what we can buy for the dollar.

**MRS DUNNE**: How many beds does this provide?

**Mr Jacobs**: We are looking at a combination of purchasing beds from current providers and buying outreach workers from them who will support people in their own accommodation—that type of thing.

**MS MacDONALD**: Yes. It says here in their own home as well as other places.

**MRS DUNNE**: How many beds would you envisage?

**Mr Corbell**: It's still a process of negotiation. The exact mix will depend on the extent to which beds can be purchased through existing bed providers and the extent to which people can be supported in their own beds in their own homes.

**MRS DUNNE**: Minister, is this another initiative that is really still in the developmental stage? This is the first time I've said this today, but it's been said before: there are initiatives in the budget which really boil down to thinking it's a good idea and putting some money there but not being quite sure how it will work in practice.

**Mr Corbell**: We know how it will work in practice, Mrs Dunne. Mr Roberts has explained that. The issue is working out the exact details of how many beds we will provide. We would all agree that in many circumstances it is desirable to provide support for people in their own homes. Equally, there are some clients whose mental health issues are best served by having some form of supported accommodation provided by a service provider.

These are the issues that will be worked through in discussions. It's not a case of having not thought it through; it's simply a case of the implementation now being developed. Given that, it's not even the commencement of the new financial year.

**Ms MacDONALD**: I'm sure that it will take quite a bit of time to negotiate it through. Moving away from acute services to supportive services, which we're talking about here, is a fairly radical shift, isn't it?

**Mr Jacobs**: We do buy a number of beds with providers in the community now. We also buy a number of outreach services that support people in their own accommodation. We're looking at building on this with more of a step-down function in mind. I need to say that the talks thus far have been positive but, until we do the deal, we haven't got it in place and the dollars won't be available until next financial year, anyway.

**MS MacDONALD**: What sort of timeframe do you think it will be?

**Mr Jacobs**: We're talking with them now, so we can try to have it operational from July 1.

**THE CHAIR**: Is this being done at the expense of the acute services? I notice they're dropping from 1,500 occasions to 1,400.

**Mr Corbell**: No, this is additional money. There's no reduction in payment.

**THE CHAIR**: Why then the drop in the provision of acute services?

**Mr Jacobs**: The numbers in the acute service areas relate to the raw separations or throughput. One of the difficulties we have is that, if some longer term clients who have been through their acute phase are sitting there because they need a step-down arrangement or there's no bed for them at all, they block up the system. We're hoping this will help with that throughput. We will still look after people appropriately, but in a less restrictive environment.

**MRS DUNNE**: I need to clarify what I asked before: how many beds? How many bed nights of service, or whatever, do you envisage providing with the $240,000?

**Mr Jacobs**: We're still negotiating with the group, so I don't want to lock it down.

**MRS DUNNE**: How many do you have in mind?

**Mr Jacobs**: We're looking at buying at least four beds that are supervised 24 hours, plus a number of beds that will be purchased on an outreach support basis.

**MRS DUNNE**: You should be able to tell me how many bed nights you thought you needed when you formulated this policy.

**Mr Jacobs**: We thought we needed the equivalent of at least 24 supported beds out there. They can be supported in two ways. One is that we are buying them from a service that already provides beds and then they can hook some extra beds onto their capacity. The other is that we may have to purchase outreach workers, who then go out and support people in their own homes.

**MS MacDONALD**: I am moving on to page 150 of Budget Paper 3, still on initiatives in Mental Health. I'm looking at the issue of support for carers. Is this new money?

**Mr Jacobs**: Through ACT carers we are now funding a 12-month project with $100,000. This is to provide better support for carers—particularly around the PSU—better education for those people and more peer support systems. That's now under way. The $35,000 was to carry it through to the end of the next financial year plus provide an evaluation of the effectiveness of that program.

**MRS CROSS**: But this goes through to 2006-07, with $35,000 each year. You haven't increased it at all. It's the same.

**Mr Jacobs**: That money, which we provided on an ongoing basis, is reflected there. If the program is effective, we'll be trying to put in submissions to top that up.

**MRS CROSS**: But wouldn't you forecast that anyway—the way you have with clinical data management, the way you have with dental adult waiting list reduction, the way you have with the implementation of the drugs task force? Why haven't you forecast an increase in one of the most critical areas of need: support for carers, which is a national concern?

**Mr Jacobs**: We're going to have an evaluation of this program, which is made up of several components. Once the evaluation is occurring, we'll be looking at potentially topping up that initiative.

**MS MacDONALD**: So you're not pre-empting?

**Mr Jacobs**: Yes.

**MRS DUNNE**: Is this a pilot?

**Mr Jacobs**: The $100,000 was provided on a one-off basis for a 12-month program. This $35,000 will carry it through to the end of this coming financial year plus provide moneys for the evaluation. In essence, the program will be running for 15 months, and there'll be money in there for an evaluation of the effectiveness of that program.

**MRS DUNNE**: So, you've got $100,000 for—

**Mr Corbell**: This financial year in last year's budget.

**MRS DUNNE**: This current financial year?

**Mr Corbell**: Yes.

**MRS DUNNE**: But you're rolling over the $100,000 into the next financial year.

**Mr Jacobs**: The one off-funding of $100,000 was provided for the program to get under way in March and to take it through to March next year. The $35,000 provides the top-up to take it through to the end of that financial year, plus the evaluation moneys.

**MRS DUNNE**: What's the $35,000 in the outyears for?

**Mr Jacobs**: It just tracks through at this point.

**MRS CROSS**: With no cushioning for extra. It's got nothing to do with pre-emption; it's got to do with planning for the future, the way we do in any budget.

**Mr Jacobs**: When we were talking to ACT carers, it was clear that it was one-off funding, and we were going to evaluate it to check its effectiveness. If it is effective at the $100,000 level, we'll then put in for top-up funding through the normal budget initiative process.

**MRS CROSS**: Taking just a broad look at pages 150 and 151, there are increases in every initiative except that one. One could be cynical. One could presume to say, "Obviously, that's something they don't think is going to do very well or doesn't need any attention, so we'll just leave the status quo for the next five years."

**Mr Corbell**: You've had the explanation, Mrs Cross.

**MRS CROSS**: I find the explanation unsatisfactory.

**Mr Corbell**: The program will be evaluated, and future decisions about funding will be made on that basis.

**MRS CROSS**: I take your point, and if you were consistent throughout I'd say, "Yes, okay. I understand the consistency." But there's no consistency here.

**Mr Corbell**: With all due respect, you're not comparing apples with apples.

**MRS CROSS**: Does that mean you care less about this than the other things?

**Mr Corbell**: Far from it. I'm saying that it's wrong to compare this, as you did, with the dental adult waiting list reduction. That is an ongoing need that we know will be there and that we want to supplement for that period of time.

**MRS CROSS**: Support for carers is an ongoing need as well.

**MRS DUNNE**: Support for carers is going to be an ongoing need as well.

**THE CHAIR**: Let the minister finish.

**Mr Corbell**: Yes, support for carers will be an ongoing need. Whether it's best delivered through this program or through some other measure is the purpose of the evaluation. Once the evaluation takes place, we'll know whether the public's money is best spent supporting carers in this program or in some other program.

**THE CHAIR**: Wouldn't it be better represented by having an 0 in the years 2005-06 and 2006-07 to indicate that the phase has finished or that it would be $135,000 in those two years, and growing, because you don't have $135,000 for the following year?

**Mr Corbell**: Yes, the committee would have a point in that regard.

**MRS DUNNE**: Getting back to my earlier point, in what sense, Minister, is this an initiative?

**Mr Corbell**: It's an initiative in that it allows for the program to continue and for an evaluation to take place.

**MRS DUNNE**: You had a program that was $100,000, Mr Jacobs.

**Mr Jacobs**: Yes, the program was offered $100,000 for a 12-month window of time. We did actually see this as being a very important project.

**MRS DUNNE**: Was there no money in that $100,000 for the evaluation?

**THE CHAIR**: Please. Let him finish.

**Mr Jacobs**: No, not in the bid that came up. That's why we actually built—

**MRS DUNNE**: What was the point of having a program that was considered to be very important if there was no money in it to evaluate it?

**Mr Corbell**: That's why the government chose to ensure that the evaluation took place this year.

**MRS BURKE**: I asked this question yesterday and I'll ask it again, but probably in a slightly different way. Do all your contracts contain a rise-and-fall component? This issue goes across a few things. I have an issue with the SACS and HACC awards—the initiatives and the funding in the outyears. Where is the CPI rise-and-fall component in that? Is it a flat figure?

**Mr Corbell**: Sorry, what's the question, Mrs Burke?

**MRS BURKE**: Do your contracts in health contain rise-and-fall components? You're not telling me that your requests for tender don't contain a rise-and-fall component. So will you not be allowing for that in the services that you're offering under contract? Why isn't it reflected in this document Mrs Cross is talking about or in the SACS award and the HACC?

**Mr Corbell**: In referring to rise and fall, are you referring to increases in the cost of providing the service, like the CPI increase? Is that what you're referring to?

**MRS BURKE**: Yes, CPI. Why isn't that reflected?

**Mr Corbell**: All government funding makes provision for CPI increase.

**MRS BURKE**: It's not reflected here, though.

**Mr Corbell**: I'm not sure where it's reflected, but the government does make provision.

**MRS BURKE**: I agree. But can somebody please tell me where that will be swallowed up or shown?

**Mr Foster**: Indexation is provided, and the majority of those that are rising are rising because of indexation. The $35,000 issue was advised to us at those amounts, which indicated that either the indexation was a small amount on $35,000, which is hundreds of dollars—

**MRS BURKE**: But not on HACC and SACS, and that's the same issue.

**Mr Foster**: I'll come to HACC and SACS. In relation to a lot of these other ones, the indexation is reflected in these movements across the outyears, as you can see. The 80s going to 82, 84 and 86, for example. The SACS figure was advised to us by Treasury and passed over to us as that figure. We had no say in what that figure was in the outyears; it was provided to us as that amount.

**MRS BURKE**: Didn't that seem strange to you?

**Mr Foster**: We're one of a number of agencies that were advised that SACS funding was being provided in the budget, and this is the amount.

**MRS BURKE**: But flat in the outyears?

**Mr Foster**: Without knowing what the implications of SACS are in the outyears, I can only say that—

**MRS CROSS**: Mr Foster, do you think you just forgot to put it in? You can just tell us. If it's a mistake, we'll understand.

**Mr Foster**: No, I didn't forget to put this indexation in for SACS. Figures for SACS are as provided to us by Treasury. That's Treasury's document.

**MRS CROSS**: So it could be a Treasury problem. That's all right.

**THE CHAIR**: We're drifting away from Ms MacDonald's original question. Back to Ms MacDonald.

**MS MacDONALD**: I'm curious about what the support for carers program involves.

**Mr Jacobs**: A worker is employed, who'll develop peer support networks in against the PSU, full time for the period. A range of education options will be developed to help with carer understanding of mental health and how to access this system, et cetera. Basically, the project is being steered by the Carers Association of the ACT. They're going to guide where the developments need to occur in terms of improving carer support around the system. They will be looking at a number of issues: carer participation in case management and that type of thing.

**MS MacDONALD**: I imagine there'd be a certain amount of cost getting certain things started, as well as the ongoing costs.

**Mr Jacobs**: That's true, too. We see carers as important in the system. In our health service agreement process we're going through now we're involving them extensively. We also have carer representation on the strategic executive of Mental Health ACT.

**MRS DUNNE**: I want to go back to the whole issue of the false initiative. This was a pilot program in the last budget.

**THE CHAIR**: Reannounced.

**MRS DUNNE**: It's been reannounced.

**Mr Corbell**: No, it has not, because it's new money.

**MRS DUNNE**: The new money is for an evaluation that should have been in the money that you announced last year.

**Mr Corbell**: It's new money.

**MRS DUNNE**: You had a pilot program without an evaluation. There is no point having a pilot program if you're not prepared to evaluate it. So the new money here this year is evaluation money, and the money in the outyears in meaningless because there is no prospect of providing any of the services that Mr Jacobs has just described for $35,000 a year with no rise and fall. Mr Jacobs has said that carers provide an equal part of the health system, and anyone who has had anyone in the health system knows how important the role of carers is. This seems to me to be a false initiative that is just a rebadging of something you did last year. It is not an initiative.

**Mr Corbell**: Mrs Dunne, we can have an argument about semantics all you like, but the reality is that the government's put in extra money to allow this to continue. If you follow through your logic, money to increase elective surgery because we've always done elective surgery isn't an initiative. I haven't heard that argument from you, so it's just a silly argument.

**MRS DUNNE**: I haven't got on to elective surgery yet.

**MRS BURKE**: On page 148, BP 3, there is the drug and alcohol/mental health worker initiative. As a member of the Health Committee, I'm very keen and pleased and I encourage the government in doing this. I would also like to welcome new members of

the health department whom I haven't met and look forward to getting around to meeting you soon.

Is it true, Minister, that you have advised Winnunga Nimmityjah that they will also be tucking into this mental health outreach service and facility and that you're not providing their own one? They will be able to use this—this is the answer for Winnunga.

**Mr Corbell**: I've made clear to Winnunga that the government will be honouring its election commitment for culture-specific indigenous dual-diagnosis workers, and the government's intention is to meet all of its election commitments over its term of government. That means that the specific commitment around indigenous dual-diagnosis workers will be addressed in next year's budget. Nevertheless, dual-diagnosis workers are provided for in this initiative, as you rightly identify. No, they are not specifically for Winnunga; they are not specifically for indigenous clients. Nevertheless, I'm sure that there is equally the capacity for indigenous clients to access this service.

**MRS BURKE**: Have you advised them of that?

**Mr Corbell**: I accept Winnunga's position that indigenous and cultural-specific services are important. That's why the government will be honouring its commitment in next year's budget.

**MRS BURKE**: My advice is that they have been advised by you and all of your department that this will be a service for them, and that this is answering and meeting their need. Are you leading them down the path? Is this a false statement? Can you explain?

**Mr Corbell**: As I've explained, we have funding for dual-diagnosis workers who will service the needs of anybody who has a requirement for this support. The government will also be ensuring that we have culture-specific indigenous dual-diagnosis workers funded in next year's budget, consistent with our election commitment.

**THE CHAIR**: But your election commitment said that they would start much earlier than next year. Why have you chosen to delay the process?

**Mr Corbell**: There's been no delay.

**THE CHAIR**: There has; they were meant to be funded last year. They're not in this year's, and you're going to do it next year. That's breaking a promise.

**Mr Corbell**: Mr Smyth, they're not your election commitments, they're ours.

**THE CHAIR**: Yes, and we've got your document.

**Mr Corbell**: And, Mr Smyth, we are responsible for ensuring that they are implemented. As the previous government did, so does this government. We implement our election commitments over the term of our office, and that is the case in relation to indigenous dual-diagnosis workers.

**THE CHAIR**: Except that you gave quite specific dates on which these two workers would start. They've now missed two budgets, and we're expecting them in the third. That is the breaking of an election promise. You promised them on a certain date.

**Mr Corbell**: It is not the breaking of an election promise. We are implementing our commitments over the term of the government.

**THE CHAIR**: That's not what your document said.

**MRS CROSS**: Tell that to Winnunga. Can I ask a question on that, Minister?

**Mr Corbell**: I will finish my answer. They will be funded on a recurrent basis from next year's budget.

**MRS CROSS**: Can I just ask the question to clarify the promise so we can straighten this out? Did you promise this at a particular time or did you promise it during the term of your office? Was it the first year, the second year or the third year?

**Mr Corbell**: I'd have to check the policy documents, but my understanding is that all election commitments will be funded over the term of the government.

**MRS CROSS**: Okay, so you've still got another year to meet the commitment.

**Mr Corbell**: That's right.

**THE CHAIR**: Except it was promised at a particular time. I'll bring Gerritsen down after morning tea, we'll have a quick look at your publicist. We'll have a quick question from Mrs Cross and then one from Mr Cornwell.

**MRS CROSS**: I wasn't going to look at the initiatives but, thanks to Ms MacDonald, I'm paying closer attention to the initiatives. On page 152, BP 3, I notice the initiative that provides funding for the joint Commonwealth-ACT home and community care program, HACC. There's no increase there either. You've got the same figure in all the outyears for that. Is that because you're not expecting it to accrue an increase over time or because you're expecting it to stay stagnant? I'm looking at that, and the support for carers two pages previously, and wondering why there's no CPI increase.

**Mr Corbell**: I'll ask Ms Killion to provide the details. The funding for HACC is matching funding. We provide funding on the basis that the Commonwealth will provide a level of funding as well. I'll ask Ms Killion to address growth in the outyears and how that can be anticipated.

**Ms Killion**: Minister, you're right: it can't be anticipated. We put this number in anticipating that the Commonwealth would come up with a like number. This anticipates what the Commonwealth will come up with in terms of the percentage increase for growth in HACC services, and this government just took the punt and said, "Yes, we'll match it at the rate we anticipate them coming in at." Each year will be different. All this does is allow for this amount to go through the outyears, but each year it will change.

**MRS CROSS**: If it's going to change, why didn't you allow for it in the outyears here?

**Mr Corbell**: Because we don't know how it will change.

**Ms Killion**: We don't know what that will be, because we don't know what the Commonwealth will be putting up.

**MRS BURKE**: Couldn't you go on the rate of CPI and adjust it fractionally?

**Mr Corbell**: I wouldn't rely on the Commonwealth funding on the basis of CPI.

**MRS BURKE**: Yes, but it's your job to push hard, isn't it?

**THE CHAIR**: No. This year on hospital funding they wanted to give 7 per cent, which is more than double the CPI.

**Mr Corbell**: A billion dollars less for public hospitals around the country, Mr Smyth.

**MRS CROSS**: One of the questions that were put to you earlier related to the purchase of equipment, and I want to refer to that. You said that the previous minister deferred the purchase of equipment to help solve the budget blow-out. Minister, isn't equipment a one-off or capital funding that has been used to resolve a recurrent funding? In other words, you're addressing a short-term solution by creating a long-term problem.

**Mr Corbell**: There are two ways of answering this, and I'll provide you with the full answer. Yes, funding for equipment is one-off, in that it's a capital purchase. But every year the government provides funding for equipment replacements, so there is recurrent funding for capital purchase. The previous minister took the decision that the capital purchase in one year would be deferred to address other cost pressures in the hospital, but there is recurrent funding for capital purchase each year, which means the capital purchase will be able to take place in the following financial year.

**MRS CROSS**: So the previous minister screwed up.

**Mr Corbell**: The previous minister took the decision that, to address cost pressures in the hospital, the funding for some capital purchases that year would be spent on operational cost pressures.

**THE CHAIR**: If money was appropriated for capital expenditure, how can you then spend it on services? Is that not a breach of the FMA, in that money appropriated for a purpose can only be spent on that purpose?

**Mr Foster**: This particular money is not appropriated as capital injection; it comes through the government payment for outputs.

**THE CHAIR**: No, I didn't say "capital injection"; I said it was for capital purposes.

**Mr Foster**: The point is that it's provided to us in relation to the cost of providing services, and one of those costs of services is equipment.

**THE CHAIR**: So it's money out of the general pot.

**Mr Foster**: Yes, that's right.

**Mr Corbell**: It's not capital works.

**Mr Foster**: It's categorised as assets for the purpose of accounting because it's for items over $5,000. But certainly it comes in through the $400-odd million that this government is providing for the purchase of services or payment of services in 2003-04.

**THE CHAIR**: But if it's appropriated for assets, physical things rather than services, isn't it a breach of the FMA to use it for—

**Mr Foster**: It's not appropriated for assets.

**Mr Corbell**: It's an internal allocation of funding.

**THE CHAIR**: So it's from the general funding and the internal breakdown.

**MRS DUNNE**: Minister, you've said that we got money every year for the purchase of equipment. But this year you haven't spent $2 million on what? What wasn't purchased?

**Mr Corbell**: Dr Ramsey has taken that question on notice. He will be providing an answer to you.

**MRS DUNNE**: Yes, sorry. But that means you're going to spend $2 million, plus CPI, this year purchasing that equipment, one would presume, which means that something else that's in the equipment line will have to fall off until next year. Isn't there going to be an ongoing effect because you didn't purchase the equipment that you did?

**Mr Corbell**: Demands for equipment replacement vary from year to year. As you can appreciate in an institution like any tertiary care hospital, there are a hell of a lot of pieces of equipment—everything from crutches to multimillion dollar machines and everything in between. How a hospital allocates that funding is an internal management issue for the hospital. It is not necessarily a decision that has an impact on the overall equipment replacement program.

**MRS DUNNE**: It must have an impact. You've just taken $2 million out of the equipment replacement program. Even if it's $2 million worth of crutches, it still means that somewhere along the line, when you need to buy a machine that goes "ping", you can't, because you've got to buy crutches.

**Mr Corbell**: Not necessarily.

**MRS DUNNE**: If it's "not necessarily", it means that there's $2 million too much in the equipment budget.

**Mr Corbell**: No. What I'm saying is that demand for equipment and the need for equipment replacement vary from year to year, and it's difficult to anticipate what they will be, particularly depending on what the equipment is. I'll just ask Dr Ramsey to elaborate a bit on my answer.

**Dr Ramsey**: We identify replacement equipment and prioritise it in order of safety requirements. That equipment would always be replaced, down to desirable equipment that could make some difference to the way services are provided. Working within a fixed budget, we work down our priority list and we ensure that we continue to provide safe practices.

At some stage, if there is a budget imperative to redistribute resources, we will identify the impact upon the service delivery against equipment. It's also a balancing act of the age of equipment and the optimum time to replace equipment. At some stage, with some equipment, a decision will be made. "Can we get another year of life out of this equipment, or does it need to be replaced?"

You asked who makes the decision internally. Ultimately, I made the decision about which equipment we were going to procure or not, and it was based on very clearly defined criteria of allocation.

**MRS DUNNE**: Was there $2 million more than you needed?

**Dr Ramsey**: No, there wasn't. From a service provider perspective, our clinicians provided a list of $20 million worth of equipment. That's not to say we're going to buy $20 million worth of equipment, because they put in what I would describe as a wish list. It's a matter then of deciding realistically which equipment is required and prioritising it.

**MR CORNWELL**: My questions relate to the HACC funding—the other end of the pipeline. Minister, you sent a letter back to me about HACC funding, answering some questions that I raised in relation to this community service charge. This now comes in a dinky little envelope—something like what those few of you who go to church will recognise and some of you will no doubt remember—asking clients to pay money for various trips. I'm confused as to what they pay and what they don't. On the one hand, between $2 and $3 a trip—your advice, Minister—is charged across the ACT. This contribution is capped for clients who are using multiple services on a regular basis, and no client is refused services based on their inability to pay. I presume, therefore, that nobody should have to pay at all if they can explain that they don't have the money available.

**Mr Corbell**: The decision on that is made by the service provider. I notice the envelope you have there is from the Belconnen Community Service. That is how the Belconnen Community Service has chosen to charge those fees.

**MR CORNWELL**: How do they establish capacity to pay?

**Mr Corbell**: That is often a very sensitive and difficult subject, but it relies upon the discretion of the officers in the relevant community service administering the program.

**MR CORNWELL**: I see. That rather knocks into a hat your comments here about this envelope allowing the confidentiality, privacy and dignity of clients.

**Mr Corbell**: That's the view of the Belconnen Community Service, and that was the advice that was relayed.

**MR CORNWELL**: Why are there differences, then, in the charges of the various community services across the territory?

**Ms Yen**: Mr Cornwell, I don't think that there are agreed or capped funds that a community services provider can charge. I think that a community services provider can determine what it charges for the services it provides.

**MR CORNWELL**: Can the chairman have a list of these for each community service?

**Mr Corbell**: It's actually based on guidelines provided by the Commonwealth government, Mr Cornwell.

**MR CORNWELL**: I have a copy; you've kindly sent me this. But I don't have a list of the charges being made by individual community services. Mr Chairman, through you, I would like to ask for one.

**Mr Corbell**: I can endeavour to provide that information. It would mean asking the relevant community organisations. It's worth pointing out that other states and territories, which all receive HACC funding, have similar fee-charging regimes in place already. They are based on national guidelines developed by the relevant Commonwealth department.

**Ms Yen**: Can I add to that, Mr Cornwell, that most HACC services funded through the Commonwealth have an expectation of a co-payment by the person who's receiving the service. It's not just in relation to transport; it might also be in relation to personal care services provided at home or equipment that the person is enabled to buy through HACC funding. It may be helpful if we got for you the guidelines from the Commonwealth on co-payments.

