LEGISLATIVE ASSEMBLY FOR THE AUSTRALIAN CAPITAL TERRITORY

SELECT COMMITTEE ON ESTIMATES

(Reference: Appropriation Bill 2004-2005)

Members:

MR B STEFANIAK (The Chair)
MS K MacDONALD (The Deputy Chair)
MS R DUNDAS
MRS V DUNNE
MR J HARGREAVES

TRANSCRIPT OF EVIDENCE

CANBERRA

WEDNESDAY, 26 MAY 2004

Secretary to the committee:
Ms S Leyne (Ph: 6205 0490)

By authority of the Legislative Assembly for the Australian Capital territory

Submissions, answers to questions on notice and other documents relevant to this inquiry which have been authorised for publication by the committee may be obtained from the committee office of the Legislative Assembly (Ph: 6205 0127).

The Committee met at 9.22 am.

Appearances
Mr Simon Corbell MLA, Minister for Health and Minister for Planning

Health portfolio
Dr Tony Sherbon, Chief Executive, ACT Health
Dr Max Alexander, Deputy Chief Executive, ACT Health
Mr Ron Foster, Director, Finance & Risk Management, ACT Health
Ms Susan Killion, Executive Director, Policy and Planning, ACT Health
Mr Ian Thompson, Executive Director, Community Policy, ACT Health
Mr Brian Jacobs, General Manager, Mental Health, ACT Health
Ms Laurann Yen, General Manager, Community Health, ACT Health
Mr John Mollett, General Manager, The Canberra Hospital, ACT Health
Mr Robert Cusack, Chief Executive Officer, Calvary Public Hospital, ACT Health
Ms Jennifer Beutel, ACT Chief Nurse, Chief Executive, ACT Health
Dr Paul Dugdale, Chief Health Officer, Population Health, ACT Health
Mr Doug Jackman, Director, Human Resource Management, ACT Health
Mr Owen Smalley, Chief Information Officer, Information Services, ACT Health
Kerry Arabena, Chair, Healthpact, ACT Health
Richard Refshauge, Deputy Chair, Healthpact, ACT Health
Ms Sam Moskwa, Director, Healthpact, ACT Health
Mr Ken Patterson, Commissioner, Community Health Services Complaints, Public Authorities & Territory Owned Corporations

THE CHAIR: First up is the Community and Health Service Complaints Commissioner. Ladies and gentlemen, to all of you who are going to be witnesses, you should understand that these hearings are legal proceedings of the Legislative Assembly protected by parliamentary privilege. That gives you certain protections and also certain responsibilities. It means you're protected from certain legal action such as being sued for defamation for what you say at this public hearing. It also means 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. Do you all clearly understand that? They nod!

Also would each witness who comes to the table state your name and the capacity in which you're appearing. If witnesses are going take a question on notice, please identify that you are doing so. It is then your responsibility to check the transcript and to respond to the question. As you are probably aware, responses to questions on notice are required to be within three full working days. The transcript will be emailed to the minister and the departmental contact officer for distribution to witnesses as soon as it is available. Can members clearly identify if they want a question to be taken on notice and give page references. Proceedings are broadcast to certain government offices and the media may come in to record and take visual footage.

Mr Patterson: I'm Ken Patterson, Community and Health Services Complaints Commissioner.

THE CHAIR: Welcome, Mr Patterson. On page 163 of budget paper 4, I note that the number of written complaints closed is 290 and the target for both the current year we're in and the year we are looking at is 290. Your estimated outcome, though, for the year about to end is 270. Why the drop of 20? What has happened there?

Mr Patterson: Probably it is because the number of new complaints has dropped; so the actual numbers coming in and going out are slightly different from that which we expected. We're always concerned about timeliness in my office. We've been criticised whenever we have had complaints that have lasted too long. I'm pleased to say that the number of complaints that have been in our office for a long time has been considerably reduced over the last year or two.

We're doing some more work on this. We've just developed a complaints management standard that aims at better standards for timeliness. We expect that, next financial year, the time it takes to deal with matters will be reduced still further. The main reason for the drop in the number of complaints completed during this year is really a drop in the number of complaints coming in. We still anticipate that the number completed will be greater than the number coming in.

THE CHAIR: Also under costs—and I might say I'm a little amused by this—you've got "average cost per complaint closed", and then the figure which would indicate in the thousands; then you've got $3.2, $3.5 and $3.2 on that line. There is the "average cost per health service improvement project/consumer" et cetera, which again is in the thousands. Then there is $63.7, $63.7 and $62.5. It is a little unclear. What exactly does that mean? Does that mean $3.2 million, which would seem too much? What exactly is it?

Mr Patterson: I think it is $3,200 per complaint. But do you want to talk about the complaints or the projects?

THE CHAIR: Firstly the complaints. So you think that is $3,200?

Mr Patterson: I assume so, yes.

THE CHAIR: You assume so!

Mr Patterson: Sorry. We don't calculate that figure; the department does. But that is what it would be, yes.

THE CHAIR: Similarly the one below—the $63.7 would be $63,700?

Mr Patterson: As well as dealing with individual complaints we find ourselves dealing with a number of other projects that are aimed at promoting consumer rights and addressing more general issues. As a general rule we have several of these going on at once, so we basically divide that by the amount of time we spend on it. There is an assumption in those figures that we spend about 12½ per cent of our time on that, but the actual figure might vary slightly. For example, we're presently doing some work on the national health information privacy code, which really means that we're talking about the future of the ACT health records act. We've tried to make sure that, in the future, that gets redeveloped in line with the national policy, so that there is consistency around the

country. That is an example of a current project that I'm doing some work on.

MS DUNDAS: Do you feel that you've had appropriate input into the review of statutory oversight bodies?

Mr Patterson: Yes. The FEMAG review team spoke to me and my staff on a number of occasions, and they received written information from us. So we had adequate opportunities to provide information to them. After that it is up to a government committee to look at it further. I'm not yet familiar with what they've decided to do.

MS DUNDAS: We're waiting on those decisions as much as you are, Mr Patterson. I remember that, a number of years ago, there were some concerns about the ability to review decisions of the Health Services Complaints Commissioner. Was that looked at in the review? Are you confident that those issues will be addressed?

Mr Patterson: It was looked at in the review. As I recall, the reviewer suggested that there should be opportunities to review the processes not only of my office but also of other similar offices. Their proposal was that the Ombudsman's office undertakes that function.

MS DUNDAS: Do you think that having the Ombudsman just look at the process will address all the concerns?

Mr Patterson: It could deal with all the concerns, yes. I'm not sure of the detail, of course.

MR HARGREAVES: As I understand it the corrections health board oversights provision of health services for people in the Belconnen Remand Centre and Quamby. Do you have any relationship with that board? Have you received any issues brought to you by people in those institutions?

Mr Patterson: From time to time we have had complaints lodged with us by people in those institutions, but not as many in the recent past as we did some time ago. That is partly because of changes to how medical services are provided at the remand centre.

MR SMYTH: Yours seems to be the only output class in health where the budget is going down. It is only by about $1,500, but is that a problem for you? Is there a reason why it is going down when every other area of the health portfolio has gone up appreciably?

Mr Patterson: That is an inviting question, isn't it?

MR SMYTH: Yes. I thought you'd enjoy it!

Mr Patterson: To be fair, I suppose the real questions are going to be what happens following the government's consideration of this review of a number of agencies. I suppose at that time the question will be: are the budgets for all those agencies appropriate? That would be the best time to review it. There are some things that I'm sorry we're not doing more with. The particular example in my mind is the implementation of the Health Records (Privacy and Access) Act.

In other cases privacy commissioners or health services commissioners who have similar responsibilities in that area have been able to do a lot more, as far as public education of health service providers is concerned, regarding their obligations under that legislation. It is one of the areas for which we didn't have any resources. There are always extra things we could do if we had a bit of extra cash. There has been no refusal to consider reasonable requests by any governments.

MR SMYTH: How much extra would you need to help with that work on educating people about privacy and health issues?

Mr Patterson: Having one extra person would be good, particularly if that person could do a bit of education and outreach work. If so, we could also get them to do some other education and outreach work on our services. By the way, the situation might change in the near future because of the likely passage of the health professionals legislation. As a consequence of that there will be more investigations, probably undertaken by my office, flowing from reports by health professionals about unsatisfactory practice. We already do some of that, even though the legislation is not there, but there will be more of it.

MS MacDONALD: Are you in discussions with the minister's office at the moment in relation to that?

Mr Patterson: Not currently, but we will be.

Mr Corbell: My name is Simon Corbell, I'm the Minister for Health.

Dr Sherbon: Tony Sherbon, Chief Executive, ACT Health.

THE CHAIR: Do you wish to make an opening statement, Minister?

Mr Corbell: No, thank you, Mr Chair.

THE CHAIR: It has been revealed that Goulburn Hospital is to shut down its histopathology unit, presumably then referring clients to the ACT. Will this have an effect on services here?

MS MacDONALD: Can you tell me what histopathology is?

Dr Sherbon: Histopathology is the examination under the microscope of tissue specimens. It is an examination of biopsies, post-operative specimens and fine-needle specimens. If the histopathology service at Goulburn Hospital is closed there may be a small impact on the ACT, but my understanding of the New South Wales plans are that most of the Goulburn Hospital pathology will be managed out of Liverpool Hospital.

THE CHAIR: Last year's annual report at page 207 showed a blow-out of $37.89 million. What is the likely blow-out for this current financial year?

Mr Corbell: Are you referring to the overall operating result for ACT Health for the hospital? What reference is it?

THE CHAIR: Page 207 of last year's annual report for the hospital—ACT Health.

Mr Corbell: Is it the operating result for the hospital? Is that what you're referring to? Is it ACT Health as a whole or for the department of health?

THE CHAIR: I will get the exact reference—I will check that.

MR HARGREAVES: Last night I was asked a question about the future of the rehabilitation independent living unit. It was in the paper this morning, coincidentally. I was looking through the capital works and I noticed the heading, "Further car parking in Gaunt Place" which is where the unit is. Can you clear that matter up for me? Is it going to change that? Are there going to be plans for another RILU? Is RILU going to stay there? What is the story?

Mr Corbell: I received some advice on that this morning. The car parking at Gaunt Place doesn't deal just with RILU; it also deals with the renal dialysis facility. Car parking in that area has been quite poor. At the moment, it is a dirt car park, so the prospect is obviously to make the car park safer. I think it is intended to seal the car park and make it generally more accessible to the health facilities located in that area. In relation to RILU, there are proposals to change the configuration of some of the services in the hospital.

The reason for that is that, as members would be aware, we are moving to establish a transitional care facility as part of the government's agreement with the Commonwealth last year, to accommodate nursing home type patients within our hospitals in a transitional care facility. They will be in aged care type beds rather than in acute care beds. The transitional care facility will be taking up some room in the existing hospital, and I'm advised that it is proposed to use some of the area of RILU to achieve that purpose. RILU will be relocated into a larger facility as part of the rehabilitation ward.

Dr Sherbon: The functions of RILU will be performed within a facility within the hospital and/or the community-based team, so there will be no reduction in services to rehabilitation clients. As the minister outlined, there will be an addition of beds through the additional transitional care places. That will allow the hospital to provide suitable accommodation for nursing home type patients currently occupying acute care beds while awaiting nursing home placement.

MR HARGREAVES: From my understanding and from my own history within rehab, one of the major facets of that unit is that it is not within the hospital grounds itself; it is, in fact, right away from what was termed in those days the "sickness syndrome", so that people were placed back in the community for their slower, less acute rehabilitation. Are you signalling a return into the hospital campus for those sorts of facilities?

Dr Sherbon: For a small number. That is the current proposal, which hasn't yet been fully presented to the minister for his appraisal. The current proposal is that a small number of RILU residents would return to the rehab ward, but a large number would be cared for in the community in an appropriate non-acute environment.

MR HARGREAVES: What sort of appropriate non-acute environment?

Dr Sherbon: In a community.

MR HARGREAVES: Is that their own home or a facility built for the purpose?

Dr Sherbon: No. In their own home.

MR HARGREAVES: You're going to reduce the amount of rehabilitation/independent living facility within the community itself, return part of it to the hospital and then allow people to do it at their own home. Is that what I'm hearing?

Dr Sherbon: No decision has been made. The minister is yet to consider the proposal. The proposal is that there'll be appropriate rehabilitation facilities for residents through a RILU type environment within the hospital, a greatly improved transitional care arrangement for nursing home type patients who are awaiting transition to a nursing home, and expanding community rehab services.

MR HARGREAVES: I heard you say that bit about the transitional unit for nursing home type patients. I don't think anybody has a quarrel with that; I think it is an excellent move. I signal my concern, however, about the reduction of rehabilitation facilities for people within a community context which is not within their own home and the concern I have that a return into the hospital campus might not have quite the positive rehabilitation outcomes you might desire.

Mr Corbell: Clearly that is a legitimate issue to raise. As Dr Sherbon has indicated, I will be receiving further briefings on this issue before a final decision is made on how the service will be delivered. I'm very happy to take it into account.

MR HARGREAVES: I appreciate that.

MR SMYTH: We're about to lose a third of the rehabilitation beds and put them over to nursing home type patients. Isn't this simply a case of robbing Peter to pay Paul?

Mr Corbell: No, there is no loss of beds overall. There is no loss of capacity to support those people. But, as Dr Sherbon has indicated, the proposal is still in its formative stages and I have yet to make the final decision on it.

MR SMYTH: You just said that there will be no loss of beds.

Mr Corbell: I'm advised that there will be no reduction of bed occupancy.

MR SMYTH: At what rates are the beds occupied at this stage? That is not the same; they are different measures.

Mr Corbell: RILU currently has capacity for 14 beds, and the average occupancy is six to eight patients.

MR SMYTH: How many beds will go across to the hospital?

Mr Corbell: I received advice this morning—and again I have to indicate that it is not yet a decision that has been made but it is a proposal being considered within the

hospital, for advice to me. Currently we have a rehab ward that has 20 beds; the current occupancy is 12 rehab patients and eight "outlier" patients from other wards. So overflows from other wards are using beds in that ward. The new capacity will be 20 dedicated rehabilitation beds, which will include a number of RILU type patients.

MR SMYTH: The concerns in the paper were raised by a lady who was the senior social worker for rehab. Her concern is that people will be forced back into the community too early, affecting their long-term rehabilitation. Can you guarantee that their long-term rehabilitation will not be affected by these changes?

Mr Corbell: We obviously want to make sure they get the best quality of care that can be delivered. That is something that will be a high priority when I look at the proposal.

MR SMYTH: That is a fine answer, but will you guarantee that their long-term rehabilitation will not be affected by these changes?

Mr Corbell: Look, I'm not going to play those games. The objective is to ensure the best possible quality of care, and that will be the priority.

MR SMYTH: These changes will not deliver the same standard of rehabilitation for these patients. Is that what you're saying?

Mr Corbell: As I've indicated, there is yet to be a formal decision on this matter. The proposal is being progressed within the hospital and within ACT Health for advice to me. I would expect that we will deliver a high quality of care which is necessary to meet the needs of these patients.

MR SMYTH: How will the services be delivered if these patients are sent home instead of remaining in the hospital?

Mr Corbell: I think that is a bit pre-emptive at this stage. There has been no formal decision yet on how that will occur. It is a matter still under consideration.

THE CHAIR: I'll quote from the annual report at 207 under "total expenditure". There are components of the department's expenditure for the 2002-03 year. It goes on to show that total expenditure, excluding extraordinary expenditure, for the year ended 30 June 2003 was $510.416 million. That was $37.89 million higher than the amended budget of $472,526,000. What is the likely blow-out for the current financial year?

Dr Sherbon: The figures you are reading from in the annual report are distorted by the fact that there was a change in entities in the ACT Health transition from a dispersed reporting arrangement to a consolidated portfolio arrangement. The figures that you've delved into have been explained to annual report Assembly committees in the past—and to the Standing Committee on Health as well, as I understand it, in anticipation of the result as explained to this committee last year. If you're asking what the budget overrun at Canberra Hospital will be for 2003-04, as at 30 April the projection was $1.377 million, which is less than one per cent of the budget. In fact, it is less than .5 per cent.

MR SMYTH: That is for the hospital—for the entire department?

Dr Sherbon: The department is in surplus.

MR HARGREAVES: That is a terrific result.

MS MacDONALD: The extension of the newborn hearing screening program has been discussed in previous years and I see it is finally happening as an initiative. At the moment at the Canberra Hospital that operates on two or three days a week—it does not operate on all five days. That is from memory—I could be wrong about that. How will it be running out of John James and Calvary hospitals? Will we have somebody assigned to those hospitals permanently, or will there be somebody who is based at Canberra Hospital who goes to the other two hospitals?

Mr Corbell: The Canberra Hospital will have the responsibility for rolling out the program for John James and Calvary hospitals. Funding of $201,000 will cover the cost of equipment, yearly consumables and labour. As we've already got phase 1 of the program established at TCH, the approach would be that TCH would roll it out to the other hospitals.

MS MacDONALD: How?

Mr Corbell: It would be a case of, as I understand it, staff from TCH doing work at those other campuses.

Dr Sherbon: Yes, that is correct. The plan is to expand staff capacity, either through expansion of existing staff commitments or by new staff, to provide a regular service to the other two hospitals. The bottom line will be that every newborn child in the ACT will be screened for hearing deficit.

MS MacDONALD: I understand the equipment is fairly expensive. Is it portable or will you need to purchase a set for each hospital?

Mr Corbell: There is funding for the additional equipment. I'm advised that additional equipment worth approximately $72,000 needs to be purchased out of that total initiative of $201,000. It is a very valuable initiative. Detecting hearing problems early is extremely important for the life opportunities of children, particularly in the early months and years of learning, when they are growing. This, I think, is a very positive step forward.

MRS DUNNE: But how is it going to be rolled out to the other two hospitals? Is there going to be someone in each of the hospitals to screen the babies as they're born? With the propensity for mothers and babies to go home early from hospital, if you're in Calvary and your baby is born on Tuesday and the hearing person is not coming until Thursday, you might be home before the baby can be screened. How is it going to be rolled out?

Dr Sherbon: We're just in the process of planning the additional staff commitments. Every child will be screened. Whether it is somebody who's coming out from TCH on that morning or that afternoon, or a process whereby staff rotate amongst themselves is still to be determined. We're discussing that with the staff and management at this point

in time. The bottom line is that we'll be providing a service whereby every child will be screened. I can't answer as to the portability of the machine. From my experience in New South Wales they were portable. I'll have to check whether the equipment we're buying is portable.

MS DUNDAS: I have a question on a number of the initiatives you're putting in this year. Can you provide us with a breakdown of how much of that money will go to the suicide prevention project officer and how much will go to support community based programs?

Mr Jacobs: Brian Jacobs, General Manager, Mental Health ACT. There is $45,000 specifically going for the project officer. The rest is going to the operation of the program.

MS DUNDAS: The budget paper indicates that that will be additional funding for the range of community organisations which are already running suicide prevention projects. Is that the case? Will you tender for this new money or will it just supplement the funds that are already in the community?

Mr Jacobs: We'd be looking at building on the work that has already been done there and rolling it out through that program.

MS DUNDAS: What is the future of the YWCA/University of Canberra joint project on the suicide prevention initiatives?

Mr Jacobs: I'll need to take that question on notice—to talk about how they're going to hook in.

MS DUNDAS: Maybe on notice you could give us a list of the organisations that are set to benefit from this extra funding, and the projects that they're running.

Mr Jacobs: No worries.

Mr Corbell: We are happy to do that.

MR SMYTH: Minister, this is new money for suicide prevention, I take it.

Mr Corbell: Yes, it is.

MR SMYTH: Is that the only money that goes into mental health, apart from the community based forensic mental health teams?

Mr Corbell: I don't think that is the case. I'm advised that the other money is for outreach workers for child/adolescent mental health services into Gungahlin.

MR SMYTH: That is the community based forensic mental health team—or is that other money?

Mr Corbell: No. There is a specific measure that provides for support for community outreach workers into Gungahlin for the support of the mental health of children and

young people.

MR SMYTH: Is that the same announcement as last year? Is that more money for last year's announcement?

Mr Corbell: No, it is not the same as last year. Last year we expanded adult services into Gungahlin.

MR SMYTH: Is this the only new money that will be available to mental health to implement the mental health strategy you announced last week?

Mr Corbell: These are the government's initiatives.

MR SMYTH: Is this the only new money that will be available to implement the mental health strategy?

Mr Corbell: There was a significant increase in funding in last year's budget, and this year's budget continues that increase. What you see in front of you is what exists.

MR SMYTH: So there are only the three initiatives that come as new money in the coming financial year that will be used for implementing the mental health action plan?

Mr Corbell: There is the addition of a couple of million dollars for mental health services in this year's budget.

Dr Sherbon: Mr Chairman, I have to clarify a previous answer. You asked me before about the financial position of ACT Health. I said it was in surplus, but my chief financial officer has just asked me to correct that. We are favourable to budget but we budget for a deficit. Our deficit is less than budgeted for, but we're not in surplus per se.

THE CHAIR: What was the deficit you budgeted for, and what is the actual deficit?

Dr Sherbon: We budgeted for a deficit of $18 million or thereabouts. Our deficit will be $2 million less than budgeted.

THE CHAIR: In other words, $16 million?

Dr Sherbon: Exactly. You've got to remember the reason. We budget for a deficit because we're not funded for depreciation. So the portfolio has always been in deficit and budgeted so.

THE CHAIR: That is the cause of the deficit for this year of $16 million?

Dr Sherbon: Yes, but the deficit is less than budgeted. So we are favourable to budget.

MR HARGREAVES: Gentlemen, I refer you to budget paper 4 at page 147 where it shows, in the 2004-05 budget policy adjustments column, continuation of growth initiative for the year 2007-08 of $11 million. I understand why that it is set that way; however, when I look at BP3, pages 198 through to 202, possibly these are the same things. Would you like me to go back on this bit?

Mr Corbell: No.

MR HARGREAVES: In BP3 you talk about agency growth funds, and you list a whole heap of items for the years 2007-08. I'm assuming that they're the same thing, only more detailed in BP3 than in BP4.

Mr Corbell: Which page are you referring to in BP3?

MR HARGREAVES: Pages 198 through to 202. It starts off halfway down page 198. It reads, "Expansion and support costs for various information access projects (agency growth funds)". I'm assuming—and this is where I need clarification—that the figure in the 2007-08 year is the same, only more detailed, than the one in BP4 with the $11 million.

Dr Sherbon: The growth funds were budgeted in last financial year's budget for the outyears—2004-05 was obviously an outyear for last year's budget. The amount of $8.3 million was programmed. As you quite rightly point out BP3, from the middle of page 198 downwards, details the allocation of those growth funds. The outyear that you've highlighted on page 147 of BP4 of an $11 million allocation in 2007-08 is an additional outyear that has been put into the forward projections from the 2004-05 budget. The 2002-03 budget extended the outyears to 2006-07 and this $11 million is an additional outyear as projected by government in 2007-08.

MR HARGREAVES: Am I right in assuming that those items both there and in budget paper 3 for the year 2007-08 are the same funds? Mr Foster shakes his head.

Dr Sherbon: The $11 million is as projected by government in its forward estimates to be additional at that point.

MR HARGREAVES: I need to clarify this.

MS DUNDAS: A different way of asking the question is: what is the difference between the money that is being used for the agency growth fund initiatives versus the ongoing growth initiative? Is the ongoing growth initiative that was budgeted for in previous budgets now being used to fund these new initiatives?

Dr Sherbon: The 2003-04 budget highlighted growth funds in the outyears, of which 2004-05 was the first. The 2004-05 growth funds will be used as detailed in BP3, as Mr Hargreaves suggested. In BP3 we've detailed how we're going to use that $8 million in growth funds. The outyears contain additional funds that increase in a stepwise manner each year. There is $8 million for 2004-05, a further increase each financial year thereafter and government is outlining, in 2007-08 in BP4, that there will be a further $11 million increase in 2007-08.

MR HARGREAVES: What I'm hearing you say—and you may have to correct me—is that if we take all the initiatives contained in BP3 that is all you provide. This is an additional $11 million, on top of that?

Mr Corbell: That is correct.

Dr Sherbon: The minister has outlined in the Assembly that it is a program by which government will meet the expected increase in demand for existing services, due to expansion of the population and the ageing of the population.

MR HARGREAVES: Are we looking at a $21.4 million injection into the system to take care of growth needs for the hospitals and the health system?

Mr Corbell: Yes, that is right. It is new, additional money.

MR HARGREAVES: An additional $21 million?

Mr Corbell: That is correct. It is something that I must say not all of my cabinet colleagues like because it is a base increase that comes to the health department. But it recognises the cost pressures that health service delivery faces—increased cost in consumables, increased costs in other areas, as well as the increased volume of activity which has to be accommodated in the base funding.

MS DUNDAS: On page 147 of BP4, what is "return of unused funds"? We've been talking about how you're getting ongoing growth initiative funding because of ongoing cost pressures in health. How is it possible that you have unused funds that you're returning to the territory's bottom line?

MRS DUNNE: We're running in deficit.

Dr Sherbon: A budgeted deficit.

MRS DUNNE: Yes, I know, but it's still a deficit.

Mr Corbell: I don't consider a health system as something that should make a profit.

MR SMYTH: That's not the argument.

MRS DUNNE: No-one said that.

THE CHAIR: Let Ms Dundas ask the question.

Mr Corbell: I am just making the point. We can have this esoteric argument about deficits, if you like.

MS DUNDAS: I just want to know what the unused funds were for.

Mr Corbell: I don't consider a health system as something that needs to make a profit. That would miss the point.

THE CHAIR: Ms Dundas wants to know what the unused funds were for.

Mr Corbell: Indeed. ACT Health identified during development of the budget that funding for several items should be returned to government. The funds were for medical school positions, hep C financial assistance and SACS. I'll ask Dr Sherbon to elaborate

on that.

Dr Sherbon: I will take them one by one, with the minister's permission. As to medical school positions, we received a significant funding allocation from government. The amount of $2.2 million was originally sourced in the 2002-03 budget and flowed forward into 2003-04. In 2003-04 we were unable to fill all those positions. We do expect to fill them in 2004-05. So there was, in 2003-04, underexpenditure in that enhancement from government. Given that we couldn't fill all those positions, we were able to return a portion of those funds, $1 million, in 2003-04.

The hep C financial assistance program, as many of you would be aware, has been in existence for several years. It's a program that assists those who obtained hepatitis C through blood transfusions in the 1990s, before comprehensive testing was initiated in the mid-1990s. The expenditure of those funds has been less than expected, so $250,000 has been returned to government.

Similarly, we provided full SACS award supplementation to NGOs and we received a budget supplementation of $0.66 million for that purpose in 2003-04, but in actual fact the request from NGOs for SACS supplementation has been less than expected and the amount of $400,000 has been returned to government. That was in 2003-04, but it's important to note, and I note your concern, that all NGOs have been covered for SACS award increases. The amount was less than expected.

MS DUNDAS: Is that what's flowing on into the outyears, that $400,000? Is that for SACS or is it because of the fewer positions in the medical school?

Dr Sherbon: Sorry?

MS DUNDAS: Budget paper 4 at page 147 has a return of unused funds flowing into the outyears of $400,000.

Dr Sherbon: Yes, that is the SACS increase going across the outyears.

MS DUNDAS: If I may, I have one last thing on the financial position of ACT Health. You have been quarantined from finding the general savings that most other departments have had to find over the financial years. Will health be going through the ERC process?

Mr Corbell: Health has already been through the ERC process and the government has agreed that any savings that health have agreed through the ERC process to identify, and there have been a number of millions of dollars identified through that process, will be reinvested into other service delivery in ACT Health. So it will not be returned to government. There are efficiencies and changes to delivery which can be identified and implemented and then those savings will be reinvested in other areas of ACT Health.

MS DUNDAS: This goes back to Mr Hargreaves's question: is the funding that is going to the agency-funded initiatives for this year, 2004-05, all just agency growth funds or is it actually a part of savings that have been found through the ERC process?

Mr Corbell: No, the funding for growth is additional. Health is within its own budget also reprioritising its activity to fund other activities in addition to that which is funded

by growth.

MS DUNDAS: But no new initiatives are being funded through general savings.

Mr Corbell: No, none of the initiatives outlined in this budget paper are being funded through savings. This is new money.

MS DUNDAS: So the savings money is going to support ongoing programs.

Mr Corbell: It's to support other activities that the government has chosen not to fund through the budget process, and that's determined in consultation between me and the department.

MS DUNDAS: Where is that information available? If there are new things being supported that aren't listed in the budget papers because they're not new money as such, where do we find out what areas are being supported by those savings?

Mr Corbell: Normally it would be identified through the annual report as to how that expenditure is occurring. It's not new expenditure of which the government is seeking the Assembly's approval.

MS DUNDAS: But it would be interesting to know what health is prioritising.

Mr Corbell: Sure. Normally we would deal with that through the annual report.

MS DUNDAS: So, for the 2004-05 financial year, have those decisions been made, or will we have to wait for the annual report?

Dr Sherbon: The ERC process identified some areas by which we could internally source funds for improved services and improved infrastructure. One of the decisions that have already been made is that some of those funds will go towards the improvement of manual handling training in the ACT Health portfolio, with a considerable increase in the intensification and scope of our manual handling training program with the aim of reducing staff injuries. You will have noted in your examination of the budget papers that there is a contribution from this budget for additional equipment to reduce manual handling injuries for nurses and other staff at, particularly, Canberra Hospital, but there is also internally sourced a significant increase in funding for manual handling training. That is one initiative.

Other initiatives involve expansion of the capacity of quality and safety infrastructure and other expansions of existing services to meet demand which we can detail once we've finalised our own internal budget. At this point in time, our internal budget is not yet finalised. My team and I will meet soon to finalise our budget for 2004-05 and, if so agreed, we will provide that information to you in July.

