LEGISLATIVE ASSEMBLY FOR THE AUSTRALIAN CAPITAL TERRITORY

STANDING COMMITTEE ON HEALTH AND DISABILITY

(Reference: Annual and financial reports 2005-2006)

Members:

MS K MacDONALD (The Chair)
MS M PORTER (The Deputy Chair)
MRS J BURKE

TRANSCRIPT OF EVIDENCE

CANBERRA

MONDAY, 20 NOVEMBER 2006

Secretary to the committee:
Mr D Abbott (Ph: 6205 0129)

By authority of the Legislative Assembly for the Australian Capital Territory

APPEARANCES

The committee met at 10.39 am.

Appearances:

Gallagher, Ms Katy, Deputy Chief Minister, Minister for Health, Minister for Disability and Community Services, Minister for Women, and Minister for the Arts

Health ACT
- Cormack, Mr Mark, Acting Chief Executive, ACT Health
- Reading, Ms Jenelle, Acting Deputy Chief Executive
- Vickerstaff, Adj Prof Joy, Acting Deputy Chief Executive
- Murphy, Ms Karen, Allied Health Adviser
- Mollett, Mr John, General Manager, Canberra Hospital
- Cole, Dr Deborah, Chief Executive, Calvary health care, ACT
- Guest, Dr Charles, Acting Chief Health Officer, Executive Director Population Health
- Cahill, Ms Megan, Executive Director, Government Relations and Planning
- Thompson, Mr Ian, Executive Director, Policy
- Hewat, Mr Andrew, Acting Manager, Financial and Risk Management
- Smalley, Mr Owen, Chief Information Officer
- Childs, Ms Judi, Director HR Management Unit
- Brown, Dr Peggy, General Manager, Mental Health ACT
- Stuart-Harris, Professor Robin, Director, Capital Region Cancer Service
- Jones, Dr Catherine, Manager/DON, Capital Region Cancer Service
- Stone, Mr Bill, Director, Aged Care and Rehabilitation
- Ramsay, Dr Wayne, Director, Clinical Governance Unit

Human Rights Commission
- Moss, Mr Philip, Acting Health Services Commissioner
- Shaw, Ms Roxane, Principal Investigations Officer

THE CHAIR: Good morning, everybody. The committee has authorised the recording, broadcasting and rebroadcasting 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 attached 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 understand everybody here understands that.

Mr Cormack: Yes.

THE CHAIR: I also add just before we get under way that on 10 October this year I sent out a letter to all members of the Assembly notifying them that it was the intention of the Standing Committee on Health and Disability to undertake the annual reports process in a slightly different way. I will just summarise with regard to health.

The committee wishes to use the annual reports inquiry this year to take a more systematic look at two important aspects of the health, disability and community services portfolio. The last budget noted that the growth rate in expenditure on health in the ACT cannot be sustained; thus it is timely to examine the distribution of funds within the health portfolio, identifying the proportions that go to each level of care and comparing both the overall expenditure and the distribution of that expenditure with the situation in the states and the Northern Territory. The committee would hope to gain a thorough understanding of the financial and other pressures within the health system and the areas where savings might be made. I note for the record that the committee received no responses from any of the members with regard to that, so we have proceeded along that path.

As per usual, members of the committee will be given precedence over non-members of the committee. Minister, welcome. Is there a statement you'd like to start with?

Ms Gallagher: Thank you, yes. I will be brief. I should begin by thanking the committee for the opportunity to come and speak with you today about the annual report for ACT Health. The report goes through many of the highlights and achievements of ACT Health and some of the challenges that ACT Health are facing this financial year and for years into the future.

I think this annual report covered about nine months of the time that I wasn't minister and about three months of the time that I was, but from my briefings with health for this period of time, the 2005-06 year, I think it is fair to say that a focus was on integrating services across the portfolio, bedding down some of the changes from the previous years in terms of the establishment of the clinical streams in mental health, in the Capital Region Cancer Service and in aged care and rehab.

It was also a year which saw the roll-out of the access improvement program across the emergency department, the older persons journey and mental health. It was a year where the focus was on patient safety and quality, with the establishment of the patient safety and quality unit and a range of improved patient safety systems across the portfolio. It was also a year where we started, under the previous minister, the quarterly reporting across the ACT public health service's performance report, which provides a great deal of information for the public around the performance of the health system.

In some of the areas where we have set targets, particularly around areas of pressure, we are seeing some improvements. We can go into all of that, because it is hard to look at the finances of this portfolio without looking at what the portfolio offers

through services, because that is where the funding goes.

Some of the challenges for the portfolio this year—and we went through this is in the budget—are pegging back our costs, moving towards 10 per cent of the national peer group average costs over the next four years, continuing to focus on areas of pressure in the emergency department, in elective surgery and in access block. There are more discussions to be had with Calvary around the relationship between TCH and Calvary, but also between ACT Health and Calvary health care, which will be ongoing this year. The other challenge that I am looking at closely is around staff—attracting health professionals to the portfolios—and that's really across the board. So there is a lot there and we are happy and stand ready to take questions from the committee on those.

I should say that Ron Foster, the man who understands all the numbers, is ill today, but he will be very adequately represented by Andrew Hewat. I am sorry about that, because Ron obviously has memorised this report, including the key areas of it, for his appearance today, but he's not here with us.

ACT Health has seen record growth across all areas of the portfolio, and that is outlined in this annual report. I am advised that that growth continues into this year, but certainly a challenge in managing the portfolio is to manage the growth and the demands on the system and at the same time try to peg back some of our costs in line with the decisions that the government took in this year's budget.

THE CHAIR: Thank you, minister. Just a general question to start off with: in the budget speech given by the Chief Minister on 6 June, at page 14 he states that, put simply, the growth rates in health expenditure over recent years cannot be sustained. The Chief Minister goes on to comment that both the hospital system and the community health costs are well above the national benchmark and higher than average. Looking at the last financial year, can you outline for the committee the main areas of health expenditure that you see as contributing to these higher costs and the factors that contribute to them, and, if you are able to, could you foreshadow what measures you would be looking at to contain them?

Ms Gallagher: Sure. I don't have that copy of the speech but I think he was talking in general about our, I think, 20 per cent higher costs than other peer group measures; I'm not exactly sure how that is measured. I'm sure Mark can go into that. We are doing some work around that already. Benchmarking of, particularly, clinical operations at the hospital is being undertaken now. We will have to lose staff through that process. What we are looking at, though, is certainly no frontline delivery of health services per se, but that our administration costs are higher in the ACT, and so that is work that is under way now.

Our staff costs are higher than other jurisdictions as well. I think some of that is the reason why we are not looking to move to the same cost. The target being set is to move to within 10 per cent of the cost over the next five years, but certainly the staff costs contribute to our higher than average costs in the health system. Some of that may be dealt with through the government's decision to cut super back to nine per cent. So work is being done in benchmarking.

I am in the process of taking a piece of work back to cabinet for discussion around community health. I think we have been quite up front about that; it's around access to community health services and whether we should look at a system of co-payments, or restrict eligibility, or both. There are models within community health where that already happens. The dental program is an example of that: it is restricted to health care cardholders, but also a co-payment is sought for access to those services. So it is not a new model, but this is looking at it more generally across community health services. But that work has yet to go back to cabinet.

Basically, the work is under way. We have to meet these targets. Cabinet has made a decision that we have to live within a certain amount of resourcing and that resourcing has been provided in the forward estimates. Whilst there is additional money in the budget, making us live within our means means that we also have to achieve some savings as well.

THE CHAIR: I note on page 181 of the report, for total employee benefits there has been a significant jump in the amount spent from 2005 when it was $75,272,000 to $83,813,000. Are you able to explain that?

Mr Cormack: There are a number of factors behind that movement there in terms of employee costs and benefits. Clearly, one factor is that there has been a significant growth in staff between the other two years. The principal reason for the growth in staff is related to a growth in activity through our emergency departments, activity through our public hospitals, activity through our elective surgery programs. We have seen growth in our community-based programs. So the first effect is an overall increase in the number of staff. Then, of course, you have got the year-on-year effect of award increases and industrial agreement changes. Those two factors would account for most of the movement in employee costs.

THE CHAIR: Minister, you also said in your answer to the question earlier that both our admin and our staff costs are higher compared to other states and the Northern Territory. What's the explanation for that? Is it that because we're a jurisdiction we still have to provide the same service?

Mr Cormack: In terms of the differences between the jurisdictions, there are a number of factors at work there. The first one is that the ACT is a small jurisdiction and has the normal fixed costs that you would get with any jurisdiction. We have the same legislative responsibilities, we have the same policy responsibilities, and the fact that we're a lot smaller than others doesn't necessarily mean we have a correspondingly smaller overhead. There is a minimum critical mass required to support both the requirements of government and the administration of the health care system itself. So that's an important factor—diseconomies of scale—and you'll find similarly that another smaller jurisdiction, the Northern Territory, has higher costs for similar reasons.