**MR CORNWELL**: I'm interested in the question of transport and the mobility of these people, who are often elderly and may be disabled. They need and want to get out into the community at some time.

**Mr Corbell**: And they can. You haven't been able to demonstrate any case where they haven't been able to.

**MR CORNWELL**: Perhaps you can tell me what it means that this contribution is capped for clients who are using multiple services on a regular basis. What is the cap? You told me earlier that there wasn't a cap.

**Mr Corbell**: Again, I imagine that would be based on the national guidelines, and I'm advised by the voice behind me that it's $10 a week.

**MR CORNWELL**: Therefore, for $10 a week, if I'm in this group, I can travel as often as I wish?

**Mr Corbell**: Based on your need, yes.

**MR CORNWELL**: Who decides the need? Is it a question of going to the doctor, the dentist, the candlestick maker?

**Mr Corbell**: The client determines the need, Mr Cornwell.

**MR CORNWELL**: Therefore, it's not just going out for medical, dental or shopping needs; it could also be for other activities that they regard as important—socialising, for example.

**Mr Corbell**: Mr Cornwell, I'll seek clarification of that. I think it's important for you to appreciate that this program has guidelines set on it by the Commonwealth department. The territories and the states contribute to HACC funding, but it is predominantly funded by the Commonwealth and the guidelines are set by the Commonwealth.

**MR CORNWELL**: States and territories may develop their own fee policies within the HACC fee policy framework.

**Mr Corbell**: Within the guidelines.

**MR CORNWELL**: But the guidelines do not state that these trips will be limited to the butcher, the baker and the candlestick maker.

**Mr Corbell**: No, it's based on the needs of the client.

**MR CORNWELL**: Thank you. In that case, there are no Commonwealth guidelines for this. If it's based on the needs of the client, how can you draw up Commonwealth guidelines? You have individual client needs.

**Mr Corbell**: No, the guidelines are in relation to fee charging, not in relation to what journeys they can or cannot undertake.

**MR CORNWELL**: Well, you understand what I'm driving at here.

**Mr Corbell**: No, I don't, actually.

**MR CORNWELL**: Don't you? Well, I think the committee does.

**MRS BURKE**: I do; it's pretty clear.

**Mr Corbell**: With all due respect, Mr Cornwell, you have in no way demonstrated that anyone is being disadvantaged by this.

**MR CORNWELL**: If they're going to be capped at $10 a week, I would like to know how often these people—the elderly, the disabled—have the opportunity to travel under that $10 cap per week and where they can travel to.

**Mr Corbell**: It's based on their need, Mr Cornwell. I'm happy to try to get more accurate information for you.

**MRS CROSS**: Minister, the head of the hospital earlier mentioned a wish list. Could he provide a copy of that wish list to this committee?

**THE CHAIR**: A $20 million wish list of equipment and cheer, I suspect.

**Mr Corbell**: I'll see whether it's appropriate to provide that information.

## Short adjournment

**Mr Corbell**: Mr Chair, Dr Ramsey has some additional information that Mrs Dunne requested on orthopaedic costs.

**Dr Ramsey**: I was asked for information on the impact of implant surgery, and I'd like to indicate that, on average, we undertake 10 elective implant procedures at the Canberra Hospital on a monthly basis. We made the decision to curtail elective implant surgery at the beginning of March. It's not a straight-line correlation, though, because from March until the end of June a down time had been planned, a hospital wide activity down time anyway. In particular, in April there was a decision, because of the Easter period and public holidays, that we would curtail elective procedures; and that decision had been made some six to nine months previously. In addition, one of the orthopaedic surgeons who normally perform these procedures had planned routine leave.

While, at first glance, it appears to be 10 per month for March through until June, the figure wouldn't be that total number; it would be significantly less than that because of patients who had cancelled elective surgery. I'd like to state, though, categorically that the decision was made that any category 1 urgent elective surgery that required implants would be performed. So no category 1 patients were cancelled or have been cancelled.

**MRS DUNNE**: So what impact has this had on categories 2 and 3 implant surgery?

**Dr Ramsey**: I can't give you a definitive figure; all I can say is that we would usually undertake 10 elective procedures per month in this category. It depends on all the other activity pressures that occur in the hospital whether we would achieve that number or not. Indeed, it also depends on the case mix at the time, because some of them are very, very complicated cases we would undertake. In a particular month we may do fewer than 10. So there is no hard and fast figure; this is the projected impact of that particular activity.

**THE CHAIR**: Thanks for that, Dr Ramsey. If we could just go back to something Mr Foster said before the break on the growth funding. You said that the programs that were funded last year are funded this year but in recurrent, which leaves the figure of $7.9 million free for new initiatives. The chart on page 147, BP 3, shows that the new funding provided in the budget is $11.1 million as new funding, with $7.963 for growth funding already included in the forward estimates for growth.

**Mr Foster**: That's correct.

**THE CHAIR**: How can that be? That sounds like the money that was put forward for programs last year has now been double spent.

**Mr Foster**: No, the growth funding initiative from several years ago had incremental growth annually of about $8 million. So in 2002-03 there was $8 million, and we advised the then committee how that was being spent. And that was flat recurrent across the outyears. And then there's another $8 million available in 2003-04, as there will be another $8 million available in 2004-05. But those amounts are built into the forward estimates.

**THE CHAIR**: So it's stepped, in other words.

**Mr Foster**: It's stepped; that's right. It's growing by $8 million annually.

**THE CHAIR**: So there's an $8 million new component, with the assumption that all will continue in the outyears.

**Mr Foster**: That's right.

**THE CHAIR**: So the programs—the older persons mental health, the psycho-social support services, the expanded haematology, the radiotherapy, Canberra midwifery, the expansion of the hospice, et cetera—all continue, with the additional funding that came out of the $7.9 million.

**Mr Foster**: Whatever the figure was in 2002-03; whether it was $7.7 million, $7.8million, $7.9 million, I'm not sure exactly. But the $7.963 million relates to the amount of free allocation that was available for 2003-04.

**THE CHAIR**: The figures that were outlined in last year's budget paper came to about $4 million. We asked questions about what the other money was being spent on, and Dr Gregory said that there was an additional $3 million for growth and throughput at Calvary Hospital. Calvary got that money?

**Mr Foster**: Yes, they did. We provided the committee with a list, from memory, of how that amount was fully allocated, the $7-odd million, subsequently. We took it on notice, from memory, and provided that list.

**THE CHAIR**: So Calvary's base this year has the $3 million that was given for additional growth and throughput which Dr Gregory then expanded on and said that it was for keeping the anaesthetic services and intensive care services running.

**Mr Foster**: That's right.

**THE CHAIR**: So that money's gone into Calvary's base.

**Mr Foster**: That's right.

**THE CHAIR**: The $2 million for elective surgery is over and above that $3 million.

**Mr Foster**: Yes, that's right.

**MS MacDONALD**: Let us go back to mental health again.

**Mr Corbell**: Sorry, Ms MacDonald, if I could just get some clarification from the Chair: officers are going backwards and forwards. At what stage do you want to move through the output classes and try to deal with them in a more orderly way? Are we still doing a general overview?

**THE CHAIR**: General overview probably till 12, and then we'll start the output classes. I understand there was some discussion during the tea break about continuing with Health all day. I understand that would suit the staff. So we might continue with Health all day.

**Mr Corbell**: Yes, we're available. I'm going to be here all day anyway.

**THE CHAIR**: You're here all day anyway. As are we.

**MS MacDONALD**: Just on Budget Paper 3, page 149: I'm particularly interested in the expanded community teams because this is an area which is going to my own electorate. Can you tell me a bit more about where the hours are going to be extended and how that will actually improve the services?

**Mr Jacobs**: Basically, it's an extension of the current teams that are there because of the work force demand. We have estimated we need the extra PFT there. But there are a number of clients that just by their nature need a seven-day a week coverage; so what's happening is on the Saturdays/Sundays they will also have access to a clinician that can deal with some of the more emergent problems that actually come up and that can't wait until after the weekend. Again, it should help get a more timely intervention in place and, hopefully, stop people from deteriorating to the point where they might need admission because, by the nature of their condition, it doesn't just work on a five-day week.

**MS MacDONALD**: Being related to somebody with a mental illness, I know some of the problems. Are all of the mental health initiatives being linked in in some way, or how will they be linked in?

**Mr Corbell**: Well, broadly speaking—and I'd ask Mr Jacobs to perhaps provide some more detail—these initiatives are all designed to work consistent with the philosophy that is underpinning the mental health action plan, which is designed to focus on where those real areas of need are in our community. This is an area of significant need in our community.

Mental health funding has traditionally been very poor. The previous administration severely neglected mental health services. We have seen over a 10 per cent increase in the total mental health budget since we came to office to address these issues. So that's a very significant increase, 10 per cent of the total budget just in the past two budgets. That is a level of the government's commitment. In terms of their relationships and how they work together: I'll ask Mr Jacobs to give some more detail.

**Mr Jacobs**: Basically, all the initiatives that have been funded are consistent with the directions that are being mapped out in our current strategy and action planning process. So there's nothing inconsistent. Looking at future demand: that will actually be assessed as a part of that health services strategic planning document process. But all that's needed will be linked. I don't know that I can say anymore.

**MS MacDONALD**: That sounds good. It should hopefully lead to a seamless process across the service. For example, somebody may have an issue in court or something. I notice that you've got officers now being allocated to dealing with mental health problems within that area. These people could then go back out in the community and seek to find a job as well.

**Mr Jacobs**: Basically, the initiatives that have been approved for this year stemmed out of the Patterson review and also our own internal planning processes. But, with the current strategic planning processes we're going through, everything is consistent with where the consultants are identifying that there are areas of need. There will be an assessment made as to what we can provide within the territory and there may be some services that we do acknowledge we have to buy elsewhere—one could be forensic mental health beds—just because of the economies of scale issue.

**MRS CROSS**: Minister, when we get to the output classes I'll tackle mental health, but I will congratulate you and your department on putting a lot of energy and effort into that area. I'd like to ask a few questions on waiting lists. I've actually asked the secretary of the committee to distribute something that I got off the internet, which is the ACT elective surgery waiting list and times; it's just a summary which the members and the witnesses can look at. Minister, has the restructure in Health assisted in delivery of better health services to the people of the ACT—for example, in bringing waiting lists down? That's my first of a number of little questions relating to waiting lists.

**Mr Corbell**: Well, I think it would be wrong to characterise the administrative restructure as primarily assisting the area of waiting lists per se, but what the reform does achieve is greater efficiencies in terms of the overall operation and administration of health services in the ACT. For example, instead of having HR personnel and a range of other activities operating separately in three separate institutions—community care, TCH and the department itself—we now have a single department that has a number of divisions, including the hospital, including community care. There are some efficiencies of scale there—I shouldn't say "scale" so much, but efficiencies in terms of overall operation and making sure that we get a better coordinated level of activity.

As I said earlier, one of the real advantages I see as minister is that I now have the capacity to make sure that various divisions, in particular the Canberra Hospital, are able to provide a fully accountable management regime and financial expenditure regime to the government; whereas previously management of the hospital did not report to the minister; it reported to the board, and the board reported to the minister. So the minister was another step removed from the administrative and financial operations of the hospital, our single largest health entity. Those are the advantages that come. I can get a better focus on where money has been spent; I can make sure that it is spent most effectively; and I can focus on need.

In relation to the waiting lists: it would be wrong to characterise the reform on its own as addressing waiting lists, but it does have advantages in terms of making sure money is available to be focused in ways to address areas of need.

**MRS CROSS**: Thank you, Minister. The information, however, that appears to be missing from both hospitals is: one, the appropriate time frames for each category as set out by the Australian wide standards. Are they 30 days, 90 days and 365 days, respectively? The second part of that question is: what is the number of people who are on the waiting list but who did not have their surgery completed within the appropriate time frame for that category—the number of people who overstay the time for that category? Those are the two things that are missing. Minister, would you provide that information to this committee?

**Mr Corbell**: I would be very happy to, Mrs Cross, because they are already publicly available. The hospital bulletins, which are provided publicly and are available in the Legislative Assembly library every month, outline first of all what the clinical times are. To the best of my knowledge, category 1 is 30 days or less; category 2 is 90 days—

**MRS CROSS**: It's already on the sheet that I've handed out. I handed it out so that I didn't have to read all that out.

**Mr Corbell**: They are available and they are available publicly. Sorry, if I can just finish my answer to your question, Mrs Cross. In relation to those who are waiting longer than is clinically desirable, that is also information that is available every month, publicly in the hospital information bulletin. However, I would like to indicate to the committee that I have asked the department to develop a revised reporting regime that still provides all that information but makes it clearer what it is we're reporting on so that it is a more straightforward set of information for people to understand. I will be releasing that new format shortly.

**MRS CROSS**: Thank you, Minister. The information that I want you to provide to the committee in all these areas is, for example, what is currently on the web and what I have just requested for February 2002, February 2001 and February 2000.

**Mr Corbell**: I can do that.

**THE CHAIR**: Minister, the figures for the previous month are normally available on about the 20th or 21st of the month, which would be today, yesterday, the day before perhaps. Are the March figures available?

**Mr Corbell**: I'll be releasing the March figures later this week.

**THE CHAIR**: Is that a break from routine where they're normally available on the 21st of the month?

**Mr Corbell**: Well, as I indicated in my previous answer, I've taken the decision that we need to improve the format, to improve the accountability. We're not proposing to remove any information from the bulletin which is already in the bulletin or in the waiting list figures, but I have asked the department to improve the accountability so that people can see what is going on in relation to elective surgery waiting lists. I've asked for the development of a new format. That format has been completed, and I'll be releasing it later this week.

**THE CHAIR**: Have you got those figures with you now?

**Mr Corbell**: I don't personally have them with me now, no.

**THE CHAIR**: Do officers have the March figures with them now? Has the waiting list grown or has it shrunk in March?

**Mr Corbell**: Well, officers do have that, but I will be releasing those figures later this week.

**THE CHAIR**: Could we have a raw figure now and the breakdown later this week?

**Mr Corbell**: No.

**THE CHAIR**: Why not, Minister?

**Mr Corbell**: Well, the government will make the decision on when it announces and releases things. As I've indicated to you, I'll be releasing these figures later this week.

**THE CHAIR**: Is this being done to avoid the scrutiny of the Estimates Committee, Minister?

**Mr Corbell**: No, it's not.

**THE CHAIR**: Well, I think others will have a different opinion.

**Mr Corbell**: Well, the reason for the change is that there is a new format that has taken time to produce, and I'll be releasing that new format later this week.

**MRS CROSS**: Just a little statistic that I had here: in June 2001, the waiting lists had decreased by 8 per cent, that is, by 307, from the previous month, down to 3,711. I just thought that was a very interesting statistic you might like to keep in mind when you give me the information that I requested earlier. I wanted to find out from you, Minister: are you presiding over increasing waiting lists and waiting times whilst substantially increasing your expenditure in Health?

**Mr Corbell**: There has been an increase in waiting lists. In relation to elective surgery, you've got to remember that it's wrong to compare the total level of expenditure in Health with how effective the territory is in relation to waiting lists for elective surgery.

In relation to elective surgery: as I indicated this morning, the previous government relied on a one-off payment from the Commonwealth to reduce elective surgery lists and waiting times. That payment ran out. It wasn't removed; it ran out the year before last. The previous administration made no provision in their forward estimates for compensating for that runoff which they knew would occur. They knew it would occur from the moment they signed up to the previous health care agreement. They knew it was going to run out; they made no provision in their forward estimates for that; this government has had to move in and pick up that provision; and we have picked that up to the cost of $8 million over the next four years.

**MRS CROSS**: So when your government negotiated with the nurses, were you able to achieve workplace reform such as flexible rostering that would assist in reducing waiting times and lists? Specifically what reforms did you achieve through the EBA process?

**Mr Corbell**: Well, I think the suggestion that nurses' work practices in our theatres are inefficient is quite insulting to those nursing staff.

**MRS CROSS**: Did I use those words?

**THE CHAIR**: It's actually in your document. You would achieve better efficiencies in your theatres.

**Mr Corbell**: The reality is that nursing staff in our theatres work extremely hard. There are always work practices that can be refined and improved in consultation with that work force—and that's the approach of the government—but that is not the reason behind the problem we currently face with waiting lists.

I've been very up front about the issue we have with waiting lists. Category 2 and category 3 are not acceptable; we need to improve them; and the government has put its money where its mouth is and is investing $8 million over the next four years to see an extra 600 Canberrans every year, on average, have their elective surgery done in addition to the over 4,000 Canberrans that receive elective surgery every year.

**MRS CROSS**: But the EBA for the Canberra Hospital nurses did not expire until 30 November 2001, when you were in government.

**Mr Corbell**: So? What's your question?

**MRS CROSS**: Well, you're blaming the previous government for something.

**Mr Corbell**: The point I'm making is that your proposition is incorrect. The clear issue with numbers of people on the waiting list for elective surgery is based very strongly, predominantly, on the run out of the one-off Commonwealth payment, what was called the CUTS funding, which the territory received when the previous government signed up to the last Australian health care agreement.

**THE CHAIR**: And just on a historical note: the Chief Minister then, as health minister, said that they took the decision in the last budget not to put funding in to accommodate that. I think the quote was: "We knew there would be some pain, it's a decision we took."

**Mr Corbell**: Indeed.

**MRS DUNNE**: Can I just follow up the point that Mrs Cross made. I think, Mrs Cross, the question you asked was: were there efficiencies in the EBA, like flexible rostering? Did you make any assessment or assertion about the work practices?

**MRS CROSS**: None at all, no.

**MRS DUNNE**: I didn't think so. Minister, were there any moves towards flexible rostering? One of the issues that have been raised with me on a number of occasions is that the way the rostering works is that the roster finishes at 4 o'clock; the surgeons could go on, but there are no staff to assist.

**Mr Corbell**: I'm advised that that is the case at the moment, yes.

**MRS DUNNE**: It's still the case that, because we don't have flexible rostering, basically the surgery list cuts off at 4 o'clock because that's when the staff have to go. Rightly so. I'm not saying that they should stay on.

**Mr Corbell**: These are issues that can only be addressed through an effective negotiation. The negotiation for the next agreement commences next year. It's obviously an issue the government will have to seek to address.

**MRS DUNNE**: You didn't address it in the last effective negotiation.

**Mr Corbell**: No, and I don't think any government has effectively addressed it yet, Mrs Dunne.

**THE CHAIR**: But that was one of your election commitments, Mr Corbell.

**Mr Corbell**: Indeed.

**THE CHAIR**: I think the line is: "We will get better value for the money we spend and we will reform the theatre practices."

**Mr Corbell**: Indeed, and we will continue to strive to do that. Can I ask Dr Ramsey to add to that.

**Dr Ramsey**: Our theatre session timings are built around the availability of staff. That is determined by the nursing work force. But we ensure that out-of-hours, urgent surgery—acute surgery—is provided. Indeed, on weekends semi-urgent surgery is also provided. So we work within the parameters of the EBA to ensure that we can provide the best service that is possible.

**MRS DUNNE**: So what are the hours that the theatres operate on for elective surgery on an average working day?

**Dr Ramsey**: The elective lists finish at 4 o'clock in the afternoon; and the start time is 7.00 am.

**MRS CROSS**: On page 142, under "capital works", you have $2.4 million for the—

**MS MacDONALD**: Sorry, which budget paper?

**MRS CROSS**: Sorry, BP 4. There is $2.4 million for the Moore Street refurbishment over two years. I notice that the department of disability also dedicated $1.2 million to refurbishment, as I recall, of the same building. Is this double dipping?

**Mr Schmidt**: I'm not aware of the disability folk seeking to refurbish that building—I'd need to check the papers—but we have certainly bid for $2.4 million; Urban Services have bid for $840,000 to contribute to the refurbishment of that building. The split there is: fundamentally, Urban Services are our landlord. There are some, we have argued, landlord-related issues that we believe it's in their court to address, and they've obtained the necessary capital funding to do that. The $2.4 million we have sought is to refurbish level 5, which we currently occupy, to bring that up to basically the same standard as the rest of the building.

**Mr Corbell**: Mrs Cross, I think we got your clarification. It's not a double dip. The two departments are both located on Moore Street. Disability is at 12 Moore Street. I'm not quite sure of the number of the Health building, but it—

**Mr Schmidt**: It is No 1.

**Mr Corbell**: Sorry, 1 Moore Street. So they're in the same street, different buildings.

**MRS CROSS**: In future, when we include those in the budget, we could distinguish those so we don't have to ask double dipping questions. But thank you for that explanation, Minister. One little question and then a comment—

**THE CHAIR**: No sermons.

**MRS CROSS**: It's not a sermon, Chair; don't make assumptions. When I questioned Treasury it appeared to be extremely top heavy with males. In that case the top seven levels were all dominated heavily by men, while from the ASO5 level down there is a predominance of women. Does Health have an equitable balance between men and women; and if not what are you doing to address the inequality?

**Mr Corbell**: Well, you'd normally be able to find this information in the annual report of the department. The last annual report of the department would provide this sort of break-up. I don't know whether we can provide that information now. I'll certainly take it on notice.

**THE CHAIR**: It's on page 29 of your ownership agreement.

**MRS CROSS**: I know that you have a particular interest in gender equity issues, Minister; I know that you genuinely have an interest in this. I thought, because you do, you would know the answer. But I'm happy for you to take it on notice.

**Mr Corbell**: No, I don't know the staffing levels in the department overall in terms of men and women. Obviously, to make some broad generalisations, Mrs Cross: most of the nursing work force is of course women.

**MRS CROSS**: Well, I'm thinking of your senior executive service in particular.

**Mr Corbell**: But in terms of my senior executive side, I see a pretty good mix of men and women walk through my office door every week. But I'll provide the exact figures to you.

**MRS CROSS**: I also notice a range of other very sensible redevelopments, Minister, at places like Karralika Drug and Alcohol Rehabilitation Service, the ICU and CCU at Calvary, and the bone bank and the medical school at the Canberra Hospital. I think that these are just a few examples of very good decisions, and I would like to extend my congratulations to you for those initiatives.

**Mr Corbell**: Thank you, Mrs Cross.

**THE CHAIR**: Just on the staffing, Minister: on page 29—and I'm sorry, Mrs Burke, for jumping in here—of the ownership agreement there is the staffing profile of the department. As I look at it, it's identical this year to what it will be next year. Is this just that somebody's dropped the same numbers in the chart, or you just don't expect to have any people leave and any new recruitment? Even the age profiles remain the same; the number of women working in the department remains the same.

**Mr Corbell**: I'll ask Mr Schmidt to answer that question.

**Mr Schmidt**: I think, Mr Smyth, what we're seeing there is the most reasonable approximation we can make on the staffing profiles at the time at which the document is produced through until the end of the coming financial year. Based on the anticipated changes or changes in profile of services to match that, there have been no significant major changes in terms of ups and downs; and we anticipate that the level of staffing will remain constant through the year. There will be people who will leave and there will be people be recruited; but of course, as each year goes by, we all move to the next decile point in the age profile and it's pretty much level.

**THE CHAIR**: Except nobody's moved. Don't you have birthdays in the department of health? If it's identical it remains exactly the same.

**Mr Corbell**: No, we've cancelled that.

**THE CHAIR**: Cancelled birthdays.

**MRS BURKE**: Perhaps that comes under page 27, stage 4, reality check.

**THE CHAIR**: Well, as long as you don't cancel Christmas that will be okay.

**Mr Corbell**: I wish we could actually; we'd have better waiting lists if we did.

**MRS CROSS**: Cancel Christmas?

**Mr Corbell**: Yes.

**MRS BURKE**: BP 3, pages 148 and 149 again: I know it's been said this morning, but we should praise the department and whoever came up with these initiatives and took it to the government and the government accepted. I applaud that. Calvary link, drug and alcohol mental health worker, forensic court liaison and discharge planner. There seem to be four positions created. That's the first part of the question. Who would be coordinating these services, as I presume there would be clients common across those areas? And what would be the cost of coordination of those services?

**Mr Corbell**: Well, Mental Health ACT will be coordinating the service provision. That is a division within the department of health. Mr Jacobs can give you more information.

**Mr Jacobs**: Basically, with those positions, we do have an infrastructure in place; and they'd just be placed in the appropriate management stream.