MR SMYTH: Minister, you just said that you couldn't tell us where the savings had been redirected. Are they not the agency-funded initiatives on page 153 of budget paper 3? There is a list of about a dozen recurrent initiatives under ACT Health.

MR HARGREAVES: And what are they called?

MS DUNDAS: That was, I thought, the first question I asked and the minister said that it was grants money.

Mr Corbell: No, that's money from growth funds.

MR HARGREAVES: Agency growth funds.

MS DUNDAS: So there's a different between the growth funds and the savings.

MRS DUNNE: But they're recurrent.

MR SMYTH: Will you provide a list of where the savings have been redirected?

Mr Corbell: Once, as Dr Sherbon has said, the internal budget is finalised, we can provide that information.

MS MacDONALD: I refer to budget paper 3 and the home-based oxygen scheme. I think it's good that we are not going to be doing means testing anymore. As to the appropriate supplies that you say will be provided, there is a difference in the amount that it costs for the different types of tanks that you get with the oxygen canisters. Will that provision be for the portable packs, which are a lighter pack to travel with, or will it be for the heavy oxygen canisters?

Mr Corbell: As I understand—the officers can provide further information—the program operates on a tender basis. We have a tender for oxygen services. Currently, a particular provider provides those services and they provide, as I understand it, and Ms Yen can correct me if I'm wrong, a range of tank types for both out and about as well as at home.

MS MacDONALD: So it will be for both types of tanks.

Mr Corbell: Yes.

MS MacDONALD: That's good.

MR SMYTH: Would that be included in the tender documents?

Mr Corbell: We already have a contract with an oxygen supplier. The only difference is that we're now not means testing it. We have an existing contract. The existing contract provides that range of services already. What this budget funds is no longer means tested and we pick up the cost of the additional demand that results from that.

MR SMYTH: I've had concerns raised with me that the existing holder of the tender only supplies large tanks, which I think is what Ms MacDonald was alluding to, and that the smaller travel tanks aren't available.

MS MacDONALD: I wasn't alluding to that, but I was concerned to know that both types are being provided for.

Mr Corbell: My understanding is that both types are provided for. It is perhaps worth making the point that different suppliers have different types of mobile and, if you like, stay at home oxygen cylinders. In my discussions with Ms Anne Cahill Lambert, who has been an advocate for this, she has raised concerns with me that one supplier's type of mobile tank is heavier than another's. That's something that we can look at when the tender comes up again for the supply of oxygen, but both suppliers that I'm aware of in the ACT do make available the mobile type cylinder as well as the larger cylinder for at home use and this scheme will obviously make that available.

MS MacDONALD: How soon is the tender likely to come up and will you be able to find out in the meantime whether the current suppliers are providing that lighter type pack?

Mr Corbell: They're providing a mobile cylinder, which is the important thing. Whether it's heavier or lighter than other products is something that can be assessed when the contract comes up for renewal. I'm not sure when the contract will come up for renewal. I'll take that on notice and come back to you on that.

MS DUNDAS: In terms of new budget initiatives, the improved enforcement of the tobacco legislation will work to prohibit the sale of tobacco products to minors. Are you planning on doing what is done in Queensland, which gets young people to go in and buy cigarettes and then fines are issued? The last time I raised this issue I was told that there were problems in terms of entrapment and that the ACT would not be able to do that.

Mr Corbell: That is the general intention. We will need to explore some of the legislative issues around entrapment, but it is intended that we will take an approach along those lines to see whether tobacco retailers are complying with the legislation.

MS DUNDAS: On what will that $150,000 be spent?

Mr Corbell: I'll ask Dr Dugdale to answer that question for me.

Dr Dugdale: Paul Dugdale, ACT chief health officer. We are looking, first of all, to change the legislation to enable us to employ young people to purchase cigarettes. At the moment, they're not allowed to do so and we need to make the change so that they can for law enforcement purposes. Once those changes have been made we'll look at employing young people to do it. We're also looking at employing people to supervise them and make sure that they get adequate support, so that they get strong team support behind them. Finally, for each one of these where they do make a purchase, where tobacco is sold to them and the operator shouldn't be doing it, having sufficient human resources and financial resources to make a prosecution. That's the summary of what those funds will go to.

MS DUNDAS: How much of the $150,000 for 2004-05 will go to young people? How many young people are you expecting to employ?

Dr Dugdale: We haven't done a detailed breakdown of those costings.

MS DUNDAS: When can we expect to see the legislation, if it is to start on 1 July?

Dr Dugdale: No, we will be putting up a proposed legislative change to the government during the 2004-05 financial year.

MS DUNDAS: So this money won't start to be expended until—

Mr Corbell: The money is for the development of the program as well as the implementation of the program.

Dr Dugdale: There are costs in putting legislation to the Assembly, as you know. We have to obtain a regulatory impact statement.

MR SMYTH: Why wasn't that work done before the money was bid for? It seems like we've got a process where you seek some money and, if you're lucky enough to get the money in the budget, you then work out the detail. It's very hard for a committee to work out whether this money will be wisely spent when the details are not available.

Mr Corbell: The program funding identifies that there is a range of policy work that needs to be done before the program can actually be implemented. The funding is over a period of four years. Some of the funding in the initial years is for the development of the policy and the legislative change that is needed to allow the program to be implemented, and that's quite a normal process. You'll see across the budget a range of initiatives identified for particular projects to develop legislative reform. For example, in my other portfolio, in planning, there is funding specifically to do work on reviewing the land act. It is a normal part of the budget process to identify the funding first of all that's needed to develop the program and then in later years to implement the program.

MRS DUNNE: Dr Dugdale, are you saying that this money is, essentially, targeted at entrapment and you're going to work out how to do it legally?

Dr Dugdale: At the moment, there is a problem with tobacco retailers selling tobacco to children. In order to obtain a prosecution for that, they need to be caught in the act. So we will be using young people to purchase cigarettes to see if the retailers are selling them to young people.

MRS DUNNE: So that's a yes.

Mr Corbell: Yes, it is a yes.

MS DUNDAS: And it is a program that is being currently used in Queensland.

MRS DUNNE: I'm sorry, I don't care where it's being used. What we're actually doing is we're going to create a legislative arrangement that makes entrapment legal.

Mr Corbell: That's correct. It occurs in Queensland and New South Wales. As Dr Dugdale says, we cannot prosecute sellers of tobacco to minors unless there is clear evidence that we've been able to catch them in the act. I know that members of this Assembly have raised with me the issue of the enforcement of legislation on sales to minors. Quite clearly, if we have an inspector standing in a shop watching, a shopkeeper is not going to sell tobacco to minors. So it's difficult to enforce the legislation except through a random regime of testing whether retailers are complying with the legislation.

THE CHAIR: What legislation do you need to change? You would need to change legislation to enable that to happen, otherwise you would have trouble with the Supreme Court.

Mr Corbell: That's exactly what we've been saying, Mr Stefaniak: that it will require legislative change, and part of the funding for this project is to allow that legislative change to be implemented.

THE CHAIR: When do you envisage that legislative change will occur?

Mr Corbell: As Dr Dugdale indicated, the work will occur in the next financial year so that the government can introduce amendments to the relevant legislation to allow the program to get up and running.

THE CHAIR: Some time in the next financial year.

Mr Corbell: Given that we are heading into an electoral cycle, there's a range of uncertainty as to what the priorities of the future government may be and the department, obviously, can't anticipate all of those. Therefore, they're indicating it will be something that will be implemented in the coming financial year. I'm obviously keen to see it implemented as soon as possible. I'll be doing everything I can to facilitate that. In relation to the legislation, perhaps I can ask Dr Dugdale whether he knows which legislation requires amendment.

Dr Dugdale: I haven't got it at my fingertips, I'm sorry.

Mr Corbell: We will take that on notice for you so that you can have that information.

MRS DUNNE: Minister, would you envisage, if this project were successful, that you might go out and recruit underage drinkers to entrap liquor licensees? Where will it end? You can say that about selling alcohol to underage drinkers, but there are ways of policing that without entrapment, without the health department and the liquor licensing people getting together and paying kids to go into pubs and buy beers. Have you really and truly exhausted all of the possibilities? Have you looked at the legislation in terms of the evidence that is required under the legislation before you go down this path, which, I have to say, is morally fairly questionable? I don't care whether it is done in Queensland. Even Bill Stefaniak has problems with it.

THE CHAIR: Yes, I have some problems with it, I must say.

MR HARGREAVES: With respect, Mr Chairman, perhaps this is a subject for debate on the floor of the Assembly when the legislation comes forward.

THE CHAIR: It may be, but I'll allow the question, Mr Hargreaves.

Mr Corbell: Mr Hargreaves is right, I must say. The Assembly will have the opportunity to scrutinise any legislative change and to make its judgments about that. Yes, entrapment is a difficult area. I don't disagree that certain members may have difficulty with the notion. That said, perhaps using the liquor licensing parallel, it is relatively

easier to identify, first of all, whether a young person is intoxicated.

MRS DUNNE: It's not about whether they're intoxicated; it's about whether they buy it.

Mr Corbell: The police, along with liquor licensing, do pay close attention to what occurs in nightclubs, for example, around town. It's more difficult in a retail environment, particularly in a suburban retail environment. We can't monitor the activities of every single small supermarket that sells tobacco in Canberra. Clearly, that's where a large number of these sales will occur—in a suburban setting, in a supermarket, in a petrol station—and it's appropriate that we have some form of legislation that tests whether people are abiding by the law. It's only going to catch those people who are not abiding by the law, not those who are.

THE CHAIR: You do have inspectors, I take it, and they would not necessarily have to go out in a uniform; they could be in plain clothes.

Mr Corbell: I'm not sure what the operational aspects of that are, but Dr Dugdale may be able to help you.

Dr Dugdale: Yes, that's the case. To use crude language, entrapment is one, but we have tried stakeouts in the past and there are a couple of problems with that. One is that shopkeepers know where they're operating very well and they are alert to people observing what's going on. Perhaps there are other professions that are more adept at that than my environmental health officers, but these are well-known people. The environmental health officers are well known to the small business community because they're a presence there.

The other problem is that the first thing they would have to do is apprehend the young person to check that they were underage and there's a high level of discomfort in doing that because we don't have powers to apprehend the young people for it. We have made strong attempts to work with the current legislation and the current arrangements but we've been unsuccessful in getting a prosecution in that way.

MR HARGREAVES: I will ask both of my questions at the same time because they are about following lines in the budget paper. They are about technical adjustments. I refer to page 147 of BP4. It's the sort of thing that Dr Sherbon and possibly Mr Foster will be able to handle straight off the top of the head. I would like an explanation for the appearance of the reduction in Commonwealth funding. It goes down in 2003-04, continues to go down 2004-05, goes down $1 million in 2005-06 and pops up $1.2 million in 2007-08. I want to get a handle on what that is about. While you are at it, the next line down refers to the transfer of nurses from the Department of Education, Youth and Family Services. Where did that department have nurses?

Mr Corbell: School nurses. A small number of school nurses still exist in a number of schools. I think they're mostly in the schools that assist children with disabilities.

MR HARGREAVES: The Woden special school type of thing.

Mr Corbell: Yes, I think that's the case. It was felt more appropriate, given the very small number of them, that they be wrapped into our administrative arrangements at the

health department rather than being a very small, isolated pocket of professionals in education. That occurred about 12 months ago or so. The other item I'll ask Mr Foster to answer.

Mr Foster: Ron Foster, director of finance. As you'd appreciate, in putting together a budget with Commonwealth amounts involved we have to work before we know what the Commonwealth budget is going to provide, but also we have to make decisions across the outyears when we do set our budget down. The main reason for the reduction across the first three years is the fact that when developing the budget for 2003-04 and 2002-03 we built in across the outyears a level of funding from the Commonwealth for the national health development funds.

We had anticipated when setting the budget that that would continue into the new Australian health care agreement. That hasn't been the case, so we have had to reverse out of the forward estimates revenue items and out of the expenditure items the $1.6 million for that item. There has also been an adjustment to the level of the quality funding that we had assumed coming through the budget. On the positive side, there are small increases announced annually for mental health, aged care assessment teams and various things like that, but the reduction is because of an assumption we made around the national health development funds continuing.

MR HARGREAVES: Was the ACT treated in the same way as the rest of the states in the gutting of that funding source?

Mr Corbell: I'm sorry, could you ask that again, Mr Hargreaves?

MR HARGREAVES: Certainly. Mr Foster has just indicated that there was a reduction in the funds that the ACT thought were going to come forward from the Commonwealth with the continuation of programs, but that didn't happen. I just wanted to know whether the treatment of the ACT was the same as the treatment of the states or whether the states got more favourable or less favourable treatment in this exercise.

Mr Corbell: We were all treated equally harshly.

MR SMYTH: Were Mr Foster's assumptions borne out? Were the numbers that you included as assumptions borne out by the outcome of the budget?

Mr Corbell: No, these aren't assumptions; these are based on what we know we're going to get.

MR SMYTH: Mr Foster just said that they were assumptions.

Mr Foster: Sorry, what I said was, correctly, that when developing the budget we assumed the revenue from the Australian health care agreement would continue across each of the outyears, and that has not been the case because of the Commonwealth decision not to fund the national health development fund through the Australian health care agreement. As it turns out, it was a one-off program that they allowed for in the 1998 to 2003 AHCA.

MR HARGREAVES: The generosity of the federal health minister knows no bounds.

On the same item, we're losing $1,059,000 in 2005-06, we get back pocket money of $32,000 in the next year and then we go up to $1.22 million. What do you anticipate happening with that positive of $1.2 million? Are you making an assumption that the federal government will be more generous than it is now?

Mr Foster: There is no assumption being made in terms of the Australian health care funding in relation to a national health development fund because we have ended thinking about that particular fund. The figures going across the outyears reflect an assumption that there will be increased funding coming through from the national public health agreement for immunisation funds. It is forward advice from the Commonwealth that we can expect to see rises in that program. Similarly, we would assume increases in HACC from the Commonwealth going across those outyears as well.

MR HARGREAVES: Is that the pneumococcal and meningococcal vaccination program?

Mr Foster: Yes.

Mr Corbell: It includes that.

MR SMYTH: Has Press Ganey done another satisfaction survey in recent years?

Dr Sherbon: The hospital will be undertaking a satisfaction survey. Whether Press Ganey will be doing that, we'll have to review. But we will be continuing the satisfaction survey appraisal.

MR SMYTH: Have you done an internal satisfaction survey recently?

Mr Mollett: John Mollett, general manager, TCH. We haven't done a satisfaction survey this calendar year, no.

MR SMYTH: When is the next one scheduled for?

Mr Mollett: At the moment we're planning potentially in November-December.

MR SMYTH: Isn't there a requirement for the annual reports that you deliver a satisfaction survey? If you're not doing one this calendar year, how will you meet that requirement in your annual report?

Mr Corbell: I think there was a satisfaction survey done in the second half of last year, which would fall within the relevant reporting period.

MR SMYTH: So the first half of this financial year.

Mr Corbell: That is my understanding.

MR SMYTH: Can we have a copy of that satisfaction survey?

Mr Mollett: Yes, with the minister's permission.

MR SMYTH: Will that be provided to the committee?

Mr Corbell: Yes, we can provide the last satisfaction survey.

THE CHAIR: Thank you. You can take that on notice.

MR SMYTH: Is Press Ganey due to do another satisfaction survey? How does Press Ganey get involved? Do they approach you or do you approach them?

Mr Mollett: As Dr Sherbon indicated, at the moment we're looking at an appropriate organisation to effect the survey and the thing that we are most concerned about is, first of all, to ensure that the cohort that is surveyed allows us to look at TCH relative to similar institutions in Australia so that we start to get a feel for how we compare.

MR SMYTH: So you might be moving away from Press Ganey, even though they're the acknowledged world leaders in this in-hospital satisfaction service?

Mr Mollett: If that's their publicity. I don't know, Mr Smyth.

MR SMYTH: Okay. What other organisation might do such a survey?

Mr Mollett: At my fingertips, I wouldn't have an exhaustive list, but there is a company from memory, and I could be wrong, called TQA who survey hospitals, particularly in Victoria and Queensland, but TQA—I may have got the letters wrong—equally would argue that they are an internationally renowned company.

MR SMYTH: Is the search for somebody other than Press Ganey to do a survey dissatisfaction with how the results came out last time, or was the service provided by Press Ganey not acceptable?

Mr Corbell: If your question is whether we are changing or looking at changing the organisation that does the survey because we were unhappy with the results we got from the last one, the answer is no in terms of the outcome of the survey, but we do want to be satisfied that the methodology and the comparative analysis that occurs as a result of the data from that methodology are accurate and relevant to TCH as it compares to equivalent hospitals in other places.

MR SMYTH: So you have doubts that Press Ganey was accurate and relevant in the last survey that they did, that its methodology was somehow flawed.

Mr Corbell: I think we have highlighted through our analysis a range of concerns with how relevant some of the assessment is and we want to make sure that we get the best possible data so that we can improve where we need to in the Canberra Hospital based on customer feedback.

MR SMYTH: So you will guarantee the committee this isn't shooting the messenger.

Mr Corbell: Absolutely not.

MR SMYTH: You're not shopping for a different organisation that might deliver a

different outcome.

Mr Corbell: Absolutely not. I certainly accept that there are always areas within the health system that need improvement. It's a continual process and customer satisfaction surveys are an important part of that process.

MR SMYTH: Will the survey be done before the election?

Mr Corbell: At this stage, Mr Mollett has indicated probably not.

MR SMYTH: Sorry?

Mr Corbell: At this stage, Mr Mollett has indicated that it's not intended to occur before the election. The important thing to stress is that the department will continue to meet its reporting requirements.

THE CHAIR: Gentleman, you will be providing the latest survey, which you did in the second half of last year. It might help the committee to have the two previous surveys before that. I have one final question in this general area. We will start on the output classes after morning tea. Following through on some of Mr Hargreaves's recent ones, I refer to page 147 of BP4. Down towards the bottom there is a reference to revised indexation parameters. Is that some sort of balancing item?

Dr Sherbon: I am advised that there has been a reduction in government programmed indexation of goods and services expenditure.

THE CHAIR: What about the $8 million in 2007-08?

Dr Sherbon: I have to confer with Mr Foster. Similar to the presentation of $11 million above that area for the government adding in growth funding, there is a requirement to add in base indexation as we add yet another forward year to the budget papers. That is the net impact of adding indexation on the whole base.

MR SMYTH: How can it go down for three years and then jump by a factor of eight in the fourth year?

Mr Foster: Because the reduction in those first years is a change in the indexation rate from 2½ per cent to 2 per cent only for 2004-05 and then there is 2½ per cent in our base in the other years. The last year is adding in a whole year's indexation of 2½ per cent on the total level of our admin expenses.

MR SMYTH: Why would you treat the years differently?

Mr Foster: We have to add the last year to provide indexation on our base through the government process and the other year is a decision of government, based on their own advice that the indexation that should apply for 2004-05 is 2 per cent.

Meeting adjourned from 10.40 to 10.55 am.

THE CHAIR: We will start with output class 1.1, which relates to acute services.

Mr Corbell: Mr Chairman, before you do, I have some additional information for you. You were asking questions about the acts that would need to be amended to deal with the entrapment issue in relation to the sale of tobacco to minors. I am advised that, at this stage, the analysis suggests that the ACT Tobacco Act 1927, which currently makes it an offence to sell tobacco to minors, would need to be addressed, as would potentially the Crimes Act, which currently makes it an offence to incite or aid and abet a crime. The interaction between those two acts is quite complex and further legal advice is being sought on that.

THE CHAIR: I thank you for that interim response, Minister; it is helpful. Minister, where are you at with the subacute facility?

Mr Corbell: The subacute facility is in the detailed planning stage right now. The facility is a very important one, which will provide a range of subacute care, rehabilitation and psychogeriatric services to the community. It is to be located on the Calvary Hospital campus and is in the detailed planning stage at the moment.

MRS DUNNE: I would have thought that the answer was that it was in a time warp, Minister. Wasn't it supposed to be finished by December of this financial year but has now blown out to February 2006?

Mr Corbell: I don't think it was due to be finished this financial year. I think it was due to be commenced this financial year.

MR SMYTH: According to the 2003-04 budget paper No 4, page 142, the subacute facility phase 1 was due in December 2004, Minister. Can we go back a little bit? In the 2002-03 budget the government put aside $300,000 for the forward design. How much of that has been spent, Minister?

Mr Corbell: I'll need to ask officers to answer that for you.

Dr Sherbon: All of it.

MR SMYTH: That's interesting because the capital works program update that was tabled in the Assembly in the same sitting week as the budget said that, of the $300,000, at the end of December only $22,000 had been expended.

Mr Corbell: It's not December, Mr Smyth.

MR SMYTH: I'm asking whether it has all been expended.

Mr Corbell: It's five months later and, as Dr Sherbon has indicated, it has been expended.

Dr Sherbon: It's all committed to the planning process. The planners are on board. They've been working intensely. As the minister outlined, he has secured additional funds from the Commonwealth to build a larger facility than first announced. The site has been determined after some considerable analysis and we're now proceeding to construction as soon as we can finalise the design.

MR SMYTH: So the $300,000 on the forward design has all been spent.

Dr Sherbon: All committed, sorry; I should qualify that. It's all committed and will be spent.

MR SMYTH: Can we know how much has actually been spent at this time?

Dr Sherbon: I can get you that: $130,000. I'll get you that on notice.

MR SMYTH: I noticed in the update that according to the latest report—I can't see what page it is—$5.15 million was appropriated under departmental new works in the 2003-04 budget, which I assume was for the construction of the building, and $130,000 has been spent at this stage. Is that the same $130,000 that was spent out of the $300,000 or is that different money?

Mr Corbell: That would be the same money.

MR SMYTH: It would be the same money.

Mr Corbell: Yes.

MR SMYTH: So, of the $300,000 for forward design, $130,000 has been spent.

MRS DUNNE: Or is it out of forward design money? There is $5 million in this year's budget and there was $300,000 in the previous budget. How much has been spent on forward design and out of which budget?

Dr Sherbon: I'll get you an exact figure for what has been spent, but I'm advised that we're fully committed to the forward design process and the full amount of $300,000 will be spent in the forward design process.

Mr Corbell: Sorry, which page are you referring to, Mr Smyth?

MR SMYTH: I'm in the December quarter capital works report that was tabled in the Assembly a fortnight ago.

Mr Corbell: But you were referring to the total capital works figure of $5 million.

MR SMYTH: Yes.

Mr Corbell: It's normal in reporting on capital works that capital works include the provision for forward design. So it's the same money. It's reported differently in that document than it is in the budget documents.

MR SMYTH: Except that you have appropriated them differently, Minister. You have appropriated one in the forward design section of capital works, which is standard, and you have appropriated actual construction money in the actual works in progress part of the budget, which is also standard. It's just when you try to reconcile this. This has been going on since May 2002 and we now find that the expected completion date given—you

have put an extra $4.6 million into this year's budget—is February 2006.

Mr Corbell: That's correct.

MR SMYTH: Minister, is it appropriate that such a process take four years?

Mr Corbell: I have raised my concerns with the department about the adequacy of their forward planning for major capital works projects. I'm uncomfortable with major revisions coming back to government for further consideration. There was certainly a major revision both in this case and in relation to expenditure for the medical school improvements, which is also an additional appropriation in this year's budget. I've indicated to the department that I want to see an improved process for planning and estimating the costs of projects so that the department does not have to revisit the overall expenditure and have to consider requests for significant additional expenditure. Yes, I accept that the planning process has not been as adequate as I would like it to be. That process is now being addressed for future project planning.

MR SMYTH: What was the major revision that caused the delay?

Mr Corbell: My understanding is that there was significant revision of the scope of the project and there was a range of costs that had to be recalculated. Obviously, building costs have significantly increased. That has had an impact on the cost of the overall project, as had the additional detailed scoping exercises that had to occur to understand what was fully required in the building.

MR SMYTH: But the project has actually doubled. In the 2003-04 budget you put $5.1 million aside. In this year's budget you have put in an extra $4.6 million. Effectively, it's going from a $5 million to a $10 million project. How could it be out by 100 per cent?

Mr Corbell: The additional work has identified the need for a significant additional capacity to that which was originally projected.

MR SMYTH: Which was what? It has gone from what to what?

Mr Corbell: The overall capacity of the facility—I don't have those details available, but I'm happy to provide them to you—in terms of psychogeriatric care and subacute and rehabilitation services needed to be larger than was originally anticipated when the original scoping work was done. That scoping work has now identified the full extent of the service that is needed and that has been taken account of. It's worth making the point that the Commonwealth has provided additional funds for this project, so we've taken advantage of the availability of additional funds from the Commonwealth to increase the scope and size of the facility.

MR SMYTH: What will it be now; how many beds?

Mr Corbell: I don't have those details to hand. I'll ask officers if they have that information.

Dr Sherbon: I can give that answer. The facility will have a 40-bed rehabilitation

convalescent care service with a 20-bed psychogeriatric facility.

MRS DUNNE: Minister, when was the decision made to put the subacute care and the psychogeriatric services together in the one building?

Mr Corbell: I think that was made following the election of the government. We made a commitment to work to provide a specific psychogeriatric care facility. It's not something that the ACT has previously had and members would be aware that on some occasions we have seen in particular older Canberrans have to leave Canberra to be placed in an appropriate facility interstate. I couldn't tell you the exact date, Mrs Dunne, but certainly the department took it on board in its planning once it was aware of the government's commitment to make provision for that sort of service.

MRS DUNNE: I don't have a problem with funding psychogeriatric services and I recollect—correct me if I'm wrong—that some of the bonus for signing up to the health care agreement was extra money for psychogeriatric services. Is that part of that money?

Mr Corbell: No, it wasn't extra. The Commonwealth government, as part of its pathways home program, which was part of the overall offer to all the states and territories, had money available for capital expenditure and our project fitted the bill. What we were able to achieve as a result of negotiations with the Commonwealth was early agreement on their part to use that money for this facility.

MR SMYTH: Is that for recurrent or is that for actual construction of the building?

Mr Corbell: It is for capital.

MR SMYTH: How much capital is the Commonwealth contributing to the $10 million?

Mr Corbell: The sum of $4.6 million.

MR SMYTH: Is the supplementary funding that is listed in the budget this year, $1.6 million, all Commonwealth money?

Mr Corbell: Yes.

MR SMYTH: It's a shame that that wasn't acknowledged, Minister.

Mr Corbell: I have announced it publicly previously and acknowledged that.

MRS DUNNE: Somewhere along the line a decision was made to co-locate a step-down facility, a subacute facility, with psychogeriatric facilities—for a layperson, quite high care. When was that decision made? If you can't answer that, I'd like you to take it on notice. What are the clinical indications for both streams being co-located and what are the clinical contraindications?

Mr Corbell: I'm happy to take the first part of your question on notice. I'll need to see exactly at what stage in the process that was agreed to by government. In relation to the second issue, I don't know whether there is anyone available here to answer that.

Dr Sherbon: Yes, I can assist. The planning principles that point out the benefits of co-location are as follows: psychogeriatric patients are generally older people with either a severe mental health illness or an acute exacerbation of their underlying dementia, and they benefit from joint care from psychiatrists, geriatricians and similarly trained nurses. So there is a benefit in having that facility next to the rehabilitation facility, which will be a combined general rehabilitation and aged care rehabilitation facility. So there will be a sharing of staff and some common patients, despite the fact that the emphasis on the caring of patients will be slightly different in the two sections.

MRS DUNNE: Do you envisage, Dr Sherbon, that with patients who are potential clients of the step-down facility—that is, people who are on the way to recovery but not well enough to go home yet but shouldn't be occupying a hospital bed—you may encounter some consumer resistance if it's widely known that they're being sent to a facility which is also a psychogeriatric facility?

Dr Sherbon: No. Ms Killion might comment on the design principles that are being brought to bear, but I think most consumers will be comfortable that they'll be going to a rehabilitation facility that will care for their needs, and for many that will involve a range of general supports as well as psychological supports. If your question is asking whether they will be concerned about potential stigmatisation, I think we can address that through the education of clients, their families, staff and in some minor way the design of the facility.

There are many facilities around Australia, standalone rehabilitation facilities, that care for younger people who are recovering from major incidents, like amputations or hip replacements, and the older age group of the frail aged that generally require strengthening before returning home or to an independent living environment. Many of those facilities around Australia are interacting closely with pyschogeriatric services because many of the clients, although they might be different on a particular day, will incur the need to avail themselves of both services at some point in their recovery.

Mr Corbell: Ms Killion will give you some further information on the proposed design.

Ms Killion: Susan Killion, executive director, policy and planning, ACT Health. At the moment, we have architects on deck who are looking at the design of the subacute facility and it is not envisaged at this point that the clients themselves would share the same areas, so the psychogeriatric clients would have a different area to the rehabilitation and convalescent clients. The staff may share common areas, but the clients themselves will not be interacting.

MRS DUNNE: Dr Sherbon, you said before that there would be some sharing of facilities—I presume rehabilitation facilities.

Dr Sherbon: They'll be in the same building.

MRS DUNNE: Okay, but there are going to be separate, isolated rehabilitation facilities for the psychogeriatric patients and the subacute patients.

Dr Sherbon: As Ms Killion just said, the early design indicates they'll be separate but they'll be part of the same building and there will be a lot of staff interaction between the

two. That's the benefit of the co-location; there will be staff who are experts in aged care, whether they be doctors, nurses or some other form of professional, who will be interacting with client groups across both of those sections and there will be clients who will benefit from both services over various points in time in their rehabilitation process.

MRS DUNNE: Where at Calvary is this facility going to be built, seeing we've now allocated the site?

Ms Killion: Near the O'Shannassy Centre and located close to the gym so that rehabilitation can occur. That's being looked at at the moment.

MR SMYTH: Where is the actual design at? It is two years since this money was first appropriated. Are the plans finished or are you still consulting with the architects and the designers?

Ms Killion: We're still consulting with the architects and the user groups. There aren't any sketch plans for the subacute facility yet.

MR SMYTH: So you haven't even entered the ACT planning system at this stage.