The second factor of significance relates to the superannuation arrangements that apply in the ACT government. They are derived from the commonwealth, the former CSS and PSS superannuation schemes, and they are significantly more generous than other jurisdictions. Most jurisdictions offer the nine per cent superannuation arrangements, whereas in the territory, depending on which scheme employees belong

to, they're significantly higher than that. So they are two of the very significant factors in relation to the differences between jurisdictions on salary costs.

A third area, and a subject of the work that the minister just referred to, is looking at our benchmarking. Having put those two factors aside, we need to be assured that our staffing levels, particularly our administration and overhead costs, are measured against other similar peer organisations, and on that basis we can set some targets to bring our overhead costs in relation to salaries and wages closer to the national average. That is a significant piece of work, but it is a piece of work that we've embarked upon as part of the budget announcement by the Chief Minister and Treasurer.

THE CHAIR: Okay. In a press release of 31 May 2006 you note that the ACT public hospitals run three low-volume high-cost units: the neonatal, neurosurgery and cardiothoracic units. Do we have a cost comparison between those units and similar units in state capitals?

Mr Cormack: No, we don't, but, as I mentioned before, we are participating in a benchmarking exercise, and the Canberra Hospital also participates in a group called the national health roundtable, which is a group of similar-sized hospitals and they work to examine each other's cost structures, each other's throughputs and relative levels of efficiency and patient outcomes. But we don't have a figure available in those three specific units for you.

THE CHAIR: Do low-volume units achieve as good results as units serving a larger population and having a higher volume of patients?

Mr Cormack: Generally speaking, we are very comfortable that the volume going through those three units that you mentioned is sufficient to generate the quality of service that you would expect of a tertiary or teaching hospital. There is some research out there that suggests that the higher the volume of work through specialised units the greater the efficiencies you tend to get; you also tend to attract a greater degree of specialisation. But we have no evidence to suggest that the work that is being done by those three units is of any lesser standard than any other jurisdiction providing those subspecialty areas.

Ms Gallagher: I would just add to that that they are all essential services. That is part of the burden of having the Canberra Hospital as the regional hospital: all of those three units that you mentioned are essential, even if they are low volume, high cost. It is not as if we could take the NICU away or not do neurosurgery.

THE CHAIR: I appreciate and understand, having been on this committee in this Assembly and in the last Assembly, that we're not just servicing the ACT; we are servicing the surrounding region as well, and I know that often, for example, the NICU has others flown in from interstate when there is a need to do that—flown in or brought in by road ambulance.

MS PORTER: I just want to reflect on what you were just saying, chair. Because we are a region and we do accept patients from New South Wales, is that part of the cost to us? How do we work that arrangement with New South Wales? Are we any closer

to having a satisfactory arrangement with New South Wales about the number of patients that we receive and that are sometimes quite high care?

Ms Gallagher: That is covered through the New South Wales and ACT cross-border arrangements, but I understand we have agreed on an arbitrator to go through the terms of reference, which I think we've agreed on, so really now it's just a matter of those discussions being had. So hopefully we will see a resolution to that—for our satisfaction, hopefully.

THE CHAIR: I have a question following on from that, because it seems to me that with the New South Wales and ACT arrangement, agreement, whatever, that we have been arguing forever.

Ms Gallagher: That is because health costs money.

THE CHAIR: How long have we been negotiating this time around?

Mr Cormack: Each time there is an Australian health care agreement—or before that a Medicare agreement, which was a five-year agreement—a certain arrangement is built into that agreement as to how transfers of patients and corresponding transfers of funds will work across jurisdictions. Each agreement gives you the opportunity to renegotiate the arrangement, and I think on each occasion New South Wales has taken up that opportunity. This current round of negotiations has been going on for, I guess, much of the current agreement period, which commenced in 2003 and concludes in 2008.

That is not to say we are going without funding. We're receiving the cross-border revenues, but we are now focused on just a particular subset of the cross-border patient work, which is principally around elective surgery. That is the sort of area that we are focusing on. We are well covered for other areas of activity, in particular the specialist areas you mentioned before such as neonatal intensive care, neurosurgery and cardiothoracic. They are non-elective, so the current agreement generally covers them off pretty well.

MS PORTER: Minister, page 14 mentions that there has been an increasing incidence of chronic disease in the ACT community. One would imagine that is partly due to the country's ageing population and we have an ageing population here. Are there any other causative factors, and how does this impact on the health budget? It must have an impact on the health budget.

Mr Cormack: Certainly chronic disease management is a major national focus. I guess there are a couple of aspects to it. We seem to have made some big inroads in other areas of burden of illness and disease on the community and on the health system. But chronic disease is an area of growing importance, in particular heart failure, respiratory disease and diabetes. They are the areas that are causing us some concern.

The principal areas of concern there are that these conditions can be better managed than they currently are and they can be managed in a number of ways. They can be managed through more effective partnership arrangements between patients, general

practitioners and specialist services in hospitals, and we are working in that area. There is also increasing recognition of the importance of patient self-management; that is, patients taking much more responsibility for looking after their chronic conditions. As part of our chronic disease management programs for 2006-07 we will be looking at both better coordination of care for those people who are high users of the system due to their poor management of their chronic disease and, secondly, we'll then move on to a larger number of people who are currently experiencing chronic disease management but not necessarily using the system as much, and we'll be looking at ways of preventing and reducing their impact on the health system and also improving their own health and longevity.

MS PORTER: I noticed on page 219 that indicator 11 mentions increased prevalence of diabetes, which is one of the chronic diseases that you mentioned. It seems that there is a difference between the rates in Canberra and the rest of Australia, and that we are sort of ahead in some way, that we're getting on top of it. Is that the case, or is it just a blip at the moment?

Ms Gallagher: You are talking about that sort of 0.4 per cent difference?

MS PORTER: Yes. I know it's a small point.

Ms Gallagher: Megan Cahill can help you with that.

MS PORTER: If we can make some inroads in these chronic diseases, that is going to result in savings to our budget, I would imagine, over time.

Ms Cahill: Yes. The figures show that at this point in time the rate of prevalence of diabetes in the ACT is not as high as it is in other jurisdictions. The data we have, in terms of where we predict future trends in diabetes to go, would lead us to expect that we will face an increase in the number of people that are diagnosed with diabetes over the next five to 20 years.

At the moment, we are in the process of developing a diabetes plan, which is part of our overall chronic disease strategy. With an emphasis on prevention and early intervention, we will be looking at strategies to make sure that people are not developing risk factors for diabetes and other chronic conditions. We will be looking at working with non-government organisations and general practitioners to provide early detection and intervention. As mentioned earlier, we will be increasing the integration between the services that ACT Health and those other health service providers deliver so we can have a much better focus on self-management when that is appropriate, ensuring that we are making the best use of the resources we have.

MS PORTER: Mr Cormack, is the partnership program that you were talking about part of that, or is that a different program?

Mr Cormack: In relation to diabetes, it is very much a partnership arrangement between our own directly run services and with the division of general practice and the programs that are funded by the commonwealth through the divisions and through the MBS items. So there are a number of opportunities for partnering there.

MRS BURKE: I must apologise to all those present and to all those listening. I am having a challenge with my vocal chords—not very clever for a politician. Minister, I refer to page 27 of the report—future directions. Often you can read a lot in-between lines. I do not want to do that. I would like somebody to expand a little on the first paragraph there, which says, "As part of a portfolio-wide approach, community health with contribute to reducing access block," et cetera. Would I detect from that that there may be potential for excess pressures to be placed upon community health services?

Mr Cormack: In response to that, I think in framing the budget for 2006-07 and reflecting back on 2005-06, we are seeing quite significant growth across all program areas. We need to take different approaches according to the program you are looking at.

In relation to community health services, the ACT has an outstanding community health care system. In fact, we had some external people have a look at it last week in another context. It is a really top-quality service. Unlike other community health services in other jurisdictions, community health actually runs a lot of the programs that support hospital care in the ACT, particularly at TCH. Community health looks after the allied health services within the hospital and the discharge planning.

In answer to your question, yes, there are growth pressures on community health. The minister mentioned earlier that we were looking at a combination of access restrictions and user charges as one way of managing that growth. But we also need to look at what are the priorities within community health. In particular, we are seeing significant growth in the acute care sector. You can see that last year we had a significant increase in our elective surgery, a significant increase in our hospital admissions, and a significant increase in our emergency department presentations.

A big proportion of those people require support in hospital and out of hospital by community health services. This year, in addition to what the minister mentioned, we are also going to be looking at targeting some of our community health services, our community-based services, to look at better management of chronic disease.

We did some internal work looking at the pressures in our hospital system. We identified a relatively small group of people with poorly managed chronic conditions. The two groups we were looking at were those with heart failure and those with chronic respiratory disease. We were looking at a fairly small group of people who were accounting for a very high demand on the hospital sector—people coming in time and time again because their condition is not well managed.

There are two big benefits in getting off that treadmill. The first one is that the patients get better care. If you can work with general practitioners, work with the community teams and work with the hospital to help people to be more educated about how to manage their condition, it is less likely that they will keep turning up at the emergency department or having to get admitted. The big benefit there is that patients are feeling better, they are looked after better and they do not have to keep turning up at emergency departments. The big benefit, of course, for the hospital system, if we can reprioritise our services to focus on that group, is that we get fewer admissions coming into our hospital that could have been prevented.

