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

THURSDAY, 21 MAY 2009

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

By authority of the Legislative Assembly for the Australian Capital Territory

APPEARANCES

Privilege statement

The committee has authorised the recording, broadcasting and rebroadcasting of these proceedings.

All witnesses making submissions or giving evidence to an Assembly committee are protected by parliamentary privilege.

"Parliamentary privilege" means the special rights and immunities which belong to the Assembly, its committees and its members. These rights and immunities enable committees to operate effectively, and enable those involved in committee processes to do so without obstruction, or fear of prosecution. Witnesses must tell the truth, and giving false or misleading evidence will be treated as a serious matter.

While the committee prefers to hear all evidence in public, it may take evidence in-camera if requested. Confidential evidence will be recorded and kept securely. It is within the power of the committee at a later date to publish or present all or part of that evidence to the Assembly; but any decision to publish or present in-camera evidence will not be taken without consulting with the person who gave the evidence.

Amended 21 January 2009

The committee met at 9.32 am.

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 Psychiatrist, Mental Health ACT
- Cahill, Ms Megan, Executive Director, Government Relations, Planning and Development
- Guest, Dr Charles, Chief Health Officer, Population Health Division
- Reading, Ms Jenelle, General Manager, Community Health
- Smalley, Mr Owen, Chief Information Officer, Information Services Branch
- Carey-Ide, Mr Grant, Executive Director, Aged Care and Rehabilitation Services
- Bassett, Professor Mark, Medical Appointments and Training Unit, Clinical Operations, ACT Health
- McGlynn, Ms Lisa, Executive Director, Capital Region Cancer Service
- Stone, Mr Bill, General Manager, Canberra Hospital
- O'Donoughue, Mr Ross, Executive Director, Population Health Division

Department of Disability, Housing and Community Services
- Hehir, Mr Martin, Chief Executive
- Whitten, Ms Meredith, Executive Director, Policy and Organisational Services
- Hayes, Ms Roslyn, Senior Manager, Therapy ACT
- Hubbard, Mr Ian, Director, Finance and Budget
- Collett, Mr David, Director, Asset Management

THE CHAIR: Welcome back, minister, Mr Cormack, Mr Thompson and officials. I will take you through the same stuff we went through the other day but I am sure you are all aware of it. Please ensure that you have read and understood the privilege card in front of you.

Today we have the Minister for Health and officials. Would you like to make any opening statement or shall we get straight into questions?

Ms Gallagher: No, just continue on, thank you, chair.

THE CHAIR: Okay, fantastic.

MS BURCH: I was thinking as I came here about the swine flu in Sydney and Melbourne. I was just wondering what impact that has on anything here. It is probably not in the papers but it was my last thought before I came into the room.

Ms Gallagher: Yes, sure, I think it is probably timely. We can ask the Chief Health Officer to come and give an update on what is going on because there is a national situation of course and then a local situation. Are you happy to do that, Charles?

Dr Guest: Of course, minister. The situation is that we do now have cases of swine

flu in Victoria and New South Wales. In Victoria there has been a school closure. This has not been unexpected. We have been working on the swine flu matter, as you know, for several weeks very intensively following the World Health Organisation's escalation of the level of alert.

In Australia we are following the Australian health management plan for pandemic influenza and we have escalated the level of activity to delay; that means delaying the entry of swine flu into the country for as long as we can. That delay has perhaps bought us two weeks of extra preparation time. During that time we have been working very intensively with the Communicable Diseases Network Australia, the Australian Health Protection Committee and all agencies across government to ensure that the public has information it needs, that agencies understand their business continuity plans, that all parts of government and non-government organisations understand their responsibilities.

Here in the ACT the local stakeholder group, the ACT Influenza Pandemic Action Committee, has met, and there has been a newsletter since that to that group. It is not surprising that yesterday there were cases in Victoria and there were decisions taken to close a school. That is a step that is taken unusually in the disease control actions that we can take. We have done it in the ACT actually, at a school at Jervis Bay a couple of years ago that did not receive much publicity. We really staunched an outbreak of disease at Jervis Bay, where there was an isolated community with obvious local spread, by closing a school. So it is not a step we take very often, but it is an effective one.

We do from time to time close childcare centres for similar reasons, and if it was necessary to do so we would do so. All services are on alert, as I have said, and we are staying very close to the situation. I expect that there will be a case of confirmed swine flu in the ACT before too long. It makes sense if there are cases in New South Wales and Victoria that somebody will cross the border incubating the disease and need to be socially isolated at home, and we will take those steps.

THE CHAIR: Thank you, Dr Guest.

MR SMYTH: Just a follow-up on that, are there adequate stocks of things like Tamiflu and other antivirals in the ACT? And how are they distributed?

Dr Guest: We have supplies of personal protective equipment, particularly masks, and antiviral medication, oseltamivir or Tamiflu. These are additional measures to standard infection control. Do we have enough? That depends on how wisely we use it. We will be using the local stockpile and having access to the national stockpile of antiviral medication when we need it. There is enough to manage the kind of situation that has arisen in Victoria and New South Wales at the moment.

We have many months of supply of masks, but of course if everyone puts them on tomorrow in Civic they will run out very quickly. So they will be used on an as-needed basis to manage the risks appropriately. And, yes, we do have enough.

MS BURCH: We read stories around the community overreacting and responding by putting on masks unnecessarily, so is the information going out? You have made

mention of a newsletter going to the committee, but what information now is going out to communities?

Dr Guest: The information that is going out to the community at the moment is that routine wearing of masks around the place is actually unhelpful. There is an important message that we do not overstress—that the wrong wearing of masks, the wearing of masks for excessive periods, actually increases the risk of infection. So wearing masks is something to be done with care and advice. If we believe that there is need for people to put on masks, they are advised very carefully on how that should be done. At the moment the advice to the general public is that they should not be worn in public. If people are walking around Civic with masks on, that is to be discouraged. It is not helpful. The general word in the Australian community at the moment, coming from the relevant committees, on all the websites and in all the press releases is that masks should not be worn in public without specific medical advice.

MS BURCH: So, except in areas where the school has been closed in Melbourne, you are not advocating that people stop doing their normal routine things with standard infection control processes and procedures?

Dr Guest: That is right. At the moment in Melbourne the families concerned have been isolated. The unusual step of closing a school has been taken. That is a precautionary measure. But any other measures have not been needed so far.

MS BURCH: Finally, presentations to the hospital: if that should happen, would it be manageable?

Ms Gallagher: We are encouraging people to contact Health Direct first and Health have been working with Health Direct around standard information to be provided from Health Direct in the first instance before going to your general practitioner or the hospital, just in terms of again trying to delay and manage it, if there is influenza, in terms of the potential spread to the community.

Dr Guest: This is a very good time to use the telephone. Infection does not spread down a telephone. Call Health Direct or call the GP first, if need be to attend a GP. We are encouraging people to phone ahead for an appointment so that sitting in a waiting room for a long time does not happen. The last resort, of course, if people are very unwell is to attend an emergency department where everyone knows the drill about infection control, isolation et cetera.

THE CHAIR: All right. Thank you, Dr Guest.

MR HANSON: I have a follow-up question. I just want to confirm: this committee you are talking about is whole of government planning, so, if we are talking about closing schools or making changes to public transport and so on, is this a whole of government response, and who runs that?

Dr Guest: The whole of government response: let us be quite clear. The pandemic action committee is a group of stakeholders, government and non-government. That committee is not charged in any way with the operation or management of a state of emergency, a public health emergency or a more general territory-wide state of

emergency. That is done through the usual channels, through the Emergency Management Committee with cabinet, territory controller and/or territory health controller during a public health emergency. So the usual all-hazards approaches apply to a pandemic as they do for a bushfire or anything else.

MR HANSON: Has the Emergency Management Committee met over this issue and conducted rehearsals or discussions and pre-emptive planning?

Ms Gallagher: Certainly, cabinet has met and been briefed twice now, I think, by Mark Cormack and the Chief Health Officer. The subcommittee has met, the emergency—

Dr Guest: The health emergency management subcommittee has met, I think it was on 29 April, very early in the piece, and they report up to all the groups represented on the EMC as well.

Ms Gallagher: And basically it is all up to Charles to solve it, if it hits the ACT. I have got a delegation under the—

MR HANSON: You get to lock people up, don't you, minister?

Ms Gallagher: I do not get to lock people up.

MR HANSON: I thought it was you.

Ms Gallagher: No. Dr Guest, if emergency powers are granted, can quarantine people at home, yes.

THE CHAIR: We thank you, Dr Guest, and your response gives us a lot of comfort. It appears to me that this has been handled pretty well really, nationally and internationally. Some people criticise an overreaction, but I think that is better than being slow to respond, so it seems well in hand at the moment.

Dr Guest: The over-response, I guess just a final point: the mortality due to this virus at present is some three or four times higher than routine seasonal influenza. There is always the potential of influenza viruses changing, mutating into a more virulent strain, so we are preparing for those two points.

THE CHAIR: There is no evidence yet, though, that the swine flu has mutated in any way from the original form?

Dr Guest: As far as I am aware, not.

THE CHAIR: Okay, thank you.

MS LE COUTEUR: On a totally different subject, the environmental health unit: apart from your normal regulation work, what are the emerging issues that you have been having to deal with?

Dr Guest: Environment is a very big subject.

MS LE COUTEUR: Yes.

Dr Guest: And so there are, in the health protection service environmental health unit, matters to do with particularly air and water. Air quality in the ACT is generally very good but this is a subject that we monitor carefully. As you would have read in the Chief Health Officer's report, the standard six air pollutants are monitored here as they are for the national environment protection measure.

Drinking water quality is generally excellent in the ACT. We get into discussion with the National Capital Authority about the management of Lake Burley Griffin from time to time. The looming environmental question of climate change and appropriate health responses to that are under intense discussion, I think it is fair to say, at this point.

The other perhaps major issue for the environmental health unit as it currently works is all matters to do with tobacco control. There is an extensive regulatory approach to that that we consider is an environmental health matter as well. That is a matter of terminology, isn't it?

MS LE COUTEUR: I guess so. I have lots of things I would like to follow up on that. First, you said that generally we have good air in the ACT. Tuggeranong winter is coming, with smoke. I assume you monitor that. Can you talk to me a bit about how that is going, because I would not have thought that was really good?

Dr Guest: We do, and every year we see an increase in the level of suspended particulates in air in wintertime, but that is a problem that is lessening as wood fires are being phased out.

MS LE COUTEUR: But you just said that every year it was getting higher.

Dr Guest: I said every winter we see some rise, so it is a seasonal thing.

MS LE COUTEUR: But winter to winter is it getting higher?

Dr Guest: No.

MS LE COUTEUR: So the winter peak.

Dr Guest: Winter compared with summer?

MS LE COUTEUR: No, I appreciate winter compared to summer, but winter peak compared to next winter peak, it is going down more?

Dr Guest: The trend is generally favourable. There are data set out on that in the Chief Health Officer's report.

MS LE COUTEUR: And do you think the current measures are adequate or what do you think we should do about it?

Dr Guest: I think the end point that we in the health portfolio are concerned about is respiratory health, related to air quality. Asthma, as I am sure you are aware, is very common, but in fact the trends for asthma are favourable. The level of asthma in the community is probably going down somewhat, which is a good thing. The level of air pollution during winter time in Tuggeranong and elsewhere is going down somewhat. I am not saying that the reduction in air pollution is exactly correlated with the reduction in asthma but one would like to think so. So I think the measures in place to phase out open wood burning are helpful.

MS BRESNAN: Just in relation to that, three areas in Australia, Launceston, Armidale and I think Tuggeranong, have been identified as areas where that is at the highest level, because obviously there is an inversion layer which creates the situation where wood smoke does cause issues. Has there been a committee looking at this? I think particularly Armidale are taking some action around that, because obviously it does still cause an issue in that area with the wood smoke because of other factors which affect it as well.

Dr Guest: I do not think that I should comment on what is happening in Armidale.

MS BRESNAN: No. I was just wondering if you had looked at what they are doing there in terms of addressing the issue.

Dr Guest: We could take that on notice. I think that we are certainly in touch—

MS LE COUTEUR: That would be helpful.

Dr Guest: through the environment health council, the enHealth Council. We are in touch with all national developments on air quality, improvement measures being taken around the country, so let us take that on notice.

MS LE COUTEUR: Thank you. You said you were having intense discussions about climate change. Could you share some of those discussions with us?

Dr Guest: Yes, I could but, minister, would you like to—

Ms Gallagher: No, you are all right, Charles.

MR SMYTH: Go on, minister, dive in. Come on. This is your opportunity to have your say.

Dr Guest: One area in the Population Health Division that we are exploring at this point is the linking of the health concerns of young people with matters that we know they really care about. Young people are not particularly interested in your standard health promotion messages but they are interested in environmental matters. So part of the feasibility study for the centre for adolescent health will include an assessment of how far we can link environmental health concerns with health promotion concerns. To take one example, cycling initiation is certainly good for the environment and certainly good for people's health.

MS LE COUTEUR: Yes.

Dr Guest: So there is an obvious one. Linking some of the more traditional health promotion concerns with matters that would mitigate climate change is an area that we are looking at.

MS LE COUTEUR: Have you been looking at the more direct things like heat in the summer and what that does to our aged population?

Dr Guest: We have had heatwaves in Australia that have been very closely studied and we have modified messages during heatwaves here in the ACT in the light of that experience. Social connectedness in the ACT is better than in many places so the heatwave deaths that have been reported in Adelaide, in France in 2003, and elsewhere we really have not seen here. But it is a topic we watch with care.

MS BRESNAN: Has there been a cross-government approach to looking at planning around climate change? Obviously it does take in a number of areas and I appreciate that health is the lead agency.

Dr Guest: The short answer is yes. There is a ministry and there is a—

MS BRESNAN: I know there is a ministry but obviously it does need that cross-government approach to address the health impacts that are associated with it.

Dr Guest: We are fortunate in being adjacent to the ANU where there really is a centre of world excellence in climate change impacts. They are doing work with us and we are doing work with them. Professor Tony McMichael's group is plugged into what we are doing in the environmental health unit. So, yes, we are very interested in that. You have mentioned heatwaves as a direct effect of climate change; that is not likely to be a big killer in the ACT of old people.

Then there are the communicable diseases that are expected to increase. Dengue fever is much talked about now in Northern Australia. Again, that is not likely to become a major problem here in the ACT but we are looking with considerable care at the arrival of Ross River virus infection during summer in the ACT. So far, we think there might have been one case a few years ago that was transmitted from a horse to a young woman, but that was about as far as we got.

MS LE COUTEUR: I guess another one which relates to one of the other things you were talking about is water quality. The lake has been closed a few times and I assume that also relates to temperature and reduced water flows, which are climate change effects.

Dr Guest: That is my understanding also.

MS LE COUTEUR: So that is another health impact that you are dealing with?

Dr Guest: People should not swim in blue-green algae. Every year a few people swim in it and get nasty rashes and inflammation of their eyes and so on, and occasionally dogs drink it and do not do well either.

MR SMYTH: Just to follow up on a couple of other areas: I understand there has been an increase in whooping cough?

Dr Guest: Yes, every three or four years we see a rise in whooping cough. This is an endemic infection for which we have very good immunisation and I am sure you have all had your shots at two, four and six months and then at about four years and then there is a booster in adolescence.

MR SMYTH: I remember having them very clearly.

Dr Guest: However, the immunisation does not confer lifelong immunity, and what we now see is that young adults, and young grandparents even, are no longer immune to whooping cough. So this year the ACT government introduced a one-off campaign to immunise parents and grandparents as a way of reducing the transmission of whooping cough in the ACT, and I am pleased to say that appears to have had some effect. So the increase in whooping cough that we saw January, February, March and into April has tapered off somewhat. But whooping cough is a nasty infection, particularly harmful for young babies. Our efforts are to get in between babies and people who might be carrying the infection, which is their parents, their grandparents and, of course, their siblings. But their older siblings will have been immunised and be immune. So that has been the strategy adopted here in the ACT and I think it has been a good one.

MS BURCH: Is it just whooping cough that you are re-immunising out of the—

Dr Guest: Yes, it is.

MR SMYTH: Excuse me. Was that sort of like a whooping cough sound? We have been hearing a lot of it in the last couple of days.

Dr Guest: In adults, the cough is usually atypical and it is very hard to diagnose. It is a diagnosis easy to miss. So, when it is played on the radio, the typical whooping cough, you actually hardly ever hear it.

MR SMYTH: Ray has been hearing a lot of coughing. But it is a serious issue and well done on having the program because I know, through childcare, of older people that have copped a dose. Croup is the other one that I understand is fairly prevalent at the moment.

Dr Guest: Croup is a viral infection for which there is no immunisation and that is a seasonal matter. It is managed symptomatically and the important risk factor that is avoidable or preventable for croup is smoking by the parents.

MR SMYTH: So at the moment there is not an increased prevalence; it is standard for the time of year?

Dr Guest: We expect at this time of year to see an increase in croup. Notification of croup is patchy so it is actually something that I do not have a very accurate picture on, as opposed to occurrence of swine flu in Australia, which we are counting very accurately.

MR SMYTH: So should we have reporting of croup?

Dr Guest: I think that many children with croup will not be diagnosed. I do not think the notification itself will make much difference to the management. I do not see any particular need for that. If we ever got a vaccine, it would become desirable to make it notifiable to measure the effect or lack of effect of a vaccine, but that is not on the horizon at the moment.

MS BURCH: And just on notifiable diseases generally, are we trending across on any area outside national standards?

Dr Guest: The ACT does well because of our very active immunisation program. Immunisation is very competitive between the jurisdictions but we often are best; the counts are best. The endemic return of whooping cough has been noted; that is to be expected. I think we will see across jurisdictions in coming years new programs immunising adults more routinely, so this experiment that we have carried out here in the ACT—a very good one I think—will possibly become more commonly done and may even get onto the national immunisation schedule.

To answer your question more specifically, I suppose communicable disease, generally speaking, is a disease of low burden but high threat. The burden of disease that we carry as a community and the expenses associated with communicable diseases are actually quite low but because they are communicable they get a lot of column inches. I think we are doing the best we can here in the ACT and we are as good as anywhere in the country, or the world really, with communicable disease control. The various parts of the health sector are well plugged in. GPs are very active in reporting here. So I think we are doing as well as we can. We will keep trying hard.

THE CHAIR: Were there a couple of follow-ups on this, Ms Bresnan and Mr Hanson?

MS BRESNAN: Just quickly in terms of heatwave effects, you said that that was not likely to have as great an impact on older people here in the ACT.

Dr Guest: I said it was not likely to be a big killer.

MS BRESNAN: Why is that? I am just wondering why that is ruled out—not as an issue but as a major factor.

Dr Guest: So why not?

MS BRESNAN: Yes.

Dr Guest: Temperatures are lower. We do not often get here in the ACT the two-week-long heatwaves that you see in Adelaide.

MS BRESNAN: I guess I am just thinking about summer here. We did have a period, pretty close to two weeks, where we had temperatures in the high thirties—38 degrees—and up to 41 on a couple of days.

Dr Guest: That is true. And we did not see any great peak in mortality during that time. The usual thing that happens with heatwaves that are really severe—Adelaide is the worst one that I know of, but in India when it gets up into the 50s—is that old people die, prematurely. Given the high standard of living here in the ACT and given the relatively moderate temperatures, I do not expect it to be a big killer.

That is not to say that we should not take the measures and the messages people are sending all around the country appropriate to heatwave mitigation—taking medication, seeking advice on hydration. We are doing all those messages as actively here as elsewhere. I just do not expect, given our standard of living, standard of housing and the climate, that it will actually loom as a very big problem here.

MR HANSON: Following up on the air quality issue in the Greens-Labor agreement at section 10, it calls for measures to address indoor air quality. It calls for funding to be there for monitoring and awareness programs. Has that been implemented?

Ms Gallagher: It was not in this year's budget, no.

MR HANSON: When will that be implemented? Do you have plans for that?

Ms Gallagher: It will be subject to budget considerations in years to come.

MS BRESNAN: There is already some work occurring around that, though, isn't there, I believe?

Ms Gallagher. Yes. We are looking at the parliamentary agreement where we can progress things within budget. Certainly I have asked that that work happen, but, in terms of a specific budget initiative with funding that was not in this year's budget. That is really just about staging and doing what we can with the money available this year and the priorities. In my discussions with Ms Bresnan and her colleagues, priorities were around mental health training, and that is what we started this year.

MR HANSON: Yes, I appreciate that. With all the other pressures that we have on health, do you still see that as a priority, moving forward?

Ms Gallagher: Sure. I think there are some really good reasons and I would have to say that probably in the areas of health Charles's area perhaps has a big impact but not as much focus as other areas of health in terms of funding dollars going into, say, acute health services. Where there is room and funds available I think it is always worth while.

MR HANSON: So you will look at that in next year's budget, I guess.

Ms Gallagher: We have discussions with the Greens around progressing items in the parliamentary agreement that have funding and we have got an established process that is outlined in the agreement around budget considerations, so we will just follow that, as we have done for this year.

MS BURCH: I was just looking at your priorities on page 189—I do not know if

Charles needs to come back again or not—and expanding services for the growing number of people living with chronic illnesses.

MR HANSON: Where are we actually?

MS BURCH: It is the second-last dot point on page 189 in budget paper 4. My questions are: what is the burden of chronic illness in the ACT and what are the measures that we are doing within existing resources and within this budget?

Mr O'Donoughue: Thank you for that question. I think, as a general answer to the burden of illness associated with chronic disease, it is nationally about 70 per cent of the burden of illness, predicted to rise to 80 per cent by 2020; so it is a very significant contributor to burden of illness.

The ACT has a chronic disease strategy, which was launched in 2008, and there have been a series of budget initiatives that are aimed at the prevention of chronic disease or its better management. The specific chronic disease management budget initiative in this budget builds on, as I say, a series of budget initiatives over the past years. Earlier initiatives were seed funding and, I guess, a range of technologies to improve the repertoire of support for people to self-manage their condition, where they can, for people with moderate illness. These included SMS reminder systems for our outpatient appointments and direct mail of recruitment for people at risk to seek health checks.

The present initiative plans to roll out telephone and web-based coaching for people with chronic disease, which is an intervention that has been used successfully in other countries and other jurisdictions, where usually registered nurses provide telephone or online coaching for people to better manage their condition at home. We are piloting, at present, a home telemonitoring initiative where smart technology enables parameters like blood pressure, spirometry, and weight to be dialled up from the home to a website so that clinicians can monitor on a daily basis how people are going in terms of those parameters and provide them with feedback.

MS BURCH: So these are people registered, that one group?

Mr O'Donoughue: Yes, patients who have been identified with chronic disease and who are at the moderate stage of their illness and can be successfully managed in the home but with the support and the feedback of that technology, just so that they can be accurately monitored, without having to travel to the hospital or to their GP. So these devices actually dial up literally from a set of kitchen scales. For example, they are able to dialup a website and report your weight in to your clinician so the clinician can see how you are going.

MR BURCH: It is too scary to think about, isn't it?

Mr O'Donoughue: Not all of us would enjoy that but it is helpful. We are also building on work we have already begun to establish a register of patients with chronic disease, to enable both them and their clinicians to accurately monitor that they are getting the best treatment and the best outcomes. I think that is generally the scope of the present initiative.

MS BURCH: Is the telephone web coaching, again, managed by people who are known to the end user or is it open to the general public so that they can put in their details and get advice? Is it like a decision-making tree, or how does that work?

Mr O'Donoughue: That is a good point. I guess the chronic disease strategy says that prevention goes across the continuum of care. So there is a separate initiative in this budget on prevention of chronic disease. It also includes some telephone and web-based coaching but this will be made available to the general population. People who might identify themselves to be at some risk or who think they would benefit from improving their lifestyle by perhaps doing more exercise or eating more healthily can get support in the same sort of way, but it is obviously pitched at people who basically do not have a chronic disease but are at risk of it. So it is not quite at the level of—

MS BURCH: Or undiagnosed?

Mr O'Donoughue: Or undiagnosed, indeed. It is a bit like the health check that I referred to. We are writing to all Canberrans aged 45 to 49 years of age, encouraging them to measure their waist circumference at home. If they are in the risk areas where their weight circumference exceeds what is considered to be a safe level, we are suggesting they might like to go to their GP to have a health check or they might like to look at improving their physical activity and their diet. To support them in that, they will now be able to access a website or get telephone coaching, to help them, a bit like a personal coach, but doing it a bit more remotely by telephone or by web rather than by having a personal trainer, that kind of approach.

MR BURCH: Would the staff going in there be a designated team for that or will they be part of general health services?

Mr O'Donoughue: We do have chronic disease self-management teams that work out of, presently, community health; so we do have our staff who provide those courses. That is a slightly different modality; that is a kind of a course that you join up and you attend once a week for six weeks or so. Again, it is providing you with self-management support. But these telephone-based systems are usually done by external providers. We would be engaging a provider who would in turn employ nurses, for example, or trained lifestyle coaches to provide the service for people we refer there or for the general public.

MS BURCH: If they are known to the health system as having a chronic disease, will this then link in through e-health or their patient records or their GP records?

Mr O'Donoughue: Absolutely. I think one of the great enablers of the future will be an e-health system that allows greater communication between the providers. The chronic disease strategy identifies that one of the great problems with people with chronic diseases is negotiating that complex journey between different providers so that the more we can have a system of communication between providers the better off we will be.

In a sense, the patient care register is an embryonic approach to that, where patients

enrol in the idea of having a register to maximise their care and their providers also join in that register. Then that is a way of doing the same thing, tracking their care over time. But it is obviously a bit clunky and nowhere near as good as having a joined up e-health record that is kept up to date all the time.

Ms Gallagher: To finish on that, I think the organised groups in chronic disease, the NGOs but also the patient groups themselves, are perhaps the strongest advocates of e-health technology.

MS BURCH: Is that like the Heart Foundation and others?

Ms Gallagher: Yes, who are probably a few years ahead of the general population about interest and excitement in the possibilities of e-health. When we do start, where there may be concerns on privacy and technology and what it means, an obvious group to commence with is groups who have a chronic illness because, in my experience, probably because they have more experience with the health system and understand how some of these processes could actually improve their experience, they do not seem to have some of the same concerns.

MS BURCH: Because they are the ones trying to navigate through all the privacies and stuff?

Ms Gallagher: Exactly. Their time is precious too.

MR HANSON: A follow up on, I guess, the tape measure issue. I think it is a great idea to be writing to people and alerting them to this. When the federal government did its advertising regime, with the walking with the tape measure, which I thought was very effective, there seemed to be a lack of coordination, I guess, within the ACT.

Some of the comments I got were that we did not have our measures in place; so all that money was being spent federally and we did not then necessarily have the measures in place locally to take advantage of that. It looks like we are starting to do that now but there has been a bit of a lag. Have we identified that as an issue and better coordinated our communication with the federal initiatives with local initiatives?

Ms Gallagher: That was actually a national initiative that we had. The Australian better health initiative is—

Mr O'Donoughue: COAG.

Ms Gallagher: Yes, COAG and co-supported by federal and state and territory governments. It was actually part of the strategy that the ads went first and then the follow up, the letters, went out a bit later. I think it was signed off—

MR HANSON: Have the letters gone out?

Mr O'Donoughue: Yes.

Ms Gallagher: Yes, they went out.

Mr O'Donoughue: We are sending them progressively; so we are only mailing them out to cohorts of people at a time. So not everybody got their letter at once but we—

Ms Gallagher: You are too young, Mr Hanson, I think.

Mr O'Donoughue: We start off at the start of the age cohort and then we only sent out a couple of thousand each month. The minister is correct there. The measure up campaign that you are referring to is a national campaign. The ACT contributed funds to that campaign and also participated in the development of the campaign.

Ms Gallagher: The minister has, excitingly, got to sign off on that ad. We have got it on the—

MR HANSON: On the tape measure one?

Ms Gallagher: Yes. And amazingly there was agreement reached.

THE CHAIR: This was not one of those because you were annoyed or something? You thought about this one?

Ms Gallagher: There was a lot of work behind this ad.

THE CHAIR: It is good to hear that that happens. Fantastic.

Mr O'Donoughue: And the ACT is the only jurisdiction that has taken the innovation of doing the mail-out to complement the 45 to 49 health check.

MR HANSON: I think that is a good idea but some of the feedback I got from GPs, I guess, was that they were not alerted to exactly what the strategy was and, as this strategy came up, they were playing a bit of catch-up. They had people ringing up and they did not have their measures in place or the strategies in place to deal with it. That was provided back to me. I thought I should offer that.

Ms Gallagher: You do get that feedback from time to time. We do our best to get information out to general practice. Pretty regularly, actually, information goes out to general practice from ACT Health. At some times we rely on their stakeholder groups, such as the Division of General Practice, to sign off on a process, which I think in this case was done. I am conscious of it.

The latest one was the whooping cough one. When we decide to actually go ahead with a program like that, where we do rely on GPs who are already busy—to then have another group of well people ring and wanting to make appointments to see them—we do try to communicate as best we can. I think, in large part, it goes pretty well but from time to time there are practices that say, "I did not know about that." To a large extent, we still rely on fax stream for some of that information.

Mr O'Donoughue: That is right. As far as the letter goes, that was developed with the Division of General Practice. The commonwealth did inform or try to inform general practice through divisions about the measure up campaign. But I take your point: we

could always do better in terms of getting the information out there.

Ms Gallagher: Yes.

THE CHAIR: Mr Smyth and then Ms Le Couteur.

MR SMYTH: On page 207 of BP4, under "Cost weighted separations", I notice the target for this year is 2,250; 2,786 is the expected outcome; and next year it is 3,152. But next year is measured under a different version of the AR-DRG. What is the effect of that? Why does the figure represent an estimated three per cent growth on the estimated outcomes?

Mr Thompson: Sorry, could you repeat the question?

Ms Gallagher: The increase, basically.

MR SMYTH: In the notes, note 2, you are using version 5.0 and version 5.1. Why does version 5.1 require an estimated three per cent growth on the estimated outcome?

Mr Thompson: The versions do not actually require growth. The growth is applied once the updated version has been calculated. So the intent behind the footnote is to explain why you will see that 3,152 is not three per cent above 2,786. What we have got is a situation where the cost-weight update increased the number of cost weights that were delivered this year. Then we have applied three per cent on top of that.

To put it another way, for the 2008-09 targets and outcomes, we have used the same cost-weight versions so that we have got comparability between target and outcome. The fact that 2,250 and 2,786 are in the same version of the cost weights means you can calculate the increase as a consequence. What we have done with the updated cost-weight version for the 2009-10 target is: we have recalculated the 2,786 on the new cost-weight version and then added the three per cent increase on top of that.

MR SMYTH: What is the figure 3,060 in footnote 2? Where does that come from?

Mr Thompson: The 3,060 is what you get when you change from the round nine weights that got us 2,786 to round 11 weights. In other words, the same activity that we produced would have generated 3,060 in round 11 weights.

MR SMYTH: What are the additional two weights that are added?

Mr Thompson: Sorry. It is just a different version. The cost weights are developed on a national basis and they are developed on the relative cost of different types of activity in the acute sector. Periodically they are updated because changes in technology, changes in practice, result in different relativities between different service types. What we try to do is use the most recent version of weights because it is the best reflection of the relativities for different types of inpatient activity. Periodically, though, because of timing of the release of particular cost-weight versions, we do not always go 7, 8, 9, 10, 11. In this case, because of the timing of the release of the version 10 cost weights, it did not fit well with our setting of targets and calculating outcomes. What we have done is moved from nine to 11.

MR SMYTH: How do you reasonably compare the different versions? Can you compare them or is it irrelevant?