Ms Killion: It has definitely been in the ACT planning system. It's just that the architects are on deck now.

MRS DUNNE: How far are you away from a development application?

Ms Killion: I'm sorry, I'm not sure what you mean.

Mr Corbell: The advice I have is that it's anticipated that the plans will be finalised by late 2004, so I'd anticipate that at that stage the development application would be lodged.

MR SMYTH: And then it would take 14 months to build it.

Mr Corbell: Yes. The proposal is to call tenders for construction in early 2005.

MRS DUNNE: Are you comfortable, Minister, with the amount of time this has taken?

Mr Corbell: I think I answered that question earlier.

MR SMYTH: Minister, how many nursing home type patients or people that would use this facility are caught in Calvary and Canberra Hospital because they have nowhere to go? The previous government announced the start of this project in the 2001-02 budget. On average, how many nursing home type patients or convalescence patients are caught in wards at Woden or Calvary?

Mr Corbell: I'm advised that nursing home type patients are not the sorts of patients who would be using this facility.

MR SMYTH: Convalescence patients, then.

Mr Corbell: But certainly convalescence patients potentially would be. In terms of the exact numbers, I don't have a read on that, but I'll ask officers if they can assist on that.

Dr Sherbon: The numbers will accord closely to the bed allocations as described—40 in general rehabilitation/convalescent care and 20 in psychogeriatrics. In a general rehabilitation ward—we're probably one of the last major cities not to have a general rehabilitation dedicated facility—you'd expect that there'd be a mixture of around half and half of older people, and this fluctuates from day to day, who require general rehabilitation so that they can reacquire their activities of daily living skills. Generally, these are older people who've had an illness that has progressed, they've come into hospital acutely with heart failure, pneumonia or another infection, their general body strength has deteriorated over some months, and they need general rehabilitation to restore their functions.

Also, there will be another rehabilitation client group which are probably less in number but are younger people who have had a major hip operation and require mobilisation, amputations or strokes and who are progressively improving. This client group will also be part of the facility, although the balance of that client group between Calvary and Canberra Hospital probably will still be a significant portion of that latter client group at Canberra Hospital.

MR SMYTH: Given that Canberra is a major city that doesn't have such a facility, I get back to Mr Hargreaves's first question this morning: why are we considering shutting beds down?

Mr Corbell: We are not closing beds down. In the medium term when this facility opens we will be having this facility service the major bulk of people who need that type of care.

MR SMYTH: But you've got a proposal before you in the short term that possibly a third of the RILU beds will disappear. How can you say that two years from now we're finally going to have a convalescent facility when you've got an initiative before you at this stage to shut down a third of the rehabilitation beds in the ACT?

Mr Corbell: What the question ignores is that both RILU and the rehabilitation ward operate at less than full capacity. Indeed, RILU operates at about 50 per cent capacity at the moment and the rehabilitation ward—I have the figures here—at a similar level. The average occupancy rate for RILU is six to eight patients. It has 14 beds. The advice I have is that the current occupancy rate for the rehab ward is 12 rehabilitation patients. It has 20 beds. So we are looking at making sure that we utilise our resources more efficiently to meet demands on other parts of the system whilst not compromising the level of care that's available for rehab patients.

MRS DUNNE: On that subject, Minister, and this is probably something you might have to take on notice: if the average is six to eight beds, how often are the 14 beds occupied?

Mr Corbell: I can provide that data for you. I'll have to take it on notice.

MRS DUNNE: And equally with the rehab ward.

Mr Corbell: Certainly.

MS DUNDAS: I want to ask about the problems that nurses are facing in our hospitals. There are problems of nurses resigning because they feel that they cannot do anything but do back shifts and overtime shifts. Has there been any move to address those problems in terms of shift loads for nurses?

Mr Corbell: The government is currently negotiating a comprehensive new pay offer to nurses through an enterprise bargaining agreement. That also acknowledges issues to do with shifts, issues to do with payment associated with certain shifts, and a range of other workplace and professional development issues. The offer currently focuses on improving the arrangements in terms of managing workload in the hospital. I have to say that we do not require double shifts. Double shifts do occur, but it is not a requirement of nursing staff to work those shifts and we do wherever possible obviously seek to avoid those. Dr Sherbon has some additional information, I think, on a range of these issues, so I'll ask him to add to my answer.

Dr Sherbon: Yes, as the minister outlined, we have a range of strategies to deal with nurse recruitment in addition to the EBA negotiations. Our chief nurse is now busy on a whole gamut of career improvement arrangements and educational improvements to nurses as well as professional development that will assist in retaining and recruiting nurses. Just to clarify, we do monitor closely overtime utilisation in nursing and we do keep a very close eye on agency nurses because both indicate the need for additional staff.

I can report that our overtime rate for nurses is 2.9 per cent of our total FDE, so it's not extremely high. Our agency nurses per month ranged between, over the last financial year, 22 FDE and 24 FDE; as at 30 April, 24.34 FDE. We monitor very closely the use of agencies, casuals and overtime, all of which are within reasonable parameters for a busy large hospital, although we are concerned about the fact that some nurses are having difficulty accessing annual leave. We recognise there is a general shortage across the nation and, as the minister has outlined, there is a range of strategies being brought to bear to improve attractiveness and retention at our hospitals and other services for nurses, but there is no excessive request for overtime utilisation at this point in time.

MR SMYTH: How many nurses are we short?

Dr Sherbon: By 127 positions out of 1,800 on the last figures I got, which was a month ago. I can get you the precise details.

MS DUNDAS: Can you also, in terms of getting us precise details on the number of nurses we are short, give us a breakdown of the level of classification where you are short?

Dr Sherbon: Yes, I can certainly do that. The bottom line is that we are short of some specialist nurses. Intensive care, emergency, oncology and mental health are our current shortages. The minister and I work closely on those particular issues.

MRS DUNNE: If we can also get a full list of the shortages in speciality. How are we going for paediatric nurses, for instance? When I was last in the paediatric ward there

were lots of temporaries. Maybe it was because it was a weekend.

Mr Corbell: We can give you a breakdown of the specialities.

MRS DUNNE: Yes, thanks.

Mr Corbell: The key issue, I guess, that's worth revisiting is that the system overall has sufficient nurses but there are shortages in particular areas which are more critical than others—as Dr Sherbon indicates, ICU nurses, ED nurses. Obviously, these are pressure points in the system and it's not for lack of adequate wages or conditions of services; it's more the overall work force shortage which all jurisdictions are struggling with. So it's not related specifically to ACT type conditions, although we do obviously need to make sure we keep our conditions and rates of pay competitive. It's as much influenced by the overall work force shortages that every other state and territory is facing.

MS DUNDAS: In terms of the offers that you're putting forward to the nurses, has consideration of what has been going on in those areas of specific shortage actually influenced the pay offers that you're putting forward or the working conditions that you're putting forward?

Mr Corbell: Perhaps Dr Sherbon can give you some more details, but in general, no. Nurses are employed by their classification and, effectively, their rate of pay accords to their seniority and level of experience. That is how we pay nurses, as we pay any other professional group. Clearly, nurses who work in an ED type environment tend to have a greater level of experience and expertise and that's reflected in their relevant classification levels. The classification levels are what guide our pay increases.

Our pay increases for particularly registered nurses at level 1, which is the bulk of our nursing work force, will mean our RN level 1s will be the most highly paid nurses in the country, based on existing rates of pay in other jurisdictions. Our enrolled nurses will be amongst the very best. They will be, I think, about $100 or so short of the recent offer in Victoria, which has been accepted by the ANF in Victoria. Equally, for registered nurses at level 2 an 18 per cent increase in pay and for registered nurses at levels 3, 4 and 5 an increase of 23 per cent. So this is a very generous and timely offer designed to indicate our value of the nursing work force, the need to retain a skilled and experienced nursing work force in the ACT as well as encourage future professional development.

MR SMYTH: Just for the record, over what timeframe are those pay increases?

Mr Corbell: That's over a three-year period.

MR SMYTH: And what are the percentages?

Mr Corbell: It varies, depending on the different classifications.

MR SMYTH: For, say, an RN level 1.

Mr Corbell: I don't think I have that information with me. Yes, I do. I have a very complex table. Perhaps I can take that on notice and give you an accurate answer, without trying to interpret this table I have in front of me.

MS DUNDAS: Continuing with the discussion about nurses, has the government considered creating positions that are exempt from requests for recall, overtime or double shifts so that nurses who are feeling the increased pressure of not being able to meet those demands can still remain nurses and still look after their families?

Dr Sherbon: No, there's no process of designating exemption, but there is a process in discussion with the ANF over reasonable overtime requests. I'm happy to say that that's one of the components of the negotiation that seem to be reasonably well progressed at this stage. We, as an employer, are willing to agree to a set of parameters over reasonable overtime requests. Don't forget that some nurses actually like to work overtime.

MS DUNDAS: Yes, and some don't, but it's about finding that balance.

Dr Sherbon: Yes, exactly. What we are also looking at by way of discussion with the ANF is provisions for older workers. As you know, our work force is ageing and there are many nurses who indicate they wish to continue their careers into their 60s. We actually have some in their 70s who wish to continue to work. They say in feedback to us, "I want to work, but I don't want to work the sort of lifestyle I was working when I was 25." We're in discussions with the ANF about building in some trade-offs for those workers whereby they might have greater leave provisions in return for lower penalty rates. That's in discussion; that's not finalised yet.

The other thing to add is that for experienced nurses, apropos your previous question, we have removed what was in the last EBA an arbitrary cap between level 1 and level 2 nurses. We had a cap and only 25 per cent of the nurses could be level 2 under the previous EBA. That cap has been removed, so skilled nurses will be assessed on their personal criteria as to whether they are eligible for level 2. We anticipate the numbers will increase substantially. That arbitrary cap has been removed and people who have the skills will be recognised. That will help in emergency, ICU and mental health because, as you know, many of those nurses are highly skilled.

MR SMYTH: Where are the negotiations at with the nurses, Minister? I notice that you've sent them a letter of final demand: sign up or it's all off by 25 June. Why have you entered the fray when, until now, questions in the Assembly on issues of wage negotiation have been handled by the Minister for Industrial Relations?

Mr Corbell: I think your question misunderstands the administrative arrangements. The Minister for Industrial Relations is responsible for the overall bargaining arrangements for the government and, in particular, is responsible directly for the whole-of-government template agreement for general clerical staff. There is a range of areas where the Minister for Industrial Relations is not directly responsible. For example, teachers, nurses, VMOs and salaried medical officers are not included in the template agreement; they are recognised as a separate work force and dealt with separately by the responsible minister. Ms Gallagher, for example, deals with the teachers as minister for education, not as Minister for Industrial Relations. Equally, I am responsible for nurses and VMOs as Minister for Health.

As to where the negotiations are at, no, I have not sent them a final letter of demand. I have indicated to them that the government made its offer in November last year and the

government's offer is not an offer that can be back paid, no matter how long negotiations take. The government is willing to back pay to the expiration of the previous TCH agreement if negotiations are resolved within a certain period, but the government does not have the capacity to offer back payment to the expiration of the previous agreement on an indefinite basis, and that's what I have indicated to all nursing staff in the ACT. I think it is legitimate that they know on what basis the government is negotiating and when certain things will or will not be available.

I have to say that negotiations are continuing at a reasonable pace. The government did have some concern with the pace of negotiations in the last couple of months, but the most recent report I've had from the negotiating team through Dr Sherbon is that they are now progressing in a more timely manner and I am hopeful that the negotiations will be resolved within the next one to two months.

MS DUNDAS: If the back pay offer is not accepted by 25 June, will any back pay be offered or will the back pay just disappear?

Mr Corbell: No, no back pay will be offered past that period. The pay increase will simply take effect from the date of certification of the new agreement.

MS DUNDAS: Even if you had the capacity at the moment to back pay until a certain date—a certain number of weeks of back pay, say, the six weeks or eight weeks of back pay that you have—and that date keeps moving forward, you won't back pay until another fixed date.

Mr Corbell: That's correct. Expiration of the agreement at TCH, which is the date we're using, is from 14 February this year, so it's not a matter of weeks; it's a matter of months. Obviously, the longer the negotiations take, the more the cost is to the government of back pay.

MS DUNDAS: I understand that there is a difference in back paying from June to February and back paying from August to February, but February to June is a four-month period of money that you have available; so, if negotiations finish in August, you still have in theory four months worth of back pay that you could offer.

Mr Corbell: The government is in negotiation and there is a range of elements that we bring to that negotiation to try to reach a conclusion.

MRS DUNNE: So it is a letter of demand, Minister.

Mr Corbell: No, it's not a letter of demand; its an indication of the government's negotiating position, one which we think is reasonable. Having made the offer in November of last year, we feel that there has been quite a considerable period now to have these negotiations. It's over a six-month period now and we do want to see the negotiations resolved. We will highlight to the ANF and to nursing staff what the government's negotiating position is, and I think that's a reasonable thing to do.

MR SMYTH: So your offer hasn't changed in six months.

Mr Corbell: No, the government did revise its offer. We made an original offer in

November and we made a subsequent offer either in December or January which was in response to wage movements in other jurisdictions, so we have revised our offer formally at least one since we made it.

MR SMYTH: So it's not true to say that the offer has been on the table for six months, since last November?

Mr Corbell: You have to appreciate that there is a range of issues involved in an offer and the wage levels are only a component—a significant component, but nevertheless only a component. There is a range of other issues to do with conditions of service and other entitlements which have been in progress for some time. Yes, it is an evolving process, but we don't think that negotiations should be extended out indefinitely. We do want to reach some resolution because the longer it takes, the longer it is that staff aren't able to access improved rates of pay and conditions which are clearly on the table, compared with what staff currently receive.

MR SMYTH: What is the sticking point at this stage? What are the nurses holding out for?

Mr Corbell: I wouldn't want to comment on what is the ANF's negotiating strategy; you'd have to ask them that. From our perspective, we feel we've put a good offer on the table. I don't know whether Dr Sherbon can extrapolate on that. I don't want to speculate on the nurses' position; that's a matter for them to comment on.

MRS DUNNE: Minister, a while ago you said that the pay offers of 18 per cent, 22 per cent, et cetera, would put ACT nurses at the top of the range or close to the top of the range compared with other jurisdictions. Is that when they get their first pay rise or when they get the full complement over three years, and are you comparing them with nurses in other jurisdictions now?

Mr Corbell: Obviously, you make a range of comparisons. You make comparison of what the pay increase is over the whole life of the agreement. Equally, you make comparisons at the different stages of the agreement.

MRS DUNNE: Actually, I just want an assurance.

Mr Corbell: Let me see if I can find this information for you. For example, RN level 3 at TCH, Calvary and Mental Health ACT have a pay of $65,171 per annum. At the date of commencement, it's proposed that that go up to $72,857; at six months, $74,314; at 12 months after date of certification, $76,543; at 18 months, $78,074. So we have there a range of pay increases over the period of the agreement and we make the comparison over the life of the agreement but also at particular points within the agreement.

MRS DUNNE: And you're saying that at most or all of those points it's comparing favourably with nurses in other jurisdictions.

Mr Corbell: Obviously, if your quantum is higher than other jurisdictions over the term of the agreement and you compare that with what other jurisdictions pay, it's also higher at the individual pay points within the agreement.

Dr Sherbon: The most recent settlement was in Victoria, where the wage offer that was accepted by the ANF was less than what we've proposed.

Mr Corbell: We are proposing an across-the-board increase of 9½ per cent for enrolled nurses and increases of between 10.1 and 18.4 per cent for registered nurse level 1, 18.4 per cent for registered nurse level 2 and 23.2 per cent for registered nurse levels 3, 4 and 5. These are significant pay offers and very competitive ones.

MRS DUNNE: Could you also provide the committee on notice with a profile—we may have already asked for this—of how many fit into each of those categories?

Dr Sherbon: We've got that on our list, yes.

THE CHAIR: Whilst we're on the nurses, I have a question that relates basically to rostering problems and overtime. All members of the Assembly would have got this letter from a registered nurse—I won't name her—who describes herself as aged 43, one of the younger ones. She makes a few derogatory comments, which I won't go into, in relation to yourself and the department. In talking about the EBA, the letter states:

> Other areas included the blatant and incomprehensible assertion by ACT Health that the rostering problems associated with understaffing would be addressed by rostering staff onto overtime shifts. This amounts to compulsory overtime. Every day in the hospitals in Canberra, particularly in TCH and in the speciality areas at Calvary (EDI, CU and maternity) staff are asked to work double shifts. Is ACT Health proposing to roster us onto 14 and 16-hour shifts, and how can compulsory overtime ever be equated with access to better conditions, as so confidently asserted by the minister?

I was concerned to hear those comments about nurses working 16-hour shifts on a pretty regular basis.

Mr Corbell: I'll ask Dr Sherbon.

Dr Sherbon: As I reported earlier, the overall overtime rate for nurses in our system is 2.9 per cent of total FDE; so that's a fact. There are higher overtime rates in some disciplines, but, as I might have mentioned earlier but just to confirm, there is no compulsory overtime either in current agreements or in proposed agreements. There may be rostering practices in some areas that rely upon staff overtime, but if the staff member refuses to do overtime the manager has to find an alternative arrangement. That's the current state of play.

THE CHAIR: It seems that you do have very dedicated staff, and I think this goes on. Another letter I have indicates that staff feel compelled to do the right thing by their patients and, if someone is not there, they will do double overtime. I regularly hear that from nurses. There are some nurses I know who are into their 60s who regularly do double shifts simply because there seems to be no-one else available. I hear what you say about the 2.9 per cent, and it is probably in certain areas. But surely it is a very worrying situation when you've got nurses working lengthy hours perhaps feeling compelled to do that simply because there are problems getting other persons. And there is the tiredness factor that obviously kicks in after working those very lengthy shifts.

Dr Sherbon: I agree with that entirely. It is not optimal to have staff working double shifts. Hence the emphasis in this EBA round, plus the chief nurse's work program over recruitment and retention initiatives. You're quite correct: it is not appropriate for staff to be exposed to any form of coercion in overtime. If there is coercion, then I'm more than happy to look at it.

I receive feedback from the workplace about the need for some areas to do overtime so the system can function. That is something we are working to avoid, especially in high intensity environments like intensive care, mental health and emergency. The strategic riding instructions from the minister are to alleviate that work force stress by improving retention rates of and attractiveness to the nursing profession in the territory. As I mentioned, we agree with that entirely. If possible we should avoid overtime and work towards minimisation of double shifts. There is no doubt about that.

Mr Corbell: It is also worth elaborating that there is an element of practice in the nursing work force where—and I'm not saying that this is solely the case, or the only reason—some nurses choose to work overtime or additional shifts. It is part of the way they manage their income. The nurses union acknowledge in negotiations that access to overtime is still an element of overall access to wages for their members. I don't say that to try and downplay the fact that overtime can be a serious issue and can impact on the operations of the hospitals. As Dr Sherbon says, it is a serious issue.

MRS DUNNE: You've said that the average overtime is 2.9 per cent. To enable the committee to better understand the impact of overtime, is it possible to give a breakdown in specialties?

Dr Sherbon: That would take some time. We can take it on notice.

MRS DUNNE: Yes.

Dr Sherbon: We have it for nurses as a whole, as I've mentioned. We can perhaps drill down by particular units.

MRS DUNNE: Intensive care, emergency and maternity were the ones highlighted to members.

Dr Sherbon: We can certainly do that, with the minister's agreement.

MS DUNDAS: Are nurses involved in consultation in relation to the restructure of specialty areas? If there are internal restructures going on, the nurses are involved?

Mr Corbell: Yes. It is a requirement of their EBA.

MRS DUNNE: We've addressed the issue of nurse shortages in various ways. At the current time are there shortages in other professions? What other shortages are we experiencing with specialist doctors—either visiting medical officers or salaried doctors? After my recent experience I've been led to believe there is a shortage of orthopaedic surgeons in Canberra working in the public hospital system. Are there other specialist shortages at the moment?

Mr Corbell: There is a range of shortages in a range of specialties—medical, nursing and allied health. The ones I'm most immediately concerned about include access to radiation oncologists and the relevant allied health staff. I always get the two confused. We did have some shortages in the hospital pharmacy but I'm advised that that issue has now been addressed.

MRS DUNNE: You've done that, have you?

Mr Corbell: In the surgical specialties we certainly do have limitations in some areas, for example, plastic surgeons. We have only two plastic surgeons in the ACT. That is a pressure point. We have a limited number of orthopaedic surgeons and also a limited number of other medical specialties, especially in some subcategories. For example, paediatric orthopaedics is especially limited in the ACT. It is a very specialised field and it is an area where there are particular pressures. As far as I'm aware there is only one orthopaedic surgeon here who does paediatrics. As I understand it, there is some reluctance on the part of that surgeon to do paediatrics because of the insurance issues associated with doing work on young children.

There is a range of shortages and not all of them are within the government's control. For example, the issues around surgical specialties are very much driven by the individual decisions of surgeons as to where they choose to practice. Obviously they do both private and public work and are predominantly employed as VMOs. That is something that we are working in the longer term to address through our investment in the medical school, for example.

Investing in the medical school ultimately allows us to build up a base of medical training in the city, firstly at the general practitioner level and later in surgical practices or specialties. All the evidence shows that where people train they're more likely to stay, or come back to, so investing in the medical school is a very important long-term strategy. I have advice there are pressures on radiation oncology, as I've mentioned; neonatal specialists; emergency medicine; rehabilitation specialists; plastic surgery, which I've already mentioned; and endocrinology.

MRS DUNNE: What is left?

Mr Corbell: Lots of things. Medical imaging staff specialists, obstetricians, paediatricians, renal dialysis, surgical intensive care, registrars, surgical anaesthesia, VMO staff specialists, geriatrics and pharmacists. You'd be surprised, Mrs Dunne.

MS DUNDAS: I think we've all received a letter from a member of the community who's been quite upset because he was not able to access an orthopaedic surgeon. He was informed that the reason surgery couldn't go ahead was not that there was a shortage of orthopaedic surgeons but a shortage of theatre space, and that theatre space is limited to the number of surgical procedures that can be performed at any given time. Is there a problem with access to theatre space?

Mr Corbell: The issue you're touching on is really the issue of elective surgery and the number of places funded for that. There are a number of orthopaedic surgeons who operate only at Calvary Hospital who have already completely filled their public lists for this financial year.

MR SMYTH: Does that mean there'll be no further elective surgery at Calvary for the rest of this financial year?

Mr Corbell: There are other orthopaedic surgeons who are yet to complete their lists. They will continue to undertake their activities.

MS DUNDAS: If a surgeon wishes to access theatre space the only thing that would be holding that surgeon back is whether or not they've completed their list, not whether or not that space is available?

Mr Corbell: You would appreciate that the government pays for a certain number of public procedures. That is allocated by individual hospital management, in consultation with the surgeons, as to what they anticipate they will need, along with what is available. If they fill their lists within the financial year, then that is all the public activity they are able to perform that financial year. It obviously doesn't limit their capacity to perform additional private work if that is what they choose to do.

MS DUNDAS: If a surgeon wants to do private work, theatre space will be made available?

Mr Corbell: It will depend on what is available in the system. It is a bit difficult for me to comment without knowing the details of each individual surgeon and what access they have on both a private and public basis. There are individual negotiations between the surgeons and the hospitals in relation to their private lists. In relation to their public lists ACT Health, through the hospitals, determines the amount of activity they will be funded to undertake. If they undertake that activity and complete it within the financial year, as a number of surgeons have, they have obviously done it more quickly than was anticipated for the year. They will obviously resume public work in the new financial year when the funding is available.

MR HARGREAVES: I refer you to page 150 of BP4, at the top of the page, where it has "orthopaedic theatre refurbishment". Could you explain a bit about what is happening with the orthopaedic theatres with reference to what Ms Dundas was going on about?

Dr Sherbon: That is at the Canberra Hospital where there will be an extensive refurbishment of the theatre to introduce improved facilities for major joint replacements. It is a medium-sized project that we are to undertake next financial year. Apropos Ms Dundas's question, perhaps I can amplify the minister's response. Theatre space per se is not the issue. We have ample theatres in the territory.

As the minister outlined, Calvary is allocated a budget by ACT Health with the minister's supervision. Calvary Hospital management, with our agreement, then allocate an appropriate distribution of that budget between their services. As you will recall, last year there was a $2 million increase in elective surgery throughput. Calvary Hospital management phased that program over the course of the financial year. The issue of availability of funds at Calvary is unique to Calvary, in that Calvary has consumed that elective surgery component for some surgeons, although not all surgeons. Some of them are still proceeding with their lists.

Mr Corbell: It is worth emphasising that, in respect of overall elective surgery activity, the government in the next financial year will be spending an additional $3.8 million on increasing access to elective surgery. We're already seeing the results of that.

Mr Smyth: What—in record waiting lists?

MR CORBELL: The record is held by one of your predecessors, Mr Smyth. Mr Chairman, to the end of March this year a total of 6,401 people will have had surgery in ACT public hospitals. That is the highest ever total for the first three quarters of a financial year. This total eclipses the 6,069 total reported for the first nine months of 2000-01, which was the previous best ever year.

MS DUNDAS: So if we have more elections we'll get more people through the surgery waiting lists? I am sorry, Minister!

Mr Corbell: You can laugh about it if you like, but we're talking about extra Canberrans getting access to elective surgery—a total of 6,401 people—which is the highest ever number of people accessing elective surgery in the first three quarters of any calendar year since self-government. There will be $3.8 million extra for elective surgery this coming financial year. We have already exceeded our target for the number of people accessing elective surgery. We indicated that, with the additional $2.8 million we were providing, we would get an extra 600 people treated. We are already well in excess of 600 additional people accessing elective surgery. At the same time that our volume goes up, demand is continuing to increase—and that is the issue we are continuing to address.

MR SMYTH: As it ever did!

MR HARGREAVES: Dr Sherbon, am I correct in assuming that the refurbishment of the orthopaedic ward will in fact produce a better outcome, not a greater throughput?

Dr Sherbon: You're quite correct. The objective is to provide a better environment for major joint replacements. We'd expect better outcomes for patients.

MR SMYTH: For what periods of time have theatres at either of the hospitals been closed this year for elective surgery? Calvary Hospital was closed for how long? Three weeks in April?

Mr Corbell: Yes, Calvary Hospital was closed for three weeks in April.

MR SMYTH: At this stage has Canberra Hospital closed for this financial year?

Dr Sherbon: There were Christmas and Easter closures, the details of which we can ask officers for. It was a standard closure, from my memory. It was six weeks over Christmas and January and a further two weeks at Easter at Canberra Hospital. I'll confirm that in a minute.

MR SMYTH: Will there be closures between now and the end of this financial year at either of the hospitals?

Dr Sherbon: No. There will be no program closures in theatres. If you're asking me whether, at Calvary Hospital, there are surgeons who have reached their quota, yes—but there have been no program closures that I'm aware of at this point in time.

MR SMYTH: How many orthopaedic surgeons do public lists?

Dr Sherbon: From memory—I'll get the figure for the minister to give you—somewhere between 12 and 14. We have just recruited three additional orthopaedic surgeons. As you know, some orthopaedic surgeons have indicated a wish to retire. I must say orthopaedic surgery is attractive in the territory. Those three orthopods are looking forward to a long career in the territory.

THE CHAIR: Those are the three you announced in the budget?

Dr Sherbon: No, they are three general surgeons.

MR SMYTH: Are there any scheduled closures for the coming financial year—2004-05?

Dr Sherbon: Yes. There will be a program but it is yet to be determined by the hospitals. As you know we're building our internal budget as we speak. It would be senseless to operate in January at full capacity. Nursing staff like to build in leave and so do medical staff—and patients often don't like to have elective surgery over the Christmas/January period. Therefore it would be senseless to operate normally. We will be building in a program of reductions over that time. They're not closures per se; they are reductions in theatre capacity. If anyone—and this is important to translate to the public—is acutely ill they are cared for as usual. There will probably be some reduction in profile at Easter as well at both sites, as has been the case in the past. The volume of reduction is to be determined in the coming weeks.

MR SMYTH: When will the information be available as to what closures will occur?

Dr Sherbon: I'd expect that in early July we would have a good idea. We can probably confirm that with you by August.

MR SMYTH: There isn't adequate funding in this year's budget to ensure that the operating theatres will remain open for elective surgery for the full year, barring the holiday period?

Mr Corbell: It is not traditional to have all theatres open all the time. The normal holiday periods, as Dr Sherbon has indicated, over Christmas/New Year and around Easter are the periods where we have traditionally seen some reduction in capacity that accords with school holiday periods or the end of year holiday period.

MR SMYTH: That is not what I asked. There will be ongoing elective surgery for the rest of the year, barring the holiday periods?

Dr Sherbon: As the minister answered, there is a significant increase.

MR SMYTH: It will operate for the rest of the year barring the holiday period? You can

have a significant increase and still have theatre closures?

Mr Corbell: Let me answer the question this way: I'm not aware of any proposals to close theatres outside of the normal holiday periods, but that issue is yet to be fully finalised as the department does its internal budgeting for the next financial year.

MRS DUNNE: Dr Sherbon, are you aware of any closures outside the normal holiday periods?

Dr Sherbon: No, I'm not, at this point in time. I'll confer with my officers but I'm not aware of any program closures. There can't be because I have the final say—and nothing has been presented to me.

MRS DUNNE: Does that include Calvary?

Mr Corbell: Both our public hospitals.

THE CHAIR: How many theatres are there at TCH?

Mr Corbell: I'm advised that there are 10 theatres at TCH.

MR SMYTH: At what percentage do they operate? How often are they open?

Dr Sherbon: Eight theatres are routinely in full-time use; a ninth will be commissioned as part of the surgical enhancement announced by the minister; and we need a tenth in reserve for cases of major catastrophe.

MR SMYTH: At what capacity do they operate? Are they in use 20 per cent of the time, 50 per cent of the time, 80 per cent of the time?