It is very disappointing when you are running and managing a hospital system to see people coming in time and time again because they are not taking their medication; they are not following their lifestyle script, if you like; or they are continuing to smoke—all those sorts of things. If we can focus our resources on those groups, we get two big benefits. That is part of the reprioritisation process we are talking about.

The third area is just improving our discharge management overall. If you get discharge planning right and people have a nice, planned transfer from hospital to home, with all the supports in place, then they are more likely to heal and recover effectively and quickly in their own home and are less likely to bounce back into hospital. That is what we mean by reprioritising. That is what we are focusing on in community health in 2006-07.

MRS BURKE: Thank you for that. You talk about efficiencies. How are you going to manage efficiencies across the whole spectrum—as you have said, it is portfolio-wide—and still maintain a service?

Mr Cormack: There are a number of efficiency areas that we are looking at. The minister mentioned before the importance of benchmarking and comparing our staffing levels, particularly our overhead staffing levels, with other peer organisations. That is a piece of work that we are focusing on at the moment.

The second area of work is to look at our rostering practices. We are particularly focused on doctors and nurses. They are the two largest groups of employees. We are very keen to ensure that, by rostering our staff correctly and appropriately, rather than leaving it to the last minute, we avoid the need to put people on overtime to cover short shifts. And we can avoid the need to engage locum services or agency services, which all come at a very significant premium, through not managing our rosters appropriately. That is the second area of work.

MRS BURKE: Can I just pick you up on that. Why have they been mismanaged or not well done to this point? What has brought about this sudden change?

Mr Cormack: Certainly it is not a sudden realisation. We have been working away for some time at improving our efficiency. In fact, if you compare our national performance in 2004-05 using the AIHW figures and preceding years, you will find that we have actually started to make some gains. We still have a fair way to go, but we are making some gains. It is not that we have just suddenly discovered it. We have been working at it for a while. But, clearly, the government has set for us an objective to improve our efficiencies. This is part of the approach we will be taking.

THE CHAIR: In answer to questions, you have talked a couple of times about emergency presentations being up. At page 13 you have talked about them being up by six per cent over the previous year, after a decline in 2003-04 and 2004-05. You covered off a little bit on that when you were talking about people not taking their medications and some of the other things that occur. But can you say what other factors might be influencing the increase and, more particularly, the steady and significant increase in acute presentations, which is shown on the table at page 14?

Mr Cormack: I think there are a number of factors behind growth in emergency department presentations and activity. Obviously, each year there is normal population growth and ageing that will contribute to a proportion of the increase in emergency department presentations.

A second factor is the availability of good quality general practice. We are very fortunate in this town that we have a good GP sector. We have very good general practitioners but, unfortunately, we do not actually have enough. We do not really have a lot of control over general practitioners.

There is a sense there, or people think, that people come to the emergency department because they cannot get into an after-hours GP. That is part of it. But if there are insufficient general practitioners in the community, then often people will not build up that relationship and that care planning relationship that they have with the general practitioners if there are more about.

So there is the factor of people not having access to after-hours general practice, but there is also a lack of access to general practice overall. That leads to not getting on top of conditions soon enough, because it takes you longer to get in to see a GP. You might miss the opportunity to pick up on a disease pattern early enough and get in place some good management programs. That is certainly another factor.

A third factor in relation to emergency departments—and this is more over a longer period of time—is that, in our surrounding region, most of the health services are experiencing similar difficulties with general practice. But also the level of service available at smaller country hospitals is not what it is like here in the national capital. Over time we have seen a bit of a decline in the level and depth of services in rural and regional areas. Those people will tend to find their way into our health care system.

It is a combination of factors. That is why it will require a combination of solutions and programs, some within the control of the ACT government, but many of them well beyond the control of the ACT government, to achieve some reduction in that demand.

THE CHAIR: On the issue of shortage of GPs do we, as a country, have a shortage of GPs? Obviously, we have a shortage within the ACT and regional areas, but is there an overall shortage within the country of Australia?

Mr Cormack: I think the short answer is yes. Somebody else might be able to give you a slightly longer answer.

Mr Thompson: There is an overall shortage, but the primary issue, particularly for areas like the ACT, is actually a maldistribution issue. GPs tend to be concentrated in capital cities and larger urban areas. For whatever reason, the supply of GPs in the ACT is in fact more like some of the smaller rural areas. As a consequence, we are experiencing it more acutely than others.

THE CHAIR: Obviously, we do not have the final say; it is the federal government that has the say on what happens with GP training. What are we doing in terms of

trying to influence that? What are the other factors that go on?

Mr Thompson: We have been working very hard with the Australian government to try and do it. We got agreement for parts of the ACT to become outer metropolitan areas, to get GP incentives. Over the last two years our estimate is that that equates to about eight extra full-time GPs that have come into the ACT. Despite that, we are still well short of where we should be.

The other thing is that we have the medical school which is training graduates. We expect we will have essentially an export market in medical graduates in the next few years. However, until we get enough training places approved by the commonwealth, we cannot actually train them to become GPs. We are potentially going to see a number of them leave the ACT because we do not have the GP training places available. We are still pursuing that with the Australian government to try and get further GP training places, but that is still an issue for us.

MS PORTER: You mentioned that there are some regions within the ACT that have been recognised as having special needs, as far as the commonwealth is concerned. Could you outline where those would be?

Mr Thompson: It is basically everywhere except for north and south Canberra and Woden.

MS PORTER: Do you mean inner north and inner south?

Mr Thompson: Yes, inner north, inner south and Woden. The other areas are outer metropolitan. That enables GPs to move there from capital cities. They get incentives to move there. It also means that GPs who do not have vocational registration—and vocational registration is the process whereby GPs are essentially recognised as having specialist expertise in general practice—can work there under the supervision of vocationally registered GPs and perhaps work towards their vocational registration. While that is not an ideal sort of work force for us—we would prefer fully vocationally registered GPs—it gives additional support in the work force.

THE CHAIR: This is slightly off the track, but it still relates to GPs in outlying areas. It relates to the provision of GPs down in the Lanyon Valley area. I noticed on the weekend that there was an advertisement for sale by tender of a site specifically earmarked for a doctor's surgery in Conder, or, if you prefer, the Lanyon shopping centre area, which has been long awaited, I have to say. How much input has health had into that? My understanding is that it will be an auction, so those people who are interested in setting up a surgery will go along. Do you think there will be enough people to bid?

Mr Thompson: We are hoping there will be enough people to bid. The question of GP supply in Lanyon has been, as you say, a very long-running issue. The major issue has been about the availability of GPs who are prepared to practise there. That is one of the features of the general practice work force, of course. They are private sector practitioners. Once they are registered and vocationally registered to practise as GPs, they are not required to practise in a particular area; they can choose where they practise.

We have been working with the division of general practice and the Tuggeranong community over a number of years, and with a number of different strategies, to try to find a solution for the Lanyon area. It looks like there is a potential solution there, but at this stage I would not make any definitive statements in that regard.

MS PORTER: You would probably be aware, minister, that the west Belconnen community co-op has formally formed now. I believe they will go ahead with that community model of health care at the west Belconnen site within the near future. There are some doctors interested in practising there. That will hopefully help with that particular area. They have not had a GP there for a number years. That whole west Belconnen area has been without general practitioners for quite a length of time.

Mr Thompson: Yes. The other thing I will note about that is that a new general practice has recently—over the last six months—opened in Charnwood as well.

MS PORTER: Yes. They do not bulk-bill. They are just equivalent to one full-time doctor. I think the idea is that the co-op is trying to get a bulk-billing centre going. That is what they are trying to get under way.

Mr Thompson: Yes. The idea is that they will bulk-bill, but the members of the community who participate will pay a subscription fee. It is a different approach.

MS PORTER: That is right.

Mr Thompson: So while there will not be co-payments for each individual service, the members of the community will be contributing via a subscription fee.

MS PORTER: Yes. I believe it is quite cheap. That is good.

MR SMYTH: I go back to where we started. The chair said that the focus of the hearings would be on how we get the efficiency of the health system up so we can bring down the cost of public care to within 10 per cent of the national average. Minister, you said you were going to achieve that over the next five years.

THE CHAIR: I believe you are putting words in my mouth, Mr Smyth.

MR SMYTH: No. I am just quoting your speech. How much is the target in actual dollar terms?

Mr Cormack: At this stage we are working on a target of approximately $23 million over the time period you are referring to—over the five-year time frame.

MR SMYTH: Is it broken up over the five years, or is it going to come at the end of the process?

Mr Cormack: Like all good budget processes, there is a step-wise progression. We have identified components for each of the years. I do not have them in front of me, but for this year we are looking at just under $5 million. That is the efficiency improvement that we will be looking to achieve.

MR SMYTH: Is it possible to provide the other years, the outyears, to the committee?

Mr Cormack: Yes. I do not have that available to me at the moment.

MR SMYTH: That is fine. On page 6 of the annual report it says that you are going to do this over the next four years. Has that now changed to five years, or is it a misprint in the annual report?

Mr Cormack: I suspect it is a misprint in the annual report.

