LEGISLATIVE ASSEMBLY FOR THE AUSTRALIAN CAPITAL TERRITORY

SELECT COMMITTEE ON ESTIMATES

(Reference: Appropriation Bill 2005-2006)

Members:

MS K MACDONALD (The Chair)
DR D FOSKEY (The Deputy Chair)
MR R MULCAHY
MS M PORTER
MR Z SESELJA

TRANSCRIPT OF EVIDENCE

CANBERRA

THURSDAY, 19 MAY 2005

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

By authority of the Legislative Assembly for the Australian Capital Territory

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

The committee met at 9.34 am.

Appearances:

Mr S Corbell, Minister for Health and Minister for Planning

ACT Health
- Dr Tony Sherbon, Chief Executive
- Mr Mark Cormack, Deputy Chief Executive
- Mr Ron Foster, Director, Financial and Risk Management Branch
- Mr Ian Thompson, Executive Director, Policy Division
- Ms Megan Cahill, Executive Director, Government Relations and Planning
- Mr John Mollett, General Manager, The Canberra Hospital
- Ms Laurann Yen, General Manager, Community health
- Mr Brian Jacobs, General Manager, Mental health ACT
- Ms Karen Murphy, Allied Health Adviser
- Ms Jennifer Beutel, ACT Chief Nurse
- Mr Owen Smally, Chief Information Officer, Information Services Branch
- Mr Doug Jackman, Director, Human Resource Management Branch
- Dr Charles Guest, Acting Chief Health Officer, Population Health Division
- Dr Robin Stuart-Harris, Director, Cancer Stream
- Ms Jenelle Reading, Director, Dental Health
- Ms Helene Delaney, Manager, Alcohol and Other Drug Policy

Community and Health Services Complaints Commissioner
- Mr Philip Moss, Commissioner

HealthPact
- Mr Richard Refshauge, Deputy Chair

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

Please clearly identify when you are taking a question on notice. It is then your responsibility to check the transcript and respond to the questions. Responses to questions taken on notice are required within five full working days. The transcript will be emailed to the minister and the departmental contact officer for distribution to witnesses as soon as it is available.

Can members please clearly identify if they want a question to be taken on notice, and give any page references, including the budget paper that they are referring to or other document if they are referring to other documents such as ownership agreements. Proceedings are being broadcast to specified government offices and the media may be

recording proceedings and taking visual footage.

As I informed committee members yesterday evening, and for the information of Mr Smyth, we don't have the health complaints commissioner; it now comes under the Attorney-General's Department. Minister, welcome. Would you like to make an opening statement?

Mr Corbell: Thank you, Madam Chair and committee members, for the opportunity to appear before you. I would like to make a brief opening statement in relation to the health budget as outlined by the Treasurer in his presentation speech a few weeks ago. This is a strong budget for health. It's a strong budget for health because we focus on improving access to acute care services, we focus on investing in new infrastructure for our public hospitals, and we're also focusing strongly on the provision of primary care services, as well as a range of other very important measures to meet what is without a doubt the single most difficult area of public service delivery in the ACT—difficult because of the pressures that our health system and, indeed, all other health systems around the country are facing.

Our health systems are facing increased presentations, increased complexity of cases and increased costs. Combined with that are increasing work force shortages and the need to better deliver services to meet growing community expectations. So the government has sought to respond to all of these issues through the budget papers that you have before you. I'd like to go through and address a range of the initiatives that are before you.

The government is spending more money than ever on elective surgery. In this year's budget, an additional $2 million, recurrent, will be made available for elective surgery procedures. These will be again targeted at patients with long waits, and some of the specialities we will be looking at in that regard include orthopaedics. The surgery initiative will see an additional 300 Canberrans and other people on the elective surgery waiting list get access to elective surgery in the coming year. In the outyears, an additional 400 people every year will get access to surgery based on our estimates of the expenditure in this item.

The government is also making significant commitments on access to acute care. In particular, we have fulfilled our election commitment to fund an additional 20 public hospital beds for Canberra's public hospitals. These 20 medical beds will come on line over the next 12 months. They will be located at both the Canberra and Calvary public hospitals, fully staffed. The objectives of this initiative are first to reduce the number of times that we see patients' elective surgery cancelled because a surgical bed needs to be taken by a medical patient, admitted particularly through an emergency department; and, second, more importantly, to increase the flow-through of patients in our emergency departments and reduce access block and waiting times for people who present through emergency departments.

The government is focusing very strongly on other areas that also address issues to do with access through emergency departments, and this includes the maintenance and funding in full of the ongoing operation of discharge lounges at Calvary and Canberra public hospitals. These discharge lounges, particularly at Canberra, are proving to be a significant success. Since the discharge lounge at the Canberra Hospital has been in operation, over 1,000 people have used it. That's 1,000 people discharged a little bit

earlier—well, not discharged but moved from their bed to the discharge lounge, freeing up that bed for a new person to use, and having the consultation and final checks that need to be done prior to them being formally discharged from the hospital done in the lounge. It is an important part of our bed management strategy and again is designed to address issues around access block.

The government is also maintaining funding for a range of other services in our public hospitals. In particular, we have a significant commitment to deal with the enormous growth in the cost of pharmaceuticals—an additional $1.7 million to fund additional costs in pharmaceuticals. I think members would see from that item that that's a very significant amount of money, but essential if we are simply to provide the increasing range of complex and expensive pharmaceuticals that are required to treat people who present to our public hospitals.

We also are putting in place funding to deal with a range of other issues. It's worth perhaps highlighting the after-hours GP service. That service, again a government election commitment fulfilled, will see after-hours GP services operating at both of our public hospitals and at Erindale on weekends. These services are very important. With our having one of the lowest levels of bulk-billing in the country and, more importantly, being well below national averages for numbers of GPs per head of population, the after-hours GP service provides an important safety net for Canberrans. I'm delighted that we've been able to work with the Canberra After Hours Locum Medical Service to deliver this program in our public hospitals.

It's a significant achievement to get these after-hours GP clinics into our hospital grounds. Culturally, that's been a very difficult barrier to overcome for some members of the GP community, but I'm very pleased that the model has been overwhelmingly adopted by the members of CALMS. What this means is that all Canberrans now have access to a GP after hours. They do not need to be with a GP who is a member of CALMS, as anyone can access this service, and certainly lowest priority, category 5, type patients who visit emergency departments will also have the option—and I want to stress the option, the choice—of using the after-hours GP clinic if that better suits their needs.

In community health, we are also making significant investments. Additional moneys are ongoing for the dental services program, and we're expanding dental services in particular to the indigenous community in the ACT, where we know health outcomes are poorer than in the non-indigenous community. We are also focusing on high-needs children and the needs they have for additional care, and on issues around providing care for mental health clients who have complex and difficult needs and who need to be accommodated within our community.

The final thing I'd like to talk about is the work force. The government is making some important commitments in the area of our health work force. First of all, we are providing funding to make it easier for nurses who have left the profession to re-enter. A new nurses re-entry and refresher program will allow those nurses who have left the profession to reskill, to get back up to speed, and to get back into the work force, with significant assistance from ACT Health. In addition, we will also be funding the first of our nurse practitioners in the ACT, providing a very important role between the nursing work force and the medical work force, bridging some of the gaps that exist between

those two work forces and providing an enhanced level of care in particular settings, whether that be aged care, community nursing, or potentially a range of other even non-government settings. So there is an important investment also in nurse practitioners.

There are two other significant programs I would like to highlight. The first is our falls prevention program, which is occurring in our aged care facilities. Falls are a major reason why older Canberrans are admitted to public hospitals. Falls can be debilitating and chronically painful for older people, and preventing falls is the best way of addressing this issue. This program will be rolled out in nursing homes in the ACT and it will provide real opportunities to prevent these injuries from occurring and prevent the costs to the individual and the costs to the health system that result from falls. Up to 50 per cent of aged people in any one facility can suffer a fall in any one year, so it is an important investment.

Finally, the government has made a commitment to new X-ray technology at the Canberra Hospital. The picture archival communication system is a significant capital initiative, with over $2 million, designed to provide state-of-the-art picture imaging services for medical staff and nursing staff at the Canberra Hospital. We are one of the, regrettably, last hospitals in the country to have this technology, but it is an absolutely essential investment, not only in terms of the time it saves because we eliminate the need for the film-based technology that we currently use—this is a digital technology—but also it improves patient quality and safety of care because of reduced chance of errors and reduced chance of the wrong film being put to the wrong patient, so those sorts of errors in care and diagnosis can be further reduced. We have a strong budget for health. Health faces a range of pressures, which I believe the department is managing and the government is funding in a responsible and very diligent way, and I'd be very happy to take any questions the committee may have.

THE CHAIR: Thank you, minister. We'll start with the overview statements in capital works, where they're relevant. If people want to deal with indicators within that area, that would probably be the best place to deal with it. I imagine, if we follow what's been going on for the last couple of days, that the overview area will take quite a bit of time before we get to the output classes and we'll deal with the output classes as ordered: 1.1, acute services; 1.2, mental health services; 1.3, community health services; and 1.4, public health services.

Minister, there have been a number of delays in the following areas and I refer to page 213 of budget paper 3, which refers to the underspending by a number of different departments in capital works. These include, for health, Calvary plant and building upgrade of $1.6 million, the ANU Medical School at the Canberra Hospital and Calvary of $6.5 million, and the subacute and non-acute facility of $5.3 million. Minister, would you or your officials be able to explain the reason for these delays and when you expect those works might commence and be completed? If some of those have commenced since the budget was put together, I would be happy to hear about that as well.

Mr Corbell: A number of these projects are now under way. In particular, the one I will highlight is the ANU medical school at the Canberra Hospital. Construction work is now under way for that important project, which will establish the medical school's building at the Canberra Hospital campus. That was delayed pending, as the budget papers highlight, resolution of some funding issues and final design issues. At the Canberra

Hospital we're working within a very constrained campus. It involved the demolition of an existing building for the new building to be built. That demolition has now occurred safely and a new building is being built, but I'll ask Dr Sherbon or his officers to provide you with further information on the other projects.

Dr Sherbon: The Calvary plant and building upgrade is infrastructural issues to existing buildings at Calvary. It was one of three major repair issues at Calvary, including major lift maintenance and other structural issues to do with Calvary roofing. It was one of three projects. Calvary advised that they considered this the third of the three major projects. It is fair to say that ACT Health has reminded Calvary of the need to push on with that project, and I can now advise it is under way and the advice we have from Calvary is that it will be completed in June 2006.

On the subacute and non-acute facility, the minister has answered in previous hearings on the annual report of ACT Health, but the status of that program is that we are now in the detailed design phase. We're in the process of preparing to submit a development application to the ACT Planning and Land Authority in June, with the expectation that the construction will be complete by December 2006. That project was delayed on account of the need to formalise our model of care and that process took extensive consultation with the mental health constituencies, consumers, carers, and older persons' constituencies in Canberra, including the aged care and rehabilitation service, but it's back on track and due for completion in December 2006.

MS PORTER: You mentioned the capital works that are yet to come on track from the previous year. I was wondering if you could outline for the committee the capital works that are planned in this budget and what benefits they will bring to the health system of the ACT.

Mr Corbell: There's a range of new capital works funded in this year's budget. Some are actual construction activity; others are upgrades and feasibility or assessment works. Some, whilst seeming mundane, are important investments. For example, there's the refurbishment of the roof of the analytical laboratories building in Holder. This is the facility run by the Health Protection Service. The analytical laboratories survived the fires of 2003, fortunately, although the building was very significantly damaged by ash and other stuff getting into it. Members will probably recall that the front part of the building, which was the offices of the Health Protection Service, burned down. That building is shortly to be rebuilt. As part of that rebuild work we will also be building a new roof to replace the existing roof on the laboratories. The existing roof is extremely old, leaks and creates problems for protecting the fairly significant amount of complex and delicate machinery and instruments that the analytical laboratory houses.

There is also money for the government to progress options for the refurbishment or otherwise of either Karralika or other drug rehabilitation facilities in the ACT. That money has been deliberately put into the budget to provide the government with scope to continue work that the consultative committee, which I have established, is doing with the Fadden and Macarthur communities and other stakeholders on future options for the Karralika drug rehabilitation facility.

There is also some work to do with master planning of mental health and community health facilities. This will give us for the first time a master-planned approach to how we

continue to provide mental health facilities and community health facilities. Previously, decisions about community health clinics, baby clinics and mental health facilities have been made in a fairly ad hoc and piecemeal way. We want to master plan the provision of this infrastructure across the city for the coming five to 10 years and this will allow us to start that work.

In terms of construction activity, some very important things are happening at the Canberra Hospital. The first is the medical records relocation. Medical records relocation involves the relocation of the existing medical records area in the Canberra Hospital to a different part of the TCH campus, and that essentially unlocks a core area of the centre of the hospital which allows us then to look at the realignment of a range of other facilities. You will see that there is money, in particular, for the building one tower, ambulatory care and hot floor work to allow us to then do the work on how we can realign facilities and better co-locate facilities in building one at the Canberra Hospital so that we get greater continuity of care without people having to move in very odd journeys around the TCH campus.

Work will also be done to investigate the feasibility and options for relocating the helipad, which currently is located on the northern side of the TCH campus. We'll also look at the provision of an additional multistorey car park at the TCH campus. There's also money to do the traffic and parking investigations that need to be done prior to the implementation of pay parking at the Canberra Hospital in particular.

Aside from that, I have already mentioned one significant capital purchase, the PAC system, picture archival communication system, which will provide us with new X-ray technology for the Canberra Hospital, and there's a range of other capital upgrades, which we're happy to look at if you would like.

Dr Sherbon also highlights for me that there are fire safety upgrades at both the Canberra Hospital and Calvary Hospital to ensure that we maintain high levels of fire safety for those buildings, and work also on a new sterilising facility for surgical equipment at the Calvary Hospital.

MS PORTER: Minister, could you just outline a little bit more about the imaging systems that you mentioned in your introductory remarks. I'm just interested to know whether the GPs will be able to access that service, and whether that would go directly to them, or how that would work.

Mr Corbell: This will certainly give us the capacity, Ms Porter, for GPs to access those images. As members would be aware, currently patients are required to take their X-rays around from doctor to doctor. If you've ever been in that situation, you take your X-ray with you to your specialist, to your GP and back to your specialist. This system potentially allows that image to be transmitted electronically to the medical and other people that you need to see. But I might ask Dr Sherbon to elaborate on how it works in practice; he's more of an expert than I am.

Dr Sherbon: The minister is accurate. As he described, the films will be accessible technologically. There will be some security and infrastructural issues to sort through with GPs, in that they are not part of the ACT government network and therefore the IT systems in their rooms are not subject to our levels of security. It will require signing

them on to the ACT government network, which we are currently exploring with VMOs at this point in time, and also ensuring that their end of their IT network is consistent with our level of security that's required. But it has been done elsewhere and technologically can certainly be done.

The other thing that can be done technologically with this equipment is that images can be beamed by microwave across extensive distances, so we'll be talking to the Greater Southern Area Health Service in New South Wales, particularly Cooma Hospital, which receives, as you know, a large number of fractures from the snowfields. We would be asking them to beam the images down to us so that we can decide whether the patient needs to come here or not. That's something we've got to explore with greater southern, but it has been done elsewhere.

MS PORTER: Yes, I visited Samsung hospital in Seoul, where they use that technology, and it works very well for them. As you say, they can beam images great distances.

THE CHAIR: Minister, you alluded to the issue of parking on the hospital campuses. Can you outline for the benefit of committee members how you anticipate this will work and how much you anticipate will be raised?

Mr Corbell: I think the figure that we anticipate being raised is around $500,000 to $800,000 per annum; that's across both campuses. The key purpose of this is to better manage parking arrangements at our public hospitals. I don't know whether anyone in particular has tried to find a park at Calvary lately, but it's very difficult, and Canberra Hospital is facing increased pressures on its parking as well. We are aware anecdotally that people use the free car parking at the Canberra Hospital campus to avoid pay parking in other parts of the city, particularly Woden. That's for long stay parking, obviously, not short stay, but we are aware, anecdotally, that there are instances of that occurring. The money that's been set aside in the budget will allow us to properly analyse the traffic and parking situation at both the hospitals and I want to stress that it is the government's commitment that we will not see staff of the Canberra Hospital or Calvary Hospital, or volunteers at those hospitals, having to pay for their parking. We recognise that it's hard enough at the moment to recruit and retain staff in a number of key areas without this particular other issue complicating that further, so staff and volunteers will not be affected by these changes.

THE CHAIR: I'm assuming that the work on this is in the early stages. You have said staff and volunteers of the hospital will not be charged. Will that include staff of places like the Red Cross and the medical imaging services provided, which are on the campus of TCH?

Mr Corbell: These are all issues that will be considered through the master planning study, to which $70,000 has been allocated.

THE CHAIR: I'll just ask one more question before I move on to others: with the amount that you anticipate raising, has fringe benefits tax been taken into account?

Mr Corbell: Yes, we will take that into account, and parking charges will not be able to go over a certain threshold without the fringe benefit threshold being triggered, so we

will be ensuring that we work within that threshold so that fringe benefit issues will not be triggered.

DR FOSKEY: In relation to the paid parking, I wonder if you plan to give consideration to families of patients—that there could be some system of car parking, a voucher or something, so they can purchase parking on a cheaper, longer-term basis, weekly and so on? I am very aware that we shouldn't be disadvantaging people visiting their families. As you say, it's hard enough to find a park. If it costs a lot of money, that's a further disincentive to visiting people, and visiting is part of recovery for health.

Mr Corbell: Thanks, Dr Foskey. I and the department are very conscious of the circumstances that occur frequently at our hospitals and the need to be compassionate in those circumstances. Obviously, there are instances where people visit for long periods of time at regular intervals, particularly if they're caring for someone who is chronically or seriously ill. We will need to take those issues into account, and that's what this study will be doing.

I should stress that already now we do have a process for exempting people if they are booked. Whilst there is no pay parking at the Canberra Hospital, you can still be booked if you park in a time-restricted spot for longer than you are allowed, and there are already circumstances where we arrange for those fines to be waived in compassionate circumstances. It is an understood issue at the hospitals and we will be taking those issues into account, and talking with, in particular, the different carer groups involved, to make sure that we have the best possible way forward for managing parking at the hospitals.

MR SMYTH: Minister, will the fines from people who are caught breaching the regulations go to the hospital, or will they just go into consolidated revenue?

Mr Corbell: At this stage, our revenue projections are based on the payment for the parking. We are not assuming revenue from fines in this projection. Fines are, as I understand it, collected by the ranger service in urban services and the funds are dealt with through consolidated revenue. That is an issue that we are yet to finalise but I would imagine that if we are asking ACT parking inspectors to police the site, as they do now, fines would go to consolidated revenue. But we do not make revenue projections based on expecting a certain amount of fines to occur. We make revenue projections based on the number of people we expect to pay for parking.

MR SMYTH: But in budget paper 2 it lists the fees and fines that you will collect. Of course you make revenue projections on the fines you collect.

Mr Corbell: Not in relation to pay parking is the point I am making.

MR SMYTH: The whole purpose of this, you said earlier, was that you have anecdotal evidence that some people are using particularly TCH as a long stay car park. Since when did we start making government policy on anecdotal evidence?

Mr Corbell: Well, I think it is not solely a decision based on anecdotal evidence. The point I am making, Mr Smyth, is that we know that people are parking at the TCH campus to avoid long stay parking charges at other locations, and in some respects I have

got to say it is amazing what Canberrans will do to avoid paying for a park. We equally know, for example, that people park on the other side of Woden—in places like the Lyons shops—to avoid pay parking in the Woden Plaza area. So it is a reasonable assumption to make, and the traffic analysis that we are doing will properly work through these issues so that we are in a position to implement a fair and equitable scheme.

MR SMYTH: Let's be honest here: this is just fundraising for the hospital. You have gone from anecdotal to assumption in the space of 10 minutes. Anecdotally, how many people are using the Canberra Hospital car park for long stay parking?

Mr Corbell: I can't tell you that figure, and I have never—

MR SMYTH: Why not, minister? Why not? It is a reasonable question.

THE CHAIR: Mr Smyth, let him answer the question.

Mr Corbell: I have never asserted that this is the sole reason, but it is one of the factors that we know is at play at the Canberra Hospital campus in particular. We also know that it is a reasonable measure to put in place to assist the hospital to meet growing costs. It has been done at almost every other major metropolitan hospital—in fact, at every other major metropolitan hospital in the country, except Royal Darwin—and our proposed parking charges are the lowest of any major metropolitan hospital, except Royal Darwin, where it is free.

MR SMYTH: Yes, they always start low, minister. Will you take on notice then and inform the committee as to how many anecdotes have been related to the department of long-stay parkers.

Mr Corbell: Well, anecdotals are just that: they are anecdotal. So I don't think I can answer that question, except—

MR SMYTH: So there is no evidence.

Mr Corbell: The point I am making is that anecdotal evidence is just that: it is anecdotal. It is not recorded; it is not in the form of any sort of written thing that I can provide to Mr Smyth. Anecdotal evidence, by its very nature, is just that.

MR SESELJA: Other than anecdotal evidence, is there other evidence then that you rely on?

Mr Corbell: Not in relation to the issue of whether people are using TCH car parking to park at the Canberra Hospital.

THE CHAIR: I think we might move on to another issue.

MR MULCAHY: Can the minister inform us how many non-medical staff are holders of passes in the boom gate restricted area for parking at the hospital? As I understand it, a number of specialists struggle to find spots and they are forced to park on the lawn and elsewhere. How many of those who are using that protected facility are not in fact

medical staff?

Mr Corbell: I need to take that question on notice. There is a small boom-gated area underneath hospital building one, which is available primarily for specialist staff. I think some management staff members also use it. We will take that question on notice and provide the answer to Mr Mulcahy.

THE CHAIR: Thank you, minister.

DR FOSKEY: Mr Corbell, I wish to ask a couple of general questions that you might have answered in passing but I would like you to consolidate that information for me. What percentage cut has there been for the departmental allocation in this and future financial years?

MR MULCAHY: Are we moving now to general questions? I thought we were dealing with capital works.

DR FOSKEY: We are dealing with overview statements and capital works.

MR MULCAHY: I have not yet heard a question about capital works. I was waiting for an opportunity to ask questions.

THE CHAIR: I do not believe that they have to be separated out. We are not moving off capital works, if that is your question.

MR MULCAHY: I listened to what the chair said about the way she wanted to run the committee and I tried to comply.

THE CHAIR: That is fine, Mr Mulcahy. I refer you to the updated and detailed timetable that you were given yesterday. It refers to overview statements and to capital works, so general questions can be included in that. There is no reason why we cannot let you ask a question relating to capital works. Dr Foskey, could you repeat your question?

DR FOSKEY: I think the departmental officials are all right with my question, or do they need me to repeat it?

Mr Corbell: I would just like to clarify what you were asking.

DR FOSKEY: What percentage cut has there been for the departmental allocation in this year's budget and what percentage cut will there be for departmental staff in future years?

Mr Corbell: Overall there has been a net increase this financial year in the allocation for ACT Health. Spending will reach a total of $671.3 million. That is an increase of $35.5 million, or six per cent on the estimated outcome for 2004-05. So it is a net increase of six per cent. Based on our forward estimates, spending will continue to rise by $30.9 million, or five per cent, in 2006-07; $26 million, or four per cent, in 2007-08; and $25.8 million, or four per cent, in 2008-09.

It is worth highlighting also that spending has increased by 61 per cent since the last four

years of the previous Liberal government—from $418.1 million, and that is adjusted for the removal of the housing and disability and portfolio merger, to $671.3 million in 2005-06. A number of staff changes will occur as a result of efficiency measures within ACT Health. I am advised that we will see a decrease of approximately 30 positions over the coming 12 months. If you like we can elaborate on that further.

DR FOSKEY: I would like you to elaborate.

Mr Corbell: I will ask Dr Sherbon to give you an outline of the staff efficiencies that will be occurring.

Dr Sherbon: The answer to the question is that it is expected that 30 full-time equivalent staff members will be reduced in non-clinical administrative areas. The focus will be on the outcomes of a finance review that I conducted earlier this year. We are now currently planning our implementation of restructured financial services support to the ACT Health portfolio.

Similarly, a reduction in human resources administrative staff will be the subject of a review currently under consideration. I hope to commission an external review in human resources in the coming months. We are just completing a procurement process to conduct that review. Similarly, there will be reductions in departmental staff located at 11 Moore Street. We will be reducing a number of positions in that function.

So, in total, there will be a reduction of 30 full-time equivalent staff across the entire portfolio. There might also be some minor reductions in pathology support staff as we are improving our workflow in pathology and automating some processes that are conducted manually. However, that will be small number. We are in discussions with relevant stakeholders, staff and unions in relation to that reduction in 30 full-time equivalent staff. Naturally, we will be conducting that process in accordance with government policy, which involves no forced redundancies. The emphasis will be on natural attrition.

MR SESELJA: How many of those 30 staff members are likely to be voluntary redundancies given that there will not be any forced redundancies?

Dr Sherbon: I hope fewer than 10.

MS PORTER: Minister, you just mentioned the record spending on health that we have in this budget. I was wondering whether the committee could have some more detail about how that is distributed across the health system. In particular, I would like to see what is being spent in the primary health area and in the mental health area. I just wanted some idea of how it is spread across the different services.

Mr Corbell: Yes.

MS PORTER: If that is not possible I am happy for that question to be taken on notice.

Mr Corbell: I will see whether I have that break-up for you, Ms Porter.

MS PORTER: Thank you.

Mr Corbell: If you look at page 167 of budget paper 4 you will see the break-up across the different output classes in health and community care, acute services, mental health services, and so on. For example, on page 167 in output 1.1, acute services, you will see increases from $429,726,000 to $447,140,000. Equally, in mental health services you will see increases from $43 million to $47 million, and so on. In community health services you will see increases from $89 million to $98 million and in public health services you will see increases from $23 million to $21 million.

