LEGISLATIVE ASSEMBLY FOR THE AUSTRALIAN CAPITAL TERRITORY

SELECT COMMITTEE ON ESTIMATES 2009-2010

(Reference: Appropriation Bill 2009-2010)

Members:

MR Z SESELJA (The Chair)
MS C LE COUTEUR (The Deputy Chair)
MS A BRESNAN
MR B SMYTH
MS J BURCH

TRANSCRIPT OF EVIDENCE

CANBERRA

TUESDAY, 19 MAY 2009

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

By authority of the Legislative Assembly for the Australian Capital Territory

APPEARANCES

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Amended 21 January 2009

The committee met at 9.28 am.

Appearances:

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

ACT Health
Cormack, Mr Mark, Chief Executive
Thompson, Mr Ian, Deputy Chief Executive, Clinical Operations
Brown, Dr Peggy, Director and Chief Psychologist, Mental Health ACT
Cahill, Ms Megan, Executive Director, Government Relations, Planning and Development
Guest, Dr Charles, Chief Health Officer, Population Health Division
Foster, Mr Ron, Chief Finance Officer, Financial Management Branch
Reading, Ms Jenelle, General Manager, Community Health
Smalley, Mr Owen, Chief Information Officer, Information Services Branch
Kennedy, Ms Rosemary, Executive Director, Business and Infrastructure
O'Donoughue, Mr Ross, Executive Director, Population Health Division
Ainsworth, Ms Brenda, Director, Access Improvement

THE CHAIR: Good morning, minister and officials, and welcome to the third day of the estimates hearings. Today the committee is meeting with the Minister for Health and departmental officials from ACT Health. Minister, would you like to make an opening statement?

Ms Gallagher: Thank you. Yes, I will make a fairly brief opening statement, if I can. As members would be aware, the 2009-10 budget for health has taken place in a very challenging economic environment for the ACT government. It has also taken place in the context of a major reform to commonwealth and territory financial relations, where partnerships to address the key priorities both in the ACT and across the country have been forged. Our health budget has made commitments that link in with the recent major commonwealth commitments in health.

The health budget also complements our overall infrastructure package within the broader budget, to which we are deeply committed. In the ACT over the past year, health has continued to experience record levels of demand for services and we have responded by factoring in guaranteed growth funding in the key areas of pressure, particularly on the hospitals, care services for older Canberrans, mental health and cancer services.

No matter what else we do in health, the ACT government has a responsibility to make appropriate provision for the current and future demands that our system faces. Despite the fact that reducing health expenditure over our forward estimates would certainly have assisted our bottom line, we have made the decision not to do that and to factor in growth in health year on year right across the forward estimates.

Some of the challenges facing health in the ACT and indeed across the country and probably across the world, I would imagine, are areas such as workforce, chronic disease, early intervention and prevention, building appropriate infrastructure,

efficient use of the health dollar and the embracing of technology. In the 2009-10 budget you will see initiatives that go to all those areas of challenge in particular. We can work through the initiatives, I imagine, through the course of the day. This budget has the single biggest allocation that I can recall in terms of embracing technology and implementing e-health systems to support not only the public health system but the entire health system across the ACT.

There are a number of other exciting initiatives in the budget. They primarily go to supporting areas of growth in health service demand that we are seeing across the country but also are looking at how we support our workforce, how we work with general practitioners and how we implement new models of care to address areas of pressure across the health system.

In terms of the budget and the challenges that we face with finance, you will see that health was a major winner in terms of the dollars allocated through this budget. We do not apologise for that. We think that health will always remain the number one issue for state and territory governments, with the number one cost, but that is not to say that we do not constantly look at ways to improve our efficiency, improve our outcomes and improve the costs of providing health services to the ACT budget.

Health has not been exempt from the efficiency dividend. We are seeking a one per cent efficiency improvement from Health, and Health, like other agencies, will have this year to work through how they can deliver that return of just over $6 million to the budget, with a focus on protecting front-line health services.

But there is a lot in this budget for health and I know we have got almost two full days to go through it. My officials and I are here ready to assist you with your questions.

THE CHAIR: Thank you, minister. I will start. You talked about finding efficiencies in the health budget going forward. I think it amounts to around $19.8 million in the three outyears. Are you able to talk us through what will be the process for finding those efficiencies, including what will be the community consultation?

Ms Gallagher: Yes, sure. The efficiencies being sought are a one-off, just over $6 million cumulative total, though that is repeated, but we are not actually asking health to find $6 million and then another $6 million and then another $6 million.

THE CHAIR: So they will find $6 million, which they will then have to keep in the outyears, obviously. They cannot then return to spending that money.

Ms Gallagher: That is right. People should understand that we are not ripping $20 million out in one year, that it is a $6 million savings which is then factored across the forward estimates. I might hand over to Mark about how he is going to manage that internally.

In terms of the one per cent efficiency dividend, I was not necessarily thinking of consulting with the community about internal agency savings but I am sure, as we lock down the process for the community conversation, that really was going to be targeted at the unallocated savings, which is a significant task nonetheless.

THE CHAIR: Will some of those unallocated savings come from health?

Ms Gallagher: They are unallocated.

THE CHAIR: You are not ruling out that they will come from health? There is no particular area that is being quarantined from those savings?

Ms Gallagher: No. I think it would be difficult to find savings in addition to that. I think one per cent is a fair thing to ask of Health. I think, in addition, it would get difficult to deliver savings that did not impact on front-line services. Health remains the agency within government that faces the most substantial growth pressures out of any agency; so we have been pretty upfront that demand for health services continues to grow, that we need to factor in growth money for that. Without pre-empting a process that is going to take the next year, I would be surprised if we can find any significant additional savings in health that do not impact on what we currently provide to the community.

MS BRESNAN: Could it potentially affect community organisations that are providing services?

Ms Gallagher: The one per cent?

MS BRESNAN: Yes.

Ms Gallagher: Again, I guess it is difficult to answer when we are at the beginning of a process that is designed to examine where that one per cent should come from.

MS BRESNAN: I understand that. If it is going to potentially affect those sorts of groups, I would imagine they would be involved; they would be consulted if that was going to occur?

Ms Gallagher: Absolutely. Again, the focus has very much been on looking inside the agency rather than looking to cut services or to reduce services outside.

THE CHAIR: Before you hand over to Mr Cormack, you have just made the comment, though, that it would be difficult to find the savings without cutting front-line services. Isn't every minister going to come to the table with that very position? Surely the Minister for TAMS will say, "We cannot really find the savings other than by cutting services." The minister for education will say the same thing. That does not really get you anywhere, other than to say that it is going to be a challenge.

Ms Gallagher: Which I have said already, as well.

THE CHAIR: Indeed. But the question then becomes: will you be looking for part of those unallocated savings in health or have you broadly written off health; the one per cent efficiency will be all?

Ms Gallagher: I have not written off anything. They are unallocated savings and we are going to embark on a task over the next 12 months to work through how we allocate those savings.

THE CHAIR: But you do not believe that many can be found without affecting front-line services?

Ms Gallagher: I think, in terms of the fact that demand for health services continues to grow, I would say yes, it would be difficult. We can have a look at everything we do. We will talk to the community on what they think about health services—in fact, what they like, what they do not like. I have spoken to my Health Council. They are going to embark on a fairly aggressive community consultation process that might include things such as deliberative democracy, talking with people about what they expect from Health, what they are prepared to pay for health, what they currently pay for health, and really open this discussion up.

THE CHAIR: Talk us through some of that potential community consultation on health.

Ms Gallagher: That has not been determined.

THE CHAIR: No, but you are flagging some of the things you might do.

Ms Gallagher: I have talked to the Health Council and I have asked them to undertake a piece of work on my behalf. They have agreed to do that. They will come back to me on how they are going to do that. They are my peak advisory council in health and they have asked me what I want out of them for the next year, and that is what I want out of them. I want them to undertake a piece of work on my behalf.

We have tried in the past to hold general public meetings. That has not worked. We have usually got about 10 people to those. So I am asking them to consider different ways of engaging with the community that are not just a letterbox drop or a public meeting per se—to talk on health, the cost of health and what people are prepared to consider in either how much they pay for it or what they expect in terms of service delivery. It will be a pretty honest discussion.

At the moment I think people expect and receive first-rate public health care in the ACT but that comes at a cost to the budget—a considerable cost, a cost that is growing all the time. I think it is a fair enough discussion to have with the community on meeting expectations, with capacity to deliver.

THE CHAIR: It will be done through this advisory group who will then determine what kind of consultation is undertaken? Is that right?

Ms Gallagher: They are going to get back to me—they meet monthly—once they have discussed it more openly amongst the entire council. I have met with the chair and deputy chair on this.

MR SMYTH: Have you given the department any direction on how you expect any savings to be found?

Ms Gallagher: The direction I have given is that they have a year to work through and then I expect front-line services to be protected.

MR SMYTH: Have you given them any suggestions from your experience as health minister on what you think could be enough?

Ms Gallagher: No, I have not. I have left it open. The chief executive is an extremely competent individual, as is his executive team, and this is a responsibility I have charged to them.

MR SMYTH: So you have not got any ideas on where savings can be made?

Ms Gallagher: I have a whole range of ideas floating around in my head—flying around my head actually; they do not really float. But I have given them, as I have given to all agencies, as Treasurer, the job to come back to budget committee with a list of where they think savings can be made. I think that is fair and reasonable. I am not going to tell them how to do their jobs.

MR SMYTH: In your conversation as Treasurer with yourself as health minister, what are your ideas? You are the health minister; you set the parameters; you give the direction. What are you telling them about how you want it done?

Ms Gallagher: I have already told you the directions I have given.

MR SMYTH: Just "find some savings but do not do it at the front line"?

Ms Gallagher: I have said, "This is the savings task. I would like front-line services protected." I expect that Health will come back to me with a list of possible savings options. I am sure Mr Cormack has already started that work.

MR HANSON: Given that the one percent is going to basically leave essential services alone—that is your guess at this stage, because you have not done the analysis—you have got $122 million of further savings over the four years across the budget. You are going to be going back to Health, I imagine then, to say, "We want to look at what further savings can be made." You are saying that that then will have to come from services.

Ms Gallagher: No, I have not said any of that. No.

MR HANSON: That is the impression that you gave, because you said that there is one per cent and to go beyond that you would have to start cutting into services. That is what you said before.

Ms Gallagher: I have not said anything on the unallocated savings.

MR HANSON: What I am saying is that you have—

Ms Gallagher: They are unallocated.

MR HANSON: You have got unallocated—

Ms Gallagher: That is why they are called unallocated savings.

MR HANSON: Sure. But you have got to take them from somewhere. Are you then saying that you are ring-fencing Health?

Ms Gallagher: You are presuming that they are all—

MR HANSON: Are you ring-fencing Health then? Are you quarantining Health from those further cuts?

Ms Gallagher: No-one is quarantined. The discussion has not even started. The budget has not passed. The discussion has not started. We have got a job before us that is going to be extremely challenging and nobody has been exempt from that.

MR HANSON: What I am asking then is: over the next 12 months, as the department is looking at those initial one per cent of savings, are you going to ask them to start looking at what cuts to services that they could make in a prioritisation so that you can look at what further savings you can make out of those unallocated cuts that you have got to make?

Ms Gallagher: No.

MR HANSON: You are not going to ask them to do that process?

Ms Gallagher: I am asking them to find one per cent. That is what I am asking them to do this year. That is the job that they have before them.

MR HANSON: Then how are you going to go through the process of identifying the further cuts that have got to be made out of that $122 million, if you are not going to ask the department what services they are going to cut?

Ms Gallagher: That is a separate piece of work that also has not been started yet.

MR HANSON: But they are going to be doing that over the next 12 months, are they not?

Ms Gallagher: Who is going to be doing that?

MR HANSON: I assume that someone is going to have to look at where savings can be made across the board, including in Health?

Ms Gallagher: You do realise that the savings target we have set ourselves is around $60 million per annum; so we do not have to find $122 million of savings next year. The process starts and it gradually builds up.

MR HANSON: But if you do not start making the decisions this year—

Ms Gallagher: Indeed, we have found some of those savings already and then there is additional work to be done. In that process, in terms of allocating those savings or indeed revenue measures, nothing is off the table.

MR HANSON: Sure, but what I am saying is that work happens this year, does it not?

Ms Gallagher: It has not actually started.

MR HANSON: What I am asking then is: when does that process start to identify those extra savings?

Ms Gallagher: Which process are we talking about—the one per cent or the unallocated savings?

MR HANSON: No, you have covered the one per cent.

Ms Gallagher: Right; thank you.

MR HANSON: I have got it.

Ms Gallagher: Excellent.

MR HANSON: What I am saying is that beyond there you have got $122 million that you are at the moment not worrying about, or you are saying you are going to worry about that later?

Ms Gallagher: I am worrying about it a lot actually.

MR HANSON: When does the process start to identify what cuts need to be made? Are you ring-fencing health or are you saying no, we are going to cut to health?

Ms Gallagher: I have answered all your questions.

MR HANSON: No, you have not.

Ms Gallagher: The process starts this year and no-one is exempt.

MR HANSON: And I am asking you about that process.

Ms Gallagher: And this is the third time I have said that.

MR HANSON: How is that process going to work so that you can actually say what services are going to be cut? I assume that is the way it is going to work then, because, if you are saying beyond one per cent you are going to have to cut services, how does that process work and what services are you going to start prioritising? Are you going to give that guidance to the department or will the department give you that advice? How is that process going to work?

Ms Gallagher: In regard to the process on the unallocated savings—and I do not know what trouble you are having here understanding the concepts; they are fairly easy—Health is in charge of returning one per cent of its budget to government.

MR HANSON: Got it.

Ms Gallagher: Good. Then there is another process on unallocated savings.

MR HANSON: That is the one.

Ms Gallagher: I have not outlined the process on that.

MR HANSON: And you are not going to?

Ms Gallagher: That work will happen over the next 12 months but we can start a bit early. We will have it done before the budget passes. Indeed, I said yesterday that the process that we are going to embark on, on how we are going to find those savings, I will have finalised by the time the budget is debated in mid-June.

MR HANSON: Sure, but given that those cuts are going to come out of services, because you said beyond one per cent—

Ms Gallagher: They may not.

MR HANSON: I thought you said beyond one per cent would need to come out of services; that was your view.

Ms Gallagher: It may not. The process has not actually started. The conversation has not started. We are having the conversation with the community, something this time last year you guys were urging us to do. We have taken some of your advice and we are applying it.

THE CHAIR: I will finish on this and then I will be happy to go to other questions. Are you going to give direction then on that? You have said, on the one per cent, not front-line services and that is the extent of it. Will you be giving directions in relation to your agencies, particularly Health, on where they should be looking for the savings, what areas are reasonable to find savings in?

Ms Gallagher: I think I have outlined that in terms of the direction I have given to the Health Council, which is: I have asked them to do a major piece of work on engaging the community. I have already given that direction.

THE CHAIR: So that is the process but, in terms of direction to your department, you will give direction or you will not?

Ms Gallagher: The direction to the department has been on the one per cent.

THE CHAIR: I understand that. We have covered that. On this other unallocated area, will you be giving direction or will you simply be saying to your department, "You need to find another X million dollars in savings"?

Ms Gallagher: No, I am not asking them to find additional savings at this point in time. I am asking them to find one per cent and I have directed the Health Council to undertake a major piece of work across the ACT in terms of cost of health, expectations about service delivery and capacity to deliver. It is pretty clear.

THE CHAIR: Ms Burch, did you have a question on this area?

MS BURCH: I do. We were going to go to Mr Cormack on some of the savings that are found. Given that interest in savings, I would be interested in that discussion.

THE CHAIR: I think we are about to move there once we have done with the minister, but if you would like to move there we will be very happy to. Mr Cormack, you were going to elaborate on the one per cent?

Mr Cormack: I think the best way to answer this question is to look at how health is addressed—the challenges of delivering efficient, accessible and timely healthcare services over the years: what we are currently doing, what we need to do in the next 12 months, and, probably most importantly—and this is really the context of this budget and the previous budget—what we need to do over the medium to long term. I will come to an answer to each of those questions.

Just to confirm it, the minister's instructions to me are clear: no cuts to front-line services. And she has not specified any particular areas within the portfolio that I need to focus on to be able to achieve the necessary 2010-11 one per cent. We just need to be clear on that.

But I think what we need to do is to also go back to the 2006-07 budget, which for health introduced a number of key parameters. The first one was the growth funding envelope, and that has been a feature of the subsequent budgets since 2006-07. But most importantly, in the context of savings, there has been the requirement that Health achieve over a five-year period its public hospital costs being down to within 110 per cent of the national benchmark cost structure. That has been a piece of work that we have been undertaking on an ongoing basis. We will bring forward that work into the 2009-10 financial year as well.

It is important to note the progress that Health has made in responding to the government's directions in the 2006-07 budget. At that time, ACT Health's costs were 24 per cent higher than the national benchmark, based on 2004-05 Australian Institute of Health and Welfare data in hospital statistics published midyear each year. In the 2005-06 data, we have brought those costs down to 15 per cent above the benchmark average; in the 2006-07 data we have brought that down to 13 per cent. So we are on a trajectory of improving the efficiency of our hospital system. That is measured by the unit cost of production benchmarked against other jurisdictions. The data for 2007-08 will become available in the near future; we are optimistic that that trend will continue, but we do not have the finalised figures available to us.

That is an important context, and we have maintained that drive towards improving the efficiency without service cuts. There have been no service cuts since 2006-07, particularly in the hospital areas. That is the important point.

The next issue is how we respond to the government's requirement of a one per cent efficiency saving to be achieved in 2010-11. I would like to reflect on that, because, first of all, we keep going with the effort that we have put in place over the last three budget years, as I have just outlined, but also we need to look at a number of areas

where we know there is some scope for improvement.

I will just identify some of those for you. One is the way we manage our leave. The biggest cost, clearly, in the public healthcare system is staffing costs, so it is important that we ensure that our rostering practices and our leave management practices are very tightly managed. If we find ourselves in a situation where we have insufficient staff to meet peaks in demand, we have to procure that staffing resource through agency and locum services, which can come at a very significant mark-up on the base cost of labour. So it is important that we continue to manage our leave. That is around rostering, workload management and activity planning, and that is ongoing work.

Related to that is the need to ensure that our overtime usage is carefully managed, there are appropriate controls in place and those controls are being implemented to ensure that overtime is well managed. We have made some improvements in that area.

Another area is to continue to ensure that we build on procurement reforms—that we are able to access the best possible price for the consumables that we use in the delivery of healthcare services, that we keep an eye on discretionary expenditure. As I mentioned before, we do have a particular objective in reducing our reliance on expensive agency and locum staff.

They are the sorts of initiatives that I will be pursuing with my colleagues to respond to the minister's direction around delivering up a one per cent productivity saving in 2010-11.

The third aspect is really the medium to long term. The context of this budget and the previous budget is around the capital asset development plan. That requires us to take a more structured approach to how we will deliver services in the future. As we begin to implement aspects of the capital development program, we are able to revise models of care. We are currently doing that in areas such as women's and children's health, in preparation for the women's and children's hospital; in mental health, in preparation for the new mental health facilities; in surgical services; in community based services; et cetera.

So there is a much more systematic review of the models of care to make sure that we are delivering the best possible services for our patients and our clients but also doing so in the most efficient manner that reduces waste.

I think that is a reasonable summary of how I would respond to the minister's requirement that we deliver up the productivity savings from 2010-11.

THE CHAIR: Thank you very much. Ms Le Couteur has some follow-up questions for the minister.

MS LE COUTEUR: Thank you. I want to go back to your interesting comments about deliberative democracy. Firstly, what is the scope that you are giving your group? Are they looking at what the health budget should encompass? Are they looking at the breakdown between preventative and acute care and between mental health and community services?

Ms Gallagher: I am hoping that all of that—

MS LE COUTEUR: It sounds really interesting.

Ms Gallagher: Yes. I am hoping all of that is still part of it. I have asked the Health Council to come back to me. They were very excited about focusing on an exercise like that as well. I have asked them to come back to me with their ideas about how they would like to scope that work. That council is a representative of a number of health organisations. It is led by Kate Moore, and the deputy chair is Russell McGowan, as many of you will know, and then there are representations from the Division of General Practice. I am trying to think of them all; it is about a 15-member council.

The reason I would like them to consider a model such as that was that when, a couple of years ago, we embarked on a similar process to engage the public in the provision of health services and what they would like to see, we did not get a really great turnout at the meetings we held. We have just gone and consulted the community on the walk-in centres. We held public meetings. We had a discussion paper. The discussion paper works for organised health stakeholder groups, but does not really engage the community. Again, the three meetings we held on the walk-in centre were not well attended at all. In fact, I think it was numbers of less than 10 at each of the meetings.

There has been a genuine desire to engage on health issues with the community, but I have been frustrated in terms of trying to get that model right. I have asked them to consider a deliberative democracy type approach. I have not given them firm directions. Again, if there are people interested in how we scope that work, I would be more than happy to take ideas on board. But yes, it is to look at the extent of the services we provide. I am sure the focus on the acute sector will come up as part of that work, but it is also around expectations and cost.

This is probably a debate that we as a country should be having nationally, but that is not happening. The ACT is a good place to start. It is a difficult discussion, because Medicare, particularly, is such a loved part of our community. But when you look at the data, the costs of providing health services and the expectations around health services do not really run alongside each other.

MS LE COUTEUR: Can you tell me a bit more about the deliberative democracy part of it as distinct from what we are going to be talking about? How do you envisage that working?

Ms Gallagher: I have asked Kate and her group to go away and come back to me with a proposal about how that would work. Again, it could be randomly selecting a number of Canberrans across a random sample and bringing them together. We did some of this in disability: the Disability Advisory Council did it a couple of years ago. I thought that model worked quite well. The selected community members were engaged almost in a situation like this; bureaucrats and ministers turned up and engaged with them in that sense. That was quite time consuming; we were lucky that there were people that wanted to engage at that level. But again, there are different models. I have asked the Health Council to come back to me on the way they think we

could manage it the best, in terms of trying to get very good engagement and participation from a sample of the ACT community.

THE CHAIR: I will go to Ms Bresnan in a second, but just following on from one of those comments, let me ask this. You talked about Medicare being much loved and you seemed to be leaving open the possibility of more user pays in some of your discussions. Can you elaborate on that?

Ms Gallagher: No, I am not. For me, as health minister, watching the budget grow, as it continues to grow—we have very good access to a public health system here, and that is shown in all of the national data about utilisation of our public health system. But the cost of providing health care continues to grow at a pretty rapid pace. If people want the same level of services that they are getting now, we have to look at what that means in terms of how we fund it. It is an honest discussion. I have not formed a view that we have to impose charges on services in the public health system here—outside the hospital in our community health system. I have not formed that view—

THE CHAIR: But that is something that is under consideration?

Ms Gallagher: I am not ruling it out as part of this discussion that I want the Health Council to have. Why would I rule stuff like that out when I want a discussion about expectations, services, growth and how we meet those costs as a community? The answer to this might come back that we do not want all those services—the community health services—and we should just focus on the hospital. I doubt it very much, but it may come back like that. It may come back that people want to pay more for their health services. I do not know; I do not want to pre-empt it.

I do think that the time is right for a discussion around how we get health and health funding right. The Canberra community are smart enough to engage in that without fear of any underlying pre-decision or decision that has already been made by the government. It simply has not.

THE CHAIR: Ms Bresnan?

Ms Gallagher: I have to say that our health budget, as it continues to grow—this is not a problem for this government; but in years to come, for other governments, if Health continues to grow at the point that it is growing now, there will not be any other money for other services in the government, because it will just continue to consume larger and larger slices of the pie. I think that, at this point in time, any responsible minister undertaking a massive reconfiguration of the health system, with reform of the way we do things, looking at new roles coming in, a new workforce and the use of e-health as technology to support that infrastructure—why wouldn't we be looking at the system as a whole and expectations around that system? I think the time is right and I think the community is educated enough. Hopefully, we can find enough of them who will genuinely want to engage in that discussion.

THE CHAIR: Ms Bresnan?

MS BRESNAN: Thank you, Chair. Yesterday, in looking at Treasury, we were

talking about the indexation for community organisations. You did actually note, minister, that we would need to be less demanding of community organisations in terms of what they can provide and reflect that in their outputs. I have had concerns raised with me, particularly with community health organisations, about having to provide services for the AMC—that they are having additional outputs put into their contracts.

Ms Gallagher: Yes.

MS BRESNAN: That has been mentioned in discussions but they are not receiving additional funding for that. I am just wondering, given that conversation which we had and the fact that there are additional pressures being placed on these community health organisations, in particular in relation to the AMC, how that process is going to be managed, given the discussion we had yesterday. It is a reality that we have got the AMC opening and there is going to be demand for services both in there and when people get out of prison.

Ms Gallagher: Yes. I know you and I have gone to this in questions on notice and questions without notice. I have to say that I cannot recall having this raised with me by a community organisation providing services at the AMC, although I can check that. I am more than happy to follow up. I do this all the time where organisations come and say, "Look, we cannot meet this output" or "We are really stretched; our work has grown to this point." I am happy to look at how we can accommodate that.

Health probably have not caught up with the comments I made yesterday. This was around the indexation at 3.15 being less than what community organisations were expecting to get. The point I was making was that we have to be considerate of our expectations of community organisations as we roll out this year the indexation arrangements. We are forecasting that that returns to a more normal situation next year. But I am working in the absence of specific information about what people are finding hard here.

MS BRESNAN: I am not in a position to name organisations.

Ms Gallagher: Sure.

MS BRESNAN: But I do have names of organisations.

Ms Gallagher: Yes.

MS BRESNAN: The issue, too, is that, when organisations are renegotiating their contracts, there is a power imbalance there, in a way. They are worried, obviously, that, if they do question anything around that, they feel they are in a position where funding could be involved. It needs to be recognised that that is an issue.

Ms Gallagher: Yes, sure. It is not my expectation of dealing with NGOs that they are worried—

MS BRESNAN: No, but you can imagine—I know, but that is their—

Ms Gallagher: I accept that.

MS BRESNAN: The thing is, too, that the AMC is opening. These community health organisations are being asked to provide services, but no additional funding is coming through. I appreciate there is a corrections element there as well, but I know corrections health are working on this.

Ms Gallagher: Yes.

MS BRESNAN: I know you have said that you have not had any particular issues brought to you, but this is an issue which has been raised, and it has been raised in a couple of forums with me. How is that going to be addressed given the conversation we did have yesterday as well?

Ms Gallagher: The best way for me to deal with that, in the absence of issues being raised directly with me, is that maybe those organisations are gently asked—or just asked—to raise their concerns in a more formal way so that I can pursue them.

MS BRESNAN: Sure—appreciating, too, that it is, I can understand, too, coming through corrections as well that this is an issue.

Ms Gallagher: Yes.

MS BRESNAN: Obviously, that is not in your portfolio.

Ms Gallagher: Yes.

MS BRESNAN: I guess that comes to a point—

Ms Gallagher: Corrections health is, though.

MS BRESNAN: Yes, I know corrections health is. There are a number of different forums which are happening, particularly with the AMC, about how that is going to be approached in terms of services going in there. That comes to the issue of that cross-government issue there as well, where it is a cross-government issue but there does not appear to be a lot of cross-government negotiations going on—working out how that is going to be dealt with.

Ms Gallagher: Yes.

MS BRESNAN: I am just wondering, in relation to that, if there is anything happening and if that is going to be dealt with. And is there going to be recognition about it being an issue?

Ms Gallagher: Around?

MS BRESNAN: Around the health services that are going to have to go in there and then otherwise when people get out.

Ms Gallagher: Do you want to add something, Mr Cormack?

Mr Cormack: I can only add a little bit to what the minister has already said. Any response or any request from NGOs for assistance, either due to their present circumstances—NGOs, like government organisations, sometimes face forces majeure, and we need to be able to respond to those sorts of things. Certainly we are regularly in touch with a range of non-government organisations to respond to those sorts of concerns. I would just suggest the same as the minister has suggested—that they put those concerns to us. We will respond to them on a case-by-case basis.

There are mechanisms established within the sector, some mechanisms being established within the sector, to be able to get a sector-wide approach on certain issues. Those forums are a good opportunity for people in the sector to raise those with us. I cannot recall having received a formal request for assistance for services arising from demand due to the AMC that we have not responded to, but I am happy to check the record on that.

MS BRESNAN: I can follow up with some of those groups.

Ms Gallagher: Yes.

Mr Cormack: That would be great.

MS BRESNAN: And get that information to you, have that discussion.

THE CHAIR: Ms Burch, do you have a follow-up?

MS BURCH: It is. The health services provided at AMC—are they all through NGOs or are ACT Health services in there as well?

Ms Gallagher: ACT Health provides the major component of services within the AMC. NGOs are certainly a provider of services as well. But our employees, ACT Health employees, run the health centre at the AMC.

MS BRESNAN: There is a therapeutic community as well which is going there, which is being run by an NGO.

MS BURCH: Are those services staffed and—

Mr Cormack: We might ask Jenelle Reading to talk to us about health services at the AMC.

Ms Reading: I am Jenelle Reading, General Manager, Community Health, and the corrections health program falls within the programs that I manage.

THE CHAIR: I am not sure if there was a particular question to Ms Reading.

Ms Gallagher: Can you list some of the NGOs that provide a service and also what corrections health provides?

Ms Reading: We provide generalist services to the AMC. We have got visiting

medical officers, we have got nursing services, we have got mental health services and we have a whole range of specialist services. We have an agreement with the acute sector for a pain clinic and for management of sexually transmitted diseases and other infectious diseases.

What we work towards with NGOs is clearly identifying the roles of referral processes for when people are actually leaving the facility. That might be, for example, for a client who is opioid dependant, making sure we have a good referral process through to the alcohol and drug program for the continuing care that he or she requires, plus case management services for any referral to non-government organisations that might be required. We also have good relationships with the Winnunga Nimmityjah, and we have Aboriginal liaison officers that assist in this community as well.

MR HANSON: Where are we at with the NSP as part of health policy within the AMC?

Ms Reading: There has been no decision from my perspective on this.

Ms Gallagher: The government's position remains the same—we are going to collect some data over the first 12 months of the operation of the AMC and review that data before making a decision around the needle and syringe program.

MR HANSON: So are you going to put a report together in about 12 to 18 months, is that right?

Ms Gallagher: That's right. In fact I think the timetable we specified was 12 to 18 months, from memory.

MR HANSON: Okay.

THE CHAIR: Ms Bresnan had a follow-up question on this, and then I will move to Mr Smyth.

MS BRESNAN: Just while we have got Jenelle here, I understand that there is not going to be a detoxification unit at the AMC, and that prisoners who are detoxing will be given their medications and transferred back to their cells. Is that correct?

Ms Reading: Each client or detainee, depending on what their needs are in prison, works through a harm minimisation strategy. Our doctors will put people on methadone programs. They will do it in consultation with the mental health staff for the requirements of what they need. There would be processes in place just to support the individual needs of clients, but we have not started working up a detoxification facility at this point in time.

MS BRESNAN: I guess I am just getting to the point of whether you have considered this, because there can be some quite severe side effects from detox or withdrawal, so how is that going to be dealt with?

Ms Reading: We have got medical clinics, we have got nursing services, and the detainees have the same access to medical support as we do in the community. We

have our doctors that are all qualified to prescribe methadone. Our doctors are very well trained in the other drugs that they might need to minimise the symptoms of withdrawal. Again, that is just managed within the facility, and there have been no major issues that I am aware of, even within the other facilities, that we have not been able to cope with. Our whole philosophy is the provision of services equal to what is available in the community sector.

MS BRESNAN: I appreciate that you cannot give stats off the top of your head, but do you have any idea how many prisoners there might be in the AMC going through withdrawal or detox?

Ms Reading: I cannot give you those figures, but, generally, from a statistical perspective, 80 per cent of prisoners have an alcohol or other drug issue. I am happy to provide further information out of session on what the national statistics are with that.

THE CHAIR: If you could provide that, that would be fantastic.

Ms Reading: Yes.

THE CHAIR: Mr Smyth.

MR SMYTH: Thank you, chair. Just a question for Mr Cormack: in light of the government's policy on wages for Australians—you said in your response to a question that an area that has scope for improvement was addressing the issue of using costly agency staff—how competitive are we in what we offer for nurses at this stage, and how will wage restraint assist you in your objectives?

Mr Cormack: I think that we are very competitive right across the board with all of our collective agreements—that's nurses, allied health and doctors. So, I think the overall position of the ACT has always been one of being competitive. There will be some aspects of some agreements in other states that would be better than ours but overall it is pretty good.

