LEGISLATIVE ASSEMBLY FOR THE AUSTRALIAN CAPITAL TERRITORY

SELECT COMMITTEE ON ESTIMATES 2012-2013

(Reference: Appropriation Bill 2012-2013 and Appropriation (Office of the Legislative Assembly) Bill 2012-2013)

Members:

MS A BRESNAN (The Chair)
MR J HARGREAVES (The Deputy Chair)
MS M HUNTER
MR B SMYTH
MR A COE

TRANSCRIPT OF EVIDENCE

CANBERRA

THURSDAY, 21 JUNE 2012

Secretary to the committee:
Ms S Salvaneschi (Ph 620 50136)

By authority of the Legislative Assembly for the Australian Capital Territory

APPEARANCES

Privilege statement

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Amended 9 August 2011

The committee met at 9.16 am.

Appearances:

Gallagher, Ms Katy, Chief Minister, Minister for Health and Minister for Territory and Municipal Services

Health Directorate
Foster, Mr Ron, Executive Director, Financial Management
Brown, Dr Peggy, Director-General
Thompson, Mr Ian, Deputy Director-General, Strategy and Corporate
Martin, Mr Lee, Deputy Director-General, TCH and Health Services
Carey-Ide, Mr Grant, Executive Director, Service and Capital Planning
Kohlhagen, Ms Linda, Executive Director, Rehabilitation, Aged and Community Care
Bracher, Ms Katrina, Executive Director, Mental Health, Justice Health and Alcohol and Drug Services
O'Donoughue, Mr Ross, Executive Director, Policy and Government Relations
Kelly, Dr Paul, Chief Health Officer, Population Health
Woollard, Mr John, Director, Health Protection Service
O'Donnell, Ms Rosemary, Executive Director, Medicine
Reid, Ms Barbara, Executive Director, Surgery and Oral Health
Chatham, Ms Elizabeth, Executive Director, Women, Youth & Children

THE CHAIR: Good morning and welcome to this fifth day of public hearings of the Select Committee on Estimates 2012-2013.

The Legislative Assembly has referred to the committee for examination the expenditure proposals in the Appropriation Bill 2012-2013 and the revenue estimates in the 2011-2012 budget. The committee is due to report to the Assembly on 14 August 2012.

The committee has resolved that all questions on notice will be lodged with the committee office within three business days of receipt of the uncorrected proof transcript, with day one being the first business day after the transcript is received. Answers to questions on notice will be lodged with the committee office within five business days of receiving the questions, with day one being the first business day after the transcript is received. Answers to questions taken on notice will be returned five business days after the hearing at which questions were taken, with day one being the first business day after the question was taken.

Proceedings this morning will commence with an examination of the expenditure proposals and revenue estimates for output class 1, health and community care, starting with output 1.1, acute services; output 1.2, mental health, justice health and alcohol and drug services; output 1.3, public health services; and output 1.4, cancer services.

There will be a morning tea break at approximately 10.30 and we will stick to that time even though we started 15 minutes late. We can come back to acute services after morning tea if needed.

I am sure you are all very familiar with the privilege statement but I will just draw your attention to the privilege card, the blue card in front of you. Can you just indicate to me that you are aware of that? Thank you. I also remind you that proceedings are being broadcast today.

Before we go to questions, minister, would you like to make an opening statement?

Ms Gallagher: Thank you, chair. We welcome the opportunity to speak with the estimates committee and answer any questions you may have. I will just provide a short opening statement to provide the context for this year's budget.

The budget builds on years of targeted investment by the government in our health system. We have been investing in more beds, more doctors, more nurses and health professionals and more services, including services that have never been provided in Canberra before. At the same time we are undertaking a massive infrastructure program to ensure we provide the services we do in contemporary, cutting edge health facilities that will meet our needs into the future.

The budget builds on these investments and this year the budget provides more than $1.2 billion in annual and recurrent funding for health services for the people of the ACT. It includes growth and new initiatives of $31 million, which will assist health services in the ACT to move to the future.

The funding provided in this budget continues our commitment to the people of the ACT to provide a safe, effective and efficient health service. We continue to see growth in acute services, intensive care, cancer, mental health, chronic disease, emergency departments, elective surgery and other surgical services. In these growth areas you will see targeted investments in the budget, such as the $12 million to enhance emergency department services and more funding to provide elective surgery operations over the coming year.

In order to meet increasing demand for health services, we will continue to open more beds and we will work hard to reduce waiting lists for health services across the ACT community.

I am pleased to report that the Health Directorate is making inroads, despite the ever increasing demands. We have funded an additional 250 beds for the public health system, which makes up for some of the beds removed prior to 2001. We are also delivering new health facilities through our health infrastructure program, including the new women's and children's hospital, new community health centres at Gungahlin and Belconnen, an expanded health centre for Tuggeranong and a modern cancer centre that will enhance health services to Canberrans.

We are also implementing the agreements reached under national health reform and you can see from the budget papers for the first time that those new arrangements reflect the changed arrangements in the budget papers.

$1.2 billion a year provides much more than elective surgery operations and treatments through the emergency department. These two areas will receive 90 per

cent of the attention of commentators; consequently 90 per cent of the marvellous work of the health system is often overlooked—the exceptional care delivered every day in our community for the community.

Each year community nurses diligently care for patients in their homes and at community clinics. Neonatal intensive care specialists and nurses save hundreds of babies. New mums attend their local community health centre for advice on their baby's health and development. Twelve thousand women access free breast screens. Four thousand women receive care during pregnancy and birth. Children are immunised to protect them against potentially deadly illnesses. Fifteen thousand people get access to free care at the nurse-led walk-in centre. 6,500 people receive emergency surgery, often saving their lives. More than 200 patients receive dialysis to keep their organs functioning. Hundreds of thousands of treatments and appointments are provided by cancer services and through the outpatient clinics. Support and treatment are provided for those living with debilitating drug and alcohol addictions. We provide dental services, plastic surgery, an eye clinic, pathology services, CT and MRI scans and of course support for those people suffering with a mental illness.

This budget funds all of those services and much more. In Canberra we have excellent access to extremely high quality health services. This is a credit to all the people who work incredibly hard every day to ensure that this is the case. I might leave it there, but I just wanted to provide that context before we move to answering any questions the committee might have.

THE CHAIR: Thank you, minister. My first question relates to cross-border health receipts and there are a couple of references to them in budget paper 3 on page 87 and page 89. I am just wondering if we could get an explanation as to why the budgeted amount for cross-border health receipts for 2011-12 and the estimated outcome for 2011-12 are exactly the same. I think it is about $99.27 million?

Ms Gallagher: Are you asking why we are not predicting any more over the estimated outcome?

THE CHAIR: Yes, given that there has been a lot of discussion around this and about getting various payments, just how do we arrive at that figure being exactly the same for each year? I would imagine there would be some variances to it across different years.

Mr Foster: We have not varied the actual outcome from the budget, because we do not yet know what the final data will be for the year, our activity. We will not have that activity until after 30 June. We also rely on prior years being finalised in determining the final amount of revenue that we might book in any particular year. We are still in negotiation with New South Wales on finalising the financial years that we have talked about previously and which we are hopeful of having agreement on in the next week to enable us to make some adjustments to the level of revenue that we have been accruing or expecting to get from New South Wales.

THE CHAIR: There were findings of the Auditor-General with respect to the control systems in place with Health for capturing the actual costs of delivering services to residents from interstate. In question on notice 2359 you indicated that you were able

to have an agreed position with New South Wales to allow the acquittal of three outstanding years by 30 June 2012; you have just mentioned that.

Given we have got those findings of the Auditor-General and the time it has taken to reconcile prior costs of providing these services, can you give us assurances that there will not be write-back of prior year revenue once the acquittal process has been completed with New South Wales?

Mr Foster: There is absolutely no chance of any write-off. The amount that we have accrued is the amount that relates to non-disputed data, through a process of agreeing with the agreement. It reflects all the issues in the agreement about price and contributions for capital. So, no, the revenue will only increase.

THE CHAIR: So we will not be in a situation where we will get back less than we expected?

Mr Foster: No.

MR SMYTH: How can you know that if the review is ongoing?

Mr Foster: Because the review looked at data. There were certain elements of data that were being looked at. There was a block of data that was not in dispute so we have only accrued that in the financial statements at this point in time.

THE CHAIR: I will just go back to my question then. Can you also explain what grossing up payments as part of the national health reform arrangement means and how this adds approximately $20 million to cross-border health receipt revenue in the 2012-13 budget?

Mr Foster: Until the signing of the national reform agreement and the creation of the OHN, the figures shown for cross-border in the financial statements were always a net figure, so they were New South Wales patients treated here less ACT patients treated in New South Wales. It was the net amount. What is required under the national reform agreement is to have the grossed up amount so they can adjust New South Wales payments and pay us directly for that activity and then get our figures and take an amount of money off us to pay New South Wales. The commonwealth's reform is changing the way the funds will flow. There is no change in the net outcome; there is just a need to gross it up to reflect payments coming from different directions.

THE CHAIR: Given the historical issues with systems in place with health for capturing the actual cost of providing services to interstate residents, what assurances can you provide that the budgeted revenue figures for cross-border health receipts for 2012-13 and the forward estimates years are completely correct?

Mr Foster: It is a plan. The budget figure, a grossed up figure, is purely grossing up what we had anticipated would be the amount in 2012-13, which was a fairly conservative figure. That was arrived at several years ago. Approximately $102.6 million was our net figure that we anticipated for 2012-13. If activity does not come through at the level it is, we will not receive that amount of money. It is purely based on what levels of activity we receive from across the border and the acuity of

that activity. At this stage, given where we are at with New South Wales and officer-level discussion, and with an anticipation of outcomes for the current year, we do not envisage the 102 would be a difficult figure to achieve if activity continues to come to the ACT.

THE CHAIR: Just one final thing. In terms of some of those issues that were raised by the Auditor-General, have those sorts of issues been resolved in terms of the processes that are now in place?

Mr Foster: From my perspective, they have certainly been resolved in relation to observing the agreement through the spreadsheet that calculates the amount. The data issue is—I believe that the organisation has responded to the issues around the data, and that the data that we have been reported on in New South Wales is data that we believe is appropriate to be charged against the agreement.

THE CHAIR: Do you think we will continue to be in a situation of resolving exactly how much New South Wales need to pay?

Mr Foster: It is hard to know where we will go with agreements with the cross-border arrangements given the national reforms, but at the moment we have got an agreement in place that deals with payments for cost-weighted separations, some outpatient services and contribution towards capital based on New South Wales prices. We will work down to, at some point in time, looking at whether we progress to the new way of national-weighted activity units versus efficient price. That will be a subject of some discussion over the many months ahead, I am sure. The next two years are transitional years through the national reform. We are not in a position to see the need to change the agreement or seek a change to the government funding agreement at the moment, but that will be discussed.

THE CHAIR: So we may still have those issues?

Ms Gallagher: I think so. I have not known the New South Wales government to willingly accept what it costs every year. As is within their right, they scrutinise it and they contest the elements of it. And then, usually at the eleventh hour, we get an indication of what their view on that is when they provide us with a cheque, pretty close to 30 June.

THE CHAIR: Mr Hargreaves.

MR HARGREAVES: I apologise for being late, Chief Minister; I had other things to deal with on a domestic front.