**MRS BURKE**: Under that, on page 148—it doesn't actually allude to a person in Calvary link and drug and alcohol—it says "mental health outreach worker", but it talks about integrated services management of consumers. It talks about more of an administrative role, and I was just concerned whether this actually will be a human being on the floor. I'm just asking if you can expand on those two particular services. The other two quite clearly state that they will be people; those two don't.

**Mr Jacobs**: There's a worker in each of those programs, but a key function of these programs will be to be able to network in with the rest of the organisation to get the relevant services needed for these people.

**MRS BURKE**: Are you combining these services? I guess there would have to be a commonality of clientele.

**Mr Jacobs**: Using the drug and alcohol worker as an example: there will be a certain case load it carries, that position. Also there are other people that have mental health and drug and alcohol issues that are in the current case loads, distributed around the teams. This person will provide expert advice into their management.

We also have an arrangement with the Drug and Alcohol Services and Mental Health Services where, if there is a difficult to manage client or there are some critical issues around a client that's being case managed on either side of the Drug and Alcohol Services or Mental Health services, and it needs to be more effectively case managed or reviewed, then these two positions, one on the Drug and Alcohol side and one on the Mental Health side, can actually sit together and map out the best care plan for that person and get the best service we can to them.

**MRS BURKE**: I'm obviously pleased to see there is rise and fall and, hopefully, CPI attached to these four positions, which is good. I guess that's it. But there is no further impost to cost on the bottom line for ACT Health having to manage yet another administrative capacity or another role and these four positions?

**Mr Jacobs**: When we put up these initiatives, we assessed that we could actually still manage them within the current structure.

**THE CHAIR**: Minister, back to the numbers: on page 8 of BP 2, it says that the total expenses for the department will be $554.5 million this year. If you look at the financial statements on page 130 of BP 4, it says that the total ordinary expenses for the department are expected to be $546 million. Where would the other $10 million be?

**Mr Foster**: The other money is the territorial expenditure, which appears in Budget Paper 4. We didn't produce Budget Paper 2, but I do know that it is produced by the departmental accounts, and some expenditure in the territorial account relates to the payments for Healthpact and the payments to Calvary for capital works.

**THE CHAIR**: So Healthpact is getting about $2.6 million and Calvary is getting $7.5 million?

**Mr Foster**: For capital works?

**THE CHAIR**: For capital works.

**Mr Foster**: It wouldn't exactly make up the territorial—

**THE CHAIR**: What page would that be on?

**Mr Foster**: Territorial appropriation is referred to on page 141 of Budget Paper 4. There's also another item, which is supplementation for any additional pay that will occur at the end of 2003-04.

**MRS DUNNE**: Well, Calvary is getting $6.325 million in capital works, isn't it?

**Mr Foster**: Healthpact gets $2.4 million.

**THE CHAIR**: So it's on page 141?

**Mr Foster**: Page 141 gives you the detail on the changes to the appropriation for territorial, which shows you a forward estimate of $5.365 million; plus the new capital works money for Calvary at $1.330 million; plus supplementation, which goes to Calvary for the cost of additional pay. That gives you a total of $8.4 million, which is what was added to the $546 million for the department to come up with that $550-odd million in BP2. Healthpact gets $2.4 million; Calvary gets $6 million basic, made up of capital works decisions for '03-04, plus the contribution towards the additional pay.

**MRS DUNNE**: Calvary's capital works was, you said, 40304, Mr Foster?

**Mr Foster**: I said Calvary gets $6 million. The capital works would total $4.3 million for Calvary in a cash sense.

**MRS DUNNE**: $6.325 million is what Calvary gets for capital works. That's new and ongoing?

**THE CHAIR**: Where does that figure $6.325 million appear?

**MRS DUNNE**: Sorry, I added it up. I could have got it wrong.

**Mr Foster**: Page 143 shows the level of funding for Calvary capital works, which is $4.3 million; add $1.7 million for the additional pay; that takes you to $6 million; plus $2.4 million for Healthpact.

**MRS DUNNE**: Sorry, I made a mistake before. On the subject of Calvary and the initiatives: we have $2 million, with some indexation over the outyears, for increases in elective surgery at Calvary Hospital. How many patients will this be, or what is the most convenient way of showing this—cost-weighted separations?

**Mr Corbell**: Well, it's difficult to determine exactly. It all depends on the surgeons' classifications of need. But based on previous trends, the department has advised me approximately 600 people per year additional.

**MRS DUNNE**: Does this mean, Mr Cusack, that Calvary's operating theatres will operate five days a week for most weeks of the year?

**Mr Cusack**: Most. Well, the situation is: this year we were closed for 14 weeks of the year because of the reduction in funding. Most hospitals would normally close over the Christmas period for a period of time.

**MRS DUNNE**: That's why it didn't say 52 weeks, is it?

**Mr Cusack**: Yes. That will still happen. There will probably be a need to close for a couple of additional weeks beyond that, but certainly not 14 weeks. So that's more of the order of about, instead of the normal four weeks, probably seven weeks.

**MRS DUNNE**: So you're still not going to be back up to par with what you were in the financial year before this?

**Mr Cusack**: In relation to elective surgery, that's the case, yes.

**MRS DUNNE**: So you're still going to have spare capacity in Calvary Hospital. And how will you manage that? How many theatres do you usually run, three?

**Mr Cusack**: Six.

**MRS DUNNE**: So will you sort of stagger that or will you actually close all six down for seven weeks.

**Mr Cusack**: We will probably do what we've done this time. It's more efficient to actually close theatres for a particular block of time. We do keep them open for emergency and urgent surgery. It's also, we've found, efficient to make the closures around the school holiday period when surgeons, anaesthetists and staff in the theatres are likely to want to take their leave as well. So it's more efficient to do it in a block than to try to spread it out over the year, because you don't get the same efficiencies.

**MRS DUNNE**: So what's actually happened with this? Last year you lost 14 weeks. Sorry, current year.

**Mr Cusack**: Current year we're talking about. We plan to close for 14 weeks. There's been an additional allocation of $500,000 from ACT Health and the government, which will mean that we don't have to close for two of those weeks, which was planned for June.

**MRS DUNNE**: That's about $250,000 a week. Is that right?

**Mr Cusack**: That's it. I think it's a little bit difficult to put it directly into weeks. That takes it to 12 weeks.

**MRS DUNNE**: Well, it's a pretty gross measure. That means that on that basis the $2 million for next year will give you seven to eight weeks. Seven weeks was your calculation.

**Mr Cusack**: It does depend. The minister alluded to the fact that the type of surgery that's being done as well has a bearing. Clearly orthopaedic surgery involving expensive implants is much more expensive than, for example, eyes. You can get through many more patients in ophthalmology surgery because of the different costs associated with those.

**Mr Corbell**: It's worth highlighting that point: if any government wanted to be very cynical about adjusting waiting lists, it would just spend all the money on eye surgery, and the waiting list would go down significantly—very significantly. But that wouldn't be fair or reasonable or, I believe, moral.

So what the government has done is provide funding to redress the running out of the one-off funding the previous government received from the Commonwealth and increase our capacity again in elective surgery across all types of surgery, from both the cheapest type of surgery, eye surgery, right through to some of the more expensive types of surgery such as orthopaedic surgery.

That's the focus and, yes, we are not running at the same capacity as the theatres were previously running at. The difference is: now we're having to pay for it ourselves; we're not relying on a one-off payment from the Commonwealth. We have increased the amount of throughput significantly in this budget.

**THE CHAIR**: But the promise was made in the lead-up to the election that you would address waiting lists. You said waiting lists were unacceptably long and Labor would fix it. In fact, this year the waiting lists, according to Mr Cusack's estimates from last year, show that probably 900 or 1,000 patients are worse off. We see some recompense this year where $2 million comes into it. So something like 600 patients will be dealt with—and that is welcome—but it doesn't take into account CPI costs for two years that haven't been indexed in; it doesn't take into account two years of population growth. Calvary at this stage will still look to have to close its wards, what, six to eight weeks this year that normally would have been open with the funding?

**Mr Cusack**: I should point out there is some indexation built in on the existing payments, but there is still capacity in relation to theatres and wards. In relation to the funding that is available at this point, there would still be a need to close theatres and wards for a period beyond what we would consider the normal Christmas closure.

**THE CHAIR**: So how long will that be? How many weeks?

**Mr Cusack**: As I said, it's difficult to estimate; but we would normally close between four and five weeks over the Christmas period. It may be eight weeks, but it depends on the types of surgery that are going to be purchased as well, because that has an impact on it. We're in the process of negotiating that with ACT Health at the moment.

**Mr Corbell**: In relation to the CPI figure, Mr Chairman: if you look at the outyears in this initiative on page 151 of Budget Paper 3, you'll see that there is an increase in funding which, as far as I can tell from my initial discussions, includes the CPI. So it's wrong to suggest, as far as I can tell, that CPI isn't taken account of.

**THE CHAIR**: I accept that, but CPI wasn't certainly given last year.

**Mr Corbell**: The real issue here—and I think it's worth the committee thinking on this—is that we're having to pay now, ourselves, for the pressure from our community on elective surgery. For the past four years or three years the previous government got a lot of elective surgery activity going by Commonwealth money; didn't put our own money in; didn't put any more ACT money in; they relied on that payment from the Commonwealth as part of signing up early to the Australian health care agreement.

That money ran out. The previous government built in no expectation in their forward estimates that they would have to pick up the slack. That's what this government is doing. It's not to the same level as the Commonwealth, but we are paying for it, ourselves, and we are making sure an extra 600 Canberrans get the surgery they need each year on top of the 4,100 or so that are treated every year already.

**THE CHAIR**: Well, perhaps you should negotiate better with the federal health minister. I understand there's an extra $50 million-plus on offer for an early resolution.

**Mr Corbell**: It's news to us.

**MRS CROSS**: Minister, I'm just looking at the hand-out from the net that the secretary gave you. It says here, under "Summary", "There are now 4,124 people on the list—an increase of 21 people from January 2003. At the Canberra Hospital there are 2582 people waiting, and at Calvary Public Hospital there are 1542 people waiting. The number of people admitted for surgery in February 2003 was 739, this compares with 682 in February 2002." That's an increase. So if the aim is to decrease the numbers that's not what I'm seeing, on what I got off the net.

**Mr Corbell**: We admitted more people for surgery in 2003 than we did in 2002. Isn't that a positive thing?

**MRS CROSS**: No.

**Mr Corbell**: Well, I'm sorry, Mrs Cross; what's your question?

**MRS CROSS**: Your waiting list has been increased. It says here that there are 4,124 people on the waiting list, which is an increase of 21 from January 2003. If the aim is to reduce the numbers, why is there an increase?

**Mr Corbell**: Well, there's an increase for a range of reasons, Mrs Cross. For example, it's important to remember that waiting lists are not determined by the government; they're determined by surgeons, surgeons seeing sick people and determining what their level of need is for surgery. We have no control over that whatsoever. The only control we have is how much money we provide for surgery for public patients.

So an increase of 21 people out of a waiting list of 4,124 is statistically small—very, very small. Yes, there are 21 extra people on the waiting list. But, in the overall list of around 4,000—3,500 to 4,000—it's a very small variation, an extremely small variation. It could be simply because one surgeon has gone on holiday and therefore is not available to conduct surgery for that period of time. Therefore, the total number of people waiting has gone up. It could be because more category 1 people have had to be seen, which means more categories 2 and 3 people have to wait.

It is a supply driven activity, and all we can do, as a territory, regardless of which government it is, is ensure that we get best value for money in getting people treated. If you look at the increase in the number of people admitted for surgery in February 2003, it's an increase there to 739 from 682—again, not significant in the overall list. Nevertheless, I think it's important, when looking at waiting lists and waiting times, to see how many people are going through our hospitals; how many people are accessing surgery every month and every year; and how many people are waiting longer than is clinically appropriate. Those are the two measures I focus on when I look at waiting lists, not the total figure.

**MRS CROSS**: Can you advise the committee then what you are doing to address the waiting time for category 1 people, because I notice that the average waiting time for Calvary is 27 days and the average for the Canberra Hospital is 23 days. My understanding is that there have been some very serious category 1 people that have had to wait in excess of these amounts of time, and they've needed urgent attention. What is the government doing to address that priority?

**Mr Corbell**: Less than 1 per cent, I think, of all category 1 patients wait longer than is clinically appropriate. The clinically appropriate waiting time for category 1 is 30 days or less. So the 27 days and the 23 days are less than the time which is clinically appropriate. Our average waiting time for category 1 is less than that deemed to be clinically appropriate.

**MRS CROSS**: Are you looking at reducing that number?

**Mr Corbell**: No, we don't need to reduce that number because, the reality is, virtually every single person who is classified as category 1, with the exception of maybe one or two people, get treated within 30 days. That's an outstanding record for any public hospital system, and it's one of the best in the country.

**MRS CROSS**: And what's the benchmark that you use to say that that's an outstanding record?

**Mr Corbell**: Well, we compare it with other states and territories, and we've got one of the best rates in the country for category 1. But when it comes to categories 2 and 3, we're not that good; we need to focus on that; and that's where the government's initiative is focused.

**THE CHAIR**: I know Mr Cusack has to go. If your supplementary is on this matter, that would be kind; but we might focus on Calvary shortly and then let Mr Cusack go to his appointment.

**MRS DUNNE**: Well, actually it still is on the issue of Calvary elective surgery. Mr Cusack, could you provide for the committee, on notice, a timetable of when you are closed for elective surgery through this financial year?

**Mr Cusack**: Through this financial year?

**MRS DUNNE**: Yes, the 14 weeks this year.

**Mr Cusack**: I can pretty well tell you now there was three weeks around the October school holiday period; there was six weeks over the Christmas/New Year/January to early February; three weeks over the Easter periods, two weeks in April and one week in May. We no longer have to close for the two weeks in June. That's a total of 14 weeks.

**MRS DUNNE**: So you were going to close in June, but you're not going to.

**Mr Cusack**: That's right.

**Mr Corbell**: Yes, the government provided an additional half a million dollars to ensure that that did not occur.

**MRS DUNNE**: My question is, Mr Cusack, in regard to last year's 12 rather than 14 weeks closure. When we were here this time last year we were talking about the impact, and you thought it might be 900 to 1,000 patients—a simple term. Do you have a feel for how many it has actually been?

**Mr Cusack**: I do. As at the end of April, in the order of 350 patients, bearing in mind that there was one week of closure that wouldn't be in the April figures and there was estimated to be another two weeks in June. So it hasn't been as high as expected, but there would have been three more weeks of that period. It also needs to be put in perspective that during the January period there was a traditional closure period anyway.

**MRS DUNNE**: You have three or four weeks but you closed for six.

**Mr Cusack**: Yes. Really the areas where it would have had the greatest impacts are the October, the April and the June periods. Could I make a point just about the elective surgery, because it is relevant? It's not just about elective surgery on its own; the other pressures are that we've had an increasing number of patients going through our emergency department, which is where the predominant medical patients come from. We've also had an increase, as was indicated before, of both emergency and urgent surgery—the category 1 type surgery. They're all areas that we couldn't negotiate on,

because of the increases there. So it really only left elective surgery where we had some discretion, and that's the reason that area was targeted.

**MRS DUNNE**: Yes, I understand that; but what I wanted to find out is: what impact has that 300-odd patients had on the elective surgery waiting lists in terms of waiting times?

**Mr Cusack**: Waiting times, as the minister indicated, have predominantly been—almost exclusively—in category 2 and category 3. Category 1 patients take precedence, and they all get their surgery in clinically appropriate times.

**MRS DUNNE**: But what impact does it have on categories 2 and 3?

**Mr Cusack**: Certainly there's been some growth in both those areas, and that's where the increased figure of 350 would be.

**MRS DUNNE**: And can you elucidate on what that growth has been—what are the waiting times in categories 2 and 3 at Calvary?

**Mr Corbell**: Well, I think if you have a look at the sheet that Mrs Cross distributed, you can see there, Mrs Dunne, the average waiting times for category 2 and category 3. For category 2, for instance, at Calvary Public Hospital it is 136 days; the clinically desirable time is—

**MRS DUNNE**: Ninety?

**Mr Corbell**: Yes, 90 days; and for category 3 it is greater than 90 days; it is some time in the future.

**THE CHAIR**: Mr Cusack, last year you also mentioned that, because of not being funded for the $3½ million, you had to reduce other services. How much growth is expected in emergency this year? You quoted 7 per cent last year. What's the expected growth this year?

**Mr Cusack**: The funding that's been provided has been provided for 7 per cent as well. We really would hope at some stage this will plateau out, but indications are that it isn't occurring. We're actually running at 4 per cent growth at this particular point in time of the year; so it's a little bit unknown and it really is driven most particularly beyond the population growth in the northern suburbs, which is running at about 14 per cent in Gungahlin. The availability of GPs is the biggest impact that we're finding in relation to that, and the GP workforce is going to impact on that figure. From what we know at the moment, I would still be inclined to predict the 7 per cent, until we get any further information.

**THE CHAIR**: Are there any cuts to some of the other services you listed last year at this time that would be covered, things like mental health and other outreach services; or have you been able to make up the shortfall last year in the coming year; or are there further reductions in service this year?

**Mr Cusack**: One of the things we have been able to do in relation to our prediction—we predicted a growth in medical patients that were admitted through the emergency department; it hasn't been quite as high as we expected—is redirect some of that money across to additional elective surgery as well. So it's a bit of a balancing game about our total number of patients, and that's assisted as well.

**THE CHAIR**: Sure, and the additional services?

**Mr Cusack**: Predominantly it was around elective surgery; there had been some associated services that come from that—ward-based services, your allied health, et cetera, that relate to that—where our strategy is to meet that reduction.

**MRS DUNNE**: One final question on the elective surgery, Mr Cusack, at this stage: are theatre operating times impacted in the same way by rosters as they are by cancellations?

**Mr Cusack**: No, we've got a different enterprise agreement at the current time. Theatres actually start at 8 o'clock, but there's set-up time for nurses, et cetera, and they are required to come in earlier. We basically run a staggered arrangement with their roster. Some will start at 7.00; some will start later; and so it goes. We make sure that the theatres are able to operate right through that time.

**MRS DUNNE**: They start operating at 8.00? What time do you finish?

**Mr Cusack**: Normal theatre times are 8.00 till 12.00 and then 1.00 till 5.00, but I have to say that rarely do they run exactly to those times; and more often than not they run over. Sometimes they do finish early, and there's a little bit of flexibility there. The staff are quite flexible in that regard, and we make sure that we maximise the efficiencies of the theatres.

**MRS DUNNE**: And, through the enterprise agreement, you've got a different rostering arrangement?

**Mr Cusack**: Yes, that is the situation. But I don't know how far it goes back. That's been the situation at Calvary for many, many years. It may have been before enterprise agreements were actually in place that those arrangements were made.

**MRS CROSS**: Minister, one of the things that I'm pursuing through estimates with all ministers is that concern of empire building. Are you able to provide this committee with information on how many SES officers you've budgeted for within the health department? The statistics I would like are for 1 July 2001, 1 May 2003 and 1 July 2004. When you provide this information it may be appropriate for you to tabulate it, showing the losses and gains according to the restructures that have gone. I'm particularly interested in the losses and gains right across the health care sector in what is now the department of health.

**Mr Corbell**: What do you mean by "losses and gains", Mrs Cross?

**MRS CROSS**: Profit and loss, losses and gains, where you've lost; and then input/output costs, yes.

**Mr Corbell**: We'll do our best to answer that question, Mrs Cross, in relation to the second point. The first point of the question is easy to provide, and we will provide it.

**MRS CROSS**: Good, thank you.

**THE CHAIR**: Any further questions for Calvary hospital? No further questions? Mr Cusack, thank you.

**MRS DUNNE**: Can we do the output class?

**THE CHAIR**: We are about to move to the output classes.

**MRS DUNNE**: Isn't there an output class for Calvary?

**THE CHAIR**: Well, that was the point. Mr Cusack has to go. If you have any further questions for Calvary Hospital, now would be a good time.

**MRS DUNNE**: No.

**MRS CROSS**: We'll put it on notice if we need to.

**THE CHAIR**: Yes, we'll put it on notice. Mr Cusack, thank you for attending. You are free to leave.

**Mr Corbell**: Mr Smyth, just a follow up to Mrs Cross' question: it's just been brought to my attention that, following the restructure, in fact three senior executive positions were removed from the ACT Health structure. They are: the previous chief executive of community care; that position no longer exists; the head of community care now is at a general manager level; so a different grade. There was also a division head in community care, which is no longer the case. There was also a deputy chief executive position at the Canberra Hospital, which no longer exists either.

**MRS CROSS**: So the three SES positions have been removed and have either been downgraded or not replaced. Is that right?

**Mr Corbell**: I'm not sure about the division head, but certainly the chief executive of community care and the deputy chief executive at the hospital have moved on; so those positions have subsequently been re-graded.

**MRS CROSS**: Downgraded?

**Mr Corbell**: Well, I wouldn't say downgraded.

**MRS CROSS**: Well, it's either up or down. Sideways?

**Mr Corbell**: It's not as expensive a position, no.

**MRS CROSS**: Are they SES?

**Mr Corbell**: They are SES positions, yes, but they are at a lower grade. They've got a lower grade.

**MRS CROSS**: But they're still SES positions?

**Mr Corbell**: Yes, but they cost less money, Mrs Cross.

**MRS CROSS**: Yes, but my question was rather generic.

**Mr Corbell**: Is your concern about the number of SES officers or is it about how much it is costing us?

**MRS CROSS**: My question was: how many SES officers did you have, or have you budgeted for, within—and I gave you the years—and then I asked you to give me the other figures. I didn't specify grading; I simply said "SES". So anyone that falls under SES, it applies to.

**Mr Corbell**: That's fine; we can provide that information. I just wanted to make the point that there are three senior positions that have gone, but there are other SES positions replacing those, albeit at a lower level.

**MRS CROSS**: Thank you, Minister.

**Mr Corbell**: Is the committee going to need Mr Cusack for the purposes of the output of Calvary Hospital?

**THE CHAIR**: No. Do committee members have any further questions for Calvary Hospital?

**MRS CROSS**: If we find one, we'll put it on notice.

**THE CHAIR**: Mr Cusack, you're free to go.

**Mr Cusack**: Thank you very much.

**MS MacDONALD**: Before I ask the question generally, I want to acknowledge that there is a general shortage, not just across Canberra but across the country, of general practitioners. I know it is very acute in Canberra at the moment, but I would like to know because it is an issue of importance for a number of constituents in my electorate. What efforts are we making to try to address the GP shortages in Tuggeranong Valley.

**Mr Corbell**: The Tuggeranong Valley, I think, cannot be seen in isolation from the rest of the city; there are also serious shortages of GPs in other parts of the city. I think Belconnen in particular is in a similar situation to Tuggeranong.

There are a range of issues affecting the GP shortage. One of them is the fact that, unlike many other regional and rural areas, the ACT, whilst having the same lack of work force, full-time GP equivalents per 100,000 head of population, does not get the incentives that those areas get to get GPs in. And that is a serious concern for me.

Some regions, I think, have about 82.5 full-time equivalent GPs per 100,000 head of population; we're down in the 60s. That is a real issue for us, and I am going to be continuing to make the point both publicly and to the federal health minister that it is discriminatory against ACT residents who pay their taxes, like every other Australian, to not receive that assistance when our number of GPs per 100,000 head of population is worse than many rural, regional or outer metropolitan areas.

That's the first issue. There are a number of other issues affecting GP availability. I think, in the longer term, the government's commitment to assist in the funding of the Canberra Medical School will give us a greater opportunity to retain GPs in the region, because, where GPs train, there's a greater likelihood that they'll stay because the social networks and so on are there. That is something which, in the longer term, will help address GP numbers.

There are a range of other issues, and I might ask Mr Thompson to outline those.

**Mr Thompson**: One of the major other issues that the minister didn't talk about was the restriction of provider numbers and access to GP training places. As you may know, the current federal government in 1996 introduced legislation to restrict the number of new GPs who could enter the work force in particular areas. Urban areas have the restrictions; rural areas don't.

One of the consequences of that is that the ACT finds it very difficult to attract new doctors. The way we do it is either through trying to recruit doctors directly to the ACT—and a number of the GP organisations have tried to do that, with very little success. The other is to try to train GPs; and to train a GP you need to have an accredited training place. The Commonwealth controls the numbers. The ACT gets four training places a year through that, which is nowhere near enough to compensate for the loss of GPs.

