LEGISLATIVE ASSEMBLY FOR THE AUSTRALIAN CAPITAL TERRITORY

SELECT COMMITTEE ON ESTIMATES 2007-2008

(Reference: Appropriation Bill 2007-2008)

Members:

MR M GENTLEMAN (The Chair)
MR B STEFANIAK (The Deputy Chair)
MS M PORTER
DR D FOSKEY
MRS J BURKE

TRANSCRIPT OF EVIDENCE

CANBERRA

FRIDAY, 29 JUNE 2007

Secretary to the committee:
Ms G Concannon (Ph: 6205 0129)

By authority of the Legislative Assembly for the Australian Capital Territory

APPEARANCES

The committee met at 9.31 am.

Appearances:

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

ACT Health
Cormack, Mr Mark, Chief Executive
Thompson, Mr Ian, Deputy Chief Executive, Clinical Operations
Brown, Dr Peggy, Director and Chief Psychiatrist, Mental Health ACT
Cahill, Ms Megan, Executive Director, Government Relations and Planning
Childs, Ms Judi, Executive Director, Human Resource Management Branch
Cole, Ms Deborah, Chief Executive Director, Calvary Public Hospital
Dugdale, Dr Paul, Chief Health Officer, Population Health Division
Foster, Mr Ron, Chief Finance Officer, Financial and Risk Management Branch
Reading, Ms Jenelle, General Manager, Community Health
Smalley, Mr Owen, Chief Information Officer, Information Services Branch
Stone, Mr Bill, General Manager, the Canberra Hospital
Trompf, Ms Linda, Acting Executive Director, Policy

THE CHAIR: Good morning, minister, officials from the Department of Health and members. Welcome back to the 2007 estimates committee hearing into the budget. I will just read the card for you before we begin. We will be hearing from the Minister for Health today. We will be dealing with output classes 1.1 through to 1.7; we hope to get through 1.3 before the lunch break.

The committee has authorised the recording, broadcasting and re-broadcasting of these proceedings in accordance with the rules contained in the resolution agreed by the Assembly on 7 March 2002 concerning the broadcasting of Assembly and committee proceedings.

Before the committee commences taking evidence, let me place on the record that all witnesses are protected by parliamentary privilege with respect to submissions made to the committee in evidence given before it. Parliamentary privilege means special rights and immunities attach to parliament, its members and others necessary to the discharge of functions of the Assembly without obstruction and without fear of prosecution.

While the committee prefers to hear all evidence in public, if the committee accedes to such a request, the committee will take evidence in camera and record that evidence. Should the committee take evidence in this manner, I remind the committee and those present that it is within the power of the committee at a later date to publish or present all or part of that evidence to the Assembly. I should add that any decision regarding publication of in camera evidence or confidential submissions will not be taken by the committee without prior reference to the person whose evidence the committee may consider publishing.

I remind witnesses to bring their name tag from the side table and make sure they

mention their name and title when they are addressing the committee, for Hansard.

Minister, would you like to make any opening comments in this output class?

Ms Gallagher: Thank you. I will be very brief—just set the context of what this budget means for health. As you can see, a number of officials stand ready, willing and able to answer any of the committee's questions.

This year's budget continues to be a very strong one for health. The government has prioritised health in all of our budgets since coming to government. This year, expenditure on health will exceed $800 million for the first time. We have targeted a range of initiatives which go to areas of significant pressure and demand for services; I do not think it is any surprise to committee members that some of that growth—quite a bit of that growth—will go into the hospital system by way of increased access to elective surgery and increasing hospital or acute care beds.

There is a range of initiatives in this budget to continue the work done in other budgets around improving our services to the Canberra community. Whilst the acute sector certainly gets a significant proportion of the new expenditure in this budget, we are also prioritising other areas—mental health and chronic disease management, for example. We can go through those initiatives with the committee if they desire.

We believe that the package we have put together is responsible in terms of the commitment we have made to government to rein in some of our costs. This year will be a tight one for health. In last year's budget, we set ourselves a target of 6.4 per cent average over the forward estimates growth. This year the growth is 5.1 per cent, but the growth in previous years remains in the system. In terms of money, this budget probably has the least percentage of growth—if I can try to explain it this way—that we will face. It will be one where our efficiencies and measures that are underway to improve the efficiency of the health system are really important.

Overall, it is a very good news budget for health. There is significant capital expenditure in relation to a new car park at the Canberra Hospital and it also kicks off some very important pieces of work around the neonatal intensive care unit and planning for future in-patient facilities in the area of mental health—so looking at moving forward with feasibility and design for an adult mental health in-patient unit along with a secure unit as part of that project.

In relation to Calvary, importantly, there is also a commitment around a new intensive care, cardiac care unit at the hospital, which is something that I have been lobbied very strongly for by doctors at Calvary. I am very pleased that this budget is able to deliver that project.

I am sure there are many more questions that the committee have. As I said, we are ready, able and willing to answer those questions. Thank you.

THE CHAIR: Thanks, minister. I might kick off. Minister, it was announced on radio Triple J this morning that elective surgery waiting lists Australia-wide have risen. Does this budget include any additional funding for elective surgery, and will that funding directly affect the waiting lists?

Ms Gallagher: The waiting list—it is great to get straight into the waiting list! This budget provides an extra $10.5 million—I am sure I will be corrected if that is wrong—over four years for increased elective surgery. That is similar to the increase that we invested last year. That money will go to commissioning the 10th operating theatre at the Canberra Hospital, which is currently the only one left to commission. It will provide for an estimated additional 300 procedures, which is what we delivered—it is 30 June tomorrow, and we are on target to meet that from last year's initiative, which was a similar allocation of increased funding.

In terms of throughput, yes, it will increase throughput in elective surgery. This year we expect around 9,300—those numbers will be finalised over the next few days—in terms of removals from the list. But at the same time, whilst throughput has certainly grown and increased dramatically—we are talking of an increased 1,500 removals from the list compared to three four years ago—the waiting list remains fairly static. I should point out that I have no say about additions to the waiting list. It is just not something that the government controls at all. It is doctor initiated, as it should be. My emphasis as health minister has been to concentrate on throughput—that is, how many we remove off the list—because that is something we can control.

In answer to your question, we would be hopeful that our increased investment would improve waiting times for people on the elective surgery list, but I cannot answer as to whether that translates into less of a list. I cannot control it either. But I make sure that the numbers of operations being performed, the efficiencies of our operating theatres and access to our theatres are as good as they can be. That is what this budget focuses on.

MRS BURKE: Would you consider working with the private hospitals? There is an option for you to do that, surely.

Ms Gallagher: We do that already.

MRS BURKE: Have you thought of increasing the capacity there?

Ms Gallagher: Where we can. Again, throughput is not our problem; we are increasing our throughput every year. As I said, I think it was 7,500—

MRS BURKE: But the waiting list is still unacceptable, isn't it?

Ms Gallagher: The waiting list remains stable. It might not be unacceptable in the sense that people join the list and are categorised. I think it is unacceptable in relation to long waits—people waiting too long. They are a proportion of the list. But it is not unacceptable to have a list and to have a wait, particularly if you are—

MRS BURKE: What is an acceptable wait in your mind?

Ms Gallagher: I would say what the categories are, what you are triaged at, what you are classified at. Seventy per cent of all people on the list receive their treatment on time. That means that 30 per cent do not. I hope I am right with that figure.

THE CHAIR: Ms Porter.

MS PORTER: Yes—

Ms Gallagher: Sorry, if I can just finish.

MS PORTER: Sorry.

Ms Gallagher: For people who exceed their waiting times greatly, I would say that that is unacceptable. That is what we are working on. But in relation to private hospitals, we certainly look at them. We look at what work we can contract out if they are willing and able and it fits in with some of the priorities that we have.

MS PORTER: So—

MRS BURKE: Thank you. I just want to pick up on another point about something you said about the throughput in surgery in relation to relationships between administration and the surgical department. Was I to understand that you recently instigated meetings between admin and surgical?

Ms Gallagher: Some time ago—certainly within the last year—we established the surgical services task force, which is a range of people—professionals from within the department, within the hospital and within the surgical area, including doctors and nurses and colleagues from New South Wales—to look at this as part of the access improvement program.

MRS BURKE: It is a fairly recent initiative?

Ms Gallagher: Probably about a year.

MRS BURKE: Whilst we have been seeing the list growing, wouldn't this have been something you could have done—

Ms Gallagher: I have only been minister for a year.

MR STEFANIAK: Why hasn't it happened before? It may not have happened under the previous government. Perhaps Mr Moore should have done that too. Why has it only happened in the last 12 months? I would have thought that it was basic that the admin staff and the surgical staff get together occasionally—

Ms Gallagher: It is not to say they were not. This is part of the access improvement program targeting the patient journey through the hospital and identifying areas where there is room to improve. It is certainly not the case that admin and surgical would not have talked in the past. What we have done—

MRS BURKE: That is a cohesion thing.

THE CHAIR: Mrs Burke, do you want to hear the answer to your question?

Ms Gallagher: What we have done is set up a task force specifically to look at the

surgical journey and, under the access improvement program, identify areas to improve that. That is what the task force is about. Would you like to add anything there?

Mr Cormack: Yes, thanks. The minister is correct. The Surgical Services Taskforce was established to look at surgery access across the ACT. It covers both the Calvary and Canberra Hospital public hospitals. In the past, we have always had interaction between surgeons and administration. Ever since public hospitals have been commissioned, there have been regular meetings between the administration of the various hospitals and surgeons. Each sub-specialty tends to have a director or a nominated head. There are regular meetings between the surgeons, the nursing staff and the administration of the hospitals to address issues regarding the improvement of surgical performance. The Surgical Services Taskforce takes it up another level and recognises that we have to also take a long-term view about what our surgical service requirements are. The Surgical Services Taskforce will assist with that as well as addressing whole-of-ACT policy issues. That is the more recent work that we have commenced.

MS PORTER: Minister, with regard to the waiting list that we were just discussing, I believe that there are additional beds in this budget. I was wondering (a) what is the total number of beds that we will have and how that compares with previous years and (b) whether that will help us with this particular issue that we were just discussing?

Ms Gallagher: I do not think that we can increase elective surgery to this extent without increasing bed capacity, because people leaving their surgery need somewhere to go. The two initiatives are certainly linked. This budget provides for 20 acute care beds—I am not sure of the exact mix of those—although 10 of them will be for orthopaedic use, which is a commitment we have given the orthopaedic surgeons. Of course, we see quite a bit of demand for orthopaedic surgery at our hospitals. This is sort of unrelated, but there is one other bed—it is an intensive care bed—as well, as part of the budget, at a cost of $5.1 million over four years. It is an expensive bed, but that is what it costs. So we are increasing critical care capacity as well as capacity to deal with the extra demand we are seeing in the hospitals.

This will make it a total of 147 new beds that we have put in over the last four budgets. In recent reports, we have seen that the average number of beds per capita in the ACT is rising against a national trend of decreasing beds per capita. I am very pleased with that. We started from a low base. We have just done some work around bed numbers in the ACT over, I think, the last 10 years—having a look at them and where they are. That work shows that we saw a decline in the early 2000s. Whilst we have been investing for the last four budgets, we are now seeing that pick up again. We will have over 800 beds in the system in the next few years.

MS PORTER: The Calvary unit you mentioned in your introductory remarks—is that surgical as well as medical? What nature will that take?

Ms Gallagher: The ICU?

MS PORTER: You mentioned a cardiac unit.

Ms Gallagher: The cardiac unit, yes.

MS PORTER: At Calvary.

Ms Gallagher: That is an intensive care—a refurbishment of their current intensive care unit, which also will have a cardiac care unit as part of that. The agreement we have worked out with Calvary Health Care ACT—it is a joint project in the sense that we will fit out and equip their unit and pay a capital charge for the work that is undertaken to establish that unit. This is something that has been long sought after at Calvary. The intensive care unit at Calvary has been operating out of inadequate facilities, and that has placed a strain on the hospital. This is a very welcome initiative for all—not just for the doctors, but also for ACT Health and for the broader community who may need to use those services.

MS PORTER: Thank you.

THE CHAIR: Dr Foskey.

DR FOSKEY: I am interested in strategic indicator 2 on page 159 of budget paper 4. I note that there is no change predicted for the two per cent of people readmitted to hospital within 28 days of their separation, due to complications. There are a couple of questions around this. First of all, why is there a figure of one per cent for Calvary and two per cent for the Canberra Hospital? Could you just explain that differential to me? And how useful an indicator is this of the efficacy of hospital services?

Mr Cormack: The difference in the two targets reflects the different casemix and complexity of the two hospitals. It is recognised that in a hospital such as the Canberra Hospital, which sees a far more complicated mix of patients and undertakes higher risk surgery and higher risk procedures, you would anticipate, in the normal course of events, a higher rate of unplanned hospital readmissions.

The usefulness of this indicator for both hospitals is, first, that are we able to monitor on a regular basis against a nationally accepted indicator, and this can be benchmarked against the Australian Council on Healthcare Standards, ACHS, which is the national accrediting body for hospitals. This can be benchmarked against the clinical indicators that are published by that body. We are able to not only look at how we are tracking compared to our own goals, but also compare our performance against similar sized hospitals. Hence, we have a two per cent target for Canberra Hospital, which will be compared against the top tier of teaching and referral hospitals; and Calvary will be compared against the next rung down, the major metropolitan hospitals.

DR FOSKEY: Are they tracking well with that comparison?

Mr Cormack: Certainly; they are. The estimated outcomes are on target. You do get fluctuations from month to month, but we look at these as a trended set of indicators, and we are comfortable that the readmission rates are under control.

MR STEFANIAK: Has—

DR FOSKEY: I will just finish my line of questioning, if you don't mind.

MR STEFANIAK: Sorry.

DR FOSKEY: I note that there is similar proportionality in the hospital-acquired infection rate—Canberra Hospital 0.5 per cent and Calvary 0.1 per cent—with Canberra Hospital having an estimated outcome slightly higher than the predicted outcome. Could you explain that? I am quite sure that there is a good reason for it, but those figures do request explanation.

Mr Cormack: I am certainly happy to do that. The same explanation applies to the different rate for the two hospitals. We also need to recognise that there is normal statistical variation that applies. The advice that we have is that the outcome for 2006-07 is not statistically significantly higher. Yes, it is higher, but it would be within the normal expected bandwidths of variability in a statistical sense.

DR FOSKEY: Is that an increasing problem that hospitals are dealing with, though? Anecdotally I have heard that it is, generally speaking. What measures can you take to reduce the likelihood of bacterial infections?

Mr Cormack: It is always a challenge for public and private hospitals to deal with hospital-acquired infection rates. There are a couple of approaches that we take. The first approach is to ensure that we have rock-solid monitoring systems. Those monitoring systems kick in from the time the patient presents. We look up their record; we are able to see, for example, whether they already have hep C, hep B or other sorts of infections. So we look at the patients before they come in. We also monitor the records to ensure that we pick up infections early. And then we put in place a range of remediation strategies. Those strategies can include simple things like education about the importance of cleanliness and washing our hands. In fact, in the last 12 months, anybody who has visited Canberra and Calvary hospitals will have seen our staff—doctors and nurses—at times wearing badges saying, "Where have your hands been?"

DR FOSKEY: I don't want to hear the answer to that!

Mr Cormack: That is really to raise awareness amongst the treating staff and also the patients. We have those sorts of campaigns running. Also, if there is an outbreak—and from time to time there will be an outbreak—of hospital-acquired infection, we look at segregation measures, extra nursing practices and a higher use of protective equipment and garments. It is a constant problem, and we need to keep on top of it. We in the ACT are very fortunate to have a very passionate leader in infectious diseases, Professor Collignon—

DR FOSKEY: Yes, he is passionate.

Mr Cormack: He is very passionate. His passion is very heavily directed towards safety in the hospital environment. We think we have the right program in place.

MR STEFANIAK: I have a couple of quick supps on that. Can you provide the figures as to how many patients represent the two per cent and the one per cent in

strategic indicator 2—and also for strategic indicators 3 and 4? That would help. I would also be interested to know if you can give us figures as to how our rates compare with, say, Sydney metropolitan hospitals.

DR FOSKEY: Could I just finish that off? Are you taking this on notice?

Mr Cormack: I am happy to take those on notice. Our advice is that we compare very well against all other peer hospitals, but I am happy to take it on notice.

MR STEFANIAK: If you could. It is not as though they are in front of us.

Mr Cormack: Sure.

MR STEFANIAK: We are doing as least as well as them. If you could, though, I would like to see the figures on that.

DR FOSKEY: Finally, in relation to the first question I asked about readmission, does the government put any resources into looking at, caring for and monitoring people—especially people who might be deemed to be at risk—who are separating from hospital just to keep those figures for readmission down?

Mr Cormack: Yes, certainly we do. Through our discharge planning processes, we identify, out of the 70,000 to 80,000 separations across the hospital sector, those who are at risk. We make sure that there are discharge plans in place, particularly for those most at risk. We monitor those. They are part of our ongoing work; they are also part of the access improvement program, which is a program that we have had in place for two years which looks at that transition from the hospital environment to home. That very much focuses on managing risk: we want people to go home and not come back unexpectedly to hospital.

DR FOSKEY: Thank you very much.

MRS BURKE: We have all read the papers this morning. My concern is that we hear that you have espoused—that we have pumped a lot of money into the health system. The problem that I have is that the Australian Institute of Health and Welfare issued a report in May. The federal government has issued its own report today—which I have not seen, and probably you have not at this stage. Obviously all indicators would say that we are still the worst in the country when it comes to elective surgery and emergency departments. Minister, my question to you is this: what has changed, despite all the money being pushed into the system? Why aren't we seeing those big improvements that we should be seeing given the amount of money?

Ms Gallagher: The Australian Institute of Health and Welfare report identified three areas which we have talked about in the Assembly previously. The report on the state of our public hospitals, which I understand will be released today, really draws on the same data that the AIHW uses. The data are embargoed to midday—

MRS BURKE: But the situation has not changed drastically, has it?

Ms Gallagher: In relation to categories 3 and 4 in the emergency department and in

relation to the median waiting time for elective surgery, the figures in this report will be the same as the AIHW. So yes, when you measure them next to other jurisdictions, we come out at No 8. Around the elective surgery issue, I have explained that we are targeting the long waits. That has been reflected in a number of the reports as well, so that is substantiating my explanation for that. I myself and the previous minister asked that long waits be prioritised off the waiting list; that has affected our waiting times. On the one hand, that is good for the patients who have received access to their surgery, but it is not good when you look at this data like a report card.

The issue around the emergency department—again, I have been up-front: more work needs to happen there. There are explanations for it, but it is difficult to just stand up and say that there are reasons for it when you are constantly criticised for having the worst times in the country. There are reasons such as—

MRS BURKE: But rightfully so. You cannot expect people to sit back if they are languishing on a list, can you? You would be the same; I would be the same. You cannot blame people.

Ms Gallagher: In the emergency department, there is no list, but in elective surgery—

MRS BURKE: There are numbers indicating that a 46-minute wait would not be acceptable.

Ms Gallagher: That is right. But, for example, a larger jurisdiction has a number of small, rural hospitals that run emergency departments where there is no wait for anybody. You present; you get seen. That is because of the nature of the services provided in a small country town.

MRS BURKE: I do not think that is an acceptable response given that we are the capital city of Australia and we have two major public hospitals.

Ms Gallagher: Yes.

MRS BURKE: I do not think you can keep deflecting the issue.

Ms Gallagher: I am not deflecting it. I accept the reports, but I am saying that it is not comparing apples with apples. That is what I am saying. I know that it is a hard line to run, but if you are a small, rural hospital and you run an emergency department and you see one person a day, that person will be seen on time. If you run two major hospitals, as we run here, you do not have those same smaller hospitals which contribute to your data and your timeliness. We do not have the benefit of that. We could open a number of tiny places around the city, for example—establish little hospitals with EDs—to try and make our numbers look better. But I am trying to explain to you that it is not comparing apples with apples. Whilst I accept that our waiting times are not acceptable for categories 3 and 4, I am saying that there is a range of reasons. Another reason is that, in other jurisdictions, the clock stops or starts when treatment starts, whether that treatment comes from a doctor, a nurse or another professional in the emergency department.

MRS BURKE: With respect, we are talking about the capital city, not a little regional

hospital.

Ms Gallagher: No. Can you just let me finish my answer, because this is quite important? For example, take a hospital in Sydney. If you present to an emergency department and you are seen by a nurse or physiotherapist, that is when the treatment starts. That is when the clock stops in terms of time waited. In the ACT, we have not done that. Patients have waited until they have seen a doctor for that time to start. You can talk to anyone: that is a reason why our times look so poor when compared across the country. There are reasons for it—not just that people are waiting. Some of it is around data and some of it is around the situation we are in—in that we do not have lots of different types of hospitals offering—

MRS BURKE: But we have a smaller population, don't we? You have to concede that.

Ms Gallagher: We have the highest rates, next to the Northern Territory, of people accessing our emergency department. Your overall population has nothing to do with it. We are 100 ahead per capita of other jurisdictions when you exclude the Northern Territory, which is out on its own. We are number one in the country for people presenting to the emergency department. It is not about having a small population at all. That is not relevant in the discussion. Our community comes to the emergency department more than any other community outside the Northern Territory. That is reflected in national reports. They are not my figures.

THE CHAIR: Ms Porter.

MRS BURKE: I am sorry, I have a couple of things. Staff morale, obviously, is of grave concern to me. There is a website—I think you are probably aware of it—the blog, where nurses post their innermost thoughts and feelings. I am very concerned to see that a number of those postings—you would probably be aware of this—come from the ACT, where the pressures exerted, particularly in the emergency department, are causing people to leave the system. We are saying that we are putting more money in, but it still is not fixing the problem. What are you doing to try and assist with the morale of the hospital, by working with management, to ensure that we are not getting masses of people leaving? It is getting out of control because so many people are leaving. They are disillusioned and downhearted—they are giving up.