In relation to the issue of wage restraint, certainly when I discuss this with my colleagues in other jurisdictions, we are all in the same boat here. I don't know of any other jurisdiction in Australia that is not subject to the economic conditions that prevail in the ACT. I think that each state and territory will respond to its government and its ministers in relation to wage restraint, as we will respond to ours, but we will remain competitive. Our working conditions in many other areas outside of collective agreements are as good if not better than anywhere else. So I am confident that we will be able to weather any issues arising from wage restraint that sit within the budget.

MR SMYTH: How do we compare, say, with New South Wales as the closest jurisdiction? Do we pay more or do we pay less?

Mr Cormack: It depends on which classification you are looking at, but generally speaking we compare favourably. At some levels we pay more; at other levels we pay the same or less. But we also have to look at the overall package that is offered here in

the ACT, particularly for nurses. We have got some very generous study support arrangements. We certainly have a different and more generous PBI FBT exemption that applies here compared to New South Wales—a favourite topic of yours, I believe, Mr Smyth.

MR SMYTH: Always a favourite topic.

Mr Cormack: So there are a range of other things, and you need to look at the total package. We have generally found that we remain a very competitive jurisdiction, albeit we lack a beach, which seems to be something that a lot of people prefer. We can't actually fund a beach.

MR SMYTH: When do the negotiations start on the nurses award?

Ms Gallagher: Now. I think the agreement expires on 23 September, so preliminary discussions have been had.

MR SMYTH: What are the key areas of staff shortage that we have?

Ms Gallagher: In nursing?

MR SMYTH: No, across the whole health department.

Ms Gallagher: Across the board.

Mr Cormack: We have shortages from time to time in some of the allied health areas—occupational therapy, physiotherapy, radiotherapy positions, medical imaging people. There are shortages in some categories of consultant level specialist medical officers, and some subspecialties within nursing are also in short supply. Mental health nursing is an area where we could always do with more. Intensive care nursing is another area where we could always do with more. Overall, it remains a challenge to recruit the necessary staff, but, again, when I compare our situation with that in other jurisdictions, we are doing okay.

MR SMYTH: Is it possible to get a breakdown of the positions that are currently vacant?

Mr Cormack: I am happy to take that on notice.

Ms Gallagher: Yes, I get a report once a month, I think, around positions. I can provide you with the latest one, as long as it is used carefully.

MR SMYTH: I am always careful.

Ms Gallagher: Which I doubt, but anyway.

MR SMYTH: Now, now, now.

MS BURCH: I have a further question on staffing. You make mention of the use of agency staff. You have noted a number of vacancies there, and there is some growth

across ACT Health. I would just be interested to know if there are items in this budget or within your operations to address the recruitment and retention of staff.

Ms Gallagher: Yes, sure. Do you want to do it?

Mr Cormack: Yes. Let's have a look at some of the initiatives in the 2009-10 budget. In budget paper No 3 there are some really very exciting initiatives regarding the health workforce that are being put in place here in the ACT. While we have done well in terms of competitive remuneration—we have been well supported in that—and in the typical activities of recruitment and retention, we also need to look at innovation and change. As the population grows and ages, there will be a bigger workforce shortage in the future than there is now if all things remain the same. So the challenge for us is to look at different models.

In the workforce development budget for this year we received $8.2 million over four years to expand and support the roles and activities of health professionals and to increase the potential recruitment pool and the attractiveness of employment with ACT Health. We have 15 health professional support roles—assistants in allied health and nursing. They will not be degree qualified, but they will be either diploma or certificate IV qualified workers who will be able to assist nurses and allied health workers. In fact, we have a very successful Australian-first program that was developed here in the ACT a number of years ago in allied health assistance run through CIT. So we have got 15 new health professional roles coming on board.

We have also got extended-scope-of-practice physiotherapy positions. Certainly in other parts of the world these physiotherapists are performing a different and a more advanced function than has traditionally been the case in Australia. So we have got one extended-scope-of-practice physiotherapy position in the emergency department and another in the orthopaedic unit. These two roles will greatly assist in dealing with musculoskeletal and minor injuries in the emergency department and will also work closely with our surgeons in relation to people on the elective surgery waiting list that require hip and knee replacement or revisions. To support the growth and development of our workforce we have got further clinical training and development roles for four enrolled nurses and five allied health positions. So that will make sure that we are well equipped to train and develop and deploy these new classes of workers.

We also need to look abroad, and we are looking at a partnership arrangement with a number of countries that will provide a two-way arrangement whereby nurses in particular who may wish to upskill and get an Australian-level degree qualification but who are otherwise very well trained and very experienced clinical nurses in their own country will be able to participate in an exchange program. That will enable us to assist with migration et cetera and recruit people from partnering countries and bring them into our workforce over a period of time—it may be three or four years, it might even be longer—and get them up to Australian-degree standard.

We get the benefit of a diverse workforce plus extra skills along the way, and they are then able to return to their countries of origin with a more advanced nursing qualification. That is a win-win, because we have an absolute shortage of nurses, and in some countries around the world they have got an oversupply. We have got a more

well-developed training and accreditation system for nurses than some countries, so we are able to do a skill exchange, a labour exchange. That is being funded in the budget.

We have got scholarship funds available for nursing and midwifery. We support 86 nurses and midwives every year through our scholarship program. The funding that has been made available in the 2009-10 budget will provide an additional 140 full scholarships over the next four years. So in 2010-11 we will have an 40 additional scholarships on top of the 86, which will take us up to 126. The following year there will be a further 50, which will take us up to 176, and in 2012-13 we will go up to 226 scholarships. That is greatly appreciated by nurses and midwives. It says, "We need you, and we are also prepared to support your study requirements and the cost that you bear in terms of undertaking training." They are just some of the workforce initiatives that are in place within the 2009-10 budget.

MS BURCH: While we are on allied health assistants, that is quite an innovative way forward in care. So you have identified those positions and given them a place?

Mr Cormack: We have done that work. Indeed, the partnership that we have established with CIT has also extended beyond the government sector as well.

MS BURCH: So going into the private and NGO sectors?

Mr Cormack: Yes, some are going into the private sector; some are going into the aged care sector. We are seeing a gradual change in acceptance, because this is a new category of worker.

MS BURCH: That is what I was going to ask around: what is the acceptance and support across the other health professions and the users of the service?

Mr Cormack: Generally speaking, it has been pretty good. We have not inundated the labour market place with large numbers of these people. We have just trained, I guess, manageable numbers each year. As these people find their way into the workplace, gain acceptance, they are supported. One of the budget initiatives that I just talked about is to support these new categories of workers. Then the workforce is able to adapt, become more flexible and have greater diversity in the sorts of people we have providing direct care. It helps to significantly ease the skill shortage.

We think it is the way of the future and we will continue on the innovative path that we have been on for the last four years. As I said, the ACT was the first jurisdiction to actually set up this arrangement and offer a VET qualification for these people. We are going to build on that great partnership that we have with CIT.

MS LE COUTEUR: I would like to ask the minister a full-on question about the overseas recruitment. I am talking here not just about nurses but about doctors and the whole lot. My understanding is that a significant amount of them are coming from countries where they have even more medical workforce problems than we do—a significant undersupply of health professionals and usually lower incomes. What do you think are the moral issues in terms of moving health professionals from a place where they are very scarce to a place where they are, compared to where they came

from, comparatively abundant? Recognising we do have a problem here, what are we doing to the rest of the world?

Ms Gallagher: The workforce, particularly medical and nursing, is an international workforce now. That is the reality of the market we operate in. We lose a lot of our local graduates to positions overseas and that requires us to look overseas to fill positions here. I understand the heart of your question but I also think there is a benefit, particularly for doctors and medical graduates from developing countries to come here and be exposed to the experiences they have in our health system before they return home.

There are some benefits for countries in the long run too and many of these doctors do come for a short period of time and then return overseas. Some do not, but some do. But they are exposed to our health system, which is very good, and it gives them the support and mentoring they need in order to take our skills back and invest in their own countries. But the reality, as I said from the beginning, is that country boundaries do not impact in terms of people making decisions about their employment any more. We are not exempt from that and we need to recruit doctors to fill positions.

We are growing our own local workforce. That was very much at the heart of the reason behind the medical school a number of years ago. We are seeing more and more graduates every single year wanting to stay and work in the ACT. That is pleasing because it means it reduces our reliance on looking overseas for graduates. We are focusing on our local workforce but certainly, at the end of the day, we operate in an international environment.

MR SMYTH: On that, is there data that supports what you said about people going home? What percentage does actually return to their country of origin?

Ms Gallagher: I am sure we can find that.

MR SMYTH: Take it on notice?

Ms Gallagher: I have spoken to a couple of doctors who have. Certainly.

MS BURCH: On that exchange, is that a new initiative or has that been going for some time? It is a new initiative? It has been going for some time?

Mr Cormack: No, it is a new initiative. We have had a number of approaches over the last couple of years that have led to some, I guess, informal discussions and we have had from time to time agencies approach us with a group of people from particular countries that indicate that there is a degree of oversupply in some countries. But we have decided to take an overall look at that and, I think, that is picking up some of the points that Ms Le Couteur just raised on ensuring that, if we do structure an overseas program and the numbers are significant, we are able to give something back and that the nurses in question get the benefits of learning here and a qualification that is better than what they had when they left their countries. So it is largely a new initiative for us and we will be working on that over the next few years to get it right.

THE CHAIR: Thank you. Moving to another area: minister, prior to the last election, I think it was 11 days from the election, you said that governments must put their plans on the table. You went on to say, "We have put our plans on the table." That statement was not true in relation to your negotiations with Calvary, was it?

Ms Gallagher: Yes, it was true.

THE CHAIR: In what sense was it true?

Ms Gallagher: Our health plans were very clear.

THE CHAIR: Is not a negotiation to buy Calvary Hospital a pretty significant part of the overall future of ACT Health?

Ms Gallagher: The time frame on that was: I think initial discussions had started in August and they had not certainly progressed to a point where there was any need or purpose to progress it in a public forum. I have a number of discussions with organisations on a whole range of matters in the health system that I do not put a media release out about. That is not saying that I am hiding anything. It is just saying that there are ongoing discussions and indeed, as you have been told and as Mr Hanson has been told by the Little Company of Mary themselves, at that point in time, because of the nature of the discussions that they had to pursue internally, they asked that the discussions remain confidential for a period of time. You have been told that; Mr Hanson has been told that.

In terms of any statements pre-election, there was really nothing to progress and inform the community about. We had had initial discussions and that is all. I have that all the time, as you would have all the time. I do not imagine you put out a media release—

THE CHAIR: Negotiations for such a major change—

Ms Gallagher: The negotiations had not started. The idea had been raised.

MR HANSON: They were initiated by you, though, were they not?

Ms Gallagher: The idea had been raised and we had—

MR HANSON: By yourselves?

Ms Gallagher: I have had a discussion with LCM, who—

MR HANSON: It was not that they approached you; you approached them.

Ms Gallagher: I have regular meetings with them. I did not approach them with this idea on its own. I have regular meetings with them and we were discussing a range of issues they had. I am sure you have received the letter from Tom Brennan that was sent yesterday, because I have a copy here and I am happy to read it in its entirety into the *Hansard* because it really does support the claim that I have been making that these discussions were in the very early stage in August and—

THE CHAIR: But before you do—

Ms Gallagher: No, if I could just say, and this is from LCM, "At the outset of those discussions"—

THE CHAIR: Before you do, I will allow you to read that into *Hansard* if you like.

Ms Gallagher: Good. I will read the whole letter.

THE CHAIR: Or you can table it; you can read the relevant bits. We do not mind.

Ms Gallagher: No, I prefer to read it.

THE CHAIR: But regardless of what request comes from an individual private company, do you think it is reasonable that you withhold this kind of information from the community prior to an election? This is a major change.

Ms Gallagher: No, it is not a major change.

THE CHAIR: It is a—

Ms Gallagher: It is not a major change. The government funds all the health services in the public hospital at Calvary.

THE CHAIR: So you do not think this is a major change?

Ms Gallagher: There is no change.

THE CHAIR: If there is a takeover of Calvary—

Ms Gallagher: For the average person walking in off the street into the emergency department or being treated at Calvary, there is no change if the sale or the transfer of ownership goes ahead.

MR HANSON: Why are you doing it then?

Ms Gallagher: There is no change. Because in a small jurisdiction, where there are two public hospitals, we think there are opportunities to be realised from one provider across two public hospitals.

MR HANSON: I thought there was no change.

Ms Gallagher: We think—

MR HANSON: You cannot have it both ways.

Ms Gallagher: If I could just finish. There are two public hospitals in this town. We, every year, negotiate at length with LCM on the provision of services at Calvary. I have put my cards on the table. We think that, in terms of the overall health system,

it makes sense for the public provider to own and operate both public hospitals. That was the beginning of the discussions with LCM. I have to say that they agree with me and they have been upfront. They agree that there are benefits from one provider in a two-public hospital town. If I could just go back to Tom Brennan's letter to Mr Hanson—

THE CHAIR: Sure.

Ms Gallagher: And in this letter he says:

> At the outset of those discussions I asked that the Minister keep them confidential. She agreed to do so.
>
> The reason for my request was that before I and my Board could decide whether to proceed from informal discussions to negotiation I needed to conduct a series of discussions with key stakeholders within the Catholic Church. It would have been very difficult for me to have done that, and very destabilising for people working at the hospital, if that had needed to be done with the full glare of publicity.
>
> While views within the Church and among members of the public differ on the question, my personal judgement is that it would have been better if the discussions had remained confidential for a little longer—so that some of the internal Church discussions that you will have no doubt have read in the Canberra Times in recent weeks could have occurred without the hurt that public ventilation of conscientiously held differing views can cause.
>
> I appreciate the fact that the minister agreed to the confidentiality I requested, and honoured her word.
>
> I also informed the Minister at the outset of the discussions that the Canon Law of the Catholic Church constrained us from selling the hospital–so if the sale is to occur it must be at full value as determined by at least two independent valuers.
>
> While I understand your point that it is for the government to provide the public policy justification for any substantial government outlays, from our point of view a sale cannot occur without the payment of full value. The public policy question for government is then one of whether it seeks ownership and is prepared to pay full value, or whether it is prepared to proceed without ownership.
>
> In this regard, the source of the figure of $100 million that you quote appears to be Sir Peter Lawler. While I accept that Sir Peter is quoted as claiming some basis for knowledge of the figure the facts are somewhat different. I have known Sir Peter for 32 years. Notwithstanding that, he did not talk with me or any other officer of this company before his comments were reported by the Canberra Times. I am not aware of any factual basis for the comments.
>
> When we met on 21 April 2009 I undertook to keep him informed of the progress in the discussions.
>
> Progress continues and we continue to expect a positive outcome. The government and we have each commissioned valuers who continue to discuss the myriad of complex issues that arise in independently valuing infrastructure of the

> complexity of Calvary Public Hospital. We expect, within the next day or two, to send to the Government Solicitor our draft of a Heads of Agreement to provide the basis for detailed negotiations with the government on all aspects of the government's proposal.
>
> As a separate exercise, we are continuing to discuss the proposal with the Archbishop of Canberra and Goulburn. We will hold a workshop with the Archbishop and his advisers on 28 May 2009. Following that workshop we will make a final decision to proceed or withdraw from the discussions.
>
> If we decide to withdraw as a result of these discussions that will be because of matters relevant to the internal deliberations of the Church. There is nothing the government could have done or done differently which will affect those discussions in any way.
>
> I thank you and your Parliamentary colleagues for your continuing support for our work in Canberra and your continuing interest in this proposal.
>
> …
>
> Yours sincerely
>
> Tom Brennan.

You can see from that that informal discussions had taken place and that I had given my word to Calvary that over the next period—as it turned out, we would have liked it a bit longer—discussions would remain confidential until the internal deliberations of the church had progressed to a point where they were comfortable with that information becoming public.

THE CHAIR: How long did you anticipate that this process would have remained secret?

Ms Gallagher: There was no timetable set. LCM said these would be very difficult discussions for them to have internally, that there would be mixed views on it. Unless LCM agree to this, there is nothing the government can do. So we were very much in their hands. We remain in their hands. They have a lease to own and operate a public hospital on that site until 2070. Unless they are prepared to transfer the ownership, really there is nothing the government can do.

There is no timetable the government can set to tell them that they need to come up with a view about when they are going to reconcile those issues within their church for us. We are not setting the timetable. We have merely put an idea on the table that they are considering internally and they have not made a decision about that.

THE CHAIR: On your point that nothing will change, we had before our committee on Friday Paul Jones from the ACT branch of the AMA, and he had this to say:

> But I find it … hard to get my head around … $100 million, give it to the LCM, in order to spend $200 million … over a 10-year period …

That is, on the Calvary site. He went on:

> It is also … hard … to understand why you take a service which currently runs to

> budget and hand it over to … another service which regularly runs over budget and … says, "Please, sir, I want some more."

The figures in the budget papers, if you look at pages 191 and 192 where there is a comparison between outcomes at Canberra and Calvary in regard to the rate of unplanned return to the operating theatre, show there is a significant difference. Canberra Hospital marginally outperforms on rate of unplanned hospital readmission—1.3 per cent to 1.4 per cent. On hospital acquired infection rate, Canberra Hospital is less than 8.6 per 10,000; Calvary Public Hospital is less than three per 10,000. There are some pretty good outcomes there at Calvary. Does Dr Jones have a point that things would—

Ms Gallagher: What is your point? Are you saying Calvary is a better and safer hospital than Canberra?

THE CHAIR: What I am saying is that there are some figures there that are pretty strong at Calvary and the thing you are saying—

Ms Gallagher: That would not be to do with the level and complexity of care and services operating across the two hospitals?

THE CHAIR: What you are saying is that you will be able to—

Ms Gallagher: That would not have anything to do with it?

THE CHAIR: What you are saying is that you will be able to maintain or improve those. Dr Jones has raised questions about that. The question is: how will you ensure that, if the sale goes ahead, you will either equal those outcomes or improve on them?

Ms Gallagher: There are a couple of things here. Calvary regularly run over budget; indeed, every year we negotiate annual additional payments to them. The difference—they have different targets indeed, from memory—in those output classes reflects the natures of the services delivered, in that Canberra is the major tertiary referral hospital for the region and Calvary provides a lower level of services—or range of services and indeed, complexities. So there are some different issues there.

This has never been around quality of care. The discussion we are having with LCM has not been driven by our unhappiness with the service they provide at Calvary. It has been around a once in a lifetime opportunity to regain for this community full ownership of a public asset and invest in that public asset—invest in that public asset in the way that we invest in our other public assets across the territory. We cannot invest in Calvary in the order of $200 million without that hitting our bottom line as a grant to a third party. We also then, interestingly, do not own that asset. If we were to invest $200 million in Calvary, and it was owned and operated by the Little Company of Mary, that asset is then owned by the Catholic Church.

These are the issues that are on the table. It was not about quality of care at all; that has never been a part of the discussions. It has been around the once in a lifetime opportunity we have to rebuild a public health system here for the people of the ACT, for the long run, that includes a significantly enhanced public hospital on the north

side of Canberra.

Because that is owned and operated by a third party, we cannot, in terms of capital outlay, treat it the same way as Canberra Hospital. That has frustrated us from time to time—including the fact that the subacute facility that was built out there sits on the Little Company of Mary's balance sheet. The ICU that we are funding now has hit our bottom line, and that is in the order of $9 million. Those decisions are very difficult when you are looking at a budget like ours is at the moment.

The alternatives are that we do not invest $200 million in Calvary, that we invest it but it hits our bottom line and that we look at the provision of public health services on the north side of Canberra and how we can do that in a way that protects our bottom line. They are the choices before the government. I have to say that LCM have been more willing to engage and have an honest discussion on this than members of the opposition have. I am absolutely—

MR SMYTH: You should withdraw that imputation. That is a ridiculous statement.

Ms Gallagher: No. I am absolutely astounded as to why the opposition has taken the view that they are.

MR SMYTH: Withdraw the imputation.

MR HANSON: If I can just clarify a point here—if I can make a point here, minister—

MR SMYTH: It is ridiculous.

MR HANSON: What we are doing here is questioning to understand the full implications of the purchase of Calvary and the process that led up to it.

THE CHAIR: Why it was done in secret.

MR HANSON: When we had a briefing a few days ago, I made it very clear that the opposition retains an open mind about this sale. What we are trying to do is investigate the full details. As the AMA has said, there needs to be more close scrutiny of this whole proposal. To suggest that, because we are scrutinising this proposal, it suggests that we are either for or against is misleading. What we are trying to do is get to the bottom of all the detail.

Ms Gallagher: What a surprise! The opposition does not have a view on it—just like they do not have a view on the one per cent saving.

MR HANSON: You have not really made a case, minister. That is why.

Ms Gallagher: You do not have a view on the budget; you do not have a view on this.

THE CHAIR: It is a ridiculous statement.

Ms Gallagher: But you are going to go and try and up-end the whole negotiation on

process.

MR SMYTH: By asking questions?

MR HANSON: No; we are scrutinising.

Ms Gallagher: Mr Hanson has a personal briefing from me. I explain everything. I give him all the details I can give him.

THE CHAIR: So that is what the personal briefings are about—to shut him up, to stop him asking questions?

Ms Gallagher: No, they are not to shut him up—but then to have a media release put out and comments in the appropriation bill that questions why we would be spending money on this and the fact that these discussions have been secret—

THE CHAIR: They were secret.

Ms Gallagher: when I went through all of that in detail—

THE CHAIR: That is pretty obvious; they were secret.

Ms Gallagher: is taking the position that what you would like to do is ruin this before it has even begun. That is the only view I can take.

THE CHAIR: I know that you do not want to answer the question, minister.

MR HANSON: That is completely disingenuous.

Ms Gallagher: I am not necessarily saying that all members of the opposition have this view, because there are some that have been quite restrained, I think, in their comments, but I think, from Mr Hanson's point of view, that he is out here to spoil. Otherwise why would Tom Brennan need to put that in writing? Obviously, he is concerned.

MR SMYTH: I do not know. Did you ask him to?

Ms Gallagher: I have certainly had discussions with him.

THE CHAIR: So it was at your urging, was it, minister?

MR HANSON: No doubt.

MR SMYTH: So you asked him?

MR HANSON: Coincidentally, it arrived on my desk at 9 o'clock last night—very coincidentally.

Ms Gallagher: No, I have not. I had discussions with him the night you made the comments, when I met him at a function.

MR HANSON: Go read *Hansard*.

Ms Gallagher: I said, "This is what the opposition are saying, trying to spoil this before it has even had an opportunity to begin."

THE CHAIR: And what evidence do you have to back that, minister?

Ms Gallagher: Well, read the *Hansard*.

MR HANSON: In what way am I trying to spoil it?

Ms Gallagher: Read the *Hansard*.

THE CHAIR: So which part of the *Hansard*?

Ms Gallagher: It is there—Thursday.

THE CHAIR: Which part, though?

Ms Gallagher: In the appropriation bill.

THE CHAIR: What part of that shows that Mr Hanson is trying to spoil?

Ms Gallagher: Because he is trying to create fear and misconceptions—

THE CHAIR: By asking questions of the minister instead of allowing you to keep it secret?

Ms Gallagher: in the community that we were holding secret discussions about something.

THE CHAIR: They were secret.

MR HANSON: You were.

Ms Gallagher: Which we were not.

MR HANSON: You were.

Ms Gallagher: I think we have been clear that we had had informal discussions.

MR HANSON: No. You have got your rationale for why they were secret, but they were still secret negotiations.

Ms Gallagher: Spoil away, Mr Hanson, at your own peril.

MR HANSON: You may have had the rationale for that.

Ms Gallagher: This is a once in a lifetime opportunity for the people of Canberra to

own and operate two public hospitals.

MR HANSON: Well, make the case to the public; make the case to this committee; make the case to the community.

Ms Gallagher: I am doing that without your help.

THE CHAIR: We will ask you, then, some facts. We will get back to some facts, because there is a lot of spin there in your answer.

Ms Gallagher: What is the spin, Zed? What is the spin?

THE CHAIR: You have made a lot of assertions you cannot back up. You have made a number of assertions.

Ms Gallagher: No, what is the spin?

THE CHAIR: You have made a number of assertions without backing them up.

Ms Gallagher: What assertions?

THE CHAIR: Assertions that Mr Hanson is spoiling.

MR HANSON: That I am spoiling.

THE CHAIR: You have not backed it up with one statement.

Ms Gallagher: Well, he is. It is very clear from my mind what Mr Hanson is up to.

THE CHAIR: You are very sensitive when questions are asked of you, but that is not a fact.

Ms Gallagher: No, I am not sensitive. I think it is very clear to me what Mr Hanson is doing.

MR HANSON: I think my main responsibility as a shadow health minister is to hold you to account in what you are doing. The fact that you conducted these negotiations for about six months in private, in secret, and then only as exposed when it was leaked to the media—

Ms Gallagher: And it just keeps going, doesn't it? Keep on spoiling; derail.

MR HANSON: Don't you think that it is appropriate that we should then inquire and ask the questions?

THE CHAIR: You do not want to deal with facts, do you, Katy? Just spin it.

Ms Gallagher: I am dealing with the facts. You have got the facts in front of you.

MS BURCH: Chair, are we breaking at all?

THE CHAIR: We will in a minute. We are dealing with this issue.

Ms Gallagher: The facts are pretty clear.

MR HANSON: No, we do not have the facts in front of us.

THE CHAIR: I will come back to the question.

Ms Gallagher: What is your position on Calvary? Do you have one?

THE CHAIR: I will come back to the question, minister.

MR HANSON: We are opposition. We want to find out more information before we can form a view.

THE CHAIR: Minister, page 191 of budget paper 4—

MR HANSON: I made that very clear to you, Katy.

Ms Gallagher: Okay. Well, you just sit there and don't have a position on anything, Jeremy.

THE CHAIR: You made a number of claims.

Ms Gallagher: It must be a comfortable world you live in.

THE CHAIR: Do you want to come back to order, minister? I will ask you some questions.

MS BURCH: So there is no commercial-in-confidence—

THE CHAIR: Page 191 of budget paper 4—you made a number of assertions there that there were differences in the type of care provided by Calvary. But the numbers and the description are indicative. It says:

> **Rate of unplanned return to the operating theatre**
>
> The proportion of people who undergo a surgical operation who require an unplanned return to the operating theatre within a single episode of care due to complications of their condition. This provides an indication of the quality of theatre and post-operative care.

And we have Canberra Hospital with an estimated outcome of 0.9 per cent and Calvary Hospital with 0.46 per cent, about half.

Ms Gallagher: And the targets are different.

THE CHAIR: The targets are different.

Ms Gallagher: Yes.

THE CHAIR: In fact, the target, in one case, was met and in another case was not. But could you clearly state—

Ms Gallagher: So what is your line on that?

THE CHAIR: Can I ask the question? Can I ask the question?

Ms Gallagher: I was just asking what—

THE CHAIR: If you let me ask the question, I will.

Ms Gallagher: That Canberra does not provide good quality care or Calvary provides better?

THE CHAIR: Could you indicate to us how, with that gap in that indicator, you will, in taking over Calvary, ensure that the services that are delivered at Calvary at the moment are continued or improved? What will you do to ensure that, given that there is that significant gap in that indicator?

Ms Gallagher: There will be absolutely no change to the level of service—indeed, the staff that are provided.

THE CHAIR: How can you guarantee that?

Ms Gallagher: Because we are talking about investing $200 million. What, we are going to invest $200 million and then reduce services and staff at the Calvary Hospital? It does not make sense.

THE CHAIR: But are you suggesting that the management of a particular organisation makes no difference to the outcomes? Are you satisfied with what you get from Calvary in terms of the service that you purchase?

Ms Gallagher: Yes.

THE CHAIR: So you are satisfied but you are saying—and the indications we get in a number of indicators are that it is a better outcome and yet you are saying, "Well, there will be no change; there will be no change if we take over"?

Ms Gallagher: It reflects the nature of the service. I do not accept that.

MS BURCH: Can I please ask for an explanation of the difference.

Ms Gallagher: So now it is clear that you were saying to the people of Canberra that Calvary Public Hospital provides a better level of care than Canberra? That is what you were saying today.

THE CHAIR: I want you to justify how you will achieve those outcomes, which are significant?

Ms Gallagher: You be careful with that. You be careful with that. That is what you were saying.

THE CHAIR: Are you going to answer the question, minister? You can throw all the warnings to us you like.

Ms Gallagher: I think it is extremely worrying that the Leader of the Opposition would sit here and say—

THE CHAIR: We will continue to ask the questions. Why won't you answer the question?

Ms Gallagher: that Calvary Public Hospital provides a better level of care than Canberra.

THE CHAIR: Will you answer that question?

MS BURCH: Can I ask a question as to why they are different?

Ms Gallagher: What is the question? I have forgotten the question.

MS BURCH: I think if they answer that you will understand the difference in indicators, Mr Seselja.

THE CHAIR: Hang on. I have asked her a question, and she is still not answering. It was a very clear question. There is a different outcome; one met the target and one did not. How will you ensure that you deliver on those kinds of outcomes if you take over Calvary Public Hospital?

Ms Gallagher: The nature of the work at Calvary Public Hospital will not change; nor will the nature of the staff.

THE CHAIR: So nothing will change? Everything will just go on as it always has?

Ms Gallagher: No, it will not go on as it always has; it will be vastly improved by a whole range of new services and new staff.

THE CHAIR: So the service that is delivered there is not up to scratch?

Ms Gallagher: But the nature of the work that Calvary does at their operating theatre is not expected to change. The nature of the work that is done at the Canberra Hospital operating theatre is not expected to change.

THE CHAIR: So the service that is delivered there is not good enough at the moment and it will be improved on?

Ms Gallagher: That is not what I have said. In fact, I have said all the time—

THE CHAIR: That is the implication in what you have said.

Ms Gallagher: I have said that this has not been around—this discussion has not been at any point around the quality of the care provided at Calvary Public Hospital. It just simply has not factored into the discussions at all.

THE CHAIR: But you have just said that it will be better if you take over.

Ms Gallagher: The services will be better because there will be a wider range because we will have invested $200 million on the north side of Canberra, and that brings with it increased services for the people on the north side of Canberra. So it is better in terms of more. Unhappy with that?

THE CHAIR: Ms Burch?

MS BURCH: Given that you are looking at indicators, and just to explain the differences, why are there differences and what generates the differences? I do not think you can measure one against the other.

Mr Cormack: I am happy to respond to that. I think it is important that we understand why there are differences in the targets and therefore differences in the outcomes. The targets are set differently for the Canberra Hospital and the Calvary hospital for a couple of reasons. As the minister said, they are quite different hospitals. They do different sorts of work; they see different sorts of patients. The averaged cost complexity of cases at Canberra Hospital is vastly greater than that at Calvary hospital.

The second point around that is that Canberra Hospital is a major regional trauma centre. A very large proportion of its work is with people who have life-threatening conditions, major surgery, complex retrieval processes. With all that comes a higher degree of risk. That higher degree of risk is recognised by the Australian Council on Healthcare Standards, which publish benchmark levels around their clinical indicators that differentiate between major tertiary hospitals and district hospitals such as Calvary. It is actually not correct to say that the outcomes for the Canberra Hospital are better. You are comparing apples with oranges. Yes, the percentage rates outlined in strategic indicators No 2 are different, because they are different hospitals. That is the reason for the difference in the outcomes.

When we are discussing community infrastructure that is of vital importance to the people of Canberra, it is very important that, when we hear statements that suggest that one hospital is better than another, they really need to be corrected on the record. I want them corrected on the record. I have the leadership team from the Canberra Hospital here, and we have the leadership team from Calvary hospital, though they are not here today. They have a look at these things. It is really important that the public have confidence. These hospitals are different hospitals; they achieve different levels of outcome for perfectly logical reasons, as benchmarked by the principal national accrediting body for hospitals and health care in the country.

MS BURCH: Thank you.

MR HANSON: I want to make it very clear about Calvary. Minister, you may consider what I am saying as spoiling or fear and loathing. The point I have made all along, in all of my speeches in *Hansard*, in public and in this committee hearing today,

is that I have not in fact formed a view. The opinion of the opposition is that we have not formed a view. But our responsibility is to hold the government to account and to find out all of the facts that would merit a potential purchase of Calvary, both financially and also for the health of the ACT. Not to do so would be entirely negligent.

That we have not rolled over and just accepted what you have put on the table as a fait accompli does not mean in any way that we are spoiling. And we will continue to question whether it is a viable thing or not. If you make the case then I am sure the opposition will give you its full support, but the point is that you are yet to make the case.

THE CHAIR: We will break now.

MR SMYTH: Just before you do, Chair—

Ms Gallagher: Oppositions are also the alternative government, and the alternative government needs to take positions on things.

MR HANSON: Indeed it does, when it has the full raft of facts—

Ms Gallagher: And you have failed to do so.

MR HANSON: and in a timely manner.

Ms Gallagher: You have had a full briefing from LCM; you have had a full briefing from me.

