LEGISLATIVE ASSEMBLY FOR THE AUSTRALIAN CAPITAL TERRITORY

STANDING COMMITTEE ON HEALTH

(Reference: Annual and financial reports 2002-2003)

Members:

MS K TUCKER (The Chair)
MS K MacDONALD (The Deputy Chair)
MRS J BURKE

TRANSCRIPT OF EVIDENCE

CANBERRA

THURSDAY, 6 NOVEMBER 2003

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

By authority of the Legislative Assembly for the Australian Capital Territory

The committee met at 1.07 pm.

Appearances:

Mr S Corbell, Minister for Health and Minister for Planning
ACT Health
Dr T Sherbon, Chief Executive
Dr M Alexander, Deputy Chief Executive
Dr P Dugdale, Chief Health Officer
Mr R Foster, Chief Finance Officer
Mr A Schmidt, Executive Director, Corporate Services
Ms S Killion, Executive Director, Policy and Planning
Mr I Thompson, Executive Director, Community Policy
Mr B Jacobs, Executive Director, Mental Health
Ms L Yen, Executive Director, Community Health
Mr J Mollett, General Manager, Canberra Hospital
Mr R Cusack, General Manager, Calvary Public Hospital
Dr H Munro, Chairman, Medical Board

THE CHAIR: We will now commence this hearing. Thank you for supporting the work of the committee by attending this afternoon. I welcome Simon Corbell as minister, and I welcome Vicki Dunne as well.

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

For your information, if questions are taken on notice, the committee would appreciate responses within seven working days of the hearing. It's the responsibility of witnesses to check the transcript of proceedings to ensure that they meet any commitments they have made regarding the provision of information or answers to questions on notice. The secretary will email a transcript to all witnesses as soon as it's available. Depending on how long this hearing takes, we may break at 2.30.

Since Heather Munro, the chair of the Medical Board, is here and Karin MacDonald wanted to ask some questions of her, we will do that first so Heather doesn't have to sit here for the whole proceedings.

MS MacDONALD: I have been going through some of the reports and I noted that a some things seem to be common to a few of the annexed reports, so I'll ask you about that. You talked about the proposed health professionals bill not being in place yet. How do you see the future of that bill? I will ask the minister to talk a bit about it as well because I'm unaware of the progress of that bill. I have to apologise: I did mean to find out a bit more before we came here today, but I haven't had the opportunity.

Mr Corbell: Ms MacDonald, thank you for the question. I'm sure Dr Munro can outline the board's concerns. From the government's perspective, the health professionals legislation has been a long time in development. It commenced under the previous government and has been ongoing during the term of the current government.

There has been extensive and exhaustive discussion with all of the boards that represent the different health professions, and that legislation is now being finalised. Dr Munro, Dr Sherbon and I were discussing this prior to the hearing. I'm advised that that legislation will be introduced into the Assembly during the December sittings. Dr Munro will outline the Medical Board's views.

Dr Munro: The concern of the board is that it has taken a long time for this document to come to the Assembly. When I was asked to join the board in June 2000, I was told that the bill was in draft form and it wouldn't be long before it went through, and here we are in November 2003, and the legislation is still not in place.

The major concern of the board is that we're finding it increasingly difficult to protect the public adequately under the current legislation. The main reason for that is that the inquiries we conduct are formal inquiries, conducted by at least five members of the Medical Board. We cannot caution, reprimand or otherwise speak to doctors unless we hold a formal inquiry, so that's a very cumbersome mechanism for dealing with relatively minor matters. For major matters, it's a long, drawn-out procedure.

We are faced with significant delays. Formal notices have to be served, witness statements have to be taken as statutory declarations and a convenient time has to be arranged for five members of a board to sit together with the doctor that we're inquiring about.

One of the major problems for the board has been the perception of bias. If a board member is aware of a complaint against a doctor and the intricacies of that complaint, there's the problem of whether that person then sits on the panel and whether he or she can be accused of being biased before the inquiry begins. As I understand it, before I joined, the board was given legal advice that members of the professional standards committee, which comprises two members of the board, could look at all the information that was being given to it by the health complaints commissioner and then recommend to the board whether to hold a formal inquiry or not.

The board was not given any reason for holding a formal inquiry. We had to take it entirely on the recommendation of two members of the board. I found this very frustrating. It means that I have had to sign notices of inquiry without really understanding why we were inquiring into a doctor. More recently, we have had further legal advice that we can be given some information about a complaint. That process has not yet been tested but it will be shortly, and that should improve the processes.

The main advantage of the new bill for us is that inquiries will be conducted in a tribunal chaired by a legal person. There will be two members of the medical profession, who will not necessarily be board members, although, until we find our feet, they will probably be members of the Medical Board. There will be some other lay people on that tribunal. That will take the actual inquiry away from the board.

It means that, as a board, we can discuss complaints and decide, as a board, whether there is a problem before we send it to a tribunal. It means we will be able to conduct informal hearings ourselves, but that formal inquiries will be taken away from the board and put before a tribunal. That's why we desperately need the new legislation.

MS MacDONALD: We hope that it will be introduced in December and that it will address those concerns. I had another question, which was more about an administrative matter: I note that some of the smaller boards are forming a coalition or alliance.

Dr Munro: At the moment, there are 11 health professional boards: the Medical Board, the Nurses Board and nine other smaller boards—the physiotherapists, the pharmacists and so on. At one stage, the registrar of the Medical Board was the registrar for all the boards. Earlier this year, that responsibility was divided because he was just too busy, so the registrar is now the registrar of the Medical Board, there's a registrar for the Nurses Board and there's a registrar for the nine smaller boards.

Ms MacDONALD: Okay. That answers that question.

Mr Corbell: I've met with representatives of all the boards, Ms MacDonald, and the smaller boards were initially concerned that consideration that was being given by the Medical Board to locating its secretariat outside the existing arrangements and funding it from the registration payments that doctors make to the board would mean that they would be in some way disadvantaged because they were reliant on shared secretariat-type functions.

Following a meeting with the boards and subsequent discussions that I've had with the department, I now understand that those small boards will continue to be supported by a registrar and that the funding that they are able to levy through registration payments is adequate to provide secretariat support for those smaller boards. Clearly, the Medical Board and the Nurses Board are two of the largest boards, just given the sheer volume of professionals in those two areas, so they have greater capacity to raise money for their operations.

THE CHAIR: I'm also interested in the length of time that it takes to conduct inquiries. That has been a matter of concern and you would be aware of that. For example, in the report, we have a note of the inquiry on 16 December 2002 and that's ongoing. There are two issues in which there has been community interest: the length of time that it takes and also the length of time it takes to actually impose some form of discipline, if that is deemed to be necessary. Is this due to the provisions of the current act? What's the issue there?

Dr Munro: There are two issues. One is the current act, but more important as far as we're concerned are the problems that the health complaints commissioner has with his act that means that it takes him a long time to investigate any matter. When he then refers it to the board, he often doesn't have witness statements that have been taken as statutory declarations, so we then have to get further witness statements.

One example recently concerned complaints that had first arisen seven years ago. When the investigator went out on behalf of the board, five of the people were no longer interested in giving evidence or making statements and two of them couldn't be found.

So there is a major problem with his investigative processes that is not all his fault, but it is a long slow process. Once we get his recommendations, we then have a long process too.

THE CHAIR: The answer to this might be the document. I'll confess I haven't read every single page of it: is there a distinction made between what you would call error and misconduct when you look at incidents?

Dr Munro: There are two separate charges that we can make against a doctor. One is called professional misconduct and one is called unsatisfactory professional conduct. Professional misconduct is a much more serious charge and can lead to suspension of a doctor's licence. Unsatisfactory professional conduct is a lesser charge and, under that, we would perhaps bring complaints about communication issues. That would be the major complaint. That is not actually a major problem for the public. It's not going to be a life-threatening matter, but certainly it is a problem. Claims are often made about the arrogance of doctors so we try to address those.

The other issues we've addressed recently are those of privacy, where doctors have issued certificates or letters to other bodies without the patient's permission. We have brought charges of unsatisfactory conduct against them.

THE CHAIR: Where you think it's appropriate, do you provide some sort of support for the person concerned to help to improve his or her practice?

Dr Munro: Yes, we have asked doctors to attend communication courses as there are now quite good communication courses available in Australia. We have mentors who talk with a professional about the practice and particularly about the problem that we have addressed, but often we make it wider, so that they address other issues in that doctor's practice. I send out regular newsletters trying to draw doctors' attention to problems. The most recent one was drawing their attention to this release of information without permission.

THE CHAIR: I had a young lesbian woman constituent talk to me recently who felt that she was having a real problem accessing a GP who didn't have some form of prejudice against her because of her sexuality. I was going to ask questions about this later, during discussion of the general report, because we're looking at cultural diversity, which I assume also includes different kinds of cultures, not just people who have different language or ethnic backgrounds. Do you take an interest in such concerns? If a member of the community raised that with you, is that something you can proactively respond to?

Dr Munro: It's not something that has been raised with us, but we could easily do that. We have very good general practitioners on the board and I'm sure they would be able to suggest other GPs. It could be done as an informal thing.

THE CHAIR: You're telling me the community could go to you seeking doctors? Do you take a proactive role in addressing such complaints, because that was obviously a fairly serious complaint?

Dr Munro: If she wants to address it as a complaint she would have to complain to the health complaints commissioner and then that would have to be investigated by him.

THE CHAIR: No, but as a system. She doesn't want to.

Dr Munro: If it's justice—

THE CHAIR: It's the system. For the sake of everyone, she wants know who could deal with this.

Dr Munro: Okay. I would have thought there were enough people around town from whom she could obtain that information, through her own little cultural groups—and let's use the term "cultural" as you've used it. Otherwise we, as a board, don't recommend GPs or any specialists. That's not our role.

THE CHAIR: Sorry, I am obviously not being clear enough. I was interested to know whether you in some way promoted a system response, a profession response. For instance, you just said you have a newsletter, so do you take on that function by raising issues in the newsletter?

Dr Munro: Only if my attention were drawn to it and I thought it was—

THE CHAIR: Yes, by someone who contacted you. You would see that it was your role as well to say, "Is this something we need to think about?" Is there the potential for some professional development in that area? For example, you were talking about communication and I wondered if you had such a systemic role.

Dr Munro: There's nothing in place but I'm sure we could organise it if there were sufficient interest.

Mr Corbell: There are other bodies that provide advice to GPs that could raise the issue. For instance, the Division of General Practice, which also has very extensive links with GPs, could provide information about understanding same sex relationships and understanding the particular needs of people in those sorts of relationships.

Dr Munro: I'm sure there are lots of facilities in Canberra for that.

Mr Corbell: This is an issue that I am exploring already. I have held some preliminary discussions with the department on convening a series of forums, in which both service providers and consumers from gay, lesbian, transsexual and similar backgrounds can provide feedback on the adequacy of service delivery as it affects them, given their particular sexual preference.

THE CHAIR: Okay. That is good to hear.

Mr Corbell: It is something that warrants further investigation and I've asked the department to prepare some work on that.

THE CHAIR: Okay, good. Thank you. Mrs Dunne, do you have any questions for Dr Munro?

MRS DUNNE: No.

THE CHAIR: Okay, thank you very much. Now I propose that we go through the report and I will start off with a couple of questions about Dr Sherbon's summary, which is on page 3. You talk about having a solid partnership with the local Aboriginal and Torres Strait Islander community, which will provide the basis for improvements in a range of services. Could you elaborate on that?

Dr Sherbon: Yes, Madam Chair. We meet regularly with Aboriginal community-controlled health organisations. We also have an Aboriginal health section in our department which reports directly to one of our senior executives. We work closely with those community-controlled organisations to develop our own Aboriginal health strategy, which is evolving. We also work closely with them on a range of specific issues such as recent initiatives in antenatal care, midwifery and diabetes, and we're currently discussing a range of children's care issues, particularly with Winnunga, but also with other Aboriginal community-controlled organisations.

We also provide regular liaison, through Aboriginal liaison officers, at our two major hospitals and through community health consumer feedback mechanisms. Also, as the minister has reminded me, we are working on a program of comprehensive training in cultural sensitivity and the specific needs of Aboriginal people, to train all of our staff who deal with patients directly, and our managers who deal with the broader issues of access to our health services for those of Aboriginal background.

THE CHAIR: What is the situation with regard to the accommodation of Winnunga Nimmityjah?

Mr Corbell: The situation with Winnunga is that the government has given a commitment, which is currently being implemented, to allow Winnunga to transfer a large number of its services from the existing facilities in Ainslie to the Narrabundah Health Centre. The Commonwealth will be meeting the bulk of the cost of the refurbishment work and the ACT will probably be picking up some of the cost associated with some reconfiguration of the facility to allow us to continue to adequately accommodate the existing services that are there, along with Winnunga. That is currently in train.

THE CHAIR: Is that settled now? Have you worked out the funding arrangements?

Mr Corbell: Yes, the funding arrangement is essentially a Commonwealth funding arrangement. ACT Health, though, is very proactive in liaising between Winnunga and the Commonwealth to coordinate the relocation and about a whole range of other issues. That work is now well under way and, yes, agreement has been reached that Winnunga will relocate a large number of its services to Narrabundah.

THE CHAIR: Last time we talked to you there was still an argument going on with the Commonwealth. You're telling us that it's settled and that they are moving. What's the time line?

Mr Corbell: Yes, they are moving. I'm not aware of the time line.

Dr Sherbon: Design of the final configuration of the facility is actually under way now and we expect construction probably in the first quarter of next year.

THE CHAIR: So early next year?

Dr Sherbon: Yes.

MRS DUNNE: How long is the construction phase? Will the construction phase be commenced and completed in the first quarter of next year?

Dr Sherbon: If we can do it earlier we will, but my estimate is early next year.

MRS DUNNE: So that's for the completion?

Dr Sherbon: Of the facility, yes.

THE CHAIR: Have you asked the liaison officers for an evaluation of their positions, their roles, whether they feel that those positions are properly resourced and so on? Do you have an evaluation of that?

Dr Sherbon: I'll have to take on notice the part of the question that refers to our formal process, but what I can report today is that our Aboriginal health team is located in the department, I meet regularly with all senior executives who have a role in Aboriginal health issues, and we do receive feedback from ALOs on issues that are being raised by community members as they use our health services.

We also get general feedback from those ALOs about their role and their level of comfort with the health system. I can't give you any comment today—and I'll take this part of the question on notice—about whether they've provided any feedback about workload. However, I can tell you that they have provided feedback that they feel that they are achieving significant results for Aboriginal people. I can also indicate that hospital managers are reporting to me that a wide range of Aboriginal issues are being resolved at both hospitals.

Community access, as measured by feedback from the Winnunga board and other Aboriginal community members, is positive. I'll take on board the issue of feedback about workload, but I can report significant improvements in Aboriginal community confidence in our hospitals and also in access.

THE CHAIR: How have you measured that improvement?

Dr Sherbon: With feedback from ALOs and community members. I can give you figures, on notice, of Aboriginal use of our health services, but the general feedback I'm getting is that the ALOs have provided a significant improvement in community confidence in using our hospital facilities.

THE CHAIR: Is this feedback anecdotal evidence from the liaison officers or have you done a consumer survey?

Dr Sherbon: No, we haven't done a consumer survey that I'm aware of, but I do rely on the feedback from my staff. Nevertheless, it is positive at this stage.

THE CHAIR: Sure. I just want to know how you work it out.

Mr Corbell: It's also worth noting that there was an initiative to fund an additional two Aboriginal liaison officers in the most recent budget.

THE CHAIR: Winnunga got to the point where it had to say no to non-indigenous people because of funding and the pressure that was on them because of the lack of bulk-billing doctors. Cultural issues are also apparently quite important in determining whether non-indigenous people, particularly marginalised people, use Winnunga, because it is very accepting and has a holistic approach that these people feel comfortable with. What is your response to that situation?

Mr Corbell: In what regard, Ms Tucker?