Ms Gallagher: They are not, Mrs Burke.

MRS BURKE: They are not?

Ms Gallagher: Separation rates—

MRS BURKE: They are not leaving?

THE CHAIR: Mrs Burke, let us hear the answer.

Ms Gallagher: Separation rates from the ED would not support what you are saying; they just wouldn't. Hordes of people leaving—we have not seen that.

MRS BURKE: I did not say "hordes"; it starts with one, two or three.

MS PORTER: You did. You said "masses".

Ms Gallagher: You said "masses of people are leaving in droves".

MS PORTER: That is right; you did.

Ms Gallagher: Anyway, you are saying—

MRS BURKE: Morale is bad—yes or no?

Ms Gallagher: I do not disagree that morale in the emergency department from time to time—and I think it does change—goes up and down. I think it is a high-pressure environment. It attracts a particular type of health professional. There are frustrations, particularly on busy days when the system might not work as well as it should.

I personally have had two staff meetings with staff at the emergency department, aside from a number of other visits that I have done to the emergency department, along with Mark Cormack. We have sat down with staff and talked with them through some of the issues they have had. I have then returned, three months later, and had another talk with them. Whilst there are still areas of concern for them, largely on busy days when they are under enormous pressure, a number of nurses—mainly nurses—on that day indicated that some of their concerns certainly had been addressed. They raised a range of issues with us and many of them we were able to work on or fix.

I have been in constant discussion with some of the doctors there, particularly when I visit there for whatever reason, around some of the things they like to see improved. They would like a paediatric registrar in the new paediatric area we have opened there. We are sorting that out. A couple of professionals from Sydney—a doctor and a nurse who run an emergency department in Sydney—come down, have a look and give us some extra ideas about how we can improve and relieve some of the pressures in the emergency department. We have opened the MAPU, a ward specifically designed to relieve pressure off the emergency department and target—

MRS BURKE: Can you say what the acronym is for Hansard?

Ms Gallagher: The management and planning unit?

Mr Cormack: The medical assessment and planning unit.

Ms Gallagher: The medical assessment and planning unit particularly targets complex patients who present to the emergency department, who previously have had very long waits in the emergency department, taking up beds because of the complexity of their condition, and their admission to other areas of the hospital. We now have a dedicated unit. Staff from that unit come down to the emergency department and scan it for patients that are eligible for MAPU.

MRS BURKE: What has your feedback been on MAPU?

Ms Gallagher: So far the feedback has been excellent. It is working as it was intended. There are short stays, largely, for people. Many people are returning home after they have been stabilised, with some being referred to other areas of the hospital. It has created an extra 12-bed capacity within the hospital. I understand that it is moving to 16 beds on 1 July. There is daily capacity, certainly for the emergency department, to relinquish certain patients to another area of the hospital.

There are still areas to work on. I recently went to Sydney and visited a number of emergency departments to look at what they have been doing. They face the same demands and pressures that we have here. I looked at how they have dealt with some of those issues. New South Wales Health undertook the access improvement program probably 18 months before we did. The feeling I got from that is that we have all the right ingredients ready to go in our emergency department. It is just a matter of pulling it together, listening to staff and making sure that we can reflect and address their concerns—pulling together the skeleton of what we have to make that emergency department run, particularly at the Canberra Hospital—these pressures and demands are not as obvious at Cavalry, perhaps—and making sure that we are dealing with and addressing staff needs and morale.

In relation to morale, whilst I accept that from time to time nurses are under enormous pressure and that we have been short of doctors, our separation rates would not support anything that they are giving up and leaving. In fact, I think they understand they have a very receptive department and minister who wants to make things better for them.

MRS BURKE: I am just concerned that with three health ministers, six years on, we seem to be going backwards rather than forwards. I will leave it there.

Ms Gallagher: I don't think that is the case.

MRS BURKE: The figures show that, don't they?

THE CHAIR: Ms Porter.

MS PORTER: Minister, I would just like to go back to the priorities on page 151 and focus a little bit on preventive health. There are two areas there that the committee would like some more information about. The third dot point from the bottom says that we are looking at:

> extending the existing health services for marginalised and disadvantaged young people in Belconnen/Gungahlin and Tuggeranong areas …

Just above that it talks about the HPV vaccination program in the ACT. Again, that is targeting young women—high school students, I believe. I just wonder if we could have some more information about those two.

Ms Gallagher: Sure. The budget allocation for the HPV vaccination program is largely funded by the commonwealth. There is a big figure of around $8 million in there—$8 million overall. We are providing a small proportion of that in terms of

extra resources needed to do such a big vaccination program. That is underway. I think it is a great initiative and I really congratulate the commonwealth government for funding it the way they have.

I think the issue to look out for there—and it has been reflected in some of the latest reports—is that girls and women in the younger ages, those under 40, are not having regular Pap tests every two years. In fact, the 20 to 24-age-group is the worst in joining the national cervical screening program. One of the issues around this will be how to make sure that girls do not think they have been cured or that they are immunised against all strains, because that is not the case. I think this deals with about 70 per cent, but we still need young women particularly to join and understand that they still need to go through the regular screening program that all women do, regardless of whether or not they have had the vaccination program.

That is something we will keep an eye on in terms of promotions. We are the best in the country with cervical screening. I think we are 65 per cent against the national average, which is in the fifties. But, once you get down to the younger age groups it is fifty-fifty—50 per cent are and 50 per cent aren't. A large number of women are not joining the program. We will keep our eye on that.

Young people's health services are basically going to be modelled on the Junction youth health service that operates in Civic. It was an election commitment of ours to look at expanding this to other areas of Canberra. That is what that money will do. This will go through a tender process, but certainly the preference is that it be based around a Junction model, which has been successful.

MRS BURKE: Minister, on 7 June you were a signatory, along with the other states and territories, to a report called *Caring for our health?*

Ms Gallagher: Yes.

MRS BURKE: On page iii, you stated:

> We believe that the more governments are open and accountable the more effective they are.

Ms Gallagher: Yes.

MRS BURKE: A noble statement. What I want to know is: why have you denied access to the Assembly in regard to capital works quarterly reports? For the last 18 months, I think, that has been the case, to be fair.

Ms Gallagher: This has been an issue across government. We have not denied any access. If anyone has asked me questions around capital works, I have answered their questions. There has been no denial.

MRS BURKE: Thank you for raising that. That has been a cause for the tedious numbers of questions on notice about capital works. If you were to release the report, would that not be easier for all members?

Ms Gallagher: The information is there. This is probably a matter you can raise with the Chief Minister or the Treasurer.

MRS BURKE: What is your view, though? Do you think it should be released? You have signed up to it.

Ms Gallagher: My view is that I am here to give any information that I can to anyone who asks. If you look across the country, ACT Health reports more than most about every single aspect of our health performance. Capital works is no different. Every time I have been asked a question, it doesn't have to be taken on notice. If you are interested in something, I am more than happy to give you an update or all the details of where that program is.

MRS BURKE: Would you consider perhaps stepping out, not having to go through the Chief Minister, and saying, "We'll make our capital works program available," considering that you have signed up to something that says just that—openness and accountability?

Ms Gallagher: As I said, we provide all the information that is required, Mrs Burke. I am more than happy to deal with your questions, and I have been in the past.

MRS BURKE: It is extra work for officials.

Ms Gallagher: We do not hide any information about capital works.

MRS BURKE: No, but you make it very hard to access it.

Ms Gallagher: No, I don't think we make it hard to access it. There are a number of forums where you can ask us for it, including picking up the phone.

THE CHAIR: Mr Stefaniak.

MR STEFANIAK: Thanks very much, chair. I just want to ask a couple of questions about the patient admin system. This might be relevant to it. Back in March—unfortunately I have a fair experience with hospitals because of my family—my wife broke her wrist in Sydney and had it treated in Bathurst. After one hour and 10 minutes, we were then sent to Cavalry. It was on a public holiday. It was treated at Cavalry, and they took all the details. We got to emergency services at 8 o'clock in Woden, which was great. It was very promptly attended to, but there was no way that the information which had been entered at Cavalry was transferable to Woden.

When we went to the front desk, we were asked, "Are you seeing a doctor?"—"Yes." We had to go to another person on the desk, who took details. Then we were sent back to the person who initially told us to go to that person, and the same details were taken again. We then saw the medical staff and were given excellent treatment. I congratulate them. That seems to be messy admin. Are you doing anything to speed up administrative things which just seem to be a bit of duplication and, in many instances, triplication?

Mr Cormack: I am happy to respond to that. You have certainly identified an issue

within the ACT that not only health ministers but also first ministers have identified as a national priority. You would be familiar with the February 2006 COAG decision whereby they announced the funding for a significant amount of work under the National E-health Transition Authority, NETA.

The work of NETA is about addressing just that issue. It is about building the framework nationally for a unique patient identifier and unique health provider identifier. It is envisaged that, over time, with the work of NETA—it will probably come back to COAG in 2008 for further consideration—there will be the rollout nationally of the notion of a shared electronic health record which will address that issue.

MR STEFANIAK: That is great, Mr Cormack.

Mr Cormack: The local issue?

MR STEFANIAK: Yes, thank you.

Mr Cormack: The local issue is obviously what you are focused on.

MR STEFANIAK: Yes.

Mr Cormack: It is true: we do have two separate patient administration systems across our two hospitals. That is in part due to the separate governance arrangements for Cavalry—you would be aware of that. We work very closely with Cavalry to try to join up the dots across our patient information systems. We are also working towards an ACT-wide patient master index, or PMI. Work is underway to bring that about at present. However, it will be some time before we are able to have a single, accessible set of patient data that applies across the two hospitals that will be available in real time when, in the case that you describe, a person turns up to the emergency department.

MR STEFANIAK: What about within the hospital itself? I found it a little surprising that you could not get the info from Cavalry, but, even more so once we got to A&E, that we were sent to one desk to give info and then went back to the first desk to give exactly the same info. What are you doing to fast-track that basic admin work?

Mr Cormack: Good question. The patient admin system, ACTPAS, which was introduced in this current financial year, is really about replacing a very old, outdated system, which may well have been in operation. I am not sure when your particular experience took place.

MR STEFANIAK: March or April.

Mr Cormack: We were operating off a very old patient administration system that did not really link up the patient care across the various parts of the hospital. With the new PAS, even though it has been a major piece of work—with any new IT implementation, you do encounter difficulties—we are now very close to having that functionality available within Canberra Hospital, within the clinical streams, and community health and mental health as well. So we are very much on that path, and

the PAS enables us to do that.

MR STEFANIAK: Great. I take it that PAS is operational now. Are there any components that are not fully operational, and when will they be fully operational?

Mr Cormack: The PAS is effectively fully operational. There are a couple of minor areas that we are just finalising.

MR STEFANIAK: What are they?

Mr Cormack: There is the operating theatre module, which was always going to be staged as part of the implementation. It is just about ready for rollout. In fact, I will check with my CIO, but I think this weekend we will be rolling that one out. The other area really is finalising some reports. We have had some difficulty extracting some of the reports that we publish every quarter. Certainly by the time the fourth quarterly report is published, we will have that set of reports available. So, in effect, the system is fully operational. There will be further refinements over time. We will improve our standard—

MR STEFANIAK: How long? You have a couple of little things to do. How long will that take?

Mr Cormack: They will be rolled out and sorted out over the coming couple of months. The core functionality of the system is already in place and fully operational. I have just been advised that the theatre module has been delayed by the Newcastle floods. The theatre trolleys are being made. There has been a delay caused by the Newcastle floods and that has been put back for one month.

MR STEFANIAK: Have there been any penalties applied because of the delay in having PAS fully operational?

Mr Cormack: No.

MRS BURKE: Minister, budget paper 3, page 21, states at the fourth paragraph down:

> The expenditure envelope incorporates efficiency targets that will bring the cost per separation to within 10 per cent of the benchmark over the next five years.

What is that benchmark?

Ms Gallagher: The national benchmark?

MRS BURKE: Yes, the benchmark that you are referring to in that statement there.

Ms Gallagher: That is the national benchmark for cost of separation.

MRS BURKE: Yes, "cost per separation to within 10 per cent of the benchmark over the next five years". What benchmark?

Ms Gallagher: It is the national—

MRS BURKE: I am just wondering what your words mean. Can you explain what your words mean?

Ms Gallagher: It is the measure used to measure cost per separation across similar hospitals—the cost of providing this service. We have traditionally been 24 per cent, I think, above benchmark. If we take the benchmark to be the 100 per cent figure, what we are trying to do essentially is reduce our over-the-national-benchmark costs from that level to 10 per cent above the national cost. Again, in the AIHW report and the state of our public hospitals report, you will see that that work has been very successful.

MRS BURKE: Why would you only want to aim to within 10 per cent? Why not be the best?

Ms Gallagher: It is a funny measure in the sense that we do not apologise for spending money on health care and on professionals who provide health care. We have traditionally had a system that has been, as I said, about 20 per cent above benchmark. The government has taken the view that that is too high. But we are not trying to be the lowest common denominator in terms of cost.

The target we set ourselves over the next five years is to try and bring our costs down to within 110 per cent. Cavalry is pretty much there at 110 per cent already. Canberra Hospital, I think, is around 114 per cent to 116 per cent. Certainly we are well on the way to meeting that target. When we had this discussion in cabinet, it was the view of cabinet that we have a very high-quality health system in the ACT. We pay our professionals very well. Of course, a lot of the cost comes through salaries. One hundred and ten per cent is a reasonable benchmark in the short term.

MRS BURKE: Is that your explanation for why the cost is so high—those things you have just said?

Ms Gallagher: The costs traditionally have been high around staff costs, superannuation particularly. We are doing some work around efficiencies and administrative efficiencies within ACT Health to reduce some of those costs as well. So largely staff, largely super costs.

MRS BURKE: Finally, in terms of all of that then, what is the overall cost to the ACT of inefficiencies in public hospitals, as a result of having the highest per patient costs in Australia?

Ms Gallagher: Do you want a dollar figure?

MRS BURKE: Yes, the overall costs to the ACT of inefficiencies?

Ms Gallagher: I am not sure how we would provide that to you. I would not say necessarily that it is all down to inefficiencies. I would say some of it is down to quality and the prices we are prepared to pay for good service. For example, we pay quite a bit more for our visiting medical officers than any other jurisdiction. We are

not aiming to cut that back. I would not say that is inefficient use of money. We pay what we need to pay in order to have qualified staff providing a service here. To be able to answer your question would be to accept that that above benchmark figure is due to inefficiencies, and that is not something I would accept.

MRS BURKE: But what other things would impact on that, though? Surely it is not just the VMOs.

Ms Gallagher: No. I just gave you an example there. It is largely around salaries. That is the cost. What would salaries be as a percentage of the health budget? Upwards of 60 per cent would be salaries. As helpful as I try to be in these committee proceedings, I do not think I am in a position to give you a dollar figure, because, in a way, I do not accept your question.

What I would say is that we have set ourselves a target. We have accepted that being 120 per cent above benchmark was too high. In actual fact, what we are trying to do is not reduce our costs in any way. It is around reinvesting those savings into health. The government accepted that there was 10 per cent that we would like to see delivered through efficiencies, reinvested and applied to growth within health. So we are not seeking to take anything out; we are just seeking to make the best of what we have within the health system.

THE CHAIR: Members, it is 10.30. We will go to the break and come back at 10.50.

Meeting adjourned from 10.28 to 10.50 am.

THE CHAIR: Thank you, members. Welcome, minister. We are still on the overview on output class 1.1. The committee has a view to try and move to mental health services at about 11.30. Are there any questions?

MRS BURKE: Thank you, minister. I want to go back to the emergency department access block, on page 158 of budget paper No 4. The strategic indicator for access block is the proportion of persons who wait more than eight hours from commencement of treatment to admission to a ward. In the 2006-07 budget, it was 25 per cent. Why is the estimated outcome for this indicator in the 2006-07 budget 30 per cent, instead of 25 per cent?

Ms Gallagher: You are going back to a previous budget paper?

MRS BURKE: Yes.

Ms Gallagher: You are saying that our target in 2006-07 was 25 and our estimated outcome is 30? You are asking why there is that difference.

MRS BURKE: Yes. Can you try and find that?

Ms Gallagher: We can certainly find that information for you. I would say that in the latest performance report that we have released, access block is the lowest it has been since 2002-03. In the last quarter, it is down to 27 per cent. Access block is a key indicator of how your hospital is travelling overall. It is not reflective, really, of the

emergency department as such. It is more about how the rest of the hospital is working. The decision has been taken to admit these patients. They go into the hospital and their wait is around that transfer to the hospital. Access block continues to improve. I am very pleased with it because I think that overall it show that we are heading in the right direction in terms of reaching our long-term target of 20 per cent. That means we are improving the patient journey from the emergency department into the hospital.

A range of measures have been implemented to improve this, not the least being more beds, and that is certainly helping. In relation to the difference, I do not know what the actual outcome for 2006-07 is. I do not know if we know that yet. We do not have that figure.

MRS BURKE: We will take that on notice or as and when it comes.

Ms Gallagher: We probably just did not achieve our target as quickly as we had hoped in the sense of the estimated outcome being around 30 per cent. I certainly know that now, in the third quarter, we are down to 27.4 per cent. That has been declining gradually. Overall, the actual outcome will probably be just under 30 per cent. But next year we will certainly head towards 25, and I think that 25, based on the decline I have seen in access block, is entirely achievable.

THE CHAIR: Mr Stefaniak.

MR STEFANIAK: Thank you very much, chair. I am looking at page 152 of budget paper No 4. In the 2006-07 budget, the budgeted employment level was 4,767. In the 2007-08 budget, the estimated employment outcome is 4,128. What is the explanation for the difference of 639 between the budgeted employment level and the expected outcome? Could you tell me where the reductions in employment occurred?

Ms Gallagher: I think Ron Foster has more detail than I have, but I understand the difference is around a head count and full-time equivalent. It is largely a technical adjustment.

MR STEFANIAK: Why the discrepancy?

Ms Gallagher: We have not lost staff. In fact, I think we will be—

MR STEFANIAK: Mr Foster is putting his hand up, minister.

Ms Gallagher: I am sorry. I had better stop talking, then.

MR STEFANIAK: Maybe I should let you keep talking.

Mr Foster: It was a decision taken by government to move from reporting on a head count basis to full-time equivalents. The 2006-07 year was made up of a head count. Full-time equivalent is what we are using in 2007-08, and that reflects a productive workforce as opposed to number of bodies at desks or in corridors or whatever.

MR STEFANIAK: Were there any actual reductions? For that matter, were there any

increases in personnel?

Mr Foster: There were planned reductions in 2006-07 for transfer of staff to the Shared Services Centre. There were some transfers of functions of the health complaints commissioner and also the cessation of the Healthpact board. In offsetting those reductions, there were increases because of growth in the initiatives. At the end of May we were about 61 above the head count that we started with in 2006-07. In fact, we did not transfer as many people to shared services as we had intended. We went through a negotiation process. We agreed that some of those functions should actually stay in health. Also, we have just employed some more staff to meet the growth in services, again through health.

MR STEFANIAK: Was there any impact on the delivery of services as a result of those reductions you mentioned?

Mr Foster: Not at all. The service has been provided in the Department of Treasury for payroll and transactional finance functions. There is no reduction in service.

MR STEFANIAK: There is an increase in the current budget of 43. Where will they be? What is that explanation for that?

Mr Foster: Because we are putting more money in for extra beds and in emergency departments and subacute facilities, the need becoming higher, there are obviously going to be more staff employed to—

MR STEFANIAK: In what areas?

Ms Gallagher: In all of those areas.

Mr Foster: It will cross all areas. It is across all service provision areas of health.

MR STEFANIAK: In terms of the ageing workforce, I still hear stories of nurses who are in their sixties and would like to get out, but they are dedicated to the job and they come back and do some double shifts because of the great difficulty in getting new staff and retaining new staff, especially in the nursing profession. What are you doing in terms of recruiting new nurses? What are you doing in terms of ensuring that some of those older nurses who I understand wish to retire actually can do so?

Ms Gallagher: We let them retire if they want.

MR STEFANIAK: I know you let them retire.

Ms Gallagher: Begrudgingly.

MR STEFANIAK: I still hear of older nurses doing double shifts because there are simply not the people there.

Ms Gallagher: I will let Mark take the detail of the question, or another officer, if that is relevant. Our turnover rates are pretty good now. I cannot give you the exact figure off the top of my head.

MR STEFANIAK: What do you mean by "pretty good", minister?

Ms Gallagher: Well, from where they have been in the past. They were certainly quite high. I am trying to think of the figures, and I am sure we can provide you with them.

MR STEFANIAK: If you could, that would be helpful.

Ms Gallagher: But it has reduced. One of the figures I saw was about eight per cent. I do not want to quote that if it is wrong. That is very good turnover when you are looking at other areas, certainly areas that I work in.

MR STEFANIAK: Perhaps you could get me the figures for how many nurses you had two years ago, how many you had 12 months ago and how many you actually have now?

Ms Gallagher: Numbers of nurses?

MR STEFANIAK: Yes.

Ms Gallagher: Yes. I am sure we will be able to provide that. It will be in the annual reports, I would imagine. But there are a number of initiatives and programs that we run to upskill nurses, to attract and retain them, not the least being the recent EBA to make sure that we are either number one in the country or very close to it in relation to pay and conditions for nursing staff. We are in the process of signing off on that now. I think we have got a very attractive employment framework for nurses now. We have always had that, but we have maintained it. There is a range of programs and we are happy to provide the committee with the details.

MR STEFANIAK: If you could.

Mr Cormack: If I could just respond with some details?

MR STEFANIAK: Sure.

Mr Cormack: We had 2,128 full-time equivalent nurses as at June 2007. That is an increase of 142 FTE over the same period last year. That is a 7.1 per cent increase. These increases are the result of good nursing management practices, good recruitment practises, investment in training and also longer term investments in scholarships.