Mr Thompson: It can be compared and that is what we have done in terms of the translation of 2,786 into 3,060. When each version is released, what you get is a different set of relativities for particular types of activity. So what you can do is calculate the cost weights using the old version, look at exactly the same activity and then calculate it against the new version. That gives us the comparison between the two weights. But in terms of actual activity, that does not change the number of inpatient services we provided, in this instance to people receiving inpatient mental health care.

MR SMYTH: What is the usefulness of it?

Mr Thompson: It is just an updated calculation of the relativities between different service types. For example, if you have got a surgery and a particular type of surgery using old technology results in a four-day length of stay post-surgery and your keyhole version is introduced that means people are out the next day, that changes the cost of providing the service. It is important periodically to calculate it globally, because cost weights are relativities between different types of services. If one service goes down, and if it is only one service, it will have a very small effect. But as services go down in cost and in resource use, it does have an effect on the overall relativities across inpatient care.

MS BURCH: Other jurisdictions would be going through the same—

Mr Thompson: Yes. These are national cost weights and, again, the importance of using national cost weights is that you can see that you get standardisation and consistency across all jurisdictions.

MR SMYTH: When is the next version due? How often is this updated?

Mr Thompson: I will need to take on notice when the next version is due, unless—

Mr Cormack: They tend to come out approximately every 12 months. Sometimes it can be longer. It is just when the national costing studies are complete. It is not as if in a certain month each year there is a change, because, as Ian said, it depends on changes in technology. And I think we saw a similar or related development in the commonwealth budget, where there is an issue on ophthalmology, where the commonwealth has adjusted the resource weight through the MBS for what ophthalmologists are paid, based on technological changes that reduce the cost and reduce the resource consumption associated with that procedure. We do it right across our 600 to 700 product lines, which we deliver in the hospital system.

MS LE COUTEUR: Can you make an adjustment if you are still using the old methodology?

Mr Cormack: Yes.

Mr Thompson: Yes.

Mr Cormack: Just to give you a very simple example of that, it would be a knee replacement in a person over 65, without complications. That is a product type and if you use the round eight version of cost weights, it will have a certain cost weight, a resource consumption. If you use that same product type which I just described and they re-weight it in round 11 cost weights, you will just see its relativity go up and down. So the actual product types—and they are called diagnosis-related groups or DRGs; they are case-mix terms—they do not actually change that much. There are roughly between 600 and 700 of those product types but from year to year the relative resource consumption of each type is rebalanced using this cost-weighting process.

THE CHAIR: Thank you. Ms Le Couteur.

MS LE COUTEUR: I have got a question about balancing acute services versus community health services. As far as I can tell, the budget does not have any more money for community health services, in particular for night time services, but I understand that they are actually–

Ms Gallagher: Sorry, in terms of night time?

MS LE COUTEUR: Night time and community health services. I understand this is an area where there is an undersupply. You have people who are capable of living in the community or being discharged from hospital but you do not have the facilities, say, for night time nursing—but they live at home—or the requirements are more than they can do so that people are not able to leave because there is not the support at home.

Ms Gallagher: The general question of balancing acute and community is a vexed one and there is no easy answer to it while your acute costs continue to grow. It is an area where the government cannot delay putting resources in. We have been attempting—indeed, the whole health rebuild is trying—to address this in building up our community health facilities and removing some of the services that are provided in the hospital into the community-based settings to just make even a mental shift for people around the ability to provide services in the community.

In the acute, there are two initiatives that spring to mind. I am sure there are a few more. Ross has gone to a few in terms of chronic disease management. The ultimate goal of that is to ensure that people with chronic disease do not actually come to hospital—that they better manage their condition at home. And there is an issue about preventative health which we went to the other day, particularly about getting in early with children and educating parents about healthy lifestyle activities.

There is certainly an initiative there in meeting demand for an older persons service. I am sure that Grant Carey-Ide can talk through that. But also, in our funding of beds—it is usually seen as beds—in the acute care capacity, there is funding for a number of hospital beds but there is also funding for expansion of the hospital in the home program. I do not know if you know much about that.

MS LE COUTEUR: I know a small amount.

Ms Gallagher: In that initiative, there are 25 hospital bed equivalents being provided through that—again, to care for people, if they are able to, more appropriately in their home rather than in the acute setting.

MS LE COUTEUR: How do you balance the provision of funds for hospital in the home and those other community things with the acute beds? What is the decision-making process?

Ms Gallagher: What is the science behind it?

MS LE COUTEUR: Yes.

Ms Gallagher: There is a lot of thought that goes into what is manageable. Hospital in the home is a fantastic program, but it is a program that we monitor and manage very carefully, including around our workforce but also for people who are coming—maybe it is better for Mark to go through hospital in the home. But for the group of people that hospital in the home is targeting—I am not sure how many beds we have totally in hospital in the home now, and Mark can go to that as well, but it is about managing the correct patient load with what services you can provide in the home. This is an area I am very interested in.

I have had a chat with the Capital Region Cancer Service. There is a lot of demand for cancer beds in the hospital. You cannot necessarily do all types of chemotherapy at home; it is quite risky and you need the proper environment, particularly for staff and for family members who are at home. But there are other opportunities in terms of looking at a middle way—not necessarily an individual's home but a more home-like environment outside the hospital—that I would like to explore further. I have started off that discussion with the cancer service.

MS LE COUTEUR: Have you looked at the relative costing of, say, hospital in the home or the other more community-based versus acute? I assume it is a lot cheaper at home, but I could be wrong.

Ms Gallagher: It is cheaper, and I think you can see that. We can go through the initiatives and the costs included in that growth in demand for acute care capacity and the rough figure of what an acute bed costs as opposed to a hospital in the home bed. But hospital in the home will only be appropriate for a particular type of patient. It is not just about costs; it is also about the appropriateness of the treatment and the treatment environment, the protection of the quality of care for the patient, safety for the patient and the ability of the workforce to provide that care in the home.

MS BURCH: What are the extra 25 beds working off? What is the base? It is 25, you say?

Mr Cormack: We will have to take that on notice. I do not have that base figure for the hospital in the home beds, but I am sure we will be able to get that to you fairly quickly. I think the minister has covered most of the reasons. The sorts of things we look at are these, and we have done this in the context of our capital asset development plan in particular. You look at the future growth of certain types of care

requirements associated with specific diseases. You also draw upon what the literature says about the benefits of providing care in the home.

The benefits are a multiple. One benefit is a reduced risk of hospital acquired infection. That is an obvious benefit. The second one is that many patients—probably the majority of patients—would prefer to spend as little time in hospital as they possibly can, because they find that their home environment, with the right sort of support, is generally conducive to healing and recovery. So we look at that.

We also look at the advent of new technologies which would assist with care in the home. Renal dialysis is an area where there are a lot of home-based dialysis programs. There are centre-based dialysis programs as well. And there are a number of conditions—such as infections, cellulitis—that are common conditions that cause people to be unwell and present to hospitals but in many instances shortly after them coming to the emergency department we can assess them and then plug them straight into hospital in the home and they can manage their antibiotics and other supports at home. So it is a combination of reasons.

The other thing is that, as technology has become available—and that is what we have very much factored in with our new health initiative—we envisage that many of the constraints to seeing people in their home are around rapid transmission of clinical information and the ability for health professionals to be able to carry around with them the necessary information systems they need to be able to look after patients and get that kind of backup and support.

They are the sorts of factors that we see. Over time, and this is certainly demonstrated internationally, the context of hospital care is for more acute management and more unwell people to be concentrated in hospitals and for those that are less unwell increasingly to be seen at home or their lengths of stay shortened with a commensurate provision of community-based services.

MS BRESNAN: Part of the issue, too, is about community nursing services.

Mr Cormack: That is right.

MS BRESNAN: And obviously recognising the workforce issues as well. That is one of the areas where there is a lack of services. It does then put that additional pressure on people. You might be able to stay at home without having to possibly go into hospital if you receive that care. Has there been some thought given to that particular area?

Mr Cormack: There certainly has. While our community nurses do a great job and they work hard, I am not aware of people not being able to access community nursing services in the home when they require them. There is always juggling, but we offer seven-day-a-week, extended-hours community-based nursing care. That is well established here in the territory.

MS BURCH: It is a stable workforce.

Mr Cormack: Yes, a very stable workforce. They like the pattern of work; they get to

know their local area; they form relationships with the general practitioners. Part of this initiative around expanding hospital in the home and CAPAC, which is community acute and post-acute care, is about increasing that.

There are some specific aged care out-of-hospital care arrangements, such as RADAR. Grant Carey-Ide, our executive director of aged care and rehab, might be able to give some more information on that initiative.

Mr Carey-Ide: The RADAR service was established two years ago, RADAR being the rapid assessment of deteriorating, at-risk older persons service.

Ms Gallagher: There will be a test on these later.

Mr Carey-Ide: Yes; the exam will follow. It has been a hugely successful service that incorporates specialist geriatrician leadership with two aged care nurse practitioners. Last year we were fortunate to receive funding to enhance the service by adding a social worker service to that service, and for this coming year we are hoping to add to the service additional specialist geriatrician services, additional nursing staff and an occupational therapist.

The key outcomes of the service so far have been that we have been able to support general practitioners in managing any presenting acute exacerbations of illness or emergence of illness for older people and hope to avoid—have in fact avoided—around 70 per cent of avoidable admissions to hospital. That increases safety for older people in the community but also increases the qualitative outcomes in terms of disruption from home. That has been our most significant tranche of achievement around supporting older people better in the community.

We are also working on different strategies to adapt our rehabilitation support services so that they complement the community health services, particularly the community nursing services that are available, by making sure that people are well supported once they actually transition to home and so that avoidable problems do not escalate.

MS BURCH: Do you have rehab and allied home-based visits as well as that community nursing?

Mr Carey-Ide: We do. We have a community rehabilitation service. That comprises a large range of different allied health professionals as well as medical registrar and medical specialist services that are able to quickly support people who have emergent problems arising from their disability or who are able to provide routine monitoring, advice and a care plan for those clients.

MS LE COUTEUR: This is not quite health but it is also relevant to it. Are there enough aged care packages for people? That is the other thing that stops you staying nearby?

Mr Carey-Ide: I am certainly not aware at the moment that we have any great challenge around accessing our packages for clients—great delays. We have got two residential aged care liaison nurses who work closely with the ACAT service and other parts of the older persons services to make sure that people are quickly able to

be transitioned to the right place for them. It has been a challenge in the past to find the right package of care for a person, but that is working well and our flows are going very well.

MS BURCH: When they go home after that ACAT and there are links to modifications that they need at home—is that through ACT Health or does go through the HACC service?

Mr Carey-Ide: There is a very minor service that is run through ACT Health, for very minor home modifications. The major services are run through HACC funded agencies.

THE CHAIR: Ms Bresnan has been waiting patiently and so has Mr Smyth.

MS BRESNAN: I have been getting my two bobs worth in so it is okay. My question is about page 207, BP4, in relation to the mental health indicators, indicator (i). It relates to the proportion of clients seen within seven days of inpatient stay. The budget paper proposes here a target of 75 per cent for 2009-10 with an estimated outcome for 2008-09 of 71. I just want to ask this in relation to the national mental health benchmarking project. Your review of key of performance indicators proposed at least 90 per cent of consumers, should we say, within seven days. That was following discharge from a key inpatient unit. I wondered, in relation to that indicator and what has been proposed here, how that has been developed and whether that 90 per cent indicator has been considered.

Mr Cormack: I will ask Dr Peggy Brown to assist us with that, but as she is coming to the table let me say this. What we do with all of our output class targets is this. Where appropriate, we use national standards; that is one source of information. Another one can be to adopt a professional standard that may have less national credibility. Another type of measure we might use is simply a stretch target against what we did in the previous year. So not all of these targets are necessarily gold standard, top of the shelf national indicators. Peggy might be able to address that.

MS BRESNAN: How do you decide, then, what one you would use?

Mr Cormack: What we would typically use is—we would start with the best available national indicator and have that as our long-term goal. In a number of those indicators, you will see that we have expressed the long-term goal. If there is a fair distance between where we are and a national long-term goal, we will set a series of annual targets that basically push the services towards getting to that optimal level, recognising that in some instances, for a whole range of reasons, it is not possible in one year to simply go from getting 50 per cent of the national standard to 100 per cent of the national standard.

MS BRESNAN: My question then being, in relation to output—what are the circumstances which are preventing us from reaching that national goal?

Mr Cormack: I might ask Peggy to talk about that national goal.

Dr Brown: I think the target you are referring to in the national benchmarking project

is an aspirational one. Without a doubt—

MS BRESNAN: So it is an aspirational target?

Dr Brown: It certainly is. If you look at the 2009 report on government services and the mental health data in relation to that, they indicate that the data is not entirely reliable because it is difficult to compare state with state. But the ACT certainly leads all jurisdictions in our performance there with the results that we have had. The nearest comparable jurisdiction is Victoria, which comes in at about 60 per cent.

The issues in relation to the follow-up are around the collection of the data. But, for example, in the ACT there is a difference between the figures that we obtain from the PSU versus 2N versus the older persons unit. 2N caters for a different category of client. They are often referred from interstate, they are referred from private practitioners or, indeed, from GPs and they wish to return to the care of those individuals.

So the indicator captures the contact with the public sector mental health services post discharge. In a certain percentage of clients, that is not the preferred follow-up method. The preferred method is to go back to their private psychiatrist or, indeed, to their GP. If they go interstate, we have no way of capturing that data. So the 90 per cent in the benchmarking project is still clearly an aspirational target.

MS BRESNAN: Obviously data is hard to collect and those processes are difficult to form, but has there been any work around improving those processes so you do know that people are actually being seen? I know when some people go interstate you cannot follow it up, but that does not give any guarantee that those people are actually going to get follow-up care. So has there been any thought about trying to improve those processes? It is about that national coordination of data collection.

Dr Brown: Yes.

MS BRESNAN: I appreciate that happens at a national level though.

Dr Brown: Yes, within a jurisdiction it is challenging. Some jurisdictions do not have a unique identifier and do not have the capacity to track, for example, if a patient is discharged from one hospital and is followed up at another service. When you try and extend that beyond the public sector to incorporate GP care and private psychiatry care, you are talking about major issues around information management.

The benchmarking project which ran for a couple of years and is just concluding—they have not actually published a final report from it as yet—aimed to explore a lot of these issues. I do not think it has come up with the solutions to all of the problems that have been identified.

MS BRESNAN: Here in the ACT do you get the information from GPs about whether people are going to see a GP or a psychologist?

Dr Brown: No, we do not have a process in place to track whether the GP has followed them up.

MS BRESNAN: Has there been thought given to developing that sort of process so we know that people are actually getting that after-care?

Dr Brown: Look, our aim is very much to work in conjunction and collaboration with GPs as much as we can. So it is advising GPs when consumers are admitted, keeping GPs involved in terms of planning treatment and care, involving them in the discharge planning, advising them of the discharge plan and giving them a copy of the discharge summary. It is another thing again to then have a process to capture whether they actually attend an appointment. We do try and arrange appointments with GPs prior to discharge, but it is another thing again to capture whether they have actually attended.

MS BRESNAN: I presume the e-health project might actually assist with that?

Mr Cormack: It might. But, again, all of these data exercises that cross the public and private sectors and cross jurisdictional boundaries, as in commonwealth and state, require national agreements to be put in place. Some of those will be fine, others will require more work.

MS BRESNAN: So there is a national agreement that is required in the ACT to be able to work with GPs normally?

Mr Cormack: No, not to work with GPs but to be able to collect a nationally consistent set of data that is contributed to by both the ACT services that we directly run and fund and those that are not funded at all by the ACT government but by a combination of patient fees and the commonwealth through Medicare or related arrangements. There is work that is still required to come up with nationally agreed data sets and the mechanisms available to collect those. It is just one of the intricacies of our system.

MS BRESNAN: Thank you.

THE CHAIR: Mr Smyth has some questions, and then we will take a break.

MR SMYTH: On page 212 of budget paper 4, there is a line about halfway down, "Medical retrieval services", and there is about $4.5 million over the four years. What is that for?

Ms Gallagher: To fund a full-time medical team on SouthCare. I will be corrected if I am wrong, but this program has started and the workload has grown. We have used people from our trauma service that work at the hospital to staff that helicopter. It is getting to the point now where the amount of call-outs they are getting and the amount of work that they are doing cannot be balanced with their hospital work as well.

MR SMYTH: So this is a full-time medical team with a doctor on every flight?

Mr Thompson: We currently have a medical team. The way the medical team works is that people have mixed roles within the hospital. Specifically what this funding will provide for this financial year is a full-time director and operations manager for the service plus a deputy director. That will reduce for the people who are currently

providing direction to the service the amount of work they are required to do in those roles. But it will also free up time for other doctors who are currently providing administration of the service so they can focus on direct service delivery.

MR SMYTH: So this is a bureaucrat to run the service, or is this a doctor?

Mr Cormack: No, a medical director.

Mr Thompson: A medical director.

MR SMYTH: It will be a medical director. Sorry, you said director.

Mr Thompson: The intent behind this is to improve the consistency and quality of the service as well as to provide the coordination.

MR SMYTH: So will the medical director fly as part of the service?

Mr Thompson: Yes, we would expect so.

Ms Gallagher: That is what happens now. And there is a component around the ambulance—

Mr Thompson: Yes, and that is what I describe as the health component of it. Approximately $300,000 of it will go to the ambulance service to boost the paramedic resource with the service as well.

MR SMYTH: So it does not lead to a larger retrieval area?

Mr Thompson: No.

MR SMYTH: Or an extended service?

Ms Gallagher: No, it is just meeting the growth in call-outs and work.

MR SMYTH: And the current area that Snowy Hydro SouthCare flies to?

Mr Thompson: There is not a specifically defined area that we fly to, because we participate in cooperation with the aero-medical retrieval services across New South Wales generally. The call-outs are a combination of what is the most logical location for the helicopter to fly to and from as well as whether or not there are other commitments of that service. So, for example, if our helicopter is out, then the helicopter from Wollongong may actually fly to a retrieval that is quite close to us. It is not specifically changing the area we cover. As the minister has said, it is responding to the fact that we have an increased call on the doctors to provide services on the helicopter.

MR SMYTH: You may want to take this question on notice: how many call-outs in the last three years? What is the growth?

Mr Thompson: It is approximately 400 a year at the moment, but we can take on

notice what the growth is.

MR SMYTH: Thank you.

THE CHAIR: We will adjourn now until—

Ms Gallagher: I keep forgetting, can I just table the output and programs?

THE CHAIR: Yes, thank you.

Ms Gallagher: I hope it is what you are after—

Mr Cormack: Sorry, could I just—

MR SMYTH: We will tell you if it is not.

THE CHAIR: We will not adjourn quite yet. We will table the outputs, and we will take all of those. Mr Cormack?

Mr Cormack: I have a minor correction from yesterday. I was asked by Mr Smyth how long the accreditation award would be, and I said five years. The correct answer is four years. In anticipation of a further question, I add that that is the maximum amount available under the accreditation arrangement.

THE CHAIR: Thank you, Mr Cormack. We will break until 10 past 11.

Meeting adjourned from 10.51 to 11.15 am.

THE CHAIR: Mr Smyth has some questions.

MR SMYTH: Just a question for you, minister. On Tuesday, when asking about the healing farm, I asked about a possible conflict of interest and Mr O'Donoughue stated that Health did not deal with the owners per se, Health had no dealings with the owners of the property. The question that I asked was about any conflict of interest with anyone at all. Minister, was your officer ever notified about any possible conflicts of interest?

Ms Gallagher: No. Are we talking about conflict of interest around who owned it?

MR SMYTH: With anything in regard to the purchase of the healing farm.

Ms Gallagher: No.

MR SMYTH: So not at all?

Ms Gallagher: Not that I recall. I do not recall being notified of any potential conflict of interest. I remember, in fact, having a conversation with a journalist on one occasion who raised the name of the owner or the seller of that block with me and that was the first point that I heard the name of who was the seller of the property.

MR SMYTH: So you do not recall an email from your then chief of staff, Brendan Ryan, saying—I will just read the email:

> Katy, this story is about to break
>
> I received a call from the lease holder at—

somewhere out at Tidbinbilla—

> He explained that the grapevine is running hot about ACT Health spending over the odds for the block (in particular given that we already hold several parcels of land in the area), and that the purchase is not at arms length given that the vender (a mental health "professor" at ANU) has a role to play in the future use, understood in the district to be a mental health facility.

Ms Gallagher: Do I recall the email?

MR SMYTH: Do you recall the—

Ms Gallagher: I do recall an email and I recall Brendan—

MR SMYTH: So you do recall?

Ms Gallagher: I do now. Again, I do remember a couple of emails and conversations that Mr Ryan had with a landowner out there and I asked indeed that he keep talking with him and address any concerns. At the time there were concerns raised around the price and I did follow up with Health and ask again about the valuation and what that had found and the process around the sale.

MR SMYTH: So you did follow up on the discussion on the potential conflict of interest?

Ms Gallagher: I did not see it as a potential conflict of interest, which is why my answer to the question—when I read that I did not see that as a potential conflict of interest. I saw it as a landowner raising concerns around Health purchasing some land and certainly when those were raised with me I did follow them up with Health around process and price, which were the issues that had been raised.

MR SMYTH: It says specifically in the email that the process was not at arm's length.

Ms Gallagher: I think that was the concern that had been raised by the landowner—that the process was not at arm's length.

MR SMYTH: So was that investigated? Was that conflict of interest investigated?

Ms Gallagher: I certainly raised the issues, and indeed I think I asked that Health speak with the individual who had raised those concerns with my office. As I understand it, that happened. I do not know if we should name the individual, but if we are talking about the same person, I think that is what happened.

THE CHAIR: We do not need to name the individual. What was the nature of the

concerns and what investigation took place to ensure that there was no conflict?

Ms Gallagher: The concern, as I understood it, from an individual out there, was a view that too much had been paid for the land and that really is the issue that I took up. I cannot recall the other specific concerns, other than people were not that happy with ACT Health coming in to buy a piece of land out there. There was a general feeling that ACT Health had come in and paid too much for a block of land and people did not like it. And that is what I certainly asked Health to follow up. I asked around the valuation and I asked around how they came across the block and that was followed up.

MR SMYTH: How did they come across the block?

Ms Gallagher: As I understand it, there was a consultant who was looking for blocks of land. I think Mr O'Donoughue went to this yesterday. They were looking at blocks that had already been identified at Jedbinbilla, at Ingledene. I think there was a block at Stromlo that was being investigated, from memory, as well. Although the Stromlo block in the end was only about a couple of kilometres away from where the Molonglo development would be, it was ruled not appropriate by the reference group. They thought it was too close to what would be a suburb in years to come. It was around the same time that it became clear that Miowera was on the market and I think it was investigated.

Mr Cormack: It was purchased through Peter Blackshaw Real Estate. The property was on the open market, for sale through Peter Blackshaw Real Estate, so there was already an agent involved on behalf of the seller. We then sought an independent valuation prior to making any offer on the property. We got an independent valuation and, on the basis of that, negotiated the final sale price which, as Mr O'Donoughue mentioned on Tuesday, was consistent with the independent valuation. The process of conveyancing was undertaken by the Government Solicitor's office on behalf of the government. I am not quite sure what you are suggesting in terms of a conflict of interest because the issue is–

MR SMYTH: I am not suggesting–

Mr Cormack: You are. It is exactly what you are doing.

MR SMYTH: No, sorry—I will read the email again. The minister's office had a constituent report to them that the process was, and I quote, "not at arm's length given that the vendor"—

Ms Gallagher: That was the allegation. We never really got to the bottom of that allegation, other than that the seller—

MR SMYTH: That is what I am asking you to explain.

Mr Cormack: That is a pretty routine way of purchasing real estate. The other thing is that, on behalf of government, of course, the important part of that is that it was through Procurement Solutions. We had a government procurement plan that guided the whole purchase of the property. I am not quite sure what other process you would

suggest, or whoever is providing you with the email would suggest, but–

MR SMYTH: The email is from the minister's chief of staff.

Mr Cormack: The source of information that led to that email—I am not quite sure what it is, but if you have any queries or questions or concerns about the process that I have outlined about acquiring a piece of property that was on the open market then I would suggest that you identify for us which aspect of that that you believe could be a conflict of interest.

THE CHAIR: Going to the question, we seem to be missing the point. Mr Smyth has said that the issue of conflict of interest was raised with Ms Gallagher by her chief of staff in response to constituents. That is where we got to. The words used in the email are, "The purchase is not at arm's length." That is not a conclusion; that is what has been put to Mr Ryan, presumably.

Ms Gallagher: That is right.

THE CHAIR: Given the vendor, a mental health professor at ANU, has a role to play in its future use, understood in the district to be a mental health facility, presumably whoever has had the conversation with Mr Ryan has raised a concern about the seller having some sort of relationship with the ACT government. That is the only way I could read that.

Ms Gallagher: Which they do not, as it turns out.

THE CHAIR: I think that is what the question was about: what investigation has taken place?

Ms Gallagher: There were a lot of views and I recall this at the time. When Health bought that block of land, a number of local landowners were unhappy about that for one reason or another, which I have never really fully understood. There were a lot of misconceptions around what the land was being purchased for. I think it goes to that in the email—that it is a mental health facility when it was never intended to be that.

What I did on receipt of information—and there were several phone calls with the individual that Mr Ryan talked to—was to ask Health to go and speak with each and every one of them individually and let them know exactly what was planned on that block and what we were considering in order to address some of those concerns—what I saw as really not urban myths but rural myths about what was going to occur. Health did that and that is really all there is to it.

THE CHAIR: But the allegation that was made by landholders conveyed to you—

Ms Gallagher: Was wrong.

THE CHAIR: That is what I want to get to the bottom of. You have not said whether you investigated whether or not there was a potential conflict between the seller and the ACT government in purchasing. What investigation was taking place, given this was brought to your attention? A concern, whether it had any factual basis or not, was

put to you. What investigation then took place about that particular point, about conflict?

Ms Gallagher: I asked Health all of those questions. I followed up on all of the concerns that had been raised with me. I said, "Look, I expect that there will be some opposition to this facility going out there." Let's face it; it is an Indigenous bush healing farm nestled in between a rural community that has been there for a long time. I had no doubt in my mind that the sale of this land would be controversial to the local population. I went back to Health and I said, "I want to be assured that everything is clear about what is going on here and that the valuation is supported by the price because there are a lot of views out there that we paid too much"—and that had been put to me—"I want to make sure that everything is above board because it has been put to me that it is not."

Health assured me, in much the same way Mr Cormack has just assured the committee, that everything was done above board, that there was no reason for the concerns that the local landowners had, or a landowner in particular, and that those concerns were not supported by the evidence or the process. I was comfortable with that. Several months later, and indeed only a couple of months ago, a journalist rang and ran the same line with me around an individual who I think is an academic at ANU and works in the area of mental health research being the owner of that block of land, and did I see that as a conflict of interest, and I said, "No." It was a block of land that was for sale. It was for sale at a particular price. It suited the needs of the reference group for an Indigenous bush healing farm. The price was agreed between the seller and the purchaser and we now own a block of land.

THE CHAIR: Just on that point, in terms of the apprehension of a conflict you said you were satisfied that there was no conflict.

Ms Gallagher: That is right, and I am still yet to find one.

THE CHAIR: That is fine; there may well not be.

Ms Gallagher: There is not.

THE CHAIR: What I want to know is how you satisfied yourself that there was not. Did the department then look into that issue and say: "Well, no, someone has raised this. We've looked at it. There is no pre-existing relationship. There is nothing that would cause any genuine concern about a conflict of interest"? An investigation took place and then you had a report from the department that said, "Look, this is all fine"?

Ms Gallagher: That is as I recall it, yes. I remember we had several discussions. I meet every Monday with Health. As we went through this I had a number of meetings with Mark and Ross about it. I was very concerned, as I remain, that local opposition to this could—not jeopardise it because we own the land now and we will build this facility, but I wanted to make sure that, as much as we could, we had the support of the local community as we went on this journey to build this fantastic service. For the first time in the ACT we would have an Indigenous specific healing farm which had the support of the Indigenous community and it was in a great location.

I did not want to pursue this in a way that antagonised or did not address the concerns of local landowners, by any means. That is not my approach and I understand this project is high risk in terms of community acceptability of it. But I am very satisfied with the work that Health did both in advising me around concerns and in going out and talking to a number of landowners in addressing or attempting to address concerns. I am aware of allegations of conflict of interest but I am not aware of any conflict of interest that exists.

THE CHAIR: Indeed. Just finally on that—and I think Mr Smyth has some more questions—are you able to provide the details of that investigation to the committee?

Ms Gallagher: I can certainly look at the briefs that were generated around that. I recall a couple or at least one. I will see what I can provide, for sure.

THE CHAIR: Thank you. Mr Smyth.

Ms Gallagher: It would be great if we had a unanimous Assembly position on this bush healing farm.

MR SMYTH: We have always been in support of a bush healing farm. I remember the early days when—

Ms Gallagher: We are having a go each way here.

MR SMYTH: No. It is about getting it right, as you said.

Ms Gallagher: Well, it is right.

MR SMYTH: This email—

Ms Gallagher: It is right.

THE CHAIR: We are just asking the questions.

MR SMYTH: This email is dated 30 June. The property was purchased in late July-early August?

Mr O'Donoughue: It was finalised in August 2008.

MR SMYTH: It was finalised in August. I assume it is the same person that spoke to Mr Ryan who then sent a further email, I am not sure—it was sent to you—

Ms Gallagher: Yes.

MR SMYTH: where he said:

> The ACT department of health had offered $1.4 million or $1,555 per acre. This does not compare favourably with what the market is saying. The last sale of a rural property in the area was a far superior property which sold for $750 an acre in 2004.

Why are we paying, four years later, double?

Mr Cormack: Because we got an independent valuation undertaken by a registered property valuer to provide advice to the government on the value for money aspects of this purchase.

MRS DUNNE: Who was the valuer, and were they valuers of rural property?

Mr O'Donoughue: It was Egan National Valuers who conducted the valuation in June 2008. They have expertise in the valuation of rural properties.

MRS DUNNE: They do?

Mr O'Donoughue: An aspect of the valuation, as I said on Tuesday, was a comparison of sales of comparable rural properties both in the territory and in New South Wales.

THE CHAIR: The final price was $1.4 million, I think. Is that correct? Was that the first and only offer that was made or was there a lower offer that was given originally?

Mr O'Donoughue: There were some negotiations around the price. There was an initial lower offer made.

Ms Gallagher: I should say, in balancing up some of those concerns, that it has also been put to me by somebody else—and these are some of the myths and a bit of the nuisance that has happened, as I see it—that a number of local people who wished to purchase that land for their own purposes were unhappy with the price that ACT Health came in and paid. That has been put to me as well. I just put that as another view about what happened and we leave it at that. There has been quite a bit of turbulence flying around about this. What I would love out of your processes—and I am happy to provide you with whatever I can to address your concerns—is that we move on and build this bush healing farm.

THE CHAIR: Just on the land price, before we move on to other questions: with the $1.4 million that was paid, I understand it was on the market for some time. Was that the original asking price or did they drop it? I think it was on the market for several months; is that correct?

Mr O'Donoughue: I am not aware of how long it was on the market, Mr Seselja, I am afraid.

THE CHAIR: Okay. The first you became aware of it, or the department became aware of it, was in March or April, was it?

Mr O'Donoughue: That is correct.

THE CHAIR: And it was asking $1.4 million.

Mr O'Donoughue: That is correct.

THE CHAIR: So that was the actual asking price and then the valuation matched up with the asking price?