**MS MacDONALD**: Why is it so low?

**Mr Corbell**: Well, there are a range of other issues affecting the GP work force. First of all, it is an ageing workforce; there is an issue there. Secondly, there are issues around medical indemnity, and that is influencing GPs' decisions in terms of whether or not they stay in practice. The government is developing its second stage of tort law reform in relation to medical indemnity, and we think that will work to address that issue to a degree.

The other issue, I guess, that is out there is that there is also an issue with after-hours availability of GPs. The government has made a commitment to fund—and the former minister, Mr Stanhope, announced an initiative to provide funding assistance—CALMS, the Canberra after-hours locum medical service, to provide for more GPs to be available after hours to conduct locum services. That initiative is still being progressed, but it is an issue that will be implemented. I think that is a small step we can be taking.

But fundamentally the issues, I think, as Mr Thompson highlights, are around training places, provider numbers. Those are very, very significant in whether or not we're able to get a reasonable number of GPs for our population.

**MS MacDONALD**: I have a question to follow on from what you were saying. You said the Commonwealth gives us four training places. Why is that so low?

**Mr Thompson**: It is, I think, based on a forward methodology that was used by the Australian Medical Workforce Advisory Committee in its 2000 review of the general practice work force. For reasons that I can't explain, they chose to look at the number of GPs in the ACT, as opposed to the full-time equivalent numbers, in making those assessments.

One of the features of the GP work force in the ACT is that a lot of GPs work on a part-time basis, and that contributes to the relative lack of access to GP services. But that was not recognised in the Australian Medical Workforce Advisory Committee report. I will add also that that's currently being reviewed, that methodology, and I'm working with that committee to try to make sure that that mistake is not made again.

**THE CHAIR**: Mr Thompson, was that criteria applied straight across all the states and jurisdictions, or is that just something that was applied to the ACT?

**Mr Thompson**: The main way that the committee allocated trainees was based on urban and rural allocations; so they differentiated between urban areas and other areas in allocating the training process. But at the same time they applied a supply measure; so the ACT was doubly disadvantaged by being considered an urban area. That initially discounted the number of trainees we got. Then there was the mistake about a head count rather than full-time equivalent.

**THE CHAIR**: Yes, sure. But was the head count applied to all the jurisdictions?

**Mr Thompson**: Yes.

**MRS DUNNE**: I just wanted to go back into the question of indemnity. Mr Thompson, I think you might be able to answer this. What does the average GP pay by way of professional indemnity?

**Mr Thompson**: I don't know that.

**Mr Corbell**: We don't know that.

**MRS DUNNE**: Could you get that answer for me?

**Mr Corbell**: I think it's important to note that tort law reform is the responsibility of the Attorney-General, Mr Stanhope.

**MRS DUNNE**: It's not a question about tort law reform.

**Mr Corbell**: No. Well, the reason I say that is simply that they would be the people who would be looking closely at the issue of costs to general practitioners. I think it would be fair to say that it's very difficult to determine that, depending on the company, the premiums, and the work that individual GPs do.

**MRS DUNNE**: Look, there is a monetary figure. It has been quoted to me by federal officials, and I would like an up-date.

**Mr Corbell**: Well, go and ask the federal officials then.

**MRS DUNNE**: I will, at lunchtime. But I would expect that the health policy area would be able to give me a ballpark figure on what a GP pays in indemnity.

**Mr Thompson**: I will add: GPs are private practitioners, and the nature of their indemnity arrangements are private arrangements between GPs and their funds. The ACT government has no role in those arrangements. For us to get the information, we'd need to approach the general practitioners. We can approach the Division of General Practitioners to get that information if it's available, but there's no guaranteeing that the GPs will be comfortable giving it to us.

**MRS DUNNE**: Well, I think in that case the minister can't really spend—

**Mr Corbell**: If I can just—

**MRS DUNNE**: No, let me finish. The minister can't spend time saying it is one of the factors and criticising the federal government about indemnity costs if he can't even tell us what the indemnity costs are.

**Mr Corbell**: I can, Mrs Dunne. The reason I can is that the AMA and the Division of General Practitioners here in the ACT make that claim consistently.

**MRS DUNNE**: But you can't verify that for yourself.

**Mr Corbell**: The AMA nationally makes that claim. I have no reason to doubt that it's the case, and I have no reason to doubt that premiums are increasing. I know that those are issues. I also know that GPs are concerned about the statute of limitations and how that applies, and the fact that it applies long after they can potentially retire from practice. So I don't need to know the actual figure to be confident of those claims, because I think they're fairly well established. I might just ask Dr Alexander to make a comment on some other issues.

**Dr Alexander**: Really, just to expand about the usefulness of applying an average: the premiums are constructed so that they're different for different depth of procedure. So the person who doesn't do procedures might be paying, broadly speaking, around about the $2,500 mark. It goes up depending on the—

**MRS DUNNE**: On the amount of procedures.

**Dr Alexander**: The amount of procedures. Furthermore, because of the calls from the funds, it's not just simply an annual rate that's applicable; it's also the calls because of the crisis in the actual indemnity funds, which has added to the actual annual cost.

You may regard it as a useful figure, but in fact it's a commercially determined figure. The people who are being seriously driven out of practice are those who are in obstetrics and, if you like, high-end, tertiary services.

**MRS DUNNE**: What do you mean by "high-end tertiary services"?

**Dr Alexander**: Things like neurosurgery.

**MRS DUNNE**: But GPs generally don't do neurosurgery.

**Dr Alexander**: No. Sorry, the point I'm getting around to is that the concern at the GP end is largely to do with the legal exposure rather than the actual cost, unless they're into procedural areas where the cost is a very substantial portion of their income. So relatively the non-procedurals aren't nearly as threatening compared to the people doing obstetrics.

**THE CHAIR**: Minister, on medical indemnity, as it falls under public liability: the question is: if you leave it to the Attorney-General and it's tort law reform, that of course is looking at the end of the process when patients haven't got better. You're the Health Minister. In terms of medical indemnity, bringing that insurance down and getting better outcomes for people who are injured, shouldn't we have in place a system more like that which is in place now for workers compensation which insists on rehabilitation rather than cash pay-out?

**Mr Corbell**: Well, issues of tort law reform are considered at a whole-of-government level. Justice is the lead department, and the Attorney-General is lead minister. But obviously it has implications for me as Health Minister in terms of looking at the range of ways to address GP availability.

I am in close contact with Mr Stanhope on these issues. I receive briefings and have discussions with his officers on these issues. These are issues that are ultimately considered at a whole-of-government level. Just because one minister is taking the lead does not mean that no other minister is involved or taking an interest. It's quite the reverse.

**MRS DUNNE**: Well, I certainly got the clear message that you weren't taking an interest.

**Mr Corbell**: No. I think I was making the point that I don't know the detail, for the obvious reasons that my officers have provided in relation to the average cost of premiums.

**THE CHAIR**: Well, the workers compensation reforms, anecdotally at least—and we'll have to wait some time for data—have at least kept workers compensation premiums at last year's level rather than dramatically increase them. The workers compensation system that was put in place in the previous Assembly was based on getting injured people immediate care, rather than giving injured people who survive, through a system, compensation at the end. Tort law reform is about compensation at the end—often seven, 10 years after the injury.

As Health Minister, are you pushing in the negotiations and the briefings with the Chief Minister as Attorney-General for a system that will lead to, if necessary, as it is under the workers compensation system, rehabilitation plans and immediate access to medical

assistance as required, rather than waiting seven years for tort law reform and the golden egg?

**Mr Corbell**: There are a range of measures being considered by the government. I'm not in a position to announce those; they have not been announced by the lead minister. I'm not in a position to announce them at this time. All I can say is that there are a range of measures being considered that certainly look up front at the issues that occur around the beginning of the process as much as at the end of the process.

**THE CHAIR**: So, as Health Minister, are you pushing for rehabilitation to be part of the reform?

**Mr Corbell**: I'm not going to disclose the issues that are being discussed within government. The Attorney-General, as the lead minister, will make the announcement at the appropriate time. But I'll ask Dr Dugdale, as Chief Health Officer, to give some more context to this discussion.

**Dr Dugdale**: The situation is very much as you're describing it should be. Whenever there is an adverse incident in a hospital, or a medical error that may or may not turn out to be negligence, if it's tested in court, it's been general practice in the medical profession to look after those patients as well as we possibly can to rectify the situation or to look after their injuries. That has been increasing in recent years.

One of the particular things there is the notion of open disclosure, where doctors are being encouraged to front their patients and talk frankly about the outcome of their care and to work with the patient to obtain the best outcome. Open disclosure is a cultural change in the profession that's being pursued at the national level by the Australian Safety and Quality Council, which the ACT is represented on, and at local level by the ACT Quality and Safety Forum and by a number of quality and safety audit groups and activities in our facilities here.

So you're absolutely correct that the approach should be to minimise any problems by addressing them as soon as they're identified, and certainly the medical profession and health facilities in the ACT are very much working to improve that, particularly by being open with patients about what problems might have arisen.

**THE CHAIR**: Thanks, Dr Dugdale. I've got one more question on the maths. I notice in BP2, page 8, you say that there's an increase of $17.8 million from the 2002-03 estimated outcomes that are backcast. You've said there are an extra $19 million worth of initiatives which you've assured us is all new money, and we know that there must be at least another $7.963 million to cover the recurrent for the growth funds last year. That comes to about $27 million.

If the increase is only $27.8 million on services delivered in this current year, that leaves you a shortfall of about $9¼ million. Does that mean that $9¼ million worth of services that were delivered in this year won't be delivered next year? Or are there programs finishing; and, if there are, could we have a list of those programs?

**Mr Corbell**: Well I'll refer the question to Mr Foster, in terms of the accounting. I think you've asked the question: are there any cuts to staffing or activity?

**THE CHAIR**: No, I said, "Are there any programs finishing or terminating that would explain the $9¼ million?" But if there are cuts or whatever, that would be—

**Mr Corbell**: I think I provided that answer, and the answer is no. But I'll ask Mr Foster to deal with the accounting.

**Mr Foster**: Not my figures, of course, BP2.

**THE CHAIR**: So we heard earlier.

**Mr Foster**: As always, there are some things that don't continue and there are some items that were dealt with in 2002-03 that aren't continuing in 2003-04. For example, in regard to the Commonwealth's FBT transitional allowance compensation of several million dollars, there was $2.7 million less of second appropriation money than was provided two years ago, which was $8.7 million dropping down to $6 million—and this is the year that drops down to $6 million, 2003-04. So there are reasons why.

But in the context of understanding this number, I actually have to go away and look at how Treasury's come up with that, because Treasury produced this backcast figure. But certainly, there are things that happened in 2002-03 that won't happen in 2003-04—for example, the ones I mentioned.

**THE CHAIR**: And you're happy to provide that list?

**Mr Corbell**: Yes, we'll take that on notice.

**THE CHAIR**: Thank you. No more general questions? Minister, it being about 4 minutes to 1, perhaps we'll stop there and come back to the output classes at 2 o'clock. Members, thank you. Ladies and gentlemen, thanks for your patience this morning.

## Luncheon adjournment

**THE CHAIR**: Minister, thank you for returning. We will move to output class 1.1, acute services.

**Mr Corbell**: Mr Chairman, just before we do—and this is certainly relevant to acute services—Dr Ramsey has some further information on the equipment issue at Canberra Hospital, which was being discussed earlier.

**Dr Ramsey**: I took a question on notice in respect of the deferral of plant and equipment this financial year. I would like to indicate that only one set of equipment was deferred—defibrillators—to the tune of $224,000. That equipment is identified as the highest priority equipment for replacement next financial year.

**MRS DUNNE**: So there is $220,000 worth of defibrillators?

**Dr Ramsey**: That is right. There were 18 defibrillators.

**MRS DUNNE**: What happened to the rest of the $2 million? What was the rest of the $2 million going to be spent on? An amount of $2 million was diverted from equipment purchases to go into other recurrent areas. You said that there is $200,000 worth of defibrillators. Where is the other $1.8 million?

**Dr Ramsey**: There was a deferral of plant and equipment this financial year to manage this year's budget pressures.

**THE CHAIR**: Earlier in the proceedings, Mr Foster said that $2 million had been diverted to meet urgent needs at the hospital, and that the $2 million had come from money that had possibly been allocated for the purchase of equipment.

**MRS DUNNE**: Mr Foster is nodding his head in agreement. Was it $2 million, Mr Foster?

**Mr Foster**: That is correct. Canberra Hospital advised us that that was an action it needed to take during the course of the year.

**THE CHAIR**: Was the other $1.8 million uncommitted?

**Dr Ramsey**: It was uncommitted, that is correct. Against that allocation there was equipment. Again, this is from a priority list of equipment that we intended to purchase. As I said previously, depending on the allocation for plant and equipment, we will work against that priority list to purchase equipment. The allocation was such that we deferred—and they will be purchased next year—an angiography system worth $1.2 million, a replacement gamma camera valued at $500,000 and a transmission electron microscope valued at $300,000.

**THE CHAIR**: The defibrillators were the only urgent item that was deferred, and the other three things you have just mentioned were also deferred?

**Dr Ramsey**: The defibrillators were identified during the financial year as being items that could be deferred until next financial year, to enable us to manage budget pressures.

**THE CHAIR**: The sum total of the other items you just mentioned is $2 million.

**Dr Ramsey**: Thereabouts.

**MRS DUNNE**: I am still confused. You said earlier that you deferred purchasing $200,000 worth of defibrillators and you then listed all these other items. I am sorry, which is it? Did you defer all those items?

**Dr Ramsey**: Those items were deferred from this financial year until next financial year. In addition, during the financial year, we deferred the purchase of $224,000 worth of defibrillators.

**THE CHAIR**: As well?

**Dr Ramsey**: We deferred them as well, to enable us to manage budget pressures. All those items will be purchased next financial year. In fact, we have already entered into negotiations on a number of those items because they have a long lead time.

**MRS DUNNE**: That begs another question. Mr Foster gave us the impression this morning that, during the course of the financial year, you identified $2 million worth of stuff that you would not buy this year. You then decided to divert those funds into other aspects of the hospital. But now, Dr Ramsey, you are saying that you identified those before the beginning of the financial year.

**Dr Ramsey**: If there was a requirement to defer, we identified the items that we could and would defer. Those were the items.

**MRS DUNNE**: When were they identified?

**Dr Ramsey**: They were identified at the beginning of this financial year. Once we received our budget allocation, we decided which items we intended to defer. It was those items.

**THE CHAIR**: Does that mean that, at the commencement of the financial year, you had already identified that you had been underfunded to the tune of $2 million for the provision of services?

**Dr Ramsey**: No. Once we receive our plant and equipment allocation, we decide on expenditure against our priority list. That is what we did.

**MRS DUNNE**: How much do you normally expend on plant and equipment?

**Dr Ramsey**: We normally spend in the order of $4.5 million.

**MRS DUNNE**: So it is nearly half. At the beginning of the last financial year you decided that you would not spend money on the purchase of plant and equipment?

**Dr Ramsey**: I will take on notice that part of your question which relates to the amount of the allocation and to the deferral.

**Mr Foster**: From our point of view, $4 million-plus would probably buy a lot of things, such as surgical instruments, outside that allocation. We can clearly identify that $4 million goes into Canberra Hospital's budget each year for equipment over $5,000.

**MRS DUNNE**: So there is $4 million in the budget, which is what it is set up to have. But at the beginning of the financial year—perhaps even a bit before the beginning of this current financial year—you identified that half that money would be diverted and used somewhere else?

**Dr Ramsey**: No, that is not correct. We identified the areas that we could defer, if required, to manage our recurrent expenditure.

**MRS DUNNE**: I think that answers my question.

**Mr Corbell**: You do not want us to take that question on notice?

**MRS DUNNE**: No.

**THE CHAIR**: We will now deal with output 1.1—acute services. Minister, this morning you corrected the figures. It appears that last year, against what was expected, you did not manage to deliver just over 1,000 services, depending on whether you use ACT public hospital contract weights or national public hospital weights. The excuse given in the notes is the lack of certain professions. Have you corrected that, or do you expect to under provide again this year?

**Mr Corbell**: There is often an issue in relation to the availability of surgeons in a particular speciality or craft group, to use that language.

**MRS DUNNE**: Minister, I do not think you should use the words "craft" and "surgeon".

**Mr Corbell**: People do use those words, Mrs Dunne; that is the language.

**MRS DUNNE**: That is very cynical.

**Mr Corbell**: That is the language that is used.

**THE CHAIR**: It is all right, Mrs Dunne. I have been operated on by an orthopaedic surgeon wearing a Makita power tool hat, which is somewhat scary when you have had your premedication!

**Mr Corbell**: The point I am trying to make is that, in some surgical specialities, a limited number of VMOs, or staff specialists, undertake that work. If those VMOs go on holiday, take leave, or are sick, that has a direct impact on surgery throughput in our hospital. That is a factor we have to take into account. We are working in a small system, so that would have an impact on our targets. However, I am confident that the now-adjusted targets can be met. But that depends, as always, on the availability of surgeons in particular.

**MRS DUNNE**: As you said earlier, Minister, if an orthopod goes on holidays or something like that, you could do a whole lot of eye surgery for that money.

**Mr Corbell**: I am sorry Mrs Dunne, could you repeat your question?

**MRS DUNNE**: If a specialist goes on leave, is sick or something like that, is his spot in surgery not filled by somebody else?

**Mr Corbell**: Sometimes surgeons look after the lists of other surgeons. Sometimes, though, there are no other surgeons around to do that work. I will ask Dr Alexander and Dr Ramsey to give you more information on that.

**Dr Alexander**: A specific reference in the explanatory note relates to recruiting staff for cancer treatment. I wish to say a word or two about that issue, which I believe was also raised last year. The difficulty lies in the two groups that are treating cancer patients. The first group comprises radiation oncologists who are medical specialists prescribing

radiation therapy, and the other group comprises people who are actually operating the machines. Canberra Hospital has a shortage of both types of workers. This is in the context of a national and international shortage, so it is not possible to recruit easily either from Australia or overseas, because of the lack of people being trained.

**MRS DUNNE**: There is a lack of people being trained?

**Dr Alexander**: Yes, not enough people are being taught how to do the work.

**MRS DUNNE**: Is that something the college is doing anything about?

**Dr Alexander**: Susan Killion could talk about the policies that lead to choosing numbers in each speciality, including radiation oncology. Broadly speaking, the problem has been recognised. There is agreement to train more people, but there is a long lead time to get people through. That is one factor. The second factor is attracting people specifically to the ACT. Broadly speaking, that is related to pay and conditions and that kind of thing. That issue is being addressed. The physical set-up of the service is more than adequate; there are simply not enough people to operate the machines. That is one of the reasons why the target was undershot this year.

**MRS DUNNE**: So it is not because orthopods go on holidays; it is because we do not have enough radiation oncologists?

**Dr Alexander**: I mention this because it is one of the significant factors in undershooting in this area and in elective surgery, which is a slightly different area of explanation.

**MRS DUNNE**: You are quite right; it is not just in elective surgery. Does this year's target of 63,000 or 62,000 services—depending on how you count them—take into account the fact that we do not have enough radiation oncologists? Are you predicting less oncology work this year, or is the premise for this year's target the same as the premise for last year's target?

**Dr Alexander**: It is based on performance this year, plus a quantum from growth funding. The way it has been constructed takes into account extra funding in other areas. It is hard to estimate an immediate increase, especially in the throughput of radiation therapy, because of staffing shortages. That is my understanding of the way it was formed.

**MRS DUNNE**: You said that you had growth funding and that 3,000 extra services over the estimated number were funded from that growth funding. However, the reason given for not meeting targets in previous years relates to the unavailability of professionals to perform the services. Is there another explanation for not meeting those targets? Is the unavailability of specialists only part of the reason?

**Ms Killion**: Yes.

**MRS DUNNE**: What are the other reasons?

**Ms Killion**: The estimated outcome for 2002-03 is based on data that is not fully coded. So we are looking at data from just the first two quarters—through January. The estimated outcome relates to the way in which we were tracking. We now anticipate that we will hit the target pretty closely.

**MRS DUNNE**: I am getting contradictory statements. When I first asked why we were not meeting our targets, I got a lot of answers about the unavailability of specialists. Now you are saying, "Don't worry about that because we will meet the targets." What is it? Are we meeting the targets; or are we likely to meet the targets; or are we not meeting the targets because of the unavailability of specialists—or something else? It cannot be all of them.

**Ms Killion**: Yes, you are right. Earlier in the year it looked like we would not meet the targets. That is because we have a shortage of plastic surgeons. We also have a shortage of radiation therapy staff—doctors and other staff. That was the explanation. We have looked further at the data. We may hit the targets, given that we have more throughput at Calvary because it has had extra funding. The staffing issue has not changed but, because of the way in which trends are working in other areas, it looks like the throughput is going up.

**MRS DUNNE**: Do you think the throughput will go up in the second half of the year?

**Ms Killion**: Yes.

**Mr Corbell**: Dr Ramsey has some information that will give you a better picture about the trends.

**Dr Ramsey**: You need to appreciate that the target is a global target of cost-weighted separations, which is made up of a series of subsets. In fact, this focuses only on our in-patient activity. During the year, unexpected things occurred. As an example, this time last year I indicated to you that we were having a continued decline in the number of deliveries and that there had been a downward decline in the number of deliveries at the Canberra Hospital over several years. For the first time that trend has changed direction. This year there has been an increase in the number of deliveries.

That trend, which was clearly unexpected, has generated the equivalent of over 200 cost weights. That was something we had not factored in. We predicted that the number of deliveries would go down, but it has gone up. So that was quite clearly unexpected in one area.

We were talking earlier about surgical specialities. While Canberra Hospital delivers a tertiary level service, its size is such that our sub-speciality numbers are small. In some areas we have only one sub-specialist. Even in the field of orthopaedics, there are orthopaedic sub-specialities. So if one orthopaedic surgeon goes away, there is nobody else to take over the work that that person does.

**MRS DUNNE**: My question then was: if there is no orthopod present at the surgery to perform the necessary operations, is there any flexibility in the system to put in an ENT or O&G man, or something like that?

**Dr Ramsey**: That is what we do. That is how we balance underperformance in one area. We shift the surgical lists and allow another surgeon—if we are talking about surgical specialities—to pick up the slack.

**MRS DUNNE**: Ms Killion referred earlier to the reasons why we are short on plastic surgeons. Where do they fit in, on the scale of cost-weighted separations? Are they at the eye surgery end or the orthopaedic end?

**Mr Corbell**: It can vary. Plastic surgeons are involved in trauma and emergency surgery as much as they are involved in elective-type activity.

**Dr Ramsey**: By way of percentage, it is about the middle of the range of our surgical services, which run from 500 cost weights a year to date for low-end urology, up to 3,000 for orthopaedics and around 900 for plastics. So you can see it is about the middle of the range of our surgical services. If we are short in that area, the cost weights will go down and we allow that to be picked up in another part of the surgical service.

**MRS DUNNE**: I am not really satisfied with the answer that, because we are lacking special surgical staff, we are not meeting our cost-weighted separations. I am sure there is enough flexibility in the system to enable you to fill a hole in the surgery list.

**Dr Ramsey**: Yes, you are quite right. That is the way we manage our operating figures.

**MRS DUNNE**: I hope so.

**Dr Ramsey**: It is more complicated in the example that was given relating to radiation oncology. As that is a discrete specialty, we cannot backfill in that area. So, if our cost-weighted separations are down in radiation oncology, they are just down.

**MRS DUNNE**: Yes, I understand that.

**Dr Ramsey**: The same argument was put forward in relation to midwifery. If those numbers are up—

**MRS DUNNE**: Are you saying that deliveries at Canberra Hospital are up?

**Dr Ramsey**: The number of deliveries at Canberra Hospital this year has increased.

**MRS DUNNE**: Does that mean that the number of births in Canberra has increased, or is it just that people are using Canberra Hospital in preference to some other service? Do you know?

**Dr Ramsey**: I do not know.

**MRS DUNNE**: Will you find out for me?

**Dr Ramsey**: Yes.

**THE CHAIR**: Ms Killion, you just told the committee that you now expect to meet your target this year.

**Ms Killion**: We think we will go close to it.

**THE CHAIR**: Why then did we receive a document this morning that states that you will not; that you will be off the mark by about $1,100? Would it be closer to $62,000 or closer to $60,900?