In respect of separation rates, that is, how many people leave each year, overall, 163 nurses and midwives separated in 2006-07. Again, that is a rate of 7.6 per cent, which is not dissimilar from previous years. Our appointment rates, which are new starts, are much higher than the previous year, largely due to a specific policy that we put in place to focus on new graduates. The local universities and other universities are turning out more nurses. We target the appointment of new graduates. In 2006-07 we appointed 241 from that pool compared with 197 in 2005-06. They are some figures. We are happy to provide you with anything further.

MR STEFANIAK: Thank you.

Mr Cormack: There is some good work going on to ensure that we do not fall prey to an ageing workforce.

MR STEFANIAK: That is pleasing to see.

THE CHAIR: Minister—

MR STEFANIAK: Just one more question, if I could. Are the new nurses all graduates? There is often a vexed question as to whether all nurses actually need to be graduates. Do you have any other categories of people who come into the profession or are coming into the profession who do not actually have to be graduates, which, I imagine, would assist in terms of making sure our numbers stay up?

Ms Gallagher: Tertiary graduates?

MR STEFANIAK: Tertiary graduates.

Ms Gallagher: Registered nurses have to be tertiary graduates.

MR STEFANIAK: Yes.

Ms Gallagher: It is a four-year degree.

MR STEFANIAK: Yes.

Ms Gallagher: Enrolled nursing is not. That is a diploma.

Mr Cormack: That is a Certificate V.

Ms Gallagher: We can get that. I am not sure of the duration of that course in terms of time in the classroom.

MR STEFANIAK: I am interested in time in the hospital too.

Ms Gallagher: Yes, that is right. This new agreement gives us a third criterion of nursing, which will be called assistants in nursing. It will be a lesser qualification than what is required for an enrolled nurse. We have not worked through the detail with the ANF about the guidelines for the use of that program, but the attempt there is to diversify the workforce to ensure we have a pool to choose from and that we relieve the RNs, particularly, of duties that perhaps they do not need to perform, that others could perform but which they are regularly performing as part of their work. That is the idea behind the assistants in nursing. The ANF has supported that new criteria of nursing, and once the agreement is signed off we will work through how we implement that. We will be very careful with that, of course.

MR STEFANIAK: Yes.

THE CHAIR: Minister, are you able to touch on some of the other outcomes for nurses in this EBA?

MR STEFANIAK: Just before you do, could you tell me—if you cannot now, take it on notice—in the training for a registered nurse or a certificate nurse or the new category, how much actual on-the-job training will they do in the actual hospital?

Ms Gallagher: Yes, sure. That would differ, but there are extensive work placements for all of those.

MR STEFANIAK: Yes. I think that is essential. If I could have some detail of that, that would be great.

Ms Gallagher: Yes, sure.

Mr Cormack: Could I correct something? I just mentioned to the minister that EN training is two years. It is actually 12 months. Could I correct that? EN training is a 12-month certificate course run through the TAFE sector.

Ms Gallagher: Signadou, the Catholic university, has got funding to do an EN to RN course. That is upskilling ENs to registered nursing training. They will do RN training as well to complement the University of Canberra. As much as we can sign and seal the deal whilst it goes through the other processes, we have reached agreement with the ANF. It is for a 2½ year agreement, with a 12 per cent payment scheduled periodically through the term of the agreement.

We got some significant wins from the ANF in terms of allowing us more flexibility in the workplace, particularly around the length of shifts. In the past that had been a discussion that could only be initiated by the nurse. The employer is now allowed to initiate that discussion. But we did give the commitment which was so important to nurses, and always has been, that the 8-8-10 roster is the core standard hours for nurses, apart from those nurses who may wish to work different hours.

We cannot just say to everyone that they can start at 9 instead of 7 in the morning, because we need a complement of staff on at the beginning of the shift. We did a survey of nurses before the EBA and there was a lot of feedback around the desire to have more flexibility in starting and finishing times. You can understand that. It is a mainly female workforce with kids and other responsibilities. Many people would want to be able to pick their kids up if they started at 7 and have not seen them in the morning. At the moment the shifts are from 7 to 3, and that did not allow for that. Again, in the evenings, you start in the afternoon and finish at 9. There is some flexibility there. For example, we may not need two full complements of shifts together at the same time for a two-hour crossover period. I think this is the way to go and we are expecting that, with voluntary hands up, there will be some flexibility there for us.

The assistants in nursing will help in terms of workforce planning. There were some changes around part-time overtime arrangements and agreement with the ANF around workload management—how many nurses are needed to provide the services. You know the nurses union. They are not about to take a deal that they do not agree with.

In the end, the nurses got what they wanted and we got what we wanted, and that is why the government agreed to shorten the term of the agreement. The flexibilities contained in this agreement will be able to offset the costs, which was our line in the bargaining all along. I think it was a good result. Nurses do not like to engage in industrial action, and it was good that we could avoid that.

MRS BURKE: You mentioned part-time arrangements there. Has been there a move and a shift towards people, women particularly, wanting that sort of flexibility that you talked about?

Ms Gallagher: Yes. It is not unusual in a female dominated workforce—

MRS BURKE: Not at all, no, I think it is great.

Ms Gallagher: that part-time arrangements apply. Of course they do in nursing. The issue with the part-time overtime arrangements was that it worked as a disincentive. This is not how it was envisaged in the beginning. Part timers were able to qualify for overtime if they worked more than their part-time shift, so a full timer could be working along with a part timer who was on overtime but the full timer would not be on overtime just because they chose to be full time rather than part time. Even if the part timers were doing full-time work—

MRS BURKE: Often part timers are better off financially in a sense?

Ms Gallagher: They were. In a way, it was an unintended consequence of that arrangement. The ANF has agreed with us that overtime rates should be paid once you move to overtime hours; that is, more than full-time hours. Hopefully that will work for us in the sense that we can recruit more full-time staff, but it will not create an unlevel playing field for part timers.

MRS BURKE: People like choice.

Ms Gallagher: Yes, and you can still be part time as well.

MRS BURKE: Yes. I probably only have one more question. Then we will move on, and if Dr Foskey is listening she will be pleased. Minister, generally this morning I wanted to touch on all state and territory health ministers signing off on the recent report *Caring for our health?*

Ms Gallagher: Yes.

MRS BURKE: Who wrote the report? What financial contribution, if any, did the ACT government make to the development of the report? What other information did the ACT government provide for this report?

Ms Gallagher: This was a decision of health ministers some time ago. I am trying to recall. It was in the last year. We decided to produce a report that would give information against a whole range of where health dollars essentially go. It adds to the commonwealth government's report *The state of our public hospitals* and the AIHW's report *Australian Hospital statistics*, which pretty much target just one area of health.

With the amount of money that goes into all areas of health, the state and territory health ministers made a decision that it would be useful to provide information to the community and interested stakeholders about where all that money is going. Certainly the ACT participated.

As to who wrote it, it was a combination of all jurisdictions. Officers from ACT Health took part in the work and certainly provided information, as we do to the AIHW and as we do to the commonwealth, against a range of indicators reported in this report. I think the interesting thing in the report—and it is picked up in the other two reports—is that the shift of resourcing to private health insurance has not made any difference for our public hospital system. Whilst it has been obviously very good for people who have taken out private health cover, this report, more than the others, shows that in the ACT it has made no difference at all to the pressure on the public hospital system. Despite our having the highest rates of private health insurance in the country and a very good quality private health system with capacity, people will still choose to come to the public hospital system and exercise their choice to be treated as public patients.

In a way it sets the scene for us as we move into the negotiations around the health care agreement. It paints the picture that all the money going into private health insurance—and I do not discount the benefits it may have given some people—has not removed the pressure that is being experienced in the public system. One of the arguments used at the time was that we should free up the public hospitals for those that need it and place the money into the private system. It also confirms what we knew about GPs and access to bulk-billing rates. That is reflected in other reports as well.

MRS BURKE: What contact was made with the Australian Institute of Health and Welfare by the developers of the *Caring for our health?* report?

Ms Gallagher: I might ask Mark to answer that.

Mr Cormack: I am happy to do that. That data used and quoted in *Caring for our health?* is public domain information from a range of sources, including the Australian Institute of Health and Welfare. All their stuff is publicly available. It was based on that. We also accessed other published data from a range of commonwealth sources, including Medicare statistics and PBS statistics. It is all drawn from public domain information.

MRS BURKE: Minister, why then did this report apparently misrepresent the Australian Institute of Health and Welfare? Are you aware of that?

Ms Gallagher: No, I am not.

MRS BURKE: I am happy to table for the committee a media release from the Australian Institute of Health and Welfare which states that, contrary to information contained in the report, the AIHW has not made any recommendations in regard to the appropriate level of funding of public hospital services. What would your comment be to that?

Ms Gallagher: I certainly have not said that they did.

MRS BURKE: You have signed the report, and in the back the report alludes to recommendations made by the Australian Institute of Health and Welfare.

Ms Gallagher: This is around the arbitration issue. It makes reference to an independent arbitrator—

MRS BURKE: It refers to the Australian Institute of Health and Welfare. It is on page 23 of the report. I do not want to spend too long on it. I just wondered if you were aware when you signed this that you were actually signing something that was not correct. I was just concerned.

Ms Gallagher: As I said, we took part in the discussions around this report. I understand that the link to the issue of the money, how much we have all been short-changed, was through an independent arbitration process conducted in 1998-99. I think the AIHW report does mention next to that—

MRS BURKE: This particular document does not, and this is what we are referring to today. In fact, the AIHW has put it out to correct the record. I just wondered why you would sign something that was not particularly—

Ms Gallagher: I will have a look at it, Jacqui—

MRS BURKE: Thank you.

Ms Gallagher: but my understanding was that the costing was around an independent arbitration that occurred as part of the Australian health care agreement back in 1998.

MRS BURKE: I will read to you from the report. Page 23 of the report *Caring for our health?* released in June 2007 states:

> The Australian Government ignored that recommendation. It also ignored statements made by the Australian Institute of Health and Welfare, an expert body funded by the Australian Government, that health prices should be adjusted by a figure higher than the inflation rate.
>
> Instead, the Australian Government has adjusted funding by a figure lower than the inflation rate. The result is that it contributed far less to Australian public hospitals than the arbiter recommended, and than the Australian Institute of Health and Welfare would expect.

That insinuates that the institute made a recommendation.

Ms Gallagher: I will have a look at that.

MRS BURKE: Maybe the wording is bad, but it actually puts you in a bit of a spot.

Ms Gallagher: Not really.

MRS BURKE: Well, yes. You have signed something that the Australian Institute of

Health and Welfare has had to correct.

MR STEFANIAK: It does.

Ms Gallagher: No.

MRS BURKE: Maybe you need to read reports before you sign them.

Ms Gallagher: I will have a look at what you say and get back to the committee. But the issue of whether we have been short-changed in funding is—

MRS BURKE: That is—

Ms Gallagher: You might say it is another matter, but—

MRS BURKE: Of course it is.

Ms Gallagher: the share of—

MRS BURKE: You have got a responsibility, minister.

THE CHAIR: Order, Mrs Burke!

Ms Gallagher: commonwealth funding into our public hospital system is, I think, the lowest in the country at 36 per cent now. So if they were—

MRS BURKE: Well, because of the most expensive—

THE CHAIR: Order, Mrs Burke!

MRS BURKE: If you can do something about that—

THE CHAIR: Order, Mrs Burke!

MRS BURKE: the commonwealth will listen.

THE CHAIR: Mrs Burke, if I have to call you to order again, I will warn you.

Ms Gallagher: Anyway, we are hopeful in terms of the Australian health care agreement negotiations that we will move forward and be able to get a better deal from the commonwealth.

MRS BURKE: I am sure the people of Canberra will be too.

Ms Gallagher: I hope so. If we were able even to get back to where we were at 42 per cent, we would be able to deal with quite a bit more activity.

THE CHAIR: Minister, during your answer to Mrs Burke's question, you referred to bulk-billing rates.

MRS BURKE: I do not think she did.

THE CHAIR: How many doctors in the ACT bulk-bill at the moment? Do we have a figure on that?

Ms Gallagher: It is 52. I understand that the most recent figures have us at around 50 per cent. I think the national average is around 74 per cent, so we are still way below the national average for bulk-billing rates. Really, I think the issue is that, again, commonwealth payments for the schedule fee haven't kept pace with the costs to GPs of running their services, plus the workforce shortage, which was a decision by governments essentially not to train a workforce of the size that was needed to provide the services. So we are playing a bit of catch-up now. It is a combination of a shortage of GPs and the cost of actually being in general practice.

THE CHAIR: And that has an effect on hospital waiting times as well, I would imagine?

Ms Gallagher: I think that is reflected in the state of our public hospitals report today, which shows that we are way above other jurisdictions in terms of per capita presentations to the emergency department. Without a doubt, some of that would be due to the cost of seeing a GP and the difficulty in accessing a GP, particularly if you don't have one, or the wait associated with having to see a GP. Waits in the emergency department are one thing, but waits for a GP can be several weeks. Access to primary health care is a big issue for us.

MR STEFANIAK: Minister, in relation to cross-border issues with New South Wales, how much did the ACT recover from New South Wales in 2006-07 to cover the costs of treating patients presenting to public hospitals in the ACT for treatment?

Mr Foster: At this stage we have estimated receiving $65 million from New South Wales for cross-border activity during 2006-07. Of course, we are currently in the process of finalising agreements with New South Wales—it is going through an arbitration process—to determine the rate of payment, but we have estimated getting $65 million for 2006-07.

MR STEFANIAK: Did that payment cover the costs of treating New South Wales patients in our hospitals?

Mr Foster: That's the purpose of the payment.

MR STEFANIAK: But it didn't, I take it. I suppose it was short-changing us.

Ms Gallagher: That's why we are in arbitration.

Mr Foster: We haven't been paid that yet. We have estimated receiving $65 million for activity. The process is that New South Wales pays a base grant and then it adjusts through an acquittal process in subsequent years once the data has been confirmed and indexation has been agreed.

MR STEFANIAK: What is going to happen? What do you propose to do if the

arbitration is unsuccessful? What can you actually do? Are you going to turn their patients away?

Ms Gallagher: No, you can't do that.

MR STEFANIAK: Is there any way we can actually extract proper payment from them? This is probably a perennial issue, but I would be interested in just how much they are actually proposing to short-change us.

Ms Gallagher: That's why we are in arbitration, and we are very hopeful. That is the only avenue for solution of this, and that is part of the reason we are in arbitration, because part of the New South Wales position is that they do try to cap activity for New South Wales patients in our hospitals. That isn't something that we can do. It would require us to enforce it, and it's probably legally not allowed under the Australian health care agreement. The idea of having to turn away someone from Queanbeyan because they were one over their mark for the month is not something that we would do, which is one of the reasons we are engaged in a lengthy arbitration process. It has been underway for well over a year, but we are hopeful of a resolution shortly. I think the final submissions are being dealt with as we speak.

MR STEFANIAK: If we are after $65 million, what are they actually offering at this stage?

Mr Foster: We haven't talked about what they are offering in a dollar sense. It's about the issue of thresholds and capping. It's not so much, "Here, have $50 million." It's really about the important issue of working towards activity constraints.

Ms Gallagher: I am hopeful that with some of the investment in Queanbeyan Hospital and some of the hospitals down the South Coast they might be wanting to control a bit more of the flow.

MRS BURKE: I have a question on the terms of reference for the review of the health services. What would they be?

Ms Gallagher: Is this around the possible third hospital?

MRS BURKE: Yes.

Ms Gallagher: That's the way the story has been sold. It's a piece of internal advice to me at the moment. There haven't been terms of reference established. I have just asked that some work be done to provide advice to government about the future needs of our health system as a whole. This has really arisen through questioning via the budget process. Demand for elective surgery continues to grow; for example, demand for cancer treatment continues to grow. What is the capacity to meet that growth? I am not expecting the growth to slip off. Maybe in certain parts it will even out. For example, in elective surgery, we are commissioning the tenth theatre. Cavalry's theatres are all running. So, if we are to provide more elective surgery and continue to provide more elective surgery every year, then where do we do that and how do we do it? That's the question for me. We know from performance reporting, particularly at TCH, that 50 per cent of the surgery on any given day is emergency surgery; so we

know, to be a bit crude, that five out of 10 theatres are tied up with emergency work. Our cancellation rate for elective surgery is declining. We are trying to get to a target of two per cent. At the moment it is about 10 per cent. Cancellations are largely due to a take-up of emergency patients or high-priority patients.

There is a question in my head about how we provide particularly those surgical services, but other areas of the health system as well; for example, cancer services. How best do we provide them into the future? I know there are views around community health and chronic disease management in prevention programs, how to link in primary health care. I need this work commenced so that we are in a position, probably not to the benefit of me or our government, in the future that we are not left in the situation of saying, "Oh, my goodness, demand is outstripping capacity and now we need to think about what we do about it." At the moment it is very early work. There is a lot of interest in this work, so there will need to be some sort of consultation process.

MRS BURKE: What is your time frame on that?

Ms Gallagher: In initial advice to the government, I have asked that it be completed in the next few months or so, by the end of the year. We have done a lot of planning work. ACT Health has gone from not having enough plans to certainly having a number of plans now. There has been a lot of planning work around critical care and surgery. We could list them all for you. Megan, I'm sure, could rattle them all off. It is about pulling those plans together and, in a capital and infrastructure sense, pulling out what we need from that: how many beds will we need in the future, will they be acute beds, will they be rehab beds, will they be day stay? Will we need an elective surgery centre to take some pressure off the Canberra Hospital, somewhere we can specifically staff a place that doesn't have SouthCare flying over every five minutes dropping off an emergency patient, somewhere that work can be planned and throughput can go a lot more easily? These are ideas. It's just a vision. You have been asking for a vision in health for quite a while.

MRS BURKE: In terms of that, who is actually conducting the review and what consultations will be undertaken with the community, and at what cost?

Ms Gallagher: I might let Mark answer that. Certainly in the initial sense it's advice to government and then we will go out. I need some advice first about what service demand is going to be potentially and then we can go out and consult around the range of services that we may need to provide.

MRS BURKE: I was just thinking of the developments with New South Wales, following Mr Stefaniak's question, and how we are going to link all that together.

Ms Gallagher: We work very closely with New South Wales. In fact, they have been fantastic, New South Wales Health, in assisting us with a lot of the work we have been doing with the access improvement program. Aside from the money issue, putting that aside for a moment, the jurisdictions work very well together.

MRS BURKE: Was it you that raised the issue of the third hospital, minister, or was it somebody else?

Ms Gallagher: It came up in a conversation I had with a journalist in the sense of everything is on the table and nothing is off. Do we need a third hospital? Do we need an elective surgery centre? Do we need a cancer centre, a centre of excellence? Do we need more subacute facilities? Do we need a rehab unit? In that conversation I had, yes, I raised it.

MRS BURKE: What focus will be there on early intervention or the lack of early intervention?

Ms Gallagher: That is part of the work. As I said, I have asked them to try to give me a snapshot of where we are going. We are going to need more beds in the future, but in every budget we have been putting in at least 20 beds. At some point, without a new building, we would either have to stop putting in new beds or build a building to put in the new beds that we will need, or make a decision that we don't need any more beds. Those are the discussions we have to start having now before we have decisions. Yes, there is a big push on making sure that people have access to the type of care that is appropriate for their needs. Part of that is early intervention, prevention and chronic disease management.

MRS BURKE: Haven't you seen this building, though, for quite some time? You said you have had lots of plans and reviews. Is it that all of a sudden we are like startled rabbits, we have realised we have got a problem?

Ms Gallagher: No, not at all.

MRS BURKE: Surely you have seen this coming.

Ms Gallagher: Not at all. There is capacity to keep growing in the system we have got. Mrs Burke, I'm probably trying to help you out for when you are health minister.

MRS BURKE: I like your confidence. Thank you. You are doing yourself out of a job here.

Ms Gallagher: As I said, this planning work may not benefit this government at all. It may say that in five or 10 years we will need another 60 acute care beds providing this level of care.

MRS BURKE: I am just wondering why you didn't do it a few years ago, halfway into the term of the government. We are now nearly coming to the end of this term.

Ms Gallagher: You could always ask about any piece of work you commence why you didn't do it four years ago.

MRS BURKE: But you would have seen it coming, surely. I just think we have got to such a point now where it is a big problem to tackle.

Ms Gallagher: It's not a big problem, that's the whole point. We won't have a third hospital up next year because there is a crisis. We can continue to put in new beds within our existing hospital infrastructure, that's not a problem, but—

MRS BURKE: But we have got a system that is failing people.

THE CHAIR: Mrs Burke, let the minister finish the answer.

MRS BURKE: We have got a system that is failing people.

Ms Gallagher: I totally disagree with that, that we have a system that is failing people. We have a system that works very well, that measures against every standard very highly in terms of patient safety, quality of care and urgent access. We have the best urgent access to our hospital system of anywhere in the country in terms of access to emergency surgery and access to emergency departments.

MRS BURKE: You can't get away from the bad figures, though, that are out and the pressure on staff is not acceptable.

Ms Gallagher: The bad figures are around timeliness. They are not around quality—

MRS BURKE: It puts pressure on staff.

THE CHAIR: Mrs Burke!

MRS BURKE: It puts pressure on people.

Ms Gallagher: The issues are around timeliness of care in two areas in the emergency department, two out of five areas in the emergency department, and in waiting time for elective surgery. I have been up front about saying that, against those three areas, yes, we need to continue to work, but if you say those three bad measures mean our health system is failing—

MRS BURKE: They are key ones.

MR STEFANIAK: They are pretty important.

THE CHAIR: Members!

Ms Gallagher: If you are saying that those three measures mean that our health system is failing people, then I would disagree with that completely. I would.

MRS BURKE: Ask people who wait 46 minutes, or 61 days for elective surgery. It is not me saying it. Mr Stefaniak has given you a good case.

THE CHAIR: Is there a question in there, Mrs Burke?