THE CHAIR: You have had secret negotiations for six months and then it comes out in the media. You would not have even had it come out yet. And you are claiming—

Ms Gallagher: No, that is right. I would not have.

THE CHAIR: And you are claiming that the position should be concluded.

Ms Gallagher: Neither would LCM.

THE CHAIR: You do not even have a concluded position, it would seem, other than that you are in negotiations.

MR HANSON: You refused—

THE CHAIR: So—

Ms Gallagher: No. Our position is that we would like to own and operate Calvary Public Hospital.

THE CHAIR: When did that become your position?

Ms Gallagher: It would have been at the beginning of the discussion.

THE CHAIR: So before the election?

Ms Gallagher: The discussions would have started: "Would you consider the ACT taking over ownership of the Calvary Public Hospital?"

THE CHAIR: So let us just get that clear then. You had that position before the election but you kept quiet about it?

Ms Gallagher: That is the conversation that I certainly had with them: would they consider it?

THE CHAIR: So your position was formed—

MR HANSON: Because you had formed the position that you wanted to do that?

THE CHAIR: prior to the election?

Ms Gallagher: I was looking at how to invest the amount of infrastructure that we need to invest in that hospital. This was one way we could have done it. I raised the idea with them. I am guilty of raising an idea.

MR HANSON: No; you had formed your decision—

Ms Gallagher: I raised an idea with them.

THE CHAIR: You just said you had formed the position—

Ms Gallagher: The government cannot—

MR HANSON: You said you had formed the position.

Ms Gallagher: force Calvary to do anything.

MR HANSON: No. But you had formed the position that is what you wanted to do.

Ms Gallagher: I raised an idea with them which I asked them to consider and—

MR HANSON: That was your plan.

Ms Gallagher: shock, horror, they said, "We will consider it." That is—

THE CHAIR: You have gone back and forth and now you have confirmed that your position prior to the election was to do this and you kept quiet about it.

MR HANSON: And all you wanted to do is stitch up the deal.

Ms Gallagher: I think it is clear from everything I have said. I raised an idea, yes—"Would Calvary consider this?" Calvary said, "We'll consider it, but at the moment we would like to consider it in private." I said, "Okay."

MR HANSON: Now, if I can make a final point on this, that—

Ms Gallagher: I mean, what an enormous scandal that is!

MR HANSON: about an hour ago when I asked you to—

Ms Gallagher: That I would have the temerity to actually try and forward-think for our health system of the future in the ACT!

THE CHAIR: Why not be open about it?

Ms Gallagher: What a—

THE CHAIR: Why not be open about it?

Ms Gallagher: Did you not hear what I read into the *Hansard*?

THE CHAIR: I heard what you read into the *Hansard*.

Ms Gallagher: Because LCM said, "We have some very"—

THE CHAIR: Just because you are requested does not mean you do not have responsibilities.

Ms Gallagher: Right, okay; so that is right. Okay; so the actual third party that holds all the decision-making capacity about whether or not they do it, says: "Yes, we will consider it. But, please, while we are considering it, can we just keep this amongst ourselves?" I say: "No, sorry. I am going to go and tell everybody that this is my idea." What do you think that would be?

THE CHAIR: Don't you think it is reasonable that you are honest before an election?

Ms Gallagher: I am honest. Do not attack—

THE CHAIR: Like, on major policy issues—

Ms Gallagher: me on honesty, Mr Seselja.

THE CHAIR: Well, you were not. You did not put it on the table.

Ms Gallagher: Do not attack me on honesty.

THE CHAIR: You said all of your plans were on the table and they were not.

Ms Gallagher: For an opposition that puts out media statements which are riddled with things that are incorrect, do not attack me on honesty.

THE CHAIR: Look, you can make all the assertions you like. There is a clear statement you made—

Ms Gallagher: Do not attack me on honesty.

THE CHAIR: There is a clear statement you made—

Ms Gallagher: You will never trip me up on honesty.

THE CHAIR: and it was wrong.

Ms Gallagher: Ever.

MR HANSON: Really?

MS BURCH: Can I—

Ms Gallagher: Well, it is a sore point because it is something—

MR HANSON: It is a sore point because you said—

Ms Gallagher: that I hold actually very close—

MR HANSON: you had a plan—

Ms Gallagher: to my heart, is to maintain—

MR HANSON: You said that you had a plan, you formed a plan—

Ms Gallagher: honesty at all times, which is what I have done.

MR SMYTH: Like no school closures.

Ms Gallagher: I go to bed every night with—

MR SMYTH: Like no school closures before the 2004 election.

Ms Gallagher: a clear conscience. I am honest to the point that it causes me political pain from time to time.

THE CHAIR: Well, you can repeat it as much as you like.

MS BURCH: Can I ask a question?

MR HANSON: Can I just follow up on the point I was going to make as well? You said that the opposition should have a view right now on what the position is, but when I asked you about two hours ago what cuts you were going to be making to the health system for the $122 million of unallocated cuts, you refused to give me an answer. You said, "No, we have got to go and have the conversation with the community, we have got to talk to the health"—

Ms Gallagher: Well, you go and have a conversation with yourself, Jeremy, and

work out what your view on Calvary is.

MR HANSON: "We have got to talk to the health council." You said that you have got to form a view. You refused to put a position on the table. So why is it that it is okay when we are talking about some cuts to form that view and to delay but when you present a plan on the table for a purchase of Calvary, the opposition should instantly form a view and should not conduct any engagement or consultation?

Ms Gallagher: I am not asking you to instantly form a view. I was merely inquiring—

MR HANSON: It is actually what you said.

MR SMYTH: You just said that.

MR HANSON: It is exactly what you said before, that we should have a position on this.

Ms Gallagher: I think you should. It has been out and been discussed now and you have had—

MR HANSON: Well, so has the need for cuts in our health system.

Ms Gallagher: briefings on it and you still have not had a discussion on—

MR HANSON: Where is your position on that? Where are those cuts coming from?

Ms Gallagher: We have gone through that.

MR HANSON: Oh, you are going to engage. You are going to consult; you are going to wait; you are going to consider. It is all right for you, but not for us. Is that right?

Ms Gallagher: Well, we look forward to your position on Calvary coming soon.

MS BURCH: A question, please?

MR HANSON: We look forward to more facts.

THE CHAIR: Ms Burch has a question and then we will go to morning tea.

MS BURCH: Thank you for the offer of morning tea. My question relates to the discussion around purchasing or not purchasing Calvary. How well or where does it align with your overall reform of our health system for the next 10 to 20 years? Does it fit within an alignment there?

Ms Gallagher: The work that we did around the capital asset development plan really did indicate the difficulties that we would have in investing to the point that we have to on the north side of Canberra if the ownership arrangements remained the same. It is very much a part of the overall reform of the health system.

In respect of the capacity to build a health system for the future, and in this case looking at the two hospitals, this is a once in a lifetime opportunity to have this discussion and to see whether it actually can proceed. The opportunities for the people of Canberra, I think, in terms of the amount that we can invest, the fact that one provider would own and operate both hospitals, is integral to the whole capital asset development plan. I do not apologise for having a longer term view about the health system. Again, this will not help me for the time that I am health minister. This is about a 10, 15, 20, 30, 40-year plan for the people of the ACT.

I have certainly formed the view, and it is largely around the financial implications, that this is the best way to rebuild the hospitals that we need, based on the fact that Calvary is located in the best place on the north side and Canberra Hospital is located in the best place on the south side. This is the best way forward in terms of taxpayers' money and the fact that our balance sheet would retain those assets. Calvary would be an ACT public asset. That is my very strong view. In terms of completing the rebuild in a way that I think provides maximum benefit back to the community for the dollars that we spend, I think the government owning and operating Calvary is the best way forward. I have to say that it is a view shared by Little Company of Mary on those grounds alone.

Meeting adjourned from 11.06 to 11.25 am.

THE CHAIR: We will recommence. Mr Smyth has some questions.

MR SMYTH: Minister, when you made the phone call to the Little Company of Mary in August, I understand, what prompted you to make that call?

Ms Gallagher: It was not a phone call. It was at a meeting—

MR SMYTH: It was at a meeting?

Ms Gallagher: as I understand it. I have regular meetings with LCM and it was at that regular meeting. It was just a normal, standard meeting that I have with them.

MR SMYTH: Before you made the approach in that meeting, what due diligence had the government done to determine that it was more effective for Calvary to come back in within the general public hospital system?

Ms Gallagher: At that stage it was an idea that I had discussed with ACT Health and I merely raised it as an idea.

MR SMYTH: So you raised it with Health—

Ms Gallagher: I think your argument about being secret and not being up-front would gather more weight if I had done a considered and thorough piece of government analysis on what that would mean. That was not the case; we are doing that now.

MR SMYTH: Sorry, so—

Ms Gallagher: We are doing that now.

MR SMYTH: you asked to buy something without having done any analysis?

Ms Gallagher: Sorry?

MR SMYTH: So you made an offer to purchase something without having any—

Ms Gallagher: No, I merely raised—

MR SMYTH: factual basis on—

Ms Gallagher: the question as to whether they would consider a transfer of ownership; that is what I asked.

MR SMYTH: All right. What prompted you to raise that question?

Ms Gallagher: Without going into the private discussions that we were having, LCM were having their own issues. I am not going to go into that; you can ask them what they were. We were undertaking further work around the capital asset development plan.

MR SMYTH: But as of then, as a function of that further work, you made this—

Ms Gallagher: I said they could consider it—

MR SMYTH: offer of an idea.

Ms Gallagher: but let us be honest: this issue around Calvary has not come out of the blue. There have been considered pieces of work done over the years, pre-dating me as minister, and in the functional review we were commissioned with a piece of work to look at actually removing ourselves further from the relationship. So the issue of ownership and contractual arrangements between the government and LCM have a long history that no doubt you would have been aware of when you were involved in cabinet decisions.

In addition, there was an Auditor-General's report that was released. I can't remember whether it was in June last year. It was before the election last year. It went to some of the issues around the contracts—issues such as cross-subsidisation. In fact, as I recall that meeting, it was looking at some of the comments that the Auditor-General had made, which led us to have a discussion, as a group, a very organic discussion that emerged in this meeting, around how we deal with some of those issues. As I said, LCM had their own priorities which I am not going to go into here, and that is how the idea emerged. Since then, a lot of work has been done.

MR SMYTH: So the idea of getting the public hospital back into the fold was raised in the functional review?

Ms Gallagher: No. In fact, if you go back to those estimates at that time, the discussion was around government removing themselves—it was the opposite, I guess, of what we are looking at now. For example, I can't remember the exact term but the

work that was done at that time was around Calvary having much more say, without government influence, around the running of that public hospital, which would have meant taking over, for example, staff.

MR SMYTH: So why wasn't that path followed?

Ms Gallagher: We went through a piece of work at the time and, at the end of the day, the government made a decision in light of the amount of public money that goes through the contract each year and some of the issues around employees, and we listened to our employees in those discussions. These were not secret discussions. I am surprised you are not aware of the work that had been done. The government decided that, in the interests of scrutiny of public money and the stability of the workforce out there, who very much wish to remain being considered as public servants, that was not the right path to follow.

MR SMYTH: So you posed a question to the Little Company of Mary but no work had been done to back that up?

Ms Gallagher: I think it goes to the point that I say. I raised an idea with them and said, "Would you consider this."

THE CHAIR: But you said you had formed a position at the beginning of those negotiations.

Ms Gallagher: No. You can twist and turn this as you like.

THE CHAIR: I am not twisting it. That is what you said before.

Ms Gallagher: That is my personal view. My personal view is that—

THE CHAIR: So what led you to form that view?

Ms Gallagher: I would like the ACT government to own and operate the two public hospital systems. In that discussion—

THE CHAIR: What was the process that led you—

Ms Gallagher: In that discussion—

MR SMYTH: What was the process that led you to that?

Ms Gallagher: In that discussion I posed the question to LCM; they undertook to consider it. That was the extent of it.

THE CHAIR: I think what Mr Smyth is asking is: you had come to a position that it would be a good idea to take over; you then want to launch a discussion and negotiation with LCM. What had led you to that position given that, a couple of years ago, you were considering a different path? You then came to a different position. When did you form that conclusion and what piece of analysis or research led you to that position which led you to then ask the question and undertake those negotiations?

Ms Gallagher: It has been my job as health minister to monitor the arrangements that we have in place between Calvary and ACT Health. I have been involved in all the work that has been done on a whole range of options around ownership and contracts. I have also been involved in the work that the Auditor-General did and I formed my own view.

THE CHAIR: Had any detailed analysis been done on all of the costs and the implications of that decision?

Ms Gallagher: At that time, no, they had not. I raised the idea. With respect to the processes, this goes to my point that it was very much an idea that was raised and the due diligence work only started after LCM agreed to consider it. If they had not agreed to consider it, it could not have progressed.

MR SMYTH: But the question is: how did you know the offer was a good offer if you had not had any work done to back it up—

Ms Gallagher: The work that—

MR SMYTH: and if you did not know—

Ms Gallagher: There has been work done—

MR SMYTH: that there were to be efficiencies?

Ms Gallagher: over the last three years around ownership, governance and contracts with Calvary. There has been.

THE CHAIR: You seem to be going back and forth on this point, though, minister.

Ms Gallagher: Well, you guys are going back and forth.

THE CHAIR: No.

Ms Gallagher: It is very clear in my head—

THE CHAIR: You are going back and forth as to whether—

Ms Gallagher: what has occurred.

THE CHAIR: there was work underpinning it, whether you had made a decision, whether it was just a preliminary discussion.

Ms Gallagher: It was a personal view of mine. There had been a whole range of work that had been done over the previous years about the ownership and the contractual arrangements that Calvary Public Hospital work under.

MR SMYTH: So a personal view worth $200 million was not discussed with cabinet before the question was raised?

Ms Gallagher: I have no idea where you get the $200 million figure.

MR SMYTH: You have been talking about $200 million all morning.

Ms Gallagher: You are talking about the investment in Calvary under the capital asset development plan?

MR SMYTH: Yes.

Ms Gallagher: Yes, that work has all been done very thoroughly. In fact, you have got it all. You FOI'd it.

MR SMYTH: Yes, but was it being done—

Ms Gallagher: Don't tell me you don't read the FOIs we give you!

MR SMYTH: Was it being done with a view to acquiring Calvary hospital?

Ms Gallagher: No, not at that stage. It was really around the costs that would be incurred if the CADP goes ahead as the planners and the people involved in that work had intended it to.

MR SMYTH: So the $200 million is included in the billion-dollar health plan?

Ms Gallagher: Yes.

MR SMYTH: It was your intention, if you could not acquire it, to spend the $200 million anyway?

Ms Gallagher: With the capital asset development plan, the work that was done outlined very clearly what infrastructure had to be built on the north side of Canberra and what had to be built on the south side of Canberra. At that point in time, when that work was being done, I had not got to the point of thinking about how the cash to deliver that would actually work, and how we would manage that through the budget process. The capital asset development plan was work that I commissioned in saying, "What are our health needs going to be over the next 10 to 15 years and how do we deliver it?" Once that work was finished, it was then up to my work, through the budget cabinet process, to have a look at how we staged that and how we rolled it out.

At the same time, our budget has taken quite a significant beating, as you are all aware. The capital investment that is required on the north side of Canberra, if that is to hit our bottom line, will deteriorate our budget further. So, yes, I have been thinking about ways to ameliorate that. But that is not a new issue, in a sense. We have been managing it with the subacute facility and the ICU-CCU that we are building at Calvary, but they are nowhere in the ballpark of what we are talking about if we are to build up that hospital as it needs to be built up. So, yes, part of my thinking was how we could deliver the services we need and deliver it in a way that we deliver other capital across the ACT without it hitting our bottom line. That is very much at the centre of me forming my view around ownership of Calvary. The work

that had been done shows that Calvary is in exactly the right place for a hospital.

MR SMYTH: I don't disagree.

Ms Gallagher: So we know that it is in the right place, we know that it is a good, functioning public hospital and we know there is land there to further develop. If the discussions that we are having at the moment actually proceed, there is opportunity for a private hospital on that site. So, in a way, it is excellent in terms of what it offers for us in an outcome.

The difficulty comes when we look at how we finance that. But there are other issues as well. There are issues that the Auditor-General raised about the cross-subsidisation and how we clear that up. I have to say that LCM have already instituted processes to address that, even if the transfer of ownership does not occur. There are opportunities for a common IT system. At the moment, we do not have that operating between our public hospitals. There is an opportunity within one governance model and not having to, once a budget is passed, then negotiate outputs with another provider. There are some other issues here which we think could benefit from having one owner-operator.

We are only a two public hospital town. I can't think of another place where there are only two public hospitals that are owned and operated by different providers. So at the heart of it is the investment that we need to make, but there are other areas where we believe a one governance model could benefit the people of the ACT in the long run. But I do not want that to be mistaken as me saying that I am unhappy at some level with the quality of service provided at Calvary. It is not that.

MR SMYTH: So is there a document that supports the view that the one governance model is the better model?

Ms Gallagher: A document specifically?

MR SMYTH: Yes. Is there evidence to support that claim? Is there something you or the department could table for the committee that says, "This is the work we've done and this supports the claim"?

Ms Gallagher: I would have to go back and have a look. There has been so much work done on the government's model at Calvary, and I am very happy to look at what we can provide to the committee, for sure.

MR SMYTH: All right. Mr Cormack, when was the first discussion that you had with the minister about the one governance—

Ms Gallagher: He was at the meeting with me. Weren't you?

MR SMYTH: But were there discussions before that meeting where the idea was apparently floated?

Mr Cormack: I have had discussions with the minister about governance issues—and with the previous minister, I have to say—in relation to Calvary going back to 2006-07.

MR SMYTH: And did those discussions include reacquisition of Calvary?

Mr Cormack: Former minister Corbell is on the public record in 2005 as expressing a government intention to run and own Calvary hospital. That issue emerged in 2005. There are media releases. So this is not new. In fact, I could take you to—

MR SMYTH: So work had been done before the discussion, before the idea was floated in the meeting?

Mr Cormack: The point is, Mr Smyth, there has been—

MR SMYTH: No, the question is: had work been done on the one governance model and the reacquisition of Calvary before the meeting, before the idea was floated at the meeting?

Mr Cormack: There has been ongoing consideration around governance models in relation to Calvary. I have been with ACT Health since February 2005.

MR SMYTH: Have there been cabinet decisions on that? Are there any cabinet decisions on reacquisition?

Ms Gallagher: As I said, looking back, there have been many cabinet decisions around this over the years that I can recall being involved with.

MR SMYTH: All right. Mr Cormack, you were about to say?

Mr Cormack: Could you just refresh the question, Mr Smyth?

MR SMYTH: What work had been done in the lead-up to the idea being floated in the meeting?

Mr Cormack: I have been here since February 2005, and there are a number of documents that were already on the table. The Mick Reid review led to the current structure of ACT Health. It talks about clinical streams, and we implemented those. We have clinical streams in mental health, aged care and cancer services, and they are the contemporary model for governance of complex healthcare systems. They are the contemporary model for governance of complex healthcare systems because they recognise that patients with a particular condition follow a certain pathway from home to hospital to outpatients and back home. They follow a pathway. So what we endeavour to do is to build our organisational structures around those pathways. That is what we have done. That was one of the recommendations of the Mick Reid review, and we have found that model certainly to be a very successful governance model.

However, you can only effectively implement that patient-centred, patient journey oriented service governance model under a single governance system. When you have got an organisation that is not governed under the stream model then you can only be so effective with implementing that patient-centred service model. This has been a matter of discussion over many years and—

MR HANSON: Can I ask a question there, just to interject? Why is it once in a lifetime now? This has been a matter of discussion since 2005 or for many years. Minister, could you explain why it is now once in a lifetime but previously it was not? Why is it such a unique opportunity now?

Ms Gallagher: In case you have not noticed, we are attempting to rebuild the health system with very significant capital infrastructure. That is one of the reasons. The other reason is LCM will have to make decisions for themselves about their investments on that site if they maintain ownership of it, and they will have to make those decisions fairly quickly.

MS BRESNAN: Can I just ask a quick question?

THE CHAIR: I will let Ms Bresnan ask some questions around this and if there is anything further, we will come back to it.

MS BRESNAN: Thank you. You have been talking about the work you have done on governance around the health system and looking at TCH and Calvary and how they work together. You also mentioned earlier that particular services might be hitting the bottom line. I think you mentioned the ICU in particular. Obviously it depends on the transfer occurring, but has there been any thinking about consolidating particular services or integrating them in one location? I know it is hard to say now because it has not occurred but, obviously, if you have done a bit of work around governance, I wonder if that has been a consideration.

Ms Gallagher: We have been very clear that that work should not proceed until the transfer of ownership is to go ahead or not. The reason around that—and I have spoken to staff about it—is some of the uncertainty that exists at the moment. Some aspects cannot be addressed until we know if this is going to go ahead or not. The commitment I have given, certainly to the workforce that I have spoken to—I have not had any organised meetings around this, before anyone gets too concerned around that; it is just in discussions I have had as I have moved around the hospital—is that there is no intention to downgrade services at all. In fact, all we can see in the health demographics and data that I have seen is continued growth, and if we were to be successful in having the ownership transferred to us, we would then embark on those discussions with staff. But the way I see it is that I cannot see significant change occurring because the services Calvary provide will need to be provided, whoever owns and operates that hospital. In fact, we will need to build up on them.

MS BRESNAN: Yes. So services like the ICU—and of course there are other units there which would service that side of Canberra—will remain there?

Ms Gallagher: Yes, that is right.

MS BRESNAN: Because obviously, if those things go as well, it affects what else is provided at Calvary.

Ms Gallagher: There will be no reduction in the services. It is not on the radar in health service provision—reduction in services. It is just not part of the work.

THE CHAIR: Are there any further questions in this area? Ms Burch, and then Mr Smyth.

MS BURCH: No. I want to move to general services on the north side.

MR SMYTH: I have just got a few more to finish on this.

THE CHAIR: I think there are still some questions around this and then we will move on to other questions.

MR SMYTH: What is the quantum of savings that the efficiency of having Calvary back under the one governance model would bring to the system?

Ms Gallagher: We have not factored in any efficiencies. This is not driven by a cost saving measure. This is being driven by a desire to rebuild and reform the health system.

THE CHAIR: But before you said that there were efficiencies as a result of having the two hospitals.

Ms Gallagher: I am not putting a dollar figure. That work has not been done and—

THE CHAIR: But that answer seems to contradict what you said before.

Ms Gallagher: Well, I have to say that this is you guys having a go each way. If I were looking at it from a cost reduction point of view, I would expect a fair bit more criticism than I am getting this morning. It has not been driven by cost. It has not been driven by service reductions or lineback. What it has been driven by and what I am guilty of is having a long-term vision for the health system.

MR HANSON: But you said a large part of your argument was the single model of provision. That was part of your argument.

Ms Gallagher: No, it was not a large part of my argument.

MR HANSON: It was just having one service provider.

Ms Gallagher: I did say there was an element there of one governance model, and that is certainly part of it, but I am not attaching savings to that. The issue around finances and savings is very much around the infrastructure, trying to protect our bottom line, and, yes, I am guilty of that as well. I am trying to protect our bottom line and I am trying to build a fantastic new hospital on the north side of Canberra. I am having discussions with the current owner and operator of that hospital about how we could make that happen in the best interests of the people of the ACT. That is what I am guilty of. If I am guilty of anything, I will stand by that and I am happy to be charged accordingly.

THE CHAIR: But you talked before about efficiencies. Now you are saying that efficiencies are not a factor.

Ms Gallagher: No, I am not saying that. I am saying there may be efficiencies, but I was asked about what number, how many savings—what is the work that has been done on the savings that are to be achieved by this, and that work has not been done.

THE CHAIR: So you do not know if there are efficiencies?

MR HANSON: They are a part of your argument, but you are saying that you cannot quantify them.

Ms Gallagher: There are two levels to efficiency. You know, you can be efficient and improve efficiency without necessarily reducing cost.

THE CHAIR: Well, no-one is disputing that.

Ms Gallagher: Good. We are on the same page, then.

THE CHAIR: Well, what efficiencies, then, have you identified as a result of this takeover?

Ms Gallagher: Well, as we know, it is not a takeover. Indeed, our discussions have not even reached that point. At the moment we are in discussions about the transfer of ownership. We believe there are efficiencies in terms of being able to have a common IT system, one governance model and the need, after the budget passes every year, not to negotiate contracts for outputs, indeed, renegotiate them through the year when budget pressures emerge. We believe there may be opportunities for the workforce to transfer more easily between Calvary public and Canberra Hospital and vice versa. They are some of the things that I consider to be in the area of efficiencies under one governance model.

THE CHAIR: Are you able to quantify some of those efficiencies?

Ms Gallagher: What are you after, a figure?

THE CHAIR: Yes.

Ms Gallagher: No. That work has not been done, because this is not being driven by a cost-cutting exercise. I have to say that—

THE CHAIR: But don't efficiencies save you money so that you can spend it elsewhere?

Ms Gallagher: we love the health workforce to death, but when you start a piece of work that is being driven by reducing costs, people get pretty cynical. This is not about reducing cost. This is about improving and building the health system for the future that our community needs. I have to say it will not benefit me in my time and it might not even benefit this government, but in years to come, in 20 or 30 years, my hope, my most sincere hope, is that this Assembly has supported the rebuild and reform of the health system so that generations in future will benefit from it.

THE CHAIR: But you seem to be giving a confused message on efficiencies.

Ms Gallagher: I am not confused at all. You are confused. I am not confused.

THE CHAIR: Surely efficiencies allow you to make cost savings, which can then presumably either be used in other parts of the health system, other parts of the hospital, but you are saying—

Ms Gallagher: Well, that may be the case, Mr Seselja, but it is not being driven by it. It may be the case, but it is not being driven.

MR HANSON: It is just being justified by it?

Ms Gallagher: No. I am not using costs or cost cutting as a reason.

MR HANSON: You did. You used efficiencies—

MR SMYTH: You used efficiencies.

MR HANSON: as a motivation for doing what you are doing.

Ms Gallagher: Okay. There are efficiencies which deliver savings and there are efficiencies which just improve the system. Can you imagine being able to type into a computer at Calvary and pull up information from a computer at TCH?

MR HANSON: So it is impossible to have—

Ms Gallagher: I think that is pretty good.

MR HANSON: the IT system that could talk to itself otherwise? You have got to spend $900 million on buying the whole thing—

Ms Gallagher: Sorry?

MR HANSON: I am sorry, $90 million buying it. You cannot have the systems—

Ms Gallagher: Well, I do not know where you are getting that.

MR HANSON: talking to each other?

Ms Gallagher: I do not know where you are getting that figure from.

MR HANSON: $92 million was the Auditor-General's figure, wasn't it?

MS BURCH: Chair, can we have some questions on another matter?

MR HANSON: $92 million was the Auditor-General's figure.

THE CHAIR: We will. We are just finishing off. That is why we have allowed a lot of time for Health.

Ms Gallagher: I do not know where you are getting that from.

MR HANSON: $92 million is the Auditor-General's figure.

MR SMYTH: Just two final questions.

Ms Gallagher: I do not know where you are getting that figure from.

MR SMYTH: If the sale was to go ahead, where would the money come from?

Ms Gallagher: It would come from the territory's cash.

MR SMYTH: From the cash, okay.

Ms Gallagher: And the assets would transfer to our balance sheet.

MR SMYTH: And if it does not go ahead, what happens then?

Ms Gallagher: Well, we continue as we are now. In terms of the infrastructure we will have to have another look at how we provide that and where we provide it.

MR SMYTH: Thank you.

THE CHAIR: All right. Thank you. Ms Burch?

MS BURCH: Thank you. Services on the north side seem to be a theme at the minute. Capital—looking at an enhanced community health centre in Belconnen. Can you tell me when that will come online and what will be different in that new community health centre in Belconnen?

Ms Gallagher: The idea for the enhanced community health centre—we have a block identified. I cannot actually picture the block, but I have got the block number. It is part block 8, section 50, Belconnen. We will give a better description of where that is. The idea is that we would relocate all the current services in the existing Belconnen health centre, but we would also look at adding some services which are currently provided at the hospital. This is again part of the reform work that is underway through the capital asset development plan, which is to gradually shift those services that we currently have in the hospital out into community-based settings, where that is appropriate. The enhanced community health centre in Belconnen gives us that opportunity. There is just over $50 million in the budget for it and the expectation is that it would be ready in 2012.

MS BURCH: And what new services or what are the enhancements that are going in there?

Ms Cahill: The intention is to maintain the current range of community-based services that we have at the Belconnen community health centre, so community nursing, dental services et cetera and some of our allied health services. The intention is also to move some of the services that are currently provided at the hospitals, particularly outpatient services, into these enhanced community health centres.

Examples of those services include things like dialysis. We would like to provide those services in those centres because it enables us to provide services closer to people's homes without their having to travel to a congested hospital site.

MS BURCH: So that would improve the links between the allied health professionals and, say, someone under dialysis for home care and after care?

Ms Cahill: Certainly that is the intention, and building on the comments that have already been made around streaming of care, it will allow a much better continuity of care between general practices, community-based services and acute services. The intention is also to enable GPs to be able to operate out of the enhanced community health centres as well as potentially some of the walk-in centres to be located there.

MS BURCH: So with having GPs there, is that bringing in a practice that is around the area? Have GPs expressed an interest in being sited there?

Ms Cahill: The model that we are proposing to offer around general practice is still under negotiation with GPs, but our ideas to date revolve around a model of practice that is quite different from what happens now. Essentially the other healthcare providers in the centre, such as the nurses and allied health professionals, would actually be making referrals to the general practitioner rather than the general practitioner being the first point of call or people being able to make direct appointments with a GP. It is very much about building those relationships with facilities like aged-care facilities and non-government organisations. It is very much about building community-based multidisciplinary teams.

MS BURCH: Will it be that the client comes into the centre, or will the centre be outreaching to some client bases?

Ms Cahill: It will be a combination of both. A number of the services that are currently provided out of the community health centres are outreach services. So we will continue to provide those, and others will be based at the centre.

MR SMYTH: What is the recurrent funding after the upgrade?

Ms Gallagher: Well, it is the funding that we already provide, and then there will be some services which are already provided in the hospital. Any new services will be factored in through our growth envelope.

MR SMYTH: When you say "the hospital", is that Calvary or TCH?

Ms Gallagher: Well, you couldn't say they wouldn't come from either, but it is mainly from TCH.

MR SMYTH: Dr Jones, when he appeared for the AMA on Friday, said things like no case had been made and he questioned the need. He particularly raised questions of what services would be transferred, how was the business case justified for the spending, what need was assessed and what services will actually be transferred.

Ms Gallagher: This is one of the projects included in the capital asset development

plan, so the work underpinning that, of which you have all of the details in reams of paper, is there.

MR SMYTH: Yes, but the committee does not have that. So perhaps you could explain it for the committee.

Ms Gallagher: Well, the work has been done in terms of the capital asset development plan, and the business case forms part of the work. I guess it is underpinned by the work that was done.

MR SMYTH: Yes, I understand that.

Ms Gallagher: And that has gone to cabinet and it has been given the thumbs up.

MR SMYTH: Okay. So what is the case? Can you restate the case for us?

Ms Gallagher: Well, the fact that if we continue going the way we are going in terms of the concentration of a whole range of services at the hospital, as our growth continues every year, we will not be able to manage it within that campus. We need to look at what services that are currently provided in the hospital could be provided in a non-acute setting, and that is part of it. That would allow us to free up some space in the acute setting to build up our acute services. Now this is not something that is peculiar to the ACT; this is part of the national reform agenda which is easily summed up—keep people away from hospital; when they are in hospital, make sure they need to be in hospital and are actually in the right place; and when they leave hospital, keep them out of hospital. That's it in a nutshell.

MS BURCH: You made mention of allied health. Will some of the innovative models of care or the allied health assistants be out of the enhanced Belconnen community health centre? Is there a thinking that they could come in there?

Mr Cormack: Certainly there are a couple of very specific workforce initiatives announced in the 2009-10 budget, and I mentioned those earlier—orthopaedic, advanced practice physiotherapists and emergency department. Advanced practice physiotherapists will clearly be more formally associated with a hospital. But we are building a platform of new categories of workers—assistants and advanced practitioners—and they will be a part of our future developments, and they will be deployed at enhanced community health centres such as Belconnen. So we have not got down to the detail of exactly which one will be there on day one, but they are meant to be part of our new and emerging workforce for the future.

MS BURCH: You made mention of walk-in clinics at the enhanced health centres. Can you explain that a bit?

Ms Gallagher: There will be a capacity for a walk-in centre, and we are building the Gungahlin community health centre with the same capacity. But the discussions around that and when they start will be dependent on the hospital walk-in centre model getting the thumbs up from professional groups. I genuinely believe that we need the support of health stakeholder groups before we introduce a new model of care. We have got conditional support for that as long as they happen at the Canberra

Hospital, and this budget funds that service.