**Mr Corbell**: I think Ms Killion was making the point that we will come close to reaching that target. There are a number of variables. They are estimates—they are not exact. The department has provided the most reasonable estimate, but it depends on trends for the remainder of this year—and data that comes through.

**Ms Killion**: We were not changing the targets or the estimated outcome for 2002-03.

**THE CHAIR**: But you are more confident now that you will get closer to the $62,000?

**Ms Killion**: We have been looking at trend data for the last few years. We think that we may hit that target.

**THE CHAIR**: The increase in in-patient cost-weighted services is about 2 per cent and the increase in outpatient services is about 4.8 per cent, yet the cost per head of population is set to go up 20 per cent. What is driving that increase? We are spending a lot more money and getting a bit more service, but not anywhere near what we should be getting for that 20 per cent increase.

**Dr Alexander**: We run into difficulty when we compare the two years. I think I am right in saying—Mr Foster might have to help out here—that it is to do with the accounting treatment in those two years. I do not think the number is as high as that.

**Mr Foster**: Sorry—I did not hear the question.

**THE CHAIR**: In 2002-03 we paid $316 million for acute services and, in the coming year, we will pay $383 million, which is $60 million or so more, or a 20 per cent increase. However, we are not getting anywhere near a 20 per cent increase in the number of cost-weighted separations.

**Mr Foster**: As mentioned this morning, the presentation in the operating statement for the organisation for the first year has, under the purchaser-provider framework—which has the department with no depreciation, no provisions and no expenditure for the hospital related to its user charges revenue—$30 million in other revenue, which translates to expenditure. The government payment for outputs represents the government payment; it does not take into account all the other revenue that comes into the system as expenditure against it.

Note (3) on page 146 of BP 4 refers to the fact that the restructure is the main reason for that variation in figures in 2002-03—moving from $316 million to $355 million. The move from $355 million to $383 million is as a result of the impact of indexation, wage rises, new initiatives as they relate to the acute sector, plus the full-year effect of that 2002-03 estimated outcome—which includes only six months of hospital activity—depreciation provisions and costs associated with other revenue.

**THE CHAIR**: The hospital did not previously comply with accounting standards by including depreciation and all those other accounting treatments?

**Mr Foster**: It did in 2002-03.

**Mr Corbell**: It complied with the Financial Management Act.

**THE CHAIR**: Mr Foster said earlier that this year was different because something was added.

**Mr Corbell**: As I understand it, the financial management reporting requirements are different.

**Mr Foster**: In 2002-03, three entities were presented in the budget papers. Each of those entities had an operating result and planned deficits in the case of Canberra Hospital and ACT Community Care. For the purposes of this presentation, we cannot change the original budget for the department because the Financial Management Act does not allow that. So what is presented here is the original budget for the health department.

During the course of the year we brought in Canberra Hospital and ACT Community Care at the consolidated level on page 130. Page 146 brings in Canberra Hospital, as it relates to acute services only. We reflect transactions that occurred in 2002-03 now that the model has changed. However, the budget cannot change and that is why there is a large variation. We are now showing issues that would have been recorded separately by the hospital—directly to Treasury against its original deficit.

**Mr Corbell**: That is a compelling argument as to why accrual accounting is so transparent.

**THE CHAIR**: Exactly. So why was there a move from $316 million to $383 million?

**Mr Foster**: The move from $316 million to $355 million relates to depreciation, planned movement in provisions at the hospital and expenditure associated with third party revenue collected by the hospital. The hospital collects $30 million to $40 million in revenue from patients for meals, facility fees and high-cost drugs. That forms part of the budget for 2002-03, recognising that the hospital received $245 million from the government, plus another $30 million or $40 million in other revenue. So that is a straight expenditure line.

We recognise in the budget hospital expenses for the six-month period since January when the set-up authority ceased. The large rise depicted in the budget papers simply reflects that. In addition, about $3 million is associated with the pay rises that were announced recently and paid in June.

**THE CHAIR**: This is not about the hospital, the department or the other entities; this is about acute services. How many acute services did the department deliver in the first six months of this year?

**Mr Foster**: None. But this outputs-based model relates to the buying or receiving of services on behalf of the community. Each year for the last seven years this budget paper has presented the level of acute care costs and growth, which is linked into the department's accounts and not the hospital's accounts. The hospital's accounts reflect the true cost of services. As a purchaser we were only paying a price over which we had control—the price of services that we were funded to buy. The hospital reflected the full cost of those services in its accounts. It all goes through to whole-of-government reporting.

**THE CHAIR**: Can you back-cast to show us how it works? Is there a simpler or more complex method of producing numbers that confirm the path from several entities to one entity?

**Mr Corbell**: I guarantee that there is a complex method.

**THE CHAIR**: I am sure you could find an even more complex method now!

**MRS DUNNE**: As was said early this morning, we are not sure whether we are comparing apples with apples, because of the number of accounting changes that have occurred. If the committee is to continue to scrutinise this, we need something more transparent. Accrual accounting might be transparent, but you can also make it dense.

**Mr Corbell**: My comment was an ironic one.

**Mr Foster**: Page 147 in Budget Paper 4 reflects the Canberra Hospital component. We put that statement in the budget papers to continue the level of transparency that existed in the past when Canberra Hospital appeared as a separate entity. We produced an operating statement for Canberra Hospital that reflects an estimated 12 months of activity.

You will see in the original budget a deficit of $4.6 million. I mentioned earlier this morning that that item had been back-cast to remove mental health. So if you look at the published budget in 2002-03, you will find a deficit of $5,028,000, which reduced to $4,648,000 as we took out the mental health figures. There you are presented with Canberra Hospital's estimated outcome for 2002-03 and its budget for 2003-04.

**THE CHAIR**: Noting all that, is there a reconciliation we could see which shows the inputs and outputs and lists all the changes from $316 million to $383 million?

**Mr Foster**: Yes. I would have to produce that.

**THE CHAIR**: Is that not too onerous?

**Mr Foster**: It will not happen this afternoon.

**THE CHAIR**: I would be happy if you took that question on notice.

**Mr Foster**: We can do that, but it will reveal what I have said—depreciation provisions, recognition of revenue the hospital collects and spends, new initiatives, indexation and wages—less any one-offs that would have occurred in 2002-03, like the fringe benefits

compensation I mentioned this morning—as well as any second appropriation money that had run out.

**MRS DUNNE**: Mr Foster, there seem to be substantial discrepancies. We are talking about acute services.

**Mr Foster**: There are two hospitals, and other things are spent against acute services. At Calvary Hospital we spend money on behalf of the acute sector for legals, et cetera. So you would not look at the Canberra Hospital figures and think that they equalled output class 1.

**MRS DUNNE**: If it was Calvary plus other hospitals, it would add up to something more.

**Mr Foster**: Calvary has third party revenues that are not represented in our accounts. We provided Calvary's operating statement in these budget papers for the first time, to provide some level of information to the committee and the public. So Calvary would overstate the costs.

**MRS DUNNE**: It just goes to show how murky it is!

**THE CHAIR**: Mr Foster, you referred to Canberra Hospital's chart on page 147 of BP 4. Total ordinary expenses in the outyears do not seem to grow at a very high rate. If my mathematics are right, 2004-05 over 2003-04 grows by only 1.8 per cent; the following year grows by only 1.7 per cent; and the following year grows by only 1.4 per cent, which is less than the CPI increase. Is the budget for Canberra Hospital in the outyears sustainable?

**Mr Foster**: Canberra Hospital's budget for the outyears does not reflect any share of the growth funding we have available for distribution—we make those decisions annually. An amount of $8 million has to be distributed annually, but Canberra Hospital's share has not yet been determined.

**THE CHAIR**: How much growth funding did the hospital get this year?

**Mr Foster**: It got the lot. It got $7 million going into 2003-04.

**THE CHAIR**: It got all of it?

**Mr Foster**: Yes.

**THE CHAIR**: How much did it get in 2002-03?

**Mr Foster**: I would have to check that but, as I mentioned this morning, it got the $627,000 we had not allocated as of last year. I will go through Budget Paper 3 for last year and show you the various initiatives that were funded out of growth funding.

**THE CHAIR**: So in the year 2003-04, Canberra Hospital will get all the $7.9 million growth funding?

**Mr Foster**: Acute services will get all $7 million. Canberra Hospital will get a slightly smaller amount of that.

**THE CHAIR**: There is a split?

**Mr Foster**: Yes. The outyears do not include a share of the growth and they would assume modest pay rise issues—1.3 per cent—which is the framework set up by previous governments.

**MRS DUNNE**: There is no CPI.

**Mr Foster**: There is; there is CPI on the non-salary component of 2.5 per cent. But 2.5 per cent is on a smaller amount.

**MRS DUNNE**: That is not reflected in total ordinary expenses.

**Mr Foster**: It should be, because figures for supplies and services, for example, are going up.

**THE CHAIR**: It is probably because wages are not all of the cost.

**Mr Foster**: That is right.

**THE CHAIR**: The CPI, which is built into wages, would cover the wages cost and you would be taking your chances on the rest of it?

**Mr Foster**: No. Supplies and services are increasing across the outyears. I am not sure why we are assuming that there is no indication in the budget papers, when there is. Employee expenses are also increasing because of the built-in safety net of 1.3 per cent. What is not reflected in the budget papers is any share of the growth money, which would account for larger percentage increases in acute services.

**THE CHAIR**: It makes it difficult for the committee when there is no transparency. You said earlier that a bit of the CPI was built in to cover wages and that there will be more CPI increases in growth funds. Perhaps I should ask this question of the minister. I could sit here with my calculator and book, and quiz 20 people to find out by how much it will go up, but ordinary citizens cannot work it out and they are not able to talk to the minister or officials. Is there some way in which you can improve transparency?

**Mr Corbell**: It is an issue to do with financial reporting across the whole of government. I do not think it is unique to health, albeit health is a large component of the budget. We would, in some ways, take the view that the purpose of estimates committees is to understand these figures better and to report on them to the Assembly. That is why we are able to make that information available to you today.

I am quite happy to look at this issue further and to raise it with my colleague, the Treasurer. Whatever way you cut it, when you look at a budget as complex and as large as the health budget, it is always difficult to report on it accurately and comprehensively. I guess one of the advantages of the estimates process is that you can get a better interpretation of the meaning of the charts and tables.

**THE CHAIR**: All right. Does this assume that in the outyears 2005-06 and 2006-07, acute services will receive all the growth funding as well?

**Mr Foster**: No. If you turn to page 130 of BP 4 you, members of the public and others will see that growth funding is represented because of large rises across the outyears in, for example, government payment for outputs. That is where the growth funding is and, when decisions are taken annually, that is where the growth funds are spent. Acute services will expect to get a major share but other sectors are also entitled to some growth. The $8 million is not hidden somewhere; it is reflected in the outyears on page 130 of BP 4.

**THE CHAIR**: Sure, but, even in the context of page 130, you do not know where it is going. You know that the growth is there because you can see it.

**Mr Foster**: We know that it is in health.

**MRS CROSS**: I refer to page 146 of BP 4 and to two lines at the bottom of that page that set out hospital funding. One is headed "Total Cost" and the other is headed "Government Payment for Outputs." Is it correct to say that, on all indicators, Treasury believes that the bottom figure under "Government Payment for Outputs" is what hospital service costs should be and the top figure under "Total Cost" is what it is actually costing?

**Mr Corbell**: The simple answer to your question is no. Mr Foster can give you some more information.

**Mr Foster**: The bottom line is "Government Payment for Outputs", so we are net funded. The government net funds the organisation. I refer you back to page 130 where you will see that we collect $70 million or $80 million. An amount of $82 million comes in from a variety of non-government sources, including New South Wales, for cross-border people, and patients covered by health funds.

We get money from the Commonwealth for high-cost drugs, we get money from doctors using our facilities and we get bank interest, et cetera. So $528 million is our total revenue for 2003-04, of which the government contributes $433 million. Treasury is not saying that it thinks it should be $200 million when it is costing $380 million. The reality is that we are a net funded organisation.

**MRS DUNNE**: I note that on page 146 you have set targets of one to five for all categories in the hospital's emergency department. Those targets seem realistic. However, I also note that you are not seeking any improvement. Would you explain why you are not seeking any improvement as a result of the extraordinary levels of extra funding that are going into the public hospital system?

**Mr Corbell**: Treatment times in our emergency departments are good, compared with treatment times in jurisdictions nationally. In the highest priority cases we have a good record, as we need to have. People who need treatment straight away get it straight away. In the other categories the targets are both realistic and, I think in all cases, above

national averages. So our hospitals do better in waiting times in emergency departments than the average across the country.

I think there will always be some latitude in relation to the ebbs and flows in an emergency department. The reality is that you do not get a smooth flow through of people all the time—there are ups and downs. These targets are based on the targets of the Australasian College for Emergency Medicine—the college or craft group for medical specialists who work in emergency, which is another debate. We do well within those targets.

**MRS CROSS**: The craft group provided to us the figures that are quoted in these budget papers. Why is it that the craft group provides these figures to us and not to specific hospitals? Does the hospital not have its own measuring system for improving things, rather than maintaining the status quo? I would have thought that 75 per cent could have been improved on by at least 5 per cent.

**Mr Corbell**: I will defer to the experts on this.

**Dr Ramsey**: These national benchmarks are accepted and managed around Australia by all hospitals. What you are asking is whether we aim to improve on the performance indicators?

**MRS CROSS**: Yes.

**Dr Ramsey**: These benchmarks or targets set safe care. The notion is that, if somebody is a category 1, he or she must be treated immediately. The notion of safe care is that you must achieve 100 per cent.

**MRS CROSS**: In a perfect world I suppose we could, but we are not in a perfect world. I am just looking at improvements.

**Mr Corbell**: With category 1 we do. We must ensure that they get a safe level of care.

**MRS CROSS**: I was not talking about category 1; we understand category 1. The figures in this budget reveal that you do not aspire to improve.

**Dr Ramsey**: We beat all these national targets, which you have to understand comes at a cost. We require additional staff to beat these targets. The ACT community pays a premium to enable us to beat those targets. Our emergency department is now an efficient department and, likewise, our staffing levels are benchmarked. If we were seeking to achieve 100 per cent in all those categories, we would have to double or triple staff in our emergency department. We are proud of the fact that we beat those benchmarks. Very few hospitals in Australia do that regularly.

**MRS DUNNE**: I seek clarification on that question. Is the 80 per cent target for category 2 and other categories higher than the national benchmarks?

**Mr Foster**: They are the national benchmarks.

**MRS DUNNE**: What is our performance compared with those national benchmarks?

**Mr Foster**: We beat those benchmarks routinely.

**MRS CROSS**: Why are they not in the budget?

**Mr Foster**: This merely indicates a target.

**MRS CROSS**: So can you tell the committee how we perform?

**Mr Corbell**: Perhaps Dr Alexander can clarify that.

**Dr Alexander**: Bear in mind that the figures apply to both EDs, not just Wayne's ED. The TCH emergency department is geared up as a trauma centre. If you like the worst of the worse cases, as Wayne said, that means a premium on staffing. Calvary, by contrast, which is relatively thin in its staffing, sees an enormous number of patients. So what we have here is a sort of averaging effect. That needs to be borne in mind. What Wayne said is right, but it is not just the TCH experience that is reflected in the table.

**MRS CROSS**: I am pleased that we are doing better than the national benchmarks, but I would like to see it somewhere.

**MRS DUNNE**: Where is it?

**MRS CROSS**: It would be good if we could use it. If our benchmark is higher than the national benchmark, it would be good to boast about it.

**Mr Foster**: We report that in our annual report.

**MRS CROSS**: Could you provide it to the committee?

**MRS DUNNE**: This committee does not look at annual reports; this committee looks at the budget.

**Mr Corbell**: I am advised that that information is also in the quarterly reports I tabled in the Assembly.

**MRS CROSS**: Could you provide that information to the committee, Minister?

**Mr Corbell**: I can provide you, again, with the last quarterly report.

**MRS CROSS**: Your party promised a series of GP clinics in Canberra, which would have at least reduced category 5 patients in emergency departments. When do you expect to deliver on that promise? I have not been able to find it in the budget papers.

**Mr Corbell**: First and foremost, the government did not say it would provide those clinics; it said it would investigate the provision of those clinics on hospital grounds.

**MRS CROSS**: I agree to disagree on that one.

**Mr Corbell**: That is what the government said. The government and I were not going to commit to those measures until we knew the outcome of the Australian health care agreement. As you heard this morning, the provision of GP services, which is a primary care issue, is the responsibility of the Commonwealth. I will be seeking a range of things, through negotiations as part of the Australian health care agreement, to try to get better levels of Commonwealth assistance for GP services. Only when I know the outcome of that will these other avenues be pursued further. It is unreasonable to ask Canberrans to pay twice for something they have already paid for through their taxes which they are not getting from the Commonwealth government—that is, decent primary care.

**MRS CROSS**: Minister, you are misrepresenting what I said. One of the rules established by health is that you cannot misrepresent a member of these estimates committees. My question did not infer that Canberrans should pay double; I was saying you made an election promise that you have not kept and which I do not see in the budget papers. That is what I said.

**Mr Corbell**: I have explained it to you, Mrs Cross.

**MRS CROSS**: What you are doing is digressing and putting—

**Mr Corbell**: This is a bit like the Assembly, Mrs Cross. You cannot require me to give you the answer you want. I am giving you the answer that I believe to be accurate.

**MRS CROSS**: As long as you do not mislead this committee by misrepresenting me.

**Mr Corbell**: I am not misrepresenting you, Mrs Cross.

**MRS CROSS**: Yes, you are.

**Mr Corbell**: Where?

**MRS CROSS**: Did I say that Canberrans should pay twice as much?

**THE CHAIR**: No, you did not, but I do not think the minister said that you said that.

**Mr Corbell**: I do not think I said you said that, Mrs Cross.

**MRS CROSS**: We will check the minister's statement in *Hansard*.

**Mr Corbell**: I would be delighted if you did that. Let me clarify my answer for you. First, the government is committed to investigating the provision of those clinics. Second, the government will still do that, once I know what provisions are in the Australian health care agreement to improve primary care and the access of Canberrans to GPs.

**MRS CROSS**: In elective surgery, you have included only category 1 patients as targets. Surely you would be keen to set targets for each of those categories, considering the large additional sums of money hospitals are spending?

**Mr Corbell**: Could you repeat your question?

**MRS CROSS**: In elective surgery you have included only category 1 patients as targets.

**MRS DUNNE**: Budget Paper 4 refers to "Percentage of persons classified as Category 1 patients on the public elective surgery waiting list."

**MRS CROSS**: I would have thought you would have been able to set targets for all categories, considering the large additional sums of money hospitals are spending.

**Mr Corbell**: I believe that the government is accountable on this. Every month a hospital bulletin outlines how we are performing in relation to our waiting lists. That includes the number of people receiving treatment within clinically-appropriate times in all categories.

**MRS CROSS**: Would you be prepared to suggest targets for all categories of elective surgery and provide that to the estimates committee for its consideration?

**Mr Corbell**: I am happy to consider that for future budgets, yes. It depends on whether or not you make a recommendation along those lines.

**THE CHAIR**: Mr Corbell, for the sake of your memory and in order to assist Mrs Cross, I quote from page 2 of your three-page health fact sheet, which states that Labor will therefore establish at least two after-hours clinics.

**Mr Corbell**: Yes, but that was dependent on getting federal government policy settings which allowed that.

**THE CHAIR**: It does not quite say that.

**Mr Corbell**: Yes, it does.

**THE CHAIR**: I will read the whole paragraph. It says:

> Labor will therefore establish at least two after-hours clinics, staffed by general practitioners, to treat those patients with less serious illnesses. This initiative will be developed in consultation with the AMA and existing locum services.

It goes on to state in the next paragraph:

> These new after-hours clinics should be at Canberra and Calvary Hospitals. But current Commonwealth–Territory funding arrangements prevent this. Kim Beazley's Medicare after-hours policy will help fix this.

Well, maybe not.

**Mr Corbell**: Obviously not.

**THE CHAIR**: Quite clearly, there is a promise to establish two after-hours clinics. However, two budgets later, they have not arrived.

**Mr Corbell**: It was dependent on Commonwealth policy settings. That is the answer I have given to the committee.

**MRS CROSS**: Minister, I refer to the last line in the table on page 146. Does that mean there was an increase between what you budgeted for last year and what you were able to deliver in this output alone, of $112.60 for every 1,000 people in Canberra? Are you now budgeting for an extra $86.60 for every 1,000 people? What actions are you taking to ensure the figure remains at $86.60 and does not blow out to an extra $100 or $200 on top of that?

**Mr Corbell**: Are you referring to the cost per 1,000 head of population?

**MRS CROSS**: Yes.

**Mr Corbell**: If I am reading your question correctly, we could only achieve that outcome by not paying people adequate rates of pay. We are not going to do that. The reality is that the cost to the service goes up if we have to pay them all.

**Mr Foster**: The same issue relates to the restructure—bringing into this table full costs of acute services that were not there before.

**MRS DUNNE**: Minister, for the edification of this committee, you made the point earlier that a lot of this stuff was dependent on the outcome of the health care agreement, which is about the provision of primary service. Correct me if I am wrong, but I thought the health care agreement was about the provision of hospital funding. If I am wrong, can you give me an exposition on what the health care agreement covers?

**Mr Corbell**: Yes, you are correct. The Australian health care agreement covers funding for public hospitals. However, there is a close relationship between the Australian health care agreement and the arrangements the Commonwealth makes through Medicare in relation to the provision of improved bulk-billing services and GP numbers. The Commonwealth, after negotiations, seeks to split these and to say, "That is our business. We are talking to you only about public hospitals."

The Commonwealth is ignoring the close relationship between how primary care works and how hospitals work—something that I am sure everyone would accept. If there are fewer GPs in the community, more pressure is placed on our emergency departments. That is just a simple example.

**MRS DUNNE**: Minister, I have to ask you to withdraw a misrepresentation.

**Mr Corbell**: I have not misrepresented anything.

**MRS DUNNE**: You said that the health care agreement was about the provision of primary health care.

**Mr Corbell**: Mrs Dunne, if you just let me answer the question, I will ensure that I put your mind at rest. The point I was trying to make is that, nevertheless, there is a capacity in the Australian health care agreement to incorporate particular programs and measures to address, for example, issues such as the category 5 demand in our emergency

departments. Those issues can be explored through the Australian health care agreement, if the Commonwealth is willing to negotiate.

The problem I have at the moment is that the Commonwealth is not willing to negotiate on any aspect of its offer—even though, across the country, it means $1 billion less into public hospitals—at the same time as it is delivering to private health insurance companies a 17 per cent increase in the amount of premiums they charge on health insurance. That is just not equitable. I will ask Mr Thompson to elaborate a bit more on the Australian health care agreement issue that Mrs Dunne has raised.

**Mr Thompson**: It is important to examine exactly what the Australian health care agreements have covered in the past. With the introduction of Medicare, the Medicare agreements were solely focused on compensating states for extra costs arising from the provision of free hospital services to meet the Commonwealth government's policy settings. Subsequent agreements have expanded the role of Australian health care agreements.

The vast number of agreements included a range of additional programs—things such as palliative care, mental health, case-mix development, national health development, funding, quality, safety and so forth. So it is a routine feature of Australian health care agreements, and it is a feature of the Commonwealth offer that is on the table, to include not just public hospital funding but a range of other funding measures.

**MRS DUNNE**: Of the list of things you rattled off, which ones do not directly relate to public hospital funding?

**Mr Thompson**: They all have a component of public hospital funding but they all have a component that is not about public hospitals. Mental health is a good example. Mental health is provided in a range of settings, from acute in-patient settings and public hospital settings right through to community-based services. So, unquestionably, the Commonwealth's policy direction in mental health is to limit the amount of hospitalisation and to support people, wherever possible, in their homes. That funding is provided through the health care agreements, with the explicit intention of reducing hospitalisation for that area.

**THE CHAIR**: Mr Thompson, is it not true then that current Commonwealth-Territory funding arrangements prevent the establishment of after-hours clinics at Calvary or Canberra Hospital?