Dr Sherbon: It depends. If you were to take business hours, eight out of 10 theatres would be in use and soon nine out of 10 will be in use.

MR SMYTH: Business hours for an operating theatre are what?

Dr Sherbon: They are 8.00 till 4.30 at Canberra Hospital. We negotiate that with the VMOs. There is a longer period at Calvary—I think it goes to 5.00.

MR SMYTH: Are they the standard operating times for theatres around the country? Do they operate only business hours?

Dr Sherbon: No. As you know, theatres don't operate business hours. You asked me, "What is the utilisation of theatres?" I said that in business hours eight out of 10 are working. After hours there are theatre staff working 24 hours a day, and those particular theatres are fully occupied. I can assure you that the workload at TCH is such that those theatres are fully occupied, as some of you who've had to avail yourselves of after-hours surgery know. Are we equivalent to our peers in respect of theatre occupancy? Yes.

MRS DUNNE: With the after-hours theatre—and it is essentially emergency surgery—how many theatres would be operating on a Thursday night?

Dr Sherbon: I will have to confer with Mr Mollett on that.

MR SMYTH: Yes, that would be fine.

Dr Sherbon: Yes, one or two, depending on the demand. There would be one programmed every evening—right through the night—and a second if required. The staff can commission a second with 30 minutes notice.

THE CHAIR: You've probably answered part of my question, but is it possible for all theatres to operate at all times? Obviously, from what you say, no-one does that but can you have all 10 theatres going for even a limited period of time—be it, say, the normal daytime shift?

Dr Sherbon: Theoretically, yes, but operationally it is unwise to have all theatres committed at every hour of the day. At any moment an emergency caesarean section or an extreme emergency from the emergency department may be required. Some places take a risk and manage that by hoping that one of the nine or 10 cases currently underway will be close to completion. Personally I think that is unwise. As you're aware, Canberra is a potential terrorist target so I want to make sure that we have the capacity to ramp up if required.

MR SMYTH: In respect of the readiness times or treatment times—I am referring to budget paper 4, page 154, acute services, output 1.1—I notice that, in the 2003-04 budget papers, category 1 is 100 per cent of treatment inside the timeframe, which is immediate; category 2 is 80 per cent, then 75 per cent, 75 per cent and 85 per cent, for all of which the estimated outcomes were reached in the 2002-03 year. The targets have remained the same and yet the expectations for this year in categories 2, 3 and 4 are only 65 per cent against the target of 80 per cent in category 2; 65 per cent against 75 per cent in category 3 and 65 per cent against 75 per cent in category 4. Why is there significant non-reaching of targets?

Mr Corbell: The emergency department is significantly busier, and that is putting pressure on our response times. That said, I think it is worth making the point that our emergency departments still perform better than the national average in terms of response to those targets, and that is something we will continue to aim to achieve. The bottom line is that we have seen increased levels of acuteness at our emergency departments. That is fundamentally what is driving problems with response times.

We also have bed block pressures in our hospitals. That is why we are making some systemic changes to improve activity in the hospital. For example, there was a recent public comment on the issue of when people should be admitted to surgery. We are trying to improve our day of surgery admission rates so that people who come in for elective surgery come in on the day of their surgery rather than the night before. That allows us to get greater bed utilisation and improve the throughput, especially through the ED up into wards where that needs to occur.

We are taking a range of other steps to improve the capacity of our emergency department. A $3.2 million extension of the emergency department at the Canberra Hospital is virtually completed. Having been there last week, there are a few minor

fit-out issues still to be addressed but the bulk of the work is now completed. That has expanded the capacity of the ED, as well as improving the workability of its arrangements.

We have also put in place a new emergency management unit, or EMU, which gives us some additional capacity in ED at TCH. The clinical decisions unit is now open and operating, with appropriate funding, at Calvary Hospital. That has also increased our capacity at that emergency department. In addition to that, the government is very close to announcing the outcomes of our GP clinics at both Calvary and Canberra Hospitals.

MR SMYTH: Only three years late!

Mr Corbell: It is not three years late; it is a commitment being met and honoured in full, giving the capacity we need. That will assist with people who are rated less acute—category 4 and category 5—giving them an option other than waiting for treatment in the ED.

MR SMYTH: Referring to the change to the admission of patients for elective surgery to the day of the operation rather than the night before, if the beds they would have occupied are therefore occupied by patients coming out of the ED, does that mean you run the risk of not having beds for elective surgery patients when they come out of elective surgery? Are you just transferring the problem from one ward to another?

Mr Corbell: No, I don't believe that is the case. A lot of surgery can occur on the day, and people go home on the same day that they have their surgery.

MR SMYTH: We already have that in place for day surgery. People come in early in the morning and go home that afternoon.

Mr Corbell: Yes. There are some practices, though, where people are prepped—or the thinking has been that they come in the night before and have the surgery on the day. We believe that there is a level of that occurring which is unnecessary. It is not unnecessary in all cases but it is unnecessary in some cases. That is what we're trying to focus on achieving. I will ask Dr Sherbon to elaborate on that.

Dr Sherbon: The surgery would not proceed on a day of surgery admission basis unless the staff were confident that there would be a bed available at the end of the surgery.

MR SMYTH: Is there a risk that this change of practice will lead to people being bumped off the elective surgery list?

Dr Sherbon: No. The benefit of this practice is that we can get to do more people and more people get taken off the list because they have been done.

MR SMYTH: Where will they go if there is no bed for them? You've just said that people won't be admitted unless there is a bed.

Dr Sherbon: Their procedures won't proceed. Every day there are discharges from the hospital so the bed planning staff are well able to anticipate—and the hospital staff are very practised. We're operating at a day of surgery admission rate which I'm happy to

report has increased from 51 per cent in December 2003 to 68.6 per cent in April 2004. We're operating at below the rate of our peers.

MR SMYTH: The elective surgery waiting list grew by 10 per cent in that period.

Dr Sherbon: In April?

MR SMYTH: No, over the 12 months. In the last 12 months the elective surgery list has gone up another 10 per cent.

Dr Sherbon: As the minister has already described, there would be a significant increase in throughput with these additional funds. Perhaps that is more of an Assembly level question. By way of system performance, the bottom line is that day of surgery admission rates are better for patients—they prefer to stay in their own beds. Not many patients like being woken up by the cleaner at 5.30 am.

MS MacDONALD: Or for their cup of tea, which they can't have anyway!

Dr Sherbon: Yes. It is better for the system throughput. It is not satisfactory at this point in time—and the minister's expectations are clear—that we have 11 or 12 well patients in the hospital every night.

MR SMYTH: How many times has TCH gone on bypass in the current financial year?

Mr Corbell: We can take that question on notice. I think it is worth making the point that "bypass" means that usually non-urgent cases, and even some at levels of urgency, get referred to the other hospital—to Calvary Hospital. So it is mostly for ambulance referrals. They go to the alternative hospital. They go to Calvary instead of TCH or to TCH instead of Calvary.

MR SMYTH: You'll take that on notice?

Mr Corbell: We'll take it on notice—the occasions.

Dr Sherbon: For TCH I'm advised it is up to twice per week. We'll get solid figures for you.

MR SMYTH: Thank you.

MS DUNDAS: On the question of the category 2, 3 and 4 time frames and those targets not being met, there seems to be an indication that there could be a possible change to the classification of patient episodes.

Dr Sherbon: There is certainly no change proposed by the department.

MS DUNDAS: Sorry, it is in budget paper 4. It is actually referring to cost-weighted separations. There is reference to a resolution of a number of processes, including a possible change to classification of patient episodes. Does that not relate to categories 1, 2, 3, 4 and 5?

Dr Sherbon: No.

Mr Corbell: Categories 1, 2, 3, 4 and 5 are emergency department admission protocols.

MS DUNDAS: So they're not looking at a reclassification?

Mr Corbell: No.

Dr Sherbon: You're referring to the cost-weighted separations in the footnote, is that correct?

MS DUNDAS: Yes.

Dr Sherbon: The big change that we expect this year in admissions will be that our oncology admissions in recent months have all switched to outpatient attendances. People are just not staying the time that's required to fulfil the admission criteria, particularly those who are attending for routine chemotherapy. So that group of patients will actually shift from admissions to outpatient occasions of service and we will be looking also, perhaps, at endoscopy as well, although we're not clear on that at this stage.

Mr Corbell: For your information, Ms Dundas, the categories 1 to 5 ranking, which is there for emergency department presentations, are, as I understand it, a nationally developed criterion by the College of Emergency Medicine—is that correct?

Dr Sherbon: Yes.

Mr Corbell: So the emergency specialists college has determined that that's what they believe is appropriate, and that's what all EDs work on.

MS DUNDAS: In terms of what's happening in the emergency department: you've said that there's been increased demand. Do you have any feeling of why there has been increased demand?

Mr Corbell: It's difficult to gauge. The most common thinking—and certainly this is shared by my ministerial colleagues interstate—is that we are seeing increased levels of acuteness, so people are getting sicker before they present to a hospital. It has been attributed to a decrease in the availability of GP services and access to primary care services. We're seeing two things: we're seeing an increase in the level of acuteness, categories, say, 2s and 3s in particular. But we're also seeing an increase in category 4/5. So the less acute people who perhaps could otherwise be very easily and capably dealt with by a GP are instead presenting to an emergency department. Whether that's after hours or during hours, that's where we're also seeing an increase. So predominantly it's being put down to increased levels of severity of illness and lack of capacity for people to get treatment at an earlier time through their GP.

MS DUNDAS: The Health First initiative—the phone line and the website—has it had an increase in demand as well?

Mr Corbell: I'm happy to provide you with the figures on Health First. I don't think I have them to hand. I don't know whether there has been an increase. My last

recollection—I'll have to check—is that it has been fairly constant. But I'll provide the figures for you.

MS DUNDAS: I remember initially when Health First was established there was some concern that people would be picking up bits of information through the phone or through the web and deciding that they needed to then go to emergency as opposed to going to a GP. And there are ongoing problems with GPs. So it would be interesting to know how Health First is dealing with its demand and whether or not it is able to support people with, I guess, low-level situations.

Mr Corbell: I think it is a useful service. And it is particularly useful at providing reassurance for relatively minor or moderate concerns. But at the end of the day the advice is still: if you have a concern, go to the hospital. So people who are worried and who aren't reassured by the advice they get from Health First still go to the hospital.

MR SMYTH: I asked you—and I don't think I got an answer: how many nursing home type patients are in the hospital at the moment?

Mr Corbell: On average, I think there are approximately 20 to 25.

THE CHAIR: That's at TCH?

Mr Corbell: Across both hospitals. There are about 15 or so at TCH, and about 10 or so at Calvary.

THE CHAIR: If we could just get the figure as at today, that might be a bit of assistance.

Mr Corbell: It will be that figure, Mr Stefaniak, but we'll get it for you.

MR SMYTH: The number of public acute beds per 100,000 in the ACT is what? How many public hospital beds have we got?

Dr Sherbon: It varies from day to day. I'll have to get the exact figure. To be frank, we don't really think a lot in terms of beds anymore. As health planners, we try to work on services. But I can get an exact figure for you as at today. It will vary at the margins.

MR SMYTH: It's about how many?

Dr Sherbon: I'll have to just check. It would be five hundred at TCH and another 70-odd at Calvary—70 to 100, depending on the throughput on the day.

MR SMYTH: And what's the cost of an acute bed, on average?

Dr Sherbon: I can't tell you because we work on cost per weighted separation, which is the national tool that we use to measure cost. And it is actually in the budget papers, which I can find if you would ask another question. But we're up around the $3,500 cost per weighted set, which is high nationally. And we are working on measures to bring that towards the national average figure. But we will never be at the national average because the number of units that we retain in the territory, by their low-volume nature, will

always engender high cost per weighted separation.

MR SMYTH: If I can just explore the beds issue: the AIHW report for 2002-03 says that the average number of public acute beds per thousand in the ACT is 2.1, whereas the national figure is 2.6. Is it not the case that the reason that we have problems with our waiting lists and the ED is that the hospital is just always full?

Mr Corbell: No, I wouldn't say that. What I would say is that the figure that you're comparing, the national figure, would obviously include those large jurisdictions that have a large number of small hospitals, especially rural and regional hospitals, which are very small. Lots of the base hospitals, for example, that you could think about in our surrounding region would undoubtedly increase the overall level compared to our figure, where we're just simply a metropolitan area treating a metropolitan area.

MR SMYTH: But how? Let's face it: Queanbeyan Hospital apparently is always full. Those smaller regional hospitals are just as full. We get the overflow here in the ACT.

Mr Corbell: No, the point I'm making is that the national figure takes account of a high level of small hospitals with small numbers of beds, which we don't have. So it's not appropriate to make a direct comparison on that basis.

MR SMYTH: Why not? Does it matter where the bed is or what size facility the hospital is? It's an average. How does the size and nature of the facility change the average?

Mr Corbell: Well, for example, we don't have a need for small rural hospitals. But clearly other jurisdictions do have a need for small rural hospitals, and they, in particular, I'm advised, accommodate a large number of nursing home type patients and non-acute type patients, whereas that's not what we do here in the ACT. In the ACT we predominantly deal with higher acuteness.

THE CHAIR: Categories 1 through to 5—1, which is treated immediately, going up to 5, which is treated within two hours of emergency—can you briefly explain what they are?

Mr Corbell: Well, I'm no expert on that.

Dr Sherbon: I can give a brief scenario.

THE CHAIR: Very briefly, because I've got a couple of questions in relation to the times.

Dr Sherbon: Category 1 is a cardiac arrest or major trauma, somebody who needs to be resuscitated. Category 2 tends to be high-urgency patients who come in with major injuries, perhaps not to the extent of the resuscitation that I just described, or people with acute heart attacks—acute myocardial infarction is the proper term—and abdominal emergencies like burst aortic aneurysm, something like that. Category 3, you're looking at more your general medical admission with chest pain, acute infections, et cetera—lower down the scale. By the time you get to category 5, you're looking at general practice type care.

THE CHAIR: What concerns me—I mentioned it in the Assembly—is the case of an 85-year-old woman who came in with a broken arm. It was at Easter, I think; she was admitted at about 9.30 pm on the Friday. I was contacted by her husband on the Monday, I think, and she was still in. The arm was sorted out and fixed and she was discharged at 3.30 on the Tuesday. But that was 3¾ days for a broken arm. That just seemed to be an inordinately long period of time, especially considering the age of the lady.

I've also seen less serious injuries. For example, last year, one of the football players in the team I was coaching went in with something wrong with his hand. It was one of your least acute; it would be a category 5, I'd imagine. I can recall that those things several years ago would take 2 hours, but this person didn't re-emerge for six. I'm more concerned, obviously, about the elderly lady, but it seems that there are quite a lot of incidents where we're nowhere near those optimum times for treating persons.

Mr Corbell: Yes, that's correct, and the experience of the Canberra Hospital and Calvary Public is, in most respects, less severe than many other emergency departments in Sydney, Melbourne and other places. Our emergency departments are the front line of our health system and they have to cope, obviously, with the unexpected every day. There's no way you can plan what's going to occur in your emergency department. You can only respond to what's presenting at the door or coming in on the ambulance. That said, there are circumstances where people who have a broken arm, as long as the pain is appropriately managed, are not as high a priority as someone who has just been admitted with a heart attack or so on.

Yes, these are difficult circumstances and are obviously very difficult emotionally and otherwise for the person who perhaps is in the position of the elderly woman you mentioned or her husband. And I can fully understand that. The hospital has to prioritise its work based on the acuteness and the seriousness of the conditions that people have who are presenting, and they deal with everyone as soon as they possibly can.

But where we do have extended periods of busyness in the emergency department and where that is compounded by the incapacity to move people from the ED into a ward, that does lead to delay in treatment, especially for less acute patients. So that's why we're taking the steps we are taking, for example, through day-of-surgery admission to free up beds so that we can move people from the ED into the hospital better; it's the same reason that we are establishing the new transitional-care facility so we can take the nursing home type patient out of the acute bed into a nursing home type bed and free up our acute beds for more emergency department cases as well as elective surgery cases.

So we are doing the work to improve the functioning of the hospital, but our circumstances are by no means unique. The circumstances that we are facing are, regrettably, the same right around the country, but we are doing the work to improve it in every way that we possibly can.

MRS DUNNE: I wanted to go back to the issue of bypass. I know that, minister, you've undertaken to take on notice the number of days that Canberra Hospital is on bypass. Could we also find out the number of days that Calvary is on bypass—presumably the same thing happens at Calvary—and the number of days where ambulances are used as overflow beds? Does it have a technical name?

Mr Corbell: If I can deal first of all with the issue of bypass—it's also, I'm advised, described as load sharing—the Canberra and Calvary hospitals have been on bypass 37 times in the past 7 months; Calvary to the Canberra Hospital, 11 times, that's with Calvary referring to TCH; and TCH to Calvary, on 26 occasions.

The average time of bypass was just under 4 hours; so the effect on patient care was minimal, I'm advised, varying from no patients to five or six patients bypassing a hospital each 4-hour period. I'm advised that bypass is usually called in the late afternoon or early evening, although there has been one occasion when bypass has been called at 11.30 in the morning.

In relation to ambulances: clearly there may be some circumstances where people will be accommodated in an ambulance for a period of time before they're brought into the emergency department. That's a judgment made by the staff on the day as to where most appropriately the people need to be and where they can be accommodated prior to being admitted to the ED.

MR SMYTH: How often has that happened?

Dr Sherbon: It's most unusual in the territory. We can consult with the ambulance service to get us the figures; we can provide them on notice, if they have them. I'm not sure if they keep them here. But I conferred with the head of the ambulance service last week who confirmed our understanding that it's highly unusual in the territory and the incident 2 weeks ago was the only one for any significant period of time, say, more than 10 minutes, that people can remember that ambulance unloading was a major problem. But we'll confirm, because that's the understanding of myself and the head of the ambulance service; but we'll get you figures.

MR SMYTH: The head of the nurses union some weeks ago claimed that had happened and it was denied, I think, by both you and the minister. Had it happened on that occasion, or has it only happened since?

Mr Corbell: I think the response, at least from my office, was that we were not aware of it but were investigating the allegation.

MR SMYTH: And what did your—

Mr Corbell: Well, Dr Sherbon has indicated that it did occur. I was certainly not—

MR SMYTH: It occurred recently, but did it occur several weeks ago when the nurses union claimed that it was occurring?

Mr Corbell: That's the incident I am referring to.

Dr Sherbon: It's the same incident. It did occur. The ambulance service weren't able to confirm to me the times in the allegation of 1 hour 20 minutes for one ambulance, but I can confirm that. With the permission of the head of the ambulance service, we will be able to get that information.

Dr Sherbon: Sorry, could I just clarify that, when somebody is held up in an ambulance,

they're done so with the head nurse's knowledge, and care is still provided by the ambulance officer. There is no abandonment of patients. That's a very important point. It's obviously not the case for the high-urgency patient. You just wouldn't leave a high-urgency patient in that circumstance.

MR SMYTH: But isn't it more an indication that you're stretched absolutely to the limit?

Dr Sherbon: On that day.

MR SMYTH: And beyond the limit.

Dr Sherbon: That day was a busy day.

Mr Corbell: Yes.

MRS DUNNE: In relation to that incident, Dr Sherbon: can you inform the committee, in consultation with the head of the ambulance service, how many people? Is it only one incident or were there other incidents? What level of emergency category were those patients?

Mr Corbell: We can clarify that information for you.

MRS DUNNE: Thank you.

Mr Corbell: The advice I do have, Mrs Dunne, is that, during the week 17 to 21 May, which I think is the period we're referring to, the—

MRS DUNNE: Well, that's only last week.

Mr Corbell: Yes. That's when the claim was made. The claim was made last week.

MS DUNDAS: Yes, it was last week.

Mr Corbell: No urgent patients, category 1 or 2, were turned away from the hospital; that did not occur. These patients were seen as soon as possible and certainly within the specified time period. Many of the patients waiting in the emergency department were categories 4 and 5 and were considered non-urgent.

This is the issue that members need to keep in mind: the emergency department can look full, but frequently the people that you see in the waiting room are category 4 or category 5 patients; they are not patients who are in a life-threatening situation. Those people who are in a life-threatening situation are inside the ED being monitored and treated directly by the ED staff. Emergency departments are busy places and, quite frankly, they can be unpleasant places. People are in many instances seriously ill and they are receiving care, but it is not the sort of environment that the average person on the street likes to be in.

I say this from some experience last week. My own father was admitted to the emergency department last week; it was on one of the very busy days. So I had the opportunity to be in the ED for a full day, seeing what was happening. And that was

a very valuable experience for me. There were a number of people waiting in the waiting rooms; they were clearly less acute patients; there were a number of children there; but they were clearly not in serious distress compared to the people who were inside the ED. And that's the way an ED has to operate when it's dealing with high volumes of people. It has to prioritise the work to get the people through.

As for complaints that you read in the paper about people moaning and groaning and it being unpleasant: I'm sorry, it's an emergency department; that happens. Equally, as for complaints that parents and their children are waiting in the emergency department waiting room: yes, they are waiting but they are not in the life-threatening situation that the people inside the ED probably are, which is the reason they're waiting longer than we would otherwise want them to.

THE CHAIR: I note the time. We'll resume at 2 pm. We have, I would think, the Healthpact people and then back to 1.1.

Meeting adjourned from 12.35 till 2.00 pm.

THE CHAIR: It is now after 2 o'clock; we will start with Healthpact. Three members of the committee are present. We have some new officials. Welcome to the Healthpact segment. I need to read; I have almost learnt it off by heart. It is like a police caution—as Mr Refshauge would appreciate.

Ladies and gentlemen, you should understand that these hearings are legal proceedings of the Assembly protected by parliamentary privilege. This gives you certain protection 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, because giving false or misleading evidence will be treated by the Assembly as a serious matter. Do you all understand that?

Ms Arabena: Yes.

THE CHAIR: Welcome. If you have to take something on notice just say so. If members want something taken on notice, say the page number and the budget paper number to help people out. Questions taken on notice have to be answered within three clear working days. Also, when you give evidence please introduce yourselves: give your name and the capacity in which you appear before the committee. Thank you very much for attending.

In relation to the estimates, I see the budget is now close to 2.5 million aiming to go up to about 2.8 million in 2007-2008. Is that all from the proceeds of tobacco taxes?

Ms Moskwa: Sam Moskwa, Director of Healthpact. The money is received from ACT Treasury, ACT government money. The tax money now belongs to the Commonwealth. It is distributed through government—with the territory government.

THE CHAIR: All from Treasury; yes.

Ms Moskwa: Yes.

THE CHAIR: I note that Healthpact has now been going for a number of years. I have heard some groups express some disquiet at how the grants are allocated. Specifically, ACTSport raised a concern with me about grants for sport and physical activity up until the current round. I have a question on that. They are now somewhere between—I think they said—26 per cent and 31 per cent. This is certainly down from what I think it used to be in the 1990s.

When Healthpact was started I think the figure was about 35 per cent for that activity. That was much the same with health promotion funds and Healthpact type bodies around the country. Is that correct? ACTSport now says that the amount given to sport and physical activity is down on what it was some years ago, and that it is from about 26 per cent to 30 per cent.

Ms Moskwa: It was 31 per cent this financial year. Over the last five years it has gone from about 26 per cent to 31 per cent.

THE CHAIR: Are you saying it is going up?

Ms Moskwa: It was up last year because of the Australian Masters Games.

THE CHAIR: I see. So it was down to around 26 per cent, and went up for the Masters Games. My other question in relation to that is this: have the grants been made for this year?

Ms Moskwa: Yes, they have been announced.

THE CHAIR: I thank the minister for answering my question on notice. I have all the grants made to date for 2003-2004, but if there is one extra round—which I think you said had been made recently—could I have a copy of those grants?

Ms Moskwa: The small grants rounds?

THE CHAIR: Is that the full grants rounds? What have you made so far in the last month or so?

Mr Corbell: The full grants rounds I think is in the information I have already provided to you Mr Stefaniak—the major round. As I understand, there is a minor $5,000 grants round still being considered by Healthpact—that has not yet been announced.

THE CHAIR: Right. Has there been a change in rationale for grants being given. Again, sporting bodies particularly have raised this issue with me. A specific concern was raised—I will not go in it—by someone who missed out. I think Tenfit was initially told that it provided a very good program and then missed out. I am not quite sure what happened after that. But it seemed to reinforce the concerns of some of the sporting fraternity that there has been a change of direction; a change of emphasis. Would someone like to comment on that?

Ms Arabena: I am Kerry Arabena. I am the Chair of Healthpact. I would like to reiterate to the committee that the strategic plan tabled in mid-2002 to the Legislative Assembly

has been a guide for the last three years and, although it is coming up to the end of its tenure, we found that implementing the programs has been very beneficial to a range of players in the community.

We are focusing more on the ACT health plan and the social plan that is now being developed for the ACT. Throughout the last 12 months, we have emphasised addressing the social determinants of health: basically risk behaviours that attribute or make contributions to people's ill health or wellbeing. We are trying to impact positively on that. We have really reiterated those principles. It does not necessarily negate that people cannot achieve those through sports, but there has been a different kind of assessment process, which I believe has been transparent, and community organisations have had the opportunity to be mentored in and supported in making the applications.

But also Mr Stefaniak, I would like to say to the committee that the rounds have become far more competitive. There are far more applications for health promotion activities in the ACT. This has been of great benefit to the community. Community agencies have made the applications and the recipients of those programs.

THE CHAIR: Thank you. However, I have a concern. If you get away from issues such as childhood obesity and issues around younger people—perhaps being involved in healthy physical activity is one way of addressing anything ranging from social ill balance to all sorts of potential medical risks in the future—then you are getting away from one of the prime motivations for Healthpact being set up.

Mr Refshauge: I am Richard Refshauge, Deputy Chair of Healthpact. I will add to that, Mr Stefaniak. There are two things that the committee will want to understand. The first is that one of the important underpinnings of Healthpact is its capacity building. When we fund a large number of the more senior and capable sporting organisations to deliver a health promotion message, we then transfer the funding on to other organisations that are not so capable, and expect them—and have been gratified to find that they have been able—to continue a health promotion message.

Funding many of those organisations does not in fact in itself add to addressing things such as childhood obesity. For instance, funding the Raiders is good for the Raiders and has achieved very substantial health promotion benefits in that organisation and as a leader in that field, but does not necessarily of itself—as opposed to funding smaller organisations—get individuals out and active.

There is a refocusing in order to achieve what you are suggesting, but that has led to a change in the recipients of the grants. This achieves what you are saying, although it changes some of the balance in the grant mix.

THE CHAIR: I would agree with virtually everything you say. Funding an organisation such as the Raiders might not necessarily guarantee that you get your message across. Conversely I can recall a very good program the Cannons had. It was a Healthpact program. It probably got many children in schools active, and certainly helped the Cannons.

But surely emphasis should be placed on other organisations—smaller organisations—that can provide a healthy message that can get people active. I get concerned when

I hear that groups such as Tenfit miss out—it was initially told it had a good program; I am no expert but it looked to me as if it was a very good program aimed particularly at kids but also applicable to grandparents—and I wonder about the direction.

This is especially so when I think that one of the main rationales for Healthpact—and indeed health promotion funds—initially was to buy out tobacco sponsorship. Certainly here in the territory there were a couple of races and a couple of sporting events that had tobacco sponsorship. When the health promotion run first started, that was one of the main aims: to buy out government involvement in tobacco sponsorship. And invariably that was at sporting events.

Mr Refshauge: We have grown beyond that a bit, though. And that is because of the Assembly's legislation, which has mandated specific directions in the legislation, which is not simply to buy out tobacco sponsorship. As Kerry has pointed out, it has also been reinforced by a strategic plan—which under the legislation we are required to, and do, table—in the Assembly. This place clearly and specifically indicates the direction that we are moving in—and have moved over the last 10 years.

THE CHAIR: I note you have not done any more grants since the ones the minister has provided; you are in the process of doing some I take it. That is obviously something we would not have by the time this committee is meant to report. I commend to you the concerns that a number of people in the sporting and recreation community have. I share those concerns in terms of those particular points.

Mr Refshauge: Bear in mind, Mr Stefaniak, that sporting organisations are not solely dependent upon Healthpact funding. Healthpact funding is targeted; we have a statutory obligation. We are not there simply to have the sporting organisations survive. Much more money comes from sport and rec, and is much more significant in the sporting area. In order to balance across the Territory a proper delivery of services—particularly health promotion services—it is necessary to bear in mind the proportion that is going from sport and rec to sporting organisations.

THE CHAIR: But Mr Refshauge, you can use the same argument for the arts.

Mr Refshauge: And we do.

THE CHAIR: In fact, I think the arts grants are higher than the sports grants—and indeed any other number of activities funded right across government. Many of these initiatives would dovetail into other areas right across the government spectrum.

MS MacDONALD: You obviously go through the funding round process—I will look at the answer to the question on notice that Mr Stefaniak has put in because I have not seen it—and Healthpact has become more noticeable in the last few years, which is a good thing. That has been shown by the fact that there has been an increase in funding applications through Healthpact.

It is also a good thing that people know that you are there and say, "Here's a body that we can go to. We've got a healthy promotion message to sell, so here's a body we can go to and actually put our ideas forward." Is any assessment made of the balance of the programs that you do grant funding to, to make sure that you are covering all the areas

that need to be covered?

Ms Arabena: Thank you for the question. I would like to reiterate the quality of people that we currently have on the Healthpact board. We have really exemplified, I think, public commitment to the kinds of principles that the government wants to pick up and run with on health promotion. The fact that many people are able to make those applications represents the quality of the people who are on our board.

They represent both international and national expertise and interests. We have become, over the couple last decade or so, far more sophisticated in how we do our business. That includes the assessment materials and the assessment tools that we use to ensure that all aspects that have been named in the strategic plan tabled at the Legislative Assembly can be measured and evaluated on the credit of the programs that come up.