MR SMYTH: It is definitely over five years?

Mr Cormack: Yes.

MR SMYTH: To quote your annual report, clearly part of that will be improving access to care on the basis of need. What is the cost of a presentation to the emergency department? Has that been worked out?

Mr Cormack: It has been, but I do not have that available at the moment.

MR SMYTH: Could that be taken on notice?

Ms Gallagher: Yes, sure.

MR SMYTH: The third dot point on page 6 talks about expanding access to elective surgery and reducing waiting times. What was the elective surgery waiting list at the end of October?

THE CHAIR: Sorry. That would be within the reporting year of 2005-06, would it?

MR SMYTH: No. I am looking at their statement about what the challenges are for 2006-07, as contained in the annual report. That was also the starting point of your opening speech when quoting page 14 of the Treasurer's speech in the Assembly.

THE CHAIR: It is all right. I would have been disappointed if you had not asked the question.

Ms Gallagher: I am sorry. We do not have the October figures available.

MR SMYTH: September or August?

Ms Gallagher: We have August: 4,701. I understand it is a bit late because of some of the PAS-related issues.

MR SMYTH: So it is another flaw in the PAS.

Ms Gallagher: Some of the implementation issues; yes.

MR SMYTH: Two dot points down, it talks about achieving accreditation of ACT Health as a single integrated health service. Minister, why have you gone to achieving single accreditation instead of doing it as we currently do, which is Calvary, TCH, ACT Mental Health, community care and corporate?

Ms Gallagher: My understanding is they are components, but it is going to be happening across the board. That is the issue. So they are still being done that way. For example, corporate accreditation was done this year for the first time.

MR SMYTH: How did we go?

Ms Gallagher: I do not know yet.

MR SMYTH: It is still coming.

Ms Gallagher: It only happened last week—or in the previous couple of weeks, actually.

MR SMYTH: When will that be available?

Ms Gallagher: We had mental health a couple of months ago—in August. That may be available before Christmas. I guess we are in the hands of the accreditors. For the rest of the components that are being done, that might be early next year. I am sorry; I need to correct that. The waiting list is 4,703 as at the end of August. Apparently the feedback has been very positive across all of the areas, so I look forward to getting it.

THE CHAIR: I noticed you referred to the acronym "PAS", which is not in the glossary of acronyms. Just for the record, do you want to state what it means?

Ms Gallagher: Patient administration system.

MR SMYTH: In the outlook on page 6 it goes on, a little bit further down, to clarify the ownership and control arrangements for the delivery of health care services by Calvary Public Hospital. I note your recommendation of Calvary in your answer to a question on Thursday—that they are meeting all their KPIs and how well Calvary Hospital is doing. What needs to be clarified about the ownership and control arrangements? What is the timetable? What action are you taking?

Ms Gallagher: That is actually a piece of work that is being finalised at the moment. It will go to cabinet in the next month or so. It is looking at essentially governance arrangements for Calvary Hospital and what are the best governance arrangements to deliver the outcomes that ACT Health, the ACT government and Calvary Health Care can offer. It is difficult, because it is going to cabinet. I have not had the discussions with my colleagues. As much as I can say, it is having a look at the governance arrangements and how the relationships between the ACT government and Calvary Health Care operate.

MR SMYTH: In terms of the background, what prompted the need to clarify the ownership and control arrangements?

Ms Gallagher: I am not sure, historically, what the reasons may have been. Calvary has been set a benchmark target as well to reduce costs. There are certainly views from Calvary Health Care as to how they can achieve those and some directions they would like to go in.

I guess we, the government, need to have a look at that. I think the contract between the ACT government and them for Calvary Public Hospital is around $90 million. It is obviously a relationship we want to get right. Part of it is generated out of listening to Calvary Health Care, having a look at some suggestions around governance and then, ultimately, the ACT government making a decision about that.

MR SMYTH: The last dot point on page 6 actually talks about the PAS, the patient administration system. Are we any wiser, after Thursday's question time, as to billing arrangements and how we are coping with those? What moneys have not been collected at this stage?

Ms Gallagher: I do not know if there is someone more knowledgeable than I am—there probably is—in this room. There are probably quite a few. I understand it relates to delays in billing, rather than missing out on any money. The Chief Information Officer is here. He can provide more information about PAS-related issues. Certainly the advice I have been given is that it is around billing. It is about a delay, not a lack of receipts.

Mr Smalley: In reference to the billing issue, in going live with PAS there was an issue with provider information not being migrated across from the old care system. That, in effect, meant that we did not have accurate provider information, requiring us to go to manual billing in a number of areas. The processing of manual bills takes an additional three weeks over normal electronic billing, and that commenced about a month after going live.

During the go-live period, areas were instructed, as per normal, to do manual billing, and then we go through a process of catch-up. So in the first months of September and October, revenue was reported as being down and we are expecting it to pick up in November and December as the bills get processed. But as far as I am aware all areas were doing manual billing during that time frame.

MR SMYTH: Surely, as part of the standard functionality, billing is built into these systems. Why was the provider data not migrated to enable it to go live on day one?

Mr Smalley: Because the provider information that we provided was of a different structure to that which was required for new PAS. The quality of the information was such that it was not suitable for loading into the new PAS. It was suitable for billing but not suitable for loading. Provider information is a function of the clinician, the location and the speciality combination. The other system was not too fussed about location information, whereas the new system was. So it basically it came down to a quality issue. Provider information for 4,500 had to be manually entered, and that delayed us by two weeks. That work started a month before go-live, but was still going two weeks after going live.

MR SMYTH: When did you become aware that this was an issue for the new

system?

Mr Smalley: A month before going live.

MR SMYTH: So in the pre-planning to install the system, you were not aware that you needed the provider data in a different format?

Mr Smalley: We were guaranteed the provider data was okay. It was not until we started loading it that we discovered the quality of the provider data was erroneous.

MR SMYTH: Was that a fault of the provider, in that they did not make it quite clear to you exactly what format they needed the data in?

Mr Smalley: No. It was more of a function of the old system, the way it provided information.

MR SMYTH: That has all been loaded now?

Mr Smalley: That was loaded, effectively, in two weeks of go-live. Then there was a month after that where we did clean-up. We had some duplicates. They were duplicates in the sense that the provider number is an eight-digit number—it is actually split into three parts—with a leading zero. Some came across without the leading zero; some came across with the leading zero. It all tends to look the same, but it turns out to be a duplicate. We had to do a manual clean up on around 150 providers as well, and that was finished last Friday.

MR SMYTH: I am also told that some areas are maintaining manual appointment schedules for patients. Has that ceased or is that being maintained?

Mr Smalley: There is one area that does manual scheduling of patient appointments. Those appointments are still electronically recorded. The scheduling process itself is manual. There we have brought in an expert to look at their business processes and workflow. It is a much more complex issue than just a system issue. It is a workflow issue as well to do with the management of the patient appointments and also to do with the functionality of the system. It is to do with the complexity of patient appointment. In effect, the system is not a point of care clinical system. It does not understand the complexities of clinical treatment. It is a diary appointment with time recording system. The old one was no different from the new one.

MR SMYTH: But they were not maintaining manual schedules in the old system, were they?

Mr Smalley: No, they were not maintaining manual systems in the old system because the old system had a different layout. It was sort of like the XY coordinates on a spreadsheet being rotated. The new one worked down; the other one worked across. People were having difficulty transitioning across to the new design of the system. We were working on how to get the new system to look similar to the old system. The system has the capability of recording, because that is what we are actually doing.

MR SMYTH: Sure. Which is the area most affected, did you say?

Mr Smalley: That was in cancer services.

MR SMYTH: When did this problem become apparent?

Mr Smalley: That problem was apparent, effectively, day one.

MR SMYTH: Getting your patients in and out is surely the key issue here. Why did we not purchase a clinical system? You said you have brought in an expert to look at the system. Are we paying for that or is the provider paying for that?

Mr Smalley: No. That is built in as part of the contract. The functionality of the new system is no different from the functionality of the old system.

THE CHAIR: I think Mr Cormack has something to add.

Mr Cormack: PAS is a complicated system. It governs and manages many important aspects. This is a big implementation. There are several hundred users. Whenever you have an implementation or a transition from a system that is more than 20 years old into something that belongs in the 21st century, there are clearly going to be some work practice changes, training issues and turnover issues that will happen.

It would be naive, I think, of us to expect a system of this complexity to be introduced without any glitches. I think the important point is that we are working through those issues. We have identified the problem areas and we have got additional training available. Where the system is not supporting business practices, we have got workaround solutions so that we are able to maintain all the essential functions of running a hospital and health care system, and that is what we have been able to do. We are confident that we will have worked through the bulk of these issues in the very, very near future.

MR SMYTH: What is the very near future?

Mr Cormack: I would imagine that probably by towards the end of this calendar year and into January most of the bugs should be out of the system just in terms of people's familiarity with it and work practices. That is what I would think. But it is a big system and I certainly would not like to guarantee that there would be no problems with it past December or January. I think it is important to add that computer systems are inherently complex.

MR SMYTH: Sure.