So there is a change in the budget position for public health services. You will also see new investment in cancer services, from $15 million to $18 million, as we bring together our cancer stream. For the first time we are bringing together the delivery of cancer services into a single stream and funding it accordingly rather than having different elements of cancer care and treatment scattered across the health portfolio. Aged care and rehabilitation services also see increases in funding from $17 million to $21 million, and early intervention and prevention also sees an increase from $15.1 million to $16.6 million.

So there are significant increases across the portfolio with the exception of public health services where there is some change to the budgetary arrangements. Aside from that there are significant increases. To some degree I have already gone through the way in which that spending is occurring, whether it is in better access to acute services, whether it is in community health services in the provision of public dental services, and so on. I am happy to elaborate on those if you like, but I think that gives you a general overview.

MR MULCAHY: Minister, I am sure you will recall the Treasurer said in his budget speech that health costs had escalated by seven per cent to eight per cent each year, yet the forward estimates for health average at about four per cent a year. I am sure you are aware that he made the observation to this committee that the compound influence of that eight per cent growth per annum would be astronomical over a period.

Basically he said that it has to level out, that you have a budget that you have to live with, and that within normal economic activity, which averages at about three per cent, that is the range within which you will have to operate. Do you honestly think you are going to achieve that, given past trends—the national expectation in growth and health costs set against the budget that you have submitted to the Assembly?

Mr Corbell: I am sorry, Mr Mulcahy, do you honestly think that I will be able to do what?

MR MULCAHY: To live within the budget framework, given that you have had a 60 per cent increase in health costs over the past five years? We are now being asked to accept that you will achieve a four per cent growth.

Mr Corbell: The health portfolio, like all other portfolios, must work within the allocations given to it by the government. Certainly the health portfolio faces a broad range of challenges, but I take the view that the portfolio is no different from any other portfolio in the territory government, in so far as it must work to meet, and not exceed, its budget.

There are factors impacting on the territory's financial position that cannot be ignored. The health portfolio has been asked to contribute to managing the overall budgetary position of the territory. Given that the health portfolio has the largest expenditure of any portfolio, it is simply untenable to state that it cannot be expected to contribute in any way to the efficiency of the overall budget.

We have chosen to ensure that clinical services and the provision of services to the community are not affected through efficiency measures. Dr Sherbon indicated in answer to the last question, or the last series of questions, that efficiencies are being looked at in the context of the department's administrative areas, in particular, those administrative areas that are most open to potential reform because of the government's decision to merge the different paths of the once segregated health portfolio into a single organisational entity.

It is probably also worth highlighting that there is increased funding and expenditure to cover the not yet finalised pay increases for medical officers, that is, salaried medical officers for health, in 2005-06. That will increase the percentage growth in health expenditure. Members may or may not be aware that we are yet to finalise—in fact, we have only just commenced bargaining with salaried medical officers—the new enterprise bargaining arrangements. Once those bargaining arrangements are finalised that will have to be factored and appropriated into the health portfolio. Provision has been made in the budget but not yet appropriated to the health portfolio.

MR MULCAHY: So that will mean another appropriation bill?

Mr Corbell: It will mean another appropriation bill.

MR MULCAHY: So we are not living within our budget at this stage?

Mr Corbell: No, that is not correct. Those provisions, what the government is prepared to offer salaried medical officers, have been built into our budget but the money has not yet been appropriated and allocated to that portfolio. The reason for that is that we are in negotiations. We are not going to signal to the Salaried Medical Officers Federation—good people that they are—what this government's budget bottom line is and what its negotiation bottom line is. That would undermine the territory's negotiating position. So we will negotiate with salaried medical officers knowing what capacity we have. Cabinet has taken a decision on what it believes to be an appropriate negotiating position. That has been built into the budgetary provisions but the money has not yet been appropriated.

MR MULCAHY: On that point, minister, even if you have not appropriated it, your deficit would exceed the deficit of $92 million that was forecast by the Treasurer.

Mr Corbell: That is a question you would have to ask the Treasurer.

MR MULCAHY: I will take up that issue with the Treasurer.

Mr Corbell: I am not privy to how those issues are managed at a whole-of-budget level. That is not my responsibility. All I can say to you is that the government has made provision to take account of the need to give a pay increase of some quantum to salaried

medical officers. We are in negotiations with them at this stage.

MR SMYTH: Where is that money being held if it is not appropriated but it is in the budget? I am not asking for the quantum of it but exactly where is it being held? Is it being held in finance, in Treasury, or in the Chief Minister's Department? If it is in the budget but it has not yet been appropriated, exactly where is it?

Mr Corbell: Again, I am not privy to the way the budget is structured in that regard.

MR SMYTH: No, you are a cabinet minister.

THE CHAIR: Order! Mr Smyth!

Mr Corbell: It is a question that you will need to ask the Treasurer. It has not been allocated to the health portfolio.

MR SMYTH: Perhaps Mr Foster would know where that money is being held?

THE CHAIR: Order! Mr Smyth! Mr Seselja, did you have a question?

MR SMYTH: It is a reasonable question because I suspect that the minister was wrong.

THE CHAIR: I am sorry, but you need to direct your questions through the chair.

MR SMYTH: Through you, chair—

THE CHAIR: Mr Seselja had already indicated to me that he wanted to ask a question.

MR SESELJA: I am happy to wait for another 30 seconds to hear the answer to this question.

THE CHAIR: I am sorry; it does not work that way, Mr Seselja. What is your question, Mr Seselja?

MR SMYTH: If you want to cover up the minister's inadequacies that is fine.

Mr Corbell: Madam Chair, I am quite happy to answer the question as openly as I can. There is a difference between—

THE CHAIR: That is fine, minister. All I am saying is that if Mr Smyth wants to ask a question he should indicate his intention to the chair and I would be happy to allow him to ask a question.

MR MULCAHY: I will ask the question if there is an issue.

THE CHAIR: No, it is all right. We can come back to his question.

Mr Corbell: Madam Chair, let me just clarify the position. I draw members' attention to page 13 of budget paper 3, which states:

> An expenditure provision has been made for planning purposes where negotiations are not materially progressed, and for future wage negotiations in the forward estimates beyond the terms of current agreements.

It is a fairly standard statement to say "the budget" as opposed to the "appropriation bill." I am sure members would realise that there is a difference between the two. The budget makes provision for anticipated expenditure, but expenditure that cannot yet occur because negotiations around wages have not been completed. That is a normal process for the government to embark upon. The point I am making is that you need to take that into account when you look at the overall level of expenditure in the health portfolio.

I make the point that there is also provision for general wages growth for staff. That has been taken into account. I guess it is worth referring to the wage provisions the Labor government has made since it has been in office. Under Labor there has been a significant increase in the provision for wages simply to ensure that we are able to retain the medical, nursing and other staff that we need to run our health system.

In 2001-02 the growth in wages was 13 per cent; in 2002-03 it was eight per cent; in 2003-04 it was 10 per cent; and in 2004-05 it was 13 per cent. I am advised that that is total spending. So the government is committed to ensuring that it has a wages regime that is competitive.

MR MULCAHY: Are you saying that that is total wages growth?

THE CHAIR: Order!

Mr Corbell: That is very important.

MR MULCAHY: The minister said something that is not clear.

THE CHAIR: Mr Mulcahy, I ask you to direct your question through the chair.

MR MULCAHY: The minister and Dr Sherbon seem to be talking at cross-purposes. Is the growth in wages the percentage that the minister quoted or is it growth in the expenditure of your department?

Mr Corbell: I apologise, Mr Mulcahy, I have just been advised that the figures I am quoting are total growth—expenditure growth including wages growth.

MR MULCAHY: Which takes you back to my question, does it not? How can you possibly expect the committee to accept that you can live with an average of four per cent growth, given the figures that you have just put on the record—figures that the Treasurer also confirmed yesterday?

Mr Corbell: In the same way that the federal government only indexes Australian health care agreement funding at four per cent per annum. The commonwealth government's position on the indexation of health costs and the money it gives us for public hospitals is based on the WC1 price index, which is four per cent. In comparison—

MR MULCAHY: But how does that sit with your expenditure pattern?

Mr Corbell: It is worth making the point that in comparison the federal government allows private health funds to increase their premiums by between seven and eight per cent. So that is a contradictory position on the part of the Liberal Party when it comes to funding for public health systems.

MR MULCAHY: Madam Chair, we are not here to listen to the commonwealth budget being analysed. I am asking for answers to my questions.

THE CHAIR: Order! Mr Mulcahy!

MR MULCAHY: It seems that the minister is not answering the question.

THE CHAIR: Order! Everybody will refrain from talking.

MR MULCAHY: I would like answers to my questions, not a dissertation on Mr Abbott's policies.

THE CHAIR: Order! Mr Mulcahy, I have explained to you—and the Speaker has explained to every member of the Assembly during question time—that the chair cannot direct a minister as to how he or she answers a question. I know you would like that to be the case.

MR MULCAHY: He needs directing when he has gone completely off the track.

THE CHAIR: That is not the way it works. The minister might not have answered the question in the way that you want him to. I suspect that if you allow him to finish his answer he might get there. If he still does not answer your question you could ask a supplementary question through the chair.

Mr Corbell: The point I am making is that one of our key funding sources for public health services, the Australian health care agreement, is only indexed at four per cent growth. That is a significant source of funding for public health services in the ACT. The ACT government is structuring its budget to meet the overall financial position and pressures that the territory faces. Health is contributing to that process. I have indicated to the committee that there is real growth in health funding in this year's budget—net growth of a significant amount of money. We will be working to deliver our services within that budget.

You will see in our output classes increases in occasions of service across the board, improvements in service delivery and new programs being provided. This is not a budget that reduces funding and services for health; this is a budget that increases funding and services for health in a sustainable manner. At the end of the day this portfolio, like any other portfolio, will need to work within its budget.

THE CHAIR: Mr Mulcahy do you wish to ask a supplementary question?

MR MULCAHY: Yes. Minister, I am still struggling with finding the detail that I require in what you are saying. Your colleague the Treasurer said you were going to

achieve those outcomes through administrative savings. Dr Sherbon indicated that about 30 full-time equivalent staff would go. I acknowledge that nearly one in four of your employees are involved in administration, that is, more than 1,000. I do not see those 30 full-time equivalent staff positions in any way achieving the savings that you will need to achieve if you are to get your expenditure levels down from an average of 12 per cent per annum to a growth rate of four per cent. What services in the health area will go to enable you to live within the framework that the Treasurer has given you?

Mr Corbell: The savings measures for health are clearly spelt out. Equally, the target that we are expected to deliver has been clearly spelt out to me by my cabinet colleagues and it is spelt out in the budget papers. It is a savings target with which I agree. Health must contribute to the overall position. If you like, I can give you an analysis of that.

MR MULCAHY: That would be helpful.

Mr Corbell: In the coming financial year we have to return $2.5 million to consolidated revenue. Health's savings target is $2.5 million. That represents 0.3 per cent of health expenditure. That is the target we are looking at for health. Other internal efficiency measures are being taken that will allow us to redirect expenditure within the portfolio. That is a separate matter to the matter that I am addressing now. I am addressing now what the government said health needs to return to the central bucket of money.

MR MULCAHY: So you are saying that will amount to about 0.3 per cent?

Mr Corbell: About 0.3 per cent, or $2.5 million.

MR MULCAHY: You have been running at about eight per cent per annum above what you have been given this year.

Mr Corbell: We are running within budget this financial year; we are not going over budget this financial year.

MR MULCAHY: I am not saying that, minister. I am saying that what you are being allocated, based on past patterns, is radically different. That is what I am struggling to understand. How do you achieve it?

Mr Corbell: No, it is not. I am not too sure how to explain this to you. I am not quite clear how I can answer your question any better, Mr Mulcahy. I have indicated to you what the savings target is for health and what it is expected to return to consolidated revenue—unallocated funds, or however you want to describe them, to the central pool. I am not quite sure how I can better explain that to you.

MR MULCAHY: There are inconsistencies in your comments and in the Treasurer's comments.

THE CHAIR: Mr Mulcahy, we might move on. Mr Seselja wanted to ask a question.

MR SESELJA: Minister, you referred in your opening address to after-hours general practice clinics. Are you able to tell us how that will serve to address access block in particular? If not, what sorts of positive effects will it have?

Mr Corbell: It will assist, not so much with access block, but with waiting times for lower category people in the emergency departments. With category 5 type patients, in some but not all non-urgent, non-life threatening cases, a general practitioner could potentially assist. Potentially even cases such as fractures can, in the first instance, be assisted by a GP. After-hours general practice clinics will operate after hours, on weekdays and at weekends, at both public hospitals.

Category 5 type patients who present to the emergency department will be told, once they have been triaged, what their circumstances are. They will be told as a matter of course, as they always have been, that they are category 5 and that there may be a wait depending on the workload of the emergency department at the time. More urgent cases may be in front of them or more urgent cases may arrive after them. With the new general practice clinics patients will be offered an opportunity to utilise those clinics if it is after hours. They will not be told that they have to and they will not be told that that is their only option; they will be given a choice.

If someone is prepared to remain in the emergency department and see how long it takes that is no problem. The government does not expect people to go away and the emergency department will see everyone as soon as possible. But they have the option to go to the after-hours clinic. That could lead to a much shorter waiting time because they get an appointment, they have a set time, they see the GP and they get the diagnosis and the assistance they need through the GP. The real advantage is that anybody can access this service, whereas previously the local family GP would have had to be a member of the Canberra After hours Locum Medical Service before anyone could access the service.

The advantage now is that anyone can access that service. One of the agreements that we have been able to reach with CALMS is that people now have universal access. The second advantage is that the clinic is now located on the hospital campus. In the case of Canberra Hospital and Calvary public hospital the clinics will operate within the main hospital building close to the emergency department.

I encourage members to visit Canberra Hospital, to go to the emergency department and to follow the signs around to the after-hours clinic, which is close to the emergency department. It will be well signposted so that people are able to find their way from the emergency department to the after-hours clinic. That is a real improvement in the visibility and availability of that service for people who use it after hours.

MR SESELJA: So I guess it will be good for category 5 patients as there will be fewer patients hanging around waiting rooms for a long time. However, it will not have any impact at the other end for more acute care patients. It will not free up beds or space and people will still be seen in those areas.

Mr Corbell: The advice I have is that it will free up some staff time in the emergency department. That will contribute to the overall efficiency of the emergency department. But you are right; the service is mostly targeted at improving waiting times for non-urgent cases in the emergency department and giving people a choice.

MR SESELJA: You said that it would free up some staff time. I guess that will just

affect some triage nurses?

Mr Corbell: It will free up triage nurses and lessen the volume of category 5 patients that are seen. They might be seeing fewer category 5 patients. We do not know yet; we will need to see how trends go over the next 12 months in particular.

MR SESELJA: Is its primary purpose to have fewer people hanging around waiting rooms? Is that the nub of it?

Mr Corbell: We know that there are concerns about access to general practice services after hours. This is one of the government's responses to that situation. First, this is about providing universal access to general practice services after hours, which I think is an important aim. Second, it is about reducing waiting times for category 5 patients in emergency departments. We have seen an increase in the number of category 5 presentations because people are experiencing difficulties in finding a doctor after hours. So we are trying to address those two issues.

THE CHAIR: Minister, on that issue, there is growing concern about people's ability to access general practitioners during the day and not just after hours. Obviously that would not necessarily be an issue to which you would turn your mind, unless it started impacting on those who are presenting during the day to accident and emergency departments, thus increasing the number of category 5 people coming in. Is there any evidence to show that that is the case? That question just occurred to me now.

Mr Corbell: I could not tell you off the top of my head what the situation is during normal business hours. Obviously, the level of activity in the emergency department fluctuates across the day and across the days of the week. The point I make is that CALMS is a service that is provided by local GPs and not by ACT Health. We have been able to work in partnership with it and provide funding to assist with its operation. But the consultations are done by local GPs. They provide their services after hours. During normal working hours they are running their own practices. The pulse position of the government is that the need to find a GP during business hours is not as pressing as it is to find a GP after hours.

MR SESELJA: In your budget ministerial statement to the Assembly on acute care you referred to this initiative and said, "This initiative would, in turn, free up emergency departments to focus on genuine emergencies." A patient presents to a triage nurse, is assessed as a category 5 patient and, at some stage, moves off to a GP. How would that free up the emergency room? Would that not mean that a patient was not sitting in a chair in the emergency department rather than freeing up staff to do other things?

Mr Corbell: Clearly, Mr Seselja, we are dealing with a number of issues. Someone might be categorised as a triage category 5 patient but that does not mean that he or she is left alone without any sort of supervision for the duration of the time that he or she is in the emergency department. It still involves triage and other staff members monitoring what is going on in the waiting room. I am sure that you and other members have been in a situation where you have been a low priority, where you have been waiting and you wanted to know how long you were going to be. You would go to a staff member and ask, "When am I going to be seen?"

There are many pressures on front-line staff when they are managing all these different people. The important issue that we are trying to address is to free up the time of front-line staff, whether it is triage nurses or admissions people, aside from nurses and doctors in emergency departments, to let them know that there is less of a workload coming through. That is what we are talking about there. We are saying, "If patients are low category 5, non-urgent cases, let us give them an opportunity to go and see a GP if it is a GP-related complaint that a GP can deal with." That just adds to the better management of the emergency departments and waiting rooms.

MR MULCAHY: Is it right that you have reduced the size of the waiting room at Canberra Hospital? The waiting room area has been rebuilt. I understand that it is now smaller.

Mr Corbell: I think there have been some refurbishments, but the capacity to hold people has not changed.

DR FOSKEY: I would like to talk more about that later.

THE CHAIR: Yes, we will come back to that.

MR SESELJA: I can see the benefit of that for category 5 patients but it would seem to have a marginal impact on the operations of the emergency department as a whole.

Mr Corbell: It is part of a suite of measures, Mr Seselja; I guess that is the best way of putting it. When I made my ministerial statement I was seeking to outline to members the suite of measures that the government is putting in place. No one thing on its own necessarily makes a huge difference, but when a whole series of things start to work in conjunction with one another they start to make a difference. So whether it is a discharge lounge, after-hours general practice clinics, or an emergency medicine unit in the emergency department of Canberra Hospital, that range of measures all contributes to the better management and operation of the emergency department area of the hospital.

MR SESELJA: I note that category 5 presentations dropped significantly between 2002-03. The figures from ACT Health's annual report show a significant drop in the figures for 2002-03 and 2003-04. Will that significant drop continue, or is it likely to have reached its trough?

Mr Corbell: It is difficult to predict, Mr Seselja. I think I will adopt a wait and see policy on that. Health statistics are very difficult to predict.

THE CHAIR: The committee will take a break and resume at 11.05 am.

Meeting adjourned from 10.48 to 11.07 am.

THE CHAIR: Welcome back minister, officials, committee members and visitors. Dr Foskey has a question.

DR FOSKEY: In budget paper No 4, at page 186, under "Changes to Appropriation", there is an item called "Return of Discontinuing Projects" for the years 2004-05 and 2005-06. Would you please explain what projects have been discontinued? It is the

second last item in the second table.

Mr Corbell: The "Return of Discontinuing Projects" line refers to the government's decision to withdraw funding announced in previous budgets for the redevelopment of Karralika and also some money associated with fit out of the existing health department offices at 1 Moore Street.

DR FOSKEY: That is the total of it?

Mr Corbell: Yes, I am advised it is the total.

DR FOSKEY: I am going to talk about Karralika again under community health, but what happens if, after this process that you have briefly alluded to, there is a decision to go ahead again with the redevelopment of Karralika? Will there need to be a new appropriation entirely?

Mr Corbell: Yes, there will need to be a new appropriation for capital works. As I have already indicated, there is funding of $400,000 for feasibility and investigative and preliminary work, depending on the outcome of the consultative committee process. But that would simply inform a bid in the next budget for any capital works activity. It has been brought to my attention that $83,000 was returned in this line, which was the surplus following the implementation of the satellite renal dialysis service. So that funding was also returned to budget.

DR FOSKEY: To move onto another matter, did any of the departmental staff give comments on sustainability indicators or have you had any community feedback on them? For instance, I would like to register that I do not feel that the mental health indicators on page 173 of budget paper 4 are appropriate indicators to suggest how we are faring in helping mental health consumers achieve wellness or access services. For instance, strategic indicator 4 is about reducing the usage of seclusion, and strategic indicator 5 is about increasing consumer and carer participation. They may be useful indicators but they do not refer to how mental health consumers are faring. I was wondering whether you had had consultation with consumers of services in order to make sure that you were really measuring what matters to them?

Mr Corbell: I am advised, Dr Foskey, that these indicators are based on the work of the national mental health working group, which is developing a national policy framework for all state, territory and commonwealth health ministers, but I am open to any recommendations the committee may choose to make. I will ask Dr Sherbon to elaborate a bit on this issue, too.

Dr Sherbon: As I just mentioned to the minister, I chair the national mental health working group. One of our subcommittees is preparing for all governments—state, territory and federal government—information priorities in mental health policy. As the minister mentioned, that has not yet made its way to ministers. It will do so in the ministers' meeting in July. These indicators foreshadow the work that I have seen in that policy. They are not the only indicators that will be developed in that policy but they are by far the most valid in terms of measurability at this point in time. Consumers were involved in that.

DR FOSKEY: Do you mean easiest to measure when you say valid?

Dr Sherbon: No, valid. They are not easy to measure.

DR FOSKEY: What do you mean by "valid"?

Dr Sherbon: Well, we could dream up a measure that is immeasurable and hard to validate in terms of accuracy. These measures are work that nationally is the advice for the mental health care providers in conjunction with consumers who have been part of that whole process and are represented on the various subcommittees—indeed, are represented on the national mental health working group itself through the Mental Health Council of Australia. That entire cooperative process has reached a point whereby governments will be presented with a series of advice on measurable outcomes in mental health. These are the early outcomes of that process and these are the early parameters that the process has identified are likely to be accurately measured for governments. The minister has foreshadowed in previous discussions that our strategic reporting arrangements under these indicators right across the board is a work in progress and will be developed over future years. This is a substantial increase on outcome indicators that we have presented before. So I would ask you to note that national work is going on and this is the early outcome of that process.

THE CHAIR: Mr Mulcahy?

MR MULCAHY: Minister, my questions relate to the finance and risk management branch of health, which I understand is defined as being responsible for managing the department's budgets and finances, capital planning, property management, and administration. I believe that is a correct description of the branch. Issues relate to a decision that Dr Sherbon took following the last election to extend the FBT-exempt status for salary packaging purposes to most areas of ACT Health. I am wondering how the FRMB, to use the acronym, meets the requirements of ATO ruling 2003/40 in relation to FBT salary packaging?

Dr Sherbon: The process of reaching that decision was based on a series of advice that I will ask the chief financial officer and director of finance, Mr Foster, to outline to you. But I took advice in relation to the tax status of our staff and in that process evaluated whether or not we were in accordance with the existing regime that applies to hospital-related staff. We basically compared ourselves to existing arrangements in place in New South Wales area health services where deductible gift recipient status is granted to those area health services on account of their link with hospital services—a longstanding federal taxation arrangement. What we did basically is compare our existing operations to those that prevail in New South Wales area health services and drew equivalents. So if a function was equivalent to that that prevailed in a New South Wales area health service and already had DGR status, then we conferred that status on our own. Mr Foster will be able to detail the advice that we received and the sources of that advice.

Mr Foster: The process that we followed, as Dr Sherbon pointed out, was to compare ourselves to the New South Wales area health service model. We used PricewaterhouseCoopers to assist us in that work with the tax office to gain deductible gift recipient status for a component of health that was recognised as being a public hospital. We originally sought approval from the tax office for the whole of the

Department of Health to be recognised for DGR purposes—deductible gift recipient status. It rejected that on the grounds that it felt that policy functions, executive functions, should not be seen as part of a broader public hospital description, but it did not recognise that in the same way it did for New South Wales area health services—that the functions of mental health, community health, population health and the corporate support functions of those area health services were part of the greater description of a public hospital.

So the ATO provided a broadened description of a public hospital for the purposes of DGR status. PricewaterhouseCoopers advised the department that on the basis of that outcome with the tax office, that is the granting of DGR status for the greater component of ACT Health as a public hospital, exempt salary packaging could be extended to the staff in those areas or those functions, but at the exclusion of the policy functions of health and the communications and executive function. So, we differ from New South Wales in that we have gone by a function approach. They were able to go on an employment approach, being under area health services.

MR MULCAHY: But I put it to you, Mr Foster, are you not extending this exemption to people who are predominantly, as one of the memos from your department describes it, involved with the Canberra Hospital, as opposed to the Australian Tax Office ruling that refers to the need for an employee to work exclusively for a hospital?

Dr Sherbon: Well, can I just correct that? The ATO ruling does not proscribe to the extent that you have, Mr Mulcahy. It outlines that DGR status is conferrable on those who work in hospital-related services, not to the same level of specificity that you just described.

MR MULCAHY: Would you like me to read it to you, Dr Sherbon?

THE CHAIR: Order, Mr Mulcahy.

Dr Sherbon: No. So, if I could just explain; in an area health service—the area health service next door to us—the entire area, including the area health service administration office, is DGR status positive. It is conferrable upon those employees. We then drew the comparison between New South Wales and us, and drew a line in our department that says these functions are equivalent to an area health service—because we provide a dual service, not only are we a department, we are also a service delivery agency—and then there are other components that are more traditionally in other jurisdictions associated within a central department, notably the executive, executive co-ordination, which is a discrete unit within our department, and the policy unit. So, on other functions like finance, human resources and population health, which are in existence in area health services, we confer the benefit on the basis of that PWC advice.

MR MULCAHY: Well, Dr Sherbon, you said that it was not as proscribed as I have suggested, but I would submit that subsection 57A (2) of the ATO ruling says in part that, "the duties of the employment of the employee are exclusively performed ..."—not associated with or an extrapolation of what happens in New South Wales—"... in connection with a public hospital." My concern, minister, is whether or not you are complying with your tax obligations, and whether the ATO was consulted on this new arrangement that was extended following the election.