Mr O'Donoughue: It did.

MR SMYTH: If I could just finalise this one. The government recently had resumed Robert Tanner's property, according to this email, Piney Creek on Uriarra Road. It is a property with a 99-year rural lease, similar size, better access, better utilities and indeed would have cost the taxpayers zero. Why was Piney Creek not considered?

Mr Cormack: I am not aware of the reason why Piney Creek was or was not considered. Mr O'Donoughue, I think, outlined yesterday the process that we went through in identifying potential sites. That is obviously what we do whenever we are looking for real estate for any government purpose. We had sites suggested by ACTPLA and LDA, I think it was—TAMS, sorry. Over a number of years we worked our way through a list of different options that had come up through the government side of things as opposed to the open market. And then this opportunity came along in the course of evaluating those other properties. I repeat: we got an independent valuation done and, as a guide for us in making sure that the use of taxpayers' funds was appropriate, the process of sale and negotiation around it was assisted by the Government Solicitor.

MR SMYTH: Was Piney Creek considered though? Were you aware that Piney Creek was owned by the government and was it considered?

Mr O'Donoughue: I could stand to be corrected, but if Piney Creek is Stromlo block 485, which is one of the blocks that was referred to us by ACTPLA—I suspect that it is, but we can clarify that subsequently—that block was investigated, but it was—

MRS DUNNE: It is on the Uriarra Road.

Mr O'Donoughue: Yes. I cannot place it by that address, I am afraid.

MS BRESNAN: Can I just ask: the property that was potentially—

Ms Gallagher: We did want Miowera as well. It was a great block

MS BRESNAN: That is what I was going to ask. The property was selected in consultation with Indigenous people, wasn't it? That was the site they approved of as opposed to other sites.

Ms Gallagher: They loved it. They have had a smoking ceremony. It is fantastic.

MR HANSON: When this was all going on, as well, there were allegations about a plan for a cellar door next door? We discussed this in the briefing as well. Can you extrapolate on those plans for the cellar door?

Mr Cormack: There were not any.

MR HANSON: There have never been any plans?

Mr Cormack: There was a media report when we had our briefing with you. We referred to recent media reports that had come up about the time that this came up in the media most recently. We undertook the necessary checks and established that there had been no DA for a winery, no DA for a cellar door. The person may have had an individual desire to have a winery and a cellar door—a noble aspiration, I would have thought—but in this case, when we did our searches, there was no evidence of that.

MR HANSON: But when you build a winery, I assume that the plan is to have a cellar door. Why else are you doing that? I thought that would be evident. When you gave me the briefing, you were refuting the fact that there was any plan for a cellar door.

Mr O'Donoughue: Mr Hanson, as I said to you on Tuesday, or as I answered the question on Tuesday, viticulture is a permitted use of a rural lease—that is, the growing of grapes—but a business of the nature of a winery or a cellar door operation would require a specific development application for that purpose. Our searches looked for any relevant development applications on neighbouring properties, and there were no such development applications for that type of business.

MR HANSON: Could I have a—

Ms Gallagher: What are you worried about? That someone is going to leave the bush healing farm, go to a cellar door and buy some cleanskins? Where are we going with this?

MR HANSON: No, it is just that it was raised in the media. No. Where I am going is that it was raised in the media. We did not make these allegations raised in the media that there were plans for a winery next door. The briefing I received, and I think yesterday, said no, there were no plans for a winery next door.

Ms Gallagher: As far as we are aware.

MR HANSON: I have correspondence dated 9 July from the owners of that property to the Chief Minister. It says: "We had hoped to contribute to the agricultural, aesthetic and tourism of the area by establishing a vineyard and ultimately, with government approval, cellar door sales and possibly a bed and breakfast establishment."

Ms Gallagher: Sounds lovely.

MR HANSON: So in correspondence to the Chief Minister on 9 July the property owners had made quite clear what their intention was for this property and that part of the rationale for buying the property was to establish a cellar door and that is why they were going through with the process of building the grapes. And that was their plan for the management of the land.

Ms Gallagher: I wish them all the luck in the world with that business proposition. I wish them all the luck in the world. What we will be doing next door is creating a wonderful environment for Indigenous people to address substance issues in their lives.

MR HANSON: I am not qualifying that, and I am not making an assessment myself on whether it is appropriate or not—

Ms Gallagher: Aren't you?

MR HANSON: No, I am not. I am certainly not. What I am asking for, though, is a clarification of—when the question was put about plans for cellar doors and so on, this was very clearly refuted by Mr Cormack, Mr O'Donoughue and yourself.

Ms Gallagher: That is right, because there is no development application. An email of someone flagging something they might like to do in the future—

MR HANSON: I think it goes beyond that. This is correspondence to the Chief Minister clearly articulating that that is the long-term management plan for that land, which is—when you take on a rural lease or buy a property, that is part of the process: you have got to articulate that. That was part of this process—saying that that was their intent. Whether that is appropriate or not is a completely separate discussion we are not entering into, but to say then that there was no intention to have that vineyard and the cellar door seems not to be the case.

Ms Gallagher: I do not think that they ever said there was no intention. I think what Mr Cormack and Mr O'Donoughue have said is that they did a search on development applications on any neighbouring property and they did not find any evidence of one for a cellar door.

MR HANSON: But when this issue was raised in the media, it was quite clear that that was the planned use of this land by the property owners. That has never been acknowledged. That has not been raised—the fact that this was correspondence to the Chief Minister; this was raised as the intention for the use of that land.

Ms Gallagher: So what is your point?

MR HANSON: My problem is that this was raised as an issue in the media and there was quite a bit of sensationalism around it. The department, your department, has said, "No, that is not the case."

Ms Gallagher: We can only go on what evidence there is. Somebody talking about future business plans for their block cannot constrain our consideration of an acceptable, suitable block for another purpose. Otherwise nothing would ever happen in this city.

MR HANSON: But why, when it came out in the media—that is not my question. When it came out in the media, though, why was it that there were so many denials around this—that that was the case? Why was there not a more open process to say that, yes, that was the plan? Clearly, now, it is going to affect their ability to pursue

their plan for that land.

Ms Gallagher: Why?

MR HANSON: I imagine that it will affect the process of the DA. Why is it that you refuse to present all the information?

Ms Gallagher: A number of local landholders raised concerns. This is part of what I have been saying. I did not expect this project to go with the unanimous support of surrounding residents. Nothing like this ever does.

MR HANSON: In relation to that—

Ms Gallagher: But it is a large block of land—386 hectares—and there is capacity to co-exist. I have to say that I see no problems with a boutique winery, if in the future one arrives on that site, and a bush healing farm within the types of areas we are talking about.

MR HANSON: But there were a lot of denials around this when it was raised in the media. I just ask: in the FOI documentation—

Mr Cormack: Mr Chairman, can I just clarify the denials? I just want to be clear what we denied. What we said is that we did a property search and there are no DAs, no permitted use for a winery or for a cellar door. I stand by that. I have not denied the existence of a letter. I have simply denied, and we briefed Mr Hanson—there is no DA and no permitted use for a winery and a cellar door on the block in question. That is the end of the story.

THE CHAIR: I was not in the briefing.

MR HANSON: Can I just ask this, then. In the FOI that was provided on this issue, on a copy of the letter, why is it that the words "cellar door" were blacked out? What was the rationale behind blacking that out in the FOI that was provided? The original correspondence reads: "The aim was establishing a vineyard and ultimately, with government approval, cellar door sales and possibly a bed and breakfast establishment." What was the rationale behind blacking that out—

Mr Cormack: I will have to—

MR HANSON: if you were not trying to hide the purpose of that land?

Mr Cormack: Okay. I will have to check the decision maker's justification against the legislation for deleting references. As you would be aware, the FOI legislation contains a number of clauses that enable full release, partial release or no release. I am happy to take that on notice.

THE CHAIR: Okay.

MR HANSON: All right.

MS BURCH: Can I—

MR SMYTH: In terms of checking—

THE CHAIR: We will just finish on this and we will move on.

MR SMYTH: Were the land management agreements checked? Every property has a land management agreement, a leasehold. I assume that you guys have put together a land management agreement and submitted it for approval, so you know that process. Were the land management agreements that outline the intention of the leaseholder and what they want to do with their property checked?

Mr O'Donoughue: Mr Smyth, it is my understanding that land management agreements are private between ACTPLA and the rural lessee. We have made our land management agreement available to all the rural lessees. But just to clarify a point that Mr Hanson made—it would not be possible for a winery or a cellar door to be part of a land management agreement with ACTPLA as it is not a permitted use. You can go to what you need to do about stocking the property, what you want to do about viticulture or what you want to do about any other agricultural pursuit, but you could not possibly prescribe future land management for a non-permitted use in a land management agreement.

MR SMYTH: We can go to communications facilities, data centres and indeed some of the correspondence over whether a health spa was permitted out there. These things are part of the process, and the process allows people to vary the use on their lease. That is a given. Everybody has that opportunity to apply; they do not necessarily get what they want. But in consultation, when this issue arose out of the email, what action did the government take in addressing the concerns of the next-door neighbour?

Ms Gallagher: Ross, you went out and met him, didn't you?

Mr O'Donoughue: I did indeed. During September and October of 2008, I personally went out and made arrangements to speak with all the neighbouring leaseholders. Those concerns were raised by that particular couple who had aspirations to have a future bed and breakfast or cellar door operation. I said, as the minister had said, that therapeutic communities exist in many rural communities in other parts of the country and co-exist quite happily. In fact, they co-exist happily in some metropolitan settings without any disturbance to their neighbours. Our intention was to be good neighbours and not disturb the amenity of the area. In that sense, I wished them every success and—

MR HANSON: When we had the briefing—

THE CHAIR: We will need to wrap it up—

MR HANSON: Just one question.

THE CHAIR: and then we will move on.

MR HANSON: I was very much left with the impression that there was no information surrounding the cellar door or any intention there. You are saying that you met with them, that they had raised their concerns, that that was their intent and that was what they wanted to do. You would remember that at that briefing that we were in when we raised the issue that this was being mooted, that they were planning for a cellar door there, the response from yourself and Mr Cormack was adamant.

Mr O'Donoughue: If we could—

MR HANSON: You did not raise any mention that you had had these discussions that they wanted to do a cellar door. You completely omitted that information when you gave me a briefing.

Mr O'Donoughue: No. If I could go through the sequence with you again. The searches—the due diligence searches—that we undertook about development applications were prior to the sale, obviously. The discussions I had with the neighbours were after the sale, in September and October.

MR HANSON: Sure, but—

Mr O'Donoughue: And all we said in the briefing was that our diligence did not reveal any development applications for such a purpose.

MR HANSON: But you had had the—

Mr O'Donoughue: We did not deny that there had been media statements about the proposed use.

Mr Cormack: In fact, I think we initiated clarification of those media statements with you. I repeat my earlier comments: we have been absolutely clear about what we deny the existence of, and that is a DA for a winery or a cellar door on that property.

MR HANSON: The media allegations were that there were all these plans for it and when you go to—

THE CHAIR: All right. Mr Hanson clearly has a different recollection of what was in the briefing so—

Ms Gallagher: What are you alleging now? That you were not told the truth in a briefing?

MR HANSON: I just think it could have been a bit clearer. This would have cleared it up at the time when I had the briefing.

Ms Gallagher: Cleared what up?

MR HANSON: There is a point being made that they did have plans for it—this is part of their ongoing land management plan.

MS BURCH: Chair, are we wrapping this up?

THE CHAIR: We will wrap it up. Just going forward from that, we will have the details of the investigation and that question—

Ms Gallagher: It is details of an advice. A specific investigation or inquiry was not called for. I merely—

THE CHAIR: I asked you if you did an investigation and you said yes. If there is now no investigation—

Ms Gallagher: Well, I did. You know, in my head, I did.

THE CHAIR: We will look forward to the detail of that.

Ms Gallagher: Are you for the bush healing farm or against it?

THE CHAIR: We will look forward to the details of the process.

Ms Gallagher: Really? Yet again, another no position from the opposition.

THE CHAIR: We look forward to getting that extra information. Ms Burch?

MS BURCH: I just want to make a comment that I think it is commendable to pursue an activity like an Aboriginal bush healing farm and—

THE CHAIR: Yes, me too.

MS BURCH: I think that doing that in work with local elders and finding a suitable site is good.

MR SMYTH: Sorry, just before we start, in that regard—

MS BURCH: No. I am asking the question, thank you.

THE CHAIR: We can come back to it if you want, Mr Smyth.

MS BURCH: The question then is around other activities and support for Aboriginal folk in that community around health services and what you do to support them.

Ms Gallagher: We work in very close partnership with the main Indigenous health provider, which is Winnunga Nimmityjah. Increasingly, they have taken over pieces of work that ACT Health used to do and now manage a pretty large—certainly in financial terms—organisation providing excellent care to our Indigenous community. We can go through the programs that they provide and the extent of our funding with them. I do not know if you know that off the top of your head, Ross.

Mr O'Donoughue: Maybe I will just highlight that, under the COAG closing the gap process, there is a new national partnership on Indigenous health. The territory has committed $15.75 million over four years for that initiative and there will also be investment by the commonwealth. It will be very exciting to roll that out over the next

four years. It will feature some funding to the community-based organisations. Some of it will be related to smoking cessation again, which is mentioned in the preventive health initiative for this budget. There will be funding for reproductive health and antenatal care for young women and for some primary health initiatives, including extensions of our midwifery services and outreach services. That is one sort of highlight for this budget.

MS BURCH: Is that midwifery around supporting them through their pregnancy and then through the early stages after that?

Mr O'Donoughue: Yes. It will be an extension of the program that Winnunga currently operates.

MS BURCH: And with the services they provide at Winnunga—that is an independent service, but are there partnership arrangements with services from ACT Health into Winnunga?

Mr O'Donoughue: Very much so. There is an Aboriginal and Torres Strait Islander forum that is the principal mechanism for consultation between us, the commonwealth government, other territory government agencies and the non-government sector. That is a very active group that meets regularly and basically reviews the national strategy frameworks, including the closing the gaps work. That is the principal mechanism; there is very much an active partnership between all of those agencies.

MS BURCH: Are the numbers growing through Winnunga? Are they able to cope with their own service needs?

Mr O'Donoughue: I hesitate to speak for Winnunga. They service a regional population and they service a non-Indigenous population in addition to the Indigenous community. They are a very in-demand service. They are partly funded through the commonwealth government as well as through the territory. I think they are always ambitious to improve and expand their service base. We are in discussion with them, as are the commonwealth.

MR SMYTH: Just one last question on that other area. In the selection criteria, there is a criterion called "removed from temptation". Could you explain what that means?

Mr O'Donoughue: I was going there when I was talking about Stromlo 485 in the sense that the notion of a rural location was that it would be somewhat distant from the temptations, if you like, of the metropolis. In the Indigenous community's mind, being out of sight of the city was an important consideration. Stromlo 485 was only one or two kilometres away from a proposed development, so it was excluded on those grounds. In a sense, both from an asylum point of view and also from a slightly reclusive point of view, the rural location was important from that point of view as well as the connection to land and the opportunities that offered point of view.

MR SMYTH: It may be slightly hypothetical, but if the cellar door was operational and if the B and B was there—

MS BURCH: Haven't we closed this? Chair, haven't we—

MR SMYTH: would that have been "removed from temptation"?

Ms Gallagher: Miowera will not be adjoining a suburb in the city within one or two kilometres. It is in a bush setting.

MR SMYTH: But being near a vineyard or cellar door and a B and B is certainly not removed from temptation.

Ms Gallagher: So you are running the line that people will leave the bush healing farm and knock on the cellar door and buy a case of cleanskins.

MR SMYTH: No. I am just asking a question. I am just asking the question. I am just asking what "removed from temptation" means.

Ms Gallagher: I hardly think that is a realistic line.

MR HANSON: It is an alcohol rehab centre which is meant to be removed from temptation.

MS BURCH: You are interjecting, Mr Hanson.

MR SMYTH: If you are happy with that, that is fine.

Ms Gallagher: I am more than happy and very comfortable that the block at Miowera offers the opportunities that we need to provide a therapeutic community to the Indigenous community and their families dealing with their own substance abuse issues and I am very confident that a boutique cellar door on an adjoining property will not affect the rehabilitation offered at that site.

THE CHAIR: Okay. Ms Le Couteur had some questions.

MS LE COUTEUR: Ms Bresnan.

MS BRESNAN: On a completely different topic, at page 202—sorry, I am just going to get the right page here.

Ms Gallagher: Sorry, Amanda. Where are you going?

MS BRESNAN: Page 202 in BP4, strategic indicator 23, that comprehensive discharge plan. Does strategic indicator 23 show 75 per cent of patients with a length of stay greater than 30 days prior to the discharge plan and that the goal is 90 per cent? Could you give a bit of information on why. That 25 per cent of people—again, I understand, given the conversation we had about mental health, that it could have been due to data availability, but could you provide me with an explanation about that figure.

Mr Thompson: Yes. As the description of the indicator says, this is about complex discharge planning to target those patients whose length of stay is greater than 30 days. The other aspect of this indicator is that this is about the completion of particular

documentation around the discharge plan in order to audit that the complex discharge plan has in fact taken place. With this indicator—our performance to date is that we actually did have problems with the documentation earlier in this financial year, which has contributed to the lower than targeted outcome, but the advice that I have received is that the discharge planning is in fact taking place and what we are trying to do is to improve the documentation of that.

MS BRESNAN: Okay. The other day we were talking about e-health as well and some work which was being done particularly in discharge, so presumably that is again improving the processes?

Mr Thompson: Yes. We do expect to have an improved performance next financial year. I have just had advice that the most recent quarters are over 80 per cent, so we are already seeing evidence that it is improving.

MS BRESNAN: Okay. So hopefully in the next budget we should see a much more accurate figure.

Mr Thompson: Yes.

MS BRESNAN: Thank you.

MR HANSON: Chair, I have a follow-up on that.

THE CHAIR: On accountability?

MR HANSON: Yes.

THE CHAIR: In that case, yes.

MR HANSON: On the strategic indicator about discharge plans, Robert Wells, who is the Co-director of the Menzies Centre for Health Policy, in response to the budget, talked about these plans, and I am interested in your comments on this. He says:

> In the ACT, attempts to have good discharge planning for all patients, particularly those with multiple and chronic illnesses, have been dismally unsuccessful. Resource pressures and turf wars have stymied every attempt.

Would you care to comment on that? Would you concur with that assessment?

Mr Cormack: What I can share is a spectacular success. I have just been advised that we now have 160-plus general practices across the ACT and south-eastern New South Wales that are now transacting their discharge summaries fully online, directly into their practice software. This has been a major piece of work that has required intense cooperation between the commonwealth government—in fact, much of this was supported by the commonwealth government—and general practices in both the ACT and New South Wales. I think this is very good evidence that, when technology is made available and when parties are able to work together to achieve a common outcome, you can get spectacular successes.

I think we recognise that discharge planning is always an area of challenge but it is an area that we are making some good progress in. I think that there are always opportunities to improve relationships between the hospital sector, the community-based sector and general practices et cetera, but the will is there and we have certainly put a lot of effort and resourcing into making that better.

MS BURCH: Can you explain the process on discharge and on determining who needs a discharge plan or who would benefit from a discharge plan and who does not?

Mr Thompson: It is not as simple as saying who would benefit from a discharge plan and who would not, because effectively all people have discharge plans. Discharge plans involve what you are expected to do immediately following discharge and no-one leaves hospital with no immediate follow-up healthcare needs.

What we do with our discharge planning is identify those who have more complex discharge planning needs than those who have simple discharge planning needs. Simple discharge planning needs are things like requirements to follow up with a general practice and maybe get another script and things like that. That is the very simple end. For the more complex end, that can involve working with occupational therapy, social work, home modifications, disability support and those sorts of things.

The process that is undertaken is that, in the course of a patient's stay in hospital, their health needs are assessed. The assessment involves not just the immediate health needs that have resulted in their admission to hospital but also the broader social and health problems that may make it more difficult for them to be discharged or support themselves following discharge. On the basis of that assessment, the discharge planning is tailored to the range of support needs that they have.

MR SMYTH: Have you spoken to Dr Wells? I assume you are aware of the article?

Mr Cormack: Yes.

MR SMYTH: Has there been communications with Dr Wells as to what was the basis of his claim?

Mr Cormack: We have not communicated with Dr Wells in relation to his article but we are certainly aware, as I indicated, that in the past there have certainly been some difficulties and it is always a challenging area and it is always an area that we seek to improve upon. If you go to strategic indicator No 17, you will actually find for, an aged care and rehabilitation service, 100 per cent.

MR HANSON: We could equally go to many other strategic indicators where it is—

Mr Cormack: We are talking about discharge planning here, aren't we?

Ms Gallagher: Yes, we are.

Mr Cormack: I am just saying that strategic indicator 17 is about the proportion of aged care clients—they are similar to the group that Mr Thompson was talking about; they are people with complex requirements—that the management of the aged care

and rehab service discharged with a comprehensive discharge plan. That has actually exceeded our target there, which was pretty high at 98 per cent, but we will be getting 100 percent of that. So I think there is some good evidence that we are making good progress.

THE CHAIR: Ms Burch?

MS BURCH: On a different theme?

THE CHAIR: Sure.

MS BURCH: Again, I am going through a number of your 2009-10 priorities on page 189. I am looking at the third dot point on implementing the partnership program with hospital and workforce reform. Can you tell us how we are going with that? We have had some comment on Aboriginal programs.

Ms Gallagher: Sure. The national partnership programs were signed off in February, were they? February at COAG?

Mr Cormack: November last year, with COAG. But they have been finalised and formally signed off later this year. The agreements were taken in November.

Ms Gallagher: That is good news. I am trying to recall those meetings but yes, November. At the same time, the SPPs were signed off formally. The national partnership programs indicate, I think, a specific focus on certain areas within Health and they exist in a number of areas across government as well. There is one on hospital and workforce reform; there is one on Aboriginal and Torres Strait Islander health; and there is one on prevention. How many do we have in Health? Maybe I will hand over to Mark.

Mr Cormack: We have got hospital reform and workforce reform. The hospital side of it includes subacute care, emergency department primary care reform, activity-based funding. It also includes the workforce component, which is a very large national partnership payment, which provides a consistent national approach to workforce planning, policy, professional boundaries and proposes—in fact, not even proposes but will establish Health Workforce Australia, which is a national entity to oversee all aspects of workforce planning, including clinical training, postgraduate and undergraduate training. At the same time—and we mentioned this briefly the other day—there was an agreement with COAG on e-health through NIETA. There is also a national partnership payment on prevention, which both Dr Guest and, I think, Mr O'Donoughue, alluded to in their evidence the other day.

There are very significant areas of reform. In particular, the hospital reform will look at ways of improving safety, will look at ways of improving the timeliness of care. It will also pick up the commonwealth's recent elective surgery funding component. The subacute care will address issues such as geriatric evaluation, maintenance, palliative care and a range of community-based support arrangements for people who have gone past their episode of acute care in the hospital. So it is facilitating their transfer into the community, facilitating their transfer into residential care or supported community care. There are quite a range of initiatives there.

MS BURCH: Some of them are threaded through your daily functions of the hospital and then some of them are reflected as initiatives here? Or is it more for your routine operations?

Ms Gallagher: Some of the initiatives will fit into the national partnership program.

Mr Cormack: That is right.

MS BURCH: Such as the workforce?

Ms Gallagher: Workforce, prevention, healthy future.

Mr Cormack: Yes, healthy future, healthy workforce development.

Ms Gallagher: Our walk-in centre will fit into the hospital reform, through improving ED processes. So it is a mixture. The national partnership themes naturally align pretty well with areas that we were already working on or concerned about, wanted to see improvements or additional focus. I think that was true probably for most states and the other territory government. It was not something that we were not already focused on. Certainly where there are requirements for additional money to meet those programs in the payments from the commonwealth, then that is being provided in the budget.

MS BURCH: On workforce planning, I know the national view is to look at innovative models. That may necessitate scope of practice and some changes to legal boundaries of practice and the like. Where are we at with that sort of thinking, noting allied health assistance, which was probably slightly outside the scope but perhaps not?

Ms Gallagher: I think we are very well positioned. Every jurisdiction is facing similar workforce pressures. I think there is a general acknowledgement that the health workforce, as it has traditionally existed, will be unable to provide the labour that is required as the community ages and as demand grows. So we had already put in place things such as allied health assistance. In our nurses agreement, there is capacity for an assistant in nursing, of which there—

MS BURCH: Which is different to an enrolled nurse?

Ms Gallagher: It is.

Mr Cormack: That is right.

Ms Gallagher: It is a lesser scope than an enrolled nurse. Just as there is capacity at the other end with an advanced practice nurse and a nurse practitioner, to broaden out the role of the traditional nurse and to make sure that our degree qualified nurses, our RNs and advanced nurses are actually focusing on the work that they are specialised to focus on, we believe there is scope for that. As e-health develops, I think there is general agreement that there will be a technological health worker, a worker that is specifically skilled in analysing data from a whole range of—

MS BURCH: That is coming from the scales at home and all sorts of other things?

Mr Cormack: Indeed.

Ms Gallagher: That is right. In the hospital of the future, someone will walk in with their Blackberry that has got all their latest health data contained in it, can download that information quickly and make it available to a doctor. There is a lot of work that we have been doing here anyway that will feed into a national process. I think the agreements on the workforce have really been to make sure that we are all on the same page and that we have a national health system. I think there will be some challenges as we go through with this. It is not always easy to reach agreement between jurisdictions about what is a priority and what is not a priority but the agreement is to have Health Workforce Australia—is that what it is known as?

Mr Cormack: That is right.

Ms Gallagher: To provide funds for that is the first step on the journey. From my discussions both at COAG and at health ministers meetings—and I think I am the only health minister that goes to COAG—after I had seen this, it was the first ministers' and the health ministers' view that there is a lot of buying into this because there is a general acknowledgement that we have got to build the workforce that we need.

THE CHAIR: Mr Smyth.

MR SMYTH: Minister, on Tuesday, we had some discussion about the approach to the Little Company of Mary over the sale of Calvary and you said you were going to review and think about when the offers were made and whether or not certain phone calls were made. Have you any more detail for the committee?

Ms Gallagher: Sure. I certainly do not recall making a phone call to Calvary prior to my meeting with them in the beginning of August, when we had the first discussion on it.

MR SMYTH: I have checked with a number of LCM officials, including Mr Brennan, and he stands by the briefing he gave members of the Liberal Party that the first time they knew of the government's intentions was a phone call from a senior Health official to the head of LCM who said that you should ring the head of the board, Mr Brennan, and that they were quite agreeable to taking that phone call.

Ms Gallagher: I have not spoken to Tom. I was—

MR SMYTH: There is no memory or recollection; nobody can recall it ever being raised at the meeting prior to the phone call.

Ms Gallagher: Sorry, nobody can?

MR SMYTH: Nobody from Little Company of Mary that I have been able to contact can recall it being raised at a meeting prior to the phone call from you to Mr Brennan.

Ms Gallagher: One, I do not recall the phone call, but I have not spoken to Tom. He is the only person that I can really ring to check whether I made the phone call to him, and I have not called him. But I am happy to stand corrected if I did call Tom and speak with him. I certainly do not recall that. I vividly recall the meeting where he was in attendance, on 6 August, as the first discussion on this. If Tom says I called him, I will take Tom's word for it that I called him. I do not recall it but I certainly recall that meeting on 6 August.

MR SMYTH: It is a fairly important phone call that potentially launches $200 million or $300 million worth of expenditure. You cannot recall phoning anyone in the Little Company of Mary?

Ms Gallagher: It was not around $200 million or $300 million worth of expenditure; it was around—

MR SMYTH: Approximately a $100 million acquisition and $200 million expenditure.

Ms Gallagher:—whether or not they would be prepared to consider an approach on the transfer of ownership. As I said, I did spend the last couple of days going through records, in my head, on this. It is unusual for me to call the chair of the LCM because I do see them at regular meetings. I recall a couple of times where I had called Helen O'Kane, the previous chair. I just genuinely cannot recall ringing Tom. I had not met him. My first physical meeting with him was on 6 August, as I recall. So I was trying to think—

MR SMYTH: So he was at the 6 August meeting?

Ms Gallagher: I think he was. But our records would show that. I am pretty sure he was. I was trying to recall whether I did ring. I would have to ring him and introduce myself, "Hi, I am Katy Gallagher; I am the minister." I do not recall doing that.

MR SMYTH: Hence the preceding phone call from the senior official to the CEO of LCM saying would it be possible to make the call?

Ms Gallagher: I have discussed this with Mr Cormack as well, working out the chronology of the events, and Mark certainly recalls speaking with a Mr Doran. Was it Mr Doran?

Mr Cormack: Peter Hedge.

Ms Gallagher: Peter Hedge, who came in before the meeting of the 6th; so we were talking. At that point in time there were quite a lot of issues going on for LCM. They are a big provider of health care in the territory. So there were a lot of discussions at that time just to make sure everything was going okay. As you would be aware, we would want to make sure that some of the organisational issues that they had were not going to impact on the public health system here. There were some concerns on that. So it is not a surprise that Mr Cormack would be speaking to Mr Hedge at that time.

I think the reason for the actual organising of that 6 August meeting was to bring all the new players together because there had been a change of chief executive and a change in the board. Peter Hedge had come in, with a very specific job to do, and it was really about pulling all that together.

If Tom says I called him, I called him. I genuinely do not recall it. I have called him a number of times in the past six months or so. I do not recall ringing to introduce myself to him over the phone and asking whether he could transfer Calvary's ownership to me or to the ACT government. I do recall having a meeting with LCM, with Mr John McKay, actually, who is on the board. I think Peter Hedge was at that meeting. And they explained to me some of the issues that they had as an organisation. There are some genuine concerns from all sides on the situation they were in, and that really led to pulling together on 6 August where I recall—

MR SMYTH: So the meeting when you floated the idea was not 6 August?

Ms Gallagher: Yes, it was. I had met with LCM, I think in the month prior to that, in July, where they had lost their chief executive and they had lost their board chair. They came to have a pretty frank discussion with me and with Mark about some of their pressures, which I have to say I was very concerned about and which they have addressed now, I should say. There were some urgent matters that they needed to attend to, which they have done. But at that time there was certainly a health minister wanting to ensure continuity of service and that everything was going to be okay.

We had seen some changes at John James in relation to cancer treatment that we had to manage. Extrapolating that out, I did have some concerns when we had had that meeting in July. I know it certainly led to another meeting where I think Tom was there. I will check the attendees at that meeting but I am pretty sure that is the first time I met Tom Brennan.

THE CHAIR: Ms Le Couteur.

MS LE COUTEUR: I have a totally different question. On 1 May this year, I understand the Food Regulation Ministerial Council meeting decided to review the food labelling law and policy. Can you provide the terms of reference for that review and the timing, when it will start and—

Ms Gallagher: I am sure we can, yes.

MS LE COUTEUR: Is it also going to cover GE ingredients in food?

Ms Gallagher: Yes. Charles can cover that, I think.

Dr Guest: Could you clarify that question, please?

MS LE COUTEUR: Firstly, I think we will be provided on notice with the terms of reference.

Dr Guest: Yes.

MS LE COUTEUR: The second was: is this going to cover GE ingredients in food?

Dr Guest: The Food Ministerial Council?

MS LE COUTEUR: Apparently it is doing a review of food labelling law and policy. Is that review going to cover GE ingredients, genetically engineered ingredients?

Dr Guest: I believe it is but we will check that for you.

MS LE COUTEUR: Will it include small levels? It seems to be one of the areas that—

Ms Gallagher: How about we get you the paper.

MS LE COUTEUR: Okay.