**Mr Thompson**: Current Commonwealth policy settings prevent the billing of Medicare for those clinics.

**THE CHAIR**: But it does not prevent the establishment of after-hours GP clinics at Canberra and Calvary hospitals?

**Mr Corbell**: It prevents the establishment of after-hours clinics that bulk-bill.

**THE CHAIR**: The question was directed to Mr Thompson.

**Mr Corbell**: The issue is a matter of government policy. I will answer the question. The government's policy was targeted at making bulk-billing available to people again. The whole point of having after-hours clinics is to enable people to bulk-bill, otherwise we are simply funding a service that should be provided by the Commonwealth.

**THE CHAIR**: I do not see anything in your policy that refers to bulk-billing. Quite clearly, the current arrangements do not allow—

**Mr Corbell**: If you look at Mr Stanhope's speeches and comments in the lead-up to the last election you will clearly see this government's policy intention—that is, to improve access to bulk-billing. Reference in that fact sheet to Kim Beazley's Medicare plan is all about improving access to bulk-billing—something that has been sadly lacking for the past seven years or so under the federal Liberal government. We have seen a massive decline in bulk-billing. Bulk-billing in the ACT is now at a record low. Only about 50 per cent of all GPs bulk-bill compared to the national average, which is 74 per cent. So that is the issue. Mr Smyth, you can try to interpret Labor Party policy all you like, but the reality is that you are not an expert on it.

**THE CHAIR**: Mr Corbell, I would not want to be an expert on Labor Party policy. I wish to read the entire section from priorities health care fact sheet 3 entitled "Labor's New Initiatives", as it is very instructive. Stop me when I refer to the word "bulk-billing." This is the fact sheet that you issued to the community. Under the heading "Labor's plan to rebuild ACT health", it states:

> Labor will therefore establish at least two after-hours clinics, staffed by general practitioners, to treat those patients with less serious illnesses. This initiative will be developed in consultation with the AMA and existing locum services.
>
> These new after-hours clinics should be at Canberra and Calvary Hospitals. But current Commonwealth– Territory funding arrangements prevent this. Kim Beazley's Medicare after-hours policy will help fix this.
>
> Further, Labor will address health needs in the area of mental health. Labor will provide greater support for people with mental health problems. It will give greater opportunity for people, and the broader community, to influence the development of policy.

The document goes on to state, in bold print:

> Labor accepts that there are cost implications in these commitments. As part of its Code of Good Government, Labor undertakes to have all its commitments independently costed and presented to the community before the election.

The word "bulk-bill" does not appear.

**Mr Corbell**: As you have made that comment, Mr Smyth, I would appreciate an opportunity to respond.

**THE CHAIR**: I am just reading your fact sheet, Minister.

**Mr Corbell**: Indeed, and I would appreciate an opportunity to respond to your misrepresentation of that fact sheet.

**MRS DUNNE**: Did you add any words or take any out, Mr Chairman?

**MR HARGREAVES**: The minister has the right to respond in silence.

**Mr Corbell**: The reference to Kim Beazley's plan and to current policy settings demonstrates an inability to establish GP clinics that bulk-bill. That is pretty obvious.

**THE CHAIR**: It is clear, if you had bothered to read Mr Beazley's plan. I would suggest that most Canberrans did not read it.

**MR HARGREAVES**: This is an estimates committee hearing. The minister should be permitted to respond to the Chairman's question.

**THE CHAIR**: After the minister has responded, we will wrap up this section.

**Mr Corbell**: That document explicitly refers to the fact that it is not possible to do this under current Commonwealth policy settings. Those current Commonwealth policy settings prohibit any charging for medical services—even bulk-billing—on the grounds of public hospitals. Clearly, our intention was to establish bulk-billing clinics on the grounds of public hospitals. We cannot do that because, as it states in this policy document, current policy settings prohibit it.

**MRS DUNNE**: Are you saying, Minister, that current policy settings prohibit the levying of a charge for a medical service on hospital grounds?

**Mr Corbell**: Public hospital services have to be provided free of charge.

**Mr Thompson**: The issue is billing to Medicare and our billing to the program the Commonwealth funds, as opposed to ACT government funding.

**MRS DUNNE**: Let us take, for example, Calvary Hospital. If someone established a bulk-billing clinic, or any sort of clinic, in Calvary Hospital, would that contravene current policy settings in the health care agreement, or would you have to co-locate a bulk-billing clinic in the emergency room?

**Mr Thompson**: A couple of elements are involved. It depends on the employment arrangements of the staff. If the ACT government is employing the staff, it is prohibited. If private practitioners provide services on the grounds, that is okay and they can bulk-bill.

**MRS DUNNE**: Which is why CAHMS operates.

**Mr Thompson**: Yes, exactly. CAHMS currently operates on both TCH and Calvary campuses. The Commonwealth is very concerned about this issue. Essentially, if the Commonwealth believes that we are setting up these services to reduce ACT government outlays at the expense of Commonwealth outlays, it will prohibit it.

**MR HARGREAVES**: I would like Mr Thompson to explore further the notion of cost shifting. As I understand it, that is what the Commonwealth's beef is all about. In fact, the Commonwealth is not keen on copping the cost of a GP service because of our agreement to fund hospitals. That is the root cause of this problem. I would like Mr Thompson's opinion on that and on the difficulties we are experiencing attracting GPs in both the private and public sectors.

There has been some criticism about the fact that the government is not attracting GPs. We would like to have as many GPs as possible, but if they are not available and no-one wants to come to Canberra, we have to come up with alternatives. As Mr Thompson has been looking at alternatives, I would like him to address this issue.

**Mr Corbell**: The part of your question relating to attracting GPs was answered this morning. For the purpose of the record, Mr Thompson can certainly outline some of the measures the government is taking to improve access to GP services.

**Mr Thompson**: I do not want to comment on the reality or otherwise of cost shifting. The ACT is experiencing a steady decline in the number of GP services. The number of GP services per capita in the ACT is the lowest of any state or territory except for the Northern Territory.

I will refer to some of the government's initiatives. One important point is attracting doctors to the ACT. A related issue is where and how doctors choose to practise—an important factor when giving consideration to the models we have developed. Currently, we are working with local CAHMS services to try to improve the coverage and the number of after-hours services that are provided. I believe that working with local GPs in that way, in the first instance, is a more effective way of doing it. If that does not work, obviously we will need to look at other measures, but that is a current undertaking we are hoping to roll out soon.

The issue of attracting doctors to the ACT has been the subject of a lot of consideration and attention by doctor groups, as well as the ACT government. As I explained earlier this morning, part of that involves federal policy settings, which exclude the ACT from incentive programs provided to rural and outer metropolitan areas, and part of it involves the restriction of provider numbers and limited training places.

There is another factor about Canberra. For whatever reason—you will see this also in hospitals—it is difficult to attract doctors to Canberra. We do not know why that is. We could speculate and say it is because of competition from Sydney, but why would someone come to Canberra when he or she could work in Sydney?

**MR HARGREAVES**: It is because they are geese.

**Mr Thompson**: It is difficult to establish the reason for that. I do not have a clear answer.

**MR HARGREAVES**: The family medicine program used to be a great source for the training of "baby doctors". How many doctors are going through that program?

**Mr Thompson**: The numbers are restricted. It is not called the family medicine program anymore; the doctors are called GP registrars. Several organisations around the country undertake GP training, but the number of doctors that go through that program is tightly regulated.

**MR HARGREAVES**: Who is the regulator?

**Mr Thompson**: The Commonwealth government. We have been advised that the ACT will have four trainees in the 2003-04 financial year.

**MR HARGREAVES**: Can you tell me, off the top of your head, how many trainees there were in the last couple of financial years?

**Mr Thompson**: I cannot tell you off the top of my head. I can take that question on notice.

**MR HARGREAVES**: Would the figure be greater or lesser?

**Mr Thompson**: It would be similar. Since the Australian Medical Workforce Advisory Committee report in 2000, the number of trainees in the ACT has been largely stable and at a similar level—about four per annum.

**MR HARGREAVES**: So what you're saying is that, apart from the environmental issues you spoke about previously, the federal bent on not allowing the ACT to be regarded as a rural area and all those sorts of things—in fact, keeping that low level of people going through those programs—is acting as a further disincentive to us in recruiting GPs. Is that true?

**Mr Thompson**: It's not even a disincentive, it's just a barrier. We can't vary that, because we can't get past that barrier.

**MR HARGREAVES**: That's not within our rights at all, because the Commonwealth government has full charge of that?

**Mr Thompson**: Yes.

**THE CHAIR**: Minister, looking back over the past couple of years as to the readmission rates, in the year 2001-02, we aimed for 3.4 per cent but the estimated outcome was 2.9 per cent. For the year 2002-03, we've set ourselves a target of 3.2 per cent. It looks like that is still the estimated output for the year. If the target for next year it to remain at 3.2 per cent, is there a reason why we're not going to strive to get down to the 2.9 per cent that we might have achieved the previous year?

**Mr Corbell**: I'm happy to ask our office to provide some more information. However, my understanding is that this is based simply on our experience to date, and the trend. These are very difficult things to anticipate, so we rely on what occurs in previous years to determine the target for future years. I might ask Dr Alexander to elaborate.

**THE CHAIR**: I understand programs were put in place for the specific purpose of bringing this target down. Could you confirm that, and tell us how effective those programs have been?

**Dr Alexander**: I can address the first bit, but will have to defer to others for the second bit. The first bit is that 3.2 per cent is the national standard set by the Australian Council of Healthcare Standards. That is a national benchmark number which allows comparisons between places. That is why it's chosen as one of the output classes. We're aiming for 3.2 per cent or less. I suppose it could be argued that it should gradually come down. However, the reality is that that's considered to be acceptable practice, similar to the discussion about the ED responsiveness.

**THE CHAIR**: Will we achieve 3.2 per cent this year, or will it be less?

**Dr Alexander**: From looking at the data over the past few years, it's been that or less—yes.

**MRS DUNNE**: What was it last financial year?

**Dr Dugdale**: Sorry, what was the specific question?

**THE CHAIR**: The readmission rate.

**MRS DUNNE**: In 2001-02, the target was 3.4 per cent. At estimates time last year, the estimated outcome was 2.9 per cent. What did you achieve in 2001-02?

**Dr Dugdale**: I haven't got those figures.

**THE CHAIR**: We are happy for you to take that on notice.

**Dr Dugdale**: Could we clarify the question?

**MRS DUNNE**: What was the final readmission rate for 2001-02?

**Dr Dugdale**: We'll take that on notice and get back to you shortly.

**MRS CROSS**: Minister, regarding oncology, could you advise the committee if the oncology unit of the Canberra Hospital has requested any additional funding?

**Mr Corbell**: I'm not sure if the oncology unit has requested additional funding. We have a number of pressures in radiation oncology, with radio-oncologists and technicians. Those relate primarily to national work force shortages and our lack of ability to attract people to Canberra because of the national work force shortages. That is putting pressure on radiation oncology. It means we are not performing as well in radiation oncology as we should be, because we just don't have enough radiation oncologists. Either Dr Ramsey or Dr Alexander can elaborate further in relation to any funding requests.

**Dr Alexander**: There's no formal request through the budget papers for additional funding.

**MRS CROSS**: Have you put money in the budget for the oncology unit?

**Dr Alexander**: It's part of the Canberra Hospital's funding.

**Mr Corbell**: I'll ask Ms Killion to clarify the situation.

**MRS CROSS**: Has it received extra funding? Ms Killion, thank you for coming to the table. This is an issue that your government has said it is interested in, since we got into this Fifth Assembly. There is a reason why I remember this issue specifically. In the first sitting week of the Assembly, I caught Mr Quinlan sleeping in the chamber. At the time, my colleague Mr Pratt and I were having a bit of a giggle about it. When Mr Stanhope got up to talk about the oncology unit at the Canberra Hospital, he had a go at me because he thought I was laughing about cancer and oncology. You will probably recall that.

I know the issue of cancer is very close to his heart. It's certainly very close to a lot of us who have had family members suffering with cancer. I have lost someone to cancer in the past six months. I have gone into the oncology unit and seen how dedicated and hardworking the staff there are. You've had a year and a half to address the serious problems, including the radiographer issues. At the time the Chief Minister said that said was a problem, and that it was going to be treated as a matter of priority. I've spent a lot of time going through the health aspects of the budget. I don't see anything in there which specifically addresses the urgent needs of the oncology unit. Maybe it's there and I haven't seen it.

**Mr Corbell**: I'll ask Susan and Wayne to respond but I will say briefly, first of all, that the government has taken steps to ensure that rates of pay for the various specialists we need in radiation oncology are competitive. We now have competitive rates of pay.

**MRS CROSS**: So you're attracting them to Canberra?

**Mr Corbell**: We are still having difficulty attracting people to Canberra. The reason is that there are simply not enough people who are trained to do this work. That is a national work force shortage issue. It's not unique to Canberra, it's not driven by decisions made in Canberra—it's driven by a lack of sufficiently trained people.

**MRS CROSS**: What is your government doing to address it?

**Mr Corbell**: It is not something we can address on our own. We do not train radiation oncologists. We rely on our representation at national forums, such as the Australian Health Ministers Forum, to discuss these matters and get a coordinated national approach. The only way you're going to address work force issues is through a national approach. This is not unique to the ACT—every state and territory has this problem.

**MRS CROSS**: But you can't pass the buck. Someone's got to take ownership of it.

**Mr Corbell**: I'm not passing the buck. The point I'm making is that, on our own, we can do nothing about the national work force. However, the ACT is a member of the COAG forum, which has all health ministers sitting on it. This issue has been raised with the Commonwealth and the Commonwealth has taken particular views about how these

issues can be addressed. I'll ask Ms Killion, first of all, to speak about what supplementation has been provided in this area. I will then ask Dr Ramsey to address some of the capital works money appropriated in this budget for this area.

**Ms Killion**: There was a second appropriation in the financial year 2001-02. In January there was funding for two multi-leaf collimators and a scanner planner. There was also funding to establish pay parity for therapists and there's $80,000 in the capital works budget for upgrade of the medical oncology unit in 2003-04. So some funding has been put towards that. My understanding is that the shortage is not so much a funding issue as just a shortage issue. I'm sure Dr Ramsey can tell you about that.

**Dr Ramsey**: I'd like to follow on. There's a lot more to the issue about radiation oncology than remuneration of staff. There were issues with the quality of the equipment available to deliver the service. That was quite clearly recognised. As Ms Killion has indicated, that issue has been addressed. The equipment is there now and is operational. It's made a big difference to the work environment.

The staff who were working in radiation oncology 12 months ago were very dissatisfied because of the work environment. That's often translated into anxiety about remuneration. By improving the work environment and allowing our therapists and radiation oncologists to practise high quality medicine, there is now a much better feel in that part of our organisation.

That's translating it, from my perspective, into retention of the staff who are there. Up until then, we were experiencing wastage of staff because we couldn't replace them. We now have a steady state with the staff we have there. That then starts to factor into: can we recruit? I'd suggest that, once you have a stable work force and a work environment that is providing high quality care—and it does—then we have a greater ability to attract into our locality.

However, at the end of the day, there are national and international work force shortages, and Canberra has to compete with the open market. It's a sad irony that we have difficulty attracting people to work in Canberra but, when they get here, the members of our work force are happy to stay. It's just a matter of attracting them.

**MRS CROSS**: For how long would you say the morale of the oncology unit staff has been on the upswing? You said that, 12 months ago, it was low.

**Dr Ramsey**: Yes, it was.

**MRS CROSS**: For how long would you say the improvement's been in place?

**Dr Ramsey**: Now we're being very subjective.

**THE CHAIR**: This is a very good opportunity to suck up to the minister. Had you said that in December last year, you'd have a job for life.

**MR HARGREAVES**: I'd take that one.

**Mr Corbell**: Thanks for the vote of confidence, Mr Smyth.

**Dr Ramsey**: I can't say that, because I started at the Canberra Hospital only in April last year.

**MR HARGREAVES**: I'd say 11 months, Dr Ramsey, if I were you!

**Dr Ramsey**: In fact, when I arrived at the Canberra Hospital, morale was very low in that department. That was a little over 12 months ago. As I've visited that department on a number of occasions more recently, I've found morale to be improving. This year, I'd say that morale is much better. That's not to say that there's no room for improvement—quite clearly there is. The staff there believe that a lot more can be done.

You'll find that any health professional in a hospital wants to do more. They know what the shortfalls are, and they find it very difficult to be associated with a service that has to turn patients away—and so do I. I find it very difficult that we can't manage the throughput which exists in our region. They at least have a satisfactory work environment.

Some of the equipment that we had was creating occupational health and safety problems. We were physically harming our staff because of the nature of the equipment. We've been able to resolve those sorts of issues by putting in place new equipment. With those sorts of changes, the staff understand that we take their health and well-being seriously—and we put a lot of money into that particular area.

**MRS CROSS**: Dr Ramsey, when was the new equipment put in place?

**Dr Ramsey**: It was phased in over last year.

**MRS CROSS**: When was it finished? When was the phase completed?

**Mr Corbell**: It was purchased by this government.

**MRS CROSS**: We're not interested in the purchase. I want to know when it was put in.

**Mr Corbell**: It was put in last year.

**MRS CROSS**: When?

**Dr Ramsey**: It was put in during the year—and the last pieces of equipment were put in towards the end of the year. I can get the exact dates, if you like.

**MRS CROSS**: Okay. So the equipment has been upgraded—that's great. We still have a serious morale or staffing problem.

**Mr Corbell**: No. I think Dr Ramsey's saying we have an improving morale scenario, actually.

**MRS CROSS**: Perhaps you could do a survey on that. The complaints I get from constituents are not against the staff, the doctors or the quality of care, but the fact that many of these people are overworked. There seems to be an inflexibility with the nursing

roster, which means that the hours make life much more difficult for those staff. If you've got the equipment right, that's fantastic and I congratulate the government on doing that, but we have a serious problem with staffing. This translates through, in many cases, to terminally ill people. This flows on to their families—their relatives—and they wear a lot of the stress.

Wouldn't it be better for us to look at addressing the nursing issue? Couldn't we introduce a more flexible nursing working arrangement so the nurses are not as stressed-out because they have to work from then to then? We could have a situation that's more flexible. That's one thing. The second thing is fixing the department up—because it looks bloody awful. It's one of the most miserable looking places where a terminally ill person can go to get treatment.

**Mr Corbell**: Dr Ramsey will give you some good news in relation to capital works, Mrs Cross. In relation to pressures on staff, yes, there will be pressures on staff when we are not able to see people and provide them with treatment within appropriate times. That's always going to create a very difficult environment for the staff to work in. I think they manage exceptionally well in that very difficult environment.

The reason we cannot treat all people within the appropriate timeframes is because of work force shortages. We cannot employ the technicians and medical specialists we need to do that work, because there aren't enough of them. It's not because we are not paying them enough, because our pay rates are now good.

**MRS CROSS**: Are you putting programs in place to train people for the future?

**Mr Corbell**: Just let me finish. It's not because of our pay rates because our pay rates are competitive now. It's not because of our equipment because our equipment is good quality now. It's because there are not enough of these specialists. You can't just start training someone and expect to fix the problem now, because training medical specialists takes extended periods of time. It's not even one, two or three years—it's five or ten years.

**MRS CROSS**: So your contingency plan is what?

**Mr Corbell**: The way the government is addressing this is by working with other governments in national forums, along with the Commonwealth, to get sufficient work force responses in place so we can address it. That's the only long-term solution to the issue. We hope we can sell Canberra better as a place for people to come and work. A lot of effort goes into that.

**MRS CROSS**: You've just said that the problem is a shortage in the work force. Selling Canberra better to people who don't exist is irrelevant.

**Mr Corbell**: Yes, but we can try to poach people from other places.

**MRS DUNNE**: Actually, this is a question I've been wanting to ask for some time. Are you poaching people? Are you knocking on people's doors and saying, "Come to Canberra to practise?"

**Dr Ramsey**: We try to poach all the time.

**MRS DUNNE**: Good!

**Mr Corbell**: I will ask Dr Ramsey to address the capital works issues that were done at this unit.

**Dr Ramsey**: I indicate that we, likewise, have concerns about the facilities for both radiation oncology and medical oncology. This financial year both areas have had money allocated for a feasibility study for capital works. Both of those feasibility studies will commence shortly. We will undertake a feasibility study—and that will identify future works to improve those areas.

**MRS CROSS**: Could you give us a timeline for that feasibility study as to commencement, when you hope to have your draft report ready, and when it's going to the minister for consideration?

**Mr Corbell**: I think it's important to stress what the process is. The feasibility study will be completed in the next financial year.

**MRS CROSS**: In time for the next election?

**Mr Corbell**: No. In time for the government's consideration of the next budget.

**MRS CROSS**: The election budget?

**Mr Corbell**: Well, how about that? Elections happen every three years and our third budget is coming up. Gee, that's a coincidence!

**MRS CROSS**: Yes, I'll go and tell all the people who are dying of cancer that we'll wait until the next election to get this resolved.

**Mr Corbell**: No. With all due respect, Mrs Cross, I don't think it's reasonable for you to make a cheap political point out of an issue which, quite frankly, is beyond our control.

**MRS CROSS**: I don't have to make cheap political points with you, Minister. I'm an independent.

**Mr Corbell**: With all due respect, don't accuse me of timing initiatives in the context of people dying of cancer. We all know people who have died of cancer. I've had people in my family die of cancer. It's a cheap political point. The reality is that this government has, in the past 18 months, introduced better equipment and better rates of pay—and has invested the money in capital works to start an upgrade of this very important facility. The only reason we don't achieve reasonable levels of service is because there are national and international work force shortages. That is the only reason. Don't give me this nonsense about people dying on my shift. That is outrageous, and I won't put up with it.

## Short adjournment

**Mr Corbell**: Mr Chairman, with your forbearance, Dr Ramsey has some additional information about unplanned readmissions, which you asked about earlier, so I'll hand over to him.

**Dr Ramsey**: You recall that you asked for the unplanned readmission rate and the benchmark was 3.5. The average for the territory is 2.8 per cent, which combines Canberra Hospital and Calvary, and Canberra Hospital for June 2001 to June 2002, which was 13 months rather than the 12 months, was 2.97 per cent. That would indicate that Calvary Hospital's readmission rate is better than Canberra Hospital's, and both are much better than the benchmark expectation.

**THE CHAIR**: Congratulations.

**Dr Ramsey**: And that mix is what I would expect as well. Canberra Hospital is taking the higher acutes, so there's a slightly increased chance of readmission.

**THE CHAIR**: Well done, and well done to all that made that happen.

**Dr Ramsey**: Thank you.

**THE CHAIR**: We have one last question for output class 1.5, and it had better be a good question, and then Dr Ramsey and his staff may depart.

**MRS DUNNE**: It is a good question, yes. In the initiatives, there is money for additional registrars, $300,000 this year and increasing in the outyears. Where is that going to be applied? Is that an issue for accident and emergency or is it across-the-board?

**Dr Ramsey**: No, it's across-the-board.

**MRS DUNNE**: How many additional registrars do you get for $300,000?

**Dr Ramsey**: That's a good question. It depends on the area that we employ them because, depending on the area that we employ them, it has an impact on the amount of overtime that they do. In some specialities, there's more overtime, so it actually costs us more per registrar. The $300,000 will buy us at least two registrars, and it could be in the order of 2½ registrars.

The funding that we have received for the next financial year is immediately targeting two registrars. Because of the way the registrars are recruited–they recruit on a calendar year rather than a fiscal year—and because of service demand requirements, those two registrars have, in fact, started in the medical department, so the two are medical registrars.

We've carried the cost of those, we've held the cost of those registrars, and we've managed that from within our own budget, so this money will allow us to maintain those two registrars, and we would expect over outyears to increase the number of registrars so that we can continue to provide the growing services and also to meet our research and teaching requirements as a teaching hospital, in part, and linked to the ANU medical school.

**MRS DUNNE**: What sort of impact will that have on throughput, or is it more an occupational health and safety/best practice sort of issue?

**Dr Ramsey**: It's best practice. These positions are tied to training positions. This is training of the future work force, so it comes into the discussion we've previously had about growing the work force. It will assist us to continue to grow the work force. It will have a marginal impact on throughput, but only marginal. Where it will make a difference for us will be that, with the additional registrars, we'll be able to provide a better service in the emergency department to patients who are going to be admitted.

If those patients can be seen earlier in their speciality area, they can be admitted to the hospital sooner. There's a lot of solid evidence to indicate that a prolonged wait in the emergency department is compounded by complications in that patient type, so their average length of stay increases. So, when you talk about throughput, I say not directly into throughput but indirectly, by managing them in the emergency department and in the hospital, we will actually indirectly increase throughput.