Another shift that I have made—again, it is probably because of my community sector experiences—is that we have wanted to fund programs to be successful and not fund programs to be under-resourced. That has meant that we can now measure the quality of those interventions in light of our work with the assessment tools, the mentoring programs that we have in place and the kind of applications that are coming through that are then becoming successful.

I am really looking forward to doing the research and evaluation work that will determine the quality of the programs that Healthpact is undertaking and the fact that we are appropriately resourcing the capacities of organisations and individuals to take up health promotion activities.

MS MacDONALD: This is a bit of a follow on to that and to what Mr Stefaniak has asked as well. There will always be organisations that will apply for funding and miss out. That is the nature of things; we all understand that—the bucket is never big enough. But when people apply or have had funding previously and then you say, "We're not going to continue to fund your program because we've looked at it overall" are they given information or other options about other ways they can access funding in order to continue their program, such as going through sport and recreation?

Ms Arabena: My understanding from the council is that, if people are unsuccessful, they are personally contacted by the director of Healthpact and walked through their application process. There is an indication during that verbal communication—which I think is much more respectful of a person who has not been successful than getting it in the mail—and that level of communication then provides information about things that they could have done to improve the quality of their application. Information is also given about community funding round forums and workshops that Healthpact is also looking to hold, and then other possible funding sources for that kind of program.

So we are not only funding community funding rounds but also mentoring and advising community organisations about other parts of the sector from which they can attract monies in order to progress the kind of work that they want to do.

Mr Refshauge: I add three things to that. The first is that we table, in our statement of intent, targets for the amount that we propose to spend in each of the focus areas. So it is absolutely transparent and public what we are proposing in various areas. Those are

based on the national health promotion priorities of smoking prevention, sun protection, physical activity, healthy nutrition, safe behaviours, promoting mental health and community development, which has been the big growth area in this area.

The second is that every year, after the committees that look at each individual grant consider the grant, the program committee, which is comprised of the chairs of each of the assessment committees, meets in order to ensure that there is an appropriate spread, not only over the focus areas but also over what we call the statutory areas of sport and the arts, education and health, to make sure that that is done.

As a chair of an assessment committee, I can say that, when we are assessing a program, if it is not to be funded but we regard it as a valuable program, for the most part the committee will look at other options for funding and recommend to the secretariat that it pass on suggestions about where funding might be obtained.

We have gone even further and, in a number of cases, we have tried to broker funding from other organisations. Our assessment committees are made up of people who have great knowledge in those areas and contacts. We are sometimes able to assist and broker support from another area, particularly when it is something that falls a little outside what we are doing in terms of health promotion, but is well in the areas that others are involved in.

MS DUNDAS: In terms of the statement of intent and the identified program areas that you want to spend money on, there is actually a decrease in the total money being put on identified program areas. Is there a reason for that?

Mr Refshauge: The reason is that three years ago, I think, we had reserves of some $500,000. The last board—although there are some continuing members—then took the view that it was inappropriate for us to have reserves; that that money ought to be out there. But there was no point in spending $500,000 in one year and so we spent it over a period of years. As that has been spent, it has gone back to a level where our income is now funding the program, rather than the income plus the reserves. We have done that in two ways: not only by injecting that money into the ordinary grant round but also by funding some special program, some special initiatives, in conjunction with the ACT Council of Social Services and the Mental Health Foundation.

MS DUNDAS: Are they the large projects mentioned or are they separate initiatives?

Mr Refshauge: Those are the large projects mentioned.

MS DUNDAS: The research and evaluation centre, NGO-based health promotion development officer and the social determinants health modelling?

Mr Refshauge: Yes. That is correct.

MS DUNDAS: But in terms of the identified program areas, there does seem to be an increase in the amount of money to be focussed on the initiatives fund and research, and evaluation and field development in education programs. What is the underpinning there?

Mr Refshauge: The board took a view that it should follow a request that came from government to spend 10 per cent on research and evaluation, which we had not done before. That makes sense as much of our work was by common sense and experience rather than being evidence based. We want to move more effectively into evidence-based funding. We have put $180,000 into creating that external research for that purpose.

MS DUNDAS: I am trying to understand page 18 of the statement of intent. I am looking at $522,000 going to research and evaluation field development education programs. Is that separate to the $180,000 that you just mentioned, which is for the establishment of the research and evaluation centre?

Mr Refshauge: It is included in it. The $180,000 is included in that. But it also includes things like the assistance to organisations to deliver and to prepare, which comes within field development and our education programs.

MS DUNDAS: Okay; that makes sense.

THE CHAIR: I have a question on that. I see that for physical activity—1.1, page 18—the target is $253,000 for this current year. It drops to $210,000 for 04-05. Why is that?

Mr Refshauge: Because the reserves money has run out. We have spent it all.

MS MacDONALD: Is it also because you have had an increase in the other areas such as mental health?

Mr Refshauge: We are trying to moderate those changes. There were years when we would emphasise one of the focus areas, or a number of the focus areas. We would give them a bit of a boost for a couple of years and then readjust our priorities. We felt that in fact that was not a good way to go. We are trying to get into a more balanced but continuous approach. To some extent there is no doubt that community development has spawned a tremendous number of applications and in order to meet those, we have had to do some reallocation of monies. You can see that in an increase there from 302 to 340.

MS MacDONALD: Sorry. I said mental health and I misread it; it should have been "community development". I did not read across the line properly.

MS DUNDAS: In terms of the childhood obesity measures, which is an initiative under the health department, budget paper 3 tells us it includes funding for school-based obesity projects, which will be expended through a special Healthpact funding round. When will that round be taking place?

Ms Moskwa: There are negotiations on that project and the aim is for the next financial year 2005-06, three years.

MS DUNDAS: The sport and recreation area of CMD has two ongoing pilot projects it runs. The important one is the kids at play project, which we were told last week is designed specifically to help obesity levels in children in the ACT. It is targeted through schools. So how will your funding specifically target it at schools, and work with the funding that is already coming through for the kids at play project?

Ms Moskwa: The one that we are negotiating with the department of health is the health promoting schools model. It will be a grants round that goes to the schools. The schools would identify the particular areas they want to work with with children and obesity, whereas the one that you are talking about with sport and rec is a specific project. We can work together with people, but it is a grant round. It would be identified by the school setting.

MS DUNDAS: You are funding a much more diverse range of options with that, whereas the kids at play project is a specific project. Is that right?

Ms Moskwa: It is a specific project. Health promoting schools—Healthpact initiated that program through ACT education—has grown very strongly. We had a quarter of a million dollars worth of applications this year. It has grown phenomenally. Schools are ready for more grants in health promoting schools.

MS DUNDAS: So over the next two years there will still be separate funding going through to the schools; it is just that there will be a targeted round in 05-06 for obesity along with the—

Ms Moskwa: It has grown to have its own category.

MS DUNDAS: Where will the research and evaluation centre be located?

Ms Arabena: At the moment we have taken up a scoping paper that has had a look at a range of options. We have investigated an appropriate place for that. It is being considered at the next council and also board meeting. It was undertaken by Latrobe University. It will be giving us a range of information about what key stakeholders would like to see happen, where that place can best be managed and the kind of focus on the research or the research emphases that we will be looking at for the ACT community.

Mr Refshauge: We would expect it to be located in Canberra. We have been fairly keen to make sure that the scoping study is as effective and impressive as possible. So we looked around for the appropriate person who could do that. Some objectivity helped to get some distance. Latrobe ended up being the appropriate people for the scoping study, but the centre is almost certainly to be located in Canberra.

MS DUNDAS: I was asking the question more in the sense that you, Mr Refshauge, said that it will be an independent evaluation centre—

Mr Refshauge: Yes.

MS DUNDAS: Would that be independent but still in the department of health or independent as not in any—

Ms Arabena: No, we are looking at a tertiary institution.

Mr Refshauge: No. The likelihood is the University of Canberra or NCEF or something like that.

MS DUNDAS: Will the NGO-based health promotion development officer be located

with one NGO or will it be a resource for the entire non-government sector?

Mr Refshauge: It will be located with one NGO. Each one—we hope that we will be able to get more than one—will be located with an NGO but available to a whole range of NGOs. We want to outsource that for effectiveness. But obviously it is not just for the benefit of the outsourced organisation but also for the benefit of the sector. So far that has been very positively received. We think it will be very effective.

MS DUNDAS: You indicated that you hope to be getting more than one development officer?

Mr Refshauge: In due course, yes. The plan for next year is two.

MS DUNDAS: Sure; next financial—05-06.

THE CHAIR: If there are no further questions Healthpact you are excused.

Mr Corbell: Mr Chairman, with your indulgence, I have some further information to a question that Ms Dundas, I think, asked before lunch about the suicide prevention funding. I now have a break up of the dollars for that initiative: $240,000 will go to AusHealth; $40,000 will go to VINE.

MS DUNDAS: Sorry, to whom?

Mr Corbell: VINE.

Mr Corbell: There will be $40,000 to PANDSI, which is a post and antenatal depression organisation, and $45,000 will go to a project officer to map existing suicide prevention services and develop a strategic framework for the better coordination of these services.

MS DUNDAS: The question still remains: what is the future of the YWCA/University of Canberra combined SIP project?

Mr Corbell: Sorry, I also have that here on the piece of paper. The YWCA is funded by Commonwealth suicide prevention money to provide a worker to run a peer support project for young people at the University of Canberra. It is a 12-month pilot project completed in December 2003 with one-off funding from the Commonwealth. Evaluation of the pilot to consider expansion of the project will be part of the suicide prevention project to map suicide prevention services.

MS DUNDAS: I also have one overview question. When we were talking to the Department of Disability, Housing and Community Care I raised a question about statutory responsibilities in relation to mandatory reporting. The department indicated that there are officers in health who also had statutory obligations in relation to mandatory reporting.

Mr Corbell: Yes, that is correct.

MS DUNDAS: Have those officers been undertaking the training in relation to mandatory reporting offered by the department of education?

Mr Corbell: I understand that training has been taking place for the relevant officers who are both in I think the community health setting and also the hospital settings. I will ask Dr Sherbon to give you some more advice on that.

Dr Sherbon: A wide range of health professionals are required, as you have pointed out, to mandatorily report child abuse. That is the mandatory reporting you were talking about. It is fair to say that we have identified that there needs to be greater training in the health specific nature of mandatory reporting, as well as a greater uptake of the training program you have mentioned. We are currently, through internal funds, supplementing our training program with expanded child protection training. We aim to ensure that all frontline staff who come into frequent contact with children go through that in-house program this coming financial year.

MS DUNDAS: You are relying more on your own internal training mechanisms than the training that I understand is being offered by the department of education.

Dr Sherbon: It will be a complementary process. Ms Yen can give you more information if you want further elaboration on that answer. The two will not work against each other. But we definitely do need some health specific training because of our circumstances. As you know we are a major port of entry for children into the child protection system. We need our workers to understand their obligations. That training program will be designed in-house complementary to the education.

MS DUNDAS: Have your found the training offered by education adequate and easily accessible?

Ms Yen: Laurann Yen, General Manager, Community Health. The training has been offered and available to people in other government departments since the change in the legislation, in 1999 I think. Over that period, most public sector workers working with children were trained in the first round.

But the thing that we probably need to have been more explicit and rigorous about was ensuring that all staff continue to have updates to their training. One of the things that we have been conscious of is that we need, as Dr Sherbon has said, to develop much more explicit training in relation to what sorts of issues health workers might come across and how we actually manage not just the reporting of child abuse and child protection issues but also the ongoing healthcare and management of children who may come from vulnerable families or who may be at risk of abuse.

We are working closely with the department of family services or what will become the new department or the new division. We are working to develop training in conjunction so that there will be a number of different options available that will suit different types of health worker with different requirements. We are working very closely together.

MS DUNDAS: Sure, thank you.

MRS DUNNE: I want to go back to output class 1.1 and ask about—in the quantity measures—the number of inpatient cost weighted separations and the number of cost weighted occasions of outpatient service. Can you provide a breakdown of those by

hospital: how many are in Calvary and how many are in TCH?

Dr Sherbon: Yes, we can.

MRS DUNNE: On notice?

Mr Corbell: I think it will need to be, yes.

MRS DUNNE: Yes, all right.

Dr Sherbon: As we described earlier, we are in the process of divvying up our own internal budget. So we would be able to do that for you in a reasonable timeframe.

MRS DUNNE: Do the outpatient services include accident and emergency? Or is that a separate figure?

Dr Sherbon: I will just have to check that. Separate is the answer.

MRS DUNNE: It is a separate figure. Do you have a meaningful measure of the number of services provided at accident and emergency?

Dr Sherbon: Emergency department attendances and admissions?

MRS DUNNE: Yes.

Dr Sherbon: Yes, we can get that figure. It is something that we do measure.

MRS DUNNE: Can we see that over the last three years?

Dr Sherbon: Yes, sure.

MRS DUNNE: Why is attendance or admission at emergency department—sorry, I am not up with the current nomenclature—not a measure in the budget?

Mr Corbell: It is a very difficult figure to predict. Therefore we do not attempt to try to set some sort of target. We do not want to say, "We expect 65,000 presentations"—or whatever it may be—"at the emergency department." It is a completely unpredictable figure. The department's advice to me is that putting in place a particular target would be a fairly meaningless process. But we are certainly able to provide you with information on what has been the volume of activity in that department over the past three years, as you have asked.

MRS DUNNE: Thank you.

MR SMYTH: I can recall a press release last year saying the growth of Calvary A&E was expected to be about 7 per cent. I notice that the hospital budget, across the board, has gone up something like 3 per cent. How sustainable is your hospital budget? I see on page 155 of budget paper 4 that the total ordinary expenses for the hospital for this year was meant to be 281. It has blown out to 298. What is that—about $17 million?

Mr Corbell: No, 285. It is 285 there, not 298.

MR SMYTH: The budget for 03-04 was $281 million. It went to 298. Total ordinary expenses—not revenue.

Mr Corbell: Yes, I see.

MR SMYTH: So it has gone up more than $17 million there. So in a given year it has gone up $17 million. But your prediction for the next year—the difference between 298 and 308 is only 10—is that it will grow at half the rate of this year. How can you believe that? How can you try to even say that that is sustainable?

Mr Corbell: Mr Smyth, it is about getting better management of the hospital's finances and administration. We obviously do need to work to contain costs in a reasonable and sensible way. That obviously reflects that.

MR SMYTH: I understand that the annual growth at TCH is also about 7 per cent. Yet you have calculated the increase at only 3 per cent. Okay, I accept you might get some better management practices in, but the health index goes up somewhere between 9 and 16 per cent, depending on which way you want to look at it. How can a 3 per cent increase for the hospital be considered sustainable?

Mr Corbell: It was pointed out to me that the increase in admissions at the hospital has been approximately 4.8 per cent in the past year. So the rate of growth of activity is not as high as the figure you quote in relation to total admissions over that period.

The government makes an assessment about what is a reasonable level of funding for our health services. The focus is on the system overall, as well as individual parts of our system. In terms of this budget, the total increase in funding is approximately $71 million worth of new initiatives. It is not a small input.

MR SMYTH: Yes, but the hospital goes up only 3 per cent. You are saying it should go up 4.8 based on last year. You are saying that it is growing; the population itself is growing.

Mr Corbell: The population is growing very slowly.

MR SMYTH: One per cent on CPI.

Mr Corbell: It is not an appropriate comparison to say, "Overall growth is X, therefore funding should match that." You make the assessment based on what the need is—not just on the straight growth percentage. It is not comparing apples with apples.

MR SMYTH: What is the health CPI?

Mr Corbell: The health CPI?

MR SMYTH: Yes.

Mr Corbell: The health CPI is, I think, around 10 per cent.

MR SMYTH: So you are not matching CPI. The population growth is what?

MRS DUNNE: It is 0.9.

THE CHAIR: It is ageing too.

MR SMYTH: The level of acuteness is rising. How can you say the system is sustainable when you are not meeting any of the indicators?

Mr Corbell: The main increases in terms of the health budget, outside our particular consumables, are in wages.

MR SMYTH: Sure.

Mr Corbell: And the government has expended a significant amount of money in wages. We have a new wage offer on the table, for example for nurses, which we discussed this morning. This highlights a considerable increase in the level of wages to nursing staff: well over 10 per cent in almost all instances.

We have had similar increases in relation to VMOs. I anticipate we will have similar pressures on us in relation to salaried medical officers when their negotiations come around. Those are the key pressures in terms of the health sector. We are working quite hard to increase that. In fact, the additional funding—I am advised—is a 12 per cent increase in funding in 2004-2005.

MRS DUNNE: In the hospital system or over the health system?

Mr Corbell: In the system overall; in the health service overall: a 12 per cent increase in funding.

MR SMYTH: What is then the increase in the hospital, on your figures?

Mr Corbell: I do not have the particular hospital figure to hand. I am happy to get that checked for you and provide you with that information.

MR SMYTH: Yes.

MRS DUNNE: It would be good. I would like to go back, Minister. This morning there was a discussion about the fact that we have 500-odd public hospital beds. In further discussion we were talking about the bed blockers—people in rehabilitation or nursing home type patients in acute beds that did not need to be in acute beds. That figure, by the time you added the rehabilitation patients and the nursing home patients, was in excess of 30. So it is a substantial proportion of the number of hospital beds. I know we do not talk about beds; we talk about cost-weighted separations.

This morning we talked about the sub-acute facility, which is now substantially behind time. What are you doing in relation to the nursing home type bed blockers? Part of the signup bonus for the health care agreement was at least some bringing forward of some resources there. What has happened with those?

Mr Corbell: That process is well underway. It relates to the discussion we had this morning about the rehabilitation facility.

MRS DUNNE: So they were only rehabilitation beds?

Mr Corbell: No. The discussion that Mr Hargreaves brought to the attention of the committee relates to the operation of the rehabilitation independent living unit, which is located in premises in Gaunt Place adjacent to TCH. It is being considered at this time as a site for the transitional care facility.

The Commonwealth has agreed—the ACT is leading in this sort of approach in Australia; I am not aware of any other jurisdiction having achieved the same agreement from the Commonwealth at this time, although I would not be surprised if others are having negotiations—is to have approved, but not yet operational, nursing home beds. The Commonwealth has agreed that we be able to utilise that funding with the permission of the approved provider—the nursing home provider who has been allocated that—to make those beds operational immediately before they become operational in the nursing home context.

MRS DUNNE: You are borrowing beds.

Mr Corbell: We use that money to pay for a nursing home type bed. It will be on the campus of at least one, and probably two, of our major hospitals. That will allow us to take those nursing home patients from acute care beds into nursing home type beds. The beauty of the scheme is that the Commonwealth, all things being equal, will continue to make allocations to the ACT each year for additional funded nursing home beds. As new beds become operational, the already approved, but not yet operational, will simply flow through into the transitional care facility.

MRS DUNNE: So you are effectively saying that you are borrowing the beds while you are building them.

Mr Corbell: We are not borrowing them because, effectively, the territory has already got them. As far as the Commonwealth is concerned, it is approved and the money is there, but it is not being used. We are able to use it sooner.

MR SMYTH: Will this involve opening, say, one of the unused wards in TCH?

Mr Corbell: No, the proposal at this stage is to use—that is the discussion we had this morning—the premises at Gaunt Place. But that is still under consideration.

MR SMYTH: Are there any unused wards or unused floors in the main building at TCH?

Mr Corbell: I had this discussion this morning. I am happy to stand corrected by one of the staff from the department. I am advised that there are some floors on TCH where there were previously wards but which are now being converted for other uses. So there is no ward sitting there that is physically empty—where you just have to open the doors and turn the lights on and you have a ward. There are spaces in the tower block in

particular that have been converted to other purposes. For example, we now have at least one half of one floor of the tower block, which is now for the medical school. There is a range of other activities.

MR SMYTH: So there is no empty space and there are no empty wards?

Mr Corbell: There are no empty wards floating around at TCH.

MRS DUNNE: What about Calvary?

Mr Corbell: I am advised that there is some capacity at Calvary.

MRS DUNNE: What capacity, Mr Cusack?

Mr Cusack: Robert Cusack, CEO of Calvary Health Care ACT. There is a small number at Calvary—five beds.

MRS DUNNE: I know that Calvary has already created a rehabilitation step-down type facility in one of the wards. Minister, considering that there are, for instance, 100 unallocated beds for Calvary, would you consider using the small amount of space that Calvary already has in the short term?

Mr Corbell: The government is keen to see the transitional care type facility also operational at Calvary. We couldn't operate it solely on the basis that the Little Company of Mary has a bed allocation; it would need to be more sustainable than that. But there certainly is capacity to do that, given the Commonwealth's agreement, and that issue is being progressed with Calvary. At this stage the focus is on the Canberra Hospital, given that the majority of the nursing home type patients are in the Canberra Hospital.

MRS DUNNE: But the Little Company of Mary does have 100 unallocated beds.

Mr Corbell: They are not yet operational.

MRS DUNNE: The beds are not yet operational but they also have, from what Dr Sherbon said as a result of Mr Cusack whispering in his ear, an unused five-bed capacity. Mr Cusack, come and answer the question.

Mr Corbell: What is the question?

MRS DUNNE: Is there capacity to take up some of the currently allocated but unused bed capacity given to the Little Company of Mary at Calvary Hospital?

Mr Corbell: That's a decision for the Little Company of Mary, if they want to operate that stand alone.

MRS DUNNE: Would the government facilitate that?

Mr Corbell: It wouldn't be our role per se. The Commonwealth would have to give agreement for that to happen, not the territory.

MRS DUNNE: You were saying before that you have agreement from the Commonwealth to use unused beds.

Mr Corbell: Yes, we do, but obviously they would still need to say. Our agreement is on the basis that we are able to pull effectively, with the agreement of the providers, all those places up to a certain number—up to 40—for a transitional care facility. We're obviously doing it on a collegiate basis rather than with individual operators.

MRS DUNNE: You were talking about the possibility of using the RILU beds. There is not a 40-bed capacity there, is there?

Mr Corbell: There are 15 to 20.

MRS DUNNE: Where else might you locate these beds?

Mr Corbell: There is the potential to locate in Calvary. The key issue with both hospitals is that we will still be required by the Commonwealth to meet the relevant accommodation standard for a nursing home type patient. That will require some refurbishment in whatever hospital setting we choose. A hospital board wouldn't meet the standards required for a nursing home type patient. Hence it is not a case of just finding some empty hospital ward beds and putting people in them. To use the nursing home type funding we'd still need to meet the relevant standards.

Mr Cusack: Going back to the issue about the 100 places, they're Commonwealth places, allocated by the Commonwealth. It certainly would require their agreement to re-utilise those. I expect they would not do that at this point in time. In relation to the capacity at Calvary at the moment we've got only one area of eight single rooms that is currently not allocated for approved beds, although we regularly overflow into that area. That means that, in real terms, there are only five beds available in the entire inpatient capacity on the site.

MRS DUNNE: Where are you with the Little Company of Mary's venture into high care aged accommodation across the road in Bruce?

Mr Cusack: We've recently got all the planning parameters from government, so we know what the restrictions are in relation to the site. There are environmental issues and issues in relation to bushfire setbacks, et cetera. The final piece of information in relation to that was received about two weeks ago. We're now in the process of assessing the financial viability of the case on the development side and also the operational model for ongoing provision of aged care. We expect to make a recommendation, based on that analysis, to our national board. That would occur in mid to late June. We would be in a position to make an announcement about that prior to 30 June.

MRS DUNNE: I noticed a news report a fortnight or so ago where Mr Butt gave the impression that you were having to go back to the drawing board to some extent. What planning restrictions have been placed on you, if any?

Mr Cusack: Essentially it is to do with environmental issues on the block. There are also issues, particularly after 18 January last year, about bushfire setbacks that are necessary on the block. A number of those issues have an impact on the size of the development on

the block. It is pretty widely acknowledged that an ageing-in-place facility relies on some cross-subsidisation of the building of independent living units to fund the nursing home/hostel part. If we can't physically put enough independent living units that are going to be saleable on that site, it would jeopardise that part. We're looking at those numbers very carefully at the moment.

The other area is ongoing operational management of an aged care facility. That requires a funding stream that is almost exclusively from the Commonwealth. We have to make sure that that funding stream is sufficient to make this operation viable into the future. The very worst thing that could happen is we would go ahead with this and find that it wasn't viable in one or two years time, and then have at least 100 people to find places for.

MRS DUNNE: People who do aged care assessments and things tell me on a regular basis that they are hanging out for this facility. Are you telling the committee today that there is a possibility it won't go ahead?

Mr Cusack: I can't give any guarantees. I don't think we will know the final situation of that until we analyse the business case. That is a possibility but I certainly hope it is not the case. We've put 2½ years of fairly solid work into this. The sisters of the Little Company of Mary are looking forward to moving forward with this. If they wanted to have something that was a profitable business, it wouldn't be in aged care. They're doing this for reasons other than just the profitability issue, but they can't afford to lose money. The community can't afford to have something that is not financially viable both on the development side and in the ongoing operations.

MRS DUNNE: Am I reading too much into it in saying that the amount of land that you've been allocated has been constrained?

Mr Cusack: Because of the issues we spoke about earlier it is a sensitive site in relation to the bush that surrounds that area. It abuts Canberra Nature Park—that is one issue. There's an existing residential development there—the South Bruce community—and we're keen to be good neighbours with that group. Calvary is very fortunate to have that beautiful bushland setting. We value that and want to make sure we work within that. The bushfire setbacks that are necessary for the safety of the site are important as well.

MRS DUNNE: Are you now effectively working with a smaller parcel of land than when you started?

Mr Cusack: There's no doubt about it. The usable land that will be available for development on the block is smaller than we originally envisaged.

MRS DUNNE: How much smaller?

Mr Cusack: I can't give you the specifics; I could only have a guess, which is a little dangerous. The site is in the vicinity of five hectares. Probably about 3½ hectares of it is useable development space.

MRS DUNNE: There has already been a DA or preliminary assessment. Presumably you were working on a piece of land that was originally larger than that which you now

have.

Mr Cusack: The preliminary assessment is lodged by government, and we've provided some input into that. Since that time further things have come to light about issues on that site that would impact on the land available for development.

MRS DUNNE: When the PA was put in how much land, roughly, were you looking at developing?

Mr Cusack: It was slightly more than that but the financial viability, particularly in relation to the number of independent living units that can go on that site, is at a sensitive point because of the impact on things like internal rate of return, et cetera. Any reduction in that has a significant impact on the business case.

MRS DUNNE: Yes, I understand that. If you go ahead, would you say that you'd be able to determine that before the end of this financial year? When will you put in the DA?

Mr Cusack: We would be attempting to do that as soon as possible after that. In fairness, my governing body needs to make an assessment about that and it needs to be approved by the owners. If it is a positive outcome we will be looking to lodge a development application very soon after that. We've got most of the things ready to go.

MRS DUNNE: With a view to building when?

Mr Cusack: I think, realistically, it is going to take probably 14 to 16 months to get the full development going. Our priority would be to do the nursing home/hostel first but, as I mentioned before, it requires a cross-subsidy—so building of some independent living units to pay for that development. Hence they will be a dual thing. Realistically, I would say 18 months before completion and then it would be a couple of months before you could have residents in there. Our biggest issue is about making sure that we can deal with the nursing home/hostel component. As I mentioned before, that is the area the Sisters of the Little Company of Mary are most interested in but, of necessity, we need to have the independent living units to fund it.

MRS DUNNE: Yes, I understand that.

THE CHAIR: Members, I think we all got an email from a lady in Queanbeyan whose elderly mother has been waiting for a back operation. They are real battlers. The mother injured her back on about four occasions. She worked in the kitchens of a couple of places. She never complained, rarely took sick leave and has now been waiting to get in to have her back attended to. Her daughter is terribly concerned that, with the time it takes, she may be crippled.

In the email she sent, the daughter said that she phoned the hospital because she wanted to see the waiting time reduced. She was told that her mother had been revised from a category 3, which is an 18-month waiting list, to the higher category 2, which is supposed to be a two to three-month waiting list. However, further inquiries by her revealed that, in fact, the waiting time for category 2 can be up to 19 months. Effectively that did not assist her mother in any respect. She also indicated that there was a certain

doctor who had offered—and she accepted—some extra sessions. Obviously that was of benefit to her, but then the hospital seemed to say that that wasn't the case. I'm very concerned to hear that, in a situation like that, where one would think that being a category 2 would get this lady in a lot quicker, it has no real effect.

Mr Corbell: I do not know the specifics of the case, although I recall the email generally.

THE CHAIR: She wrote to you too.

Mr Corbell: Category 2 is obviously an upgrade of the clinical urgency of her mother's condition. That said, there are still a lot of people who are waiting for category 2 surgery. I think that, in this case, it is compounded by the type of surgery and the relatively limited number of surgeons we have who are able to do that work.

Dr Sherbon: I might point out that, in this case, we have offered a neurosurgeon additional time, as you've recorded, but at this stage he has been unable to take up that time. We're hoping to secure his availability to take up the additional time. He has taken up some sessions but not all that have been offered.

THE CHAIR: I'd appreciate it if you will keep trying. All further questions on this output could go on the notice paper. We will now move to 1.2, mental health services—BP4 on page 157. How do you reconcile the mental health strategic action plan with the fact that the services in output 1.2 remain static? That is the second line, $175,000.

Dr Sherbon: The minister and I are conferring over the details of the answer. The mental health strategic action plan outlined a number of key initiatives in community based care, most of which were anticipated in the 2003-04 budget. As the minister outlined this morning, there are a considerable number of enhancement projects in the 2003-04 budget, which I can list for you in a minute.

The emphasis in 2004-05 is on consolidation of those projects plus the addition of the three projects the minister outlined this morning—the expansion of child and adolescent services to Gungahlin and the forensic community mental health based initiative. It will take some time to form that team and have it up and running. So there won't be a large impact on activity from that initiative this financial year. The third initiative, which Ms Dundas questioned us on, was the suicide prevention initiative, which is an education and support prevention program rather than a service delivery program.