Dr Guest: Small levels of what?

Ms Gallagher: It is a pretty technical council.

THE CHAIR: We will look forward to getting that. Mr Hanson has some questions. Ms Bresnan, were you waiting as well?

MS BRESNAN: Yes.

THE CHAIR: Mr Hanson and then Ms Bresnan.

MR HANSON: Minister, if you could look at the strategic indicators, and specifically in this case strategic indicator 14, acute rehabilitation, average length of stay. That is on page 198. There has also been some media attention and some debate in the Assembly around this issue, and that is the transitional patients, ward 12B, from the health system into disability and the provision of support packages. Can you tell me what the status is there? This seems to be an area where, if I am reading it right, we have an estimated outcome of 11 days stay but we are heading for a target of 15, so it seems to be deteriorating. Is that correct and what are we actually doing in this area?

Ms Gallagher: From memory, I think the target for 2008-09 was 15 days. Grant can correct me. From my understanding, the 2008-09 target was 15?

Mr Carey-Ide: Yes.

Ms Gallagher: Yes, so we have exceeded the target this year, but we have not changed the target for next year. The nature of the clients that you would be looking after there would indicate that a reasonable average length of stay would be 15 days overall. Yes?

Mr Carey-Ide: The length of stay is actually consistent with the Australian Rehabilitation Outcomes Council's benchmark length of stay. They are set and reviewed nationally by that council. We review our performance against those benchmarks on a quarterly basis.

MR HANSON: Right. We also have some long-term patients now in this ward 12B that, as reported in the media, have been there for a long period, a number of months. What is happening with those patients, in particular?

Mr Carey-Ide: We continue to work with community providers and other government agencies to facilitate the discharge of those patients from hospital. Of course, that varies dependent on the individual needs of each of those patients.

MR HANSON: Sure.

Mr Carey-Ide: Some of those patients have a minimal amount of needs, whereas some of them have quite large amounts of needs. We would expect that that will continue to be the pattern for our services. Given the success rate with having people live longer lives with disabilities, whereas in the past that did not happen, that is a challenge for us all. It is a good challenge, and we are taking that seriously.

MR HANSON: Right. In terms of providing those people with the information on how the individual support packages are progressing, there seems to have been some disconnection between Disability Services and Health. Has that issue been addressed?

Mr Carey-Ide: Disability and Health and Housing, the other significant party to transition to the community, are working very closely together. The officials from Disability, from Housing and I and my senior staff are meeting together on a regular basis to make sure that we have got similar processes in place. I think you are aware, Mr Hanson, also that we have established a formal project with Disability and with Housing, in partnership with Health, to make sure that we have got as seamless a process as possible for the future.

MR HANSON: But who is responsible for updating the patients on that progress?

Mr Carey-Ide: In terms of the patients, that would be the responsibility of the team within ACT Health, within the rehabilitation service. At times I have personally done so.

THE CHAIR: I just have a follow up on the strategic indicators before I move to Ms Burch. Minister, strategic indicator 21, emergency department time limits, we continue to lag in categories 3 and 4.

Ms Gallagher: Yes.

THE CHAIR: We are doing well again in 1 and 2, which is—

Ms Gallagher: And 5.

THE CHAIR: And 5, indeed, but 1 and 2, more importantly, perhaps. But 3 and 4, which—

Ms Gallagher: Yes.

THE CHAIR: And 3 is serious, isn't it? It is urgent. Why do we continue to lag on that indicator, and what progress are we making towards achieving those targets?

Ms Gallagher: Yes, you are right. I mean, three out of five indicators, we do very well. On categories 3 and 4, which are probably the largest patient groups out of those categories, our times are not where we would want them to be. I think enormous effort is going into improving our timeliness in our emergency departments. We have one of the busiest emergency departments, I think. Well, we have two very extremely busy emergency departments, both at Canberra Hospital and Calvary. The answer—well, there are a couple of answers, but one of the focuses is on more beds, and you have seen that in every budget. It is getting people in and through the emergency department, admitted to the hospital.

We have seen some improvements, continued improvements, in our access block, despite continuing growth in the numbers of people being seen, and we have certainly brought that quite a bit down from where it was a couple of years ago. We have got more beds online. I think the MAPU unit is helping in terms of getting people through. We are now going to have the SAPU, which is the surgical model of the MAPU, which is the medical model.

The Mental Health Assessment Unit will also open this year, again taking some of those difficult clients, the clients that take a long time to get through the emergency department and be seen.

THE CHAIR: You are talking about improvements though, Ms Gallagher. I mean, it is still a fair way behind. Is that 50 per cent a significant improvement on what we have seen before or is it about where we have been?

Ms Gallagher: I think it is about where we have been.

THE CHAIR: So you are talking about the improvements and what is happening? It is good that that money is being spent and the beds are being provided, but why are we not seeing improvements in particularly those categories?

Ms Gallagher: Well, presentations continue to grow and particularly in those categories 3—urgent and semi-urgent presentations. We want to see continued improvement. I have spoken at length with Mr Cormack. He has spoken at length with Canberra Hospital, and similar discussions with Calvary around focusing on categories 3 and 4 and improving our benchmarks.

THE CHAIR: Can you, for a lay person—category 3 urgent, what types of conditions are being presented to you with category 3?

Ms Gallagher: There are better minds than mine to talk through what you might see in category 3. We might go to someone with some triage—

Mr Cormack: Professor Mark Bassett is the principal medical adviser, amongst many other portfolios, and is also a practising physician.

Prof Bassett: Category 3 patients are patients who would normally be seen within

30 minutes of presentation so they are patients who are less seriously ill than category 2, who normally would be seen within 10 minutes. So a category 3 patient might be a person with a chest infection or something like that.

THE CHAIR: Okay. So that would be one. What would be another in category 3?

Prof Bassett: A patient with abdominal pain without a clear diagnosis and requiring assessment and treatment for pain.

THE CHAIR: So these are people who are fairly ill? These are not people who you would expect to be able to go to a GP in those circumstances? They need to be in emergency?

Ms Gallagher: Yes.

Prof Bassett: Yes, that is correct.

THE CHAIR: Okay. Just getting back to you minister, then, what are the strategies, then? We have talked about more beds, and you have been doing that, but it seems like demand continues to increase and we are increasing how much we spend. What is the strategy to catch up between that gap between the growth in presentations and the ability to see them quickly?

Ms Gallagher: Yes.

Mr Cormack: If I could just respond to that, clearly the biggest impact, but not the only impact, is the provision of additional beds, and that is also dependent upon being able to staff up. Over the last four or five budgets there have been 230 beds funded across the territory, and we can grow those beds. It is not really funding that is the great limiting step; it is about having the nursing staff in particular to be able to open those beds. So we open as many as we can.

There is a second important point, though, and that is around looking at the processes of care that are provided throughout the hospital and within the emergency department. Certainly over the last couple of years we have done a lot of work on redesigning care processes, and an example of that is Fast Track, which is a zone of the emergency department that focuses on dealing with less urgent cases down in one pathway so that you can promote more of your resources into the more urgent categories. So that is an important redesign issue.

Two budgets ago we commissioned the MAPU, which is the Medical Assessment Planning Unit. The Medical Assessment Planning Unit was a specialised ward which focused on the needs of older patients and those with more complicated needs with a view to getting them out of the emergency department quickly and into a more appropriate ward environment. We have made some good improvements in terms of reducing access block for that group.

But there is also a range of other initiatives, and Mr Carey-Ide mentioned before the RADAR program. That is about prevention, and it is very important that while we focus on providing more capacity for hospitals, we focus on the processes of care that

are in place. We also need to look at preventing people from coming into hospital in the first place, and the RADAR program is an excellent program because it picks up on older people whose health may be declining to the point where they may require admission, so we get on top of them quickly and prevent their admission.

Similarly, a few budgets ago we enhanced after hours general practice through the CALMS initiative, and in the medium to longer term—and Mr O'Donoughue spoke about chronic disease management—a lot of our presentations to the emergency department are around people who have poorly managed chronic illness, which could be heart failure, chronic respiratory disease or diabetes. So those programs that we talked about, they have a longer lead time, but they serve to stem the tide of people who turn up to the emergency department because they have not got well managed underlying chronic diseases.

So it is a long haul, but I have to say this is a challenge right across Australia. Indeed, when we look at work that is done in other capital cities, we find that, certainly in a teaching hospital environment, waiting times for the emergency department are a constant challenge, particularly in teaching hospitals. It continues to be a work in progress, it continues to be a priority, but there is no quick solution to turning these problems around.

THE CHAIR: Thank you, Mr Cormack.

MR HANSON: I have a follow up question.

THE CHAIR: We are 12.30. Ms Burch, did you want to come to your question before lunch or do you want to come to it after?

MS BURCH: I am happy to come back to it after lunch.

THE CHAIR: Okay. Is yours a very quick one?

MR HANSON: Yes, just a follow up on it.

THE CHAIR: Then we will finish with that.

MR HANSON: On category 4 we are targeting what seems to be a worse outcome than last year. It is down by five percent. Is there any reason for that?

Mr Cormack: Where are you looking?

MR HANSON: I have got last year's budget that says—

Mr Cormack: Yes.

Ms Gallagher: Yes, that is right.

MR HANSON: the estimated outcome was 55 per cent and the estimated outcome for this year is 50 per cent. So is there a declining rate in that?

Mr Cormack: I do not think I can add much more, other than to talk about—

THE CHAIR: Is this page 201?

MR HANSON: This is 201, but I am going through last year's budget, page 158.

Mr Cormack: Yes. I do not think I can add much more to the answers that I have heard being given, other than that patient demand in category 4 has been increasing. It is just an element of a lot of issues that people have been explaining.

MR HANSON: Sure. With relation to category 5—and we discussed this at the annual report hearings—within that period there are a number of patients that actually just give up, and I am not sure if that is the right word, but—

Ms Gallagher: We call it the did-not-waits.

MR HANSON: Did-not-waits, yes. We said at the annual report hearings that it would be useful if that was incorporated into those figures, because to say that 73 per cent were seen within those times, if you do not actually count the ones that basically give up because they had had enough of waiting, does in my view skew those figures a lot. Have you considered incorporating those into those figures so that you can see the ones that were actually treated but also the ones that just gave up, essentially?

Mr Cormack: We use the Australian College of Emergency Medicine benchmarks so that we can compare apples with apples, and that is how we count our triage performance. But I think it is important just to come back to this issue of did-not-waits. It is of concern that people do not wait, but there is also the issue that we are providing people with information at that time as to other alternatives because we do try to inform people: you are in for a long wait, it is a very busy time in the emergency department and we suggest other options, and people take up those options.

One of those options could be to go around the corner and to see the general practitioner in the CALMS clinic. Another one might be to come back at another time if it not a critical condition—these are category 5s—or to have the matter followed up with general practice. In both of our emergency departments we have got more information available to people to provide them with those alternatives. Indeed, we have got a duty of care to provide people with alternatives if there is going to be a longer than anticipated waiting time.

MR HANSON: Thank you.

THE CHAIR: All right.

MRS DUNNE: Could I just follow up very quickly?

THE CHAIR: Well, yes, very quickly.

MRS DUNNE: Because it will be a question that will be taken on notice. Can you provide the committee, please, with information by categories of people who

presented at accident and emergency, how many and what proportion are admitted from each category?

Ms Gallagher: Are admitted?

MRS DUNNE: Yes.

Ms Gallagher: Yes. For how long?

MRS DUNNE: Who end up with a hospital admission.

Ms Gallagher: Over the last year, though? It is a big piece of work; that is all.

MRS DUNNE: Is that the sort of statistic that you collect?

Ms Gallagher: Yes.

MRS DUNNE: Okay.

Ms Gallagher: We collect it on a daily basis, so it is about making that manageable, you know.

MRS DUNNE: Okay. Well, make it manageable. I do not want to—

Ms Gallagher: It is anywhere from a third to 40 per cent.

Mr Cormack: In some categories, yes.

MRS DUNNE: But it varies? It varies from category to category.

Ms Gallagher: Across categories. Overall, yes.

THE CHAIR: Okay. Likewise, could we get the did-not-wait numbers? They are collected, are they, for the last year?

Mr Cormack: Yes.

Meeting adjourned from 12.32 to 2.02 pm.

THE CHAIR: Minister, this may have been touched on previously but not in any great detail. The $80 million in extra money which was agreed to at COAG in November, are you able to give us a bit of a breakdown of what that is being used for?

Ms Gallagher: The $80 million?

THE CHAIR: I think it is $80 million, yes. Is that figure incorrect?

Ms Gallagher: No. Well, I am not sure what money we are talking about. There was money that came through the SPPs which covered education, health and housing, I think.

THE CHAIR: How much was that?

Ms Gallagher: With my Treasury hat on, it was around $120 million over a five-year period across all of those groups, the majority of which went to health.

THE CHAIR: Okay. So $80 million would be a rough figure for health?

Ms Gallagher: I am not sure where you are getting the $80 million from. That is why I am a bit confused.

THE CHAIR: I am not sure either. It is in the briefing.

Ms Gallagher: More than $80 million of that component went to health.

THE CHAIR: So how much did go to health out of that COAG money, that SPP money?

Ms Gallagher: I will have to get you the exact figure. I think it was about $100 million or $120 million.

THE CHAIR: Can you give us a bit of a breakdown of what areas that has been targeted for?

Ms Gallagher: The normal way to deal with the SPPs is that they just go into consolidated revenue, because we appropriate for health through here. So the arrangements are that that money would go into the budget. Cabinet did make a decision to flow on the SPP money into the areas for which it was intended, but that is the first time we have ever done that. Ron will correct me if I am wrong, but it is in the forward estimates for health; it has been built into that money. There has been a slight revision back just in the commonwealth budget on that, because the indexation arrangements have changed because CPI is lower. So the amount flowing to us in health is about $5.3 million less than that, I think, and cabinet has not discussed how that will be resolved.

THE CHAIR: Whether you will make up for it, whether you will seek more funds?

Ms Gallagher: Exactly. We will just deal with that in next year's budget.

THE CHAIR: Okay.

Ms Gallagher: Yes.

THE CHAIR: Ms Le Couteur, do you have questions?

MS LE COUTEUR: Yes. Minister, you are building a new women's and children's area in the hospital, which is all very good. But what is happening with men's health? Men do not live as long as us and they probably have some extra needs.

Ms Gallagher: Yes. We have begun work on a men's health plan. I do not know if

Megan wants to talk about that. We have had some initial discussions with men's health groups, and that work is underway. It is actually running alongside the development of the women's health plan. The women's and children's hospital really is about collocating services for women and children—not necessarily all. Women will still be using other areas in the health system.

MS LE COUTEUR: I hope so.

Ms Gallagher: It is really around some gynaecological services, obstetrics, paediatrics and neonatology. Whilst I accept that men have specific health needs as well, they do not fit into that group. But it is not that we are not looking at how we provide our services to men and making sure that we are covering all the planning work that we need to do. Do you want to answer any more on the health plan?

Ms Cahill: In relation to the men's health plan, one of the first things we are doing is actually developing a profile. When we developed the women's health plan we developed a profile of women's health in the ACT to enable us to get a better understanding of what the health needs of women in the ACT were. So we are undertaking a similar process in relation to men's health. Once that profile is completed, which should be within the next couple of months, that will form a good basis for us then to go on and develop the plan. As the minister has indicated, we already have had some discussions with men's health stakeholder groups.

THE CHAIR: Mr Smyth?

MR SMYTH: I noticed in the *Canberra Times* this morning that there is an article about the Prime Minister being a bit outraged that Centacare staff and Defence staff have been getting assistance with meals from WeightWatchers. Should he be outraged that this is occurring in the ACT public service, in particular, the health department?

Ms Gallagher: I have not got across that article, I have to say.

Mr Cormack: I am certainly not aware of any special weight loss dietary programs, with food being offered to our staff, but I am happy to have a closer look at that. I am certainly not aware of it.

MR SMYTH: But on assistance to staff, the nicotine replacement therapy that has been offered to staff when we went to smoke-free hospitals—which I think is a great initiative—how many staff have taken that up?

Mr Cormack: I will have to take that on notice.

MR SMYTH: Do we have an allocation in the budget for it? Do we know its estimated cost?

Ms Gallagher: We have made an allocation for it. I remember seeing a figure. We will get that for you.

MR SMYTH: Right.

Ms Gallagher: That was certainly provided to me in a brief.

MR SMYTH: Good. What other assistance in that vein do we offer staff?

Mr Cormack: In terms of smoking cessation?

MR SMYTH: Things like smoking, any other sort of problems?

Mr Cormack: We have got—

Ms Gallagher: It is very individualised.

Mr Cormack: Yes. We have got an occupational medicine unit that provides a range of assistance such as vaccinations et cetera. We also have an employee assistance program, which is an outsourced arrangement to provide for counselling advice for staff and members of their families. So that is a program that we have had in place for a number of years. Indeed, most public sector agencies have a similar sort of program. In the budget we have $750,000 per annum to fund the development and implementation of workplace health promotion programs, including health assessments, risk modification programs and referral for people in need of further assistance.

MR SMYTH: Thank you.

THE CHAIR: I will go to Ms Bresnan and then Mr Hanson.

MS BRESNAN: Thank you, Mr Chair. Just on page 212 of BP4, there is a line item there, "Offset—base funding envelope". There are some quite big savings listed under that. Can you just explain what that actually is?

Ms Gallagher: Yes, that is our growth.

Mr Cormack: That is the growth formula.

Ms Gallagher: That is the money we have built into the forward estimates. It does not affect the budget bottom line. We have built that money into the budget, the growth in health costs. What we are doing when we are allocating those initiatives is that they are offset against those costs which are in the budget. Then the ones that appear after that are not funded through the growth, so they are in addition to that.

MS BRESNAN: That makes sense. So there is no decision about where it will go to or anything as such?

Ms Gallagher: Every year we allocate the growth funding, yes.

MS BRESNAN: Yes.

MS LE COUTEUR: So that is the opposite of the unallocated savings? This is the unallocated spend?

Ms Gallagher: That is right.

MS BRESNAN: There you go.

MRS DUNNE: They are sometimes known as hollow logs in some accounting treatments.

Ms Gallagher: This is not a hollow log. This is never a hollow log.

MR SMYTH: It is full at this stage?

Ms Gallagher: It is the growth.

MR SMYTH: It is full at this stage?

Ms Gallagher: Yes, it is full.

MR SMYTH: It was a good initiative of the previous government when it was started in the 2000-01 budget. The Labor Party then thought they were slush funds, but we will not go back on that history.

THE CHAIR: Mr Hanson, and then Ms Burch and Mrs Dunne.

MR HANSON: Turn to page 207, elective surgeries, output class 1.1, acute services, subparagraph c, the percentage of category 1 elective surgery patients who have received surgery within 30 days. Can we broadly discuss electives?

Ms Gallagher: Which page?

MR HANSON: It is page 207 in BP4, 1.1, acute services, subparagraph c, top of the page.

Ms Gallagher: Yes, the percentage of category 1.

MR HANSON: Yes, that is right. But if we could discuss elective surgery more broadly, could you tell us where we are at in terms of percentages across all categories? What does that actually mean in terms of numbers? How many people are on each list? Are you able to provide that information?

Ms Gallagher: The last time I saw the waiting list, it was about 4,700.

MR HANSON: That is which category?

Ms Gallagher: That is across the board. I think for that detail, we would have to take a brief.

MR SMYTH: You do not have a brief there, minister? A former health minister got into trouble for not telling the committee what the waiting list, for example, was in 2004.

Ms Gallagher: I am sure we have that data. I am sure we have the data available.

Mr Cormack: The number of people waiting for elective surgery at the end of March 2009 was 4,740. It was 4,958 some 12 months ago.

MR HANSON: Within the categories, I know that category 1 and category 3 is where we are putting the effort in, but how are we going with category 2? It has been the problem, has it not? Do you have a track on where we are at with that?

Mr Cormack: Just to correct you, we put our efforts into people who overstay the recommended waiting periods, so we consistently do well on category 1 because it is the highest clinical priority. We are typically in the 90s for that. But we have been putting an additional amount of effort into long waits, which can either be category 2 or category 3, patients who have overstayed the recommended waiting period. There has been a 25 per cent drop in the number of people waiting longer than one year for surgery over the last year. It was 851 in March 2008 and it is now down to 638 in March 2009. That would include, predominately category 3s, but there would be some category 2s in there as well.

MR HANSON: What is the specific number of category 2s? Do you have that there?

Mr Cormack: I do not have that in front of me.

Ms Gallagher: We can provide it.

MR HANSON: Well, I would like that, because I know that efforts have been made.

Mr Cormack: I can give you a median waiting time.

MR HANSON: It just seems to me that category 2s do seem to be the problem area.

Mr Cormack: We will make that information available.

MR HANSON: Thank you.

THE CHAIR: Ms Burch and then Mrs Dunne.

MS BURCH: It is mentioned in budget paper No 4 on page 216 and also in budget paper No 3 on page 78. It was diagnostic mammography or digital mammography. Can you tell us that there is a work in progress?

Ms Gallagher: They are two different programs.

Mr Cormack: Which one are you interested in?

MS BURCH: I am interested in both, work in progress, the digital mammography, and also in budget paper No 3, the diagnostic.

Ms Gallagher: The diagnostic.

MS BURCH: Yes.

Mr Thompson: On diagnostic mammography, prior to this initiative the ACT government provided breast screen services, but that was screening not for symptomatic women, and the only services available for symptomatic were in the private sector. What this service will do is provide a publicly funded diagnostic mammography service for diagnostic and symptomatic and at-risk women in the public sector.

MS BURCH: So this is a new service offered to younger women?

Mr Thompson: Yes, it is. Well it is not age specific; it is around their health profile. When I say symptomatic, it is where they show symptoms that may be consistent with breast cancer or they have had breast cancer previously and they have not reached the five-year clearance period and people who are at high risk, whether it is for family history or for other reasons, who do not fit into the eligibility criteria for the breast screen program.

MS BURCH: All right. And it will be provided in the locations where BreastScreen ACT—

Mr Thompson: No. This will be specifically at the Canberra Hospital. The reason why it has to be at the Canberra Hospital is that it is an integrated mammography plus breast MRI service, and we only have MRI machines within the Canberra Hospital. The benefit that MRI machines provide is that they have the capacity, particularly for younger women, to pick up cancers that are more difficult to detect in denser tissue through the mammography or x-ray machines.

MS BURCH: And is there a target on numbers?

Mr Thompson: Yes. We are expecting to see about 2,000 women per year in this. That is an estimate on what we know of in terms of the profile of the population. Whether or not it actually turns out that way, it is still only an estimate.

THE CHAIR: Thank you Ms Burch. Mrs Dunne?

MRS DUNNE: Thank you.

Ms Gallagher: Oh, the digital.

THE CHAIR: Sorry, Mr Smalley. My apologies.

Mr Smalley: In reference to the digital mammography program, it is a project to convert our analogue mammography service to digital mammography services, both inside the Canberra Digital Mammography Screening Service and the surrounding district that ACT BreastScreen services.

The project was scheduled was to be—at this stage it was supposed to have been at tender, but the tender has been delayed due to difficulties recruiting a project manager during the last 12 months, during the boom time. It is very difficult getting IT staff,

and when we did get one they then subsequently dropped out and we had to go through the recruitment process a second time. So that project is primarily delayed because of recruitment of the project manager. That is now on board and moving. We are hoping to get out to tender in the next two months. We are just doing the tender specifications now.

MS BURCH: And what enhancement or improvements will that—

Mr Smalley: Well, what we will doing is moving towards digital diagnostic, digital screening services, which will now enable us to effectively record the information digitally and have that information shared and also, as with any new digital technology, gives us the capability to scan and have that information shared and viewed outside the ACT. So it also supports remote viewing as well, and sharing.

Mr Cormack: So it is actually one of the building blocks of the whole e-health system—to digitise as much of your information as possible so that it is easy to share with the troops.

MS BURCH: You will not be walking around with those big x-ray sheets.

Mr Cormack: Exactly, yes, exactly.

THE CHAIR: Mrs Dunne?

MRS DUNNE: Thank you, Mr Chairman. Minister, over the last few months you and I and Ms Bresnan have had conversations about HACC payments.

Ms Gallagher: Yes.

MRS DUNNE: And you wrote to me in May giving me an update. First of all, can you assure me and assure the community that all of the outstanding HACC payments for this financial year have been made to all the organisations?

Ms Gallagher: As far as I am aware, they have.

MRS DUNNE: And when were they made?

Ms Gallagher: Can you answer that, Ross?

Mr O'Donoughue: I just need to double check that. The only circumstance where payments may not have been made is where the organisation in particular has not completed their side of the documentation. I am not aware of any—I cannot think of any examples of that having occurred. Essentially, all the funds for this year have been fully expended.

MRS DUNNE: Ms Bresnan and you and I had conversations about the delays that had been experienced by HACC agencies in receiving their payments over the past few years. What steps are in place to ensure that that will not happen in this next financial year?

Ms Gallagher: I think one of the biggest changes is that we have signed a three-year agreement now with the commonwealth, so it is not an annually negotiated arrangement, which should assist.

Mr O'Donoughue: That is correct. The HACC funds require approval by the commonwealth minister as well as the territory minister. In this last round of negotiations we have completed a triennial plan. It gives forward direction over that period. We also will be using an EOI process that we ran during this year which sets out priorities for funding for greater funds into the future. Through those two steps, we will be able to expedite and reduce delays over that three-year period.

MRS DUNNE: Could I come back to the EOI process in a minute? Minister, there were two years in a row where there were substantial delays, where HACC organisations did not receive part of the funding that they normally received in August-September until April-May. What were the causes of that?

Ms Gallagher: I think, as I explained to you at the time when we met over this, Mrs Dunne, that there were delays relating to the commonwealth government election and there were delays relating to our election. I am trying to think of whether there were other systemic issues in relation to the delays. I think we have now put in place processes where we will not see that happen again. I think I said to you at the time that I did not think it was acceptable that there were such substantial delays, but from my understanding it was the two election dates that seemed to be the contributing factor.

MRS DUNNE: What would have stopped the ACT paying their contribution of the indexation to HACC organisations rather than waiting for the commonwealth to come on board?

Mr O'Donoughue: Historically the level of indexation offered by the commonwealth government has been lower than that offered by the ACT.

MRS DUNNE: Yes.

Mr O'Donoughue: Through negotiations, the ACT has been able to get the commonwealth to agree to a higher level of indexation being passed on. While the delay from the federal election did delay the overall process, at the end of the day the outcome was satisfactory in the sense that we were able to achieve that higher level of indexation.

It would have been possible to pass on a partial payment of indexation sooner, and that is a mechanism that we could look at should that situation ever arise again. But also it would involve a little bit more paperwork and potentially a little bit more paperwork for the funded organisations as well. Some of the organisations indicated to us that they were happy to essentially plan for the future indexation and receive it in one lot rather than get it in two small parcels.

MRS DUNNE: That is not what I heard. The concern that was brought to me was that they were concerned that they were never going to see the money, especially in this current financial year.

Can I come back to the expression of interest process, because that is about the growth funding and what agencies might use the growth funding? It has been put to me, minister, that the expression of interest process that was used—there were agencies that did not put their hand up for that expression of interest process because that was for this financial year and they found out afterwards that the same process was going to be used for the next financial year and they had plans for next financial year to put in bids for growth funding. What is going to happen—or what accommodation can be made—to agencies who did not participate in this current expression of interest process because they were not looking for funding this year but were looking for funding next year?

Ms Gallagher: You are saying that because this EOI process was for two years, it was—

MRS DUNNE: It was not the understanding of HACC organisations that it was for two years. A number of them have put it to me that, had they known it was for two years, they would have put in, but they did not—they were expecting another process next year.

Ms Gallagher: We can have another process next year unless it is all tied into longer funding contracts. I just do not know the details of these funding arrangements with the individual organisations.

MRS DUNNE: Mr O'Donoughue, could you perhaps come back to us with some way forward to build in some flexibility for agencies who were not aware that the expression of interest process you ran was a two-year process?

Mr O'Donoughue: Certainly we can come back to you on that. I would need to seek advice about to what extent it is locked into the triennial plan. I do not believe that it actually is, but we can come back with advice on that.

MRS DUNNE: Okay; thank you.

MS BRESNAN: Just very quickly on the triennial plan, with that plan now will there be a set time when organisations will receive the indexation or will that still be a fluid process?

Mr O'Donoughue: We will still face the same level of negotiation potentially around the level of indexation because of the difference between the commonwealth offer and the territory offer, as I understand it, because indexation is calculated in each given year. But we have explored whether there can be an expedited way of offering a partial indexation by the ACT. We do believe that there are ways of doing that that do not involve onerous paperwork. So we think that, if that situation does arise, we can at least make a partial payment of the indexation.

MS BRESNAN: I thought the triennial plan was going to somewhat address that situation of having to renegotiate the percentage.

Mr O'Donoughue: I would need to take advice, but I believe that indexation is

calculated based on the economic circumstances in a given year—it cannot be set in advance. There is a formula within HACC that calculates indexation and then there is a commonwealth offer of indexation in a given year.

MS BRESNAN: Yes, I understand that. I just thought that the plan might then make the process a bit easier in terms of giving organisations a bit more of an idea of when they will receive that funding.

Mr O'Donoughue: In all other respects the plan will indeed expedite the payment of funds, but I just have a doubt about how that indexation matter will be dealt with.

MRS DUNNE: In that case, Mr O'Donoughue, can you explain what the triennial funding arrangement does and how it is different from what currently arises? I thought that the triennial arrangement would do away with the problem of having to negotiate every year on indexation.

Mr O'Donoughue: I would need to take on notice the matter of indexation; I must say that it is a matter of detail that I am not specifically across. The triennial plan in broader terms sets out the strategies and priorities for that entire period, and that expedites the process.

MRS DUNNE: Could you get back to the committee on the indexation?

Mr O'Donoughue: Certainly—the indexation matter.

MRS DUNNE: Thank you.

Ms Gallagher: It might be just like what we have seen. We have signed up to the healthcare agreement for four years, but the money is appropriated annually and we have just seen the indexation rate change and we have lost a bit of money through that. It might have the same arrangements, but we will come back to you.

THE CHAIR: Thank you. Minister, I just wanted to return to page 91 of BP4. We had some discussion yesterday in relation to the rate of unplanned returns to the operating theatre. We were talking about a comparison between Calvary and Canberra.

Ms Gallagher: Yes.

THE CHAIR: I just wanted to focus on Canberra for a moment. The target was less than 0.7 per cent, the estimated outcome 0.9. Could you take us through why that target was not reached—what are some of the factors—and also why the target has now increased to less than 0.85 for 2009-10?

Ms Gallagher: I am sure we can.

Mr Cormack: As I think I mentioned yesterday, the 0.85 target for 2009-10 is the aggregate rate for hospitals similar to the Canberra Hospital—that is, the tertiary hospital peer group. As you can see, it is quite different from the peer group that Calvary hospital belongs to. That is benchmarked with the Australian Council on Healthcare Standards for its most recent reporting period. Along the lines of the

earlier discussion, we do try to adopt nationally consistent benchmarks. I guess that explains why we have got a difference in targets between the two and why we have got a difference in targets between the two years, because it does go up and down.

THE CHAIR: So the national target changes every year, does it?

Mr Cormack: Not necessarily every year, but ACHS collects a lot of the clinical—this is clinical indicator data sets. Because hospitals move in and out of peer groups to a certain extent and the nature of the work they do changes, when they do their aggregated collection by peer groups you then get a different rate. That is why there is a variation between the target for 2008-09 and 2009-10.

THE CHAIR: Why was that not met in 2008-09 and why is it not expected to be met?