Once we have trialled that service and it has gone through the required processes of analysing and looking at the data about how successful it is—again, I believe that it will be successful, and I hope it is successful—we would then look at how we move out to a similar model in the community. There will be further discussions with the professional groups about moving out of the hospital with a walk-in centre. There is concern from GPs that it will take work away from them or that it will create additional work, and that is certainly not the intention. Those discussions must be around getting right the model of care that is provided at the walk-in centres so that it fits the target population that we are aiming to address through these centres. We are building infrastructure with the capacity for these services, but the timing of when they are operating is dependent on some further discussions.

MS BRESNAN: Do you have a time frame for judging the success of the walk-in clinic at the hospital?

Ms Gallagher: With the demand that we are seeing continue to grow in our emergency departments, I think a year would be a good measure of time.

MS BRESNAN: The professional groups you are consulting with, does that include nursing groups?

Ms Gallagher: Yes. The nurses are very excited about it. I have to say that the Division of General Practice and the AMA here have been excellent as well. Rather than reflecting a national position, I think it reflects an understanding of the local position that we are in. Consumer groups are broadly supportive. Again, they have raised concerns around the model of care that is provided, but I think if we start carefully and have the right governance in place for that first year we can then analyse how many people are using it, what types of presentations we are seeing, what is the patient satisfaction with that service, how the doctors in the hospital who will have some role in governance actually feel about how it has gone, and how the nurses themselves feel—the one in the hospital will employ around 15 nurses, I think—and all of that will feed into how we progress out into the community.

MS BURCH: How far away do you think that is? How progressed are your plans and thoughts and discussions?

Ms Gallagher: The walk-in centre at the Canberra Hospital we are hoping to have operational in March. It is contingent on the availability of the part of the hospital that we are looking to use. If you know the hospital well, it is the back end near radiation oncology, that large area. Maybe Ian had better explain it.

Mr Thompson: It is actually the allied health areas that are across the forecourt from the emergency department. If you know the hospital, there is the emergency department with the central driveway and then a building that is across the forecourt from that. We would have it on that corner there, which gives good access for the public as well as good access to the emergency department.

Ms Gallagher: It is contingent, though, on us being able to move an equipment loans

scheme and a few other bits out of the hospital into the new community centre in Kambah that we are building. That is expected to be finished by October, so we can decant the hospital into there, then the walk-in centre work can commence and progress and be finished by March.

MS BURCH: In addition to governance arrangements and staffing, what are some of the challenges that you foresee or you think you will need to overcome? Is it community acceptance or is it service charges?

Ms Gallagher: My first one would be demand; I would go straight to demand for a service. I think some of the challenges will be those that just come with a new model, a new way of doing things. We are integrating this into the hospital, and we went through a similar exercise that pre-dated me as minister when we introduced the CALMS model and the after-hours clinics. There have certainly been no issues raised with me by the community about nurses seeing patients. In fact, at the emergency department that is what happens to you before you get to a doctor. You are triaged by a nurse, you are then seen initially by a nurse and then a doctor after that. So I think that is okay.

Some of the other challenges are getting the scope of the practice agreed upon. I think the nurses will probably want to go further than the doctors will probably be comfortable with. So trying to get agreement on that will be a challenge. Again, everyone is working really well on this. From the beginning, all of the professional groups have been working well, so we just need to pull it together.

THE CHAIR: Ms Bresnan and then Mr Hanson.

Ms Gallagher: I should say that we are looking at the operating hours being from seven to 11, I think.

Mr Thompson: That is right, seven to 11, seven days a week.

Ms Gallagher: And it would be a free service.

MS BRESNAN: My question is in relation to the mental health young persons unit. In BP 4 at page 214 there is rollover funding there for that. In answer to a question it was stated that it would be located at TCH rather than Calvary, and that was apparently primarily due to ACTPLA concerns.

Ms Gallagher: Partly it was, yes. The other concerns were from the health professionals that provide services to young people, mainstream services in addition to mental health. Our paediatric unit and our adolescent unit are located on the Canberra Hospital site, and so certainly a number of doctors and nurses have spoken to me about the fact that that would not necessarily allow the most streamlined care if they were caring for patients and then moving to the other side of town to care for them just because they had a mental illness.

MS BRESNAN: Yes. I guess space is an issue in the type of the facility provided. Another issue is access to services.

Ms Gallagher: Yes.

MS BRESNAN: We have also been previously told that the forensic unit had to be moved because the adult unit needed more outdoor space at TCH. I am just wondering if the relocation of the forensic unit is also because the young persons unit is being moved there.

Ms Gallagher: No.

MS BRESNAN: So what has been the decision process around this? I would imagine space is still going to be an issue and having the right sort of facility for both those groups.

Ms Gallagher: Yes, that is right. The young persons unit is not envisaged as being next to the adult in-patient unit.

MS BRESNAN: So when was the decision actually made to move the young persons unit to TCH? We were under the impression not that long ago that it was going to be at Calvary.

Ms Gallagher: Yes. I must say I originally had concerns around the trees on the Calvary block when I saw the work that had been done in looking at the preferred site. Some of that originally was around synergies with ward 2N and the private mental health facilities that are there at Calvary. In relation to that, there was support for it to be located at that site. Pretty much as soon as the budget came out I was approached informally—not through a letter or anything but just at a function—by a number of our specialists in child and adolescent health who raised concerns with it being located at Calvary. In addition, it became clear there would be some issues around the trees on the back of that block at Calvary. I asked the department to look at whether there were opportunities on the Canberra Hospital site.

Once all the work that we have already outlined in the capital asset development plan is completed at the Canberra Hospital, because we are better using the space, there will still be pockets of space available for future growth outside of the capital asset development plan. So I think a formal decision, as I recall it, was taken around the same time that cabinet decided not to proceed with the forensic unit on that site.

MS BRESNAN: So it was actually the same time?

Ms Gallagher: If it was not at the same time, it was around the same time when cabinet was considering not only the mental health precinct but the young persons unit as well.

MS BRESNAN: I do not believe that was made public at the same time. I do not recall it being made public at the same time.

Ms Gallagher: Yes, I think it was.

MR HANSON: The young persons unit?

Ms Gallagher: Yes, I will check that.

MR HANSON: Yes, it was.

Ms Gallagher: I will check that, but I thought it was.

MS BRESNAN: We have had some carers and consumers who are concerned about that. Obviously, Calvary was a good location in terms of the sort of facility, because that is part of providing a good service as well. But they have raised some concerns around how it will operate. Obviously, at TCH the PSU is subject to that involuntary culture, so has there been any thinking as to how the young persons unit is going to run in terms of the culture which operates at TCH as opposed to that operating at Calvary? That has been raised as an issue.

Mr Cormack: We may ask Dr Peggy Brown to respond to that.

Dr Brown: Yes, we have done some preliminary work around the model of care for the young persons unit. The intention is for it to have two separate subcomponents. One will service adolescents between the ages of 13 and 17 years. The other section will service young adults between the ages of 18 and 25 years.

The developmental needs of the two groups are quite different; so we need to provide services that are appropriate for those groups. We do have the issue of whether we have it as a closed facility or not. That is one of the design features of the current PSU that does impact on the culture, because it is a gazetted unit under the act. It accepts involuntary clients and it is currently a locked facility. We will be seeking to have some high dependency capacity, particularly for the young adults, but our desire is for it to have a more open culture than I think currently operates at the PSU.

In terms of developing that model of care, the work is being commenced and there are some consultations to occur in the next four to six weeks around the site selection for the young persons unit. Following that we will go out then for some public consultation and input into that model of care.

MS BRESNAN: In terms of the model of care, has there been thinking behind how staff will operate between the two different units, between the young persons unit and the adult unit? Will they work across units or separately?

Dr Brown: I think that there is a desire for staff to have the capacity to work across both and to have the skills to work across both, but we have to develop that model of care further yet in terms of the staffing profile and how it actually operates.

MS BRESNAN: I understand that and I guess that will sort of have an impact on the type of model which is then going to operate at both those facilities.

Dr Brown: Yes, we need to balance the different needs of the two groups versus staffing availability, efficiencies and all of that.

MS BRESNAN: And I think the type of service you want to actually be providing to young people as well, as opposed to adults, because they will possibly have very

different needs.

MR SMYTH: Just following up on that, the decision on the new PSU, is it going at Quamby or is it going out—

Ms Gallagher: In relation to that process, there is community consultation going on now as we speak. I think it started at the end of—

Mr Cormack: Of April.

Ms Gallagher: April, and we are hoping that it will be finished by July 2009. They are consulting on three sites, is it?

Mr Cormack: Three sites.

Ms Gallagher: Yes, three.

MR SMYTH: And the three sites are?

Ms Gallagher: There are two at Gungahlin. We can give you the block number and everything.

Mr Cormack: The third one is at Quamby.

Ms Gallagher: And the third one is Quamby, yes.

MR SMYTH: Right, and the timetable for the young persons unit?

Ms Gallagher: In terms of the consultations around that?

MR SMYTH: Yes, and the site.

MS GALLAGHER: I think that is again by July, is it?

Mr Cormack: The consultation period is the same time and we envisage that the design will be finalised within the next 12 months, subject to the site being sorted out, of course.

MR SMYTH: Sure, and in the ground when and open when?

Mr Cormack: At the moment the appropriation for the young persons mental health unit covers its design. At this stage that will require a further government decision in a future budget as to when it goes forward to construction. Many of the projects were funded for design and construction, such as the skills development centre, and a number were funded for forward design.

MS BRESNAN: I guess that is a question in terms of budgetary consideration. Why didn't the young persons unit have the construction aspect funded also? Why was that not considered?

Ms Gallagher: I think we have got a longer time available for us in terms of demand for the service. I think it is eventually a 20-bed facility. The issues around the design and the scope really meant that we will take those decisions once that work is complete. It is not unusual just to get it to a design stage and then fund.

MS BRESNAN: No, but I guess that there has been a need for this sort of facility for some time in the ACT.

Ms Gallagher: Yes, there has been, and there is a growing need, I would say.

MS BRESNAN: Obviously, it relates to young people and it is where you need to identify mental illness.

Ms Gallagher: That is right.

THE CHAIR: Mr Hanson.

MR HANSON: Minister, just reflecting back on some of the earlier discussion about the increase in growth across health, you talked about growth at a rapid pace and that if you extrapolate that growth it is going to eventually consume the whole budget—that there will be little for anything else.

What growth factor are you considering? I think when you went to COAG last year you were talking about a figure of nine per cent. That is a figure that I guess the AIHW seems to be tracking as a cost increase across health. Is that the figure that you are using or could you tell me what figure you are using?

Ms Gallagher: The growth factor that we have built into our forward estimates is on average 6.2 per cent per annum.

MR HANSON: When you went to COAG last year you were arguing the case that the real cost increase across health is nine per cent, and there is quite a bit of evidence out there about this. That was argued by a number of the other states. There are federal figures that were put out as well as the AIHW figures. If you track the real cost of health, it seems to be a net nine per cent figure, and I heard you on the radio—

Ms Gallagher: And that is about what it is tracking at—a little under, I think, nine per cent for us.

MR HANSON: It seems to fluctuate a bit, but at nine per cent, so—

Ms Gallagher: Other jurisdictions are between eight and 10—

MR HANSON: The growth funding envelope that was referred to earlier in the 2006-07 budget, that is looking at a six per cent figure.

Ms Gallagher: Growth every year.

MR HANSON: Every year.

Ms Gallagher: Yes.

MR HANSON: So if the real cost of health is nine per cent and we have factored in a figure of six per cent, if you do some figures—I did some very rough figures in terms of the delta of those two figures—extrapolating it out about 10 years, that is a $2.6 billion hole or a delta in that figure. At the 10-year mark that is about 500—

Ms Gallagher: I would like to see your working sheet.

MR HANSON: I can show you that, but if you consider that the—

Ms Gallagher: You are talking about the difference between—

MR HANSON: The real costs.

Ms Gallagher: the eight per cent—

MR HANSON: Well, what I am saying is that you have argued the case and the evidence—

Ms Gallagher: Our outcome of, say, 8.5 and the budget funding of 6.2—

MR HANSON: Yes, that is what I am saying. You have argued a case at COAG and you have talked about the cost of health. You have established that that seems to be around nine per cent. But the funding increase that has been delivered in the budget is six per cent.

Ms Gallagher: That is a provision that we have made that is in the budget.

MR HANSON: But extrapolating that out, you can see that over time there seems to be that gap between the cost of delivering health and what is provisioned for in the budget. I just want to know what the impact of that delta is. Does that mean a loss of services? Does it mean that we have got to increase taxes? Does it mean we have got to go through a user panel? What are you going to do about that growing delta?

Ms Gallagher: The beauty of the 6.2 per cent that is built into our budget year on year is this: it means that for the first time from 2006 ACT Health were guaranteed a certain amount of money through the budget process which allowed them to plan, develop and, indeed, recruit staff.

I do not think any other government around the country makes the provision for health that we do. I think it is just indexed at whatever they index their government services at. Then they manage it year by year with what the true cost is. Usually there is a fairly big gap between, say, indexing your agency at two per cent and your health coming out at eight or 10.

In the ACT I think we have factored into the budget growth at around 6.2 per cent. We are, of course, looking to make our services continue on their efficiency target and that is to bring our overall costs down, which they are. Mr Cormack went to that earlier.

We also look for other ways to manage our health budget outside of the budget. Mark can go to some of the details of that, but it really goes to our third party revenue, our special purpose payments from the commonwealth in relation to which we did get a good result from COAG, and that comes in.

So those payments are over and above the 6.2 per cent, and they help us meet the budget pressure. Indeed, as I am advised—I am sure Mr Cormack will correct me if I am wrong—Health, with the adjustments from the commonwealth and with the higher third party revenue including access to those cross-border payments, will live within the appropriation for this year and will not be a call on the Treasurer's advance. So 6.2 is what is being provided in the budget, and then there are other additions which can come in over the top should Health need that to manage their budget.

MR HANSON: But those other provisions rely on outcomes at COAG or I guess are not—

Ms Gallagher: It would be pretty unusual for the commonwealth to say that they are not going to fund anything in health in the ACT. Those agreements have been in place under both governments. We got a better deal this time from the commonwealth. We got indexation at around 7.4 per cent, which has been revised back slightly because the indexation factors have changed. But those agreements are in place. We know we are going to have to continue to provide services to New South Wales. That will not change and we know they are going to have to pay for it. In addition, there are some other areas.

Mr Cormack: Yes, I am happy to run through those. I think that when you look at the year-on-year growth, you have got to look at rollovers that are all part of the growth. Rollovers happen for a range of reasons. We also need to recognise fluctuations in activity. The underlying growth rate that is built into the growth formula is of the order of between three and four per cent for acute activity.

We also need to factor in third party revenues and that includes sales of medical, surgical and pharmaceuticals to private hospitals, which we currently do, and reimbursement of high-cost drugs from the commonwealth. From time to time, and throughout the course of the year, we can get adjustments for a range of commonwealth programs such as immunisation. We can get variations, and this is one of the things that arose from the 2006-07 ACT budget decision around the shift to memberships of super schemes. That has an impact on the bottom line as well. A few years back everybody was pretty much in the CSS or the PSS. Now we have seen quite a different set of circumstances arise.

Of course, the other big factor is growth in revenues related to growth in activity. That is sourced not only from New South Wales through cross-border revenues but also through DVA and other third party revenues. Yes, the average is as you have described but the budget is really the plan for the year ahead and we have a plan for the year ahead based on a set of assumptions that are built into our growth formula. If those assumptions cannot be met for reasons beyond our control and we cannot generate the necessary efficiencies then we will have those necessary discussions with government at the appropriate time.

MR HANSON: So that measure of about three per cent is sort of anticipated from those revenue streams you are talking about? That runs at about three per cent?

Mr Cormack: No, the three to four per cent I was referring to was when the growth formula was decided in 2006-07. It was based on annual growth and admitted activity of around three to four per cent. So that is one of the assumptions—

Ms Gallagher: And in previous years we have seen in excess of that, which has put pressure on the 6.2 per cent. But the position of cabinet is that we maintain the 6.2. That gives certainty around growth in budget. If there are increases over and above 6.2 per cent, we look at how we manage that through our payments from the commonwealth, our payments from New South Wales or from other third party revenue.

MR HANSON: Given the analysis that is being conducted in ACT Health about the future and about the increase in demand in 20 years and 25 years and so on, does that—

Ms Gallagher: 2016-18, so it is—

MR HANSON: Yes, I have seen the growth figures in the ACT for up to 2020 and 2022—

Ms Gallagher: For population?

MR HANSON: For the population and the ageing population—what that means for demand and I think it is like—

Ms Gallagher: A quarter by 2020, yes.

MR HANSON: It is a 49 per cent increase in demand that is coming up in about 15 years. Does that 6.2 per cent still stack up then if we had to revise that figure based on that new analysis of the growth and the ageing?

Ms Gallagher: We have not because we have been able to manage it. I am not saying it is easy to manage the health budget at all. It is not. The governments of the future may have a different view about that. They may want to reassess it after 2016-18 when we are predicting the peak in terms of demand for hospital services. In 2020 people may want to revise it backwards; that would be a good day for the budget and for the ACT.

MR HANSON: You did the growth in 2006-07; then there was the analysis done on the demand that we are going to expect was done after that. That did not trigger a decision that we actually need to increase that 6.2 or decrease it based on that analysis? That work has not been done?

Ms Gallagher: That work continues to be done at all stages as we roll out the capital asset development plan, but in terms of what the government is prepared to budget fund every year we would do that. At this point, in this budget, for the forward

estimates outlined in this document, we have committed—it is an average of 6.2; it goes up and down a little bit depending on the year.

MR HANSON: All right.

THE CHAIR: Mr Cormack, last year you authorised the use of the Canberra Hospital by the Australian Labor Party for election advertising. Are you able to take us through what was the process for authorising that?

Mr Cormack: Sure. Basically, in August last year I was approached by the minister to ask if it was appropriate for the Canberra Hospital facilities to be made available for the purpose of backdrop for an advertising campaign. I considered the matter. The considerations that I used were the ACT government guidelines on the caretaker period, which were issued at about that time, as well as just the requirements under the Public Sector Management Act, section 9, which govern the behaviour of public servants.

On that basis, I was able to agree, on a number of conditions. The first condition was that it be at no cost to the public funds. That was the first condition. The second condition was that our staff—that ACT Health would not be canvassing or asking any staff to participate in any political activity. The third criterion was that there would be no disruption to the operation of the health facilities during the use of the facilities for any form of advertising or media, and that the activity be supervised. The matter was then referred to a staff member within the minister's office to deal directly with one of my staff members who has responsibility for any such approach to use public facilities for filming, documentaries or, indeed, advertising and—

THE CHAIR: I guess—

Mr Cormack: if I could just finish—

THE CHAIR: Sure.

Mr Cormack: We receive those approaches on a regular basis. In fact, I was approached only yesterday by an external organisation that was seeking to use public facilities as a backdrop for, I think, a film or a documentary. I followed exactly the same process. So that is how that matter came about.

THE CHAIR: Okay. In your answer to our question on notice, you said it was following a request from the Australian Labor Party. You have indicated now that it was a request from a minister to you. That seems to be a different scenario, in the sense that you work for the minister rather than—you do not work for the Australian Labor Party. How is that separated out?

Mr Cormack: The approach that was put to me was by the minister, and it was on behalf of the Labor Party. The Labor Party wished to access the facilities for the purposes of producing a series of commercials. The subsequent contact was between the ALP and a member of my staff who is responsible for dealing with any communications in media arrangements that involve any of our facilities.

THE CHAIR: So why is there no documentation in relation to this process? We put in an FOI request and all that came back was the answer to the question on notice.

Mr Cormack: Because I am the sole delegate in these matters, and it is my responsibility to take guidance from the official ACT government guidance on this matter—and that is what I did—and to communicate back, as we always do when we receive requests from external organisations to make use of our facilities.

THE CHAIR: So it was an oral request from the minister to you which you then actioned but there was—

Ms Gallagher: I recall—the conversation I had with Mr Cormack was: "Would this be possible?" "Would it be possible for the Labor Party to use a part of the hospital? Would this be something that ACT Health would consider?" "If so, there will be an approach made from the Australian Labor Party." And that is indeed what happened.

THE CHAIR: Okay. So that seems to be—

Ms Gallagher: That was over the phone, as I recall it. Yes.

THE CHAIR: So the minister called you and asked you whether that would be okay. You went away and considered it—looked at guidelines and the like—and then you subsequently dealt with representatives of the Australian Labor Party more directly—

Mr Cormack: I did not deal with them.

THE CHAIR: Members of ACT Health?

Mr Cormack: A staff member who is responsible for media matters and the supervision of access to our premises for any form of media activity was given as the contact person for the Australian Labor Party to be able to take the matter forward.

THE CHAIR: Okay. But the other question I asked, which has not been answered, is this. We had the oral request; then there were the subsequent dealings between staff and the Labor Party. In arranging this, why is it that there is no documentation of the advice that you considered in terms of the guidelines, the advice you provided to the minister, any arrangements that needed to be put in place, any advice to staff about the filming? Is there a reason why none of that is documented?

Mr Cormack: I answered that before, and the answer is the same. That is that I am the sole delegate in these matters, and the staff member involved, who is always the staff member involved—there are one or two people involved in the supervision of access to ACT Health premises for the production of any form of use, as a backdrop in any form of media activity. The conditions are the same irrespective of the nature of the inquiry. The guidelines that I followed are guidelines that I received from the Chief Minister's Department and were made available to my executive team prior to the commencement of the caretaker period. They are the guidelines that we follow in those circumstances, and they are the guidelines that were followed.

So that is the documentation. I do not document every single request for every single

organisation that wishes to make an approach to have access to our facilities. We have a very set instruction procedure to follow, and that is that I am the sole delegate and the arrangements go through our communications and marketing area.

THE CHAIR: Would it be ordinary practice when other groups ask to use Health facilities that there is no documentation in relation to that?

Mr Cormack: Yes, that is right.

THE CHAIR: So this is just all normally done in oral terms as phone calls and—

Ms Gallagher: I think the point is that it can be done that way.

Mr Cormack: Yes. The media contact us all the time—sometimes several times a week, sometimes several times a day. That can be local media or it can be national media if they are, for example, filming a documentary. They make those approaches. I advise the area responsible—it is the same area all the time—and we just follow the same set of guidelines and principles that I just outlined.

THE CHAIR: So it is just a phone call to that particular area saying, "There will be a film crew coming at this time"—

Mr Cormack: It can be a phone call or an email. If it is from a group we have not heard of before—sometimes an approach can come through saying, and this is a common one: "I am a journalism student from the University of Canberra. I am researching this particular aspect of health for my final year assignment or thesis. I would like permission to be able to access the facilities at Canberra Hospital," or Calvary hospital, community health or whatever, for a particular purpose. Sometimes we get those in writing. But basically it is the same response, because it is a very straightforward set of principles that we follow.

THE CHAIR: Are there any insurance issues when you have film crews coming onto the premises of Canberra Hospital?

Mr Cormack: No. No, there are no specific insurance issues. It is part of our overall insurance arrangements. It is just normal public liability. Provided they are authorised and provided they are supervised, that is part of the normal public liability arrangements that we have. It is a public facility. We have people coming in all the time, for differing reasons. We make sure that, particularly if it is a film crew, they are supervised to ensure that they adhere to the conditions that we set in those circumstances.

Ms Gallagher: And if you had asked—and if your advertising budget had stretched, which I doubt, looking at the quality of your political ads—you would have been able to use it too.

MR SMYTH: Well, that is witty!

THE CHAIR: Minister, do you think—

Ms Gallagher: Well, it is the same. It is. It was there. It is there and available—

THE CHAIR: Okay, but we have got no documentation.

Ms Gallagher: And we made a request.

MR HANSON: Could I ask: is it—

THE CHAIR: Sorry, I will just ask one more. Minister, was it appropriate for you to be making this request rather than the Australian Labor Party?

Ms Gallagher: I think the request, the formal request, came from the Australian Labor Party. But I—

THE CHAIR: That is not what Mr Cormack said. He said it was a—

Ms Gallagher: I flagged it—

THE CHAIR: request from you—

Ms Gallagher: I flagged it.

THE CHAIR: as minister.

Ms Gallagher: I certainly flagged it with Mr Cormack.

THE CHAIR: But is it appropriate for you as minister to be using that position?

Ms Gallagher: I said, "Is it okay?" I raised the question: "Would it be okay to use the hospital for this purpose if the Australian Labor Party approached you?" I remember him saying: "Well, I consider those. We get them from time to time for third parties to use the hospital. We usually introduce a range of conditions"—for all of the reasons that Mark has gone to.

THE CHAIR: But none of those are in writing.

Ms Gallagher: And he said, "And if I get any other requests they will be treated accordingly."

MR HANSON: Mr Cormack clearly—

Ms Gallagher: "In the same way." I said, "Rightio." That was the end of it.

MR HANSON: He clearly indicated that his understanding was that the request had come from you. You might say that it was a flagging—

Ms Gallagher: Certainly I raised it.

MR HANSON: but I think that you are stepping away from the fact that, if a minister speaks to the department head and makes a request like that, to say it is now a flag—

this appears to me like a conflict of interest. If you had your time again, do you not think it would be more appropriate that it would be from a member of the party? It appears that you have now compromised in some way the relationship between yourself and the department and the—

Ms Gallagher: I doubt that very much.

MR HANSON: The head of the department is having to answer questions about why a political party—

Ms Gallagher: Look, I expect—

MR HANSON: was represented by the minister.

Ms Gallagher: I always expect Mr Cormack and the quality of his advice to me to be honest and frank. I asked a question about whether a facility could be used. He indicated that, yes, it could. I do not think that compromised or put me in a conflict of interest situation at all. I will leave it for others to judge that.

THE CHAIR: And you are comfortable, then, with the fact that these kinds of arrangements are put in place without any documentary evidence whatsoever?

Ms Gallagher: I do not think it is unusual that arrangements from time to time are made over the phone. Are you suggesting that there is something untoward going on—that there was not paperwork and therefore there is something sneaky about it?

THE CHAIR: We do not know. We have not seen the paperwork. So—

Ms Gallagher: But what are you expecting from the paperwork?

THE CHAIR: We would think some basic paperwork, some advice to staff about what was going on—any of the issues that need to be dealt with. It is surprising that the request—

Ms Gallagher: Well, there was no—

THE CHAIR: came from the minister rather than from the Labor Party.

Ms Gallagher: Look, again—

THE CHAIR: I mean, do you really think that is appropriate?

Ms Gallagher: Again, I think I asked a question about whether a facility could be used. I do not see how that compromised me in my role as minister or indeed compromised Mr Cormack.

THE CHAIR: We might come back to that. We will break for lunch. We gave gone a little bit over time. Minister, we are at your mercy—and the officials'. We can come back at two or we can push it back 10 minutes if there is a need.

Ms Gallagher: I would prefer an hour and a half.

THE CHAIR: Okay. We will resume at 10 past 2. We will also have a brief private meeting.

Meeting adjourned from 12.40 to 2.09 pm.

THE CHAIR: Welcome back, minister and officials. We will go straight to questions. Ms Burch has some questions.

MS BURCH: I have questions on e-health. It is a considerable budget item of $90-odd million. I would like a bit of an overview about how this money will be spent and what we will end up with.

Ms Gallagher: Yes, we can give you that.

Mr Cormack: I ask Owen Smalley, the chief information officer of ACT Health, to give us an overview.

Mr Smalley: In reference to the $90 million project and what it is scheduled to deliver, the project is focused in four areas: patient records, clinical decision support, supportive services and infrastructure. To put that in a bit more detail, the system focuses on delivering an electronic medical record, electronic health records, personal electronic health records, in the first instance. It will also be focusing on delivering clinical note capabilities for community health services, typically out in the field; within the hospital, an upgrade to the renal systems; integration of the theatre systems, that is, around sterilisation and advanced supply systems and scheduling; staff rostering around resource management; bed management inside the hospital; a new food services system.

Across at Calvary, we will be looking at establishing a single IT network with Calvary as a foundation layer and, from that, we will build an extension of our existing patient administration system, loading the patients to be managed across Calvary and TCH; a common patient identifier; a common medical records system. At the moment there is a split records system. We will also be upgrading the existing infrastructure to a medical-grade network and wireless connectivity, which allows clinicians to operate in the facilities using mobile devices so that they do not need to have to find a PC; and installing tracking facilities so that we can track the whereabouts of equipment, patients and staff.

That is a quick rundown of what that $90 million is to deliver.

MR HANSON: Can I clarify a point there. You just said that at Calvary you were going to be creating a single IT network.

Mr Smalley: No, we are extending the ACTGov network, what we call the ACTGov network, to Calvary so that we have the same network running across both sites.

MR HANSON: We heard this morning that an issue and a justification in part for the purchase of Calvary were the problems in, I guess, talking between the two and

having the same systems. But what you are saying is that this $90 million that is in the budget is actually going to achieve that. Is that right?

Mr Smalley: It is going to extend it. We already have connectivity to Calvary today, because as at today we already have layers running at Calvary. A mental health system runs across both sites. Our radiology, this PAC system, runs across both sites. There are a couple of others too. Pathology runs across both sites as well. But that is problematic because at the moment, because we do not have common systems and common identifiers, often people have to double-data entry at Calvary.

MR HANSON: But that is going to be resolved through this, is it?

Mr Smalley: We are moving towards a common infrastructure that allows us to get to the point where we do not have a double entry and double records.

MS BURCH: I have a question on clinical note capabilities with patient record. Is that for staff management or is that—

Ms Gallagher: What is so interesting, sorry?

MR HANSON: It is a different story than you gave this morning.

Ms Gallagher: No, it is not different. It is not a difference.

MR HANSON: You said that we needed the—

Ms Gallagher: It is not a different story at all.

MS BURCH: Can I ask a question?

THE CHAIR: The minister has asked Mr Hanson. So there is a bit of an exchange.

MR HANSON: A point of clarification—

Ms Gallagher: It is just the aside that there is a further conspiracy on Calvary here. It is not a—

MR HANSON: It is contradictory evidence.

Ms Gallagher: No, it is not contradictory evidence.

MR HANSON: Yes, it is.

Ms Gallagher: We will have to negotiate with the owner-operator of Little Company of Mary in order to implement that initiative. What I said this morning was: a single governance structure would take away that requirement to negotiate under contractual arrangements, on a whole of range of things, including IT.

MR HANSON: Do you anticipate that offering to spend tens of millions of dollars on their IT system will be problematic in the negotiations and that they would not want to

pursue it?

Ms Gallagher: We have had discussions with them on IT in the past.

MS BURCH: Have you have finished answering Mr Hanson?

Ms Gallagher: Sorry.

MS BURCH: Can I go back to the line of questioning?

Ms Gallagher: I just could not let the aside go. I should not respond.

MR HANSON: No, you should not. Please note that.

Ms Gallagher: I should just let the conspiracy theorists at the end of the table continue in their own mad world.

MS BURCH: Clinical notes capability, can you explain that a bit please?

Mr Smalley: Sorry, which?

MS BURCH: You made some comment about clinical notes capabilities.

Mr Smalley: Yes. The particular areas here are the clinical systems we are bringing on board, some of the bigger ones. The electronic medicines management is probably the biggest clinical system we are rolling out and this is providing clinicians with the capability to do electronic prescribing, that is, prescribe drugs, administration of those drugs and progress those drugs, as well as keeping track of interactions between the drugs, the effectiveness of those drugs.

It is well recognised in the health vicinity that medicines management is a big area of reducing errors and improving safety. This EMM system, as we refer to it, electronic medicines management, is all on enabling clinicians, supporting clinicians with their decision support and managing that process.

At the moment, drug management is primarily done on paper and interaction requires a significant amount of manual interaction. They have to type in various drugs, weights, pathology, to see whether there are going to be potential interactions.

MS BURCH: And would that be linked to a patient's record?

Mr Smalley: Yes, it will. Fundamental to the whole system is establishing an electronic medical record, an EMR. At the moment at TCH, they have a scanned medical record. What we are looking at here is extending that record to be both scanned and real-time entry medical records. So information that is captured, say in the wards, at the moment is captured on bits of paper and then at some stage, usually after discharge, is scanned in.

Under this new system, it will be actually done real time and that of course requires wireless connectivity as well. It will be real-time data entry, real-time sharing and

forward controls. If you integrate that with the medicines management you have got full real-time sharing of information.

MS BURCH: Will the record be unique to that person and then on discharge they maintain that record? Will that link to community health?

Mr Smalley: At the moment, because we have a common system across TCH and community health, we already have a single record for a patient's visit, what we call an episode, and we have what we call a common record for a patient, based upon their identifier. Once they are uniquely identified, each episode is just added to that identifier set. We already have that today. The issue at the moment is the timeliness of that information because it is paper based and is not linked in and scanned.