Mr Corbell: Well, I am concerned, Mr Mulcahy, that you make the assertion that we are not, but I will ask—

MR MULCAHY: Well, it is my role to ask the questions.

THE CHAIR: Order! Mr Mulcahy, let the man answer.

Mr Corbell: I will ask Mr Foster to correct some anomalies in your statement.

Mr Foster: The legislation you refer to, and section 57A, relates to fringe benefits tax legislation, which rightly did, and does, refer to the original status around public benevolent institutions, and working on a hospital campus. Our approach, through PricewaterhouseCoopers, to the taxation office was through the deductible gift recipient legislation and status, and the tax office gave that ruling in our favour—that we recognised the greater part of ACT Health as a public hospital—in the same way that it did for New South Wales. We have taken that advice from PricewaterhouseCoopers that we can therefore extend salary packaging. The tax office has reviewed the practices in New South Wales and has not required those practices to be changed.

Mr Corbell: So, in basic terms, Mr Mulcahy, you are referring to the wrong piece of legislation.

MR MULCAHY: No, I do not think I am. I am talking about the fringe benefits tax implications, minister.

Mr Corbell: No, but that is not the regime that Mr Foster is referring to.

MR MULCAHY: You are not talking about fringe benefits tax obligations, Mr Foster?

Mr Foster: I am referring to accessing exempt salary packaging through having the deductible gift recipient status allowed on a greater component of ACT Health. Fringe benefits tax is an issue, that's right.

MR MULCAHY: That is the basis though, is it not, on which you are operating?

Mr Foster: That is the exempt component of salary packaging, that is right. As Dr Sherbon pointed out, we have followed the same process that New South Wales followed in applying these conditions.

MR MULCAHY: I will ask my earlier question again. Have you sought advice directly from the ATO that the arrangements that you have embarked on in the ACT health department are in accordance with its rulings under the FBT legislation?

Mr Foster: We have not approached the tax office about FBT legislation for ACT Health employees.

MR MULCAHY: Could you provide the advice that you received from PricewaterhouseCoopers to the committee?

Mr Corbell: I will take advice on whether that advice can be made available to the committee and inform the committee accordingly.

MR MULCAHY: All right. Now, on the basis of this, minister, is it not correct that you would have staff working at Moore Street, side-by-side potentially, some of whom have different tax treatment from other employees working in the administrative side of your department?

Mr Corbell: Yes, that is correct.

MR MULCAHY: You do not have concerns about the inequities that arise from potentially a difference of $170 a fortnight for your employees by virtue of utilising this tax exemption?

Mr Corbell: I think your question needs to be put in the context of the answer that Dr Sherbon gave earlier, Mr Mulcahy that is, that ACT Health is a unique entity because it is both a department and also a service provider. So, we have some people within our organisation, within ACT Health, who provide service delivery, or assist in service delivery, and others who do not, particularly around the functions of public hospitals. It is appropriate that we seek wherever possible to give our employees the benefit of their employment arrangements. But it is an unusual situation insofar as it is not the whole entity being included. It is part of the entity being included, but that is the nature of ACT Health as both a service deliverer and a policy department.

MR MULCAHY: But I understand the finance and risk management branch—I detailed its functions, which you confirmed at the beginning of my questions—is the beneficiary of this new arrangement. It is involved in budget, financing, capital planning, property management and administration.

Mr Corbell: That is correct.

MR MULCAHY: It does not sound too much like the hospital functions that are intended under the legislation?

Mr Corbell: I am not privy to the advice; it is a management matter for the department. But, as Dr Sherbon has indicated to you, advice has been sought—detailed accounting advice and taxation advice has been sought—on how the salary arrangements for these individual officers within the department should be managed. We are undertaking that process in accordance with that advice.

Dr Sherbon: Chair, can I just elaborate on that answer? The functions that Mr Mulcahy just outlined—budget, capital planning, financial reporting—are exactly the same functions that the finance section of area health services in New South Wales are performing.

Mr Corbell: I think the bottom line here is that we are putting in place the equivalent arrangements to arrangements that apply to area health services in New South Wales. There is nothing illegitimate or inappropriate about it. It is an entirely legitimate and acceptable way of maximising the arrangements for employees who work in support of public hospital services. That has been recognised in area health services interstate for

many years, and I think it is entirely appropriate that we take a consistent and similar approach.

MR MULCAHY: Minister, finally could I ask through you of Mr Foster whether he is entirely comfortable with these new arrangements that have been embarked upon in terms of their compliance with the act, their legality and their conformity with Australian tax law?

Mr Foster: It is really—

Mr Corbell: I think that is a matter for the chief executive. He is responsible for the day-to-day management of the department. So I will ask Dr Sherbon.

MR MULCAHY: He is the chief financial officer.

THE CHAIR: Order!

Dr Sherbon: The buck stops with me, so to speak.

MR MULCAHY: The buck stops with the minister, actually.

THE CHAIR: Order! Would you allow them to answer the question?

MR MULCAHY: Let us drop the partisanship. I am keen to get answers.

Dr Sherbon: The first point to clarify is that the decision was taken by me. The minister was not briefed; it was a management decision. The second point to clarify is that I was satisfied that we had received advice from sufficiently competent accountants who were familiar with the tax law. Thirdly, I satisfied myself that it was in accordance with the arrangements that I had just moved from in New South Wales. So, the advice to me made sense. The advice to me allowed us to draw equivalents with our colleagues elsewhere, and I was satisfied that the appropriate legal issues had been addressed in that advice.

MR MULCAHY: If I could ask a supplementary, please?

THE CHAIR: Okay, but this is the last we are doing on this. I think we should move on.

MR SMYTH: Well, it is a very serious issue, though.

THE CHAIR: Yes, Mr Smyth, and I do not disagree with you.

Mr Corbell: I must say, Madam Chair, you are talking about $600 million worth of health expenditure, and we are arguing about the tax treatments for some people in ACT Health.

THE CHAIR: Yes.

MR MULCAHY: Well it's very important, minister, for most of us.

MR SMYTH: Well, it is tax treatments.

THE CHAIR: Order!

Mr Corbell: I am really pleased the Liberal opposition has its priorities straight in this issue.

MR SMYTH: Well, it is a tax treatment, minister, which may have put your staff at risk by allowing them to put in tax returns that do not comply.

Mr Corbell: Well, you have nothing to substantiate that, Mr Smyth.

MR SMYTH: If you are going to laugh at exposing your staff—

Mr Corbell: It is an outrageous claim that you are making.

THE CHAIR: Order!

MR SMYTH: No, I said "may".

THE CHAIR: Minister, do not respond.

Mr Corbell: Yes; "may".

THE CHAIR: Order!

Mr Corbell: That is the coward's defence, Mr Smyth.

THE CHAIR: Order!

MR SMYTH: If you want to talk about cowardice, Mr Corbell—

THE CHAIR: Order, Mr Smith! I am calling you to order.

MR SESELJA: Are you going to call the minister to order?

THE CHAIR: I just did, Mr Seselja.

MR SESELJA: Are you getting him to withdraw the "coward" comment?

MR MULCAHY: That was an inappropriate term, Chair.

MR SESELJA: Is it appropriate or not?

MR SMYTH: Mr Corbell is the first one in the Assembly to jump up and get us to withdraw all sorts of things.

MR MULCAHY: The discourtesy shown to Mr Smyth is not appropriate.

THE CHAIR: Oh, dear. He is a shrinking violet and he cannot cope with it.

MR SMYTH: Can I ask my question please, Madam Chair?

THE CHAIR: Yes, but I would like to make this point, Mr Smyth. I also make this point to the minister and to the officials. I am actually chairing this hearing and trying to have some form of order going on. I would ask that all members of the committee and the witnesses take notice of what the Chair actually says. If they cannot comply with that, then I suggest that they actually make themselves not available until they are able to comply. Mr Smyth, I have actually mentioned on several occasions that I do not want banter going backwards and forwards because that is when you end up having all sorts of comments being thrown around. Now, Mr Smyth, I have said to you that I am happy for you to ask the question and I ask that the minister not antagonise Mr Smyth or any of the other members of the committee.

Mr Corbell: I will restrain myself, Madam Chair.

THE CHAIR: Thank you. Mr Smyth, do you have a question?

MR SMYTH: Dr Sherbon, you said when Mr Mulcahy started asking his questions that it was really the DGR, not the public benefit sections that you had applied this ruling on. Yet the memo that David Jackman, the director of HRM branch, sent out actually does quote ATO decision ID2003/40. That decision refers to an employee of a state or territory department.

THE CHAIR: Sorry, Mr Smyth. What are you referring to?

MR SMYTH: I am referring to the minister's answers and Dr Sherborn's answers earlier. A memo was sent out by the union, apparently—or through the union, to the union—about the changes. It quotes ATO decision ID2003/40. That is the basis of the changes, yet it was seemingly portrayed that the basis of the changes were, in fact, under the DGR.

Dr Sherbon: I will have to ask Mr Foster to answer that question. Just before I do, can I just take one brief moment? In my last answer I said the minister was not briefed about this decision. Can I point out: the minister was not briefed before I took the decision, but he was briefed about the outcome after the decision was made. May I clarify that point?

Mr Foster: I cannot speak for that letter you are referring to, but what I stated earlier was correct. We used PricewaterhouseCoopers to obtain deductible gift recipient status for ACT Health. The benefits of that were twofold. It enabled the organisation to receive donations from third parties and to issue tax receipts to those donors. It also, on the advice of PricewaterhouseCoopers, gave us the opportunity to extend salary packaging to the greater part of the workforce in ACT Health. The basis for that advice in PricewaterhouseCoopers has been around the deductible gift recipient status.

MR SMYTH: The actual case, though, is an individual who actually worked in a department who was responsible for the development of alternative funding options for public hospitals, was monitoring expenditure of public hospitals, and providing advice to the minister in relation to the allocation of funding to public hospitals and hospital performance. That individual had her claim denied, so—

Dr Sherbon: That is a departmental function. In New South Wales, that would be performed by a person in Miller Street, North Sydney.

MR SMYTH: And is that function not performed by a person in Moore Street in Canberra inside the department? The blurring of state functions into area health services might be a neat device, but if you were satisfied, as Mr Mulcahy asked previously, why did you not go back and ask the ATO for clarification, rather than relying on PricewaterhouseCoopers?

Dr Sherbon: We were satisfied with the PWC advice and the arrangements that were drawn and the logic of that advice, drawing on arrangements in New South Wales.

MR SMYTH: How many staff in the entire department are now not eligible for this access?

Dr Sherbon: I would have to take that on notice, but it would be less than 100.

MR MULCAHY: So out of 4,700, 4,600 are getting this benefit?

Dr Sherbon: I would have to guess that off the top of my head, but it would be a small percentage, that is true.

MR SMYTH: Because the important thing is that the decision actually says that two arms, or two limbs, as they refer to, need to be satisfied. The ruling states: "This second limb needs to be considered for employees whose duties of employment are not exclusively performed within the physical precinct of the public hospital." It goes on to say that they must work exclusively for the benefit of the public hospital. Now, clearly, not all of the administrative staff works exclusively for the benefit of the hospital.

Dr Sherbon: That is why not all of them get it. You are quite correct. Those who work for the benefit of the public hospital receive the benefit. The precedents established in New South Wales, which, as Mr Foster said, have been tested, are broader than the simple provision of services on the campus itself. Mr Foster is able to clarify the issue of the ruling.

Mr Foster: Again, I think that RAT ruling relates to an application to the tax office under the fringe benefits tax legislation by an individual. The tax office has responded to that I do not know which jurisdiction it is from and when, I do not know. But certainly, as I said, we are not applying 57A in our interpretation. We have gone through a process with PricewaterhouseCoopers consistent with the process they followed in the New South Wales jurisdiction. By obtaining agreement from the tax office to a broader description of a public hospital—broader than the description that is in the fringe benefits tax legislation—fringe benefits tax exempt salary packaging can be made available for a greater number of the workforce.

MR SMYTH: But if you are not making it under ruling 57A, why does the memo that has been sent out actually quote that section? It quotes decision 2003/40 from the tax office, which is all about 57A.

Mr Foster: As I said at the start, I am not the author of that minute. I would have to see it and ask the other people as to why it is written that way. I do not think it is something I can respond to.

THE CHAIR: No, Mr Smyth, that is not the way it works. You know it does not work that way.

MR SMYTH: Well, he wants to see the document.

THE CHAIR: You would like to make it available for all the rest of the committee, would you?

MR SMYTH: There you go. Perhaps you can photocopy it and circulate it, Chair. If we are advising staff that they can seek this status under a tax ruling and then you say that you have not used that tax ruling to make the benefit available, have we—and I go back to you, minister—therefore exposed staff who may have submitted inaccurate tax returns?

Mr Corbell: The advice the department has received from PricewaterhouseCoopers is no, that is not the case.

MR MULCAHY: Minister, you have got 4,700 employees in health and, by the advice of Dr Sherbon, there are only about 100 who are not going to get this benefit and yet you have got over 1,000 employed as administrative services officers. Do you think you are acting in accordance with the spirit of this tax measure, designed to assist people who are giving the gifts to charitable and appropriate causes, in making this tax benefit available? Is this in the spirit of legislation, would you suggest, or not?

Mr Corbell: You seem to be varying your grounds, Mr Mulcahy. At one point we were in breach of the law. Now we are in breach of the spirit of the law. I think the issue for me as minister is: is the department acting on appropriate advice and in accordance with the law? The advice I have from the department is that, yes, it is. Because of the nature of ACT Health as an entity and the way it works in the territory, as both a service deliverer, as well as a policy department servicing the government, these types of issues arise.

I will ask Dr Sherbon to elaborate, but I have no difficulty with the arrangements. The advice I have from the department is that this is an appropriate way forward for managing salary arrangements for staff in the department. They have sought and got the appropriate advice on which to make their decision. It is a decision of the chief executive, in terms of managing the department, and it is a decision that I am very comfortable with as minister because I believe the process that has been gone through is appropriate and thorough and it would seem to be consistent with approaches taken in other jurisdictions. But I will ask Dr Sherbon to elaborate.

Dr Sherbon: Yes, if I can reinforce that answer by pointing out that your question was about the spirit of the legislation. Yes, the advice from PWC was that we are in accordance with not only the spirit, but also the substance of the legislation. The spirit of the legislation draws from the history of the legislation, which was based around support for public hospitals in the days when hospitals were largely the sole source of service to

the community. As you know, the whole process of health care administration has been area-ised, for want of a better term. We manage health services on a regional basis now, not on a hospital-by-hospital basis. Precedents in New South Wales have recognised that change in the way hospitals are supported and public health services provided in the community.

In my judgment, having received the advice from tax competent accountants and lawyers at PWC, I was satisfied that we were operating within the substance of the law and the spirit, and because I had come from the jurisdiction where arrangements were in place to the same extent that we have now put in place.

MR MULCAHY: Just one last comment, if I could, on that point.

THE CHAIR: I am sorry, Mr Mulcahy. Mr Seselja asked for a supplementary question.

MR SESELJA: I am just rounding it out. The nursing and midwifery office, I assume that is then just a purely policy function, no service delivery, as such?

Mr Corbell: I ask Dr Sherbon to answer that question.

Dr Sherbon: The development of the profession of nursing across the territory has service delivery implications that enable nurses in the workplace to deliver a good service. If you are asking me now if they are in or out of the split, I honestly cannot remember and I would have to check that through—

MR SESELJA: They are out and I am just wondering why. It seems like one that would be more appropriate, perhaps, than the finance branch.

Dr Sherbon: I am just advised by Mr Foster that the nursing and midwifery service that is located in my department was not included in DGR status arrangements because it has an equivalent in the New South Wales Office of the Chief Nursing Officer. So the chief nurse is not included in the process because her function and her associated staff who report to her are not able to directly draw equivalents in New South Wales area heath services.

MR SESELJA: I though the split was based on service versus policy, rather than what happened in New South Wales, as such.

Dr Sherbon: No. I said the split was based on the precedents in New South Wales.

MR SESELJA: So it is purely based on the precedents in New South Wales, not on an objective test of what the various areas do?

Dr Sherbon: Well, a combination of two, but the predominant precedent is that set in New South Wales. So if a member of staff were to come to me tomorrow and say; "I reckon I should get this benefit," the test would be: show me where in New South Wales you have an equivalent officer who does a similar function for an area health service and gets that benefit.

THE CHAIR: We might move on. If members have further questions on this issue, I

suggest that they place those questions on notice. I understand that both Ms Porter and Dr Foskey have a few more general questions.

MS PORTER: Minister, in your introductory remarks you mentioned the nurse practitioners' initiative and the development of that program. I was just wondering if you could give us some more detail on that? I believe that you mentioned in your introductory remarks that it may be possible for the nurse practitioners to work in the community, and I thought you said in government and in non-government settings, but I may have misheard you. So I wanted some more detail about where, in fact, the nurse practitioners will be located overall or where it is planned that they may be located, because I think there probably is some work still being done on that, and whether at some time in the future you perhaps could envisage that they might work in accident and emergency during the day to assist with the Cat 5 patients.

Mr Corbell: Thank you, Ms Porter, for the question. I will ask the chief nurse, Jenny Beutel, to give you some detail on this issue. While she is coming to the table, the initiative is a quarter of a million dollars. That will allow us to develop these positions in mid to late 2005 in different parts of the ACT health system. This has been facilitated because the government has recently legislated to provide for the position of nurse practitioner and there is now a masters nurse practitioner course at the University of Canberra. In addition, because of the legislative change, the Nurses and Midwifery Board of the ACT is able to accredit and register nurse practitioners. So I will ask our chief nurse Jenny Beutel to outline the further work of this initiative.

Ms Beutel: Just to go on to the broad components of the nurse practitioner program, first of all, there is the aged care nurse practitioner pilot project, which is a joint ACT-commonwealth initiative. With that project we have three experienced registered nurses, who are also student nurse practitioners with the University of Canberra, undertaking activities throughout the continuum of aged care services. That is through the acute sector, community and also in the aged care residential sector. The idea of that project, which is a 12-month project that finishes in June, is to really look at how that role in aged care actually develops and functions. We will certainly be guided by the outcomes of that project as well. But aged care is certainly one area that we will be looking very seriously at.

In regard to other services, we are in discussions with other service providers, both within ACT Health and outside ACT Health. I am looking at the most appropriate places for nurse practitioners to be in. One of the very important aspects of that is that it has to be able to provide a benefit in addition to the services within that community environment. I think—please correct me if I am wrong here—you were asking about exactly whereabouts those services would be or those positions would be?

MS PORTER: Not exactly by suburb, but in general terms, would they be within a community—for instance, the initiative that is happening at Charnwood? Would it be possible for that initiative to have a nurse practitioner some time in the future?

Ms Beutel: There is certainly potential for that to actually be looked at, yes. What we would need to be doing is looking at what services they would be providing and how they would best benefit that community.

MS PORTER: And the issue about some time in the future their being able to work with Cat 5 patients in A&E?

Ms Beutel: That is certainly a position that is functioning in other jurisdictions, particularly in New South Wales and certainly internationally. There is demonstration that they work very, very well in emergency departments. That is an area that we will also be looking at.

MS PORTER: Because that would free up the doctors, one would presume, to work with the acute patients, to improve the throughput for the acute patients if the Cat 5 patients were being seen by the nurse practitioners, I would imagine.

Ms Beutel: It certainly facilitates better access for clients—for patients.

THE CHAIR: Does anybody else have any questions of the chief nurse while she is at the table on this area or any other area? Thank you Ms Beutel.

DR FOSKEY: I just wanted to talk about commonwealth grants. In this year's budget it is dealt with in budget paper No 4, page 189. Unfortunately I do not have last year's budget, which gives the amount for last year, but I am sure that the minister and the officials are aware of the details. There appears to be a reduction in the national public health outcomes agreement even if we add the funding for the Australian immunisation agreement to it. I wonder if you can explain the details of this decrease. Is it a decrease? If so, why, how?

Mr Corbell: As I understand it, Dr Foskey, and I will ask some officials to provide some further advice on this to me, there was a dispute with the commonwealth over the level of indexation that was provided as part of the national public health outcomes agreement. That resulted in, as I understand it, and I will take further advice on this, a real decrease in the level of expenditure available because of the lack of sufficient indexation, if indexation at all. I think it was just a flat offer with no real indexation. So we did see a net decline in the amount of funding offered through the public health outcomes agreement. I will ask Dr Sherbon to elaborate.

Dr Sherbon: Just to clarify, there was some indexation, and during the lunch adjournment we will get the figure for you, but the minister's point is correct. There was substantial negotiation with the federal government over the initial offer from the federal government, which was a significant decrease in 2005-06 funding under the public health outcomes funding agreement. We did manage, through the minister's efforts, to correct that to the extent that the federal minister did increase the 2005-06 offer, but as Minister Corbell has just outlined, as far as I understand, and I will check this during the lunch break, it did not quite reach a point in the 2005-06 offer where it increased the 2004-05 funding by the CPI. I think it fell short of that mark. We will check that in the break.

The other source of decrease from 2004-05 to 2005-06 I understand, having just received advice from the finance officials here, is the reduction in the meningococcal C vaccination program, which reached its peak in 2004-05 and has continued at a much lower level in 2005-06, the catch-up effect being obtained in 2004-05. But to return to the substance of the question, which was: what was the relative funding between

2004-05 and 2005-06 in the FOFA agreement, we will seek an answer to that in the lunch break, but it is my recollection that in real terms there was a slight reduction.

DR FOSKEY: The $1.26 million, also on page 189, provided under the illicit drug diversion program, is that new funding as it appears? Could you explain how it will be spent?

Mr Corbell: The illicit drug diversion program, Dr Foskey, has been running for a number of years. Each year the territory puts forward its proposals for spending the money based on our split of that program, and that is agreed. The structure of that program ultimately is agreed by the Ministerial Council on Drug Strategy, which I sit on and which police minister Mr Hargreaves is also a member of. So that is a continuation of the existing arrangements we have with the commonwealth. I am not sure whether it is exactly the same level, but it is a roughly equivalent level. It is at a roughly equivalent level, and I am advised by Dr Sherbon that we are at this moment negotiating funding for future years as part of the continuation of the illicit drug diversion program.

DR FOSKEY: What does this program involve in terms of health? It does not sound like a health program.

Mr Corbell: Well, it is designed to assist people to get access to treatment as an alternative to criminal sanction. Primarily that is what it is about. So for people who are apprehended and charged with drug offences, wherever possible the program seeks to divert them into treatment and rehabilitation, rather than getting them caught in the criminal justice process without any treatment and rehabilitation. As is noted there on the page, Dr Foskey, it also allows us to support needle and syringe programs as well, which is an important public health function.

DR FOSKEY: So all of that money is spent within health, rather than any of it in justice?

Mr Corbell: I will need to take advice on that. I think it is spent primarily by the health portfolio. Is there any money spent in justice?

Dr Sherbon: I will just introduce Helene Delaney, who is our manager of alcohol and drug policy.

Ms Delaney: Presently there is a position in the Australian Federal Police as part of that program. It is currently funded through the public health outcomes agreement. We are looking in the new agreement for that position to be funded under the illicit drugs strategy under COAG. We are looking at a change for the source of that funding, but at present the funding from the illicit drugs strategy is spent only in the health portfolio.

MR SESELJA: How many people who have been diverted in a given year, say in the last financial year, would have come under that program? As a supplementary to that: is it primarily for first offenders or does it encompass others?

Mr Corbell: I will ask Ms Delaney to answer that question as she is more familiar with the program than I am.

Ms Delaney: The figures are certainly available but we would need to take that question on notice and come back to you. The objective of the program is about early intervention. While there would be people coming through the program that have been through the system previously, the focus is on early intervention.

MS PORTER: Page 166 of budget paper no 4, under the 2005-06 highlights, talks about continuing the pilot intermittent care service to test the effectiveness and efficiency of combining health and aged care funding to provide short-term care services for older persons. Could you enlarge on how that will be developed in the future?

Mr Corbell: It is an 18-month pilot, if I recall correctly. It is being delivered by Baptist Community Services. Baptist Community Services have been awarded funding by both the ACT and the Australian government to deliver this service. They provide occasions of care for up to a 12-week period for individuals. That can be a very broad range of rehabilitation and other support to allow an older person who has been assessed as eligible for an aged care residential bed to stay in their own home and prevent readmission or admission to hospital or indeed to assist with discharge from hospital back into the home.

The focus is very much around ensuring that, wherever possible, nursing home type patients, as they are known, are not occupying our acute care or medical/surgical beds. The opportunity is always constrained by the fact that there will be people—nursing home type patients—who will need to remain in hospital whilst they await placement in a nursing home facility because of the seriousness of their illness, and we are dealing with very chronic levels of illness for people in that category. The program allows people who are at a less chronic stage to be accommodated in their own home with an appropriate level of support. That is better for the older person concerned and it is also better for management of beds in the public hospital system.

Two objectives are being met there. I think that to date the program has been effective. Certainly the feedback from Baptist Community Services is that it is well received and working well. I am grateful for the support of the commonwealth minister, Julie Bishop. She and I jointly launched the program a little while ago and I am looking forward to it continuing. It is a significant investment for the territory of over $1 million. I think it is making a real difference to the quality of life of older Canberrans.

MS PORTER: This is not on the same subject. In your introductory remarks you mentioned the allied health work that is being done with regard to BP4. What do the allied health assistants do? In what areas do they work? Sorry, that is a nursing question. Can I ask you, minister, about this particular matter?

Mr Corbell: Thank you for the question. Karen Murphy is our allied health adviser, but I will ask Dr Sherbon to answer.

Dr Sherbon: Sorry, Ms Murphy is not here today but I can answer your question. Allied health assistants are a new category of staff. We are working in extensive cooperation with the CPSU on designing a new role that will assist allied health professionals—physios, OTs, speech therapists, et cetera—in freeing up their professional time by allocating non-professional duties to the assistant whilst the professional person focuses their time on the professional aspects of care. A simple example is physiotherapy.