Mr Cormack: It is probably a lag issue. The previous target of 0.7 per cent was set from an earlier benchmark. You can see that nationally there has been a movement upwards. We would have used 0.7 per cent, being the pre-existing benchmark; we have now adopted a higher benchmark. So what you are seeing is that within that benchmark group the rate of unplanned return to operating theatres has gone up modestly right across the peer group. There could be—

THE CHAIR: Why has that happened? You are not sure?

Mr Cormack: There can be a range of reasons why that can happen. It can be just changes in procedures. It can be changes in complexities of patients that appear within the particular peer group. These things do not remain perfectly static; they do vary quite a bit. When we look at the average complexity of cases for the Canberra Hospital—and we will probably see that when the national figures are released in the next few weeks—we see that the average cost complexity of the Canberra Hospital is higher than average. So you will get a higher than average rate of unplanned returns to the operating theatre because they are in part related to the complexity of the case load of the hospital.

That is the principal reason. A difference of 0.9 per cent and 0.85 per cent is probably not something that we would be overly concerned about, but if we saw a trend where there was a very significant difference over time between our benchmark rate and the national benchmark rate, that is what we look at. These things need to be tracked over time rather than on a month to month basis.

THE CHAIR: Are there follow-ups on that?

MS BURCH: Yes, if I could.

MRS DUNNE: Yes.

THE CHAIR: Ms Burch and Mrs Dunne.

MS BURCH: I had a similar question on the rate of unplanned hospital readmissions and the variance in that.

Mr Cormack: I believe it is the same response.

MS BURCH: It is the same answer?

Mr Cormack: Yes.

MS BURCH: Thank you.

Mr Cormack: Sorry; do you want to add something?

Mr Thompson: The only thing I would like to add there is that in this instance the outcome of the Canberra Hospital is actually significantly lower than the target. Amongst other things, this represents the volatility associated with small numbers in the ACT in measuring these indicators. While we think we do have a good process of minimising readmissions, we have to be aware that year on year, because of the small numbers of readmissions that these indicators report on, we can get what appear to be quite large variations in rates. In this instance, it was actually lower. The return to the theatre was slightly higher. This is just one of the things that we have to live with because of our small numbers.

MRS DUNNE: In the case of readmissions and returns to theatre, what is the quantum we are talking about? What does 0.9 represent in a number of cases? Do you want to take it on notice?

Mr Cormack: It is per 1,000 occupied bed days.

Mr Thompson: We do not have the raw numbers in front of us; we can take that on notice.

MRS DUNNE: It is 0.9 per cent of every 1,000 occupied bed days, is it?

Mr Thompson: Yes.

MRS DUNNE: Is it possible to take on notice and come back to the committee with this data set cast back? Mr Cormack makes a valid point about whether the variation is consistent and that the variation being consistent over a period of time might be a problem. Can you back-cast this data set?

Mr Cormack: You can have a look at the previous budget papers.

MRS DUNNE: That will take me back one year.

Mr Cormack: We have been reporting this for a couple of years now. We also publish this on a quarterly basis in our public health performance report.

MRS DUNNE: Could you come back to us, then, with where we would find this information?

Mr Cormack: You will find it on the website and you will find it in the previous

budget papers, but I am happy to provide you with a copy of what is already there.

MRS DUNNE: Thank you.

THE CHAIR: Mr Smyth.

MR SMYTH: I want to go to page 201 of budget paper 4, strategic indicator 20, in regard to the cervical screening program. It is a new measure. Last year's measure gave a raw number, a target. It strikes me that strategic indicator 20 as written there is simply a statement of fact rather than an indicator.

Mr Cormack: I will ask Lisa McGlynn from Capital Region Cancer Service to talk about that. Would you just repeat that question?

MR SMYTH: It is strategic indicator 20. It simply gives the ACT rate. I note that last year's strategic indicator, which was also 20, had the 2007-08 target, the 2007-08 outcome and the 2008-09 target. This is more or less just a statement of fact from a report that was based on data in 2006-07. What do we learn from it in regard to your strategy for addressing cervical cancer?

Mr Cormack: I think what we learned from it was that we are doing better than the national average, so that is good.

MR SMYTH: All right. Where does it take us, though? All it is is a snapshot in time. There is no aspiration in it; there is no target in it. Ms Le Couteur and I have just been to the biennial conference of the Australasian Council of Public Accounts Committees in New Zealand. It was very exciting. Part of the discussion was about indicators and how having statements like this without any previous data or an aspiration were in fact useless because they simply give you a snapshot at a point of time. What is your target, minister, for addressing cervical cancer and what progression will we see over the next couple of years?

Ms McGlynn: I take your point; it is a statement. One of the things that were raised when reviewing this indicator was that there is no denominator. So it is just a statement of the numbers of people who come through. With that in mind, what we are proposing to do is look at that indicator as a percentage—changing it to be defined to reflect the percentage of women between 20 and 69 who have had a pap test in the last 24-month period, which is the two-year participation rate. That will address that issue.

MR SMYTH: When will that occur?

Ms McGlynn: That will occur in this next financial year, 2009-10.

MR SMYTH: So we will see that as a strategic indicator in next year's budget?

Ms McGlynn: Yes—in recognition of the point that you make.

MR SMYTH: You are saying that you had already planned to do that.

Ms McGlynn: Yes.

MR SMYTH: Otherwise this is just a snapshot. I notice the data is three years old. Do we not have more up-to-date data?

Mr Cormack: It is provided to us. We rely on the national data collection for that; that is where the lag time is. With a number of our indicators—like hospital statistics, et cetera—we tend to run behind the national data sets.

MR SMYTH: All right. Do we have access to previous data? Do we know if the 63.3 per cent is staggered? Is it getting better? Is it getting worse?

Ms McGlynn: I do not have that today, but we can take that on notice.

MR SMYTH: Could you?

Ms McGlynn: Yes, sure.

MR SMYTH: And a question for you, minister: would you like to set a target for the coming years? And perhaps Ms McGlynn might be able to detail how we are going to address the rate of cervical cancer in the ACT.

Ms Gallagher: Certainly we would like to. I would like to see a rate more than 63.3 per cent. We have had a couple of campaigns to try to raise awareness around the importance of cervical screening. I would need to take some further advice. I have not actually considered the issue of a target for cervical screening. I know that all the work we have been doing is about trying to raise awareness and get more people to take part in the screening test. But I think it is a worthy point; we have targets in other areas of screening.

MR SMYTH: I appreciate that you have taken it on notice, but is there a trend? Do you have a broad view of what the trend is?

Ms McGlynn: I can take that on notice too.

MR SMYTH: You do not know at the moment?

Ms McGlynn: I do not know that today, no.

Ms Gallagher: I think some of the concern that goes to the point is around some of the younger population not seeing the need to go through cervical screening, particularly with the immunisation program that has been running. I think it is worthy of a further look.

MR SMYTH: Particularly with the immunisation that has occurred. That may take some time to come into—

Ms Gallagher: So they still need to go and get screened.

MR SMYTH: They still need to get screened, yes.

Ms Gallagher: I genuinely think that young women might think that they have been given–

MR SMYTH: Just like measles.

Ms Gallagher: Yes: they do not need to worry about it any more.

MR SMYTH: So we need to look forward to next year to see an establishment of this.

Ms Gallagher: It is a good point and we will do some further work on it.

THE CHAIR: Thank you, Mr Smyth. Ms Le Couteur.

MS LE COUTEUR: Thank you. The ACT health promotion grant program is a little program.

Ms Gallagher: Yes; $2.1 million.

MS LE COUTEUR: Which year was 2.1?

Ms Gallagher: Every year.

MS LE COUTEUR: It is every fiscal year? It is not indexed at all?

Ms Gallagher: No. It is just over $2 million—certainly from my experience—but I could be corrected.

MS LE COUTEUR: And what do we spend it on?

Ms Gallagher: There are different subjects within that program. I think there are five different grant rounds for organisations to apply for. Some are targeted at schools, some are targeted at falls prevention. I cannot do a Megan Cahill and list them off the top of my head. There are a number of subsets to that program. They all on our grants website and they go out every year. Ross, you can list them all off, I am sure.

Mr O'Donoughue: Wearing a former hat, I used to be responsible for the operation and grants program so it is still reasonably fresh in my mind. All the successful grant recipients are listed on the website. The website information is generally available through the government grants portal. There are five grants funding rounds in each year. It is currently going through a process of strategic review. It last went through a process of strategic review a year or so ago.

There is the health promotion sponsorship round, there is the community funding round, which is the largest, there is a falls prevention funding round, a health promoting schools funding round and a capacity building funding round, which is a rather small one. In 2008-09 a total of 95 projects and sponsorships were funded across the five funding rounds, providing a total of $2.167 million to go out to the community. I would also bring to your attention that it is a peer review process. Expert peers from the community and the health promotional profession assess the

applications for funding and make recommendations to the delegate for approval.

MS LE COUTEUR: And what are the aims of the health promotion fund? I am guessing you have different aims for the five rounds.

Mr O'Donoughue: There are two broad aims—to promote and facilitate healthy lifestyles, policies and environments and to build the capacity of individuals, groups and communities to make healthy choices. Broadly speaking, these aims were inherited from the health promotion authority, the former Healthpact, which administered the earlier iteration of this grants program, and those strategic directions have been brought forward.

The strategic review that was undertaken a year or so ago put a particular focus on nutrition and physical activity, given the importance of chronic diseases and particularly rates of obesity among children. There are affirmative action areas for the advanced program that include mental health, Aboriginal and Torres Strait Islander peoples and isolated communities.

MS LE COUTEUR: Do you have anti-smoking? Does that come into here or is that somewhere else?

Mr O'Donoughue: It is in here too. One of the branded sponsorships available is the SmokeFree branding which is owned nationally by the Cancer Council but which is licensed to the ACT. Organisations can choose to become a smoke-free sponsor. They carry that logo and they undertake to encourage smoke-free events and to have SmokeFree participants for their events. It could be the Canberra Raiders or Triathlon ACT or other organisations which choose to adopt one of our brands, be it SmokeFree, Go for 2 and 5 or Find thirty. They are all brands that they can choose to be aligned with.

THE CHAIR: Just on that—and I do not know if this is a question for the Chief Health Officer—and on the smoking issue in particular, strategic indicator 18 is probably one of the more impressive indicators in the very large drop in youth smoking between 2002 and 2005. Given that we are now in 2009, how is that tracking and what was seen as the major factors responsible for that fairly significant drop?

Ms Gallagher: This data was done through the secondary schools health survey, so it should have just been done or is about to be done again.

THE CHAIR: So 2008 would be just about ready, would it?

Ms Gallagher: It should be. I think it was done late last year.

Dr Guest: So reasons for?

THE CHAIR: Reasons for the large drop and whether or not we have any indication as to whether the trend has continued since 2005.

Dr Guest: The reasons for the large drop are to do, I think in part, with the wide range of measures that have been taken in the ACT. There has been regulation, legislation

and social marketing campaigns and those have all contributed. It would not be possible to attribute a proportion of the drop to each of those activities, but they all certainly contribute.

THE CHAIR: I have not seen the latest in terms of adult smoking, but I imagine that drop would be larger than is evident in the adult population.

Dr Guest: That is true. It is this age group that has been targeted by a number of initiatives, including banning at point of sale, advertising and enforcement of bans of cigarette sales to minors and so on.

Ms Gallagher: And banning the cigarettes that were particularly targeted to young people—fruit flavoured, iPod-style.

Dr Guest: That is right.

THE CHAIR: Do we have a gender split on any of these figures? Is it still the case that more young women take up smoking?

Dr Guest: Yes, we do. I will just see if I can put my finger on it in the Chief Health Officer's report, which you will have. Certainly, a concern in recent years has been smoking in young women, but it used to be pretty popular in both males and females. I think it is best if I take that on notice, but we do have that information, yes.

THE CHAIR: And just the final part of that question which I asked earlier: when are the more up to date figures going to be available? Where are we up to with that?

Dr Guest: I will take that on notice as well.

Ms Gallagher: I am pretty sure we are doing or have done the secondary school smoking survey which was probably done late last year.

Dr Guest: So the data on that would come out—I will not guess.

Ms Gallagher: Soon.

THE CHAIR: Soonish.

MR SMYTH: My favourite word.

Dr Guest: We will take that on notice.

MR SMYTH: From my discussions with the Cancer Council on the strategies, what would most hinder people in taking up smoking or continuing to smoke is price. They have said to me that the best way to get people to stop smoking is by increasing the price so that people understand it is going to keep going up and it is going to be harder and harder to pay for it. Do you have an opinion on that?

Dr Guest: Certainly price is an effective lever over cessation or non-initiation from lots of activities. Whether it is the most effective I think is harder to say. The trial that

would need to be done to prove that point is actually not possible, but it is thought to be a very effective approach, yes.

MR SMYTH: Minister, will you be taking up with other health ministers at COAG the whole issue of price of cigarettes and using the lever that it is effective as described by the Chief Health Officer?

Ms Gallagher: I had not specifically considered taking it up myself. Health ministers do from time to time talk about tobacco control measures and price forms discussion as part of that. I am pretty keen on pursuing—and I think the ACT has a history across governments of all types—a pretty strong agenda around tobacco control, so I am certainly happy to raise it with my colleagues.

THE CHAIR: Thank you. I will go to Ms Bresnan and then Mr Hanson.

MR SMYTH: I have a new one.

THE CHAIR: I will move down the line.

MS BRESNAN: My question relates to page 189 of BP4. I think this was brought up earlier about one of the points here—the priorities about expanding services for residents living with chronic illness. I know it came up early this morning. Has the ACT government done some work around the rates of growth and the main areas of growth or the illnesses that are contributing to the rate of chronic illness growing? I know there would be national figures, but I am wondering what work the ACT government has done on that.

Ms Gallagher: I do not know what—

MRS DUNNE: Sorry, where are we at the moment?

MS BRESNAN: Page 189 of BP4. It relates to one of the priority areas, expanding services to a rapidly growing number of ACT residents living with chronic illness. I was just working out what information we have about the rates of growth in the ACT and the areas where there is growth.

Dr Guest: Chronic disease is a correlate of ageing and the diseases that we are talking about are circulatory disease, cancer, degenerative disease, particularly in the nervous system, dementia and a wide range of other conditions that I would refer you to the Chief Health Officer's report on. As the population ages, we will see increasing levels of all of these conditions and, as treatment effectiveness grows, we will also see a greater prevalence of any of them.

MS BRESNAN: Do these often relate to the burden of disease as well—the areas of chronic illness?

Dr Guest: Yes. The burden of disease is the load that is carried by the community once people start to become sick. If we have effective treatment which contains morbidity and enables people to live a reasonably healthy life while they have these diagnoses, the burden of disease is not so great. But some conditions, chronically

disabling conditions, do have a high burden of disease.

MS BRESNAN: Obviously it would be in your report, but do we have an idea of what those areas are? I know you have just mentioned degenerative disease, where the burden of disease rests and some of those areas.

Dr Guest: We certainly do. That has been an area of intensive study in the ACT and worldwide. On burden of disease, one area that I should have mentioned is mental health. That has become a very well recognised priority now with depression and other illnesses in later life. There is a high burden of disease. Quantifying the burden of disease, that is done. A typical metric for that is the disability adjusted life—the daily—that you have perhaps heard of.

MS BRESNAN: Yes.

Dr Guest: There are tables of those that we could refer you to.

MS BRESNAN: I am aware of those.

Dr Guest: A whole unit has been set up at the University of Queensland to document the burden of disease for all conditions in Australia. The World Health Organisation does it as well, by country.

MS BRESNAN: Does the ACT pretty much relate to what is happening nationally? Are our figures fairly similar to the national levels of burden of disease and chronic illness?

Dr Guest: Yes. When you correct for socioeconomic status, we are like the rest of Australia. As I have pointed out before, we have a number of indices that are favourable in the ACT because of our relatively advantaged status in some areas and so it goes with burden of disease. Burden of disease is also a reflection of adequacy of treatment. So in areas where, for example, there is a great shortage of some service or another you may see a higher burden, but that is not the case here in the ACT.

MS BRESNAN: And do these figures guide the ACT somewhat to where funding goes and where there are areas of need?

Dr Guest: It is certainly a consideration, yes.

MS BRESNAN: So that is used as a consideration?

Dr Guest: Definitely. Burden of disease is not the only thing though.

MS BRESNAN: No.

Dr Guest: It is also amenability to intervention.

MS BRESNAN: That is why I referred to chronic. Thank you.

THE CHAIR: Before I move to Mr Hanson, just to follow up on an earlier question,

Ms Gallagher, in terms of the $80 million from COAG that was reported on 1 December, I will table the ABC report.

Ms Gallagher: I think there was a little uncertainty when the money came out, the final numbers, because the equalisation goes through another process, the Grants Commission. So what was actually decided on that day then goes through another process.

THE CHAIR: So did the 80 million end up less or more?

Ms Gallagher: In Health, as I understand it, we ended up with about 101, around that—but we will check that figure—of which we have lost about 5.3, and that is through the indexation.

THE CHAIR: Okay. Mr Hanson.

MR HANSON: Thank you. The issue of access block is referred to in the budget papers as strategic indicator 1 and 15 and that is at pages 191 and 198. Strategic indicator 1 talks about the whole figure for our hospitals and has a rate of 27 per cent, but strategic indicator 15 talks about those people who are over 75.

Ms Gallagher: The elderly, yes.

MR HANSON: Yes. There seems to be quite a big difference on this.

Ms Gallagher: Yes.

MR HANSON: The figures are not good anyway—27 per cent in its entirety, but 38 per cent for people over 75. I was quite surprised that we would have such a high figure for the elderly. Why the difference?

Ms Gallagher: It is primarily the complexity of the over 75-year-olds.

Dr Guest: That is right.

Ms Gallagher: These numbers are heading the right way. They are not where we want them to be.

MR HANSON: They have been static now—I think the elderly one was 38 per cent last year as well. The general figure has now declined by one per cent.

Ms Gallagher: And it does fluctuate within the calendar year as well. I have seen it better than 38, but overall—

MR HANSON: For the last two years that has been static, but I do not have the budget papers from before that.

Mr Cormack: Just on the older persons access block, it was 47 per cent in 2005-06, 40 per cent in 2006-07 and 37 per cent last year and it is about 38 per cent for this year. So it has come down.

MR HANSON: Sorry, is that 37 last year, 38 this year?

Mr Cormack: Yes.

Ms Gallagher: Yes. It has come down from 47.

Mr Cormack: It has come down from 47. Let us just run through it again. It was 47 per cent in 2005-06, 40 per cent in 2006-07, 37 per cent in 2007-08, and the estimated outcome for 2008-09 is 38 per cent. It has not changed over this year compared to last year. There are a number of reasons for that. One is a 14 per cent increase in admissions to hospital by the ED for people aged 75 years or more in the first eight months of this year. Clearly, that is a very big increase. Our growth formula normally works on a three to four per cent increase, so we have had a 14 per cent increase in that. So in that sense, to not go backwards is not a bad outcome.

The minister has explained why we have a different rate for the general and the older persons. It is simply because the older persons tend to be more complicated. One of the initiatives that we put in place that actually assisted us to bring it down from 47 per cent back in 2005-06 was the Medical Assessment and Planning Unit, the MAPU, which has made a very significant improvement. In addition, some of the initiatives we are doing in the community setting have made a significant difference.

In relation to general access block, we have seen a similar pattern of improvement where four years ago it was 41 per cent and it is now down to 27 per cent. We have a target of 25 per cent. We will certainly be working to bring that down. Again, there are a number of keys to sorting that out but the principal key is the provision of additional beds and the funding of additional beds. Certainly over the last four or five budgets some 230 additional beds have been added to the system, 196 of those through specific budget initiatives. So there has been quite a significant effort and a lot of resources going into access block. We have certainly made some improvements. I would also point out that a figure of 25 or 27 per cent is not at all unusual for teaching hospitals, but we want to get it down even lower than that.

MR HANSON: The figure of 38 per cent—you said that it is a good effort to stay static considering the increase in demand.

Mr Cormack: Yes.

MR HANSON: I would imagine with our ageing population that we are going to see that extrapolate now. Would you then anticipate a good result is to stay at 38 per cent?

Mr Cormack: No.

MR HANSON: I know you have got the targets in there.

Mr Cormack: No. It would not be a good result to just stay flat. Clearly, older people have very specific needs in the hospital environment. We are very concerned to ensure that they get timely access to beds. I would not be happy if we were not able to improve on that over time.

MR HANSON: Obviously it is going to be challenging. The Western Australian hospital system, I believe, has brought in a recent initiative about treatment within four hours.

Mr Cormack: Yes.

MR HANSON: Basically, you are either discharged or put into a ward within eight hours. Have you had a look at that initiative to see how it is tracking?

Ms Gallagher: Yes. They have modelled theirs on the NHS. Mark can probably speak more on this, because he has actually visited hospitals and had a look at how that works. I think the merit in it is that everybody is focused on access block, from what I understand from discussions I have had, and indeed from the WA minister himself, who is a GP. As soon as he was elected I think he went and did a trip and had a look at all this. From what I can pick up, the benefit of it is that everybody in the hospital knows that there is this target that their performance is judged by and it keeps everybody very focused. I do not know if you want to add to it.

Mr Cormack: No, I think you covered it well.

MR HANSON: Do you anticipate doing something similar here?

Ms Gallagher: Our time limit is eight hours. That is the time that everybody is focused on in the hospital. So we have set ourselves a time limit. It is not as quick as WA. I think the NHS is the same as WA, is it—four hours?

Mr Cormack: That is right: four hours, yes.

Ms Gallagher: From my discussions with emergency department staff and indeed the rest of the hospital—because in order to do it the rest of the hospital have to work with the emergency department to move people out—I think everybody is focused on it. I do not know if Bill wants to come and talk a bit more about access block at the hospital—your favourite subject. At this point in time, with the indicators going the way they are—they do fluctuate a little bit but they are coming down overall—I would prefer to reach the targets we have set before we change the rules about what we have asked people to deliver on, which is to reach our 25 per cent target on access block.

MR HANSON: If you see that that is having success in WA, though, will you keep an open mind and—

Ms Gallagher: We will certainly watch what happens in WA. Do you want to expand on what is happening, because it does have some other impacts?

Mr Cormack: Yes. It is a policy position that they have taken and I think it also reflects that in many ways WA were a bit slow off the mark in terms of getting on board with what has been a national and international effort to reduce access block. I think they have kind of taken up the cudgel with great vigour. It is early days and, as certainly the committee points out year after year, while the targets are important, it is

actually what you achieve that is the most important and I think that it sends a strong message. In places like the NHS, you have got a very different system. You have got a very different way of organising care and you also have a lot more hospitals where you can move people around and sub-specialise certain sorts of services.

In the ACT we have two hospitals, and juggling the demand between the two hospitals at any one time is challenging. In metropolitan Sydney, even though it is a much bigger population, you have a much larger number of departments so you get the ability to redistribute workload across Sydney. Indeed, in Sydney they have a very complex ambulance transportation system, which redirects people according to varying demands at varying different hospitals and you get a similar thing in Perth where you have got more hospitals. We will watch with interest. We are always trying new things in access block and I am sure that Bill Stone will be able to elaborate on that.

Mr Stone: I begin by reiterating what has already been said. The two issues really are around capacity. Mark specifically talked about increasing capacity across the system, because the reality is that obviously if you have an increasing number of patients presenting to your ED—that is where they come from; the vast bulk of our admissions come through ED; that is our main front door, if you like—in order to clear the ED within that time frame we have got to have the larger capacity, and that is what we have been working on very much over the last four years particularly.

The other one is very much the internal focus on identifying. We run a process where we provide time limits, if you like, or time goals, for the emergency department to review patients, to make the decision to admit, for the in-patient team to review the patient and then transfer the patient to the ward. So there is an enormous focus on it. It is something we would like, obviously, to improve. I think four hours would certainly be an adventurous target at the moment, until such time as we increase our capacity to a point where we could do that.

MR HANSON: Thanks for that.

MR SMYTH: On that, though, one of the issues is: how long are beds empty between the discharge of one patient and the placement of a new patient in the bed? What is the turnaround time for a bed?

Mr Stone: The time from a patient being discharged to the bed being clean, terminally clean—which is probably an unfortunate term to use in a hospital—varies somewhere between about 25 minutes and about 45 minutes, thereabouts.

MR SMYTH: All right, so from one patient leaving to a new patient taking that bed?

Mr Stone: From a patient leaving to the bed being ready for the next patient to be admitted, turnaround time can be as low as that. We have actually done a measure quite recently and the lowest I think was about 22 or 23 minutes; the longest I think was about 50-odd.

MR SMYTH: And is there a national standard for that?

Mr Stone: I do not think so, not that I am aware of. I do not know that too many people time things to that degree.

MR SMYTH: If you are doing it that well, that is a very quick turnaround. Caroline and I heard at a conference that in some hospitals it is four to eight hours.

Mr Stone: No. We turn them around very quickly. We make them ready very quickly. We have an electronic patient management system, as do all hospitals, so the beds are immediately declared. That is a transparent system and so the availability of that bed is immediately apparent to the people in bed allocation and to the emergency department, so they are re-allocated very quickly.

THE CHAIR: Thank you. I will go to Ms Burch and then Mrs Dunne.

MR SMYTH: Before we get off the indicator that Mr Hanson has asked about, I notice that—

THE CHAIR: Okay, quick.

MR SMYTH: in the 2008-09 budget the target for 2008-09 was in fact 25 per cent. It would be good for comparative purposes not to have to dig out—perhaps this is for the minister and the Chief Minister's directions—a series of budget papers. If you look at that 27, 25, 20, it looks like a downward progression, and I note that it was 28 and it has come down to 27 this year, but the target was 28 down to 25 this year, so in fact in this indicator you have missed the target of last year. Can I make a suggestion that—

Ms Gallagher: So you want to see the target from 2008-09—

MR SMYTH: Yes. As well as the estimate outcome, so then—

Ms Gallagher: then the outcome, then the target for the next—

MRS DUNNE: A little bit of progression so that you can actually—

Ms Gallagher: So you would see four graphs there instead of three.

MR SMYTH: Yes, you would see four columns instead of three.

THE CHAIR: It is certainly done in some other areas of the budget, I think; it varies from area to area.

MR SMYTH: Just in terms of a practical sense of getting what we were trying to achieve, where we got to and where we are going.

Ms Gallagher: Yes, I understand what you are saying.

MR SMYTH: Looking at that, the trend is down, which is a good thing. But we have actually missed the target this year, and is there an explanation as to why we missed the target?

Ms Gallagher: We have never made the target.

MR SMYTH: Is there an explanation as to why we never made the target?

MRS DUNNE: They are an aspiration.

Ms Gallagher: It is not aspirational; we will get there. I guess we have set the target as where we want to be and we are working every year to get there. I am very hopeful that it will not be too long until we do. It just goes to all the reasons people have outlined around improving our processes within the hospital, creating capacity within the hospital and keeping people out of the hospital who do not need to be there.

MS BURCH: On page 196, indicator 11 on diabetes, the data seems to be quite old, so I am just wondering if there is any updated data. Again, it is probably a similar question to before about how we are going with diabetes diagnosis—

Dr Guest: Worldwide there is a pandemic of diabetes—that is for certain—if not of other things. Here in the ACT we are tracking along with diabetes at about the Australian pattern but somewhat less, for the reasons that I have suggested before, which is the relative advantage here. The figures in the Chief Health Officer's report are not more recent, so—

MS BURCH: Do you rely on national health surveys data? Is there any local population health—

Dr Guest: Yes, we do

MS BURCH: So there is no local population health data to get a sense of diagnosis of a problem—

Dr Guest: No. We rely on national health surveys. The point about diabetes prevalence is that, while some people have type 1 diabetes, which is much better documented and known about, a lot of people have type 2 diabetes and are on treatment, for example, only from their general practitioner and the health department does not hold any central data set on that. So, yes, we are dependent on national data sets.

MS BURCH: Any idea when that data will be updated? I think it is 2004-05.

Dr Guest: Yes, it will be soon but I would have to come back to you on that.

MR SMYTH: I have a supplementary to that, and it is perhaps for the minister. Minister, indicators 10, 11 and 12 in the 2009-10 budget paper at a quick glance are word for word exactly the same as indicators 10, 11 and 12 from the 2008-09 budget, and again it goes to the usefulness of them as a strategic indicator. If they are not changing year from year, if they are a statement of fact in time, they are not an indicator, there is nowhere we have been, there is nowhere we are going. Yes, it does compare us with the national average. I appreciate that some of these surveys are long term and you cannot get updates. But the strategic indicator for prevalence of diabetes

in the 2008-09 budget was ACT 3.2, Australia 3.6; it is the same in this year's.

Is there any way that—this might be a recommendation from the committee—they could be more useful? Statements of fact are lovely, but in terms of trying to judge where we have been and where we are going they are perhaps useless.

MRS DUNNE: Also we are relying on three-year-old data which we have repeated for the last two years—

Ms Gallagher: It is hard in health, though, because a number of the national data sets do have three-year delays.

MR SMYTH: Yes, I appreciate that, but I reckon if I went back to the 2007-08 budget paper it would probably be almost the same for the three of those. Mr Cormack just said that it is not a good result to just stay flat and—

Mr Cormack: Unless staying flat is where you want to be, as in the case of newborn screening at 100 per cent.

MR SMYTH: That raises the question on strategic indicator 12. The 2007-08 outcome was 5.4, the 2008-09 is 5.4, the 2009-10 is 5.4, the long term is 5.4. Is it impossible to improve on that?

Mr Cormack: That is a target that we have set and we believe it is a good target.

MR SMYTH: Yes, but we have achieved that target; where to from here?

Mr Cormack: To keep it at that.

MR SMYTH: To keep it, so it cannot get any better than that?

Mr Cormack: Each year we have a look at these targets. We make revisions to stretch our system a bit further where possible, but there are also some data items where we are exactly where we should be but it is important that we stay there. For example, this is a very important one. If we were to start slipping in performance in terms of fractured neck of femur, the impact on people and on our system is quite major. I do take your point, though.

MR SMYTH: I agree with you. If 5.4 deteriorated to 5.7 or six, that would be dreadful. But can we not at least aim to get better than 5.4 and what would be the factors that stop it being less than 5.4 per thousand?

Mr Cormack: Some of them are just epidemiological. There are some things that you just cannot prevent totally.

MR SMYTH: Sure, I agree with you.

Mr Cormack: You can put in place a whole series of interventions but there is a reasonableness of target that you can get to. We will not be able to stop people over 75 fracturing the neck of femur. But, if we can keep it down to kind of the best in the

country and keep in place the interventions that we have—and we do have interventions in place to keep it there—that is a good thing. But I do agree with your general comment, and the staticness of some of the data and the staticness of some of the targets are things we can take on board.

MR SMYTH: You said it is good to be best in the country; what is the national average, do we know?

Mr Cormack: I do not actually have that on me. Sorry.

MR SMYTH: Could that be taken on board?

Dr Guest: The national average for which condition?

MR SMYTH: For femur fractures.

Dr Guest: Fractured neck of femur. The other thing to say is that diabetes and circulatory disease are chronic conditions and there is not going to be much year-to-year difference. We are presenting the most recent data.

MR SMYTH: Okay. If there is not going to be much year-to-year difference, what is its value as a strategic indicator? What does it tell us about what we are pursuing? It might tell us where we are and where we have been, but it does not tell us where we are going. Therefore its strategic value, I would put to you, is nil. As a maintenance value or as a record or recording value, it is very useful, but as a strategic value all it says is that you are in a holding pattern; that your strategy is a holding pattern. Perhaps you should change the indicator.