THE CHAIR: Question?

MR HARGREAVES: When I was travelling along the parkway today, Chief Minister, I was greeted by your dulcet tones talking about mental health services. The Institute of Health and Welfare has put out a report. I did not get the full gist of it, but it sounded to me as though we were leading the—

MR HANSON: We are doing acute services, not mental health.

MR HARGREAVES: Do you want to start now or do you want to leave it till later? Why don't you just leave it till later?

THE CHAIR: Mr Hargreaves—

MR HARGREAVES: You are really irritating, Jeremy.

THE CHAIR: Mr Hargreaves, I am speaking to you. Is this in relation to mental health?

MR HARGREAVES: Yes, it is; on output class 1.

THE CHAIR: Mental health is actually a separate area. We are going through acute services; then we will go to mental health.

MR HANSON: If you had been here on time, John, you would have known that.

MR HARGREAVES: I was wanting to know whether or not the Chief Minister and Minister for Health addressed the issue in her opening remarks that I missed.

MR HANSON: If you had not turned up late, you would realise that we are doing mental health later on in the day.

THE CHAIR: Mr Hanson, can you just direct comments—

MR HANSON: I think that is the point of order that is being made.

MR HARGREAVES: You are one of the most rude, ignorant, bullish people I have ever met, you are.

THE CHAIR: Members!

MR HARGREAVES: By a long shot.

THE CHAIR: Mr Hargreaves, can we please stop this.

MR HANSON: I will take that as a compliment from you, John.

THE CHAIR: Mr Hanson!

MR HARGREAVES: I would not bother.

THE CHAIR: Mr Hanson, direct any comments through me. The same to you, Mr Hargreaves. We are not going to have this degenerating. Thank you. Please direct all comments through me. Is this directed to acute services or mental health services?

MR HARGREAVES: I just wanted to know whether the Chief Minister addressed those issues in her opening remarks.

Ms Gallagher: Mr Hargreaves, I did make some comment on mental health services in my opening remarks quite broadly. I am very happy to answer in detail when we get to that output class.

THE CHAIR: That is what we will do.

MR HARGREAVES: Thank you.

Ms Gallagher: Madam Chair, could I just ask: we are not doing a general overview? We are just going to stick to the output classes?

THE CHAIR: I am going to try and stick to the output classes as much as we can. Obviously my first question was in relation to acute services. It was my intention to work through it that way. I did state that at the beginning, so we will see how we go. Ms Hunter.

MS HUNTER: I wanted to go to growth in funding in the area of acute services. There is obviously significant growth funding in this budget. I just wanted to understand whether it is going to be an ongoing trend that we are putting more into the acute end of health as a proportion of the budget.

Ms Gallagher: This is something that we look at every year. Based on what we have been seeing, certainly in my time as minister, the demand on the acute system continues to grow rapidly and we have to deal with that. I know that at the same time we have to deal with the other end in terms of managing people with chronic disease and also preventing people from becoming unwell, and particularly trying to influence lifestyle factors. There is some increased effort going into that area as well.

I know people would like to see more in the prevention side and less in the acute side, and I think we will get there. But at the moment we are having to deal with what we see walking in through the door. They continue to walk in through the door at a fairly rapid rate. Nothing would give me greater pleasure than to not fund the acute system as much as it is getting funded and to put more into the early intervention prevention end, but at the moment I just do not think there are realistic choices before us.

What you would have to do at the moment is find more money to go into health rather than reduce the effort in the acute end. We have tried to, I think, find some money and build on some of the work that we have done in previous budgets, particularly with the national reforms—the national partnership on preventative health and the new Preventive Health Agency. Some of the budget money that we have allocated is starting to be rolled out through those processes. This budget includes significant amounts of money—millions of dollars are going into chronic disease and some other smaller initiatives—which I think will pay off in the long run. But it is always a balance year by year.

MS HUNTER: Just to explore that a little bit further, as you say, you need to meet the need that is walking in through the door, but is there some sort of strategy into the future around how we can re-profile a bit and have more in that preventative end? You have mentioned a couple of initiatives and things that have been happening, and I think there is some money there for obesity and so forth. Is there a strategy around

this?

Ms Gallagher: There is. Perhaps it is not as coherent as it should be. In actual fact, a lot of the work that is being done under the national health reform is to restructure the health system here. Medicare Local has now been established and is building on the Division of General Practice. But it is much more than that now and them taking an increasing role in the delivery of primary health care services.

The best thing that would help the acute system is to have the primary health care system working as efficiently as it can. That is not just GPs. That is a whole range of services that exist there. Within the acute system, a lot of the reforms that we are doing here locally, like building the community health centres, and even some of the money that is allocated in mental health and in chronic disease, are going to the non-government sector to build up their capacity to provide services in the community.

You could even link the infrastructure program in, like I said, with the health centres. What we are trying to do is ensure that people come to hospital when they need to come to hospital, not when they need to, for example, attend an outpatients clinic. If that can be done in the community close to where people live then we are reducing some of the pressure on the hospital system. It is all part of a bigger plan.

Then, of course, there is the work that the National Preventive Health Agency are doing. All states and territories have a vested interest in that. They are going to take an increasingly prominent role in the delivery of nationwide programs to deal with early intervention, prevention and healthy lifestyles. We will make sure that our work here—indeed, we have already started doing that; we have provided an implementation plan to the commonwealth, for example, around the money that we are putting in and the money that they have provided under the national partnership—aligns with theirs.

There is a little bit of money in the budget to do a healthy weight action plan. It is the first time that we will have done a document like this. That is recognising that obesity is increasingly becoming one of our biggest issues going forward in the health system. We have started quite a bit of work on that, but this money will pull that together and provide a roadmap for us locally about what we need to do. It will very much feed into the work that the national agency is doing. In fact, all of the reforms are targeted at shifting some of the pressure off the hospital system, but we are, again, in that transition stage.

MS HUNTER: With that implementation plan, I think you said it was for the national prevention—

Ms Gallagher: It is the national partnership on preventative health.

MS HUNTER: Is that implementation plan publicly available?

Ms Gallagher: I do not see why not. I am sure we can provide a copy to the committee.

THE CHAIR: So that will be provided?

Ms Gallagher: We have provided it to the commonwealth. It has been agreed and signed off, from my memory, so I do not think that is a problem.

THE CHAIR: Thank you. Mr Smyth.

MR SMYTH: At the top of page 63 of budget paper 4 there is strategic objective 17. It contains no results. We all understand that there is an investigation underway. When will we have the results so that we know the performance for the 2011-12 year?

Ms Gallagher: I am not sure. It will be when those investigations are complete. They are not being managed by me so I cannot give you a date.

MR SMYTH: To the best of your knowledge, where is the investigation at at this stage?

Ms Gallagher: Which one are you referring to?

MR SMYTH: Any of the investigations that would lead to the data being released.

Ms Gallagher: Perhaps the director general can answer that. I understand the Auditor-General's inquiry is due to be completed fairly soon but, again, that question is best placed to her.

Dr Brown: We have, as the minister has indicated, two investigations underway, one being conducted by PricewaterhouseCoopers and one being conducted by the Auditor-General. I am anticipating that both of those investigations will be concluded with a report within a two-week time frame. That is the aim at this point in time. Just to clarify that, in terms of the data being made available, the PWC forensic data audit will advise us in terms of the scope of the changes, but then we need to go back and correct the data. It will actually take a period of time after we receive that report for the data correction to occur and for that to be published.

MR SMYTH: So PWC are doing the forensic audit and they will tell you what data has been corrupted?

Dr Brown: Yes.

MR SMYTH: And then you will have to go and find the correct data and put that into the system?

Dr Brown: Yes. They will give us an indication of the scope of the changes and advice in relation to how that is best completed; correct.

MR SMYTH: What does "scope of the changes" mean—they will advise you on the scope of changes? What exactly is that?

Dr Brown: There were alterations made to the timeliness data in relation to individual triage categories and then there were changes to the timeliness data for the NEAT data. The issue is whether or not we need to go back and correct every individual record or

whether they can give us a quantum change that will allow us to make the corrections without a very labour intensive process.

MR SMYTH: How would they be able to give you a quantum change if they do not know what the level of corruption of the original data was?

Dr Brown: That is what they are doing. They are looking at the original data.

MR SMYTH: They will look at the original data and compare it to the data that has been placed in the data sets and then tell you what the difference is? What is the benefit of doing it that way as opposed to actually going back and correcting it? Do you lose detail if you do not correct every individual piece of data?

Dr Brown: That is the expert advice that we are relying on them for. Quite clearly, we want to have accurate data. We will rely on their expert advice as to how best to achieve that in the most efficient way.

MR SMYTH: If they come back and say, "You need to go and correct the individual records," do we know how many records were corrupted?

Dr Brown: That advice will be provided to us in their report, but I do not have that at the moment.

MR SMYTH: So their report is due in about two weeks?

Dr Brown: That is the current working time frame.

MR SMYTH: If they come back and say you can do it as a lump sum, as it were, rather than correcting individual records, how quickly after that would you have the data that is missing here? For instance, minister, will you issue a correction to the budget paper, an erratum to the budget paper?

Ms Gallagher: I have already acknowledged that there will be corrections to a whole range of data. There will be corrections to quarterly reports, to annual reports and to budget documents as required once that information is available.

MR SMYTH: All right; so PWC is doing the numbers, as it were. When do you accept the AG's report?

Ms Gallagher: I think that is probably a question best asked of the Auditor-General. I do not know that we are in a position to speculate. It is not something within our control.

MR SMYTH: And the individual responsible for the corruption of the data, what is the status of that person at this stage?

Dr Brown: They remain suspended from duty.

MR SMYTH: Suspended on full pay or are they on leave?

Dr Brown: Yes, based on legal advice, yes.

MR HANSON: A supplementary?

THE CHAIR: Yes.

MR HANSON: Has the individual concerned or individuals given you a motive as yet as to why they manipulated the data?

Dr Brown: I have had no further conversations with the individual since the time that I have spoken publicly. So, no, I have no further indication.

MR SMYTH: And the Auditor-General will ask those questions?

Ms Gallagher: It is probably best a question asked of the Auditor-General. This is not an inquiry that we are conducting.

MR SMYTH: So suspended on full pay until the two reports are available; what is the process then?

Dr Brown: There will be a formal process to investigate a breach of the code of conduct. The officer has been advised of that commencing but that cannot conclude until such time as the other investigations that actually provide findings are delivered. That third investigation will continue after those two reports are handed down. Once that third investigation is complete, I anticipate that a report will come to myself and the head of service.

MR SMYTH: Thank you.

THE CHAIR: Mr Coe?

MR COE: While we are on this topic, over the last couple of months have you had to give any updated information to the commonwealth? Obviously, you have had to say that there are doubts about some of the other data but have you collated any new data and given it to the commonwealth?

Dr Brown: We were required to provide to the commonwealth the NEAT data, the national emergency access data, for the first quarter of the 2012 calendar year. We were able to submit that data, albeit just a few days after the target date. Because that was very recent data, we were able to actually undertake the corrections and provide that. It was a small number of files that we had to look at to do those corrections. So we were able to provide that to the commonwealth as required.

MR COE: When you say that it was a small number of files, how many are we talking about and what was the overall impact of that adjustment?

Dr Brown: I do not have the actual number of files in my head, I am sorry. But the overall impact was to reduce the result by around about two per cent.