MRS BURKE: No, I've just asked it.

Ms Gallagher: Mr Stefaniak's case was excellent. In fact, the case he has given me was that he received excellent access.

MR STEFANIAK: The service was good. There were some admin problems there.

Ms Gallagher: That's right.

MR STEFANIAK: I can give you some bad cases, Katy.

Ms Gallagher: I see those from time to time, too.

MR STEFANIAK: An 85-year-old woman waiting 3¾ days with a broken arm.

Ms Gallagher: In those situations now with the MAPU, that should not occur. That is exactly why we have opened the MAPU, to deal with those kinds of patients who are elderly, they present with complex conditions and there is perhaps need for four or five doctors to consult before deciding on the best pathway for the patients. That should not be occurring. That's why we are putting in place these measures. But, as I said, we are looking at a range of measures in the emergency department. I have been proactive to the point that I probably have to calm down a bit around the emergency department and let the professionals run the emergency department.

MRS BURKE: Isn't that something that should have been done a couple of years ago, though? You've seen it coming.

THE CHAIR: Mrs Burke, I've given you plenty of grace. You are going to be warned.

Ms Gallagher: I've been health minister for a year and I have spent quite a bit of time at the emergency department listening to staff and working with staff around areas that they are concerned about. In elective surgery, as I said, once we clear the long waits off those lists, I expect that figure to be a great deal better. Seventy per cent of patients get their surgery on time. There is a proportion of patients that we need to continue to work on, and they are the long waits. Our long waits have declined by, I think, about 26 per cent over the previous year. So we are getting to those people that have been waiting too long for their surgery, and that is impacting on the results that we see in terms of standards across the country. Is that a hospital failing its community? I would argue no.

MR STEFANIAK: Minister, earlier, in terms of speeding up the process, you briefly touched on using the private hospitals more. I understand you actually did book some limited time for public patients to be dealt with in, I think, John James. I think the figure was maybe 50 operations.

Ms Gallagher: Yes.

MR STEFANIAK: I am going back about 12 months on this one, but I understand that they could do something like 150 and, indeed, they could probably do them a bit quicker. The operations were either three a day or three a week compared with an average of one at Canberra Hospital. Why aren't you outsourcing those services more than you are doing? I am pleased to see that you have made a start, but it seems that there is significant capacity in that system to take an overflow from the public system and actually reduce these waiting times further.

Mr Cormack: If I could just respond. We use the private sector to clear long waits for particularly low urgency and relatively simple procedures. We did that in 2005-06, to a more limited extent in 2006-07, and we will look at that again in 2007-08. We have to continue to analyse our waiting lists, look at if there is a large enough group of a particular type and approach the necessary doctors and the private health sector as required. It does provide some assistance, but it is not necessarily as readily available all the time as one might think.

MR STEFANIAK: The other point I made—correct me if I am wrong here—was that I had heard that that system, the one about John James, was able, for example, to do three operations for the one operation that could be done at Canberra Hospital. That may be wrong, but if it isn't wrong, is there anything that we could learn as a public system from what they are doing perhaps to speed up the number of operations which could be done?

Mr Cormack: In fact, that is a piece of work that we did under the access improvement program, which was the surgery redesign program focused on TCH. That picked up a number of practices, such as starting on time, making sure of the changeover times between cases, the way you compile the particular list, ensuring that anaesthetic and nursing clean-up times run to a particular standard. We certainly have applied a lot of those. Cavalry Public Hospital is particularly good in that sense. But I think it is important to note that it is not just a question of the private sector versus the public sector.

MR STEFANIAK: No, I'm not saying that.

Mr Cormack: I think the point is that the private sector doesn't have to worry about emergencies. It doesn't have to worry about people coming in with half their guts spilling out on an emergency department floor. They don't have their ingrown toenails and their minor procedures interrupted through major trauma. We are a major trauma centre for 750,000 people. We have helicopters flying in at all hours of the day or night, and they are the sorts of pressures that operate on major public hospitals. Despite that, the bulk of the elective surgery in this territory is done by TCH and is done at a price that is lower than the private sector.

MR STEFANIAK: That doesn't mean, though, that you can't pick up any good practices they have.

Mr Cormack: We do.

MR STEFANIAK: You indicated there were some good practices.

Ms Gallagher: Or vice versa. They could pick up some of ours.

MR STEFANIAK: Indeed, it is a two-way street, obviously.

Ms Gallagher: The other thing I would say in closing is that it is not always as easy as it sounds to outsource work, either. In fact, I am aware of an example where we sought to go out to the private sector but there was a number of issues which meant that the private sector could not pick up that work, so that piece of work wasn't done.

We would have loved it to have been done, and it would have contributed very nicely for 100 or so people. But, in the end, the relationships that were required in the private sector to do that work weren't available and meant that that work couldn't be done in the private sector, so it was back to us. So it's not always as easy as it sounds.

MS PORTER: Can I ask a quick supplementary?

THE CHAIR: Yes, the last one, and then we will move on.

MS PORTER: From my experience, some of the operations that would be dealt with in a hospital like TCH would be extremely complex. I have personal experience of one that lasted 10 hours.

Ms Gallagher: Yes.

MS PORTER: Is it true that it depends on the type of surgery, that we are not comparing apples with apples here?

Ms Gallagher: That's right. The complexity of the surgery performed is different as well, and what you need to look after post-operatively is different. That constrains some activity in the private sector, for sure. If you need a top-level ICU to do the work, you are not going to get that done in the private sector.

THE CHAIR: Thank you, minister. We will move on to output class 1.2. I know Dr Foskey has a lot of questions, but I might just kick off.

MS PORTER: I have one too.

THE CHAIR: Page 153 of budget paper 4 shows an increase in funding from the 2006-07 estimated outcome to this budget of over $4 million. What do you hope to achieve and what initiatives have you got in this to address mental health issues?

Ms Gallagher: There is a range of initiatives in this budget for mental health. The budget includes $12 million over four years to target particular areas within the mental health sector. Additional to that $12 million, there is some very important work being done around planning for the facilities in a mental health precinct at the Canberra Hospital. Part of that money will be used to improve levels of staff in the older persons mental health unit, which is part of the Keaney building at Cavalry Hospital. It will also go to emergency department mental health nurses, having them available in the emergency department. And something that the community sector has been after for some time—an adult step-up, step-down facility, plus some additional resourcing for the young people's step-up, step-down facility, most of which was funded in last year's budget, but when we went out to tender the community sector indicated that they would not be able to deliver for that price so we have topped that money up. There is some extra money for community organisations, which do quite a lot of work with us in the planning and advocacy areas. There is a lot of planning underway in mental health. There is some extra support for training of mental health workers and some improved services at the PSU. That makes up the proportions of the $4 million per annum.

THE CHAIR: Ms Porter, you have a supplementary?

MS PORTER: Yes. Minister, you mentioned the mental health infrastructure at the hospital. That would be the new PSU and forensic unit? Is that what you are talking about?

Ms Gallagher: That is right. This has been funded to forward design capacity. It is unusual in the sense that it is quite a bit of money to do this and then not fund the outyears for the building itself. But before we can build these buildings, we have to build a car park—because the location for this precinct will be the current surface-level car park. Until we can replace those car parks, we cannot build the building. The government decided that the best way to go was not to delay the work whilst we built the car park but to progress the work over the next year so that next budget we will be in a position to have all of the costings finalised. We will pretty much be tender ready—ready to go and move on. Hopefully, the car park will be in its final stages of delivery so that we can take up the land that we need in order to build the forensic and the in-patient facility.

There is still a discussion to be had with the mental health community. I have met with them many times over the past year—the various groups—around the type of building and the design of the building. There is a lot of interest, particularly noting that the PSU is badly designed and is an inadequate building. I do not think anyone wants to make those mistakes again. Over that time, whilst we are doing the forward design and planning and the final costings of those buildings, we will be going through a process with interested people around trying to reach some agreement around the design and capacity of those buildings.

I know there are mixed views around that. People want to see a better in-patient facility, but they do not want to see a bigger one. I understand that view. But my view is that, if we are going to spend this sort of money, we need to build a building that can deal with our community growing. Even if we do not commission all of that in the first instance, we need to build a building with capacity. The secure unit, again, is very important, particularly in light of the prison coming on line and the need for some secure mental health facility.

MS PORTER: Yes.

THE CHAIR: Dr Foskey.

DR FOSKEY: Thank you. On page 154 of budget paper 4, a key strategic priority is to reduce the waiting time for mental health clients for acute psychiatric units. But on page 161 it says that the proportion of mental health clients admitted to hospital from the emergency department who wait for more than eight hours for transfer to the PSU is forecast to remain at least at 10 per cent for now and into the long term. I have a few questions around this. How does the ACT's waiting time for mental health clients to transfer to acute psychiatric units compare to those in other states? And why is there no plan to reduce the waiting time for a proportion—and to maintain that at 10 per cent of mental health clients?

Mr Cormack: I am happy to respond there. The 10 per cent target is pretty good,

actually; in other jurisdictions it is significantly higher. We are aiming to keep it under 10 per cent. That is an important goal. I know that in New South Wales some of the waiting times for people presenting to emergency departments requiring admission was getting up to several hours. Within the 2007-08 budget, we are also looking to beef up the staffing in emergency departments. That will assist with more timely health assessments and facilitate the transfer of those patients from the emergency departments through to the in-patient units. That is why, as part of the overall 2007-08 initiatives for mental health, we are recruiting additional mental health nurses to undertake that function. It is also important to note that the pathway into an acute psychiatric in-patient unit is not always through the emergency department; it can be through community teams. Best practice would be to have as few people going through the emergency department as possible, but we do recognise that that does happen.

DR FOSKEY: Can you give me some indication of what percentage of people who find themselves in the PSU present through emergency in the first instance?

Dr Brown: I am sorry; I cannot provide you with that statistic. It would be the majority that arrive after hours, because the policy is for all presentations to the hospital after 5 pm to occur via the emergency department. That reflects the resource level available after hours.

DR FOSKEY: Does that mean even if they come through with the CAT team as a result of CAT team intervention?

Dr Brown: Yes.

DR FOSKEY: So they still present at emergency?

Dr Brown: Yes. They present at emergency with the CAT team, and they are then seen by the psychiatry registrar. So they are logged through the emergency department, but they are not necessarily processed by the emergency department medical staff, for example.

DR FOSKEY: So they are not triaged—it is through the system and physical presentation?

Dr Brown: On presentation to the emergency department, everyone is seen by the triage nurse and an assessment is made of whether there are any physical health needs. If they are brought in by the CAT team, usually there is quite a fast-tracking for assessment by the psychiatry staff. During hours, if it is a direct admission—for example, with the CAT team, they present to PSU. So the figures about how many come via the emergency department are very much influenced by the procedures.

DR FOSKEY: Okay. I have some more questions to get to a bit of detail here. At page 161 in budget paper 4, the strategic indicator talks about the proportion of mental health clients subjected to seclusion. I note that it is forecast to reduce by only about one per cent this year and next. I wonder if you can tell me what are the benefits and disadvantages of the use of seclusion for mental health clients attending the Canberra Hospital and whether it is something that is done as a choice or whether it is done

because other options are lacking.

Dr Brown: Currently, seclusion is used when other avenues are deemed to have been tried and unsuccessful. It is generally used in response to clients who are aggressive, particularly agitated or at risk to themselves or others. The reason we are aiming to reduce it is that it is experienced as very aversive by consumers. Some carers will describe how stressful they have found it, and indeed some staff describe the same thing. Our aim is ultimately to reduce it to the very minimum, if not eliminate it altogether. We are participating as part of a national project with a clear focus on reducing the use of seclusion. That work is in its early stages, but I am pleased to be able to inform you that for the last quarter, up to the figures of two days ago, our use of seclusion has halved compared to the first quarter of the 2006-07 year.

DR FOSKEY: What sort of number is involved in that?

Dr Brown: The number of clients secluded in that last quarter was 21.

DR FOSKEY: Does that mean that other means of dealing with the clients were found or that there were fewer people needing that kind of response?

Dr Brown: There has been a lot of effort gone into training and working with staff, looking at alternative means of addressing the aggression.

DR FOSKEY: I think everyone would be happy about that. That is good.

THE CHAIR: Mr Stefaniak.

MR STEFANIAK: Page 176 of BP4 refers to the "High Secure Mental Health" unit. You have $1.2 million in the upcoming budget. What is that proposed $1.2 million for? And what work, if any, has already been done on this long-delayed project?

Ms Gallagher: As I just explained to the committee, this is forward design, essentially—tender-ready stage for the project.

MR STEFANIAK: What is the time line for the project?

Ms Gallagher: It has to be funded in next year's budget before I can do that. As I said at the beginning, it is unusual in the sense that we have not funded these big projects in the outyears. That is partly because we will be able to finalise the costs over the next year in terms of leading up to a budget bid through that forward design and tender-ready stage and also because of the complications of the car park. We need to resolve that before we can finalise all the details about exactly how big the building is going to be, how many beds it will be and ultimately what cost it will be.

MR STEFANIAK: So it is going to be near the car park?

Ms Gallagher: The expectation is that it will be built on the far car park—the surface car park—near Yamba Drive and Hindmarsh Drive, on the corner there.

MR STEFANIAK: You mentioned that, as a general rule—and we have seen it

through the budget—you are given forward design money and nothing else.

Ms Gallagher: Yes.

MR STEFANIAK: In your case, you can almost understand it, because you have to work it out with the car park. But, even so, you should have some indicative idea of how much this facility is going to cost. We saw the same with the Belconnen police station, for example—forward design, nothing else. That seems to indicate that nothing may happen—that these great projects simply may never eventuate and you are going to have to go back to cabinet—

Ms Gallagher: Then you would have a good go at us at next year's estimates, I would imagine, for spending almost $4 million on tender, on getting some forward design.

MR STEFANIAK: We certainly will; we will probably have a good go this year. But I am just wondering why you have not—

Ms Gallagher: These buildings will be built. The Chief Minister has indicated that. There is no doubt that these projects will be done. The issue—and we saw it yesterday when we discussed Quamby—is that we put aside some money and we have now had to come back and top that up because we had not determined the final costs. In that case, it was the choice of the site which escalated those costs because it did not have the hydraulics, water and sewerage going to the land that we needed.

The $29 million car park gives us the opportunity to finalise those costings—to be pretty exact by the time we go back through the budget process next year. In a way, through this budget process we have announced the capital works program for next year. The discussions we had in cabinet around this project were around "Sort the car park out; don't delay the project. Put some money in to keep it going." Even if we had funded in the outyears, this year would have been spent on that forward design and tender-ready stage anyway. The decision I took was to keep the project going as it would have gone if we had funded in the outyears, but that the funding be realised through next year's budget process.

MR STEFANIAK: When would you anticipate this building being up and running?

Ms Gallagher: Subject to everything going well—the car park being up and ready and being able to commence building—I would expect within a year of next year's budget.

MR STEFANIAK: Right.

Ms Gallagher: So it would be somewhere around June 2009.

MR STEFANIAK: How many people is it anticipated that this facility can take?

Ms Gallagher: In the adult in-patient unit, we are talking around a 40-bed facility. In the secure unit, it is about 15.

MR STEFANIAK: So 15 and 40.

Ms Gallagher: Yes. There is some disagreement on that, I would have to say—less around the secure unit and more around the in-patient facility. That is largely around mental health consumers' desires to have a smaller building rather than a larger one. I am going forward with a proposal of around 40.

MRS BURKE: On page 170, "Patient activity", accountability indicator (g), I note that the proportion of clients seen at an ACT health community facility during the seven days post discharge from the in-patient services is running at 75 per cent constant from this year and out to next year. Why can't we increase it? What is happening to the 25 per cent—the three out of 10 people? What happens to them? Where are they?

Dr Brown: I can respond to that. The 25 per cent accounts for people who are discharged from our facilities and return to private psychiatrists or psychologists; to GP care, by preference; or to interstate care. Again, Mental Health ACT is participating in a national benchmarking process at the moment. The issue was discussed at the most recent meeting of that benchmarking forum. Nationally, 80 per cent is the maximum we could expect to reasonably achieve on that figure. Of the participants in the forum, Mental Health ACT, running close to 75 per cent, is leading all of the participants in our achievement.

MRS BURKE: Perhaps a better note in the budget paper would have helped. Thank you.

THE CHAIR: Dr Foskey.

DR FOSKEY: In regard to the memorandum of understanding finalised in December 2005 which formalised the protocols for the AFP's dealings with mental health clients, the AFP conceded when it was established that they do not have the expertise to handle mental health clients. I believe that the MOU was to recognise that police presence is sometimes necessary and often might be the first encounter. Does the memorandum of understanding accord with the ACT bill of rights?

Dr Brown: I have no reason to believe that it does not. The memorandum of understanding sets out roles and responsibilities between Mental Health ACT, the Canberra Hospital and the AFP. It allows for police involvement in circumstances where there is actual violence or a high probability of violence—or, indeed, when there is an emergency situation and police are able to respond most effectively and most quickly. I do not think that there is anything in that that would not accord with the bill of rights.

DR FOSKEY: I suppose it might be one to run past the commissioner for human rights. Given this memorandum of understanding, do AFP officers receive training with regard to how to handle people who are presenting with mental illness?

Ms Gallagher: By Mental Health ACT? Are you talking about police officers getting training?

DR FOSKEY: I do not know—at all and by whom?

Dr Brown: Yes, they do. Mental Health ACT participates in some of that training; the police undertake some of it through their own resources. It covers a range of issues, including not only likely diagnostic presentations but also actual presentations that they can expect to deal with—ways to deal with that, de-escalation techniques, what to do, what not to do, et cetera.

DR FOSKEY: I have some questions about the step-up, step-down facility. I am sure that other people are interested in that.

MRS BURKE: I just have something on accountability.

DR FOSKEY: I am interested in the model that will be used—if you have got this far ahead in your thinking—for the adult step-up, step-down facility.

Dr Brown: We have not as yet drawn up any specifications around that particular model, but what is intended is that it will be run by a community organisation.

DR FOSKEY: Good.

Dr Brown: They will, as part of that, have the capacity to do some outreach, but there will be a close working interface with clinical services from Mental Health ACT, as required, because it is intended that this will provide an alternative to admission for people who may otherwise be admitted to the PSU. We have work to do yet in drafting those final specifications, but that is the thumbnail sketch of what is intended.

DR FOSKEY: I believe that the youth coalition has asked for a separate facility for adolescents and children with mental illness. Is that in the pipeline or in the vision?

Ms Gallagher: Yes. Last year's budget funded a 24-hour step-up, step-down facility for young people, I think at a cost of just over half a million dollars a year. When we went out to discuss that with the community sector, they indicated that they could not provide the services for that.

DR FOSKEY: I think you might have mentioned that before.

Ms Gallagher: Yes. So in this budget we have topped that up with another couple of hundred thousand, based on advice.

DR FOSKEY: Is there a physical facility yet?

Ms Gallagher: There will be.

DR FOSKEY: Is it going to be purpose built or an adaptation?

Ms Gallagher: We will probably be working with housing.

DR FOSKEY: What is the timeline on that?

Dr Brown: The contract for that is in preparation; it should not be that far away at all,

depending on the contract.

DR FOSKEY: That is the contract with the community organisation?

Dr Brown: Yes.

DR FOSKEY: Then there is the building to be adapted and all that?

Ms Gallagher: We are working with housing over a suitable building. It is for five young people, so it would need a fairly big property: we will need room for staff as well.

DR FOSKEY: Is that equivalent to an adolescent in-patient facility?

Ms Gallagher: No, that is a separate issue.

DR FOSKEY: Which goes with the PSU?

Ms Gallagher: Yes. There are mixed views around that. It is not a funded part of the forward design we are doing, but it is something for the future.

DR FOSKEY: When you say "mixed views", do you mean for and against?

Ms Gallagher: Mixed views about where it should be located, how big it should be, whether it should be near a secure unit with adults—those sorts of things.

DR FOSKEY: But there is general acceptance that it makes sense to have a separate—

Ms Gallagher: That in the future we will need an adolescent in-patient facility, yes. Perhaps the demand is not there as yet to prioritise that in terms of adults and secure, but in the future—again, this is part of some of that broader discussion we are having.

MRS BURKE: I am getting a bit confused here. We went from adult to youth.

Ms Gallagher: In the step-up, step-down, we have adult and youth covered in the community sector.

MRS BURKE: Yes.

Ms Gallagher: But a young people's unit is not part of the in-patient facility project at this stage—although, again, in that forward design work, we will need capacity to make a decision about where an adolescent unit should go, if it should go on that site.

DR FOSKEY: Would you hope that it might have the capacity to work with young people who present with dual diagnosis—which, I guess, is going to be more and more likely in the future?

Ms Gallagher: Yes.

MRS BURKE: Have you—

DR FOSKEY: You go. I have more, but you go.

MRS BURKE: I will just finish on the accountability indicators on page 170 of budget paper 4, again under "Patient activity", item h, "Percentage of clients with outcome measures completed". The target was 60 per cent in 2006-07, the outcome was 58 per cent and now we are jumping to a more amiable target of 65 per cent. It is still fairly low. What are the inhibitors to that and why has it fluctuated so much over the past few years?

Dr Brown: It is quite a complicated answer to give you in relation to the outcome measures. A range of factors impact on it. Some of them are technical and some of them are about staff practice. The technical ones relate to how you measure what is a completed outcome. It not only requires the completion of a particular scale, but there is a requirement that it be done within a certain time frame and that other information is collected at the same time as part of it, which includes diagnosis. With our electronic database there have historically been some issues about the diagnosis not being captured in the right field and being written in another field instead, hence it seemed to indicate that we were not doing the outcome measures when, indeed, we were.

MRS BURKE: That has been fixed now?

Dr Brown: We have been progressively working on these issues, but they are not simple or quick to rectify. In addition to that, there are issues around the staff completing the outcome measures. That is about two things—possibly more than two, but two at least. It does take time to complete these measures, and some staff have indicated that they do not see a lot of value in undertaking the measures because they can, for example, through their mental state assessment, make a clear assessment of whether or not the person has made an improvement. So they do not necessarily see the value of putting some numbers on to the database.