There is another aspect to this as well and that is to recognise that we have a number of clinical systems already, such as pathology and radiology. Part of this program is to introduce or expand the clinical portal. The clinical portal is an application that brings all these other small systems together and presents them on one page so that the clinician, for example, can have a look at the person's ED visits, their theatre information, their drug interactions, any other piece of information associated with those particular visits or that particular patient's care.

That is also an important part of building the discharge summary print episode, because to build the discharge summary it requires you to gather information such as radiology results, pathology results, drugs et cetera. The portal brings those systems together and allows you to assemble information for the production of a discharge summary, which we have just introduced. That discharge summary is then electronically sent to the GP and kept in an electronic health record.

MS BRESNAN: Can I ask: with the system you are implementing, will you be using or building on the work that the National E-Health Transition Authority has been doing? I guess that is particularly on the language which is used, the privacy blueprint and the unique patient identifiers which they have done a lot of work on.

Mr Smalley: Yes. If we look at the national program, particularly what NEHTA has been doing, NEHTA has been working on the establishment of national standards for improving connectivity. Probably the big area of interest to us, most interest to all of us, is the common identifier. It is a national health identifier. That is critical to enable consistency of sharing of information electronically so that we know we are talking about the same person. They also have other identifiers such as provider and organisation identifiers. These are critical in identifying and managing security of access to information so that we consistently identify who is trying to access somebody's record and what rights they have.

We will be leveraging off the design associated with the IHI and, once those systems become implemented, we are looking at trying to be an early adopter of that technology as well, because that is a significant advantage to all of us, particularly with cross-jurisdictional communication.

The other aspect of NEHTA to consider is the standards on, say, discharge summary and already we have been working with NEHTA on our current discharge summary

program to develop to the national standards at the design phase and now, with implementation, we use NEHTA to come through and validate what we have implemented as close as possible to the NEHTA standards. The importance here is that we can therefore send a discharge summary to anywhere in Australia and the GP practice software, if it is complying with those NEHTA standards, will be able to receive it, understand it and load it back into their system. That is really the big benefit of NEHTA; it is to provide that connectivity outside our region.

MS BRESNAN: Have there been any discussions or thought about whether it is going to be an opt-in system or an opt-out system? There has been a lot of discussion through NEHTA about that also.

Mr Smalley: For the identifiers, they are going to be universal, which effectively means that the identifier will be—

MS BRESNAN: So it will be an opt-out system?

Mr Smalley: It does not actually make sense to opt out. An identifier will be created at point of contact. To op out is nonsensical because we already use identifiers internally. As soon as you turn up to a hospital we provide an identifier.

MS BRESNAN: I guess with the e-health—

Ms Gallagher: You are talking about opt out of the record?

MS BRESNAN: Yes.

Mr Smalley: Yes.

Ms Gallagher: Not the identifier?

Mr Smalley: Yes. You can come through as being anonymous or pseudo-anonymous. We do it for example in sexual health today, where records are not associated with any other record. For example, other areas where it is accepted that a person is not to be identified, they will be given a pseudonym or some alternative identifier. It allows them not to have their records blended with other records, such as your sexual health record maybe being associated with a fracture record. You would separately have two records.

MS BRESNAN: A lot of the issues on that have been, for consumers, about how you notify people when a record has been established. Obviously you are given a unique patient identifier and that is a separate process and we have the record established. How are people then going to be notified? Are people going to consent to having the actual record created?

Mr Cormack: I want to clarify a point and come back to the national health information regularity framework in a minute. It is a very important technical point. Commonwealth, state and territory ministers agreed that there would be a unique healthcare identifier. Every person will have one but they do not have to use it. It is not a prerequisite for access to any healthcare service across Australia's public

healthcare system or Medicare or anything like that. So they do not have to use it.

However, if they choose to participate in the e-health and e-health record system, a national e-health record system, then they will use that identifier. So it is an important distinction. There are some other aspects of the NHIRF, which is the national health information regulatory framework, which perhaps Ian, who has been very actively involved with that over the last few years, might be able to clarify.

Mr Thompson: To answer the specific question about how does a consumer know that a record has been created, the way a consumer knows that a record has been created is by consenting to have a record created.

MS BRESNAN: So they will actually use it, yes.

Mr Thompson: That is attached to the individual health identifier. To expand slightly, it will be introduced. I will have an individual health identifier. If I turn up at an emergency department, I can choose to say, "I am Ian Thompson. Here is my identifier. Create a record."

MS BRESNAN: Activate the record, yes.

Mr Thompson: Or I can choose to say I do not want my identifier used. Either way, the care then and there that the emergency department provides to me will not be different. However, the capacity of the emergency department then to look up any records there are about my allergies or previous history and/or to pass on a discharge summary to my GP will be taken away if I do not use it. So there are advantages in using it. However, if you choose not to, that is your choice, but you will not be able to participate in the advantages.

MS BRESNAN: Yes. Obviously, if you have got the need to work around the UPI, you will also be using that because I know that they did a lot of work around privacy, developing a privacy blueprint about how that will operate.

Mr Thompson: Yes.

MS BRESNAN: Yes. So that will be a part of it?

Mr Thompson: Yes. The work is continuing on the privacy legislation. However, there has been a draft set of national privacy principles for health around for a bit over five years. The ACT legislation currently is consistent with the previous set of draft privacy principles and has been embedded in our Health Privacy and Access Act. When the updated principles are endorsed nationally, we will then look to incorporate them in our legislation as well.

MS BRESNAN: I have a really quick question.

THE CHAIR: Sure. There are a number of questions in this area. Ms Bresnan—

MS BRESNAN: Just one really fast last question.

THE CHAIR: No, that is fine. I am not making a limit. Ms Bresnan has another question, Joy Burch has another in this area and Ms Le Couteur, and I believe Mr Smyth will ask questions in this area.

MR HANSON: I do not want to miss out either.

THE CHAIR: I will come to you eventually, Mr Hanson. So we will go in that order, if we could.

MS BRESNAN: I know obviously there is a lot happening in the area of privacy. Have you spoken to the Privacy Commissioner at all about this process?

Mr Thompson: Yes. The national privacy work is being conducted at a national level in the context of the Australian Law Reform Commission's review of overall privacy legislation. The current approach is that the health privacy principles will be embedded within broader privacy principles.

MS BRESNAN: And that will go before the commissioner?

Mr Thompson: The Privacy Commissioner obviously is front and centre in that discussion.

MS BRESNAN: Thanks.

THE CHAIR: Ms Burch?

MS BURCH: You made mention also around e-health in admitting or administration of patient movement and you also made mention of records going into the GP network on discharge. When somebody is coming through and being admitted, is that pre-admission work part of this e-record and will that feed into the admission process?

Mr Smalley: Yes. There are two parts of it. Yes, at the moment, when a person is admitted, we already send a notification to the GP letting them know their patient has been admitted as well as the process by which they start the build-up of the admission, which actually can happen before a person is admitted if it is not an emergency admission. That information is recorded electronically and does feed into the electronic medical record and also then will feed into the electronic health record.

MS BURCH: Okay.

THE CHAIR: Ms Le Couteur?

MS LE COUTEUR: My question is related to privacy, but it is more about accuracy. What work are you doing to ensure that the information, which may or may not be kept private, is actually accurate? In particular, do patients have a right to and would they routinely see their records so that they can say, "No, I did not turn up with a broken leg. I think it was my arm," or whatever?

Mr Thompson: Yes. That is, in fact, one of the advantages of having an electronic system and a feature that is being explicitly incorporated into the national work and

into the ACT work—that, as an individual, you are able to access your own record and review it and to make requests for change. We have not reached the point about the precise mechanism that would be involved to make the changes, and that is contingent on final decisions about where the records will be held and the like but, yes, that is an explicit feature of what we are looking for.

THE CHAIR: Mr Smyth?

MR SMYTH: Minister, Deloitte did a review of implementation of e-health and that review has gone to health ministers. I understand the executive summary has been released, but not the full review. Will it be made public?

Mr Cormack: I am pretty sure—I will take it on notice, but I understand that at the last health ministers meeting the ministers actually launched the national e-health strategy. It was either the last one or the one before that. I understood it had been made publicly available.

MR SMYTH: I understand the executive summary has been released, but as of 12 March the strategy itself had not been released.

Mr Cormack: I will have to take that—

MR SMYTH: But if you have got a copy and you want to make it available to the committee, we would be delighted to have it.

Ms Gallagher: Let us just have a look at it. I think we have had a meeting post 12 March.

MR SMYTH: Yes. Okay. I understand that in the report Deloitte called for NEHTA to be disbanded and a new model to be set up. Is that something the government is considering or health ministers are considering?

Mr Smalley: I could probably put that in context.

Ms Gallagher: Yes.

Mr Smalley: The strategy was focused on establishment of a group to operate the national infrastructure. That was framed around the concept that NEHTA's work, under the title NEHTA, was to develop and then a new body would need to come into existence for the purpose of operating the national infrastructure. That is the context behind that statement.

MR SMYTH: Okay.

Ms Gallagher: And then COAG confirmed arrangements around NEHTA—

Mr Smalley: NEHTA is effectively starting to—

Ms Gallagher: at our meeting either late last year or early this year.

MR SMYTH: So NEHTA will remain?

Mr Cormack: The COAG decision was to continue the foundation work that NEHTA has been doing. The first ministers agreed to $210 million to continue that work, the foundation work of NEHTA. That work will be ongoing for the next few years and, as Owen mentioned before, the Deloitte report points the way to ensuring you have got an appropriate governance framework in place when you set up the national e-health system. It is not quite set up yet, but NEHTA continues, and continues with the brief that it has been given by COAG.

MR SMYTH: All right. So you will look at to whether or not you can release the report to the committee.

Ms Gallagher: Sure. We will see.

MR SMYTH: Minister, e-health has been tried in various places around the world and around the country. There has been some trouble with the systems in Sydney recently. Is the department aware of them and should we be worried by the failures?

Mr Smalley: Yes. The one you are referring to I understand is the recent outage they had in one of the data centres in Sydney affecting their IT systems for a number of hospitals.

MR HANSON: Is that the Nepean one, is it?

Mr Smalley: That was one of the hospitals impacted by it, yes. I have a meeting with my CIOs on Friday where I will be discussing the details behind that, but there are some basic lessons to learn around any data centre outage about single points of failure. I do not quite understand how that outage could actually take them out for such a great period of time. Our position here is that when we build our systems, a couple of points to note: one, redundant infrastructure, where we have two data centres and two systems so that a failure of one data centre will not take out the whole system. We also try to avoid having common infrastructure, so a failure of a piece of infrastructure does not cause the system to fail as well. In our industry we talk about things such as high availability, fault tolerant, business continuity and disaster planning. All those aspects have to be balanced.

What I referred to before, the medical grade network, that was all around developing a highly available fault tolerant network as opposed to, say, a normal network, an administrative network; when it fails, the network is out. Under a highly available fault tolerant system, any one failure will not cause the whole system to fail. Having said that, that does not necessarily mean there will not be disruption and your BCP plans, business continuity plans, are designed to support that when you do have a major outage.

I do not know the exact details, and I understand there is an investigation being launched as to—the cause I think is known—why it took them so long to restore services, which is probably the bigger issue to me. We will definitely learn from it if there are lessons that can be applied here.

THE CHAIR: Ms Le Couteur, Ms Burch and then Mr Hanson.

MS LE COUTEUR: Will the data centres you are talking about be located in Canberra? If they are not, is that going to imply that an increase in bandwidth will be required into Canberra? I am aware that we are fairly constrained in bandwidth to Canberra.

Mr Smalley: From what I understand at the moment, the data centres will be located in Canberra. That is not within my brief at this stage. I understand that, from my concern, one of the primary data centres really needs to be located in Canberra, preferably very close to the hospital. Where the secondary member is located is really a business decision the government needs to take. Amongst all the other businesses, it has to support emergency services et cetera as well.

THE CHAIR: Ms Burch?

MS BURCH: I am just curious around, you know, costing to benefits or efficiencies through e-health across such a wide range of activity, from bed management to patient admin. How do you quantify all that?

Mr Smalley: In terms of benefit studies, we looked at international research around what the perceived benefits were to implementation of e-health. The best research we have came from Chandra out of the United States. They are indicating a 12 to 20 per cent improvement in process efficiency through the introduction of e-health, properly introduced. Now, that is probably reasonably achievable, simply because of the reduction in double data entry. The other thing to consider, too, is that when you bring e-health in with any IT system, you tend to do a significant amount of revisiting of existing business processes and in the process you actually make existing business process more efficient regardless, just through that process of review.

I would be expecting to see significant improvements in efficiency through the system—through reduction of double data entry; through an improvement in safety through reduction of errors, particularly around medication errors; appropriate treatment; decision support and supporting best practice. All these things tend to lead to better efficiency, better quality and better patient outcomes and also improved transparency of activities as well.

MR SMYTH: Just on that point, there are reports that in the system in Sydney medical staff used to get through eight to 10 patients in a shift, they are now getting through five to seven and that the system is actually cumbersome and data retrieval is awkward. Is that a teething problem or is that the experience overseas?

Mr Smalley: It could be. As I said, well implemented e-health, but e-health can also be implemented poorly as well. It depends if they have integrated the work practice issues. Quite often, when you introduce e-health you must also introduce a change to the work practices, the way people perform their tasks and functions. For example, recently I visited Melton hospital in Victoria where they introduced a queuing system for managing outpatients. They have pretty well reduced their waiting times and improved productivity and patient satisfaction, but what they did was spend 10 months re-engineering the work practice and design of the work practice associated

with the technology. You just cannot bring in technology without changing work practice and also changing the culture of the way staff operate. So it is a blend. All those things must come together to make it work well.

MR SMYTH: So will every hospital, every medical outlet across the country have the same system, the same software?

Mr Smalley: No. At the moment, for example, in New South Wales their core power system is a blend of Cerner and iSOFT, which are two major vendors. Those two vendors also operate across Australia, with iSOFT operating in Victoria and iSOFT operating here. In terms of clinical systems, there is Cerner operating in New South Wales, and Cerner may operate some of the other clinical areas as well, such as pathology.

We have a blend of clinical vendors here, such as Kestrel, ACT Pathology and Siemens for our RIS/PACS and Orion for our clinical discharge summary. So there are a number of players across the board providing services and systems. Having said that, it is not a very big market. There tends to be only two or three major vendors in any one product range. We do not have hundreds or even tens of vendors operating in different clinical streams.

MR SMYTH: So will it go out through procurement and have a full tender process?

Mr Smalley: Yes. We tend to leverage off each other. For example, at the moment we are looking around breast screening and we are looking at the Tasmania experience. South Australia has just recently gone through it, and New Zealand. The first thing we do is look at what products they have implemented, whether they worked or they did not work and what are the lessons learnt. We use that then to set up our own tender process. That is a standard process we do.

MR SMYTH: Right.

THE CHAIR: Right. Mr Hanson?

MR HANSON: Obviously, when patients move around the system in the ACT, they seem to move between public and private and GPs and so on. The 90 million that is allocated, is that just the public system? Does it extend to GPs? Does it extend to private hospitals? Where is it going to be rolled out?

Mr Smalley: It will touch on those other areas. For example, in terms of the GPs, part of the process will be to enable the GPs to interact with our clinical portal. We will be developing a clinical portal and making it available to GPs and setting up the GPs to be able to interact with it in that sense.

Around the EMM, the electronic medical management referred to before, we are also looking at extending that to nursing homes because they are a major transfer of us, and it is important to keep the drugs aligned when they are out and they come back again. So where there is an opportunity to get that benefit and consistency of approach, we will do so. It is mainly around those touch points. We are not planning, for example, to spend any money buying systems for GPs. We will certainly be spending

money to enable them to—

MR HANSON: Have you done any analysis then—if a GP is going to be able to integrate properly into the system, how much that is going to cost an individual GP to then enable them to be part of the system?

Mr Smalley: Recently the commonwealth put out incentive payments around connectivity associated with the NEHTA program. What we are doing is developing our programs to be NEHTA compliant; therefore, any GP who also is NEHTA compliant can connect. The commonwealth is providing incentives to GPs to go down that pathway. GPs have a natural incentive to want to connect as well, because they will get access to information more quickly and easily. We are working with the GPs and the business GPs to enable that to happen for ourselves. The nice thing here is that, if we set this up so that GPs can connect to us, the GPs will certainly connect to other parts such as New South Wales, because they will be following consistency of standards, and would also—

MR HANSON: So you are pretty sure they are all going to join up to this?

Mr Smalley: No.

MR HANSON: Because if they do not, the problem might be that you do an electronic record, someone gets discharged and then, if there is not a written record—and you will not know when you admit that patient who their GP is—you cannot talk to them.

Mr Cormack: Can I just say something on that? I think you are describing the situation as it is now. What we have already begun to implement, and will implement through this initiative, will be to create a whole lot of signals in the marketplace that will require people, if they wish to remain successfully in business and connected, to be able to participate in that. But underpinning that—we go back to the earlier discussion: it is the work of the National E-Health Transition Authority, NEHTA; and NEHTA's job is to develop a set of national standards.

It is the rail gauge argument: you might use a different locomotive, you might have different carriages, but you are all running on a standard-gauge railway line. That is when we have railway lines. The same approach will apply to e-health—the terminologies you use, the form of messaging, the secure messaging that is used. All of the software vendors, the practices and the businesses who want to participate—and they will all want to participate, and they will be incentivised by practice incentive payments from the commonwealth for doing so—will need to buy into a system one way or another.

The most important thing about this is that this actually puts consumers in the centre of the care system. At the moment they are out to the side. When you empower consumers with control over their own health information and the ability to be able to link up the providers by virtue of an e-system, you are really getting down the path of quite a revolutionary approach to health care. I think we are well placed here in the ACT to do that, especially with this initiative.

THE CHAIR: Are there any more on e-health?

MR HANSON: No, that is fine.

THE CHAIR: We will move to other areas. Ms Burch.

MS BURCH: Cancer services, if we can move on. There are a number of lines—in fact, there are a number of lines in the book—around growth across a range of services, but this is on the cancer services. Recently there was an announcement of a cancer centre. The questions are around what the cancer centre will bring to the region and what we are doing to meet the demand for and growth of cancer services.

Ms Gallagher: There is a range of initiatives in the budget around the growth that we are seeing in cancer. This goes to a number of areas, particularly things such as diagnostic mammography, but also just meeting the general growth in demand for cancer services across the hospital. We can go to those initiatives.

With the cancer centre, we were successful within our application to the health and hospitals fund—I think that is its name—for around $28 million to build the infrastructure for a cancer centre of excellence, really to co-locate a whole range of services in one specialist cancer area within the hospital. Whilst we have the new radiation oncology area, our in-patient unit is in the hospital and a whole range of specialties exist in different places within the hospital. This is all about streamlining it. From my discussions with Nicola Roxon, who thought our application was very good, I think it is a model that they would like to see replicated in the regions. That was outlined in the budget, although we were the first one to actually get the tick to go ahead with it. Part of the strength of our application was around having that regional focus—that this is to provide an integrated cancer care centre for around 600,000 people in the catchment. Did you want to add something?

MS BURCH: I am just interested in any of the new services or the enhancements.

Ms Cahill: In terms of funding that the commonwealth government have provided, it will be for what we are calling stage 1 of the integrated cancer centre. That will provide space to deliver multidisciplinary outpatient or ambulatory care clinics. A lot of people who are receiving cancer treatment need to have inputs from a variety of services, whether they be radiation oncology, medical oncology, haematology or social workers. It will allow us to create a space where all of those health professionals can be located in the one space, and the person can just come to that centre and much more easily be seen by a range of health professionals.

Stage 1 will also allow us to create space for research and training, which will be important for us in terms of developing our capacity for research in the ACT.

The funding will also allow us to develop patient information services as well as to house administrative functions. The intention is that, as we move forward with the implementation of the capital asset development plan, stage 2 will involve the provision of additional acute care services, in particular more in-patient beds.

MS BURCH: How does it align with the cancer centre that we have got now? The

service we have got at the moment will integrate into the cancer centre?

Ms Cahill: In terms of the physical location, as you have just recognised, we have just recently expanded our capacity in that area. We have got space for more linear accelerators, so we will be building in that area where the existing entrance to building 3, near the radiation oncology services, is. This funding from the commonwealth will be used to build a structure that will be cantilevered over the entrance. Then, once we go into rebuilding the new building 3, that will be where we locate the new in-patient beds.

MS BURCH: And just a final question: will this expand the options for local treatment? We hear stories where people need to travel, so having a centre of excellence will increase the options locally?

Ms Cahill: Certainly it will allow us to provide more access. And, aligned with the introduction of the PET CT as well—which was funded in this budget and which is an important tool in the management of people with cancer—that will enable better access for the management of cancer for people in this region.

Mr Cormack: I think one of the other things is that it becomes not just a hub to bring together the treatment services but a hub for research as a major regional cancer centre. And, when you bring together very solid, state-of-the-art infrastructure, backed up by information management and backed up by a research centre, you attract and keep the best quality medical, nursing and allied health people and scientists that are required to service the area.

So it is actually a great investment in developing intellectual capacity. Also, it is a big boost to the economy. When you see a sizeable cancer centre develop, they really pull in a lot of people. They pull in a lot of community support as well. They pull in sponsorship arrangements. In fact, we saw that when a local company, Independent Property Group, made a very generous contribution to add another little extra bit—or a big extra bit—onto our cancer services.

So it is a big seed-planting exercise and it recognises the ACT at the centre of a very big region, 600,000 people. Our people will have access to almost all they need in terms of cancer management, particularly for adults, and also a greater range of support for children's and young persons' cancer services. Most of those are concentrated in the larger capital centres. That is really what it delivers.

Ms Gallagher: The other thing that we would be looking at—Mark sort of touched on it—is to build on non-government organisation cancer support services. I know that over the years many of them have talked with me about the opportunities of co-locating or being able to work alongside the clinical teams as people embark on their cancer journey through the system. I would be hoping that we could do some work around that as well.

The idea behind the cancer centre, certainly when I have talked to the clinicians, particularly Professor Robin Stuart-Harris, who has been driving this for a number of years, is that the patient, again, becomes the most important thing; the clinicians, the different support services, the treatment, the counselling and the recovery path all

wrap around that person rather than that person travelling to different points of the hospital at different times on different appointments, because people run clinics at different times, to get their full comprehensive treatment. If anyone has gone through watching someone go through a cancer journey—and I am sure, knowing the statistics, that we all have—they will know just how difficult some of those arrangements can be. So this is a really exciting opportunity for Canberra and for the region.

THE CHAIR: Ms Bresnan has supps on this and then we will move to Mr Smyth.

MS BRESNAN: Obviously it is a significant investment. Looking ahead, and if you have done any examination of it, are there still going to be some other major priority areas in cancer that are going to require investments in coming years? I noted you said that most adults will be, but will there still be some services particularly for children, where people will have to go interstate, or this is going to consolidate services for people?

Mr Cormack: This will consolidate services. It will increase the self-sufficiency of Canberra in terms of it being able to provide a very high percentage of the cancer-related services that it needs. I think it will provide the critical mass—the greater critical mass—of patients that will support some services that are not currently viable because of small numbers. That was my reference to expanding the range of services we could provide for younger people and children.

But I think there will always be some rarer forms of cancer or some particularly high-tech interventions where they will be confined to national centres. And that is the way a good cancer system works in a country: you have major national centres, larger metropolitan centres and regional centres; then you carry your support right out into regional and rural areas. That is really what we are doing here. We support a medium-sized city but a very large regional and rural population. But there will still be some services that we may need to travel for.

MR SMYTH: Just on the PET scanner, when will it be operational?

Mr Cormack: I will get you an answer on that in just a minute. Soon.

MR SMYTH: There have been some very interesting definitions of "soon" in estimates committees over the years.

Ms Gallagher: You have been around here too long. It always comes back to Ted Quinlan at some point.

MR SMYTH: It always comes back to "soon". At the same time, when will the cancer centre be fully operational?

Ms Gallagher: The profiling is just coming from the commonwealth; the flow of money is coming from them. I understand that will be early 2012.

MR SMYTH: So the cancer centre is 2012? We get the money or we get the completed centre?

Ms Gallagher: No, that will be finished. The majority of the money flows in 2009-10 and 2010-11—almost fifty-fifty, as I think I recall seeing the figure.

MR SMYTH: And the scanner?

Mr Cormack: It is 2010—April 2010.

MR HANSON: Minister, we look forward to seeing these delivered on time and on budget, but, assuming that is the case, this is good news for Canberra, and I certainly welcome it. In your election commitments, you had $14.2 million to build a cancer centre of excellence. Does this commonwealth initiative replace that, is it supplementary or how does it fit in?

Mr Cormack: Just in response to that, the $14 million that I think you are referring to—I do not have the policy—

MR HANSON: I have it here: $14.2 million to build a cancer centre of excellence to provide the people of the region with more coordinated care. It sounds very similar to what—

Ms Gallagher: We continue with that.

Mr Cormack: Yes. What the commonwealth initiative will do will be to develop a major centre. As part of the broader CADP, we still have other elements to build, which are the in-patient components. We currently have an in-patient cancer unit, and we will need to be able to build up additional capacity into the future. So part of the next phase of the capital asset development plan will be to join up the in-patient components of cancer with the integrated cancer centre. That is what Megan was referring to before—where we create a cantilevered structure at the southern end of the campus and then build, next to that, the main tower block, which will articulate the in-patient components with the cancer centre. So there will still need to be a provision made.

MR HANSON: When does that element get delivered?

Mr Cormack: We do not have an appropriation for that just yet. But that is part. We do have a planning appropriation, which was allocated in the 2008-09 budget, to develop a project definition plan for the whole program. That will be required to be submitted to government for further consideration in upcoming budgets.

MR HANSON: Thank you.

THE CHAIR: Okay. Ms Le Couteur.

MS LE COUTEUR: I have got what I think is a very quick one. In budget paper 3, on page 80, we have got reference to extension of paid maternity leave. It says:

> This will assist in providing an additional four weeks in paid maternity leave for ACT Public Service employees …

Is this just for the Department of Health?

Ms Gallagher: Yes. I think it is reflected in every department's initiatives, from memory, when I looked through. You can see that it is in DHCS as well—"Extension of Paid Maternity Leave". It is just the component of that overall initiative being applied to agencies, and because Health has a large female workforce—

MR SMYTH: So you are not extending it to Treasury officials, who do not have it as a separate line?

Ms Gallagher: It is not in the Treasury one?

MS LE COUTEUR: It is not in all of them.

MR SMYTH: It is not in all of them.

MS LE COUTEUR: I do not guarantee that it is not in any others, but it is certainly not in all of them.

Ms Gallagher: Right.

MS LE COUTEUR: I was just wondering if you were taking it on for everybody.

Ms Gallagher: All I can say is that it is an inconsistency. I cannot explain the rest of that. It applies the global figure, which I think is reflected in CMD's appropriation, from memory.

MS LE COUTEUR: We will need to talk to the Treasurer about this, I guess!

Mr Cormack: It is in the Department of Education and Training.

Ms Gallagher: Yes, it is.

Mr Cormack: So it has perhaps targeted the larger employing agencies. Health and Education and Training have accounts of probably—

Ms Gallagher: I understand what it is. I think it is because the decision around paid maternity leave was to cost it and fund it to front-line service delivery where there could not be reconfiguration of work to pick up. If someone is taking maternity leave, say, in a clerical area, it could be that project work does not get continued while the person is on leave or someone else picks it up in a temporary capacity. But when you are looking at nurses and teachers and social workers, those front-line service delivery agencies, that is the overall global budget to backfill those positions.

MS LE COUTEUR: So, in effect, it is not being funded in the office areas; the office areas are just having four weeks—or whatever number of weeks—less work done by the person?

Ms Gallagher: That is right, yes.

MS LE COUTEUR: So it is not funded.

Ms Gallagher: That has been our practice in the past as well, when we extended it from 12 to 14 weeks. If a nurse goes on maternity leave, you still have to have that nurse's position filled, and it is unfair to ask the agency to pick that up, particularly those large agencies where there is a large female workforce, and that is in health, education and DHCS.

THE CHAIR: Mr Hanson has some questions in another area.

MR HANSON: GPs, minister.

Ms Gallagher: Yes.

MR HANSON: We have been through this—

Ms Gallagher: You are not happy with the budget for GPs, I read, Mr Hanson?

MR HANSON: Well, I want to understand what it is actually going to do. The situation we have had over the last few years is that we have gone from 370 GPs down to about 330, which is a decline, while across Australia we have seen actually an eight per cent increase in the same period. In recent data in the last couple of months, we have seen GP surgeries close across Canberra, particularly in north-west Canberra. That leaves a situation where we are approximately 60 GPs short in the ACT, which is the lowest per capita in Australia. Until now, we have seen a government that has really not done much about it. Your line up until recently has been that it is not your responsibility; it is a federal issue. You have washed your hands of the issue.

I am encouraged to see some money that is now in the budget to fund some training and initiatives for GPs, but what I would like you to do is to outline what those initiatives are and, more importantly, tell us how that is going to take us from the situation that we find ourselves in now and move us forward. You understand very well the impact that that has on preventive and early intervention measures and the flow-on effect to elective surgery and emergency departments and so on. These measures in the budget, how have you quantified those? What will they do? What tangible outcomes will they have in addressing our GP crisis in the ACT?

Ms Gallagher: Well, I think these initiatives have been very much focused around supporting our existing general practitioners on the one hand and growing the workforce for the future on the other. That would be the way I describe it and, indeed, that is the way I have described it at several GP meetings that I have had in recent months. So there are initiatives there to support bonded scholarships for ANU medical students in years 3 and 4. That is to give five in each year, so once the scheme is up and running—it is a cost of about $1.2 million—at any one time we would have 10 students on scholarships at $30,000 each. Obviously they will be students who are showing an interest in becoming GPs. Although they do have to leave the ACT at some point to complete their training, those students on scholarships will agree to return to the ACT to work. We are hoping to start that in 2010.

The GP pre-vocational placement program is a very successful program that we have been running with general practice. Again that is looking at getting students into general practice and offering rotations for junior doctors so that they actually do pick up clinical loads through that, with some supervision obviously. But the GPs who I have spoken to who are involved in that actually say that, whilst they are doing some supervising and mentoring, they are actually seeing more patients through their clinics through the day through the use of junior doctors. The other benefit is that junior doctors are exposed to life in general practice. Hopefully, some of them may choose to specialise in that area.

We will be funding an in-hours locum service in aged-care facilities. This is something that the GPs that I have spoken to—I spoke to a meeting of about 50 of them last Wednesday night—are very interested in and supportive of. This is for a north side and south side in-hours visiting service, similar to the CALMS model that operates in the hospital, but one where the GP visits the residential aged-care facility. This will address the call-outs that existing GPs have to often do at night or after hours for their patients in nursing homes. Of course, if we can get there earlier and treat conditions earlier, hopefully there will be a reduction in elderly admissions from nursing homes into our emergency department.

We will work through the detail of these initiatives with GPs, because the GPs I have spoken to have a whole range of different ideas about how this fund should be used. It is a fund to support infrastructure within their practices. We obviously need to tailor this to make sure it gets to the practices that we would like to support, which are community and family-based small general practices. We don't have a set size of how many you have to be before you qualify. I need to work that through with them. I am meeting with the division and the AMA on this matter on Monday. Basically, the goal of the infrastructure fund will be to increase GP services. Again, I have not been too prescriptive about it at this point in time, because I want to make sure that the money actually helps. We need to make sure we do not make it so restrictive that it does not actually do the job that GPs are after.

The other area is that, for the first time, we will pay GPs $300 a day for taking on a student load. Again, what we would like to see is all of our third-year medical students, hopefully, getting the opportunity to take part in the clinical experience of general practice. We believe that if they are exposed to it then maybe we will get a higher return on the number of students that actually want to become general practitioners. But also it rewards our general practitioners, some of whom are already taking on a client load which is reducing their income because they have to block out every third appointment in order to mentor the student and talk the student through the decisions they have made.

We have not taken over responsibility for areas which are controlled by the commonwealth in terms of Medicare or anything like that. I think that would be a big step for the ACT government. What we have tried to do with a small but reasonable amount of money—about $12 million over four years—is target areas where the ACT government has a logical responsibility, and that is around training and developing our own workforce and supporting the existing workforce that is here.

MR HANSON: It is good to see some money going into it, and I guess we will have

to wait and see what impact that will have, unless you have got some modelling. But given your government has had eight years to watch this steady decline in GP numbers, do you take responsibility for the position that we are in now with our GPs?

Ms Gallagher: Well, I do not regulate or control GP numbers in the territory, Mr Hanson.