MR COE: Is that information—the NEAT data that you submitted to the

commonwealth—public already?

Ms Gallagher: I do not know that it is public. It is provided to the commonwealth.

MR COE: Would you please—

Dr Brown: I do not think that it is yet. I am just getting some advice. No.

Ms Gallagher: We will take some advice. If your question is: can we provide it to you, we will take some advice. We have reporting obligations to the commonwealth. The issue with the NEAT targets is that they are done on a calendar year as opposed to a financial year for some of the other data. So it is looking at different data but—

MR COE: Sure, but simply given the shortage of data that is out there due to all these issues it might be of some assistance to the committee to have whatever data is available that you have authenticated.

Ms Gallagher: What are you after? Are you after just the figure, the timeliness figure? Because the target is 64 per cent for the calendar year under NEAT. The first three months was 57. So that is the data.

MR COE: If you have collated data for the commonwealth, would it just not be quite simple to give it to the committee?

Dr Brown: We have told you the result.

Ms Gallagher: That is the result.

Dr Brown: That is the result. We have not collated the timeliness down for the triage categories. That is a different report and we do not have that data cleansed yet.

Ms Gallagher: So the NEAT data is the four-hour target, which is separate to the triage category. So you are not going to be comparing like with like.

MR COE: Yes I understand that but there are no further breakdowns of figures? It is simply that headline figure which is tabled?

Ms Gallagher: Yes.

MR COE: Okay.

MR SMYTH: Sorry, just to confirm for the first quarter of the year, the target was 64 per cent seen in four hours?

Ms Gallagher: No, the target for the entire year is 64 per cent and we were sitting at 57—

MR SMYTH: sorry, 64, and the outcome is 57—

Ms Gallagher: for the first quarter.

MR SMYTH: for the first quarter.

MR COE: The health quality performance report for October to December, I understand that should have been published by now. Is that correct?

Ms Gallagher: It would normally have been, yes.

MR COE: So the reason for that is also because of these data problems?

MR HANSON: Why are you holding up the whole quarterly report for a data set?

Ms Gallagher: Because I would like it to be complete and correct. I have got no problem with—and we have had some discussion—

MR HANSON: You released the budget with it.

Ms Gallagher: Thank you, Mr Hanson. I have got no problem with releasing other parts of the quarterly report if people are interested in it. Now that we know that some of the data that we have published is incorrect, my own feeling was to make sure that when we publish the next quarterly reports—indeed, there are probably a couple due now—they are complete in their entirety and correct.

MR HANSON: Are you concerned then that there is data that has been corrupted beyond what you know in the emergency department?

Ms Gallagher: No.

MR HANSON: It is just isolated to that area? I have another question. It is about the four-hour rule. The *Medical Journal of Australia* published earlier this year talked about the four-hour rule. The view was that it can save lives. I will quote the journal: "The introduction of a four-hour rule into three Western Australian tertiary hospital EDs was followed by fewer deaths. Presentations increased by 10 per cent while the overall relative mortality rate fell significantly by 13 per cent."

The view, I suppose, is that ED waiting times are important, that they do save lives. Have you done any analysis in the ACT to sort of match that analysis so we can map, I suppose, mortality rates compared to the four-hour rule? If we are meeting the four-hour rule, how many lives are we saving exactly?

Ms Gallagher: Can I just say that that is not new information. The published data, particularly from emergency department specialists, would align with that of the triage categories. That argument that has been put forward I think has been put forward a number of times.

MR HANSON: So these figures are important? I just go back then to 5 March 2010 to an article entitled "Stop whinging about waiting times". Jon Stanhope said, "At the end of the day, these are perhaps the least relevant of all the indicators in the way that our health system is operating and undue focus on waiting times and waiting lists detracts attention from the quality of care, the clinical outcomes and the overall health

and wellbeing and the overall function of the system."

You backed him up, saying, and it is reported in *Hansard*, "In terms of whether waiting times are an accurate reflection of the performance of the health system, I completely support the comments of the Chief Minister." So the Chief Minister was saying that they are not relevant in 2010 but you are saying that they are relevant. We have been making this point for a long time that they are important. You and the previous Chief Minister have been saying they are not.

Ms Gallagher: That is not what I said, Mr Hanson. What I said was that the argument that you have just put is not a new one. In terms of timeliness data, I have always accepted it is a measure of emergency department performance—

MR HANSON: The least relevant, the least relevant.

Ms Gallagher: but there are a whole range of other measures that are as important, if not more important, than timeliness. I still believe that, Mr Hanson. We might have a difference of opinion on this and that is fine. There is a difference of opinion on a whole range of areas in health care. But I would see the quality of care provided in the emergency department and the outcomes of the care delivered in the emergency department as important, if not more important, than looking at the triage categories as a whole.

For example, I would see that it is much more important that you meet your timeliness quotas in categories 1, 2 and 3 because they are the sickest people presenting to your emergency department and we have excellent results—

MR HANSON: But you agreed that they are the least relevant indicators—"emergency department waiting times are the least relevant indicators of our health system". But you have just said that they are important because they save lives in the triage categories.

Ms Gallagher: No, I did not say they are important, that they save lives.

MR HANSON: Getting people admitted within the four-hour rule saves lives.

Ms Gallagher: I said they are an indicator of emergency department performance. Whether they are the best indicator is another question—

MR HANSON: The least relevant is your position.

Ms Gallagher: or whether they are the least relevant.

THE CHAIR: One person at a time, please.

Ms Gallagher: We can have a difference of opinion on this, Mr Hanson—

MR HANSON: Clearly, indeed.

Ms Gallagher: because I do not think there is a right answer necessarily.

THE CHAIR: Just on that—Mr Hanson, I have got a question, thank you.

MR HANSON: I am in the middle of a question, if I may finish with the line of questioning.

THE CHAIR: I have got a supplementary to your question. I am the chair of the committee. I am going to ask a question if that is okay. Thank you.

MR SMYTH: People are normally allowed to finish their line of questioning.

MR HARGREAVES: They are allowed to finish their answer as well.

THE CHAIR: I am asking a supplementary. I will let him finish his question. I have got a supplementary. Just on that, Mr Hanson has referred to the WA study. I am aware of a number of studies that have also raised some of the concerns with the four-hour measure, particularly from the UK, where that has been in place for a number of years. Are those sorts of things being taken into account as well, particularly because this is coming from a national level and there are the performance payments being attached to it? How are all those factors taken into account across the board, taking into account what Mr Hanson has mentioned but also the other concerns that are being raised, so that we are doing the right thing by patients and their outcomes? That is where my concern is with this.

Ms Gallagher: Peggy, I will hand over to you, but under the four-hour rule, for example, some work has been done by an expert group to look at the people that might not qualify for the four hours out of the hospital or into the hospital category. There is an acknowledgement that the four-hour rule will not be able to apply to all presentations to the emergency department, for quite legitimate reasons.

There is some work that is being done around that, and that will be progressed. These issues have been raised. With the national health reform, when jurisdictions signed up to the four-hour neat target—I think it was the following week that the UK indicated that they would be moving away from the four-hour rule, for a range of different reasons that they have had in practical experience. I think it is fair to say that it will be monitored.

Dr Brown: I was just going to add that it is very easy to achieve the four-hour rule if you see people and push them out in less than four hours without any regard to the quality of care or the outcome. What we need to do in association with the four-hour target is to ensure that we have measures that speak to the quality and the outcome of care. There are discussions at a national level as to what sort of indicators might be added to the indicator set to give us a more complete picture of the outcome. Certainly, we are very interested in making that data available as well.

THE CHAIR: You said that it is going to be reviewed, but how are we going to make sure we are doing the right thing by the patients? Again I mention the performance payments, because that puts an added level of pressure—

Ms Gallagher: Yes, it does.

THE CHAIR: Is it going to—

MR HANSON: Change the results?

Dr Brown: No, it is not our intention to change the results. Our intention is to deliver timely care but ensure that we also deliver high-quality care and that we achieve good outcomes for patients. That means, for example, that we will aim to see and discharge people, if they are going home, in that time frame, and admit people to the ward in a timely way, if not within the four hours then as soon as possible thereafter.

One of the things that make a difference is how quickly you are able to get people from the ED and admitted into the wards. If you have missed the four-hour target, there is not a lot of incentive, perhaps, to ensure that you put that person through as the next available bed; you might aim to take the person who is under the four hours because that will help you hit the target rather than having both of them slightly over the four hours. We are looking at measures that will ensure that there is not that sort of gaining in terms of who gets in and who gets out. And we are looking at things like re-admission rates to hospital so that we are not discharging people inappropriately to make beds available to take people out of the ED. It is how the whole picture comes together.

THE CHAIR: Mr Hanson.

MR HANSON: Thanks. I just want to clarify your position, minister, if I can. I will reiterate what Jon Stanhope said:

> At the end of the day, these perhaps are the least relevant—

I say it again: the least relevant—

> of all of the indicators of the way in which our health system's operating.

In relation to that, you then said:

> In terms of whether the waiting times are an accurate reflection of the performance of the health system, I completely support the comments of the Chief Minister.

Do you still support the comments of Jon Stanhope that waiting times in our emergency department are the least relevant of all indicators of our health system?

Ms Gallagher: I think I have answered that question, Mr Hanson.

MR HANSON: Yes or no?

Ms Gallagher: I do not know—

MR HANSON: Yes or no?

Ms Gallagher: You cannot tell me how to answer questions, Mr Hanson, as much as

you would like to.

MR HANSON: So you are refusing to answer the question?

Ms Gallagher: No.

MR HANSON: Do you stand by that or not?

Ms Gallagher: I am not refusing to answer the question. What I am telling you is that I have answered your question. It is quite different.

MR HANSON: No, you have not.

Ms Gallagher: It is quite different.

MR HANSON: Your story has changed.

Ms Gallagher: I think the answer is that I have not answered it to your satisfaction, which is something I cannot help you with. I have answered your question.

MR HANSON: So in 2010 they were the least relevant and now you are saying that they do save lives and they are important?

Ms Gallagher: I have not said that second part of what you have just put to me, Mr Hanson.

MR HANSON: So you do think they are the least relevant?

Ms Gallagher: You can review the *Hansard* and check what I have said, but I will not be verballed by you.

THE CHAIR: Is there anything further on that?

MR SMYTH: So is the four-hour ruling affected—

THE CHAIR: Can we just have questions directed through me, please?

MR SMYTH: Just a supplementary.

THE CHAIR: Okay.

MR SMYTH: Is the four hours an effective measure or not?

Ms Gallagher: It is the measure that we are going to be measured against, Mr Smyth.

MR SMYTH: Is it an effective measure? Why would we sign up to an ineffective measure or measures that, as Dr Brown said, may lead to adverse outcomes for patients? Why would you sign up to something—

Ms Gallagher: No, she did not say that. What she is saying is that the system has to

be reconfigured to make sure that it does not have adverse outcomes for patients. That is what Dr Brown said, and I support that. Under national health reform, the COAG table, all of us sit there and we can have our views within that group. At the end of the day, we have signed up to the four-hour rule; we are implementing the four-hour rule. It is requiring significant change across the hospital, but it will also bring significant resources to the hospital, and that is a good thing.

MR SMYTH: So you believe the four-hour rule, therefore, is a good thing—by signing up to it and implementing it?