Mr Cormack: They are upgraded. Even simple office systems are subject to regular annual vendor upgrades. Every time there is an upgrade you will get changes in the familiarity of the screen, the layout, the way you do things. So we just roll with those and put in place project management and risk management arrangements to ensure that we are able to maintain functionality throughout those changes.

MR SMYTH: All right. The company that provides the system is doing similar work,

I understand, in Victoria and Queensland, but the head office in the UK has suffered significant upheavals and a lot of the computer newspapers are speculating whether or not the company will actually survive. Are we at risk in a $7 million contract with a company that has a huge cloud over its future?

Mr Smalley: The company is split, in a sense. The parent company is in the UK, but we are dealing with the Asia Pacific company, which is actually financially quite sound and quite operational. The discussions in the newspapers have been around whether the UK company might be bought out by NHS, which is effectively the government, which is running the show, or whether they will split off the Asia Pacific to run as an entity in their own right. They could because they are financially viable to do so.

At this stage we do not see ourselves to be at any significant risk because the product section in an operational sense has a very large Australian user base. Effectively, it is the New South Wales system. It has just taken the contract for Victoria, as well as being on the agenda for Queensland. So there is a very strong installed base here. The product is going through a significant development framework, working mainly out of India, and I think the main issue that might be impacted would be the development framework, rather than the support of our existing system.

MS PORTER: I guess one of the indicators of the effectiveness of a system is the number of compliments and complaints that one may receive. That is only one indicator, of course, but I note that page 122 talks about the number of compliments exceeding complaints. It says that the number of compliments is on the rise. I think it is quite unusual for people to register their compliments. They are usually more likely to register a complaint than a compliment. But I do notice from the table on page 122 that there seems to be an issue around communication. What are we doing to rectify that particular issue of communication in the community health complaints category?

Ms Reading: When we receive complaints and commendations within the community health division, our strategies are initially to provide feedback to the client and work with the client about how they see we can improve our communication with our consumers. We have worked very, very hard in terms of building up our consumer communication strategies across community health, indeed ACT Health, and we were given quite positive feedback in the periodic review from our accreditation last year.

Communication, I think, is an issue that is brought up in every review of a service that can always be improved. From a community health perspective, we look at key issues that are identified in our complaints activities, and we also work to develop strategies about how we can improve. Quality improvement projects are developed as a result of client feedback and we work hard at implementing systems and processes to improve all communication with our clients. We also have several forums where we invite consumers to be represented on community health committees, in an informal and a formal sense. That is how we respond to it, both at the coalface and also at the more formalised part of community health.

MS PORTER: Do these compliments that are received—there are complaints, obviously—get fed back to the particular units they are related to?

Ms Reading: Most definitely. All feedback is provided back to the clinicians, to the unit, the program and the divisions. We also have a formalised process for capturing that information, not only in the community health division but across ACT Health. Particularly for communication and complaints, we have a more formalised relationship with the Community and Health Services Complaints Unit.

MR SMYTH: Just as a follow-up on customer satisfaction, you recently announced that a satisfaction survey had been done. Could you tell the committee when it was done, how many people responded to the survey and whether or not the full satisfaction survey can be made available?

Ms Gallagher: Sure. That was across the hospital.

MR SMYTH: Yes.

Ms Gallagher: I have some information here. When was it? I am sure someone will get me that answer while I am talking, but 444 patients were sent a questionnaire and 182 patients participated. So there was a 41 per cent response rate. It was September 2005 and February 2006.

MR SMYTH: Who conducted the survey? We are not using Press Gainey anymore?

Mr Cormack: In this instance we did not use Press Gainey. We are part of a Victorian patient safety monitoring group—this is, the Canberra Hospital—and that way we are able to benchmark our performance over time against ourselves and also against other organisations.

MR SMYTH: All right. Is the full survey available to the committee?

Ms Gallagher: I am more than happy to give you the information, yes.

MR SMYTH: All right. Thank you.

MRS BURKE: I refer to an original question. It might have to be my last question. Across the whole portfolio we are doing some wonderful things in terms of programs, and these are currently being delivered. From what I can read in the report, they are looking like they are going to be maintained. We talked about efficiencies this morning. We cannot do everything all of the time. I think the minister has made that clear. You have made that clear, Mr Cormack, too. What types of programs do you believe will no longer be in need that you are going to make efficiencies from? Are you looking not to cut programs and, moreover, to just go the admin overhead line?

Ms Gallagher: The decision the government has taken has been to provide 6.4 per cent growth a year in the budget. So there is more money in every single budget for the forward estimates. I think the budget for this year is about $751 million, and over the period of the forward estimates it rises to around $900 million. So there are significant amounts of growth money there.

The issue that we are tackling through the health system is managing demand. We know demand is going to grow and there is going to be growth in every area across

the portfolio. The issue for us is to run the most efficient health system that we can. That is why the benchmarking is being done. It is not about cutting programs, although if there are programs that are no longer relevant it makes sense to have a look at those.

We are having a look across the portfolio. We fund a range of services in the community. We are having a look at those to make sure all the grants that we are providing there are actually targeting areas that we acknowledge are areas that require increased support. There is no-one on the chopping block. There is no list of programs that will be cut or reduced. I think it is about efficiencies. It is about achieving more benchmark-like outcomes in back of end functions, I think it is fair to say, although some of the decisions taken by cabinet may reduce some of our staff costs at the front end, too. I am talking there about superannuation, but that is more of a long-term area, and, in community health, looking at access and eligibility arrangements.

So it is not about cutting programs. It is about efficiency and making sure we are targeting health services to those who are most in need. That is what it is about. That is essentially the big picture of what we are trying to do here.

Now, there will be little bits going across the portfolio, but that is essentially the work that is being undertaken. Recognising that health is growing faster than any government can afford to pay, we need to make sure that we are providing growth money, adequate growth money, which we have done in this year's budget, in the context of making some efficiencies in the health system. We are looking at areas where we can achieve savings but not reduce services. That is what we are doing.

MRS BURKE: Following on from that, page 43 of the report deals with community engagement. Can you give me an update on how that is actually working towards what you have just said in terms of identifying what is needed, what is not needed, or looking into the future a little bit, if we are able to?

Ms Gallagher: How do we talk with the community?

MRS BURKE: Yes. How is that working to identify those things that you have just said in your comments?

Ms Gallagher: For any piece of work that is undertaken—let us take, for example, community health and the work that we will undertake through that—community engagement and community consultation will be a very big part of that work. For example, we will be going out with a discussion paper to the community. I have not taken this through cabinet yet but it will go through in the next couple of months. There are some issues that perhaps we do not need to consult with the community on. They are around our benchmarking of our management costs. Things like that you would not—

MRS BURKE: Directly relating to people.

Ms Gallagher: But for those key areas where we are looking to shift our focus or change the rules of engagement, then certainly we would be having significant community consultation.

MRS BURKE: So you have no general feel for that at the moment through the sector? It is about shifting cogs. This is not a catch question; I am just trying to see if there is a trend, a theme, to see if there is something that you have identified where more is needed over here and less is needed here.

Ms Gallagher: From the community's point of view and that of the community organisations I meet with, I would say mental health is the key area.

MRS BURKE: Yes.

Ms Gallagher: All mental health groups, be they consumers or service providers, will be arguing that they need more resources. I guess part of juggling that is to look at what else is being provided and whether we can look within the pool that we already provide to the community to be able to change that mix. That is very hard to do. I do not know how many successful ministers have done that. We have had this discussion a number of times around the family support programs. It is a similar thing. It is very hard once you fund community organisations to say to them that they are no longer offering an area that is a key pressure for us and that we are going to remove that funding and put it somewhere else.

For those discussions we would have very broad community consultation. I meet with a number of community health organisations. From my point of view, I feel pretty well briefed on where the areas of pressure are. I have not had too many people offering up their grants. In fact, I have not had anyone come and say to me that what they do is no longer a key priority area for the health system and that we should take it from them.

MRS BURKE: I did ask that because I know it is the Stanhope government's view that there are a lot of programs across all of our portfolios, not just the health one. So it is a difficult task.

Ms Gallagher: Yes. Some things the government does as well in community health. We fund community organisations and we offer that service as well. So we are looking at that. But certainly before any major changes are made there would be lots of discussion and consultation with the community.

MRS BURKE: Yes. I think "consultation" is your key word. I will be looking very carefully to make sure it does happen through the working groups and so on.

Ms Gallagher: Yes.

MRS BURKE: Thank you, minister.

MS PORTER: I just have a very quick follow-on question. We were talking about community groups and whether they are funded or not. There has been some discussion around CAHMA, the peer-based drug program that was being auspiced previously. Could you update us on that situation with regard to peer-based services and that particular service?

Ms Gallagher: There is not a peer-based service operating in the ACT at the moment, but ACT Health is looking at what we can do to get one back up and running as soon as possible. I have not had further advice on that, other than I know some work is under way looking at how to establish a peer-based service fairly shortly. My understanding is that CAHMA is still operating out of the Griffin Centre, but they are not operating a needle and syringe outlet.

Meeting adjourned from 11.59 am to 12.13 pm.