Mr Cormack: If your holding pattern is holding around excellence, as it is in the case of newborn screening, as it is around immunisation, as it is around—

MR SMYTH: Is it in circulatory diabetes and femurs?

Mr Cormack: a number of indicators, that is good.

MR SMYTH: And I agree.

Mr Cormack: I think we need to do that. I do not think we just need to present budget papers that show all the things that we are struggling with; we have also got to show things that are important from a health outcome point of view, and these are very important indicators. If we are achieving them, I think that is good.

MR SMYTH: I do not disagree but in terms of a strategic—

Dr Guest: It is important to have on record the condition that causes the most mortality and a very high proportion of morbidity, and that is what circulatory disease is. Diabetes is an important risk factor for that.

MR SMYTH: I agree. But then I can make the counter case: if it is that important, why are we dealing with data that is four years old, five years old?

Ms Gallagher: We look forward to the committee's recommendation and we will take it on board.

MRS DUNNE: I would like to talk about dental health. One of the strategic indicators is one of the excellent ones that Mr Cormack spoke about which is 100 per cent of emergency dental within 24 hours. But there are issues of the waiting list as well and I notice that we are better than targeted in the waiting list. In output class 1.3 on page 208, the target for mean waiting time on the waiting list was 12 months and you have got that down to nine, and that has been like that for a while. Again, what is the quantum of people on the waiting list—this may be for a question on notice—and what is the age spread of people on the waiting list? This is adults, I presume?

Ms Reading: The waiting list that is outlined in the budget papers is for adults, so they are people from 18 years of age to 75 and older. The mean waiting time of nine months is for routine restorative care, and the target of 12 months and the fact that we are doing very nicely now at nine months also allows us to have a balance in provision of services to really high-risk groups.

We have an excellent emergency service. People are seen within 24 hours if they have an emergency dental need and within two weeks if they have a high need. But we must remember that the people on the special needs program do not have a waiting time. They are clients that have severe disabilities or chronic illness or alcohol and drug issues or mental health issues.

You also need to know that the people on the routine restorative list are also clients that are dentally fit. When they come into the program to have their dental treatment, they have a full course of care which allows them to be able to maintain their dental health until they are recalled again. We have a mix of those people. The minimum standard for having a routine dental appointment nationally is three years, so we are doing very well.

MRS DUNNE: Ms Reading, what is routine restorative care?

Ms Reading: Routine is for your general assessment, your routine fillings and those services that can be provided by a general dentist. We also have visiting dental officers in our program. We also have the specialist facio-maxillary registrars from the hospital that provide us with general anaesthetic services as well. So we have the capacity to refer to the higher needs services, if required.

MRS DUNNE: And what are the eligibility requirements for public health adult screening?

Ms Reading: A current Centrelink card eligibility—the primary holder of that card.

MRS DUNNE: What happens for children of people who are on Centrelink benefits?

Ms Reading: They are free services.

MRS DUNNE: They get free services?

Ms Reading: The beneficiaries, yes, they get a free service from nought to—

MRS DUNNE: Through this program?

Ms Reading: They are not on this waiting list. There is no wait lists for child and youth services. We have an excellent program for families who have children from nought to 14, with very low membership rates. They can come in and their treatment and assessment is done and they are recalled according to what their oral risk assessment is. So that again gives our program the opportunity to better target high-risk kids.

MRS DUNNE: Ms Reading, you used the term "low membership rates". What does that mean?

Ms Reading: Low membership rates. I beg your pardon. Low fees for membership rates, sorry.

MRS DUNNE: Low fees, okay.

Ms Reading: So it is very affordable for families and it is capped. I just need to check what the current fees are, but it was about $200 for a family of five, and that gave them the whole gamut of routine restorative treatment.

MRS DUNNE: What are the eligibility requirements for those processes?

Ms Reading: All families with children up to the age of 14 in the territory have access to that service.

MRS DUNNE: Do they?

Ms Gallagher: It is very generous, yes, and it is a very good service.

MRS DUNNE: But do people know about it?

Ms Reading: Yes, they do. There is actually a very low take-up in private practice for children and youth. That is why we have dental therapists providing that service. We also have—

MRS DUNNE: Does the school dentist still operate?

Ms Reading: No, but we have screening services in schools where the dental therapists go in and screen the children. In fact, it is better for children to come to clinics because you have the clinic conditions to do assessment, but we do do screening in the schools.

Ms Gallagher: There are special children's clinic rooms. They are friendly and have giant toothbrushes and teeth. So you do not get frightened, apart from the giant teeth.

THE CHAIR: I just wanted to follow up on dental health, particularly with the young

people. It is strategic indicator 8. I can confirm I have had a recent experience with dental care for children, and it was a fairly prompt appointment that my son was able to get. The mean number of teeth with dental decay, missing or filling teeth at ages six and 12, we beat the national average at six years, but we are a reasonable way behind at 12 years. What are some of the factors influencing that?

Ms Reading: The last survey was undertaken in 2002. They are about to undertake another survey this year, but nationally there is the same problem because our 12-year-olds are starting to get into the group where they are not around mum and dad so much to be able to monitor the school tuck shop money. There is also a prevalence of bottled water. It is the thing to do in families now, and if the children are not given that constant supply of fluoridated water, that really does have an effect.

We are hoping that with the next survey our result does improve because we do have, as I said, a lot of preventative measures in place these days for sealants with treatment and assessment. But from a national perspective it is the same issue about high calorie, sugary drinks—just children moving into that element where there is a bit of independence and they have some flexibility about sneaking lollies and not brushing their teeth.

THE CHAIR: Is there a reason, though, why we are a fair amount behind the national average? That is happening nationally, that kids are in that position, but why are we almost 25 per cent behind?

Ms Reading: Yes. If you do not mind, I would not mind getting some advice from the chief dental officer on that, but my advice today to you is that it is a bit of an issue nationally, for the factors that I have already outlined.

THE CHAIR: Yes. Ms Bresnan had some questions.

MS BRESNAN: Thank you, Mr Chair. My question relates to budget paper No 3, page 79. I know we did talk the other day about the preventative health program and the centre for adolescent health. I just wanted to ask a few more questions about that. Obviously, the feasibility study is going to be undertaken, but has there been any thought to how this will operate, what services will be provided and what best practice models it is going to apply in terms of what will then be provided, and the model of care as well?

Ms Gallagher: This is a feasibility study into whether or not we have really got the capacity to have a centre for adolescent health. I will ask Charles to expand on this, because he will lead the work. We did this as part of our election commitments. It was based on a number of discussions I had had on meeting the needs of a particular age population who have quite distinct health needs from other groups in the community.

MS BRESNAN: Yes. I guess this is the age group, too, where a lot of things will emerge and can be dealt with then?

Ms Gallagher: Yes. I have looked at the model they have in Sydney, and there is another model in Victoria. I am not sure we could go to the point that they go, just based on our size, but I think there is some merit in investigating further exactly how

we should be providing services and what services we should be providing to this group.

Dr Guest: As the minister has indicated, a feasibility study is an appropriate thing to do when you have got a scatter of problems, many of which turn into chronic disease and high burden of disease later in life. It does appear, or did appear, that there may be some gaps there that could be filled. I think it is too early to talk about a new model of care. We will be looking at communications with young people about health problems. I would expect that there would be an electronic component to this—looking at websites and looking at use of information technology that appeals to young people to engage them in their health concerns and to try to make prevention and health concerns real and interesting and important to young people.

MS BRESNAN: So is it the thought that it is going to be a virtual centre, is it, rather than an actual centre?

Dr Guest: It is too early to talk about what the findings of the feasibility study would be. It may well be that that is an appropriate thing to do. We are not at the point of making recommendations about what services need patching up or what new services should be started.

MS BRESNAN: I appreciate that. I guess it was just a thought—whether there had been some thought given to how it actually would operate and be structured.

Ms Gallagher: I guess we are at point about whether or not we should have one. There is a question about whether or not we can support a centre for adolescent health. When you look at the models that exist in Australia, I am not sure we could support something quite as sensitive as that. I guess the next question from that is: based on our size and our population group and their requirements, what would be something we could look at?

MS BRESNAN: Yes.

Ms Gallagher: Then, again, within that, what would be the most useful in terms of health messages for young people? We have got the Junction operating here. That is a very good model in terms of getting primary care to young adolescents. There is a very strong group of young women involved in the eating disorders groups here.

MS BRESNAN: And headspace is a good example, too.

Ms Gallagher: We are building a young persons mental health unit. Obviously mental health is going to be a focus. Then you talk to the paediatricians and the staff on the adolescent ward. They will have a view as well. I do not think anyone wants it just to be a medical model. It think it is broader than that.

MS BRESNAN: Yes. I guess that is why I was asking the question, because usually, particularly for adolescents, having a more holistic approach and a place where they can go which is not just about just that medical model—

Ms Gallagher: Exactly.

MS BRESNAN: It is more likely you are going to get youth coming in of their own volition, too, I guess, in some essence, if you have that sort of model?

Dr Guest: We will be consulting widely. The feasibility study will include extensive consultation. Certainly the idea is not to have ageing doctors telling young people what they should or should not be doing.

MS BRESNAN: No. That does not usually work. Do you have any idea when that will be completed?

Dr Guest: It is for this financial year and—

Ms Gallagher: It is probably at least a year-long work, I reckon.

MRS DUNNE: Does this mean that you do not have a firm plan for the final destination of the adolescent ward?

Ms Gallagher: No. The adolescent—

MRS DUNNE: Is it going to be part of the women's and children's hospital or are you not sure?

Ms Gallagher: Let me just check that. Yes, it is. The adolescents, paediatric, NICU, health, gynaecological and prenatal and postnatal—they are all in the women's and children's. No, it is running alongside that for non-hospital.

MRS DUNNE: Non-hospital?

Ms Gallagher: Non-hospital, I guess, is up in the air, and that is why this study, I think, will talk to people and see what the best way forward is.

THE CHAIR: Thank you, minister. Mr Hanson?

MR HANSON: Thank you, Mr Chair. It seems that during the holiday periods we experience more problems in our hospitals anecdotally. We get a lot more representations from people that they have had bad experiences at the hospitals, that there seems to be a lack of staff—

Ms Gallagher: During holidays?

MR HANSON: Holiday periods. I am talking about specifically the Christmas period and then Easter. Indeed, Mrs Dunne was one of those. We did not represent that one to you, minister. I do not know whether staff are going away on holidays or whether we are seeing a surge in demand. What the issue is, I do not quite understand, but certainly you would appreciate that I have not been here as long as you, but in those two periods that I have been here, Christmas and then Easter, I have seen that spike. Could you confirm for me whether you see that spike in terms of problems or do you have reduced staff? Do you know what the issue might be?

Mr Cormack: I am happy to respond to that. What we tend to do around Christmas—less so Easter—is wind back on less urgent activity, and we wind back for a couple of weeks, sometimes three weeks, in terms of elective surgery. We do that for a number of reasons. The first thing is that it is important that we are able to give our staff a break. So we schedule periods of lower activity, and that is typically elective activity, typically elective surgery. We will wind that back a bit, and the effect of that is that it reduces the overall workload on the rest of the hospital, because operating theatres generate a lot of activity, and we build that into the overall targets for the year. Certainly for the current financial year we are running well ahead of target in terms of the number of operations we have done.

That also frees up beds to a certain extent and that assists us with our access block issues over Christmas because, unfortunately, what happens, not only in Canberra but in the whole of the southern part of New South Wales, is that just about every hospital out there seems to close down and it is poor old Canberra Hospital that is propping up a region of about 600,000 people. So by reducing our elective surgery activity over that period we are able to create a bit of additional bed capacity to deal with any emergency presentations. Our emergency surgery and our urgent surgery programs continue.

So my experience, certainly over the last three Christmases at least—and Bill Stone can confirm or otherwise—is that we have actually had very easy times in terms of the pressure on the hospital. The waiting times in emergency departments are frequently lower and access block is lower around those periods of time. We have had some this year mainly because we had done more elective surgery than we had initially planned for, and because we had a large number of staff who had excessive leave balances we did also wind back on elective surgery over the Easter period for a period of about a week and a half. That enabled us to maintain our annual target but it also gave our staff the opportunity to take the necessary leave that they had.

So my response to that is that some services are less available over the weekends and over Christmas periods but, generally speaking, all of our essential services and our urgent services are available 365 days a year.

MR HANSON: I will just make a comment, then, and certainly I have got no empirical evidence to back it up, but it seems to me that there was a spike—and it may have been coincidental—in those two periods and it was not just about sort of access block issues, although that was an issue; it was about ward staff and so on, general services at the hospital. So if I just put that on the record, you might have a look at it in terms of rostering.

Ms Gallagher: We watch this every day. Mark and I watch it every day. Probably everyone in this room watches it. I have not been able to pick a particular time of the year that we can say that we can expect the next six weeks necessarily to be busy, outside of winter—August-September seems to be the build-up of the winter and flu seasons—but if you watch it over a period of time, if you have had four or five busy days in the emergency department, for one reason or another by day six the bed availability is down and the pressure is really on. You do see two-week periods like that and then it reverts back to normal. There does not seem to be a sign as to why.

MR HANSON: I think if you are looking at it just in terms of stats, I suppose, what you might see is a surge in demand, but unless you correspond that with a reduction in the staff because of Christmas or Easter or other holidays, you might think, "We are doing all right; we have got a reduced demand at the moment." But if you also reduce the staff, it is a matter of that balance. It just seems anecdotally that you are getting that sort of spike in representations during those periods.

THE CHAIR: I am going to go to Ms Burch in a second, but just before I do, on Tuesday, minister, you undertook to look into whether it was your office or someone from the ALP who liaised with ACT Health in relation to the ad. Have you heard anything further on that?

Ms Gallagher: Yes. I can confirm that it was ACT Labor—the ALP—that liaised and made the arrangements with ACT Health. There was one conversation with my media adviser to the media person in ACT Health, which was probably what Mr Cormack was referring to, on the name of the person that would be calling them to make the arrangements.

THE CHAIR: Mr Cormack, you undertook to look as to whether any forms were signed stating that they understand and accept the conditions that are placed on them and whether that happens in the ordinary course as well?

Mr Cormack: I have not been able to—there was certainly no form signed for that particular advertising exercise. I can confirm that. In relation to other forms, the forms that are routinely signed on 100 per cent of occasions are when a patient may be identified or identifiable in an episode of filming. In those instances we have signed consent by the patient and a release to that effect. But in this particular instance there was no use of patients and, as I said, that was not required.

THE CHAIR: Right. But you are still looking into whether, in the ordinary course, someone using the hospital for filming needs to sign any forms?

Mr Cormack: As I said the other day, the policy is very clear and the people are supervised at all times. That is the process that I have got in place and it has worked well to date. That is, people cannot walk around the hospital filming. They must be supervised at all times, and that supervision is far more powerful than people signing a piece of paper.

THE CHAIR: Ms Burch had some questions, and we are getting close to the time to finish. We are due to break at a quarter to and then come back with a brand new minister. We will complete a couple more questions and then we will break in the next few minutes.

Ms Gallagher: I have got a few answers to give the committee as well.

THE CHAIR: Sure. Ms Burch.

MS BURCH: In budget paper 4, page 204, there is a line around improving accessibility and appropriateness of services for women from a diverse cultural background. There is just a bit about those programs. I see various women-focused

strategies throughout the documents. Are there any men-focused strategies?

MRS DUNNE: I thought we had the discussion earlier on—that there was a men's health strategy in the documents.

Ms Gallagher: Yes, there is. We are currently putting together a men's health plan. We have had the initial meetings with men's health providers.

MRS DUNNE: I think it has been answered before.

MR HANSON: I think it was answered before, wasn't it?

Ms Gallagher: I think Ms Burch's question was around women of culturally and linguistically diverse background.

MS BURCH: Yes, that was the primary question.

MR SMYTH: The question for Ms Reading is: can she give us exactly the same answer?

Ms Reading: Can you repeat the question?

MS BURCH: Maybe we should have gone to the coffee break! There is a point around accessibility and appropriateness of services for women from a culturally diverse background. I confused the officer by talking about men's health; can we stick to women's health.

Ms Reading: This indicator is primarily related to the women that come through for well women's screens, in the women's health service. We have improved access to that client group by outreach in four other facilities by going to work sites to improve access, communication and information about how they come through for a well women's screening. That is what that indicator is specifically about. We also have a migrant health unit in community health. That is in the child, youth and women's program. Again, they do a lot of outreach communication. It is not only about community health services; it is also about how to access ACT Health services and it is about very culturally sensitive issues for a client group in a specific culture in the community.

MS BURCH: And linked to NGOs, because there is a range of interests?

Ms Reading: Yes, very much so.

MS BURCH: Are numbers increasing, and are you able to manage that increase?

Ms Reading: We have not had any issues to date because they are our priority group, through the women's health service. As with all priorities in ACT Health, we identify based on clinical need but also on our priority target groups for that group.

THE CHAIR: Just on the linguistically diverse issue, how much access is there to, say, interpreters for women accessing hospital services in particular? I know from my

own family experience that, for my mother, with her first child, it was extraordinarily difficult because she did not speak any English. Are there interpreter services in those circumstances?

Ms Reading: We have got interpreters in the migrant health unit for a range of languages. They can have either a telephone consultation or a one-to-one consultation. There is also the telephone interpreter service, and we use that quite a lot.

MRS DUNNE: It does not go very well in the delivery room, I bet!

THE CHAIR: No, I imagine.

MR HANSON: The universal language, isn't it?

Ms Reading: Generally it is an area on which I have very good feedback and there is a low level of complaint about the service. That is usually an indicator of how we are doing.

THE CHAIR: We have probably run out of time for more questions, unless there is something super-urgent.

MRS DUNNE: No, there are some things that I can put on notice.

THE CHAIR: I know that Mr Hanson wanted to make a brief statement.

MR HANSON: Yes. As the shadow health minister, obviously you and I, minister, will have regular disagreements, but there is also a lot that we agree on. At the top of the list would be the superb job that is being done by your staff, both within the department and in the front-line services. Certainly, when I have attended Canberra Hospital with my young child, or whatever else it may be, I am very impressed with the staff that I meet on those occasions and with the job that they are doing. On behalf of the opposition, I would like to put that on the record and say thanks for the work that your department is doing.

Ms Gallagher: Thank you. That means a lot to officials who have sat through two days of estimates.

THE CHAIR: Mr Cormack, do you want to answer some questions taken on notice?

Mr Cormack: Thank you, chair. There was a question on the trend for cervical screening. The Chief Health Officer's report for 2008 quotes 2005-06 figures for cervical screening at 63.8 per cent, which is more or less the same as the more recent data that is presented in the budget papers. So it is remaining steady and exceeds the national rate. I bumbled on a few explanations, and I do need to clarify that. A question was asked by either Mrs Dunne or Ms Burch around page 191, which is the rate of unplanned return to operating theatre.

MRS DUNNE: Yes, that was a bit confusing.

Mr Cormack: I recognise your confusion and I feel duty bound to fix that. It is the

percentage of total operations that actually involve a return to theatre.

MRS DUNNE: Thank you; that makes more sense.

Mr Cormack: The other one was unplanned readmissions, which is, again, the percentage of admissions. I was referring to another one, which was per 10,000 bed days, and I apologise for completely confusing you there.

In terms of the smoke-free arrangements, since 30 March, 94 staff have accessed the nicotine replacement therapy program. For hospital in the home, the baseline is up to 18 bed equivalents for the existing hospital in the home, plus 10 beds for the oncology in the home program. So it is 18 bed equivalents for hospital in the home plus 10 bed equivalents for oncology in the home, making 28, and we are adding 25 through this budget initiative. So that is nearly double.

Mr Hanson wanted to know the numbers of patients waiting by category. I can give you an even more up-to-date total figure. As at 30 April—the previous figure of 4,700 and whatever was for March—the total is 4,807. Category 1 is 144; category 2 is 2,656; category 3 is 2,007. With respect to the percentage of those that are waiting longer than the standard waiting times as at 30 April, zero per cent for category 1, 50 per cent for category 2 and 18 per cent for category 3 are waiting longer than the standard times.

Somebody asked about the percentage of patients who present by triage category and are subsequently admitted. For category 1, it is 77 per cent; for category 2, it is 63 per cent; for category 3, it is 45 per cent; for category 4, it is 15 per cent; and for category 5, it is three per cent, giving a grand total of 27 per cent. For retrieval services, the total number of retrievals for 2002 through to 2007 were 370 in 2002, 358 in 2003, 366 in 2004, a big spike up in 2005 to 449, exactly the same number in 2006, which is 449, and in 2007 it was 444.

Ms Gallagher: I have got another one in preparation, for the output classes and programs for the next load. I do not know if you want them now.

THE CHAIR: Excellent, yes.

Ms Gallagher: For DHCS.

Meeting adjourned from to 3.50 to 4.07 pm.

THE CHAIR: We welcome the minister and representatives of the Department of Disability, Housing and Community Services. Minister, would you like to make an opening statement in this area?

Ms Gallagher: I will just make a very short opening statement that really picks up on a conversation we started on Monday under the Treasury portfolio. I undertook to update the committee on the $3½ million one-off funding which was provided for volunteers and carers in the community and say what point we were up to with that money.

The funds were allocated to existing ACT funded service providers for distribution to the community following the second appropriation's passage in December 2008. Some $850,000 was distributed through the six regional community services such as Woden Community Services and Tuggeranong Community Services and existing ACT funded emergency support agencies such as St Vincent de Paul, the Salvos and UnitingCare Kippax. Some $150,000 was held by DHCS staff to use to provide emergency assistance to clients in need. These funds were used for petrol vouchers, phone cards, essential household goods, pharmacy supplies, clothing, grocery vouchers and assistance to support the purchase of education supplies.

Since December 2008, approximately 2,227 people have received assistance, with 58 per cent of the clients being female. Most clients are aged between 35 and 60. To date $323,198 of the funding has been expended; the remainder remains available to agencies to distribute to clients in need.

Some $1.25 million was distributed to the six regional community services, Carers ACT, Anglicare, the CYCLOPS program; Tandem and the Mental Health Foundation, for carer support. Carers, foster carers and kinship carers are eligible for the assistance. To date, 222 carers have received support. The main purpose of the funding has been for transport costs and assistance with purchasing whitegoods to assist in the carer's role. Some $190,396 of the funds have been expended, with most of the funds flowing to carers via Carers ACT.

Some $1.25 million was given to Volunteering ACT. They are distributing $1.17 million through a grants process. Funds can be used to assist volunteers with travel costs associated with volunteering. To date, Volunteering ACT has expended $271,850 of their funding, with grants going to 48 organisations.

In relation to other areas in the budget covered by the community services portfolio, which includes Therapy ACT, the budget delivers $3½ million in funding over the next four years for additional speech therapists and $2.279 million over four years for play therapy and intervention programs for children with a disability.

I would also take this opportunity to clarify the decision about not including a women's budget statement in this year's budget. Mrs Dunne would be aware from previous years that I have always found that budget statement to be fraught in terms of the content and how useful it is.

MRS DUNNE: I thought I found it fraught.

Ms Gallagher: I think we have shared the fraughtness, if we can say that, over the women's budget statement. I just do not feel that we have ever really got the statement right so that it is a useful analysis of the budget.

The government has decided to phase in gender analysis in government publications. We are starting this through the women's health plan. I think that the results of this work will inform how we best approach gender analysis of budget initiatives. We will be working on that for next year's budget. It was certainly not an attempt to ignore women in the budget; it was just that I do not think we have ever got it right. It was my idea to begin with, so I thought I should take responsibility and end it. I will leave

it there, chair.

THE CHAIR: Thank you. Minister I think this falls under JACS, but there is a crossover so I will put it to you because I know you have been involved in some discussions on this issue. I have had some discussions with the Women's Legal Centre about their funding. My understanding is that they have not had recurrent funding from the ACT government to date, but they did get some program funding. When last I spoke to them, they were still a little bit in the dark about that funding. Do you have an update for us?

Ms Gallagher: I do. I have half an update. I think that program is funded through the community inclusion fund. The government decided to find ongoing funding for that program. It is to be managed through JACS. The Attorney-General undertook to identify the funds for that program and make them available. I have not caught up with the Attorney-General about that, but I have met with the Women's Legal Centre and given them that commitment. It was certainly a very clear decision of the government.

THE CHAIR: So that funding will be maintained as it was prior to this budget?

Ms Gallagher: That is right. I think that grant is about $32,000 a year; it is quite small.

THE CHAIR: Indeed, but a fairly important part of what they do, from what they tell me.

Ms Gallagher: Yes.

THE CHAIR: Thank you for that. I will move to members' questions. Ms Bresnan.

Ms Gallagher: I think the attorney might be able to answer it—about where it is coming from.

THE CHAIR: Sure.

MS BRESNAN: Thank you, chair. Just going on from that with the community inclusion fund, we heard from Gugan Gulwan on Friday and questions were asked of the Chief Minister about the program as well. In particular, I am interested in finding out—obviously, there was a date and most organisations knew the date and when the funding would be finishing—what work was done with some of these organisations to help them find alternative sources of funding, such as going to another department to seek this sort of funding. That is particularly for programs like the Gugan Gulwan literacy program, which is a really key program—understanding that there are other literacy programs running now, but that was one of those key community-based programs.

Ms Whitten: In October of last year the department wrote to the government partners and the community partners in terms of each of the initiatives under the community inclusion fund to inform them about the extension of funding to 30 June this year but also to let them know that we needed to work on alternative funding arrangements for

each of those projects. Since that time, the department has met with most of the projects' government partners and community partners together. One of the projects that we are still working through is the Gugan Gulwan project. However, I think Ms Davison mentioned in the hearings last week that she has been meeting with education separately as well. The intention was for the government partners to work with the community partners in finding alternative funding sources, and our department was helping to facilitate that.

MS BRESNAN: When I asked Gugan Gulwan that question, they said they had not been given any assistance in finding alternative funding sources.

Ms Whitten: I think that conversation is still going on with education.

MS BRESNAN: So they are having discussions with education?

Ms Whitten: That was my understanding.

MS BRESNAN: That was not made clear from them in particular.

Ms Gallagher: I think it does go to the heart. This is the problem we struggle with with the community inclusion fund. It was established for projects for three years—partners within government and non-government agencies, targeted to specific projects. Mr Smyth, when you were a minister I do not know if you had the same problem, but you set up these one-funding projects that then turn into becoming part of the social fabric and then you have to start looking around and finding where you find your current resources from for them. We bought ourselves an extra year in slippage money to keep them going whilst we did further work. I am sure that we have got a list of all of them. I think that we would have to say that we picked up 70 per cent of them in some way or another—haven't we?

Ms Whitten: There are 20 projects; we funded about six of those projects, but we are still having negotiations with some of them as well. There are some that have also identified that either the community partner or the government partner thought together that the project is not an ongoing one.

MS BRESNAN: I understand that they were identified and it is community inclusion—it is about those sorts of issues around that. As you said, once the service does come—

Ms Gallagher: The idea there was that we would provide them with seed funding and partnership and then they would have a bit of time to keep that project going. We have not been very successful, I think, outside of just looking back to government to find that ongoing funding. There are a number of those programs that have been very, very successful.

MS BRESNAN: Yes. I was just going to ask around that. Did the Community Inclusion Board or any part of that evaluate any of the programs, or all of them, and how were they conducted?

Ms Gallagher: This is going to be a frustrating part of this hearing. The Community

Inclusion Board sits with the Chief Minister, so I have not had any—

MS BRESNAN: We were told to ask you.

Ms Gallagher: Were you?

MS BRESNAN: Yes.

Ms Gallagher: The fund sits with me.

MS BRESNAN: They also told us the board. I did ask about the board and they said we needed to ask you.

Ms Gallagher: And CMD told you—

MS BRESNAN: Yes.

THE CHAIR: Were they dodging questions, minister?

Ms Gallagher: I do not know why, because they do not fall under my portfolio responsibility at all. What I do know is that the board has—

MR SMYTH: It is an old ploy: "Ask them."

THE CHAIR: Ask mum; ask dad.

MR SMYTH: That is all right; we will just recall the Chief Minister.

Ms Gallagher: I just cannot assist you, because I have not had the board under my management.

MS BRESNAN: We will find someone to assist us.

Ms Gallagher: I do know that they have been—I do not know if they have been evaluating the projects. I know that in the last year they have been doing evaluations, but I am not sure if it is on these projects that were originally funded.

Ms Whitten: No, not that I am aware of.

Ms Gallagher: Yes.

Ms Whitten: And certainly not in the last 12 months.

MS BRESNAN: So we are not sure what they are evaluating—

Mr Hehir: I might be able to add a little bit of clarity as I am currently a board member. I have not, to my recollection, seen anything on the agenda papers around the evaluation of the specific CIF funds. While I have been a board member for only a few months, it has not come across my desk in that time.

MS BRESNAN: So we do not know if there have been any coordinated approaches to looking at how successful the programs were, as in achieving what their outcomes were?

Mr Hehir: In a sense, that has largely been left to the departments—the partner of departments—to actually look at, which is why the emphasis has been put back onto the department to decide and assist those ones to keep going where they believe they have contributed. Really it has been done on a departmental by departmental basis.

MS BRESNAN: So each department where each program would sit has had to evaluate it separately? Is that what you are saying? Or is DHS is evaluating it or Chief Minister's?

Mr Hehir: No. The partner department, from my understanding, has actually had the ride in terms of saying, "Is this actually an ongoing project that needs to be funded that we need to find funding for or find assistance or other forms of funding for?"

MS HUNTER: So there were not necessarily evaluations undertaken on each one of these? It was not part of the contract that was handed out?

Ms Whitten: My understanding is that some of the projects, or a majority of the projects, had some form of evaluation built into their individual deeds of grants.

MS HUNTER: From that, we would assume that there had been some form of evaluation taken out within each individual project?

Ms Whitten: Yes.

MS HUNTER: But not necessarily collated centrally?

Ms Whitten: That is exactly right.

MRS DUNNE: Could I just ask this, Mr Chairman, for the sake of clarity. We have had this discussion in about four departments so far. Is there a central list of the projects and which department manages, oversees and—

Ms Gallagher: Yes. I manage the fund; we have got that, yes.

MRS DUNNE: It would be useful if we could have a list of the programs and where they are—as to whether they are non-ongoing or—

Ms Gallagher: Yes, we have got that. I am sure we can table it.

MRS DUNNE: That would be great.

THE CHAIR: I will just flag for the committee members and others that I will give committee members an opportunity to lead off with questions and then come to Ms Hunter and Mrs Dunne for other substantive questions. I will go to Mr Smyth.

MR SMYTH: Thank you, chair. Minister, on Tuesday, in the discussion with the

health department, there were some questions about the relief funding that was in the second approp. You said that you would come back today and give us a breakdown.

Ms Gallagher: You missed my opening statement.

MR SMYTH: I do apologise. I was about to say "in case I missed it". I do apologise.

Ms Gallagher: Yes. I read it in.

MR SMYTH: I will get it off the *Hansard*. Thank you.

THE CHAIR: Ms Burch.

MS BURCH: Budget paper 3, page 81, "Play therapy services for young children"—can you tell us whether that is additional funds or a new program and what the expected outcomes of that are?

Ms Whitten: That is additional funds for Therapy ACT. It relates to the election commitment for the government around play therapy for children in the early years in terms of autism spectrum disorder and any other developmental delays. The four-year total of that funding is 2.279 million—over four years. It is a really good injection of funds into Therapy ACT.

MS BURCH: Will there be new modes of delivery or locations?