Ms Gallagher: I am not an expert in the four-hour rule. I will watch how it is rolled out.

MR HANSON: You signed up to it.

Ms Gallagher: Well, yes.

MR HANSON: Without knowing what you were signing up to—

THE CHAIR: One person at a time, please.

MR HANSON: Or were you not concerned with that?

Ms Gallagher: Mr Hanson, that is not what I have just said. We have signed up to the four-hour rule. We have signed up under the terms of national health reform. We are implementing it. We are making sure we do it carefully and that it does not impact on patient outcomes, because that is the focus of this government, and indeed the Health Directorate. There may be some issues that we have to monitor as the four-hour rule is implemented. All jurisdictions will be doing that—as has WA, with the implementation of it several years ago in its jurisdiction. As to whether I think it is an effective measure—it is a measure. It is a measure we are going to be measured against. We are implementing it and I will be monitoring it just as closely as everybody else.

MR SMYTH: Dr Brown, is it affecting patient outcomes?

Dr Brown: I am sorry; I am not sure in which—

MR SMYTH: In a positive sense or in a negative sense?

Dr Brown: There is nothing magical about four hours as a treatment period different from three hours and 39 minutes or four hours and 20 minutes. However, we do know, from the studies that have been done that timely treatment in the emergency department, minimising delays in terms of access to appropriate investigations and minimising delay in transfer and admission to the inpatient ward all deliver better outcomes for care. So yes, we think it is good to actually have a target that puts the focus on that.

It is not, however, just a target about what the emergency departments do. It is a target about what happens in the rest of the hospital—whether it is in the wards, whether it is

in X-ray, whether it is in pathology. It also says something about what is happening in the primary health care sector—GPs, community services that we run. All of those things need to be in our focus as we go forward aiming to meet these targets. Indeed, that is what we are doing. We are taking a whole-of-system approach to this. We welcome things that actually help us to sharpen our focus on the broad spectrum of care.

THE CHAIR: Thank you. I want to ask you a question about the progress of the subacute hospital. Is there a definite time line?

MR HANSON: Does subacute come under acute, Madam Chair? Can I just clarify?

THE CHAIR: Yes, it does. It is about providing services that normally would be provided in hospital in a subacute facility.

Ms Gallagher: Subacute services are provided in the hospital setting.

MR HANSON: Under acute? That is ironic, isn't it?

THE CHAIR: Thank you, Mr Hanson. It is about whether there is a time line for the design and consultation phase in terms of particularly what services are going to be provided there.

Ms Gallagher: That work is underway and ongoing. In some of the comments that have been made about the budget—the work was not ready to progress in terms of extra money going into this project in this financial year, but the discussions on types of service, looking at the funding arrangement or possibilities for how it might be funded, and indeed some negotiations around the land, are all ongoing.

THE CHAIR: So is there a time line for the design and consultation?

Ms Gallagher: For the design?

THE CHAIR: In terms of what. That has been discussed—about the design phase and what actually will go in there. I just wanted to get some information.

Mr Thompson: The design process involves service planning work as well as, after we have settled a location, a design program to design what a facility would look like with a certain service profile on that particular piece of land. So there are two pieces of work. What we are looking at the moment is confirming the location. Negotiations, as the minister has said, are continuing on the location. We hope to confirm that soon. The service planning work is happening concurrently with that; we are expecting that by August that information will be available.

THE CHAIR: So by August we will have an idea of what sort of service it is? Is it possible to get an indication of some of the service? We have had particular things like a palliative care unit, obviously. Also you are probably aware that the midwives have been talking about having a stand-alone birth centre there run by midwives.

Ms Gallagher: That will not be there.

THE CHAIR: That will not be there?

Ms Gallagher: It will not—

THE CHAIR: Even though that is a proven successful model?

Ms Gallagher: My view on that is that it is not appropriate in that location. I have taken a fair bit of advice on it. That is really about the fact that there will not be operating theatres or the possibility for acute intervention at that site if it is required.

THE CHAIR: So even though we have got it in New South Wales, and it has been successfully working there, having excellent outcomes, when you say—

Ms Gallagher: That is part of the reason. The other element, which is probably just as important—we have been doing a fair bit of work, as you would know, with maternity services—is that we currently have two public maternity services for a small jurisdiction. There are some within that who would argue that we probably only need one, but we have two. If you fragment it to three, again you will have issues around staffing it, safety and fragmenting a service for a small population of 360,000 people. And, to be honest, the clinicians would not support it either.

THE CHAIR: Okay. What about palliative care going there?

Mr Thompson: We expect—it is all provisional at this point, so please do not accept that this is the final word on it by any stretch—

THE CHAIR: No.

Mr Thompson: But we are expecting that palliative care services will be provided in the subacute facility.

THE CHAIR: Thank you. One particular service—this is something we have had raised with us by a couple of people—is about those sorts of specialist services where you look at providing, at this subacute facility, support for adults with eating disorders. Is that something in terms of those more specialised services? What we have heard is that people have to basically travel interstate to get access to that. Is that something we would look at providing given that we are going to have this additional facility—so that we can start providing some of those sorts of services to people?

Dr Brown: It is not entirely true that people have to travel interstate. There are both outpatient and inpatient services for people with eating disorders available within the ACT for both adolescent and adult populations. Some people do choose to access an alternative model of care and go interstate. In terms of the consideration of what goes to the new north side facility, there has been some thinking about whether or not mental health services should be included within that. At this point in time I do not think there is a final decision in relation to that. But it would be extremely unlikely that we would be considering developing a unit for eating disorders separate from the broader mental health services.

MR HANSON: A supplementary.

THE CHAIR: Is it on this, Mr Hanson?

MR HANSON: Yes, it is directly on the north side hospital. The majority of the funding that was in last year's budget for specification and documentation processes has been rolled over, $3.5 million of it, and that is on page 218 of budget paper 3. So what has actually been done? Why are we not actually getting on with this?

Ms Gallagher: We are.

Mr Thompson: We are working on it. The work that has happened to date includes—we have talked about the service planning, we have talked about the work to identify and consult on possible locations. We are in the process of trying to finalise that. Other work that we have done has included environmental studies, geophysics analysis of prospective sites, so that we can confirm they are suitable to support a hospital building. So there has been quite a lot of work. It has just taken a little bit longer to reach the point that we are at now.

MR HANSON: Are we looking at the University of Canberra as the site?

Ms Gallagher: That is the preferred location.

MR HANSON: When we went through this last year—this came out of the inquiry that had occurred in the health committee—we looked at the various options, and the government decided the options included a north side hospital and an enhancement to Calvary, a couple of hundred beds in Calvary. At last year's estimates in relation to this you said that will really be determined by the master plan, decisions taken around the subacute and that in a year's time that should be complete.

Ms Gallagher: Yes.

MR HANSON: What we were expecting, I suppose, and what you led us to believe, was that we were going to see the plans for the subacute and also the plans for what was happening at Calvary, but there is nothing in the budget about Calvary. So what is happening there?

Ms Gallagher: There is quite a lot in the budget for Calvary. What I would say in a very general way is that the work is ongoing. It was not ready for this year's budget. I do not know what the other alternative would be. Should we just say, "Oh well, the work's not finished but we'll chuck in a couple of hundred million to progress it without the work that we need to underpin that"? So we remain committed to the work. We have taken our time with site selection. I have done a number of consultations around that. These things do lengthen the time—

MR HANSON: That is for the subacute, but what I am saying is that the—

Ms Gallagher: The work with Calvary is ongoing as well.

MR HANSON: But has there been any money allocated in the budget for scoping

and—

Dr Brown: Can I just clarify in terms of what will be available, hopefully at the end of June, or very close thereafter. We have talked about a clinical services plan; also there is a master planning exercise for the Calvary campus. Mr Thompson might provide some more detail about those. The clinical services plan will be close to completion by the end of June for a draft to go out for consultation. The master planning for the Calvary site is obviously work that is being conducted through Calvary, and that has to be completed by the end of June. So that commitment around work being done for the end of June I think still stands.

MR HANSON: With both of those projects, both the subacute and the rebuild or enhancement of Calvary, have we got an estimated date for completion of those projects? If things at the start of the process are pushing to the right, does that mean that the completion date is pushed to the right? We know that there is this wave of demand that is coming. We are already seeing bed occupancy increasing. We have problems with emergency departments. So the build at Calvary and the subacute are to alleviate that and also to remediate some of this surge in demand, but if we seem to be pushing to the right now, in terms of the scoping studies and what is happening at Calvary, what is the date on which we are going to get those facilities up and running?

Ms Gallagher: I think the most important thing from my point of view is to make sure that the work that underpins the decisions about the redevelopment and the build of a new subacute facility are robust. In terms of the new subacute facility, that work was not finished to put in money to design and start that construction process. We know that, overall, with the rebuild of the health system, the big demand is going to peak in 2018. We are in 2012. We are four years into a program of capital redevelopment. My expectation is that all of those projects will continue right up to 2018, 2020. That is the point where I think the capital program will be nearing completion. It is a long period of time.

MR HANSON: We will probably go through each of the projects in more detail.

Ms Gallagher: Yes.

MR HANSON: But when we see every single project in the budget from last year subject to delay, what confidence can we have when we see that the subacute is subject to delay, and that with Calvary we do not yet see a master plan or a way forward there?

Ms Gallagher: Well, you will see a master plan.

MR HANSON: What confidence can we have that we are going to have these hospitals and this new infrastructure up and running by 2018, based on track record?

Dr Brown: We have other options as well that we are pursuing at the same time in relation to reconfiguration of the space at Canberra Hospital, enhancing space for clinical usage there and decanting off-site for non-clinical usage. We are also, in conjunction with Calvary, looking at the best use of their available site and looking at decanting options there that can increase clinical usage space. So it does not rely just

on a new hospital or the additional build at Calvary hospital. There are a number of strings to this particular—

MR HANSON: Yes, but all of them are subject to delay, aren't they? The various programs that we have looked at that relate to this are all subject to delay.

Dr Brown: As the minister has indicated, our preference is to ensure that we have the very strong foundations on which to progress the ongoing—

MR HARGREAVES: Can I ask a question please?

THE CHAIR: I will come to Mr Hargreaves then we will go down the line.

MR HARGREAVES: Thanks very much. It touches on some of the things that Ms Bresnan was talking about regarding maternity services. In BP4, page 77, with respect to works in progress, the women's and children's hospital: I am interested to know how we are travelling on that. What sort of and when can we expect the benefits to flow from it?

Ms Gallagher: The women's and children's hospital is due for physical completion at the end of July, with a commissioning date towards the end of August. That gives staff the opportunity to safely move into the new work environments because they are quite different to the current work environments. We want to make sure that is done very carefully and with the right support.

I have not been inside the facility lately but I have seen the mock-up rooms, and it will be a state-of-the-art facility. We are intending to open it for a community open day in early August, so that everybody who wants to come in can come in and have a look at it. It will provide all of the treatment spaces, clinical spaces, all the birthing suites, the neonatal intensive care unit, the paediatrics area. They will all be included in stage 1 of the development.

Once we move everybody out of where they currently are, the refurb, which is a much smaller element of the project, will be done on the current maternity building. That is due to take perhaps another year to complete.

MR HARGEAVES: What sort of effect will it have on the midwifery program?