In our estimation of community based activity next year—the second line is the one I think you're referring to—we don't expect any major expansion beyond that incurred this year because we're consolidating the 2003-04 budget initiatives and also adding a service—forensic mental health care and the outreach of the child and adolescent unit to Gungahlin. That probably won't add a large amount to that program in the next financial year. In our estimation we're being conservative and we've evaluated the fact that we're likely to increase, but not by a great deal. There is service enhancement, but most of the service expansion has been incurred through the 2003-04 year and will carry into 2004-05.

MS DUNDAS: There are a number of actions under the mental health strategy that have

indicators attached, including action 27. The aim is "proportion of failed referrals between services is reduced". Do you have benchmark figures for the current proportion of referrals between services that fail?

Mr Jacobs: At this point in time we haven't established a benchmark figure for that. There are some KPIs being established at a national level. We are going to participate in that program and the ongoing mapping of the service. How we're performing against those KPIs is going to be a key consideration for the next financial year. We're already starting to look at recording a fair bit of that data now. We will have a full year of collection next year.

MS DUNDAS: The measure will start working from the 2006-07 year?

Mr Jacobs: No, from the next financial year.

MS DUNDAS: The 2004-05 year.

Mr Jacobs: Yes.

MS DUNDAS: Even though you don't have any benchmarks to meet yet, the action will take off from 2004-05?

Mr Jacobs: We will be targeting the recording of that data for 2004-05.

MS DUNDAS: I have further questions about that but I will continue on performance indicators. Actions 29 and 30 have performance indicators in relation to the proportion of involuntary admissions that are reduced. Can we get some more detail? Is that the number of admissions to hospital, specifically?

Mr Jacobs: At the current time it is perceived that we have a high population of involuntary clients in the adult bed based area.

MS DUNDAS: In the psychiatric unit at TCH?

Mr Jacobs: Yes.

MS DUNDAS: Do you have a figure on the proportion of involuntary admissions?

Mr Jacobs: We can provide that, but I don't have it here.

MS DUNDAS: That's taken on notice?

Mr Jacobs: Yes.

MS DUNDAS: Have you worked out what the aim is—what you're trying to reduce it to?

Mr Jacobs: We're perceived to have a high number compared to other jurisdictions.

MS DUNDAS: It's a national benchmark that you're working on?

Mr Jacobs: That's right.

MR SMYTH: Is that perceived or actual?

Mr Jacobs: It is actual. We have a high percentage by comparison with other jurisdictions.

MS DUNDAS: There is also a performance indicator that talks about placement, and flow of patients between existing inpatient facilities, and it is enhanced. How are you going to measure whether or not patient flow is enhanced?

Mr Jacobs: Can I get you to repeat the question?

MS DUNDAS: Yes. Again it is from the strategy. There's a performance indicator that reads, "Placement and flow of patients between existing inpatient facilities is enhanced." How are you going to measure that?

Mr Jacobs: Basically the target for that was to try and get our acute adult bed based service beds operationalising more effectively in meeting the need. We have already had improved enhancement in moving people between the adult acute beds at 2N and the psychiatric services unit. There has been a freeing up so people are placed where their needs are best catered for.

MRS DUNNE: How do you measure that?

Dr Sherbon: We've included in the budget papers the performance measure which reads, "Percentage of clients seen in the community during the seven days post discharge…" That is one measurement of smooth transition. It is a process based measurement. It indicates that, when patients are discharged from the unit into the community, they will be seen within seven days.

MS DUNDAS: This measure talks about flows between in-patient facilities, not between a facility and the community. I'm not saying that is not a good measure but I'm still trying to get at the heart of this measure.

Mr Jacobs: The reason for potentially adding a high percentage of involuntary people against the PSU is that we make very good use of Calvary 2N. Essentially people are there on a voluntary basis. If someone does not need to be involuntarily detained in PSU and it is suitable that, because of their condition, they be cared for at Calvary, we will organise their transfer. Because we now operate both sites, there has been a freeing up of that.

Dr Sherbon: A potential indicator about which we're in discussion is the waiting time between request for transfer and the effected transfer.

MS DUNDAS: That's when somebody ceases to be on involuntary detainment but would still like treatment?

Dr Sherbon: No. We can't detain anyone who's no longer clinically an involuntary

patient.

MR HARGREAVES: Is one of the measures shrinkage of the number of people who are on voluntary admission to the PSU, and therefore the sending of those people to Calvary? Is that one of the measures you would use numerically?

Mr Corbell: Can you repeat that? I don't quite follow you.

MR HARGREAVES: What we're trying to do is find out how you're going to measure that numerically.

MS DUNDAS: Maybe another way of putting it is: at the moment, can you tell us the mix of people who are on involuntary and voluntary orders at both facilities?

Mr Jacobs: Yes, we can.

MS DUNDAS: Is the aim to have fewer involuntary admissions so you can cater for more voluntary admissions? The aim is to have a reduction in involuntary admissions—that is in the mental health strategy.

Mr Corbell: Yes. The focus on that therefore is improved community setting type care to prevent the need for people to feel that their only option is to voluntarily admit themselves to PSU or Calvary. The focus is on improving the level of community outreach and support to prevent that from occurring.

MS DUNDAS: To prevent both involuntary and voluntary admissions?

Mr Corbell: No. What are you referring to? We don't have the document that is in front of you, Ms Dundas.

MRS DUNNE: It's the strategy—you launched it last week.

Mr Corbell: I know it is my action plan but health release a lot of documents. Because we don't have them all in front of us, we're at a bit of a disadvantage.

MR SMYTH: You didn't expect to be asked questions about your own health action plan?

MS DUNDAS: Can we just get the answers?

Mr Corbell: Mr Smyth, next time I'll bring a trolley, if you like!

MR SMYTH: Good, bring the trolley—that would be useful.

Mr Corbell: You know, smart arse answers like that don't really help.

MR SMYTH: It was actually a smart arse question, but it is a real question. Are you not prepared to discuss your own action plan?

Mr Corbell: If you're conceding that it is a smart arse question, that's fine.

THE CHAIR: Gentlemen, I think you should both withdraw the words "smart arse".

MS DUNDAS: Excuse me, Chair. I would like to hear the answer. I think this is a fun debate but I do have some questions.

Mr Corbell: I'm just trying to assist the discussion but I'm indicating that we are not able to refer to the document that Ms Dundas has in front of her at this time.

MR SMYTH: What page is it?

Mr Corbell: That is very cute, Mr Smyth!

MR SMYTH: You can have a copy of your own document. I am happy to help!

Mr Corbell: Ms Dundas, as I understand it, the measure relates to assisting people who are voluntary. It is in that context that I'm giving you the answer that I'm giving you.

Dr Sherbon: As the minister outlined, the implication of the observation that we have a high number of involuntary admissions is that our community care could be improved to prevent involuntary admissions. One would hope that no-one would have to be voluntarily admitted either, if things were perfect. But in the short term the emphasis will be on involuntarily measures.

MS DUNDAS: This is the question I was asking before. It is not necessarily about improving or changing the mix in relation to the beds being used and who is in the wards; the long-term goal is to decrease overall the amount of demand on the wards and have more community outreach care?

Mr Corbell: The long-term goal is to prevent people getting to a crisis point where they feel that the only option for them is to be voluntarily admitted to PSU or 2N. That's the objective. We want to try and avoid people getting to such an acute stage that they feel they have to, for their own safety, for their own security or for a range of other reasons, be voluntarily admitted to PSU. It is trying to prevent that escalation of acuteness.

MS DUNDAS: There's also a factor about involuntary admissions. That is where we have a high proportion nationally, as Mr Jacobs was saying, of involuntary people in our wards. How are we going to reduce that?

Mr Jacobs: As I said, early intervention and being more progressive, or more active, in engaging people before they deteriorate to the point where they end up as involuntary clients in the inpatient unit.

Dr Sherbon: One of the key initiatives we're discussing with carers and consumers at the moment is greater use of advanced treatment orders. That is an agreement between a consumer, usually a carer—but not always—and the service over early warning signs of deterioration, particularly in cases of psychosis and schizophrenia. Early deterioration is usually evident by a certain pattern of behaviour which is often well known to the carer, or at least to the community mental health team.

We're seeking to implement those advance treatment orders more pervasively through the service so we can have more of an understanding with our consumers as to when they would like us to intervene early in their illness. These are early days and there are some civil liberty and human rights issues that we've got to be very careful of. But with the consumers we've spoken to, and especially the carers, there is a lot of support for greater use of advance treatment orders. That process is starting as we speak. We will need to be very careful about how we progress because the last thing we want to do is treat someone early when perhaps they don't want to be treated. The intention is to get people earlier in their deterioration so they don't end up requiring involuntary admission.

MRS DUNNE: We've just had a discussion about the aim being to intervene early and to manage the treatment in the community so people don't feel that they're in a situation where they have to front up to a hospital and say, "Please admit me." That is a laudable aim.

Mr Corbell: That's a voluntary admission.

MRS DUNNE: Yes. What are you doing now—today—for the patients who are turning up at Calvary Hospital and places like that saying, "I've just done this"—or, "I've seriously contemplated this"—or, "I've swallowed this and I really feel that I can't cope; will you please admit me?" They are being sent away.

Mr Corbell: My understanding is that they're not usually sent away.

MRS DUNNE: I have personal experience of an ongoing case of someone who is turned away on a regular basis after self-harming activities.

Mr Corbell: I said that, in general, I wouldn't anticipate that to be happening. It may happen on occasions. The range of interventions is there. The mental health crisis team is obviously there for crisis incidents; the support and outreach programs run through the different area offices of Mental Health ACT service different elements of the city; there is a range of other outpatient type services, especially for young people; there are programs like the Cottage; there are the Outreach workers we are funding into areas like Gungahlin which previously haven't been funded; there is outreach into other parts of the city; and money spent on suicide prevention. There is a whole range of areas where we are investing to improve the service.

MRS DUNNE: Yes, but there seem to be people falling through the cracks. From my family's personal experience of dealing with someone and the wider circle of friends, there seem to be continuous failings on the part of the mental health system. It is draining on the patient, draining on the carers and draining on the wider circle supporting the family and the patient.

Mr Corbell: There's no doubt that this in an extremely difficult area of public policy and an extremely difficult area in which to focus on service improvement because of the complexity of the issues. That said, the government is investing considerably in improving mental health services. We are now at a level, I'm very pleased to note, where mental health services in the community are funded at a far higher level than has previously been the case. There has been a 42 per cent per capita expenditure increase by the government since we came to office. That is a very significant investment in mental

health services.

We have done the work in providing additional funding for community outreach services, suicide prevention activity, refurbishment of our acute care facilities and planning for new acute care facilities. I'm very open about acknowledging that there are weaknesses in our system and that we need to work to address those. That is exactly what we're focusing on.

MRS DUNNE: Minister, could you or Mr Jacobs give me an exposition? If somebody presents at a hospital saying, "I've just done this"—or, "I've come very close to doing this, that and the other, and I feel that I'm not in control", what happens to that person?

Mr Jacobs: When they front, the emergency department staff will have a look at the person and assess that they do need some sort of invention from mental health. From there the CAT team is contacted. They will organise to attend the ED and do an initial assessment and, from there, they will map out a way forward. There's a flowchart for this, which we could provide.

If they think the person is able to be maintained back in the community or something like that, they will map out how they can do that and hook them back in. If the person is assessed as needing follow up for admission, they will contact, in Calvary's case, the psychiatric registrar. He will determine if admission is necessary and, if so, liaise with the relevant psychiatrist and organise a bed. The issue will be whether the person comes in voluntarily or involuntarily. An involuntary person will go to the PSU.

MRS DUNNE: What happens when somebody who has turned up at the hospital is turned away and told, "Be on your way" after the mental health crisis team, the CAT team, assesses them—or they might have a talk to the psychiatric registrar but they're not admitted. What is the follow up? Are these people case managed? Are they supposed to be case managed?

Mr Jacobs: I don't know the individual you're talking about. As an example, we have a person who is a very high user of services. An individual service package has been put around them. They are a regular attendee at Calvary. They have two particular people who are involved in their case management while they're in the community, plus a couple of NGO agencies for after hours support and RET cover—that type of thing. There is a package around that person but they still draw on the main system from time to time. The problem is that, with the presenting condition these people have, you've virtually got to target an individual plan for each one of them to try and cover their needs.

Dr Sherbon: If people have a well-established arrangement with a GP or private psychiatrist, they may well be discharged into the care of that person.

MR SMYTH: Dr Sherbon, you said that the reason there weren't so many initiatives in this year's budget for mental health was that the bulk of the additional money had come in last year's budget, and the services had been provided then. How do you judge that against the fact that the number of raw inpatient separations went down 11 per cent in last year's budget? The target for 2002-03 was 1,500 and the target for 2003-04 is only 1,400.

The number of inpatient services has gone down at a time when you claim to be expanding your service. The number of community-based services did go up, but remained static this year. Hasn't the system stalled? There is no additional capacity to even attempt to meet the very vague objectives of the mental health strategy. If you're going to do more work in the community because you want to do less inpatient work, why hasn't the number of community based activities risen? It's static at $175,000.

Dr Sherbon: We don't expect it to rise much more this financial year because we're still, as I said, consolidating from the 2003-04 expansion. The forensic mental health care service will probably not come on line until towards the end of the financial year. The Gungahlin outreach won't add a great deal of occasions of service to the total, as it is more of an outreach service rather than a new service per se.

MR SMYTH: But you haven't allowed yourself any growth. The target for 2002-03 was $157,000 and the outcome was $169,000 and the target for 2003-04 is $175,000, which you're met. You've not allowed yourself any growth. How can you tell us that you're going to achieve the vague outcomes of the mental health strategy when you've not allowed yourself any growth?

Mr Corbell: I think it is a misplaced conception that there must be growth in occasions of service for there to be improvements in the quality of care. We know generally the number of people in the population who are encountering mental health services, or need mental health services, who are suffering from mental illness and where we need to provide assistance. What we're hearing from commentary around the table—and I think it is legitimate commentary—is that the issue is as much in making sure there is effective service delivery as in trying to increase the overall volume of occasions of service delivery.

The government is focused on improving the capacity of the service to achieve quality service delivery in a way that, as Mrs Dunne properly highlights, stops people falling through the cracks, allows them to transit from one type of care setting to another more effectively and more easily and with the appropriate level of support. That is what this measure is reflecting. It is simply wrong to say, "Well, your number of occasions of service hasn't gone up; therefore you're not doing anything." That is simply not the case. The measure is as much around quality as it is around quantity.

MR SMYTH: I'm only questioning what Dr Sherbon said, which was that the expansion was last year, which will allow us to accommodate what is going to happen this year in respect of the mental health action plan; that the expansion last year has already been met—target for 2003-04: $175,000; estimated outcome for 2003-04: $175,000. You've set yourself all these additional things to do in your action plan but there is no capacity to use it—you're already using it to the max.

Mr Corbell: No. It is a false premise that you're working on, Mr Smyth. It's about focusing on improving the quality of the care, not just the occasions of service.

MR SMYTH: That's the answer? We're just going to do it better?

Mr Corbell: I would think many people in our community want us to do it better—and

that's exactly what we're doing.

MR SMYTH: I'm sure they do, but there's no allowance for growth. You don't expect any growth in the need for mental health services this year?

Mr Corbell: We have anticipated that we will continue to service approximately the same number of people. The issue is about the quality of the care; it is not just about the volume of care.

MR SMYTH: You will get less care, but it will be better?

Mr Corbell: Perhaps you want to be fixated on targets and that we must be treating more people. Ideally, in a health situation you want to be treating fewer people, not more.

MR SMYTH: Prove to us how you're going to achieve that.

Mr Corbell: The focus is on improving the quality of the care so that over time we are able to reduce, for example as Ms Dundas has highlighted, the number of people who are presenting through voluntary admission because they're not getting to that stage. That's where the government's focus is. That is what the community is expecting of the government and that is what we are working on delivering.

MR SMYTH: How much did the mental health strategy cost to develop?

Dr Sherbon: We can get that on notice for you, but it was in excess of $100,000.

MS DUNDAS: The mental health strategy talks about the referrals between services and how you're going to benchmark those. There's also, though, a concern that the community sector, who are working with clients with these health issues, are already working at capacity; that their services are full and they cannot take on any more referrals from the department. How will you address that problem?

Mr Jacobs: Currently the way we're addressing it is that we have a person designated as the intake worker, if it is a referral to the community team. They maintain those people until they're hooked across against the case manager. The case manager would then take on their ongoing care. There is a process in place of the team working through the people who have been referred to each community mental health team, to work out how they're being managed now, and when they can be disengaged and hooked in with a GP—that type of thing. There's a process of providing the care that we need to have for them in a holding pattern, hooking them to a case manager and then discharging them out to some other person, like their GP or others, to maintain them down the track.

MRS DUNNE: Is there any follow up to ensure that, when you release somebody out into the community into the care of their GP, they front up to the GP or to their private psychiatrist?

Mr Jacobs: As part of the discharge planning, we are looking at that, particularly for those who aren't referred to the case management team, because some aren't automatically referred to case management.

Mr Corbell: To follow up on Ms Dundas's question around support for that community setting, last year's budget allocated just under half a million dollars for expanded community mental health teams. These are now just being finalised. There has been difficulty in recruiting the specialist staff needed, so we have had an underspend in that area. Nevertheless, we now have additional community mental health teams available to provide support in the community setting.

Again I have to highlight the government's emphasis on expenditure in areas such as the adult Gungahlin outreach service which was provided for in last year's budget, the aim of which is to improve service delivery to Gungahlin residents. We are working to provide greater support in the community setting. That is fundamentally where we will achieve the most in terms of prevention and lessening the strain on our acute care services—by investing in outreach and community based support. Whilst it is perhaps the less "sexy" area of the mental health debate, in my view, it is nevertheless the most important and one that I'm very pleased to say the government is investing considerable amounts of money in.

MS DUNDAS: Do the community mental health teams manage people through both government and non-government support mechanisms?

Mr Corbell: This is a government service but it is an example of how we're supporting the work of community based non-government organisations. We also have our own mechanisms in place to support people in a community setting.

MS DUNDAS: I guess the point I'm trying to get at is in respect of the work being done by the non-government sector in the community, their level of resources and their ability to work with the government with these people who are in need of care. What is being done to ensure that they are supported?

Mr Corbell: The government continues to provide funding to these organisations. Earlier today I gave you an example of funding support around a suicide prevention activity. A quarter of a million dollars went to one organisation and over $50,000 to a number of other organisations. We are continuing to support that activity, as well as provide our own community outreach services.

MS DUNDAS: You don't have the situation where there are community organisations which are refusing referrals because they can't manage the client caseload?

Mr Corbell: I'm not aware of any but that may be occurring in some instances.

Mr Jacobs: We have had occasions where some NGOs, because of the nature of the clients, aren't happy to take them on. It is then a process of negotiating with those that are willing to engage how we provide a package of support around those people. That has happened but I need to say it is not a common occurrence.

MS DUNDAS: Has that happened in the 2003-04 financial year?

Mr Jacobs: I know of at least one occasion where that has happened, yes.

Meeting adjourned from 3.35 to 3.51 pm

THE CHAIR: Minister, on output class 1.2, why did the measure for supported accommodation change? The clear message I get is that there do not seem to be enough accommodation options for people with mental illnesses and I do not think you are ever going to have too much trouble with occupancy. I want to know how many places there are and whether there are enough to meet demand.

Mr Corbell: You will see that there is a footnote to that measure which, I think, gives you the answer you're looking for.

THE CHAIR: It does; 116 is the total number of contracted supported accommodation places and then you discontinue that performance measure and replace it with a new measure which will be the occupancy rate for supported accommodation places, which you have at 95 per cent. I am saying that I do not think that there has ever been any problem with filling up these places; the problem seems to be with having enough places. It seems to me to be a little strange that you are getting rid of a performance indicator in terms of the number of available supported accommodation places and just replacing it with an occupancy rate that, logically, you are never going to have any real problems filling.

Mr Corbell: What we are trying to do is to demonstrate the utilisation of what we have available, which we think is a more meaningful measure. I'll ask Mr Jacobs to provide additional comment on that.

Mr Jacobs: Basically, when we have actually contracted for beds, we've contracted for a set number. It's currently 116. But what we want to do is to provide a more meaningful measure as to the utilisation. We think it will be above 95 per cent, but we have set 95 per cent as the minimum target that we should have in making use of those beds. I do need to say that those beds range across a number of different needs. With the last lot of beds, we actually contracted for a heavier weighting towards women's mental health services and, of the $240,000 we spent last year in buying accommodation places, roughly 75 per cent of it was spent on buying respite and supported accommodation beds and some outreach beds.

THE CHAIR: You said that that would be a minimum occupancy rate. Effectively, you are envisaging that the 116 beds will be pretty well occupied all the time.

Mr Jacobs: Currently, there is a very high utilisation, probably getting up to around 98 per cent.

THE CHAIR: I'm asking whether it would be better to keep that accounting measure of the number of available supported accommodation places as well.

Mr Corbell: If that is a matter that the committee wants to comment on in its report, it's something the government would be willing to consider.

MR SMYTH: If the accommodation is 98 per cent at this stage, why are you accepting an occupancy rate of 95 per cent as a target? Why isn't it 98 per cent and striving for 100 per cent?

Mr Corbell: I presume that it's simply a matter of trying to make an assessment of what is a reasonable overall level of utilisation. It may be sitting at 98 per cent at the moment, but is that necessarily always going to be the case. We have set a target that, by any reasonable person's assessment, is a very high one.

MR SMYTH: On the issue of accommodation, I notice that action 32 in the action plan says, "Review the role and operation of the Brian Hennessy rehabilitation centre and other rehabilitation services with a view to replacing rehabilitation services in the community." Some members of the community said to me, "Are they shutting Brian Hennessy House?" Is there any view with this to reducing the services and operations of Brian Hennessy House?

Mr Corbell: The short answer is no, but I'll ask Mr Jacobs to elaborate on what that is referring to.

Mr Jacobs: With the feasibility money that is being provided in the current budget, we're looking at child and adolescent beds and the PSU beds. When you are starting to look at beds you need to look at the overall system, and one of the things we will be doing is looking at the rehabilitation and semi-secure beds that are at Brian Hennessy just to see how the whole system works. There is no plan to reduce the number of beds on that site.

MR SMYTH: You say that you are doing it with a view to replacing rehabilitation services in the community. Is that back to where people reside as their normal place of residence or is it back with community providers rather than government providers?

Mr Jacobs: With the Brian Hennessy site, a key focus of that service is trying to provide rehabilitation for clients where we will need to put in a package of services, virtually getting them back out into the community with a lot of daily living skills training, awareness and medication training, that type of stuff. As we translate them across into the community, we will actually need to outreach with them so that we can hook them into using buses, accessing supermarkets and that sort of stuff that they will need when they're actually out in the community as a community-resident client. But it is slower stream than when someone goes through the acute system. So a part of the service will be outreaching.

MR SMYTH: I will take your answer, but that's not how action 32 reads.

MRS DUNNE: I get back, Mr Jacobs, to the issues that I was raising before afternoon tea. I took the time at afternoon tea to check and confirm something that I thought I knew. In the case that I was speaking about, which I understand is not the case that you were speaking about, the client does not go home and has not been referred to a case manager. He has asked to be referred to a case manager and has been told that there are not enough resources to allocate a case manager. He does have a GP. When are you going to have enough resources to provide for someone who is basically pleading for a case manager?

Mr Corbell: Can I just ask the committee to proceed with some caution here? I can't ask my officers to respond on individual cases.

MRS DUNNE: Okay, I'll ask a general question.

Mr Corbell: If there are particular circumstances around a particular case, please write to me and we can investigate them with the permission of the client.

MRS DUNNE: What are the circumstances in which someone who presents asking for admission and doesn't receive admission would receive case management?

Mr Jacobs: Basically, as the minister was just saying, we do have protocols for identifying how a person might be assessed as needing a service. We can provide those to you. But I don't know about the particular client that you're talking about. If it's clinically assessed that they do need a service, then we will do our utmost to get them that service.

MRS DUNNE: If clients are told by, say, the CAT team that they really think that they need case management and they ask for case management. Will they get it?

Dr Sherbon: Sorry, are you saying if the CAT team assesses that they need case management? Yes, we will try to fit them into the program.

Mr Jacobs: The process is that, if the CAT team assesses that they do need to be referred to another area of the service, that is, getting into case management, then they'll actually fill out a referral for acceptance into the case management program, whether it's the city team, Belconnen or whatever. I was talking about the intake process before. There is someone there who assesses the referrals as they come in and then either holds them and actually manages them until a case manager can be identified or, depending on how pressing the need is, actually gets them in earlier than that. But the people who are referred are supported.

MRS DUNNE: Without exception.

Mr Jacobs: If they're referred by CAT, then they'll be picked up by that team.

MRS DUNNE: I had better take that up privately with the minister.

MR SMYTH: Just on that approach, I assume that an example of the 175,000 occasions of service would be a call out by the CAT team; a carer or a family member says, "My son is having an episode. Can you come now?"

Mr Jacobs: Yes.

MR SMYTH: We receive constant complaint that often the CAT team is not available and they're told to ring the police or the police will respond. Has there been a count of how many times the CAT team has not responded and the police have been sent in lieu?

Mr Corbell: I'll ask Mr Jacobs to give some more information, but I will preface that by saying that the perception of who should respond to a particular incident may differ between the assessment of the CAT team and the person making the request, whether it's a family member—

MR SMYTH: This is when the CAT team is unavailable and the police respond in lieu. It's before anybody gets there. As a first port of call, somebody is having a crisis with a loved one. They call the CAT team. That's what they would normally do; that's what is suggested.

Mr Corbell: Yes.

MR SMYTH: And the CAT team is either already doing a job or is unavailable for other reasons and the police have responded.

Mr Corbell: Sometimes, given the nature of the request, a judgment is made by the CAT team that it's more appropriate for the police to respond. There might be different messages, depending on whom you're talking to, about that sort of situation. I understand what you're getting at and I'll ask Mr Jacobs to provide some more information.

Mr Jacobs: When a person rings the CAT triage line, they will have to assess the urgency and what the presenting problems are. In some cases, it may be referred to the police because of the riskiness of the situation, what's being described. But usually what will happen is that they will actually try to work out whether a service is needed by us or someone else and then, if it is needed by us, they'll then triage it as to its urgency and then they'll get someone out there as soon as practical. Sometimes we will have to attend with police. The other thing is that I've been at CAT when it's quiet and then not much later you've got four calls, all fairly pressing, and it does get stretched.

MR SMYTH: I don't doubt that. I've been to the set-up and seen how it works. But on how many occasions as a necessity would the police be responding because we don't have enough CAT personnel? Has any work been done on counting the number of times the police have responded?

MS MacDONALD: You didn't say that they attend as a result of the CAT personnel not being available.

Mr Corbell: Ms MacDonald is quite correct: I did not say that police have responded because CAT were unavailable. I said that a judgment—

MR SMYTH: Mr Jacobs just said that on occasions if CAT personnel are stretched the police will respond. That's what I'm asking about.

Mr Corbell: No, he said they got stretched. Obviously, a judgment is made as to whether it's appropriate for CAT to respond and there are circumstances, particularly where people have become violent, where CAT prefer the police to respond in the first instance.

MR SMYTH: But in a case like that, wouldn't it be appropriate for CAT to respond as well?

Mr Corbell: It would depend on the individual circumstances.

MR SMYTH: That's why I'm asking: on how many occasions are the police responding

instead of CAT?

Mr Corbell: I don't know whether we have any way of measuring that.

MR SMYTH: Why haven't you measured it? You've said that you have enough services here because you are going to improve the quality, but clearly we have this avenue where the police get to respond, and the police complain to us as well that they get to respond to more and more mental health instances and they don't think they're appropriately trained, even though the training for them has become better as a consequence of what has been happening. I just use that as a highlight. You have a problem in that, I think you're saying to me, you can't tell me how many times the police have responded instead of CAT.

Mr Corbell: I guess you would have to ask the police how many instances they responded in those circumstances.

MR SMYTH: I'm asking the gentleman who runs triage. Is there not a record of when the police respond?

Mr Corbell: Mr Smyth, if I can just answer the question, I'm not sure whether triage would contact the police or whether the person making the request would have to contact the police directly.

MR SMYTH: Mr Jacobs has just said that if there isn't an officer available and it's urgent, they would get the police to respond. Do you get the police to respond?

Mr Corbell: That is not what he said.

Mr Jacobs: No, I didn't quite say that. What I actually said was that with triage, if they assess that the matter is presenting in a way that the police need to be called, then they'll actually organise that. We have siege situations that happen where someone might be bailed up in a premises with a weapon. Police will actually be called. CAT will prioritise it; we will also get out there but, because of the risk issues, the police actually manage that one.

MR SMYTH: Sure, and I agree with you that if there is a siege and somebody is violent or very dangerous the police should respond. I'm trying to find out whether there is a count on how often your triage would mobilise the police instead of sending a CAT team?

Mr Corbell: We don't send police instead of a CAT team.

Mr Jacobs: If it's assessed that we need to attend, then we will attend. The only thing is that there will be a time issue on some occasions.

MR SMYTH: Okay, on the occasions where there is a time issue, how many times have the police been the respondent and how many times, instead of CAT, have triage organised the police to attend?

Mr Corbell: I think that's a matter you'd need to ask the police, because—

MR SMYTH: You don't keep that statistic?

Mr Corbell: No. If I can answer the question, because in those circumstances CAT would indicate—Mr Jacobs will correct me if I'm wrong—when they would be able to respond. It may be the case that, as a consequence of the time delay or the period of time that the person making the request deems to be unacceptable, they would then ring the police, but that's not something that we can have any control over or keep track of.

MR SMYTH: Why not?

Mr Corbell: Because they haven't rung us asking for the police, so we don't know.

MR SMYTH: But in cases where triage organises the police to attend, do you keep a record of that? That's all I'm asking for.

Mr Corbell: You are confusing the issue because—

MR SMYTH: No, I'm not confused at all, Mr Corbell.

