LEGISLATIVE ASSEMBLY FOR THE AUSTRALIAN CAPITAL TERRITORY

SELECT COMMITTEE ON ESTIMATES 2006-2007

(Reference: Appropriation Bill 2006-2007)

Members:

MS M PORTER (The Chair)
DR D FOSKEY (The Deputy Chair)
MR M GENTLEMAN
MS K MacDONALD
MR S PRATT
MR B SMYTH

TRANSCRIPT OF EVIDENCE

CANBERRA

FRIDAY, 30 JUNE 2006

Secretary to the committee:
Ms S Lilburn (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 that have been authorised for publication by the committee may be obtained from the committee office of the Legislative Assembly (Ph: 6205 0127).

APPEARANCES

The hearing commenced at 9.36 am.

Gallagher, Ms Katy, Minister for Health, Minister for Disability and Community Services and Minister for Women

ACT Health
Sherbon, Dr Tony, Chief Executive
Cormack, Mr Mark, Deputy Chief Executive, Clinical Operations
Foster, Mr Ron, Chief Finance Officer, Financial and Risk Management Branch
Thompson, Mr Ian, Executive Director, Policy Division
Cahill, Ms Megan, Executive Director, Government Relations and Planning
Reading, Ms Jenelle, General Manager, Community Health
Brown, Dr Peggy, Director mental health, mental health ACT
Cole, Ms Deborah, Chief Executive, Calvary Public Hospital
Mollett, Mr John, General Manager, The Canberra Hospital
Beutel, Prof Jennifer, ACT Chief Nurse, Nursing & Midwifery Office
Dugdale, Dr Paul, Chief Health Officer, Population Health Division
Murphy, Ms Karen, Allied Health Advisor, ACT Government Agencies
Stuart-Harris, Prof Robin, Director, Capital Region Cancer
Jones, Ms Catherine, Operations Manager/Director of Nursing, Capital Region Cancer
Stone, Mr Bill, Director, Aged Care and Rehabilitation

THE CHAIR (Ms Porter): Before we start, for anyone who has not been here during the week, Hansard has been having trouble hearing people, so you must lean forward into the microphone. Do not lean back and become relaxed at any stage of the game.

MS MacDONALD: No being relaxed and comfortable in this place.

THE CHAIR: No-one is allowed to be relaxed and comfortable. I am just going to read the card. You should understand that these hearings are legal proceedings of the Legislative Assembly, protected by parliamentary privilege. That gives you certain protections but also certain responsibilities.

It means that you are protected from certain legal action, such as being sued for defamation, for what you say at this public hearing. It also means that you have a responsibility to tell the committee the truth. Giving false or misleading evidence will be treated by the Assembly as a serious matter. I am sure you all understand that. Minister, would you like to make some opening remarks?

Ms Gallagher: Yes, I will, madam chair. I apologise for being late this morning. We welcome the opportunity to appear before the committee and answer your questions around any matter relating to the health portfolio for this year's budget.

I will briefly talk through some of the highlights across the department of health for the 2006-07 budget. This year's budget provides record expenditure across the portfolio of $751 million. This is an increase of $61.2 million, or 8.9 per cent over the 2005-06 year. In addition to this funding, over $20 million has been allocated for major capital works, and over the forward estimates we are estimating that growth will continue on an average of 6.4 per cent.

To meet growing demand, the budget has injected $8.6 million, and $57.5 million over four years, into initiatives that will go towards increasing the capacity of our public hospitals to treat the ill and address the growing need for cancer and aged care services.

Within this funding there is $12 million to enhance acute bed capacity, which will build on the additional beds provided for in previous budgets. The new capacity within that $12 million will enable up to an additional 20 beds to be commissioned at peak times throughout the year. These beds are in addition to the 60-bed subacute service that will be fully operational I think in December or January—early 2007.

Almost $5 million has been allocated to provide additional critical care bed capacity across the hospital system. This will be a combination of emergency department, intensive care unit and high dependency unit staff and beds. This additional resourcing in both the acute beds and the high dependency or critical care beds will work together at targeting reductions in ED access block, improving emergency department waiting times and reducing the cancellation rate of elective surgery.

The budget has also provided a $1.8 million increase in HACC funding. This will be used to provide additional support for the frail aged and younger people with a disability to assist them to remain at home, and to prevent their admission to nursing homes.

There is also money in the budget for additional cancer services. That is across $2.4 million for additional specialist staff, including an oncologist and nursing staff, to meet some of the demands we are seeing in that area. Of course in the major capital works initiative there is the commissioning of a third linear accelerator to meet the growing need for radiation therapy now and into the future.

In mental health the budget provides an additional $8 million, basically across two streams. Almost $5 million will be used to address capacity—to increase specialist mental health providers, increase numbers of consumer consultants and provide supported accommodation for young people.

The young people's accommodation will be targeted to young people early on in their diagnosis or episode of mental illness, and it will look at mixed short and long-term 24 hour support. That initiative, the detail of which we can go through later, is obviously a very important initiative in the budget.

There is also around $3.1 million to promote prevention and early intervention strategies around mental health. This is in line with national frameworks, national policy and, of course, the ACT government's mental health strategy.

There is a range of smaller allocations of funding around prevention of illness and injury. There is money in the budget to strengthen our response for avian influenza preparedness. There is money for supporting the introduction of food safety programs for high-risk food businesses, again I believe in line with national agreements.

Some $780,000 has been allocated over four years towards the introduction of a national bowel cancer screening program in the ACT. We expect to see some increases in follow-up testing once the Australian government begins their testing, which is sending

out the faecal occult blood tests to people between the ages of 55 and 65, to ensure that we are prepared for any increase in workload we will see there.

Importantly, there is a further injection of an additional $10 million into elective surgery to increase the number of elective procedures performed each year. We are expecting that that will provide an additional 350 procedures. That will be targeted to areas of greatest need on the waiting list. This of course is in addition to the investments made in previous budgets.

There is some money there to continue the access improvement program, which is to improve a patient's journey through the hospital system and make sure it is as efficient and effective as possible. Already we are seeing some benefits from that program, which was funded in the previous budget.

We have also put aside some money for work force recruitment and retention. There is a range of strategies there, in terms of positioning ourselves to make sure we are providing work force planning for the future. There is money there to support our participation in the National E-Health Transition Authority program. That is essentially to make sure we are moving along in line with the national e-health system. We can talk more about that later.

We will also be purchasing a second MRI machine for the hospital. This will allow increased services of up to 10 to 15 scans a day, or 3,000 scans a year. It will also be available at times for research for students at the hospital, or for that research work which is not able to be done at the moment.

The manual handling program at the Canberra Hospital will be expanded by just over $1 million over four years. That program was funded I think in 2004-05, with the aim of reducing injuries amongst staff and increasing patient safety. Again, we are having some pleasing results there, so we are building on that program.

There is also $1.2 million to improve the security of patients and visitors to the hospital. I think people will be aware that some of the security issues seem to be on the increase. We need to be making sure that our staff and people visiting the hospital are doing so in a safe environment. There will again be a range of strategies, including wards people, and some improvements on the ward in terms of safety for patients and staff.

There is a bit more, but that is it in a nutshell. The challenge that has been given to myself and ACT Health over the next few years is to ensure that growth remains within what is being provided in the forward estimates. This is the first time any government has recognised the level of growth in health to the degree that we have. We have been growing at around 10 per cent. This will need restraint in the future.

Whilst there is additional money every year—over $200 million additional money; I think the budget in the end rises to $898 million or is heading towards there—we need to be growing within that. We cannot continue to go back to government seeking further funds in addition to that. That is the challenge that has been set.

It is going to be difficult, I think, and we are going to have to be smart about the way we go about this, but that work is underway already. We will be moving through those

discussions with appropriate consultation methods over the next year. This year has provided growth of about 8.9 per cent but, as I said, over the next three years we are going to be working within 6.4 per cent on average growth allocation. I look forward to answering your questions. We are all here for the day to assist the committee with their deliberations.

THE CHAIR: Thank you very much, minister. I might just kick off. There are obviously quite a number of initiatives this year. There are a lot of different areas I could probably focus on, but I would just like to ask a little bit more about the aged care area. We have, as you know, a rapidly ageing population. That must be of concern to you as minister in facing the challenge you were just talking about of keeping the health budget to a certain limit. I was wondering if you could talk a little bit more about those aged care initiatives you mentioned before.

Ms Gallagher: I will begin where I can. I am sure there are things Tony will be able to add. Of course we have the subacute facility coming on line in December this year, or we expect that it will be finished in December this year. Already there are beds in operation at Calvary Hospital, but this will provide 60 beds to ensure that, for people who are elderly and requiring some extra support, but maybe not hospitalisation, we have the capacity within the system to meet some of those needs.

The home and community care initiative is targeted at ensuring that people are getting support in their homes and therefore not needing to come to hospital in the first place. I think the range of additional beds that will be provided is one way of making sure we can stream people, particularly elderly and more complex patients, through the emergency department more quickly and into more appropriate responses from the hospital.

Dr Sherbon: As the minister outlined, there are three components in this budget for improved services to the elderly. There is continued construction of the sub and non-acute service at Calvary Hospital. As the minister said, it is on target for completion in December, with occupation in early 2007.

There is the expansion of the home and community care program that the minister detailed, but also expansion, which is detailed in page 76 of BP3, of $1.35 million for the aged care and rehabilitation stream, or ACRS. That money will be used for the establishment of an expanded acute care support service within the Canberra Hospital.

For acute admissions of elderly people who have multiple complex problems, they will have a specifically designated pathway. There will be an acute care support program for them within the Canberra Hospital, so they will not have to rely upon the usual mechanisms that have been employed in the past.

There is also a more comprehensive community outreach and assessment program for falls. Our falls prevention program has been well constructed over recent budgets with the establishment of falls clinics.

There is now an expanded outreach program. That will reduce the numbers of fractures in elderly people, particularly those in residential aged care, and thus reduce the trauma associated with fractured neck of femur which, as you know, is a common injury for elderly folk caused by falls. There is also an expansion of ambulatory and outreach aged

care services. We are establishing a new multidisciplinary program to provide more outreach to clients in their homes.

Those are the ACT initiatives. We are also working with the commonwealth and contributing funding for the transition care program. I am happy to report that the Baptist aged care organisation is about to commission 15 transitional care beds for people who are awaiting nursing home-type placements.

That will reduce the number of nursing home-type patients in our hospitals. We are looking forward to those commencing in the near future. That will probably be next month, without wishing to pre-empt the host organisation who are busily completing those works. So there is a range of service enhancements for the elderly in this budget.

THE CHAIR: Thank you, Dr Sherbon. I do not want you to comment about this, but I think the additional capacity in the area of oncology and the bowel screening program will be useful in this area as well.

DR FOSKEY: One of your priorities, and the first dot point, is achieving efficiencies and reforms to bring ACT hospital costs closer to the national average. How realistic is this really, given that we are a small jurisdiction and it will cost more? I know these costs are often called inefficiencies.

Given that we are servicing the most complex and difficult cases from New South Wales and Victoria and the fact that this community also has very high expectations of its health service, just how realistic is it? Do we need to keep making this a sort of major aim? Bringing costs down is one thing and reaching the national average is another.

Ms Gallagher: To begin with, it is acknowledged that our costs here across health are 22 per cent higher than the national average. The job I have been asked to do is not to bring that back to national benchmarks.

The cabinet has accepted that—as you say, the expectations of the community are high—we should not be having to force it back to the national average; that would be too hard a job to do. But over the next five years we are bringing it down to within 10 per cent of the national average—still quite considerably higher than the national average.

We are not saying that that has to be achieved in a year, but that we need to look at ways in which to reduce those costs. I think to not be doing this would be to say that health would be continuing to grow at the speed at which it is growing. The government has decided that that is unaffordable. Our budget would exceed $1 billion very quickly, and the ACT government cannot afford those sorts of increases.

I have to say that, for the first time, in this year's budget we have acknowledged that growth is more than has been acknowledged in previous budgets. In every single year there is considerably more money for health over the forward estimates.

This budget has projected an additional $200 million, acknowledging that growth will continue to occur. At the same time as we have injected that money, we are saying we have to look at ways to bring our costs down, that it is not sustainable into the future to keep our costs that much higher than everywhere else.

MR SMYTH: On that point, you say that you have determined that our health costs are 22 per cent higher than the national average. What contributes to that 22 per cent?

Dr Sherbon: There are a number of components in which we are higher than our national average colleagues. The first is a contextual issue, as Dr Foskey pointed out. We are a small jurisdiction and there are administrative costs associated in running a department of health—a bureaucracy on top of a health service. There are also issues arising from infrastructure required to simply administer a separate jurisdiction.

MR SMYTH: What percentage of the 22 per cent does that contribute by?

Dr Sherbon: Only a small percentage. I will get to the rest. Probably the most significant contribution is superannuation, and hence the 10 per cent margin we are required to achieve. We are, as the minister outlined, required to achieve costs within 10 per cent of the national average. We expect that a good 10 per cent of the 22 per cent is due to superannuation alone. I cannot give you an exact figure, but I could probably give it to you on notice.

MR SMYTH: If you would, that would be nice.

Dr Sherbon: We know that some of our costs are higher than they should be. Administrative costs are a problem for us. We undertake to reduce administrative costs and have commenced a benchmarking review that will, in association with unions, work towards reducing administrative costs. We expect that there will be some reduction in positions as a result.

We know that we have a higher RN to EN ratio—registered nurse to enrolled nurse—than peer hospitals throughout the country, so we will be examining more effective use of enrolled nurses when appropriate.

We know that we could do better with the purchasing of consumables and medical supplies. We tend to use national or New South Wales contracts where we can because New South Wales has a greater purchasing power than we do, but we think we can do better. We will continue to snip at the edges.

One very significant cost that often is not included in other jurisdictions' calculations of cost per weighted separation is insurance. As you know, the ACT is required to purchase reinsurance on the market. Most other jurisdictions self-insure, particularly the larger ones. Often that does not appear in the health costs; it is often a central cost of government. So there is often a bit of apples and apples work to be done.

Having said all that, it would be foolish of the health system within the ACT not to deny that our costs are higher. We have an obligation to the community to ensure that costs are at least within a reasonable range of the national average. And, as the minister outlined, we have a strategy to do that.

MR SMYTH: You mentioned that one of the things that contributes to the higher costs is the fact that we are a small jurisdiction. Is that not also a saving, though? We do not have the vast area of the Northern Territory, so we do not have to run a rural service; and

we do not have the diversity of South Australia, for instance, where you have a range of population scattered over a big area. Is it not true that there are offsets from being small?

Dr Sherbon: Yes is the answer, but do they outweigh the cost of running a small jurisdiction? The answer is no. Small country hospitals are actually quite cheap to run. Their cost per weighted separation can actually be right down as low as $2,200.

I am dealing with some figures from my previous role in Illawarra, where some of the small country hospitals I used to run—or even before that in northern New South Wales—were very low case-mix hospitals. The patients were largely long-stay patients who required minimal nursing intervention. They can be very cheap to run, so they reduce your average cost per weighted separation quite markedly.

We are actually comparing ourselves to metropolitan peers; we are not comparing ourselves to national average. We recognise that, even compared to metropolitan peers, there are issues we need to address. As the minister said, health has been taking an honest approach to these issues and recognises them as a challenge before our system, to ensure that costs are appropriate to the community's needs.

As the minister outlined, we are not in a fierce cost reduction campaign for the sake of it. I think we recognise that, in some jurisdictions—I might even hazard to stick my neck out and say Queensland perhaps—the cost is too low. The Queensland community have said to their government, "We want more investment in health." Queensland is a very low cost. It is not a mindless pursuit for its own sake; it is an appropriate adjustment to bring us into line with appropriate community expectations.

MR SMYTH: Could you take all of those things on notice and give us a breakdown as to what percentage they are of the 22 per cent and what the dollar value is?

Dr Sherbon: Yes, I think I can do that. What I can certainly provide, with the minister's permission, is a line by line explanation of where the difference is between us and the national average.

MR SMYTH: Thank you.

DR FOSKEY: You said 10 per cent of that 22 per cent is superannuation. Do you see that as an intractable cost; and, therefore, when you talk about getting our costs down to 110 per cent of the national average, that 10 per cent will remain as superannuation cost? I would like a bit more explanation there.

Dr Sherbon: Yes. For the coming years, at least for the next decade, it will be a significant contribution, as the superannuation scheme that closes today continues for current employees. As you know, people who start tomorrow will start on a new scheme.

MR PRATT: Minister, on 7 June you told me, in answer to a question without notice in the Assembly, that there will not be a reduction of staff in health because of other initiatives which will require employment in health. I am talking about the reduction of staff in health of 82 in 2006 from 4,849 to 4,767. What is the actual position? What is the correct position?

Ms Gallagher: There will be a reduction in staff. I think the number you talk of is in the budget papers, if you are using the staffing head count. I guess in my answer to you in the Assembly I was not acknowledging the transfer to the Shared Services Centre. With that component of 82, there are 136 staff transferring to the Shared Services Centre; a number of staff with health complaints are going to justice; there is the transfer in of Healthpact; in new initiatives we are expecting an additional 91 staff. That is therefore a savings or staff reduction of around 30 staff. Those are the ins and outs.

MR SMYTH: Why does the budget paper say 82?

Ms Gallagher: That includes the transfer out to shared services. It is not a staff reduction; they are just moving elsewhere. But they are out of ACT Health. There are 82 if you count in the transfer out.

MR PRATT: That is a net movement.

Ms Gallagher: But it is not a reduction of 82.

MR PRATT: What is the impact on functionality of that net loss?

Ms Gallagher: Are we talking about the staff reductions we will see?

MR PRATT: I am talking about the operational functions of health services—the hospital services.

Ms Gallagher: I am never really sure what you mean by operational staff. Do you mean front line staff?

MR PRATT: Yes.

Ms Gallagher: Therefore in the hospitals. Are we talking about that sort of staff?

MR PRATT: Yes.

Ms Gallagher: There will not be a reduction in staff at that point. We are looking at staff from within areas such as community sector purchasing, the grants area—some of those functions are transferring to DHCS—and some savings from Healthpact being incorporated into the department.

MR PRATT: Do you anticipate a reduction in the delivery of services in the hospital as a consequence of those staff reductions?

Ms Gallagher: No. In fact, there is a range of new initiatives which will increase the capacity in the hospital, in terms of operational staff—to use your phrase.

MR MULCAHY: I have a supplementary. I am confused. Minister, you said there would not be any reductions or changes in the front line staff. Are you saying now that there will be increases?

There is clearly a community sentiment that there is a need for greater resources in the

front line of health care. What is the position? Are you increasing the number of people you are going to have available to deliver health care, to address issues such as waiting lists and those waiting in the emergency room? What is the position on that?

Ms Gallagher: There is. You missed my opening statement.

MR MULCAHY: I was listening upstairs.

Ms Gallagher: Were you? Good. It is nice to know that. There is a range of new initiatives in this budget for which we expect a staffing component of around 91. Some of that is in cancer services—for example, the employment of an extra oncologist and some nurse coordinators—and there is an additional registered nurse in that initiative. In the mental health initiative there is the employment of an additional mental health specialist. So yes, we are increasing the number of front line services.

MR MULCAHY: An overall head count increase then, you are saying, in the front line area of ACT Health.

Ms Gallagher: Yes, I expect there will be.

MR PRATT: Can you put a number on that?