Ms Gallagher: The birth centres will be operating from there, so there will be additional capacity within that service. In terms of a working environment, there will be no other place like it, perhaps other than at the other end of the campus at the mental health unit, in terms of the quality of the working environment. For staff it will be a much better place to work. It has been designed to be a much better place for patients, particularly young children and babies, to have their care in.

The neonatal intensive care unit, for example, at the moment—I do not know if anyone has been in there—is quite an open plan, cramped area, without privacy and without individual areas for babies to be cared for. The new neonatal intensive care unit will have much better privacy of facilities for families, and again will allow staff to care for babies in a much better environment.

MS HUNTER: You mentioned that there would be a community open day in August.

Ms Gallagher: Yes.

MS HUNTER: When will it be actually operating and taking patients?

Ms Gallagher: I think commissioning at the end of August is the plan.

MS HUNTER: So patients will be coming in from the beginning of September?

Ms Gallagher: Yes. End of August.

MS HUNTER: At the end of August.

Ms Gallagher: Yes. We need to take a lot of care in moving people. We have just been through it with the mental health unit, which perhaps does not have some of the clinical complications with moving that the patients who will be moving into this area will. From my own point of view, and I know this will be supported by the hospital and clinicians, we need a reasonable amount of time to make sure everything is done carefully and safely, and that is why we are building in that quite lengthy three weeks or so.

MR HARGREAVES: I have one final question on it. You talk in BP3 around the growth in demand for acute services and you talk about additional beds. Are those additional beds in the women's and children's hospital? Is that part of the process or is it different from that?

Ms Gallagher: No, there is some extra funding in the budget for the neonatal intensive care unit. That will be extra cots. There is a relatively small increase in overall bed numbers once the hospital is commissioned.

Dr Brown: The new women's and children's hospital, when it is fully open, will have additional bed capacity but we will stage the bringing on of those beds to meet projected demand over the next five to 10 years. The beds available in this current budget are 40 in total. They are across Canberra Hospital and Calvary hospital and cover things like medical beds, surgical beds, as well as some intensive care beds, hospital in the home and neonates. So there is a range of beds.

MR HARGREAVES: So these are not the only additional beds that are going into the system?

Dr Brown: No.

MR HARGREAVES: What are the other ones? Where are they?

Dr Brown: There are 20 beds at TCH, 13 at Calvary. There are eight medi-hotel beds, there are 15 hospital in the home bed equivalents, two ICU, two paediatric high dependency what we call IPatCH beds, one neonatal intensive care bed.

MR HARGREAVES: Is that all?

Dr Brown: It is quite a lot.

MR HANSON: You did well; check the numbers.

Ms Gallagher: She is correct.

MR HANSON: I have a supplementary on the women's and children's. In budget paper 4 on page 77 it says that the women's and children's hospital will be open in August 2013. So obviously that is—

Dr Brown: That is stage 2.

Ms Gallagher: I think that is with stage 2 included.

MR HANSON: Okay. So I am just trying to get a—

Ms Gallagher: But can I just refute the "half a hospital" line, which—

MR HANSON: Can I finish my question?

Ms Gallagher: Yes. I just want to respond to that. You asked a question about August 2013.

MR HANSON: Can I finish my question?

Ms Gallagher: All of the beds that are provided will be provided in stage 1. So it is not fair to say half a hospital is opening. The entire hospital is opening. The refurb of the second element, which will provide some other space when we need to, particularly when other areas of the hospital are being redeveloped, will be complete in August 2013.

MR HANSON: So what exactly are you doing between the opening in August and when it says it is going to be complete in 2013?

Ms Gallagher: That is refurbing the existing space, which will not be used for patients.

MR HANSON: So what are you refurbing it for then? What is it used for?

Dr Brown: I can run through it, if you like, Mr Hanson. Services that will move to their final operational location in stage 1 include the postnatal ward, the antenatal and gynaecology ward, the NICU, the special care nursery, the birth centre and the paediatric day stay. There are then services that will be moving to temporary locations as part of stage 1. They include paediatric outpatients, the birthing suite, the foetal medicine unit, postnatal short stay, maternity assessment unit and maternity and gynaecology outpatients. Then, as the minister has indicated, there will be refurbishment of that existing space where services are moving out from and then there will be a reconfiguration.

MR HANSON: You sort of indicated it has got nothing to do with patients but includes the birthing suites?

Ms Gallagher: The birthing suites are in the new stage 1 of the hospital.

MR HANSON: No. Peggy just said that they move out as part of this. They go to temporary and then they go into phase 2. So you are wrong, minister.

Dr Brown: The birth centre will go to its—

Ms Gallagher: No. The birth centre will be—

MR HANSON: Based on what Dr Brown just said.

THE CHAIR: Just let Dr Brown answer the question.

Dr Brown: The birth centre will go to its final. The delivery suite or the birthing suite will go temporary and then relocate.

MR HANSON: To the—

Ms Gallagher: New.

MR HANSON: bits that are being refurbished?

Dr Brown: No.

Mr Thompson: The final location for the birthing suite will be in the refurbished areas of the current maternity building.

MR HANSON: Okay. Thank you.

Ms Gallagher: But they will be operating out of stage 1. All of the services will be operating out of stage 1.

MR HANSON: Yes, but in temporary accommodation.

Ms Gallagher: It is not temporary accommodation. It is the new hospital.

MR HANSON: You said it is. That is the word that was used.

THE CHAIR: Just one person at a time, please.

MR HARGREAVES: Badgering will not get the answer.

THE CHAIR: Can we have one person at a time, please.

Mr Thompson: The process here, and what we are aiming for with this project, is to continue and enhance the current operations while freeing up the space to refurbish

the current building to complete the full range of services that will be used into the future.

MR HANSON: So the birthing suite will be in temporary accommodation. I think those were the words that you used, Dr Brown, and then it will move back into the refurbished current—

Mr Thompson: It will be in a temporary location but it will be a very effective and fully functioning service.

MR HANSON: So is it temporary or not? You say it is temporary and then you say it is not temporary. I get confused.

Dr Brown: I guess it depends on what you are implying when you mean temporary—temporary as in it will be in one—

MR HANSON: Temporary means it is not there permanently, I would have thought.

Dr Brown: location and then will move. But the quality of the facility and the service will not be compromised.

MR HANSON: Temporary has never meant the quality of the service. Temporary means that it is not there on a permanent basis. You said it was temporary and then the minister said, "No, it is not temporary," and then Mr Thompson said, "Yes, it is temporary," and then we argued about the definition of temporary. The point is that it is in a temporary location, then it moves into the refurbished?

Ms Gallagher: It will be there for a short period of time while the redevelopment of the entire hospital—

MR HANSON: A short period of time we will use as temporary then; that is a good definition.

Ms Gallagher: But the line that you have been running, Mr Hanson, to diminish the project, for political purposes, is that it is half a hospital opening. And it is not half a hospital opening. The entire hospital is opening, as will all the services be operational out of there.

MR HANSON: No. The new beds—

Ms Gallagher: That is an important clarification.

MR HANSON: that are opening do not include the birthing suites and a number of other important facilities which have been put in temporary accommodation. They are not put into new elements until August 2013. So it is quite true to say, in terms of—

Ms Gallagher: They are put into new accommodation.

MR HANSON: Temporary.

Ms Gallagher: A full hospital—

MR HANSON: It is open as temporary.

Ms Gallagher: with the full range of services will be operating from the women's and children's hospital from August. And, yes, as the hospital refurbishment continues—and this is happening right across the hospital, Mr Hanson—places and clinics and services are being moved around as more space becomes available. For example, we have just converted an old auditorium into acute beds. So they might be used for a temporary period of time while some other beds—

MR HANSON: Sure.

Ms Gallagher: are operational somewhere else. That is the nature of a—

MR HANSON: I do not dispute that.

Ms Gallagher: hospital redevelopment.

MR HANSON: I think then my language, which was that what is opening in phase 1 is half of the new hospital and then what happens later on is the second half of the new hospital, is entirely valid, because—

Ms Gallagher: It is not. It is entirely wrong.

MR SMYTH: It cannot be entirely wrong if things are going into temporary accommodation.

MR HANSON: It is not all new in August, is it?

Ms Gallagher: It is all new in August, Mr Hanson.

MR HANSON: The new bits in phase 1 and then the refurbishment—

Ms Gallagher: I will look forward to showing you around at the open day.

MR HANSON: in phase 2.

THE CHAIR: Okay. It does not really help either of you, the bickering.

Ms Gallagher: It is all new and all the services will be operating out of there.

MR HANSON: All right.

THE CHAIR: Mr Smyth, I will come to you because I know you had a supp. I do apologise.

MR SMYTH: I want to go back to the subacute hospital. Page 218 of budget paper 3 talks about the finalisation of the scoping requirements. Have they been finalised?

Ms Gallagher: Sorry?

MR SMYTH: Under the north side hospital specifications and documentation, page 218 of budget paper 3 talks about the finalisation of scoping requirements.

Dr Brown: That very much ties into the whole clinical services plan.

MR SMYTH: That is fine, but have the scoping requirements been finalised?

Mr Thompson: No.

MR SMYTH: No. So you need to get the clinical services plan and then that tells you the scope?

Mr Thompson: Yes, essentially. Until we know definitively which services are operating out of the hospital, we cannot confirm the final scope of the hospital.

MR SMYTH: So the Calvary master plan, the draft, is due by the end of June?

Mr Thompson: Yes.

MR SMYTH: Then by some time in August you will get the clinical services plan?

Mr Thompson: The planning for the north side hospital is a separate exercise from the Calvary master plan. The Calvary master plan is about the Calvary campus. The north side hospital is underway and is well progressed.

MR SMYTH: But it does impact on the—

Mr Thompson: There is no question it impacts. However, the purpose of a master plan is not to develop the fine level detail of how the Calvary campus will work and operate in the future. It is a higher level document.

MR SMYTH: Sure, but what goes on at Calvary will affect what is or is not in the subacute?

Mr Thompson: Yes, it would.

MR SMYTH: Okay. So Calvary master plan draft is by the end of June?

Mr Thompson: Yes.

MR SMYTH: The clinical services plan is the end of August or some time in August?

Mr Thompson: The clinical services plan is the whole of territory services plan. It is due to go out to consultation in July.

MR SMYTH: Okay. We said August before, but it is July now?

Mr Thompson: July for consultation; finalisation in August.

MR SMYTH: Okay, July consultation and then August. So when you have got those documents you can come up with the scoping requirements?

Mr Thompson: No. That is the point I was making. The scoping requirements are being done concurrently. This is to ensure that we have got integration of the different elements; each depends on the other and so they are being developed concurrently and in reference to each other. Similarly, the way to get the work done most quickly is to try and do it concurrently and to minimise the delays associated with a strict sequential development process.

MR COE: Does that $111 million price tag include phase 2?

Ms Gallagher: Are we back on the women's and children's?

MR COE: Sorry, women's and children.

Ms Gallagher: Yes. Stage 1 is about $84 million and stage 2 is about $26 million.

MR SMYTH: When will the scoping requirements be available?

Ms Gallagher: Are we back on the north side now?

MR SMYTH: I have always been on the north side.

Mr Thompson: We have not confirmed a specific date for the scoping requirements. But the process will involve finalisation of the services plan and, based on that, finalisation of the location. Different locations have different implications for how you design and scope a hospital. Once we have those key pieces of work we will be able to work to finalise the scoping.