THE CHAIR: The last I heard—and maybe this has changed as I think it was a few months ago—Winnunga had said that it would no longer be able to accept non-indigenous patients because of the pressure on its facility and services—not just the physical space but the services themselves—and its staff are extremely overworked and physically stressed. They said they wouldn't take non-indigenous people. It was a very hard decision for them because it was the only place dealing with, particularly, excluded people. I want your response to that.

Mr Corbell: That is consistent with the pressure, of which the government is very aware, produced by the decline in the availability of GPs in the workforce, and also the decline in bulk-billing, both of which, in the ACT, are more severe than the national average. In respect to GP numbers, the average figure across the nation is about 82 GPs per 100,000 people and we have 62 GPs per 100,000, so we are significantly below the national average.

In my recent negotiations with the then Commonwealth minister, Senator Patterson, that was one of the reasons the ACT government was able to achieve agreement on a number of initiatives to assist in our GP workforce, including designation of the ACT as an area of workforce shortage, meaning that GP practices that were seeking additional doctors and that had been unable to recruit within Australia, could recruit outside Australia and get assistance, through streamlined processing from the Commonwealth, to get those doctors into the ACT. We have already had a number of GP practices take advantage of that opportunity.

It's also the reason that the Commonwealth agreed to declare certain parts of the ACT as outer metropolitan for the purposes of its incentive package for GPs relocating from inner metropolitan to outer metropolitan areas. That's of advantage to us in trying to convince doctors from inner city Melbourne and Sydney to consider relocating to the ACT. There are financial incentives provided by the Commonwealth to assist with that. We've previously been excluded from those programs, but we're now included by those programs. It is also the reason that the Commonwealth agreed to fund a new after-hours GP service, the model yet to be determined. ACT Health is in discussions with the Commonwealth department about that.

We have worked hard to try to get some of these new initiatives in place to address the GP shortage, but the shortage is simply endemic. Given that Winnunga is funded by the Commonwealth to provide, first and foremost, services for Aboriginal people, clearly it has taken a very difficult decision that that is where it has to focus its activities.

THE CHAIR: In the meantime, are you able to respond to the situation it is facing and assist it?

Mr Corbell: It is an Aboriginal health service, and Aboriginal health services are primarily funded by the Commonwealth. The ACT government's focus has been on trying to improve the availability of GPs overall.

THE CHAIR: No, I'm aware of that work, but we have a crisis right now and we have had for a while.

Mr Corbell: I know that, but my response to that, Ms Tucker, is that there is no simple silver bullet that will fix the problem. We need a range of responses across a range of policy areas and that's what the government is focusing on.

For example, the government has already increased funding to provide for the viability of CAHLMS, the Canberra After Hours Locum Medical Service. We now provide an on-call payment to GPs who make themselves available as locums after hours. We also pay for security for GPs to make house calls after hours as a way of increasing the availability of GP services after hours. We are responding in a range of ways to try to address the service availability.

THE CHAIR: But CAHLMS isn't bulk-billing, is it?

Mr Corbell: No, it isn't. This is the difficulty in the health debate: GP services are primarily the responsibility of the Commonwealth government under the Australian health-care agreement.

THE CHAIR: No, I understand that. I was wondering if you were able to—

Mr Corbell: However, we are working in a collaborative way with the Commonwealth to try to address the issues.

THE CHAIR: Yes. You know what my question was—

Mr Corbell: Yes.

THE CHAIR: And you are obviously not doing anything about that.

MRS DUNNE: You said a couple of minutes ago, Minister, that there were two additional Aboriginal liaison officers. Where did the money come from, and when did they start?

Mr Corbell: They haven't yet commenced but $152,250 was allocated from the 2002-03 budget.

MRS DUNNE: Where is that in the budget?

Mr Corbell: I couldn't tell you off the top of my head. I'll have to take it on notice.

MRS DUNNE: Okay, could somebody take that on notice?

MS MacDONALD: That's a budget question, not an annual report question.

MRS DUNNE: Okay. It is funded in the budget.

Mr Corbell: It is funded in the budget and there has been a delay in implementing this service while discussions have been held with the current ALOs about the role and the location of the new positions. That has now been agreed and we're able to progress with implementing the initiative.

MRS DUNNE: So there is money for ALOs but they aren't actually on the ground.

Mr Corbell: Yes, that's what I said.

MRS DUNNE: That's not what you said a couple of minutes ago, though.

Mr Corbell: No, I said that two additional ALOs were funded in the most recent budget.

THE CHAIR: All right, that's clarified. I have a question for Dr Sherbon. Still on page 3, you say, "Older people will benefit from the expansion in acute hospital services…improved respite care availability, expansion in older persons mental health services" and so on. However, I notice on page 13 that—and this may be a question for the minister, a political question—most of these have non-recurrent funding. If you look at page 13, you will see that, apart from the respite for families where parents have a mental illness, all the rest have non-recurrent funding. I know that the community is very happy to see these initiatives, but there is a concern as well that the funding isn't there. Can you tell us anything about that, Minister?

Mr Corbell: It's not usual for a pilot program to receive recurrent funding. A pilot program is just that, a trial, so it's funded for a set period of time.

THE CHAIR: But it's a very important service that the community has been asking for for a long time, very loudly. We like pilots, what we don't like is how they drop off when we know they're good. Maybe I should ask you what your intention is. Are you intending to evaluate these pilots with the thought of recurrent funding? What are your plans? Dr Sherbon is telling us on the first page that this is a good thing, so there's obviously an interest in what will happen in the future.

Mr Corbell: I'll ask Mr Thompson to give you some more detail on these particular programs, Ms Tucker.

Mr Thompson: Yes, these are pilot services, but the funding for the additional respite services is recurrent funding.

THE CHAIR: Is recurrent?

Mr Thompson: Yes, for the overall program. The intention is that, based on the evaluation of these pilots, we will then proceed to put out to tender recurrent provision of those that have been successful and, if they weren't successful, to look at alternative models. As it stands at the moment, based on preliminary results, we will probably be in a position to advertise for additional respite services on a recurrent basis early in the new year, as December is a bad time to advertise.

THE CHAIR: So what's the amount of money that you're saying is recurrent?

Mr Thompson: One million dollars.

THE CHAIR: Is that what this adds up to? That's all these programs basically?

Mr Thompson: Exactly. This was the first year's allocation. We're looking at some innovative ways to see if we can provide not just additional services but a better way of making our services available.

THE CHAIR: One more question generally on the annual report: I understand that you had to get it reprinted? Why was that?

Dr Sherbon: There was one erratum issued and I believe that has been passed to the committee. There was one error in one of the tables that we felt was of significance and therefore required correction for the committee. At the same time we also took the opportunity to correct some minor typographical errors. There is one table that does need to be corrected through an erratum. I don't know that we'll be issuing a revised annual report, but we certainly will have that erratum available.

MRS DUNNE: So is that why yours is blue and ours is black—because it has been reprinted? You've got the reprinted ones?

Dr Sherbon: No, these were issued some weeks ago, as you know, and published some weeks ago. As you know, there's copious data in there and there was a problem at the printer with one table in the capital works program, which we have corrected. There has been no second edition issued, I can assure you.

MS MacDONALD: At least they're not falling apart like the education ones were.

MRS DUNNE: So it's under capital works when we get to that?

Dr Sherbon: Yes.

THE CHAIR: Thank you. We'll move through the report and members can stop me when they want to ask questions. Thank you for the organisational chart; that's helpful.

MRS DUNNE: I find the organisational chart for the hospital very difficult to interpret. It's very hard to see where the patients are and where the patient services are. It's easier to read in the overall health organisational one, where the patient services are—

Mr Corbell: Well, all of those clinical services are patient services, Mrs Dunne.

THE CHAIR: Which page are you looking at?

MRS DUNNE: The one on page 19. It's difficult to read in a way that points out where the patients are. There seems to be higher priority to the financial officers.

MS MacDONALD: On page 8, you talk about SARS. Of course, the immediate risk of SARS has been dealt with, but I have heard some talk that it's not necessarily over. This is what comes from watching BBC World. I am interested in where we are at. They have said that there's a possibility that it may come back to Hong Kong. Your report says that Canberra Hospital is able to isolate 12 patients in negative pressure rooms and that Calvary Hospital has a negative pressure room in accident and emergency. How many could that take at a maximum?

Dr Dugdale: It can take one person per negative pressure isolation room at any one time. As for SARS in general, the first thing to note is that we work very closely with the Australian government and with the World Health Organisation. Currently, the World Health Organisation, which do global surveillance for SARS, do not have any active infection identified anywhere in the world. So they've put the world off standby for cases from certain parts since July.

It is quite possible that there is still some of the SARS virus circulating that hasn't been identified and that it could come out from that spot. So all countries participating with the World Health Organisation are maintaining that surveillance. I think it's fair to say that, if there was any case that looks a little like SARS, there is an extensive effort to identify it at the moment.

The ACT, along with Australia, does have a SARS response plan and the plan is essentially similar to what we saw in Canberra when we were under active notice for SARS. It is part of our emergency response plans for the territory. I am happy to answer any further questions.

MS MacDONALD: No. I was just curious as to our readiness if the risk arose again. Thank you.

THE CHAIR: While you're here, I might ask you, as I think you're the relevant person.

Dr Dugdale: I'll be here all afternoon.

THE CHAIR: I know, but you're here now and I didn't tag it, so I'd like to ask you now so that I don't forget. Have you got any information about antibiotic resistance and use of antibiotics for feedlots in the ACT? Obviously, we've only got Parkwood. Have you taken any interest in that issue? I would have thought it was very important for infectious disease control to know that we are not using incorrectly or extravagantly the last line of resistance in terms of antibiotics in animal feed.

Dr Dugdale: I can't speak for its actual use in the ACT for animals; that would be a matter for the chief vet and for agriculture, but we have taken a very active interest in the policy questions of antibiotic resistance and their use in animals, through the

Australia New Zealand Food Standards Council, of which Minister Corbell is a member. This government continued the very active interest of the previous government in putting the ACT at the forefront of that issue nationally. I've had a number of meetings with Commonwealth agencies on it. The other thing is that the antibiotic resistance group of the NH&MRC has continued to be active, working on the issue. So there's been a lot of policy interest from the health side but ACT Health doesn't have jurisdiction over its use for animals as such.

THE CHAIR: But you must know; surely there's an interlinking there. The minister must have taken an interest or talked to the appropriate minister that deals with it in the ACT.

Mr Corbell: In the ACT we obviously don't have a large agriculture portfolio like other jurisdictions do.

THE CHAIR: Yes, but we've got Parkwood.

Mr Corbell: But we do have a level of agricultural activity and farming activity. The food ministers council has engaged in dialogue with the agriculture ministers to achieve an agreed position on the use of certain antibiotics as part of feed for animals. The ACT has raised concern previously about the use of particular antibiotics in food for animals and we have been successful in achieving agreement between both food ministers and agriculture ministers as to what is appropriate and what is inappropriate for use in terms of feed to animals. So we rely on the national standards that are in place and we seek to influence those national standards through the appropriate forums.

Dr Dugdale: I would just add something there. Recently the food ministers and agriculture ministers did a review of the arrangements for setting maximum residue limits for antibiotics. The problem was that in the past the levels were set by health ministers but they were set basically on the parameters established by the agriculture ministers, on veterinary recommendations. Food ministers, largely on the representations of the ACT on this issue, started to see that as a bit the wrong way round; that it should be more driven by health concerns. So the administrative path for the setting of antibiotic maximum residue limits has been revised and I think that that is, in large part, because of the concerns raised by ACT ministers over the last few years.

THE CHAIR: As I understand it, it's not just about residues in the animals; it's about the antibiotic-resistant bacteria that are left on the raw meat that will then be ingested through poor cooking or whatever, putting those antibiotic-resistant bacteria into the bodies of people, which is an issue if there's a massive trauma of some kind and they're put in hospital. That was the evidence from the World Health Organisation.

Dr Dugdale: That is a separate issue, and we're concerned about that, particularly, for example, with campylo-bacter. Not in the 12 months of this report but in, I think, the year before, we did a sample of chicken bought from supermarkets and other outlets in the ACT and found that many of them were contaminated with campylo-bacter. This is a common problem throughout Australia and is the reason why there's the advice to make sure that chicken is cooked through to the bone. We've done some education on that and we do a lot of education with food businesses.

THE CHAIR: Well, with respect, I don't think people do know about it. I don't think we've got time to go into it in detail now, but thank you for the information. I'm glad I was able to raise it anyway in a preliminary way.

I note that you have responded to some of the recommendations of this committee last year in terms of how you present the annual report. You said that you've picked up our recommendations. But there are still some areas, in particular our recommendation that the department should review its performance measures and use of numerical measures—that you should only use them where appropriate—and ensure consistency in the use of particular types of measures across various volumes of the annual report.

I don't see a lot of difference in the actual way that you've provided the measures and the measures you use. Are you doing more work on that now? What's your response to last year's recommendation on that? You can take it on notice if you want to; I don't mind.

Dr Sherbon: No. I'm happy to report that, following the minister's establishment of the ACT Health Council, which the minister has commissioned with the responsibility of overseeing and providing community input into the performance of the health system, we're currently in discussions with the Health Council over the provision of appropriate performance indicators raised since last meeting. So my staff and I are currently working on a suite of indicators to the Health Council, some of which may be numerical, some of which won't be numerical. I have before me a list of some dozen or so indicators that we're currently considering, all of which were derived from the health action plan. So that work is well under way.

Should you be interested in an indicator, I could probably give you some of the indicators that you may well be interested in today, but we are trying to get away from the simple things that we need to monitor anyway as we manage the health service—such as finance and access issues, waiting lists, emergency department access—and into more meaningful but longer-term measurements such as disease rates, survival rates for cancer, et cetera.

I would have to say that as a jurisdiction—once we broaden our performance reporting to disease rates and other more complex measures—on a national basis we would stand up well in front of our peers in terms of the comprehensiveness of our reporting. So I can report that work is now under way and, if you're interested, I do have some indicators to hand.

THE CHAIR: Yes, we'd be interested.

Dr Sherbon: Just to add to that answer: we weren't in a position at the time of publication of this report to reliably report progress or indicator results in our report, but we expect to do so next year.

We are mindful of the committee's comments regarding last year's annual report. It was one of the primary documents we took into account when compiling this annual report, as were the Chief Minister's directives on annual reports, so we were mindful of comments regarding the appropriateness of numerical information.

THE CHAIR: Yes, I can see that.

Dr Sherbon: The committee quite rightly pointed out last year that there was a zero or yes or no type thing, which was quite inappropriate. We have tried to remove those and would welcome feedback over other indicators, but I expect next year we'll be providing a suite of indicators far more long term and complex than the access and financial issues that are traditionally reported by health jurisdictions.

THE CHAIR: Thank you. I refer to page 13 and the Adolescent Mental Health Day Program. I'm interested in the whole area of adolescent mental health, obviously, and I would like to know what exactly is happening at the moment to adolescents who require to be in the acute setting. Are they going to the psych unit or are they sometimes going to the general hospital? I will have a question for the minister after that explanation about what you think should be happening.

Mr Jacobs: At present, of those clients who do need to be placed in a bed-based service, some are going to the acute psych unit at TCH. Some others with eating disorder issues et cetera would be going to the adolescent unit at TCH. Wherever possible, we do try and manage this client group in the community.

THE CHAIR: Would you agree that it's not satisfactory that adolescents are put in the psych unit?

Mr Jacobs: The mix of ages is definitely not appropriate and currently, with our strategy and action plan that we're working through at present, the indications are that we do need to identify specific beds for child and adolescent customers.

THE CHAIR: What does that mean in terms of outcomes?

Mr Jacobs: In terms of outcomes, in terms of trying to establish those beds, we have had dialogue with Southern Area Health Service and representatives from other areas in New South Wales, to talk about how we might be able to do a deal where we get a partnership arrangement and groups and beds for child and adolescent services.

THE CHAIR: In New South Wales?