Physiotherapy has an established tradition of working with assistants, but not to the formal extent that this would provide, whereby the assistant might carry out a procedure that the physio had outlined would be required. The physio can then move to the next patient and evaluate their needs and then the assistant carries out their procedures. The new category is designed, as foreshadowed in the minister's comments on our work force plan, to free up professionals in a time of shortage to see more patients and reduce their non-professional duties.

MR SESELJA: Minister, on page 188 of BP3, an extra $2 million is allocated for elective surgery. In your statement to the Assembly on the issue you claimed that that would provide an additional 300 operations, amounting to $6,666 per op. However, in answer to a question on notice, you said that the average cost of an elective surgery procedure is $7,018. Are you able to reconcile the difference between those figures for us?

Mr Corbell: I will have to take the question on notice, Mr Seselja. I do not have my previous answer in front of me and I need to go back and see what was the context of that question and the answer. I am happy to elaborate on notice.

MR SESELJA: The question, very simply, just asks about the average cost of elective surgery.

THE CHAIR: Mr Seselja, the minister has said that he will take it on notice and provide the answer to you.

MR SESELJA: I am just seeking to give the minister additional information. There is nothing else in the answer. The average cost of elective surgery is $7,018 as opposed to the figure that has been claimed in the minister's speech.

Mr Corbell: Again, Mr Seselja, I will simply need to look at the context of that question and the context of my statement. I am happy to provide you with a reconciliation of that and an explanation of that.

THE CHAIR: Mr Mulcahy, do you have a general question?

MR MULCAHY: Yes, general or specific. On page 188 of BP3, under government payments for outputs, there are two lines—I trust you know the answer, minister—"General savings", which you talked about a bit earlier, and "General savings to be reinvested" of about $7.2 million. Can you explain the difference between general savings and general savings to be reinvested and what the general savings to be reinvested are being reinvested into?

Mr Corbell: Just referring to page 188 of budget paper 3—

THE CHAIR: I think he is referring to BP4, minister, but I am not sure. Can you say what you are referring to again, Mr Mulcahy?

MR MULCAHY: Under government payments for outputs there is a table listing general savings and then, in that same table, general savings to be reinvested. I said BP3 but it should be BP4. It starts on page 185.

Mr Corbell: Your question, Mr Mulcahy, is that you want to know about general savings to be reinvested.

MR MULCAHY: I am looking at the differential, minister, at the difference between general savings of $2.5 million, in rough terms, and general savings to be reinvested of $7.2 million in 2005-06. Obviously, different years have different figures later on. What is the difference? Where those savings are to be reinvested, what are they being reinvested into?

Mr Corbell: They are being reinvested in the items immediately above that line, under the subheading "Agency funded initiatives", Mr Mulcahy. It starts with the after-hours GP service and works down the list. The last one is "Quality infrastructure". That is what it is being spent on.

MR MULCAHY: How do you differentiate between general savings and general savings for reinvestment? Are they just cuts of $2.5 million?

Mr Corbell: It is just designating the difference. The general savings of $2.5 million are savings which will be redirected to the centre, to Treasury; the $7.2 million is savings achieved within the department but then spent within the department on those initiatives.

MR SMYTH: Minister, in budget week you made a ministerial statement on acute care. You talked about the initiatives in the 2005-06 budget building on work done. On page 4 of that statement you said that the total number of emergency admissions in 2003-04 was 17 per cent higher than in 2000-01. I have checked those numbers from the patient activity data sets and I can find an increase of only 4.5 per cent over those four years. Could you detail where you got that information from or what numbers you are using if you are not using the published patient activity data sets? Madam Chair, I have enough copies of the data for all members of the committee and the minister if he does not have them to hand.

Mr Corbell: Mr Smyth, can you just repeat that question, please?

MR SMYTH: Certainly, minister. You said on page 4 of your ministerial statement on acute care that you put out during budget week in relation to the budget, in the second paragraph, that the total number of emergency admissions in 2003-04 was 17 per cent higher than in 2000-01. I have checked the patient activity data sets. In 2000-01 there were 92,884 people and in 2003-04 there were 97,145 people, a difference of 4,261 or only 4.5 per cent. Are you using different figures that we are not privy to or are the patient activity data sets, as released by your government, inaccurate?

Mr Corbell: I am advised, Mr Smyth, that you are referring to the wrong data. You are referring to attendances, not admissions. We do not have 97,000 admissions.

MR SMYTH: That is what the data shows between TCH and Calvary.

Mr Corbell: I am advised that it would seem to be the case that you are referring to attendances, not admissions.

MR SMYTH: If that is the case, I would assume that admissions are actually less than attendances. If it is different data, can we have the data that you refer to, please?

Mr Corbell: Yes.

MR SMYTH: In your speech, on page 5, you went on to say, "We have provided care for 11 per cent more people in 2003-04 as in-patients than in 2000-01." Could you provide the information there? Again, working off the patient activity data sets, the difference seems to be less. There were 17,000 in 2000-01 and only 16,000 in 2003-04. It appears to have gone down, unless you are using different data or I have got the wrong data.

Mr Corbell: Anything is possible, Mr Smyth, based on your last question. I will take it on notice and provide you with an answer.

MR MULCAHY: Page 121 of BP3 gives the estimated revenue forecast of cross-border health receipts. If you have this data at hand, what do you estimate the costs are likely to be in the 2005-06 year, and ideally in the last year, for the provision of medical services for non-ACT residents who are accessing ACT public hospitals?

Mr Corbell: Generally speaking, the level of costs you would expect would equate to the level of revenue we would receive. However, the government's position is that the cost of providing the service is probably a bit more than what we get by way of payment from New South Wales. This has been a longstanding issue between the territory and New South Wales ever since cross-border arrangements have been in place. Generally speaking, the level of cost is around the level of revenue you would expect, with the proviso that in real terms it is probably a little bit more.

MR MULCAHY: In a previous hearing of the public accounts committee, minister, you cited the New South Wales burgeoning numbers as one of the major factors, along with ageing population, putting pressure onto the Canberra hospital system. I understood from earlier remarks you made that the services being provided, and therefore the subsidy to New South Wales, are growing at a significant rate, which certainly led me, and I think many other members, to reach the view that the revenue is not meeting the cost. If that is the case, I am wondering, firstly, what it actually is and, secondly, whether you are going to do anything about it, seeking to renegotiate arrangements with your colleagues in New South Wales to get a better deal for ACT Health.

Mr Corbell: The cross-border payment arrangements are negotiated every four years or so at the same time that the Australian health care agreements are negotiated. We are currently still in negotiation with New South Wales Health around the cross-border payment arrangements. The territory has an agreed negotiating position which argues for improvements in a range of areas to better reflect the real cost of providing a whole range of acute services, and indeed outpatient services, to New South Wales residents.

So, yes, the government is working to address that. As I have indicated to you in the public accounts committee, and I have just indicated to the committee now, whilst you could generally say that the costs equate to the level of revenue received, it is a grey area. However, we do believe that the cost is not commensurate with the payment that we receive from New South Wales, and that comes down to how you measure the occasion

of service.

MR MULCAHY: Whether you are using their basis or ours as to cost.

Mr Corbell: Yes, which base you are using, those sorts of issues. That is a matter of dispute and has been a matter of dispute in the past between territory governments and the New South Wales government. I think my predecessor in the Liberal government, Mr Moore, sought mediation on that particular issue when he was responsible for negotiating a cross-border agreement. I think he was unsuccessful in that mediation in getting the outcome he wanted for the ACT. It is a difficult area, but it is one we continue to press New South Wales on.

MR MULCAHY: Do you have an estimate of the actual real cost to the ACT of these additional services? I know New South Wales like to work on a lower cost scale for their compensation. But in terms of what it is really costing the ACT taxpayer to provide these subsidies to the New South Wales community, do you have an estimate figure of what you are trying to achieve?

Mr Corbell: I need to take that on notice and see if I can provide that to you.

MR SMYTH: Minister, in the same ministerial statement on acute care you made the claim that there are now 20 per cent more people working across ACT Health than at the time you were elected. Could you detail where those people have gone to and what they are doing? Are we also therefore receiving 20 per cent more in services since your election?

Mr Corbell: I think the Canberra community is definitely getting an improved level of service in a whole range of areas, whether it is in dental health services, in after-hours GP services or more money for elective surgery. I think the government is investing to improve service delivery for the Canberra community. As to the break-up of staff from the most recent financial year compared to the previous year, I am happy to take that on notice and provide a breakdown for you.

MR SMYTH: I can do that. That is in your annual report or in other documents because of changes that your government put in place. But your claim is that there are 20 per cent more people now than in 2001-02. I would like you to substantiate that claim. In regard to the litany that you rattled off—

Mr Corbell: I have taken that on notice, Mr Smyth. I am happy to answer it.

MR SMYTH: Yes, that is okay. In regard to the litany you rattled off, people are waiting longer to be admitted to hospital.

THE CHAIR: What is your question?

MR SMYTH: People are waiting longer on the elective surgery list; the list itself has blown out.

THE CHAIR: Get to the question.

MR SMYTH: We have 20 per cent more people working across the system but have we

got 20 per cent more services, minister?

Mr Corbell: I think I have just answered your question, Mr Smyth. The issues that the committee needs to be cognisant of, and I am sure any decent shadow health minister would be cognisant of, is that health costs increase at a rate above normal indexation. So you have to continue to pay more simply to maintain the existing level of service. That is an important part of managing any health budget. The other issue of course, which is important from the government's perspective, is to continue to improve access to services. As I said in my ministerial statement, we are doing that in a whole range of ways: through additional money for elective surgery, an additional $2 million per annum for elective surgery; an additional 300 people next financial year; and an additional 400 people the year after that, targeted at people with long waits.

Since we have come to office there has been over an additional $20 million on elective surgery. Our levels of activity are very high, closest to the highest ever, so more people are getting access to elective surgery. At the same time, we are focusing on improving access to acute care: 20 new hospital beds are to open this financial year, with the nursing staff to facilitate the operation of those beds. That will assist with the waiting times in emergency departments. So the government is making the investment in those very important areas.

MR MULCAHY: I have a supplementary to that. Minister, I assume you are familiar with the Australian hospital statistics published by the Australian Institute of Health and Welfare about the cost of Canberra hospitals.

Mr Corbell: AIHW publishes a heck of a lot of figures, Mr Mulcahy, but I am happy to listen to your question.

MR MULCAHY: Let me help you there, minister. I will narrow it down and make it very easy for you. I am referring to table 4.1 of the figures I just quoted in that report. It shows that the cost of Canberra's hospitals on a casemix adjusted separation basis is $4,128—I think you are familiar with that figure—compared with the Australian average for similar hospitals of $3,184 on the last published data. That appears to make Canberra's hospitals about 30 per cent more expensive than comparable hospitals doing the same job. I think those figures, which we also discussed yesterday, showed your administration was about $14 million higher than comparable jurisdictions. Do you agree with those figures? Can you offer the committee any explanation as to why Canberra seems to be running its hospital system on a much higher cost basis?

Mr Corbell: The figures that you quote are the AIHW figures—figures that are well respected in terms of their standing. I have no reason to dispute those figures. Those figures have been around for as long as the territory has had self-government. It has historically been the case that the cost of providing an average cost-weighted separation in the ACT is much higher compared to the national average. It is not unique to this government. I can recall my predecessor in the Liberal government, Mr Moore, actually commissioning a study to explain why it was the case that they were higher than the national average.

This government takes the view that we have to work to get closer to the national average. We are not trying to explain it away or say that it is not an issue. It is an issue.

We do need to get that average cost down. The most recent advice I have, and it is preliminary advice at this stage, for the 2003-04 financial year is that the initial indications are that our average cost versus the national average will be going down. That is a very encouraging trend if that is the case.

The work the government is doing to improve the efficiency of our public hospital services will hopefully continue to contribute towards that trend. For example, some of the money that we are spending on elective surgery is going to be spent on systems improvements in our public hospitals to get our theatres working more efficiently. That means better systems management across the hospital so that more people can be seen. That is going to assist not only patients but also the overall efficiency and hopefully also the cost of providing the service. The government takes the issue seriously. I do not dispute the figure, but I am very confident, at least on initial advice, that we are starting to see some movement in the right direction.

MR MULCAHY: The other question I asked is: what do you identify as the main problem for this quite significant disparity that has been there historically or in the last year? I will not get into that debate, but I am just curious to know what you see as the major problem for your health service being so expensive compared to the rest of the country?

Mr Corbell: As I said, it is an historical issue. I think Dr Sherbon would be able to give you a bit more advice on that.

Dr Sherbon: We have examined this quite intensively over recent years in conjunction with ACT Treasury and look forward to further scrutiny from Treasury in the coming months. It is not something that Treasury is relaxed about, to be frank, and neither are we and neither is the minister. The brief from the minister is to try and move to get our costs per weighted separation, which is the parameter that you are referring to, down to as close to a reasonable figure as possible whilst maintaining the quality of service that we are proud of.

The answers really lie in three areas. One is that the jurisdictions to which we are referred have lots of small country hospitals and that gets their number down. If you were to withdraw the New South Wales country hospitals, the tiny country hospitals that I used to run in New South Wales where the costs per weighted separation would be down around $1,900 compared to the $4,100 we have here because they are largely caring for nursing home type patients, that would take the average up in New South Wales.

Also, we run three low-volume, high-cost units here in the territory: the neonatal unit, the neurosurgery unit and the cardiothoracic surgery unit. Successive territory governments of all political persuasions have expressed a community view that those units are appropriately located in the territory. So they are maintained, wonderful quality units, but they are low volume compared to their peers elsewhere because they service a smaller population. Nevertheless they are here, they are good and they provide excellent quality of care at a higher cost, to be frank. Thirdly, our salaries and wages are higher, as all of you are aware through your roles in various committees. We do require a bit of an edge in salaries and wages to recruit people to Canberra. That is just the nature of the labour market for the highly skilled people that we chase.

MR MULCAHY: In specialist areas, do you mean, in nursing and so forth?

Dr Sherbon: Yes.

MR MULCAHY: Not in administration.

Dr Sherbon: But don't forget that 60 per cent of our staff are highly skilled professionals. We are chasing a lot of people. Just to round out the answer to the question: the minister's brief to me is to work as intensively as possible to bring the administrative costs down to a level that is reasonable whilst maintaining the quality of service. The figure that you refer to is very well known to ACT Health. We are working, with seemingly early results indicating that we were headed in the right direction, to reduce our cost per weighted separation.

THE CHAIR: Thank you, minister and officials. I remind members that we have a half-hour meeting scheduled to start at 12.30.

Meeting adjourned from 12.25 to 2.04 pm.

THE CHAIR: I welcome back the minister and departmental officials. We have agreed to deal with general questions until 2.50 pm. We will then deal with output classes, unless we change that decision and decide to deal with HealthPac. However, HealthPact officials are not here yet. Mr Seselja?

Mr Corbell: Madam Chair, with your indulgence, I wish to provide an answer to a question Dr Foskey asked this morning about the public health outcomes funding agreement. She asked about the level of funding and wanted to know whether there had been a decrease. I am advised that funding for 2004-05 was $3,334,000. In 2005-06 we anticipate funding of $3,397,000, which is a 1.9 per cent increase. Obviously that is less than the consumer price index and it does not include the one-off funding in the agreement for immunisation, which is a separate component.

MR SESELJA: Minister, before the short adjournment we spoke briefly about waiting lists. However, I do not think we fully covered them. I want to ask a question relating to waiting lists. Would you agree that waiting lists for elective surgery are unacceptably long? Are you able to outline what is being done in this budget to tackle that significant issue?

Mr Corbell: Certainly, Mr Seselja. The government has committed additional funding for elective surgery activity. Approximately $2 million in recurrent funding will be invested in elective surgery. That is in addition to the level of funding that the government has already committed in previous budgets. When I became minister I was concerned—and I am still concerned—that category 2 and category 3 patients are waiting longer than is clinically desirable.

So the government's initiatives are focused on improving access to elective surgery, particularly for those who have been waiting a long time. Funding will target a range of specialities for the largest number of people waiting too long for surgery. As I mentioned this morning, that includes orthopaedics but it also includes urology, vascular surgery,

general surgery and ear, nose and throat surgery. It is worth making the point that by 2006-07 more than 1,000 people per annum will be accessing elective surgery than there were in 2002-03. So the government is significantly increasing access to elective surgery.

The other element of the budget initiative involves focusing on systems improvement in the hospital for the current financial year only. That involves focusing on improving operating theatre workflows and improving community based care. Obviously the government is also committed to providing additional hospital beds. So a number of strategies are in place to address ever-growing pressure in elective surgery.

MR SESELJA: You mentioned the figure of 1,000. In your speech to the Assembly you said:

> All up, our additional investment—

this is obviously for 2005-06, so it is not the same figure—

> will see almost 900 more people each year accessing elective surgery in the ACT compared to 2002-03.

Correct me if I am wrong, but the 2003-04 figure was about 900 up on the figure for 2002-03. What improvements are happening in this budget to bring down the number of people receiving elective surgery? It seems as though that figure of 900 additional people was already reached in 2003-04.

Mr Corbell: There is an additional $2 million, Mr Seselja; I have just explained that to you.

MR SESELJA: I understand that. You said in your speech that there would be almost 900 more, but earlier you said that there would be 1,000 more in 2006-07. You have already reached that figure of 900. So are you saying that you are not going to be doing any more than you did last year; that basically it will be staying the same?

Mr Corbell: I am not sure to which figure you are referring, Mr Seselja.

MR SESELJA: I am referring to the figure for elective surgery. In 2002-03 it was 7,488 and in 2003-04 it was 8,435. If that figure is wrong I am happy to be corrected. If it is correct I would suggest that that figure of 900 more has been reached. In 2002-03 you were doing 900 more, so in 2003-04 you would be doing no more than you were doing in 2002-03.

Mr Corbell: I am sorry, Mr Seselja, I simply do not follow you.

MR SESELJA: Are you denying the figures?

Mr Corbell: No, I am saying that I do not understand your question.

MR SESELJA: The figures that I have for 2002-03 show that 7,488 elective surgeries were performed and the figures that I have for 2003-04 show that 8,435 elective

surgeries were performed. That is an increase of about 900. You said in your speech that as a result of your additional investment, presumably in this budget, 900 more people each year would be accessing elective surgery than in 2002-03. If that figure is correct it means that you are not going forward in 2003-04.

Dr Sherbon: I think I get the drift of your question. We will have to take your question on notice. The figures are being brought across.

Mr Corbell: I am sorry, Mr Seselja, I still do not follow you. I will endeavour to provide some figures that might clarify the situation.

MR SESELJA: I do not know why you do not understand the question. Nine hundred more elective surgeries were performed in 2002-03.

THE CHAIR: Mr Seselja, rather than repeat the figures—

MR SESELJA: The minister is claiming that he does not understand my question. I am trying to explain it to him.

THE CHAIR: Let me finish. I am trying to help you here. Rather than repeating the figures, let us enable departmental officials to chase up those figures and see whether they can put together an answer to your question. We will come back to that issue after we have asked some other questions. Mr Mulcahy?

MR MULCAHY: I refer to the 20 additional beds. I gather that those beds are being funded through growth funds?

Mr Corbell: I think that is where they are listed in the budget, yes.

MR MULCAHY: You have that each year, do you not, as a standard provision? The growth funds provided to you are of the order of about $7 million. It is a unique feature in the health budget process.

Mr Corbell: Provision is made in the budget for growth; that is correct.

MR MULCAHY: If you had those funds and they have always applied to the department I am curious as to why they did not come on earlier.

Mr Corbell: They still need to be appropriated, Mr Mulcahy.

MR MULCAHY: Obviously there is a pressing demand for them.

Mr Corbell: The government, if it felt like it, could go to the Assembly every two weeks with an appropriation. We appropriate on an annual basis and growth is provided on an annual basis. The obvious time to do that is during the budget process.

MR MULCAHY: Do you believe that those beds will be sufficient to meet the major demands that exist at present?

Mr Corbell: I believe that they will be of significant assistance. I guess it is a bit like

asking, "How long is a piece of string?" How much money could you spend in the health system? The answer is, "Never enough." The government's initiative for an additional 20 beds is a positive and important one. It will enable us to manage better the operations of both our hospitals. In particular, we will be able to manage better flows through emergency departments and, hopefully, assist with issues relating to access block in emergency departments.

Those medical beds will assist us in dealing with medical patients. I hope they will also assist us in relation to elective surgery activity. They should be of some assistance in reducing the need for the cancellation of elective surgery because there are no beds because medical patients have taken them. We believe that this important and significant investment by the government was a sensible and appropriate commitment to make. It was a commitment that the government made at the last election. I think we demonstrated to the community in the budget brought down by the Treasurer that we are serious about doing that. We have now funded that initiative so it can happen.

MR MULCAHY: Would it be correct to assume the 20 general medical beds for frail and elderly patients that you announced before the election last year are not primarily surgical beds, although you said that there might be some periods when those beds would assist in the elective surgery process? Given that that is not their primary purpose, do you think they would have any significant impact on your elective surgery waiting lists?

Mr Corbell: I do not recall saying they were primarily for frail or elderly patients.

MR MULCAHY: That is what you said in your 25 February 2005 press release.

Mr Corbell: I would be interested to see that quote. You might be confusing it with the commitment the government made in relation to a subacute facility that includes 20 beds for people with psychogeriatric needs. You might be confusing those two elements. The full election commitment relates to 20 new medical beds and 60 beds in the subacute facility, and that includes a component of psychogeriatric beds. So you might be confusing those two issues.

MR MULCAHY: I might reveal to you the source of my information.

THE CHAIR: No.

Mr Corbell: Regardless of that issue I think your substantive question was whether it would assist with elective surgery.

MR MULCAHY: Correct.

Mr Corbell: The answer to that is yes; it will assist, so far as I have just indicated to you. I hope it gives us the capacity to address the issue of elective surgery being postponed due to the lack of a bed.

MR MULCAHY: Would you expect those numbers to taper or not?

Mr Corbell: I beg your pardon?

MR MULCAHY: Would you expect the escalating waiting lists for elective surgery to subside or settle, or will they continue to grow?

Mr Corbell: It is a difficult thing to predict. I would not really like to venture a prediction. The key issue is that the government has a broad suite of strategies in place to address the increasing demand for elective surgery. That includes additional medical beds because that will assist us as in managing cancellations and hopefully reducing the need for cancellations. The government is allocating funding for additional procedures. It is putting in funding to manage operating theatres better, to make them more efficient and to increase throughput in that regard as well. So we have a range of strategies in place.

I could go on and outline the issues relating to the discharge lounge, which is part of the bed management policy of the hospital. It will assist in freeing up beds more quickly so that on the day of discharge people are not sitting in a bed waiting for their formal discharge. They can wait in the lounge and the bed becomes available for someone else. So all those issues are part of a suite of measures designed to improve access to acute care.

MR MULCAHY: I have one quick question on theatre management which you mentioned a couple of times this afternoon. Which interstate model would you be looking at to reflect the way in which you manage theatres in Canberra? Is there an interstate model?

Mr Corbell: There is no particular hospital or model per se, but we will be drawing on the experience of other jurisdictions that have been through process improvement work, if you like, and trying to apply that experience here to make our processes more efficient. Every hospital and every health system are a little bit different. I would not want to point the finger at a particular jurisdiction, system or hospital.

THE CHAIR: Do you have a supplementary question, Mr Smyth?

MR SMYTH: Mr Mulcahy was talking about a reference in one of the minister's press releases dated 25 February this year, which reads, "In addition there will be 60 rehabilitation beds." It then goes on to state, "and 20 general medical beds for frail and elderly patients announced during the last election will come on line early in the next financial year". So are there 40 beds—20 general medical beds and 20 for the frail and elderly?

Mr Corbell: No, there are only 20 beds.

MR SMYTH: There are only 20 beds?

Mr Corbell: There are only 20 beds.

MR SMYTH: So is this a re-announcement of the same 20 beds? Have they changed their purpose to beds for the frail and elderly, or are they just general medical beds?

Mr Corbell: No, they are general medical beds. Dr Sherbon advised me in the interim, between my answering that question and your asking your question, Mr Smyth, that we

anticipate in general they would be for older people. They tend to be the people requiring those beds. That is where the demand is for medical beds.

MR SMYTH: These additional beds are for accident and emergency so you can break the bed block?

Mr Corbell: That is where they present. They present in the emergency department.

MR SMYTH: You said that they would help with elective surgery; therefore, the frail and elderly?

Mr Corbell: It is not a difficult explanation, Mr Smyth. When people present and they need a medical bed they come through the emergency department.

MR SMYTH: Are you quarantining these 20 general medical beds for the frail and elderly?

Mr Corbell: No. In general we anticipate that that is probably where the demand will come from. They are not quarantined for a particular type of patient outside of being medical patients.

MR SMYTH: Why did you say in your press release that the 20 general medical beds were for the frail and elderly?

Mr Corbell: I am just trying to be helpful, Mr Smyth, by giving some indication of who will be using them.

MR SMYTH: That is not what you said in your press release, minister.

Dr Sherbon: As the minister said, the vast majority of medical patients are frail and elderly people with medical problems—usually heart or lung problems.

MR MULCAHY: I seek to table the minister's press release.

Mr Corbell: There is no double count. No assertion such as that is being made. There are 20 new medical beds. As Dr Sherbon and I have just indicated to you, and as Mr Smyth rightly points out, in my press statement I said that we anticipated that, in general, they would be used by older people. That is where the demand is coming from, through the emergency department. However, they are not quarantined for any particular purpose. They will add to the overall store of beds available in the system.

MR MULCAHY: If required, and pursuant to standing order 241, I propose that that document be authorised for publication.

THE CHAIR: Sure.

MR SMYTH: I have another general question.

THE CHAIR: I might give precedence to Mr Seselja as he is a member of the committee.

MR SESELJA: I am happy to yield to Mr Smyth.