However, we have been very strongly advocating for the use of outcome measures, particularly because it is a process by which you engage the consumer in a dialogue about the level of improvement that they have made—indeed, the goals that they are setting—and invites them, I guess, to express more of their own views about their treatment and hopes for the future.

So, as a means to enhance our progress there, we have a training program around outcome measures. Again, we are making progress all the time. In the report for last month, for May, we were up to 64 per cent, which is an improvement on the year's average. We hope to see that continue. Again, nationally, we do not compare unfavourably to all other jurisdictions when you look at the jurisdictional level.

MRS BURKE: Just going back to something you said at the beginning about the technical issues in regard to the collection of data, I presume there has been some glitch in the software that you are using.

Dr Brown: Yes. We use an electronic database called Magic, which captures the

clinical record as well as a lot of the demographic information and other information such as outcome measures. Magic was developed ahead of the requirements for the national outcomes specifications, and it has not been a particularly simple process to go in and change that. We have been working on it consistently now for the past couple of years, but it was because we were ahead of our time, in a sense.

MRS BURKE: So it has not been that magic for the ACT?

Dr Brown: Yes.

MRS BURKE: Seriously, though, that is a concern, is it not, if we are not able to capture data appropriately to give these people the level of service and help that they need in a timely way?

Dr Brown: Yes, I think it would be highly desirable to have the information systems that support the clinical processes that we want to undertake. But the requirements for data capture increase each day, and, unfortunately, the people that develop the IT systems and the software do not have the foresight to know what we are going to want to do next week. Around the nation, each jurisdiction has had to grapple with this issue about how to best capture it. Whilst Magic has had its issues, other jurisdictions are saying to us, "You are really lucky, because you are well ahead of what we have." Indeed, they have expressed interest in potentially looking at taking up Magic.

MRS BURKE: So a final question: where does the data go from here?

Dr Brown: The data goes to a range of different places. We participate in outcome forums twice a year. It goes to the national outcomes and casemix classification on a yearly basis. It goes in as part of the national minimum data sent to the Australian government, so, it gets reported at a range of different settings.

DR FOSKEY: Minister, are you able to give us a rough breakdown on what proportion of funding in the budget goes to community-based services and what proportion goes to government delivery of services?

Ms Gallagher: Yes, sure, we can do that. We have those figures.

Mr Cormack: It is 25 per cent inpatient and 75 per cent community. That is basically the split at the moment.

DR FOSKEY: What is the situation with mental health and nurses? Is this an area where we are adequately supplied and is there a need for emergency mental health nurses? What is going on there?

Ms Gallagher: Yes. The answer is yes. There is a workforce shortage in the area of mental health nursing, yes. In fact, in our discussions with the University of Canberra that is one of the target groups.

DR FOSKEY: Training areas?

Ms Gallagher: Yes.

DR FOSKEY: Currently the University of Canberra does not provide specialties in that way?

Dr Brown: The University of Canberra does not provide the postgraduate qualification for mental health nursing. It provides undergraduate qualifications for general nursing. You do not have to have a specialist qualification, a postgraduate specialist qualification, to work in mental health, but of course it is desirable, and many nurses seek to have that before they work in the sector longer term.

DR FOSKEY: And at supervisory levels, I guess you would prefer the mental health training—charge nurses?

Dr Brown: Clearly we want to have nurses with experience in mental health being in charge of facilities. They are quite able to supervise general registered nurses working at a lower level and indeed enrolled nurses, provided that you have got the right proportions of those. I should add in response to your question before about the University of Canberra, we do have an arrangement with La Trobe University, and there is a postgraduate qualification in mental health nursing available to nurses here in the ACT through a distance education arrangement with La Trobe University.

DR FOSKEY: Does that involve some placements?

Dr Brown: Yes.

DR FOSKEY: One of the areas that have been raised with me by the Mental Health Community Coalition is that there are still problems around housing and accommodation for people with psychiatric disabilities and mental illness, particularly about linkages between health and housing. We heard a little bit yesterday about linkages around disability when housing was here. Could you let us know about the formal linkages that exist between Housing ACT and health in regard to mental health?

Dr Brown: A formal memorandum of understanding exists, and there are designated officers within housing that undertake the liaison around clients with mental health needs. In addition to that, there is a panel that meets, I think on a weekly basis, to look at those with special needs. A member of the staff of Mental Health ACT sits on that panel to look at priority allocations for those with special needs, which includes mental health needs. So there is a range of ways in which the liaison occurs.

DR FOSKEY: Are there formal guidelines to follow when interacting with housing?

Dr Brown: We do not have formal guidelines for the staff of Mental Health ACT, but, as I said, an MOU exists.

DR FOSKEY: It does seem one of those areas that will probably always be a vexed area for housing managers, where there is a quite a bit of movement, dealing with issues between groups of people. That seems to be something that really requires ongoing support and training.

Ms Trompf: I am sorry; I was out taking a call. The question is?

DR FOSKEY: The issues around liaison between ACT Health, particularly mental health, and housing in regard to appropriate housing for people with a mental illness, and also supporting housing managers and so on who are at the coalface facing conflict and other issues.

Ms Trompf: Dr Brown has probably already indicated that there is an MOU between housing and Mental Health ACT that we have all agreed to. There are regular quarterly meetings between the two organisations to facilitate how we work together to ensure that we can provide appropriate housing for people with a mental illness. In this financial year, too, there has also been an inclusion of mental health in the group that discusses the issues of priority housing. So mental health has a voice on that group to prioritise access for people with a mental illness.

There is also built into that MOU a protection of tenancy for mental health clients who might have to go into hospital for an extended period of time or into a rehabilitation centre or something like that. That has been a real added bonus for our clients. We do try to share training across workforces. The mental health community education officer can provide training, and has, to housing staff and we continue to do that. There has been some work between both agencies in providing some input into the certificate IV at the CIT for workers in there as well.

MRS BURKE: I hope the government will pick up the health committee's report, Dr Foskey, on the appropriateness of accommodation for people with mental illness.

THE CHAIR: Is that a question for Dr Foskey or the minister?

MRS BURKE: No, just a bit of interaction there, chair.

DR FOSKEY: A bit of advice. Thanks for that.

MRS BURKE: I could have said, "Will the government pick up all the recommendations," could I not, Ms Porter? Seriously, we will just wait and see what recommendations the government can pick up on that. I am sure you will too.

Ms Trompf: Yes, we are working with housing in responding to that report, yes.

DR FOSKEY: I have just two or three more questions. It would be great if I could ask them. Given that mental health funding is currently seven per cent of the health budget, does the minister believe we are on track to meeting the 2012 pledge of 12 per cent?

Ms Gallagher: That is something the government have agreed to in setting ourselves a target. I think we did this through our party conference, where we committed to it as part of our platform. I think the commitment was to achieve between nine per cent and 12 per cent by 2012. That was the agreement, but that is a party matter. This is something that national mental health groups have been calling for governments to commit to, and I think it is worth while that we set ourselves a target of doing that. At the end this budget year we are now up to about eight per cent, but to move to

12 per cent is quite a bit more.

DR FOSKEY: That means the health budget overall has to grow, does it not?

Ms Gallagher: The health budget is growing as well. We are trying to grow mental health in proportion, so it is a double whammy. By the time our inpatient facilities are all up and operational and investment has been made in that infrastructure, we will be heading in the right direction, and that is the best I can do. I have set myself the target. It is worthy that we have done it, because it sends a message about the investment we would like to make, and we will see how we go. But the health budget does grow itself as well.

DR FOSKEY: Accessing mental health care through the private sector is a very expensive thing to do.

Ms Gallagher: That is right, and we are yet to see the Medicare rebates from the commonwealth's plan. It will take some time for the benefits of that to be shown, if there are any, and if people will take up the opportunity to visit a GP or visit a psychologist within the GP's practice and draw down on that fund that the commonwealth has put in place.

DR FOSKEY: Do you think there will still be a role for the ACT government, though, in just guiding people around that system?

Ms Gallagher: Sure. It is in our interests that they use that system as well, if it develops to the point that it is useful. As I said, there are a few strings attached to this.

DR FOSKEY: What sort of strings?

Ms Gallagher: I think the GPs have to have training in mental health.

Dr Brown: Not for the new initiatives, but they do need to complete a care plan before they can refer someone off to access, for example, the services from a psychologist, social worker or OT. There is a limit to the number of those that are available per year. So there are some constraints upon it.

Ms Gallagher: It is whether it is taken up by the patients as well. It has to be initiated.

While I am on the subject of GPs, just to clarify for the record, the bulk-billing rates in the ACT are 51 per cent and nationally they are 77 per cent, just to add that in. Yes, access to GPs is already difficult here. So, that will be a further constraint on drawing down some of the commonwealth benefits. The commonwealth has recently engaged the Mental Health Foundation and Woden Community Service here as part of the first rollout of the personal helpers and mentors project. You welcome it, but, for us, I am trying to get an integrated system in place.

So it is a little frustrating as well, because one of the recommendations of the recent report concerned the number of groups offering mental health services. It is often confusing. It is hard for people to navigate the system. Some of the dislocation—we see it with mental health—is already occurring, because it is just adding to the

tapestry of services and people getting little bits of money here and there to go and do little bits of things.

DR FOSKEY: That leads me to my final and biggest question. It is a question that was raised with me by the community sector: does the minister have an overarching vision for the way she or the government wants mental health services delivered? You are talking about how a little bit of a federal government program might send it off in that direction, but you must have a direction.

Ms Gallagher: Yes.

DR FOSKEY: Can you articulate that, please?

Ms Gallagher: Yes, sure. I am waiting to get a draft or heading towards a final draft of the mental health services plan that has been under discussion and consultation with the sector for some time. In that plan we are specifically attempting to set out that vision. But, overall, my view about mental health would be a co-ordinated, community-based approach to managing people with a mental illness with appropriate clinical and acute supports in place, should that be required. I think there is agreement around that.

I know there has been criticism that all the money goes into the acute end and not enough in community-based services, and that we do not have enough overall spending in mental health. They are both areas that we have prioritised, making sure that we are putting a fair share into the community. But we have doubled mental health spending since coming to government, and in the doubling of that budget from $27 million to $54 million, I think it is, we have moved from a 5.7 per cent to an eight per cent increase in the overall proportion of the health budget. So you can see there is a bit of a job to go.

If I had to sum it up, that would be my view in a nutshell—that we manage people's mental wellness in the community with appropriate community supports and providers. People recover in the community. That is where they live: in the community. It is only certain periods of time when most people need to access more acute types of supports and services. That is the system that we are well on target to putting in place. But I have to say that I would like to see some streamlining of services, particularly in the community sector. But, again, that is very hard to achieve.

DR FOSKEY: Would you like to see federal funding being incorporated into the vision the ACT has developed rather than a vision that the federal government might be wanting to put overall over Australia?

Ms Gallagher: To a large extent, unless politics get in the way, governments at all levels work very closely. In mental health, we are part of a national plan for mental health. I cannot think of what the name of it is.

Dr Brown: We have two, minister.

Ms Gallagher: We have two. So all jurisdictions, including the federal government, have signed up to a national view. It is just when politicians get involved that things

get a bit dirty.

DR FOSKEY: I guess it is a fairly broad view.

Ms Gallagher: Yes.

DR FOSKEY: A consensus view?

Ms Gallagher: Yes, but all heading in areas that I would agree with and support, and I think everyone would support. But once money and politicians get involved, it is not very helpful.

THE CHAIR: Thank you, minister and officials. We will go to the break.

Ms Gallagher: Sorry, is that the end of mental health, just so that mental health staff can leave?

THE CHAIR: Yes. We will come back to output class 1.3, community health services, at 2.00 pm.

Meeting adjourned from 12.28 to 2.00 pm.

THE CHAIR: I welcome the minister and officials from ACT Health back to the estimates hearings. Moving on to output class 1.3, community health services, do you want to make any comments on this output, minister?

Ms Gallagher: I'm happy to proceed as we have been.

DR FOSKEY: A number of concerns have been raised with me in regard to the detox program for women with children. The initiative provides for a residential detoxification program with childcare facilities operating out of Arcadia House. The criticism is not of the program, of course, but of concerns about the limited offering of that service. At the moment, childcare services are only provided for about one month is year; is that the case?

Ms Trompf: Currently, there is no child minding at Arcadia. Is that your question, whether there is some currently?

DR FOSKEY: I thought there was limited child minding.

Ms Trompf: No, currently there is none, and this program is to provide a service that will accommodate women with children.

DR FOSKEY: For one month.

Ms Gallagher: One week of every month, which is what is happening at the moment, I think. This program has started and this is a continuation of it; is that right?

Mr Thompson: The budget funding for the women's and children's detox program is based on a successful pilot that Arcadia House conducted during the current financial

year, the one that ends tomorrow. Based on that, recurrent funding has been provided in the budget.

Ms Gallagher: So it hasn't been funded in the past.

Mr Thompson: It was a positive pilot and, as a consequence, has now been funded.

DR FOSKEY: Is there any chance of that being extended to services where fathers undergoing detoxification have childcare responsibilities? Has there been any demand? Perhaps that would be a better question.

Mr Thompson: This hasn't come up to my knowledge. We would be very happy to look at that and to discuss it with Directions ACT, who operate Arcadia House, but to date they haven't raised that with us as an issue.

DR FOSKEY: Okay. I am interested in having more detail on the youth health framework, where it is at and how it will be progressed, and also a bit more about the proposed expansion of the Junction health service.

Ms Gallagher: The two questions are about the same initiative. The idea is to expand on the successful youth health service that operates currently in Civic by extending it to Belconnen, Gungahlin and Tuggeranong. This will go to a tender process, I understand. The intention, certainly from my point of view, was to replicate the model offered by the Junction. I presumed the Junction were the right people to do it but I've had representations from the sector around a desire for that to go through a tender process. I think that is the best way forward and I am happy to do that. I am hopeful that the Junction will seek to be involved in that, but it may turn up other suitable tenderers as well.

DR FOSKEY: Is the Junction a purpose organisation, minister, or does a larger agency conduct the services at the Junction?

Ms Gallagher: Anglicare runs the Junction. It's the model we are seeking to replicate. The Youth Coalition approached me and sought advice as to whether that would go out to tender and, for the sum of money involved, it is appropriate that it go through that process.

DR FOSKEY: Are buildings already identified?

Ms Gallagher: I think we would be looking to use existing buildings in those areas, community facilities. This doesn't have a capital component to it, but I don't know whether there is more detail than that, whether we use health buildings or community facilities.

DR FOSKEY: You would think that for young people's services there probably would need to be a little bit of thought given to that.

Ms Gallagher: Yes. We would be wanting to link into some services already established in those regional areas.

DR FOSKEY: Did you say Woden as well, sorry?

Ms Gallagher: No, Belconnen, Gungahlin and Tuggeranong are the areas that we are seeking to extend into.

DR FOSKEY: I was going to ask which groups have been consulted, but it sounds like you have talked to the Youth Coalition. Any others?

Ms Gallagher: No, none specifically. This was an election commitment of the government's and we were just keen to deliver on it. There was consultation around that commitment in the first place. This is something that has been sought and a model that is working. It has largely been welcomed. We just need to make sure that we can get it off the ground and deliver it within the allocation that has been provided.

DR FOSKEY: Which is for four positions.

Ms Gallagher: Yes, two youth health nurse coordinators and two youth health workers.

DR FOSKEY: Do doctors come for sessional periods, or how does that work?

Ms Trompf: As the minister says, there was extensive consultation around expanding youth services a couple of years ago. A number of people working in the youth sector were involved in that consultation. There was a feeling that, rather than establishing new facilities, we should build on what is currently available to work with young people to help them access services that they require. The coordinators and the youth workers will work with the young people. It is yet to be decided where they might be based, but they will actually work closely with them to facilitate their access to the services that they require. It may be access to local GPs or drug and alcohol services, actually facilitating their access to services that way. The model may change, but certainly the feeling from the sector was that that was a better approach, rather than trying to establish new facilities on each side of town.

Ms Gallagher: But in relation to the doctors?

Ms Trompf: They may access doctors at the existing Junction service or they may use other GPs in whichever areas they are based. It may be something that can work a bit like the better general health project in mental health, where we establish relationships with GPs and actually facilitate access that way.

MR STEFANIAK: I have questions on a number of things. Firstly, there is a fair amount of money in the budget, $101,271,000 in terms of the total cost and $94 million for government payments for outputs. Could you give us a break-up of exactly how that has been spent in 2006-07 and how you intend to spend it in 2007-08? You can take it on notice if you have to.

Ms Gallagher: Yes, sure.

MR STEFANIAK: That's fine. The health promotion fund no longer exists. What are you doing in its place for health promotion?

Ms Gallagher: The health promotion fund still does exist. The only thing that doesn't exist any more is the board. Everything else—the grants process, the money available—remains. We have not changed the grants process.

MR STEFANIAK: Why doesn't the board exist any more, and who does the actual assessment?

Ms Gallagher: It was a decision taken in last year's budget to disband the board. It was primarily around efficiencies. There were, I think, 4.7 staff—around four to five staff—who supported the work of the board, and the decision was taken to reintegrate that money back into the department. There were some efficiencies around the costs for staffing it which have been realised over the past budget year. The great job of allocating where a couple of million dollars goes a year rests with the chief health officer's area.

MR STEFANIAK: Did the board used to do that?

Ms Gallagher: The board did, yes. That was a board role. Dr Dugdale is involved in the process, but I am certainly not getting involved at that level at all. It is almost unchanged, except that the panel now reports to the chief health officer, who makes recommendations around how that money should be spent.

Dr Dugdale: The board used to have a process where it would have its chief executive officer convene panels of relevant experts and community members from other government departments or from the community or non-government organisations and they would assess the grants and make a recommendation to the board. We have used exactly the same process and many of the same people, so we have what we call peer review panels that go through the grants and rank them and make a recommendation. That is then conveyed to me, and I take on the administrative role that the board used to have. I used to be a member of the board and I have executive responsibilities for that money now and make a decision based on the advice that I get from the expert panels.

MR STEFANIAK: I would like a break-up of where the money went in the last allocation immediately prior to the board ceasing and where the money has gone since the board has ceased.

Ms Gallagher: Sure. That is all publicly available information, but there are a number of grant rounds. Are you after one grant round in particular? There are small grant rounds.

MR STEFANIAK: I would be interested in just the total for the last year and also a total for the last year the board actually existed.

Dr Dugdale: That is on the public record. The role of the minister is to announce where it goes.

Ms Gallagher: That is one of my good roles.

MR STEFANIAK: Perhaps you could supply that anyway.

Ms Gallagher: Yes, sure.

MR STEFANIAK: The whole fund—correct me if I'm wrong, but I doubt that I am—was set up to buy out tobacco sponsorship of sport and it has since become a lot more than that. Could you tell me now just what percentage of last year's grants process actually went to sporting groups?

Ms Gallagher: Quite a lot, but, we can do that in the answer to you detailing the breakdown. We made an announcement recently and the money goes to about 20 different organisations, a large number of which are sporting.

MR STEFANIAK: I recall that over a number of years a figure of only about 25 per cent, for example, was going to sporting and sporting-type groups promoting a healthy lifestyle.

Ms Gallagher: That's pretty good.

MR STEFANIAK: Not really. Most other states have 50 per cent. We are at about 35 per cent. It strikes me that if you are trying to encourage a healthy lifestyle and to fight childhood obesity and things like that a logical area would be to support groups fostering physical activity.

Ms Gallagher: Yes, and we do. I haven't changed any of these. A proportion of the money goes to falls prevention, for example. None of that goes to sporting organisations. We haven't changed those; they existed before. There are small group grant rounds. What is the other one? There are three. There is a larger grant round.

MR STEFANIAK: If you could give me all the details, that would be good.

Ms Gallagher: Yes. I have to say that it is not an undersubscribed grant allocation and there are competing desires for that money across a wide range of community agencies outside of the sporting area.

MR STEFANIAK: That has always been the case. You mentioned that you have select groups who now pick and prioritise within their areas. The board was always publicly available. Would you be able to supply the names and the qualifications of those people you use to prioritise their particular areas?

Ms Gallagher: Yes, that's fine.

MR STEFANIAK: Thank you.

THE CHAIR: Minister, during the budget you announced a $1.7 million allocation for dental health. What particular issues in this budget are aimed at addressing the public health dental waiting list?

Ms Gallagher: This budget has, I think, $1.7 million allocated over four years to deal with less urgent dental problems for our adult patients. This is an area where we are

continuing to see growing demand. We have injected quite a bit of money into the dental program in recent budgets because of the demand for access to dental care and because dental care is so expensive. This initiative will reduce the waiting list for restorative dental work, so less urgent dental work, from 16 months to 12 months; that's what we are expecting. It will be for around another 400 occasions. It will assist around 415 clients a year through that. It was the maximum, I understand, that we could deliver in terms of additional services through our system. Some of that may go to the private dentists.

MRS BURKE: I was going to ask you whether you are moving towards doing that.

Ms Gallagher: I think we do already.

MRS BURKE: You do, but to a greater extent.

Ms Gallagher: Yes. We do very well nationally on dental waits. It is one of those waiting lists you never hear about. Still, a 12-month wait is a long time when you have a problem with your teeth. We know that it impacts on so many other areas of your overall health and wellbeing. We would welcome any support offered federally to assist us in the treatment of dental care, because I think all of the reports now show, quite disturbingly, that dental problems are emerging much earlier in our lives than they have in the past. Some of that is around dietary choices and the impact of some of the changes in children's diets that we have seen, but what it means is that it is a problem in the making. It is not a problem that is gradually getting smaller over the years. We have a very good child and youth dental program here. I am reluctant to say these things, but I don't think there is any substantial wait to access the children and youth dental program in the ACT, which is a very good one. It is universally available up to the age of, I think, 14.