Mr Corbell: Yes, you are, because there are two issues here. The first issue is, as Mr Jacobs has indicated, that if there is a particular circumstance where CAT believe they need to respond urgently but it is also dangerous because of violent behaviour and so on, they will also get the police to respond, and we can tell you the number of instances where that has occurred.

MR SMYTH: That's all I'm asking for.

Mr Corbell: No, it's not.

MR SMYTH: I think I know what I'm asking for, Mr Corbell.

Mr Corbell: My understanding of your question is: where have the police responded instead of CAT?

MR SMYTH: I'd like that as well.

Mr Corbell: The answer to that is that we don't get the police to respond instead of CAT. CAT advise the person when they can respond, if it's triage that's needing a response, but it may be the case that in some circumstances where people do not feel that the CAT response time is satisfactory, that they then, separately from their phone call to CAT, call the police themselves. We don't have a record of that.

MR SMYTH: I'd like both figures, if I can.

Mr Corbell: We can't provide you with that figure, Mr Smyth.

MR SMYTH: To clarify something, Mr Jacobs: if a CAT member was not available for response and the triage person thought the delay would be too long, would you on occasions get the police to respond?

MS MacDONALD: That has already been answered.

THE CHAIR: No, I think that's a bit different.

Mr Corbell: We've already dealt with that.

MRS DUNNE: No, it's different.

Mr Corbell: I'm sorry, Mr Smyth, I think we've already answered that question.

MR SMYTH: It can't be hard to answer it a second time.

THE CHAIR: I think it's a bit different. Mr Jacobs looks as if he's about to give an answer.

Mr Corbell: I have indicated to you, Mr Smyth, what the answer is.

MR SMYTH: No, you've indicated what you want to answer. I have a different question, Mr Corbell. Mr Jacobs—

Mr Corbell: Mr Smyth, I've answered your question.

MR SMYTH: I'm not asking you, Mr Corbell; I'm asking Mr Jacobs.

Mr Corbell: It's not your prerogative. It's my prerogative to choose to answer the question, Mr Smyth, and I'm answering the question.

THE CHAIR: Just repeat the question, Mr Smyth.

MR SMYTH: Through you, Mr Chair, can Mr Jacobs answer this question: if a CAT member is not available for response because the time frame is too long, have the triage ever got the police to respond?

THE CHAIR: Thank you. That is a different question.

Mr Corbell: No, it is not a different question and I have answered that question.

THE CHAIR: If you think you have, answer it again.

Mr Corbell: And Mr Jacobs has answered the question.

THE CHAIR: Just answer it again, then.

Mr Corbell: No, I'm sorry, I've answered the question.

THE CHAIR: Can't you answer it again?

MRS DUNNE: I don't remember the answer to the question, Minister. Could you answer it again.

Mr Corbell: Certainly.

THE CHAIR: Thank you.

Mr Corbell: In circumstances where the police are deemed to be required by CAT, the police are asked by CAT to attend an incident. In circumstances where CAT deem that they themselves should not respond immediately because of other pressures or because of other priorities, then there may be a period of time before they respond. In those circumstances, it's possible that individual consumers or their family or kin will contact the police separately. We do not, in those circumstances, have any way of tracking those incidents, because it's a separate phone call to the police.

THE CHAIR: But you do in the earlier incidents.

Mr Corbell: But we do in relation to the earlier one.

MRS DUNNE: And you would never on a stressed day call the police and say, "Can you respond to this?"

Mr Corbell: I think I've just answered the question.

MR SMYTH: Will you provide that figure, the figure that you can provide, to the committee?

Mr Corbell: Yes, absolutely.

MR SMYTH: Thank you.

MS DUNDAS: In budget paper 4 at page 157 there is a timeliness measure in relation to the output and implementation of quality standard reports from community service organisations being provided on time in accordance with service agreements. The target of 100 per cent was not met. Do you have an explanation for that?

Mr Jacobs: Basically, we're calling on the organisations to provide that. Some of them are on a six-month cycle, so that may be picked up at the end of the financial year reporting and improve. Next year we're trying to target 100 per cent. But some have been slow.

MS DUNDAS: Are the community organisations slow in their responses in relation to quality standard surveys?

Mr Jacobs: It's improving, but some of them have been tardy. The figure has improved on what it previously has been and we are hoping that in the second half it will be very close to 100 per cent.

THE CHAIR: There being no further questions, all the public servants attending specifically for the mental health services can go.

Mr Corbell: Mr Chairman, I have some additional information that the committee

requested. Mr Smyth asked about the cost of the mental health strategy. The total cost was $99,300.

THE CHAIR: Turning to output class 1.3, which relates to community health services, respite care is static at 4,054 bed nights. Why? Is demand static?

Mr Corbell: I'll ask Mr Thompson to answer the question.

Mr Thompson: Ian Thompson, Executive Director, Community Policy. That figure refers specifically to the Burrangiri service, which is a static service. Respite care provision for aged care is, on the whole, a Commonwealth responsibility and the ACT government just provides the Burrangiri service.

MR SMYTH: Why has it remained static for three years?

Mr Corbell: Because it's a fixed facility with a certain number of beds.

MR SMYTH: And you don't perceive that there is a need for additional respite care.

Mr Corbell: Clearly, there is a need for additional respite care but, as Mr Thompson has indicated, it's accepted between the territory and the Commonwealth that it is the Commonwealth's responsibility primarily to fund respite care services.

MRS DUNNE: Why are we funding these respite beds?

Mr Corbell: The Burrangiri facility is a unique facility in national terms. I think Burrangiri actually existed before self-government; so it's an historical legacy, if you like, of a service provided by the territory administration that—if I'm correct, and I'll check for you—was established prior to self-government.

MRS DUNNE: So that comes out of the health budget, not the Commonwealth aged care budget.

Mr Corbell: Yes, the ACT government pays for Burrangiri.

MRS DUNNE: And there's no assistance from the Commonwealth.

Mr Corbell: I'm quite happy for you to make the argument to your counterparts federally, Mrs Dunne, but no.

MRS DUNNE: I'm probably on better speaking terms than you are.

Mr Corbell: I doubt you'd have any better luck than I would, though.

MR SMYTH: The same can be said for aged care assessments. For three years the number has been 3,100. Is there any reason why that number is also static?

Mr Thompson: The aged care assessment program is a Commonwealth-funded program that we provide on behalf of the Commonwealth. The Commonwealth funding, while it is indexed, has not been indexed to allow for increased capacity. Therefore, we provide

what we can with the resourcing that the Commonwealth makes available to us.

Dr Sherbon: The Commonwealth did foreshadow increases in ACAT funding in their budget two weeks ago and we're anticipating that the territory may benefit, but we have not received confirmation. Until we do, we can't change that target.

MS DUNDAS: Does the ACT government have a women's health strategy?

Mr Corbell: Not specifically, no.

MS DUNDAS: Is the ACT government planning on developing a women's health strategy?

Mr Corbell: It's not an item that I have had brought to my attention, but I certainly would be open to considering the need for such a strategy. I don't know whether Dr Sherbon can help. The government provides a range of services specifically for women and they're listed in this output class. Our focus is on the delivery of a range of those services.

MS DUNDAS: In the services listed here, there isn't actually an increase in the number of breast screening clients, despite the initiative for enhanced support for women diagnosed with breast cancer and the breast cancer nurse positions. Why isn't the number of breast screening clients increasing?

MRS DUNNE: It has actually gone down from 2002-03.

Dr Sherbon: I can answer that question, if you so desire. The budget initiative to which you referred, Ms Dundas, is for a breast care nurse to assist women through the often labyrinthine pathways of care for breast cancer and other rare breast disorders. This line, as I think you understand, measures the output of the breast screening program. We have struggled to meet targets in the breast screening program—I think that's well known—because we have had trouble recruiting radiologists to read our breast screen X-rays after they're performed. We are currently training up a breast care physician whose job it will be to perform the procedures that are required on screening the clients who require further investigation of any anomalies discovered during the screening and we're hopeful that that position will allow our radiologists to concentrate on reading screening X-rays.

At the moment, the radiologists do both the screening and the procedures. The procedures are quite time consuming. We are hopeful that, with the procedures being dedicated to one person, the radiologists can get on with the business of moving through the large number of screens to be evaluated and our productivity will increase. But at this point in time, I think it is fair to say that we, like all other regional breast screening services around Australia, are having trouble accessing radiologists to support our service.

MS DUNDAS: When is this new position meant to come on line?

Dr Sherbon: I understand the individual has been recruited but is due to be trained in breast procedures. It's not a common discipline.

MS DUNDAS: Would you like to provide information about when this person is likely to come on line?

Mr Corbell: I'll ask Ms Yen if she can provide further information for you.

Ms Yen: The breast physician has started with us and we're going to a training program now. We're just putting together the most appropriate training package for them not only to be undertaking a number of the procedures that happen as part of the assessment, but also to be trained to be reading films so that it actually increases our capacity in the service quite substantially. It's got the support of all of the radiologists who are working in the service and it's seen, I think, as a very positive move to take us further forward.

MS DUNDAS: When will that training be complete and when will it actually begin?

Ms Yen: She's working now.

MS DUNDAS: Is she working and training at the same time?

Ms Yen: She's working in some of the procedural elements and we're looking at the training for reading screens, and that will happen over the next 12 months.

MS DUNDAS: Can you provide some information on why the level of medical and social services in terms of client contact is also remaining static under the women's health services?

Ms Yen: That was a specifically funded initiative from a couple of years ago. It was a target set then and it remained at that level because that was the level of funding that was allocated for that. It was Women's Words, a three-year program.

MS DUNDAS: Is that contract set to run out next year?

Ms Yen: I'm not sure. I will have to take that on notice.

MS DUNDAS: The question is: when will the contract expire for Women's Words and has there been any determination about the future of that service?

Ms Yen: I'll take that on notice.

MR SMYTH: Given that you have reached your target of 6,800 for the last couple of years, are you turning people away from that service?

Ms Yen: I'm sorry, I misled you slightly there. That includes the Women's Words service, but it also includes the other women's health service that, rather like ACAT and respite, had originally been part of the Commonwealth women's health program. It's a service funded through community health to provide medical and counselling services to women. I'm sorry, Mr Smyth, could you repeat your question?

MR SMYTH: Your target has been 6,800 and you have certainly met it this year. You didn't quite make it in 2002-03; you only reached 6,200. Have you turned people away this year, having achieved your target?

Ms Yen: Not that I'm aware of, no.

MS DUNDAS: In terms of the participation rate for women aged 50 to 69, which is a new measure in the budget, is that saying that 70 per cent of the entire population of women aged 50 to 69 are accessing women's health services?

Ms Yen: That's the national breast screening target. It's the national target for women in the target age group.

MS DUNDAS: What are you doing to ensure that 70 per cent of women aged 50 to 69 are having their breasts regularly screened?

Dr Sherbon: We perform a number of promotions in the breast screening service but, as we've outlined in a previous answer, we're increasing our throughput with a change in the way we provide radiological support to the service. I think it's fair to say that we are struggling to meet that 70 per cent target. We are the best performing jurisdiction in Australia, but we are still struggling to meet that national target, as are all other jurisdictions, on account of the radiologist shortage.

MS DUNDAS: So it's not that the promotion and the health message are not getting through to women; it's the fact that women are trying to access these services but can't because of demand.

Dr Sherbon: I think that's a fair summary. But, as I said, the ACT is the best performing jurisdiction in Australia on breast screening. It's a national target that has been set. It's quite ambitious and should be worked towards, but it is fair to say that with the shortage of radiologists we are not doing as many women as we would like.

MR SMYTH: If I remember rightly, when we asked this question in relation to the 2002-03 budget it was 59 per cent. What was the outcome from the 2003-04 budget and what is the expected outcome?

Dr Sherbon: The 2003-04 year? I don't think we've got that figure at this point in time because we are waiting for the national figures to come through from AOHW and other sources. If we've got it, I'll give it on notice. I doubt we would have it yet.

MS DUNDAS: Going to medical and social services, can you provide us with a breakdown of the 6,800 client contacts? Which of those are through Women's Words and which of those are through the other women's health service? I'm sure that women's health services provide more than just breast screening as a health measure for women. Has there been any discussion about other outputs that could be measured here?

Mr Corbell: Sorry, could you elaborate on that a bit, Ms Dundas?

MS DUNDAS: I am looking under women's health services and seeing medical and social services, which is about the number of contacts through Women's Words and the women's health service. There are three targets that relate specifically to breast screening. I am sure that the women's health services are more than breast screening for women and that other health services are provided. Has there been any discussion about

expanding the number of outputs that are here so that we can see how women are responding to other health initiatives?

Mr Corbell: I think the reality is that you could expand the number of measures in any range of the output classes; the number of measures you could put in place is almost infinite. A judgment has to be made as to what are the most important and meaningful figures that can be put into the budget papers and that is what has occurred. If the committee felt there were other measures that should be reported on, I would be quite happy to consider them.

MR HARGREAVES: We might consider it in the deliberative stage and suggest a few.

MS DUNDAS: If there were a women's health strategy, there would be some benchmarks in there that we could compare with.

Ms Yen: This is a very small part of the whole women's health service that is available in the ACT and it's based on the old Commonwealth program for women's health. If the committee is happy for us to give a breakdown of the services, what sorts of things are provided by that small service, that may assist in suggesting some further targets.

MS DUNDAS: Thank you.

MR HARGREAVES: With some reference also to the outreach services.

Ms Yen: That doesn't happen in that program.

MR HARGREAVES: If you would, that would be great. When it was first established in Gilmore, there was the view that it would reach out into some of the really delicate suburbs. I won't name them for this hearing, but some of them are more in need of a visit, if you like, from that service than others. I am getting quizzical looks from the gallery, so I shall expand a bit on that. There were some suburbs within the Tuggeranong area that were suffering a bit from domestic violence, a lack of sex education, immunisation, nutrition and a range of other things that we know concern women and there was an holistic attack on the problem. I have been concerned for some time about whether the location of the service in Civic means that it is not reaching those people in the outer areas, such as the outer parts of Spence, Richardson and Melba, to name just a few. There is a whole stack of them in the outer areas and I was just wondering how you actually go into those areas of targeted need. If you could address that sort of thing, I would be grateful.

Ms Yen: We can provide the locations.

MR SMYTH: As to the alcohol and drugs services, the measure has changed from the number of supervised drug and alcohol and other drug withdrawal clients to the number of bed days occupied. Is there a reason for moving to that other model?

Mr Corbell: Again, there is a note there, Mr Smyth, which I think provides you with the answer you're looking for there.

MR SMYTH: I realise there is a note, but I would like to have a fuller understanding of

why.

Dr Sherbon: As explained by the minister, that does reflect more accurately the service available. As to the number of clients, some clients stay a day or two and some stay three months. We were hoping that we would meet the community's expectations and the Assembly's expectations by demonstrating how many bed days are available so that the capacity of the unit is reflected.

MR SMYTH: Does that represent an increase in the coming year or is it just a static figure as well?

Dr Sherbon: The same.

MR SMYTH: The target was 1,130 in 2002-03 and the outcome was 1,137. The target in 2003-04 was 1,130 and you are saying that it's going to be 1,130. Why has it remained static over three years? Is there a declining need against population or it is just static? Are you turning people away?

Dr Sherbon: I'll ask Ms Yen to talk about whether we turn people away. Is there a declining need? The need for opiate detox is variable. We recently went through a significant heroin drought which reduced opiate use across the nation. One could never argue that there is a reduced need across the gamut of substance and alcohol use, I agree, but this program is continuing and there has been no significant increase in the coming financial year, but in our estimation it's meeting needs adequately in the community.

MR SMYTH: If I can just follow up on something before Ms Yen speaks: you have said that there is a drought. We all know that there is a drought.

Dr Sherbon: There was. I think it has finished.

MR SMYTH: Yes, I think it has finished as well. But in 2003-04 perhaps you had a decreased need.

Dr Sherbon: For opiate detox.

MR SMYTH: But you have still run to capacity. If there is an increase in the use of opiate and therefore an increased need of opiate detox and you have a static figure, will you be turning people away this coming year?

Dr Sherbon: Opiate detox is probably only a fairly small portion of the detoxification program. Ms Yen probably has a more accurate figure. Alcohol would be by far the largest component that requires supervised residential detox.

THE CHAIR: How have you arrived at that 6,166? That is basically about 5½ bed days per client. Is that just a means of averaging all your clients, as some will stay for three months and some will stay for one night

Ms Yen: There would be very few people who would stay for three months because we try to run quite a short program, but 1,130 doesn't represent the maximum capacity. That represents the number of clients who are actually being seen through the service. We are

looking at trying to give a better accountability for the utilisation rate of those services, the actual number of clients through, because the methods available to deal with supervised detoxification are changing quite a lot with the introduction of different approaches and the introduction of different types of withdrawal services. We believe that it was probably a better measure of the utilisation of the service to go to the percentage of occupied bed days and the number of occupied bed days out of the total bed days, so that we are actually working to a much greater maximum capacity of use of the service, recognising that people may have different lengths of stay.

MR SMYTH: Can you provide a breakdown of the various percentages of drug type detox required?

Ms Yen: We can do that.

Dr Sherbon: It would be a fairly significant exercise as there are many clients with poly-type use, but we can try to provide a reasonable picture for you. As to the other question Mr Smyth asked about whether we were turning people away, we aren't.

Ms Yen: We may not see people within three hours—for example, somebody may arrive on the doorstep and say that they want to be done now and we would plan that admission—but people are not being turned away from detox.

MS DUNDAS: Going back to the point that Mr Smyth made and you made, Mr Chair, does the 1,130 equal 6,166?

Ms Yen: Not necessarily.

Dr Sherbon: There has been no decrease in service, I can assure you of that.

MR SMYTH: If we are not turning anyone away, what percentage use is the service being provided at? Is it 100 per cent full? You said there was excess capacity.

Ms Yen: There has been at various times excess capacity. We are aiming at an 85 per cent capacity, which is about the safe level.

Dr Sherbon: Across the course of the year. There will be times when it's full. In that case, if somebody turns up at the front door the staff will make adjustments, which is challenging at the time, but across the course of the year we aim for an 85 per cent average occupancy.

MS DUNDAS: The ACT alcohol, tobacco and other drugs strategy, which I think is still in a draft form, talks about the need for a supervised withdrawal service for women with children, as well as the establishment of a benzodiazepine withdrawal and reduction program that specifically targets women. I know that the government has not put out its final response to this strategy, but has there been any movement on these particular initiatives? Will they be funded? They're not funded through this budget. Do you think that there is a need to provide more detox services specifically for women?

Mr Corbell: The documents that have been produced to date identify a range of additional needs and those are items the government will consider; but, as you say, they

haven't been identified for funding in the current budget.

MS DUNDAS: I know that there is the initiative concerning the bush healing centre.

Mr Corbell: Yes.

MS DUNDAS: It was also mentioned in the ACT alcohol, tobacco and other drugs strategy to support Aboriginal and Torres Strait Islander services. So some of the initiatives from that strategy are being picked up. I'm not saying that the bush healing centre should not have been picked up, but there has been a lot of demand over a number of years for a women and children only detox service. Why has that not been prioritised?

Mr Corbell: The bush healing centre was identified by the community task force itself as a higher priority and the government has worked to address the highest priorities as recommended by the task force group itself. The announcement I made late last year around funding for a range of immediate priorities, with $250,000 being set aside in last year's budget, along with the initiatives outlined in this year's budget, was in response to those immediate and most highest priorities as determined by the task force itself.

MS DUNDAS: When can we expect to see a service that is working to support women who have children as they go through detox?

Mr Corbell: The government will continue to implement the strategy and the government will continue to put in place new initiatives that respond to the other items identified in the strategy. Obviously, they're all worthy, Ms Dundas; the issue is about priority. Dr Sherbon makes the pertinent point to me that the provision of the accommodation services at Karralika, which the Assembly has delayed, would have responded more promptly to the issues you raised around the provision of services in particular for women with accompanying children.

MS DUNDAS: But Karralika is a mixed sex facility; it deals with both men and women.

Mr Corbell: It is, but the expansion was particularly targeted at adults with children. Without a doubt, the majority of those clients would have been women.

MS DUNDAS: But women are concerned about entering a facility that has adult men in it because they have had problems and don't necessarily want their children to experience the same problems. I am not saying that that actually does happen, but this is a fear that women who are trying to detox do hold. So there is that need to respond to that concern and have a women only facility.

Mr Corbell: Clearly, these are management issues which Karralika will address when, hopefully, they're finally able to get the facility up and running. But the point I was making was that Karralika is a key facility in providing residential rehab for adults with children and, obviously, a strong part of the sector that will be assisted by that will be women.

MS DUNDAS: Turning to Karralika, the budget papers now have it as work in progress, with a redevelopment date to be advised.

Mr Corbell: Yes.

MS DUNDAS: Would you like to provide us with some more information about the future of the redevelopment of Karralika?

Mr Corbell: Karralika could have been well commenced by now if the Assembly had chosen a different course of action. Nevertheless, Karralika has been delayed because of fairly petty politicking on the part of some members of the Assembly. Karralika has now had to go right back to the beginning. We have obviously withdrawn the development application. The process will now be that I will shortly announce a new consultative forum which will include representatives of the community, of the relevant sector and of other relevant health professionals to develop the proposal again for Karralika prior to a formal development application being made and notified, as the Assembly has insisted should be the case.

MS DUNDAS: When will we have that announcement? When will that process actually begin?

Mr Corbell: I anticipate that I will do that quite shortly, probably within the next month.

MS DUNDAS: We await with interest the announcement on how the new development will progress, Minister.

Mr Corbell: So do I, Ms Dundas. It is a very important facility and I can't help expressing my disappointment that it has been delayed in the manner chosen.

THE CHAIR: However, the Assembly has voted on it and I don't think you need to reflect on that.

Mr Corbell: Indeed, and I'm not choosing to reflect on the vote of the Assembly. I am simply expressing my disappointment with the decision.

MS DUNDAS: As to output 1.3, will we be able to get a breakdown on notice in terms of how much of this budget is for each of those different areas? How much of the resources will go to aged health care, how much to alcohol and drugs, how much to dental, how much to women's health services and how much will be used in overheads and other things? I'm happy for that to be taken on notice. Is it possible to get that level of breakdown?

Mr Corbell: We are happy to provide that information for you, Ms Dundas.

MR SMYTH: As to pharmacotherapy, how many registered clients do we have, how many of them are private and how many of them are public? Can you give us some more information on how that program works?

Mr Corbell: Sure. I don't have the figures immediately with me. I know, Mr Smyth, that you asked me a question on this in the Assembly and I was able to indicate to you that we were increasing the total number of pharmacotherapy subsidised places. The total number of subsidised places in December last year was 673. As of March this year the total number of subsidised places was 729.

MR SMYTH: An extra 56 places.

Mr Corbell: That's correct.

MR SMYTH: And the extra 100 places that you have talked about?

Mr Corbell: We will be moving, as I understand it, to achieve the full 100 by the end of this financial year. Yes, 44 additional places will be allocated by the end of this financial year.

MR SMYTH: So the 100 places will consist of the 56 and another 44, not 56 and 100 extra places.

Mr Corbell: No, it was for 100 extra places in total and we are just over halfway to that at the moment, with 44 to go.

MR SMYTH: How will the 44 be allocated?

Mr Corbell: I'm not sure how that process works. I'm not sure whether someone can assist on that.

Ms Yen: The funded places are divided between four tiers: public prescribing and public dispensing through to GP prescribing and community pharmacy dispensing. The additional places allow for us to provide subsidies to people who are getting community pharmacy dispensing.

MR SMYTH: The target is 800. Where will the other 30 places come from?

Mr Corbell: Those are people who are paying for the service.

MR SMYTH: So it's a mixture of public and private, more or less.

Mr Corbell: Yes.

Ms Yen: Fully publicly funded, subsidised, and fully personally funded.

MR SMYTH: How many fully personally funded registered clients are there?

Ms Yen: We don't keep a record of that one. We don't register that because they're not part of our scheme.

MR SMYTH: If the publicly subsidised ones come to 770 and the other 30 are private—

Ms Yen: It's the number of available places that we have, not the target of people that we want to take methadone, so we can subsidise to that number.

MR SMYTH: You have a capacity for 800.

Ms Yen: That's right.

MR SMYTH: You will be providing 770 and you have a target of 800. Do you know how many people are privately paying for these sorts of services?

Ms Yen: I don't have that information.

Mr Corbell: The advice I have is that there are 37 clients who are paying $35 per week to ACT Health.

Dr Sherbon: As at December 2003.

MR SMYTH: At $35 a week, the price is subsidised, and there are 37 clients at $35 a week.

Mr Corbell: No, that's not a subsidised price.

Dr Sherbon: The subsidy brings the client cost down to $15 per week in most of the client groups.

MR SMYTH: At $35 a week, you are paying the full price.

Dr Sherbon: Yes.

MR SMYTH: Is the methadone program now largely being provided through pharmacies across the ACT?

Dr Sherbon: A significant proportion of those places. Recent data to me suggested that well over 300 were provided in the community setting.

MR SMYTH: It has been put to me, Minister, that if you go ahead with your reforms to the current situation concerning pharmacies and allow friendly societies to operate in the ACT, many of the pharmacies will simply cease to deliver the methadone program on behalf of the government, simply because they believe that friendly societies have a number of unfair competitive advantages. Are you willing to put the methadone program at risk to allow friendly societies into the ACT?

Mr Corbell: I'm not going to be blackmailed in the way that the pharmacy guild seems to be insinuating that that's the way they will go. A couple of issues need to be put on the record. The first is that there have been two detailed national investigations into the allegation that friendly societies have some unfair competitive basis in terms of taxation treatment and so on. That has been soundly refuted in two national studies.

MR SMYTH: What is the name of the studies?

Mr Corbell: I can't recall them immediately, but they were commissioned by COAG and by the National Competition Council, I understand.

MR SMYTH: Could you get the names on notice?

Mr Corbell: Absolutely, I'm happy to provide the names.

THE CHAIR: One thing I would like you to refute, if you can, Mr Corbell, is the claim by the pharmacies that the friendly societies had a profit last year of $323 million or thereabouts and only paid tax in the vicinity of half a million dollars in relation to that figure. It seems a very low tax rate.

Mr Corbell: The friendly societies are legitimate not-for-profit enterprises.

THE CHAIR: So that figure would be correct, then. If you could check that out, too.

Mr Corbell: I'm happy to provide some information on that, but if I can just give some context to Mr Smyth's question, because it's a complex issue. There have been two national studies that have identified that there is no unfair basis on which friendly societies operate. That has been endorsed by all governments, both at a federal and a state and territory level, through the Council of Australian Governments.

It is a requirement of national competition policy that jurisdictions that do not permit the operation of friendly societies do allow them to occur. New South Wales, for example, now permits friendly societies to operate and has introduced legislation to permit friendly societies to operate in that jurisdiction. Previously they had not been permitted in that jurisdiction. Friendly societies have been established for some time in Tasmania, Victoria and South Australia. Friendly societies provide cheaper pharmaceutical products and services as a result of a person being a member of a society.

In relation to the methadone program, it's worth making the point, of course, that the ACT government facilitates the methadone program and pharmacists do the dispensing. It is not at a cost to the pharmacist. Indeed, the pharmacist in some respects will benefit from the operation of the methadone program because associated trade that comes from clients on the methadone program will ultimately end up in their pharmacy. So, in many respects, I would argue there is a benefit to the pharmacy and to the pharmacist of having the methadone program because it brings other trade through the door, that is, someone on the methadone program is likely to get any other scripts they have filled at the same pharmacist. I reject absolutely the notion that it is in some way appropriate for pharmacists to withdraw themselves from the methadone program because it's at some cost to them. In fact, I would argue that it is of some benefit to them to have that program.

MR SMYTH: How could it be of no cost to the pharmacist to deliver a service?

Mr Corbell: We pay the pharmacist to deliver the program, so it's not at a cost to them to deliver the program.

MR SMYTH: How much does it save the ACT government by delivering it through a pharmacy?

Mr Corbell: I don't know what the comparison would be, but obviously it's of greater ease and convenience to the consumer to be able to access—

MR SMYTH: No, the question was: how much does it save the ACT government by delivering it through a pharmacy?

Mr Corbell: I don't know what it saves the ACT government. I'm happy to make some assessment and provide that to you. The other point I would like to make about friendly societies is that the average discount across all friendly societies in Australia on goods and services is 18 per cent, so the consumer is getting a discounted product—discounted medicines, discounted other services and other goods.

Income is generated from non-members. If a person who goes in the door of a friendly society is not a member of the friendly society and that person buys a product, the income generated from that transaction still needs to be paid by the friendly society at the company tax rate of 30 per cent. So I think the Assembly will need to look very carefully at the allegations being made by the pharmacy guild. I believe they are simply false and, I would argue, misleading and they do not, I think, properly represent what the government is trying to do.

MR SMYTH: If friendly societies set up pharmacies in the ACT, will they offer the full range of services that are currently provided by the pharmacies here?

Mr Corbell: I'm sorry, I missed the first part of your question.

MR SMYTH: If friendly societies eventually set up in the ACT as pharmacies, will they provide the full range of services? I understand that in Victoria they don't. For instance, they don't deliver the methadone program in Victoria.

Mr Corbell: That would be a judgment for the individual pharmacy. No pharmacy is compelled to provide the methadone program. I have some further advice for you, Mr Smyth. I'm advised that the COAG study was undertaken by the Allen Consulting Group. The other one is the name of the author of the report. I can't recall it, but we'll get that for you.

MR SMYTH: That's fine. When we had the Treasurer before us and were talking about national competition policy, he said that the government is determined to go ahead with it because there are national competition payments at stake. My understanding is that the treasurers of all other jurisdictions have written to the Prime Minister asking that pharmacy be taken off the national competition agenda and that, indeed, the Prime Minister has already indicated that he is very much in favour of that. Why hasn't this jurisdiction written to the Prime Minister asking that pharmacy be removed from competition policy, given the Treasurer said we should ask you?