THE CHAIR: Let us not go there again. As I explained very clearly, I am giving precedence to members of the committee.

MR SESELJA: That is fine. I am happy for Mr Smyth to ask questions as I am still getting my notes together. If he has questions I am happy for him to ask them.

THE CHAIR: Mr Mulcahy might have another general question.

MR MULCAHY: I will yield to Mr Smyth. I am also sorting out my papers. If Mr Smyth is ready to go I am happy to let him do so.

MR SESELJA: Is there a problem with Mr Smyth asking a question? What is the issue?

THE CHAIR: Let me explain this issue again.

MR SESELJA: Please do.

THE CHAIR: I said in my letter that went out to all members of the Assembly a couple of weeks ago that precedence would be given to members of the committee. That is in accordance with standing orders. In a private meeting you requested that we have extra time for general questions.

MR SESELJA: Are we now divulging in a public forum the discussions we had in a private meeting?

THE CHAIR: No.

MR MULCAHY: Madam Chair, I suggest that you let Mr Smyth ask the questions that he has on his plate. I am happy for him to raise an issue that is obviously relevant to all of this.

THE CHAIR: If you would just let me finish, Mr Mulcahy—

MR MULCAHY: I did let you finish.

THE CHAIR: If you will let me finish, Mr Mulcahy—

MR MULCAHY: I did let you finish.

THE CHAIR: I ask the member to stop interjecting on me. We have until 2.50 pm. If Mr Smyth takes up your time in asking general questions we will not be going past 2.50 pm.

MR SESELJA: We are quite aware of that.

THE CHAIR: We will not be going past 2.50 pm.

MR MULCAHY: Everyone is aware that we are going until 2.50 pm.

THE CHAIR: If Mr Smyth uses up your time do not bother to complain. At that point we will be moving to output classes. Mr Smyth?

MR MULCAHY: Everyone knows that Mr Seselja and I are happy to have Mr Smyth ask the question. You are only delaying the hearing.

MR SMYTH: Minister, I refer to page 195 of budget paper 3.

THE CHAIR: Mr Mulcahy, you are delaying the hearing by continually interjecting, making comments and not allowing me to chair this hearing properly. Mr Smyth?

MR SMYTH: On page 195 of budget paper 3 there is an initiative entitled "Care Package—returning mental health clients (Agency Funded)." Why are we accepting back patients from New South Wales correctional centres? Where will you be housing them? If they are mental health patients or, as it says here, offenders, why are they in the New South Wales correctional system in the first place?

Mr Corbell: We are anticipating the return to the territory of an individual who has previously been held in the New South Wales correctional system. He has been sentenced for a number of offences and he is due to become eligible for parole quite soon. The client involved has a number of mental illnesses and has spent some time in appropriate correctional hospital settings while he has been in New South Wales. We are anticipating that he will wish to return to the territory when he becomes eligible for parole. When he is well enough—he is suffering from mental illnesses—he will be transferred here.

The government has been advised to provide an appropriate level of care and support for that individual. That is what this initiative will provide for. It will also provide for any future instances such as this. We anticipate that a number of high needs clients will return to the ACT following a period in the New South Wales correctional system. The funding provides for a care package and, in particular, staff to provide care and support for the individual concerned.

MR SMYTH: Is this the individual for whom work is being done to upgrade security at Hennessy House?

Mr Corbell: Yes, it is.

MR SMYTH: It is the same individual?

Mr Corbell: Yes, it is.

MR SMYTH: If he is coming on parole why is he going to Hennessy House?

Mr Corbell: It is anticipated that he will return to the ACT on parole, but with a treatment order in place that will require him to reside at Hennessy House.

MR SMYTH: Is Hennessy House adequate for the housing of this individual?

Mr Corbell: With the modifications that we are making I am advised that it will be.

MR SMYTH: What do the modifications involve?

Mr Corbell: The modifications involve some improved security fencing around the secure care unit at Hennessy House and some alterations to the internal parts of the building. However, I am not familiar with the details.

MR SMYTH: Is Hennessy House currently more than adequate to house this individual?

Mr Corbell: No, not without the changes that we are making.

MR SMYTH: Is there a risk? To what degree are we upping the security level? Hennessy House is not a high security facility. Are we turning part of it into a high security facility?

Mr Corbell: Hennessy House has a secure care unit that has been in operation for a number of years, as you know. We are increasing the level of security at Hennessy House.

MR SMYTH: Does the package include training for staff to assist in the handling of this individual?

Mr Corbell: The package involves funding to provide appropriate security for both staff and the client involved.

MR SMYTH: Have staff been informed that this individual is coming and are they happy with the arrangements?

Mr Corbell: Yes. There is an ongoing process of consultation and information provision to staff at Hennessy House and to relevant unions that represent those staff.

MR MULCAHY: Minister, I have a question on Calvary maintenance of surgery activity—BP3 on page 191. I became aware this year, and I understand that it has happened previously, that surgeons fill their quotas by the second or third quarters of the financial year and then surgical activity suddenly drops away. Is this designed to ensure that this does not happen from here on out—that those services do not come to a halt? Over how many years has there been this completion of quotas early or filling of quotas early?

Mr Corbell: It does happen for some surgeons and in some specialties but it is not uniform across either specialties or surgeons as a whole. Some surgeons work through their lists much more efficiently than others. On top of that, Calvary has tended, unfortunately in my view, to not necessarily ensure that funding and the lists are spread evenly across the year. I do not believe that is an appropriate way to manage it and neither does my department. We are in discussions with Calvary about trying to ensure that the list activity is spread evenly across the year. This is designed to allow them to maintain a level of activity and try to address the issue that you raise as well.

MR MULCAHY: So that I can understand, is the spreading of the list over the year a case of spreading the activity over but really taking longer to spend the money? Or are you saying effectively that there is only so much money and that, if they finish early, the surgery has to come to a halt? Or are you saying that the work programmed for surgery is completed?

Mr Corbell: A list is just that—it is a limited amount of money for a limited number of procedures across the year. That is the way all surgery operates in every hospital. There is only a limited amount of money set aside for elective surgery in any one year. It is up to hospitals to manage that activity so that they have a viable and reasonable rate of activity spread evenly across the year. The department has accepted that there is a need, and its advice to me has been to make provision for additional funding at Calvary to assist them in making sure that we do not have the sort of shortfall that we have seen.

MR MULCAHY: That is the $900,000, is it?

Mr Corbell: That is right. But there is also the issue of making sure that lists are still managed in an even way across the year rather than saying that it is all in the first three quarters and then forget it. It needs to be managed in a consistent way across the year. That is important just for maintenance of activity, maintenance of staffing and so on across the year.

MR MULCAHY: In terms of patient benefit, if you like—I assume they are the customers in this case—what is the benefit for the patient in spreading out the time for the surgery undertaken if there are no more surgery opportunities available?

Mr Corbell: The benefit is more to the surgeons involved in that they can program their work, like their public and private work, in a more consistent way across the year. It works better for them to know—if you could speak to any surgeon they will say this to you—what their workload is going to be well in advance so that they can plan their workload and, in particular, obviously, if they are a VMO so that they can also plan their private workload around that.

MR MULCAHY: Are they not making the decision though to do this work that you are saying is being done too quickly over the first three quarters of the year?

Mr Corbell: My understanding—Dr Sherbon will correct me if I am wrong—is that Calvary have not necessarily allocated lists in a consistent fashion across the year. They have instead chosen to have lists completed within the first, say, three quarters of the year. That leads to these dips in activity rather than more of a constant level. So the list is a management issue. We have raised that issue with Calvary.

MR SESELJA: I understand that in the past few years Karinya House has received some funding from ACT Health. Correct me if I am wrong: I do not think there is anything for Karinya House in this year's budget. Are you able to either confirm that or set me on the right path?

THE CHAIR: In addition to that, minister, is it possible that some of that has been transferred over to housing?

MR SESELJA: I would be happy to be informed whether the funding coming from health has been withdrawn; if so, why?

Mr Corbell: It is not in these budget papers, I am advised, because it is simply an ongoing program that is funded from the department's base as part of the NGO grants arrangements.

MR SESELJA: So there is no reduction in funding for Karinya House this year?

Mr Corbell: No.

MR SESELJA: On another issue, page 172 of budget paper No 4 deals with strategic indicators. Under "Hospital acquired infection rate" have any cases of pseudomonas septicaemia been reported at Canberra Hospital or Calvary?

Mr Corbell: I cannot answer that question today, Mr Seselja, but I am happy to find out for you.

MR SESELJA: If there have been—could you also take this on notice—where have these cases have been reported and what action has been taken in relation to them?

Mr Corbell: Yes, of course.

MR MULCAHY: Are we going to go on to outputs? It was scheduled for 2.50.

THE CHAIR: We are finishing general questions. If you want to finish that is fine.

MR SMYTH: I have another general question.

MR MULCAHY: I am just looking. Maybe you could go to Mr Smyth. I will just check if I have covered everything.

THE CHAIR: Mr Seselja, do you have any other general questions?

MR SESELJA: No, I am happy to defer to Mr Smyth.

THE CHAIR: That was not my question. Do you have any other general questions?

MR SESELJA: I am not sure at this point. I am happy to defer to Mr Smyth.

THE CHAIR: As this came up earlier, I will take this opportunity to refer all members of the Assembly to my letter dated 25 April, which was delivered electronically as well as in hard copy format, in which I stated:

> The order for asking questions will be that set out in standing order 245, namely, the Chair first followed by other members of the committee, followed by non-members of the committee. Members are reminded that they must comply with the requests of any member of the committee and by the rulings of the Chair. As time is limited, precedence for asking questions will be given to select committee members.

Mr Smyth, do you have another question?

MR SMYTH: Minister, you are currently undertaking a study of community pharmacy in the ACT. Where is that at at this stage?

Mr Corbell: I understand it is still in preparation. I am yet to see a copy of it or to receive a report on its outcomes. I understand that the department has been in consultation with a range of stakeholders, including the Pharmacy Guild.

MR SMYTH: Did that go out to tender? What is its value?

Dr Sherbon: It is quite a significant consultancy. This is the pharmacy's access—

MR SMYTH: Do you know its value?

Dr Sherbon: It is over $100,000. It is quite a significant consultancy. We did go to tender and Allens Consulting Group won the tender. We can get the value on notice.

THE CHAIR: You will take that on notice and provide the committee with that?

Mr Corbell: Yes, we can do that, Madam Chair.

MR SMYTH: If I remember, the document asks some quite specific questions in eight or 10 different areas. Is the $100,000, or whatever the value is, adequate to cover that?

Mr Corbell: I might ask Dr Charles Guest to assist.

Dr Sherbon: I could probably answer that. I was just waiting to see if the minister wanted to answer. We understood that it is a major undertaking. The questions being asked about access to pharmacy services require quite intensive research and so we did allow in our own internal budgeting for a significant allocation to this project. I am confident that we have allocated, and set in the program to spend, the appropriate funds, to answer the complex questions to which you allude. There will be a lot of research involved. Allens Consulting Group has done a lot of regulatory impact statements across the nation that require major economic modelling and intensive statistical research, so we are confident they can meet that requirement.

MR SMYTH: Has the question been framed with an end result in mind? Is this still a push to take community pharmacy—and perhaps this is for the minister to answer—out of the hands of registered pharmacists and possibly to allow them into supermarkets?

Mr Corbell: No. The objective is to ensure that the government can be satisfied that there is optimum access to pharmacy services for residents of the ACT and that we are able to provide, as best as we can influence the marketplace—or the policy settings, I should say—the availability, access of services and the range and affordability of those services.

MR SMYTH: If the review came back and suggested to you, minister, that the delivery of pharmacy services be expanded, say, into supermarkets, what would your approach be then?

Mr Corbell: I am not going to speculate on that at this stage because I have not even seen the outcomes of the review and I would not want to speculate on what the government's policy position may or may not be. It would not be a decision for me alone; it would be a decision for the cabinet.

MR SMYTH: When is the review due?

Dr Sherbon: I cannot give an exact date, but it will take at least three months to do a complex exercise.

MR SMYTH: When did it start?

Dr Sherbon: It started last month.

MR SMYTH: Early—near the start of the month or the end of the month?

Dr Sherbon: Late last month. I signed off the tender selection only two or three weeks ago.

MR SMYTH: So late April—late June, late July-August?

Dr Sherbon: Very late April.

MR SMYTH: Thank you.

THE CHAIR: Other general questions?

MR MULCAHY: I have some questions on strategic indicators. Minister I reference BP4 on page 174. The DMFT—for those who have such an interest in dentistry, that is the decayed, missing or filled teeth—rate for the ACT is substantially worse than the Australian national averages. The minister or Dr Sherbon may wish to advance a view for that data. Could they indicate how they intend to better the Australian average by next year?

Mr Corbell: I will certainly ask either Dr Sherbon or others to give you a bit more detail but if I can just perhaps respond to some of the broad policy issues around this. The key issue, Mr Mulcahy, is that, regrettably, in 1996 we saw the complete cessation of commonwealth funding for dental health programs for low-income earners—pensioners, disability cardholders and others who could not afford to go to the dentist without that program. The program was entirely ceased—stopped, nil—by the commonwealth government. That blew out waiting times to over a year—pretty much a year and a half—before they could even get an appointment to see a dentist through a public program.

Since this government has been in office, we have significantly invested in public dental services for low-income earners, waiting times and waiting lists have been halved and access to a dentist for people on low incomes—disability and pension cardholders et cetera—has been the best since 1996. To what extent this figure reflects the inability of people to have got access to decent dental services over the past 10 years if they are a low-income earner is something that should be borne in mind. I am not across the detail

as to the other reasons. Perhaps Dr Sherbon or someone else can assist with that.

Dr Sherbon: We do not really know why the DMFT rate here is poorer than elsewhere. The most likely cause is access to dentistry, as the minister outlined. We have already substantially improved that in recent years and expect to continue to improve it in the coming months and in this financial year coming. But access to private dentistry is expensive in the ACT and that may play a role.

MR MULCAHY: If I could just put to you, minister, that it may be sensible to actually confer with the dental research community. I think you will find that the issue here is not necessarily a matter of low-income earners; it may in fact be reflective of the reduced intake of fluoride by large numbers of children who are changing water intake. A prevailing view amongst the researchers I have spoken with is that it is contributing to the deterioration of dental hygiene rather than the new defence by the minister. That would also explain why these figures are deteriorating in Canberra, where there are high levels of bottled water consumption, compared to the rest of Australia. I think it was a uniform national policy that you would see similar rates occurring.

Mr Corbell: As reluctant as I am to reopen the prospect of a fluoride debate in the Legislative Assembly—

MR MULCAHY: I am not suggesting that.

Mr Corbell: I take your point, Mr Mulcahy. If you are interested in this issue further I can ask the chief health officer's staff to brief you further on it and you can get some more information.

MR MULCAHY: I will be happy with that. I am actually making a helpful suggestion because I have taken an interest in the field.

Mr Corbell: We will certainly take that on board.

MR MULCAHY: I think you will find that there are other significant dietary factors that are perceived as impacting on the deterioration of young people's teeth in Australia right now. The second question on strategic indicators relates to your objectives for bed occupancy—page 172 for those reading BP4. How do you expect to accomplish these particular targets, minister?

Mr Corbell: There is a range of factors. Obviously the additional beds will assist. Increasing capacity in the system overall will increase our capacity to have some give, some leeway in the system. So rather than operating at 98 or 99 per cent, we are able to operate closer to 95 to 90 per cent, so additional beds assist in that regard. Obviously good bed management is also a very important part of the equation. I come back to the figures and the issues that we have discussed throughout the day, such as the discharge lounge and intermittent care service, which is about keeping people out of hospital. The whole suite of measures around improving access also assists in overall bed occupancy.

MR MULCAHY: Do you consider 90 per cent the optimal figure in hospitals?

Mr Corbell: Yes. That is a broadly accepted figure.

MR SESELJA: I have a quick question on strategic indicator 14 on page 177 of budget paper No 4. The rate of breast cancer in the ACT is significantly higher than the Australian average. Are you able to tell us why and what has been done to bring that down?

Mr Corbell: We don't know why, Mr Seselja. If Paul Dugdale were here he would probably give you a very interesting dissertation on it for a couple of hours.

THE CHAIR: Where is Dr Dugdale?

Mr Corbell: He is on leave at the moment. The bottom line is that we do not know why that is the case. Our rates of screening and participation in screening are amongst the best in the country. So it is certainly not for lack of screening activity. A simple answer is that we do not know.

MR SESELJA: This is not a trick question: is there any significant research being done anywhere in Canberra or across Australia to figure out why there is a disparity in rates and why Canberra in particular would have a higher rate?

Dr Sherbon: There is a lot of research going on nationally. Dr Guest may fill in for Dr Dugdale on this question. We will inform you that breast cancer incidence increases in affluent societies or at least reasonably well-developed societies. Dr Guest may clarify the matter here but I do not think anyone knows the reason why that is.

Dr Guest: We do not know why. There will be variation in a national population. At present we happen to be at the top.

MR SESELJA: I am not aware of the background. Has that been the case for some time or is it a more modern phenomenon that we are higher than the national average?

Dr Guest: No, that finding is of some standing. It is a very small difference. I do not think we should attach too much significance to it. We press on with screening as vigorously as possible.

MR MULCAHY: There was publicity this week—it might have been last night—that women in the 45 to 50 age range and women in the 70 to 75 age range understand that they are not necessarily the subject of the level of targeting that women over 50 have experienced to encourage them to engage in screening. Do you have a comment on that or are there different plans in the ACT compared to other parts of Australia?

Dr Guest: The ACT's policy is the same as everywhere else in the country. The effectiveness of screening is greatest in the target age group for the program—that is, women aged 50 to 70. The effectiveness of screening in women aged 40 to 49 is less; it is changing as technology changes. But, historically, premenopausal woman and very old woman have been less targeted by the screening program.

MR MULCAHY: Is there an identified margin of error in screening accuracy these days or is that too difficult to measure?

Dr Guest: There is an identified margin of error, yes.

MR MULCAHY: What would that be?

Dr Guest: We could get very technical here: there is sensitivity, specificity and predictive value of the different tests. I am not sure if this is the forum to go into those.

THE CHAIR: No. It probably wouldn't be, Dr Guest.

Dr Sherbon: From a clinical perspective, Associate Professor Robin Stuart-Harris, the Director of the Regional Cancer Service, can also provide some input.

Mr Corbell: I will just ask Professor Stuart-Harris up briefly if that is okay, Madam Chair.

MR MULCAHY: I think it is a topic of considerable interest at the moment.

Prof Stuart-Harris: As you know the territory participates in the national breast screening program. That program targets women in the 50 to 69 age group. That is because it is in that age group that breast screening has been shown to be cost effective. It is not shown to be cost effective in women below the age of 50, who are more likely to be premenopausal. Screening is more difficult in that age group, partially because of the density of the breast; therefore the pick up rate is smaller because the instance is lower and also screening is more difficult.

THE CHAIR: Thank you very much, Professor Stuart-Harris.

MR MULCAHY: I have one question of Professor Stuart-Harris.

THE CHAIR: Excuse me, Mr Mulcahy, it is actually past 10 past 3.

MR MULCAHY: I think the community of Canberra are very interested in the subject. It is a pity to prevent the question.

DR FOSKEY: There is quite a good article in the Sunday *Canberra Times.*

THE CHAIR: There is an output class on cancer services, so we can probably revisit it in that output class, Mr Mulcahy. Just before we move to the output classes, earlier Mr Seselja asked a question of the minister and Dr Sherbon. I understand that question will be taken on notice.

Mr Corbell: Yes.

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

DR FOSKEY: I will prioritise my questions because I fear I will not have time to ask them all. Madam Chair, I might seek your indulgence to go back if we do have time. On page 194 of budget paper 3 there is a reference to the caring for kids at home initiative.

Mr Corbell: Yes.

DR FOSKEY: How many children will be assisted by that initiative? What kind of support will be provided? Furthermore, will the care that is to be provided for those children be ongoing for life or will there be a point at which it will need to be provided by another program, for instance, when they turn 18? What strategies are in place to support that transition?

Mr Corbell: I am not across the full detail of this, but the advice I have received is that four children are cared for through this initiative. Those four children have profound disabilities and they need a high level of care and mobility support. Essentially, they will require that care throughout their lives.

DR FOSKEY: I suppose you have not really confronted this issue yet, but when they turn 18 they will not come under the category of caring for kids at home; it will be about caring for adults at home.

Mr Corbell: It is a bit difficult to speculate that far in advance. The government certainly views it as an ongoing funding requirement.

Dr Sherbon: As the minister said, children who are currently accommodated either in hospital or in an environment that is not their own home will be able, through this funding, to go home with support. The health support that they require is intense. You will notice that the funding is quite a lot for four children but that is because they require intensive support.

DR FOSKEY: They are high-needs children, so they require medical attention and not just ordinary care.

Dr Sherbon: They require more than personal care. Essentially, they require a level of personal care and also nursing and allied health intervention. They do not require medical attention such as the attention that is provided by a doctor, but they certainly require extensive personal care and assistance, and nursing and allied health assistance.

DR FOSKEY: I move on to maternity services. Minister, I know you are working on the government's long-awaited response to *Pregnant pause*, the report of the Standing Committee on Health. However, I have not been able to find any budget initiatives associated with your response. Therefore, I am concerned about the government's level of commitment to implement the recommendations in that report.

Perhaps you could comment on whether we are likely to see any of that action taken this financial year—for example, a needs analysis to determine the level of unmet demand for the Canberra midwifery program; increased funding to meet demand, as per recommendation 3; identifying and meeting unmet need for maternal and child health clinics; urgently upgrading and expanding the neonatal intensive care unit at Canberra Hospital; and establishing two independent primary birthing units. Those are just some of the recommendations that we hope you will decide to implement.

Mr Corbell: The government has not agreed to a response, so it is not in a position to agree to fund any initiatives that might arise out of that response. The committee has not sought the government's agreement on a response before the budget and it has not been

taken into account in this budget. So any significant spending would need to be subject to bids in future budgets. In relation to one of the items you mentioned, the expansion of the neonatal unit at Canberra Hospital, some early assessment has been undertaken, or is being undertaken, in regard to that issue.

It is also subject to government agreement to fund new capital works and other activity. So I guess the general answer to your question is that the government has not yet agreed to a response so it is not in a position to agree to any spending initiatives. That is not to say that there might not be a capacity in the existing budget for some work to be done, in particular, on analysis issues and so on, once the government's response has been prepared and agreed to.

MS PORTER: My question is about the use of the hospital by interstate patients, an issue that was briefly discussed earlier. Output class 1.1 on page 167 of budget paper 4 states that the Canberra Hospital is the major trauma referral hospital for the ACT and the surrounding region of NSW. Could you point me to the place in the budget papers which refers to the number of interstate patients who use acute services at that hospital? Is there a reference to that in the budget papers or could you take that question on notice and provide that information for me?

Mr Corbell: I do not believe there is such a figure in the budget papers. We could provide you with an historical record of the level of New South Wales usage of acute care in the past. But these things are extremely difficult to predict.

MS PORTER: I am not asking for a prediction at all.

Mr Corbell: The best we could do would be to provide you with some round figures.

MS PORTER: There could be another Thredbo tomorrow.

Mr Corbell: That is right. We could provide you with some round figures showing the usage by New South Wales patients or the episodes of acute care for New South Wales patients on a yearly basis.

MS PORTER: Thank you, Minister.

DR FOSKEY: I wish to refer to mental health issues.

THE CHAIR: We are still dealing with output 1.1.

MR SMYTH: Madam Chair, when committee members have finished I have a couple of questions, if that is okay.

THE CHAIR: We might be able to find some time, Mr Smyth.

MR SMYTH: You are very generous.

THE CHAIR: Sarcasm is not helpful and it is not needed, Mr Smyth.

MR SMYTH: Thank you, Madam Chair.

DR FOSKEY: My question relates to palliative care services. In their submission on the budget the Council on the Ageing and the National Seniors Association argued that there was a need to substantially increase the funding of palliative care services. I note that the government made a modest investment in home-based palliative care in the last budget but I cannot see any new initiatives this year. Is the government aware of the shortage of palliative care services? Are any steps being taken to address that issue?

Mr Corbell: In the budget that is before you there is no initiative for increased capacity in our palliative care services above and beyond what has already been approved in previous budgets. In the past couple of budgets the government made a commitment to improve access for palliative care and, as you rightly acknowledged, for home-based care. Before I became Minister for Health the responsible minister—I think that it was Mr Stanhope—also increased the number of beds available in the hospice. The government, in its term of office, has been committed to addressing future demand for palliative care beds.

The government, through the department, is currently undertaking the development of a clinical services plan which is designed to give us a short-term to medium-term view of the demand for palliative care beds, in particular, the demand for services in the clinical area in the medium term. As part of that work, an assessment is being done of the need for additional beds in a number of settings, including the palliative care setting. Once that clinical service planning work has been completed the department will commission the Australian National University Centre for Epidemiology to provide it with advice on the modelling it uses to anticipate demand for a number of services, including palliative care.

MR SMYTH: I think you were on leave last year and Mr Wood handled this issue when it arose, but it was brought to our attention that there was a waiting list to get into Clare Holland House. At that stage it was six or eight weeks. Does anyone know the status of Clare Holland House at this stage? What is the waiting time?

Mr Corbell: I think I recently answered a question that you placed on notice relating to that issue. If it was not for you, I provided an answer for another member of the Assembly. I will take that question on notice and try to get an answer for you a little later this afternoon.

MR SMYTH: It is an interesting issue. Those people were made Canberra citizens of the year, which I think everybody agreed was a fabulous choice. If they are working in conditions where they have waiting lists for a hospice that is quite appalling—

Mr Corbell: In the past few years we have increased resources on a couple of occasions. So the government is not neglecting that area. It is recognised as an area of demand and we have provided additional resources in previous budgets.

MR SMYTH: When will the report that you spoke of be ready?

Mr Corbell: The clinical services plan has been through an extensive process of discussion with clinicians, health care consumers and other stakeholders. The time frame on that is later this year, but I do not have an exact time at this stage.