Ms Gallagher: I have told you. It is 91.

MR GENTLEMAN: Mr Mulcahy just raised waiting lists. On page 145, the last dot point refers to "additional elective surgery episodes for the long-wait category two and three patients on the elective surgery waiting list". Can you tell me, first of all, how you define category two and three and then expand on how you will achieve this additional elective surgery?

Ms Gallagher: The additional elective surgery initiative is to deliver an additional 350 procedures over the next four years at a cost of $10.3 million. In recent days I have announced that those procedures will target particular areas, such as orthopaedics, hips and knees; ear, nose and throat; some gynaecology services and some neurosurgery services.

MR MULCAHY: Does that include changes to work practices, minister, that might make better use of your theatres?

Ms Gallagher: Yes.

MR MULCAHY: It does?

Ms Gallagher: Yes.

MR MULCAHY: So not all are being achieved through more staff; it is actually being achieved through improved work practices?

Ms Gallagher: Yes.

Dr Sherbon: I can assist there. The work practices in the theatre are subject to the access improvement program. We are currently redesigning a whole range of procedures with respect to patient flow through the theatre suite. Concerns from surgeons have been evident for some time. They were concerned that, although there has been some recent improvement, they still think we could do better in terms of efficiency of theatres. We are currently working through that with the access improvement program, with some improvements already noted in turnaround issues with patients.

To return to Mr Gentleman's original question, category two and three, and category one, for that matter, are decided by the caring clinician, usually a surgeon, who will ascribe a category based on their evaluation of whether the patient requires surgery within 30 days, which is category one; 90 days, category two; or six months, category three.

It is fair to say that we do not meet category two and three wait times—we have been open about that—although they are improving in recent months. Over the last nine months we have been steadily coming down. We do expect that we will begin to achieve them at some point in 2007. The maths are showing that the graph is heading that way.

As the minister said, category two is largely a problem with neurosurgical patients. We have a large number of neurosurgical patients who require surgery, in the surgeon's estimation, within 90 days who are waiting too long, so we will be focusing there. In category three we will be looking at ENT, ophthalmology, orthopaedics and, to a lesser extent, gynaecology.

The other important point to note about our waiting lists—and we have said this until we are blue in the face but no one seems to note it—is that the growth in our waiting lists are not ACT residents. Our waiting lists for ACT residents are stable. The growth consists almost entirely of New South Wales residents. That is where the growth is and it is due to the fact that the ACT hospital system's expansion within New South Wales continues. New South Wales people are using this hospital system because it is better than the surrounding hospital system.

MR MULCAHY: On that point, do you expect to have a comparable utilisation rate of theatre with the private hospitals in Canberra? Are you close to that? If not, could you give me a reason why you are not?

Dr Sherbon: I just have a small correction to add. I said category three within six months. It is actually 12 months. Do you mind if I answer that question?

Ms Gallagher: No.

Dr Sherbon: We will never achieve the same utilisation rates as private hospitals in Canberra because we have emergency patients who come and butt in between our other patients. If the private hospital system were to set up an emergency system, they would have lower utilisation figures than we do because we are good at it. We get people into theatre quickly. We save their lives. We put them together and they go off to ICU and we spend six weeks repairing their catastrophic illness. The private system is there chugging away on pretty low-level stuff, Mr Mulcahy.

MR MULCAHY: But you have just told us that work practice is a factor of utilisation.

Dr Sherbon: We recognise that work practices should improve and we expect utilisation will improve. But your question was: will we conduct the same number of orthopaedic operations as John James Hospital per day? Probably not, because we have to do the fractures and they have very few fractures to deal with.

MR SMYTH: As part of this reform, will the theatres open longer? If so, can you detail how that will occur?

Dr Sherbon: Yes. The hours of opening are archaic and this minister took into the budget process a proposal to extend our hours of opening at theatre lists at Canberra Hospital from 8 till 4 to 8 till 5, and that is now in effect from 1 July.

MR SMYTH: What does 8 till 5 mean, though, in terms of extra cost? What does it mean in terms of extra throughput?

Dr Sherbon: It is $980,000 recurrent cost per annum to fund that additional hour. The cases I should be able to find for you while you think of your next question.

MR SMYTH: How does this compare with theatre usage, say, in New South Wales?

Dr Sherbon: We would be up to more comparable opening hours with our jurisdictional partners right around the country. We recognise the 4 pm finish was inappropriate.

MR SMYTH: When you say more comparable, what is a comparable hospital in New South Wales open till?

Dr Sherbon: For routine elective surgery, 8 till 5 would be the equivalent elsewhere in the country. I could be corrected in the coming weeks, but I am not aware in my own mind of anywhere staying open beyond 5, perhaps 5.30 in some places. But you have to remember that we have emergency services working 24 hours a day, and if our theatres need to stay open to finish an emergency case, they stay open and we call in staff.

MR SMYTH: How many theatres have you got at Canberra?

Dr Sherbon: Nine operating at the moment. There are 10 physical theatres. You need some redundancy to deal with catastrophic events, of course.

MR SMYTH: What is the operational usage of each of those theatres?

Dr Sherbon: I cannot give you a figure. We will take that on notice. In answer to the question that was asked earlier, it is 350 cases.

MS MacDONALD: Minister and Dr Sherbon, on page 110 of budget paper No 3 there is a reference to the additional car parking at the Canberra Hospital at $1.950 million. Where is the car parking going to be placed? What form will it take?

Mr Cormack: We have secured the lease on a piece of land across the road from TCH in Yamba Drive. We envisage a level car parking arrangement there. At this stage it will be

up to 500 additional car spaces we would be fitting into that piece of land.

MS MacDONALD: So you will not be doing multistorey car park there?

Mr Cormack: We are not pursuing a multistorey car park with that arrangement.

MS MacDONALD: How will the pay parking be done? Is it going to be done on a voucher system?

Ms Gallagher: That is right. It will be the same as on the other hospital site on the other side of the road. The provision of additional car parking is very important. As people know, it is pretty tight at the hospital at the moment. But the third linear accelerator brings with it, I understand, the need to construct bunkers, and we will be constructing two of them, one for this linear accelerator and one to create capacity for a fourth in the future. That will take some car parks out as well. We needed to make sure that we were providing some extra capacity for that work to be done.

MS MacDONALD: Where are the bunkers being built?

Dr Sherbon: Adjacent to the existing radiation oncology complex. It will be an extension and remodification of the existing complex. There will be a loss of some car parks as a result.

MS MacDONALD: While we are on the issue of car parking, can I ask: was it urban services, as it was, that did the work on the meters or the voucher system?

Dr Sherbon: Yes, Mr Cormack can detail the process of administration.

Mr Cormack: The Department of Urban Services will provide the parking infringement arrangements. They will look after the regulation and monitor those people who overstay their allotted time. The pay and display arrangement that we are introducing at both TCH and Calvary will be administered via TCH and Calvary. That is our own arrangement. We have taken advice on that in the lead-up to implementation. DUS have been involved with this throughout that process, but their role will be limited to enforcement.

MS MacDONALD: I have been writing to the minister for what was formerly urban services and is now territory and municipal services about pay parking around the city generally because it is an issue. People are concerned about having to pay in advance and not knowing how long they will be there, and that is not just for the hospital. I understand they are looking into a scheme that is used in Auckland, which is some sort of electronic tag scheme where you can purchase a voucher and then you pay for that as you go so you do not actually get fined. I suppose my question is: is there the possibility of transferring that across to the hospital?

Ms Gallagher: I imagine that is something that we will have to look at as we monitor the implementation of pay parking. I have been getting a few letters myself around the pay and display, as opposed to the pay on departure. The way that both hospital sites are configured at the moment would make it very difficult to have that sort of arrangement in place. We have a number of exits and entries to a number of different car parks around the campus and we would have to shut off all those entries and exits and stream people in

one way and out one way. The pay-as-you-go system works very well in multistorey car parks, which we do not have yet at the Canberra Hospital or at Calvary, although I expect in the future—

MR SMYTH: Canberra Airport does not have multilevel—

MR MULCAHY: They have multiple exits out there, too.

Ms Gallagher: They are not dealing with the same type of campus. As you know, all the car parking at the airport is in one area. We are not dealing with that at the Canberra Hospital. We are dealing with small areas with multiple entries and exits, much more than the airport. I do not think it is comparable to the airport at all. If you have been there recently, you will know that.

I think for the longer term it is something we will most definitely look at, particularly as I imagine in the future there will need to be multistorey car parks at both of the hospitals to deal with the parking pressure. The department took advice on this, and this is the more efficient way to implement pay parking due to the layout of the current parking arrangements and the need, should I say, to have parks available for those who are exempt and then arrangements for those who have to pay. As I have said, previously, 75 per cent of the users of the car park at the hospital are exempt from pay parking.

MR SMYTH: Given that the whole premise of this was that people were parking there and going to Woden and Civic—and it was anecdotal evidence; no report has ever been produced—have you now got firm evidence that that was the case?

Ms Gallagher: My understanding is that there is evidence that people are parking there. We have not brought it in yet, so it is difficult to see. We will only get that level of understanding once people are not parking there from Woden.

MR SMYTH: So there was no monitoring to establish—

Ms Gallagher: Did you want someone standing there with a questionnaire asking them, "Are you parking here and then getting the bus to Woden?"

MR SMYTH: It is not very hard to stand there and watch people cross the road and get the bus, having parked in the car park. The whole premise of this was you were going to free up parking for people using the hospital because that parking was being used by miscreants who parked there and then walked to Woden or caught a bus to Civic. Have you actual evidence to prove that that is the case and what level of parking they were absorbing?

Ms Gallagher: I do not think that was the only driver of this. I was not the minister at the time, but I understand—

MR MULCAHY: That is what they have told us.

MR SMYTH: That is all we have ever been told.

Ms Gallagher: I understand the other side, which we have been quite open about, is that

it is raising money for the hospital.

MR SMYTH: No. Raising money for the hospital came as an excuse much, much later.

Ms Gallagher: I do not know that that is the case because I was in those discussions early on. I was in those discussions in cabinet, Mr Smyth, so I do not think you are correct. I think it is twofold. There is parking pressure at the hospital. As someone who has attended that hospital quite frequently in recent years, it is quite difficult at the moment as a visitor to get a car park. It is very difficult and if you are lucky, you will get one for two hours. Then you have to rush out and work out how to move your car.

We need to address this. We are confident that the implementation of pay parking will ensure that patients and those visiting patients at the hospital will have access to more car parks and closer car parks and they can have them all day if they want them.

MR SMYTH: What arrangements are in place for safety for the car park across Yamba Drive? That is a fair distance from the hospital. It is a fair hike. Will across the road have a differential in its rate of parking?

Mr Cormack: We are still working up the configuration and the arrangements for the extended car park across the road. We envisage that that car parking will be predominantly staff car parking, so it will not have the sorts of turnover that you would expect of visitor car parking where you have people staying for relatively short periods of time. We will be working up the safe access across Yamba Drive as part of the engineering development work that is required for that proposal and we will ensure that the staff that use that car park are able to cross Yamba Drive safety.

MR SMYTH: Will it be lit?

Mr Cormack: Yes, it will be lit.

MR SMYTH: Will it be monitored? Will there be security patrols in the area?

Mr Cormack: There are two aspects to that. The minister may care to deal with another issue in relation to increased security and safety on the campus at TCH. We are acquiring a team to manage car parking, so there will be a small team that will manage that. Part of their responsibilities will be to assist users of the car park and that, in itself, will bolster the security arrangements associated with car parking on both sites.

MR SMYTH: How will you make it predominantly for staff?

Mr Cormack: We use a prox card system. We will have a boom gate entrance. Most of the existing staff car parks at TCH are behind boom gates. Visitors will simply not be able to access it.

MR SMYTH: And discussions have been had with the ANF and other unions?

Mr Cormack: Yes. We regularly raise the issue of car parking at our joint union management consultative forums and the chief executive forums. We have committed to a process of monitoring the implementation of paid car parking with the relevant unions

that have coverage of staff on both sides.

MR PRATT: Hospital users and residents have reported to me that signage in streets in close proximity to the hospital parking arrangements has been changed. Are you aware of the net loss of parking spaces in those streets in close proximity to the hospital?

Ms Gallagher: I think that is probably a question you can direct to territory and municipal services. It is not something that I have had carriage of. I understand there has been some work done around the impact of implementing pay parking on the residential areas of Garran, in consultation with that community. I do not know the answer to that, Mr Pratt. It is John Hargreaves's area.

MR PRATT: In terms of the undertaking you are pursuing on parking, wouldn't you have some idea of the impact on street areas that hospital staff and visitors use? Why wouldn't you have some idea about that?

Ms Gallagher: Staff will not be required to pay for parking. They will be allocated car parks.

MR PRATT: But it does impact on the number of spaces available.

Ms Gallagher: Yes. We are hoping that this will actually improve visitor car parking at the hospital. We are mindful of the impact on residential areas of Garran. We do not want everyone parking up and down the streets of Garran to avoid paying for parking. That would cause safety concerns and some concerns, I imagine, for Garran residents. So that work has been done in consultation with territory and municipal services.

MR GENTLEMAN: Minister, while you are still on parking is there a difference between visitor availability after hours and weekends, as opposed to during normal business hours?

Ms Gallagher: The hospital is a pretty busy place all the time. I think you will find it pretty hard to get a car park there any day of the week.

MR PRATT: Minister, why have you not reviewed the plan that you have undertaken to penalise medical students?

Ms Gallagher: I am reviewing it.

MR PRATT: What is your plan, then? What are you thinking about this?

Ms Gallagher: I am in the final stages of some of that work now. I am having a look at what happens around the country and the number of students using the hospital sites, looking at their placements, depending on what year they are in, looking at the allied health students and the nursing students and the impact that will have on any allocations we have already made for staff car parking and visitor car parking. I will be discussing this not only with medical students but nursing students—I think we could call them hospital students really—that work at the hospital before I make my final decision.

I have come into this pretty late. Decisions have been taken, particularly around the

allocation of free car parks to those who need to pay, and I have to be mindful of that. But I am looking at it. I have some sympathy for the students.

MR PRATT: Are you sympathetic to the fact that, on average, students have to pay up to about 10 per cent of their annual income on parking?

Ms Gallagher: That is an argument that is being put, that they would be paying $800 a year and they would be earning $8,000 a year. That might be correct for a particular type of student. It depends on what year they are into their training as to how long they are spending at the hospital. There is a whole range of differences between medical students and nursing students, and then we have a whole range of other students.

I have to be looking at this from another point of view. We already have students working within the health system that pay for parking, such as students who might be doing a placement at a community health centre or somewhere like that. I have to look at this across the board and see any flow-on impacts that there may be before I make a final decision. As I said, I am in consultation with the department at the moment and I will be finalising that very shortly, certainly prior to the commencement of pay parking.

MR MULCAHY: When will you make that decision to settle the issue of medical students who, at the end of the day, are providing substantial unpaid patient care, albeit supervised? Secondly, in relation to this car parking facility across Yamba Drive, what is the possible impact on your options in relation to moving the helicopter service and the plans to move the landing location for the helicopter service? Will it have any bearing on that at all?

Ms Gallagher: In relation to your first question, I am not ready to make any announcement today about pay parking for students.

MR MULCAHY: It is imminent, is it?

Ms Gallagher: Yes, it is. I am hoping to have this all finalised soon. I have got a couple of other questions to ask about it first. Pay parking is due to commence on 28 July. It will be well before then. I might hand over to Mark about the helicopter.

Mr Cormack: We have yet to finalise options for the relocation of the helipad, and that is a piece of work that we are completing now. The location of the additional 500-space car park in Yamba Drive will have no bearing on that, based on the options that are being considered and assessed at this point in time.

MR MULCAHY: You are looking at the helicopter being on the other side of the hospital, are you not?

Mr Cormack: No. I have not seen the final advice that we have, but in the consideration of acquiring the additional land across the road, it was on the basis that it did not prevent any of the options for the relocation of the helipad.

THE CHAIR: Dr Foskey, one last question and then we are going to morning tea.

DR FOSKEY: This is an overview question and no doubt we will return to parking later

on. In the overview and in the budget itself, I cannot see any big picture plans that explore approaches that can deliver better outcomes and lower costs. Two that spring to mind are maternity services and more community-based mental health care. I know of others, too, which I might explore later on.

Covering superannuation means that there are going to be many, many cuts required. Are you looking at midwife-led care and other more community-based services that will perhaps reduce the number of people that need to go to hospital, which is after all the expensive end of it?

Ms Gallagher: There are a couple of things in the mental health initiatives, Dr Foskey. A component of both of those initiatives will go to the community sector. We currently have one of the highest rates of community service provision in the mental health area across the country. Already our rates of engaging with community sector providers are higher than average. I am pretty pleased with that because I think there is fantastic work done in the community, particularly in prevention and early intervention in the area of mental health.

The young accommodation program in mental health is trying to get to young people before they need really acute care. That will go to tender to the community sector. I think that is great because we know that the community sector provides fantastic support in accommodation and supported accommodation programs.

There is, as you know, some work being done in the community midwives program, and there is a demand for that. I think a brief will shortly be on its way to me finalising some work done around demand for that program. That has come out of the pregnant pause report. It is not in the budget because in the first instance any changes that we make to the provision of maternity services will be made in the context of reconfiguring it within budget. The community midwife program is midwife-led care. We know that there is demand for that and we will be looking at how we can reconfigure services to ensure that we are meeting the needs of women and the desire of women to have that type of care. I hope that answers your question.

DR FOSKEY: Yes.

THE CHAIR: We will come back at five to 11 and then move on to output class 1.1.

Meeting adjourned from 10.35 to 10.58 am.

MR GENTLEMAN: I refer you to page 147 of Budget Paper 4. Under "Output Description" the first dot point indicates "specific emphasis on older patients who would otherwise experience long waits". How do you fit that in the triage system if there are people coming in with high levels of injury, for example?

Dr Sherbon: Each patient in the triage process is assessed against national guidelines. An experienced triage nurse or well trained experienced triage nurse will usually take into account the fact that elderly patients are more prone to rapid deterioration than someone of younger age and greater general fitness. They would tend to ensure that people with chronic multiple conditions, which is usually the case with the very elderly members of our community, are triaged probably towards a more conservative, more

urgent end of the scale.

MR GENTLEMAN: Is there public education on the triage system? We often hear stories about people waiting for lengthy periods at hospital emergency wards.

Dr Sherbon: Minister Corbell commissioned a production company to produce advertisements explaining the emergency department process. It is not a "first in, first served" arrangement; it is an arrangement that is built around assessment of clinical need. Those advertisements ran throughout last winter and have just started running this winter. You see them on the commercial stations here in the ACT. We have had a number of jurisdictions request that we supply them to them for their consideration. To acknowledge the intellectual property, they were originally modelled on the campaigns of the Hunter Area Health Service in the late 90s. We have had favourable comment on those ads.

MR SMYTH: Minister, on acute care services we spend 22 per cent over the national average in the provision of health care, but we underperform in the number of beds available. Can you tell me how many beds are currently available in the ACT? How does that compare with the national average?

Ms Gallagher: I do not want to give a ballpark figure; I would prefer Mark to do it. I know what it is at Canberra but it has slipped my mind at Calvary.

Mr Cormack: I am sourcing from the AIHW hospital report 2004-05. The bed numbers for public, acute and psychiatric hospital available beds are 174 for Calvary, 495 for TCH and 10 for QE2, which is also recognised in the same statistical collection as the public hospital—and that gives a total of 679.