MR HANSON: No, but you could have acted a lot earlier, couldn't you? Do you not think that some of these initiatives here—the GP task force, the inquiry, some of the funding elements that you have got in there in the initiatives—could have happened a lot earlier? There have been a lot of statements from you over the last few years saying, "It is not our fault, not our problem." Why now? Why didn't you do this a number of years ago?

Ms Gallagher: The issues that I say which are difficult for the ACT government to respond to have been around GP numbers, which I have no control over, and bulk billing rates, which I have no control over. I still stand here today and say that they are the two areas over which I have no control. I don't. I cannot issue provider numbers to a whole range of—

MR HANSON: For sure, and I'm not asking you to do that.

Ms Gallagher: individuals and ask them to become GPs in the territory.

MR HANSON: What I am asking is why—

Ms Gallagher: I do not have the power.

MR HANSON: Why has it taken eight years for this government to respond to what has clearly been a degrading situation in the ACT?

Ms Gallagher: Well, it has not taken eight years. I have been through this at length with you, Mr Hanson, in previous inquiries and, indeed, in previous estimates reports. An enormous amount of work has been done across the ACT government in cooperation with the AMA, in cooperation with the Division of General Practice, in cooperation with the GP workforce working group—significant amounts of effort. But I think the fact that we still have a GP shortage is not a reflection on any lack of work or interest; it is a reflection on the complexities of solving this, and the fact that what led up to a shortage of doctors in Australia was a federal government decision to control the number of university places. Again, that is not inside my control.

This will take years to rectify. I do not think we are that far away. In actual fact, I think the year where we will see large numbers of medical graduates hit the street is about 2011. We will have more medical graduates then than places in hospitals, and then we will have a whole range of different issues at that point in time. That may well be someone else's problem to resolve. But I am happy to list for the committee in a document all the work that has gone on to address the issues and work with general practitioners. It is probably more beneficial that I do that than sit here and individually go through all those initiatives.

MR HANSON: Sure. Given that modelling then, or the anticipation that we are going to get more doctors, have you done some modelling that tells us what impact that will have on our GP numbers in the ACT? Can you say looking forward, given the number of graduates, the number that will go into general practice as opposed to other areas will be—

Ms Gallagher: That is completely in the—

MR HANSON: Is it possible to—

Ms Gallagher: It is completely in the commonwealth's control, in regard to their levers around providing—

MR HANSON: Sure, but I am assuming that you have had discussions with the commonwealth about what they are doing in this area, and you would have a pretty good understanding of what initiatives they have got going forward, the number of graduates that are coming forward and so on?

Ms Gallagher: Well, indeed, and I have spoken at length—

MR HANSON: Sure.

Ms Gallagher: I was writing on a very frequent basis around GP matters and, indeed, I have met recently with Nicola Roxon around GP matters in the territory.

MR HANSON: So given that that is the case, can you actually start to do some modelling or have you done any modelling or are you going to be able to be in a position soon to tell the community that this is where we're going to see a reversal?

Ms Gallagher: What we would like to see is that we get to the Australian average of GP numbers.

MR HANSON: Well, we'd all like to see that. What I am asking is—

Ms Gallagher: So that is our goal.

MR HANSON: When will we get there, and have you got a plan to move us there?

Ms Gallagher: What I am saying to you is I have no control over getting there, Mr Hanson. I do not know what you do not understand about that. I could sit here and pretend to you that I could magically deliver 60 GPs to the territory, but I can't because I don't have the levers that control GP numbers in the territory.

MR HANSON: All you've told me is that there is a lot of work going on federally.

Ms Gallagher: What I do have is the ability to look after our existing GP workforce and to try and get all those excited young students from the ANU medical school, and some not so young, into life as general practitioners in the ACT. That is my job and that is what we are doing through this package.

MR HANSON: But you've told me that you have regular conversations with the federal government—

Ms Gallagher: That is the job we went to the election on, and that is the job that I am implementing right now.

MR HANSON: They are doing a lot of work in this sphere, but I do not understand why you are not able to look at the stuff that is happening locally in the existing workforce and look at the initiatives that are happening federally to work out what the implications are for the ACT. I am not saying that you control all the levers, but what I am saying is that you are aware of all those levers. You should have a good understanding of what is being implemented. Why have you not got yourself into a position where you can tell us, "Okay, based on what's happening federally, what's happening in the ACT, given our current workforce, this is where we see the trend reversing and the number of GPs increasing." Why aren't you able to provide that to the committee?

Ms Gallagher: Because I do not control the decisions around what will deliver that, Mr Hanson. I don't. There is an element here of individual choice. I can tell you that we have 90 students graduating from ANU medical school every year. Now, a number of them will want to choose to work and stay in the ACT. I can try and extrapolate from the numbers of students we have the percentage that we may see end up in general practice here, if they go successfully through their training and also, importantly, if they choose to work—

MR HANSON: Well, I assume you have historical data and you have initiatives in place which you have targeted and you know that out of the initiatives you will get a certain number of recruits going to certain areas. It just amazes me that you are sort of putting money into initiatives that you have not—

Ms Gallagher: So you do not like the initiatives or—

MR HANSON: That is not what I am saying at all. What I want to know is what I am getting for the money. That is what the taxpayer wants to know. If we are putting—

Ms Gallagher: So you would like attached to each of those initiatives exactly how many of those on ANU medical graduate scholarships, of which we are funding 10, will become general practitioners in years to come, and I cannot give you that answer.

MR HANSON: Well, you talk to us a lot about, I call them estimates, you call it guesswork. But throughout these budgets are a lot of indicators. There are strategic indicators, there is a lot of analysis done that actually gives us information that says that based on what we are doing we would expect an improvement in a particular area.

Ms Gallagher: That is right, in areas where the ACT government has control and the ability to determine the outcome. That is what you see in the budget. That is why we do not—

MR HANSON: That is right.

Ms Gallagher: You have gone exactly to the right point.

MR HANSON: Exactly the right point.

Ms Gallagher: We do not have a strategic indicator—

MR HANSON: But what I am asking you—

Ms Gallagher: or an output class around GPs—

MR HANSON: Not necessarily—

Ms Gallagher: because we do not regulate or control them.

MR HANSON: Not necessarily within the budget, but certainly more broadly—if you have an understanding of what is being introduced federally, which you say you do, you know what is being introduced in the ACT and you understand the workforce environment, why are you not able to articulate it? I do not understand—not necessarily in the budget, because it is not an outcome.

Ms Gallagher: I think I will just have to leave you not understanding that, Mr Hanson. You have asked me this question 10 times, I have answered it nine times and it does not seem like we are getting anywhere.

THE CHAIR: I will ask you a question on GPs then, minister. You said you do not control it. Clearly, you do not control a number of the indicators, but you have acknowledged that you control some things; otherwise you would not have a GP task force. What is the expected outcome from the work being done at an ACT level? More broadly, you said the commonwealth decisions have obviously played a part in our GP shortage, but why is it that we are suffering a greater GP shortage than other parts of the country?

Ms Gallagher: The GP task force—and I am sure the committee has the terms of reference for that—pulls together a whole range of stakeholders and also work that was being done across ACT Health into one central location with two very eminent chairs of that work who are leading it for the government. It really is about hearing from GPs exactly how we can improve. One of the main areas is how we can improve our efforts to work with them. These are areas within our control, so they are interfaced with the hospital, they are interfaced with legislation that we have carriage of, to look at the national agenda and see if there are opportunities there to feed into the work that we are doing here. I do not know if Ross wants to come up and talk further about this.

I have spoken to the GPs. In fact, I had a meeting here, at which about 50 or 60 of them turned up. I met with them again last Wednesday night. There is good buy-in on that task force. But even the GPs acknowledge the restrictions that the ACT government has in addressing some of the concerns they have about life as a general practitioner. But that is not to say that we are not interested in constantly looking at areas over which we have control to make life easier and the system more efficient for them. And that is the work of the GP task force. I do not want to pre-empt the report;

it will be tabled in the Assembly in September. A discussion paper is being finalised now, as I understand it, which will go out in July. Is that right, Ross?

Mr O'Donoughue: Middle of June.

Ms Gallagher: In June.

MS BURCH: We heard on Friday that ACT had more than the average number of GPs but they were not practising.

Ms Gallagher: In a couple of reports which the commonwealth do, it is actually numbers of medical practitioners, I think, not general practitioners. And when you use that data to apply across our population, it appears that we have higher than average numbers, but that also includes people who are not practising or people involved in research institutions and things like that.

MS BURCH: That was part of the conversation. It was around the fact that a centre like ACT offers alternatives, such as teaching at ANU and research: we have a number of institutions and facilities that would be an attractive alternative to general practice.

Ms Gallagher: Yes, and we have two large departments to fill—ACT Health, and also the federal department of health, where a number of doctors work as well.

MS BURCH: Would there be some attraction in these various programs, whether it is scholarships, teaching payments, a GP development fund or whatever, teasing some of those practitioners back into the general practice workforce, albeit even for some hours a week?

Ms Gallagher: Yes, and I think Kirsty Douglas has done a piece of work about why general practitioners—

Mr O'Donoughue: Do you want me to speak to that one?

Ms Gallagher: Yes, because that is interesting.

Mr O'Donoughue: You are correct in the sense that there are more GPs than full-time equivalents in the sense that we have a large part-time workforce. As is characteristic of other states and territories, it is also a feminised workforce and it is an ageing workforce. Kirsty Douglas from ANU has been doing some research with a cohort of those sessional GPs to try and glean whether there would be incentives that might encourage them to come back into the workforce.

Ms Gallagher: She is also a part-time GP.

Mr O'Donoughue: And you are correct in saying—

Ms Gallagher: She is doing research into why people are part time.

Mr O'Donoughue: You are correct in saying that it is not that they are not otherwise

engaged. They are all pretty actively engaged. Either they have made lifestyle choices to spend more time with their family and work less as a GP in a traditional way or they are engaged in work with other government departments or in the universities. Her initial findings are that we are not likely to glean very much extra capacity from that part-time workforce, unfortunately.

Ms Gallagher: Do you have anything to add on the task force, Ross?

Mr O'Donoughue: Can I just run through some of it for you. Dr Clare Willington, GP Advisor to ACT Health, and I chair the task force. The ACT Chief Nurse, Veronica Croome, is a member. The AMA is represented, as are the Division of General Practice, the ANU Medical School and the academic unit of general practice from ANU; and there are two healthcare consumer representatives.

While the title of the task force is focused around GPs, the terms of reference are very much about access to primary healthcare services. We are looking at a wider brief in terms of ways that we can support the current general practice workforce and perhaps how we can offer other innovative models of delivering services. You have already heard today about the possibilities around, for example, primary healthcare centres or the use of nurses—either nurse practitioners or practice nurses—to enhance the range of services that might be offered.

We are looking to produce a discussion paper, which will be available in early June. We will be conducting a series of consultative forums, both for the general public and also for the industry. We have been asked to report in September this year.

THE CHAIR: Any more on this area?

MS BURCH: What is the buy-in or the feedback from the medical workforce on these initiatives?

Ms Gallagher: On the GP initiatives, the feedback so far has been very good. I think the key for the development fund is to make sure that we allow the scope to be broad enough to support different practice needs. Some have talked about IT; some have talked about immunisation fridges; some have talked about adding new rooms. There is a whole range of interest. It is public money, so we need to make sure that it is accountable and tight in that regard, but I think that will be some of the work that I do with the AMA and the division.

I went through these initiatives the other night with doctors, and they were very positive about them. The college certainly welcomed the increase in pre-vocational placement programs for their students. It is hard that it is a longer term solution to this, but that is the only way that we can change what has been a problem that has come about in a longer term, in terms of the control of medical places and also—

MS BURCH: General practice training places too?

Ms Gallagher: Yes, that is right.

MS BURCH: Because they were slashed significantly.

Ms Gallagher: That is right. And also in individual doctor choices about what they would like to specialise in once they have completed their training. If you talk to GPs, in a room of GPs the younger GPs are really in the minority, showing that—10 years ago perhaps was the beginning of doctors choosing to remain within hospitals and become career medical officers or go on to specialise in other areas of medicine. This is trying to turn it around and see GPs as a legitimate specialty area for junior doctors to come into.

THE CHAIR: Okay. Mr Smyth.

MR SMYTH: Minister, I was just wanting to clarify something you said this morning. This morning you said that the approach to Calvary came at a regular meeting with the Little Company of Mary that you have monthly—

Ms Gallagher: It is not monthly; it is a regular meeting.

MR SMYTH: A regular meeting. Okay. I was briefed by the Little Company of Mary and they told me that the approach initially came from the head of the department, who rang the Little Company of Mary to see if somebody from the Little Company of Mary would take a phone call from you to discuss the issue. I have checked that with other people who were at the meeting at lunchtime and had that confirmed. Was it an informal approach at a regular meeting or were there phone calls?

Ms Gallagher: As I recall it—I am trying to recall the first conversation I had with Calvary. As I recall that, that was at a meeting that I had with them. I do not recall having a conversation over the phone with Calvary about this.

MR SMYTH: You did not make a special phone call to speak to Tom Brennan?

Ms Gallagher: I do not recall that, and I am not sure I would have it written down in a record. I very much recall a meeting in my office with a number of LCM people around the table.

MR SMYTH: It is a fairly big issue to not—

Ms Gallagher: Well, that is as I recall it. The discussion when I first—I do not recall an individual phone call to Tom Brennan on this. I am able to stand corrected if that is the case—it was a number of months ago—but as I recall the first conversation I had was around the table.

THE CHAIR: Were there departmental officials at that first meeting?

Ms Gallagher: Yes. Mr Cormack usually sits in on those meetings.

THE CHAIR: So there would be some file notes that can confirm some of that?

Ms Gallagher: Sure.

THE CHAIR: Is that able to be provided—the detail of that?

Ms Gallagher: Sure.

MR SMYTH: Perhaps Mr Cormack can clarify. Did you ring LCM to prepare the ground for a phone call from the minister?

Mr Cormack: I call LCM on a lot of matters, so it would not be unusual for me to call LCM. I do not recall a phone call setting the ground for the minister to make a phone call to somebody, but I can certainly recall that we met on 6 August 2008—the minister and me with Tom Brennan and the interim chief executive of the Little Company of Mary at the time. That was really the meeting where there were the first discussions around the table with the two parties on the potential interest in the possible purchase of the public hospital.

THE CHAIR: Ms Bresnan.

MS BRESNAN: Thank you. On a completely different topic, I have a mental health related question. I do not have a reference in the budget for it, but this relates to the additional funding which has been allocated for the community sector in the mental health funding allocation. I understand that the mental health community have been calling for there to be a community sector provided after-hours service, given that after 5 pm the primary service which they rely on is the CAT team. I am just wondering if there has been a consideration of this proposal at all and if perhaps that additional funding which has been allocated to the community sector in that mental health funding would fund a service like that.

Ms Gallagher: I have got a list of services that the community sector mental health allocation will go to.

MS BRESNAN: So that funding has already been allocated and decided?

Ms Gallagher: Certainly provisions have been made. I do not know how flexible they are, but when I worked through them they all looked as though they were going to be excellent initiatives. I am sure there is more demand, more ideas out there, but—

MS BURCH: Is this the fifty-fifty split?

MS BRESNAN: Yes. But I know there has been a process, and that is something which has been raised with us. I am just interested to know if that funding has already been allocated and the process through which that was determined.

Mr O'Donoughue: The funding has not been definitively allocated. The growth funds have been allocated. There is $2 million in each of the budget years, and approximately $1 million of that is allocated towards the community sector. The department has some notional allocation that we have been working up, but we are looking forward to a process of discussion around the implementation of the mental health services plan for the establishment of a strategic oversight group for that plan to finalise the allocations. The things we have pencilled in go to sector reform and capacity building, enhanced supported accommodation and outreach, and mental health promotion and prevention—and a small amount allocated to the provision of a

secretariat for the proposed mental health advisory council. The specific initiative that you have mentioned has not featured in our notional allocations to date but, as I say, these have not been finalised.

MS BRESNAN: You have mentioned the secretariat or the committee. Wouldn't that actually be departmental? Is the secretariat coming from the department?

Mr O'Donoughue: Yes. Because of the nature of the advisory council, it would involve sitting fees and other expenses. While the department would provide the actual secretariat service, we have costs associated with the administration of the committee itself.

MS BRESNAN: I am just thinking that—if it is a committee-run service, wouldn't those funding responsibilities normally be allocated through the department? Our understanding was that this funding was to actually go to community sector services. That would not seem to be a community sector service.

Mr O'Donoughue: The majority of it does go there. We are talking about the notional allocation of about $30,000 for the secretariat function out of a million dollars.

MS BRESNAN: I know, but that is probably quite a significant amount for a community service in a way. They could actually provide a service for that. It is just because I am interested in the process which is being used to decide that allocation. I understand that you said it will go to the advisory group. Is that right?

Mr O'Donoughue: We are talking about that secretariat function?

MS BRESNAN: No. You said that the allocation of the funding would be—

Mr O'Donoughue: Yes—discussed through the oversight group for the mental health services plan.

MS BRESNAN: Okay, that is the process. But has the decision already been made with those allocations?

Mr O'Donoughue: No. There have been some preliminary notional allocations done by the department based on previous discussions with the sector, but we have not finalised those allocations.

MS BRESNAN: Then I guess in relation to that after-hours-type service, has that been a proposal which has been considered?

Mr O'Donoughue: It is not one that I have been personally aware of.

MS BRESNAN: It is just something that we have been made aware of as something that has been asked for given again, I guess, that they are relying on the CAT team for after-hours service and there is quite a gap in service provision after 5 pm.

Mr O'Donoughue: Of course, we would be happy to look at that but, as I say, it has

not been personally brought to my attention.

MS BRESNAN: I am just wondering if there is any other light that can be shed on that from the minister or from Mr Cormack?

Ms Gallagher: I am just trying to recall the process.

MR HANSON: How many is the CAT team these days? I was told that it was down to one at some stage; is that right?

Mr O'Donoughue: No.

Ms Gallagher: It is down to what—one?

MR HANSON: Do you know how many people are actually manning the phones? Do you know how many are actually staffing that? Can you give us an indication of what service is being provided?

Mr Cormack: I think we can probably ask Dr Brown to answer that question.

Dr Brown: The CAT team consists of around about 22 FTEs all up. I think you are referring to the triage worker. We have one triage worker on duty at all times. We supplement that with three shifts during the day so that we have, when necessary, two workers on during the bulk of the day from about 9 am through to about 7 pm.

MR HANSON: Do you think that is adequate? A lot of feedback I get from the community is that that is inadequate to do what they have got to do.

Dr Brown: Yes, I think we are aware that we get feedback from time to time about calls not being answered promptly enough or occasionally calls not being answered at all. We do, however, track our calls to CAT. We get approximately two and a half thousand per month come through the triage. That has actually declined a little bit in the last six months. It was running at around 3,000 per month. We also track the speed of answer. We track the number of calls that are abandoned. For the month of March, we had on average 12 calls abandoned per day. That is one every two hours. The average time to answer was actually 49 seconds in March.

MR HANSON: How many an hour was it of missed calls—abandoned calls?

Dr Brown: Twelve per day abandoned, which is an average of one every two hours. It takes on average 49 seconds to answer a call; so we get that data each month and we track it. It has actually been declining. This time last year we had on average 17 calls abandoned per day. So it has actually been coming down rather than going up.

MR HANSON: Are people giving up or—

MS BRESNAN: I am wondering if you have had any representations about that proposal I have been raising about having a community sector after-hours-type service. Has that been raised? Have you had any discussion with the community sector about that?

Dr Brown: No, the community sector has not raised that with me. Sorry, I have just been advised that Richmond Fellowship received last year $90,000 to provide additional after-hours services.

MS BRESNAN: Is that for the first step-down, step-up facility?

Dr Brown: No.

MS BRESNAN: What after-hours service are they?

Dr Brown: I cannot actually give you the details of that.

MS BRESNAN: Could we get some detail on that?

MS BURCH: I was curious about the mention of the oversight group. Who is in that and what sort of process or outline have you given around the determination about where those funds will go?

Dr Brown: The strategic oversight group is proposed to be constituted in the next couple of months. Once the mental health services plan is finalised, it will be an intersectoral group that comes together to make decisions about the allocation of priorities in that plan and oversight its implementation. But the actual constitution of that group has not yet been finalised.

MS BRESNAN: Anyway, it will comprise community sector members?

Dr Brown: The community sector will be a part of that.

MS BRESNAN: Do you know what other members will be on it? Will there be government department members on it?

Dr Brown: Yes, there will be. There will be Health, other government departments and community sector—consumers and carers.

MS BRESNAN: Was that the group that the 30,000 was going to?

Dr Brown: That is the council.

MS BRESNAN: That is the ministerial side. Thank you.

THE CHAIR: Is it possible to provide a further breakdown of the membership of that group?

Dr Brown: It has not actually been formally put together yet; so I do not think that we can provide that, no.

THE CHAIR: When is that going to be done?

Dr Brown: We are anticipating the plan to be finalised by late June, early July; so it

would be some time shortly thereafter.

THE CHAIR: Are there further questions on this?

MS BURCH: On mental health?

THE CHAIR: Yes, sure.

MS BURCH: Can you tell us a bit about the mental health assessment unit and how it will result in better care for the mental health clients presenting?

Dr Brown: Yes. Currently when people present to the emergency department at the Canberra Hospital, we have only one room within the emergency department that is set up to specifically receive mental health clients with their special needs. The mental health assessment unit will have six places and it will be a dedicated environment for the assessment of mental health clients. It will be appropriately staffed and will provide a much more appropriate setting for those assessments to occur.

MS BURCH: So designated quarantined staff for the unit?

Dr Brown: Yes.

MS BURCH: My other mental health question relates to page 79 and concerns mental health training to police, emergency service workers, teachers et cetera. We had a community rep group in on Friday that just raised the notion of youth having some targeted youth mental health training in that. Would that be in there, some youth focus?

Dr Brown: Yes, that funding will be split between the department of education for teachers and other education staff and also the Department of Justice and Community Safety for police and other emergency service workers. Very clearly, the training for education staff will need to be developmentally appropriate; so it will cover the range of ages for education staff. There will be a youth component to that. In terms of the emergency service, we are talking there particularly about police. They will need to have training that covers the life spectrum. Yes, there will be a youth component.

MR HANSON: Could I ask why that funding stops after two years?

Ms Gallagher: We just want to review both of those issues to make sure they are doing what they need to do; so we have just provided two years of funding. We are reviewing in the second year and then as budget—

MR HANSON: The Greens-Labor agreement says that that is going to be recurrent funding. You are saying—

Ms Gallagher: It is recurrent funding. That is why there is funding in the budget.

MR SMYTH: Recurrent two years, temporary for seven.

MR HANSON: Tick that box.

Ms Gallagher: That is recurrent funding.

MR HANSON: Because it is in there for two years.

Ms Gallagher: The agreement is around recurrent funding and I have talked with my parliamentary colleague and the Greens around that and ensuring that it is delivering what the intention behind the agreement is. It will be reviewed and then decisions will be taken around that.

MR HANSON: More broadly on the mental health aspects of the Greens-Labor agreement, there is a plan in there for 12 per cent of overall health funding by—well, it is a goal at this stage—

Ms Gallagher: That is right.

MR HANSON: and then by 2012, 30 per cent of that funding is community-based. I assume it is an aspirational target or it is a goal. When do you anticipate meeting that figure of 12 per cent?

Ms Gallagher: It depends on the rest of the health budget. Look, we have more than doubled mental health funding. The latest figures I saw when we came into government, it was 27 million. It is now at about 77 million. Currently, it has gone from about 5.8 per cent of the budget to eight per cent of the budget. So that considerable increase is—

MR HANSON: Sure, and that is a good history lesson. But what I want to know is that you have actually put in a parliamentary agreement that you are going to achieve 12 per cent. That is your goal. I assume that you have factored into that when and how you are going to get there.

Ms Gallagher: The ALP adopted a goal of 12 per cent a couple of years ago. Sorry, not wanting to give a history lesson again, Mr Hanson, but that was a target that we set ourselves to make sure that we always had mental health funding at the forefront of our mind as we went into budgets each year. But every time I have spoken about the 12 per cent, I have indicated, as the rest of the health budget grows, just how hard that task is. It is an aspirational goal. It is a goal to keep us focused on mental health and to keep increasing the mental health budget all the time. I am very proud of the achievements we have made to date and we will continue to build on those.

MR HANSON: But you are at 7.8 per cent.

Ms Gallagher: No, we are at eight per cent.

MR HANSON: Okay, eight per cent.

Ms Gallagher: Yes.

MR HANSON: I will allow you the point two difference.

Ms Gallagher: That is a considerable amount of money in that point two.

MR HANSON: Sure.

Ms Gallagher: You might ridicule it, but it is a lot of money in that.

MR HANSON: But where is the plan to get us there and if it is only there just to remind you that mental health important, what purpose is it serving? I do not understand why you have this figure in there, this aspirational target, but you have got no structured plans in order to achieve it.

Ms Gallagher: It is a long-term goal, Mr Hanson. It is a long-term goal.

MR HANSON: Right. What does "long term" mean? You have said long term. I have asked you to define that.

MR SMYTH: Temporary is now seven years.

MR HANSON: What is long term in your book?

Ms Gallagher: I think I have answered that question.

THE CHAIR: Okay, Mr Smyth.

MR SMYTH: I just want to inquire about the new car park at TCH that has gone from $29 million to $45 million. What was the reason for such a significant change?

Mr Cormack: There are a number of issues, but the principal issue was that the original appropriation for the multistorey car park preceded the completion of the detailed planning that the minister requested of us in the lead-up to the development of the capital asset development program.

At the stage of the first appropriation, which was 2007-08, we were factoring in a car park of a certain size—a certain number of spaces. When we completed the CADP at the request of the minister and had undertaken far more detailed work on the longer term activity base at Canberra Hospital and, indeed, at Calvary Hospital we revised the number of spaces within that development. So that was one aspect.

THE CHAIR: What were those changed parameters in terms of space?

Mr Cormack: The current car park is specified at about 1,800 and I believe the previous one was specified at about 1,400. I can confirm those figures, but that is the kind of quantum that we were talking about.

Of course, the other element there was that we believed it was appropriate not to progress with the car park until we had done the detailed site planning. That proved to be a very wise course of action because it also gave us greater guidance as to where to situate the large car park on the hospital.

The other element was some cost escalation due to the fact that it would be running at

least 12 months later than what was intended. They are the two major factors.

MR SMYTH: Some extra 28 per cent of spaces is costing an extra 55 per cent.

Mr Cormack: There are other elements as well that we need to factor in. The new car park, as well as being bigger, needs to be able to articulate in a much more structured and formalised sense with the overall master plan on the site. That means creating alignments with a proposed pedestrian street, which we call Hospital Street, and dealing with a number of those sorts of issues. It also needs to address issues relating to levels of proposed adjacent buildings.

These were issues that were not known at the time of the development of the 2007-08 budget that led to that appropriation. But on the completion of detailed planning we have a much more substantial requirement for car parking, a much more substantial car park and a greater articulation with the site master plan.

MR SMYTH: So where will that extra money come from? Will that come out of the billion-dollar health budget?

Ms Gallagher: No, it will come out of the $300 million we appropriated where there was a component for—what was the name?

Mr Cormack: Provisions for phase 1.

Ms Gallagher: Yes, phase 1, project definition.

Mr Cormack: Clinical services—

Ms Gallagher: Yes.

MR SMYTH: You have taken $21 million out of the CSR and it has been transferred to the multistorey car park and the neurosurgery. What do we get in the CSR now?

Mr Cormack: I might just ask one of my colleagues who is more involved in the detail of these.

Ms Cahill: Taking into account the transfer of funds for the neurosurgery suite and the car park, there is now $36 million in that provision for stage 1 of the budget.

MR SMYTH: Why did the neurosurgery require an extra $5 million?

Ms Gallagher: Originally when the appropriation was made for the neurosurgery there was a private individual who wished to make a substantial donation to that project, and indeed is still involved in that project. However, like everybody, he is going through the financial times that the world is going through. It is not possible for that individual to make the allocation that was previously thought would be made. It is around a $10 million project. What we have done in the meantime to allow it to go ahead on time is to take the provision and put it into the budget. Then we will work through with the person who would like to donate to this specific project the amount that they are able to donate.

MR SMYTH: What happens now with the CSR if it has lost $21 million?

Ms Cahill: That line item was allocated for us to be able to do things like decanting works that are associated with a complex program of capital works across the program. That bucket of money had not been allocated to specific projects. As we undertake the master plan for all of the implementation of the capital asset development program it will allow us to better understand the moves and decants that will have to occur to allow us to deliver the projects on time. We will look at that once we have that planning completed. We will look at the $36 million that is available in this line item then in terms of its adequacy.

MS LE COUTEUR: I have a few questions about the car park. Is it primarily intended for staff or patients?

Mr Cormack: It is for all users of the site. There will be provision for staff car parking and there will be provision for contractors, visitors and patients. There will be special provision for people with disabilities, who will clearly get the prime spots that provide the greatest accessibility.

MS LE COUTEUR: Is one of the reasons for the price going up the increased security provision? Would that be one of the reasons the price has gone up?

Mr Cormack: No. I think I have given the reasons in my previous answer.

MS LE COUTEUR: Okay. And none of it is pay parking? I know many people going to hospitals are constrained and they actually need cars, but given, as we discussed yesterday, the government has made a commitment to zero net CO2 emissions, have you looked at your assumptions, presumably, of a larger number of people using cars versus trying to look at some alternative ways, such as better bus provision? I cannot quite see how the provision of 1,800 car park places is consistent with going to zero net carbon emissions. What has been your thinking around trying to reduce the car use or the CO2 emissions associated with it?

Ms Cahill: Certainly a number of our strategies around managing car parking on that campus look at how we can reduce the number of people that are travelling to the campus via car. We are working with ACTION buses to look at the possibility of increasing shuttles from the Woden bus interchange to the hospital campus. We are looking at encouraging car pooling arrangements with staff, again to reduce the number of cars coming onto the campus. We will be actively encouraging staff to use alternative forms of transport, such as cycling. As part of our plans for the hospital we will be providing additional bike parking for that purpose.

When you look at the overall planning that we have done on the Canberra Hospital campus you find it actually makes provision for two car parks. The planning that we have done to date for car parking suggests that the car park we are about to build on the southern end of the car park will be adequate in terms of demand up to about 2016. At that point in time we will review how successful our strategies have been in terms of encouraging people to use alternative ways of getting to the campus and we will review the decision as to whether we need to construct a second car park in the future.

THE CHAIR: What will be the total number of car parks once this 1,800 has been added? What will be the total number of available at the Canberra Hospital?

Ms Cahill: I would have to take that question on notice.

THE CHAIR: Okay.

MS LE COUTEUR: You have not actually got more buses; you are possibly considering it. I notice that there is some more money for buses in the budget but it is not for this service.

Ms Gallagher: The bus service to the hospital is pretty frequent at the moment. I have done some analysis on this. I think many people who are ill or experiencing stressful times are quite dependent on a car. And then with our staff, the nurses start their morning shift at 7 am. Their shift in the evening finishes about 9 o'clock or they are there for night duty. I think that impacts on some of the choices they make about travelling to and from work. My discussions with the department around the car park have really been—and I know the data shows it, as Megan said—that it is to satisfy our needs to 2016. I would like to see processes put in place that ensure that it is what we need for the Canberra Hospital, that we do enough work between now and 2016 on alternative transport and benefits for staff and look at all of the issues you raised so that we do not have to build a second car park after that date.

I should also say something about the decision to build the car park. The original car park was to be located near the helipad site on the Canberra Hospital block. That was going to create some pretty substantial problems around where the helipad should go whilst we were building the car park and also whether the helipad would then go on top of the car park and how it would link into the hospital. In the work that the CADP has done, the car park will now go on top of the current multistorey, or in that area.

MR HANSON: It goes on the emergency department, doesn't it?

Ms Gallagher: The new car park is not where the current helipad is now. It will go onto the current multistorey car park, thereby alleviating the issues we had around the helipad. We do not need to move the helipad. We do not have to look at an alternative site for the helipad and how that links in. And then the helipad will go on the top of the tower.

MR HANSON: I thought ultimately the helipad went on to the emergency department.

Ms Gallagher: Once the new tower block is built, the helipad will be on top, and that will be as close as it can get to the operating theatres and the areas that it needs to get to. At the moment, you have to travel across a car park to get to it—not the helicopter, but people.

MR HANSON: On the car parking issue, is the development application going to be put forward in advance of the rest of the site, or is it now going to be wound back with it all coming in together?

Ms Gallagher: The development application is currently in on the car park.

MR HANSON: So it is in?

Ms Gallagher: Yes.

MR HANSON: The car park site essentially locks us in to the rest of the plan, though, doesn't it?

Ms Gallagher: Exactly. It enables a lot of that approval.

MR HANSON: Yes. I accept that it enables, but it also locks us in.

Ms Gallagher: We are locked in.