MR SMYTH: So when are the scoping requirements likely to be—

Mr Thompson: As I said, we do not have a firm date yet.

MR SMYTH: All right. Are there terms of reference for the scoping requirements? Have we determined if it will be 50 beds, 100 beds, 200 beds?

Mr Thompson: That is what will come out of the services plan. The services plan will identify the number of beds we are looking for and the scoping will follow.

MR SMYTH: And that then will drive the price for the—

Mr Thompson: Yes.

Ms Gallagher: Yes.

MR SMYTH: Okay. So have we determined a range of what we are willing to spend? Will we cut our cloth to match a price or will we just build what comes out of—

Ms Gallagher: Some of those figures I think were included in the work that was done over the options for the redevelopment of the north side hospital services and they would remain the figures at this point in time that we are working on.

MR SMYTH: So what is the cost envisaged to be?

THE CHAIR: Okay, just a final question and then we have to break.

MR SMYTH: What is the cost of the subacute envisaged to be?

Ms Gallagher: I would have to go back and have a look at that final outcome report. I will go back and have a look before I speculate. It is several hundred million dollars. And, as I said, the work that is being done now will inform a more detailed analysis of those costs.

THE CHAIR: Thank you. We are going to have to—

MR SMYTH: That is taken on notice?

THE CHAIR: Finally.

Ms Gallagher: It is online. Check out that—

MR SMYTH: That is okay, but you are going to come back and tell the committee?

Ms Gallagher: Yes, sure. I will provide you with the web link.

THE CHAIR: So it is taken on notice.

MR SMYTH: And then your timing; once you have pressed the button to go, how long to build?

Ms Gallagher: That depends on what you are building and how complex the design is. For example, the Gungahlin community health centre has had a construction timetable of about a year. Belconnen community health centre is a larger project. That has got a longer period than a year. It is a several-year period. I think you would probably build in a year for design, detailed design, and then you would have a construction period of one to two years is my guess.

THE CHAIR: Okay. We are going to have to break now; we have gone a little over. We will adjourn until about 10.40, return to acute and I will go straight to Ms Hunter for the first question.

Meeting adjourned from 10.32 to 10.54 am.

THE CHAIR: Ms Hunter, the first question.

MS HUNTER: I wanted to go to budget paper 4, page 78. It is about supplies and services. I note from the Health Directorate's annual report that the cost of medical

practice indemnity insurance has risen from $13.9 million in 2005-06 to $25.6 million in 2010-11. In answer to our question on notice 2359, you provided four areas of activity undertaken to minimise the risks associated with medical malpractice indemnity. I note we requested that you advise us what modelling had been undertaken by the directorate to determine whether its risk management work would lead to reduced insurance claims and what the projected annual savings in medical practice indemnity insurance costs would be. We did not quite get an answer to that question. So what modelling has the directorate undertaken to determine what savings were made from medical practice indemnity insurance costs?

Dr Brown: I am sorry; I am going to have to take that question on notice and provide that back to you.

MS HUNTER: Okay. What is the budgeted cost of medical practice indemnity insurance for 2012-13 and the three forward estimate years?

Dr Brown: Again, we will have to take that on notice. I do not have those figures.

THE CHAIR: Okay. Both of these will be taken notice.

MS HUNTER: I want to go to capital works rollovers. I think we have had a bit of discussion about this, but there are probably a few more questions. There is $89.6 million in rollovers. Could you provide more background as to the re-profiling? It is budget paper 3, page 218.

MR HANSON: Would you do that, if possible? There are a number of different projects on the run at the moment. If we could get a bit of an explanation where those projects are at—not just the rollover but things like the mental health young persons unit, the various health centres and the secure adult mental health unit. If we could have an explanation of exactly where we are at with all of those it would be very useful.

MS HUNTER: I note that we had quite a bit of discussion before the break about the north side hospital specification and documentation, so we probably—

MR HANSON: I am happy to leave that one alone.

MS HUNTER: covered that one reasonably well. With the rollovers, in a number of instances you state that the reason for delay was revision of the project's scope in line with the appropriated budget. Could you also include that in the answer to the question about rollovers?

Mr Carey-Ide: I note, Ms Hunter, that there are a couple of components to that question. I am not sure whether you would like me to go specifically through each project or talk more generically.

MS HUNTER: You could start more generically and then maybe we could go through some of them. Other members may have supplementaries around particular projects.

Mr Carey-Ide: Certainly. The revision of scope comment that you have referred to that is provided as an explanation for some of the re-profiling of the projects is about a number of different factors and it is dependent on individual projects. For instance, the Tuggeranong community health centre project, I guess, is one that people are very interested in and has had some delay to delivery. That has been about making sure that the project matches the original scope and also fits within the appropriated budget. For that project specifically, that is what it is about. The opportunity—

MR SMYTH: Just on that project, it is a 20-month delay.

Mr Carey-Ide: There has been, yes.

Ms Gallagher: We go back to the original decision with the $5 million allocation just to do a refurb of the community health centre in Tuggeranong. When that work was done for that $5 million it was clear that a simple refurb would not actually provide what we were looking for out of our community health centres. A further appropriation the next year—so there was 12 months where we provided about $14 million, from memory, to actually beef that redevelopment up to a $20 million redevelopment of the Tuggeranong community health centre. Then what happens is that we have set the budget and it goes out for model of care and discussions around how that is to be realised. I think that came back significantly over budget—significantly—and I said no. So then it was back to the drawing board: you have a $20 million project; fit it in within $20 million. That has been the reason for the delay.

MR SMYTH: So many of these projects seem to be re-scoped once they have started. Is there something wrong with your processing in determining what you are going to do when you start that leads so many of these projects to blow out in time and scope and budget?

Ms Gallagher: I do not accept that preamble. I would say that—

MR SMYTH: In what way is it wrong?

Ms Gallagher: If I can just address the question. In many ways what we are trying to do here is end up with facilities that everybody is happy with. We put greater emphasis on, I think—than in other areas of capital delivery—consulting with our workforce who are going to be working in this environment to make sure it is going to suit their needs, including having extensive discussions around changing the way services are currently provided. That can often be an extremely lengthy process, but what you will not get at the end of it is clinicians refusing to work in a place or saying that the place does not meet their needs. We have not had a situation where that has occurred.

For example, in other jurisdictions a hospital has been opened and the doctors walk in and say, "None of that meets my needs, therefore I do not find this acceptable accommodation." It has happened quite a lot in New South Wales with some of their redevelopment activity. You do not see that happening here.

MR SMYTH: But you contradict yourself. You say: "We put it out. We asked what people wanted. We got a number that was too big." You said, "Cut it back to

$20 million."

Ms Gallagher: I did in that instance.

MR SMYTH: So surely somebody must be unhappy with what is being provided.

Ms Gallagher: It is about expectation management as well.

MR SMYTH: Again, you have contradicted yourself.

Ms Gallagher: Part of my job, Mr Smyth, is to say, "What is reasonable and what is unreasonable?" I try to do that in a very fair way. My view on the Tuggeranong community health centre is that we have provided three times as much as was originally intended, being a $5 million refurbishment. We are now providing $20 million. The government is not going to support something that costs $30 million. We need to revise that but, again, do it with the agreement of the clinicians. There is push back, and you will see it in relation to the mental health facility as well, the secure unit. It is exactly what happened there, where large outdoor areas that were not included in the original design were put in as a request, and there is push back.

We consult heavily. We cannot always deliver what everybody wants. I think it takes detailed negotiations with very important stakeholders, but at the end of the day we do come up—and I think with Tuggeranong community health centre, as far as I understand it, it was perhaps as late as yesterday—with agreement on how it is going to be managed within the scope of the budget.

MR SMYTH: But in response to the first answer you said, "We want to end up with facilities that everybody is happy with."

Ms Gallagher: Yes, and they will be.

MR SMYTH: They are happy with what they get, I am quite sure. But what has been cut out of the Tuggeranong health facility that was asked for that will not be in the $20 million limit?

Mr Carey-Ide: If I could just comment first, Mr Smyth. Happiness is very much a subjective thing.

MR SMYTH: You should refer that to the Chief Minister.

Mr Carey-Ide: That people have not actually got the ultimate goal that they would aspire to does not necessarily mean that they are unhappy with the outcome that has been achieved. I think it is important to understand that. Clinicians and community groups will always advocate for the very, very best that they can achieve, often without an expectation that that is what they will achieve. It does not mean that they are unhappy with the result that is actually delivered.

MR SMYTH: If the price came back at $30 million, as was quoted, and you have cut it back to $20 million, there is a lot of happiness for an extra $10 million. But what specifically was cut out of the Tuggeranong health centre?

Ms Gallagher: No, there are a lot of skilled negotiations into making sure that the clinical services delivered there are done in conjunction with the clinicians and the budget available to deliver the outcome. That is what is happening.

Mr Carey-Ide: The project was revised back to the original scope. There was more future proofing being incorporated into the Tuggeranong project with the original design, such as roof slabs that would be put in place but were not actually necessary at this point in time, that would allow for expansion in around 10 to 15 years should such expansion actually be necessary. Our health service planning indicates that that is not actually the case, so that has been taken out of the project briefing.

The movement of the aged day care centre out of the centre, as members are aware, has given us the opportunity to actually re-utilise the space that had been planned for the aged day care centre within the Tuggeranong centre for the gymnasium rather than having to extend that service as well. We have also been able to revise the scope of the project around the finishes that will be used within the facility.

Predominantly, those are the things that actually go to make up the changed scope. Whilst that does equal around $10 million, it does not actually compromise the project that will be delivered. The clinicians, who are part of the user groups and the executive reference group for each project, in this instance, the Tuggeranong project, have actually signed off very happily about what will be delivered in this project.

THE CHAIR: Ms Hunter.

MS HUNTER: The other one that was due to the need to review the project scope was the Aboriginal and Torres Strait Islander residential alcohol and other drug rehabilitation facility.

Mr Carey-Ide: If I may, I will hand over to my colleague Mr O'Donoughue, who is leading that project.

MR HARGREAVES: Don't go too far.

Mr Carey-Ide: I will not go too far.

MR HARGREAVES: I am going to need you in a minute.

Ms Gallagher: It is largely the same answer, that the work that came back after consultation with a number of groups did not match the budget that had been set. I had to take a decision about whether or not to accept what people wanted or work within the provided budget. Again, on that project I felt that we should work within the provided budget and cut our cloth accordingly. That does not mean—what is possible there is future expansion, if that is required at a later date, but not expansion that had been approved under this project cost.

MS HUNTER: Also—and I am probably going to jump back to another person; I am sorry, Mr O'Donoughue—there was one that was around the enhancement of the Canberra Hospital facilities design. It was:

> … revisions to the preferred contract form caused delays in the release of tender documentation.

What does that mean?

Mr Thompson: What that means is—the scale of project that we are talking about with this particular project is the biggest part of the redevelopment. In doing that, we sought extensive advice as to what was the best form of contract to protect the territory's interests, from both a financial and a program timing sense, to achieve the outcome. Based on that advice, we decided that we needed a new form of contract that would be as watertight and as effective as we possibly could have. That was developed in consultation with various lawyers, using models that have been particularly effective in the Department of Defence. It took time to develop the new form of contract. The issue there is that until we had that new form of contract developed we could not go out to tender, because the form of contract is an integral part of the tender process. That is the consequence of that.