MR STEFANIAK: I have already asked you for a break-up, which you are going to provide, in relation to the total cost of this output. Could you indicate how much of it is actually spent at the Canberra Hospital?

Ms Gallagher: Of that proportion of the output?

MR STEFANIAK: Of the $100 million-odd budget.

Mr Cormack: There is a component there for the acute support program, which is the allied health program. I don't have that figure available to me.

MR STEFANIAK: What does that do?

Mr Cormack: It provides allied health services—physiotherapy, occupational therapy, speech pathology, psychology and a range of other "ologies"—to support the hospital's delivery of services.

Ms Gallagher: They are based within the hospital.

MR STEFANIAK: I have several questions on the alcohol and drug services. The first is in relation to the healing centre, an interesting concept which, contrary to what

your learned leader says, I actually think may be a good idea. I don't have a problem with it, apart from where he is going to put it. Where is that at? What exactly is it meant to do? Have you looked at any sites in the bush, such as Birrigai and Cotter?

Ms Gallagher: Ian might be the right person to talk about that. Ian has extensive background in this initiative. A lot of the work that was done around feasibility for a bush healing farm was done prior to my becoming minister.

MR STEFANIAK: I appreciate that.

Ms Gallagher: I do have carriage of the issue now and I have been asked to bring a submission to cabinet around it, but there were, from memory, a couple of sites examined in addition to the ones that have been publicly talked about.

Mr Thompson: The purpose of the so-called bush healing farm is to be a drug and alcohol rehabilitation service for Aboriginal and Torres Strait Islander people. Where we are up to in the process is we have developed through extensive consultation with the Aboriginal and Torres Strait Islander community locally the model of care and got agreement to the model of care through that consultation process. We also examined a number of sites—all up, probably about half a dozen—of which, I think, we got three that possibly would be suitable that are in the bush in addition to the one that you are referring to.

MR STEFANIAK: The controversial one.

Mr Thompson: At this point, in terms of our processes, as the minister outlined, she has got carriage of bringing that back to government.

MR STEFANIAK: How many people would you envisage, where ever it goes ahead, that site being able to accommodate at any one time?

Mr Thompson: We would be looking at something like 10 to 15 people at any one time. It won't be a large facility, and that's a combination of about what is suitable for this sort of service as well as the overall demand for the service.

MR STEFANIAK: Why the actual need for a specific Aboriginal site as opposed to utilising other alcohol and drug rehabilitation places? Has there been some problem with integration or everything using things, or is this a unique sort of concept that you feel should be done?

Mr Thompson: There are a couple of aspects to this. Firstly, experience overseas shows that drug and alcohol rehabilitation for indigenous people works well in a cultural reconnection-type context. That is where a specific indigenous facility can provide that cultural reconnection. That said, we don't expect that this will be the sole source of drug and alcohol rehabilitation for Aboriginal and Torres Strait Islander people in the ACT. They are currently accessing other services through the existing drug and alcohol rehabilitation providers, but it is about looking at something that is more culturally sensitive and appropriate.

MR STEFANIAK: How many other residential places have we got for people who

suffer from alcohol and drug abuse?

Mr Thompson: We've got three currently located in the ACT.

MR STEFANIAK: Where are they and how many people do they hold?

Mr Thompson: I will qualify what I am going to say in terms of numbers by saying that this is off the top of my head and I am happy to confirm it later. We have got two adult ones. One is the Karralika facility in Tuggeranong, split across Fadden and Isabella Plains sites. That has a total of about 40 beds. Another is the Salvation Army one at Fyshwick. It has about 25 beds. I am looking over my shoulder for confirmation. We have a youth facility operated by the Ted Noffs Foundation at Watson, which accommodates about 10for rehabilitation.

MS PORTER: Mr Stefaniak called it a controversial site. I don't think anybody, apart from Mr Stefaniak, thinks it is controversial that we have a site, amongst others.

MR STEFANIAK: That site.

MS PORTER: My question is around that issue of childcare that was raised before. Will that be in the mix for this particular model that you are looking at?

Mr Thompson: Very definitely. Again, as part of the concept of both culturally appropriate, cultural reconnection, and what is effective in drug and alcohol rehabilitation more generally, having the capacity to accommodate families—in particular, children—is very important to the effectiveness of these programs.

MS PORTER: Minister, perhaps you would be the best person to tell me how many other community-based drug and alcohol facilities or services we have, apart from residential ones, in the community, and whether there is any additional money in this budget for those kinds of things.

Ms Gallagher: We have a whole range of programs in both the government and the non-government sectors. I am hoping that someone will identify them all.

MS PORTER: I don't want them all identified. I just want the number as to how many we have.

Ms Gallagher: We can get that to you.

MS PORTER: That would be fantastic.

MR STEFANIAK: Would those 75 places normally be filled or would the number fluctuate and sometimes you would have places half empty and at other times full?

Mr Thompson: They are normally fairly full. It fluctuates a bit, but there is strong demand.

MR STEFANIAK: Going back probably 20 or 25 years, as part of a court order someone would go to Karralika, for example, which was a secure facility and you

would have great confidence that they would not be able to escape from it and yet it was a very good alternative to going to Goulburn jail. Are any of these facilities actually secure enough for, say, a court to have confidence that they could sentence someone and they would go there for, say, three months as part of an order to dry out and get rehabilitated and they wouldn't be able to wander off from the facility? Are any of them secure?

Mr Thompson: They are not secure or involuntary in that sense. We don't have a legislative framework in the ACT to provide for that type of care for people with drug and alcohol problems.

MR STEFANIAK: Does New South Wales?

DR FOSKEY: There is a drug prison in New South Wales, Mr Stefaniak. You will have to investigate it.

MR STEFANIAK: They would have a few places, I would think.

THE CHAIR: We are actually talking about the ACT budget, Mr Stefaniak.

MR STEFANIAK: We are. Is there any intention to do that, minister? Karralika used to be a secure facility.

Ms Gallagher: I have been out to visit Karralika. Are you thinking about Brian Hennessy House at Calvary, which does have a secure capacity, but that's not for drug and alcohol clients. It's for people with mental issues.

MR STEFANIAK: No, I am saying that simply because Karralika used to be secure, but it certainly isn't now. Do you have any plans for that? It would seem to assist in rehabilitating people, especially when there is court involvement.

Ms Gallagher: I know there is debate underway at the moment around committing people with alcohol problems to compulsory treatment, but it is certainly not something at the forefront of my mind about pursuing. I would rather pursue other less punitive treatment options, if I had my choice about extending the services we currently offer.

MR STEFANIAK: It is not much good when you have, for example, a client with about 20 or 30 offences who is sent to Karralika to get off drugs and walks out 36 hours later. That doesn't really help anyone.

THE CHAIR: Is there a question in there, Mr Stefaniak?

MR STEFANIAK: I am just suggesting that you might like to look at making something secure for them. All right, you have three facilities there. How many people—perhaps you could take this on notice—in terms of drug abuse as opposed to alcohol abuse go through your services, the ones which I think Ms Porter mentioned, on an annual basis? Perhaps if we just had last year's figures, that would be helpful. Do you have any checks in terms of people coming back on whether they have to have additional treatment, not reoffend, after going through a process? In other words,

do you keep tabs on a success rate or a failure rate in terms of these services?

Mr Thompson: We can provide you with the details of the numbers who go through and what is termed the principal drug of concern, which includes alcohol, within the national minimum data set.

MR STEFANIAK: Yes.

Mr Thompson: We do look at the frequency with which people return. It is actually a very common feature of drug and alcohol treatment services that people do return. It's a chronic relapsing condition, and the experience here of people returning is consistent with the experience right across the world when it comes to these sorts of conditions.

MRS BURKE: My question, which is along the same lines as Mr Stefaniak's, is about the accountability indicator on page 171 relating to the number of opioid treatment clients with management plans. The target was 450 and the estimated outcome is 570, and you are looking to maintain that. There is concern, I suppose, about the increase there. I am wondering about what types of opioids we are talking about here and I am wondering what the management plans related to those particular opioids look like? They would obviously have to be different, and different for each individual.

Mr Thompson: Firstly, what this target represents is the number of people who attend for pharmacotherapy treatment in the opioid treatment service in the alcohol and drug program of community health. As to the treatments that are provided, they are given generally maintenance treatment on methadone or buprenorphine, and they are also given counselling and case management support to assist them on the program and to assist them to overcome the impact that their problems have had. That is the basic content of the treatment plans.

MRS BURKE: Okay. How often are these plans reviewed? I am probably drilling down to case management a bit more, but how often are those plans reviewed? It would depend on the individual, I would expect, but I am just thinking of the process here. What does happen? What sort of financial cost is that to the community at this stage? What proportions of the budget would be going to this particular treatment?

Mr Cormack: We would have to take that one on notice.

MRS BURKE: Thank you.

Ms Reading: In response to your question about care plans for our alcohol and drug program clients—care plans are very much based on the individual needs of each particular client. The review will be based on the medical assessment once they come through the service. We have several multidisciplinary services that clients can be referred to, and they may well go into the community in being referred to general practice for management of their care planning at some point. But, as Ian said, it is a multidisciplinary team approach; if people are demonstrating behaviours that are high risk, their review processes will be more frequent.

MRS BURKE: What sort of professionals would this plan involve—the management plan?

Ms Reading: As Ian stated before, we have specialist medical services, counselling services and case management services. These clients also have access to a range of multidisciplinary teams across community health, and they have the same eligibility criteria for services across community health. They have priority service to dental health programs, because of their high oral health risk status. Again, their management plans are based on their needs at the time.

MRS BURKE: Would you have a breakdown of the gender and age? You may not be able to provide that today, but would it be possible?

Ms Gallagher: I think there are over 700 people involved in the opioid treatment—is that right?

Mr Cormack: It is 769.

MRS BURKE: So you do not keep any data—

Ms Gallagher: We would, but we would have to go through and do it specially for you. We can do that.

MRS BURKE: Wouldn't that be useful to have in terms of forward planning and tracking?

Mr Cormack: We do have that; we just did not bring it with us.

MRS BURKE: Sorry; I thought the minister said that you do not have it at all.

Ms Gallagher: No, I did not. I just said that we would have to provide it on notice.

MRS BURKE: Thank you.

DR FOSKEY: Can I follow up?

THE CHAIR: Dr Foskey.

DR FOSKEY: I am interested in what is happening out there at the alcohol and drug program given that we had quite a bit of interest in this a couple of years ago. People will remember that there were a couple of reviews around the culture of the service. I have not asked about that for a while. I am interested in tracking whether the recommendations—of three reviews, I think it was—were implemented and whether they made the difference that it seemed was needed at the time.

Ms Reading: At the time, you are aware, we had a change in the director of the alcohol and drug program. There were three reports. A probity review was conducted and tabled at the Assembly. We also had a workplace environment review; the recommendations and the government's response were sent to MLAs in 2004. We also had a review of clinical services; again, the final report and management

responses were tabled at the Legislative Assembly.

Since then we have done a lot of business planning and strategic work in the alcohol and drug program. We have dedicated clinical governance. Of the 111 strategies that picked up all those recommendations in the business plan, 99 per cent have been completed and are ongoing. We have a clearly defined clinical governance framework within the alcohol and drug program. And we are working towards continual quality improvement against the recommendations that we have identified in our strategic plan.

A lot of that can be from several levels. It can be about supporting management to understand the business of the program in terms of code of conduct. It can be about always improving clinical practice and sharing your knowledge with the multidisciplinary team. And it can be against national benchmarks and best practice as well. From that perspective the program has moved along significantly.

DR FOSKEY: Is the director—I cannot remember her name, and it is probably not necessary to do so—who came in in about 2005 still in the position?

Ms Reading: She certainly is.

DR FOSKEY: That is good.

Ms Reading: And is as passionate and committed as ever.

DR FOSKEY: I want to ask about the needle and syringe program based at Civic—forgive me if you have told me this and I have forgotten. Who is running that now and where is it based?

Ms Gallagher: Directions are running that service.

DR FOSKEY: They are running Woden and in the same premises they were running at in Civic previously—in East Row or whatever it is called.

Ms Gallagher: They are moving. I cannot give you an exact timetable.

DR FOSKEY: Are they moving to the Griffin Centre?

Ms Gallagher: No; they are moving to Moore Street, to the health building.

DR FOSKEY: That is right; I remember that. There is just a concern that that might not be an attractive location.

Ms Gallagher: They were the only landlord that would take them.

DR FOSKEY: Moving is a good idea.

Ms Gallagher: That is the issue.

DR FOSKEY: What about Griffin Centre?

Ms Gallagher: No.

DR FOSKEY: In that case, I should congratulate you on finding a venue.

Ms Gallagher: We are making some changes to make it nicer—capital changes.

DR FOSKEY: I think access was the issue, wasn't it?

Ms Gallagher: Yes; and we are doing some changes there prior to them moving.

DR FOSKEY: And having to walk through the whole building.

Mr Cormack: It will have a discrete entrance.

DR FOSKEY: It will? I think that was a major issue, so that is good.

MR STEFANIAK: I have a few more questions on alcohol and drug services. I look forward to those figures, because it sounds as though most of these patients come back, which is a shame. You may have done this, minister—my apologies if you have; I was at that meeting yesterday afternoon—but I want to ask about the corrections part of health. There you do have a captive audience. One of the biggest problems in terms of people being sent to jail is drug abuse. What steps are you taking in the new prison to ensure that prisoners are, as much as possible, cured of their addiction, weaned off their drugs?

Ms Gallagher: Sure.

MR STEFANIAK: The same applies to the new Quamby.

Ms Gallagher: Yes. As you would be aware from the Attorney-General's appearance, we are currently putting together a corrections health plan for government to consider. That will look at all aspects of health and the provision of health services in the prison.

MR STEFANIAK: Where is that up to?

Ms Gallagher: It is under consultation at the moment. It has not reached me in its final form, but it is nearing the end of that process. We need to have it agreed—between health and JACS, primarily, but across government—fairly soon.

MR STEFANIAK: It would seem that you have an ideal opportunity to get right as much as you possibly can with this thing with this new centre.

Ms Gallagher: Absolutely. And, as you know, the focus of having our own jail and the type of jail that we are building, and the new juvenile detention centre, is to provide a focus on rehabilitation and, hopefully, reduce people's reoffending and ending back in these areas. There will be a very heavy emphasis on rehabilitation, and drug and alcohol education will be part of that. I am told that it will come to cabinet before the consultation process. It is being talked about in the sector. I have certainly attended a couple of meetings with community agencies who are talking about what

type of health services they would like to see operate out of, in this instance, the Alexander Maconochie Centre.

MR STEFANIAK: One issue which was raised during the corrections hearing with the minister was whether prisoners will have access to needles. That is certainly an issue of concern—and an issue of safety for custodial officers, who were nodding at the back of the room. Have you reached any decision in relation to that? Personally, I would have great concern if that occurred.

Ms Gallagher: No.

MR STEFANIAK: The A-G did not seem to have an idea about exactly where you were with that.

Ms Gallagher: We have not reached a decision, in the sense that cabinet has not considered the corrections health plan. It is one of those issues that ultimately will just be decided by cabinet rather than necessarily agreed upon through officers. It is probably one of those public policy decisions that people have differing and strong views around. But we are looking forward—

MR STEFANIAK: Do you have a view?

Ms Gallagher: I cannot say that I have a firm view either way. I see the benefits and the risks of both approaches. I can see the benefits of having needles available to prisoners, considering that no prison in the world has been able to have a drug-free environment.

MR STEFANIAK: We have done fairly well with the remand centre, believe it or not. There has been some, I must concede, but it is very rare. Surely you should be able to do that.

Ms Gallagher: On the other side, I see the risks of having needles in the jail. I have been lobbied pretty strongly on both sides, I have to say. That is why I say that ultimately I think that it will be a decision that the government has to take. It is probably the most contentious aspect of the corrections health plan. I think we need—and this is the approach I take in most areas of policy development—a commonsense approach which tries to deal best with the competing interests. We will have a new opportunity here in the jail when it starts, but I would like agreement with the attorney. I would like agreement between the attorney and myself around how we should proceed with this. All I would say at this stage is that it is contentious and no decision has been made.

MRS BURKE: Can I follow up on that? You have hit on a couple of points. I am wondering about the interrelation between health and JACS. Where does health start and stop and where does Justice and Community Safety start and stop? In your mind, particularly, as minister, how would you like to see this pan out in terms of the new prison?

Ms Gallagher: We had some legislation passed in the last sitting which clearly defined those responsibilities and limits. We made amendments to that bill to give the

director of health for the prison responsibility for health; we also clarified some issues around public health matters—the role of the chief health officer and some issues around health records. I think we have reached agreement with JACS about what the roles and responsibilities are. Ultimately, in the area of health it is freedom within a corrections framework, I would say. The chief health officer—

MRS BURKE: That is what I am getting at.

Ms Gallagher: You cannot just stomp in there without some discussion with the head of corrections around how that should occur. But under the Public Health Act he has some statutory responsibilities which will need to be observed.

MRS BURKE: Sure.

Ms Gallagher: I think we have got a pretty good understanding. In the lead-up to the prison becoming operational, there may be some need for an MOU or practice guidelines about how the act should work in practice day by day.

MRS BURKE: I think that will be very important.

Ms Gallagher: The health records matter was a good win, in a sense, for health, in the sense that we have some protections for prisoners around their health records and the privacy of their health records.

THE CHAIR: We should move to output class—

DR FOSKEY: Can I ask just one quick question?

THE CHAIR: Yes.

DR FOSKEY: It might be a question on notice. I was wondering if there are any data which indicate the waiting times for referrals to community services such as social workers, occupational therapists, physiotherapists, nutritionists, allied health services et cetera.

Ms Gallagher: In the community or in the hospital?

DR FOSKEY: In the community.

Ms Gallagher: Okay.

THE CHAIR: We will go to 1.4. We are looking to go to afternoon tea at 3.15. Ms Porter.

MS PORTER: I want to go to 1.4, the last dot point. In relation to Healthpact, quite a while ago—it seems a while ago now—you talked about fall prevention. I presume that is one of the measures that you are going to be using to ensure that the rate of hip fracture declines over the long term. Are there any other measures that you had in mind?

Dr Dugdale: The fall prevention program is the place where we collect a variety of interventions to try and prevent falls. That is the main program, but it is spread through public education; health promotion; grants which have been put out through the health promotion grants program, particularly to residential aged care facilities; the activities of aged care and rehabilitation services, including their falls clinic; and surveillance activities run by the Population Health Research Centre.

MS PORTER: That is fantastic, but are there any other initiatives to prevent the fractures—apart from the fall prevention that you are doing? That is fine; I am not saying that it is not. I am just asking, under the dot point, whether that is the initiative or whether there are other initiatives. It is at page 155; it is the last dot point under 1.4. Sorry, you probably misunderstood my question.

Dr Dugdale: No; I was trying to answer it as best I could. All the fall prevention activities that we do are collected under that program, but that is a wide range of different activities.

Mr Cormack: There is another answer to that.

MS PORTER: Thank you.

Mr Cormack: Under program 1.6—which is aged care and rehab, which no doubt we will come to later—we offer a range of fall clinics and we set targets in relation to the number of people who will go through those clinics. That identifies people at risk or people who have had a fall—to look at preventing the likelihood of them having a fall in future. That is in addition to the population health programs that Dr Dugdale referred to before.

MS PORTER: I was just wondering about access to testing for osteoporosis—is that the right name for it?—and encouraging women to take up healthy eating practices and those kinds of things in order to strengthen their bones. Is that part of this program?

Dr Dugdale: Part of which program?

MS PORTER: Ensuring that the rate of hip fractures declines over the long term.

Dr Dugdale: That is not a program; that is a partial descriptor of output 1.4.

MS PORTER: Right.

Dr Dugdale: We do have a fall prevention program, which includes the elements that I outlined before.

MS PORTER: Yes; that is fine.

Dr Dugdale: That includes public education, including on nutrition. Coming to the other question, on osteoporosis testing, that would generally be done through general practices, but it is available through specialists in outpatient and in-patient services if the clinicians want it to be.

MS PORTER: I thought that maybe there has been a program along with pap smears and things like that. I wondered whether women are aware of the necessity to ensure that their intake of calcium is sufficient into their older years.

Dr Dugdale: It is certainly a good idea, and we try and get that message out through our nutrition education campaigns.

MS PORTER: Thank you.

DR FOSKEY: Can I ask some questions about what kinds of things come under this output class? It is quite a lot of money. I am interested in whether it covers things like the sexual health and family planning centre, pap smears and anti-obesity programs in schools. Is this where they come?

Ms Gallagher: Some of them, yes.

Dr Dugdale: Some of that. There is a full description of what we provide under this output class in the annual report of the department, which we have another estimates session in relation to.

DR FOSKEY: I am really looking forward to that.

MS PORTER: I don't think Paul is, necessarily.

Dr Dugdale: No; I look forward to it every year. We always have a good discussion on public health. It covers the things that you mentioned, except for cervical screening, which is provided through community health.

Ms Gallagher: The immunisation programs come through this area, for example.

Dr Dugdale: Immunisation; health protection, including communicable disease control and control of notifiable diseases; environmental health, including food inspectors; the immunisation distribution scheme; the HPV vaccination program that has commenced, which was one of the budget measures; health promotion, including the health promotion and grants program that we were talking about earlier; and a range of policy activities of a more minor nature.

DR FOSKEY: Does the area of food safety involve, for instance, checking that restaurants and cafes are keeping to the health regulations? Does it include things like whether supermarkets throw out rotten food from their fridges? How do you do that? How do you make sure that people are complying?

Dr Dugdale: It certainly does include that. Firstly, we license food businesses. All restaurants and cafes will have a notice up—visible to the public, signed by, usually, the director of the Health Protection Service—that authorises them as a food business. They then receive random audits by our environmental health officers. Environmental health officers will also investigate complaints. If you find any rotten vegetables in the supermarket, call the Health Protection Service through Canberra Connect and we will send out an environmental health officer to investigate.