THE CHAIR: I refer to page 165 of budget paper 4. You referred to this issue in answer to a question from Mr Seselja and you might have referred to it in your opening statement. Under the highlights for 2005-06 there is a reference to the elective surgery reform program. How will it be implemented and what will it involve? It is part of the acute care program.

Mr Corbell: It is part of the acute care program. The program I outlined earlier today is about ensuring that our systems for managing people as they go along the journey of elective surgery are as efficient and timely as they can be. It is about ensuring that from the time a person arrives until the time he or she leaves there is a more efficient track. We are using our resources well so that staff can deliver as many occasions of elective surgery as possible through our theatres.

We will be engaging assistants in that process through a dedicated tender arrangement—people who are skilled in that area—to give us advice and to work directly with people on the ground in our theatres and in other related parts of the elective surgery journey, if you like, to ensure that our systems knit together well, that they are coordinated and that they deliver more occasions of care.

MR SMYTH: I have some questions on output class 1.1. The Treasurer, in his budget speech in the Assembly, said that in 2003-04 our two major hospitals recorded around 68,000 in-patient separations. I notice that your target this year for in-patient separations is only 61,285. Was the Treasurer wrong in the figure he used in the Assembly, or have you cut the number of in-patient separations by 7,000?

Mr Corbell: No, there has been no cut. In 2004-05 the hospitals will provide more services than they provided in 2003-04. In 2005-06 they will provide more services than they provided in 2004-05. However, there have been some changes to the way in which we count and manage these services. The apparent reduction in activity from the in-patient target for 2004-05 in the 2004-05 budget papers of 64,981 cost weights and the 2004-05 estimated outcome of 59,330 cost weights is due to counting and management changes. If you like, I could go through those figures and explain them.

In the 2004-05 budget papers the in-patient cost-weight target was 64,981. There was then a transfer of cost weights to the capital region cancer service of 2,973. We now report on cancer care in a separate output. There was a transfer of cost weights to aged care and rehabilitation services of 3,153. Again, we report on it in a different output. The removal of unqualified neonates from the target was 1,610. Adoption of round six cost weights from round five added, 2,085. So that resulted in a changed cost weight target of 59,330, compared to 64,981. But it is not actually a reduction in the occasions of care. It is in fact just a change in the way these figures are reported.

Turning to the 2005-06 in-patient cost weight target, the figure for 2004-05 we are working from is 59,330, which is the outcome for this year. There will then be 670 additional cost-weighted separations because of additional elective surgery. Observation units adjacent to emergency departments will see an additional 600, Calvary maintenance of activity will see an additional 455 and Calvary additional one-off elective surgery an additional 230, which will give us our cost weighted target outcome of 61,285.

MR SMYTH: Maybe it was just a case of gilding the lily in the Treasurer's speech, but you quote big numbers and, when you view the actual budget documents, there is no correlation between them. Perhaps some more appropriate footnotes would help. I am sure you have a similar answer, because in the outpatients or in this case non-admitted occasions of service, which I assume are the old term outpatients, this year's target is only 219,310, against what the Treasurer says in 2003-04 was 427,000 occasions of service. Is he again gilding the lily or is he just using different stats?

Mr Corbell: He is not gilding the lily because Mr Quinlan is referring to a whole range of in-patient occasions of service, including aged care and rehabilitation and the cancer stream. So he is referring to all of those occasions. In relation to outpatient estimates, again there is a similar explanation. Essentially, if you look at the budget papers for 2004-05, the target was 235,000. There was again a transfer of cost weights to the capital region cancer service of 33,500 and a transfer of cost weights to the aged care and rehab stream of 1,180. There was a transfer of endoscopy activity to outpatients that added 1,000 and there was increased demand above initial estimates in a range of areas, including renal, cardiology and fractures, of 9,000.

So the revised estimated outpatient outcome is 210,320. Again, you can see that what has occurred there is not a reduction in actual occasions of service but a shift in where these occasions of service are being measured or counted. In relation to the estimated outcome for 2005-06 of 219,310, this is due to the application of growth of four per cent in outpatient services. This is our best estimate of projected growth and is principally due to growth in services related to additional elective surgery such as preadmission clinics, surgical clinics and general growth in demand.

MR SMYTH: Still on that chart, I notice the target for category one patients who receive elective surgery within 30 days was 95 per cent and you only achieved 92 per cent. The target for the coming year—

Mr Corbell: Sorry, where are you?

MR SMYTH: Page 181 of budget paper 4, your patient activity document C. Over the last two years, I don't think there has been a month when we haven't had at least one category one patient in the elective surgery list who has not been seen. How are you going to achieve this 100 per cent when you only got 92 per cent this year?

Mr Corbell: As you know, Mr Smyth, we are funding additional activity. We are looking at improving the optimal use of our theatres. Those are all going to assist us in addressing this issue. I should say that it is as a result of the Auditor-General's investigations and also ACT Health's own investigations into the way data is being recorded in the waiting lists that we are now actually seeing, I believe, an accurate representation of long waits. Previously some long waits were not being classified as long waits, but instead were being put in the not ready for care category. Both ACT Health and the Auditor-General identified this problem and we now have, I believe, an accurate representation of the number of long waits that occur in any particular month.

MR SMYTH: You just said that you are going to improve theatre efficiency and the

usage of time. Does that mean that we will be going past the 4 o'clock deadline for the start of new surgeries?

Mr Corbell: Not at this time. There is a range of other measures around how we best utilise our theatres based on our existing resources. That is what the systems improvement program will be about: how we can better utilise our existing resources to deliver more occasions of service. Certainly all of the evidence from elsewhere demonstrates you can do that very well. In terms of the 4 o'clock finish arrangements at the Canberra Hospital, if the government wanted to go past 4 o'clock we would need to budget fund that for the additional activity that that involved in terms of staff. At this stage, no, the government is not looking at that. We are looking at improving our operation within existing resources.

THE CHAIR: We will now move on to 1.2.

DR FOSKEY: I would like to start with mental health. I am sure other members have questions on this subject. A number of community organisations put in submissions. I know that mental health consumer organisations made strong representations to the government during the budget process to act on an election promise to increase funding to mental health services as there is high unmet need for these services and the prevalence of mental health issues is rising, yet there has not been any increase in funding for mental health services in this budget. I would like to know why.

Mr Corbell: The government has significantly increased the funding to mental health services in our past couple of budgets. In fact, all up, I think the overall increase in mental health funding since we have been in office has been approximately 50 per cent. So we have increased the mental health budget significantly since coming to office. In 2001-02, the total mental health spending was $29,701,000. In 2005-06, the total mental health spending will be $44,608,960; that is, from $29 million to $44 million. That is a very significant increase; it is a 50 per cent increase.

MR SMYTH: Are you comparing like with like there, because I think that the first figure did not include overheads that have recently been distributed out of the department to ACT Mental Health? Is that not true?

Mr Corbell: These figures do not include the overhead cost; that is correct. It is a significant level of increase in funding. The government will be continuing to implement a range of programs that we have previously funded, including initiatives around suicide prevention, the ongoing activities of the community-based forensic mental health team, the ongoing expansion of CALMS to provide an outreach service to the Gungahlin area, funding to the base of $150,000 in ACT mental health's expenditure.

Significant funding has been put into the system in recent years. This budget does fund additional service delivery, as we discussed earlier today, in relation to forensic-type clients who are returning from the New South Wales correction system and need additional support as they return from New South Wales. So there is a new initiative in the budget, and that is on top of a very significant commitment made by the government since we have been in office.

MR MULCAHY: Can you explain, minister, why your numbers are going to fall, your

targets have fallen, in terms of admitted patient separations, given the seriousness of this area of policy and your claims of more?

THE CHAIR: What page are you on?

MR MULCAHY: Page 181 of BP4, output 1.2, if you would like some guidance. Under patient activity; admitted patient separations for mental health services show a fall in the future.

Mr Corbell: Is this in relation to patient separation?

MR MULCAHY: The admitted patient separations, yes.

Mr Corbell: The 2004-05 estimated outcome of 1,420 for raw in-patient separations we anticipate will be an overestimate based on the current data. The published budget 2004-05 target of 1,400 raw patient separations was determined based on available access to a possible total of 30 beds in the PSU. Four acute beds in the PSU have been offline since January 2005 due to the refurbishment of that unit. There has also been an ongoing problem in recruiting sufficient mental health nursing staff and that has also affected our capacity in the PSU.

We have also recently established some community outreach activity which has reduced the need for in-patient admission. The new mobile intensive treatment teams that have been established allow for a high level of care in a community setting rather than requiring admission and that, I am advised, has also had an impact on the number of admissions we would expect. Based on this, the department has advised me, and it's in the budget papers, that a more realistic expected outcome for in-patient separations is 1,270, which is reflected in the 2005-06 target of 1,300. That is essentially the reason we see a variation in those numbers.

MR MULCAHY: The official visitor was critical of the delivery of community-based services, minister, and it sounds from what you are saying that, although that is a factor in reducing some demand, most of the problem appears to be—I don't know how long the beds are offline that you mentioned—the nursing staff shortages. So it seems to be the case that the resources aren't there to meet the demand, and the demand that is going into the community-based area has been the subject of some strong criticism.

Mr Corbell: I don't think that is the case. I meet with the official visitor regularly and she always highlights areas of concern. She also highlights areas that she has seen improvement. In our last meeting the official visitor indicated to me that overall she was very pleased with the improvements in service and the feedback she was getting from clients of ACT Mental Health. That is not to say that it was an unqualified endorsement of everything we do. The official visitor continues to raise areas of concern and areas of pressure but, in my last meeting with the official visitor, the general impression she left with me was that she was starting to see a level of compliment being paid around service delivery, and in particular of ACT Mental Health staff, that she had not previously encountered. I certainly found that to be very positive.

MR SESELJA: What were some of those areas of concern that the official visitor raised with you in mental health?

Mr Corbell: They are outlined in her report.

THE CHAIR: Which we are not examining at this particular point.

MR SESELJA: Mr Corbell raised it.

MR SMYTH: In the report that you refer to she was quite scathing in some areas. You are speaking about your most recent visit. We have only got a report that is nine months old at this stage. If she still has areas of concern, is it not reasonable—

Mr Corbell: The official visitor provides a quarterly report to me on her activity and her observations.

MR MULCAHY: Are you saying that this projected figure of 1,270 will be appropriate for the level of demand or are you saying that it is 1,270 because you don't have enough resources being devoted towards mental health, which is effectively what I thought I heard in your initial reply, minister?

Mr Corbell: No, we are saying that we believe that that is a more realistic expectation of demand.

DR FOSKEY: As there is no new funding in this budget to implement strategies and actions that were identified in the ACT mental health strategy and action plan, and the ACT mental health promotion/prevention/early intervention plan, does that mean that the time frames will need to be adjusted. For instance, under the mental health strategy, actions 44 to 46 relate to the development and review of data regarding mental health needs of the ACT community. That work was meant to commence in December 2004. Did that work commence and did the results of that work feed into the budget process?

Mr Corbell: I am not aware whether the particular initiative that you mentioned in the plan requires specific budget funding. Can you repeat the question?.

DR FOSKEY: Mental health strategy actions 44 to 46 say that there will be development and review of data regarding mental health needs of the ACT community, really important information. That was supposed to have commenced in December 2004. Were there any preliminary results and did they inform the budget process?

Dr Sherbon: Certainly there was extensive consideration of mental health morbidity and requirements in the budget process and, as the minister said, a number of initiatives from previous years are yet to be brought to full fruition as a result of staffing shortages that we are concentrating on at the moment. But there has been development of mental health data and there has been consideration of mental health needs. Also, there is a significant amount of work under way to improve the data available nationally through the work of the national mental health working group.

DR FOSKEY: On the whole, do the time frames for the particular initiatives mentioned in the two primary guiding strategies for mental health in the ACT still hold or will they need to be moved back a bit?

Mr Corbell: I have not been advised that there will need to be changes to those time frames.

THE CHAIR: I have a question on mental health.

Mr Corbell: Madam Chair, if I may, Mr Smyth asked me a question earlier in relation to average waiting times for Clare Holland House. The average waiting time across all urgency categories for Clare Holland House is five days and it is stable at five days, I'm advised.

Dr Sherbon: While we are correcting a few things, can I correct an answer I gave earlier? Mr Smyth asked me what was the value of the Allen Consulting Group tender for the pharmacy access study. I said that it was over $100,000. In fact, I have been informed that it is $49,000, but there was a tender.

MR SMYTH: Did it go out to tender or was it under the limit at $49,000?

Dr Sherbon: No, it went out to tender and three organisations tendered.

Meeting adjourned from 3.30 to 3.49 pm.

THE CHAIR: All right, welcome back. We are at point 1.1, mental health services.

Mr Corbell: Madam Chair, I'm sorry to interrupt you, but I want to provide some answers to some questions. This morning, Mr Smyth asked me if I could detail how I supported the claim that in-patient separations increased by 11 per cent over the four years from 2000-01 to 2003-04. The answer is that our public hospitals provided 63,035 in-patient episodes of admitted patient care in 2000-01. In 2003-04, our hospitals provided 70,373 non-cost-weighted episodes of admitted patient care. That's an increase of 7,338 or 11.6 per cent. The source for that is the *ACT Health Annual Report 2003-04*, page 8.

Mr Seselja asked me this morning if I could explain the difference between the average costs of elective surgery operations provided previously to the Assembly of 7,018 and the average costs of the additional elective surgery plan for 2005-06 of 6,666. The answer to that question is that the average costs of elective surgery operations provided previously to the Assembly of 7,018 are a calculation developed on total elective surgery performed using historical data. The 2005-06 budget initiative will focus on planned surgery in specific surgical areas where there are long waits for elective surgery, such as orthopaedics, neurology, ear nose and throat surgery and vascular surgery. The estimate for the 2005-06 budget is based on this mix of cases. So we are aware of what the average costs are.

MR SESELJA: So that's a less complex mix.

Mr Corbell: We're aware of what the cost is in those particular specialities and is taken account of accordingly. The estimate at 300 additional operations is just that, it is an estimate and we won't be able to accurately determine the full or the exact number until the year is completed.

THE CHAIR: Thank you, minister. This might be a question for somebody in the department, but in the output classes listed in the appendix to budget paper No 4, page 38, under "quality/effectiveness", there is reference to the percentage of clients seen in the community during the seven days post-discharge from an in-patient service. I appreciate that a number of those clients are seeing private practitioners, private psychiatrists or general practitioners, and that they can't be forced to provide information, but I am curious to know if any negotiations are taking place in order to see if any data can be gathered or provided by health on that area?

Mr Corbell: I'm not aware of that work occurring. I will ask Brian Jacobs, who is head of Mental Health ACT to give you some more background on that issue.

Mr Jacobs: We collect a range of figures that look at trying to identify the outputs for mental health, and I've got the figures here for April. Two that we collect relate to people being seen prior to admission to acute mental health services, and those seen post-admission to mental health services. The idea is that, where possible, we try to care for people in the least restricted environment. But, where it is being clinically judged that they need access to an in-patient bed, we should assess them before admission. We try to make sure our community teams or CAT teams see people and assess them prior to them going through ED into the in-patient unit.

The figures we've got for April, for people who have been seen by CAT or community teams prior to admission to the PSU, run at 97 per cent. Calvary is at 56 per cent, but I need to flag that a number of their admissions come through other means such as private psychiatrist, interstate, and that type of stuff. The next set is the ones seen within seven days of discharge. That is identified as a target because, for a number of our clients translating from bed-based to the community, it is identified as risk window. We see 84 per cent for PSU and 50 per cent for Calvary, but 74 per cent of total acute discharges are seen by the community mental health team or CAT within that seven-day window. Others may move interstate, see private psychs or go back to their GP, because that's the best way to manage them. The acuity on the PSU is a good deal higher than the acuity on Calvary 2N because a good number of our admissions in PSU are involuntary.

THE CHAIR: So for those 26 per cent that aren't covered by the CAT team, for other reasons, is there a notation made of the reasons that they are not followed up by the CAT team?

Mr Jacobs: There could be a number of reasons they are not seen in that seven-day window. Some people, when they leave the unit, may automatically be hooked back to their GP or to the person previously providing their care in the community. Some go on leave. So there is a range of reasons why they're not picked up in that first seven-day window.

THE CHAIR: Yes, I understand that. But is that reason actually noted?

Mr Jacobs: It should be, but I couldn't guarantee it happens in 100 per cent of the cases.

DR FOSKEY: Is it possible to have that data, as it exists, tabled? You and Dr Sherbon referred to the data that commenced in December 2004 regarding the mental health needs of the ACT community. Is there any way of passing that on?

Mr Corbell: I think I need to take that question on notice, Dr Foskey, and just see what the state of that is. I'll see what can be done.

DR FOSKEY: Thank you. Do you need me to give you that in writing, to make that clear?

Mr Corbell: No, I think we're familiar with what you are referring to.

DR FOSKEY: Actions 49, 50 and 51 in the mental health strategy action plan concern the development of criteria for determining whether resources or services are best allocated to the government or community sector, and a review of the distribution of resources across the sector with a view to adjusting allocations where appropriate. Has this work been done and applied to the budget process?

Mr Corbell: Well, in relation to the budget process, the government takes account of all relevant information in making judgments about budget initiatives, and that would include any work that has been done in that area. The advice comes through to me from the various areas within the department. Certainly Mental Health ACT would be aware of what issues it believes need to be considered by the government in the budget deliberations. I then obviously provide that advice to cabinet and we work that through. Whether that specific action has been undertaken at this stage, I'm not sure. Maybe Mr Jacobs can answer that. However, I'd like to assure you that I certainly take full account of the whole range of issues in the health portfolio that are brought to my attention.

Mr Jacobs: Currently, we have the mental health services planning project under way and that involves us being involved in a feasibility or consultation process. The purpose of that is to assess the population-based needs and identified costed options for an adolescent in-patient and outpatient and ambulatory mental health services for the ACT and region, assess the population-based needs and identify costed options for the provision of adult in-patient and outpatient mental health services including the replacement of the Psychiatric Services Unit at the Canberra Hospital, identify the models of care and costed options for the provision of mental health crisis services in the ACT, prepare procurement feasibility plans for all of the above and develop a design brief for a high security mental health facility as a part of that. In regard to the mental health strategy and action plan, there is a range of things that we are incorporating in our planning around that and that will feed into the mental health services planning project. That is actually driven by population-based planning needs.

DR FOSKEY: On page 181 of budget paper No 4, and this is a similar question to the one Mr Mulcahy asked before, it's estimated that the number of children and young people to be seen by mental health services is 28,500 in this financial year but projected to be 24,300 in the next financial year. Given the real concern about the prevalence of mental health issues in children and young people, how do you explain this proposed decrease in activity?

Mr Jacobs: That figure is a target figure that we're putting into the budget papers for this year but I do need to say that the demand actually ebbs and flows within mental health and it's quite likely we may actually exceed that figure.

MR SESELJA: So it's just a demand-driven thing; it's not based on a lack of resources?

Mr Jacobs: No, there have been no cuts to the child and adolescent mental health team in terms of resources. I do need to flag, though, that work force is always an issue and it is hard to hold people with these skills within the service, because there's such a demand nationally.

MR SESELJA: So there is a strain on resources but it's not from a lack of funding it's from a lack of—

Mr Jacobs: No there's been no reduction in funding at all.

MR SESELJA: But it's from a lack of suitably qualified professionals?

Mr Jacobs: Yes.

Mr Corbell: As I previously indicated, Mr Seselja, mental health nursing is a real area of work force pressure in the ACT, and elsewhere. Finding sufficiently trained mental health nursing staff is very difficult and it has had an impact on our service delivery here, as it has had on other places around the country.

DR FOSKEY: When young people present with a dual diagnosis, are they more likely to be dealt with by ACT Health or move through the mental health service or the alcohol and drug program? This is a growing area of need but I cannot see any specific measures mentioned in the budget.

Mr Jacobs: Basically we need to assess each individual as they come to the services and we work with the agency identified as having the principal role or the lead role with that individual. Quite often it's Mental Health ACT, just because of the presenting problems. But we do have a dual disability team for people with intellectual disability and mental health issues, plus on occasion we work in conjunction with the drug and alcohol services. It depends on how their needs line up and how we can best deal with those.

Mr Corbell: It's also worth mentioning, Dr Foskey, that the government has funded a position at Winnunga Nimmityjah for a dual diagnosis worker specifically to work with indigenous people with dual diagnosis concerns.

Mr Jacobs: And there's also been an increase in resources at Quamby, with an extra psychologist going in to help with that population.

DR FOSKEY: Just recently I went to a meeting held by the Mental Health Community Coalition about housing options. It has become clear that it is a major issue within the mental health community, especially particular kinds of accommodation, supported accommodation services. Will mental health be undertaking any work to improve housing options for people in this situation?

THE CHAIR: There's an inquiry going on at the moment as well.

Mr Corbell: Yes. The Standing Committee on Health and Disability has recently

initiated its own inquiry into the provision of accommodation options for people with mental illness.

DR FOSKEY: Okay, that's excellent.

Mr Corbell: And that is under way. The government has agreed that Mr Hargreaves, as housing minister, will have lead responsibility for dealing with those matters. However, ACT Health and I will be contributing to the government submission on that. Mental Health ACT certainly works very closely with Housing ACT in coordinating accommodation and care services for mental health clients with particular needs.

DR FOSKEY: How much of the budget allocated to suicide prevention initiatives last year was spent on the development of the draft strategy, *Suicide prevention: managing the risk of suicide in the ACT 2005-2008*? Of the total $365,000 allocated, how much was spent on the strategy and how much has been spent on community-based programs to prevent suicide?

Mr Jacobs: I think the project officer cost for that study was $45,000 and they, along with the officer, ran that process. The rest went out to OzHelp, VYNE, and that sort of thing, for suicide prevention type programs.

MR SESELJA: How much went to OzHelp, just out of interest?

Mr Corbell: $250,000.

MR SESELJA: That's recurrent funding is it?

Mr Corbell: It's a contract; it's time-limited. I think it's a three-year period.

Mr Jacobs: We have a range of community-service based contracts and we've actually got those in at three years to give them a bit more certainty about their funding, so that addition will be to the contract.

MR SMYTH: Minister, I understand that Mental Health ACT applied for accreditation from the Australian Council of Health Care Standards. Where is their accreditation? Have they passed? Has it been completed?

Mr Corbell: I will ask Dr Sherbon to answer that question.

Dr Sherbon: Mental Health ACT is due for an accreditation review later in the year. We have not been reviewed at this point.

MR SMYTH: I've got a recollection that getting accreditation used to be one of the indicators of success. It's not here in the new indicators. Are we still committed to getting annual or biennial accreditation from the Australian Council on Healthcare Standards for all ACT health services?

Mr Corbell: We're certainly committed to getting accreditation, yes.

MR SMYTH: And that includes community care?

Mr Corbell: Yes, community health.

MR SMYTH: Has community care gone through the process?

Mr Corbell: Yes, they have.

MR SMYTH: And did they get accreditation?

Mr Corbell: They received accreditation for a two-year period.

MR SMYTH: What year was that done?

Mr Corbell: This year.

MR SMYTH: So would two years indicate that they didn't get the full four-year accreditation?

Mr Corbell: I beg your pardon; I'm advised that was done last year.

MR SMYTH: So last year, so in the changeover period, because the new guidelines have come into effect this year. So community care also got partial accreditation instead of full four-year accreditation?

Mr Corbell: No, it's not partial accreditation. There's no such thing as partial accreditation. You get accredited for a period of time and the accreditation—

MR SMYTH: Did you seek a four-year accreditation?

THE CHAIR: Let him finish.

Mr Corbell: You seek accreditation and ACHS tells you what they're prepared to give you based on how you have performed through the process, but there's no such thing as partial accreditation. It is incorrect to suggest that. Community health has received accreditation for a two-year period.

MR SMYTH: What sort of accreditation can you achieve? What's the maximum and minimum length of time you can get?

Mr Corbell: The maximum length of accreditation is four years.

MR SMYTH: And community care got two years?

Mr Corbell: That's correct.

MR SMYTH: In regard to mental health, before we went to the break, we were talking about the official visitor. Page 5 of her latest annual report says:

> The official visitors have formed an impression that mental health services in the ACT are struggling to cope with the increasing demand placed on them.

She goes on:

> We also hear consistent stories from consumers and carers about the limitations of community based services. In December 2003, the official visitors advised the Minister for Health that we have doubts about whether ACT Mental Health Services are presently able to meet their obligations of duty of care.

Minister, that is the latest report, as I understand it. It has been tabled in the Assembly. Do you have documents since then that you could give the committee that show that her opinion has changed? You said before the break that her opinion had changed.

Mr Corbell: I didn't say her opinion had changed necessarily in relation to the issue you have just raised in that comment from the official visitor. What I said to the committee was that, with my last meeting with the official visitor, she indicated to me that she was starting to hear feedback from consumers that were complimentary of the efforts being made by Mental Health ACT staff. In the time that I have been minister, and in the times that I have met with the official visitor, I have found her to be a very thoughtful woman who understands the complexity of delivering mental health services in the ACT. She does her job in identifying issues of concern and she also does her job in providing feedback to Mental Health ACT on other issues that are brought to her attention. The comment I made and the comment you made are in no way inconsistent. I think the official visitor outlines a range of comments, both of concern and of a complimentary nature.

MR MULCAHY: But you did say to me that you were confident that the services to be provided, both for admitted patients and community services would be "adequate to meet the demand"—I think those were the words used—whereas this is clearly saying that mental health services in the ACT are struggling to cope with the increasing demands placed on them. That seems at odds with that observation.

Mr Corbell: That is the observation of the official visitor. As you have heard from Mr Jacobs and me this afternoon, there is a range of pressures on mental health that see us falling short in terms of our capacity, particularly around work force issues, and that's something we are continuing to address. I am not suggesting for a moment that everything is rosy and that there are no problems with mental health services. Of course there are challenges and issues that need to be addressed in mental health. The government has a strategy to do that. It has a demonstrated record of being prepared to fund those things and we will continue with that approach.