MR HANSON: Which item is this, please? Can you just clarify which item in the budget paper we are talking about?

MS HUNTER: That was "Enhancement of Canberra Hospital facilities (design)". Then there was the provision for project definition and planning. What is that about?

Mr Carey-Ide: I would have been very happy for Mr O'Donoughue to take that question. This one, which relates to PDP, project definition planning, is about delays in project initiation. This funding actually supports individual projects and funds the staff who are provided within Health to support the health infrastructure program as well as the project director fees and the Shared Services fees. So the delay in any adjacent projects means that there will also be a delay in spending from this particular budget, and therefore we have needed to roll over funding that has not yet been allocated to specific projects.

MR HARGREAVES: While we have got Mr Carey-Ide here, Chief Minister and Minister for Health, with your permission, could I ask a question about the Tuggers health centre, the Tuggeranong health centre, the community health centre. Could you let us have a bit of a discussion on the transitional arrangements which will be put in place. This is a significant refurbishment of the centre. It has a range of activities. I just wanted to know how you are going to manage the thing—providing community health services in a construction zone.

Mr Carey-Ide: One of the ways that we have been able to expedite the project—and thank you for the prompt—which I had forgotten to mention, is that one of the ways that we also have been able to contain costs is by a total move of the staff out of the existing Tuggeranong community health centre into leased facilities that are very close to the current facility, which means that the project managers, the builders, actually have free rein throughout the existing centre, which means that the project is expedited effectively. We are currently in the final stages of negotiating the lease for the premises from which the staff will operate. We expect to finalise that in around two to three weeks time.

MR HARGREAVES: Does that include the private practitioners that are in that centre?

Mr Carey-Ide: All of the services that are currently located in the Tuggeranong health centre, with the exception of dental services, will be moving to the leased facility. That does include the general practices.

Ms Gallagher: And, as I understand it, dental will be managed in Phillip and Civic during the redevelopment.

MR HARGREAVES: So you are going to close that service down, close that centre down, and relocate the services, most of them in the proximity.

Ms Gallagher: Tuggeranong, yes.

MR HARGREAVES: Except the dental into Phillip

Mr Carey-Ide: Very close.

MR HARGREAVES: What about access? I know that the community nurses have parking access and the doctors have it. Is there underground parking access?

Mr Carey-Ide: There is.

MR HARGREAVES: Are they are going to have those sorts of provisions in the leased premises?

Mr Carey-Ide: Yes. There will be secure parking provided with that centre.

MR HARGREAVES: You also mentioned, rather quickly, that there were some sort of user groups or consultative groups involved in the consultation. I can remember talking about this last year and wanting to be assured that the practitioners in the building were actually on board as you went down the track. It sounds as though you are. Could you give me an idea of who those groups are, who is on them and how often they meet?

Mr Carey-Ide: Sure. Do you mean just for the Tuggeranong project or for the whole of that?

MR HARGREAVES: I am not interested in anything else except Tuggeranong and what is going on.

Mr Carey-Ide: For the Tuggeranong project, as with every health project—

MR HARGREAVES: Except the Canberra Hospital.

Mr Carey-Ide: Of course.

Ms Gallagher: That is in north Tuggeranong, though.

MR HARGREAVES: That is right. It is in north Tuggeranong.

Mr Carey-Ide: We have a process by which we set up a really extensive consultative framework. That begins with user groups being established around specific projects and sometimes within specific projects. For the Tuggeranong community health centre, as an example—and it is tied up with the other community health centres so that they have the same model of care, the same look and feel for patients and their families when they arrive to receive care or advice from a community health centre—the user groups will focus on areas such as administrative services and how they will provide that first point of contact to the public when they enter a community health centre. Then there will be often very specific user groups.

In the case of community health centres, there are user groups around community nursing, for example, and around the way we will provide mental health services. There has been very close work which has involved lots of our dental staff around a different way of providing service in terms of the equipment that we will be able to be using in the new centres, which is incredibly exciting. It is state-of-the-art equipment that is coming from the United States and will kick off for the first time in Gungahlin in September. That model of care transposes across the whole territory to all of the community health centres as they are refurbished or rebuilt.

The user group information then feeds up into an executive reference group that is run for every project. So again community health has an executive reference group. That is to make sure that all of the pieces of the jigsaw fit into that one jigsaw puzzle and, for patients and the consumers of community health centres, they make up a complete picture that provides joined up care for them and means that the experience of actually receiving care in our community health centre is the sort of care that they would wish to receive.

Having said that, it is really important to note that consumer representatives that come from various advocacy groups or representative groups throughout the community, including mental health consumer representative groups and carers groups as well as the Health Care Consumers Association, play very active roles in those user groups as well as in the executive reference groups, and are part of the sign-off process for what the services will actually look like as well as for the design—so the look and feel of those centres.

MR HARGREAVES: Two final questions: one is very brief and I hope the other one will be brief. The first one is this: who is actually on the executive group for the Tuggeranong community centre? The second question is: how are you going to manage the consultation process for the older persons services there? From my own experience, that is quite often the most difficult consultation process, to allay fear from change of environment for the older people who use that. They are moving out and going somewhere else. The individuals affected by that—how has that consultation been moving?

Mr Carey-Ide: I probably need to refer to my colleague Linda Kohlhagen, who has actually managed that process of the move at the aged day care centres. We should note that that has already occurred.

Ms Gallagher: A lot of work went into making sure that went smoothly.

Mr Carey-Ide: And it did go smoothly.

Ms Gallagher: And it did.

MR HARGREAVES: Yes. I would like to know just how you actually managed that, because I know that that is fraught with massive danger.

Mr Carey-Ide: I will come back with some—

MR HARGREAVES: Do not stay away too long.

Ms Kohlhagen: You specifically wanted to talk about the aged day care relocation?

MR HARGREAVES: Yes and how you actually managed the consultation—not with the providers of the service but the actual older people themselves, the ones who are going to get scared witless by a change of environment.

Ms Kohlhagen: It was a long process that we did over quite a number of months. We first met with all the patients or the clients of the service and family members to talk about the consultation that we were going to do. We followed that up with letters. We had regular meetings and sort of feedback sessions with the clients in both services. We had a dedicated staff member who was able to talk to or respond if there were any issues or concerns about the consultation process that was going on. We also made sure that the staff were very much kept in the loop about what was going on. They worked with the clients on a day-to-day basis so that they had very good relationships with the clients.

So it was a combination of making sure that we were very open and transparent about what the consultation was. We had regular newsletters and updates and kept their families involved as well. Towards the period when we were actually closing down we also made sure that there was a transition, so that when the clients went to the new providers we actually had our old staff spend a couple of days with them; they went to see the facility with them before they were actually transitioned there so that it was not brand new. They certainly did not leave the service on one day and start the next day; there was quite a period of transition during that time.

MR HARGREAVES: Where is the new place?

Ms Kohlhagen: It is in Gowrie.

MR HARGREAVES: In Gowrie?

Ms Kohlhagen: Yes.

MR HARGREAVES: Good.

THE CHAIR: Mr Smyth?

MR SMYTH: Another rollover you have got there is the healthy future; $41 million were due to be spent this year. That has now been broken down over the next—

Ms Gallagher: The e-healthy future?

MR SMYTH: Yes, e-healthy future. Why was it not delivered this year and why is it now spread over three years?

Ms Gallagher: The majority of the reason is to realign the e-health program with the infrastructure redevelopment to make sure that those are happening in conjunction with each other. From my reading I think there are about 25 projects that have been delivered or are underway and then there are about three or four projects that are impacted by the re-profiling. So a lot of work has gone into different projects that have already been implemented—not very sexy in terms of getting any attention: clinical portals, digital mammography, clinical information systems in the intensive care unit, wireless connectivity, digital nurse call, individual health identifiers, consumer portal to a pilot group.

There is a whole range of projects that are underway: the digital intensive care at Calvary hospital, e-referrals from GPs, community-based clinical records, cancer information systems, renal medicine systems. It goes on and on. I think the big ones that are being impacted are probably electronic medication management and the electronic health record that have been delayed due to the re-profiling.

MR SMYTH: This was all due to be up and running on 1 July. Was there a commonwealth requirement that this be—

Ms Gallagher: The capacity for electronic health records, the commonwealth side, is on 1 July, and we have a project—

Mr Thompson: It is the personally controlled electronic health record which is due to commence on 1 July. What commencement means in this instance is actually the ability for people to register their interest in participating as connectivity gets successively added to it. In the ACT we are one of the more advanced jurisdictions. We were expecting to commence with a small group of people with chronic diseases in July, to start to access some aspects of their record through the functionality provided at a national level. But the full national rollout of the personally controlled electronic health record is still some years away before it will be fully available.

MR SMYTH: There was an article in the *Financial Review* in late May about this and the AMA have raised concerns that it will not be functional and that they have not been trained in it.

Mr Thompson: It is open to individual medical practices to choose to sign up to it. There has not been a lot of sign-up to date from medical practices. That is one of the reasons why the commonwealth is looking at it as a staged and a longer term rollout. That work is underway to work with the stakeholders, including the AMA, and identify how that can be most effectively connected.

MR SMYTH: But the main federal budget shows that the federal government will take away existing e-health payments from GPs who do not use it even though it is not ready on 1 July. Does that have an impact for us in the ACT?

Mr Thompson: We do not believe that will impact on the plans that we have. We have been working closely with the commonwealth.

MR SMYTH: The AMA and the GPs have all raised concerns about the security of data and records. How will the system be secured, particularly given the increasing use of mobile facilities?

Mr Thompson: Within our developments we have got a very clear security framework that is building on other work that we have done. Again we are not concerned about the security in our involvement; we would not be entering into it if we were concerned about the security.

Dr Brown: Just to add to that, from a national perspective there has been a very strong focus from NEHTA on security as one of the foundational elements to the PCHR system as well.

MR SMYTH: All right, but a lot of productivity gains are seen as occurring in this e-world. If this is now delayed for three years, have we factored in any productivity gains over the next three years that are now at risk?

Dr Brown: Are you referring to the PCHR or our e-health?

Ms Gallagher: I can only answer from our e-health.

MR SMYTH: E-health across the board is touted as one of the ways of saving health budgets in the future. By delaying this for three years are we—

Ms Gallagher: We are not delaying it for three years. We are re-profiling against a range.

MR SMYTH: Delay, re-profile? It is not being delivered this year.

Ms Gallagher: I am talking about—

MR SMYTH: You have rolled it over. Is it not delayed? You can say "re-profiled" but it is delayed.

MR HANSON: It is like temporary, mate.

Ms Gallagher: E-health in—

MR SMYTH: It is a temporary delay?

THE CHAIR: Can we stick with one person, please?

Ms Gallagher: The e-healthy program encompasses probably over 40 different

individual projects. We are talking about a small number of those being re-profiled across a period of time where the e-health program is being rolled out.

MR SMYTH: Sorry but "small number" means a $41 million budget for this year is re-profiled to $4 million next year, $22 million in 2013-14 and $15 million in 2014-15. It is hardly small beer.