Mr Jacobs: No. I think the focus would be to try and establish them here, and regions in New South Wales close to us would access those beds as well. The issue is about the size of the unit that we're trying to get in place and the economies of scale.

THE CHAIR: Where are they going now in New South Wales? Are they being put into adult psych units?

Mr Jacobs: If you talk to people just over the border, Queanbeyan, et cetera, they do have very limited access to the child and adolescent beds available in New South Wales. A lot of people who would benefit from a short stay in a child and adolescent bed are actually being managed in the community.

THE CHAIR: But the feedback, which I imagine you're getting too, particularly from parents, is that their adolescent children won't go near the psych unit, but they should be

hospitalised for a period of time because of the seriousness of their condition. So they are actually not going anywhere at this point.

Mr Jacobs: Well, I need to say that we are using those beds in the PSU and in the child and adolescent ward, but it would be preferable if we did actually have—

THE CHAIR: Yes, but what I'm saying is that they won't go there.

Mr Jacobs: I understand that.

THE CHAIR: So you're trying to find greater economies of scale by working with New South Wales Health to set up a unit here; is that the idea?

Mr Jacobs: That's right, yes.

THE CHAIR: Are you taking that into account with your thoughts for the budget coming up? Is this a serious strategy or are you just talking about it as maybe one day a long way away? Is it a priority for you?

Mr Corbell: Well, there is a whole range of priorities across the health portfolio; I don't want to pre-empt budget processes. But it would be fair to say that the department has given me advice on the establishment of a purpose-built facility or a specific facility for young people with mental health concerns, and I'm considering that at the moment. It's certainly part of the government's budget considerations.

MRS DUNNE: Mr Jacobs, how many beds do you think you need to meet the needs of ACT and regional people in child and adolescent mental health?

Mr Jacobs: It depends on the model you look at. But, for the population we've currently got, just focusing on the ACT, the suggestion is that we need around four to six beds. That's why we are looking at a wider catchment, to increase the bed numbers.

MRS DUNNE: So, if you weren't looking at the region, you'd be looking at something less than six beds, and therefore it becomes prohibitively expensive to do?

Mr Jacobs: It does become very expensive and—

MRS DUNNE: What would be the optimal number?

Mr Jacobs: We have done some research around various jurisdictions. Some of the better-run units are around 15 beds. I do need to say that they are still costly beds compared to general psychiatry, but a 15-bed unit seems to be around where it's optimally placed, from what we've seen.

MRS DUNNE: There has been a lot said about the appropriateness of the facility at the Canberra Hospital and whether it should be redone, remodelled or removed to another place. Is there scope for co-locating adult and child and adolescent so that the two groups are quarantined? Are there economies of scale by co-locating them?

Mr Jacobs: That is a very complex question. Basically, as we look at it, we really need to look at all the planning issues that impact on this. One issue about adolescent beds is that it is clearly indicated that it would be useful if they were in close proximity to an adolescent day program. Currently, the acute psych unit is at TCH and the adolescent day program is next door to Calvary. The reason for change is that people in the in-patient unit could then graduate into a day program and that sort of thing. As part of the master planning process, we need to look at how we can best co-locate those beds.

MRS DUNNE: Okay.

Mr Jacobs: On your other comment: if you're looking at four to six beds, co-locating with another facility would probably need to be considered to get some benefits of economy of scale.

THE CHAIR: Are you interested in the EPPIC model in Victoria? Is that what you're envisaging when you're looking at this?

Mr Jacobs: Around the early psychoses component?

THE CHAIR: Yes.

Mr Jacobs: We currently have staff that were involved in that and rolling that out within our organisation. The evidence is very clear that, if you can have early interventions with first onset psychoses and such, you can significantly reduce the demand on the mental health system longer term, so that would be a focus for this type of unit.

THE CHAIR: Yes, because they've obviously got the in-patient facility with that centre in Victoria, so that's seen as critical. So that's part of your thinking?

Mr Jacobs: Yes.

THE CHAIR: Thank you. I have what is a comment, really. On page 15, your nursing pay rise is listed as an "initiative" and I'm just a bit curious.

MRS DUNNE: It was in the budget as well, Madam Chair.

THE CHAIR: It's really a responsibility and an obligation rather than an initiative. That's just really a comment; but, if you want to respond, Minister, go ahead. I just wouldn't have thought it was a new initiative.

Mr Corbell: Well, I guess we can go around the mulberry bush, if you like. But I think it's reasonable to say that, when the government commits to providing significant wage increases, it is certainly an indication of the government's commitment to valuing its work force, recognising the level of expertise that that work force has and appropriately rewarding that. In the context of significant work force shortages in a whole range of health professions, it's not unreasonable for the government to highlight that, and that's what we've done.

THE CHAIR: Okay. You've mentioned the midwifery program. We are actually doing a full inquiry into that at the moment as well, so I don't think I will ask any questions on that, unless someone else wants to. We'll be dealing with that in more detail.

MRS DUNNE: On page 25 there are three tables in relation to outputs of activity, the quantity of activity and the quality of services. My understanding is that TCH has conducted patient satisfaction surveys over a long period. How long have they been happening?

Dr Sherbon: I'll have to take that on notice, Mrs Dunne.

MRS DUNNE: A long time.

Dr Sherbon: It is a considerable period of time. I can't give you the first date.

MRS DUNNE: Don't bother to take it on notice. Is it a consistently administered survey? Has it changed over time or is it consistent?

Dr Sherbon: I believe there were some changes this year, but the essence of the survey remains valid in terms of the basic understanding of patient satisfaction. There were some variations in the year that is reported here.

MRS DUNNE: Okay. Do you see, Minister, that there seems to be a fairly dramatic decline, nearly eight per cent, in in-patient satisfaction over the period of this annual report, and to what can you attribute that?

Mr Corbell: The advice I have from the hospital, from the Director of Epidemiology, is that it's very difficult to compare the figures year by year in a survey of this kind. The number of people surveyed and the different treatment for each patient will give a variance in patient satisfaction. So it's always a difficult exercise to compare like with like. That said, I would make a couple of comments. First of all, overall any satisfaction rating of 78 per cent is still a very strong satisfaction rating, with the qualification that I've just made. Any decline is a matter for concern. It's interesting to note that the most significant decline in these figures is in relation to the emergency department—

MRS DUNNE: Yes, I'm getting on to that.

Mr Corbell: It's worth highlighting that in regard to that we have seen a significant increase in presentations at our emergency departments over the past 12 to 18 months.

MRS DUNNE: Can I just stop you there, Minister?

Mr Corbell: Can I just finish my answer? Therefore, there are concerns about the timeliness with which people with lower priority health complaints are seen. That may account for some of the decrease in relation to the emergency department.

MRS DUNNE: I think you need to read the table on page 25, Minister, and see if you are comfortable with the view that you've just expressed—that the decline year on year is the largest in the emergency department—when it is in fact less than a one percentage point decline in satisfaction in the emergency department. I take your point about the

number of people and the different conditions that they might present with, but consistently over three financial years—interestingly enough not all those figures are in the report—there has been a figure in the high 85 per cent. In the 1999-2000 hospital annual report, it was 86.1. In the hospital annual report for 2000-01 it was 85.5. Last year it was 85.4 and then there is a massive drop of 7.6 per cent, nearly eight per cent. It is a consistent pattern of the high 80s. Do you feel comfortable saying that 78 is still very strong when for the three years previously it was around 86?

Mr Corbell: I was simply referring to something your leader said today in his statement when he indicated that those most dissatisfied were those visiting the emergency department. I'm simply responding to that particular claim.

MRS DUNNE: No, I don't want you to respond to a claim in a press statement. I want you to respond to the question.

Mr Corbell: If I can just finish my answer, I'll be very happy to answer your question. The level of satisfaction is still very strong. There are a number of qualifications which I have received advice on from the hospital with regard to the reliability of some of these figures and the variability in the outcomes. Whilst any decline is a matter of concern, I would still have to say that, when over three-quarters of all patients express satisfaction with the public hospital, that is still a very strong satisfaction rating.

MRS DUNNE: Could you provide for the committee then the advice from the department about the unreliability of the figures? This is definitely something to be put on notice: could you inform the committee whether there has been an ongoing concern about the reliability of those figures or whether this is a new and sudden concern, given the dramatic drop in in-patient satisfaction from 2001-02 to 2002-03.

On the subject of decline in the emergency department over the period of reporting here, 2001-02 to 2002-03, the largest drop is in the emergency department, but I was asking you about the drop over the last year, Minister. I still haven't got a satisfactory answer. You're saying that any drop is a matter of concern, but what are you going to do about that drop, apart from blame the figures?

Mr Corbell: I'm not blaming the figures; I'm simply seeking to put the figures in some context. I'm happy to take the question on notice, Mrs Dunne, and provide you with what I can provide you. In relation to what the department and the government are going to do about it, if you look at the note under that table you will see that it is already indicated in the annual report how these particular issues will be addressed by the Clinical Governance Executive Committee.

MRS DUNNE: So does that mean that the comments that go with the survey—the qualitative information rather than the quantitative information—is being addressed?

Dr Sherbon: Yes, indeed.

MRS DUNNE: And what sorts of things are in the qualitative information that would contribute to patient dissatisfaction?

Dr Sherbon: We can get you, on notice, a brief precis of those comments. I can't give you a run-down today, but I can confirm the minister's statement that the greatest concern of patients that is reported to us is the waiting time in emergency departments. As the minister is on record as publicly saying, we are working with the federal government to improve GP access so as to reduce that waiting time.

There will be a range of other issues, Mrs Dunne, so we will give you a summary of those.

MRS DUNNE: Minister, would you be committing yourself to try to set a target of getting your client satisfaction, say for in-patient services, back to the 85 per cent mark—where it has been for at least the last three years, to my knowledge?

Mr Corbell: It's interesting that we have this discussion in the context of numerical measures versus other measures, which is the issue Ms Tucker raised earlier and the desirablility of those.

MRS DUNNE: I'm quite happy to talk about qualitative measures as well.

Mr Corbell: Mrs Dunne, I'll be committing myself to improving health service provision in ACT Health—and that's across the board.

MRS DUNNE: So that's a no.

Mr Corbell: No, it's not a no. I am saying that I will commit myself to improving health service provision for public health services across the board, as I have been since I've been minister.

THE CHAIR: I think this question is related to complaints as well, which we can talk about a bit further on.

MRS DUNNE: While we're on this subject, would you be prepared to set a target of getting back to the 86-ish per cent for client satisfaction in the emergency department?

THE CHAIR: I think the minister just answered that.

MRS DUNNE: No, no. I asked about in-patients.

Mr Corbell: I think I've answered that question.

THE CHAIR: So you have the same answer? What are you saying to that? Mrs Dunne is asking for a target for a different area.

Mr Corbell: What I am saying, Madam Chair, is that my commitment is to improving health service provision across all the services provided by ACT Health.

MRS DUNNE: Minister, can you tell the committee when you became aware of the results of the client satisfaction survey for 2002?

Mr Corbell: I was not aware of the detail of it until today.

MRS DUNNE: Until today?

Mr Corbell: Yes. I don't for a moment pretend that I know the annual report back to front.

MRS DUNNE: But aren't you interested in whether the people who go to hospital—

MS MacDONALD: Mrs Dunne, I don't quite see how that informs the debate about the annual reports, and I don't think that's a relevant question.

THE CHAIR: Hold on. I'm chairing this meeting.

MRS DUNNE: This is a measure in the annual report.

THE CHAIR: Order! You've asked specific questions and the minister has answered them. We don't have the time to get into this political argument at the moment.

MRS DUNNE: I just asked when he became aware and he's saying—

THE CHAIR: Yes, and he said "today", and so you want to ask whether that means he's not interested. I don't see that that's useful.

MRS DUNNE: No. I haven't said that. But you have given an explanation of sorts and I've asked that you might table that explanation.

Mr Corbell: I will just briefly respond to Mrs Dunne's assertion that I'm not interested.

THE CHAIR: No. I've said we're not pursuing it.

Mr Corbell: I'm sorry, Ms Tucker, but she has put it on the record and I would like the opportunity to briefly respond.

THE CHAIR: Well, be brief then, because we've actually got real information we want to get out; we don't need a political bun fight.

Mr Corbell: Indeed, and I'm very happy to facilitate meaningful information provision to the committee. I think it would be churlish and childish in the extreme to suggest that any minister is aware of the detail of absolutely everything that is covered in an annual report of a department of this size.

THE CHAIR: Thanks. Can I ask a question on the same page, on ecologically sustainable development. The whole-of-government section of the report is on page 184. This is really just a comment. I know you do have it in the index; but if you could just put a page number in when you refer to another section of the report, it speeds it up for people reading. It is in the contents, but you have to go backwards and forwards. It's easier to just flick through.

Mr Corbell: Yes, it's a reasonable comment and I'll take that on board.

THE CHAIR: I'm interested in how health is looking at this. You say, for example, that you're attempting to meet greenhouse gas emission targets and so you've acquired four-cylinder vehicles and you have trialled a hybrid electric/petrol vehicle, which I assume is the Prius. What was the result of that?

Dr Sherbon: I'll have to take that on notice in terms of the actual reported result; but you are aware that the Chief Minister and the Chief Minister's Department have given a commitment that each department will have such a hybrid vehicle, so we're currently acting on that commitment.

THE CHAIR: So one vehicle?

Dr Sherbon: The directive is at least one. So we're working on that at the moment. I can't give you a report as to how the vehicle performed; I can take that on notice. But the department is enthusiastic about playing its role in the sustainable development strategy of government.

THE CHAIR: Do you have targets?

Mr Corbell: In what regard?

THE CHAIR: In any regard. You've got an energy audit completed, energy saving recommendations included in the capital works program and then you've got another list here of other ways that you have reduced energy use. That's commendable, but I'm just interested to know what the direction is if you have a strategy to reach certain targets in terms of reducing greenhouse gases. You're recycling paper. You're recycling your toner cartridges. I don't know how much paper you're recycling or if you're setting yourselves targets to improve your performance in terms of the energy use of the hospital. Do you have that kind of depth of your response to the requirement to report on ESD, or do you just report on what you've done, without particular targets or time lines in mind?

Dr Sherbon: We do report on what we've done. I'm advised that we don't have a particular target for ACT Health per se, but we are participating in the whole of government ESD strategy. I can let you know how we performed with the hybrid car and give you the feedback from that trial. We participate in the whole of government strategy; we are a significant component of that because our facilities are large and energy intense, as you know. We don't have targets per se.

THE CHAIR: And do you link up with the Office of Sustainability in this exercise?

Dr Sherbon: I can only inform you that we work through our whole-of-government strategy.

Mr Corbell: The Office of Sustainability is obviously a key element of establishing and formulating the whole-of-government position, which departments are then asked to work towards, so it would not be normal for ACT Health to be engaged day to day in discussions with the Office of Sustainability. Their role is more—not exclusively—at a whole-of-government level.

THE CHAIR: No. My point wasn't that they should be engaging on a day-to-day basis. My point is that the Office of Sustainability is supposedly where the expertise lies and that they could be assisting Health, who would not have normally in their field of expertise how to save energy. I was just interested to know what the role of the Office of Sustainability is in supporting agencies trying to do this important work.

Mr Corbell: The Office of Sustainability doesn't have all the expertise that you would expect for a whole range of issues to do with environmentally sensitive and ecologically sustainable approaches to energy use or otherwise. Certainly they have a level of expertise, which is welcome, but it's still very modest in the context of, say, other jurisdictions. If there were particular issues that needed to be addressed, I would imagine that ACT Health, and indeed any other department, would seek that expertise externally if it was not available within government.

THE CHAIR: So each agency's being left to deal with these questions on their own?

Mr Corbell: No. I didn't say that. There is a whole-of-government strategy which departments are asked to work towards and required to work towards.

THE CHAIR: Co-ordinated by whom?

Mr Corbell: It is the responsibility of each chief executive to ensure that their department adheres to whole-of-government positions. There are management functions within government that allow for coordination between departments. For example, chief executives meet on a regular basis to coordinate their approaches to whole-of-government issues. Environment ACT, I'm advised, has a role in coordinating the implementation of that particular strategy, as it is the relevant portfolio area.