THE CHAIR: We will now deal with mental health and I ask Dr Brown to make her way forward. According to pages 20 and 21, the inpatient separations are declining fairly steadily. Congratulations. Can you provide a bit more detail on how this is being achieved, particularly on the increase in services being provided in a community setting?

Dr Brown: Essentially, what we are seeing there is a trend towards fewer people being admitted but for slightly more complex presentations. The length of stay is not necessarily going down; in fact, it is probably going up slightly, which reflects that. In terms of the care in the community, we are looking at a couple of things. One is at more focused individual treatments, but we are also looking at trying to enhance the number of group treatments. We don't offer a lot in the way of group treatments as yet, but we do run depression groups and we are now running DBT groups, dialectical behaviour therapy, on both the south side and at Belconnen. Our child and adolescent teams are also looking at offering more in the way of group programs as well.

THE CHAIR: Are you looking at increasing the amount of group treatment?

Dr Brown: We would like to do that. One of the things that we want to do is to offer more treatment to what we call the high prevalence disorders, depression and anxiety. Some of those can be effectively offered in a group program setting. That is something we would like to move towards.

THE CHAIR: You mention as well on pages 20 and 21 the crisis assessment and treatment team review. Can you outline the results of that review and where you are up to in implementing the recommendation?

Dr Brown: The review of the crisis assessment and treatment team had a large number of recommendations. Many of them related to the function of the community mental health teams, and we have undertaken a subsequent review of our community mental health teams and are awaiting that report. In terms of the work that we have done around the crisis team, some of the things that we have done there include having a designated coordinator of the shift for each shift of the crisis team. We have looked at the rostering practices there. We have recruited staff to some long-term vacancies. We have also looked at the criteria for access and discharge from CAT. We have specified a time limit for case management for the crisis team, with then a transition to the community mental health teams. We have also reviewed clinical policy and procedures and we have had the community mental health teams increase their management of crisis presentations for clinically managed clients within the community mental health team, rather than deferring them all to the CAT team. So quite a number of things have been completed arising out of the recommendations of

that review.

MR SMYTH: Was that report made public?

Dr Brown: It wasn't made public as such, but it is available to anyone who requests it.

MR SMYTH: Can I request a copy?

Dr Brown: Yes, most definitely.

THE CHAIR: If you provide one to the committee, we will pass it on to Mr Smyth.

MS PORTER: I have a question on the reference to partnerships on page 22. We were talking about partnerships before. It talks about the mind matters program being a partnership between the mental health and education sectors to promote and protect the mental health of school communities. Any work in this area is going to have obvious benefits for us down the track in preventing some mental illness from occurring and perhaps helping young people identify that they have a problem and be able to find ways to seek treatment if they need it. I was wondering if you could talk a little bit more about that program and similar kinds of programs and whether you believe that you might expand those kinds of programs.

Dr Brown: Yes. Mind matters in the ACT is part of a national mind matters program under the auspices of the Australian government and implemented in all states and territories. Mind matters focuses on children in the secondary years of school. A new program has commenced called kids matters which focuses on the primary school years. In the ACT there will be, I believe, six schools trialling kids matters next year, three of them public schools, three of them independent schools. Essentially, the focus is on upskilling teachers and providing mental health awareness as part of the core curriculum. Training is provided to schools and teachers for that. The mind matters drama festival is an extension of that. That has been a very successful undertaking. It was bigger than ever this year. It was held just a few weeks ago. In fact, a couple of schools from New South Wales, I believe, came to participate in the ACT drama festival. Essentially, it is about raising awareness in young people, school students, around mental health matters generally and, as I say, incorporating it into the curriculum. So it is a very worthwhile initiative and we would be keen to see the roll-out of kids matters in the same way as mind matters has occurred.

MR SMYTH: On page 21 there is a paragraph on the planning for inpatient facilities. Where is that up to and when will we find out what the government is proposing?

Ms Gallagher: I guess it is up to me. There is a bit of work going on. It will go through the budget process. That is about all I can say. When I took over the portfolio there was disagreement. I think I have said before that community representatives wanted a smaller inpatient facility than ACT Health's preferred model, which was a 50-bed model, and I met with some community organisations that desired a 30-bed model. The process, I guess, is to finalise those discussions and have something ready for the budget next year.

MR SMYTH: What is the current occupancy rate of the PSU?

Dr Brown: It runs between 90 and 100 per cent, generally around 90 to 95.

MR SMYTH: And it has 26 beds.

Dr Brown: It has capacity for 30 beds, but we can only staff it routinely to 26 beds, so we call 26 beds the full number.

MR SMYTH: I notice that there is not a figure here, but in 2005-06 how many suicides were recorded in the ACT?

Dr Brown: I'm sorry; I could not give you that number for the ACT in general. I would have to get back to you with that.

MR SMYTH: Okay, that's fine. Could I have a comparison with the previous year?

Dr Brown: Sorry; are you wanting suicides for the ACT as a whole or in the inpatient unit?

MR SMYTH: No, for the ACT as a whole.

Dr Brown: As a whole. Yes, we can certainly provide that.

MR SMYTH: All right, and the previous year. If you could do it from an inpatients perspective as well, that would be kind.

Dr Brown: Sure. We didn't have any in the inpatient facility.

MR SMYTH: That is what I thought.

THE CHAIR: Are you able to tell us about the balance of funding between acute care and community care within Mental Health ACT?

Dr Brown: I would have to take that on notice to give you an accurate distribution.

Ms Gallagher: It would be 75 to 25.

Dr Brown: Yes, it is roughly 75 to 25; 75 per cent to the community and 25 per cent to inpatients. Do you want it more accurate than that?

THE CHAIR: I think it would be worth while to have a close look at exactly what it is.

Dr Brown: Sure.

Ms Gallagher: That 75 to 25 is for the government's community service provision as well as community organisations. Seventy-five per cent of the budget is delivered in a community setting by various providers, of which government is one, and the 25 per cent relates to the acute inpatient service.

THE CHAIR: Is there a big difference in costs between the PSU and ward 2N?

Dr Brown: Yes, there is a difference in price. It reflects a couple of things. One is that the PSU runs a high-dependency unit, which obviously has higher costs involved. The second is that in general terms the complexity of clients who require care in the PSU is higher than in 2N. That is reflected by the fact that the majority of clients in the PSU are there as involuntary clients. The opposite is the case at 2N, where the majority are voluntary clients.

THE CHAIR: Is that listed in the annual report?

Dr Brown: The cost? No.

THE CHAIR: Is it possible to get a copy of the costs for both the PSU and 2N?

Dr Brown: Yes.

MR SMYTH: On page 9, about halfway down the second column, you mention the national sentinel events report. If I recall rightly, in 2004-05 we had nine sentinel events. How many were recorded this year?

Ms Gallagher: I thought I had answered a question on notice for this year. Did I, or was it for a different reporting period?

MR SMYTH: It might have been for a different reporting period.

Mr Cormack: Dr Wayne Ramsay, who is the Director of the Clinical Governance Unit, will answer the question. We do not have a label for him.

Dr Ramsay: Since July this year we have had two sentinel events reported.

MR SMYTH: What about for 2005-06?

Dr Ramsay: Seven.

MR SMYTH: In the previous year, 2004-05, were there nine?

Dr Ramsay: That is my recollection, although that was not for a full financial year. That was the beginning of the reporting.

MR SMYTH: All right. What has been the outcome of these events and how is the process going in ensuring that, to the best of our ability, they do not happen again?

Dr Ramsay: Sentinel events reporting is but one element of the reporting system that we have in place. We have done a lot of work around notification of all significant incidents and sentinel events are a very small subset of those. We have introduced a new software tool called RiskMan that has replaced the Australian incident management system. We introduced it nearly two months ago and we have mandated the reporting of all significant incidents. We mandated that at the beginning of this year. So we now track all significant incidents, including sentinel events. Indeed,

since introducing our new software system, the number of reports has increased, which for us is a very positive thing, meaning that we are capturing much more clearly all mandated and significant incidents.

MR SMYTH: Is a sentinel event the most significant?

Dr Ramsay: No, a sentinel event is a very specific event. It was defined originally by the national safety and quality council. It is now an agreed national list of incidents that the ministers have agreed to. So they are very specific incidents that are very rare. For us, a significant adverse event is the full suite of significant events that include death or significant disability associated with an adverse event. Sentinel events are just one small element of those events.

MR SMYTH: RiskMan has been in for two months. How many significant events have there been in that period?

Mr Cormack: We do not have that information available at the moment. We have only just bedded the system down, so we haven't really got a detailed profile on how many have been reported and what type they are.

MR SMYTH: I thought Dr Ramsay said that you were getting data already.

Mr Cormack: Yes, we are capturing them, but it is a new system. It has only been introduced in the last couple of months and we haven't yet seen the first report from RiskMan.

MR SMYTH: When is the first report expected?

Mr Cormack: We will be looking at these probably on a quarterly basis. But, as we talked about before, as with any new software there are bedding-down issues that we have to attend to.

MR SMYTH: Minister, will the significant events that are recorded by RiskMan be included in your quarterly reports from here on in?