MR MULCAHY: So you believe they are going to be adequate to meet the demand? That is the point I am trying to be comfortable about in my mind.

Mr Corbell: I think it is very difficult to say with absolute certainty that we will be in a position to meet all demands that are put upon us in any part of the health sector. However, I believe the government has taken a responsible approach. We have a responsible level of funding, which is sustainable. We are continuing to expand services. We are working closely with consumers and we will monitor every area in terms of our capacity to meet demand.

MR SMYTH: You said that she gives you a quarterly report. Can you table her latest report?

Mr Corbell: I see no reason why not.

MR SMYTH: Thank you.

THE CHAIR: Let us now move to output class 1.3, Community Health Services.

MS PORTER: Previously, minister, you mentioned the improvement in dental services, particularly in terms of a waiting list and the way that you are tackling that and reducing it. You may want to talk a bit more about how you are achieving that, but I want to focus on Aboriginal and Torres Strait Islander work. How much is going to be appropriated to that area in this budget and what do we hope to achieve for our indigenous community in the ACT region?

Mr Corbell: Thank you for the question. The second appropriation that the government presented, and was passed by the Assembly earlier in this term, made provision for a special amount of funding to allow the Winnunga Nimmityjah Aboriginal Health Service to operate a dental surgery, targeted at indigenous people and others who use the Winnunga service. That provided the Winnunga facility with both the appropriate equipment in the Narrabundah Health Centre, which Winnunga now occupies, and the employment of a dentist and a dental nursing assistant.

I was very pleased in April this year to go along and formally launch the service and, as I understand it, the service is now up and running. So this budget makes provision for that funding from the second appropriation. A sum of $222,000, recurrent indexed, is in the budget for that. More broadly, in 2005-06 the dental health program has received $278,000 to reduce the denture and general anaesthetic waiting list and to maintain the restorative waiting list at its current waiting time of seven months.

Funding of $162,000 will be allocated for either the recruitment of dentists or referral to private practice, and one of the real successes of this program has been that we have been able to engage with dentists in private practice who do the work for us and where we basically pay the cost of that work, apart from a small consumer contribution. There will also be funding of $116,000 to increase access to services requiring treatment under general anaesthetic, about 36 clients per annum, and also for restorative dental and a denture waiting list of about 80 people per annum.

So it is a very important public health program which I think is making a real difference to the quality of life of people. Poor dental health can be an indicator of more chronic illnesses in a person so maintaining good dental health is important, as well as obviously the quality of life issues. If you have poor dental health, it can be very extreme and painful and, in my view, unacceptable. This funding will continue to make quite a difference. I will ask Jenelle Reading, the director of the dental program, to give you a bit more background on what else is happening in the program.

Ms Reading: The dental health program has made very favourable downward trends with the restorative waiting list since the government introduced 500 recurrent funding in the 2002-03 budget. At that time, 1 July, we had a waiting list that I think was about

2,400 clients, with a waiting time of 22 months. At the end of April 2005, our waiting numbers are about 1,400, with a waiting time of seven months.

What this demonstrates is that we have a manageable system now where clients who come in for restorative services get a full course of care after seven months if they go on the waiting list and then receive a full course of care again 19 months later. Those who have never received a course of care, once they are on the waiting list, are currently waiting seven months but have access to excellent emergency services. I am very proud to say that we can provide that to our emergency clients, that is those with facial swelling, pain or bleeding, on that day. That is a service that certainly can't be provided by most private practices in Canberra. From a national minimum standard, they are suggesting that adult clients have a course of treatment every three years. As I said, we are currently doing that on the 19th month.

Because we have been so successful in reducing our restorative waiting list, it means that it has put a bit of pressure on our denture waiting list and our oral surgery under general anaesthetic. The initiative at 278 will provide us with the money to have increased private sessions at Lidia Perin for urgent cases. Usually they are with clients with a disability or for high-needs oral surgery and for children over a certain age because we have children that are seen from 15-under at TCH, and that is our priority.

With our child youth services, we have recently improved access to families so that their children can access dental services until the age of 14. It is free for children and families who hold a healthcare card. It is a very affordable membership for any family in Canberra, for a cost of $40 per child for all their routine dental treatment needs to be met. Our membership, since we opened up access last year, is at the highest rate—24,000 children on that membership scheme.

MS PORTER: Just to clarify: people on the waiting list who would normally have been seen in the past by the ACT Dental Service can also now be given an appointment with a private practitioner. That is one way that that waiting list has been lowered?

Mr Corbell: Yes. Two things have happened. We have employed additional staff ourselves but we have also contracted the work, if you like, out to private dentists.

DR FOSKEY: I just wanted to continue some questions from this morning about Karralika. I was just wondering; having understood that the $5 million for redevelopment has been returned to general revenue, what is the time frame for identifying development options for Karralika? How will the $400,000 in the budget be expended?

Mr Corbell: I expect the consultative committee that I have established, Dr Foskey, to report to me in approximately May or June this year and I will then be considering the outcome of the issues raised in their report—the outcome of the fairly extensive work, I must say, that that committee is now doing because they have commissioned, with the support of ACT Health in terms of funding, a range of consultancies that are looking at traffic issues, fire issues, other planning issues—

DR FOSKEY: In a little while perhaps you could tell me who is on this consultative committee; not necessarily their names but what kinds of representation we have there.

Mr Corbell: Sure. That committee, Dr Foskey, is chaired by an independent chairperson. Ms Chris Purdon from a private planning consultancy, Purdon Associates, is the chair of that body. It then has representation from Karralika, from the local primary school, from other stakeholders in the drug and alcohol sector. It has representatives of the Karralika Action Group and—

DR FOSKEY: Which is the local, residential—

Mr Corbell: The local residents group that has been formed around this issue—and other residents who are not directly associated with the Karralika Action Group. We also invited representatives of the police and of the Tuggeranong Community Council, I think. There is a fairly broad membership. They meet every two weeks. They met for the first time in November last year. The chair of the committee recently provided me with a mid-term report on the progress of the committee's work. As I say, we expect the final report in May or June this year.

DR FOSKEY: So that $400,000 has been funding these consultancies?

Mr Corbell: No, the $400,000 that is allocated in the budget will allow the government to do more detailed work on the development of options for drug rehabilitation facilities, including, potentially, depending on the government's decision on the outcome of the report, at Karralika once the report has been presented to me.

DR FOSKEY: Does the government have an ongoing commitment to redevelop Karralika?

Mr Corbell: The government's preferred option—and it has been put to the committee—is for a modest expansion of Karralika, with an additional 10 beds at the facility. However, this is subject to the outcomes of the report of the consultative committee on the best way forward.

DR FOSKEY: In the meantime, how is the government responding to the increasing demand for residential rehabilitation services?

Mr Corbell: The government put forward its preferred approach a number of budgets ago now. That approach was rejected by the Legislative Assembly. So the government is working to finalise this issue at Karralika, before proceeding with other activity.

MR SMYTH: In other words, no other approach?

Mr Corbell: The government put forward an approach that was for a very substantive increase in the number of beds at Karralika to meet demand. Unfortunately the Liberal Party and the Greens did not support the government's approach to facilitating that output.

MR SMYTH: There is no such restraint now.

THE CHAIR: Order!

MR SMYTH: A supplementary on this issue of Karralika, please?

THE CHAIR: Yes, briefly.

MR SMYTH: Minister, there were also moves to put a childcare centre on the site. Is it still the government's intention to build a childcare centre there?

Mr Corbell: That is an issue that is open in the consultation process.

MR SMYTH: Were you aware of reports of children from the existing facility being found walking on Bugden Avenue?

Mr Corbell: No.

MR SMYTH: There have been a number of incidents, I understand, reported to the police or where the police have found children already wandering from that centre.

Mr Corbell: That wouldn't be anecdotal, would it, Mr Smyth?

THE CHAIR: It sounds like it would be, minister.

MR SMYTH: No, it is not. I can give you the names of the people that have come and said that—

Mr Corbell: No, I am not aware of that.

MR MULCAHY: Same output, page 182, BP4, the number of opioid treatment clients with management plans, minister: you have a target of 450. This appears to be quite a dramatic reduction in the number of clients under the old measure, which I think was formerly 740. Could you explain to the committee why the numbers have fallen so dramatically in this area, which ought to be going in the other direction?

Mr Corbell: It is not a reduction in service provision; it is not a reduction in funding for that program. It is simply a reflection of demand for that program for people who use our methadone clinics; it is simply a fluctuation in demand.

MR MULCAHY: Why would it halve, though, minister?

Mr Corbell: It hasn't halved, as far as I am aware.

MR MULCAHY: Wasn't the previous figure 740 patients?

Mr Corbell: We have previously had an estimated outcome of 700 occasions of service. The revised target is 450. We believe that is a more accurate assessment of the level of demand. The advice I have that indicates to me the reasons for that change is a decrease in the number of people requiring methadone, particularly because of the usage of drugs in the community other than heroin. So heroin use is not as high as it previously has been and the use of other illicit drugs, which cannot be supplemented by the methadone program, is resulting in a decrease in the total number of people needing to use methadone.

MR MULCAHY: So the drug problem wouldn't be contained so much by, if you like, a drought. A dramatic fall just in heroin usage is the driving consideration in that reduced number of patients?

Mr Corbell: I am advised that a reduction in overall heroin usage is leading to a reduction in usage in the methadone program.

MR MULCAHY: I am not sure how the control of this works, but there is a facility on the site of the Canberra Hospital for treatment, as I understand?

Mr Corbell: Yes. That is the methadone clinic.

MR MULCAHY: The impact of methadone on the cognitive skills of people in driving vehicles immediately after use of this treatment: are there other risks for people to use motor vehicles and the like? If so, what measures have you taken to ensure the safety of residents and schools in the Garran area as a result of patients leaving that facility? It has been raised with me as an issue by people in the area. It is to do with the way the facility is run.

Mr Corbell: We provide methadone through two avenues. One is through the clinic at the Canberra Hospital. The other is through the pharmacy-based program. The people who use the clinic at the Canberra Hospital do so because they require a high level of supervision to ensure their maintenance on the program and it is only when they have satisfied some of the thresholds there around their ability to maintain themselves on the program that they are able to be transferred to the pharmacy-based program where they can collect methadone, hopefully, from a pharmacy close by.

In relation to the physiological effects of methadone on people's cognitive ability, I would have to take advice on that. I am not really in a position to answer that.

Dr Sherbon: Just to add to that: the answer is that opiate tolerant people are those who are enrolled in the methadone program, obviously. If you and I took a dose of methadone, we wouldn't be able to walk out the door. But people who are tolerant to opiates can function normally. A lot of people take their methadone dose in the morning and go to work, function normally through the day. So I don't want you to assume that we are not taking into account general public safety. The methadone dose is calibrated to the need of the patient and their tolerance level. But as to the specific effect on driving and the scientific evidence: as the minister said, we will get formal, scientific advice to you. There is not a direct safety issue because the dose is calibrated by the medical staff to the needs of the patient.

MR MULCAHY: Just a last question on this issue: have there been any issues with the management of that clinic at the Canberra Hospital in the last 12 months that might give concerns about the way in which it is operating?

Mr Corbell: Only insofar as the clinic is part of the alcohol and drug program. As you would be aware, Mr Mulcahy, there has been an extensive series of investigations into the management of the alcohol and drug program. I have tabled a number of those reports in the Assembly as well as the government response to the management of the program overall. So only insofar as the methadone clinic is part of ADP.

MR MULCAHY: Nothing specifically about the clinic? No issues in management there, minister?

Mr Corbell: There may be issues around the concerns of some staff about the management of the program insofar as they are staff who work in the methadone clinic as part of the alcohol and drug program. I am not trying to be evasive; I am just saying I am not aware of any particular issues about the management of the methadone clinic. I am aware of issues about the overall management of the alcohol and drug program, of which the methadone clinic is a part. There have been three reviews commissioned, and a number of those completed, into issues around the management of the alcohol and drug program in ACT Health. We have also recently recruited a new director for the alcohol and drug program.

DR FOSKEY: Did we meet the new director earlier today? Was the new director here today?

Dr Sherbon: No, she is not, sorry.

DR FOSKEY: To follow up on those three reviews: given that they identified a number of areas for action, such as improving the internal working environment, the need for a systematic approach to service delivery and addressing specific needs for groups such as methadone users, I am wondering whether there is room in the budget—I can't see any specific allocations—to implement those recommendations.

Mr Corbell: The management of the program and the improved management of the program do not require additional budget appropriation. It is a matter of ensuring that there is better leadership and direction provided within the program. I believe that our new director will assist significantly in providing that.

The reviews have also outlined a whole range of areas for action, which are about the adequacy of policies and processes within the ADP, and these are matters that, in my view, should substantially be able to be addressed within the existing administrative resources available within ADP. It is not about finding heaps of new money; it is about changing the practices and policies of the program. We have taken a very extensive look at the operation of the ADP and the need to improve a whole range of policies and procedures. That work is progressively under way.

DR FOSKEY: I did hear you mention earlier that there is a new position within Winnunga Nimmityjah for indigenous people with dual diagnosis. Is that right?

Mr Corbell: Yes, the dual diagnosis worker; that is right.

DR FOSKEY: Has that position commenced yet?

Mr Corbell: Yes.

DR FOSKEY: That was in the last budget?

Mr Corbell: It was in the budget before last—last budget.

DR FOSKEY: I am not sure whether you have read the report *I want to be heard*, which has been prepared by the National Centre for Epidemiology and Population Health at ANU and Winnunga Nimmityjah. This is a copy of the community report. It has extensive consultation with indigenous youth users of illegal drugs in the ACT. I guess that the prime call was the need for indigenous targeted services.

I just can't see any initiatives in the budget linked to that need for specific rehabilitation and other services. I am just wondering whether the government is taking any action in regard to indigenous drug use. It is a major issue, as you are probably already well aware.

Mr Corbell: Yes, it is a significant issue, Dr Foskey. The government is funding a range of programs and other activity at the moment. Certainly I wasn't aware of the actual details of that report until pretty much right around budget time; so I am not sure whether they helped informed decision making within the department prior to the budget, given that I was only aware of it quite late in the piece.

However, we are doing a range of things, as I have already mentioned. The dual diagnosis worker is in place at Winnunga. Within government, through the Chief Minister's Department, work is progressing on the development of a bush healing farm model to provide an alternative therapeutic setting for indigenous people who encounter drug and alcohol problems. Those are the two that I can recall immediately off the top of my head. Dr Sherbon or others may be able to expand on that. However, that is an example of some of the work that the government is doing in this area.

DR FOSKEY: That bush healing farm is looked forward to by many in the indigenous community. I just wonder how that feasibility study that was in the last budget is proceeding.

Mr Corbell: I will ask Dr Sherbon.

Dr Sherbon: As the minister mentioned, the Chief Minister's Department is overseeing the co-ordination of that study but we have been intensively involved in the community consultation which has been a very complex and thorough exercise. It has got to the stage now where we are just about to commission a feasibility plan for the facility itself. So the community consultation has been extensive across a number of government functions, including health. Health has been intensively involved.

We now have a much clearer idea of what the indigenous community sees as the most benefit they could obtain from such a facility. We are nearly at the stage where we can move into the process of facility planning itself. This has been a very complex exercise because, as I think many of you know, there was much store placed in this facility by the indigenous community but, for different reasons, depending on whom you spoke to. So it was important to get an aggregated community view before we started to move to a facility planning process. And that has been a very complex exercise. It is nearing completion.

DR FOSKEY: Are there funds to plan the facility?

Dr Sherbon: Yes, there are funds in the 2004-05 health budget for a feasibility study into the facility itself. But, as I said, it was unwise to move into that until we gained a clear community view across a range of government functions. There were some who saw this as an accommodation facility; some saw it as a detox facility; others saw it as a rehab facility; others saw it as a cultural facility. So we had to bring all those views together and that process is not quite finalised; we are nearly there.

DR FOSKEY: I can understand it would have been a complex exercise and I commend you for taking time over that consultation.

MS PORTER: Minister, in that same output class, 1.3, it mentions providing healthcare assessments for people detained in corrective facilities, in detention, et cetera. I was wondering how the provision of these services will or may change when the new Maconochie Centre is opened. What are the plans?

Mr Corbell: They will change quite significantly, Ms Porter. Obviously the Belconnen Remand Centre will close with the development of AMC, the Alexander Maconochie Centre, and that will lead, I think in all of our views, to a significant improvement in the quality and safety of the environment in which people are generally detained. Unlike others, we take the view, as a government, that the provision of appropriate prison services in the ACT is essential and a fundamental social justice issue that needs to be addressed.

In relation to healthcare: healthcare will be comprehensively provided within AMC. There will be a whole range of services provided and there will also need to be close working links with the Canberra Hospital, in particular, for people who are incarcerated at AMC and who need to spend extended periods of time at the hospital.

So these issues have been well addressed. The government has recently agreed to a revised model of service provision for healthcare in AMC. The majority of the costs have been built into our forward projections. Others will be considered as we get closer to the delivery on the ground of these services.

MR SESELJA: Page 182 of budget paper 4, accountability indicators for output class 1.3, the proportion of new referrals to community health aged over 65 years, with a completed falls assessment: the target is 60 per cent. Are you able to explain to the committee just how that will work? What happens to the other 40 per cent? Is it based on the highest risk or will some just not be assessed due to lack of resources? Are you able to give us a breakdown of how that 60 per cent will work?

Mr Corbell: I will ask Dr Sherbon to give you some further detail on this, Mr Seselja, but this is actually a very important part of the government's program. You are probably aware that this budget makes provision for a dedicated falls prevention program in residential aged care facilities.

MR SESELJA: It is to be commended.

Mr Corbell: Thank you. And what that is about is ensuring that we work to prevent falls in nursing homes and other residential aged care facilities, to prevent the admission of elderly people with fractures and so on into the acute care setting, into our hospitals. In

terms of how that figure has been derived, I will ask Dr Sherbon to just explain that rationale.

Dr Sherbon: Yes. This program in the community health component of falls prevention largely revolves around assessment. You are quite correct. This 60 per cent represents the proportion of the population that we think would be at higher risk. As you know, many 65 to 75-year-olds, particularly women, are very healthy and don't require intensive assessment. So 60 per cent is our best estimate of the group over 65 who would require assessment.

MR SMYTH: Just to go back to health and community care's accreditation with the Australian Council of Healthcare Standards, when did you receive the final report from the council?

Mr Corbell: When did I or when did the department?

MR SMYTH: When did the department and you?

Mr Corbell: I am not aware of the dates when I was advised.

MR SMYTH: Dr Sherbon?

Mr Corbell: I am certainly happy to take the question on notice. In relation to when the department was made aware—

Dr Sherbon: In 2004. I can't give you the date. I will get it for you. But I think it is fair to say that I was not satisfied that there was an expeditious transfer of the information to me or the minister.

MR SMYTH: I am sorry, would you repeat that?

Dr Sherbon: I was not satisfied that there was an expeditious transfer of the report to me or the minister.

MR SMYTH: Was that early 2004 or late—

Dr Sherbon: It was announced last year, but the report was not received by the minister until 2005.

MR SMYTH: Were there any high priority recommendations in the report?

Dr Sherbon: No, there were no high priority recommendations.

MR SMYTH: How many low achievement classifications were achieved?

Dr Sherbon: In the mandatory criteria, 14 of 19.

MR SMYTH: How many were of some achievement?

Dr Sherbon: No, not low achievement. I will just correct my answer, sorry. Of the

19 mandatory criteria, five were moderate achievement and the other 14 were of some achievement or low achievement.

MR SMYTH: What is the split between some and low?

Dr Sherbon: I will have to get that for you; I don't have that here today.

MR SMYTH: Normally when you receive a report like that you then have to put in an action plan on how you will remediate it. When was that action plan due?

Dr Sherbon: It was submitted in 2004. I can get you the month, but it was submitted within the required time frame.

MR SMYTH: That would be good. The minister has since made available the report on the hospital. Will you now, minister, make available the report on health and community care?

Mr Corbell: Of course.

MR SMYTH: When will that be available?

Mr Corbell: I will provide it within the normal time frame for the committee's questions on notice.

THE CHAIR: Output class 1.4, public health services.

MS PORTER: In this output area, minister: on page 168 it states that the ACT, with regard to overall life expectancy and general population health, is fairly strong as far as life expectancy is concerned. I was just wondering whether you would want to talk about that. I particularly was interested in the area of cardiovascular disease in the community. How are we achieving that result?

Mr Corbell: Yes, Ms Porter, we do have the greatest life expectancy in the country. That is widely attributed to the relatively affluent nature of our community and, therefore, the improved health outcomes that come with rising standards of living. In relation to the incidence of cardiovascular disease in the community, I will ask Dr Guest to talk a little bit about how we are addressing this priority area.

Dr Guest: The main risk factors for cardiovascular disease are smoking, high cholesterol and high blood pressure. The ACT has a number of programs addressing all of these principal risk factors. We do best in smoking rates. That is very significant. It correlates with educational advantage, which is greater in the ACT than anywhere else in Australia. We support actively a number of programs through the Heart Foundation and a number of other non-government organisations through HealthPact, the Health Promotion Board of the ACT. Together, these programs contribute a small amount to putting the ACT at the lead of the table for this indicator at the moment.

MS PORTER: Earlier there was a discussion about breast cancer. It seems to me that there is a correlation between being affluent and increased life expectancy. The other side is that there is perhaps a greater risk of breast cancer. Because of this good outcome,

are we having success in life expectancy around breast cancer? Am I just making some assumptions here or do you have any figures around that?

Dr Guest: Breast cancer is one of the few diseases that select people of higher socioeconomic status. For example, because of the higher socioeconomic status in the ACT, more women delay pregnancy for professional reasons. Therefore, they are at greater risk for this disease. It is unfortunate that this particular disease is associated with the otherwise favourable indicators for cardiovascular disease, although smoking is not a risk factor for breast cancer. So it is just one of those things. Overall, mortality is certainly better here and cardiovascular disease is the most important part of that in terms of burden. Breast cancer, unfortunately, is one of those diseases that are more common when most of the other indicators are favourable.

MS PORTER: But the screening would, hopefully, be catching breast cancer earlier, therefore giving a greater life expectancy. I am trying to say that it depends on when you catch it. If it were caught early, obviously the life expectancy for people would be better than if it were left late. Therefore, the screening must be a very important part of that.

Dr Guest: Screening is an important part of prevention of breast cancer mortality. As we said before, it is most effective in women aged 50 to 70. We are still striving to get that subpopulation most screened.

MR MULCAHY: Minister, in relation to your overall budget for public health, how can you cut that budget by $2 million but not cause changes in the services that you hope to deliver?

Mr Corbell: I am advised, Mr Mulcahy, that these are the following reasons—

MR MULCAHY: You do not say that with much conviction, minister.

Mr Corbell: No. It is 5 o'clock. I must admit that I am starting to get other things on my mind. My apologies. The decrease in total cost of $2.332 million—I will try to be more animated—in the 2005-06 budget from the 2004-05 estimated outcome relates to a number of factors. The first is a reduction in the Australian immunisation agreement of $1.5 million-odd; the removal of Howard Florey Centenary House rent, $756,000—that is the building that burnt down in the bushfires; the removal of one-off extraordinary expenses associated with bushfire costs of $350,000; and lower levels of deferred government payments for outputs of $398,000. These have been offset by a number of increases including an increase in EBA funding of $319,000, indexation of $188,000, and new initiatives in this year's budget of $300,000.

MR MULCAHY: Are there any cuts to services, minister? In relation to the child immunisation program, can you expand on what that will mean in terms of those sorts of programs in the territory?

Mr Corbell: No, there is no reduction in services. Secondly, in relation to the immunisation agreement, we were funded to get a particular cohort of children and young people up to scratch with their meningococcal C vaccine. This is a new vaccine recently available and funded across the country. That is essentially a one-off because we had to do a number of cohorts to get them all captured. Now we will simply have

reduced level activity as cohorts move through. That is the reason for that.

MR SMYTH: I have a supplementary on that. Why will you not pay the rent for Howard Florey Centenary House?

Mr Corbell: Because we cannot rent it; it is not there.

Dr Sherbon: I can answer that. It used to be owned by DUS, but in the spirit of goodwill they have donated it to health. We now own it, so we do not have to pay any rent on it. Having said that, we have lost the budget as well. It is a very mutual transaction.

DR FOSKEY: Last year's budget allocated funding to childhood obesity measures, which included surveillance in the first year to develop a better understanding of the determinants and trends of child obesity in the ACT, with an intention to fund a group of programs to address the issue. Has that surveillance work been undertaken? Is there a report available? If so, I would like it tabled. What programs have been funded through this measure?

Mr Corbell: Dr Foskey, I am not aware of the status of that work. I think we will need to take that question on notice. I will provide further advice to you.

DR FOSKEY: Here is a very Greens' question on the topic of composting toilets. How many applications have been received for composting toilets in the last year? How many have been approved?

Mr Corbell: I will need to take this question on notice. I am aware of at least one. I have received a number of representations on it. I think there have been a number of requests. It is probably worth making the point that a couple of processes need to be followed in relation to putting in place a composting toilet. One is the development approval process; the other is clearance from Health Protection Services as to the adequacy of the system proposed to be installed. As you are aware, Dr Foskey, a range of technologies use different methodologies to compost human waste and those are looked at on a case-by-case basis.

DR FOSKEY: I gather that some guidelines are being developed by ACT Health on the use of composting toilets in the ACT. I am wondering how they are proceeding. Will there be a draft for public consultation?

Mr Corbell: I understand Health Protection Services are doing some work in this area in terms of what the process would be for public comment in relation to any documentation produced. I will need to take that question on notice also.

DR FOSKEY: Given the water saving involved in such a system, it would seem one for ACT Health to actively encourage once the guidelines are out.