MR SMYTH: What about the national average?

Mr Cormack: That is just absolute bed numbers.

MR SMYTH: That is absolute bed numbers. At 330,000 that is about 200 beds per 100,000—a little under. What is the national average? If we are working towards national average and we are reducing health costs towards national average, are we at the same time going to increase bed numbers to national average, if national average is the measure that we are going to work off?

Dr Sherbon: This budget proposes a significant number of increases in bed numbers, which we can detail. The minister has the information to hand in a minute. Can I just interpret the gist of your question: I think you might be basing your question on the state of the hospital's report which was released last year and is due to be released soon this year. It is under embargo so I cannot discuss this year's figures. But what I can say is that the ACT does not have small country hospitals. If you go to New South Wales there are vast numbers—over 200—of small country hospitals that have 30 to 40 per cent occupancy. A lot of their beds are just basically not used, so their beds per population look high. We do not have those small country hospitals, so our beds per population will never really be as high as those larger jurisdictions with rural areas. But, as we foreshadowed in the Treasurer's speech, there is a significant increase in bed numbers in this budget.

MR SMYTH: Minister, this is perhaps a question for you. If we are using the national funding model as the standard and we are reducing to a couple of per cent above health CPI in that regard—and that is a measure that you want to work within—within that measure and all the other jurisdictions they have a far higher proportion of beds than we do.

Ms Gallagher: I am not sure that is the case.

MR SMYTH: If it is good for one figure, is it not good for the other figure to use the same measure; if so, how will we move towards national average of bed numbers?

Ms Gallagher: I can tell you how we are moving towards increasing bed numbers. As I said, depending on what report you read, we are under the national average per 1,000 of population but I do not think there is a great difference between us and other jurisdictions—certainly not as you are alluding to. By the end of December this year and in the last couple of budgets this government has increased beds by 106 and there are an extra 20 beds in this budget, bringing the total over the next financial year—an increase in bed numbers—to 126. That is what we are doing about increasing bed numbers. In this budget we are looking at those areas where we can reduce costs, not necessarily in front line staff, and redirecting our growth money into direct service delivery.

As I said, there are 20 additional acute care beds and some extra $5 million is going into critical care capacity as well in this year's budget. Let us look at previous budgets over the years that I was not the minister: there were 20 medical beds in last year's budget; three intensive care beds in the 2004-05 budget; 60 sub-acute beds, 51 of which are extra beds; 17 emergency department short stay beds, which are in place now at Canberra Hospital and Calvary, in the 2004-05 budget; and 15 transitional aged care beds, which have been jointly funded by the ACT and Commonwealth governments. That just gives you a quick outline of the extra beds. Whilst we will remain under the national average, we are making a pretty concerted effort to ensure that we are increasing beds to match demand in our hospital system.

MR SMYTH: There does not seem to be an overall approach to how you make the system work better. Could you outline, firstly, these reforms in the broad. Each year we have had band-aid measures—there is a little bit here and a little bit there; there is a new machine here there is a new machine there. There does not seem to be an approach that builds on the fact that we have got the youngest population in the country, the fittest population in the country, the longest longevity in the country. The system should work much better but it does not. What are you going to do to make the all up system work better?

Ms Gallagher: I do not accept that the system does not work well at all.

MR SMYTH: The longest waiting lists, highest costs, lowest number of beds—it is not a bad start.

Ms Gallagher: They are measures that you are just fascinated with as the only measures of a health system's performance.

MR SMYTH: No, not at all.

Ms Gallagher: I think if you reflect back on your media releases, Mr Smyth, most of them will be about waiting lists and bypass, as you call it. I do not see your level of interest in other areas across the health portfolio.

MR SMYTH: I have spoken about mental health; I have spoken about—

Ms Gallagher: I will not accept that the system is not working well. I will accept that there are pressures on the system and there is a range of measures in place to deal with those pressures. But whether or not those pressures are alleviated by those measures is something that I am going to be quite open about. The pressures are particularly in emergency department waiting times and some of the waits on the elective surgery waiting lists. I do not know yet whether we can ever solve them.

I am new to this job. I am taking my time to learn the portfolio and I will certainly look at ways that we can improve some of those areas. There will be pressures on the health system, but I do not think anyone in the ACT would say that we have a bad health system here. I think everyone accepts that we have a very good quality health system. If you present to either of our hospitals you get first-rate care, as you progress through the hospital you get first-rate care, and as you transition out of the hospital and into other health service providers you get first-rate care. Through that journey there may be times when you have to wait a little while. We are doing what we can to reduce those waits, but, on the large front, our hospital system is, if not the best in the country, certainly right at the top.

MS MacDONALD: You mentioned the issue of bypass, so I thought I would talk about that, if that is all right. There have recently been a lot of media reports about bypass, including Mr Smyth recently suggesting that Canberra Hospital has been closed to patients in the emergency department. Could you explain for the benefit of the committee, and of course for Mr Smyth as well, how load sharing works and whether patients who present at hospital emergency departments are impacted by load sharing?

Ms Gallagher: As I said, being new to this job you look at things with a new set of eyes. From my understanding, and as I have been briefed by the department and understand it to work in a practical sense, bypass—I do not really mind whether it is called load sharing or bypass; bypass sounds a little more alarming than load sharing, but they are essentially the same thing—is a management practice used to deal with demands and peaks in demands as they exist from day to day. What it means is that less urgent ambulance patients—say, for example, the Canberra Hospital is on bypass—will be taken to the Calvary Hospital to be seen. That is largely based around clinical decisions, as I understand it, about timeliness of seeing those people. If they are going to have a longer wait at Canberra Hospital because of the pressures in the emergency department right at that minute, at that hour of that day, and they can be seen in a quicker way at Calvary who might not be as busy at that particular minute, at that hour of that day, then it is appropriate that they can travel the 10 or 15 minutes to Calvary Hospital to be seen.

In May this year we saw quite an increase in the amount of time that the Canberra Hospital was on bypass. That directly related to the number of presentations at the emergency department and the type of presentations that were there. It is something that

no doubt I will respond to frequently in the media. Because it sounds like heart bypass, everyone gets worried about the term "bypass". That is from me, not being a medical person, and that is what I think when I hear "bypass". I think people do get alarmed.

There is some anecdotal evidence that, when people hear that the hospital is on bypass or closed, they might not present if they need to. But, for anyone who walks into the emergency department, for anyone who is needing access to different services—such as paediatrics or cancer services, for example—the hospital remains open. It remains open to anyone who walks in the door, but it does reflect the peaks in emergency departments. That is completely demand driven. It is not something that we can plan for, but I think it is appropriate that a mechanism be put in place between the two hospitals so that they can share the load—that is where the term "load sharing" comes from—during those busy times. I do not think it has been reported as a measure of hospital performance, of quality, in any other report—and there are numerous reports around hospital statistics. It is not something that alarms me. I think it is more a sensible way of managing presentations to the emergency department.

DR FOSKEY: I note on page 177 that there has been an increase in cross-border revenue evidenced in this budget.

Ms Gallagher: Is that in Budget Paper 4?

DR FOSKEY: Yes. The second dot point in the notes. I am interested in exploring this because I come from a region in Victoria and I know that people come to Canberra Hospital. I am interested to know whether the costs of patients are recouped through New South Wales; their nearest hospital is Delegate Multi Purpose Hospital. I am also interested in how this rather complex figure, I have no doubt, per patient is worked out. Is it worked out on an average cost of separation and does it take into account the complexity of cases that Canberra Hospital deals with from regional patients? In other words, is it a fair amount that actually covers the costs of treating those people in our hospitals?

Dr Sherbon: The minister has indicated that I will assist in this answer. The costs that New South Wales pays the ACT for each New South Wales resident that is admitted to an ACT hospital were determined by an arbitration that was handed down in the 90s and has since been used by both jurisdictions as the basis for the cross-border agreement, despite the fact that the agreement lapsed in 2003. We have continued to use that previous arbitration as the basis for payments. The 2003-08 agreement is still subject to intense, frustrating negotiations, I would have to say.

The price paid per New South Wales resident admission is the New South Wales average cost per weighted separation, determined by the arbitrator. Your question is: is that a fair price? We know that our costs are probably slightly higher than that, but it is paid as an average cost per weighted separation, not as a marginal cost per weighted separation.

When I sit across the table from New South Wales colleagues, they argue that they should only be paying marginal costs per weighted separation because a system is set up here, we already have ACT residents using the system and New South Wales residents count for a third of separations. So they are marginal costs to our system and not sufficiently large to account for average costs. But on our side of the table we argue that

these are complicated patients with difficult discharge arrangements and that they probably cost more than the average cost per weighted separation. We could do a massive study at the cost of millions of dollars to determine who is right and who is wrong. We would probably end up not too far from where we are.

DR FOSKEY: That was interesting. But what about the people who come from Victoria—are they included in the New South Wales—

Dr Sherbon: No. We have a separate arrangement with Victoria. Because it is a minuscule flow, we simply have a national arrangement. We pay—I will just check with one of my colleagues in a second—according to national arrangements. There is a small payment of some hundreds of thousands of dollars between the two jurisdictions.

DR FOSKEY: No matter how many you get?

Dr Sherbon: We pay, I think, something close to an average national cost per weighted separation. I think there was a small net payment—I can confirm this on notice—from the ACT to Victoria of less than $1 million, I can assure you of that—a six-figure sum. Compare that to the figure in New South Wales, which is $40 million.

MR SMYTH: Minister, one of your targets on page 154 is "Reaching the optimum occupancy rate for acute overnight hospital beds". The target for this year, if you go back to last year's budget, was meant to be 95 per cent; it will come in at 96 per cent. The target for the coming year is 93 per cent. In the long term—if you can define what "long term" is—it is meant to be 90 per cent. How are you going to achieve that? This is a measure of how we use our beds; it is directly impacted on by the number of beds. I noticed when I asked about beds that there was an answer. The chart that I have been given says that the number of beds per 1,000 residents in the area is 2.1 in the ACT; the national average is about 2.6. The point I make is that we have 20 per cent fewer beds than other parts of the country. We are getting more and more occasions of bypass. The waiting lists are, at best, static; at worst, trending up.

MS MacDONALD: Can I just ask what chart Mr Smyth is referring to?

MR SMYTH: It is a chart from the AIHW report.

MS MacDONALD: You might like to refer to it and mention it when you ask the question.

MR SMYTH: Minister, how will you achieve this target of getting the occupancy rate down, which leaves your beds open for elective surgery and for emergency admissions? When will you achieve the target of 90 per cent?

Ms Gallagher: I have outlined the number of beds that we are putting into the system, through the last three budgets—an additional 126 beds. That is what the government is doing to improve access to the hospital. As I understand it, we are already seeing improvements in bed occupancy rates. It has come down from 97 per cent already, so we are seeing a decrease, which is what we wanted. This will ensure less cancellation of elective surgery.

MR SMYTH: In what time frame? That is not what the budget says.

Ms Gallagher: We are improving our discharge practices and looking at a range of initiatives through the access improvement program to ensure that individual workplaces are designing a workplace which meets their needs and ensures efficient patient journey through the hospital system. You can see the targets that we have set. The increase in bed numbers, the better discharge planning and the range of initiatives being developed through the access improvement program will assist us to meet those targets. We are already seeing the percentage coming down.

MR SMYTH: According to your own documents, on page 172 of Budget Paper 4 the target for 2005-06 was 95 per cent.

Ms Gallagher: And we got 96.

MR SMYTH: On page 154 of Budget Paper 4 for 2006-07 the estimated outcome is 96 per cent. So, according to your own documents, it is not coming down; it is going up.

Ms Gallagher: I think it was at 97 per cent.

MR SMYTH: This year it has not gone down to the target that you expected. How will you get to 93 per cent? When is the 90 per cent target going to be achieved?

Ms Gallagher: Can you answer that?

Mr Cormack: Yes, through you, minister, and madam chair: there has been an improvement in our occupancy rates. They were 97 per cent at the beginning of 2005-06. We actually reached our target of 95 per cent in March 2006. The estimated outcome that you are referring to on page 154 of Budget Paper No 4 recognises that there is still a quarter of the year to go and that we are coming into the peak time of the year.

From a system perspective, to reduce occupancy even by one per cent is a significant improvement. As the minister outlined, we have a three-pronged approach: we are looking at the demand that is coming into our system; we are looking at the capacity and supply—and the minister has described the bed capacity and the other capacity that we are putting into the system—and we are redesigning the way we do things to reduce length of stay to an appropriate length of stay. That reduces the pressure on the beds, easing the time that people spend in the emergency department, and results in better care processes in the operating theatres. They are part of the access improvement program.

So we have a three-pronged approach: reduce the demand, boost the capacity and supply, which we have with the 126 beds that the minister referred to, and change the way we do things. The long-term target of 90 per cent is based from emerging international literature that suggests that that is really where we should be heading. But we need to recognise, madam chair, that it is going to take some time to do that, and this is the experience in other jurisdictions as well. New South Wales, for example, has embarked on this path. It has been on this path for three years and is starting to get reductions, but they are gradual reductions.

MR SMYTH: What are their occupancy numbers currently? What are they aiming for?

Mr Cormack: They vary across the different hospital peer groups, but they are certainly aiming for a 90 per cent occupancy. Almost none of them has achieved a 90 per cent occupancy; most of them are running in the high 90s at this point in time.

MR SMYTH: When will we achieve 90 per cent?

Mr Cormack: It is going to be difficult to predict when we will achieve 90 per cent, which is why we have not specified it as a 2006-07 target.

Dr Sherbon: I think that our best advice to the minister at this stage is that we would aim to get to 93 in the coming financial year, probably 92 and 91 thereafter, and aim for about 90 per cent around 2008-09, perhaps 2009-10. The process of adding beds and improving internal processes is swimming against the tide of greater demand at the front door. So it would be foolish for us to advise the minister that we could simply reduce occupancy overnight. We could have an announcement about opening additional beds, but we have to find nurses to staff them and we have to ensure that they are appropriately staffed. We cannot simply open beds willy-nilly without appropriate safety guidelines with safety infrastructure around them in terms of appropriate staffing.

Our advice is conservative; hence the use of "long term" in the terminology. If this committee were concerned about a time frame, then my best guess at this stage—and it is only a guess—is that you are probably looking at at least two years, probably three.

MR SMYTH: You mentioned an increase in presentations. What is driving the increase in presentations?

Dr Sherbon: The increase in demand is driven by an older population—people are getting older and they require more services. Secondly, there are more options, greater technological options, available to people. So people are using health services more, and we are swimming against that tide.

There are a lot of improvements taking place at all health systems—better primary care, better preventative outcomes, which the minister has already outlined, particularly in mental health. One of the unsung milestones in this budget is a very significant government strategy around early intervention in mental health, focused on young people. All that work takes place against a growing, steady increase in the age of the population.

MR SMYTH: I have more questions.

THE CHAIR: If you have another on 1.1 we will take that and then we will move to 1.2.

MR SMYTH: I refer to page 162 and to strategic indicator 21. The timeliness indicators do not seem to be improving significantly. Minister, how do you lift a target from category 3 of 41 per cent—"urgent (seen within 30 mins)"; only 41 per cent of presentations are seen in that time—to 60 per cent?

Ms Gallagher: My understanding of these areas is that in categories 2 and 3—I might be corrected on this; it might be 3 and 4—there has been a 30 per cent increase in the

presentation rate to the emergency department.

Dr Sherbon: They are 2 and 3.

Ms Gallagher: They are 2 and 3. We are seeing big increases in presentations, and that has significantly affected those targets. Initiatives to reduce the emergency department waiting times are around the access improvement program, which we can talk more about. They are making sure that access block in the hospital is coming down—and it is. My understanding is that access block has been reduced from about 44 per cent to about 31 per cent, which is a significant decrease.

MR SMYTH: Could you explain that percentage?

Ms Gallagher: Access block?

MR SMYTH: No. Could you explain the percentages. You said that you have reduced access block from 44 per cent to 31 per cent. Could you explain that measure?

Ms Gallagher: Yes: the number of patients waiting in emergency for more than eight hours to get into the hospital. Is this an exam?

MR SMYTH: No. It is not an exam.

Ms Gallagher: One point for Katy.

MR SMYTH: Mr Corbell used to change the measure.

Ms Gallagher: That is my understanding.

MR SMYTH: How we measured it used to change. I am just trying to compare apples with apples.

Dr Sherbon: Can I pick that up? I do not want our department to be accused of changing measures. We monitor three parameters of access block: we use the Australasian College for Emergency Medicine measurement and we use New South Wales and Victorian definitions and ACT definitions. Those are used constantly by my team to monitor performance. Mark might remind me which one is actually published.

Mr Cormack: The one that is published in BP4 is the New South Wales method.

Dr Sherbon: We do not play with data in my department. Last year you accused me of rorting the FBT system. I am not having my department accused of rorting data—we don't.

MR SMYTH: I will go and find the press release, which shows that how it was determined was changed.

Dr Sherbon: No. It was changed for appropriate reasons.

MR SMYTH: I am happy to be proven wrong.

Dr Sherbon: We do not alter data in my department.

MR SMYTH: No, I did not say that. I have never accused you of altering data.

Dr Sherbon: Well, don't.

MR SMYTH: You have just said—your own words were, "We have changed the way it was presented."

Dr Sherbon: No. I said we monitor three different forms.

MR SMYTH: No, after that you said "we have changed".

Dr Sherbon: We keep a very close eye on data in my department.

MR SMYTH: You used the words "we have changed".

Dr Sherbon: Don't accuse me of that. Our department does not alter data.

MR SMYTH: No, I am sure you do not alter data—I am quite happy to accept that—but you just used the words "we have changed". I will get it off the *Hansard* if you wish.

THE CHAIR: I do not think we need to continue on that. Do you have a question?

MR SMYTH: What percentage have presentations to emergency increased by, and can we have a breakdown of the increase in each of the categories.

Ms Gallagher: Yes.

THE CHAIR: Are you going to take that on notice?

Ms Gallagher: Yes.

THE CHAIR: We will move on now to 1.2.

DR FOSKEY: I note that accountability indicator g for mental health on page 164 of budget paper No 4 shows that, although the target for the percentage of clients with outcome measures completed was 75 per cent, the estimated result was only 53 per cent, and the target for this coming year has in fact been reduced to 60 per cent. I guess you would agree that these results are disappointing. I was hoping you could outline how the ACT government has interpreted these results.

Ms Gallagher: Yes. I will let Mark take the detail of it. My understanding is that this is a new measure and that we have seen improvements throughout the course of the year in those figures.

Mr Cormack: Yes, the minister is correct, it is a new measure. For that reason we are very happy with the improvement we are starting to see flow through in our monthly figures. I am just searching for this month's figure on that, which had improved

significantly from the beginning of the year. It was up to 57 per cent in May. We are quite happy to see progress.

Certainly in other jurisdictions they are not seeing the same sort of improvement that we have. There is quite a lot of work going on within the mental health service, led by Dr Peggy Brown, to focus on these key strategic indicators. We are seeing gradual improvement towards that target.

DR FOSKEY: How is it assessed that outcome measures are completed? Is the patient given an exit interview?

Dr Brown: There is a range of measures used. It depends on the age group of the client. There are specific measures for children and adolescents, there are other measures used for adults, and different measures again used for the older persons population. They comprise measures that are self-rated by the client and measures that are completed by the clinician based on their observation of the client.