Ms Gallagher: I knew this was going to be the next question. I was waiting for you to say it. I will have to take some advice on that. I have no problem with reporting information to the public against the performance of the health system but I am sure there are some pros and cons around it. If it is information that is in the public interest, I would be more than happy to look at how to incorporate information from RiskMan into the performance report, but I have not taken any advice on it yet and I just need to do that.

MR SMYTH: Sure. In the *Weekend Australian* of Saturday before last, I think, Dr Collignon was reported on readmission rates and infection rates. What is happening in the Canberra Hospital with regard to that?

Mr Cormack: You will notice in our quarterly report that we publish six indicators. They give you some idea of the trends and the normal variance rates, and those reports are available on the website for public scrutiny.

MR SMYTH: Are you happy with what is happening?

Ms Gallagher: I think it is in here as well.

MR SMYTH: Yes, I know; I am aware of what they are. I am asking whether you are happy with how it is going.

Mr Cormack: Yes, we are.

MR SMYTH: Given what was reported?

Mr Cormack: Sorry?

MR SMYTH: Given what Dr Collignon was saying, are you happy with how the Canberra Hospital is performing?

Mr Cormack: I am happy with the way that we are performing on the indicators that we are reporting in our quarterly performance report. In relation to the specific article about Professor Collignon that you are referring to, that is a different issue and I can't really provide you with the information on how TCH is performing, or indeed Calvary is performing, on that. Joint revisions, I think, were what he was referring to. We don't publish those.

MR SMYTH: You do collect that information, though, don't you?

Mr Cormack: We do collect information on joint revisions and we are contributors to the database that was referred to in that article. There is quite a degree of controversy over the interpretation of that data, as I am sure you would appreciate.

MR SMYTH: Yes.

Mr Cormack: The angle being what an insurer's view of a revision is might be influenced by a different set of values than what a clinician's view of a revision of a joint might be.

MR SMYTH: Is the data that you provide to the national set available to the committee?

Mr Cormack: I would have to double-check on that. There is a range of reporting that we provide that is not available for public distribution, but I need to take that one on notice.

MR SMYTH: Thank you.

MS PORTER: On page 223, under strategic indicator No 19, relating to a reduction in the youth smoking rate, there is a note that the target for 2006 was to reduce youth smoking rates to 13 per cent. Final data obviously was not available at the time of the report. However, preliminary data from a 2005 Australian secondary school alcohol and drugs survey showed that 8.6 of students between 12 and 17 had smoked in the

last seven days, but that that was down 15 per cent on a previous report in 2001 and 20 per cent on one in 1996. Minister, I know that you have been introducing some measures in this area with regard to smoking and tobacco purchasing.

Ms Gallagher: Compliance testing, yes.

MS PORTER: I was just wondering whether you wanted to talk about these figures and whether you are continuing to target youth in your new measures, or is it an overall strategy for smoking per se? When we began this hearing we were talking about respiratory disease being one of the chronic diseases that are chewing up a lot of our budget.

Ms Gallagher: Yes. I must say that when you find statistics that look that good you do want to shout from the rooftops that, obviously, all your policies and programs are working, but what I would say around the alcohol and drugs survey is that you can see those numbers bouncing around a fair bit. So I guess there should be a bit of caution there in that it is students themselves filling out forms, and the numbers for the ACT are small, with a jump from 15 to half of that a few years later. Having said that, we hope that that is so. Certainly the indication is that those numbers are going down. I understand that is the general view.

As to compliance testing, members will be aware that we have just passed the legislation and those amendments are there now for us to move forward. Dr Guest might have further information to provide, but I think that the procedures are just being finalised now around how those compliance tests are going to occur. Those processes will be disallowable in the Assembly, but we will certainly have a much more public discussion around those once they are finalised.

Dr Guest: The control purchase operations are the best remaining intervention known to bring down youth smoking rates. That is based on extensive research done here and in other jurisdictions. We hope to see further improvement.

MS PORTER: Do we have any record of whether or not it is young men or young women?

Dr Guest: Yes, we do. I do not have those data in front of me. We know that the initiation of smoking is a very serious problem in both young men and young women. Young women taking up smoking has become a more recently documented problem. If you want a specific breakdown on gender differences in smoking in the ACT, I would have to take that on notice.

MS PORTER: It would be good if you would take that on notice. In respect of older people who used to smoke, with all the different disincentives to smoke in our community, are we finding that more and more older people are now stopping smoking? Do we have an idea about that or not?

Dr Guest: There is a steady decline in smoking prevalence by age in every age cohort in the ACT and in Australia.

MS PORTER: That is good. Thank you very much.

THE CHAIR: Does anybody else have questions of Dr Guest on the smoking issue?

MR SMYTH: Not on smoking. I was wondering if we could discuss Jindalee and the process there. You are happy with the way Jindalee has conducted its operations and their openness and their communication with the ACT government and yourself?

Dr Guest: The Jindalee aged care facility notified us before they were required to do so that they had a problem with respiratory illness in the centre. The occurrence of undiagnosed upper respiratory infection is not actually notifiable, but they came to us early and we have been involved. We immediately set about a comprehensive diagnostic work-up which has revealed, unusually, the outbreak of influenza in late November. That is a very unusual occurrence.

Yes, we are very happy with the way Jindalee have worked with us closely from day one. We are investigating their accreditation with the commonwealth authorities who accredit nursing homes. There may be some remediable minor problems there of a very routine nature from the last accreditation. We are checking on the remediation of those problems. I am happy that Jindalee have done everything they possibly could.

MR SMYTH: The issue of a pandemic and the government's response, for instance, was raised on the radio this morning. Are you happy with the arrangements? The director of the division of GPs said that they thought they were getting more information from the ACT government—so flaunt it there, minister—than any of the other jurisdictions. I am sorry; I am not suggesting that Jindalee is the start of a pandemic at all. Are you happy with the arrangements that are in place and that everybody—the various sectors from the hospital to the nursing homes to the groups—knows their place, their role and what they are required to do?

Dr Guest: Point one: the Jindalee outbreak has nothing to do with bird flu, avian influenza, highly pathogenic influenza or pandemics.

MR SMYTH: Yes. I am not suggesting that at all.

Dr Guest: Are we happy? We are doing everything that can be done to promote understanding of the possibility of this problem. It is always a balance between doing everything for a problem that is not yet here versus managing the day-to-day pressing priorities. I think we have, in Australia, a better state of preparedness than anywhere else in the world. The director of the World Health Organisation has said as much.

I think in the ACT we were the first jurisdiction actually to have a jurisdictional plan against pandemic influenza, back in 2004. We have not rushed to publish the public version of that plan because we have waited for the commonwealth, with whom we are working very closely, to elaborate all their plans in the *Australian health management plan for pandemic influenza*, which was published in June this year. This week, or last week, we have out for consultation the corresponding document, which is the *ACT Health Management Plan for Pandemic Influenza*, which is an entirely complementary activity. I think we are doing all we can.

Ms Gallagher: We went through Exercise Cumpston in October, which was, certainly

from a government point of view, a very useful exercise, with all jurisdictions and all cabinets being involved. I think it showed up some areas we can look further into, particularly around providing information to people about how to minimise risks.

The Chief Minister said that we have a fridge magnet about what to do if a bushfire comes, but in terms of information for preparing the public—and some of that will come through this work that we are undertaking now—it is around information to the public about what steps can be taken to minimise risk. We do not want to frighten anyone either. That is certainly one of the issues that came out of it for me.

THE CHAIR: I wanted to ask a different question, not about Jindalee or potential bird flu outbreaks.

Ms Gallagher: Do not put those two together in a sentence. We do not have "Jindalee" and "bird flu".

THE CHAIR: Yes. It is a potential, but hopefully not to be. I go back to pages 222 and 223. This is not specifically to do with Dr Guest's area; it is to do with the process of target setting. I note that, in a number of cases under the strategic indicators, the performance targets that ACT Health has set itself are described as too conservative or unrealistic when they are missed by considerable margins. I know this has been a topic of conversation in previous years, as to how they are set.

Can you explain the process of target setting? How is it being set now? Is it based on historical experience, national best practice or some other mechanism?

Ms Gallagher: Yes. I missed—I could not hear—the beginning. Did you say somebody had been critical, saying they were too conservative?

THE CHAIR: If you look at page 222, under strategic indictor 16, in the last line it says:

> This is a new indicator for 2005-06 and the initial target proved too conservative.

Ms Gallagher: I see what you are saying; yes. I thought you were saying someone had been critical of the target setting in the department.

THE CHAIR: No.

Ms Gallagher: No. The department had been.

THE CHAIR: The department has been critical of it themselves.

MR SMYTH: Self-assessing.

MS PORTER: It says the same in 17.

THE CHAIR: Yes; in 17 it says the same. Another one was an unrealistic target. If the targets are too conservative or unrealistic, how are we going about setting them? One would hope that, if you are deciding that they are unrealistic or too conservative,

you are then reassessing and rejigging the way you set them.

Mr Cormack: That is a very good question. I think the answer to that question is that there are a number of ways that targets are set. I think at the outset it is important to note that no other jurisdiction reports as comprehensively or as publicly on targets as the ACT does. We draw upon a number of national and, in some case, international sources of target setting. I can run through some of those with you.