THE CHAIR: So sustainability actually includes social outcomes as well, and that's listed here, which Environment ACT, from what I'm aware of, has staff to deal with. That's where we thought the Office of Sustainability came in. How would you report on working with the social issues of ESD?

Dr Sherbon: The social issues of sustainability are vital to our organisation. We work with the Chief Minister's Department, who you're probably aware are coordinating a whole-of-government approach to social issues across the territory. I attended all of those consultations, and sustainability was a key discussion point at each of those consultations convened by the Chief Minister. Health issues will figure prominently in the whole-of-government response to social issues across the territory, which I understand the Chief Minister is currently considering.

THE CHAIR: So you're saying Chief Minister's coordinates the whole-of-government approach to social sustainability? Environment ACT is working with agencies on ecological, physical and environmental issues?

Dr Sherbon: Correct.

THE CHAIR: And the Office of Sustainability is where in that?

Mr Corbell: If you want to ask more detailed questions about policy coordination regarding ecologically sustainable development, it might be appropriate to ask the responsible minister. I understand what you're trying to get at. But, with all due respect to my colleagues, I and officers of ACT Health are not across the intricacies of coordination of ecologically sustainable development policy. That is the responsibility of the Chief Minister as Minister for Environment, so you should pursue that with him.

THE CHAIR: That is a fair point, but I'm interested in how it feels from your end, for exactly that reason. That's why I've asked you where you feel you're getting support; that's why I was interested.

Mr Corbell: Okay.

THE CHAIR: I think it's afternoon tea time. I welcome Brendan Smyth here.

Sitting suspended from 2.30 to 2.44 pm.

THE CHAIR: We'll recommence this hearing. We've just been talking about pages 24 and 25. Minister, perhaps you could explain the figures on the emergency department access section. I'm particularly interested to know what it means as far as people and time are concerned. This is a good example of a measure that's a bit of a worry in some ways. You have this increase in waiting time and an obvious drop, depending on the seriousness of the issue, I'm assuming. You've still got a high response rate for those that have to be seen immediately, if I'm understanding these figures correctly. But the further you go down, you see the biggest drop in the appropriate response.

Mr Corbell: That is correct.

THE CHAIR: Can you explain what this means with regard to waiting times and the number of people we're talking about in these categories? Can you also explain what you see as the problem? Why is this happening? What are you doing to address the issues?

Mr Corbell: I'll give a quick overview and then ask officers to give you a bit more detail. Both of our public emergency departments handle around 50,000 people every year. TCH sees about 50,000 people and Calvary public hospital sees about 46,000 people per year.

THE CHAIR: They have seen 1,000 fewer emergency department attendances this year, by the look of it.

Mr Corbell: I'm advised that that is at TCH, not at Calvary. It is my understanding that they are seeing growth at Calvary. I was at Calvary today launching the new clinical decisions unit, which provides an additional 12 beds to allow Calvary public to accommodate that growth in the emergency department. With these figures, categories 1 to 5 are based on the Australian health-care standards. They are uniform national standards for seeing patients within particular periods of time, based on their acuity. The performance of our hospitals places both of our hospitals in the top 33 per cent of hospitals around the country. We perform much stronger than many other hospitals in other major metropolitan centres, but we are seeing pressure in the lower acuity categories, particularly categories 4 and 5.

In those categories, they are essentially people presenting to EDs with the sorts of complaints which could normally be dealt with by a GP. That comes back to the GP work force issue and the availability of GPs. We are seeing increased waiting times in those lower categories simply because we are seeing more people. We are seeing higher acuity, so that means we are seeing more people presenting with more complex or more urgent problems and they must be seen first. That, combined with an increase in the number of presentations of people with low acuity, is putting pressure on our EDs and results in longer waiting times for people with lower acuity. Perhaps Tony would like to expand on that.

MRS DUNNE: Before Dr Sherbon expands, can I go back? You said, Minister—and this seems to be something that is often said—that we are seeing more people with higher acuity and that we're seeing more people in categories 4 and 5 because of a lack of GP services. This is stated by the states and territories, but it isn't necessarily borne out by the figures. Do you have figures to demonstrate that this is the case? The Commonwealth doesn't agree and I would like to see the figures the ACT has to bear this out.

Dr Sherbon: I can confirm, as the minister answered, that there is a very rapid growth in emergency department attendances at Calvary. It's less emphatic at TCH, as you've noted in your examination of the report. There is an increase in acuity through the emergency department which brings greater stress. There is also an increased requirement in the amount of investigation and treatment that is expected in the emergency department as technology and the options available for patients increases.

We also have profound evidence in the ACT of impaired GP access. If you compare the March 2003 quarter with the March 2002 quarter in respect of utilisation of the medical benefits schedule in the ACT for GP items, there is a 4 per cent decrease in access. That's profound—a one in 25 decrease.

MRS DUNNE: What would be the reasons for that?

Dr Sherbon: Reduced GP availability, higher gap costs for patients and reduced GP hours. It's a multifactorial problem which, as the minister has outlined, is an issue we're working on with the federal government, through the negotiations on the Australian health-care agreement and other issues. There is ample evidence in the ACT that fewer and fewer people can get to see a GP, which is borne out by the federal government's Medicare statistics.

Mr Corbell: On the issue of statistics, Mrs Dunne, I'm advised by officers that we've seen a 15 per cent increase in the last couple of years in categories 4 and 5, presentations at EDs. I'm happy to take on notice and provide some further details on those statistics.

MRS DUNNE: That would be great. I'd like to see the figures.

THE CHAIR: What happened with Health First? I thought that it was making an impact on reducing the load on A&E.

Mr Corbell: The numbers speak for themselves. We're still seeing a growth in ED, regardless of claims that may be made about the success of Health First.

THE CHAIR: Have you done an evaluation of Health First?

Mr Corbell: Yes. There has been ongoing monitoring of the impact of Health First in relation to presentations at hospitals. From my examination of it and the advice I've seen from the department, there's no demonstrated impact in the level of reduction of presentations at EDs. It may be that, if we didn't have the work force issue with GPs, there would be. But I think there are too many factors there for a claim to be made that Health First is having an impact, because the figures speak for themselves.

THE CHAIR: I will go back to my original question, which you may need to take on notice. I would like to understand more what these statistics mean as far as people and times are concerned. Is that something you can talk to now, or would you prefer to get back to us?

Mr Corbell: I'll take the question on notice.

MR SMYTH: Will the breakdown in answer to that question contain details on the number of category 1 patients being seen, for instance?

Dr Sherbon: Yes. I don't wish to pre-empt the minister, but I was hoping to have that information for you now. It may be with us in a matter of minutes, if you wish to wait, but the minister may be able to provide it.

THE CHAIR: We will move on, because we have a lot to get through.

MR SMYTH: Before we move off that table on page 25, it seems that there are two sets of targets and two sets of outcomes. On page 25 you quote one set of figures, but there's a different set of figures on page 210 referring to emergency department access. On page 210, the third paragraph says, in relation to the timing of the treatment of patients within emergency departments, that the results were unable to be independently verified. You list electronic records which show a very different picture from what's listed on page 25. Why are there different sets of figures and why are they contradictory?

Mr Corbell: I will deal with the verifiable issue and ask Dr Sherbon to address the other element of your question. In previous years, the auditor has signed off on these measures as being able to be audited and independently verified. This year, the auditor has taken a different view. They have indicated that they are not satisfied that that particular measure can be independently verified, the reason being that this information is entered electronically by the staff in the emergency department. The auditor is now requesting that there be a secondary source of data entry, effectively, so that he or she can audit it and it will be independently verifiable.

MRS DUNNE: There's no paper record.

Mr Corbell: There is no paper record. It is entered electronically by the staff. The advice I have from the hospital and from ACT Health is that it would be unreasonable to request that staff in the emergency department make the time to go back and write the

information down manually, as well as entering it electronically. I don't think it's reasonable to ask staff in the ED to do that. That point has been addressed in the footnote to that particular measure. The standards we use are the standards used nationally. The standards have previously been agreed by the auditor for many annual reports before this one. This year the auditor has taken a different position.

MRS DUNNE: What you're saying, Minister, is that the table on page 25 is a continuation of the practice over many years and that nothing in the information this year deviates from the way it was compiled previously.

Dr Sherbon: The minister was addressing the auditor's comment about not being verifiable. The discrepancy in the figures on pages 210 and 25 can be explained thus: the figures on page 210 are the electronic figures and, particularly with more urgent patients, medical officers who see patients often do their electronic record after they have seen the patient. Often, as the record is entered onto the electronic system, it is some minutes, or even hours, out of date.

You may be caring for a patient who is critically ill for two hours. You then go to the computer to record the necessary information and the record that's automatically clicked up on the electronic data is out of date. There is a process within the emergency department to examine that electronic data, as it is aggregated monthly, and then reconcile it to the records of the patients. If we were being sneaky, we could give you the electronic data, but we have given you the reconciled data, which is different. That is why the two sets of data are different.

In respect of the audit, as the minister said, we have the same system that's in operation around the nation. Some places have fully automated systems with bar coding, et cetera, but their data is no better than ours, I'm reliably informed. The data is collected electronically and then retrospectively adjusted, particularly for the higher urgency patients.

MRS DUNNE: The reason there would be an apparent non-meeting of the target for category 1 patients, if you rely entirely on the electronic record, is simply that doctors are actually seeing the patient, rather than writing about it?

Dr Sherbon: That is the case.

MRS DUNNE: In fact, it shows a better performance for categories 4 and 5, which would possibly bear that out as a reasonable explanation.

Dr Sherbon: The electronic data is biased towards 4 and 5 because it tends to be easier to collect. But, often when we go back and check that, in the lower urgency categories we tend to err on the side of conservatism. That's why the figures are different.

MRS DUNNE: How are the figures reflected on page 25 captured? Are they paper figures? How is the information on page 25 captured—the emergency department access?

Dr Sherbon: Those figures rely on the emergency department and hospital interpretation of an amalgam of electronic data and paper-based data, whereas the figures on page 210 are purely electronic.

MRS DUNNE: I have further questions, now that we've sorted out the discrepancy in the figures.

THE CHAIR: Can you put them on notice?

MRS DUNNE: I can put some of them on notice, but I want to address the minister. Minister, there seems to be a worsening of the outcomes. I don't want to dwell on categories 4 and 5, but categories 2 and 3—especially category 3—are below the national target. We have always been above the national target for categories 2 and 3 but, over the past three financial years, we've seen an 8-percentage point decline in the time it takes to be seen as a category 2 patient. Can you explain that?

Mr Corbell: I'm sorry, Mrs Dunne. Could you repeat the last part of your question?

MRS DUNNE: Over the past three financial years, there seems to have been an 8-percentage point decline in the number of people seen in 10 minutes. Although it is above the national target—in the high 90s—it has gone from 99 per cent to 91 per cent. Can you explain that decline?

THE CHAIR: The minister has explained it. He has already told the committee what the pressures are. Which bit of that answer aren't you satisfied with?

MRS DUNNE: I haven't had an explanation for the decline.

THE CHAIR: What the pressures are?

MRS DUNNE: We have had an explanation in relation to categories 4 and 5 and I take that as granted, but—

THE CHAIR: I thought the minister was talking about the whole table—the pressures.

MRS DUNNE: We all know about the pressures. I see a marked decline in category 2 patients of 8-percentage points over three financial years, and an even larger decline of category 3 patients—people who should be seen in 30 minutes—of, in fact, 20-percentage points over two financial years. Is there an explanation over and above the fact that there are pressures on the hospital system?

Mr Corbell: As I said before, Ms Tucker is quite correct. Our EDs are busier and the acuity is higher.

MS MacDONALD: My question is in respect of pages 29 and 31, relating to food services. I note from page 29 that you've extended the cook and chill food service to external clients. On page 31, there's discussion of food services in general. When was cook and chill introduced?

Mr Corbell: It was introduced by the previous government. I can't recall the exact date.

MS MacDONALD: How does it operate? I've heard that it's being produced in Goulburn.

Mr Corbell: No. It's produced in the ACT—in the hospital. If you like, I can arrange a tour, Ms MacDonald, because it's very interesting.

MRS DUNNE: I've seen the food. I don't want the tour!

MS MacDONALD: I've eaten the food recently!

Mr Corbell: I know there's much mythology around cook and chill, but when it comes to the quality and safety of food, it's a significant improvement simply because the temperature of the food is able to be maintained at a constant level and the food is delivered in a way which is safer for patients. I believe the staff at TCH do a very good job in delivering a very high quality product.

MS MacDONALD: I was a recipient of the food recently. I notice that it is said on page 31 that the department is committed to producing meals in support of the individual's, psychological, sociological and dietary needs during each stage of their hospitalisation. I note that actually tasting good doesn't appear in any of that.

Mr Corbell: I know you were in hospital recently!

MRS DUNNE: I can add to that, because we've had the same experience in our family. When it got to food, the client satisfaction declined a lot!

MS MacDONALD: I spoke to somebody who was recently in hospital—in the last five to 10 years she has spent nearly every second year in hospital for various reasons—and she made the comment that she believes the standard of the food has gone down. That's coming from somebody else. I know that, in a hospital situation, it's difficult to maintain mass-produced food which tastes good and also does what you need it to do, but I do have to say that the jelly tasted like fly spray!

Mr Corbell: There are always jokes about hospital food. The reality is that the hospital delivers an enormous number of meals every day and attempts to do it in a way which ensures that the food is first and foremost safe and nutritionally adequate for patients.

THE CHAIR: How do you assess the quality of the food in a hospital?

Mr Corbell: In terms of safety and quality, I'm not across the detail of that. I'm happy to take the question on notice.

THE CHAIR: There are two questions there. How do you assess the quality in terms of customer satisfaction? That is obviously a very important issue for people who are sick. Surely, there must be some benchmarking or some way of evaluating it.

Dr Sherbon: I can report that it is part of the patient satisfaction survey. When we get back to you with some analysis of the figure we were concerned about in our earlier

discussion, there may be a food component. Our aim with hospital food is that it be nutritious and that it contain a wide variety of menus for those who have special needs.

We're often compared to hotels and occasionally private hospitals, but we have a far broader challenge. We have to meet the needs of people who aren't able to eat solids and the needs of people who require intricate and well-measured diets. Some people in hospital are at very high risk if they get food that's not calibrated to their needs. It is a challenge for health-care services, but we measure the quality through patient satisfaction and also through nutritional audits by our nutrition department.

I can assure this committee that, although there is often a concern about hospital food, it is nutritious and it is tailored to the needs of the patient. I can assure you that, where a special diet is required, our people work very closely to ensure that that diet is accurate and meets the patient's needs. We get feedback from a range of patients whose stay is short, but you've got to remember that about 80 per cent of our patients stay only two or three days at the most. We do have a program of ensuring that it is nutritious.

THE CHAIR: On page 28, you make a comment about the patient episode initiation fee for pathology laboratories. I'm curious about what you're actually saying there. You're putting it as a major issue—that it's inequitable Medicare funding because the private providers can charge that patient episode initiation fee, which covers overheads, but you don't get that as a public provider. What are you saying there? What are you saying needs to happen?

Dr Sherbon: We're saying that our revenue per test is lower because we don't get the component that the Commonwealth pays private operators for their overhead costs. That's a Commonwealth policy under the medical benefits schedule.

THE CHAIR: You're just highlighting it as a problem—an inequitable situation.

Dr Sherbon: It highlights our competitive position. I must say that, as a recent arrival in the ACT, I was impressed to learn that we do have a very large share of the private market in ACT pathology because we provide a good service. However, we don't get the same revenue as a private operator would for that same market share, because we don't get the episode initiation fee. A pathology market expert examining this report would wonder why we weren't getting the revenue for the test. The answer is that we don't get the episode initiation fee.

MR SMYTH: How much is the fee?