Ms Gallagher: The idea arose from parents, particularly parents of children with a disability in those very early years, talking with me about having a place to go at times to play with their children. There are always standard playgroups that they can go to—but just an additional service that the more individualised, specialised services offer, that Therapy could offer. We are still to work through the detail of it. I think we will talk to some parents and maybe get a parent reference group together to work out how best this will be provided—whether it be provided through child and family centres, at Therapy ACT or both. It is really about having a social focus and somewhere to take the children, if you need to, in a therapeutic environment. You could still be getting skills, but these children are also entitled to have fun and play.

MS BURCH: Have fun. From what I understand, then, it is outside going into Therapy ACT's centre: it could be like a playgroup or a preschool—

Ms Gallagher: It could be. Exactly. For some, particularly for some children who might have some complex physical disabilities, it may be appropriate that a playgroup be held at Therapy, where there are some large spaces and some of the equipment, cushions and things, that you might need. But exactly. And we could schedule them like playgroups are scheduled so that you do not have to turn up, but if you are at home and you have got nothing else to do and the kids are driving you mad or whatever, you know that Therapy is running a drop-in playgroup at 10 o'clock at the Tuggeranong Child and Family Centre and you can pop down there with your child. That is the kind of service that I would like to see established through this. I think we have just got to work through, with Therapy staff and parents, how we would roll that out.

MS BURCH: And age bracket?

Ms Whitten: Under five years.

MS HUNTER: Just to follow on from that, are there any other eligibility criteria that have been laid down around it apart from age? And, just following up Ms Burch's question around talking to the groups about how it looks and how it rolls out, what sort of time frame is around that?

Mr Hehir: I think we have identified that that would be for a broad range of children with disabilities—predominantly disabilities. That would include some young children with autism.

MS HUNTER: Okay.

Mr Hehir: That is certainly a particular focus group within this phase, but it is not exclusively for that.

Ms Gallagher: I do not think that we need to restrict on eligibility at this age.

Mr Hehir: And there are certainly some things that we will need to be looking at in terms of the time frame. There is some pre-emptive work we can do in terms of—we can actually start working with some parents of children with a disability in terms of assisting their children to the point where they can participate in the group. So there is some preliminary work in terms of making sure that the young child and the parent get the skills in terms of socialising and deal with some of the issues that some young children with a disability can have.

We can begin to commence this relatively quickly while we do the work around how the playgroups are going to function and where they are going to function from. It is not anticipated that there will be a delay. There is work we can do right at the start which parents will find invaluable while we work with them about the other components of the program.

MRS DUNNE: Does this money cover staff?

Ms Gallagher: Yes.

MRS DUNNE: Is it is only staff moneys that you envisage that you will need? Any sort of equipment, modification of buildings or anything like that?

Ms Gallagher: Therapy have equipment that they trial and use now in the Holder building. Some of the spaces that we go to—the obvious ones being the child and family centres in Tuggeranong and Gungahlin—have appropriate space that we can use. So it really—

MRS DUNNE: It is clearly about staff.

Ms Gallagher: It goes to staff, and the question is about the mix of staff. I have not

had the opportunity to talk at length with Therapy since the budget has come out on the profile of staff. If you employ all OTs, or all professional staff, that would impact on how many staff, which would then impact on how many playgroups you could deliver. If you could have allied health assistants working with a team leader who is an OT, that would mean you could probably get more playgroups. I need to talk that through. My dream would be to have a playgroup every day of the week, every morning, somewhere across Canberra, where a parent, if they felt they needed to, could go and have a bit of time.

MRS DUNNE: But the thing is that you put the money in the budget but you have not really thought through the process.

Ms Gallagher: We have. Obviously, there was a business case which went through the cabinet process. I know there are mixed views. Therapy is a professional service, particularly in teaching skills to parents about how to support their children, usually at home, and also in school environments. This is a new element of that. My idea, which was generated from discussions with parents, is then blended with some professional views about how that is best approached.

THE CHAIR: Ms Hunter, do you have some questions?

MS HUNTER: Yes. In your opening statement you talked about speech pathologists and the increase in speech pathology services. Where will these speech pathologists be recruited from and when will the recruitment take place? Also, could I hear a little bit more about the speech pathology—whether it is just about cutting down that backlog on the waiting lists or whether it is also about increasing the number of hours that each child will have with their speech pathologist.

Mr Hehir: In terms of recruitment, we are ready to start almost immediately. We actually have—I am going to call them interns but I am not sure whether that is the correct phrase—students on placement working with us. I understand there is a half-year finishing of the program. So there are people working with us already who will be graduating in the half-year. We will be ready to undertake that.

Ms Gallagher: Once the budget is—

Mr Hehir: After the half-year will be after June—

Ms Gallagher: Once the budget is passed.

Mr Hehir: We are certainly ready. A number of years ago we had quite a difficult time recruiting staff into this area, but that has not been the case for quite a number of months. I get regular reports on staffing levels there, and Therapy ACT are doing very well in terms of maintaining its overall staffing levels. They certainly believe that, with their placement program and the work with the universities that they have done, there is a strong pool to recruit from.

MS HUNTER: The follow-on question was on whether it will cut down the time on waiting lists or whether it will also give children extra hours with a speech pathologist.

Mr Hehir: That is really a professional decision. Certainly, the main focus will be on cutting down the waiting time that people have to access the service, but in terms of the hours required it is a professional decision that the therapists will make. They will not necessarily increase hours where they do not think it is appropriate to do so. They will look at—

MS HUNTER: But is there that capacity to do that, to even make that decision?

Mr Hehir: That decision is really in the hands of the speech pathologists in this case. If they believe it is appropriate and necessary to continue the hours, or to expand the hours for the individual client, that is a decision they can make in consultation with their manager. That is certainly part of the process I would expect them to be doing. Where they think that a child or a young person needs additional speech pathology, then that is a conversation they would have with their supervisor. They would say, "This was the original program, they're not responding as well, we probably need to do more work." It would be part of the ongoing professional assessment they would undertake.

THE CHAIR: What is the average waiting time for speech pathology for children in the ACT?

Mr Hehir: It is difficult to give an average time. We have a system where we prioritise.

Ms Gallagher: It is triage, kind of.

Mr Hehir: Yes. I might ask Ms Hayes to come and answer some of the detail there.

THE CHAIR: In many cases, it is quite long, isn't it?

Mr Hehir: Yes.

THE CHAIR: I have had reports and we have had some experiences ourselves where it is sometimes many months or longer.

Mr Hehir: Certainly, going outside of our highest priority level, the time frame can be quite long, which is why this initiative is so welcome from our perspective.

Ms Hayes: We prioritise referrals into four priority categories. The priority 1 category in the speech pathology area normally will be young babies, and some older children, who have swallowing and feeding difficulties, which is also something that speech pathologists do. We would see those high priority referrals within 24 hours. So that is the first group.

The second group, which is our priority 2 group, covers a range of different presenting issues. Primarily, with this group, you know that, if you can provide some therapy fairly early in an early intervention model, you will get the best outcomes for that group. That group has got a large number of people in it, particularly in the early years, which is where we will focus the new resources. At this stage, that group is waiting three to six months, and it is certainly our intention to try to get that down

under three months as soon as we can.

The priority 3 group may be children who have difficulty with some pronunciation or some language difficulty that affects their literacy development but it is not urgent that you address it as quickly. The priority 4 group is usually a group that we are just following up from some earlier work that was done. So those are the priorities.

THE CHAIR: I had a constituent contact me. It was an interesting case because he was not complaining but it is worth raising. He had his child on a waiting list for some time and could not get in for a long time and then got in on Chief Minister's talkback. Once he got through to Chief Minister's talkback, his child was able to be seen very quickly. He obviously was not complaining that he was able to be seen but he just thought it was strange that it took a phone call to the Chief Minister on radio for that to happen. Was there any involvement from you, Mr Hehir, in that particular case? Are you aware of that case, and how would that work?

Mr Hehir: Not without the name, I would not be aware of the case.

THE CHAIR: Has there been more than one in relation to Chief Minister's talkback?

Ms Gallagher: There have been a few. This issue comes up from time to time.

THE CHAIR: How does that work? He felt that his child got seen very quickly after that, which he was grateful for, but he thought it was interesting that he had to speak to the Chief Minister on radio for that to happen.

Mr Hehir: It would depend on the circumstances. I am certainly aware of one where Therapy ACT had made a commitment around a time frame that was not met and it had not been met for quite some time. When we looked at that we said, "If that was the commitment we gave, then that is the commitment we should ensure that we undertake." Certainly, it was not a response around whether it was on Chief Minister talkback; it was actually brought to my attention—and I am not aware whether that one was—on the basis that someone was quite unhappy that they had received a commitment and that we had gone well past that time. When we looked at it, we said, "That's a reasonable thing to be annoyed about," and it was also reasonable for us to actually respond and meet our commitment. Without seeing the facts, I would not be able to speculate on what our response was and what drove it.

THE CHAIR: Perhaps we could correspond on that one separately.

Ms Gallagher: Maybe if you write to me.

THE CHAIR: Sure.

MRS DUNNE: Could I ask about workforce issues in relation to speech therapists. We have had conversations in estimates and annual reports hearings forever, it seems, on these issues. One of the issues has always been workforce and scarcity in some of these areas. What is the level of confidence that you will be able to fill these eight or nine speech therapist positions?

Ms Gallagher: I think it is pretty good. We have had full staffing at Therapy for a while.

Ms Hayes: We have had full staffing for almost the last 12 months. I am very confident that we will fill those positions. There is a sort of ramp-up of those positions. In the first year there is funding for 6.5 of the eight speech pathology positions. That funding is for three-quarters of the year, so we are expecting to recruit over that 12-month period. Next week the ads will go in for the first round of recruitment. We have had sufficient inquiries from people who have already phoned us, saying, "If you have a job coming up can you let me know?" So we are very confident that we will fill those positions.

Ms Gallagher: I think the issue that compounds therapy here is the lack of access to private speech therapy.

MRS DUNNE: People I know have to go to Sydney.

Ms Gallagher: Yes. I am just not sure why. I would have thought Canberra would be an excellent place to set up a private speech therapy business, but it does not seem to be the case.

Ms Hayes: Very low numbers in private practice.

THE CHAIR: I would think it would be the same with GPs. I think it would be a great place to set up a practice. Sorry, I did not mean to cut you off there, Ms Hayes.

Ms Hayes: No, that is fine. I had finished.

THE CHAIR: Ms Hunter had some questions in this area.

MS HUNTER: I have another couple of questions for Therapy ACT. Firstly, have Therapy ACT had any input into the Shaddock inquiry into special education that is running at the moment? Secondly, have you had any role in promoting that inquiry to the families of clients of your services?

Ms Hayes: Yes, we have had involvement in the review. I am on the reference committee for the special ed review. Dr Shaddock has come to Therapy ACT and met with me and the management team. We have talked about therapy and special education and how that works. The dates for the consultations have been disseminated through our network. So I would not say we have actively promoted it but we have certainly let everybody know when they are to be held, from the information that we have received.

Ms HUNTER: What is your interaction with education on a daily basis? Is there much interaction?

Ms Hayes: Yes, lots. We provide the therapy services for the department of education, so we would have therapists working in schools and with teachers on a daily basis. We provide a fair bit of professional training and development for teachers as a regular part of their training calendar, particularly on speech and language but also

on fine motor skill development, which is particularly relevant for learning to write and some other input. When we are asked to, we will do some special training for them on gross motor skill development or whatever they request.

THE CHAIR: Mr Smyth?

MR SMYTH: Thank you. Minister, on page 231 of budget paper 4, strategic indicator 6, 2012-13, there is a 41 per cent increase in participation in 2013.

Ms Gallagher: I am not with you yet. Tell me the table number again.

MR SMYTH: Strategic indicator 6, 2012-13. Is that the centenary of Canberra?

Mr Hehir: It is actually Minister Hargreaves, but I might say that, yes, it is.

MR SMYTH: Okay. It is the centenary of Canberra. How do you justify that number?

Mr Hehir: That is under Minister Hargreaves's portfolio, so if it can wait until then, we can probably talk about it in detail.

MR SMYTH: Okay. I will ask Minister Hargreaves that question. As a general comment on the indicators, I think they are probably the best laid out indicators in the entire budget—

Ms Gallagher: That is a compliment.

MR SMYTH: They go four years forward, which is lovely. So we know what is happening this year and for three years past this year.

Ms Gallagher: You have got a career after politics in strategic indicators, Mr Smyth!

MR SMYTH: I love strategic indicators, as long as they are strategic! The problem with this is that it does not tell us where we start. It is like that old Irish joke: "If I was going there, I wouldn't be starting from here." So we do not know where we are starting. It is curious, because if you happen to carry around last year's budget papers, as some people are wont to do, and if you go through them, in strategic indicator 1 for the 2008-09 budget, the number is 3,477 and the 2009-10 budget number, surprisingly, is 3,477. I suggest that it would be good to know what the previous year was and what the expected outcome was, which is what they do in others, just to give them some relevance and tell us where we are going.

Mr Hehir: We are happy to pick that up, thanks.

MR SMYTH: It might mean that you go, for these pages, to landscape rather than portrait, so that you can put a bit more data on them. Otherwise it is just meaningless. If we go to strategic indicator 1, and the number of services used by service types, why is it exactly the same last year as it is for this year, or why is this year exactly the same as it was for last year?

MRS DUNNE: It is Minister Hargreaves.

MR SMYTH: Is that Minister Hargreaves again?

Ms Gallagher: It is.

MRS DUNNE: Disability, yes.

Ms Gallagher: I would imagine it was because there was no further increase in—

MR SMYTH: I will follow that up. Minister, which of these indicators is yours?

Ms Gallagher: Strategic No 2. Child and family centres are not mine, are they?

Mr Hehir: No. Probably No 2 would be the main one there.

Ms Gallagher: Yes, unless there is one on community services.

Mr Hehir: There is the value of the community services program, which is yours as well, which is No 5.

Ms Gallagher: Yes.

MR SMYTH: Between 2008-09, last year, and the current year, the number of clients is 4,230 and it jumps 60 this year to 4,290. But in the outyears I notice there is growth of only 10 per year. What is your assumption that it will only grow by that number based on?

Mr Hehir: As we have just been discussing, there are two quite significant initiatives within Therapy ACT, which is where this strategic indicator points to, which is why you get the jump. There is just a small growth component in the outyears for that. There are no big lumps of additional funding.

MR SMYTH: There is nothing on the horizon that you are expecting to affect it?

Mr Hehir: Yes.

Ms Gallagher: Yes.

MRS DUNNE: The bump is this year?

Mr Hehir: Yes.

MR SMYTH: It was interesting that last year they were going up by increments of 30—4,230, 4,260, 4,290. But you have dragged a lot of it forward and recorded it in this 12 months, which means in the outyears smaller growth is anticipated.

Mr Hehir: Yes. It is something we will continue to look at, but we are continuing to anticipate some growth there. It is certainly something that we will keep an eye on and see how we track through the year and what our capacities are in that sort of

service delivery area. But, yes, we have wound it back slightly.

MR SMYTH: Okay. Thank you.

THE CHAIR: I will go to Ms Le Couteur, then Ms Burch and Mrs Dunne.

MS LE COUTEUR: Thank you. This might be a very quick one because I am not quite sure whether I am asking the right minister or not.

Ms Gallagher: I know. This is the problem. This is a very small portfolio. I have got a small element within DHCS.

MS LE COUTEUR: For agency-funded initiatives, you have got Indigenous traineeships that facilitate for Indigenous elected—

Mr Hehir: That is the Chief Minister.

Ms Gallagher: I have got none of those agency-funded initiatives.

MR SMYTH: Minister, are there any questions you would like the committee to ask you?

MRS DUNNE: I have some.

MS BURCH: I will try.

THE CHAIR: Ms Burch is going to have a go.

MS BURCH: At page 235—

Ms Gallagher: I am told support for Valley FM 89.5 community radio is mine.

MS BURCH: Yea!

MRS DUNNE: We love community radio.

Ms Gallagher: I thought it was Minister Hargreaves but it was mine.

MS LE COUTEUR: I thought it would have been arts.

MR SMYTH: It is a turf war, is it?

Ms Gallagher: It is mine. The areas within this portfolio are the Office for Women, the community services side. That is funding of community organisations, although there is some crossover with youth or—

Mr Hehir: Homelessness—

Ms Gallagher: Homelessness comes into it.

MR SMYTH: And they are with which minister?

Mr Hehir: Mr Hargreaves.

Ms Gallagher: The community upgrades—

Mr Hehir: Youth is with Minister Barr.

MS BURCH: Youth is with Minister Barr.

Ms Gallagher: The school upgrades are mine.

MS BURCH: I have got a question.

Ms Gallagher: Therapy—

MRS DUNNE: The school upgrades are yours?

THE CHAIR: All right. Ms Burch is the winner.

Ms Gallagher: The surplus school upgrades, the use of former school sites, is mine.

MS BURCH: On that, can you give us an update around those regional facilities refurb and where we are up to with those developments?

MRS DUNNE: Wasn't there something in the paper this morning?

THE CHAIR: I saw the headline but I did not particularly read it.

Ms Gallagher: Was there?

Mr Hehir: Yes, Village Creek.

MRS DUNNE: That is right.

THE CHAIR: I saw the headline, but I did not get to read it. Ms Gallagher can read us the article perhaps.

Ms Gallagher: Village Creek, yes. I am sure David Collett can give an explanation of that.

Mr Collett: I am Director of Asset Management and Nation Building for the Department of Disability, Housing and Community Services. The work on the regional community centres is proceeding. Firm offers have been made to all of the tenants following on from the assessment of the buildings, which has been completed in terms of the building fabric, the mechanical services and the electrical and fire services for each of the former schools which will be converted to a regional community centre. There has been some refinement when firm offers were made, particularly when the implications of the community rental were understood by the tenants. And we have been moving ahead with the minister's objectives of trying to

get some synergies between the different users of the facilities.

You will remember that when the announcement was made we identified Cook as an arts centre and we identified community facility centres and health and wellbeing centres. We have been able to achieve some synergies between the different tenant groups and the users, including not only sharing equipment but sharing spaces, receptions and those issues. A more effective use of the building, of course, reduces the running costs for the organisations and allows them to focus on service delivery.

What the architects call the blocking and stacking has now been completed, so each of the tenants can see where in the buildings they are going to go. There has been some finetuning as a result of that. Access, hours of operation, levels of security, access to car parking—those sorts of things vary from town to town and that has all been worked through. We have got two architectural firms, Paul Barnett Design and Munns Sly, and we have divided up the community centres so that we can make progress against each of those.

The engineering work has been quite extensive in terms of firing up boilers which in some cases have not been in operation for a number of years, pressure testing pipe work, checking that radiators are effective and looking at the mechanical and electrical systems. We have been looking particularly at areas in which the changes of use from schools to community centres will change the demands on the building. Access is an obvious one, but the electrical consumption of offices and community service spaces is quite different with the use of computers and other technology, which for schools of that age were significant electrical load, particularly for primary schools. So that work is all being done.

Demolition works have been identified. We have been working closely with the ACT Planning and Land Authority to understand what works will require both development approval and building approvals. We are not changing the class of use under the territory plan except in those areas where we are undertaking substantial refurbishment to the building fabric, which is very few cases. We will not be lodging development applications, but there will be a building approval requirement for the works to make sure that that is done in an appropriate way.

The work is now proceeding to final sketch plans. As there were comments on in the paper, we are now embarking on a round of consultation with the community. You will remember that there was substantial consultation in the lead-up to the government's decision, both with Purdon and then with GHD. We accessed the attendance lists from those meetings and people who made representations to GHD so that we could include those in the consultation. It is really around the form of the building and the impact on the surrounds, the landscaping.

To that extent, we are coordinating our work with TAMS and with the parks and recreation area within TAMS so that the community only has to come out once rather than make repeat visits to see representatives from the government and also so that they can understand where the community parks are going, what is happening to the remaining portions of the land and what is going to happen to the changes to the building fabric and the location of car parking.

Car parking is obviously another area in which we are having to expand on the provisions of the original building. Particularly, again, in primary schools, there was relatively low traffic generation; we need to make sure that the services being delivered by the tenants are not compromised by lack of access. That includes private cars as well as public transport.

THE CHAIR: Thank you. I think your answer now rivals Ms Cahill's in Health as the most comprehensive we have had so far.

Ms Gallagher: Without notes, yes.

THE CHAIR: Ms Le Couteur has a follow-up on this.

MS LE COUTEUR: You mentioned that you were doing substantial refurbishment of the schools. I am speaking particularly as someone who worked in an annex school in Downer for quite a few years. What are you doing in terms of energy efficiency? There are a number of issues. One is the age and when the buildings were built, but also they were built for an entirely different use, and energy efficiencies and a steady temperature were never one of the major requirements in primary schools because they were closed over Christmas. What are you doing?

Mr Collett: We will be largely reusing the existing heating and relying in the main on natural ventilation. We are testing the boilers, the hydraulic pipe work and the radiators. The efficient use of those spaces is probably the most challenging for us in terms of different hours of usage by the tenants, and so we are working with the hydraulic engineers to look at how the radiator system can be zoned. That has been one of the factors that has been fed into the blocking and stacking that I described with the tenants in terms of understanding those who might work on weekends, those who work largely out of hours and those who are carrying on largely administrative functions and would operate, in the main, between nine and five.

MS LE COUTEUR: Will you be doing additional insulation—

Mr Collett: Yes.

MS LE COUTEUR: draught-proofing and things to improve the energy efficiency, because they were not that great?

Mr Collett: No, they were not that great. The approach that we have taken is first of all to look at the requirements for occupational health and safety. They are obviously the key issues that we need to get right. Secondly, there are the services that are in the building and the electrical supply; I have talked about those. So we are taking very much a top-down approach. After we have spent those moneys, we are looking at what funds are available to do the sorts of works that you are describing. There will be areas in which we will increase the insulation, but the focus will be, in the main, on the radiator system of heating and on natural cooling and ventilation.

MS LE COUTEUR: Do you look at water efficiency as well? I assume that you are going to have to replace the toilets on account of the size, if nothing else.

Mr Collett: That is right. We do not have funds identified for running pilot programs around energy or water efficiency, but, through the work we have been doing with the public housing portfolio, we have a good understanding of how we can utilise technologies that are already available out there in the construction industry. So it is flow restriction on all outlets; dual-flush systems; to the extent that we can, harvesting water—we are talking about roofs that have got a lot of drainage points but, where we can harvest water and use it to flush the systems, we will be looking at that. As recently as last week, I was having some discussions with the new department of water and climate change, DECCEW, about their programs and how we can fit in with those.

THE CHAIR: Thank you. Mrs Dunne.

MRS DUNNE: I have a completely different line of questioning. Minister, your carer policy at the last election made a number of commitments which were four-year commitments. There was one in relation to the carer advocacy service; there was one in relation to the grandparents support service; there was one in relation to foster carers, which I think you have probably now forwarded to Mr Barr; and there was the making life easier initiative for cutting red tape for carers. The first two of those had $800,000 over four years and do not seem to appear in this budget. Can you tell me what the prospects for those are and also where we are up to with the cutting red tape administrative review?

Ms Gallagher: Sure. The grandparents one is in the budget.

MRS DUNNE: Is it?

Ms Gallagher: It is under the office's budget in the out of home care—the extra support for our home care initiatives.

MRS DUNNE: So that is a question for Mr Barr as well, is it?

Ms Gallagher: But you are right; the other one—it really just came down to the money available and the initiatives that we could support this budget.

MRS DUNNE: So the Carers Advocacy Service, which was a four-year initiative—

Ms Gallagher: I think we said 800,000 over four years.

MRS DUNNE: Four years.

Ms Gallagher: Yes. So we will be looking at the re-profiling of that.

MRS DUNNE: Does that mean that if you do introduce it next year, it will still be 800,000?

Ms Gallagher: That would be the intention, yes.

MRS DUNNE: That would be the intention?

Ms Gallagher: Yes.

MRS DUNNE: And cutting red tape. Both you and I, minister, attended the Carers ACT thing—

Ms Gallagher: Yes.

MRS DUNNE: which was probably the most powerful pre-election event that I went to. The thing about cutting red tape was that there was a very potent message there. Where are we with that?

Ms Gallagher: We have done some early work. After that meeting and some of the stories—I think some department people were at that carers forum—I have gone back and asked some questions particularly around the constancy of filling out forms. I think that is where I would like the work to start. I am not sure that there is a clear answer to solve that—just around liabilities and things. One of the stories was around that mother who—

MRS DUNNE: The lady who had to fill out the same form every month.

Ms Gallagher: For every time she went to after-school care, before-school care and holiday programs. I am not sure that it is as easy as I would like to say it would be to reduce the burden on carers, just for some of those reasons, but—

Mr Hehir: Sure. In Disability, we are doing some work under that, because often the parents of a person with a disability are in there.

Ms Gallagher: That was the context in which it was raised, yes.

Mr Hehir: And, through the Strategic Governance Group around disability, we have identified a number of issues which we are about to commence the consultation on. Again, Minister Hargreaves would probably be able to talk about that particular initiative.

MRS DUNNE: So Minister Hargreaves?

Ms Gallagher: But I do have an interest in that, because of the carers' role as well.

THE CHAIR: Ms Hunter has some questions.

MS HUNTER: I had another question while Mr Collett was here. I am not sure that you will be able to answer it, but I am going to try anyway. Under action 27 in weathering the change, there was a grant program for community groups to be able to improve the energy efficiency of their buildings. A number of those buildings would be sitting in the portfolio under DHCS and your area. I was just wondering, if you can comment on this, what the outcome was. Did any of those funds go into buildings that you are looking after, and what has been the overall reduction in energy use or what has been the outcome for water use and energy use?

Mr Collett: We did not have access to those funds for our facilities. They were

targeted at non-government agencies that were in their own buildings or buildings—

MS HUNTER: So if they were renting a government facility they were not able to access those funds?

Mr Collett: That is correct. That is my understanding. There were funds identified for the upgrading of water energy efficiency for our assets; we are currently working on that program under, I think, the third appropriation. So the funds were identified relative to that financial year.

MS HUNTER: And that was for community facilities and childcare centres?

Mr Collett: That is right.

MS HUNTER: Okay.

Ms Gallagher: Yes.

MS HUNTER: We are onto solid ground.

Mr Collett: Yes.

MS HUNTER: How is that work going?

Mr Collett: That work is going well. We have committed all of the funds. The actual expenditure, given the date of the third appropriation, is only just starting to flow out the door, but in terms of the community facilities and upgrades programs, we anticipate spending 160,000. In terms of the environmental and energy efficient upgrades to the community facilities and the childcare centres, our intention is to spend all of the funds that were available in the current financial year by 30 June. In fact, we have started discussions with Treasury about whether we can advance that program, because it is more straightforward than going and doing some of the upgrade work. Whilst the funds are there, we would certainly like to get on with that work and realise those benefits for the environment as soon as we can.

MS HUNTER: And also to the users of the building.

Mr Hehir: Of course.

MS HUNTER: How many buildings have received these upgrades?

Mr Hehir: I think we may have tabled that list at the third appropriation hearing. I think we tabled that list of the facilities. We can probably find it again if you need us to.

MS HUNTER: Great.

THE CHAIR: If it has already been tabled, I am sure we can check. If it has not, we will request that that be done.

MS HUNTER: Thank you.

THE CHAIR: Given that there have been a lot of questions that are not in your portfolio, minister, I have a question which can only be asked of you but which could have been asked in any portfolio really. It does have the word "community" in it. This newsletter, *Our City, Our Community*—I understand you had a role in its development as Acting Chief Minister?

Ms Gallagher: Yes.

THE CHAIR: This is the newsletter that goes out from the Chief Minister. You did not get your picture in it, which is unfortunate, but you had a role in selecting articles and things to go—

Ms Gallagher: I think I may have seen a brief where I approved the content.

THE CHAIR: I just wanted go through the process for that. We have talked a lot about government advertising and the purpose for it—giving information to the community. Obviously, most of this is that. It is information about various programs. What is the process for doing it and what are the priorities in terms of a document like this? What is the information that you are looking to give?

Ms Gallagher: Not having been involved in an editorial capacity or anything like that—as I understand it, it is done through CMD and agencies are asked to look at what information may be important to put in a community newsletter. It is collated and edited by CMD.

THE CHAIR: Yes.

Ms Gallagher: I certainly did not pick and choose any articles to go in there.

THE CHAIR: Okay.

Ms Gallagher: I do not recall.

THE CHAIR: The document I have suggests that you certainly played a role.

Ms Gallagher: Yes.

THE CHAIR: An editorial role.

Ms Gallagher: Did I?

THE CHAIR: I will get the secretary to hand that one to you. That is the document which had a list of potential topics for the newsletter. I understand that that is your handwriting—just going through the other documents around it, that they are your notes.

Ms Gallagher: Yes, they are.

THE CHAIR: I just wanted to briefly go through the priorities.

Ms Gallagher: They are good notes, too.

THE CHAIR: They were somewhat editorial. Just quickly, firstly, "Election commitments met", which is up high on the list. Why is that a priority in terms of information for the community?

Ms Gallagher: Because they were commitments that we made to the community. We were elected to do a job, and we are reporting back to the community about how we are progressing on that job.

THE CHAIR: There were a couple of them that you seemed to have a concern with and you crossed off. I just wanted to get your views as to why. There was the opening of new correctional facilities and more computers in schools.

Ms Gallagher: I am not sure that all of those notes are mine. They may be. I do not know. I think it was given to me as a list of suggestions. I have made a note there that we should make sure there is a balance across the portfolios. I do not know. I think it is just my view on the list that was given to me.

THE CHAIR: Okay. Just finally, before we move on, the Chief Minister obviously—there was an issue yesterday with some advertising on land rent and the process for that. Is there a reason why there is a query there about land rent being part of that brochure? Is there a concern about land rent?

Ms Gallagher: I cannot recall and I am not sure that is my annotation. I simply cannot recall. I am not sure it is. I do not know how else to answer that. I just do not recall.

THE CHAIR: Thank you. Ms Burch.

MS BURCH: On page 241, under class 3.1—do you remember those?

MRS DUNNE: Output class 3.1. That is yours.

MS BURCH: There are a number of new indicators down there around the number of partnership forums with communities and the number of visits to community service organisations. Is that a new indicator, and what will be the outcome of those visits and forums?

MRS DUNNE: The visits are one a fortnight, so what are we trying to achieve?

Ms Whitten: Thank you for the question. The purpose of indicator (b), in terms of the partnership forums, is to report to the Assembly about the dialogue that we have between government and the community sector through the joint community government reference groups and just put that on the table to say that we do that on a regular basis.

MS BURCH: It is not necessarily formalising the function; it just recognises that as

a key part?

Ms Whitten: Yes.

MS BURCH: Is that the same for the number of visits to service organisations?

Ms Whitten: The visits to community service organisations are the regular visits that we have to our funded partners, our partner organisations, and that was just there to demonstrate that we are doing that.

MS HUNTER: And that reflects across all programs? Which particular funding programs are you referring to?

Ms Whitten: It is to do with community services program.

MS BRESNAN: Were organisations visited before?

Ms Whitten: Yes.

MS BRESNAN: It is actually to reflect that you are doing that.

MS LE COUTEUR: Nothing has changed; you have just got an indicator.

MS BRESNAN: And it is departmental, presumably, officers who will be doing the visiting; is that right?

Ms Whitten: Yes. Once again, it is another demonstration that we were working with our community organisations in a partnership approach.

MS BURCH: And recognising that importance, you are putting it in as an indicator rather than hiding it somewhere?

Ms Whitten: Yes.

MS HUNTER: I was wondering about indicator (a) and the training sessions. There were 10 held in this current financial year and targets are 10 for next year. How is that training delivered? Is that delivered by the department or delivered by another organisation, a series of—

Ms Whitten: No, it is actually delivered by the ACT Council of Social Service.