MR HANSON: Yes, but there has been a cost blow-out in the car park and there has been the relocation of various bits on the site. Is it pre-emptive to be putting the car park in if it then locks us into the rest of the site?

Ms Gallagher: We cannot build the mental health facilities without building a car park first. It does lock us in, but I would say we are locked in.

MR HANSON: So you consider we are locked in now? We have seen some changes recently.

Ms Gallagher: We are locked into the car park, and that enables us to build the mental health precinct. The women's and children's, which is the other big project through this, is at the other end of the block. We have not moved that around. The neuro suite is where it is going, the SAPU is where it is going, the additional operating theatres are built where we said they would be built.

MR HANSON: Moving to the costs then: we are demolishing a car park to build a car park, essentially. We wind back the clock—it is another history lesson maybe—and we look at the issues that we have had with car parking at the Canberra Hospital. We seem to have gone through that many permutations that we are now in a position where we are demolishing a multistorey car park to build another car park at a cost of $45 million, and that is the first bold initiative of the CADP that has now almost doubled in price. It does not give us much confidence moving forward in terms of either the ability to stick within costs or the fact that we are spending that amount of money on a car park. It just seems outrageous.

Mr Cormack: I think the important thing to remember—and going to this business about locking in—is that when we did the detailed site planning in the second half of 2007 that led to the decision this time last year by the government on $300 million, we used that time to sort out the site master plan for both Canberra and Calvary hospitals. While we are locked in, we are locked in because we have had significant external expertise in engineering and traffic management—cost planners, architects, health planners. They have mapped out a site master plan for that site which represents the best possible allocation of functions on that site for the future. We have

set the foundation.

The car park is a very important part of that foundation because we cannot progress any significant development on that site without the appropriate provision of car parking. Therefore, we need to develop a car park of substance, of orientation and of connection and functional relationships with that site master plan. That is what we have done. That is why we have a very big car park, as opposed to a big car park that was originally planned before, in the right location that will unlock the site. At the moment the site is locked up with a whole lot of grade level car parks. This will concentrate all that car parking, improve access for patients and visitors and staff and articulate with the whole development of that precinct.

It was a very important first step, as indeed any major billion-dollar development starts with a whole lot of work that you do underground first. Get the planning right, get the services right and get it locked in right from the outset, rather than have a hotchpotch of developments that are not well thought through and not connected with each other. I think it represents very good quality and futuristic planning to get the car park that we need for the future for that hospital. Then we can go on to the more important aspects which are actually building the clinical services infrastructure, which are already well advanced.

MR HANSON: I appreciate there are some concerns with flight paths and the helipad, but if we were to maintain the current multistorey car park in its original location and build in the northern precinct to give us the same number of car parks, how much would that cost? I assume you have done a cost on that northern car park.

Mr Cormack: The point is we have chosen the best possible location for the car park on the site. It was not a question of which one costs more. It was what was the best place on that site to locate the car park. It happens to be the one that we are actually continuing on with. We have provision on the northern end for the future to be able to enhance the car parking there. But by putting it down on the southern end of the car park we are able to develop a women's and children's hospital with an absolutely beautiful northern orientation which will maximise its solar orientation, its energy efficiency and its outlook. Whereas if we put a great big car park there, as opposed to the other end, we would have been restricted in making the best use of the site for the women's and children's hospital. We did think about this thing as a whole as opposed to just putting a car park in the north or a car park at the south and going with whatever was cheapest. That is not the approach we took.

THE CHAIR: But that work must have been done and those considerations must have been given in terms of what it would have cost with other options. Was that done and what would it have cost?

Mr Cormack: I cannot tell you precisely what those costs were, but Megan might be able to.

Ms Cahill: The original budget bid for the $29 million car park was actually for a car park on the northern end of the campus.

Mr Cormack: It was.

Ms Gallagher: But smaller.

MR HANSON: But it maintained the other multistorey, didn't it?

Ms Cahill: The planning for that car park pre-empted the work that we did around the capital asset development plan. Once we had done that plan and better understood the demands that were going to be made on that campus in terms of additional services we needed to look at additional car parking. In the context of the size of the car park that we needed, it was more appropriate to fit with the functionality of the campus to have the larger car park on the southern end of the campus.

MR SMYTH: Could you just take on notice what each of the options cost and provide them to the committee—how much the expansion of the northern one would have cost and how many parks it would have provided with the southern one in place and vice versa? The other thing I might ask, chair, is this: minister, if we could have a list of all the programs in each of the output classes in health I would be most appreciative.

Ms Gallagher: Programs like you requested for Treasury?

MR SMYTH: The programs under each of the output classes.

Ms Gallagher: Yes.

Meeting adjourned from 4.01 to 4.22 pm.

THE CHAIR: Thank you, members. I will throw it open to questions.

MS BURCH: As mentioned before afternoon tea, I have a question on the capital asset development plan. Could you tell us about the progress on, and give an overview of, projects that are currently underway as part of the CAD plan?

Ms Gallagher: I ask Megan Cahill, executive director, government relations, planning and development to answer that question.

Ms Cahill: In terms of progress on the implementation of the capital asset development plan, one of the first things we did was appoint an external project director to Thinc Health Australia. This is a company that has undertaken a number of large-scale, complex health construction programs; so they will have the expertise to complement the knowledge that we have within ACT Health in terms of taking this program forward. They have been engaged to assist largely with the project management and implementation of the program.

In terms of the actual works that have been completed, I will start with the Canberra Hospital site. At the northern end, we are well progressed in terms of the women's and children's hospital. We have developed new models of care for mothers and baby services, paediatric services and the neonatal intensive care unit. Those models of care have informed the design of that facility and we expect the preliminary sketch plans to be completed by the end of May.

There also needs to be a number of what we call early works undertaken before we actually start the construction of that new women's and children's hospital; for example, moving the oxygen and petrol tanks that are at that end of the campus as well as rerouting some of the roads there. We anticipate being able to start some of those early works packages in September.

We are well progressed with two new temporary operating theatres on the northern end of that campus. That has been funded from the commonwealth as part of their elective surgery waiting list initiative. We expect those to be completed by August of this year.

We are well underway with the planning for the new neurosurgery suite. It took us quite a while to decide on the tender for the new equipment that will be used in that theatre. It will be state-of-the-art equipment, the first of its kind in Australia. Now that we have made that decision we can get on with finalising the designs for that theatre.

Associated with that range of works is a new surgical assessment and planning unit. Because that will sit below the neurosurgery suite, we can now, again, get on with designing that facility. As you have heard earlier, we are well progressed with the design of the mental health assessment unit and we expect that to be completed in December of this year.

We have put on site at the Canberra Hospital site two demountable buildings that will allow us to accommodate project staff associated with the CADP but also provide decanting space for other staff as we progress the construction on that campus.

As you have just heard, we are well progressed with the design of the southern car park and the development application has been submitted for that. Associated with that southern car park, before we can actually demolish the existing multistorey car park, we will need to put in some temporary car parking facilities and we have submitted development applications for those temporary car parks.

We are also well progressed in terms of completing the design for the new adult mental health unit. New models of care have informed that.

On the Calvary campus, we have completed a new operating theatre. That was opened in March.

We are continuing to do work now, just finalising the community-based services plan, so that we can start progress on the design for the new Gungahlin community health centre and the enhanced Belconnen community health centre. I think that is it.

MR SMYTH: Well done. All that without a note!

THE CHAIR: That was very comprehensive. I assume no-one has any more questions on this area!

MR HANSON: That is a bold assumption.

MR SMYTH: Can you run through rollovers with equal mental acuity and explain why they all were delayed?

Ms Cahill: The main reason for the rollovers is associated with the detailed planning that we are now undertaking. When we developed the business cases for the projects that have been funded, I guess that was looking at the projects pretty much in isolation. Now that we are looking at this as an integrated program of capital works where we have to decant staff whilst at the same time continuing to meet increasing demand for service, it has meant that we actually have had to spend more time in undertaking the more detailed planning. I will be more confident when we actually start construction that we will not have delays because we would have spent the time that we needed to in terms of doing that up-front, detailed planning.

MS BURCH: You have made mention of demountables and decanting staff but, with a growth of services, how are you managing that to ensure that services are maintained?

Ms Cahill: It is not easy.

MS BURCH: Besides struggling?

Ms Cahill: What we have done is an audit across both hospitals to look at whether there is any inch of spare space that could be used for clinical services; look at where we can perhaps move services that are front-line service delivery; look at whether we can move out, for example, space that is being occupied more for administrative functions, even though they might be undertaken by clinicians, off the main clinical area of the hospital and create some space. Certainly one of the big levers that we will be able to use in terms of creating additional space is by bringing forward some of these developments of our community health centres, as we have said earlier; by being able to move a number of those outpatient clinic services from a hospital site out into the community. That will allow us then to back-fill that space in the hospital to provide more hospital-based services.

MS BURCH: And you made mention—but remind me—of the date for Belconnen. Can you tell us the date for the Gungahlin development?

Ms Cahill: Belconnen is 2012, as is Gungahlin. I can give you the months. I will need to look at my notes for that.

MR HANSON: I think you said March for Belconnen.

Ms Gallagher: I am checking on Gungahlin. Construction in June 2010, completion in 2011. We will get a figure on Gungahlin.

THE CHAIR: We will get that clarified. No problem.

MS BURCH: You made mention of the new theatres and purchasing state-of-the-art equipment to go into them. How did you choose that equipment, given that it is the first of its kind in Australia?

Ms Cahill: The tender evaluation team, apart from comprising representatives from Procurement Solutions, also had clinicians. A number of those clinicians are highly experienced neurosurgeons and they had actually looked at this sort of technology that was operating elsewhere in the world. We were essentially faced with two options: either the machine can come to the patient and undertake the scan whilst the operation is occurring or the patient can go to the MRI scan during the operation. That was essentially the choice that they were faced with.

Based on all the evidence that they had, they felt that choosing the machine that actually comes to the patient whilst the operation is occurring was the better option. But it was certainly challenging. As our chief information officer said earlier, it is important that all of these clinical systems are integrated; so we needed to make sure that the technology was going to fit with our other imaging technology in the hospital.

MS BURCH: In the women's and children's hospital, new models of care were determining your plans and your structure of the hospital. Can you tell us a bit about that?

Ms Cahill: In the development of all the new models of care, we have taken very much a patient-centred approach. For example, if we just look at the mothers and babies, in particular birthing services, certainly when we listened to consumers, a lot of them really like the experience that they have in the birth centre. So we have increased from the current three to five the number of birth centre suites that will be in the new hospital.

Recognising again women's preferences to have a birth centre-like environment, we will be creating what we call labour birthing recovery and post-partum rooms. These rooms are very much like a home environment but also have the capacity to provide more, I guess, high-end interventions, if needed. We will have capacity to cope with an increased number of births with more of these labour birthing and recovery rooms. That is just an example.

MR SMYTH: On the bottom of page 214 of BP4, underneath all the rollovers, there is reference to the cessation of the linear accelerator project. Can you please give us a description of what has happened there?

Mr Cormack: I ask the CFO to join us.

MR SMYTH: I have checked your depreciation; it seems okay this year.

Mr Foster: I hope so. Could you clarify the question?

MR SMYTH: On page 214 of budget paper 4, the final line under the technical adjustments refers to the cessation of the linear accelerator project. What does this mean?

Mr Foster: The first column, the $500,000 reduction, means that the linear accelerator is finished in 2009-10. The way we roll out the forward years, or the budget years, means money has to be taken off the starting point. When you get to the final column, the $77 million, that is just the reflection of—if you look at the previous

page, you will see that, when we start up a new outyear, there is $80.889 million showing—the fact that we have got no project that that belongs to. Then they just remove those funds.

MR SMYTH: Those funds are taken back into—

Mr Foster: The budget. They do not exist, effectively. It is just a technical process of adding in a new outyear, which is what the $80 million was at the previous page, and then returning funds that are not needed in that outyear. The balance there of $35 million is the new projects in 2012-13 related to items appropriated in subsequent years.

MR SMYTH: Why is this project not going ahead then?

Mr Foster: It has gone ahead, the linear accelerator.

MR SMYTH: This is completed?

Mr Foster: It is completed. It is the third and fourth bunker provisions.

Ms Gallagher: It is the bunkers.

MR SMYTH: This is completed but it has not used all the funds?

Mr Foster: The project is to be completed in 2009-10. There is still money appropriated for 2009-10 for it. That description is linear accelerator and CADP projects that will be completed.

MR SMYTH: Thank you.

Mr Foster: It has definitely gone ahead.

MR SMYTH: Yes, that was what I thought.

Mr Foster: A very successful project.

MR SMYTH: I do not know who wants to answer the next question. Given that the car park is going to cost more, the neurosurgery in the short term is going to cost you more, you are moving the youth mental facility and the PSU mental facility off campus, how much of the $300 million will be overrun in the first stage of the redevelopment?

Ms Gallagher: There is not an overrun of the $300 million because we have been managing costs within that $300 million. Part of the idea of having that clinical services redesign or redevelopment was to allow some flexibility in the early stages of the project as we rolled it out. This is the largest infrastructure project the territory has undertaken and I think we have put in really good processes to manage this project. It is very strictly governed. Not only is it managed through Megan Cahill and Mark Cormack at monthly meetings of the redevelopment committee, which has representatives of Health, Treasury, CMD, consumers, probably a number of other

agencies—

Mr Cormack: GSO, Procurement Solutions.

Ms Gallagher: Yes, GSO, Procurement Solutions. Thinc Health and InTACT are there.

Mr Cormack: And environment and sustainability.

Ms Gallagher: The department of environment are there as well. Everybody at those meetings works through each individual project, including how it is tracking, what its budget is looking like. I attend those meetings when I can. I have attended two in the last five months or so. There are also regular reports to cabinet. How often are they? Two-monthly or—

Mr Cormack: Quarterly.

Ms Gallagher: Quarterly. It seems more often than that. There are quarterly reports to cabinet on each of the projects and how they are tracking. There is also a committee which involves Treasury, CMD and Health in terms of oversight and managing it. I think at this point in time it is all being managed within budget and with very close scrutiny. Indeed, individual management of this project is occurring to make sure that we stay on target that way.

MR SMYTH: All the other projects are still on their original estimates? The women's and children's hospital will still cost $9 million?

Ms Gallagher: That is right. The one area perhaps of uncertainty will be the forensic unit. There has been individual appropriation made for that but that will just depend on the ultimate site for that project. I think the two Gungahlin sites would require some major work being done in terms of servicing the blocks, from memory. That would be the one where I have got a bit of an eye looking at what is happening. That is just a little up in the air because of the consultation process on where the forensic unit should go.

MR HANSON: There is a follow-up to that remark.

THE CHAIR: Yes, and Ms Le Couteur has some as well.

MR HANSON: I am a little bit scarred by the AMC experience; so you will have to forgive me for what happened in corrections.

MS BURCH: Chair, do we have to have those comments from a visitor on the panel all the time?

THE CHAIR: I am sorry if you are offended by them but there tends to be the odd comment in both questions and answers; so I think we will let them go.

MR HANSON: The reason I raised this—and it does have some relevance—is that what has happened with the AMC project is that the budget has stayed largely intact,

but what they did was they reduced scope. So they had $130-odd million, but as they went forward they realised that they weren't going to be able to deliver what they had originally conceived within the budget, so they reduced the scope. Have we seen that starting to occur yet? For example, for the women's and children's hospital, have we articulated the number of beds that were going to be delivered in that program, and have we seen any reduction in any of the programs in terms of scope?

Mr Cormack: No.

Ms Gallagher: No, there hasn't been. We have articulated the numbers, and I am happy to provide that to the committee.

MR HANSON: Yes, if you could. I do not know quite how you break it down with the CADP in terms of each one of those programs. But in terms of measurable outcomes, for example, with the women's and children's hospital, for five birth suites, you would have a number of beds and so on. With car parks, I guess that is an easy measurable as well. I just want to be able to track over time how we are progressing. It is easy to say, "Oh, the budget's stayed the same when we look at the figures," but it is actually the deliverable outcome.

Ms Gallagher: Well, we can certainly assure you there has been no reduction in scope. There have been lengthy discussions around the design, particularly for the women's and children's hospital, but I think those discussions overall have been worthwhile in making sure we get it right. We have been through this at last year's estimates as well. There is not expected to be enormous growth in women's and children's service provision, unlike other areas such as the acute area, where we have predicted large growth in bed numbers. There is some growth in the women's and children's area; there certainly is in paediatrics and NICU and in birthing. What are the birthing units called?

Mr Cormack: LBRPs.

Ms Gallagher: LBRPs, yes. Thankfully, I won't be needing those again, but they will be very nice for whoever needs them. There will be some growth in there, but the idea behind the women's and children's hospital was also around co-locating women's and children's health into one spot. So we can provide that for the committee.

MR HANSON: Yes, that would be good. That is very useful moving forward so we can see where we started with the conceived plan. That is just right back to what I said to Ms Burch about the AMC. That is what occurred over that project, so it is just something I am mindful of.

Ms Gallagher: Sure. And in relation to the neuro suite, there has not been any cost blow-out on that; it was always scoped as a $10 million to $10.5 million project. That has been a very complex project in terms of everything revolving around this magnet, I am told. This enormous magnet is going to come in and be placed in the middle of the hospital, and that has affected the surgical assessment planning unit that sits underneath it. So we have linked those projects just because of how complex they have turned out to be.

THE CHAIR: Ms Le Couteur.

MS LE COUTEUR: Thank you. Minister, you just said this was the largest infrastructure project that the ACT government has ever delivered. Given that, how much emphasis are you placing on energy efficiency?

Ms Gallagher: A lot.

MS LE COUTEUR: I appreciate you're not going to be able to do zero carbon emissions, but what measures have you looked at from the point of view of energy efficiency?

MS GALLAGHER: A lot of effort is being put into this. I think someone has been tapped to come up and talk about this. With the establishment of the new Department of the Environment, Climate Change, Energy and Water, we have invited them to our monthly meetings at which we discuss every single project and what we are doing around them.

Ms Kennedy: Rosemary Kennedy, Executive Director, Business and Infrastructure, ACT Health. In terms of what we are looking at with respect to energy, we have undertaken a services master plan for the TCH campus, and that has looked at how we actually will be delivering our energy into the future and what we can do to actually harness as much energy efficiency as possible. So the plan is about 95 per cent complete. It is not entirely complete, but it is looking at what we will be doing on the campus up to about 2030 and how we can capture and save energy as much as possible with also the option of looking at cogeneration on the campus.

MS LE COUTEUR: So is there anything else you are looking at apart from cogeneration? I am aware that Woden Valley looked at cogeneration in the past and rejected it? Are you likely to do it this time?

Ms Kennedy: Well, as I said, the services master plan is not 100 per cent complete; it is 95 per cent complete. So decisions have to be made around that as we look at the complete plan. But they are some of the early indications of recommendations out of that plan.

MS LE COUTEUR: Have you any sort of figures for how much energy reduction you expect to make compared to your current operations?

Ms Kennedy: No, we do not have any figures on that at the moment.

MS LE COUTEUR: Water? Are you doing a process of trying to be water efficient?

Ms Kennedy: The other element that we will be taking is a sustainability feasibility plan. We are looking at undertaking that next financial year. That will actually look at the broader aspects of not just the services but water savings into the future. We have already, as you may be aware, reduced our water usage on the campus. So we have already reduced our water usage from 189,183 kilolitres in 2006-07 to 138,101 kilolitres in 2007-08. So that is a saving of 51,082 kilolitres, which is a 27 per cent reduction in water usage already.

MS LE COUTEUR: Well, that is good. I hope you can continue on that and start doing something at least along those lines in energy.

Ms Kennedy: We certainly are looking at how we can reduce both energy and water usage across the campus. We have reduced our fuel usage significantly as well in terms of our fleet operation.

MS LE COUTEUR: Have you any more information about where you are up to with the cogeneration project, particularly as I am aware that it has been rejected in the past? Is there anything more you can say about that?

Ms Kennedy: Until the plan is finalised and decisions have been made around that, we do not have an outcome—

MS LE COUTEUR: When is that likely to be?

Mr Cormack: We'll take it on notice.

Ms Kennedy: Yes, we'll take it on notice.

MS LE COUTEUR: Thank you.

THE CHAIR: Mr Hanson then Ms Burch.

MR HANSON: A question around the walk-in centre as part of the sector. I have read the discussion paper and I have attended a number of the forums. Certainly at that stage the model that is going to be used has not quite been articulated. There seemed to be a number of models on the table. Have you formed a view of what model we are going to progress?

Ms Gallagher: Yes. I will just call Brenda Ainsworth, who has been managing that project for us. In the meantime, can I just table a couple of things we have taken on notice?

THE CHAIR: Sure.

Ms Gallagher: Gungahlin community health centre, 11 September. Belconnen enhanced community health centre, February 2012. Going back to the car park, the original car park was not 1,400 places; it was 1,086. That was with the $29 million budget. The $45 million car park on the southern side of the campus is 1,860, and it brings the total number of car parks when the new car park opens to 3,406.

THE CHAIR: Just a quick follow-up on the car park, how does that then compare to the vehicular access guidelines that the ACT government has? Is that meeting the number needed, is it above, is it below?

Ms Gallagher: I think it is—

Mr Cormack: It is meeting the projected demand that was articulated in the traffic

management and parking study that was undertaken as part of the CADP program. So it lines up with that pretty nicely.

THE CHAIR: So where were we before that?

Ms Gallagher: The walk-in centre with Brenda.

THE CHAIR: Yes.

MR HANSON: So just the model that you are going to use. Have you come to a view of what you are going to do?

Ms Ainsworth: We are actually currently just working on our model of care for the walk-in centres. As you would be aware, the discussion paper put up a couple of different ways that we could potentially do it, and feedback from the community has inputted into what they liked and what they thought we could do differently.

I have also spoken to a range of health professionals about what they thought would work well and what they didn't like. That has formed the basis now of us developing up a model of care, which is kicking off basically as we speak, to look at specifically what sort of staffing will be in it, what level of staffing and do we start with perhaps a hybrid staffing model of some nurse practitioners and some advanced practice nurses, moving on to more of a nurse practitioner role into the future. So we are actually training and building our own as we go along. We certainly have identified a number of locations that would be most appropriate and that the community thought that were appropriate as well, so that matches in with our planning. But the intricate detail of exactly how it would work—and using the evidence that we saw when we went to the UK—is still to be developed through the models of care.

As I said, that is kicking off basically as we speak. We are advertising for a project lead for that, and we will have a number of working parties with a lot of the key stakeholders that have been involved with the development of the discussion paper and the community consultations. So we have certainly kept the AMA, Division of General Practice and the Pharmacy Guild et cetera involved, and we will have them as representatives on the working group as we move forward to say exactly what it needs to look like for where we are going to.

MR HANSON: Okay. Obviously one of the issues is the lack of GPs necessitating this in part. Have we got sufficient numbers of practice nurses and nurse practitioners to meet the demand that a walk-in centre would create?

Ms Ainsworth: That was one of the things that actually came up in the public consultation. There are a number of nurse practitioners working within the ACT but not necessarily any nurse practitioner roles. There certainly are a number of nurse practitioners working in the surrounding regional areas who are also not currently working in nurse practitioner roles, not so much because they can't but because there are no roles available for their skills at the moment.

So we certainly have had a lot of input from those people who have said, "Well, if you start something, we'd be really interested in going and working there." There is a

recognition, though, that nurse practitioners take a while to train up and to actually work within that environment. So to start, we will probably have a hybrid model, which was not unusual in the UK as well. We can actually start with what we call advanced practice nurses, who we can train internally and actually get them on a path to want to be nurse practitioners. So at the moment, certainly starting our first walk-in centre, we are thinking that we will have the right amount of staff around the ACT and the surrounding region who may wish to come and work with us. Of course, we can't make them, but we'll make it attractive.

MR HANSON: You might have said, but when do you reckon you will have that model crystallised in terms of how it's going to work?

Ms Ainsworth: Certainly we are aiming for a start-up date for the first walk-in centre in March 2010. So we are hoping that within the next 24 weeks we will have a model of care that is as close to an operational model of care as it possibly can be.

MR HANSON: Okay.

Ms Ainsworth: Some of the things that will restrict us are looking at more detail about our nurse practitioner workforce. We are working very closely with the chief nurse on some strategies to actually start the development and training of that type of staffing as early as possible so we have got the right amount of staff there. Also we are leveraging off some of the work that has already been done in allied health in regard to physiotherapists and physio assistants et cetera working in a walk-in centre environment.

MR HANSON: Okay. I put on the record that I thought the discussion paper was good.

Ms Ainsworth: Thank you very much.

MR HANSON: It was easy to read and simplified the issues in a glossy document that was short, concise and well written. I passed that on to the staff at the forum, but you can take that back with you.

Ms Ainsworth: Thank you, my staff will be very happy to hear that. Thank you.

THE CHAIR: Thank you, Mr Hanson. Ms Burch, and then Ms Bresnan.

MS BURCH: There's a line around healthy futures looking at preventative health programs at page 79 of budget paper 3. I wouldn't mind hearing a bit about what that is, noting that there are some target areas noted in the budget papers.

Mr Cormack: We might ask the Chief Health Officer, Dr Charles Guest, to talk to that.

Dr Guest: The initiatives include two million per annum for healthy kids, healthy future, which is a program to promote healthy habits in children to avoid excess weight gain; 200,000 per annum for tobacco use in Aboriginal and Torres Strait Islander people; half a million each year for chlamydia awareness; and 300,000 for a

feasibility study for youth health, a program that was an election commitment based on needs around some protection from sexually transmitted disease, drug use and the exposures of young people. There are many services in the ACT, but joining them up in an efficient way is something that we will be looking at in the feasibility study this year.

MS BURCH: So the youth adolescent health centre is to capture existing services for a one-stop shop type of approach?

Dr Guest: That is right; that is what the feasibility study will look at.

MS BURCH: And partnerships with the community sector?

Dr Guest: Absolutely.

MS BURCH: Okay. The $2 million on the healthy kids, healthy future program, looking at obesity and lifestyle issues—how does that work? There have been different programs—healthy canteens and school-based initiatives. Is that what you are looking at?

Dr Guest: It is looking at the promotion through grants—the promotion of active play, alternatives to passive pastimes such as computer games and television, promoting the adoption of healthy eating habits with the established two and five campaign, and promoting the acceptance of water as drink of choice. So—way to go.

THE CHAIR: Shall we let the *Hansard* reflect that Dr Guest just took a drink from his glass of water—just put that on the record.

Dr Guest: And, very importantly, breastfeeding. The other component to it is the promotion of breastfeeding, which is a very good predictor of obesity avoidance in adult life. So that is the rationale.

MS BURCH: And that will go through the child and maternal units in community health centres, I am assuming?

Dr Guest: Yes; they will be partners to that activity.

MS BURCH: Going back to a healthy lifestyle and active play with children, on Friday there were community sporting groups here that were keen to be involved in partnerships to extend the PE curriculum to out of school. Those grant systems would allow that partnership to foster through various local sporting groups—local soccer, basketball, netball and things?

Dr Guest: Yes.

THE CHAIR: Just on encouraging breastfeeding, how is that going in terms of the success rate of getting Canberra women to take that up and how are we looking nationally?

Dr Guest: The ACT has about the national performance on breastfeeding.

THE CHAIR: What is that, roughly?

Dr Guest: The figure is in the Chief Health Officer's report, which I can fetch, but it is all set out there. Nationally we are doing well with breastfeeding, but there is a way to go. It is certainly identified as an activity worth promoting in terms of nutrition in adulthood.

THE CHAIR: Indeed. Are you still on this line of questioning, Ms Burch?

MS BURCH: Yes. Given averages and above averages—is the chlamydia awareness program something we need to target on?

Dr Guest: Yes, we do. We have in the ACT one of the leading sexual health centres in the country. There is actually quite a deal of awareness of chlamydia in the ACT, but once people have been tested it is a matter of getting into appropriate treatment as well. So there will be more awareness, more testing and more treatment. That all costs money. The benefit of it is avoiding infertility.

MS BURCH: Where do we sit on the national average on that? Is that in your report?

Dr Guest: I would refer you to the Chief Health Officer's report. We are doing well. There is more identification of chlamydia in the ACT than in most other jurisdictions. We have got a very active program.

THE CHAIR: Ms Bresnan.

MS BRESNAN: I want to go back to a question I asked about after-hours mental health service provision by the community sector and say that there did not seem to be awareness that that had been raised. I did just want to go to that: it is in the mental health community coalition budget submission for 2009-10; they talk about having an after-hours service. It is on that point of having after-hours and weekend services. They do note in there that there are community-based services provided through the Mental Health Foundation, the Richmond Fellowship and Belconnen Community Service, but it is about the after-hours times and on the weekend, and having that provided by the community sector. It is priority 4 in the budget submission. I wanted to raise that, because I am a bit concerned that no-one had actually seen it, when it had been put in by the peak mental health community group in the ACT in their budget submission.

Mr Thompson: I can also comment—not answering that point specifically, but in terms of the question that was left hanging—as to what was funded last financial year in relation to the Richmond Fellowship. It was after-hours support for clients of their supported accommodation service. They do actually provide after-hours services, but it is only for their own clients.

MS BRESNAN: Yes, that is right. What the community coalition are noting is that that is where it is. It was the consultation identified for the mental health services plan. It came up through that consultation process that one of the major gaps was in that after-hours and weekend provision of services. I just wanted to draw attention to that.

Ms Gallagher: When you look at some of the breakdown of the funding—we can certainly give you a list of the breakdown in the community sector funding—you will see that in fact we have responded to the community coalition's budget submission. They did not get everything they were after.

MS BRESNAN: No, I understand that.

Ms Gallagher: But there are elements where we have picked up their ideas.

MS BRESNAN: I was just bringing it in as a point, because no-one seemed to be aware of that being raised, when it is in the coalition's budget submission.

MR HANSON: Could I ask a question on mental health while we are at it.

THE CHAIR: Sure. Have you finished, Ms Bresnan?

MS BRESNAN: Yes, that is fine.

MR HANSON: Minister, earlier this year you opened up a five-bed step-up, step-down facility.

Ms Gallagher: Yes.

MR HANSON: At the time, you suggested that there were more to follow.

Ms Gallagher: I think I said that no doubt it will be a great success and we will need to build on it in the future, which I imagine we will.

MR HANSON: Indeed. That being the case, can you tell us a little bit about how it is going? Are the beds at capacity? Is there extra demand? Is it working the way you anticipated?

Ms Gallagher: In recent years, there have been both the young persons and the adult step-up, step-down facility. From my advice from the operators, it is going very well.

Dr Brown: Yes. We have got the young persons step-up, step-down that opened in April last year; there are five beds there. Then we have the adult one that opened in January this year. The adult one is operating at around 85 or 86 per cent capacity, and the young persons likewise. There is not actually a waiting list at either facility, as I understand it, but most of the beds are occupied most of the time.

MR HANSON: Moving forward, extrapolating, do you see a need for further beds, or at this stage is it stable?

Dr Brown: I think the planning in the mental health services plan foreshadows a need into the future. We have identified, in line with moving to a greater focus on young adults, that we probably will have a need for a facility that caters for the 18 to 25-year-old age group specifically. That will allow us to move the existing adult facility to a 25-plus facility. And then, depending on the demand, there may well be a

need for additional facilities after that.

MR HANSON: Right.

Dr Brown: We are doing it in a step-wise fashion.

MR HANSON: So you are just sort of seeing how you go at this stage and then moving on. Where would that money come from—the general budget? That is not CADP money as such, is it? That would just come from within the mental health funding line?

Ms Gallagher: No; the step-up, step-down is funded separately. There is, in the mental health money in the budget, mental health growth covered off. There are a number of accommodation and outreach support services that will be expanded through this budget. There will be additional money for Centacare, for the supported hospital exit program and for Samaritan House supported accommodation and outreach. This is an area where the community sector have been strong advocates around increasing their role in the provision of accommodation and support to people with a mental illness. Perhaps it is easiest if I give a list of those initiatives to the committee. It shows we are building. We are not funding another step-up, step-down model through this budget, but there are some additional moneys going into community supports.

MR HANSON: It would be useful to see what the capacity of those organisations is—step-up, step-down or one of those other organisations—to see what pressures are building, if that is possible.

Dr Brown: So you are seeking information now?

MR HANSON: No. The minister said that she would provide that.

Ms Gallagher: I will just give the list.

MR HANSON: Yes. And, if it is possible, just say where we are at with those in terms of demand and capacity. That would be useful.

Dr Brown: Sure.

THE CHAIR: Mr Smyth.

MR SMYTH: I was interested in Shared Services and its operation inside the department of health. It has now been running for a number of years. Has any analysis been undertaken as to whether Shared Services actually delivered savings for the department of health?