DR FOSKEY: Is this a fairly key indicator, as far as you are concerned, in assessing whether services are appropriate?

Dr Brown: We are participating in a national program. As Mr Cormack indicated, our performance against other jurisdictions is actually quite favourable on this measure. In terms of what it means, we are not wanting to focus on percentage alone because it is the process, as much as the outcome we are wanting to achieve.

The idea behind the outcome measures is that it puts a focus on collaboration with the consumer, so that you engage them as being an active participant in their management planning. You engage in a dialogue with them about their current state, about what their goals are for treatment and then you assess the progress with them as you go along. The outcome measures are one way of actually facilitating that discussion.

DR FOSKEY: That is good. I turn now to funding for mental health. Most of the new money for mental health is directed to clinical services but of course, as you are aware, some members of the mental health community believe that the ACT government should be putting more money into the community end of mental health care. Could you outline the basis on which the government decided that the $8 million would be more effectively spent in clinical services over, say, community support programs, and what research or evidence supports the government's decision.

Ms Gallagher: In the ACT, 75 per cent of the mental health budget is delivered through community-based programs. I hope I have got that figure right—it is one that springs to mind—but I am sure I will be corrected. I have been trying to learn a lot of figures recently.

MS MacDONALD: Dr Brown is nodding, minister.

MR SMYTH: You are doing well so far.

Ms Gallagher: Of course a component of that is through community service provision. This budget recognises the value of the community services in providing support in this

area. I have had a number of meetings with mental health consumer groups since taking this job.

I know that the percentage of our funding going to the community services sector is also higher than the national average, so I do not accept the view that it is all going to the sharp end. There is, of course, a component of this which needs to be managed by Mental Health ACT, and I think these initiatives reflect that.

The early intervention prevention work—and I will be releasing a document around this shortly—is extremely valuable. The plan we are putting in place I think will assist all of us who have an interest in mental health to better deliver services. As I said, these two initiatives, if you separate them out, all have a component that will go to the community sector in recognition of their skills and expertise in this area.

Dr Brown: For the initiatives under promotion, prevention and early intervention, almost the entirety of that will be spent in community-based services. For that listed under enhancing mental health capacity, again almost the entirety of that will be community based. There is a component there for additional medical staffing, but it is anticipated that, again, at least half of that will be community-based work, and the increased consumer and carer participation will work across inpatient and community. So the majority of the funds are community based.

DR FOSKEY: Of the $8 million?

Dr Brown: Yes.

DR FOSKEY: Is it possible to get a breakdown of that? It is not in the budget.

Ms Gallagher: Yes, we can provide that.

MR SMYTH: On that point, is it possible to get a breakdown of the $51 million into where it actually goes, how much is acute and how much is community based?

Dr Brown: Approximately 75 per cent of our funding currently is community based.

MS MacDONALD: Minister, this one might be more for Dr Brown than yourself.

Ms Gallagher: Test me.

MS MacDONALD: I do not know. It is more of an explanation for me because I do not understand. On budget paper No 4 at page 154, the strategic indicator 4 is "reducing the usage of seclusion". I had a look in last year's budget paper for the same indicator, but a slightly different measure was used. In last year's budget paper No 4 at page 173, instead of a percentage it has numbers of clients who are subject to seclusion.

I am assuming these are people who are in acute care in the PSU who undergo an incident where they need to be separated off from the rest of the community. Can you explain how that acts as a measure, and why the rates have been changed? I see that the estimated outcome for 2005-06 was 10 per cent. I cannot work out what the aim was, because I am not comparing apples with apples, if you see what I mean.

Dr Brown: I am not entirely following your question, I am sorry, but I can speak to the issue in general.

MS MacDONALD: That is all right, speak to the issue. I am not sure I am following it entirely either, to tell you the truth.

Dr Brown: Seclusion is a treatment intervention whereby in extreme circumstances, as you say, for the safety of an individual or the safety of others they may need to be removed to a room where free access is prevented. It is generally regarded as a relatively aversive experience for our consumers, and we have a clear aim to reduce the use of seclusion in our inpatient facility.

Last year the target was set as an absolute number rather than a percentage. We felt it would actually be a fairer indicator to set it as a percentage rather than a number because, over time, our numbers of inpatients will change. However, the target last year was set at a reduction, if I am recalling it correctly, from 100 to 80. Is that correct?

MR SMYTH: That is correct.

Dr Brown: We were anticipating a 20 per cent reduction. I have to say in hindsight that that was perhaps a bit aspirational. We had a clear and stated indication to reduce the use of that. We had a program of work in mind. We are pursuing that program of work, but its introduction has been delayed.

We have a working party that has been established to look at this. We have terms of reference set. The working party will have its first meeting within the next four weeks. We had six staff attend a national forum earlier this year to assist us in getting that started. I am confident that over the next 12 months we can see some progress on this. We have reviewed the target for this coming year to perhaps reflect a more realistic goal.

MR SMYTH: Just on that, there was a report in the *Canberra Times* when the minister released the last quarterly report. The report stated that the number of seclusions for the three quarters had got to 88 occasions. Is there an update for this final quarter of the year?

Dr Brown: I do not have those figures available today, I am sorry, but they will be in the next quarterly report, of course.

MR SMYTH: Can it be taken on notice and given to the committee before the quarterly report?

THE CHAIR: You will take that on notice?

Dr Brown: Yes.

MR SMYTH: What is driving the need for seclusion, or what is preventing you from bringing its use down as quickly as you had hoped?

Dr Brown: What is driving the use of seclusion is actually quite a complex question to

answer. It is in part related to the nature of the client group we are servicing. Certainly I think it is fair to say that we have seen an increase in the use of comorbid substance abuse in people admitted to the acute inpatient unit and, along with that, an increase in episodes of agitation and aggression. That of course is where seclusion is utilised. So it partly reflects the client group.

The other key factor relates to the range of skills in the staff and the interventions they utilise. That is one of the measures we will be undertaking in addressing this. The third factor is the environment. As you would be aware, we have had some modifications to the environment of the PSU in recent times. That also will assist us in tackling this problem.

MR SMYTH: Is the use of some of the party drugs and other substances, particularly by young people, at the heart of why we are secluding more and more young people?

Dr Brown: Certainly agitation and aggression is a common occurrence in people who have used other substances, particularly methamphetamine. Yes, it is a significant contributing factor.

MS MacDONALD: Is this measure used as a measurement in other jurisdictions?

Dr Brown: There are measures available to compare our use of seclusion with other jurisdictions. It is not entirely the same indicator as is in the budget papers, but the ACHS—the Australian Council of Health Care Standards—has a range of clinical indicators for psychiatry and there are three that relate to the use of seclusion. We currently monitor ourselves against those, and we have demonstrated improvement over the last two years on those indicators.

DR FOSKEY: I am well aware that there is a lot more recognition of the dual diagnosis around methamphetamine use and that the drug services are saying that this requires quite a different response from workers in their services than heroin and other drugs of abuse. I am just wondering about the issues it raises for mental health.

Do you have any anecdotal or other response, probably from the government, to the assertions made by the Prime Minister that the COAG agreement on mental health must go hand in hand with states and territories toughening up their cannabis laws, in weighing that up against the methamphetamine situation and the way that that means mental health services have to change their response.

Ms Gallagher: Your question at the end is around the COAG agreement and whether we are looking at changing our cannabis laws.

DR FOSKEY: No, it was not really about that. Well, yes. I am just interested in how the Prime Minister has presented his stance in COAG meetings around mental health funding.

Ms Gallagher: I do not attend those meetings. From my understanding, he has gone forward with some money and a few ideas which have been announced in their budget. The arrangements are being discussed between officials and those agreements will be, I imagine, finalised at the COAG meeting on 14 July.

I think we are not planning on any changes to our laws around cannabis. I certainly have not been advised that we are. We have had a number of discussions about this in the Assembly in recent years. My understanding is that there is an increasing issue around agitation and aggression of patients across the board—not just in mental health—because of the use of methamphetamine, and that will require better ways of doing things.

That is partly reflected in this year's budget with the increased initiative there for security of staff, patients and visitors at the hospital, unfortunately. Putting $1.2 million into that is not something you do lightly. There is a range of areas that you would prefer to inject $1.2 million into, but that is the reality of the situation. Staff who work in the hospitals are being faced with that.

DR FOSKEY: To finish off my questions about dual diagnosis, does any of the new money for mental health, including the development of the young persons step-up/step-down facility provide for or build a dual diagnosis service capability, given that, anecdotally, the figures are that between 30 and 90 per cent—and that is rather a large range—of young clients seen in mental health and drug and alcohol services present with a dual diagnosis.

Dr Brown: There would only be a very small component of this year's initiatives that would contribute to enhancing the response to dual diagnosis clients. A percentage of the promotion of prevention and early intervention initiative is around mental health education in the community. That will have the capacity to raise awareness about the linkage between illicit substance use and mental illness. The increased medical input will again give us some enhancement of capacity around addressing the dual diagnosis.

More generally, however, we have a dedicated dual diagnosis worker whose key role at the moment is twofold. One is to undertake assessments for clients around their substance use and to provide input to development of management plans with their case managers.

The second role is to up-skill our staff around management issues for clients with dual diagnosis. In the future we hope to examine the need around further staff and potentially even a dual diagnosis team. That was a recommendation in the recent CAT review. We will be looking at that as part of the mental health services plan that will be undertaken later this year.

MR SMYTH: The former minister announced some planning studies to be done for a psychiatric facility. Could we have an update of where that is at, and any outcomes of the study to date. I note there is no money for it in the capital works. If it goes ahead, when is it likely to?

Ms Gallagher: Not this financial year. That is right, there has been a lot of work done around planning for a new mental health facility at the Canberra Hospital. When I took over the job there was, I think it is fair to say, still some disagreement across mental health consumer groups, working with ACT Health about the exact model that should be put forward.

There was a view that we needed a facility of at least 50 beds to create some capacity

within the system to deal with the number of clients needing to be seen. Then there are some very strong arguments on the other side, particularly from consumer groups, saying that 50 beds are too many. They wanted to see a smaller unit and they wanted to make sure that ward 2N at Calvary was maintained, as many of them are very pleased with how ward 2N is operating.

I think that, whilst the work was almost finalised, from my point of view there was not agreement about the model, in terms of pushing something forward through the budget. As you can imagine, I was meeting these groups in April and the budget was pretty much finalised by then. It was just that the timing was out, but we have to do this.

The challenge I have set myself in the next year is to progress and finalise that work, hopefully with the agreement of everybody about the model that should go forward, and to have it done in time for next year's budget.

MR SMYTH: And a youth facility within the whole project was being discussed?

Ms Gallagher: I am not sure whether a youth facility was within that.

Dr Sherbon: There still remains consideration for a child and adolescent unit. It is not optimal to co-locate children and adolescents with adults. Whether it is included in the same precinct or not is yet to be determined. The answer is probably not. That planning is, as the minister outlined, still to be finalised, in consultation with the relevant stakeholders.

MR SMYTH: Can you give us an indication of when you might have a decision on the way forward?

Ms Gallagher: I think it is essentially finding a model that is big enough to do the job that we need it to do, and meets, as much as possible—

MR SMYTH: This is your Solomon clause.

Ms Gallagher: Yes, that is right. We may not be able to reach agreement at the end of the day, but one that as much as possible reaches agreement with the consumer groups. From memory, consumer groups are looking at something between 20 and 30 beds, which just might not be big enough.

MR SMYTH: Sure, but an answer: when will the process finish?

Ms Gallagher: Certainly in time for next year's budget. I need to have it all done by then. As you know, this year the capital program was not very big and the linear accelerator won in terms of priority of need. Because there were some outstanding issues with this, I felt we needed to do a bit more work and then put it up for next year.

MR SMYTH: I am sure you will argue the need for a mental health facility over a prison. If we move to general funding, world's best practice for mental health funding in general seems to indicate that you need to be getting somewhere between 11 and 14 per cent of your health budget. For the last three years—and in the coming year—it has been about the seven per cent mark. Will the government commit to moving it up to

a higher percentage of the health budget and, if so, when would that occur?

Ms Gallagher: As you know, there have been significant increases in mental health spending. I think in every budget there have been additional funds. My understanding is that there has been an 86 per cent increase in the mental health budget since 2001-02.

MR SMYTH: Some of that was just a transfer of overheads, and again this year there is a transfer of superannuation.

Ms Gallagher: That may be the case, but there has been significant investment in each additional year from every budget in mental health spending. I imagine that in future budgets there will be additional money for mental health. I am not going to sit here and say that we will reach 11 or 12 per cent in—

MR SMYTH: I thought Mr Corbell had intimated that getting to 11 per cent was something that was quite desirable. If you look at the last three budgets, in the 2003-04 budget it was seven per cent, and the actual outcome was 6.8 per cent of budget; in 2004-05 it was 7.1 per cent, and the outcome was 6.9 per cent of total budget; in 2005-06 it was 7.1 per cent of ordinary operating expenses, and the estimated outcome is about seven per cent, based on the figures here.

This year the $50 million over the $751 million in health is about 6.8 per cent. Yes, it has gone up as a monetary value—and congratulations on that. I have said before that extra money is welcome. We need to understand that a lot of that was a transfer of overheads, but it is still stuck at about seven per cent of health.

The Scandinavian countries are saying that, if you are not spending 12 to 14 per cent, you are not serious. The other countries that are achieving really high and good, solid, long-term outcomes—and not reflecting on our health workers and what they do—are spending 12 to 14 per cent of their health budget on mental health.

As part of the policy discussion—and Dr Brown might have an opinion here—is it desirable to get to those levels? It will take pressure off your emergency department, it will take pressure off your prison system, and it will take pressure off your community care and other services by addressing the problem up front.

Ms Gallagher: I do not disagree with you. I agree that we can refocus energies where we have capacity to. Not using this as an excuse, but being new to the job it seems to me that, in the health portfolio, it is about balancing up priorities and demands and making the best of the money you have available to meet those demands where they are. I do not have those figures in front of me, but I have no reason to doubt you and your maths. Seven per cent growth per year is still quite a lot of growth.

MR SMYTH: No, it is not seven per cent growth, it is seven per cent of what you spend.

Ms Gallagher: I see what you mean.

MR SMYTH: It has been quite static over the last couple of years.

Ms Gallagher: But there has been growth.

MR SMYTH: It is a bigger amount because the budget has grown.

Ms Gallagher: But there is more money going into mental health every year as well. This year, for example, over $50 million is going into the mental health budget, a growth on previous years. I do not disagree with you that we should be looking at ways that we can increase capacity and reduce demand in other areas, but it is something that I need to learn more about and do more work on over the next year.

DR FOSKEY: Accountability indicator "e" on page 164 for mental health services shows that the supported accommodation bed occupancy rate in 2005-06 was 97 per cent, which is quite different from the 75 per cent SAAP occupancy rate that we have heard about.

Ms Gallagher: Of 79 per cent.

DR FOSKEY: Anyway, 97 per cent is pretty close to full. How will cuts in SAAP funding affect the provision of supported accommodation services to people suffering from mental illness, given that they are already running at close to maximum?

Ms Gallagher: My understanding is that these services won't be affected by the changes in SAAP.

DR FOSKEY: My next question is a housing-related mental health question. You would have heard and certainly the housing people would have heard that there are often concerns about people with a mental illness in public housing complexes or areas becoming aggressive or otherwise disruptive towards their neighbours and neighbours have found that the only people they are able to call are the police. They are not always the best people for such a situation, but we all know that all round the country police do a lot of the mental health work. Could there be other arrangements that could be called upon when such situations occur? From what I have heard from constituents, often the same person requires consistent calls from neighbours sensing that they are unsafe in their neighbourhood. Is it an issue that the mental health community takes on or is it something that is seen as a problem for housing, rather than mental health services?

Dr Sherbon: The issue of police response to behaviourally disturbed mental health clients has been discussed publicly on numerous occasions in the last three years that I have been here. The Mental Health (Treatment and Care) Act prescribes a role for police and it is not an optional role. It is often assumed that it is an optional role but it is part of their job to maintain public order and public safety. It is appropriate that professionals trained in public order and public safety fulfil that role, and in our society that is the police.

Our crisis assessment and treatment teams are available to assist with treatment, but they are not trained to maintain public order or public safety. They are trained to assist in the early intervention treatment and crisis resolution of the patient, client or consumer, whatever the person wishes to be called. Dr Brown can outline exactly how individual circumstances are met, but it would be unwise for us to duplicate a police role within the health system. We are not enforcers. We have a caring set of values in our organisation. We are not primed to maintain public order and we are not skilled in doing so.

Dr Brown: I endorse Dr Sherbon's comments, noting that we would be seeking as a mental health service to minimise the input of the police to those situations where there is an issue about safety and public order. We do work closely with public housing and our crisis teams and our community mental health teams work with the housing support officers. Where there is an individual tenant in public housing who has mental health issues, we certainly would seek to work collaboratively with them in developing individual support plans for that client so that we could attempt to intervene early or indeed try to prevent any instances that cause a problem to neighbours.

DR FOSKEY: How does Mental Health ACT work with Housing ACT to set up a plan of action or integrated service delivery to work with people with a mental illness? I suppose the issue here is that it has to be known that that person is suffering from mental illness, whereas there may be incidents where people involved aren't actually in your radar at this point in time.

Dr Brown: That is quite true and there is little that we can do in that circumstance where the individual is not known to our services. It is then up to housing to ask their tenants to disclose any special needs they have and they may wish to disclose that they have mental health needs, in which case they can be in contact with us, with the client's consent, and develop a plan. Certainly, I can tell you that there are a number of individuals for whom we work collaboratively with housing. We have a monthly meeting within mental health where we actually meet to discuss individuals with particularly complex needs. The housing support officers regularly attend those forums around the management planning for individuals.

That is just one example demonstrating how we do work with them very closely. We look at what the housing needs are for that person, where they are best located, whether they are best located around other people or away from other people, what their mental health needs are, what their other support needs are, et cetera. So we definitely do work with them as closely as we can, where the individual discloses that they have mental health needs. It is, of course, much more difficult for us to be proactive when we do not have an awareness or the person does not disclose to housing those needs.

DR FOSKEY: When the police are called in and the person involved is not known to be a mental health consumer, what is the process whereby the police may be concerned that that is an issue there? Is there a process whereby they relate to you so that mental health services do assess such people and then they become someone you can work with?

Dr Brown: Yes, the police are able to make contact with us through the triage and crisis service, and they frequently do that. If they have a concern that there is a mental health issue there, they may seek an assessment in a timely way for that assessment to occur and that individual would then be assessed. It depends on the urgency of the situation as to how quickly that will occur. It could be high priority and needing an assessment within the hour or it could be requiring a referral to the regional mental health team, which would occur within 24 hours.

MS MacDONALD: I have a question on police involvement with Mental Health ACT clients and future clients, which I suppose would be a way to put it because you do not know all your clients yet. What involvement does Mental Health ACT have with training

the police in terms of the best ways to deal with consumers of mental health services and other people in the community?

Dr Brown: We do have regular input to the training of police. We have a structured training course that covers not only the range of diagnostic groups but also likely presentations and ways to deal with more acute situations, such as de-escalation techniques. Those training sessions are conducted regularly by one of our senior officers.

MS MacDONALD: For whom? For all police? Is it a requirement of all police going through that they complete this course or is it only for certain numbers?