Mr Corbell: I'm quite happy to answer the question. I think you need to be clear on what other jurisdictions are doing. Other jurisdictions are requesting that the Commonwealth not proceed to penalise those jurisdictions that do not open up the pharmacy sector in terms of, say, pharmacies in supermarkets; but, as I've indicated already, not all jurisdictions have a concern with the friendly society policy because a number of jurisdictions already permit the operation of friendly societies and other jurisdictions have already legislated to permit the operation of friendly societies.

The friendly societies issue is not the key bone of contention between states, territories and the Commonwealth. The key issue is the issue of further deregulation of the industry to permit the operation of pharmacies in a broader range of settings, such as

supermarkets, and it is particularly on that point that Premier Carr, I understand, has raised the issue with the Prime Minister. Of course, in the ACT, we do not need to address that issue because our legislation, effectively, already permits the operation of pharmacies in a supermarket, as long as it is owned and operated by a pharmacist.

MR SMYTH: When the legislation to allow friendly societies to operate as pharmacies in the ACT went through cabinet was a business impact statement done to determine what impact allowing friendly societies into the ACT would have on existing pharmacies?

Mr Corbell: Normally in this sort of circumstance a regulatory impact statement would be required if the ACT were doing it off its own bat. Because it's done as a result of our agreement to national competition principles, the studies undertaken by the NCC and COAG are deemed to be sufficient and therefore we're not required to do our own regulatory impact statement.

MR SMYTH: Weren't you curious as to what the impact might be on local businesses?

Mr Corbell: Obviously, that is a matter that is in my mind, as it is, I'm sure, in the mind of many other members of the Assembly, but the standard practice of governments both past and present has been that, where a comprehensive assessment has been done on a national basis in relation to other competition reforms through NCC or COAG, that is deemed to be sufficient evidence to proceed with the reform and individual states and territories are not required to do their own assessment.

Can I provide some further information about friendly societies? I appreciate that this is not directly related to community health, but Mr Smyth has raised the issue. There are approximately half a million Australians who are members of friendly societies. In 2001-02, there were seven million prescriptions dispensed by friendly societies. They are not-for-profit mutual organisations regulated under the Commonwealth's Corporations Act and they are established for the benefit of members and are run by an elected community board who are themselves drawn from their enrolled membership. Membership fees range between $8 and $35 for a single membership, slightly more for families.

I think that many Canberrans would be interested in knowing that they have the potential to get a further discount on the costs of their pharmaceuticals and other services and, if the average discount of 18 per cent translates into the ACT, that's a positive thing for consumers in the ACT, a positive thing for working families in the ACT, and it's not going to be to the detriment of existing community pharmacy operations.

MR SMYTH: If it's not going to be to the detriment of existing pharmacies, why are they so concerned?

Mr Corbell: I think you would have to ask them that.

MR SMYTH: You made the statement.

Mr Corbell: I said it's not to their detriment.

MR SMYTH: But you've done no business impact statement. How do you know that?

Mr Corbell: There have been detailed studies at a national level that have indicated that friendly societies do not have an unfair advantage. It is the pharmacy guild's argument that they have an unfair advantage. Two national studies have indicated that they do not have an unfair trading advantage. On that basis, why shouldn't we permit them to operate in the market? They compete fairly, they provide discounted goods to their members and anyone can become a member. I think that's a good thing for working families. I think that it is a good thing for low income Canberrans that they can potentially join a friendly society and get discount goods and services. I'm interested in Canberrans getting access to medicines and other goods at as cheap as possible a price.

THE CHAIR: Where would you envisage them working out of, Minister?

Mr Corbell: That would be a matter for the friendly societies. They can choose to establish in Canberra. Obviously, they would still need to meet federal government requirements in terms of where they can locate and whether they can provide medicines under the PBS, but the federal government has a process for working through that.

THE CHAIR: I have a question on dental services. The units of service for adults remain the same and there is going to be an increase in the one for children to 18,300. Why? That may well be a good measure. You have a target of 95 per cent for assessed emergency dental clients seen within 24 hours. That is a new target. Why is it there now and why wasn't it there before?

Mr Corbell: I'm not sure why it wasn't there before, but we do want to indicate our capacity to respond in an immediate way for emergency cases, so it's appropriate to have that measure in there. I'm sorry, I missed the first part of your question, Mr Stefaniak.

THE CHAIR: The number of units of service for adults is static, but for children it rises by about 1,000. Why is that so?

Dr Sherbon: There was a large increase in adult dental treatments this financial year. There was a significant increase in the territory budget in 2003-04 for dental services. I'm happy to report that there has been a substantial reduction in the waiting time for adults. It is down from well over two years to a year and we hope that, as the months go by, it will continue to decrease. It is one of those beautiful sets of numbers that one waits for every now and again. Ms Yen will talk about the child services in a minute, but for adult services the large increase this year we will be sustaining into next year.

Ms Yen: The reason that we changed the target for children was to bring the way that we measure services for children into line with the way that we measure services for adults, so that it represents a different counting mechanism.

THE CHAIR: It doesn't necessarily mean more kids.

Ms Yen: It doesn't necessarily mean more children, although we are hoping that, with some efficiencies we're running at the moment with children services, we will be able to get more capacity.

MS DUNDAS: I will put my question on notice.

MR SMYTH: I have a final question of Ms Yen. Why do some clients pay $35? How is it determined that some clients should pay $35 a week for treatment and others should pay nothing?

Ms Yen: Are we back onto methadone programs?

MR SMYTH: Yes.

Ms Yen: Does somebody else want to pick that up?

Mr Corbell: What was the question, Mr Smyth?

MR SMYTH: You have 37 clients who pay $35 a week and you have 726 clients who don't pay. Why do some pay and some not pay?

Dr Sherbon: Some like not to be associated with government services. They like to have their own private arrangement.

MR SMYTH: But we don't know about the private ones.

Dr Sherbon: Some of them do not like to receive a subsidy.

MR SMYTH: Some choose to pay.

Dr Sherbon: If you ask 729 people whether they want government services, there will be 10 per cent who don't.

THE CHAIR: We will deal next with output class 1.4.

Mr Corbell: The committee asked questions about a number of measures. I have been advised that when the Standing Committee on Health reviewed the annual report it made a number of recommendations about focusing on some better measures of service delivery. A number of those measures have been changed in response to that request.

THE CHAIR: Thank you, Mr Corbell. Why has the number of hours of education training services dropped so dramatically—from a target of $840 million this year down to an estimated outcome of $380 million and to $360 million for 2004-05? The footnote claims that there is lower demand because of a shortage of health professionals, but surely that is not worth 50 per cent?

MR SMYTH: Surely there is less provision of services rather than lower demand. I do not know of any service in which anybody says, "No-one is there so I will not go."

Mr Corbell: A number of issues are involved. I am advised that there has been a significant reduction in the number of clinical services due to the recent availability over the counter from pharmacies of post-coital contraception. That factor is influencing the demand for services. People are choosing to take other measures. I will ask Dr Dugdale to elaborate on those services.

Dr Sherbon: There is a misprint in the budget papers. That figure of $840 million should be $480 million.

THE CHAIR: The figure of $840 million should be $480 million?

Dr Sherbon: Yes, but the other figures are all right.

MS DUNDAS: The budget for 2003-04 had $840 million across the board.

THE CHAIR: Is that a misprint too?

Dr Sherbon: I do not know about the figures for last year. I can only tell you about the figures for this year, for which I am responsible.

THE CHAIR: So the target this year is $480 million instead of $840 million?

Dr Sherbon: No. I have been told that the $840 million target for 2003-04 should be $480 million.

MS DUNDAS: You might want to check those figures. The 2003-04 budget papers had $840 million as the target.

Dr Sherbon: I have been advised that the reduction of $480 million to $360 million is due to lower demand, resulting from the shortage of health professionals assisting that service.

MR SMYTH: Is it accurate to state that demand is driven by the number of professionals available? Supply is also driven by the number of professionals available.

Mr Corbell: We are talking about the quantity of services that are provided. That is directly attributable to the number of staff available.

MR SMYTH: That is delivery; that is not demand.

Dr Sherbon: There is a demand for professionals to provide education services. If you have a shortage of professionals or they are busy the demand on NGO-based services would be reduced. That is what this NGO has told us.

Dr Dugdale: It is just not getting the enrolments.

MR SMYTH: It is not getting the enrolments because it cannot deliver the services.

Dr Dugdale: No, because there is a big reduction in GPs and trainees in Canberra. Nobody is enrolling in the courses, or fewer people are enrolling in the courses.

MS DUNDAS: I refer to the federal public health outcomes funding agreement for sexual and reproductive health. Is the money that is coming out of that funding agreement projected to increase or decrease over the next three years?

Dr Dugdale: We have only just received the offer from the Commonwealth and we are trying to analyse it. I understand that it has in it only CPI growth for the next years.

MS DUNDAS: Would you provide us with a breakdown of how those moneys are to be divided between the non-government sector and government sectors? Does any of that money go to non-government sectors?

Dr Dugdale: Yes.

MS DUNDAS: Would you provide us with a breakdown of where the money is going for the public health outcomes funding agreement?

Dr Dugdale: For which period?

MS DUNDAS: For the 2004-05 and 2005-06 financial years.

Dr Dugdale: It has not been finalised.

Dr Sherbon: The go forward agreement has not yet been agreed to.

MS DUNDAS: Could you give us a breakdown for 2003-04?

Dr Sherbon: Yes, with the minister's permission.

MS DUNDAS: Would you provide us with some form of time line? When do you expect to reach a final outcome on the public health outcomes funding agreement? How will you divide funding for that agreement?

Dr Dugdale: We hope at this stage to have replied to the Commonwealth by the beginning of the next financial year. The Commonwealth was very late in making an offer to us and we have only a short time frame within which to reply. The team is working on it now and we hope that things will be sorted out before the end of the financial year.

Dr Sherbon: The offers arrived so recently that we have not even briefed the minister. I do not think we can go into a great deal of detail. We can certainly give you the split-up for 2003-04.

MS DUNDAS: I refer to education and training services. This relates specifically to the training of professionals and not to training that is conducted out of schools?

Dr Sherbon: No, this relates to professionals.

MS DUNDAS: Have public health service officials had any discussion about the need to work with the federal government to give nurses a Medicare provider number so that they can take pathology samples?

Mr Corbell: It is fairly clear that the Commonwealth government will not support such a move, even though it is potentially desirable in a number of community health settings. An obvious one is Sexual Health and Family Planning ACT. The Commonwealth

government has indicated on a number of occasions that it wants to restrict people who are responsible for authorising those sorts of actions rather than enabling nurses to do so.

MS DUNDAS: I will take up this issue with a minister at a higher level.

Dr Sherbon: I have to correct a previous answer that I gave. My colleague has indicated that there is some school education in that figure, but the bulk of it is professional education.

MS DUNDAS: Would you then provide us with a breakdown? How much of the $360 million is school based and how much of it is based on professional education?

Dr Dugdale: Once they complete the year I can give a breakdown of the $380 million. It will be up to family planning as to how it allocates the $360 million.

MS DUNDAS: Are you taking on notice my question relating to the figure of $380 million, or will we not know the answer to that question until 1 July?

Dr Dugdale: That is right. I will take on notice your question relating to the $380 million. When I receive the accounts from family planning for the year, I will be able to inform you what it did with that amount.

MS DUNDAS: I understand that Sexual Health and Family Planning ACT had to introduce fees for service because of dramatically increased insurance premiums. That is a problem that has been facing many community organisations. Has the government considered providing extra support to Sexual Health and Family Planning so that it does not impose a fee for service?

Mr Corbell: It has been considered. Sexual Health and Family Planning has indicated to me that it has had to increase its insurance premiums. As I understand it, that was driven predominantly by claims made against it because of the operations of the Reproductive Healthcare Service.

MS DUNDAS: I am talking specifically about its pathology services. It used to charge only for pap smears and those kinds of things.

Mr Corbell: That is not an insurance issue; that is a charging issue through the Health Insurance Commission. It is a different issue.

MS DUNDAS: Perhaps I am confusing the two arms of that service.

Mr Corbell: Dr Sherbon has advised me—and he is quite right—that at the moment doctors are required to sign off on the pathology.

MS DUNDAS: On the pathology, yes.

Mr Corbell: That is the only way in which you can claim it through the HIC. The practice is for nurses to sign off on it. Doctors were unwilling to countersign, to give their agreement, or to sign a chit in relation to something that the nurses had done. They were concerned that they would not be covered by insurance if they signed for something

but they did not actually do the procedure. Do you understand what I am saying?

MS DUNDAS: Yes, I follow it.

Mr Corbell: I might not have explained it very clearly. Indirectly, that was the insurance issue, but I do not think there has been an increase in claims. There has been an increase in claims against SHFPACT because of the operations of the RHS and that is why it has directly faced an increase in its premiums.

MS DUNDAS: So the government has considered this issue?

Mr Corbell: It is the government's policy not to directly subsidise or pay the insurance costs of non-government organisations. If we did that for the SHAFPAC it would mean that we would have to do it for everyone. We are simply not in a position to do that. However, the government provides assistance for non-government organisations to enter into the cheapest possible insurance arrangements. The ACT Insurance Authority works with non-government organisations to actively search for insurance products that meet their needs and that are cheaper.

The ACTIA has established, through its relationship with the relevant body in New South Wales, a pooled insurance arrangement for a number of small, non-government organisations that need a level of insurance. SHAFPAC's operations pretty much put it outside that league because of the scale of activity, the potential lead-time or the tail that exists in some of its claims.

THE CHAIR: The cost of the output goes up by about $5.5 million, or 30 per cent, yet every service either is static or its target is reduced. The explanation that has been given is not super clear, to say the least. Effectively, we are looking at a 30 per cent increase. What is going on?

Mr Corbell: As the note explains, a number of products are being purchased.

THE CHAIR: Has the cost of those products gone up?

Mr Corbell: The cost has gone up for a number of products. I will ask Dr Dugdale to give you more information in relation to that.

Dr Dugdale: The first point to note is that the population is increasing, so it is costing more. The number of products is increasing, and that includes some new vaccines that were not previously available, for example, for meningococcal. The budget initiatives for this output class on childhood obesity activities and tobacco enforcement include increased costs for indexation and superannuation. So a number of factors have pushed up that total cost.

MR SMYTH: You mentioned childhood obesity. How much of a problem is that in the ACT?

Dr Dugdale: It is not as much of a problem in the ACT as it is for Australia as a whole. The Australia-wide obesity epidemic is also evident in the ACT, but it is not as severe here as it is for the rest of Australia. If you adjust it to take into account its

socioeconomic status it would be much the same.

MR SMYTH: So how would your initiative work? What would it seek to do?

Dr Dugdale: It will do a number of things. I refer in the budget papers to the school tuckshop program—the Tuckatalk in schools program. That program has been successful where it has been run, so we are looking at expanding it. A number of projects will be delivered through our schools. Healthpact will make the selections and determine which ones will be the most successful. We are working with a number of other government agencies in relation to physical activity and the overall provision of nutrition messages.

MR SMYTH: On page 192 of budget paper 3 there is a reference to "surveillance that will provide data to develop a better understanding". What data are you seeking?

Dr Dugdale: The ACT has an excellent database of children at school entry, which is run by the Academic Unit of General Practice and Community Health—probably the best-placed jurisdiction in Australia to track through the weight and height of children, their physical activity, and provide a bit of information about their nutrition.

MR SMYTH: You said that that is done at school entry. Is that at kindergarten?

Dr Dugdale: We already do that at school entry, but we do not collect data throughout their school years. We are looking at getting some additional data points there. We are interested also in data that Mr de Castella obtained after operating his program. We will be talking with him and analysing that data in conjunction with data that is publicly collected.

MR SMYTH: Before you can deliver an effective program you really need to know the extent of the problem. The only way in which you can do that is through the collection of data.

Dr Dugdale: We already know the extent of the problem. We have sufficient data to give us a very good handle on that.

MR SMYTH: Where did you get that data?

Dr Dugdale: As I said earlier, we get it from the school entry program, from national health surveys and from a few other sources. In doing that intervention we want to increase our surveillance so we can determine what is effective, establish any links and obtain more data about the epidemic.

MR SMYTH: Will there be an opportunity to extend the de Castella program for the benefit of all schoolchildren in the ACT?

Mr Corbell: That would be a fairly significant exercise. It is not funded within the context of this initiative.

MR SMYTH: I am just curious, Minister. This government has been in office for 2½ years. One of the government's first initiatives was to cancel a tender that I understand would have enabled Mr de Castella to deliver his program across a number of

government schools. Mr Stefaniak probably knows more about this issue. Does the government regret not having taken that step 2½ years ago, given that it obviously has a problem on its hands that it will have to address using the data Mr de Castella has been collecting?

Mr Corbell: That tender process, which was seriously flawed, essentially was a select tender—a one-off arrangement solely to facilitate Mr de Castella's entry. The government did not consider it appropriate to administer public moneys in that fashion.

MR SMYTH: But the government has not done anything for 2½ years.

Mr Corbell: The government has continued to support programs such as Tuckatalk in schools to increase the range of healthy foods.

MR SMYTH: Yes, but Tuckatalk is not collecting data.

Mr Corbell: You asked me what else the government has done. I am telling you what the government has done. Tuckatalk continues to provide information and support for the healthy schools program, the ACT Department of Education continues to run a number of activities, and we are increasing the overall level of activity relating to childhood obesity so that we can address issues that are continuing to emerge.

MR SMYTH: But you have missed out on 2½ years worth of data.

Mr Corbell: No, we have not.

THE CHAIR: It was interesting to hear you saying something about the tender process. I understand, though I have not seen the documents, that that occurred late in the term of the former government. I understand that Mr de Castella ran what seemed to an excellent program, but that other groups might have done so as well. I recall that the CIT was interested in doing something along the lines of Mr de Castella's program, that is, to check out children's fitness, assess their fitness, report to their parents and then to come back and check their fitness 12 months later.

What was proposed was a comprehensive program that follows a child right through primary school, which are the crucially important years. I understand that there is fairly cheap program—I think it was put out to tender because it was a little over $50,000—and some schools availed themselves of it.

Mr Corbell: The advice that I received at the time—it was some time ago that I was Minister for Education and I made that decision—was that the tender seemed to have been structured in such a way that it would achieve a particular outcome. We did not consider that to be an appropriate course of action.

THE CHAIR: Would you consider re-tendering for a comprehensive service that gives you data relating to young people's fitness, that achieves some outcomes and that can be measured by families and by the department?

Mr Corbell: We are implementing a number of programs at no cost to parents, whereas Mr de Castella's program involves a cost to parents.

THE CHAIR: I recall that it is a pretty minimal cost.

Mr Corbell: Some of the advice I received at the time was that it was questionable whether the parents of those who were most at risk of childhood obesity would participate in that program. Childhood obesity, regrettably, is more prominent in lower socioeconomic groups in our community. It was questionable whether parents would either have the money or choose to spend money on a program such as Mr de Castella's.

So we had serious reservations about the appropriateness of the program in that context. For that reason the government did not proceed with the tender. That said we are now proceeding with a number of programs at no cost to parents that target those who are most vulnerable to childhood obesity.

THE CHAIR: What makes you think that parents would be any more likely to participate in those programs?

Mr Corbell: The point is that they do not have to pay.

THE CHAIR: They do not necessarily have to pay for a de Castella program or a CIT type program.

Mr Corbell: They do have to pay for Mr de Castella's program.

THE CHAIR: It depends on how it is structured. I cannot recall the cost, but it was not much.

Mr Corbell: In his representations to me there was a repeated cost to parents.

THE CHAIR: It might be something that the government could include in the program.

Mr Corbell: There was a repeated cost to parents as they would receive a report and so forth for individual children.

MR SMYTH: If the tender was deficient why did the government not re-tender?

Mr Corbell: For the reasons I have outlined, the government believed that more appropriate courses of action could be taken. That is what we are doing.

MR SMYTH: And it took you 2½ years to come up with those more appropriate courses of action?

Mr Corbell: As you would appreciate, Mr Smyth, the government has to balance a whole range of priorities. We have now funded these commitments.

MR SMYTH: Two and a half years later?

Mr Corbell: The government makes assessments on priorities in each budget year and it determines the pressures.

THE CHAIR: We are talking about childhood obesity and the money that could be saved down the track. However, there are other demands on the health system that would be incredibly costly.

Mr Corbell: As former ministers you would both understand that things come and go in the budgetary process. I am just pleased that these programs are on the table. We are seeking your agreement to fund them so that we can increase our efforts in this area.

MS MacDONALD: Minister, there has been a lot of talk but there has been no reference to an inquiry that was conducted by a parliamentary committee into children's health. Was that inquiry, which took a substantial amount of time, a major consideration in the formulation of these programs?

MR SMYTH: The tender was cancelled before the health committee commenced its inquiry. You are making excuses after the event.

MS MacDONALD: Mr Smyth, you are attempting to ask a question on my behalf. I would appreciate it if you would desist from doing so.

Mr Corbell: In answer to your question Ms MacDonald, yes, that was a consideration. The Standing Committee on Health had initiated its inquiry into the health of school-aged children. An element of the advice that was provided to me as health minister was that it would be inappropriate to proceed with the program at that time, given that a wider ranging committee investigation was under way that could help to inform government policy.

MRS DUNNE: I have a couple of questions relating to output class 1.4 and I have a more general question to which I will refer later if there is time. Dr Dugdale, I would like to ask you some questions relating to water quality. I asked a question on notice and the minister provided me with a vast amount of information that, sadly, was a little incomprehensible to a non-scientist. Could you give a general exposition about the quality of drinking water after the bushfires?

Dr Dugdale: I apologise if the formatting of the information that we provided was not all that clear. Since the fires water quality has been an issue for us. I have been very satisfied with the quality of our water. We have considered scenarios in which it could have been worse. Essentially, a storm hit the Bendora catchment a few months after the fires and it developed fairly high levels of turbidity that would have been detectable to people drinking that water.

If we had had those levels of turbidity in the past it would have been due to trash runoff and of more concern to our health. But as the slopes had been denuded and a lot of the animals had been killed or driven out, the turbidity was as a result of clay soils. When we had a look at the problem we were much less concerned about the new type of turbidity that we were seeing after the fires than we would have been if those high levels had been reached with full forest cover.

I wrote to the chief executive of ActewAGL and changed the level of turbidity from one nephelometric turbidity unit to five NTUs. I said that we would be happy if ActewAGL supplied water with up with five NTUs, as it would still be high-quality water. In

Adelaide they have been routinely supplying water with up to 200 nephelometric turbidity units, or NTUs. A nephelometer measures haze or turbidity. So it is not a question of how turbid it was; it would depend on whether or not any health risks were associated with it.

That is what has happened in the Bendora catchment. We have relaxed our standard or our licensing requirement on turbidity because it is a different type of turbidity. The water that has been coming from Bendora is very good. That is what we have had almost exclusively for many months now. There was another problem at Googong Dam. When there were high levels of turbidity at Bendora there was also a lack of rain.

Googong Dam, which is still sitting at quite a low level, has blue-green algal bloom. That is something that happens more commonly when dams reach a lower level. Now that Bendora catchment is pretty full and it has pretty good quality water, I do not think there is a foreseeable risk to us. ActewAGL is looking at treating the algal bloom. It has a carbon filtration capacity so if, for some reason, it had to supply water from Googong while it had an algal bloom, it could filter out the toxins. We are monitoring that situation quite closely.

In summary, there has been an increase in surveillance and in our thinking about the water supply. We have to make sure that we have filtration capacity, in addition to the carbon filtration capacity at Googong. We need a general filtration plan at Stromlo for the Bendora catchment. Overall, I think we were prepared for much more serious scenarios than we have had over the past 12 or 18 months following the fires.

MRS DUNNE: Apart from turbidity, for what other things do you test? Have we come close to alarm bells ringing for any of the things for which we test?

Dr Dugdale: A wide range of tests is carried out. We have not come close to health concerns as a result of any of those tests. There was a concern about manganese, which is mainly an aesthetic concern.

MRS DUNNE: Because it is staining?

Dr Dugdale: There were some concerns that it might hit aesthetic recognition levels but, as I said earlier, it is not a health concern. From the health point of view, the parameters of the Bendora catchment have all been extremely good. We are concerned about the blue-green algal bloom, but that short-term issue is being addressed.

MRS DUNNE: People have said anecdotally that they were measuring high chlorine levels. Pool technicians have reported that they have experienced problems balancing pools and people have reported that there were high levels of chlorine in tap water.

Dr Dugdale: There has been an increase in chlorination. With higher amounts of matter there is greater turbidity and the water absorbs all the chlorine, so we need to dose it with a little more chlorine. Ideally, virtually all of the chlorine should be used up before we turn on a tap. With high levels of turbidity it is harder to get in the right amount. We get feedback from various tap sites but it is always a problem. The capacity of the water to absorb chlorine fluctuates and, from time to time, there is a detectable smell of chlorine.

MRS DUNNE: Where do you conduct those tests? Do you test the water as it comes out of the dams, or do you also test tap water?

Dr Dugdale: We do not conduct those tests. We set the testing regime in the licensing conditions but ActewAGL does the testing.

MRS DUNNE: ActewAGL does the testing?

Dr Dugdale: It tests a whole variety of points within the dam, at the outtake of the dam, at the treatment plants, and at small storage dams that surround Canberra. It also conducts a number of tests at the tap—the end user point within the network.

MRS DUNNE: Do you audit that in any way?

Dr Dugdale: Yes. We get regular reports. We have regime of set points. If there are readings above those points we have to be notified.

MS DUNDAS: This is anecdotal information, but I have heard that some cases of water poisoning occurred at the University of Canberra. A number of people that I know became quite ill and went to their GPs. They were told that it appeared as though they were suffering from the symptoms of water poisoning.

MRS DUNNE: What is water poisoning?

MS DUNDAS: That is when the water makes you sick. How many cases have to be reported before a flag falls—before somebody starts checking the pipe system in a particular area? I am referring specifically to water poisoning and not to food poisoning.

Dr Dugdale: If a disease is notifiable and it is transmitted through water, for example, hepatitis A, a single case is notifiable. Epidemic gastroenteritis is notifiable. If a doctor sees someone who has gastroenteritis but the doctor is not sure where his patient got it from, that case is not notifiable. If there are several cases and there is a suspicion that those cases are linked, we have to be notified. My rule of thumb in general practice would have been to become concerned if I got three reports within a couple of days.

MS DUNDAS: But that requires everyone who is affected going to the same GP.

Dr Dugdale: As I said, the onus is on the GP. If the GP thinks that the cases are linked, he should notify us. We have had a spate of gastroenteritis clusters in the past few weeks. It may be that you are getting reports as a result of that. I certainly have not heard about any contamination of the water supply. We have active surveillance in relation to those issues, so I would have heard. Something might have got into the water and a GP might have said that it was the faecal oral route. That might have been the explanation that was given. However, I am not aware of any water contamination in the Canberra region.

Mr Corbell: Another point that should be made about gastroenteritis is that it occurs in institutions such as childcare centres and aged care facilities. Quite often the operators of those facilities advise public health services because they are aware that a few kids are away sick. They know, so they let other people know. Equally, aged care facilities do the same thing.

MS DUNDAS: Can you recall whether any of those gastroenteritis outbreaks occurred at the University of Canberra?

Dr Dugdale: The University of Canberra is not specifically ringing a bell, so no.

MS DUNDAS: I wanted to explore that issue because of the cases I have heard about. Nobody has died.

MRS DUNNE: It sounds more like college food to me.

Mr Corbell: University union.

MRS DUNNE: I forgot to ask a question this morning so I seek the indulgence of the committee. On page 202 of budget paper 3, under agency-funded initiatives, there is an amount of $1 million, which increases to $1.4 million in 2007-08 for "other". What is the "other"? I got the impression that people have been waiting for someone to ask that question.

Dr Sherbon: Some of it is for increased insurance costs for the portfolio, the Comcare premium, that is, workers' compensation costs, and also compliance costs relating to territory records legislation. It is also for infrastructure services, including project officer staff and a chief nurse.

MRS DUNNE: Project officer staff for whom?

Dr Sherbon: For the chief nurse and the allied health adviser.

MRS DUNNE: Is that the full list?

Dr Sherbon: I think so. We can take that question on notice. There is also a slight correction to mental health funding, to the extent of $150,000. We can detail them for you, but that covers the range of issues.

MRS DUNNE: What is the slight correction to mental health funds?

Dr Sherbon: It is $150,000.

MRS DUNNE: What is that amount for?

Dr Sherbon: It was an adjustment in funding to reflect some adjustments that were made in 2002-03. It is a $150,000 correction to its base funding.

MRS DUNNE: If you needed to adjust the mental health base funding why would you do that through agency growth funds rather than in the mental health budget?

Dr Sherbon: It is not contributing any additional services. It is a correction to its base funding, which was inappropriately allocated in 2002-2003 by my department. So it is an internal correction using growth funds to correct it. It is going to Mental Health Services basically to maintain its activities.

MRS DUNNE: So there will not be any additional services? You do not just allocate funds to the mental health budget for additional services; you also allocate funds for ongoing services. Why is there no adjustment to the mental health budget?

Dr Sherbon: That occurs when they are highlighted by government as part of its significant initiatives.

Mr Corbell: It is a bit of an arbitrary line, really, Mrs Dunne. To what extent should the government highlight new additional dollars, and to what extent is it an adjustment within the existing budget? Clearly, the department has made its judgment as to whether it can manage within the resources that the government has already allocated. The department would be aware that growth funds are allocated and agreed to by government through the budget process.

The department and I then agree to those funds without needing to go to budget cabinet. Budget cabinet is made aware of the list, but there is no serious deliberation in relation to it, as it is accepted that as long as it is reasonably managed and it is not brand new, it really should be dealt with in new expenditure. It is then managed through the growth funds.

THE CHAIR: Thank you very much for appearing before the committee, ladies and gentlemen.

The committee adjourned at 5.42 pm.