Mr Corbell: As minister for both health and planning I am aware—certainly ACT Health is very aware—of the increasing level of community interest in alternatives to conventional toilets in terms of reducing water usage. Whether that can be achieved through the use of grey water for the flushing of toilets or whether you go to a composting model and you are completely offline from the reticulated system, it is very

much an individual consumer choice and preference. Not everyone is keen on the idea of a composting toilet, but increasingly more and more people are. The department and Health Protection Services are looking at this issue because they have seen an increase in the number of requests for information and advice in relation to the use of such facilities. It is something we do treat seriously.

THE CHAIR: We will move to output 1.5, cancer services.

MR SESELJA: Minister, page 183 of budget paper 4 talks about breast screening. It says that the target for 2005-06 for the waiting time for results is less than 28 days in 100 per cent of the cases. What is the current waiting time for results?

Mr Corbell: The waiting times for results of screening are currently two to three weeks from the date of screening. That is for a "no cancer detected" result.

MR SESELJA: One hundred per cent would be done within that time frame.

Mr Corbell: Yes.

MR SESELJA: Has that changed over the year? We were getting reports earlier in the year of its being at least six weeks, and sometimes longer. When has that sort of change come about?

Mr Corbell: We did—I think it is well understood now—have a period around Christmas where, due to a shortage of ACT-based radiologists, there were delays in getting screenings read. Because of that, ACT Health contracted additional radiologists including radiologists based in Sydney to read and assess films and provide that advice to clients of the breast screening service. Because of these steps, we have been able to get the analysis time back down, and to get that turnaround time to about two to three weeks.

MR SESELJA: That is good news. During that period—over Christmas or whenever the period was—how many women would have had results coming back after 28 days?

Mr Corbell: I would need to take that question on notice, Mr Seselja.

MR SESELJA: Is it possible to get an estimated figure for the year 2004-05 of the numbers coming in under 28 days, such as the percentage, given that there is a 100 per cent target for next year?

Mr Corbell: I am happy to take that on notice.

THE CHAIR: Dr Foskey, and then I will be very nice to Mr Mulcahy and allow him to ask one very quick question on 1.4.

DR FOSKEY: The annual report for ACT Health mentions that it intends to establish a network cancer care service, but there is only one budget initiative to expand the capacity of medical oncology services in this budget and that is on page 192 of budget paper 3. Will this funding expansion enable the development of a network cancer care service? If not, how will this service be established?

Mr Corbell: We do have a network service now. It is called the capital region cancer stream. Earlier today we had at the table Associate Professor Robin Stuart-Harris, who is the director of that stream.

DR FOSKEY: When it is a stream, is it bigger than a network?

Mr Corbell: It is the same thing, Dr Foskey. Let me ask Associate Professor Stuart-Harris to explain to you how it works. That would be helpful to you and other members of the committee.

Prof. Stuart-Harris: The stream was initiated on 24 January this year. It is a joint initiative between ACT Health and what was the Southern Area Health Service in New South Wales. To some extent, we had the bones of an integrated service as we already provided outreach cancer services to several clinics in the southern area.

I was appointed late last year and took up the position in January. We have a full-time operations manager who has come to us from Hobart, Catherine Jones. We also have an administrative support person and access to a business manager. So the capital region cancer stream has started. Its major aim is to integrate existing cancer services and to ensure that such services are patient-centred. This is a separate budget initiative to increase availability of cancer treatments to the population within the ACT, through both the medical oncology clinic at the Canberra Hospital and the Zita Mary Clinic at Calvary. This is a separate initiative to the cancer stream, although part if it.

MR SMYTH: If we merged the Southern Area Health Service and the ACT, would part of the treatment be post-operative as well as pre-operative?

Prof. Stuart-Harris: The majority, in terms of chemotherapy, would be post-operative.

MR SMYTH: I assume that a number of stomach and bowel-type cancers would require the placement of a stoma on the patient?

Prof. Stuart-Harris: Yes, that would be done. They would have their surgery, which might involve the placement of a stoma.

MR SMYTH: Minister, is it true that community nurses have been told that they are not to provide stoma support to New South Wales residents who have had their surgery in the ACT?

Mr Corbell: I am seeking urgent advice on this matter at the moment. However, I do understand that the decision has been taken. I am seeking further advice on it. I understand we are seeking to encourage the Southern Area Health Service to provide community nursing care for New South Wales patients once they have returned to New South Wales.

MR SMYTH: I have a letter from the ACT and Districts Stoma Association Inc. that says that the community nursing service have been directed to advise patients that they are only authorised to provide services to ACT residents and that New South Wales residents should seek support from their local area health service.

Mr Corbell: Yes, I have received the same letter, Mr Smyth.

MR SMYTH: Are you saying you were not aware that that service had been withdrawn from New South Wales residents?

Mr Corbell: I think that the situation is—and I am seeking advice from my department after receiving that letter—that, wherever possible, we are seeking to ensure that New South Wales residents receive care from nurses engaged by the Southern Area Health Service rather than our nursing staff travelling across the border.

MR SMYTH: I can understand. The letter also states that the association appreciates the need for prudent management of health resources. Would it not have been better to discuss this with the Southern Area Health Service before it was arbitrarily cut? If we are setting up a clinical stream that involves cross-border relations, surely we have some obligation to at least consult with the Southern Area Health Service and at least inform them that we are no longer going to provide what I assume is very critical care.

Mr Corbell: I am not aware of the details of the decision and I am seeking advice from my department.

MR SMYTH: Minister, why are you not aware that such a radical change to the provision of a critical service was undertaken without your permission or your knowledge?

Mr Corbell: That is what I am finding out from my department.

MR SMYTH: What will happen in the interim? These people have been cut adrift with no service.

Dr Sherbon: I can answer. For the interim the service will be provided until we have reached an agreement with Greater Southern Area Health Service. That is only a natural request of this committee and the minister. I will ensure that that is in place until we have reached an appropriate arrangement for patient transfer.

MR SMYTH: Did you take on notice why it was stopped without your approval? You said you were finding out, but will you inform the committee when you have found out what happened?

Mr Corbell: I am happy to provide further advice to the committee on the situation.

MR MULCAHY: Minister, just one question on 1.4. It says that this output area relates to the Health Protection Service analytical laboratory conducting sample analysis in connection with legislation enforcement. To the best of my memory, under the Humphries government, ACT laws were amended to make provision for the drug testing of motorists. This has now been quite extensively introduced in Victoria. Is your government considering drug testing for ACT motorists? Would that be undertaken with the use of that facility?

Mr Corbell: No. There are no plans at this stage to introduce that. I think the experience

in other jurisdictions has indicated there is still some level of unreliability around the procedures used for conducting such analysis. I think at this point in time it would be fair to say the government is adopting a wait-and-see approach. We do not necessarily need to be the guinea pig on this issue. We will carefully watch developments in the states that have introduced this service. As far as I am aware, only one state has introduced it on the ground and that is Victoria, although I think at least one other state has announced its intention to do so.

THE CHAIR: We will move on to output class 1.6.

MR SMYTH: Can I ask a question on 1.5 first?

THE CHAIR: We need to move on, Mr Smyth. We have 45 minutes left and we still have to deal with HealthPact. We also have output class 1.6 and 1.7 to deal with.

MR SMYTH: It will be a quick question.

THE CHAIR: I suggest you place it on notice.

MR SMYTH: Members are entitled to ask questions.

THE CHAIR: Members of the committee are entitled to ask questions; that is correct.

MR SMYTH: All members are entitled to ask questions.

THE CHAIR: Mr Smyth, I direct you to standing order 245 and standing order 235, which states:

> When a committee is examining witnesses, Members of the Assembly not being members of the committee may, by leave of the committee, question witnesses.

MR SMYTH: I am asking questions.

THE CHAIR: As the presiding member, I am moving it onto output class 1.6. The answer is no.

MR MULCAHY: Chair, I raise a point of order. I believe Mr Smyth has sought the leave of the committee and I think it is appropriate to seek the view of the committee if leave is to be granted.

MR SESELJA: I would be happy to grant leave. Ms Foskey?

DR FOSKEY: I would rather do this and then come back to it if there is time. This comes after we have already moved on.

MR MULCAHY: I raise a point of order. I think we have a request to members of the committee for leave to be granted.

MR SESELJA: We either accept it or reject it.

DR FOSKEY: I would like to wait until after we have done 1.6.

MR SMYTH: Are you not granting leave?

DR FOSKEY: I want to go on. But we can come back to it as we did to yours.

THE CHAIR: It is at the discretion of all of the members of the committee. It takes only one member or the presiding member to—

MR MULCAHY: So you are denying his request for leave?

THE CHAIR: I am saying that we are moving on to 1.6 and, if we have enough time at the end, we will allow Mr Smyth to ask his question.

MR SMYTH: Why can't I ask the question without this malarky?

THE CHAIR: Mr Smyth, I would ask that you follow my directions as the presiding member of this committee.

MR SMYTH: But I have asked for your leave.

THE CHAIR: If you are not happy with that—

MR SMYTH: No, I am not happy with it.

THE CHAIR: Too bad, quite frankly.

MR SMYTH: It is not too bad.

THE CHAIR: Yes, it is too bad. We are moving on to output class 1.6—aged care and rehabilitation services. Ms Porter, do you have a question?

MR SMYTH: If you are afraid of the question, that is fine.

MS PORTER: Minister, I have a question on page 39 of the ownership agreement. Strategic indicator No 17 shows a marked reduction in the time that older persons in hospital wait for assessment by the aged care assessment team. Obviously, this will free up beds and get people out of the acute system more quickly. How is that going to be achieved? Are they going to be seen by the aged care assessment team in a more timely way than possibly they have been in the past?

Mr Corbell: I am not familiar with the exact detail of how this initiative would be implemented so I will need to take that question on notice and provide some further information to you.

MS PORTER: That's fine. Thank you very much.

DR FOSKEY: I understand that a review of the services provided at Burrangiri is currently being undertaken by an external consultant. Will the government guarantee that there will be no diminution of respite care services?

Mr Corbell: Yes, there will be no reduction in the level of respite care services provided.

DR FOSKEY: Both Health Care Consumers and COTA National Seniors in their submissions raised an interest in seeing the discharge planning project supported and expanded to integrate services across the health centre, but I cannot see any sign of additional funding for this in the budget. Does the government have plans in this regard?

Mr Corbell: Discharge planning, as with some of the other issues you have raised, Dr Foskey, are matters which are about better process, better policies, better mechanisms in place. They do not require new funding to make them happen. Instead, they require a change to existing procedures and process and that is the focus of the activities that ACT Health will be undertaking in that area.

THE CHAIR: We will move on to output class 1.7—early intervention and prevention.

MR MULCAHY: Professor Stuart-Harris kindly informed me all I need to know at afternoon tea and I am happy with the answers I was given then.

MR SMYTH: The number of screens for women over 50 is 9,950 for the coming year. You have clearly separated that target out, minister. Do you have the figures for the number of women over the age of 50 who might have been screened in the current financial year?

Mr Corbell: We have a projected outcome, Mr Smyth. At this stage we anticipate that the actual throughput—projected I have to stress—will be 11,000.

MR SMYTH: I know that that is the total throughput; that is the line above. I am asking whether you have a number. You seem to have introduced a new measure of number of screens for women aged over 50. Is there current data on how many screens are done?

Mr Corbell: I will need to see if I have that here, Mr Smyth. No, I will need to take that question on notice.

MR SMYTH: Thank you.

THE CHAIR: Mr Smyth, before we move to HealthPact, do you want to ask your follow-up question on 1.5?

MR SMYTH: I do, thank you. Minister, I had a telephone call the other day from a woman who said that she had tried to arrange a breast screen but was told that the service was not taking new clients. Is any limitation being put on women attending for a breast screen mammograph?

Mr Corbell: How old was the woman involved?

MR SMYTH: She was over 40.

Mr Corbell: Was she a New South Wales resident?

MR SMYTH: No, she was an ACT resident.

Mr Corbell: There should be no problem with that.

MR SMYTH: Do we restrict New South Wales residents?

Mr Corbell: We provide services to New South Wales residents based on a contractual agreement with southern area and we are limited to the number of screens we are able to provide based on the amount of money that southern area pay us.

MR SMYTH: Have we reached that limit?

Mr Corbell: I am not aware whether we have reached the limit at this point but we do have a limit.

MR SMYTH: What limitations? Is there a limitation on a woman under a certain age receiving a screen?

Dr Sherbon: Under the age of 50 we do not restrict access if people want a screen but we do not recruit women under the age of 50; we do not actually go out and attempt to get them in the program. There has been an issue with recruitment of women turning 50 or 51 from New South Wales because the program funding from New South Wales is less than that per woman than in the ACT and there has been a limit as to the extent to which we can screen New South Wales women. I am not aware at this stage as to whether that limit has been achieved in the ACT. We will check that on notice. But there should be no restriction, as far as I am aware, of any ACT resident.

Mr Corbell: The advice I have in relation to New South Wales is that we are contracted by BreastScreen New South Wales to screen women in the southeast region. This year's contracted target is 5,400 women. We had achieved 4,394 up to April.

MR SMYTH: Is that 4,000 included in the 11,000 screens or is the 11,200 expected outcome for this year just ACT women?

Mr Corbell: That is ACT women.

MR SMYTH: If a woman is over the age of 40 and an ACT resident, she can go along and have a mammogram regularly at no charge?

Mr Corbell: No. If a woman is aged 40, BreastScreen New South Wales have a particular policy.

MR SMYTH: No, I am asking about the ACT.

Mr Corbell: The advice I have is that for women aged between 40 and 49 years, the ACT program will consult with the breast screen advisory committee and other stakeholders, including VMOs, about introducing the BreastScreen New South Wales policy. If adopted, this would provide an extra 450 more appointments available for women in the targeted age group. A policy dealing with annual screening for women

with a family history of breast cancer is also being developed. There is real evidence to support annual screening benefits to this group of women and this is an issue that we are needing to look at very closely.

MR SMYTH: Can we have copies of those policies?

Mr Corbell: The New South Wales policy I imagine is widely available. It is not an ACT policy; it is a New South Wales policy. BreastScreen New South Wales are streamlining their service to provide screening for women in the target age group. This means that women aged between 40 and 49 will no longer be routinely recalled for screening. They will still be eligible to be screened but they will not be routinely recalled for screening.

THE CHAIR: Okay. I think that means that we are done with the output classes.

Dr Sherbon: There is one incomplete answer from earlier that, if you would not mind, I would like to complete. Mr Smyth asked in relation to the community health accreditation report whether there were any criteria for which community health received a low achievement rating. At the time I was clear that, of the 19 mandatory criteria, five were of moderate achievement. I said the other 14 were either at low or some achievement. I have since received advice that there were no low achievement allocations to community health. So, of the 19 mandatory criteria, five were moderate achievement and 14 some achievement. The date at which the report was received was 12 August 2004 and the result was announced to staff of that time.

THE CHAIR: Thank you, Dr Sherbon.

Dr Sherbon: I want to give another answer. A question has been raised publicly as to whether ACT Health is rorting FBT. Can I make it clear that ACT Health does not rort anything. ACT Health is a lawful organisation under my leadership and there is no rorting whatsoever of anything, and I will be referring the matter to the Auditor-General myself so it can be determined.

THE CHAIR: Thank you, Dr Sherbon. We appreciate that clarification. I thank officials from the department. We will now move on to HealthPact. I would ask Mr Refshauge to come to the table.

Mr Corbell: Madam Chair, while we are waiting, can I answer one other question? Mr Smyth asked me this morning why the 2003-04 annual report shows a relatively small increase in emergency department presentations when I stated in my ministerial statement that emergency admissions had increased by 17 per cent on the total in 2000-01. The answer to this question is that, while emergency department presentations rose by four per cent over the four years to 2003-04, the proportion of those presentations that were subsequently admitted to hospital rose by 17 per cent. While total presentations to the emergency department rose by four per cent over the four years to 2003-04, the more serious presentations—categories one, two and three, which are more likely to result in an admission—rose by 30 per cent, or 7,064 presentations, over the same time frame. The source of that is the ACT Health annual report 2003-04, page 11.

THE CHAIR: Minister, do you want to make an opening statement about HealthPact?

Mr Corbell: No.

Mr Refshauge: I offer to the committee the apologies of Ms Kerry Arabena, the chair of HealthPact, who unfortunately has a prior commitment that prevents her from being here.

DR FOSKEY: The ACT Health Promotion Board statement of intent, on pages 5 and 6, lists and highlights a number of strategic issues for 2005-06, including a number of new funding rounds, new mentoring programs and a new research centre. Yet expenditure on grants and purchased services is projected to increase by only $82,000 from 2004-05. That figure is in budget paper 4, page 494. In what areas is HealthPact planning to reduce or redirect expenditure in order to fund these new programs?

Mr Refshauge: We are not proposing to reduce expenditure but to reprioritise. Every year HealthPact identifies priority areas and directs funds towards those areas. For example, in the first dot point on page 6, the new sponsorship lifestyle and community development capacity building fund, with increased spending in mental health and physical activity and strong funding for indigenous groups, will represent a prioritising of mental health, physical activity and indigenous groups, which is the regular process of HealthPact identifying where it must place its priority.

In relation to the small projects community funding round, that has been a process of again redirecting funding. Originally, HealthPact simply had one funding round where all projects were equally competitive and it became clear over the last couple of years that projects that were seeking funding of less than $5,000 were unfairly included in applications that were for substantially larger amounts, or larger amounts, so we have split the funding rounds so that there is a better competitive base for the approach to that.

In relation to the research centre, that is not from within the funding round payments. That is part of the expenditure that we have always had set aside for research and evaluation, so that will not reduce the funding rounds. That will achieve a huge value, better than the value that we had from that expenditure in previous times. Finally, we have reviewed the sponsorship arrangements that we had previously and we are targeting sponsorship arrangements more carefully so that we can get better value for money. That will not reduce funding to programs that will deliver health protection and health promotion, but will be more strategically targeted in that area.

DR FOSKEY: With regard to the research centre on health promotion wellbeing, is that a physical place or a virtual place? Does it have designated researchers or is it pooling research that is happening in other institutions? Finally, how much funding has been allocated to it?

Mr Refshauge: In relation to the first question, it is a physical place in the sense that we have entered into an arrangement with the University of Canberra and we will be paying to them moneys to appoint staff. We are very pleased that that will involve leverage, that they will be applying funding from within their resources to enhance the centre itself. So it is a leverage process.

DR FOSKEY: Is it a matched grant or ARC arrangement?

Mr Refshauge: I do not think they have got a matched grant or an ARC grant at this stage, but from their resources they are putting money into this project as well. Although it is a project funded by us, it will be a University of Canberra entity but there will be governance and close involvement of HealthPact in the direction of the centre and in its work. In relation to the funding, if you would pardon me for a moment, I will just check my memory. It is $600,000 over three years.

DR FOSKEY: Finally, what is the total amount to be distributed through the community development and capacity building funding round?

Mr Refshauge: There will be two funding rounds. There will be the small projects funding round and the general funding round, and there are a couple of specific ones. For instance, we administer a vitality round basically directed towards the reduction of obesity in schoolchildren through a special amount and we are hoping that there will be other similar programs that we will be able to provide. So far as the total for next year is concerned, again if you pardon me, I will just confirm my memory. I am not going to guess and we do not have that detail. I will take that on notice and let you have that figure.

DR FOSKEY: Thank you very much.

MS PORTER: I am interested to know a little bit more about the two mentoring programs for the health sector. Could you please explain to me how they work?

Mr Refshauge: Could I take that on notice? That is not an area in which, so far as HealthPact is concerned, I have taken a special interest. I would rather do it accurately than give you a potted version, if that is convenient.

MS PORTER: That is perfectly okay. Thank you.

THE CHAIR: Mr Refshauge, my apologies for not having been able to make the recent health promotion awards.

Mr Refshauge: We missed you very much, Madam Chair.

THE CHAIR: I missed you too. I was on a flight to Perth. I can assure you that I would much rather have been enjoying your company. I note that in the highlights on page 493 you talk about the expansion of these awards. Can you tell us what that will involve, where it will go and how it will be done?. It is the second dot point under "Highlights".

Mr Refshauge: We believe that the HealthPact awards, coming from a small base—a breakfast, which might have been easier to get to in 1997, through to a pretty impressive occasion which Dr Foskey was able to attend this year—are a very important part of developing an awareness of and a commitment to health promotion widely so that we can develop it beyond what you might call simply the industry to a wider group. That means that we need to bring others on board. We have brought on board a number of other groups. ACT Health has come on board and they provide a number of awards and so on and we are hoping to expand that so that we can deliver to a wider section of the community the possibility of reward for excellence.

I think those who were able to make it, including Dr Foskey, will agree with me that the quality of what we saw, not only in those who received the awards but those who were nominated, was very impressive. If we can expand that and encourage a wider group—as we were doing, but there are still more out in the community that we could encourage—then that will do a significant amount to achieve our objective, which is to lift health promotion, not just as a kind of add-on to health but as part of a sustainable, vital community.

DR FOSKEY: Yes, I would say that there was a really strong sense of being part of the community at that event.

Mr Refshauge: There was.

MR MULCAHY: One of your areas of activity is school-based obesity issues. I am not sure if this is one that you would be across as the deputy chair, Mr Refshauge, but my interest in this field is that I am curious to know how those projects work. My personal view is coloured by the fact that a lot of those involved in paediatrics, particularly with knowledge of nutrition, counsel against turning the refrigerator into a medicine cabinet whereas those often within the dietetics area argue for the prohibitive approach with children. I am just wondering what the theme is and what the science base or advice is that colours your projects, or are they much broader than that?

Mr Refshauge: They are much broader than that. They are normally school-based and they include things like more effective canteen or, as I used to know them, tuckshop options so that you are not really turning your refrigerator into a medicine cabinet but you are making options available and you are helping to lead students towards healthy options.

I think I need to say that when you say one of our issues is obesity in schoolchildren, that is true, but HealthPact still fundamentally is an organisation that works through the community by responding to applications for grants. So, while we do more and more direct and flag with our policies how we would be expecting successful applications to be made, we are not as interventionist as that might imply. So we respond to what the community is doing. Having said that, our committee was comprised of experts within health, schools and general health promotion and I am not sure that we would have gone as far as to make a distinction of the kind that you are suggesting.

I think we have got to be a little bit careful about slogans. I am not decrying the refrigerator as the medicine cabinet, but the fact is that if you do not have fat-filled chocolate in the refrigerator but you have appetising fruit and other things, you do encourage people to eat well. Eating well is not really just medicine. It is part of the necessity of being a healthy member of the community.

MR MULCAHY: I am not questioning the need for a healthy profile but there is a body of evidence—and the source of my opinion is the former chair of the American Academy of Pediatrics, so this is not someone who is not familiar with it—

Mr Refshauge: Sure.

MR MULCAHY: They set US dietary guidelines. But if you embark on programs that are prohibition based, in fact whilst it is great to support small businesses you tend to deliver that business to the corner store. You have to really encourage people to make choices rather than ban products and say, "Well you will have to eat this" because there is a lot of evidence that that does not work, but it is often a view that is propelled by those who are less qualified in these fields. That is my concern.

Mr Refshauge: We certainly don't have a Stalinist or a Nazi approach to food in the sense that we are not prohibitionist. But what is important is to give healthy options and to make them attractive. And you are absolutely right: we all know that the more you say not to eat chocolate the more you want to eat it. But if you have healthy options and you make those healthy options attractive, you will help to change lifestyle, and lifestyle and behaviour are extraordinarily difficult to change in any event.

MR MULCAHY: Video games are probably the biggest contributor p to obesity.

Mr Refshauge: Absolutely.

MR MULCAHY: But that is another issue.

THE CHAIR: I think that it is going to be an ongoing issue not just for this country. I think most Western countries are facing this problem. I think all of the articles in newspapers are pointing to that as an issue and how Western counties actually deal with this issue is the subject of much discussion. I appreciate the comment that Mr Mulcahy has made about not taking a prohibitionist-type stance. Minister, you might care to make a comment because you were involved with the two plus five a day launch. You might care to comment on how that contributes to the whole debate and discussion about the prevention of obesity and dealing with the issues in a positive manner.

Mr Corbell: Given the time, Madam Chair, I won't get into a lengthy dissertation on the value or otherwise of healthy eating because I think we are all very aware of that. Yes, ACT Health recently launched the two plus five campaign as part of a national campaign. Unfortunately, I was unable to attend the launch. However, I think Mr Gentleman did that on my behalf and it was well received. I have seen the ads down near my local supermarket in Cooleman Court so it is definitely getting out there, which is a positive thing. I think, as Mr Refshauge says, this is primarily an issue about promoting healthy choices—not trying to dictate but promoting healthy choices.

MR SMYTH: I am not sure if you can answer this and whether the results have been released. I understand some of the funding to Basketball ACT and in fact to the Capitals for their promotion of a smoke-free environment may have been cut. Are you in a position to comment on that?

Mr Refshauge: I don't have knowledge about that. I can take that on notice.

MR SMYTH: All right. Thank you.

Mr Corbell: Madam Chair, earlier today Mr Seselja, I think, asked me a question about the number of non-medical staff who have access to the boom gate parking area under the diagnostic and treatment building at the Canberra Hospital.

MR MULCAHY: No, that was from me.

Mr Corbell: Sorry, Mr Mulcahy. On the TCH campus overall there are 130 car spaces reserved for medical practitioners. Forty-eight of these spaces are behind the boom gate under the diagnostic and treatment building, which is accessed via a swipe card. Non-medical staff also have access to this area. There are eight non-medical staff who have access to this area. Access is also provided after hours to nursing shift coordinators and CHUBB security guards.

THE CHAIR: Thank you very much, minister. Mr Refshauge, I express the thanks and gratitude of the committee to you for making yourself available today in place of Ms Arabena. We appreciate that.

Mr Refshauge: Thank you very much. I am glad to be of help to the committee.

THE CHAIR: Thank you, minister and officials.

Mr Corbell: Thank you.

The committee adjourned at 5.50 pm.