Dr Brown: I can't answer that.

Ms Gallagher: That would be a question for the police.

MR SMYTH: If I remember rightly, it is actually part of the training course now, that all officers before they go on the beat are actually given an understanding of the needs of those with mental health problems. I think I set that up.

MR PRATT: My question builds on the questions from Dr Foskey and Ms MacDonald. The AFPA have been saying for a couple of years that this is a big issue for them, that too often they are the first point of response regarding consumers of mental health services, either known or unknown. I agree with the point that Dr Sherbon made that it is the role of the police to maintain order, et cetera, but, Dr Sherbon, there must also be a case where mental health workers are needed sometimes to accompany police, where the police provide safety at the point of contact but you are still going to need the health workers to provide the expertise to deal with the issues.

Dr Sherbon: Dr Brown might cite some examples, but our crisis assessment and treatment team does regularly accompany police. They are not as available as police. They are not patrolling. They are on call, but they don't have lights and sirens. They do arrange often to meet police at client or family residences and they do arrange often to attend jointly where they know that concern has been expressed about potential problems. You might give an example of how we work together.

Dr Brown: It can work both ways. If a call is received by our crisis team, they will routinely undertake an assessment about the risk to the individual, the safety of the individual and the safety of others. Depending on the outcome of that, they may make a request to the police to accompany them when they actually go out to assist the individual. Likewise, it can work the other way where the police have the first contact or the first call, make an assessment that there is a mental health aspect in the nature of the call and put in a call to the crisis team requesting our attendance as well as their own. That is a regular occurrence.

MR PRATT: Given fairly regular calls by police over three years or more for an increase in crisis team workers who can assist, what numbers do you now have? What has been the increase in staff for the crisis team in the last year to date? Has there been an increase?

Dr Sherbon: I will have to take that on notice, madam chair.

THE CHAIR: Yes, take that on notice.

MR PRATT: Has there been an increase in the mental health staff overall as part of this $50 million budget?

Ms Gallagher: Over the last few years or in this year's budget?

MR PRATT: In this year's budget.

Ms Gallagher: In this year's budget, there will be an increase in staff, yes.

MR PRATT: Do you have a number on that?

Ms Gallagher: We can give you that.

MR PRATT: Take it on notice.

Ms Gallagher: Yes, we can give you that, because it is broken up between mental health and community providers.

MR PRATT: Can you define the tasks—for example, the crisis team?

Ms Gallagher: Would you like to know the tasks of the crisis team?

MR PRATT: No, the increases in staffing against their positions.

Ms Gallagher: Okay, we have taken two questions on notice for you, Mr Pratt, one on the crisis team and one on any new staff under the initiatives.

MR SMYTH: Dr Brown, you said in response to an earlier part of the question that you would like to minimise the input of police. How do we go about that? Is that just a resources issue, more staff available so that you don't have to call on the police?

Dr Brown: Not entirely, no. It is in part about increasing the range of services in the community so that we have early intervention and that we don't get to the situation where police input is actually required. We have had significant growth in community occasions of service over the last 12 months, and indeed preceding years. We are hoping to see a sustained increase in community services indicating earlier intervention, less reliance on police and less reliance on inpatient admissions as a means of treatment.

MR SMYTH: You obviously have only a certain number of officers on at any time manning the phone triage service. What is the process for calls that are not taken? Where do they divert to and what percentage of calls are not taken?

Dr Brown: At the moment, we have the capacity to have two workers on the triage system for most of the day. Overnight we have one on and one on call. Any additional calls go into a queue. The workers are aware of the number of calls in the queue, but are not aware of who is actually calling, for example. We have installed a new digital telephone system in the crisis service, but we are awaiting some refinements to the

software that will enable us to give an enhanced message to those people who are in the queue and also add the capacity for callers to leave a message for the CAT team to call them back. If we do that, obviously there is capacity for additional crisis staff to respond to those messages, other than just the triage workers. So that is actually happening at the moment.

MR SMYTH: But how many calls are not taken? How many people hang up without leaving a message?

Dr Brown: I would have to take that on notice. I do have some figures on that, but I don't have them off the top of my head.

MR SMYTH: How many calls are taken and then diverted to the police directly?

Dr Brown: Are referred to the police?

MR SMYTH: Yes.

Dr Brown: We might have to take that on notice.

Dr Sherbon: They would only be referred after the worker had assessed whether there was a report or evidence in the phone call of a threat to public order or safety. If there is, the worker's obligation is to ensure that the caller is supported in terms of access to the appropriate service, which is the police.

MR SMYTH: I understand that.

THE CHAIR: Will you take that on notice?

Dr Brown: Yes.

Ms Gallagher: As to the two questions we took on notice from Mr Pratt, the second one was about other staff increases, not the crisis team. Under the mental health promotion, prevention and early intervention, there will be an additional four staff and under mental health capacity an additional two staff. That is just ACT Health staff, not the NGO components.

MR PRATT: Thank you for that. Minister, if I could just go again to the issue of mental health outpatients living with families. An issue, of course, is family members and carers not being able to get to crisis teams when things get out of control. Can you tell us a little bit about what is going on with that? Are you satisfied that those family concerns are being met?

Dr Sherbon: The minister might let me add something and Dr Brown will probably assist. We are aware of concerns from carers of a wide range of caring situations in which they have expressed frustration with the responsiveness of the CAT team. We have investigated those collective complaints and we do acknowledge that the CAT team's responsiveness could be improved. It is not a problem with the CAT team itself. We have determined that there is a need to expand community mental health teams who support the ongoing care of patients so that the CAT team is involved more in crisis

work rather than ongoing care. We are currently packaging up the utilisation of some of the growth funds that are in this budget to assist in that process. We are confident that the CAT team is well-configured. What we do need to improve is the discharge of patients from the CAT team and Dr Brown's team is working on that issue at the moment. Do you want to add anything?

Dr Brown: No, I think you have probably covered it. Essentially, I think the crisis team is impeded in its ability to undertake crisis work and acute treatment in the home setting because it is undertaking some functions that would be better placed in our regional teams. That requires some change to work practices of our current teams and we are actively pursuing that.

MR PRATT: Are these maintenance programs involving, for want of a better term, house calls, ongoing programs with consumers to ameliorate the need for crisis team call-outs?

Dr Brown: Yes.

MR PRATT: Okay. Is that capability growing?

Dr Sherbon: It will do so in this budget. Everything in health is growing.

MR PRATT: So has the budget.

Ms Gallagher: But not too fast, at 6.4 per cent.

MS MacDONALD: Minister, I refer to something which you mentioned in your opening statement and which is referred to on page 168 of budget paper 4, as well as page 74 of budget paper 3, namely, the mental health promotion, prevention and early intervention initiative, for which $3.147 million is to be provided over the next four years. I note that there is a short statement underneath the initiative, but it is a large amount of money, it is a good initiative and, having read the statement underneath it, I do not fully understand where the money is going to be spent and how it will be spent. So I would appreciate more information about that.

Ms Gallagher: As you can see, the different components are broken up in budget paper 3 on page 74. I can go through them and give you the allocations, if you like. There is $176,000 for integrated peri-natal and infant care.

MS MacDONALD: I am more interested in what they are doing, rather than the money being spent in the areas.

Ms Gallagher: The peri-natal and infant care program is targeted towards reducing the presentation of pre and postnatal depression amongst women and to support them and their infants through that process. I understand that it builds on the Beyond Blue postnatal depression project. The workplace mental health promotion in agencies is across government and business in the ACT, again in collaboration with Beyond Blue. As to workplace stress, as we know from annual reports and the report from the Commissioner for Public Administration, psychological stress is an increasing area of concern in workplaces. That allocation will be towards identifying and supporting the

capacity within organisations to deal with that emerging problem.

The early rehabilitation support goes to previous questions about continuity of care and being able to provide people with more support after they have been hospitalised, so it is not as if you have an acute episode, leave hospital and go back out to the community, but there is a level of support provided to you on your transition out, with the view hopefully that your period outside of needing those acute services will be longer. There is money in there for training for government and community agencies in supporting children whose parents have a mental illness. There is some money to support an existing program run by Mental Illness Education ACT around community education in mental health.

Dr Brown shows me I have missed one, that is, the continuation and expansion of the successful pilot program which I had been lobbied quite strongly on around GP involvement in supporting the overall wellbeing of people with a mental illness. This has been running for, I think, a year and I have certainly heard from some GPs involved in this program that it is very well thought of, that is, that people who have a mental illness may not be looking after other aspects of their health and by linking them with GPs the other areas of their health can be looked after and that in return will help them overall, so continuing and expanding that program.

MR SMYTH: Minister, indicator "c" for output class 1.2 on page 164 of budget paper 4 looks at patient activity concerning children and youth services. The target for 2005-06 was 24,300 services and, to your credit, you delivered an extra 40 per cent, going up to 34,000 services. I guess that reflects something in the *Canberra Times* article as well. You have increased the provision of service this year only by two per cent. Is that in expectation that you have largely now met that demand, or is that just a cap being put on the service?

Dr Brown: If I can speak to that, I think it is probably fair to say that the increase that has been captured this year reflects two things. One is a real increase in the provision of services. The other reflects perhaps better statistical data collection. We have increased the real level of services, predominantly through the introduction of some group-based services, which obviously is quite an efficient way of providing services. We are confident that further growth can occur in that area, particularly targeting the higher prevalence disorders such as anxiety in young children, a very needed area, but it won't necessarily be at the same rate of growth as you see in those figures, and that is because of the statistical issue perhaps as well.

MR SMYTH: Indeed, the older patient services are going up by a small percentage as well. Given the ageing of the population, is that a likely outcome or should it be larger?

Dr Brown: I haven't actually done the calculations, to be honest, but I am not sure that the growth of the population year-to-year exceeds the projected growth in the figures there. So I would think it is a reasonable target to set.

MR SMYTH: The provision of these services as more of us grow older is going to become a particularly interesting graph, I suspect, over the coming years. Is provision being made to ramp up those services in advance of the ageing of the population or will we just meet it as it occurs?

Ms Gallagher: Sorry, I was just clarifying something with Dr Sherbon around the subacute facility coming on line. There will be a 20-bed psychogeriatric unit within it which will assist at that end, if that answers your question.

MR SMYTH: Are they included in the older person's services or are they in the admitted patient separations?

Dr Brown: We don't actually have that 20-bed facility on line, yet. It is due to be commissioned next year.

Ms Gallagher: So there would be only a half-year effect if it was in there.

Dr Sherbon: We will have to take it on notice. I don't think they are included in the figure you have in front of you on the line item for older persons.

MR SMYTH: Are they more likely to be in part "a", admitted patients separations?

Dr Sherbon: We had better take that on notice. We do not have that to hand.

THE CHAIR: Take it on notice. We will adjourn now and come back after lunch on output 1.3.

Meeting adjourned from 12.28 to 2.32 pm.

THE CHAIR: Good afternoon, minister and Dr Sherbon. We are back for output 1.3. It is my understanding that we are finishing at 5 o'clock. We have five output areas left.

MR GENTLEMAN: Minister, could I refer you to page 148 of budget paper No 4, output 1.3, community health. There was discussion on this yesterday in another forum. I want to find out what is involved in providing health care assessments for those in correctional facilities.

Dr Sherbon: The basic elements of an assessment upon first arrival within the corrections system, whether it be on remand or in the watch-house, is essentially a nurse assessment of general health and any substance abuse that the person may be involved in at the time, and often extensive mental health assessment. Then, if necessary, appropriate follow-ups are arranged with doctors.

MR GENTLEMAN: And is that budgeted for under this portfolio or do you bill corrections for it?

Dr Sherbon: No. It is budgeted for under this portfolio. We manage it. In some other jurisdictions it is managed by corrections, but here it is managed by health.

DR FOSKEY: While we are on prison health, I did not see any mention of the prison health plan in the budget. How far is that from a final draft, and what are the obstacles?

Dr Sherbon: It will be about a month before it comes before the minister for her consideration. It will need to be considered by government as a whole.

DR FOSKEY: Is health consulting with any groups about the indigenous aspects of the health plan?

Dr Sherbon: I might ask Megan Cahill, the executive director of government relations and planning, to join us. Megan has oversight of the corrections health plan.

DR FOSKEY: Whom is ACT Health consulting with in terms of the indigenous aspects of the health plan for the prison?

Ms Cahill: We have actually had fairly extensive consultations with Winnunga Nimmityjah on the indigenous health requirements for the prison. They are doing a specific project at the moment with regard to the services to be provided to indigenous people in corrections health facilities.

DR FOSKEY: Has ACT Health been consulted at all on the design of the prison in terms of health-related issues?

Ms Cahill: Yes, they have. Yes, we have been working quite closely with JACS to ensure that the health facilities will meet the needs of the health services that we would like to provide in that facility.

DR FOSKEY: Will the decision about prevention of blood borne infections be revealed when that health plan is put together?

Ms Cahill: Yes, it will. Yes, we have certainly considered that in the plan and that will be contained within the plan.

DR FOSKEY: I guess I will watch this space.

MR SMYTH: Minister, this is more of a general question, and you never got to explain it in the Assembly in the last sitting week. We were having some banter across the chamber about an increase that the Chief Minister claims will be $41 million in the health budget, which is, in fact, $61 million according to the figures. You told me that both numbers were correct and I am intrigued. How can 41 be 61?

Ms Gallagher: They are both correct. I will be corrected if I get this wrong, but 61 is the difference between the budgeted amount for 2005-06 and the new budget of 2006-07. The 41 is the difference between the estimated amount in the 2005-06 budget and the real 2006-07 budget.

MR SMYTH: Good answer. The health CPI currently runs at what nationally?

Ms Gallagher: I do not know that answer.

Dr Sherbon: We do not have a figure here right now. With the restraint in the PBS, it has probably come down from its recent six or seven or eight. Here we are. The figure I have in front of me is 4.6 for the March quarter 2005 to the March quarter 2006. As I said, with the PBS coming under restraint nationally, it is down from about the six to eight per cent that it has been over the last six or seven years.

MR SMYTH: Minister, you said this morning that we have been increasing spending by about 10 per cent over the last couple of years. When I do the math, over the last four years it has probably gone up, on average, 13 per cent. How are you going to cut from 13 per cent growth to six per cent growth? What specifically will you do to rein in that spending?

Mr Gallagher: Well, as I said this morning, it is 6.4 per cent averaged out over the next four years; this year it is 8.9 per cent. There is a range of work that needs to be done, some of which we have talked about already, in terms of the benchmarking study that has commenced; looking at management structures and looking at staff efficiencies, which we will discuss with the unions, of course. Wage restraint is going to be one of the obvious areas where we will need to either deliver a wage outcome similar to what we are offering in other areas of the public service or productivity savings for anything that is wanted above that. We will be looking at purchase of goods and services. I do not know if there is more that you want to add, Tony?

THE CHAIR: I think Dr Sherbon went through all of this, this morning.

Ms Gallagher: Yes, pretty much. They are some of the things that we are looking at straight away.

THE CHAIR: I think Dr Sherbon outlined it fairly well. We will get back to the output classes, if you do not mind Mr Smyth.

MR SMYTH: When is the next nurses EBA to be negotiated?

Ms Gallagher: I think the agreement expires in March next year. I have got a submission to cabinet looking at a way forward, which I have not read yet; it arrived last night. We are certainly heading into the bargaining round pretty soon, in September, I think.

MR SMYTH: Given the fierce competition between the jurisdictions for the services of all medical professionals, let alone nurses, how do you intend to ensure wage restraint in the current environment?

Ms Gallagher: We are going to have to talk with the ANF, obviously, throughout those negotiations. It is pretty clear what the government's wage offers are sitting at per annum. If that is not going to be enough for the ANF, then we are going to have to talk to them about how we deliver anything above that. I do not sit here and say the discussions are going to be easy. But we are having good results. Our nurse vacancy rates and our turnover are going the right way. We are mindful that we need to keep that and we need to be competitive with wages.

We are competitive with wages and with conditions and we need to ensure that over the next round of bargaining we remain there. But there is not an endless supply of money for this, and staffing dollars or salary dollars in the heath budget is a significant cost.

MR SMYTH: What is the turnover rate of our nurses currently?

Ms Gallagher: We will get that figure for you right away.

MR SMYTH: You mentioned the vacancy rate. Is that the number of unfilled jobs?

Ms Gallagher: Yes, that is right. I think that is at around 35 positions.

DR FOSKEY: I want to go back to 1.3. The bush healing farm is conspicuous by its absence. I understand that over the last couple of years the ACT government has been working with a group of indigenous people to develop a local Aboriginal and Torres Strait Islander appropriate drug and alcohol rehabilitation centre and that a place has been identified, but that there is no funding in this budget. Could you clarify the level of the ACT government's interest in this initiative?

Ms Gallagher: I am just getting across this issue of the bush healing farm. There has been quite a lot of work done. A feasibility study identified a suitable location and some of the costs associated with it. At this point in time the money is not there to support the bush healing farm.

DR FOSKEY: But there is some commitment?

Ms Gallagher: I have to have a closer look at the work that has been done. As I said, it has been a very comprehensive piece of work. I have not read it from cover to cover. The cost involved would be around $10 million. I need to look at the demand for it and whether it is the best way forward for providing these services. As I said, I have not been around long enough to have a full understanding of those issues.

DR FOSKEY: Is that feasibility study available? I am certainly interested in seeing it myself.

Ms Gallagher: It is still with me. I will have a look at it.

DR FOSKEY: That would be great. I want to follow up the dual diagnosis material from this morning, not from the drug and alcohol side, rather from the health side. If a person presents to the ACT government, which provides drug and alcohol services, with a drug and alcohol problem but that service discovers that the person also has a mental health issue, what is the process for providing combined drug and alcohol and mental health services to that person?

Ms Gallagher: We might ask Dr Brown if she could come back.

Dr Brown: My colleague Ms Reading might wish to speak to this as well, but my understanding is that when someone presents to drug and alcohol services, just as mental health has a specialist worker dedicated to working with dual diagnosis clients, drug and alcohol services also have a dedicated worker for dual diagnosis, so they are available to undertake an assessment of that person and then arrange a follow up with the appropriate services in addition to upskilling other members of the drug and alcohol team. So on the drug and alcohol side it works in a similar way to the mental health side.

DR FOSKEY: We have heard anecdotally, and hopefully this is old information now, that when a person becomes a client of a community health organisation's drug and alcohol service and it is discovered that that person has a mental illness, the client is

often actually sent off and told to sort our their mental health issues and then come back and have their drug and alcohol problems dealt with, and that that happens vice versa when the person first accesses a mental health service. How are we going now in terms of integrating approaches from these two broad areas of services so that we do not have this shuffling around?

Dr Sherbon: Ms Jenelle Reading, who is the general manager of community health can answer that question specifically.

Ms Reading: When clients access the alcohol and drug program in community health, they undergo a comprehensive assessment by one of our doctors working in the service. You will note that in one of the outputs that we have clearly defined this year we have case management plans for the clients that access the alcohol and drug program for assessment in consultation with a multidisciplinary team, as well as mental health. If clients are diagnosed as having mental health issues, they are referred to the appropriate resource within the mental health service and our staff members, in particular, our dual diagnosis officer work very closely with the mental health team.

DR FOSKEY: Is that one person needing quite a bit of help these days? One person is rather a large task.

Ms Reading: One person is part of a team. The doctors oversee the care plan. There is a referral to case management. There is referral to the specific service needs that that client requires, and it is also in consultation with the mental health team as well.