There is the national health performance framework. That is a process that ran alongside the Australian health care agreements. That is a cross-jurisdictional commonwealth-state process whereby all jurisdictions agree to standardise and identify a series of performance indicators against which to measure the system's performance. That is one source.

There are other sources. For example, in looking at readmission rates, we might use the ACHS—the Australian Council on Healthcare Standards—which has developed some national standards, benchmarked to different sized hospitals and settings. So if there is a national indicator available, we will use that.

Another example is in relation to emergency department waiting times. We have five triage classes and a performance standard for each of those. They are nationally adopted standards and their origin lies within the Australian College of Emergency Medicine.

The answer to your question is that we draw upon a range of sources. We prefer to go to nationally agreed standards or benchmarks if they are available. If they are not, we will look at, I guess, a lesser level of rigour. That is one against which we can compare our performance with another jurisdiction. A good example of that one is access block, where we have adopted a target that aligns itself to New South Wales. So we are able to have a look at that.

In relation to some of the other ones where there has not been a target but it is an area that we felt was of significant strategic importance for the department and for government, we have recommended a standard that is at least significantly better than our current baseline. We also keep a close eye on other jurisdictions. We try to pinch their standards and their targets as they are developed. That is where we draw our targets from in the first place.

Each year in the pre budget period we review those targets. In fact, the strategic indicators did not exist until the 2005-06 budget papers—in this format, anyway. So these are quite new areas of target setting. We will set our own personal bests, if you like, until such time as there are more standardised or nationally consistent targets available for us to adopt.

THE CHAIR: I found it confusing as to how the previous targets were set. I thought it was done in a particular way. I understand it was previously done in relation to the information that went to the minister. I could be clouding the issue and confusing it. I do not want to do that. Thank you for that, Mr Cormack.

MR SMYTH: Referring to page 215, indicator 3 is the occupancy rate for acute

overnight hospital beds. The target for the year was 95 per cent but the actual result was 97 per cent. The target you have set for this year is actually 93 per cent and the long-term target is 90 per cent. How are we going towards achieving that? Are these targets still realistic?

Mr Cormack: The literature tends to suggest that, if you want to get on top of access block and improve the timeliness of your emergency department performance, an occupancy rate for your acute beds of 90 per cent is a good one to aim for. We, like almost all jurisdictions that have teaching hospitals within them, have had quite high occupancy rates. We believe the long-term target is sound, and there is plenty of evidence in the literature to suggest that that is sound.

I think it is important to note that the key to getting your occupancy rate down is managing two different variables. The first is ensuring that you continue to build up your bed base, and we have done that. There are quite significant enhancements in bed capacity—that is, bed capacity across all service types. It is bed capacity in the emergency department, ICU, subacute care, acute care and the provision of services in the community. You have to keep your capacity up.

The second variable is that each year demand for services grows, so you have to be able to keep the capacity moving in line with the growth in demand. A factor that underpins your success in getting your occupancy rate down is not just about government appropriations for additional bed capacity—of which we have had quite a bit over the last couple of years—it is actually being able to staff up those beds. We compete internationally for nurses, allied health staff and doctors. To be able to keep that capacity up is not simply a matter of finding the money; you also have to find the staff.

In answer to the question, we believe the 90 per cent long-term target is certainly the way to go. At certain points last year—you can see it in our quarterly public health performances report—we got very close to our 95 per cent. As demand continues to grow, if we are clocking up a six and seven per cent increase in emergency department presentations, a five per cent increase in elective surgery and a two to three per cent growth in admitted hospital activity, it is going to move around a bit. The important thing is to set the target and to have the resources and the work force strategy available to be able to bring that occupancy rate down in the medium to long term.

MR SMYTH: Long term is what—three years, five years, seven years?

Mr Cormack: We would like to be able to get down to 90 per cent in the short term, but we will be reviewing our success on a year-by-year basis. That is the long-term goal. I cannot advise you exactly when we would be able to achieve that. The principal limiting factor is the availability of work force.

THE CHAIR: I would like to apologise for bringing her back, but could Dr Brown come back to the table? I have one more question with regard to mental health.

MR SMYTH: While Dr Brown is coming back: minister, on Thursday in question time you mentioned the step-down facility—in December or possibly early next year.

When is it likely to open?

Ms Gallagher: I was of the understanding it was late December, but I am not sure if there have been some delays to that.

THE CHAIR: That is the youth step-down facility?

Ms Gallagher: The subacute facility.

MR SMYTH: The subacute facility at Calvary.

Mr Cormack: The construction is nearing completion. I guess practical completion will be towards the end of December or January, but there have been some delays in that process. As you would be aware, there is a lot of competition for skilled labour at the moment. The more likely commissioning time for the second and third wave of the sub and non-acute service would be February and onwards.

MR SMYTH: Thank you.

THE CHAIR: Thank you—and apologies. My question relates to strategic indicator 4 on page 215, which is reducing the usage of seclusion. The variance is quite large. I note that the explanatory comment about that is:

> … there was an increase in the acuity of patients admitted to the Psychiatric Services Unit at The Canberra Hospital, including young people with psychosis with comorbid drug use, since the target was set.

With regard to that, can you provide the committee with an indicator of the proportion of patients requiring seclusion because of that psychosis, and any other factors contributing to increased acuity of patients presenting to the PSU?

Dr Brown: Approximately 10 per cent of our clients admitted to PSU with acute psychosis currently experience an episode of seclusion at some stage during their admission. That is clearly higher than we would like. We have a seclusion and restraint working party established, looking at strategies to reduce that. That is a high priority for us.

In terms of other factors that are contributing, as you have seen listed in the report, we have reason to believe that increased use of methamphetamine is contributing. Persons who have taken methamphetamine quite characteristically present with agitation and aggression as a common feature of their presentation and are often not open to any rational discussion or de-escalation that one would utilise for other agitated clients. So seclusion for that client group is often the safest means of containing their behaviour at that point in time.

THE CHAIR: I am not a chemist, so I do not know but I understand there is a difference between amphetamines generally and crystal methamphetamine. Are you talking specifically about crystal methamphetamine?

Dr Brown: Yes; ice.

THE CHAIR: In the Assembly last week the committee announced that they would be doing an inquiry into that. I was going to move on to that issue as well. That was going to be my next question—whether or not it was crystal methamphetamine, or ice, that was causing the problems. I want to ask a question but, the way it is currently written, I do not know that it is necessarily correct. Has there been an increase in the use of crystal methamphetamine? Would you be able to say?

Dr Brown: I can just give you informal reports and opinions. I cannot actually give you any hard statistics. The national drug survey would give us a better indication of that. I am not sure whether Dr Guest is able to speak to that. Certainly, informally the advice I receive is that mental health services, police, ambulance and the emergency department are dealing with more people who they believe have taken methamphetamine.

THE CHAIR: So it has had an impact on accident and emergency services as well.

Dr Brown: Yes.

Ms Gallagher: We can obviously provide you with a lot more information about that, perhaps in the context of your inquiry. The government will make a submission.

THE CHAIR: We have written to you, minister, with regard to that inquiry. Hopefully if Dr Guest or that area has something to add, we might get them to come along as well.

Ms Gallagher: Yes.

THE CHAIR: It is one minute to one. I have several more questions but I am happy to place them on notice.

MR SMYTH: In looking at the finances, I notice that on page 146 your expected cash and cash equivalents was about $5 million and it came in at $42 million. Note 21, which is right at the back, says that it is really because of cross-border payments that it has gone from that level to the high level. It says:

> The increase in Total Cash and Cash Equivalents was due to the receipt of a higher level of Cross Border revenues toward the end of June.

What was the cause of that higher level? How was it so unexpected that you were out by about $37 million?

Mr Hewat: As to the cross-border component of that, there was a very large cash payment from New South Wales at the very end of June of around $16 million. We were expecting that money to come in, but not expecting it to come in at the end of 2005-06. That was the largest single component there.

MR SMYTH: Because that came in unexpectedly, it helped the balance sheet, in that otherwise the budget would have overrun by how much?

Mr Hewat: We would have still been recognising the revenue. The majority of that would have been still recognised in revenue, so it would have been accrued. It was just that the cash, the actual payment, arrived.

MR SMYTH: It just turned up.

Mr Hewat: Yes. It was a straight timing issue.

MR SMYTH: What effect does that have on the 2006-07 budget, given that you got the cash last year?

Mr Hewat: In relation to revenue?

MR SMYTH: Yes. Will that affect the outcome you are expecting for the 2006-07 year?

Mr Hewat: Not in relation to revenue, because we were going to be booking the revenue anyway.

MR SMYTH: It will be accrued to costs?

Mr Hewat: Yes. From a cash point of view, with the changed cash arrangements where we do not hold large cash balances within the department, that money has been transferred back to Treasury. There will not be an impact.

MR SMYTH: That is held in CFU?

Mr Hewat: It will be in the CFU, yes.

MR SMYTH: Thank you.

THE CHAIR: Minister and officials, thank you very much for making your time available today. As I said, there will probably be a few questions on notice.

The committee adjourned at 1.02 pm.