DR FOSKEY: In what time frame?

Dr Dugdale: Within 24 hours we will have made an assessment.

DR FOSKEY: Are you aware of an issue that is running in Sydney about the public feeling they have a right to know when a restaurant or cafe has been deemed not to be complying with health regulations—that there needs to be a public register of that? Do we have such a thing?

Dr Dugdale: I am not aware of the current issue in Sydney, but this is an important area for health regulation of food businesses. The approach that we take here is that, if we remove a licence, we will advertise that. If we have a prosecution, we generally advertise the prosecutions, and of course they are done publicly in the courts. But we have a very robust series of discussions with a lot of food businesses, offering them advice as opposed to issuing compliance notices. When we are offering advice and notices before things have got to prosecution, we do not move into the name-and-shame approach; but we will if there has been a prosecution or if there has been a removal of a licence.

DR FOSKEY: That seems reasonable. Finally, how do you monitor whether prevention, early intervention or integrated care services are working? Is it just by high life expectancy?

Dr Dugdale: That is a complex area, and it depends on the different measures that we are taking. We have the Population Health Research Centre within my division of ACT Health, and we have a range of specific research activities and evaluation activities going through that. I am happy to go into anything of particular interest to you. It is certainly more than just measuring mortality.

DR FOSKEY: I was being slightly facetious. I would be interested, but not necessarily now. Perhaps we will wait until annual reports.

Dr Dugdale: There is also the chief health officer's report. That is my main vehicle for reporting to the people of the ACT on that side of effectiveness.

DR FOSKEY: Forgive me for not knowing this, but is that a document that gets presented to the Assembly?

Dr Dugdale: Yes; it is tabled by the minister. The last one was in 2006. It is biennial. I will be giving my report to the health minister in the first half of 2008 for tabling in the Assembly.

MRS BURKE: I have a real supp to that. From page 155, I was interested to hear that we were maintaining the ACT's position as the jurisdiction with the greatest life expectancy. That was part of my question. I was looking—Dr Foskey may have answered it—at the tools used to monitor it.

DR FOSKEY: They answered it?

MRS BURKE: No; you asked it. I am not sure of the tools. Maybe you can provide the committee with that. I think that is what Dr Foskey asked—in terms of how you monitor prevention, intervention and integrated care services. I would be interested to know how you do it—how you monitor it and what tools you use.

Dr Dugdale: I think the best answer I can provide is that we provide the detail of that through the chief health officer's report on a biennial basis. It is required by statute. It goes into the many different prevention, early intervention and integrated care services that we have.

MRS BURKE: Great. Can you give me a quick definition of integrated care services? We have talked a lot about wraparound stuff and integration. I am just interested to know in this particular area—

Dr Dugdale: Within the public health output, we are interested not so much in the provision of care from any one clinic or any one specific service but more on the overall effectiveness of the mix of services—in-patient, outpatient, community health and private sector. We take that integrated approach in looking at the population's health overall.

The sorts of measures that we use are drawn from the in-patient statistics collection—the statistical holdings relating to the other services that ACT Health provides: community health, the screening programs and so on. We also correspond with the commonwealth department of health, looking at general practice care, particularly for people with chronic illness. This is something that we are in discussions with them over now—trying to get information for the next chief health officer's report. We work closely with the Australian Bureau of Statistics, the Australian Institute of Health and Welfare and the cancer statistics groups around Australia. We work closely with NSW Health as well, because we provide so many services to New South Wales people here. We also do computer-assisted telephone interviews with people—CATI surveys. We ring them up and ask a screed—I think, 23 minutes worth—of questions.

MRS BURKE: I am glad you have not rung me yet.

Dr Dugdale: That is a representative sample.

MRS BURKE: Let me know when you are going to ring me and I will set some time aside.

Dr Dugdale: I thought you were going to ask about when I am going to stop listing our data sources.

MRS BURKE: No, not at all. I was asking more for a definition around what integrated care services does.

Dr Dugdale: My definition is: for public health purposes, it is the whole of the care that is provided. And we look at that and the outcome for the population.

MRS BURKE: Thank you.

MR STEFANIAK: One of your key points is ensuring that the rate of hip fractures—

MS PORTER: We have just been talking about that.

MR STEFANIAK: Okay.

DR FOSKEY: Does the percentage of persons aged 12 to 17 years who smoke regularly come under your area—prevention?

Dr Dugdale: We certainly monitor it through the secondary school alcohol and drug survey.

DR FOSKEY: I am interested in the table on page 167. I would be interested to see that data as gender disaggregated just for interest, because of issues around girls smoking.

Ms Gallagher: From memory, that is available in the secondary school survey.

DR FOSKEY: I know that it comes out.

Ms Gallagher: You would like to see it in the budget papers?

DR FOSKEY: Maybe that is going a bit too far, although we are supposed to have an agenda for a women's plan.

MR STEFANIAK: Could you supply it to the committee.

Ms Gallagher: We will supply the secondary school survey to the committee. That is fine. It is a public document and has all that information in it.

DR FOSKEY: I would not be averse to seeing it in the budget.

Ms Gallagher: I guess the question is around how much detail. Do we gender disaggregate every indicator? We already report that information in the survey. We are happy to provide it to the committee, but it would be hard to justify it just under that strategic indicator and not many others—except breast screening, maybe.

DR FOSKEY: I imagine there are some where it is more relevant. I will give that some thought.

THE CHAIR: Since Dr Foskey touched on that, minister, can you tell us what programs you have in train or you are looking at in the future to try and deter young people from taking up the smoking habit?

Ms Gallagher: There is a range of pieces of work underway: some have been completed through recent changes—not so recent now; six months ago—through tobacco control indoors, indoor smoking. In relation to some upcoming measures, the government is considering further controls around point-of-sale advertising, the use of cigarette vending machines in premises, and use on the back of shopping dockets—

the incentive scheme. We have been through a process of regulatory impact consultations around that; that occurred in the past, and we are now progressing that work. We are also consulting with industry around outdoor smoking bans or further bans around outdoors and investigating a range of others. I think Andrew Barr has spoken on ones around educational facilities—so looking at government facilities and the front of building entrances. We are looking at approaches to playgrounds and areas frequented by children—underage venues, for example. They are all on the table. Have I left any out?

Dr Dugdale: There are a couple of additional ones. There is pack size control; tobacco companies cannot offer split packs with fewer than 20 sticks. Also, we banned fruit-flavoured cigarettes about a year ago.

MR STEFANIAK: I am a bit concerned to see on page 167—

MRS BURKE: Before we move to that, I have just one more thing, minister: are you considering what might happen out at Canberra stadium?

Ms Gallagher: Yes. They are themselves as well. They have indicated to me—I think anyone who goes to Canberra stadium and has to walk anywhere near getting a packet of chips, particularly at half time—

MRS BURKE: Or sitting up above where the eating area is.

Ms Gallagher: I agree.

MRS BURKE: It is a difficult one.

Ms Gallagher: I am keen on a timetable for the ban there. We have to move to a ban; it is about when we do it.

MRS BURKE: So you are looking to do that? Are you actively—

Ms Gallagher: I am. I have asked health to include that in some of the consideration that will come before government. I understand that the stadium itself is looking at doing it. I want to give them the opportunity to tell us what their thinking is.

MRS BURKE: We are the only stadium now, aren't we—or is it just one other that does it? I cannot remember.

Ms Gallagher: In a sense we have: you cannot smoke in the seating areas.

MRS BURKE: That is right.

Ms Gallagher: But it is around where you can smoke now that presents the difficulty. I do not think we are the worst, but, particularly at times through the event, we are not the best.

MRS BURKE: What is your time frame on that? What are you looking at?

Ms Gallagher: I need to speak with Canberra stadium. When I first raised this, Canberra stadium's response was, "Yes, we are keen to do it; we're investigating it." Now that a period of time has elapsed, I would like to get firmer details about when that will be.

MR STEFANIAK: I want to go to page 167 of BP4. I am a bit concerned. We normally do very well when we compare ourselves with national figures, but this is a bit scary. You are aiming to reduce youth smoking with the objective of reaching 13 per cent next year. The national rate in 2005 was 9 per cent. Why are we so much higher than the national rate?

Dr Dugdale: We are not sure. We have had a problem of higher youth smoking rates, and that has been a clear target for the government. I think that it is coming down in a very pleasing way. It is a recognised issue for us and a recognised area of investment by the ACT government in trying to push those percentages down—and there is good evidence of success.

MR STEFANIAK: I recall that when we were in government a big problem was, particularly, young women smoking.

Ms Gallagher: Yes.

MR STEFANIAK: Is that still a big problem? Out of the 15, 14 or 13 per cent, what would be the break-up? Would there be more young women than young men smoking in this 12- to 17-year age group?

Ms Gallagher: Yes. From memory, from the secondary school survey, the gap is declining. Overall, the rates of young people smoking have declined quite considerably in the period between when the previous secondary school drug survey was done and this one. I think we led the country with young women's smoking rates at one stage.

Dr Dugdale: Yes.

Ms Gallagher: That has come down quite dramatically. The gap between girls and boys is declining, but girls are still ahead, yes.

MR STEFANIAK: So you really do not know the reason. Have you done any research as to why our kids are more prone to smoking than others?

Dr Dugdale: I do not have an answer to that. I am not sure why. It has been a historical fact in the ACT. It is something that we have to do better on, and we are.

MR STEFANIAK: I think the Capitals are the Smoke Free Capitals. Have you done any research to find whether those types of campaigns—I think that was through a health promotion fund campaign—resonate with young people? I think the Capitals used to go out to schools. They are great role models for young women. Do those types of groups help with this? Have you got any feedback in terms of that?

Dr Dugdale: We do evaluate the health promotion efforts that we fund. They all help

within the mix. In terms of what was the biggest contributor to the falls, we are not able to actually attribute the success to any one measure, but over time we are seeing that the measures are being effective, as reflected in the reducing rates.

THE CHAIR: We might take this opportunity to go to the break. We will come back at 3.35 with cancer services, 1.5.

Meeting adjourned from 3.11 to 3.29 pm.

THE CHAIR: Welcome back, members and minister. We will continue on in health with output class 1.5, cancer services. I might just kick off. Minister, I refer you to page 173 of budget paper 4. Can you update the committee on the performance of the capital region cancer service and the effect that any additional funding will have?

Ms Gallagher: Yes, sure. I will hand over to Professor Stuart-Harris for the detail. This budget does have some additional funding for cancer services, in line with some of the growth in demand that we are seeing and continuing to see for cancer treatment.

Prof Stuart-Harris: For several years we have been experiencing an increase in demand for cancer services and this is going to speed up over the next five years. This is due to not only the population ageing but also more indications for intervention in cancer treatments. At the moment we have a 10 per cent increase in demand across the board for cancer service, and this will increase, as I have said, over the next five years. Plus, we will have a significant increase of about one-third over the next five to 10 years of people living with cancer in the community.

MS PORTER: What percentage of these people that we are expecting will be coming from rural areas around the ACT?

Prof Stuart-Harris: We service a population which encompasses part of New South Wales—north above us and down to the coast, the south-east. Somewhere between 30 to 40 per cent of our patients come from New South Wales.

MS PORTER: Minister, have we put additional resources into the budget in this area this year?

Ms Gallagher: Yes. There is an additional $2 million over four years to deal with some of the growth that Professor Stuart-Harris has just outlined. That will be essentially for more staff, I believe; is that right?

Prof Stuart-Harris: Of course, with the expansion in facilities for radiation oncology, it is all very well getting the machines but, of course, we have to employ more staff, more radiation therapists, more physicists et cetera, to run those machines. So there will be more staff required in radiation oncology to cope with the very welcome expansion in facilities there. There is an increase in demand across the board, not just in radiation oncology but in medical oncology and haematology, where they deal with patients with leukaemia and lymphoma. Many of those patients are outpatients, of course, but it does also impact on facilities for inpatients.

MS PORTER: Is the availability of staff an issue?

Prof Stuart-Harris: It varies according to the sub-specialty. For example, there are difficulties, particularly in palliative care at the moment, but that is a national problem.

MS PORTER: Yes.

Prof Stuart-Harris: In general, the working conditions within the ACT are attractive to people coming in from outside. Certainly it is my hope that, as the profile of cancer services increases, it will help us to not only attract and retain staff but also train more of our own staff. We are seeing a trend towards that now.

MS PORTER: Very good.

THE CHAIR: Mrs Burke.

MRS BURKE: Minister, could you talk us through the *Canberra Times* article today on the front page. I believe it was saying that cancer patients are still waiting longer now than 12 months ago. What are your comments on that?

Ms Gallagher: The report in the *Canberra Times* today detailed that we are doing very well with waiting times for urgent access to radiotherapy, but across the board this reporting period has seen a 17 per cent increase—I think it was 17 per cent. I have the performance report in front of me.

Prof Stuart-Harris: An increase in activity of 13 per cent.

Ms Gallagher: Right. But in this reporting period it says that in the third quarter it is due to a 17 per cent increase in demand for radiotherapy services. So that has contributed to people waiting.

MRS BURKE: What are the actual waiting numbers?

Prof Stuart-Harris: I will speak to that. This year compared with the same period last year, we have seen an overall increase in demand for radiation therapy of 13 per cent. But what has actually happened is that we have extended the number of treatments available, so we are now treating more patients. I think the GPs, the surgeons and those people who refer to radiation oncology have said, "Oh well, they can treat more patients; therefore there has been an increase in the referral rate." What radiation oncology has been doing, as it has done in previous years to ensure that patients are treated in a timely fashion, is making arrangements for them to go elsewhere, if that is what the patient would like. Of course, you always get a small proportion of patients who want to go somewhere else because their relatives live in Sydney, for example.

MRS BURKE: Is this an exponential increase or has it been a gradual increase to where we are in this quarter? Again, I ask the same question: have you not seen this coming? You are saying that there has been a 13 per cent increase.

Prof Stuart-Harris: There are fluctuations, of course, but it has been a gradual increase. Getting back to what I said at the beginning, that is going to increase and

that is going to continue to increase.

Ms Gallagher: Work is underway for the next two linear accelerators to deal with this growth in demand that is expected. The project is underway now. We will have one operational next year. Once we have those machines up and running it will increase capacity by an additional 50 per cent, which will go a long way to meeting some of that demand.

MRS BURKE: Again, it just smacks of a lack of forward planning. Professor, you have said that the increase is incremental. Could you not see this coming? I think I have asked this two or three times during this estimates process.

Prof Stuart-Harris: I think it was in 2005 that ACT Health commissioned a report into radiation therapy services within the ACT. This looked at future projections for the demands for radiation therapy. It was clear from that report that our capacity to comply with demand was not going to be adequate. That formed the basis of going to government for additional facilities for radiation therapy.

MRS BURKE: So you knew two years ago, basically?

Ms Gallagher: The work done in 2005 fed into the 2006 budget and was funded and will be on line in 2008. I don't know how much quicker you can be.

MRS BURKE: It is a long time out—three years from when you know you have a problem you then direct the funding. The problem was building. That is my point.

Ms Gallagher. It is not just "I need a linear accelerator tomorrow". Firstly, we have to commission them. They are not machines that are built; there is a waiting list in order to get access to one. When ours broke down, we went to the head of the waiting list in order to get another one. We have to commission the machine and we have to build a bunker at the hospital.

MRS BURKE: But, again, you knew of the problem since 2005.

Ms Gallagher: Jacqui, you cannot get $29 million worth of money without going through a budget process. We straightaway took—was it $29 million? That is the same as a car park.

Mr Cormack: It was about $16 million.

MRS BURKE: So you identified it last year?

MS PORTER: No, the year before, I think.

MRS BURKE: The year before even.

Ms Gallagher: $17 million is a bit cheaper than a car park. A bunker is cheaper than a car park. It has only got one storey, I guess.

MS PORTER: And they ordered it straightaway. What else do you want them to do?

Ms Gallagher: It was identified in one year, funded the next year and will be in place and operational next year. It just could not go any faster than that. It is on time and, hopefully, on budget.

Mr Cormack: Yes, it is on budget.

Ms Gallagher: And on budget as well. We have taken the decision to not lease the machines, as we had originally intended. We are purchasing the machines, which is a decision taken in this year's budget.

THE CHAIR: Any other questions on this output class? If not, we will go on to the next one, which is aged care and rehabilitation services.

MR MULCAHY: Thanks, chair. Good afternoon, minister.

Ms Gallagher: Good morning—good afternoon.

MR MULCAHY: It probably feels that way.

THE CHAIR: It is estimates.

MR MULCAHY: Minister, the output description of aged care and rehab services on page 156 of BP4 states that a key priority is:

> improving discharge planning to minimise the likelihood of readmission or inadequate support for independent living, following completion of hospital care.

Ms Gallagher: Yes.

MR MULCAHY: Could you inform the committee how discharge planning will be improved? What information do you have, if any, regarding previous rates of readmission or inadequate support for independent living following discharge from hospital?

Mr Cormack: I will kick off with that one. I will defer to Grant Carey-Ide, the director of aged care and rehab to talk about discharge planning. I would have to take the question on notice in relation to those sorts of numbers, I am sorry. Some of them will be available and some of them won't be.

MR MULCAHY: Do you have any broad information at this point?

Mr Cormack: Which specific aspect of your question?

MR MULCAHY: In terms of the level of readmission or inadequate support for independent living following discharge from hospitals. No overview comment to make at this stage?

Mr Cormack: No. There are quite a few aspects to that question. I would like to be able to provide you with the right set of information rather than just an unqualified

comment.

MR MULCAHY: You can't tell me what planning will be improved, even though it is stated as a key priority?

Mr Cormack: Sorry, what was that?

MR MULCAHY: The first question was: how will discharge planning be improved, which is stated as one of your key priorities on page 156.

Mr Cormack: Yes. I said I was going to ask Mr Grant Carey-Ide to cover discharge planning.

MR MULCAHY: Okay. I apologise.

Mr Carey-Ide: There has been some work undertaken in the past that has identified that our discharge planning was not as comprehensive as it could have been in that it did not incorporate good links with community-based services. It did not incorporate well the general practitioners that were providing care as primary caregivers to patients. Some opportunities were recognised for us to improve on those sorts of relationships.

We have actually put in place a specific discharge planner to work in the aged care and rehabilitation unit. That work has seen us develop a system that is better responding to clients in that it identifies on admission the sorts of issues that they presented to hospital with—the most likely scenario that will best serve that patient and their family or carers after their discharge, so it could be a range of different options that best suit the individual. It better links us in partnership with general practitioners, particularly around early appointments with their general practitioner following discharge, which, whilst it seems a very simple issue, caused quite a lot of complications around the prescription of ongoing medications and often meant that patients reverted to either no medications or preadmission prescribed medications, which meant that they needed to be readmitted because things went downhill again.

MR MULCAHY: I will just take you now to the accountability indicator on page 173. It is reported that in 2006-07 there were 1,250 non-admitted occasions for servicing aged care and rehab services and it is identified that this was 300 below your target of 1,550. The reason cited was "delays in the recruitment of rehab specialists". Is there any particular reason for the problems in recruiting rehabilitation specialists?

Mr Carey-Ide: I am really pleased to report that we are fully recruited for rehabilitation staff specialists. This year we have been able to recruit a director of rehabilitation from Orange Base Hospital and have also been successful in getting two rehabilitation specialists from the United States and Singapore, who are now on the staff.

MR MULCAHY: When did you get your establishment level back up?

Mr Carey-Ide: In April this year.

MR MULCAHY: So you should be on track for this coming fiscal year?

Mr Carey-Ide: We are back on track, yes.

MR MULCAHY: There is just one other area that it might be helpful to understand: under accountability indicator 1.6c, page 173, BP4, there are 490 episodes of sub-acute service care in the aged care and rehab services, some 220 less than your target of 710. Again, the reason advanced is the later than expected completion of the new sub-acute facility at the Cavalry hospital site. Could you just inform us what the factors were that led to the delay in completion of the sub-acute facility?

Mr Cormack: I am happy to answer that. I think this committee would be aware that there were a number of extensive delays with the project. The capital works side of that was managed by Cavalry; it was not managed by ACT Health. There were just simply a range of delays due to competing priorities for a range of contractors, particularly involved in the finishing trades. This was at a time of a major building boom in Canberra. That did cause some difficulties in finishing the project off. Also, there were some disputes with the project manager, but, as we are all aware, the older persons unit is complete and it is certainly getting up to full occupancy as we speak.

MR MULCAHY: It has nothing to do, then, with any governmental regulatory or approval process delays. They are all really just commercial problems with supplies?

Mr Cormack: Just commercial problems with the contractor, certainly at the end of the day.

MR MULCAHY: The last question, chair, if I could in this area is on page 175, BP4, "Changes to Appropriation". There is an increase in budgeted appropriations for ACT Health for aged care and rehab, service enhancement, of $2.5 million in 2007-08, $2.6 million in 2008-09, $2.6 million in 2009-10 and $2.6 million in 2010-11. Could you tell us exactly how services for aged care rehabilitation will be enhanced?

Ms Gallagher: Sure.

Mr Cormack: I am happy to do that. The major area there is—I will ask Grant Carey-Ide to fill in some of the other details—to ensure that the sub-acute area of the new older persons unit is able to cope with an increasing level of acuity and an increasing level of service demand than was originally envisaged when the project had been planned some years before. So that is the biggest chunk. We also, as part of that, converted a number of post-acute care beds, which are shorter stay, less acuity, to sub-acute beds, which meant that they stayed longer and got a more intensive form of rehab. Perhaps Mr Carey-Ide might like to add to that.

Mr Carey-Ide: Sure. One of the primary areas that we will be expanding beyond the sub-acute/non-acute service at Cavalry is in the community-based services—making sure that we have stronger services and more easily available services for older people in the community to try to prevent hospital admission but, predominantly, to try to prevent a preventable relapse for that person. Some of the services that we will be looking at, for instance, are a rapid assessment service to support general practitioners in the community where a deteriorating older person is able to be referred for a more

responsive service through an outpatient basis and, if necessary, to have a fast streamed admission.