DR FOSKEY: How does the comorbidity project straddle these areas, as I believe it does?

Ms Reading: Ian Thompson probably could answer that question more precisely. The comorbidity project officer actually works across both the alcohol and drug program and Mental Health ACT.

DR FOSKEY: How does he differ from the dual diagnosis officer, comorbidity?

Ms Reading: It is the same person. It is the same role.

MR PRATT: Minister, would a couple of private medical centres located in the far north and the far south, with a couple of surgeries, x-ray and first aid treatment capabilities take a significant load off the public housing emergency system?

Ms Gallagher: I did not hear the beginning bit of your question.

MR PRATT: Would a couple of privately funded initiatives to create a couple of outlying medical centres, in growth areas of course, take a load off the emergency system?

Ms Gallagher: We have established after hours GP clinics. They are established in Calvary, Canberra Hospital and in Tuggeranong.

MR PRATT: In Lanyon there have been a couple of very viable medical business

capabilities that have been seeking land, but it has taken a hell of a long time—almost four years—for the government to decide to make land available.

THE CHAIR: I thought that the other minister answered this question.

Ms Gallagher: The planning minister.

MR PRATT: Yes. I think Mr Corbell, in seven words, admitted that they had finally made the land available. Do you have any time frame on when that auction might occur because I understand that it may still be some time off?

Ms Gallagher: That is a planning matter.

MR PRATT: Yes, but wouldn't you, in terms of the overall community medical—

Ms Gallagher: I do not keep abreast of planning across the ACT government.

MR PRATT: You do not keep abreast of that stuff? You would not want to be hastening Mr Corbell to fast-rack this, given that it must take a load off Calvary and Canberra hospitals?

Ms Gallagher: I am happy to inquire of Mr Corbell. I have not been made aware of the project you are talking about in Lanyon. I am happy to have that discussion.

MR PRATT: There are a number of businesses, good viable businesses, all prepared to compete at auction for the land release that may be made available—the sooner the better, I would have thought. Surely it takes a load off your system, Dr Sherbon. Can you find out?

Ms Gallagher: I will certainly have a discussion with Mr Corbell.

MR PRATT: Okay.

Dr Sherbon: Just to add to the minister's answer, we do keep an eye on areas of GP shortage. The Lanyon Valley was one area brought to our attention some years ago, although there is, I understand, a surgery in Gordon. My most recent information—perhaps it is wrong—is that a new practice has opened up there. We are also keeping an eye on areas of shortages elsewhere in the city—

MR PRATT: I am just clarifying that.

Dr Sherbon: As the minister pointed out, we do not actually conduct the land transaction.

MR PRATT: I know that. You are correct. A new surgery has been opened at Lanyon by Dr Al-Naser, who I believe is testing the market. What he wants to do and what others want to do—and it is up to them to compete with each other—is to build a full-blown medical centre which provides a couple of surgeries and a bit of first aid treatment to take the load off the—

Dr Sherbon: Yes.

MR PRATT: I would have thought that would be something you would be pretty keen to encourage.

Dr Sherbon: Any development in the private health sector in the territory is encouraging. We have worked with the private sector partners, not in a land use sense because that is just not our remit, but we encourage private sector operators in a whole range of services. We have been recently trying to set up a training role for the Canberra Eye Hospital, for instance—a private eye hospital.

From health's perspective, the answer to your question is we always encourage greater health activity in the town through the private sector, but as the minister pointed out, we do not extend our advice to land issues.

MR PRATT: Would you mind taking that on notice? Are you prepared to squeeze the planning minister to try and get a time frame?

Ms Gallagher: I am not sure what I will take on notice. I am happy to speak to Mr Corbell about how it is proceeding, but I do not think there is a matter I can report back to the committee on. He is the minister with responsibility for planning approvals.

I should say—and this will be of particular interest to the chair of this committee—that I have recently been advised that there is a new GP service in Charnwood, which has been long advocated by an organisation you are patron of, Ms Porter. I know that that is a very pleasing result for the people of west Belconnen, and particularly of Charnwood.

THE CHAIR: It is, indeed.

Dr Sherbon: Chair, there was a question I took on short notice before about nurse turnover rates. In 2001 the nurse turnover rate was 14.54, down to 12.17 in 2001-02. It was 10.3 in 2002-03 and is now down to 7.8 per cent in the last 12 months. So it has nearly halved in the last five years. I am almost tempted to sing that result.

THE CHAIR: Congratulations!

Ms Gallagher: I can table some numbers in relation to increases in categories in the emergency department.

DR FOSKEY: There are 400 people on the waiting list at the indigenous dental clinic, and the clinic is unable to perform any major dental work. Why does the clinic continue to receive around $220,000 a year, rather than the $350,000 a year that would enable them it to cut through that waiting list?

Ms Gallagher: This is the clinic at Winnunga Nimmityjah?

DR FOSKEY: The one in Narrabundah.

Ms Gallagher: I went out to Winnunga, I think on Tuesday this week. Julie Tongs has given me a submission about what they would like to see at the dental clinic. As you

know, they have a dentist and a dental assistant there having very good results in terms of people coming in and accessing treatment. But I need to look at that and I need to take some advice on the management of that issue. As you know, we have significant waiting times under the public program as well.

I think one of the arguments is that Winnunga are saying they do not want to send people to join the list in the public system if they can see them more quickly. But, of course, the flipside of that, if we took resources out of that to give it to Winnunga, is that that could have an impact on the waiting list at the other end for another group of disadvantaged Canberrans. I have to have a look a bit more closely at what Winnunga wants to do there.

DR FOSKEY: I suppose they showed you the dental chair?

Ms Gallagher: Yes.

DR FOSKEY: Did they tell you about it?

Ms Gallagher: I thought it was a nice dental chair. I do not like dentists very much; they always have that feeling about them.

DR FOSKEY: Was it the old chair?

Ms Gallagher: It looked a lot more modern than the dental chair in which I sit; it had a computer screen and everything.

DR FOSKEY: It might not be the chair that was the subject of a lawsuit regarding occupational health and safety. Perhaps that issue has been sorted out.

Ms Gallagher: I do not know.

Dr Sherbon: When we first funded the dental service at Winnunga there was some controversy over the chair, but that was a matter for Winnunga and the supplier of the chairs. We fund the service; we do not run it.

DR FOSKEY: I have heard that.

Ms Reading: I wish to comment on Winnunga dental services. The dental health program in community health provides a responsive emergency service to clients that are dental emergencies, based on our triage system. If the dental officer at Winnunga is having a significant problem with a dental emergency we see clients on the same day. We drafted a memorandum of understanding with the service that we are about to sign off relating to access to oral surgery, general anaesthetics, orthodontics for children and youth, and dentures, based on the same kinds of priorities afforded to other clients who access or who are eligible to access dental services in the ACT.

DR FOSKEY: That sounds really promising. Referring to dental services more generally, prior to becoming a member of parliament I was a client of the public dental system so I know it very well and I was always extremely grateful for it. But I am interested in the waiting times. From my experience only limited treatments could be offered. ACTCOSS has made dental health a major issue. It is a precursor to other kinds

of health and it is an indicator of poverty. If you are missing teeth it is also a definite impediment to your ability to be employed. Could the government give this issue a higher priority?

Ms Gallagher: Yes. The government acknowledges the importance of dental health and the dental health program. In recent budgets we have put more money into the program. Under the program responses to emergency patients are excellent. They see everybody they can within 24 hours and, if they cannot, referrals are sometimes made outside. I think people are waiting for dentures and for restorative dental work.

Whilst a lot more people are getting treatment there has been a significant increase in the number of people joining the list and that is what we need to manage. This is another area at which I will take a good look. The government has put more money into the program, more people are being seen, but the number of people who are joining the waiting list has grown. I think ACT waiting list results are some of the best in the country.

DR FOSKEY: But this is an area that needs federal attention.

Ms Gallagher: Historically it is an area in which we have seen federal government support, but we have not seen such support recently.

MR PRATT: I refer to community services and to the fee for services. The Treasurer said in the budget speech:

> … people on higher incomes will in future be asked to make a contribution towards the cost of the community health services they access.

Where are the details of that policy in the budget papers?

Ms Gallagher: There is no detail and, based on that statement, no money has been put into the forward estimates. Following the budget, work is now being done. As members can imagine, fairly detailed work needs to be done. The government announced that it is doing this work and a discussion paper is being finalised to go out to stakeholders. They can have a look at a whole range of areas where access restrictions and/or co-payments might be applicable. However, as yet, no decisions have been taken. As I said, a discussion paper will go out, there will be community consultation and we will receive stakeholder input. When the discussion paper is returned the government will have to make decisions through the cabinet process before any new regime is implemented.

MR PRATT: Are you in a position to tell us for which services these fees might be introduced?

Ms Gallagher: I think it is for a range of services. We are looking at options, Mr Pratt; we are not just looking at fees. There might be good arguments not to have fees in any area; I do not know. I do not know the answer to that question, as the work has not yet been done. I think the view the government is taking is that the community is fairly well and, on the whole, it is a fairly affluent community. People have access to a whole range of community health programs.

If people are waiting for some services we might want to target particular groups to ensure they are getting those services and not waiting in queues. There might be some argument for access restrictions or asking for co-payments, similar to what we are doing with the dental program at the moment. Although no decisions have yet been taken we will work on these issues throughout the course of the year and probably finalise that work towards the end of this year.

MR SMYTH: Minister, the budget for next year for the output class on page 148 of BP4 is about $5,177,000 less than what you will spend this year on community health services. Is something transferred in or out in that case, or is it just a reduction to community health services?

Ms Gallagher: No, there is no reduction. There is a technical answer to this question. I have written down minus $5,177,000; I just do not have the explanation.

Dr Sherbon: Mr Foster will answer that question.

Mr Foster: A number of adjustments always occur with budgets. We can look at that as being explained with one item. In 2005-06 several properties transferred out of the ACT health portfolio and were assigned to community health, so that is $5.3 million worth of expenditure in 2005-06 that will not occur in 2006-07.

MR SMYTH: That is a good answer. Comparing last year's budget, which was $98.647 million, to this year's budget of $99 million, it is about a 1.2 per cent growth, which in real terms does not even cover CPI let alone health CPI. How will the area cope with a budget that effectively is going backwards?

Ms Gallagher: I am not sure what figures you are using but I am trying to follow you.

MR SMYTH: I am referring to page 168 of last year's BP4. The budget for community health services for 2005-06 was to be $98,647 million. This year it is projected to be $99.881 million, which is about a 1.2 per cent growth. If, as we heard earlier, health CPI is running at 4.6 per cent, how will that area cope when in real terms there has been a cut to its budget?

Mr Foster: We also adjusted the 2006-07 budget for community health by moving more expenditure and revenue into early intervention output, which is about $5 million worth of activity. The early intervention output first appeared in 2005-06, fairly late in the budget process. Through 2006-07 we have taken the opportunity to revisit what could go in there. So $5 million worth of community health activity is moved into that for reporting purposes in the budget papers.

MR SMYTH: We will get to early intervention later.

THE CHAIR: I hope sooner rather than later. We will deal now with output 1.4.

DR FOSKEY: I would like to finish this output 1.3. I want to ask some questions about the Canberra Alliance for Harm Minimisation and Advocacy, or CAHMA. I understand that ACT government funding of $180,000 a year for CAHMA has been withdrawn?

Ms Gallagher: Yes.

DR FOSKEY: Where will this funding go now? If it is not being redirected where do the cost savings appear in the budget?

Ms Gallagher: This was not a budget decision; therefore it is not reflected in the budget papers. My understanding is that some of that money, not all of it, is going to Directions ACT.

DR FOSKEY: So ACT Health does not have a commitment to continuing a peer-run needle and syringe program in Civic?

Ms Gallagher: The government is responding to the concerns of the community organisation auspicing that program. It is not a policy decision of the government that it thinks one service is bad or another service is good. However, as the government funds the grant it has some responsibilities and it needs to respond when organisations raise concerns with it. The AIDS Action Council raised a number of concerns. We looked at those issues and we worked through them to try to resolve them. I have received advice from the department and I have had a look at the work that was done. After a rather troubled history, at the end of the day I think the appropriate decision has been made.

DR FOSKEY: Last year my one and only visit to CAHMA coincided with a visit made by the then health minister. The service probably believed the government had a commitment to continue support for it but I think it got this news through a media release.

Ms Gallagher: I do not think that is the case, Dr Foskey.

DR FOSKEY: I retract my statement which was just surmise. However, the media release could have given the impression that CAHMA was to be closed. I suppose it is up to CAHMA to make a decision on whether or not to close. It still seems to have commonwealth funding and it has a lease with the Griffin Centre.

Ms Gallagher: Yes, sure. I cannot believe that CAHMA was unaware of some of the problems that existed. After reading advice to me I established that a number of meetings had been held and a lot of work had been done to address concerns raised by the auspicing agency about the program. I do not have the media release in front of me but I think it makes it clear that a decision has been taken to withdraw ACT funding of that program. Ian Thompson can provide you with some further detail.

Mr Thompson: At the time the media release was put out it was our expectation that CAHMA would be closing. Following subsequent discussions it appears as though CAHMA will continue to operate from those premises for the time being. That is the reason for the difference between the media release and what currently is the case.

DR FOSKEY: That is a useful clarification.

Mr Thompson: I can reassure you that we have been working hard to try to find a solution to this problem. CAHMA staff were not informed by media release.

DR FOSKEY: I am seeking clarification as there are different messages in the community. I will put the remainder of my questions on notice but I want to ask one further question that I think fits into this output. My question relates to an approach to health. I heard from a practitioner in South Australia, and an article appeared in the *Sydney Morning Herald* about a similar service, that this seems to be a cost-saving measure that works with disadvantaged people and young mothers. Some people seem to think that once a woman has had a baby she knows how to be a parent.

THE CHAIR: That goes for men too, does it not?

DR FOSKEY: I recognise that not everyone has access to resources to provide properly for their children, even with the $4,000 baby bonus. Has the government considered providing support to those who need it? The Sydney program provides follow-up nursing home visits for two years. This is very much about a holistic model of care, not just medical care and advice. We are talking about a broad range of nutritional advice, clothing, et cetera. Will the government consider that approach at some time in the future? We are taking an early intervention approach and we are looking at early years in education. Clearly, to do that in health would seem to be a money-saving venture in the medium to long term.

Ms Gallagher: Sure. I will have a look at the program you are talking about. Having recently had a baby myself I know that people returning home with their babies are very well monitored by the health system. They are visited by Midcall and they are followed up by baby clinics. From my experience, and from talking to other people who have used the service in a sensitive way, it is supportive of, rather than intrusive into, one's life with a new baby. Staff members are aware when you are struggling or need extra support and they link you into that.

I think governments around the country will get better at linking in with other government departments. There is a role for the child and family centres and some of the programs they run. Some of our maternal and child nurses are working in the child and family centres to provide that holistic service. As I said, I will look at that program. I think things are done very well in the ACT and they are individually managed. Just over 4,000 babies are born every year, which is not all that many.

DR FOSKEY: People who do not go looking for services do not go to the child and family centres.

Ms Gallagher: People are chased up in the first instance. Most people have their babies in hospital either at the birthing centre or in the delivery suite. Health professionals recognise those people who might need extra help and they link them in with other services. If there are concerns about the wellbeing of a mother and baby they follow up those people. I am not saying it is perfect but I think the ACT does a very good job.

MR SMYTH: This morning we heard that there is an increased demand on the hospital by older patients and as a result of greater options. I refer to 165 of BP4 and to indicator d. Instead of providing 85,000 occasions of service that number increased to 91,000 in 2005-06 and the same figure is shown for the coming year. Is that because you expect to have fewer patients or fewer opportunities to treat, or is that a way of putting a cap on the service that is provided?

Dr Sherbon: I can assist with that question. The 91,000 occasions of service was a surprise to us. It was over our estimations or our target of 85,000. When we projected out to 2006-07 we thought there might have been some one-off elements to the 91,000, which meant that underlying growth might be counteracted by the loss of one-off factors. Hence 91,000 seemed to be our best guess for the likely outcome in 2006-07 and that is what we are staffed to provide.

MR SMYTH: And the one-off factors might be?

Dr Sherbon: The figure of 91,000 is higher than we expected. I cannot give you a detailed breakdown of those one-off factors, as there is nothing specific. We were surprised at the high figure of 91,000 of occasions of service, given that we projected 85,000 occasions of service. In essence, I am saying that in 2006-07 we have been slightly conservative in suggesting that our target will remain at 91,000, which is this year's level of activity. It may well be higher, especially with the introduction of some new services, but we were being slightly conservative with that target in our suggestions to the ministry and cabinet.

MR SMYTH: Can you take the question on notice and tell me what the one-off factors were?

Dr Sherbon: I do not think there were any identifiable one-off factors. In our analysis of the 91,000 we thought that was high and we were surprised at the extent of the activity this year. Therefore we assumed there were some one-off factors that I am not able to identify. When we projected for 2006-07 we were being slightly conservative in targeting a similar level of activity just because we presumed there must have been some one-off elements. But there is no distinct factor for me to point towards in an out-of-session answer.

MR SMYTH: Are you hopeful that it will not continue? If there is nothing you can point to that led to it is there any reason to assume that growth will not continue if, as you say, we are getting more demand from older people and as a result of different services?

Dr Sherbon: No, there is no reason to assume that growth will not continue, but we were surprised at the growth this year. We expect that growth to start to flatten out. That is why we conservatively estimated 91,000 for next year, but we may well exceed that target and we have enough staff to do that.

MR SMYTH: Provisions of service must have a cost attached to them. If that figure is exceeded what is done in health and community care to cover that?

Dr Sherbon: There are always swings and roundabouts when you estimate activity. You always have to adjust from month to month, based on how your estimations have shaped up against the reality as it unfolds through the year. As one or two programs are up on our estimations perhaps others are below our estimations. It is just the natural consequence of estimating activity and managing towards it.

I do not expect anything to give way, but if activity is higher than suggested we might have to divert resources. That is something we do almost on a weekly basis. When you

run an open-ended system you have to manage variable demand as it comes through the door. We have no plans to free up resources for allied health services beyond those already announced in the community health component of the growth funds.

MR SMYTH: Earlier you took on notice a question relating to expected increases by categories through the emergency department. I will look at those numbers but I do not believe we are planning properly for the future.

Dr Sherbon: It is an estimate; it is not necessarily a fixed number of services. So we will not stop at 91,000 on 31 May and say, "For the month of June we are not providing allied health services."

MR SMYTH: Of course. At the same time if, at the end of May, you have delivered your 91,000, which is a six per cent or seven per cent increase on your estimate of 85,000, it will cost you somewhere else in the system.

THE CHAIR: Dr Sherbon has already answered that question.

MR PRATT: Under the same indicators, why is there no increase in the 2005-06 and 2006-07 figures for opioid treatment clients? Why has there been no increase?

Dr Sherbon: In our experience opioid use is not as prevalent as it was. Today we heard about the use of stimulants by young people. I am not a national expert on drug utilisation, but the data I read indicates that opioid use is stabilised across the country. That reflects the fact that the demand from clients has stabilised in recent years. We had long-term clients who moved on from the program and we had some clients who joined the program, but it has stabilised in recent years.