Mr Cormack: If I could just respond to that, basically Shared Services was not set up to create savings for ACT Health; it was a whole-of-government initiative. Those savings were delivered to government at the time that the Shared Services arrangements were established. We are a customer of Shared Services in a number of areas, and that process is bedding down pretty well.

MR SMYTH: Are the services they are providing you costing Health more or less?

Mr Cormack: They do not cost us any more or any less.

MR SMYTH: So it is absolutely expense neutral?

Mr Cormack: The Shared Services initiative was a whole-of-government initiative. There were agreements made at the time for transfer of resources for various functions associated with Shared Services. I cannot give you the precise amounts, if that is your next question, but those amounts were netted off in previous budgets, and we continue to receive services from Shared Services such as payroll, financial transactions and a number of other related matters.

MR SMYTH: It is all working well?

Mr Cormack: It is working well. We have a chief executives governance group which meets on—I think it is every six to eight weeks. The head of Shared Services, Michael Vanderheide, provides a performance report to the governing committee, and we have the opportunity to take up issues of service capacity and responsiveness at that time.

MR SMYTH: So for the services, say, the old InTACT used to provide, what are your current arrangements for the provision of IT inside the hospital?

Mr Cormack: Well, the InTACT arrangement preceded Shared Services, and that has not really changed over the last three years. IT support and project management functions have been a part of InTACT for a number of years now. We receive regular performance reports. InTACT are intimately involved in our various management committees. The minister referred to their involvement with the CADP redevelopment committee, so it is really business as usual, and has been for some time.

MR SMYTH: In human resources, then, what is the contractual arrangement with Shared Services?

Mr Cormack: In human resources, Shared Services provide us with payroll and personnel functions. They also provide a range of support services. They offer some investigation services, salary packaging and a range of other services, some of which we previously provided in-house.

MR SMYTH: So do you have a contractual arrangement with Shared Services?

Mr Cormack: There is a service agreement. It is not a formal contract, but there is a service agreement that is set up between Shared Services and each of the agencies where there are certain deliverables articulated. As I have mentioned before, we have a governance committee or governance council of chief executives and/or their representatives who monitor that.

MR HANSON: Can I ask a question in terms of the salary packaging. In February, I think you sent out a direction that everyone was going to transfer across to

Shared Services?

Mr Cormack: Yes.

MR HANSON: That was subsequently rescinded?

Mr Cormack: Correct.

MR HANSON: What happened with that?

Mr Cormack: Well, look, it was just a glitch. There was a misunderstanding that we were discontinuing with our external salary packaging providers—we have got two, I think—and that we were requiring everybody to move over to the Shared Services salary packaging arrangement. I clarified that and we now have an arrangement in place whereby, if people have salary packaging arrangements in place with the external salary packaging providers, they can continue with those. But for new employees or people who wish to change provider, they can only transition over to the Shared Services salary packaging provider.

MR HANSON: Okay.

THE CHAIR: Ms Burch has some questions and then Ms Bresnan.

MS BURCH: Moving to another area, moving to the output on public health services in budget paper No 4, page 205, can you tell us a little bit around the public health initiatives that we are doing and how we are tracking with that? In particular, the comment is made here that we have got the greatest life expectancy in Australia and you are looking to reduce the incidence of cardiovascular disease and ensuring the rate of hip fractures declines over the long term.

Ms Gallagher: This is the Chief Health officer's output class.

Dr Guest: Greatest life expectancy—yes, we do have the greatest in Australia. Measures to maintain that really cross the whole of the portfolio, and they go right through life. So we have programs, antenatal, natal and postnatal, and then for children. We have just discussed the feasibility study for adolescent health. Then there are programs for adults, of course, and the prevention and management of chronic disease, which is where the gains will be seen in coming years. We are working hard on cardiovascular disease, which is the greatest killer in Australia, and we have all the programs that I mentioned last time and many others that have been mentioned today, including mental health, which, across the spectrum, all contribute to life expectancy.

If we go to cardiovascular disease, we have the best rates for cardiovascular disease in the country. I would refer you to the Chief Health Officer's report for that.

MS BURCH: Incidence or treatment and outcomes of it, or both?

Dr Guest: Incidence is lowest; mortality is lowest; prevalence, which is the result of treatment, if you think about it, may be somewhat higher. That is, there are more people in the ACT with controlled cardiovascular disease than any other jurisdiction.

These are reflections not only of the health service, of course, but also of the socioeconomic status and the determinants of health here in the ACT. This is the most educated community in Australia, on average, and mortality and morbidity are inversely related to advantage.

MS BURCH: On cardiovascular disease, we are in the middle of the go red for women campaign, that month, and that shows heart disease is the number one killer for women with quite shocking stats of 30-plus a day dying from cardiovascular disease, from heart disease. Are some of our initiatives targeted to women or is it both men and women without a target, given it is the number one killer of women?

Dr Guest: I suppose the most obvious targeting of women at the moment is in the capital asset program with a new women's and children's hospital. That is the obvious treatment end of the spectrum. The prevention activities are aimed at females and males. To single out others that are specific for women, obviously there are the screening programs—breast and cervical screening. There is targeting by some of the weight control programs, the blood pressure programs for women, but the mortality of women is generally lower than that of men, so while we do have many programs that are specific to women there are also some specific to men. That is an indication of some of those areas.

Just to comment on hip fracture, the third dot point there on page 205, that has perhaps been the area where there has been the most reduction in the last 10 years in the ACT. Again—

MS BURCH: Through your preventive programs, your awareness-style programs?

Dr Guest: Yes. The incidence of hip fracture has reduced for a number of reasons, including falls prevention programs that have been successful. Hip fracture is an old person's disease, of course, so increased and improved treatment and management of conditions in old people.

THE CHAIR: Ms Bresnan, and then we will move on to Mr Hanson.

MS BRESNAN: Thank you. My question is in relation to page 206 of budget paper No 4. It is in relation to the aged-care rehab services funding. It is output 1.6. Just looking there, there does appear to be a decrease by about $1.6 million for aged-care rehab services. I just want to check. Does the funding which is listed there include the new expenditure of $1 million which is for the increased demand in older persons services? I note that that is in the budget. I guess if that includes that then there is actually a further decrease, in a way.

Dr Guest: Yes.

MS BRESNAN: I just wanted to find out if particular programs have ceased being funded or if they have been moved elsewhere, because it is not clear.

Dr Guest: Mr Foster will be able to address that.

Mr Foster: The major reason is we have transferred $3.8 million worth of

expenditure from the aged-care output to the mental health output. It relates to the older persons mental health unit at the subacute facility. We have been recording it in aged care from when we first commenced the subacute facility, but we have just had a bit of a tidy-up or whatever. We have realised that that should be or can be recorded in the mental health output. So it is down to $3.8 million for that transfer and up for indexation and the growth initiative.

MS BRESNAN: Yes, and it includes the $1 million for the older persons services?

Mr Foster: Yes.

MS BRESNAN: Yes, okay.

MR SMYTH: While Mr Foster is there, perhaps just moving down to output class 1.7, can you explain why the government payment of outputs appears to have declined?

Mr Foster: Yes. It is due to the commonwealth's changed method of payment for the immunisation programs. It used to come through government funding. Now it is going to be a third-party payment directly to us. So instead of going through Treasury's appropriation, it is just coming straight to us.

MR HANSON: So we are not cutting services?

Mr Foster: No.

MR SMYTH: So what output class does that then appear in?

Mr Foster: It is just a revenue item. We do not show the third-party revenues in these presentations. It is only GPO and expense. So it is still in output 1.7.

MS BURCH: On the—

THE CHAIR: Is this a follow-on from the question, Ms Burch?

MS BURCH: Yes. It is the third dot point about hearing screening for newborn bubs in the ACT. How are we tracking with that?

Mr Cormack: We are tracking very well. I think somewhere between 99 and 100 per cent is the last result that I saw for it. It is page 200. It is a strategic indicator. It is 100 per cent, in fact. So we are going very well with that.

MS BURCH: Well, 100 per cent is pretty good last time I checked.

Mr Cormack: It is pretty good.

THE CHAIR: Not bad. Mr Hanson?

MR HANSON: Just while we are talking about outputs, the money in output 1.3—I am not sure whose one that is. This is part of your preventive health exercise program. There is $9 million there. Is that a transfer of something, is it?

Mr Foster: Yes. We transferred the acute allied health service to output 1.1. It has been a formal transfer of that function, about $13 million. So down for 13 and then up for indexation on labour and administrative expenses.

MR HANSON: Okay. Thanks.

THE CHAIR: Okay. Mr Smyth?

MR SMYTH: Minister, the whole issue of the Aboriginal healing farm, could you please explain to the committee the process by which the department of health came to purchase that block?

Ms Gallagher. Sure. Ron can provide all the explanation on that. Certainly, in advice to me they were out looking for suitable sites and, as part of that, they came across Miowera for sale and included that in the sites that they were considering.

Mr O'Donoughue: I will give members some background to the project more generally. The concept of the Aboriginal healing farm has been promoted by the United Ngunnawal Elders Council for a number of years. In an Indigenous consultation associated with the COAG trials, it became one of the identified priorities for the community. In 2004, representatives from ACT Health and nominated representatives of the United Ngunnawal Elders Council visited first nation drug and alcohol rehabilitation services in the United States of America and Canada and that led to development of a bush healing farm procurement feasibility plan in 2005.

The ACT government committed $10.8 million in the second appropriation in 2007-08 and a number of sites were looked at. The feasibility plan of 2005 identified two sites as having potential: Ingledene and Jidbinbilla. In March 2008, a reference group consisting of members of the United Ngunnawal Elders Council, ACT Health and consultants, visited both of those sites. Unfortunately, they were both deemed to be unsuitable—Jidbinbilla, because it had cultural significance as a male initiation site, and as the service was intended to offer services to both men and women that was not appropriate; and Ingledene, because of its lack of environmental integrity.

We approached ACTPLA and TAMS to try to identify further sites but, in the course of our actual site visit in March 2008, the environmental consultant who was with us identified Miowera, a rural lease, that was available for sale on the private market. In April 2008, the reference group conducted a site visit at Miowera. They found that the site met all the criteria that they had set, including its cultural appropriateness. From that point, ACT Health entered a process, including a procurement plan through Procurement Solutions, negotiations with the real estate agent, conveyancing by the Government Solicitor's Office, an independent valuation which was completed in June 2008, an offer of purchase and the completion of sale in August 2008.

MR SMYTH: What was the difference between the valuation and the asking price?

Mr O'Donoughue: The valuation, the asking price and the price agreed on were all congruent.

MR SMYTH: A number of locals have said to me that it seems to have sold for well above the asking price per hectare out there at the moment. Is there a comment there? Is that correct?

Mr O'Donoughue: The valuation took into account sales of comparable properties, and that was the independent advice that we had to hand.

MR SMYTH: What due diligence did ACT Health undertake before buying this lease in regard to plans submitted by adjoining lessees as to the development of their properties?

Mr O'Donoughue: The GSO undertook the usual due diligence searches. We also undertook Aboriginal heritage search listings. All of those searches were found to be satisfactory, inclusive of the fact that we looked at all lodged development applications by neighbouring properties over the last three years.

MR SMYTH: My understanding is that, when you start developing your property out there on a rural lease, you have to submit a plan as to the long-term intention. I understand the property adjacent to Miowera submitted something in early 2000 that spoke about a bed and breakfast, a vineyard and a cellar door facility. Was that taken into consideration?

Mr O'Donoughue: That is not correct. The only development application from a neighbouring property was for a storage shed and lean-to on their property on their garage.

MR SMYTH: No, I did not say a development application. I said my understanding is that you have to submit a long-term plan for what you intend to do in the process, and that was submitted in 2000, 2001.

Mr O'Donoughue: The approved uses of rural leases include viticulture but do not include the kind of business operation that you would be referring to. So any such approval would require a development application, and no such development application lodged was discovered in our searches on the property.

MR SMYTH: The need for Health is for how many hectares for the healing farm?

Mr O'Donoughue: I think it is important to realise that the intention from the outset of the healing farm—and I suppose it is embraced in the concept of the title—is that part of the therapeutic process would be reconnecting Aboriginal people with their land. That was, in a sense, the importance of finding a culturally appropriate site and finding a rural site. We see this facility as nested within a rural lease. To that extent, it can preserve the rural lease but it also can use the rural lease to play out that cultural, therapeutic purpose of reconnecting people with their land and offer them the opportunity of learning some useful work and life skills on land management, animal husbandry or other practices associated with a rural lease.

In that sense, while this is a large property, only 40 per cent of it is cleared and suitable for grazing. In a sense, the bush character and the environmental integrity of the rest of it are important to the concept of the therapeutic healing farm.

MR SMYTH: That is fine but what was the size required for the bush healing farm?

Mr O'Donoughue: We are still working through our service model. It intends to accommodate 16 residents and a small number of overnight staff. The current rural lease has an approval for three dwellings plus, obviously, there is farm infrastructure there. We would imagine it would be a similar footprint to that three-dwelling kind of size but we have not as yet completed a full service model and design.

MR SMYTH: How big is Miowera, how many hectares?

Mr O'Donoughue: It is 386 hectares, 900 acres.

MR SMYTH: How much of that will be actually required for the healing farm itself?

Mr O'Donoughue: It would possibly be within something like 10 hectares. That would be the sort of footprint that I would be guessing at. So it is only a small space within the totality of the rural lease.

MR SMYTH: How will the rest of it be managed?

Mr O'Donoughue: As part of our obligation under a rural lease, ACT Health has entered into a land management agreement and that specifies all the appropriate management. We control feral animals, fencing and erosion control that we are obliged to undertake. That will be done and has been already commenced. Those obligations will remain under that land management act until it is varied. That lasts for five years and then we envisage in the future that there could be alternative methods of land management, for example, reafforestation or other land management practices that the residents of the healing farm could be involved in and we might seek to bury that land management agreement. But, essentially, it commits us to the proper management of the rural lease.

MR SMYTH: Health is about to be a rural lessee with a land management agreement?

Mr Cormack: Yes, we are, but I refer to Mr O'Donoughue's opening comments that this whole concept is not just about a patch of land surrounded by houses; it is a patch of land in a bush environment. There was a lot of research that went into this particular service model. If you want that sort of environment, it is good to have it out of town, surrounded by forest, farm, which provides that sort of environment. It is part of the model. So we are very fortunate that we found a suitable block that is able to provide all of that and meet the requirements of the Indigenous advisory body that has been working with us on this for quite a number of years. I think it is a very positive way to respond to the health needs of the most disadvantaged group of our community.

I think it is unfortunate that we get into these sorts of discussions on all this stuff about whether we are rural lessees or not. Yes, we are, but we are providing an essential service to the most disadvantaged group in our community in a model that is culturally sensitive.

MR SMYTH: Since 2003, their preference has always been Ingledene. Weren't there other blocks available at Ingledene? Part of the original proposal, if you have read it, is that they really wanted to be quite close to permanent water, particularly a river. The water out at Tidbinbilla is patchy at best. I understand most of the water out there is not flowing at this time.

Mr O'Donoughue: They had a number of criteria and one of them was it be in a rural location and not be too proximate to development. Clearly the cultural significance was important. They did have a preference for a watercourse, for some water to be available on the site. But they are very enthusiastic that Miowera meets all those criteria. The property adjoins Paddys River for two kilometres. There are 10 dams on the site. Our evaluation indicated that, given the seasonal nature of the drought in the ACT, it had very favourable water supply. When we designed the facility, the Aboriginal advisers were very much intending for it to be environmentally sustainable and wanted to see appropriate use of waste water and sensitive environmental design part of the feature of the facility.

MS BURCH: I think that is where I wanted to go. It is just confirming that it was an appropriate site agreed by the advisory group and the elders. What now? What are the plans forward? You are working with an advisory group on what the services may be. There are three dwellings. I would like to explore that a little and the match between the advisory group and the models of care from best practice.

Mr O'Donoughue: Sure. The project is actually nested within the capital asset development project; so it will follow a similar service model design process as the rest of the projects, even though it is a bit of a boutique service, a bit unique. The advisory board is broadly representative of Indigenous community and community organisations and does have continuity of membership back to the original COAG trials group.

We are working with that group to, over time, become incorporated and potentially take greater responsibility for the service. But it is also understood by them that ACT Health is the steward of the service; we are the budget holder; and we will be providing the service in its first years. So we are about to enter into a process of more detailed service model design. Once that is completed, we will be submitting a comprehensive development application which sets out the full design features of what is proposed on the site.

MS BURCH: But there is no compromise on quality of care or living standards, just because it is out in the middle of 300-odd acres?

Mr O'Donoughue: No, not at all. We believe we have got an adequate appropriation to deliver the service to a high standard. It is a small service. It is not a hospital environment. It is essentially a therapeutic community sort of environment; so it is more like a residence with some communal facilities than an institution. We are very confident that we can deliver an excellent service.

MR SMYTH: Time line on the proposal? It will open when?

Mr O'Donoughue: I would say we have still got some months of service model

design in front of us and then, obviously, we have to get an approval for this purpose for the use of this site. Then we would enter into a construction phase. So we are still a way off. Given that it has had a long gestation already—I hesitate to put a specific time on it—I guess towards the end of 2010 or early 2011.

MR SMYTH: Is there a requirement to vary the territory plan to allow it to go ahead?

Mr O'Donoughue: We have had advice that our proposed community is an adjunct use to the rural lease. On that basis, it may not be necessary to vary the territory plan.

MR SMYTH: It may not but it is not clear.

Mr Cormack: If it is not clear, we will submit a DA and it will go through the statutory approval process, at which time it will be determined whether that is required or not.

MR SMYTH: Who will run the facility? Will Health run the facility or will the Indigenous community run it?

Mr O'Donoughue: ACT Health will run the facility, with the view in mind to transition over time towards a more community-management model.

MR SMYTH: What will be the role of the Indigenous people in running the facility?

Mr O'Donoughue: They have been involved throughout. Obviously they were the proponents back in 2003. They are very much guiding the service delivery model. They want to continue to have the community engaged in the therapeutic model; for example, they want the residents of the service to have access to community elders as part of the therapeutic process. We would see them very much engaged throughout. Over time, we would like to support them to become incorporated, take a more active management role in oversight of the service and perhaps move towards becoming more responsible for actually managing the service in their own right.

MR SMYTH: You said 16 residents plus staff. How many staff?

Mr O'Donoughue: Because the service model is not as yet fully defined, I cannot give you a definitive answer on that but, typically, therapeutic communities are not large institutions. Obviously there is a need to have some administrative staff and then some workers. We would also like to train Aboriginal people to become involved in the program. I am thinking you might be talking about half a dozen staff.

MR SMYTH: The original proposal talked about family involvement and families helping with the rehabilitation of their own. If there are 16 residents and staff, would there be an expectation of families staying out there as well?

Mr O'Donoughue: The model wanted to be flexible about, if Aboriginal people coming in for treatment thought it important not to be separated from their family members, allowing that opportunity to arise, for partners or children or the like to be available and able to stay at the facility. As I said, there is also the consideration that it may be important that elders have somewhere to stay and be able to participate in the

program as well. But I suggest that that would be, in a sense, the exception rather than the rule. It has to be flexible to that option but it is not envisaged that there be large numbers of family members staying on site.

MR SMYTH: It is an area that has burnt a number of times through bushfires in recent years. What efforts will be put in to protect the community and assist the local community itself through its rural fire service to protect the community?

Mr O'Donoughue As part of the land management agreement that I outlined, we entered into a bush fire management plan. We do have an onsite property manager who looks after the property for us and we are actively involved in discussions with the community out there about discharging our obligations in respect of hazard reduction, appropriate equipment and everything else we need to respond to any risk of that nature.

MR SMYTH: There are some concerns in the local community that there might have been a conflict of interest in the purchase of the block. When you did the due diligence, were there any apparent or known conflicts of interest in Health buying this block of land?

Mr O'Donoughue: No. We did not deal with the owners per se. It was on the market. Our solicitor dealt with the real estate agent and the owners' solicitors. We, from a Health point of view, had no dealings at all with the owners of the property. Our offer was congruent with the valuation advice that we received from an independent valuer. I was not really aware of who the owners were until I finally saw their names on the title.

MR SMYTH: You do not believe there is any conflict of interest even now?

Mr O'Donoughue: No. As I say, we had no dealings with them. We simply dealt with a real estate agent and through their solicitors, through the Government Solicitor.

THE CHAIR: Mr Cormack, in relation to earlier questions in relation to the use of Canberra Hospital, I want to ask a couple of follow-up questions, based on some of your answers. You stated originally that the use of Canberra Hospital was subject to certain conditions, including no cost to the public, staff not asked to participate in political activities and no disruption to services and the activities supervised. Who has supervised the activity?

Mr Cormack: The activity was supervised by our on-call media community relations person, and they do that on a regular basis. For example, if we have urgent public health activities on the weekends, they are available to respond to those sorts of matters.

THE CHAIR: They are called in specifically for this?

Mr Cormack: No, they are on call and it is part of their role just to be on call to assist with a range of out-of-hours communication requirements. That person was available for that and the security officers are already on site at Canberra Hospital 24 hours a day. They are already there.

THE CHAIR: When you say there is no cost, there is a cost in the sense that it is a use of the department's resources in paying that person anyway.

Mr Cormack: We are paying that person anyway, whether she did the work or not. That is correct. She was on call.

THE CHAIR: When organisations receive permission to film, how are they advised of these conditions?

Mr Cormack: They are normally advised by the communications officer. They run through a list of restrictions, and that is that no patients can be identified, no privacy can be breached, no risks to the security of the premises. There are a range of those conditions that they run through.

THE CHAIR: Do they sign any forms stating they understand and accept these conditions?

Mr Cormack: I am not sure whether that took place on this occasion. I am happy to follow it up.

THE CHAIR: Generally, is that asked of them?

Mr Cormack: It is normally a condition that we impose for any access to certainly the patient-related areas. But I hasten to add that this area did not have any patients. This took place on the weekend and it was an area that at the time was undergoing refurbishment. There were no patients or clinical activity being undertaken in the area.

THE CHAIR: What part of the hospital was it?

Mr Cormack: It was in an area adjacent to the radiation oncology area; plus they also undertook, as I understand it, some filming outside in the grounds, just some background shots, which you probably would have seen on the TV commercials.

THE CHAIR: How long did this—

MS BURCH: I do not know whether this is relevant to the inquiry, and I have some questions.

THE CHAIR: It is relevant. I don't think I've taken many questions this afternoon, but it is relevant because it is the use of possible resources. So I will continue. Mr Cormack, you said that, following the initial approach from the minister, a staff member from ACT Health liaised with a staff member from the minister's office. This might be a question for the minister, in fact. Why was the minister's office involved after the initial approach? Wouldn't it have been more appropriate that it was a representative of the ALP?

Ms Gallagher: I understood that it was through the Labor Party. We could check on that. I will just consult with my staff about what that was. But my understanding was that it was organised through the Labor Party and ACT Health, but I will check.

THE CHAIR: If you could double-check that for us.

Ms Gallagher: Yes.

THE CHAIR: Just a final one: you stated that separate insurance is not required provided authorisation has been granted. How is authorisation carried out? How are people notified that they have authorisation, and are organisations issued any paperwork to state that they are authorised?

Mr Cormack: Basically they are not normally issued with that sort of written authorisation. The authorisation is delegated, and I am the sole delegate to give that. The communications and marketing person who works with me takes responsibility for ensuring that those conditions are conveyed to the necessary people.

THE CHAIR: Thank you.

MS BURCH: I have a question on critical care in budget paper 3, page 77. It is around increased capacity for critical care beds in ICU.

Ms Gallagher: Yes.

MS BURCH: When will they come online?

Ms Gallagher: They will be funded from 1 July, pending successful recruitment of staff. So that $2.5 million a year buys two intensive care beds.

MS BURCH: Is that what they cost these days?

Ms Gallagher: That is what they cost. It will require about 16.5 staff to staff those beds. The appropriation has to come through, but the beds are funded from 1 July. So this would take our intensive care capacity to 18 beds.

MS BURCH: Okay. Has that been growing over the last couple of years?

Ms Gallagher: Yes. I think in 2001 or 2002 it was 10 beds, and it is now 18. But they are expensive, so we grow them at about one a year on average.

MS BURCH: Is it historically difficult to get the staff, to recruit them?

Ms Gallagher: Intensive care nursing is one of those areas where there are some workforce shortages.

MS BURCH: It is just generally intensive care; it is not particular to surgical units or paediatrics?

Mr Cormack: Basically this is the Canberra Hospital. The ICU runs a unit that has got high dependency unit beds and ICU beds, which are just differing levels of intensity in the care that is required. The unit operates flexibly, so if they have more HDU patients there, they can have more of their resources involved in that area and

less in the ICU and vice versa—that is, if they have got more unwell patients then they can have a greater number of intensive care level beds as opposed to high dependency unit beds. It is one unit within the Canberra Hospital.

MS BURCH: Thank you.

THE CHAIR: Mr Smyth.

MR SMYTH: Minister, the accreditation of the public hospitals in the ACT, where are we at in that cycle of accreditation?

Ms Gallagher: We are awaiting the report. We have had a full accreditation undertaken in February.

MR SMYTH: So TCH was done in February?

Ms Gallagher: Everywhere—the whole of ACT Health, including Calvary as well.

Mr Cormack: Calvary was done separately.

Ms Gallagher: But they were done around the same time.

MR SMYTH: So is ACT Health done as one unit, or is it broken down as it used to be?

Ms Gallagher: It is broken down, but everywhere gets done.

Mr Cormack: Yes, that is right.

Ms Gallagher: Separately.

Mr Thompson: We are getting accreditation of ACT Health from corporate right down to the lowest level, to the on-the-ground service level.

MR SMYTH: Calvary is included in that?

Mr Thompson: No, Calvary is—

Ms Gallagher: They were done separately but at the same time.

MR SMYTH: So ACT Health's results are not available yet?

Mr Thompson: We have got a draft report. It is just being finalised at the moment.

MR SMYTH: Want to tease us and give us a few—

Ms Gallagher: It was very good.

MR SMYTH: How good is very good?

Ms Gallagher: It was very good.

MR SMYTH: So the current accreditation runs out when?

Mr Cormack: Well, it is still current. It officially ran out I think in February.

MR SMYTH: Yes.

Mr Cormack: But under the ACHS arrangements, providing you have the survey undertaken before it expires, your accreditation continues until finalisation of your survey results.

MR SMYTH: If you get the accreditation, it will be how many years?

Mr Cormack: Five.

MR SMYTH: It is five years; all right. If Calvary is done separately, is their report available?

Ms Gallagher: I am not sure. When I spoke with Deborah Cole a couple of weeks ago, I think she had seen a draft report.

MR SMYTH: Okay.

Ms Gallagher: So it will be soon, and from the reports I have received back, Calvary did very well as well.

MR SMYTH: So you expect to get the final report when?

Ms Gallagher: Soon.

MR SMYTH: Soon?

Mr Cormack: Well, it could be within the next couple of weeks. It is out of our hands at the moment. It is with the ACHS. We have responded to the draft according to the deadline they set for us, which was a month or more ago. Normally after that it is a matter of weeks rather than months, so any time now.

MR SMYTH: I will look forward to it. Given that you mentioned Deborah Cole, perhaps I will put on the record that, certainly from my dealings with her, she was a fantastic person to work with as a public health official, and I will miss her greatly.

Ms Gallagher: Yes. Victoria's gain.

MR SMYTH: Victoria's gain, apparently.

MS LE COUTEUR: I have a question about midwifery. The commonwealth government announced $120.5 million of extra funding for midwifery. What does that mean for the ACT government and, in particular, does that mean that we are going to be in a position where we can actually have insurance for midwives?

Ms Gallagher: No. There is no insurance product, unfortunately. We did recently discuss this issue. I am not sure there is ever going to be a good answer for independent midwives wanting to practise in the community. Unfortunately, it is just deemed by insurers to be low risk, high cost. They do not seem to want to offer a product around that. It is unlikely something will go wrong, but when something does, the damage is pretty high.

In terms of the commonwealth project for midwives, I do not know if there is anyone here that can comment on what that actually means for us.

Mr Cormack: In essence, it provides access to the MBS and PBS for midwives in private practice. We do not have it, so we have midwives, and they are able—

Ms Gallagher: It is in birth centres

Mr Cormack: Yes, that is right.

Ms Gallagher: It is not for home births. The insurance issue is around home births.

MS LE COUTEUR: Has the government looked itself at insuring the independent midwives? Given that, as you say, it is actually low risk but high cost, it would seem that the government could potentially take that one on.

Ms Gallagher: We are not in a position to insure a private workforce over which we have no control.

Mr Cormack: That is right.

Ms Gallagher: It would be highly unusual. We have looked at insurance for our community midwives who attend home births. We did not fund it in this budget; there is a bit more work to do with ACTIA about how we could get a scheme like that up and running. The advice from ACTIA is that, if we were to insure community midwives to attend home births, they would like an established fund to be funded from the beginning in the order of $1 million a year by ACT Health.

MS LE COUTEUR: How many midwives would that be covering?

Ms Gallagher: Well, it would cover all of our public midwives, but not all of our public midwives work through the community midwives program. It would essentially cover the community midwives who happen to attend a home birth. At the moment, the ambulance officers are the only insured professionals. I would prefer to insure the midwives, but in terms of $1 million a year going from the health budget in the context of this budget, there were other pressing priorities.

MS LE COUTEUR: Are the community midwives that you employ effectively self-insured by the government insofar as if they do find themselves delivering at home, I assume that you would—

Ms Gallagher: They are not insured, but we carry the risk.

MS LE COUTEUR: That is what I mean—self-insured by the government.

Ms Gallagher: We carry the risk already.

MS LE COUTEUR: Yes.

Ms Gallagher: They are the discussions that Health has been having with ACTIA around offering insurance. The issue at the moment is—I think we have got a bit of time and we will continue this work because I am committed to it—working out how we make provision in the case of a catastrophic event without necessarily having to do it all from the word go. But that is just an issue at the moment between Health and the insurer—ACTIA in this instance.

MS BURCH: How many births would the community midwives happen to be at?

Ms Gallagher: We have done the work around that. It is not many, is it?

Mr Cormack: No.

Ms Gallagher: It is under 10.

Mr Cormack: Yes, it would be less than 10 a year where they happen to be there. But it has varied. We undertook a review a couple of years ago, in fact, to just have a look at that. There was one year where it was more than 10 but, generally speaking, it has been less than 10, and it is more happenstance. They provide a very good quality home-based midwifery service, and if you do that, you might just happen to be there when a woman goes into labour and needs some help.

Ms Gallagher: Quickly.

Mr Cormack: Quickly. But the numbers are very low. Nonetheless, when we have reported those, as we are required to do through our insurance arrangements, we are promptly advised that it is not an insured event. So we are very conscious of the risk that the minister has just referred to.

MR HANSON: Given that we have a minute to go, or so—

Ms Gallagher: I have got another whole day, Jeremy.

MR HANSON: Well, I was thinking of today. I might have one or two more questions up my sleeve.

Ms Gallagher: I'm sure you do.

MR HANSON: The Greens-Labor agreement includes reconsidering the options of midwives attending home births by the end of 2009.

Ms Gallagher: Yes, we have done that.

MR HANSON: That is done now, is it? That is the position—

Ms Gallagher: Well, it is ongoing. It is done. We have not reached agreement to my satisfaction. I respect ACTIA's advice; I just want to work through it a little bit more with them. They are advising the government that, in order to allow coverage for community midwives to attend in the instance of a home birth and deliver a baby, they would want $1 million a year from ACT Health going into a fund to cover the potential costs if an unfortunate event occurred at one of those births. I have to say that in this year's budget the pressures on Health were to the point that I felt that it could wait a further year whilst we work through with ACTIA perhaps the staging of that fund. Perhaps we do not need to put in so much so early on, but just to continue those discussions.

MS BURCH: Is the program a growing program, and is the requirement for access to birthing centres growing?

Ms Gallagher: I think it is certainly the model of choice for women. That is clear. It is constant. Women write to me all the time, and probably the most well-organised form letter I get is from the women on the community midwives program. I think what we have tried to do is acknowledge that some woman do not want that program or have not been able to get on to that program, and we want to replicate the good aspects of that in the other programs offered through the hospital in the lead-up to the birth of a baby. Really, that comes down to creating relationships and continuity of care. That is what women want, and that is what they get on the community midwives program.

MS BURCH: Thank you.

THE CHAIR: I think we will leave it there for the day.

Mr Cormack: Just one point.

THE CHAIR: Yes.

Mr Cormack: I just want to correct a statement that was made in relation to the projected completion date of the integrated cancer centre. I think we may have mentioned early 2012. It is actually mid-2012; June or July is the projected date.

THE CHAIR: Thank you. We thank you, minister, we thank the officials and we thank Ms Cahill for the answer of the day. We look forward to seeing you, minister, again on Thursday.

The committee adjourned at 5.59 pm.