Dr Sherbon: It cones down, depending how many tests are ordered in a batch. I can't give you the exact figure, but it's prescribed in the medical benefits schedule. I can get you a figure—on notice.

MR SMYTH: Do you have the same overheads as a private firm? How much of the work is done in the hospitals?

Dr Sherbon: We don't have the tax overhead, so there is some justification for the federal government's position on the medical benefits schedule fee. It has been that way for a considerable number of years, I can assure you. We don't have the tax burden of the

private sector, and some of our other costs may be less because we're a large operator with a critical mass derived from our inpatients. Nevertheless, it is worth while noting that, as stated here in the report, our revenue per test is lower.

MR SMYTH: That is a fair point. Wouldn't it have been more accurate to have included another sentence that simply said that, of course, you don't have the same tax burden or the same structure as a private firm? The way it is presented there, it states that you're clearly disadvantaged, but you can't tell us by how much you're disadvantaged, or if you are actually disadvantaged. That is because you don't have the tax structure. Where are the tests done? Where are the ACT pathology labs, in the main? Are they in Canberra and Calvary hospitals?

Dr Sherbon: Yes, but the Canberra Hospital lab is larger, by far.

Mr Corbell: It's a reasonable comment, Mr Smyth. We'll certainly take that on board.

THE CHAIR: I refer to page 40—the reporting of incidents. I notice that it says that a comparison of each six months of 2002-03 indicates that patient falls and medication errors in the graph shown continued to be the major problem areas at TCH and that strategies have been implemented in an attempt to reduce these incidents. I'd be interested to see detail of what the strategies are. You can take it on notice, if you like. I'm also interested to know what "other" refers to in that graph.

Dr Dugdale: I have overall responsibility for the AIMS program for the territory. Firstly, we can get you further detail on the responses to the falls and things there. There is good documentation on that, which we can supply. "Other" refers to a wide range of incidents—the sorts of incidents that happen in small numbers. Aggregating them, they would be classed in a group as "other". It's a wide range of all the other sorts of incidents that can occur, from communication problems onwards.

THE CHAIR: It seems to be quite a lot. You've got strategies to deal with what you see as the major problem areas, but how are you dealing with the others?

Dr Dugdale: The problem is that this graph has a very long tail. If you read over to the right, the documentation is the smallest group that's been reported separately and then each of the subsequent types of incidents goes on with smaller and smaller numbers. Because it has a long tail, they add up to be quite a large group.

Dr Sherbon: We can, on notice, if you like, give you a breakdown of that group.

THE CHAIR: Thank you. I'm interested to know how this compares going further back over the years.

Dr Dugdale: The AIMS system was installed only at the beginning of this series. We don't go back further than that.

Dr Sherbon: If I may counsel caution in future years—I know you'll ask the same question next year—worldwide experience is that, when you install an incident reporting system, the first year you get a set of data and then people get more used to using the incident reporting system and, over the first two or three years, you get an increase.

I counsel the committee that there probably will be an increase next year. That means we're getting better at reporting and analysing incidents.

Mr Corbell: I'll ask Dr Dugdale to outline the issue around falls, which you asked about, Ms Tucker.

THE CHAIR: The strategy and medication.

Dr Dugdale: Falls in acute hospitals are a major problem Australia-wide. Reducing falls is a key focus for the National Safety and Quality Council, and has been a key focus in the ACT. It seems that most things work, but sustaining a reduction in the number of falls is the difficult thing. Virtually any program will reduce the number of falls, but they'll climb back up again as the program ends.

We have been working with both hospitals, in the community and with the ACT falls clinic at TCH to try to build in protocols for the management of people who are at risk of falling, to systematically reduce the numbers. Specific factors are a risk assessment to identify which patients are at risk of falling—assessment of their medications, their general frailty, and the procedures they're having. Their medical problems would go into that risk assessment.

There would then be a specific approach for each patient at risk of falls, whether that be accompanying them in the shower, making sure that they sit down in the shower, making sure that they've got the sides of their beds up, and changing their medication. That has been quite successful at Calvary Hospital, where we've been able to maintain a sustained reduction in falls. With TCH, we would be looking to see a sustained reduction come out in the figures as well.

THE CHAIR: Is it a big burden on staff to have these extra procedures? I'm aware that they're already under a lot of pressure. Is there tension there? You're trying to make it work better, but the nurses are already.

Dr Dugdale: This is not one of those programs where we have any trouble securing staff cooperation. Most staff, once they've become a bit experienced, have had a patient who has fallen and it's a terrible thing. You're supposed to be looking after them and then they fall and, particularly if the patient injures themselves, it stays with people. There's generally very good staff support for these programs.

THE CHAIR: That wasn't quite my question. I'm sure that they want to prevent falls, but I'm interested in knowing how they are supported to become part of an improved system. From my experience as a visitor to a hospital recently, I was stunned by how little spare time there was for any of the sisters or nurses.

Dr Dugdale: This isn't an activity that occurs in their spare time. Identifying people who are at risk of falling is core business. For example, in the original intake assessment, when a patient comes onto a ward and a nurse does their initial assessment, building a falls assessment into that is simple and part of the job. Doing it in a way that reduces falls can be done quite efficiently, if the systems work.

MS MacDONALD: If you've reduced the risk of falls and you have somebody who has fallen, it's going to add to the pressures on you in that workplace.

Dr Dugdale: Certainly.

THE CHAIR: What are you doing in regard to medication?

Dr Dugdale: Medication error is again a priority for the National Safety and Quality Council. They have commenced a national medication error collaborative. I think they're looking to have about 100 hospitals participate. Calvary and Canberra hospitals have both signed up to participate in that collaborative. It's early days for it.

THE CHAIR: What's the aim of the collaborative? Is it to work out how to deal with it or to do something?

Dr Dugdale: The way these quality projects proceed is by identifying the specific errors, identifying how they occurred, and then changing the system so that they can't occur again.

THE CHAIR: It's analysing the accidents or the incidents, as you call them.

Dr Dugdale: That's right. The Japanese say, "Every error a treasure." There will be national data collected on medication errors and a national analysis done. Each hospital will get the benefit of that national analysis, so that rarer medication errors which occur only once every few months in any particular hospital but are occurring at a rate of 10 or 15 a month across Australia can be identified and the systematic problem identified. Each hospital will be told, "We've worked out this one. If you change this system, you won't have any more problems with this specific error."

It's quite a long haul working through a whole series of different types of errors relating to the different types of medication and the different settings in which they're involved. Maybe cancer's the wrong analogy, but there are all sorts of different types of medication errors and we will be working across the board with all those different types, to reduce their rate of occurrence. I think the national collaborative is a great way to go, because of the power you get from aggregating all of the errors and the data from around the country. You get more power from interpreting that.

THE CHAIR: When are you expecting that to come out with suggestions or recommendations?

Dr Dugdale: It's under way now. This has been a problem in hospitals from time immemorial—so you're always trying to reduce the errors. The national collaborative is just starting to provide specific advice to participating hospitals.

THE CHAIR: When was the Tito report? That was about five years ago, wasn't it?

Dr Dugdale: There have been a few Tito reports.

THE CHAIR: The one on adverse incidents. I remember there was one on this. I thought it was about four or five years ago. Is that not right?

Dr Dugdale: I'm not familiar. It might have been before my time.

THE CHAIR: That is the first one I was aware of on this.

Dr Sherbon: I think it was about 10 years ago.

MR SMYTH: On the same chart, is there an actual number for the first and second six months of the year of the number of events that occurred?

Mr Corbell: Do you mean for this financial year?

MR SMYTH: For the year represented by the report.

Dr Dugdale: Which chart?

MR SMYTH: The chart we're talking about on page 40—about the AIMS data. What's the total number of events in the first half of the year versus the second half?

Dr Dugdale: We'd have to get you that. It's the sum of those columns, for the mathematically minded.

MR SMYTH: The columns are open to interpretation on the chart. Are the falls 240 versus 235 or 230? Can we just have the numbers?

Dr Dugdale: We can provide that information.

MR SMYTH: I can work them out and add them up, but if you've got the numbers there, that would be more accurate.

Dr Dugdale: You'd like a table that tabulates the data on this chart?

MR SMYTH: Yes.

THE CHAIR: Did you tell me what the timeframe was? Did you say there was a definite time?

Dr Dugdale: You asked me when the medication collaborative would be commencing. I said it had already commenced

THE CHAIR: No. That's commenced in terms of bringing all the data together. When are you expecting it to finish so there are recommendations for hospitals to put different systems into place?

Dr Dugdale: Sorry, the recommendations come from it continually. It's an iterative process.

THE CHAIR: I refer to page 41 also. I guess this is feedback on the information you're presenting. This is particularly on complaints. It would be interesting for the committee,

or for the community, to know more about the complaints—what they are and how they're managed.

Dr Dugdale: To which particular graph are you referring?

THE CHAIR: On page 41, you've got the complaints in a circle. So we know what areas the complaints are in. To help the committee understand where we are going with this and how the situation is improving, it would be interesting to know what the complaints are and how they are managed.

Dr Sherbon: We can do that with the minister's concurrence.

Mr Corbell: Yes, we can do that.

Dr Sherbon: The notice will provide a breakdown of the nature of the complaint. In generic terms, all complaints are acted upon and viewed in light of the systems available at the time. If a system requires improvement, then action is taken. So it's a classic quality improvement cycle.

Mr Corbell: It's worth highlighting the strong commendations the hospital receives every year. In fact, they outweigh the complaints.

THE CHAIR: Would it be possible for you, in an annual report, to give us examples of complaints and how you have dealt with them? That would give a picture of how you're working. You're telling us that the complaints are used as treasure, error and all that. That is great, but to assist us in understanding accountability issues, it would be useful for the committee to be able to see how the health department deals with complaints.

Mr Corbell: Whilst having regard to privacy issues.

THE CHAIR: Obviously, yes.

Mr Corbell: I'm happy to look at that and see if it's possible.

MS MacDONALD: I refer to page 47—medical imaging. The recruitment and retention issues of medical imaging staff are in no way dissimilar to the national situation. Is that a true or false statement?

Mr Corbell: In a number of key work force areas there are specific shortages. Medical imaging is certainly an area where there is a limited number of people available, but I'm not aware that it is as acute as in some other areas.

Dr Sherbon: Yes. There are 31 radiographer positions at the Canberra Hospital, of which four are vacant at this point in time. We want to provide a working environment that is attractive to radiographers. I point out that, as the minister reported, there's a range of other crucial hospital professional roles where we are undertaking comprehensive improvements in working environments to attract people. Some of the other major ones are radiation therapists and hospital pharmacists. So radiographers would be up there with those other two professions as our key foci for our newly

appointed allied health adviser, who'll be working with those staff to build an education, research and industrial package that is of interest to them.

MS MacDONALD: Is that package being developed at the moment?

Mr Corbell: It's an ongoing piece of work. My predecessor, the Chief Minister, commenced work on improving working conditions and flexibility of service for people in radiography, in particular, and that is continuing. I've had a number of discussions with the department about what steps can be taken to improve recruitment and retention of staff, particularly in radiography. I will continue to pursue that.

MS MacDONALD: There is another issue I wanted to ask about on page 47. Under the issues, you talk about the rapid obsolescence of existing stock. As far as I'm aware, it's one of the major issues we face in health these days—emerging technology replacing things. When we go through and buy a new piece of technology, what's the estimated time we expect it to be current?

Dr Sherbon: Obsolete?

MS MacDONALD: Yes.

Dr Sherbon: Medical imaging is a very high technological component of our health service. I think it's fair to say that, within months of the purchase of a machine, it's superseded by something better. An MRI costs just over $2 million, CT scanners range from $750,000 to about $1.2 million, depending on the quality you provide, and ultrasound is about half a million dollars for the top of the range. Obsolescence implies that it's either not useful any more or it is totally out of date. It probably takes a good four to five years for that to happen, in most of our modalities. Yet in ultrasound, in the last two years, there have been some major advances with 3D images. So much of the equipment bought more than three years ago is out of date.

What are we doing about it? We are reviewing all our procurement options. We've traditionally relied upon the purchase of equipment as a procurement option. We are now examining whether there is a benefit in leasing equipment, rather than purchasing, because it doesn't require that massive expenditure up front and allows for updating of equipment on a lower cash demand basis. There are implications for government that will be considered in that option, in that the total cost of the equipment does tend to be higher with a lease option. Nevertheless, we are looking to balance our repetitive procurement with the best value for government. That work is currently in train as part of the consideration by the government's expenditure review committee.

MS MacDONALD: Presumably the people who manufacture the equipment are prepared to lease it out.

Dr Sherbon: Definitely.

MS MacDONALD: No doubt they would prefer that we spent the money on buying it so we can pay a lot more again in four or five years.

Dr Sherbon: Sure. Their lease rates include a margin so, either way, they're usually happy. It's a matter of how the cost is spread out. Medical imaging have put forward a very good case for the fact that their specialty requires us to keep up with the technology race. So we are looking to adjust our procurement process to take that into account.

MS MacDONALD: Are the manufacturers of the equipment based mainly in the United States?

Dr Sherbon: Or Japan.

MR SMYTH: Moving on to page 49, the fourth paragraph of the reference to the medical services management team states that outpatient services increased in most clinical areas, with the notable exception of radio oncology, where staffing shortages resulted in an 18 per cent decline in the occasions of services below the target. I notice from pages 148 and 149 that the staff who appear prominently in the AWAs that have been awarded are medical imaging professional officers, radiation therapist professional officers, radiologists and pathologists. If it is attractive to those people who are in short supply to have an AWA—and the government is moving away from AWAs wherever it can—are you willing in this case, Minister, to make an exception and maintain AWAs for current signatories and give them the option to use specialists as well?

MS MacDONALD: That sounds like an ideological question, Mr Smyth.

MR SMYTH: That is why it has gone to the minister, Ms MacDonald.

Mr Corbell: That is fair enough, Mr Smyth. Previous ACT governments, particularly the previous ACT government, did not use any other mechanism to improve the rates of pay and therefore the attractiveness of positions in these sorts of work force specialities. What this government has done through the latest EBA for the staff means that there is no longer a need for AWAs and these rates of pay are now reflected and there are appropriate mechanisms in place through the agreement through the EBA to provide this level of flexibility.

MR SMYTH: If we have moved to an agreement and we still have four vacancies, has the movement to an agreement made the ACT a more desirable place to come and practise these professions, or is your move and, if you want to put it, your ideological bent in fact hindering the recruitment of individuals in these specialities to the ACT.

Mr Corbell: No, I would not suggest the two things are linked. The reality is that there is a national and, indeed, international work force shortage for this particular profession, which has made it extremely difficult not only for this health service and the hospital to recruit, but also for hospitals nationally and internationally to recruit and fill all their positions. The reality is that what we've had to do is something the previous government failed to do, which is to provide more wages growth. The previous government provided for a real wage decrease across a whole level of professions within the ACT government service. We have provided for real wages growth.

As a result, we have been successful in filling a number of positions within this particular department in the hospital, but we still have a number of vacancies and broader

recruitment activity is now being undertaken to fill those remaining vacancies, on top of providing for more flexible working arrangements, part-time working arrangements, and trying to attract staff who have previously worked in the area but who are no longer working in the area and are no longer in the work force to consider coming back into the work force to assist in making sure we've got as many people available as possible. I'll ask Dr Sherbon to outline what recruitment activity has taken place so that you can get some sense of what positions have been filled.

MR SMYTH: That will be interesting. Before we get to that, has there been any quantification of the effect of the change from AWAs to the award? Have people told you they've come to Canberra because of the award? Have you got evidence from those that have been recruited?

Mr Corbell: Quite frankly, people don't care whether it's an AWA or an award, as long as they get a reasonable rate of pay which is competitive. I don't think they think that they are not going to go somewhere because they provide an AWA only. I think that the reality is whether there are opportunities for professional advancement, whether there are opportunities that provide competitive rates of remuneration. Those are the key issues and those are the steps the government has taken. In relation to AWAs, the government's position has consistently been that AWAs are secret contracts between the employer and the employee. There is no open level of scrutiny in regard to those and we would prefer an open and transparent approach which can be provided for through an EBA. That's what we've done.