DR FOSKEY: I have follow-up questions on the alcohol and drug program. In the last year or two I have been talking to Dr Sherbon about changes to the service after the three reviews that have been done. Is this the right moment to check up on how things are going? Is the new director feeling supported? Were the cultural changes recognised as necessary? I take this opportunity to state that I read you are leaving us soon, Dr Sherbon.

Dr Sherbon: I still have five weeks of your blessed company.

DR FOSKEY: There is probably still quite a lot to do to tidy the kitchen.

Dr Sherbon: Yes, there is a lot of work to do.

Ms Gallagher: Chair, this is not really a budget matter.

Dr Sherbon: I can give a one-line summary. Dr Foskey is aware, as we have been updating her regularly, on the progress of reform in the ADP. Of the 111 strategies identified in its business plan to respond to those three reviews it has completed 34 per cent of those strategies. Fifty-six per cent is partially completed and about 10 per cent still have to be addressed. So it is making steady progress if you use that simplistic measure. The feedback from clients suggests that things have improved. There will always be a need for improvement. You cannot turn a culture around within 12 months.

However, my feedback from clients and stakeholders is that things are slowly improving.

DR FOSKEY: So there are no budget implications?

Dr Sherbon: No, most of these strategies have been met within the 2005-06 budget that was adjusted internally. Under Ms Reading's stewardship of community health she has managed to secure some internal resources for some of the strategies that have been employed.

MR SMYTH: Do public ultrasound services provided in the ACT come under this area?

Dr Sherbon: Ultrasound services are usually acute hospital services in the public sector but they are provided extensively by the private sector.

MR SMYTH: Are any 3D ultrasound machines available in the ACT?

Dr Sherbon: I will have to take that question on notice, but I think the answer is yes.

THE CHAIR: We will deal now with output 1.4.

MR GENTLEMAN: Minister, I refer to page 149 of BP4, public health services. The budget papers refer to the fact that there will be an increase in spending this financial year. Will that spending include any new programs under this heading?

Ms Gallagher: You are talking about the difference of around $2 million?

MR GENTLEMAN: Yes.

Ms Gallagher: Yes. As I understand it that is as a result of the integration of Healthpact in this area and some transfers into early intervention. That is the difference.

MR GENTLEMAN: Will that affect the grants Healthpact produced in the past?

Ms Gallagher: No, it will not. The money that is available for grants will be maintained. I think a grant is either under way or it has just been finalised. It will be adhered to and it will be paid. I think all this happened on 1 July, or when the Assembly passed the legislation. We will look at how grants are provided in future, but that money will remain.

DR FOSKEY: Is there any chance that they will go through the grants portal?

Ms Gallagher: Yes. I have not yet had that discussion with Tony and Sandra, the other chief executive. It is a question I asked myself yesterday while I was here.

Dr Sherbon: This morning I was asked what methodology we used in the cross-border agreements with all other states apart from New South Wales. The answer is we use a price that is basically a national average of Australian Institute of Health and Welfare and national hospital cost data collection. That is the price we use. Victoria made us a payment of $336,000 in 2003-04, so more Victorians are coming here than we are going there. I can also table some answers to questions asked by Mr Pratt and Mr Smyth about

the CAT team and additional resources.

Ms Gallagher: We will table them after afternoon tea.

Meeting adjourned from 3.28 to 3.44 pm.

MR GENTLEMAN: How will the additional funding provided in output 1.4 help reduce the rate of hip fractures over the long term? I refer to the third dot point on page 149.

Ms Gallagher: I do not know the answer to that.

Dr Sherbon: As mentioned this morning, falls prevention programs assist in reducing hip fractures by protecting older people or at least gearing them up or skilling them up so that they are able to exercise their balance and strength so as to avoid falls, and also using equipment such that when they do have a fall the damage is minimised. That is how hip fractures are reduced.

Ms Gallagher: That is part of one the initiatives in this year's budget.

MR SMYTH: How many health inspectors are there, how many inspections did they carry out this year, how many will they do next year, and are they being rolled into the joint unit with the parking inspectors and other inspectors?

Ms Gallagher: No, they are not, I don't think.

THE CHAIR: Is that no to the last question?

Mr Sherbon: We can definitely answer no to the last question; they won't be in the office of regulatory services. There will be no reductions in food inspectors but, with more complex requirements of food service outlets, we do expect more comprehensive inspections of high-risk outlets—residential aged care settings, childcare. Dr Dugdale may be able to highlight some other more high-risk outlets. The new regime, which is a national regime, is not as tick-a-box as the previous regime It is focused on risk and it is focused on the balance of resources focusing on the highest risk outlets. Dr Dugdale may be able to add to that.

Dr Dugdale: One of the budget measures is for improving food safety programs and this is a national agreement to look at high-risk food businesses, the ones that Dr Sherbon mentioned, and hospitals, places that provide food to the sick, the frail or the very young, and those programs will aim to improve food handling and reduce disease through those outlets to those vulnerable groups.

MR SMYTH: Do you know how many inspectors there were and how many inspections they carried out?

Dr Dugdale: I would have to get those figures for you, I'm sorry. They are reported in the annual report, which is the other hearing that we have.

MR SMYTH: In terms of prosecutions, were more penalties issued this year?

Dr Dugdale: I have to take that on notice. We usually have just a couple of prosecutions a year, but I don't know the figures for this year.

MR SMYTH: Thank you. Is there a role for the health inspectors in the new regime with smoking in pubs and clubs, or is that being left to the licensing people?

Dr Sherbon: That will transfer to the office of regulatory services. I am not sure if I am using the right title there. The administrative orders that will take effect at midnight tonight will transfer compliance with that legislation to JACS and the office of regulatory services.

MR SMYTH: Will health inspectors have any role in that?

Dr Sherbon: They will have a supporting role in terms of advice but the actual regulatory oversight will be through that newly created consolidated office.

MR SMYTH: Has your office or any other part of the department done any preparation in regard to those changes in terms of supporting the move to get people to stop smoking?

Dr Dugdale: Yes. For the introduction of the complete smoking ban in November, there is a campaign where we have been working with the affected clubs and pubs to make sure that they know what their responsibilities are and also to assist them to encourage their patrons to stop smoking by that date. The clubs have been fairly enthusiastic about this. They realise that not all of them are going to stop, but many of their patrons who are smokers would like to stop and it is a good opportunity to do it when the ban comes in. You will see a fair bit of publicity about that both in the general media and in the clubs over the next four or five months.

THE CHAIR: We will now go on to output 1.5, cancer services.

MR GENTLEMAN: According to page 149 of budget paper 4, the waiting times for access to essential services such as radiotherapy are consistent with agreed benchmarks. Minister, can you inform the committee of any developments in the provision of cancer treatment?

Ms Gallagher: This budget has a range of initiatives to improve our response to cancer services in the territory and, I think, to plan for the future. They are around the new linear accelerator and some staff increases in the cancer services area. I am just looking for the figures on some of the waiting times. I understand that times are very good. We did, of course, have one of the linear accelerators fail this year. That resulted in a 50 per cent reduction in the capacity to treat people and some of those people were required to travel interstate.

I think 100 per cent of the urgent patients received treatment within 24 to 48 hours, 96 per cent of the semi-urgent patients received treatment or are scheduled to receive treatment within four weeks, 71 per cent of the non-urgent patients received treatment or are scheduled to within four weeks and 55 per cent of the non-urgent B patients received treatment or are scheduled to commence treatment within six weeks. In relation to breast

screening, there has been a number of improvements in this area, primarily around the recruitment and retention of staff to assist us with some of the programs there. Dr Stuart-Harris has joined us. I do not know if he would like to add anything to that?

Prof Stuart-Harris: With respect to radiotherapy, we did have a problem when we had the unexpected breakdown of one of our two linear accelerators. Whilst patients who needed urgent and semi-urgent treatment were all getting treatment here, patients who could not be treated within time lines specified by national guidelines were given the opportunity of going elsewhere. With the second linear accelerator now replaced, we have gone back to our more usual situation. Certainly the proportion of patients who can't be treated within the time lines will fall very significantly and so a much smaller number may have to go away. With respect to the announcements in the budget this year, we will be going by 2008, I think, to a three linear accelerator department with a view to going on to a four linear accelerator department by 2012. That will increase our self-sufficiency rate, such that the proportion of patients who are required to go interstate will fall quite significantly over time.

MR SMYTH: Just on that, what percentage currently do end up going interstate?

Prof Stuart-Harris: We have the figures for whilst the linear accelerator was down. I think 44 went away out of 233 approximately. Some patients do choose to go away because they have family in Sydney or whatever. Of course, the proportion when the linear accelerator was down was much higher than usual.

MR SMYTH: And normally?

Dr Sherbon: We do not have those figures because many people seek treatment in the private sector, which is largely outpatient-based, and we cannot pick them up through hospital admission figures. But we think it is somewhere around the five to 10 per cent mark for people having to go away. As Professor Stuart-Harris has pointed out, it is usually those who do not have high levels of urgency.

Prof Stuart-Harris: We have tried to capture the number of patients who are going away but, as Dr Sherbon says, it is difficult. In particular, patients who are referred directly by their GP or by their surgeon we do not necessarily get to hear about; that is the problem.

MR SMYTH: When will the linear accelerator come on line?

Prof Stuart-Harris: The replacement linear accelerator is up and running.

MR SMYTH: So there are two fully operational now.

Prof Stuart-Harris: We have got two fully operational, so we are back to what we were before 6 March, I think it was. I think that the new linear accelerator, going up to three, will be 2008, after the bunker is built, going to four by 2012.

MR SMYTH: For the extra $2 million and having two fully operational accelerators, there does not seem to be a great deal of additional service. The number of admitted patient separations only goes up 60, effectively one a week, and the not admitted

occasions go up 800 over 3,700.

Dr Sherbon: Which page are you on, Mr Smyth?

MR SMYTH: Page 166 of output 1.5, accountability indicators. Given the extra resources, would it not have been reasonable to expect more activity?

Dr Sherbon: In relation to admitted patients, the vast majority of radiation oncology patients are outpatients, so you won't see any increase there. As to the occasions of service, again we could argue that perhaps that figure of an 800 increment could have been higher. Mr Cormack probably has some more up-to-date information.

Mr Cormack: In relation to the growth in admitted separations, they are impacted on by a move to round out cost-weights, which are the counting mechanisms that are updated each year, and that has the effect of lowering by 1.4 per cent the reported activity. Even though the activity moves up in the same way it would each year, the change in the cost-weights lowers the value of it.

MR SMYTH: And in the non-admitted?

Mr Cormack: In the non-admitted, in essence, that is just normal growth. The replacement linear accelerator is really bringing us back largely to where we were. It is not an increase in capacity. It will be a more reliable capacity.

MR SMYTH: Yes, you will have less downtime.

Mr Cormack: We will have less downtime, but it is not a massive boost in capacity. It is really just bringing us back to where we should be. It won't be until 2008 that we will start to see nearly a 50 per cent increase in that capacity. There is a long investment and building time for that.

MR SMYTH: In terms of staff and staff retention, are all the positions you have available filled?

Prof Stuart-Harris: We have gone up from three to 4.6 radiation oncologists, including a new director of radiation oncology. In addition, when the cancer stream started, there was a severe shortage of the therapists who deliver the radiotherapy. We now have our full complement of radiation therapists and there has been an increased supply of radiation therapists throughout this country. At the moment we are much better off for staff to deliver the radiotherapy, and I believe that we would be in a position to attract additional staff, as required, when new facilities come on board.

MR SMYTH: And the number of therapist positions that you have?

Prof Stuart-Harris: Approximately 30, but I am not sure of the exact number.

MR SMYTH: But you have a full complement.

Prof Stuart-Harris: Yes.

MR SMYTH: I turn to the strategic indicators on page 163. As to this year's figure of 54 per cent, there seems to be a slightly different presentation in the budget papers for the current year. What was the expectation for this year?

Dr Sherbon: I can't remember the 2005-06 target, but my recollection from my most recent performance meeting papers is that we are slightly under the total number of women target, and I will explain that in a minute, but ahead of our participation rate target. We will grab that figure in a second. Just to dwell on the number of women, we had a target of 12,000 and we are probably going to fall just short of that. We are now fully staffed with radiographers and we now have a full radiological staff profile on board. So we are in the busy period now of trying to recruit more women to have their breasts screened. In fact, we are looking for ACT women.

We have been promoting the service, which we have not done for a while because we have been short of staff, but we are now fully staffed, they have some new equipment, a new biopsy table, and we hope to introduce digital mammography in the next couple of years. So we are, in actual fact, promoting the service. The participation rate was 57 per cent as at May, so we are above the 2005-06 target. We still want to get to 70, and there are no jurisdictions round the country that get to 70, but clearly we want to recruit more women whilst we are at this fully staffed position, so it is important that we, as community leaders, encourage women in the bracketed age group, 50 to 69, to participate in the program.

MR SMYTH: When you say you are fully staffed, how many staff is that?

Dr Sherbon: I will have to get that on notice for you. When I say fully staffed, I am referring to a couple of weeks ago. There might have been some turnover in recent weeks, but radiographer staffing and radiologist VMO sessions have greatly improved in the last 12 months. Professor Stuart-Harris might have something more on this.

Prof Stuart-Harris: Yes. Earlier in the financial year, we did have some process issues which were highlighted after a review by Jenny Brogan, and we instituted some changes. That increased the participation of women, such that now the problem that we have with meeting the target is more the recruitment of women, such that recently I have written to all the women in the target age group in the ACT who have failed to attend when they should do, encouraging them to attend.

MR SMYTH: Has the sending of the screens interstate now ceased?

Dr Sherbon: No, that will continue. As we move to digital mammography in the coming years, that will become commonplace. Professor Stuart-Harris might have some figures, but I am sure that a considerable proportion of our films are still read in Sydney and will remain thus. With digital mammography, the turnaround will be hours, not days.

Prof Stuart-Harris: Approximately 50 per cent of the films are read by a group in Sydney; I can't give you the exact figure. We have improved the participation of local radiologists, but certainly that Sydney connection is a very important part of the service. It does not just involve reads. The chief of that practise comes down here and does assessment clinics for patients who have been found to have an abnormality.

MR SMYTH: Why is it, if we are fully staffed, that we still have to send the screens interstate?

Dr Sherbon: In terms of radiologists, particularly for a screening program, where you are screening asymptomatic women it lends itself to all forms of models of radiological service provision. So if the radiologists are in Sydney and they are providing a service, that is of equal contribution to someone locally. It is always helpful, particularly in terms of community commitment to the program, to have as much local content as possible, but, in terms of actual radiological services, it makes no difference whether the radiologist is in Sydney or here. In fact, there are a number of services around the world that are actually getting their radiological services across the other side of the globe. As I said, with digital mammography that will become more efficient and more effective. I understand we are now fully staffed with VMO radiologists and they are completing all sessions as budgeted.

MR SMYTH: Why, if we are fully staffed, do we send to Sydney? That practice only started recently, I understand.

Dr Sherbon: They are staffed, but they work from Sydney.

MR SMYTH: Why can't we attract that sort of staff to work in Canberra?

Dr Sherbon: Many radiologists participate in breast screening because they have a commitment to the program, and, like all other participants in the breast screening program, they are committed to eradicating or at least preventing as much breast cancer as possible. They don't pretend to make any great financial sum out of their participation. They see it as a community service and, quite frankly, a private radiological practise is very lucrative and it is difficult to entice people out of that practise. They can work in their own business, or someone else's business, on the hours that they choose. For us to ask them to participate in a screening program, we really are appealing to their spirit of community participation. Many of them do so and we greatly value their participation. Professor Stuart-Harris might have something to add.

Prof Stuart-Harris: We could not fill all the slots in the program for radiologists if we merely had radiologists from the ACT. We are dependent on some radiology input from, as it happens, Sydney at the moment because we just don't have enough radiologists to fill the program from the ACT.

MR SMYTH: But it is only a relatively recent occurrence, the last couple of years, that we have sent screens to Sydney. How long has that been going, about a year or a year and a half?

Dr Sherbon: At least two years from my recollection. I wouldn't be surprised if screens went to Sydney before then. No one in this room in the cancer stream has been involved in the screening service for longer than I have and that is three years. In rural areas of Australia people have been screened remotely for decades.

MR SMYTH: I am just trying to get a handle on what has caused the change.

Dr Sherbon: As I mentioned, in some of the remote parts of the United States the

screens are being interpreted by digital mammography thousands of miles away within minutes.

MR SMYTH: I am just trying to get a handle on why. Is it just the lack of availability of radiologists to do the reading?

Dr Sherbon: Yes. The availability of radiologists, as I said, is entirely dependent on their willingness to participate in a community program. We have little to offer them in terms of the sorts of earnings that they could earn in the private sector. I don't wish to sound critical of radiologists because we greatly value their participation and we have had a good year with them in terms of working on data issues that they wanted sorted out and new equipment. We are very appreciative of the work that our breast screening radiologists do because we know for a fact that if they wanted to go off and do something else for the hour or two a day that they do the screening, they could if they wanted.

MR PRATT: So the dynamics of the profession that effect local availability have perhaps changed in the last couple of years.

Dr Sherbon: I am not sure about locally, but certainly internationally. There is a lot more that radiologists can do apart from seeing 200 or 300 normal breast screens a day.

MR SMYTH: Looking at the last indicator for cancer services on page 166, the target was for 90 per cent of the people making an appointment to be seen in less than 28 days, but you only achieved 82 per cent. Is there a reason for that and is that of concern?

Prof Stuart-Harris: At the beginning of the financial year, as I said earlier, there were some process issues which were holding up some patients being reviewed within 28 days. Following some changes that we introduced, that has now improved. So, whilst it may be 82 per cent, I think that figure is influenced by the poorer figure earlier in the financial year.

MR SMYTH: There was a slow start early in the year but a good finish and next year 90 per cent is looking good.

Prof Stuart-Harris: Exactly. Yes, it should be.

Dr Sherbon: It was actually 86 per cent as at the end of May.

THE CHAIR: Earlier, we talked about the number of people that came from New South Wales and perhaps Victoria to access services here. Is the percentage of people from interstate that access oncology and cancer services higher than that for the other services or the same sort of average?

Dr Sherbon: All of our tertiary services have higher New South Wales participation rates than secondary level services. I am sure cancer is not an exception.

Prof Stuart-Harris: I believe as a rough figure it is about 30 per cent.

THE CHAIR: When you get the third and fourth machines, do you anticipate that you

will attract even more people?

Dr Sherbon: It is not the intention.

THE CHAIR: No, I'm sure it is not.

Ms Gallagher: That is to meet g the local growth in demand.

Dr Sherbon: No, we don't expect so. Most of the demand that is growing locally is, as you know, not really due to population growth but ageing of the existing population.

THE CHAIR: We will move on to output. 1.6, aged care and rehabilitation services.

MR GENTLEMAN: Will the increase in funding for aged care and rehabilitation services help those affected access the aged care assessment team more easily?

Dr Sherbon: Access to ACAT is something that we monitor closely in our internal mechanisms. We monitor the time taken for inpatient assessments, which is 1.46 days. For ACAT following a request for inpatients to be assessed is 1.46 days on average before the team arrives. In the inpatient setting, that is good. ACAT is a federal program and is dependent on federal enhancements, but the HACC commitments of the federal and ACT governments will improve aged care services in a range of frail aged community-based services. I would expect that ACAT services will improve indirectly but they are a specifically funded federal program.

MR SMYTH: I note the budget is going up $10 million. Minister, could we have an outline of what that will purchase, or is it just that something has been transferred in?