**MRS DUNNE**: And the follow-on question from that is: will this have any impact on the sorts of shifts that registrars and junior doctors do in the hospitals?

**Dr Ramsey**: Yes, it will. It will reduce some of the onerous shifts that are occurring in some of the areas, and that's part of the reason that we're doing this. There is the health and safety aspect to it, safe practice, safe working hours, but, as well as that, as I say, the requirement to fill in to the teaching and the service delivery requirements.

**MRS DUNNE**: These are both medical registrars. Do you see any scope for extending that into the surgical area?

**Dr Ramsey**: Yes indeed. The largest shortfall that we identified this calendar year was in the medical area, but we have also identified areas where we believe that it would be better for us to employ registrars, and to facilitate the training programs and in the surgical fields, yes.

**THE CHAIR**: Dr Ramsey, thank you. Members, we'll move on to output 1.2, relating to mental health services, at page 149. We've asked a lot about this output this morning.

**MR HARGREAVES**: I have a question on Child and Adolescent Mental Health Services. We moved some services from Tuggeranong to Woden and, I think, increased the outreach services for young people, adolescents. You might recall the initiative. Some water has gone under the bridge since then for either yourself or the minister. Could you give us a bit of an update on how that has actually panned out?

**Mr Jacobs**: The proposal around the moves with child and adolescent were that we were to concentrate the two main teams—one in Woden, one in Belconnen—and there'd still be officers maintained in the Tuggeranong area and also in the city. That's actually gone ahead. The main reason around that was trying to get efficiency in terms of medical and psychiatrist input to those teams. At present those teams are functioning reasonably well, even though there are staffing issues, as there always are in terms of supply. We have actually extended some outreach and I think that the service to the Lanyon area is still working okay. One of the problems that we are experiencing overall within the child and

adolescent area, though, is trying to keep our senior clinicians in place. The moment we get them up to a certain level of skill or expertise, they are poached by other services interstate, et cetera, so we're still experiencing that sort of pressure.

**MR HARGREAVES**: In terms of the young people to whom you provide the services, is there any sort of demographic profile which would point to greater areas of need than others?

**Mr Jacobs**: Basically, with the current strategic planning process we're going through, we are looking at the populations and how they're distributed. That process will be identifying some sense of the distribution of those resources across all age spectrums within Mental Health.

**MR HARGREAVES**: So you're taking into account the age demographic for, say, the Lanyon Valley, where the average age of the kids is 12, 13 or thereabouts, but also for those suburbs which are turning over in their demographics, such as Narrabundah, which has actually gone through the elderly perspective and is now into the young persons perspective. Is all of that being fed in?

**Mr Jacobs**: All that has actually come up in the analysis that's happened thus far. How we deploy the resources is the next stage. We had sessions on the 15th and 16th of this month in which we were looking at the actions that would stem from the strategic planning process. So child and adolescent, older persons and all that were in the mix in terms of where services should be moved or developed.

**MR HARGREAVES**: So you're at the tail end of the strategic planning process at the moment.

**Mr Jacobs**: Yes.

**MR HARGREAVES**: When do you actually expect to effect changes which may emanate from that? When would we actually see those sorts of changes start to appear on the ground?

**Mr Jacobs**: With the action plan, the concept is that we will have targeted actions and we will have some time lines for those. We'd be hoping some of those would be starting very early in the next financial year.

**THE CHAIR**: Brian, under quality effectiveness and maintaining national mental health standards and accreditation, the mental health services at both Canberra Hospital and Calvary have already met the requirement, even though we haven't got to 2003-04. Is that because the accreditation is given for a period of time?

**Mr Jacobs**: It is given for a set period of time, but through that period there is a self-assessment plus other checks that we have to do along the way so that we're ready for the accreditation when it falls due next calendar year. So in Mental Health ACT there will be a self-assessment process we go through before the end of this calendar year in preparation for that formal assessment that happens around May next year.

**THE CHAIR**: Is it presumptuous to say that you've already met the requirements of the national standards?

**Mr Jacobs**: In terms of being able to meet and maintain accreditation against the ACHS and national mental health standards, we are doing that.

**THE CHAIR**: It just seems odd to note that you've met something that hasn't even occurred.

**Mr Foster**: Actually, what they will be aiming for in 2003-04 will be to have it met. That's not saying that they met 2002-03.

**MRS DUNNE**: In a sense, it's a changed way of reporting a measure.

**Mr Foster**: It's a changed way of presenting the outcome on the measure.

**THE CHAIR**: Under timeliness, it is said that output reports from non-government organisations provided on time in accordance with service agreements only reached 68 per cent. I note that footnote (3) refers to a minimum of 90 per cent of output reports being received within two weeks of the reporting date. Why have you put it as an estimated outcome of 68 per cent?

**Mr Jacobs**: Because, tracking it through to the end of this financial year, that will be the estimated performance. Earlier in the current financial year people were tardy in terms of reporting. We're putting in place measures to get that up to 100 per cent.

**THE CHAIR**: Is there a downside for both providers and patients in not reporting this? Is this vital information that we need?

**Mr Jacobs**: When services are busy, this is one that seems to get put on the backburner. We're now having regular prompts going out in terms of getting people to get their reports in on time. It's important for us in terms of monitoring what the contractors are doing.

**THE CHAIR**: And their payments are made on the basis of the reports.

**Mr Jacobs**: Their payments aren't linked to the reports.

**MR HARGREAVES**: You mentioned that you're putting out prompts to these people. Are the prompts good enough or do you have to wave a stick at them? If so, what does the stick look like?

**Mr Jacobs**: When it comes to the next instalment in terms of funding, that's the stick.

**Mr Corbell**: I think a balance has to be struck. If a non-government organisation is in the middle of a fairly complex activity or program or has had additional pressures put on it, there's always a reasonable level of latitude given and I think that's what that note there under the table is also designed to reflect. It's designed to reflect that most non-government organisations do pretty well, but they are frequently working on fairly tight

budgets and often with limited numbers of staff, so overall they perform reasonably well but we want to see that improve so that we do have a better level of timeliness overall.

**MR HARGREAVES**: What kind of consultation do you have? On what sorts of occasions do you actually have dialogue with these people over those sorts of issues? Is that a fairly regular effort?

**Mr Jacobs**: The people that manage the contracts do have regular dialogue with the NGO sector, the various providers. More recently, we have actually sponsored ACTCOSS with a view to establishing a peak mental health group that would actually be representative of this group so that we can look at further ways to enhance our communication with that sector and also improve the services that we buy from the NGO sector. The concept behind it is that we do get good value for money out of the dollars that we put in and most of the sector, if not all, do a very good job. From my perspective, we'd be looking at trying to put more dollars into that area because you do get good value.

**MR HARGREAVES**: What would be the membership of that peak group? Would the consumer representatives be on it?

**Mr Jacobs**: We had a presentation within the last fortnight and the representation would involve some consumer representation—a minimum of two per the draft that I've seen. There'd also be some other representatives, plus there'd also be an NGO component, non-government organisation representation on that body. I do need to say that this is a draft and it will need to go up through the relevant mechanisms to get the thing in place.

**MRS DUNNE**: What is a raw in-patient separation?

**Mr Jacobs**: It's a person who is discharged from the service.

**MRS DUNNE**: Okay, so it's in some sense different from a cost-weighted separation. This is an actual person.

**Mr Jacobs**: It's a body.

**MRS DUNNE**: They are, in a sense, clients.

**Mr Jacobs**: Yes.

**MRS DUNNE**: What has caused the 130 decrease from the target to the estimated outcome?

**Mr Jacobs**: There are a few reasons for it; it's always complex. The main premise behind our provision of services is that we try to care for people in the least restrictive environment. If there are other options, we'll try to case manage them in the community, we'll hook them into networks that will keep them in the community.

**MRS DUNNE**: So that you could say that that was a success because you didn't have as many people in hospital as you predicted.

**Mr Jacobs**: Yes. I will say, though, that you still need a certain bed base behind the community services because some people will still need access to beds. Currently, on our bed base unit in the TCH, in the acute psych, our normal occupancy is 26 beds or less—this morning it was 22—but from time to time we will kick up beyond the 26 and we do bring in extra staff and that to cover that period where we do kick up to, say, 30.

**MRS DUNNE**: Where do you put people if you've got 30 and you've actually got beds for 26?

**Mr Jacobs**: We can actually take them up to 30 and from time to time we do have some outlyers, so to speak, where they might be cared for elsewhere in the hospital. But we do try to care for our people in the unit.

**MRS DUNNE**: In the next line, is the increase over the target for in-community services a corollary of the figure above?

**Mr Jacobs**: There is increasing demand in the community. We have put more resources in there and that's reflecting the movement of both increasing need and the dollars that are going to service that need.

**MRS DUNNE**: I'd like to go back to the issue raised by Mrs Burke this morning about the indigenous dual diagnosis health workers. Minister, ACT Labor's financial statements in the run-up to the election which were published on 15 October talk about the Labor government recognising the need for indigenous persons with coexisting problems, such as mental health problems together with drug or other alcohol problems, and says that to this end Labor will allocate $140,000 to a program administered by Winnunga Nimmityjah to help diagnose these problems and address them. This is in the Gerritsen report—$140,000 each year over three years for the budget, so that in the table it says 2002-03, $0.14 million; 2003-04, $0.14 million; and 2004-05, $0.14 million. Minister, today you said that you would be implementing this at some time in the future, whereas the clear written commitment, as published on 15 October, was to implement that in the first budget.

**Mr Corbell**: No, Mrs Dunne, what I said was that we would be funding it in the next year's budget.

**MRS DUNNE**: But the clear commitment was to fund it in last year's budget, the current financial year's budget.

**Mr Corbell**: Yes, indeed it was.

**MRS DUNNE**: Okay, so that was a promise not kept.

**Mr Corbell**: Well, in respect of that document, the timing has changed but the commitment is still to be honoured, and it will be honoured.

**THE CHAIR**: My memory of what you said this morning is that the promise was in the life of the government. Quite clearly, the commitment given was that it would be funded in the very first year of the government and that has not been met.

**Mr Corbell**: I've made quite clear the government's proposal. The government's proposal is to fund it over a three-year period from next year.

**THE CHAIR**: Is there a reason that it wasn't funded last financial year and this financial year?

**Mr Corbell**: Well, there are a range of priorities that the government has to address. There are a range of costs that the government had to take account of because the previous government didn't. That has necessarily led to some reordering of priorities—for example, the very significant funding for public service wage rises, the very important increases that have had to occur in terms of mental health funding, the very important commitments to fund things which you said you would fund but didn't actually put any money in your budget, like the Canberra medical school. These are all commitments the government has had to meet, and we have met them, and we have addressed these issues comprehensively, but that has resulted in some reordering of priorities. But it is nevertheless the government's intention to ensure that all the commitments we made are implemented.

**THE CHAIR**: And the record now shows the government's priority. Thank you, Minister.

**MS MacDONALD**: Going back to the output reports from NGOs, is there a standardised thing for each NGO? Is it tailored to them, or do they have to do their own reporting forms?

**Mr Jacobs**: There's actually a contract that's established with NGOs that's got a schedule attached to it in terms of the expected outputs and they can report to a standard template. I think that the issue is that the NGOs are focused on getting the best service they can to the customer base that they service and they need the prompts to meet the paperwork side.

**MS MacDONALD**: Yes. I asked because, having worked in an organisation with limited funding, at times the priorities are not necessarily on getting the forms back and, obviously, the simpler the form the easier it is to get it in, especially if there is a template. That would have assisted me in my previous role, but there wasn't one available.

**MR HARGREAVES**: My question to the minister or Mr Jacobs has to do with the new provision for forensic-court liaison. I understand that that is to provide psychiatric assistance to help the Magistrates Court and, I would hope, the Supreme Court as well. I'm interested to know the extent to which you see its application in juvenile justice, because there's no indication in here of whether there is greater accent on, if you like, the adult corrections component of the Magistrate Court's attention or whether you see greater accent perhaps being needed in the juvenile justice area, because that has actually raised its head in committee work that I've done when we've visited Quamby and places like that. There have been suggestions that, if psychiatric assessments were available to the court for young people, a completely different sentencing regime may be applied by judges and magistrates. In this new initiative, is there an exposure to that?

**Mr Jacobs**: The position in question actually was a recommendation that came out of the Patterson review and, basically, it was looking at addressing the needs of the adult population. It was flagged that the magistrates would benefit from having this position in place to give more timely assessments for that group of people and in some ways perhaps prevent undue incarceration in the BRC and that type of think.

When it comes to the child and adolescent area, Merrie Carling, who is our director of child and adolescent services, has flagged that it would be good to have a position that sat perhaps against the courts, not particularly for child and adolescent, where you could actually have an appropriate psychological assessment done for kids, not just for mental health reasons, but because of the reasons around the impacts of going through the court process and that sort of thing with kids where a position like that would be useful.

**MR HARGREAVES**: I have to support that view, given the investigation of my committee in the last few years and there will be comment made along that, hopefully to assist the minister, in the next wee while. Do I take it then that you are actively considering the case for that sort of thing, to make an approach to the minister in the next 12 months or so?

**Mr Jacobs**: Basically, we will be looking, at our next budget round, at putting up a series of initiatives and setting a priority. I'm sure that will be in the mix, but how high up the priority list it gets I don't know.

**MR HARGREAVES**: I thank you for that very much and just highlight with you that the Standing Committee on Community Services and Social Equity will be producing a report into the rights, interests and wellbeing of children and young people. It probably will not be published, I would suggest, until mid to late July, because of unforeseen circumstances, but there will be mention of that issue in it and I would urge you to look at the contents of it. That may help you in your deliberations because we're also talking about whether there's a case for a dedicated ward in a hospital, for example, and there will be some information on that in there. Thank you very much for that.

**Mr Jacobs**: Thank you, Mr Hargreaves.

**MRS CROSS**: Minister, I refer to the bottom lines on page 149—total costs and government payments for outputs. The figures contrast markedly with the acute services ones. In the case of mental health services, I find that there is very little difference between what the Treasury would like to pay and the actual cost of the service. Why is this the case?

**Mr Corbell**: Because we don't have revenues to the same degree that we have acute services would be the simple answer. As Mr Foster pointed out correctly earlier, in relation to acute the papers did not take account of revenues. You don't see the revenues in the presentation; it simply shows up in the total cost versus the cost of government payments.

**Mr Foster**: What the minister is saying is that the reason there's a small difference there is the fact that there's no or minimal revenue that Mental Health collects, whereas Canberra Hospital collects a lot of revenue for patient fees, et cetera. Also, Mental Health doesn't have any depreciation, either.

**MRS CROSS**: Minister, I congratulate you. I think you deserve to get brownie points when things are going well and I think Mental Health is operating very efficiently.

**Mr Corbell**: We're getting there, Mrs Cross, thank you.

**MRS CROSS**: They were genuine congratulations, Minister, rather than the patronising ministers we've had before us this week.

**Mr Corbell**: No, I know. Thank you, I appreciate it. It's taken in good faith.

**MRS CROSS**: I want to congratulate your people, too. They have done a really good job in a very difficult area. I would also like to congratulate you on the significant amount of extra funding that you've made available in this area. I would like to add that I hope that that extra funding will bring extra output. Even taking this into account, the service has been remarkably good at meeting targets. Is this efficiency, or are the targets too easy?

**Mr Corbell**: I might ask Mr Jacobs to address that question.

**MRS DUNNE**: You know the answer to the question. I know what I'd say if I were you.

**Mr Jacobs**: Do you want to tell me now?

**MRS CROSS**: I can help you out.

**THE CHAIR**: We're good, real good, would be a quick answer.

**Mr Jacobs**: Basically, with the targets that are set, we try to work as hard as we can to achieve those each year. You'll notice that with the targets around the bed base we do underachieve in a sense in terms of the raw separations, but that's clearly balanced out by the increase in the occasions of service against the community side. We do try to make every dollar work as hard as it can and that's why we achieve our targets. That's as tight a management as we can do.

**MRS CROSS**: I note that about three-quarters of the way down the page there's a glitch with non-government providers, a third of whom were not able to meet their reporting deadlines. How many providers are involved and what action are you taking to ensure compliance with contracts?

**Mr Corbell**: Mr Jacobs has addressed the second part of your question already. It was asked earlier in your absence. In relation to the first part, I don't know whether we have that information available now.

**MRS CROSS**: You can take it on notice, Minister.

**Mr Corbell**: We'll take it on notice.

**THE CHAIR**: There being no further questions on output class 1.2, we'll now move to output class 1.3, which relates to community health services. If I could open with a question on the numbers. In 2002-03 community health services received $99 million. This year you're receiving $106 million.

**MS MacDONALD**: Sorry, Mr Smyth, where are we?

**THE CHAIR**: I'm on BP 2 at page 14 or 8, depending on which year you're in. What will the extra $7 million provide?

**Mr Corbell**: I'm sorry, Mr Smyth, could you repeat the question? I have the document.

**THE CHAIR**: On page 14 of BP 2, for the current year community health services received $99 million. Page 9 of BP 2 for the coming year says that the community health services will receive $106 million. What are the Canberra community getting for the extra $7 million?

**Mr Corbell**: Sorry, which figure are you comparing it to? I've got page 9, Health and Community Care, community health services, $106 million—

**THE CHAIR**: In the coming budget you're saying it will be $106 million.

**Mr Corbell**: Yes.

**THE CHAIR**: Right. Last year's budget, same document, says that there was only $99 million for community health services. What extra services are being provided for the extra $7 million?

**Mr Corbell**: I'm happy to outline the government's initiative in this regard and Ms Yen will be able to outline in more detail a response to your question. It is worth noting that the government's key initiative in community health is on dental services and addressing dental services. We had some discussion on that this morning.

**THE CHAIR**: Yes, but it only accounts for half a million dollars.

**Mr Corbell**: All I'd like to add to that is that that is a very important initiative which addresses significant areas of need in the community and which makes a very real difference for a lot of people in terms of their quality of life, because it basically means they can use their teeth or have some teeth to use, as the case may be. But I'll ask Ms Yen to comment.

**Ms Yen**: I think I'll defer to Mr Foster.

**Mr Foster**: I'll just point out that this community output relates to ACT Community Care and non-government community services as well; so, in relation to moving into this year's initiatives, we've got increased funding for dental and home enteral feeding, we've got the SACS funding, we've got HACC funding increases, we've got wage increases for the staff, we've got indexation. It's more than those services going into community care that are represented in these figures. It relates to SACS and HACC as well.

**THE CHAIR**: Can we have a breakdown of those figures?

**Mr Foster**: Yes.

**Ms Yen**: I don't want to add any more to that.

**Mr Corbell**: Mr Foster has answered the question.

**THE CHAIR**: Dental is a nice place to start. I noticed that this year the adult services will go up to 23,000 services provided, whereas child and youth will drop from 48,000 to 17,000. Could we have an explanation of that?

**Ms Yen**: Yes, if we can start with the child and youth one. If you note footnote (3), we've changed the way in which we record the activity there; so we're not seeing any reduction in the service, we're seeing a change in the way that we count the activity.

**MRS DUNNE**: Is there a change in the way you count the activity for adult services?

**Ms Yen**: No, what we've done is we've moved the children's service over into the same measure as we use for the adult service.

**MRS DUNNE**: Previously, we were comparing apples with pears.

**Ms Yen**: Yes.

**Mr Corbell**: What you see there is an outcome which actually sees an increase for child and youth dental services from the estimated outcome this year of 54,800-odd to a target next year of 56,900-odd.

**THE CHAIR**: So it's just a change in the reporting mechanism.

**Mr Corbell**: It's a change in the unit of measure, yes.

**MRS DUNNE**: So the 17 in new money translates into 56 in old money?

**Mr Corbell**: Yes, 56,987, as in note (3) to that chart.

**MRS DUNNE**: Sorry, yes. Could you actually give an explanation of the difference in the counting?

**Ms Yen**: Yes. Could I take that on notice and give you a briefing on it, because it's a mixture of timing and staffing. If I may take that on notice, then I'll get back to you.

**MRS DUNNE**: Yes, sure.

**THE CHAIR**: Moving further down there into women's health services, I'll ask my favourite question: how is the pap smear register going?

**Ms Yen**: Fine.

**THE CHAIR**: We're still getting the appropriate number.

**Ms Yen**: We're still doing very well, yes, we're still recording good levels of participation.

**THE CHAIR**: That's good. Well done. I have memories of there having been figures for this in previous years. Is that to be found somewhere else?

**Ms Yen**: The annual report is where we had it.

**THE CHAIR**: Under women's health services, the breast screening clients have dropped. The target for this year was 12,900, the estimated outcome is 12,000 and the target has been revised down for next year to 12,000. Why is that?

**Ms Yen**: The principal reason, and we're very aware that we're still not reaching the target that we want to reach on this, is that we need to try to match the services needed to the service that we can provide, so it's a classic supply and demand question where our difficulty remains the recruitment of radiographers and radiologists to provide the service. What we've done is we've created the target that will actually enable us to meet the target.

**THE CHAIR**: Does Canberra's lone community breast cancer nurse have a role in this, or is all her work dedicated to looking after the women who have had treatment?

**Ms Yen**: Her work is related to women who have had breast cancer diagnosed and treated, and it's support and follow-up from that.

**THE CHAIR**: Minister, you and I were at a dinner three or four weeks ago that celebrated the 10th anniversary of the implementation of regular mammograms. I have to apologise: the name of the nurse who is our breast cancer nurse at the moment?

**Ms Yen**: I can't remember her name, either, I'm sorry.

**THE CHAIR**: You're about to be given it.

**Ms Yen**: Melva Walters.

**THE CHAIR**: How could I forget? Melva was clearly the darling of the room, and I would just like to congratulate you and I would ask that you might pass that on to Melva for the good work that she does. But the regret of most people in that room is that she does that on her own. In the lead-up to the election, you promised two additional community breast cancer nurses. When will we see them?

**Mr Corbell**: We are funding another breast care nurse in this budget.

**THE CHAIR**: One or two?

**Mr Corbell**: One.

**THE CHAIR**: When will we see the second one?

**Mr Corbell**: The second one will be considered further in the context of next year's budget.

**MRS DUNNE**: Is that in the initiatives?

**THE CHAIR**: I don't recall seeing that in the initiatives.

**Mr Corbell**: No, it is not. It is to be funded through existing allocations.

**THE CHAIR**: Money is coming out of the community health funds from other areas to fund the breast cancer nurse.

**Mr Corbell**: There's a number of options available to the department and I'm getting further advice from the department at the moment as to how that can be achieved.

**THE CHAIR**: Will that result in a cut to services in another area?

**Mr Corbell**: No, it won't.

**THE CHAIR**: So you can find the 70 grand a year for another nurse.

**Mr Corbell**: I think we can find the money. That's what I've been advised we can do and we'll be finding it.

**THE CHAIR**: That does beg the question: why didn't you do it in last year's budget, in the current budget, or in your first budget?

**Mr Corbell**: I can't speak for last year's budget in that I wasn't the responsible minister, but I think it's reasonable to say that we recognised this as an area of demand and, whilst it hasn't been possible to fund everything through new initiatives, we will wherever possible utilise existing resources better to get more service, and that's what we're doing here.

**THE CHAIR**: I'll follow that up at the annual reports stage. I would strongly urge the government to consider very quickly coming up with the second position.

**Mr Corbell**: I think we've taken a good step forward with the second position, but I certainly accept that an additional position on top of that is warranted and that's something we'll look at further in the context of next year's budget.

**MRS DUNNE**: On the subject of breast screening, I need to go back to the issue of the targets. I'm not entirely satisfied with the answer, which seems to translate into "we can't meet the target we've set, so we set a lower target".

**Ms Yen**: What I would like to do is take us back a couple of years where the target that was set hasn't been achieved for the previous two years at 12,900. We have agreed on a target that is realistic in terms of the funding that we have and the capacity to provide the service.

**MRS DUNNE**: When you set the target at 12,900, that's a target of two or three years standing, it goes back into the previous years, and that is a function of demand or is it a function of the service provider? I mean, the breast screening is the mammography service?

**Ms Yen**: Yes.

**MRS DUNNE**: Okay. You're saying that there aren't 12,900 people in the community who require this service or you just can't provide the service to the people who need it?

**THE CHAIR**: While we do the seat change, do members want to ask questions of the Community and Health Services Complaints Commissioner, because we'll have to get him back and if there are no questions there's no point in him coming back. No questions? Okay.