MR SMYTH: Are our radiation oncologists now the best paid in Australia? Are they at the average? Are they worse off than New South Wales? Where do the pay scales fall?

Mr Corbell: I'll ask Dr Sherbon if he can answer that question.

Dr Sherbon: Radiation oncologists, medical specialists, are better paid than in New South Wales. I cannot give you a guarantee they're the best in Australia, because there may be some packages that we're not aware of elsewhere, but they are paid better than the New South Wales award rate. To complete the minister's other suggestion, we have two radiation oncologists on staff, a third has arrived in a locum capacity and we're hoping to consolidate that to a permanent appointment, and a fourth has been offered the position. We hope that he will accept in the near future. So we'll have a doubling of our radiation oncologists. We have also had an increase of 2½ FTE radiation therapists in the last 12 months.

The feedback is that the EBA has been of assistance. I have met with the radiation therapy leaders and they do report that there has been a beneficial effect and that we expect, with improvements in the educational infrastructure of that group of staff, we'll be able to recruit new graduates next year. We're hoping to secure three new graduates early next year. We're just finalising the support structures for their appointment. We do expect further improvement.

MR SMYTH: You might have to take this on notice: over, say, the last two years, how many radiation oncologists did we start with, how many were lost and how many were recruited?

Mr Corbell: We'll take that on notice.

MR SMYTH: Turning to page 56, the surgical services division fell short of its target by 1.96 per cent this year. Is there a reason for that, given the pressure on the waiting list? They're obviously people who need surgery. We expected 16,752 and only achieved 16,242. There were about 300 operations less than expected. Is there a reason for that?

Mr Corbell: It's quite a minor variance.

MR SMYTH: No, it's 300 operations.

Mr Corbell: Yes, it is 300 fewer operations; but, in the context of over 16,000, it's quite a minor variance. Nevertheless, I'll ask Dr Sherbon to answer that.

Dr Sherbon: Yes, it is less than 2 per cent, as the minister has confirmed. I think that it's fair to say that there were increases in the medical demand at the hospital which did necessitate some restriction to the surgical side of the hospital. As you're aware, surgical patients—not all, but a fair portion of surgical patients; up to 40 per cent—are elective admissions, so they do have to give way to higher priority emergency patients, who tend to come through the medical divisions of the hospital.

The other thing you should note is that you're looking at a case-weighted figure. The one for raw admissions has increased, so the number of people who went through did increase. But we work off a case-weighted separation target basis, so it is a fair observation that they were very slightly short. I can explain that by suggesting that the other parts of the hospital were in high demand this year. You can tell from the table on the following page that referrals to the hospital in the home service escalated rapidly, and it just shows you the increase in demand in medicine.

MR SMYTH: If you go back over the data for the last 12 months of the previous government, the average for surgical treatments was about 700 a month. Over the two years of the current government it has fallen to about an average of 643 patients per month. That's a fall of about 8 per cent. How do you explain that we have been seeing fewer patients consistently for the last two years?

Dr Sherbon: The surgical throughput at Canberra Hospital is largely highly complex emergency patients. We are, as a strategy, shifting more elective surgery throughput to Calvary. These figures don't include Calvary. We've noticed, as planned, an increase in elective surgery throughput at Calvary. The reason we do that is that Calvary has less of a demand from highly complex surgical patients for theatre times, so there is more certainty for the surgeon and anaesthetist in providing elective surgery service at Calvary. That has increased and will further increase.

Mr Corbell: It's also worth pointing out, Mr Smyth, that the government's initiative around elective surgery in terms of the additional $2 million the ACT is now investing per annum on that has seen an increase in the total number of people treated every month. We had our busiest quarter for over, I think, three years in the last quarter—a very significant increase in the volume of activity—and we are continuing to see a rise in the number of people admitted. In September this year over 805 people were admitted, so we are seeing a phenomena of increased throughput—we're certainly getting more

people through—and we're also seeing an increased number of people going on the list, so we're seeing increased demand but also increased throughput.

MR SMYTH: We might have an argument in a little while about throughput and a breakdown of what operations were performed.

Mr Corbell: The figures are very plain—more operations.

MR SMYTH: But that chart does have a paragraph that says that in order to meet the 2002-03 financial targets and unexpectedly high hospital expenditure early in the financial year, surgical services implemented strategies to match expenditure to budget which resulted in activity levels falling below the four-year target. That reads to me as hospitalspeak for, "We blew the budget and we cut services." What was the unexpectedly high hospital expenditure early in the financial year, what strategies were implemented and why did they result in a lowering of activity levels?

Mr Corbell: Primarily, Mr Smyth, the surgical implants that were being used for a range of operations were higher than anticipated and that led to a higher cost to pay for those surgical implants. As a result, the hospital needed to take some steps last financial year to ensure that it was still able to manage within budget and there was a reduction in the number of surgical implants available for certain types of procedures.

MR SMYTH: When was this brought to your attention?

Mr Corbell: It was brought to my attention shortly after I became minister.

MR SMYTH: Were you happy with the strategy put in place for the reduction in activity levels?

Mr Corbell: I'm never happy with having to scale back activity, but at the time it was an appropriate measure to contain the budget issues that the hospital was facing.

MR SMYTH: As minister, do you accept responsibility for the fact that surgical services fell by nearly 2 per cent for the year?

Mr Corbell: I accept responsibility for ensuring that the hospital manages its budget as effectively as it can.

THE CHAIR: Can you explain the reference to surgical implants? What does it mean?

Mr Corbell: They are prosthetics.

MR SMYTH: Before we go there, you accept responsibility for the budget, but do you accept responsibility for the hospital not meeting its surgical targets?

Mr Corbell: I think I've answered your question Mr Smyth.

MR SMYTH: No, you haven't.

Mr Corbell: No, you don't like the answer, Mr Smyth. You don't like the answer, but I've answered the question.

MR SMYTH: So that you don't accept responsibility for not meeting surgical targets.

Mr Corbell: I didn't say that, Mr Smyth. I've answered your question.

MR SMYTH: No, you haven't, you've avoided the question.

THE CHAIR: You can make that comment.

Mr Corbell: No, you're unhappy with the answer, Mr Smyth, but I have answered the question.

THE CHAIR: I'm not interested in taking up the time; you've made your point. Can you explain what that means in terms of the answer to Mr Smyth's question? I don't understand what you mean when you speak about surgical implants. What does that language mean?

Mr Corbell: Surgical implants are prosthetics, artificial joints, mostly for orthopaedic procedures, as I understand it as a lay person, and there are different types of surgical implants. We had some surgeons choosing to use very high cost implants, greater than anticipated, and that led to an increase in the costs.

THE CHAIR: I understand that, but did you say that, because of the cost of that to the budget, there was a decision taken not to use implants particularly, because that was where it blew out, or are you saying that surgical services generally were pulled back so that you stayed within your budget?

Mr Corbell: Essentially, it meant that a number of procedures were not able to be undertaken that financial year.

THE CHAIR: How was that decision made about which surgical procedures you didn't undertake? Was it dependent on the cost of the things implanted? I don't understand what you said was the rationale.

Mr Corbell: All high priority surgery was still undertaken, but categories 2 and 3 surgery was in some instances deferred until the following financial year.

MR SMYTH: So orthopaedic lists blew out.

Mr Corbell: There are always extensive waiting times for orthopaedic surgery. There always have been. It meant that some orthopaedic procedures, lower urgency procedures, were deferred until the following financial year.

THE CHAIR: Normally, when a hospital is making decisions about its activity level, the decisions it makes are dependent on the money that it has to spend and it can't keep increasing the activity level without giving extra money; is that correct? Is that what you're saying?

Mr Corbell: That's right.

THE CHAIR: That's normal practice.

Mr Corbell: Yes.

THE CHAIR: You are saying that the decision was taken, because these implants were more expensive than had been assumed, to pull back on particular types of surgery that involved expensive implants.

Mr Corbell: That's correct.

THE CHAIR: Mr Smyth is making the point that it is of concern that the activity levels were pulled back to deal with that, but I'm trying to understand how that is different from any other year previously. I'm trying to understand how you would not always have those constraints. Is it a particularly unusual situation that you're highlighting here?

Mr Corbell: No, it's not an unusual situation insofar as all areas of the hospital have a budget. We don't have a budget to provide for unlimited demand. No health system in the world has that. You have a system that budgets for a particular level of activity. You use whatever assumptions and history you can to try to predict activity and to manage it appropriately, but all budgets are finite and it's not possible simply to allow an unlimited level of activity regardless of the amount you budgeted.

THE CHAIR: Is this an issue about implants? Is the particular problem that technology is becoming so expensive that it's putting new pressures on hospitals or has it always been a problem and were lots of implants needed this year?

Mr Corbell: As I understand it, particular surgeons were choosing to use a particular type of implant which was more expensive.

THE CHAIR: It is totally up to the surgeon to make that decision, not the hospital.

Mr Corbell: The surgeon was making the call that particular implants should be used for particular procedures and there was a higher volume of those than we predicted. That meant that there was an increase in cost. It's often difficult at first glance to understand what is going on in, say, surgical services, to understand exactly what's driving an excess of spending compared to the budget, so you often need to work out what are the particular cost drivers. It was identified in surgical services that the use of particular implants was causing a significant increase in cost and the decision was taken, given that it was close to the end of the financial year, to defer certain types of procedures where these particular implants were required because we could not continue to meet the cost and manage the budget responsibly.

THE CHAIR: Have you got no control over that at the hospital? You could end up in a situation, if I'm understanding you correctly, where you have particular surgeons making decisions which mean that the rest of the people needing surgery are somehow going to suffer. How can you work with that?

Mr Corbell: You're hitting on the fundamentally difficult dilemma that always exists between clinical judgment made by the surgeon and the management of the hospital's budget by administrators. The government, as do all health systems, seeks to reconcile what can be conflicting objectives to ensure that services are delivered within a budget but that care is given to those in order of priority. It is often difficult to manage it, but the hospital is continuing to refine its procedures to ensure that there is a greater level of coordination between the clinical requirements of surgeons in this case and the management of the hospital's budget.

THE CHAIR: Who has the ultimate say?

Mr Corbell: It is preferably done through agreement on the approach forward but ultimately, at the end of the day, the department and I, as the minister, are accountable for how money is spent and seeking to ensure that the budget is adhered to.

THE CHAIR: You could set limits, but you cannot because to a degree you cannot predict what is going to be the demand. But, going through the year, if you are seeing these kinds of trends which you could argue might be leading to a situation where a few patients are going to require such a lot at the expense of a larger group of other patients, do you have the opportunity to take control in some way? You have here. You have had to react to a degree, haven't you?

Mr Corbell: Yes, that's correct.

THE CHAIR: After the fact.

Mr Corbell: That's the point I allude to in terms of our capacity to monitor what is occurring and to working more closely with, in this case, surgeons in terms of the management of the budget for that area. Certainly, this highlighted to me—and I'm aware that Dr Sherbon is also very conscious of it, as is Mr Mollett, the general manager—the need to ensure there is stronger oversight and coordination within the different teams in the hospital. This highlights the need to do that. Certainly, since I've become minister, since Dr Sherbon has been chief executive and since Mr Mollett has become the new general manager, we have been focusing very strongly on improving systems within the hospital around this very issue.

THE CHAIR: Is the equipment itself, the implants, an issue in terms of its being more expensive?

Mr Corbell: Yes. With any form of medical technology, including implants, increased costs are an ongoing issue.

THE CHAIR: The cost of the technology is something you have to take into account in the budget for Health.

Mr Corbell: Yes.

MR SMYTH: Has the level of orthopaedic activity in the first quarter of this financial year returned to normal? Has it returned to the same level as last year or was there less orthopaedic surgery in the first quarter of this year?

Mr Corbell: We're seeing an increase in elective surgery overall, thanks to the government's commitment.

MR SMYTH: Yes, but are we taking the easy option of doing eyes or are we doing the hard stuff and replacing hips and knees?

Mr Corbell: I'm advised that that includes orthopaedic procedures.

MR SMYTH: Was the level of orthopaedic activity for the first quarter of this year the same as it was for the first quarter of last year and the same as for the first quarter of the previous year?

Mr Corbell: I'd have to take that on notice; I don't have those figures to hand.

THE CHAIR: In fact, if there are any questions that we can put on notice from now on, let's try to do so because we're running out of time. I'm interested in the reference to judicial decisions on page 66. It is stated that recommendations from a coronial inquest have led to a substantial revision of the processes surrounding child protection and that Community Health has been working with the Department of Education, Youth and Family Services to review practice and to revise the service agreements which were made some years ago. It is said that the roles of each of the agencies have been clarified, new policies developed and put in place, and work has begun on the scoping of a major education and training initiative.

I am interested in getting some more detail on how you are responding to those coronial inquiry recommendations and processes and in understanding the budgetary implications of that. I'm happy for you to take both parts on notice, if you want, but I want to know about how you see the coronial process, particularly around these children at risk, and the recommendations of the coronial process impacting on this department.

Mr Corbell: Before I ask Dr Sherbon to go into some detail, the government has accepted all of the outcomes of the coronial inquiry referred to in this part of the report and has taken very active steps to clarify the responsibilities of staff in relation to reporting suspected occasions of abuse. The hospital has worked very closely with all staff and Family Services to clarify the protocols and, where necessary, to revise the protocols to make sure that staff are fully aware of their responsibilities and that there is no assumption that the reporting will be done by somebody else, which, as a result of the information provided previously, led to staff taking that view on a number of occasions. There has been a very detailed process of education for staff, but I'm happy for Dr Sherbon to elaborate on that.

Dr Sherbon: I don't think there's much more to add to the minister's detailed answer. Roles have been clarified, protocols clarified, reporting arrangements clarified. That was a particular notation of the coroner in this case. It's also worth noting that the coroner did make an open finding in this case, so our issues relate to system improvements that predated the death of the individual involved in the case. Those matters are subject to ongoing work both within the hospital, where roles have already been clarified, and with Family Services, where joint protocols and joint training initiatives are under development.

THE CHAIR: Are those protocols finished or are they still being developed?

Dr Sherbon: We've clarified roles in reporting. There will be some improvements in training roles and some protocols on information exchange are still to be finally detailed.

THE CHAIR: But the protocols between the agencies are not yet done.

Dr Sherbon: I'd have to defer to my colleague. The work is ongoing. The reporting relationships have been clarified and Ms Yen will detail other arrangements.

THE CHAIR: Can the committee have that detail on the reporting arrangements being clarified, et cetera? We'd be interested in the work.

Mr Corbell: Yes, we could do that.

Ms Yen: There is an interagency committee between Family Services and DEYFS, Health and SACAT to look at revision of all the protocols within the whole child protection area in the ACT so that we're making sure that all the agencies are working in a way which is understood and cooperative to ensure that children are protected on the way through. So it's a much broader question that just what is the health service doing about it. It needs to be coordinated across the relevant agencies.

THE CHAIR: I understand that.

Ms Yen: That is under way as we speak.

THE CHAIR: This committee would be interested in being kept in the loop on that, as soon as you've go the protocols, and any information that you've got right now. It doesn't have to be kept with this annual report inquiry. We have an ongoing interest in how that's working and what Health is doing to link with the other agencies.

Ms Yen: I wonder whether the minister with responsibility for Family Services might pick that up, because they are the statutory agency.

THE CHAIR: You've mentioned it in your annual report, which I'm delighted to see.

Mr Corbell: Ms Tucker, can you just clarify what information it is that you are seeking?

THE CHAIR: I'm seeking to be kept in the loop on the protocols—you will be a part of the protocols—so that, as the Health Committee, we can see what Health thinks the protocols are. I'm interested also in understanding what you've done so far by seeing the detail of that. If it is going to be going on past the time of this inquiry, we would still be interesting in being kept in the loop so that we can understand how Health is relating to any change that is coming about, as you say it is here, as a result of particular judicial proceedings.