MR MULCAHY: I do not want to destroy your train of thought, but will there be a mobile service that the GP will contact to go to people's homes?

Mr Carey-Ide: Both mobile and hospital-based. The mobile service will go to people's homes. Importantly, it will go into residential care facilities to support the general practitioner as the primary care provider or the service will be able to see patients in the outpatients setting at the Canberra Hospital.

MR MULCAHY: Who will be the people providing that service?

Mr Carey-Ide: Two of the staff specialist geriatricians will be involved in the service. We are currently recruiting another nurse practitioner in aged care to support that service and it will be supported by registered and enrolled nurses.

MR MULCAHY: Do you think that will enable more people who have problems to stay in their home environment or is it more about accelerating them into one of the facilities?

Mr Carey-Ide: We are hoping the former. The service is predominantly about early identification and support of general practitioners in managing a deteriorating older person. Most of those instances where an older person is deteriorating are able to be slowed down, if not stopped, by support and advice given, and sometimes expert management given by a geriatrician to support the general practitioner.

MR MULCAHY: We have geriatricians on staff now?

Mr Carey-Ide: Yes, we do. We are fully recruited for geriatricians.

MR MULCAHY: Great. Thank you.

THE CHAIR: Dr Foskey.

DR FOSKEY: I do not know if Mr Mulcahy asked about this before I got here: strategic indicator 17, which you have just been talking about, aims to increase aged care clients discharged with a comprehensive discharge plan—100 per cent—

MR MULCAHY: Yes, I asked that.

DR FOSKEY: My apologies. I will have to read the transcript if you did. How are discharge plans administered after the patient is released? Consider the person who does not have a close family member and is not otherwise capable of organising their trips to the doctor and so on. How can you be sure that the discharge plan for those people is carried out?

Mr Carey-Ide: For those clients who do not have carers or families, we have a process of following up a client post discharge. That could be through our discharge planning service in aged care, it could be through one of our community based

services within the age care and rehabilitation service, or it could be by the provision of community-based home visiting services through community health. We also connect the patient strongly to the GP so that the GP is aware that the patient has been discharged. Those are the ways we would support someone at home.

DR FOSKEY: It would not be advisable to be in the situation where you do not have a person who is caring for you or monitoring you outside the system, though, I expect.

Mr Carey-Ide: Not at all.

DR FOSKEY: So there will be such people.

Mr Carey-Ide: There are, unfortunately.

THE CHAIR: Any more questions on this output class? It not, we will move to 1.7, early intervention and prevention. Dr Foskey.

DR FOSKEY: Again, this is a bit of a crossover from when we were talking about public health—

Ms Gallagher: It does cross over a range of the output classes.

DR FOSKEY: Right. I am interested in why there is no accountability target or time line set with regard to the screening of the target population for breast cancer. Budget paper 4, page 156, just says "over time" without any specified time line.

Ms Gallagher: We do have targets for breast screening into the target group, which is the 50 to 69-year-age group. I can, no doubt, give you that. I am sure there is a target that we try to reach; it is just not reflected in the budget papers. There is a range of targets—

DR FOSKEY: It is actually budget paper 4.

Ms Gallagher: There is a range of targets in health, but not all of them are reflected in the budget papers. We have to have a target because we are improving.

DR FOSKEY: You want a target to show that you did improve.

Ms Gallagher: We can provide you with that, Dr Foskey. I just can't find it quickly for you. There is a target; I cannot at this late stage of the day pull out that detail from my brain. It is swimming around with a number of other targets. We have traditionally been below target.

Prof Stuart-Harris: With respect to the proportion of women in the target population who actually attend, the participation rate target is 70 per cent. BreastScreen ACT and south eastern New South Wales has achieved a participation rate of 60 per cent. You might look at that and say, "That is below the 70 per cent," which of course it is, but I understand that we are second only to South Australia in achieving that participation rate. I believe we are doing reasonably well—not as well, obviously, as we would like to—but that participation rate of 70 per cent is very hard to achieve.

DR FOSKEY: You are talking about breast screening—

Ms Gallagher: We are talking about healthy women coming for a two-yearly—

DR FOSKEY: Yes, but you are just talking about people undergoing mammograms?

Mr Cormack: Mammograms.

DR FOSKEY: Are you aware of—I have forgotten the name—a particular photographic—

Prof Stuart-Harris: Are you talking about thermography?

DR FOSKEY: That is the one. Some women might find it easier to access thermal imaging as an alternative way of screening, possibly followed by an ultrasound. The fridge door analogy always comes to mind.

Prof Stuart-Harris: I know that a lot of women find mammography uncomfortable. Screening for breast cancer is improving and new technologies are coming along. I have not seen formal information on a comparison of thermography with mammography, but of course we have also got MRI coming along, which, at least in some select women, may well replace mammography.

DR FOSKEY: Given that mammography actually misses quite an amount of the tissue, which is often the place where breast cancer starts for some women, it is obviously only half of the—

Prof Stuart-Harris: Unfortunately, no technique screening for any disease is 100 per cent reliable. Mammography is pretty good but does have its flaws, like any test.

DR FOSKEY: Is any work going on anywhere about why Canberra might have the highest rates of breast cancer in Australia? It is an interesting statistic.

Prof Stuart-Harris: As far as I know, there is no formal work going on looking at that. But remember that Canberra has quite a distinct and homogenous population, quite a high socioeconomic grouping. We know that breast cancer is common in women of that kind of group.

DR FOSKEY: Dr Dugdale does not believe it is the highest—sorry.

Dr Dugdale: We did do a formal review a few years ago of the breast cancer rate we would expect in Canberra given the risk factors that we have here, including high income, low fertility and late birth of first child. We found that that explained a significant proportion of the increased rate that we do see in the ACT. We had that analysis reviewed by the top cancer epidemiologist in Australia, Professor Bruce Armstrong. There was still some component of the rate that it did not explain, so at this stage we can say that we can explain perhaps a third of the increased rate that we observe. I am sorry to jump in there.

DR FOSKEY: Thank you for that. Finally, prostate cancer is, of course, the equivalent and it is also at a high rate in the ACT. What testing techniques are available for that?

Prof Stuart-Harris: There is no formal testing or screening for prostate cancer. In fact, in terms of cancer screening, it is the most contentious subject. You find that there are people who are strong protagonists of screening and there are those who are strongly opposed to screening. Prostate cancer is, unfortunately, almost a fact of life for elderly men because it becomes more and more common as you look at older age group men. The question is that if you pick up prostate cancer, you really want to pick up those prostate cancers that actually need treating. You do not want to pick up the ones that the patient will actually live with and die with, but not from.

MRS BURKE: I have a supp on breast screening, and I did mean to mention this before. I congratulate you on this aspect, minister. Waiting times for breast screening are less than 28 days; you are at 100 per cent and the other figures are there. I just wanted to say well done. I have a question about the infrared digital imagery. What did you call it, professor?

Prof Stuart-Harris: There is MRI, which will be coming along. Certainly it is clear already that in some selected cases it may have advantages over other imaging methods.

MRS BURKE: I am sorry. Did you say the MRI?

Prof Stuart-Harris: Magnetic resonance imaging.

MRS BURKE: I know of a business that tried to set up digital infrared imaging and felt great pressure from other quarters not to proceed with this sort of technology. As women in this room would know, mammography is quite uncomfortable. Where there are other technologies available, minister, would you be open to this being pursued more rigorously than it is? Is there some fear in the health sector about one overtaking the other in terms of ownership?

Ms Gallagher: What I would like to see in public cancer services here—and this is part of the work that health is doing at the moment—is for us to look at how we can grow a centre of excellence for cancer services. This is something that I know Professor Stuart-Harris is very passionate about.

MRS BURKE: With choice, of course?

Ms Gallagher: Of course. We are well suited here with a range of extremely well qualified professionals. We have certainly got demand here for cancer services. We are a regional provider. The ingredients are here to do something else, to move the service and to grow the service into something really quite excellent, even though it is very good at the moment. I have met with Professor Stuart-Harris. We have met with health. We are certainly engaged in active discussions about how we could bring forward a cancer centre for the future which would look at a whole range of new and exciting technologies. I think that is the thing in cancer services. You have to be open

and ready for the rate of change that occurs not only in technology but also in treatment options and medications and—I do not know what the right word is—chemotherapy.

Prof Stuart-Harris: I would just like to support those comments. Cancer itself is becoming more common, with increasing indications for treatment. But the treatments are changing very rapidly. These days we are often into multimodality treatment. We might have combined radiotherapy and chemotherapy. This is often a team business now and I think that if we could integrate existing cancer services, which I agree are of high quality, more closely, then we can get a much more multidisciplinary approach to cancer management.

MRS BURKE: Are you saying that the increase is higher? Are we actually also seeing better and more efficient diagnosis? Is that why the increase is happening, would you say, because of early detection and so forth?

Prof Stuart-Harris: The increase is happening all throughout the country. I am not saying necessarily that the increase is going to be higher within the ACT than other jurisdictions.

MRS BURKE: No. I was not intimating that. You were saying that we do have high rates of cancer. Is that because we are getting better at diagnosing or early diagnosis, in your experience?

Prof Stuart-Harris: It is coming for a number of reasons: more awareness by the public; more awareness by doctors and screening. But the most important of all is the ageing of the population. The median age is increasing. As a very broad generalisation, cancer is a disease of an ageing population. That itself is the biggest single reason why it is increasing.

MRS BURKE: Thank you.

MR STEFANIAK: Thanks, chair. I must have my prostate checked. Page 174 of budget paper No 4, output 1.7: early intervention and prevention shows that immunisation coverage for the primary immunisation schedule measured at one year of age is at 92 per cent. That is a pretty good average. I seem to recall that that figure has grown to that extent in recent years, but is it going to be static? Can we actually get that closer to 100 per cent? If not, what is the stumbling block?

Ms Gallagher: Dr Dugdale might correct me, but I think the general belief is that there are a proportion of people who will not engage in an immunisation program. That is essentially the difference, isn't it?

Dr Dugdale: There are two problems in getting it much higher. One is the group that the minister is alluding to who will not participate. That is actually relatively low, probably around two per cent of people who have a conscientious objection to immunisation. But there is also a problem of just the turnover of the population and kids who are sick on the day and the practical problems of diminishing return for effort in moving up much above 92 or 93 per cent. That 92 per cent is about the best that anywhere in Australia has achieved. We got there first and we are going to stay

there.

MR STEFANIAK: Good. Item d is the proportion of clients attending a Well Women's Clinic check within the women's health service that are from culturally and linguistically diverse communities. The target for 2006-07 was 20 per cent, the estimated outcome was 28 per cent and for this year you have dropped back to 25 per cent. They are fairly low targets. Why have you dropped back to 25 per cent from your estimated outcome of 28 per cent, and what can we do there to lift that? What is the problem there?

Ms Gallagher: We have this discussion about setting targets every year. When you overachieve, should you expect to overachieve at that level again the next year or find a middle ground? I think that probably explains the difference. A quarter of clients attending that service, say, from CALD (culturally and linguistically diverse) backgrounds I think is a very good result. Do you want to add anything?

Mr Thompson: Yes. I will just emphasise that last point. When you look at the overall proportion of the population from those backgrounds within the ACT, it is actually an overrepresentation within the program that is receiving the services that are available to the target groups of the service. The service provides an accessible well women's service for people who might not be engaged with other services. It represents a target that is saying that we are trying to get higher than the population proportion of clients, if you can follow what I just said. Obviously, there are other target groups within the service as well.

MR STEFANIAK: Finally, item e is the proportion of children aged zero to 14 who are entering substitute and kinship care within the ACT who attend the child at risk health unit for a health and wellbeing screen. That is constant at 80 per cent. Is there a need to make it 100 per cent? Would it be prudent to have the level at 100 per cent for those kids at risk?

Ms Gallagher: There would be a proportion of that group, I imagine, being the minister responsible for both of these areas, who may not need to use the services at the child at risk assessment unit. It is a fairly specialised service. But if any child that is in care and protection or going into out-of-home care, substitute and kinship care needs a health screening, they get one.

MR STEFANIAK: Who decides if they need it or not?

Ms Gallagher: It is usually in coordination with their case management or their carers—the care and protection staff. I imagine even courts could have a view about that as well in terms of making orders. But it could come from a range of referrals.

MR STEFANIAK: Yes.

MRS BURKE: Could I just go back to d, the Well Women's Clinic check? We hear a lot today about this aggregation or extrapolation of different groups—

Ms Gallagher: They are all women.

MRS BURKE: They are all women in this group. I was just being general. They are all women, but would it be useful to better focus on the women from culturally and linguistically diverse communities? We talk about being this a multicultural community. Can we do better if we make it stand alone or would it make it worse to have a stand-alone representation of them as opposed to the rest of the community?

Ms Gallagher: I am not sure what you are asking. Do you mean in terms of the accountability indicator?

MRS BURKE: That is right. I am probably talking more generally. What is the total number of women attending the well women's check? I would be interested to see some figures on that.

Ms Gallagher: We could certainly provide you with that.

MRS BURKE: Okay. If that is something that we want to increase, and maybe it is recommended that we look at some of these accountability indicators generally, that may be one area where you could perhaps show the split.

DR FOSKEY: Yes. I would probably go further and ask—

MRS BURKE: I know, but where do you stop?

DR FOSKEY: I would be interested in knowing which groups are hardest to contact in order to devise strategies. Are you doing that?

Ms Gallagher: I am sure we can provide a more detailed breakdown of that indicator.

MRS BURKE: Okay.

THE CHAIR: Are there any further questions?

DR FOSKEY: Yes. I would have expected to see an explicit priority around primary health care. I cannot see it there at all and I am just wondering if there is something there that means that and, if not, why it is not there.

Mr Cormack: Within early intervention?

DR FOSKEY: Primary health care is usually an objective because it is a whole delivery method that saves money at the more acute end. It generally is an objective, I think.

Ms Gallagher: Sure.

Mr Thompson: These are aspects of primary health care. If you think of immunisation, that is a classic sort of primary health care activity operated in primary health care settings and services. Those six dot points are, in fact, all aspects of primary health care. Of course, the ACT government in itself is not solely responsible for primary health care in the ACT. We share that responsibility with the federal government and private providers, and we work very closely with them. But as

far as the activities that we undertake that are related to primary health care are concerned, these are some of the key ones that we are doing.

DR FOSKEY: I just go to the example of Victoria, where they actually have what they call a primary care partnership model which facilitates a shared responsibility of partnership between the department and the community sector for primary health care and which they expect will save them money in the long run. I am aware that Victoria has had a perhaps more explicit primary health care model for some time. Has the ACT Department of Health had a look at that? What does it think of it as a model?

Mr Cormack: We actually have had a look at that, and we have a primary care strategy. We have also got a chronic disease strategy under development. They are very much focused on drawing together and integrating the client and their self-care role and responsibilities. The general practitioner is a key primary care worker, as are the community health sector and the NGO sector. That is incorporated in work underway in the area of diabetes, chronic disease management and primary care.

I would also note that there are a number of indicators scattered across other output classes that have got a very strong primary care focus. You can see under output class 1.6 people assessed in falls clinics. You can also see under output class 1.3 mean waiting times for dental care; the proportion of offenders and detainees in our correctional facilities that get a health care assessment within 24 hours of detention; and the proportion of women's health service intake clients who receive a service within 14 days of initial referral. They are all indicators of a primary care approach. However, I think that you are quite right. I think we need to articulate those in our policies and strategies, and that is the work I referred to before.

DR FOSKEY: Yes. It is handy for people like me, I think, if you can do that.

Ms Gallagher: Yes.

DR FOSKEY: Given the increasing burden of chronic disease in the ACT, $2 million has been allocated to chronic disease. Minister, would you outline more specifically how those funds will be spent, if you have not already done so and I have missed it?

Ms Gallagher: No, we have not got to chronic disease management. Dr Dugdale can take us through that.

THE CHAIR: That is a little outside this output class, but the minister may be happy to answer it.

Ms Gallagher: As long as we do not go back to it.

MR STEFANIAK: I have got a couple more.

DR FOSKEY: I am sorry. Have I gone back?

THE CHAIR: We are dealing with early intervention and prevention.

DR FOSKEY: I think people are interested in the management of chronic disease.

Ms Gallagher: Chronic disease management probably does fit into early intervention and prevention, more so than the fracture clinic.

DR FOSKEY: Thank you, Ms Gallagher.

Dr Dugdale: I am happy to outline it. The focus of this initiative for the integrated prevention of chronic disease is on three particular diseases that cause over 50 per cent of the burden of chronic diseases, and they are congestive lung disease, heart failure and diabetes. The approach is early detention, appropriate referral, both for clinical care but also for disease management programs and community-based groups and the like, as well as optimising care to prevent disease progression.

It will be using an approach of a register of patients with chronic diseases. These are already patients of ACT Health, but we give them care on an episodic basis. We are going to try to move to give them ongoing care. Secondly, there will be a service for community organisations that are providing preventive services for that group, people running cooking classes or nutrition education or exercise classes or self-care for specific diseases, so that we can really grow that level of activity in the community.

We recognise that these people can help themselves, that they have got a contribution to make to their own care and to the care of other people with similar conditions. It is not just health professionals doing it for patients; it is community members with these chronic diseases looking after each other and working with each other to get up and exercise and cook properly and reduce their risk factors. That is the broad outline of the program.

DR FOSKEY: How would referral pathways for public and private health professionals be provided to get people into these things? For instance, would a GP have a central point of contact for referrals for ongoing care, say, to send a patient with diabetes off to a nutritionist? How do we find our way around this maze?

Dr Dugdale: We are looking at developing a website that will have regularly updated information about what providers are out there, including which non-government organisations and which community groups are available. If there is a group in Tuggeranong providing exercise for overweight 65-year-old blokes who are not going to start going to the gym but may well get out and about with each other, that will be on the website. The GP in the Hyperdome will be able to mark that page, open it up and refer the chap who comes in who fits into that target group to them. It is a web-based approach to tracking what services are available.

MRS BURKE: Page 156 of budget paper No 4 notes an increase of an additional $4 million to be spent on early intervention and prevention. It is $4,000,099, to be precise. What is the additional money to be spent on? What evaluation has been or will be done of this spending or of existing programs?

Ms Gallagher: I imagine it is a range of the initiatives reflected in this output class. That would be my answer. What are the increases? What is the money to be spent on? You do not have to answer about the evaluation.

MRS BURKE: And then issues around evaluation.

Mr Foster: The increase is predominantly to do with the HPV vaccination funding, also the chronic disease funding that was talked about and the funding for risk for children and families. There are considerable initiatives happening in 2007-08 around early intervention. The balance of the funds relates to the salaries and wages and indexation of the existing programs.

MRS BURKE: Okay. What about evaluations of the spending? Presumably it will be done across all the programs you have just mentioned.

Mr Cormack: Yes. Certainly it is much easier to have rigorous evaluation around programs before you set them up. Each of the new programs will be set up with a formal evaluation framework around them. In relation to existing programs, we have a number of high level indicators that we use and monitor through our normal internal reporting arrangements and sometimes through our external reporting arrangements that look at evaluation. But the focus of evaluation will be on a good framework for the new programs that have been announced in the 2007-08 budget.

MRS BURKE: Mr Foster, you just said that a large proportion of that relates to staff.

Mr Foster: No. The majority of increased funding relates to the HPV vaccination program.

MRS BURKE: But there is a portion related to costs?

Mr Foster: The balance of the increase relates to the indexation and salary increases.

MRS BURKE: Thank you.

THE CHAIR: Thank you, minister. You can go home a little early today.

Ms Gallagher: There are a couple of things I need to correct for the record. Mental health, as a percentage of the 2007-08 budget, is 7.1 per cent, not eight per cent. Eight per cent was the year-on-year increase, but not overall as a percentage of the health budget.

Mr Cormack: May I correct one thing, Mr Chairman?

THE CHAIR: Yes, Mr Cormack.

Mr Cormack: When we were talking about the increase in demand for radiation oncology, two figures were quoted. The minister quoted a 17 per cent increase in demand for radiation oncology in the period to March 2007, as quoted in our public report. We further identified a 13 per cent increase two months later. That is the difference between the two figures. They are two different reporting periods. I just need to clarify that.

THE CHAIR: Thank you once again.

Ms Gallagher: Just one final matter, because I am not sure whether we took it on notice. There was an issue around the Australian Institute of Health and Welfare and the quote used in the *Caring for our health?* report. I said I would take further advice on that. On page 23, the report states:

> The arbiter recommended that, as prices in health care rise faster than inflation … funding should be increased by 0.5% more than the inflation rate.

It goes on to say:

> … statements made by the Australian Institute of Health and Welfare, an expert body funded by the Australian Government, that health prices should be adjusted by a figure higher than the inflation rate.

The phrase "recommended by AIHW" was not used. We got the information for *Caring for our health?* from the AIHW report *Health expenditure Australia 2004-05*. In a statement issued on 25 June 2007, the AIHW stated:

> The report found that the average rate of health inflation between 1994-95 and 2004-05 was 0.4% higher than the general level of inflation.

That is where we pulled that information from.

MRS BURKE: It is just that they raised it, as you know.

Ms Gallagher: Yes,

MRS BURKE: I think it is probably badly worded.

Ms Gallagher: We certainly did not say that they had recommended this in the context of the report.

MRS BURKE: But you would agree that that is how they could perceive it, that you said they recommended it?

Ms Gallagher: Yes, but the report *Caring for our health?* was not wrong in that sense. We picked up public data from the Australian Institute of Health and Welfare.

THE CHAIR: Thank you, minister and officials.

Ms Gallagher: Thank you.

THE CHAIR: Committee members will return on Monday at 9.30 am with the Minister for Tourism, Sport and Recreation.

The committee adjourned at 4.24 pm.