MRS DUNNE: Could I follow up on the issue of training for community sector organisations. I asked the Chief Minister questions yesterday about changes in governance that artsACT wanted to impose on community organisations that they funded. For organisations that come under your funding aegis and receive funds from you, does the department have rules about the types of people who may or may not serve on boards? For instance, the issue that has arisen in relation to arts is that artsACT wants to prevent people who are also employees of organisations serving on boards. I was wondering whether this was common across others agencies. If there are rules about who can serve on boards, what are they?

Mr Hehir: I am certainly aware that we do have some rules on who can serve on boards. I would need to check and see whether that is a specific rule that we have, but there are certainly a number of rules that we have where we become concerned and talk to organisations about their board membership if we need to. Given that we work in disability and work with young people, that is something we pay a great deal of attention to. So it is certainly there. I am not aware of that specific issue being a particular issue for us.

MRS DUNNE: I would appreciate advice generally—

Mr Hehir: I can check on that.

MRS DUNNE: because I think it is an important issue about governance but also I am now interested to see whether this is an across-government move or what.

THE CHAIR: Ms Le Couteur.

MS LE COUTEUR: Again, I fear this may be another portfolio but, obviously, the budget is increasing bus fares and parking. This is going to impact on low-income families, including those that do not or cannot have concession cards. Is there any consideration of increasing the availability of concessions, given the economic climate, and decreasing fares?

Ms Gallagher: Yes. DHCS have been doing a fair bit of work on this and we will continue that and look at it in terms of next year's budget. In fact, it was Deb Foskey that kicked off the work on the review of concessions.

MS LE COUTEUR: Yes, I remember that.

Ms Gallagher: We have done some reports on that and we are continuing to look at the cost of increasing our concessions regime across government. Whilst we are making changes to streamline processes so that people understand what concessions are available, the issue of extending the concessions we have not addressed, because it does come with quite a bit of budget impact.

MS HUNTER: Talking about that concessions review, it is an ongoing process; so there have been some report backs. There is a clear list that people can access easily that explains their concessions?

Ms Gallagher: Yes.

MS HUNTER: How do they access that? Where is it usually—

Ms Whitten: The concession list is actually on our DHCS website. One of the initiatives that we are implementing from the review from last year is to put in place a portal, a concessions portal, so that it makes for easier access for people to find particular concessions, depending on their circumstances.

MS HUNTER: When would that portal be up and going?

Ms Whitten: We have actually talked with the South Australian government in terms of their concessions finder software and we have got permission to access that tool. We are working on getting that established on our website and just the technological aspects of that. So it should be shortly.

MS HUNTER: There was another portal that was put up a few years ago and that was on access to grant funds and tenders that were available—whatever. Is that up and going and how is it going?

Ms Whitten: The grants portal is up, and that is separate from the procurement portal.

MS HUNTER: I know it is up, actually. It is continuing, that is working well and you are getting good feedback on ease of use? It is being maintained?

Ms Gallagher: I have not had any complaints. I have not had anyone say it is great, either.

Ms Whitten: It is being maintained and each of the departments is responsible for updating the information in relation to their particular grants.

MS HUNTER: And you are satisfied it is being updated regularly? It is all very well to create something but usually the burden is in the maintenance.

Ms Whitten: As the minister said, we have not had any complaints about it.

THE CHAIR: Mr Smyth and then Ms Bresnan.

MR SMYTH: In the Ros Dundas and ACTCOSS presentation on Friday, there was discussion about the indexation formula and there was some suggestion that the department felt that they would slacken what was expected of the organisations delivering services. For those who were not here, Ros Dundas said, for instance, for one group that had approached ACTCOSS call-outs were up 60 per cent this year and they were expected to get worse. Calls on services were up 35 per cent for another group. A third group had already achieved a shortfall of $30,000 and they had no relief in sight. The indexation that they all expected to get, that four per cent, had dropped to 3.15 per cent.

At the same time Ms Dundas was saying that they were getting calls on the various services offered by their member groups from areas that had never sought assistance before and had a potentially large number of new clients. What will the government do to address that and assist those organisations who are helping?

Ms Gallagher: The forecasts for the community sector in the outyears are just forecasts. So I would be surprised if any agency should, planning ahead, say, "We are going to get four per cent guaranteed from the government," because that indexation rate does move from year to year. I know we try to project as much as we can. In good years it is good for the community sector. In this instance it has not been good for the entire budget, and the community sector's indexation rate has fallen.

I think what I said in the Health discussion—and I think I said it in the Treasury discussion—is that this year we need to be sensitive to the outputs we are asking the community sector to deliver, if they are being stretched by the indexation rate, if it impacts to that point. Also, in relation to some of those organisations that you have mentioned—and I think I am aware of a couple of them—indeed, a couple of them have already asked the department to go and speak with them and look at what opportunities there are to see them through and support them. I do not think it is in anyone's interests if a community organisation is eating into its reserves in order to pay its recurrent costs, which one of the organisations has raised with me.

But in the context of the overall budget, I think—and I said this to the community sector when I met with them the day after the budget—that 3.15 per cent was all that the budget could support this year.

MR SMYTH: But in the context of unemployment going from, say, roughly, 2½ per cent to 3½ per cent or the Access estimates of 5.2 per cent, clearly, the demand will be greater. In speaking to a representative, for instance, of the RSPCA, he said that for the first time they are actually getting requests from people to see whether they give out welfare for pets. There are now people in our community that cannot afford to feed their pets because they are finding life so difficult.

Yes, the formula was set and in the good times it seemed like a good formula. But, if we are going to relax the expectation on groups, which means they will deliver less service at a time when demand is growing, surely the gap then that is left will be even bigger. The Assembly appropriated $2½ billion before Christmas for this. But in the context of the year's—

Ms Gallagher: And a lot of that has not been spent yet; so there is some capacity in emergency relief, from the data that I have seen. I think it is something that we are going to have to monitor and watch over the next 12 months. I think there is enough goodwill within our community sector organisations and, indeed, in the departments that support them or fund them to work through some of these issues. I have no doubt there are some solutions out there that, with creative thoughts and minds, can deliver without necessarily calling on the budget every time to relieve that pressure.

MS BRESNAN: My question is in relation to this. I know we are talking about outputs and being realistic about that but, I guess, these organisations, if they are asked to provide services all the time, often might do that, even if they do not have the funding. On that, can we assume that community organisations will be quarantined from any future efficiency dividends, that that will not apply to them?

Ms Gallagher: It is hard to rule out in terms of the exercise that we have got before us. There is a big task ahead to find savings to the budget.

MS BRESNAN: That could be a part of it?

Ms Gallagher: I would be reluctant at the beginning of the process to embargo any area but I have to say that it would not be the first area you would go to, the community sector, to look for savings. I think there are efficiencies we can find within the community sector, and we are exploring that with our regional community centres

that we are setting up and we are looking at relieving some of the accommodation costs that people are paying at the moment. Many of those organisations that are moving will move into these centres.

This will not help probably this next calendar year, because of the refurb work that is going on at the moment; so they probably will not see the benefit of it immediately. But the longer-term planning on that is shared facilities, the possibility of shared receptions, so that small agencies, sometimes of two people, are not running the administration costs that they are currently running.

I am not talking about removing the diversity of the sector and consuming small organisations into large. That is not what this work is about. But I genuinely think government and the community sector can look at the way we provide services and look for efficiency, just like the government did two years ago, looking internally to find savings. I think they are there.

So I would be reluctant but I would say that we would not, therefore, necessarily look to remove that money from the community sector. In a way it would assist us to roll it back into those organisations to allow them to meet some of the pressures that they are experiencing. For example, if Carers ACT save $50,000 annually on accommodation when they move into there, we would not be saying, "You return that $50,000 to the budget." It would be much more likely that we would say, "Okay, let us look at how we can apply this $50,000 to your existing funding to see what else you can do. Or will it alleviate some pressure on some of the service demands that you have got at the moment?"

Every year all the organisations are seeking further and further assistance. The budget just cannot deliver for everybody. Every year we probably have two, three, four or five organisations that we find the money for but it does not meet the need or the requests that we get. Part of that has to be looking at the way we do things.

MS BRESNAN: Yes, I understand that. I guess, as Mr Smyth has said, they are experiencing increased demand and already are pretty stretched in terms of what they provide and what they do with the funding they already have. I guess that would probably be of concern to some organisations. I understand what you are saying about there being savings in admin and that can also assist the organisations in terms of what they provide from their resources. But it might be a bit of a concern to some organisations to hear that that could actually be applied to them.

Ms Gallagher: The efficiency?

MS BRESNAN: Yes.

Ms Gallagher: I just do not think you could say there is any area where government funds are exempt. I am not saying that to create worry or fear. I just think, as we begin the process of going through to look at where we can find savings, we genuinely have to look everywhere. Mindful of that fact, I would be very surprised if there were enormous savings in the community sector or savings that we are not already realising by having the community sector do that work.

MR SMYTH: Following on the general theme, has the department done any modelling, for instance, on what every per cent of unemployment means in terms of extra call on the community sector?

Mr Hehir: No.

MR SMYTH: Why not? If unemployment, by the government's own numbers, will increase by one per cent in the next year, does not that alert you to the fact that there will be extra call on community services?

Ms Gallagher: The department has done quite a lot of work about analysing disadvantage and what that means across the city. In relation to the unemployment rate, not specifically, but that has fed into a broader piece of work that was done, when I was the minister, for the whole department on identifying disadvantage and looking at the ways that a department and agencies—

MR SMYTH: That document was made public?

Ms Gallagher: Was it?

Mr Hehir: I do not think so.

MR SMYTH: No? Is it possible for the committee to have a copy of that document?

Ms Gallagher: We will have a look at it. It was in relation to families coming to our attention under stress, in distress, and families that we had not previously come into contact with.

MR SMYTH: Which is exactly what Ros Dundas was talking about on Friday.

Ms Gallagher: Yes. I think Sandra Lambert led the work on looking at how the whole agency interacted, from housing to the office, to community services.

Mr Hehir: This work now sits with Minister Barr but we did actually provide a briefing today on it. If you would like to contact Minister Barr's office, he may be very happy for us to get the brief. I am not sure whether Ms Hunter found it useful today but—

MS HUNTER: It was very useful.

Ms Gallagher: In fact, you have done quite a bit of work on concessions, which does look at price increases and what that means. So there has been analysis.

Mr Hehir: A lot of the work that we had previously been looking at in terms of the work that supported the $2.5 million that you referred to earlier was actually looking at quite a different set of circumstances. We were seeing people approaching community service organisations who were not actually previous clients and were not their normal clientele. A lot of that actually related to housing stress in the form of mortgage repayments, high petrol costs and high food costs. So a lot of that work then was on that particular group of people who were approaching it.

We are certainly seeing, again, another different group of people coming through. I am not sure the principles are any different in terms of the stress that they are experiencing. So, while we have not done the specific work on what does an extra one per cent of unemployment mean, we are certainly aware that it impacts on families, that it impacts on individuals. We have a look at what resources we have to apply to addressing those.

MR SMYTH: Ms Whitten has been there for a long time. Is there a rule of thumb in the sector about what some of these changes, like unemployment and wages and mortgage stress, mean to individuals and, therefore, what the call might be?

Ms Gallagher: I do not know.

Mr Hehir: I am probably not able to answer that in terms of relativately strong economic growth over the years that I have been associated with the department.

Ms Whitten: I think that the minister gave the opening statement in terms of the $3.5 million that has been appropriated. Some of that funding has been most important in terms of families. Their access to that funding has been extremely valuable.

MR SMYTH: Thank you.

THE CHAIR: Mrs Dunne and then Ms Burch.

MRS DUNNE: I want to go back to the support for community groups that Ms Bresnan was talking about and also the issue of the former school sites. I have had representations from a couple of organisations who were keen to go into the former school sites, but it appears that they may be facing increases in rental to do so, to move from one government building to another. My specific question is: are there organisations that are going to have an increase in rent because of their changed circumstances? I am aware of one who thinks that they will. And a more specific policy question: if the government is funding an organisation to fulfil a community service role and they are receiving accommodation in a government-owned building, what is the underlying philosophy of funding them and charging them rent?

Ms Gallagher: A few different arrangements exist across government, as I understand it. Essentially, in their grants they are funded for rent. Once we get our regional community facilities up, I guess we could remove that component that they are funded for rent because we are paying the costs another way. It is probably an historic arrangement around their grants—that within that grant component when we fund for staff we fund for a percentage of accommodation and other on-costs as part of that. So if we were funding it and not charging them rent, I guess they would be getting funding that was not being allocated for rent. We could then have a discussion about whether they could use it for something else. I do not know if anyone else wants to add anything. I think there is one group that have pulled out of the schools. Have they pulled out?

Mr Collett: Yes.

MRS DUNNE: Who was that?

Mr Collett: I would need to check. They have indicated that they are looking closely at the matter. I do not know that they have withdrawn yet, so I would not like to share that until we confirm that data. The opportunity arises for us to bring our charging for space into alignment with the charges that are levied by Territory and Municipal Services. We will be equating our rental level to the community rental level for TAMS. As part of the exercise, we are looking at where other space exists—it is being provided by other government agencies—and trying to rationalise that.

The community rental, which I anticipate will now be set by us and TAMS, is currently $118 a square metre a year. That has been established on the historical costs of servicing the building, undertaking maintenance and the other associated costs. It is on a cost recovery basis. If we were not to raise that rent through grants to those organisations then we would have to put in bids for budget appropriations to provide us with the funds that are necessary to maintain the buildings.

Mr Hehir: It is perhaps not a policy position but a policy conundrum in terms of the rent issue in that many of the organisations rent privately or operate out of other facilities. In a sense, say you do not have to pay rent if you are in a government building, are you treating all community organisations fairly and evenly? There are some issues around that.

MRS DUNNE: There are fairly significant issues.

Mr Hehir: Yes.

MRS DUNNE: Yes.

MS HUNTER: It was around getting some consistency across different departments which are renting facilities out.

Mr Hehir: Yes.

MS HUNTER: It was a real dog's breakfast of different arrangements. Is that moving along smoothly?

Mr Collett: We are still proceeding on that. To be honest, we are focusing on getting the tenants into the new buildings. We are members of the property forum, which is chaired by the Chief Executive of the Department of Territory and Municipal Services. We work very closely with Steve Ryan and his group in ACT property. They are the primary landlord for those facilities that are not managed by our department.

The facilities that are coming on board through the surplus schools are a significant boost. We had just under 100 community facilities and childcare centres but, as has been referred to by others, it has largely been a reflection of historical circumstances rather than a clear policy. Your question is quite right: we are keen to move in that direction. We are focused on the work, not necessarily the tenants, but the discussions with Steve Ryan in particular from property group in TAMS are ongoing. I anticipate

that we will coming forward with recommendations to the minister.

MS HUNTER: Mr Collett, is there going to be a standard approach around doing inspections of those buildings and having some standard?

Mr Collett: Yes.

MS HUNTER: Because it may well be that some organisations will move into newly refurbished buildings that are going to be great to a certain standard and there are others who are out in there in old buildings, which might be, for instance, looked after by TAMS, who are not particularly feeling that equity has been met because they have got leaky pipes or have not had it painted for X number of years or whatever. I am just thinking of a consistent approach around maintenance and getting to a standard.

Mr Collett: Absolutely. Part of the work that we are doing around the other community facilities is around an audit of the conditions, so a condition audit. It probably will not surprise you in terms of my background in asset management that I would like to move on to a strategic basis of managing those assets and have a forward program, much as we have been able to do with the public housing portfolio—rather than going out and fixing this leaking tap or that broken light switch, that we look at the work that needs to be done over the next 10 years, develop a program for it and move through it in a systematic way.

Certainly the work that I described—without testing the patience of the chair—around the refurbishment of the former schools sites with the regional community facilities and that top-down approach I described of getting the building services right, getting the fire, the electricity and then moving down, is an attempt to stop windfall gains and disparities where somebody gets a Rolls-Royce fit-out because they just happened to have a switchboard and a boiler that was in good condition and somebody else is lucky to get a repaint because the building needed more work. We will be trying to set a common standard across the sector.

MS HUNTER: Good.

THE CHAIR: Before I go to Ms Burch, who has some questions, this is just a reminder that questions to the minister in her capacity as the Minister for Women can be asked at any time.

MS BURCH: Yes, that was my question. It is a question for the Minister for Women. During the annual reports review, there were comments about the grants to women not having a great pick-up rate. I was just wondering if there has been any work done. I am trying to remember which grants they were.

Ms Gallagher: The return to work—

MS BURCH: The return to work grants, yes. Has there been a major pick-up in the last little bit, or has there been some rethinking about that program?

Ms Gallagher: Have you got a number on them? I signed off a few more at lunch today.

Ms Whitten: The current number is 68.

Ms Gallagher: Is that after I have signed those today?

Ms Whitten: I believe so.

Ms Gallagher: Okay.

MS BURCH: Thank you. So 68?

Ms Gallagher: Still not as—

MR SMYTH: Sixty-eight? Why not 42?

MS BURCH: So 68 grants this year?

Ms Gallagher: This financial year, out of 200 available.

MS BURCH: Okay. So there is still not a great pick-up really on what is available.

Ms Gallagher: We have done a bit of work around them, haven't we, about promoting them and targeting them? I think it has gone out in the housing newsletter. We are still working on that one.

MRS DUNNE: I presume that it is advertised in child and family centres?

Ms Gallagher: Yes.

MRS DUNNE: And baby health centres.

Ms Gallagher: Yes.

MRS DUNNE: Sorry, we do not have baby health centres anymore.

MS BURCH: The grants, what are they using them for? Is there any feedback on whether the criteria are not quite right?

Ms Whitten: They have been used for a range of purposes for the young women who have accessed them. The ones I have seen cover a range of education programs—first aid through to something more formal—and childcare arrangements in relation to attending formal courses. There are also particular items for study purposes or even clothing for interviews.

MS BURCH: So it is quite broad?

Ms Whitten: Yes. It is quite broad for the $1,000 that the women receive.

MRS DUNNE: Where are we at with the government's election commitment in terms of micro financing for small businesses?

Ms Gallagher: We are looking at using some of the money, the underspend—

MRS DUNNE: Double dipping.

Ms Gallagher: Well—

MRS DUNNE: Reallocation.

Ms Gallagher: Yes, looking at the underspend in this area to apply it to the micro credit. I guess we could rename the package and look at how that can support women in a different way.

MRS DUNNE: To what extent have you developed the micro credit? Has the money been appropriated?

Ms Gallagher: As I said, at the moment—there was not a specific appropriation for it in the budget—we are looking at whether, because of the under-application in this program, we should reduce this program to 100 grants for women and use the rest of the money. I think our commitment on micro credit was around $30,000.

MRS DUNNE: Is that $30,000 a year?

Ms Gallagher: Yes.

MRS DUNNE: So $120,000 over four years.

Ms Gallagher: There is capacity within that $200,000. Considering the work we have put in—

MRS DUNNE: You are thinking that you will not actually appropriate the $120,000 over four years?

Ms Gallagher: We may not need to appropriate it, but you will see in the budget there are a number of election commitments that we have not appropriated money for that we are asking agencies to reallocate internally. We will keep going and see how we can keep promoting the return to work grants, but if they are not getting the level of interest and we are not going to get 200 women who fit the criteria—and we are not going to give any woman $1,000 to return to work, so we do have an eligibility criteria—we could use a portion of that money to start off the micro credit system and see how it goes.

MR SMYTH: Just on election promises, there was a promise to audit the boards across the ACT. Has that been done, and are the results available?

Ms Gallagher: That work will have been done. It has been an ongoing piece of work.

MR SMYTH: Gender balance on boards?

Ms Gallagher: Yes. I think we had done really well and then we slipped back again.

We have an ongoing look at this through cabinet processes as well.

MR SMYTH: Where is it at now?

Ms Whitten: Boards and committees?

Ms Gallagher: Yes.

Ms Whitten: Forty-eight per cent representation of women on ACT government boards and committees.

Ms Gallagher: Where we have the ability to appoint.

Ms Whitten: That is right.

Ms Gallagher: Where we do not have the ability to appoint, I think it might be a percentage lower. It is slightly up.

Ms Whitten: It is a slight increase.

Ms Gallagher: Yes.

THE CHAIR: Is that audit available?

Ms Gallagher: Yes, I am sure we can provide you with that information. I do not think it is a problem.

MR SMYTH: If you have got that here, that would be lovely. But in previous years, say the last three or four years, what has the percentage been?

Ms Gallagher: We can provide you with that information. We had got it to about 49, it then went down to about 47, and I think it is going back to about 48. That is my memory, but we will answer it on notice.

MR SMYTH: Take it on notice; that is fine.

Mr Hehir: I am not sure if it has been done literally on a year-by-year basis.

MR SMYTH: All right. If you could give a point in time snapshot over the last several years that would be fine.

THE CHAIR: Ms Le Couteur.

MS LE COUTEUR: Thank you. ACTCOSS has expressed concern about a lack of focus on women's issues, particularly those women in the community who are experiencing disadvantage and poverty. Given the current economic climate which we have touched on already and its inevitable probably disproportionate impacts on women, could you please tell us about any new initiatives that we have which will be targeted at women on low incomes, multicultural or Indigenous women or, in fact, women who will be affected by the current economic unpleasantness?

Ms Gallagher: In terms of a specific initiative, there are a few in this budget. Ms Le Couteur, if I had the women's budget statement I could just take you to that part of the budget now.

MRS DUNNE: But you would have had to have smartened it up again, otherwise we would have agreed that it was not very good.

Ms Gallagher: It crosses different portfolios. I would start by saying that there are a range of support services that we currently fund that provide support to women. I accept ACTCOSS's position that they do not think we do enough, but there are certainly millions of dollars that go into the provision of support for women and women who are experiencing poverty. For some of the initiatives in this budget, particularly in the housing area—the transitional housing program—there is additional money there. That is particularly building on the domestic violence crisis response that we started during the Christmas initiative. I am sure Minister Hargreaves will be able to talk more with people around that.

There is the flexible support fund. Again, that is Minister Hargreaves's area, but that is again trying to better meet the needs of people with a disability and their carers through more flexibility in the grants programs. We have the quality of life and carers recognition grants. I had a lot of feedback around those grants. While they were welcomed, I think there was 200 in one—I think it was 200 in the carers, 100 in the quality of life and we have put another 200 into it—and it is now a $500,000-a-year fund to create more flexibility. When we look at breakdown of carers, people looking after people with a disability, that will, again, go to women. You can go through the budget. There are a few initiatives. There are not as many as we would like—I accept that—but this budget has been put together in a pretty tough environment. The available money was certainly restricted in terms of the initiatives that we could fund.

MR SMYTH: Just on that, the follow-up might be things that missed out. Ms Dundas mentioned that gender auditing has not been funded in this budget.

Ms Gallagher: Gender auditing of the budget or gender auditing of programs and the gender analysis?

MR SMYTH: I believe it is on the programs.

Ms Gallagher: The gender analysis that we have agreed to do through our parliamentary agreement is to start with the women's health plan and then, as I understand it—and getting this, I presume, will be up to the Chief Minister—to do it across other government publications, including the budget. I flagged that at the beginning in my opening comments as well. We are moving away from analysis just on women and looking at gender disaggregated data. That piece of work is commencing now.

MR SMYTH: And an estimate of the cost to do that across all government documents?

Ms Gallagher: There has not been an appropriation for it, so it will be added on to

somebody's already, no doubt, busy work load.

MR SMYTH: That is okay. Is there analysis of how much it will cost?

Ms Gallagher: To do the—

MR SMYTH: Yes.

Ms Gallagher: That is why we are starting with the women's health plan. We will start with one piece of work and see exactly what it entails. Then we will get an idea about what will be the cost of that, if we are to adopt it through every government publication. It may mean that we just do it for major publications.

THE CHAIR: Ms Bresnan.

MS BRESNAN: Just a follow-up question about the funding for particular groups, ACTCOSS and their focus on women. I do not know if this sits with you or if it sits with Minister Hargreaves, but what is being done specifically for Indigenous women and multicultural groups, because often they do not fit into those general programs which are being run? They may not feel they can access the programs, although they have a very different set of circumstances. Are there particular programs for them? I think Gugan Gulwan mentioned their young mums program had not been re-funded either.

Ms Whitten: I could answer as to the Gugan Gulwan young mums program. I think Ms Davison said that the Office for Women is actually funding them a grant of $13,000 for that program.

MS BRESNAN: That's great.

Ms Whitten: I think there is a similar amount for Multicultural Youth Services. They also have a young mums program as well.

MS BRESNAN: Yes, they do.

Ms Whitten: So we have another $13,000 for that as well.

MS BRESNAN: So they are the two main programs for women that are run in those for Indigenous and multicultural women?

Ms Gallagher: Are they the women's grants?

Ms Whitten: I have a list of the women's grants, if you would like me to go through them?

MS BRESNAN: Yes.

Ms Whitten: The women's grants program is $100,000. It is an annual program. A number of organisations have been funded this year. There is the Canberra Roller Derby League and Women with Disabilities ACT. YWCA of Canberra has a

particular program. We could table this list, if that would be helpful.

MS BRESNAN: That would be great. Thank you.

Mr Hehir: In addition to some of the ones that Ms Gallagher mentioned in terms of the housing area, which is always a key support, particularly for women and families, we have had discussion around the expansion of the transitional housing program. There is a specific program for housing assistance to victims of domestic violence, which is predominantly women and their children. That is a program which actually supports the women, where appropriate, staying in their tenancy—and removing the offender. That is quite a targeted program within that space.

There are also the building housing partnerships, which again are very clearly targeted to sustain people in their tenancies. A group of people who are quite vulnerable in having unsustainable tenancies or having their tenancies fail are single mums. Again, you see that mix of CAL backgrounds and Indigenous background showing up quite strongly in those sorts of figures. Building housing partnerships is, again, quite focused on working across a broad range. It will also include working with older women, particularly in terms of assisting them with their property skills and also connected to the community. So there are a number of things within the space that this department deals with that are working with women.

THE CHAIR: Mrs Dunne.

MRS DUNNE: On the subject of the transitional housing for families, there was a budget commitment for extra housing, extra properties. It may be somebody else's, but have those extra properties been funded?

Mr Hehir: It is Minister Hargreaves. The capital was not ever there. It is about a service into those properties, so yes.

MRS DUNNE: Sorry, there is no capital? There was $320,000 over four years.

Mr Hehir: Which is the expansion of the transitional housing program on page 85—is my understanding.

MRS DUNNE: Okay. I can ask Mr Hargreaves about that?

Mr Hehir: Yes.

MRS DUNNE: Okay.

THE CHAIR: Ms Burch, have you got any further questions?

MS BURCH: No, I am fine, thank you.

THE CHAIR: Okay. Ms Bresnan?

MS BRESNAN: Have we already spoken about the housing assistance for victims of domestic violence?

MRS DUNNE: I just did.

THE CHAIR: We just did.

MS BRESNAN: Sorry.

MS BURCH: It is getting to that stage.

MS BRESNAN: No, I probably do not have any other questions except for other ministers.

THE CHAIR: I have just one. It goes back to an issue we touched on before, the 3.15 per cent for community organisations. I think, from memory, that, from Monday, the growth that you are looking to constrain government to is roughly 4½ per cent a year?

Ms Gallagher: Yes, that is right.

THE CHAIR: I just wanted to get you to comment on the comparison.

Ms Gallagher: Agencies are not being indexed at 4½ per cent.

THE CHAIR: But that is the growth in spending—

Ms Gallagher: The growth in spending, and what that takes into account is 6.2 per cent growth in health.

THE CHAIR: So what will the agencies be limited to?

Ms Gallagher: What was your indexation?

Mr Hehir: Off the top of my head, I cannot say. I am going to ask Mr Hubbard if he has got it.

MR SMYTH: Mr Hubbard thought he was going to miss out.

Mr Hehir: Approximately two per cent, off the top of my head.

Ms Gallagher: It is really distorted by the size of the health budget and the growth in health that brings you up to that 4½ per cent.

Mr Hehir: For us it is also because a large part of our budget, about 45 per cent, goes out to community sector organisations.

Ms Gallagher: Lucky they are not being indexed at the government rate.

Mr Hehir: There is a top-up in that area there.

MRS DUNNE: I have one more question as well.

Mr Hubbard: I am the Chief Financial Officer of DHCS and Housing ACT. The consumer price—we are given two different rates of indexation: the wage indexation, which is captured in the EBA payments, and also additional funding for administrative costs, which this year has been set at 1.75.

THE CHAIR: So what does that average out to?

Mr Hubbard: I am not sure on the actual proportion. It would depend on the agency and what proportion of staffing to admin they actually have.

THE CHAIR: What is the wage price index for this year?

Mr Hubbard: The wage price index is 3.5, which is the same for—those indexes come from forecasts that usually come from ABS.

THE CHAIR: Yes.

Mr Hubbard: They are the ones that we use. In a sense, what we are trying to do, both in government and with the community sector, is maintain the real value of their base funding. That is the really important thing. One of the things that you do find with the community sector, and also with agencies, is that you are trying to maintain that real cost.

THE CHAIR: Yes.

Mr Hubbard: So we look at forecasts going out into the future. As you see on both the pages that are to do with indexation in the budget papers, that is what it is about. There is a slight difference between economic conditions and demand on services and maintaining the base funding for agencies—community agencies—which we are doing. We are maintaining the base, but we are also trying to maintain the real value of that base.

THE CHAIR: Yes. From an agency's point of view, that other figure of 1.75, I think—is that just based on CPI?

Mr Hubbard: CPI. It is a number that we are given.

THE CHAIR: So you basically just average out in a proportional way depending on the size of the agency and how many staff it has, the wage price index and the CPI, and that is roughly where your growth funds are coming from, apart from health?

Mr Hubbard: Yes. Each agency has its salaries and employees expenses, which you see in the budget. Each agency also has its admin costs. So it is apportioned directly to those numbers which are in the expenses part of your operating statement in the budget papers.

THE CHAIR: Yes.

Mr Hubbard. That is how it is apportioned.

THE CHAIR: Okay.

Mr Hubbard: So there is a direct relationship there.

THE CHAIR: All right. That is all from me.

MRS DUNNE: Can I just have one quick one, which is a take on notice.

THE CHAIR: Yes.

MRS DUNNE: It is probably a task for Mr Hubbard. On page 241 of BP4, there is (f), which is cost per 1,000 head of population. There are wild variations and there are footnotes. Could we have a mug's guide to what that actually means and what has gone in and out?

Mr Hubbard: You want the numerator and the denominator for those two things?

MRS DUNNE: But also the things—it goes from 104 to 38. I think the denominator is a thousand, but also I want an explanation of what footnote 6 really means, and what has gone—on notice.

Mr Hubbard: Okay.

MR SMYTH: You can take this on notice, unless you can answer it quickly. On page 248 in your operating statement, grants and purchased services have gone down 19 per cent.

Mr Hubbard: You will find that the vast majority of that is—the mixed movement in that area is the grants funding for SAAP, which has gone over to Housing. You will see that about $19 million of that is SAAP funding. That 19 per cent would be made up predominantly of the SAAP transfer directly to Housing.

MR SMYTH: And below that the other expenses dropped by 91 per cent?

Mr Hehir: We might take that one on notice.

Mr Hubbard. That is a technical adjustment where other expenses are not included. There will be a list. I can give you the reconciliation for that.

MR SMYTH: The list would be lovely, thank you.

THE CHAIR: We will wrap it up there. Thank you very much, minister, for your time.

The committee adjourned at 5.53 pm.