Mr Corbell: I'm very happy to keep the committee fully informed of all steps ACT Health is taking in relation to these issues.

THE CHAIR: Thank you; that's great. On page 67, you talk about Community Care continuing to focus on partnerships with other agencies to develop, coordinate and provide services to people who have complex needs. You're saying that you've been working on the children's plan particularly, which is dealing with early childhood development. I'm interested to know whether you have a relationship with Housing.

Mr Corbell: In what respect?

THE CHAIR: In this respect—cross-agency working, health, people not being evicted, prevention of homelessness.

Mr Corbell: Yes, indeed.

THE CHAIR: Do you have one?

Ms Yen: Yes, we do. There are a number of interagency working groups. They would go from the level of clinicians and service providers working together across departments to a range of complex care management, through to more senior level meetings to ensure that there is actually cooperation between departments. Yes, Housing is certainly part of our discussions, for example, in the development of the complex care protocol between Education, Youth and Family Services, Disability, Housing and Community Services and Health.

THE CHAIR: Could we have that protocol, please?

Ms Yen: When it's ready. It is not out yet.

Dr Sherbon: If I could just assist. It's not quite finalised yet. It's in a final draft form and we hope to have agency CEOs sign off on it in the near future. But yes, I can foreshadow, with the minister's concurrence, when it's complete we'll provide it to the committee.

Mr Corbell: Yes.

THE CHAIR: Thank you.

MR SMYTH: Where do we discuss aged care? You used to have responsibility for the aged-care, day-respite centres at Narrabundah and Dickson which were closed. Those services are now provided at Tuggeranong and Belconnen. Where are they reported upon now?

Mr Corbell: They're still provided by Community Health, formerly Community Care.

MRS DUNNE: There is nothing about aged care in the table of contents.

Ms Yen: No, there isn't. We haven't reported separately on those services; but if there are questions that the committee would like me to respond to, I'll try.

MR SMYTH: Is there a reason that they've not been reported on separately? Aged care is one of the growing areas that a large portion of the community is interested in. Why did you choose not to report on it this year?

Ms Yen: I don't think there was any particular reason, Mr Smyth. But I will certainly have it included in next year's report.

MS MacDONALD: Was there anything particularly outstanding about aged care this year that you needed to report on?

Ms Yen: If the committee is interested in the progress with the changeover from the aged day care centres to a focus which is more strongly on rehabilitation, then I'd just like to report that the two centres that are now operating, Belconnen and Tuggeranong, are working effectively. We've got good consultation with carers and we're building into those a much stronger focus on rehabilitation and links to acute geriatrics to make sure that our continuum is actually working across the whole. I think that people have made the transfer into those services successfully. We're confident that the quality of service and the type of service are more appropriate to the sort of work that we're trying to do. I think that that has been a successful change.

In terms of the broader issues in relation to care of older people in the community, the situation could fairly be said to be something which is growing, where there is an increasing demand for services for older people in the community, and we are working very closely with the division of general practice, with general practitioners and with our colleague hospitals to explore the particular needs of older clients, and that's part of the policy discussion with Health at the moment.

Mr Corbell: If I can just draw your attention to page 91 of the report. Under service delivery and process improvements there is discussion of the work being done in terms of the aged residential care liaison officer and the work being done to improve coordination and implementation of the transition of people from acute care settings to aged-care settings.

THE CHAIR: Mrs Dunne is raising the issue, as I understand what she is saying. If you look through the contents under Community Care you will see a reference to child, youth and women's health programs.

MRS DUNNE: In fairness, it was Mr Smyth.

THE CHAIR: Mrs Dunne, you did raise it before Mr Smyth arrived; you have both been bringing it up. Is there an argument for not having a particular focus on aged people in such a report?

Mr Corbell: I think in the same way that the report doesn't talk about GP services.

THE CHAIR: It's not quite the same. You've got child, youth and women's health and the aged are in another group.

Mr Corbell: If I could answer the question: in the same way that the report doesn't detail areas of primary health provision which are not the direct responsibility of any

state or territory, the focus in the report is on those parts of aged care which are mentioned in the report that are the responsibility of the ACT. For example, ACAT, the residential care liaison officer and respite care are all detailed in the report and directly relate to care to aged persons. I certainly take the point: it may be desirable to locate those together under a heading which says "aged care", but the government has reported on those areas of responsibility that it has in relation to aged persons.

THE CHAIR: The suggestion has been made that it might be useful for the community to be able to see what we do have responsibility for and how you deal with it.

Mr Corbell: Sure. In terms of ease of understanding the report, that's a reasonable comment.

THE CHAIR: We're up to page 68. I have a quick question; actually, it could be taken on notice. You say that the dental health services are now at an appropriate level. I don't know whether you have the numbers further back. What is the appropriate level? Do you have the numbers for the people on the waiting list for dental care?

Ms Yen: The appropriate numbers of staffing, I think. We're actually at full staffing. Waiting lists are favourably comparable with other jurisdictions.

THE CHAIR: But are the numbers in this report somewhere?

Ms Yen: No, but we can provide those.

THE CHAIR: Will you take that on notice? Thank you.

Mr Corbell: It's worth making the point that the government has increased funding to the dental health program of over $1 million.

THE CHAIR: I saw that. I am just interested in the numbers.

Mr Corbell: A quite significant investment to improve access for low-income earners.

THE CHAIR: Yes, and credit to you for doing it. I know it's a huge issue, and it's a Commonwealth problem, too, but we'd like to know how many people are waiting and for how long.

Mr Corbell: Yes.

MRS DUNNE: Madam Chair, are we going to go all the way through the department and then come back to Calvary, because Calvary is on page 63?

MS MacDONALD: Mr Cusack has already left.

Dr Sherbon: I can probably assist with most Calvary issues.

THE CHAIR: Yes, we will go back to Calvary.

MRS DUNNE: Sorry, I was listening upstairs, but the phone rang. Actually, what I really want to know, going back to the vexed table on page 25, is why those sorts of figures are not available for Calvary. I refer to the figures for the waiting times in accident and emergency and the number of separations in various classifications which are on page 25 for the Canberra Hospital. That sort of activity is not reported in here for Calvary Hospital. Why is that so? Is that data available? If so, can we have it?

Mr Corbell: We can certainly provide you with the data; I'm quite happy to do that. I may stand corrected, but my understanding would be that the relationship between TCH and the government is quite different from the relationship between the government and Calvary, because it issues its own annual report and there is, effectively, a contract arrangement between the territory and the Little Company of Mary.

MRS DUNNE: Are those figures contained in the Calvary annual report?

Mr Corbell: I'd have to take that on notice, but I can certainly provide those figures to the committee.

MRS DUNNE: I know that it is a relationship of a different order, but to get the full picture of public hospital services in the ACT we need to look at both Calvary and the Canberra Hospital, because we're seeing a decline in the number of accident and emergency presentations on page 25, to see how much of that has been taken up by Calvary or whatever means. It's been said to us, and I don't doubt it, that Calvary is absorbing some of that. I would like to get a feel for how many accident and emergency presentations we have overall.

Mr Corbell: It's been drawn to my attention, Mrs Dunne, that the quarterly report which I table in the Assembly includes this data in relation to Calvary Hospital.

MR SMYTH: It would be easy to make an annual comparison so we can compare Calvary next to—

Mr Corbell: I think it's just down to the technicalities of the fact that it's not ACT Health which is operating Calvary Hospital.

MRS DUNNE: Madam Chair, the committee might suggest that in future, for the completeness of the story about how public hospitals work in the ACT, there might be more data in the Calvary Hospital section.

THE CHAIR: Sure.

MRS DUNNE: While we're on Calvary Hospital, Minister, can you give the committee an update on where we are with the finalisation of the aged-care beds, as highlighted on page 64?

Mr Corbell: This is more a planning question than a health question, but I'm happy to answer it.

MRS DUNNE: And you can give us another update in January when you come before the Planning and Environment Committee.

Mr Corbell: Yes. The government is finalising the sale of that land to the Little Company of Mary and is proceeding concurrently with the necessary planning and development approval for the site.

MRS DUNNE: What is the timetable on that being finalised so that the Little Company of Mary can take over the land and start building?

Mr Corbell: I would have to take that on notice; I don't have that detail available with me.

THE CHAIR: Moving on to page 69 and future directions. I have a couple of questions before that, but I'll put them on notice. I'm interested to know whether you have had an evaluation of your early discharge processes recently?

Dr Sherbon: I can't confirm that. We will have to take it on notice. I don't think we've conducted a formal evaluation, per se, but there is ongoing monitoring of the outcomes for patients in that process and the throughput of that service. We can supply throughput data.

THE CHAIR: You are monitoring so that you are constantly evaluating.

Dr Sherbon: We are constantly monitoring the quality of the service through the outcomes for patients.

THE CHAIR: What happens to them once they're discharged into the community. If you're looking at that, what is it telling you in terms of the support for people?

Dr Sherbon: It's a very successful program.

THE CHAIR: So you're saying the community services are all there to support people adequately, including the psych unit. It is the whole hospital I'm talking about.

Dr Sherbon: The page you're referring to is Community Health, but to examine the psych unit or the mental health service as well—

THE CHAIR: What happens to people after they're discharged, as well as specifically the early discharge in surgical and whatever else you have?

Dr Sherbon: The early discharge service, which was the focus of my answer, we are confident that the service performs well. There are lots of national evaluations of the model that we have here. It is duplicated elsewhere and there's ample data to show that patients do well under an early discharge system.

THE CHAIR: If they're properly supported.

Dr Sherbon: If they're properly supported, yes. I must say there's been nothing in my five months here that indicates that that's an issue for us, but I'll confer with my colleagues and confirm that.

THE CHAIR: You would have figures of readmissions and so on, I'm assuming, if you're doing that monitoring.

Dr Sherbon: In the early discharge programs? I'll have to confirm that on notice. I'm happy to do so. I can't inform you right now as to whether that information is available.

THE CHAIR: It is fine to take it on notice. But I'm interested in that as well; it's obviously relevant.

MR SMYTH: On page 74, under "Corrections Health", the fourth dot point says that services provided to detainees at the Symonston temporary remand centre were established and the type and level of service available has been agreed to. Is that proving adequate to the need of the remandees there?

Mr Corbell: I understand that it is, yes.

MR SMYTH: As to the mental health needs of remandees, the New South Wales Corrections web page says, I think, that one in five of the people in the New South Wales corrections system have mental health problems. Are adequate mental health services being provided at both the BRC and the STRC? How are you measuring that and what sorts of service levels are there?

Mr Corbell: My understanding is that the level of resourcing is adequate. The government will continue to consider the enhancement of services at both the temporary remand centre and BRC pending the establishment of a permanent facility. In relation to Mental Health, I'll ask Mr Jacobs to elaborate.

Mr Jacobs: The figures for the ACT suggest that probably about one-third of the inmates do have some sort of mental health issue that needs to be supported or addressed. At present, we do have an adequate work force in place for the needs that are presenting for that population within both Symonston and the BRC, based on the feedback I've got from the manager of our forensic mental health services.

MR SMYTH: How have you come up with the figure of one-third? My memory is that when we asked this question last year people weren't sure what the percentage of people in the system were with mental health problems.

Mr Jacobs: A gentleman by the name of Dr Stephen Allnut will be coming down later this month to address us re the planning around forensic-type beds that we might need to access. The figures that he has given us do line up with what Keith is suggesting are the figures from his experience within the BRC and Symonston. So we're working with those.

MR SMYTH: Under "Achievements", it is said that the appointment of a corrections health manager will bring together the services across the health sector. Given that we have just heard that the figures from ACT Mental Health are that a third of the remandees have mental health problems, what special instructions or what instructions will you give to the corrections health manager to address those problems?

Mr Corbell: I'm not proposing to give them any special instructions. I'm not an expert in the delivery of mental health services, but I want to make sure that we get better coordination of mental health services and that's what this appointment allows the government to achieve.

MR SMYTH: How have you been able to determine that the type and level of service available that has been agreed to with Corrective Services is adequate to meeting the needs of the remandees?

Mr Corbell: Again, the assessment that Mr Jacobs has referred to has indicated where we need to either maintain or enhance existing service provision and I rely on that assessment in determining whether the government should consider further resourcing to allow that to occur.

MR SMYTH: Should we consider an alternative system that perhaps sees people with mental health problems not going into the corrections system, but rather being streamed somewhere else? Is that something the government would consider, given that the Chief Magistrate and some of the other judges have called for different facilities, given their preference not to send people with a mental health problem to the remand centre or the BRC?

MS MacDONALD: Surely the estimation that one-third of the prison population have mental health problems is dependent on the level and type of mental health problem that we are talking about.

Mr Corbell: I'll ask Mr Jacobs to answer that.

MR SMYTH: My question was: now that we've been told that a third of the remandees at BRC and the TRC have mental health problems, will the government consider or is the government going to look at alternative routes and strategies for dealing with these people who may not need to be in the judicial system and should be, in fact, in the mental health system?

Mr Corbell: My view is that the analysis that's undertaken by Mental Health is the sort of information that I need and which I get to make decisions about whether or not it's appropriate to provide for service enhancement. It's an ongoing process. If new measures come to light which are seen to be desirable, I'm very happy to consider them. It's an ongoing process to examine where there is a need for service enhancement.

MR SMYTH: Given that there have been calls over the last two years from some on the bench—the Chief Magistrate and Justice Burns have both called for alternative facilities—

Mr Corbell: A time-out facility.

MR SMYTH: Yes, a time-out facility is one option. What is the government doing to consider what the community is calling for?

Mr Corbell: The government has established a court liaison officer to assist magistrates in determining the severity and the particular issues associated with people who appear

before the courts with some level of mental illness, so that is assisting in magistrates and judges making appropriate decisions about what type of sentence should be provided or handed down for people who appear before the courts, and the government will continue to consider all options to ensure that our service level is the best it can be, given the resourcing available to it either currently or potentially.

THE CHAIR: I have a related question about the subclinical and before people come into contact with the criminal justice system services generally. What is your understanding of the adequacy of support for people in the community with mental illness so that they don't get to the point where they end up in Quamby or the Belconnen Remand Centre and are then sentenced? This relates to the previous questions to a degree about linking with different agencies.

Mr Corbell: The government has made significant investments in improving resourcing to Mental Health since coming to office—an increase of over $3 million per annum in recurrent funding to Mental Health. The most recent budget—the first budget that I've had responsibility for as Minister for Health—has a significant commitment of, I think, over $1 million to improve outreach support to people in the community. The focus since I've been minister has been on providing support to people in the community, working wherever possible either to prevent people needing a more acute level of care or to prevent them being readmitted to a more acute level of care. That has been the focus since I've been minister and we really are having to catch up on a very significant failure of previous governments to adequately resource funding or adequately resource services in the mental health area.

THE CHAIR: I understand that you've put money into the area, but I want particularly the detail of what you estimate to be projected need and current need, unmet need, and the areas in which you see weaknesses. Obviously, there have been issues about outreach for women with mental health problems coming out of your last initiative. I'm asking you for your analysis. You are leading into a budget period now and a social plan is going to be produced. It seems to be lacking any real detail at this point. I know that you've put some money in and there have been some good programs, blah, blah, but I also know that there is a serious unmet need in some areas. You should know that, too. I'm asking you about what you see as the main areas of need, given budget constraints and everything else, that would be the focus or your priority as Minister for Health. Where do you think you need to do the work now and what's your analysis?

Mr Corbell: Mental Health is currently finalising its mental health strategy, which includes a demand analysis which looks in detail at the very issues that you're raising, Ms Tucker.

THE CHAIR: When will that be up and running?

Mr Corbell: I'm not quite sure of the timing on that. The government hasn't yet considered the document, but it is being finalised.

THE CHAIR: Is it going to have a mapping of need?

Mr Jacobs: As part of it, there's a population analysis built into the strategy and action plan and it does look at particular areas of need, like women's mental health issues, transcultural, that type of thing.