Ms Gallagher: Let me just have a look. I think that is the subacute facility mainly, with some growth in there as well.

MR SMYTH: Is the half-year effect of the subacute facility almost $10 million?

Ms Gallagher: It is around $5 million and growth is at around $1.5 million. So now you would like the rest of the $9.9 million. I can see where you are going. Is that right?

MR SMYTH: Yes.

Ms Gallagher: Mr Foster will come and assist us with that.

Mr Foster: The subacute facility accounts for about half of the increase. Wage increases, the full year effect of the wage agreement, are worth about $600,000. The superannuation adjustment for the higher superannuation rates is $700,000. Indexation of non-labour is half a million. And, a thing you would love, a higher proportion of overheads has been assigned to this area after an examination of it, so that is the balance.

MR SMYTH: Why is that?

Mr Foster: It would just be recognising that we probably did not put enough for overheads in there in the original budget because this is a fairly new output and we just

might not have applied the full amount the first time round.

MR SMYTH: Has the same sort of indexation of wages, superannuation and overheads been applied across all the areas?

Mr Foster: Yes.

MR SMYTH: And this one is just a significant change because it wasn't as well—

Mr Foster: For the overheads?

MR SMYTH: Yes, for the overheads.

Mr Foster: No, the overheads aren't such an issue in the other outputs. It is just that our examination on this one didn't get the same share that it should have got, looking at the way we distribute overheads.

MR SMYTH: Is the subacute facility still on line to be completed in December and opened early next year?

Ms Gallagher: Yes, it is due to finish in December 2006.

MR SMYTH: A December 2006 finish, but open when?

Mr Foster: January.

MR SMYTH: How many staff will be required for that?

Dr Sherbon: We might have to ask the director of aged care and rehabilitation that question.

Mr Stone: I cannot give you an exact figure now but I can certainly get back to you on that. It is somewhere in the order of 40 full-time equivalents.

MR SMYTH: There is a substantial increase in the non-admitted services during 2005, but only a small increase by proportion in 2006. Is there a reason for that?

Dr Sherbon: I can start the answer while Mr Stone consults the papers. Again, growth in 2005-06 exceeded expectations. We have accepted that growth will continue in 2006-07, but perhaps not at the highest rate. Again one could argue that that target is a little conservative. I would not mind betting we will exceed it. As you can see, there are also episodes of care under the subacute service as well, which may divert some patients from non-admitted occasions of service, so you can pretty much add those two together.

MR SMYTH: Mark might give me the same answer in output A where the cost-weighted ones have gone down, but that is a revision.

Mr Cormack: Twenty-four per cent was the effect of the move to round eight cost weights. In fact, the biggest impact was in this output class, the second biggest impact was in cancer and a minimal impact, or not as big an impact, in the acute care classes.

MR SMYTH: Can you give me some reconciliation of that, how that has actually worked? I am happy if it goes on notice.

Mr Cormack: Yes. I am happy to do that.

THE CHAIR: What page number are you on?

MR SMYTH: Page 167, output class 1, aged care and rehabilitation services capability indicators. The number of people in falls clinics remains the same.

Dr Sherbon: In the falls clinics, but you heard before that there is an outreach program that will extend the falls outreach program into the community. It is more of a preventative focus.

MR SMYTH: What is the difference between the outreach program and actually in the clinic?

Dr Sherbon: These are people who have had a fall and are referred, usually by their GP, to be assessed by a multidisciplinary team. The outreach program is aimed at preventing falls, so it is looking for hazards in residential aged care settings and areas where older people tend to meet, et cetera. They are both aimed at preventing falls, but in different ways.

MR SMYTH: But long term, in fact, instead of seeing 420 increase, you would like to see 420 decrease because of the preventative effect of having the community-based service.

Dr Sherbon: That would be ideal. I think it would be somewhat unrealistic though because, as I said before, the number of older people is steadily increasing.

THE CHAIR: We will go on to output 1.7.

MR SMYTH: Just before we go on, the full year effect for the subacute facility will be $10 million?

Ms Gallagher: Yes, that is right.

MR GENTLEMAN: I will bring you to page 150 of budget paper No 4. I have noticed there is an increase of almost 100 per cent of the funding related to early intervention and prevention. Can you expand on what services this will include in the increase?

Ms Gallagher: This is a relatively new output class. I understand that last year was the first year. What you have seen as we progress through the other output classes is taking out of each of the other output classes the early intervention focus or component of it and putting it into here, reflecting that significant increase—almost double. I think that is just a matter of the transition to this new output class but, as I said, every other output class has a component—I think it is every other one—that has come across into this area.

THE CHAIR: I was just wondering about reducing the level of smoking in the ACT as

one of the key strategic priorities. Could you mention anything about that?

Ms Gallagher: With the indulgence of the committee, seeing you asked it, chair, I guess it can be tied in to the budget. We have released—

THE CHAIR: It is down here.

Ms Gallagher: Yes, I see it is one of those measures. We have announced a range of initiatives which we are looking at to, I guess, progress tobacco control measures across the ACT. Of course the rate particularly of young women taking up smoking in the territory is still far too high. Some of those are meaning to ban smoking in additional areas, outside dining and drinking areas.

We are currently doing this work. We will go out to a regulatory impact statement around it before cabinet makes some final decisions, but this is the direction we are heading. We are looking at banning smoking on the grounds of educational facilities. Currently most of the schools have smoking bans, but some of the colleges do not—CIT, possibly. I am just trying to think of some of the other measures. There was a range that we looked at.

We are also looking at the use of controlled purchase operations, or CPOs, which is for under 18-year-olds—in New South Wales I think it is under 17-year-olds—who go in and purchase cigarettes. If they are successful, then that operator or seller can be penalised for that.

Looking at the surveys around where young people got their last cigarette from, many of them will tell you that they purchased it themselves. I think we need to do some more work around the area of restricting young people's access to cigarettes in the first place. Dr Dugdale, there are a couple of other things that I think I have forgotten, being the end of the day.

Dr Dugdale: You have done very well. That is a good list; that is pretty much it.

MR GENTLEMAN: Minister, do you have indicators that show what effect smoking has on the health budget?

Ms Gallagher: I think nationally there are 19,000 smoking-related deaths a year across the country. I do not know. I have so many figures in my head at 4.30 pm.

THE CHAIR: We can take that on notice.

Ms Gallagher: But smoking-related illnesses are a significant cost on the health budget.

Dr Dugdale: There has been a reduction in smoking rates in the ACT. That reflects previous measures nationally and also local ACT measures. To keep that going, we need to keep the momentum up with the additional measures, including the indoor smoking measures coming in later this year; outdoor smoking measures that the government is looking at; improved control of purchasing; and surveillance of purchasing. Cigarette packet messages and point of sale messages have also been effective. I think point of sale messages is the only one you did not mention in your list.

MR SMYTH: With regard to that, minister, what is the real increase in funding for early intervention and prevention? When you transfer everything in and add up what they had last year, how much bigger is the budget this year?

Dr Sherbon: We are going to have to call on the famous Mr Foster.

Mr Foster: The presentation in the budget papers for early intervention is simply taking performance measures out of the divisions of health. There have not been any specific new initiatives funded through the budget that might go in there, except for elements of the mental health early intervention initiative, for example. This is a presentational output rather than an operating output of health. These elements sit within the various divisions.

MR SMYTH: That is fine, but at first glance it has gone from $16.9 million to $33 million. Have you doubled the budget?

Dr Dugdale: No. The budget has increased through the range of initiatives announced in the budget as detailed in the statement of appropriations.

MR SMYTH: That is what I am asking. What do they add up to? What do you consider to be early intervention and prevention? How much has the real funding increased?

Ms Gallagher: There are some in the mental health area, there are some in community health and there will be some in the NGO grants, as outlined in budget paper No 3. You are good at adding up figures.

MR SMYTH: I just wanted to know whether you knew.

THE CHAIR: It is not a test.

Ms Gallagher: It is a bit of a test. They are the ones that jumped out at me as I looked down. The components in early intervention cover elements from Canberra Hospital, mental health, community health, grants to community organisations and population health. They would sit within initiatives such as mental health and community health, if I have got that right, in some of those home and community care programs.

MR SMYTH: Is it possible to get a reconciliation? Can you add up what you consider has gone in and what is extra? I am happy if it is taken on notice.

Mr Foster: Sure.

MR SMYTH: I refer to Dr Dugdale's report—the *ACT chief health officer's report 2006*—that he very kindly sent to us all earlier in the week. On page 210 he says:

> Disease prevention and health promotion activities are a mainstay for future health gain. Major health gains are still possible by addressing the prevalence of modifiable chronic disease risk factors like tobacco smoking, which accounts for an estimated 9.7% of the total disease burden … Similarly, obesity …

He goes on to list a few other things. Take the first line, "Disease prevention and health promotion activities are a mainstay for future health gain." Keep us healthy, don't treat us in the acute system. Is there enough emphasis in this budget on early intervention and prevention?

Ms Gallagher: Yes, I think there is, within the money we have, the demand we are seeing and the allocations we have made. I am just looking for the range of initiatives which I talked about at the beginning of the day. Across budget paper No 3 you will see initiatives which cover all of those areas. Bowel screening is one, for example, which I have not covered off in my previous answer to you. If you just give me a second, I will get my list and I can tick them off one by one.

MR SMYTH: Go for your life.

Ms Gallagher: Some of the grants include a pandemic influenza plan implementation initiative, food safety programs, implementing radiation safety legislation, national bowel cancer screening program and Healthpact.

MR SMYTH: In modifying chronic disease risk factors, though, what is new in this budget that would address the concerns raised by Dr Dugdale in his report?

Dr Dugdale: There were a number of initiatives over the last few years that are continuing. So the money is continuing in this budget for youth smoking, falls prevention and obesity prevention. You will remember a significant initiative there. They were addressed in the last two budgets, and those measures are continuing.

For example, we have just signed an ongoing contract with the cancer council on youth smoking. We are negotiating with the commonwealth on the Australian better health initiative, which includes a multiple risk factor campaign across the country. The obesity work is maturing in the ACT, where we are getting a very strong handle on it. It is now impacting on things from school programs to planning.

MR SMYTH: The people who perhaps have the most impact on chronic disease, apart from the individual, is the GP. I do not see anything that says we are supporting GPs more or working with the GPs to look after those who are chronically ill to keep them out of the acute system. I know the federal government has made some payments available through Medicare to assist with that. Is there anything we can do at the local level to assist with that?

Ms Gallagher: There is an initiative which we have not talked about today, which is the community-based health care initiative on page 77 of budget paper No 3. My advice is that that is to do exactly what you are talking about—work with community-based services to ensure the management of chronic disease, with a view to reduced hospital admissions and readmissions for patients who are considered at high risk.

MR SMYTH: How will that work? I also note that it says the initiative will enhance community-based health care services, to provide for timely discharge from hospitals. There is an assumption there that part of it is for getting them out quicker or ensuring better assistance afterwards. I know it goes on to say "reduce hospital admissions". How will that work? I am sorry. I had not picked up on that as being under GPs.

Mr Cormack: The initiative the minister referred to includes a component for the development of innovative models for chronic disease management. What we will be focusing on there is the relatively manageable group of patients who have a high admission rate to hospital, generally related to poor management of their own disease.

We will look at three particular disease categories there—heart failure, respiratory disease and diabetes. The approach we will take with those three client groups or patient groups will be different. For example, in the case of diabetes, that would have a much more general practice focus. In the case of heart failure, it may have more of a focus of a relationship with cardiology. That is what that money is in there for.

It will not be to, I guess, cast a very wide net right across the community. We know the patients who are coming into the hospital on a regular basis. Our data systems tell us that. We will identify them. We will offer them this management model. That is what we intend to roll out.

MR PRATT: Obesity has a major impact on two or three of those chronic elements you just pointed out. If obesity is a major preventative planning issue, why is it not in output 1.7 as a key strategic priority? Why do we not have a program addressing the prevention of obesity?

Dr Sherbon: We do. The government has in previous budgets announced a number of childhood obesity focus programs, as well as physical activity programs for adults. I think it is fair to say that those programs are now up and running. A lot of children and, to a lesser extent, adults are participating. When we came to provide advice to the minister about this budget, we felt that activity had been well and truly entrenched in those matters by the government, particularly with children.

MR PRATT: Is childhood obesity seen more as a strategic priority within the education system? Is that why it is not identified here?

Ms Gallagher: I do not think so. The chief health officer's report, as you would know, contains quite a bit of information around that. It is something the health department looks at very closely.

Dr Dugdale: It is covered in output 1.4 in public health services. It is not specifically mentioned in the papers here, but certainly that is where I get the money to do obesity interventions—in output 1.4.

MR PRATT: Can you quantify the amount of money that you think, or the percentage of programming, is applicable to obesity preventative initiatives?

Dr Dugdale: I would have to take that on notice. It was in the budget initiatives for the year before last, 2004. We are certainly continuing that. That was the additional money. There is some base money that we spend through promotion on common risk factors. They are the SNAP risk factors—smoking, nutrition, alcohol and physical activity. We can have a look at that for you, but it is major core business for us.

MR PRATT: I am at least glad to hear that. Are you able to also advise what the

increase in the incidence of obesity among adults has been in the ACT? Do you have figures for that—maybe a decade trend figure or a five-year trend figure?

Dr Dugdale: We have had a look at it. Again, I would need to get back to you on that. It is not large in the ACT. We have had the lowest increases in Australia. If we take overweight and obesity together, there has been some increase, but I do not have it at my fingertips, I am sorry.

MR PRATT: I gather we perform well compared to most. In fact, we probably perform the best, don't we, compared to other jurisdictions—if that is a performance indicator?

Dr Dugdale: Within the limits of measurement, we have wide confidence intervals around our measures because of the sample sizes, but we are certainly looking pretty good.

MR PRATT: Can you take on notice, therefore, trends for the last decade among adults particularly, and then perhaps a snapshot of the last five years, if you have those statistics available.

Dr Dugdale: I will get what figures we have on the increase in adult obesity and overweight in the ACT. I think if we just go to obesity it is too small in numbers for me to get trends.

MR PRATT: That will be fine. Thank you.

MR SMYTH: Dr Dugdale goes on at page 210 in his report to say:

> This report highlights a number of disturbing trends: for instance, exposure to solar UVR is a risk factor for skin cancer … Yet … an emerging trend among young people who are increasingly avoiding protecting their skin.

He then goes on to talk about maintaining high levels of immunisation and says that, in the last reporting period, it has declined. What are we doing to combat both of those? Were there any other disturbing trends, in your mind, mentioned that you have not listed here as an example?

Dr Sherbon: I can just talk about immunisation. The most recent data is that we are back up around 92 per cent.

MR SMYTH: That is what your indicator says. This is the anomaly of having a report that covers a slightly earlier period.

Dr Sherbon: Yes. It is a different reporting period and a different time frame as well, for each report. What was the first element?

MR SMYTH: Exposure to UV.

Dr Sherbon: Skin cancer.

Dr Dugdale: That is a concern. Surveys of sun-protective behaviours have shown a drop

off in hat wearing by youth—secondary school-aged children. I think the message of "slip, slop, slap" has got a little bit out of favour. It is important that we reinvigorate those messages. Again, we are in the process of contracting explicitly with the cancer council to crank up our sun protection campaigns in the coming summer.

It is hard to maintain the message for these things: eat better, protect yourself from the sun and do more exercise. You have to pulse the community with these messages so they see it as something they can get into at that particular time, rather than as an old message. So we will be doing that this summer.

Ms Gallagher: We will look very favourably on the advice of anyone who comes up with a solution on how to make a teenager wear a wide-brimmed hat and pink zinc, or whatever they use, with the current hairstyles.

Dr Dugdale: Even a baseball cap is not bad. If I can just point you to page 142 of my report, that includes the immunisation figures for 2004-05, showing a return to the highest levels in Australia of immunisation in the last couple of years.

MR SMYTH: Taking on board what Dr Sherbon said, that it is now back up to 92 per cent, how do we close the gap on the last eight per cent? Is that just people who have a philosophical objection to immunisation? I would not have thought that one in 12 of the population felt that way, but maybe it is true.

Dr Sherbon: I don't think anyone in Australia is doing better than 92.

MR SMYTH: I appreciate that; congratulations. Well done. Bringing it back up is a very good thing, but how do we take it the next step? Clearly, if your child is in school with children who are not immunised, there is a risk.

Dr Dugdale: We have looked at that Australia-wide. The rate of conscientious objection is probably no more than two per cent. It probably is just around two per cent. Of the others, there are people that miss out for a variety of reasons. They may be moving, they may be recent arrivals in Australia, although they are usually caught up prior to arrival, or people where there has just been a gap in the schedule. It is pretty hard to get above 92 per cent.

The other thing is, though, that from a population protection point of view, 92 per cent is a magic number for measles. It extinguishes the virus in a population if you can get immunisation rates to that. So that is really what we are striving for. The additional cost of going up to 98 per cent and catching everybody who does not mind getting immunised is just not worth it. It is very expensive to push it up from 90 to 91, from 91 to 92 and to 95 or 96. We are working on it, but it would not be worth putting in a huge amount of resources, because we already get the levels of protection in the community at 92 per cent.

MR SMYTH: You said "for instance", and you listed solar skin cancer and immunisation. Are there any other areas of disturbing trend that come to mind?

Dr Dugdale: We talk at some length on obesity. We have covered that today. Overall the challenge, I think, is to maintain the gains in health that we have experienced over the

last decade—the actual increases in life expectancy and how we are going to continue to increase life expectancy. That is through better cardiovascular disease care, prevention of diabetes, the common risk factors and better hospital care.

MR SMYTH: I understand HIV/AIDS is seemingly on the increase again. Infection rates are moving slightly.

Dr Dugdale: Nationally that is the case.

MR SMYTH: Yes. And in the ACT?

Dr Sherbon: Not in the ACT.

MR SMYTH: Not in the ACT, or is it too small a number?

Dr Dugdale: We have not seen it yet in the ACT. We may do. We are certainly working closely with the interested community organisations and clinical services to get the message out to try and prevent that happening in the ACT. But there is a serious risk that that may happen here.

MR SMYTH: As a last question, I refer to the indicators at page 167. It says that the total number of breast screens is 12,000. The total number of screens expected this year for women aged 50 to 69 is 9,950, as well as the target. But it is the same target for next year. I accept what you said earlier about the difficulty, but now that we have the machinery and the staff in place, what will be the action taken to get that number up again?

THE CHAIR: I thought the minister addressed that before.

MR SMYTH: They touched on it, yes. Is there anything specific that will now come from it? I heard what you said before.

Dr Sherbon: The funding is determined by the federal government under the PHOFA, the public health outcome funding agreement. That is why the target stays the same. As we mentioned earlier, now that we are staffed, we are looking to fill slots by recruiting more women through promoting the program.

THE CHAIR: Thank you very much, minister. Thank you, Dr Sherbon. I would just like to recognise that this is your last estimates with us.

Dr Sherbon: I am not sure if I will get over that.

THE CHAIR: You had your little moment with the water there, just so we will always remember you.

MR PRATT: Can I just ask him, finally, does the health budget float?

Dr Sherbon: Always.

Ms Gallagher: Can I table that question we took on notice around the CAT.

THE CHAIR: I thank all the witnesses for attending today.

MS GALLAGHER: Thank you to the committee.

The committee adjourned at 4.46 pm.