**Dr Dugdale**: The breast screen program is largely funded by the Commonwealth through the public health outcomes funding agreement. There are targets set within that. I haven't got them off the top of my head, but essentially they set a population target. But there are two factors that vary here. The first is the actual reach of that program outside the ACT. The other one is the age group that is sought for it. To be frank, we are almost solely interested from the public health point of view in the 50-plus age group.

The 40 to 50 age group is allowed to access the program, but there is significantly less population health gain for that group. You can't tell them they can't have it. So there is a capacity to meet the targets by finer targeting, by really making sure that the 50-plus people do have it. We do have very good breast screening rates in the ACT. That's reported in the annual reports each year and we'll be hoping to maintain our performance against the national benchmarks.

**MRS DUNNE**: What I might do is review the *Hansard*.

**THE CHAIR**: If we've got the capacity for 12,900 screenings, one of the other requests at the dinner that the minister and I were at was that we might consider reducing the age, not starting at 50 but reducing it to 40. Why wouldn't we do that? Is there an impediment on the funding from the Commonwealth or have we just not endeavoured to do so?

**Ms Yen**: I will start and ask Paul to come in. The national breast screening program hasn't yet put out guidance about extending the screening age below 50. Currently, the screening program is targeted at women between 50 and 69. Until we're actually informed, I think, by the Commonwealth about a change to the national breast screening program and, one assumes, a change to the funding for the program, then we wouldn't extend that without that additional advice.

**THE CHAIR**: Is there an impediment in the funding arrangements to us going to 40 and using the Commonwealth money for that purpose?

**Dr Dugdale**: Basically, if you did that for the same money you would get less people in the 50-plus age group, which is where we need to meet our population targets.

**MS MacDONALD**: If you were to reduce it to 40-plus, surely it would stretch the resources so thinly, because there would be more than an extra 900 people coming from that 10-year bracket.

**Mr Corbell**: Yes, that's right. Yes, it would, and it's at the expense of screening in the 50-plus category, as Dr Dugdale makes clear.

**THE CHAIR**: But I do make the point that for a number of years we've had the target at 12,900 and it seems, I think, that previously and possibly the year before that we've only virtually done 12,000, so we're got 900 screenings available and you're funded for it—

**Ms Yen**: No, the targeting and the funding weren't necessarily the same thing.

**THE CHAIR**: Okay. The conversations that night at that dinner were interesting. People were interested in reducing it to as much early intervention as possible.

**MS MacDONALD**: Maybe we should lobby the federal government to reduce it, too.

**THE CHAIR**: I am happy to do so.

**Ms Yen**: I think we also have to recognise that the population bulge for the baby boomers moving into the screening age is getting to the point where, in order for us to maintain the national target levels, we are going to have to increase, but we need to fund that process.

**MS MacDONALD**: Is it likely, while you're looking at reducing that target for the moment, that it will have to go back up again in the future?

**Ms Yen**: Almost certainly, I think, to get us through that population bulge.

**MRS CROSS**: I refer to page 151. I just want to say that there are occasions when we pick up things that are said between you, because the microphones pick up things. Minister, I just thought you might want to note that in case you say something that shouldn't be overheard.

**Mr Corbell**: No, I'm very conscious of that, Mrs Cross.

**MRS CROSS**: The total cost for 2002-03 goes from $95,267,000 to $108 million. Can you tell me why there's a difference between the target and the estimated outcome?

**Mr Foster**: Largely for the same reasons given for the acute sector movement. It's a reflection of bringing the ACT Community Care activity in relation to business funded by their third party revenues and their depreciation coming into it and also the cost of the pay rise. So, for the same reasons, we're now reflecting the costs of ACT Community Care in relation to depreciation, the movement in provisions and the activity funded by their revenue collections. Plus there's been the funding for the wage rise in 2002-03.

**MR CORNWELL**: I begin with congratulations. The aged day care centres, I see, are operating at Belconnen, Dickson, Narrabundah and Tuggeranong. Is that right?

**Ms Yen**: No, they're operating at Tuggeranong and Belconnen.

**MR CORNWELL**: Why are they still on the website?

**Ms Yen**: I apologise for that and I'll make sure that it comes off.

**MR CORNWELL**: 13 March, and it's still there.

**Ms Yen**: I'll fix that up. Thank you for bringing that to our attention.

**MR CORNWELL**: My adviser got it off this morning. Would you mind? Thank you.

**Ms Yen**: Not at all. Thank you for pointing that out.

**MR CORNWELL**: Minister, what specifically is the sub/non-acute aged care facility valued at $5.2 million shown as phase 1 in Budget Paper 4, page 142? I haven't been able to find any information, apart from that line. Could you tell me what it is, please?

**Mr Corbell**: I'm happy to explain it in general and I'll ask Ms Killion to give you the detail. It's designed to provide a range of care, including a much neglected area in terms of psychogeriatric care, in the community. You'd be familiar with circumstances where we don't have the facilities to look after people who are both elderly and with serious psychological or mental health issues and I think many people would be familiar with the case of the gentleman who had to go to Goulburn to find an adequate place.

**MR CORNWELL**: Indeed we are.

**Mr Corbell**: This facility is, in part, designed to meet that need but also a range of other needs. There's been a scoping study developed to identify those needs and the scope of the project, and that's why it's now funded in the budget. I'll ask Ms Killion to give you more detail.

**Ms Killion**: This capital works budget bid is for a 60-bed facility. Thirty beds would be for rehabilitation, additional beds for rehabilitation in the system, 10 beds for transitional care and 20 beds for psychogeriatric, dementia-type clients that the minister was referring to.

**MR CORNWELL**: Have we decided on a site or is there to be a series of sites?

**Ms Killion**: We have not decided on the sites yet. We're doing more service modelling before we decide on the sites, but the sites are likely to be at either of the hospitals.

**MRS DUNNE**: It seems to me, Minister, that 60 beds for $5 million is extraordinary good value for money. Why can't we do it in other things?

**Mr Corbell**: It depends on the type of service you're delivering, Mrs Dunne.

**THE CHAIR**: On the theme of aged care, Minister, before we left office, we gave approval for a block opposite Calvary Hospital to be sold to the Calvary Hospital for the provision of aged care services. I believe they've got a number of approved places with

the federal government with federal funding attached. Are we at risk of losing those because a decision hasn't been made and the building hasn't commenced on that facility?

**Mr Corbell**: I'm advised that we're not. The key issue is to resolve the specific design issues for the site. The Little Company of Mary or Calvary Hospital—let's call it Calvary Hospital—does have a bed allocation from the Commonwealth. I forget the exact number of beds, but they have an allocation from the Commonwealth. They originally brought forward a proposal early in the term of this government to utilise the site adjacent to Calvary Hospital, across Haydon Drive, but were also keen to utilise the block on the corner of Haydon Drive and Belconnen Way.

You and I would be familiar with the community debate over that site and the commitments of both of our parties not to permit development on that site. Calvary were advised of this position. That meant they had to go back and rework their design to allow it to be accommodated on the other two sites on the northern side of Jaeger Circuit. That work is ongoing and I understand it is close to resolution. I would anticipate we will have resolution quite soon. The number of beds allocated is 50 high care and 15 low care beds, I'm advised.

**MR CORNWELL**: These 65 beds were allocated in January 2002 to Calvary Health Care; is that right?

**Mr Corbell**: Yes, that's right.

**MR CORNWELL**: That's what your answer to my question states, anyway, which was during your government. Eighteen months down the track seems to me to be a very long time, Minister, before we have these 65 beds. Let's face it, we are in need of beds of this nature, and we are still dithering around about the site. I take your assurances that the decision will be made soon. I accept that you can't be any more definite than that. But I would certainly hope that it is speeding up. Where are the people who could be in these beds at the moment? Are they in hospitals?

**Mr Corbell**: Some of them would be in hospitals, yes.

**MR CORNWELL**: Therefore, eating their heads off in terms of money, if I may put it that way. Could somebody clarify for me how much it costs to have somebody in a hospital bed as opposed to one of these beds?

**Mr Corbell**: I'm not sure what the costs would be, but the impact is significant in that it doesn't allow other people to be admitted who need to be admitted, so you have the circumstance of bedblock. That flows through to emergency departments and people being unable to get out of emergency departments into wards because they can't get a bed in a ward, so that puts pressure on emergency departments. We estimate that about 20 to 30 people at any one time are in our hospitals who should be in other settings and that's effectively a ward or so of capacity that we would like to see freed up.

In relation to the site at Calvary, the issues have been issues of design. The government has indicated what blocks it is prepared to direct grant to Calvary. They're the same blocks that the previous government gave in-principle agreement to, and the issue is now an issue around design. Calvary are concerned that they cannot accommodate what they

originally proposed on that site, because they thought they could get the site on the corner of Haydon Drive and Belconnen Way.

**MR CORNWELL**: Two sites or one site instead of the other?

**Mr Corbell**: There are actually three blocks. One block is to the south of Jaeger Circuit and two blocks are to the north of Jaeger Circuit. They initially anticipated and hoped that they could access the site to the south of Jaeger Circuit and have Jaeger Circuit realigned. The take they were seeking from that site was not acceptable and not consistent with this government's undertakings about retaining that site as open space, consistent with the previous government's position as well, so Calvary had to go back and look at the design again.

They have a number of concerns about whether they can fit everyone onto a ground floor on that site, on the two blocks that remain. They are now looking at some design solutions that will allow at-grade access, because there is a slope on the two blocks, and they may be able to achieve access without having to have stairs and second storeys, even though rooms could potentially be on top of each other but, utilising the slope, they may be able to access at grade. Some fairly complex design issues they're having to work through. Since I've been minister, wearing both my Planning and Health hats, I've been facilitating officers meeting on that and, as I say, I'm confident that we'll see a resolution quite soon.

**MR CORNWELL**: Could you tell me what the cost of keeping someone in hospital as opposed to in one of these beds would be?

**Mr Corbell**: Yes, I'm sorry. It would depend, I guess, on their particular condition, but I'll take it on notice and try to give you an average figure.

**MR CORNWELL**: Please, because I have heard that it is something like four times the cost of keeping somebody in a hospital bed as opposed to keeping them in aged care, and it's unsustainable.

**Mr Corbell**: It is a significant issue. I think it's also worth pointing out, however, that we do not receive the number of beds that we should receive under the Commonwealth's formula, either, in terms of funding from the Commonwealth. According to the Commonwealth's formula, we should be funded for 118 more beds than we are currently funded for.

**MRS CROSS**: Following on from Mr Cornwell, when will approval be given for that, Minister, and when will work commence?

**Mr Corbell**: Once Calvary is satisfied that they have a design that works we'll move forward.

**MRS CROSS**: And when will it be finished?

**Mr Corbell**: When will it be finished?

**MRS CROSS**: What sort of time line have you allowed for all this from go to whoa?

**Mr Corbell**: This is not a matter for the ACT government insofar as the construction of the project. The funding comes from the Commonwealth and the Commonwealth will oversight that. Our issue is around getting through the planning process so that they can get on and build it, and that's the issue that I'm facilitating at the moment.

**MRS DUNNE**: That leads neatly into my question, Minister, because you are the Health Minister and the Planning Minister. I'd like to know how much of the hold-up is a result of planning issues—not design issues; planning issues a la the planning organisations—because, although I have not attended the meetings, I've been spoken to by constituents about a range of meetings about the land use on that site and what's appropriate, and I'm just wondering whether the community consultation over a commitment that has been made and remade is, in fact, holding up the process.

**Mr Corbell**: No, it's not holding up the process. The issues are design. The issues are also in relation to trees on the site. The most northern block on the site does have a number of large and significant trees and they need to be addressed as well. Obviously, we have to seek best possible compliance with the tree protection legislation and that means that—and this is the key issue—Planning and Land Management must be satisfied that all other feasible design alternatives have been looked at before saying to the Conservator of Flora and Fauna that all other design options have been exhausted and only through this design can, firstly, the project be delivered and, secondly, that justifies the removal of trees on the site. Those are the issues that are in the mix and those issues are being addressed. It's certainly not a case of lengthy consultation processes or, indeed, hold-ups in Planning and Land Management.

**MRS DUNNE**: You might not be able to answer this question off the top of your head and I don't know whether I can ask it today or next week, but at some stage I want to know what was the timetable for the community consultation over that block, because I'm conscious of its having gone on for some time.

**Mr Corbell**: There is a residents organisation for that South Bruce area and what we have been doing is, through officers from land group in Urban Services, we have been keeping in touch with that organisation and advising them of progress on the site. They obviously have a strong interest in what occurs on the site. It's adjacent to their homes.

**MRS DUNNE**: Also, there have been consultation meetings.

**Mr Corbell**: I'll take the rest of it on notice. I might address it in the Planning estimates.

**THE CHAIR**: Perhaps you can take it on notice and come prepared for it next Thursday. We're running out of time and we still haven't done public health.

**MR CORNWELL**: Thank you for a very comprehensive answer, Minister, on question No 50. I've had people working on it for the last week, trying to work out the ratios that we should have in Canberra. You say 118 now.

**Mr Corbell**: We're 118 short.

**MR CORNWELL**: Short, yes. This one said 111, but I'm not going to quibble about it, except that I am concerned about delays. If we went up to 118, would we be still held up with design arguments for areas that may be able to accommodate these people? Is there some way we can speed up these things?

**Mr Corbell**: The federal minister for the ageing, Minister Andrews, has written to me on this issue. He has proposed the establishment of a consultative group—I forget the actual title—of officers from the relevant jurisdiction in the Commonwealth to oversight the planning issues associated with the allocation of aged care beds. I've welcomed that, I think that's a reasonable suggestion, and I've indicated to Planning and Land Management that that should be put in place, so that planning issues can be tackled in a reasonable timeframe and the Commonwealth is able to keep tabs on what's going on. I think that's a reasonable question.

**MR CORNWELL**: My final question relates to respite care. The target of 4,054 for the number of bed nights for respite care for this coming year is below the estimated 4,554 bed nights accessed last year. In answer to a question, you said that the higher figure reflects the demand for respite care at the Burrangiri centre and that negotiations with the Salvation Army regarding levels of service delivery for this coming year have not been completed. Why would you be putting the figures in here without some qualification on the matter, and what exactly is the problem with the negotiations with the Salvation Army? Obviously, they think they can take more people than is the case.

**Mr Corbell**: I'll ask Ms Killion to answer that for you.

**Ms Killion**: Yes, I believe there's a note under (1) that looks at the 2003-04 target as premised on estimated levels of service delivery pending negotiations. There's no problem with the negotiations, but we didn't think it was fair to change the target without negotiating with the Salvation Army. We may want to revisit this target once those negotiations are finished, given, as you know, that there does seem to be the capacity to take more. I think they're utilising their beds somewhat differently, so they do seem to be getting more throughput and their occupancy levels are going up, so it's highly likely that we will revisit that target.

**MR CORNWELL**: It was partly the note that caused me to ask the question, but it's all right if it can be revisited.

**THE CHAIR**: Last year's BP 2 for Health and Community Care referred on page 13 to 8,314 respite centre based number of bed nights. This year's one is saying that Health and Community Care will only fund 4,054 respite centre based number of bed nights. Is there a reason for halving that, or is that part of the new arrangements and some of it has gone across to Disability?

**Ms Killion**: This number shouldn't be confused with the budget papers in 2002-03 reporting the 8,000 that you're talking about. That refers to disability accommodation and support services, so there's a bit of a combination. Unfortunately, the terminology being used is the same as the terminology that's being used for our bed nights for respite. The same terminology is being used for disabilities as well.

**MRS DUNNE**: My next question was raised with the Chief Minister on Monday and he hospital passed it to you.

**Mr Corbell**: So to speak.

**MRS DUNNE**: It's actually an aged care question, so it was not quite a hospital pass. It relates to aged care liaison officers for the multicultural community. There was an election commitment by the government to spend $150,000 per annum, beginning in 2002-03, and, as far as I can tell, that hasn't materialised as yet. Where are the aged care liaison officers for people of non-English speaking background?

**Mr Corbell**: This is the same issue as the one we discussed and agreed to disagree with in relation to dual diagnosis workers. I won't repeat that answer; you've already heard it from me. But I will ask Ms Yen to provide you with some more information on other activities happening here that do address this need.

**MRS DUNNE**: Before Ms Yen does that, I will repeat what is in the Gerritsen publication of 15 October. That publication clearly states that there would be funding in the 2002-03, 2003-04 and 2004-05 budgets. That is a clear undertaking that the common man can test. The man on the Clapham omnibus would understand that you were introducing that last financial year and it didn't happen then and it's not in this budget, is it, Minister?

**Mr Corbell**: Again, I've explained the situation to the committee in relation to the government's election commitments. I've explained the situation in relation to other pressures the government has to address.

**MRS DUNNE**: It is not in this budget, is it, Minister?

**Mr Corbell**: We will have to agree to disagree on that, but I'll ask Ms Yen to outline the other activities that are taking place.

**MRS DUNNE**: It is not in this budget, is it, Minister?

**Mr Corbell**: I've explained the situation to you, Mrs Dunne, and I'm not going to play these games with you.

**MRS DUNNE**: Yes or no. Is it in the budget?

**Mr Corbell**: Look, I've explained the situation to you, Mrs Dunne. You don't agree with me. I don't agree with you.

**MRS DUNNE**: I can't tell whether I agree. Is it in the budget, Minister?

**Mr Corbell**: No, Mrs Dunne, I know what you're asking for. I'm not going to give it to you. Mrs Dunne, I've explained the situation to you and you can seek to disagree with that, if you like. The bottom line is that the government will honour its election commitments over the period of this term. If you're interested in the issue of aged care liaison, as aside from making the point, I'll ask Ms Yen to provide you with more information.

**MRS DUNNE**: Thank you, Ms Yen.

**Ms Yen**: There are two posts that we currently use which are associated with our ACAT team—one, a multicultural worker who works within Community Care in order to provide support for people getting access to aged care services, and the second a more recently funded liaison officer who works with the ACAT team to help families and individuals to move into more appropriate residential and nursing home care. I think that that is a foundation for that service, but it doesn't undermine, I think, or undercut the need for us to be assiduous in ensuring that people do have appropriate culturally sensitive and linguistically sensitive services to help them on their way when they need these things.

**THE CHAIR**: There being no more questions on 1.3, we will now move on to 1.4. Minister, last year, if I remember rightly, health promotion was cut by $0.5 million. I noticed from a comparison of the pie charts in last year's document and this year's BP 2 that public health services received $19.3 million in 2002-03 and in the coming year they'll receive $17.6 million. Has it simply been cut or have services been moved out?

**Dr Dugdale**: An accounting change is the largest part of that. Perhaps if I just talk a little bit about blood. There have been very major changes this year in the national blood system. The ACT shares the costs of blood for the ACT with the Commonwealth. In previous years and in this year, the Commonwealth costs come through the ACT budget and are reflected in the pie chart. As from next year, the Commonwealth costs won't come through the ACT budget, so that's the reason for the jump down in the costs.

**THE CHAIR**: Minister, health promotion, I'm told, was cut by $0.5 million last year. I can see no new initiatives that say the government has an interest in keeping people healthy rather than treating them when they get to hospital, which, of course, we have to do. What has happened with the health promotion budget in this year's budget?

**Mr Corbell**: There hasn't been any new funding provided in this year's budget. There was a savings initiative effected in last year's budget, and you're correct in that assertion. The government has to consider a range of priorities and health promotion is something I'll be looking at in the coming year as the new Minister for Health, but it's not an issue that I have immediately addressed in my five or six months as minister to date. Could I ask Dr Dugdale to elaborate?

**Dr Dugdale**: We did speak about this at estimates last year and I think I made clear that it was a savings off a projected increase. Last year at the committee I reported, and I can again this year, there will be continual growth in direct health promotion expenditure in the ACT. If I could just read through some of the figures.

This is core health promotion activity. We expect a lot of our staff in most services to engage in health promotion and I'm not talking about that. But the core health promotion expenditure for 2000-01 was $338,500. In 2001-02 that grew to $951,500, so that was a big expansion year. The previous government was quite committed to the area and did do some of the growing there. For 2002-03 the figure goes up to $1,112,100. For 2003-04 it goes up to $1,127,100 and for 2004-05, $1,152,100.

So there was a big jump in health promotion expenditure and it was very bipartisan. It was committed to by the previous government and it was honoured by this government. There were some savings off future even larger growth. It's been quite a bit to digest and get the health promotion activity going and we've been making very good progress on that, I think, this year with some campaigns—a chlamydia campaign, a vitality campaign with cooking demonstrations, good activity at the show and—

**MS MacDONALD**: It was a very nice apple I got, thank you very much.

**Dr Dugdale**: Excellent. Giving out water for the kids to drink at the show rather than having to go for the sticky drinks and things and a complete restructuring of our health promotion unit and a growing of that unit. They've now moved into Moore Street and are a strong part of the scene. Much better integration with Healthpact. The relationship between the Healthpact secretariat and the department was quite unclear for a while and that has now been clarified by a service agreement between the department and the Healthpact board for the provision of secretariat services, which has tied in our coordination with them so that we don't waste our time arguing with each other. Continuing growth of Healthpact funds, as allowed for in the legislation. That's off-budget but has continued. There has been a bipartisan commitment and that commitment is continuing. There was a big growth a few years ago and there will be steady, slow growth from here on.

**MRS CROSS**: Minister, note (1) on page 153 explains the loss in outputs for this area in terms of the bushfires. Would you please explain the level of damage that was sustained by the health laboratories in the Howard Florey building in Holder and what you are doing to ensure reconstruction as quickly as possible? I note that the Howard Florey reconstruction budget is limited to $30,000 right across the outyears. How do you intend to ensure that the reconstruction is completed quickly?

**Mr Corbell**: Any reconstruction will be funded by insurance. The facility was insured. The health protection service building and laboratories were significantly damaged, but not totally destroyed. All of the analytical laboratories are okay. They did suffer damage, mostly smoke and ash. They had to be completely cleaned. Equipment had to be reset and cleaned up. Those laboratories were operating a short period after the fire. But the administrative areas—files, records, working papers for a whole range of projects—all of the ACT's immunisation records were lost in the fire, and it's a significant task to get that all back together. At the moment, part of the health protection service is operating out of the old Totalcare building in Fyshwick. I'm expecting advice from the department shortly on what to do in relation to either the rebuilding of the facility at Holder or other options for consideration by the government.

**Dr Dugdale**: If I could just clarify, the immunisation records that were lost were just the paper records. We do have electronic records, so we've been re-creating there. As far as the actual reductions against our targets, there are two stories here. The laboratory was out of commission for a while and they couldn't do the work because the laboratory was out of commission. On the inspection of premises, we diverted the work force. There were just so many things that needed to be done after the fires that inspections of tobacconists, shops and restaurants did reduce as they swung over to the highly appropriate tasks. Actually, there was no loss of man hours due to the fires.

Some of those things included supervising food disposal, advice to and inspections with the Environment ACT and WorkCover people, close work with ActewAGL on water supply and sewerage, inspection of the river corridors—a lot of animal carcasses there and we had botulism in one creek that was used as a water supply—and a lot of work with rural householders to ensure their water was safe. They had problems for two or three months after the fires. They had the problems after the fires and then they had problems after the rain when it washed all the ash into their tanks. Mosquito control and dosing 80 pools. I won't go on, but they were busy boys and girls doing that. I think it was a credit to them what they did in protecting the health of the ACT after the fires.

**THE CHAIR**: A very quick question from Mrs Dunne and then we'll go. I give you my commitment that next year you will be the first. I've told the committee secretary.

**Dr Dugdale**: I am happy to spend as short a time on the stand as—

**THE CHAIR**: No, we want to talk to you. The committee secretary will reverse the order next year.

**Dr Dugdale**: Happy for that too.

**MRS DUNNE**: As a person who is utterly committed to child immunisation, I couldn't let the opportunity go without asking a question. Is 91 per cent the ACT's achievement or the national target?

**Dr Dugdale**: That's the target. We bettered that achievement last year. I don't have the detailed figures with us, but we expect to do very well again next year.

**MRS DUNNE**: Could you get back to us with what we actually achieved last year?

**Dr Dugdale**: We do that in the annual report.

**THE CHAIR**: Minister, I thank you and your staff for attending today. The committee will now close until 9.30 in the morning.

**The committee adjourned at 5.08 pm.**