THE CHAIR: I look forward to seeing that. When did you say that will be done?

Mr Jacobs: We're hoping it will be released in December. Perhaps early next year, but hopefully December.

MS MacDONALD: As a matter of personal interest, will it be doing a comparison with other areas as well?

Mr Jacobs: What we're actually doing is we're leveraging off a model that they're using in New South Wales. I can't give you the exact title of it, but it is a population-based model and what we've done is we've looked at how it can be a guide to apply to the populations in the ACT. It reinforces the approach that, for child and adolescent beds, you might need four to six beds, that type of thing.

THE CHAIR: In the same area, I'm interested in the dual diagnosis work. Can you direct me here to some more detail about how the current initiative is working in terms of need? Do you have a customer satisfaction table you can show me in that area?

Mr Corbell: It would be a pretty interesting table, I imagine.

THE CHAIR: No, I think we could include service providers and customers there.

Mr Corbell: Okay.

THE CHAIR: As well as the people who suffer because, to be fair, they're very articulate about the problems they have in accessing services that can deal with their two or three problems, because it can be more than a dual diagnosis. How can this committee get a sense from your work and from this report on how well this very serious issue is being managed?

Mr Corbell: Dual diagnosis issues?

THE CHAIR: Yes. You are telling us that it's going there and you're doing it, but how can we as a committee know how well you're doing so? As a member—I don't know about the other members—I am getting complaints and concerns expressed by service providers as well as by consumers that it's an issue that needs more attention.

Mr Corbell: The government has, through the drug and alcohol task force, seen a significant focus on measures to improve services to people who need this particular type of support and the drug and alcohol task force will be outlining a range of measures to government—obviously, I'll be making those public—on what can be done for further assistance for people who have dual diagnosis needs. Mr Jacobs also highlights to me that there have been quarterly reports on the dual diagnosis projects and I am happy to make those available to the committee.

THE CHAIR: Thank you. So you're pretty committed to implementing the task force's recommendations without having seen them.

Mr Corbell: I'm informally aware of the work the task force is doing, simply because they are supported by ACT Health and officers of ACT Health and the task force itself, and I've met with the task force and they have outlined to me in general their priorities. I have not seen their final report, but I am expecting to receive that shortly. The government will then need to formally consider its response to that report and I'll be announcing a response as soon as I can.

THE CHAIR: In time for the next budget.

Mr Corbell: The work is of a nature that ACT Health and I as minister are already aware of the range of issues that they are raising.

THE CHAIR: Yes, you've known them for a while.

Mr Corbell: We're taking that into account in budget planning.

THE CHAIR: Good. We look forward to seeing that.

Mr Corbell: I should also say that there's already a quarter of a million dollars in the current budget allocated for implementation, so I have an immediate capacity to respond to measures in that regard up to that value from whatever is recommended finally by the task force.

MR SMYTH: Sorry, we jumped several pages while I was gone. I had a question under children, youth and women's health about the cervical screening program mentioned on page 75. How is that admirable health register going?

Mr Corbell: I'll ask Ms Yen to answer that question.

Ms Yen: Mr Smyth, I'm ashamed to say that I haven't reported separately on the precise participation rates for the cervical register, but if I can take that question on notice I can provide that to the committee.

Dr Sherbon: I've got that figure. I can report that in the two years from 1 July 2001 to 30 June 2003, 62.05 per cent of women of the ages of 20 to 69 years have been screened. That's up from 60.72 in the two years preceding. So there has been an improvement there.

MR SMYTH: Well done; that's great. What is the target for other years, and do we have programs in place to get the other 37.95 per cent of women to participate?

Dr Sherbon: Where are we going? We would prefer to screen more women, but my understanding is that we meet targets on a national strategy. Clearly, where the opportunity provides, we would always seek to increase our coverage of women in that age group. But one has to balance the likely outcome of additional resources versus the fact that we're already meeting targets and, whether we would produce much of a health

gain by going much higher, one would have to make a judgment. At this stage I can report that we're meeting targets.

MR SMYTH: All right, 37.95 per cent of women aren't being screened. Minister, you might like to look at whether there is something more we can do within the allocation of resources.

Mr Corbell: I think it would be fair to say that the department continues to make sure that information is available through, for example, GPs, community health clinics and so on that continue to draw people's attention to the availability of the program and the appropriateness for women within that age range to have that service. We'll continue to do that and, wherever possible, seek to expand and increase people's awareness of it. But, as Dr Sherbon says, it is a matter for judgment as to how far you go.

MR SMYTH: On the breast-screening program for early detection, are we meeting targets there and achieving the results that we want?

Mr Corbell: Yes. I stand corrected.

Dr Sherbon: I can give you the figures. Again, for the two years from 1 July 2001 to 30 June 2003, 59.2 per cent is our figure. We would like to improve that. Radiographer availability and radiologist availability have affected us in the breast-screening program. We are working with our partners in breast screening, private radiologists and New South Wales to assist in that recruitment process. I'm hopeful that in coming years, if not within the next two years, technology may assist us to digitise mammograms so that they can be transmitted by distance, which would greatly improve our efforts. We're hopeful that technology will develop. It's not quite adequate at this stage, I understand. I think it's fair to say that we are close to target, but we do recognise that improved staffing in those services is required. Ms Yen and her colleges from New South Wales are working on that.

MR SMYTH: What is the target, just for information?

Dr Sherbon: We are slightly below. I'll have to confirm the target; I don't have it here.

Ms Yen: The national target for the 50 to 69-year-old age group is 70 per cent for the general community.

MR SMYTH: And we're achieving 59 per cent on that.

Dr Yen: We're doing well in comparison with other states and we're doing particularly well in comparison with other states for indigenous women screening. We would want to increase our capacity.

MR SMYTH: Because of shortages, there is more work to be done. On the same issue but in a different area of the report, on page 83, the initial breast prosthesis scheme is actually a community rehab program, but I don't know who is responsible for that. Are there difficulties with the Commonwealth on that?

Ms Yen: I'm not aware of any particular difficulties with it, Mr Smyth. As far as I'm aware, women who are seeking a breast prosthesis are able to access the service.

MR SMYTH: Minister, given the 59 per cent against the 70 per cent target, will the government be undertaking programs or activity to make sure that we achieve the 70 per cent target this year?

Mr Corbell: As Dr Sherbon indicated, it's not for lack of resources; it's a work force issue. We have, I think, a position vacant at the moment.

Dr Sherbon: We have more than one, I think.

Mr Corbell: A number of positions vacant, but the resourcing is there to fund those positions, so it's a matter of recruitment and seeking to attract people to work in that area. As Dr Sherbon indicated, Community Health is undertaking a range of activities to try to increase our capacity.

MRS DUNNE: Minister, is there any indication that there is unmet demand in the area? Are there extensive waiting periods on the basis that there are positions that aren't filled?

Mr Corbell: Clearly, we are not processing as many people as we would like to; so, to that degree, yes.

MRS DUNNE: I want to find out whether we are actually getting the message out that women in this category should be having breast screening and we cannot provide them with the breast screening. Is it that, in addition to us not being able to provide the breast screening, we're not getting the message out? If there was a long waiting time, that would be an indication that we're getting the message out but we don't have the people on the ground to do the screening, but if we don't have a long waiting time and we don't have people on the ground there's a twofold problem: we don't have the people resources as opposed to the money resources and we haven't actually got the message out.

Mr Corbell: I understand what you're saying. I'll ask Ms Yen if she can answer that in any detail. I'd simply like to reiterate the point that our coverage of the target age group is better than other states and territories and that indicates that we are providing a good service, albeit a diminished one because of work force issues, but we are getting greater coverage than other states and territories and that would suggest that we're getting the message out better than other states and territories and/or that our service is easier to access, as well as having a more aware population in that target age group of women. I'll ask Ms Yen if she can elaborate on that.

Ms Yen: No, Minister. I'd be happy to provide details on waiting lists, if that would be useful.

THE CHAIR: We will put it on notice.

MRS DUNNE: That would be good, yes.

THE CHAIR: I have a question on the same subject in a way. I think this is quite an interesting example of what happens when you have a particular service listed in an output class, as you do with breast screening clients, and the conversation that occurs around that. With the child, youth and women's health program on page 75 we have got a description and we have all those important services. When I went to find performance measures and so on for them, I found that the community health services listed on page 283 included some of these services. For example it has some details on breast screening of clients and women's health services, but I cannot see youth health services mentioned there. I am interested to know how you decide what you will give us more detailed information about.

Mr Corbell: I cannot answer that question. I will see if someone can.

Dr Sherbon: Our decision has been largely historical; but, as I mentioned to you earlier, not only in preparation for next year's annual report, which, of course, is utmost in our mind, but also in preparation for the health council's performance monitoring of the health system, we will be developing better measures. So I expect next year you will see a broader range of output measures.

THE CHAIR: It is not just about the measures; it is what you provide measures for.

Dr Sherbon: Yes.

THE CHAIR: There are all these really important services that people may like to see some more detail on in terms of how you are achieving your targets and so on. Newborn parenting programs would be an example of something that the community could be interested in, with post-natal depression being an issue in our community. It seems like it is quite random in a way. You say that it is historical. I understand that that would require you to do a lot more work and it would take up a lot more pages of a budget if you actually had all these services, but maybe that is what we need to be able to have a comprehensive picture of how you are providing services. Just having a list is interesting and we can pick something out and ask you how you are doing, as I did with dual diagnosis, but if this annual reporting process is to have meaning I think we should be able either to see a rationale for why you have certain things pulled out for more detail or to have it all.

Mr Corbell: I can certainly guarantee, Ms Tucker, that ACT Health can produce any number of statistics you would like on just about anything.

THE CHAIR: That is about the measures question again.

Mr Corbell: Indeed. I understand what you are saying. I think I would prefer an approach which had a range of measures—not measures on everything, but a range of measures—which were related to specific objectives that the government had set itself in relation to producing certain outcomes and being measured against that. I take your point that the range of measures here are, to a degree, random and are not necessarily tied to objectives. The work that the government has done since the establishment, preparation and production of the health action plan has meant that we now have a greater focus which we can use to outline the range of measures in an annual report and give some meaning to what the government is aiming for through its health action plan and what

that actually means in practice in terms of delivery through reporting such as the annual report.

THE CHAIR: It will be interesting to see how you do that.

Mr Corbell: Yes, it will.

THE CHAIR: We look forward to seeing that and seeing whether it gives us a better picture of it. I think you understand the point I am making.

Mr Corbell: I do absolutely. If you want an area which can produce statistics, you have chosen the right portfolio.

THE CHAIR: Remember that we don't just want statistics; we want measures that have meaning.

Mr Corbell: I know.

THE CHAIR: Page 138 talks about valuing cultural and linguistic diversity and ACT Health says that it didn't have any specific actions to undertake under this goal. Likewise with goal 3, you say you didn't have any specific actions to undertake in regard to utilising cultural and linguistic diversity. You have already spoken about working with indigenous people, but that may be in a separate area—I am not sure; you can clarify that for me. But I am interested to know why you do not think it is something you need to take action on, because I would have thought it to be totally essential to Health.

Mr Corbell: I think the point that is being made is that there wasn't any specific response required of the health department; nevertheless, it was an issue which Health responded to and, where appropriate, took measures to ensure that it was consistent with that framework.

THE CHAIR: Are you saying that they take account of it, but no specific action is required?

Mr Corbell: I am happy to stand corrected, but my understanding is that under the framework there is no specific item that was designated for Health to address in the framework. Nevertheless, the framework outlines a range of issues that all agencies should have regard to. Health had regard to it and it is outlined there in the annual report.

THE CHAIR: Are you talking about the multicultural framework?

Mr Corbell: That's correct. Yes, that's the section you're referring to.

THE CHAIR: Yes, it is.

Dr Sherbon: And that is the component of the annual report that we are expected to report on any specific actions required. As the minister has pointed out, there weren't any specific actions for ACT Health.

THE CHAIR: It says something here about its having to be addressed in the health action plan. That is about engaging interpreters. On page 132 you refer to actions to be undertaken by all ACT government agencies and you refer to the health action plan. You are saying that ACT Health engages the services of professional interpreters, so you are doing that.

Mr Corbell: Yes.

Dr Sherbon: Most certainly, yes.

THE CHAIR: Why isn't that an action that you have done?

Mr Corbell: That is an action that we have done, Ms Tucker, but I think you were referring to—

THE CHAIR: Valuing cultural and linguistic diversity.

Mr Corbell: In relation to particular goals.

THE CHAIR: And utilising cultural and linguistic diversity. I would have thought that action would come under valuing cultural and linguistic diversity. You are valuing it if you are providing an interpreter.

Mr Corbell: I think that refers to more specific items that are tagged against a particular agency, as I said before.

THE CHAIR: Is this just a formatting issue that I am not understanding in terms of how you are explaining what you are doing?

Mr Corbell: It could be, yes. I think it probably is.

THE CHAIR: I am a bit confused. It looks like you do have an action as you have interpreters, but there are real issues about health services and cultural issues, not just about language. Regardless of whether it is in the multicultural framework, I'm asking the question because it's so obviously essential.

Dr Sherbon: Yes. I think you would find, if you walked into any ACT Health service, that they are regularly using a whole range of skills to bring about a culturally appropriate service. That is perhaps why we have underemphasised this component of the report, in that we're responding in this report to a specific framework, but it's almost normal business for us to work with interpreters, to work with diverse groups of people, to appreciate the different cultural influences on illness and wellness. Perhaps the routine nature of that process is why it's not heavily emphasised in the report.

THE CHAIR: Basically, you are just saying that you are doing it. Once again, it would be interesting to the committee to see how you do it. You seem to be saying to me that it is just there. You say in relation to the health action plan that you use the charter of public service in a culturally diverse society as a guide to the design, delivery, monitoring, evaluation and reporting of services. You seem to be saying it's integrated

totally into what you're doing. As the chair of the committee, I am interested in understanding what that means in terms of services.

Mr Corbell: With all due respect, I think it is there, Ms Tucker. For example, if you turn to page 135, you will see that goal one of the framework is about embracing cultural and linguistic diversity. Outlined there are specific actions to be undertaken by ACT Health and what has been done in response to that. It's quite clear that, where there are specific actions identified, the department is responding to that and reporting against those. You will see that there are actually three pages of actions and responses in relation to that particular goal. In relation to other goals where there are not specific actions, the department has simply reported in general on what it does to ensure that it is consistent with the goals of that framework, even though there were not specific actions required of ACT Health.

THE CHAIR: Thank you for pointing that out. That is interesting and I am glad to see it there and can read about it in more detail, but these are objectives in a way, aren't they? You are doing things; you are reviewing outcomes and so on. I'll read it; maybe you've got it in there as well in terms of how you are actually achieving it. Once again, this is getting back to the measures. Once again, just as a member, I am hearing that there are issues. I can see what you're doing, which is good, but I need to be able to work it out a bit more in terms of how well you are doing it and where there are gaps. Obviously, I haven't read that bit in detail. I will do that. Maybe you have more information in there. Thanks for pointing it out, with all due respect.

Mr Corbell: I was trying to get to exactly what it is you're on about, Ms Tucker.

THE CHAIR: I know. I just think it's funny how people preface things with statements like, "With all due respect, you're really stupid."

Mr Corbell: Yes. There's a good scene in *Yes, Minister* about that where "with all due respect" means "with absolutely no respect".

THE CHAIR: Exactly. So I am immediately worried when you say that. Ms MacDonald has to go, so we will have to finish. I thank you, Minister, and your public servants for the time you have spent here this afternoon. If we have more questions, we will put them to you on notice.

Mr Corbell: Thank you, Madam Chair. What period are you allowing for questions to be placed on notice? It would be useful for the department's planning to know when it needs to respond. I know that you said seven days, but is there an open invitation for members to lodge questions whenever they feel like it or are you only taking questions over a certain period?

THE CHAIR: We will have the questions in by the close of business tomorrow.

Mr Corbell: Thank you very much.

The committee adjourned at 4.53 pm.