Ms Gallagher: No, it is not small beer and it is an important part of the redevelopment of the hospital, but I would go back again to say that we are going to make sure we get this redevelopment right. It is not going to be piecemeal. It is not going to have programs and IT infrastructure that are set up one year but then have to be reconfigured to fit into a new building two years later. We are not going to do that. And if that means—

MR SMYTH: So why was that not taken into consideration when you put the money in this year's budget?

Ms Gallagher: Because the project is evolving, Mr Smyth. The $90 million for the e-health initiatives, from memory, was in the 2008-09 budget probably. I am trying to recall, but it would be around then and the project—

MR SMYTH: So that is just a temporary delay as well.

Ms Gallagher: Are you suggesting that a redevelopment project of this size cannot evolve through the delivery of the program; that whatever you have at the beginning, regardless of anything that comes and changes matters or that we learn from our staff about the impact of change or that we learn about how the redevelopment is going to progress across a brown field canvas, we should not change any of our original plans for fear of criticising of re-profiling?

MR SMYTH: No. I am just suggesting that everything you put to an estimates committee in a budget evolves over the life of the project; they all evolve.

Ms Gallagher: What I am saying to you is that we are going to get the redevelopment right. If that requires us to make changes to our plans and requires re-profiling of cash, it does not take away from the important reform work that is underway or that needs to be done. What it is saying to you is that it is going to be done in a very careful and coordinated way and we are going to respond when we get feedback and advice around how that change is implemented. This involves significant change at the workplace level.

MR SMYTH: Yes, it does—potentially significant productivity gains.

Ms Gallagher: And what we are asking our staff to buy into, while they are already dealing with extra demands of patients walking in the door, requires us to change our thinking as well, and that is what we have done.

MR SMYTH: All right. Can the committee just have a breakdown into the three forward years of which projects will now be done in each of the years, please?

THE CHAIR: Okay. That is taken on notice.

MS HUNTER: I wanted to ask about the revised funding profile for the mental health young persons unit. Have you got some more information on that?

Mr Carey-Ide: This project, the young persons mental health unit, has been one of those projects that exemplify the points the minister has been speaking to, which is around making sure that we get the design and the model of care at this centre absolutely right before we then commit to construction. It was a unique proposal in that the work we have been doing has not been able to be benchmarked elsewhere in Australia. The model incorporates both young adults to the age of 25 years as well as adolescents aged from 13 to 18 years.

It has been a very complex piece of work, working out the model of care and therefore the information that would inform the service design for this centre. We have now progressed with that work and we have done some benchmarking work against New South Wales as well with this project. So we are at a stage now where we are able to take it forward, but essentially the reason for the rollover is making sure that we have got it right before we actually commit the resources to the budget.

MS HUNTER: Who has been involved in those discussions around the sorts of services—the service model and the design?

Mr Carey-Ide: Again, the user group and executive reference group model have been utilised and that has been incorporative of a great number of clinicians throughout the mental health services as well as experts from other jurisdictions.

MR HANSON: Can I ask a supplementary?

THE CHAIR: Yes, given that we are at this point and starting to ask about mental health services, we will move on to mental health, drug and alcohol and justice health. We can come back at the end with more questions. We might as well move on to that area.

MR HANSON: Come back to acute later, yes?

THE CHAIR: If we have got time.

MS HUNTER: With the user groups, you mentioned in there clinicians. What sort of groups that advocate on behalf of young people provide services to young people?

Mr Carey-Ide: I might invite Tina Bracher to speak to that. I apologise that I left the consumer and care representatives out. They are a very important group to have included.

Ms Bracher: I believe your question is around the user groups for the adolescent young adult mental health unit. We have undertaken, or are undertaking in fact, a significant redesign project within our division that is around adolescent and young adult services across the board. In line with the national agenda on mental health to move young people's services into a developmental model, move them out of an

illness model, we are actually needing to do a lot of service redesign. Part of that redesign will be used to inform the model of care for the inpatient unit.

In giving that preamble, we have six user groups that are informing the redesign of our CAM service which will need, of itself, a new name when we have young adults in there as well. It will not be a CAM service. So we have six user groups. One is around the inpatient unit, which will be the adolescent young adult in-patient unit. There is one around peri-natal care. There is one around our community services. There is one around the care that we provide in the Bimberi Youth Justice Centre. There is one around eating disorders and there is one around early onset psychosis.

They are the six users groups that we have. All of those user groups have broad representation from clinical services, both from CAMS and from the Canberra Hospital—paediatric areas and maternity areas that are appropriate. We have representation from Bimberi Youth Justice Centre management on that particular one. We have very active representation from the Mental Health Consumer Network on each of those user groups and we have from Carers ACT as well.

We are also incorporating feedback from the peak bodies separately or in addition to the user group model. I have undertaken a number of public forums with the Mental Health Consumer Network to share what we are doing and seek their input. I am meeting, in fact, with the Mental Health Consumer Network tomorrow to do yet another one. We have met with Carers ACT in the same way twice in the last three months to do that.

We are also planning with the Children and Young People Commissioner some focus groups with young people who are not part of our system currently on how they might engage with the system—what name, for example, they would like to see our service called, which might be different from CAM. We are hoping it is. So the Children and Young People Commissioner is actually doing that independently of us. Then we will use that information to inform the work as well. I chair the executive reference group and that also has another group of carer and consumer representation and more senior staff representation as well.

In all, if I was to make a guess, there would be about 150 people actively involved in those meetings regularly every fortnight. They have been going for three months or four months and will continue to go on as we move through a model of care design, design of a facility and then an implementation.

MR HANSON: This is a supplementary on the infrastructure questions. It strikes me that all of the projects are subject to delay and cost blow-out. I note that in budget paper 3, page 166, there is money allocated to the health infrastructure program project management. I would be interested to hear about what that is. I am assuming the intent is to manage all of these projects to mitigate the risk of trying to deliver them on time and on budget. I guess that is what it is there for. Can you confirm what it is and how it is going to be managed?

Ms Gallagher: Thank you, I can. Again, I do not accept the use of the term "cost blow-out", that all projects have been delayed and subject to cost blow-out. I think that is incorrect.

MR HANSON: Well, that is—

Ms Gallagher: We have just spent some time explaining some of the changes that have been made. I know the Liberal Party—I have seen your press release from this morning; so I have been waiting for the quote from the press release which you have just read into *Hansard*. For example, the Liberal Party constantly quote the southern car park and conveniently ignore the fact that we moved the car park and expanded the car park considerably and changed, really, the entire project and made further appropriations. So I simply do not accept that that was a cost blow-out.

MR HANSON: Sure. As a rebuttal then—

Ms Gallagher: If I could just finish?

MR HANSON: Sorry, minister, as a rebuttal—

THE CHAIR: Let the minister finish and then we will come back to you.

Ms Gallagher: If I could just finish, Mr Hanson? That car park project actually came in on time and under budget. I know that you conveniently like to refer back to the original project without accepting the fact that that project was completely changed. So we will just put some—

MR HANSON: Can you point me then to the example of any project that, based on how it was originally put into the budget, has been delivered on time and on budget?

Ms Gallagher: There are a number of projects, Mr Hanson.

MR HANSON: Major infrastructure projects that have done that.

Ms Gallagher: There are a number of projects that do not get any attention at all. There has been significant building work done at Canberra Hospital—new beds, for example. That is a major construction work—

MR HANSON: No, I am talking about a line item in the budget where it has been delivered on budget and on time.

MR HARGREAVES: Let the minister finish.

Ms Gallagher: These are all in the budget, Mr Hanson. They are all in the budgets that you have opposed every year. So they are all projects that have gone forward without the Liberal Party's support. I will talk about them. There are extra operating theatres. There is the surgical assessment and planning unit and the mental health assessment unit that works out of the emergency department. There has been the walk-in centre; there has been the PET scanner; the CT scanner—

MR HANSON: There is one. You promised three.

THE CHAIR: Can we have one person at a time?

Ms Gallagher: No, we are talking about infrastructure here and infrastructure that appears in the budget. I know when you get taken on and challenged on the incorrect comments you make that you—

MR HANSON: You lied. You lied at the last election. You said there would be three and you delivered one.

THE CHAIR: Can I—

Ms Gallagher: then refer to something else which is now talking about a totally different matter—

THE CHAIR: Can I just—

MR HARGREAVES: Madam Chair, that requires a withdrawal.

Ms Gallagher: There have been temporary car parks established. There has been an intensive care unit at Calvary Hospital, Mr Hanson. There has been a whole range of projects that have been delivered on time and on budget. Then we can go to the ones that you like to quote from. The car park—I have just addressed that—the women's and children's; I will address that.

MR HANSON: All of them—every single project in the budget.

THE CHAIR: Before we go on, members, can we please—

Ms Gallagher: No.

THE CHAIR: Health minister, can we just have one person speaking at a time, please?

MR HARGREAVES: I want to make a point of order.

THE CHAIR: Okay.

MR HARGREAVES: The point of order, Madam Chair, is that Mr Hanson said quite clearly that the health minister lied. That is unparliamentary, whether it is in the chamber or whether it is in committee. I ask you to seek his withdrawal of that remark.

MR HANSON: On the point of order, when she said at the last election she would deliver three emergency walk-in clinics, I asked was she telling the truth.

THE CHAIR: Minister and Mr Hanson, can we actually not use referencing such as "lying" and the like. If both of you could please withdraw it, because neither of you is actually helping in this situation. If we can try to be civilised in the way we conduct—

MR HANSON: I withdraw it.

THE CHAIR: Thank you, Mr Hanson.

MR HANSON: I would ask the minister to get, then, to the point of my question, which is about the line item in the budget on page 166, and I would ask her to explain what that is, what the purpose of it is, and how it is going to work.

Ms Gallagher: Yes, and I am getting to that. I would say that I do have to—

MR HANSON: If you want to discuss press releases in here, that is not a—

THE CHAIR: I have just asked both of you not to speak at once. Mr Hanson, you just interrupted. Can we let the health minister finish and then we will get back to you.

MR HANSON: Madam Chair, if you are going to sit here and let her litigate a political argument based on a press release instead of asking her to answer the question, it makes it very difficult for me.

THE CHAIR: Mr Hanson! As I said, neither of you is helping in this situation. Can we try to conduct this in a civil way and let the health minister finish. I have given you plenty of leeway here, Mr Hanson. If the health minister can answer the question, please.

Ms Gallagher: Thank you, Madam Chair, and I am responding with factual information, despite provocation. In relation to the project management fees, these are fees that have been paid since the redevelopment of the health infrastructure program commenced. They were funded, from memory, until this year. So this year flows into additional years of project management. That project has been outsourced to Think and the majority of the funds have been provided to that organisation. This provides ongoing funding for project management fees.

MR HANSON: It was about $19 million. It is going to an organisation called Think?

Ms Gallagher: No, it has been over the last—

MR HANSON: It has been?

Ms Gallagher: I think we had a three-year contract. This was money that was not ongoing in the budget but, now that we are in this financial year, we need to keep the project management fees going, and that provides ongoing fees for that.

MR HANSON: And is that going to Think, is it going to someone else or is it being managed internally?

Ms Gallagher: The contract with Think, I think, is up in September and we are currently in the process of making decisions around that.

MR HANSON: There will be a request for tender, or what is the process? Who is going to be managing these projects? My sense of it—and I appreciate that we have agreed to disagree—is that there is room for improvement in the delivery of health infrastructure projects and I would be interested to see what the process is in terms of who is going to be managing those projects, whether it is going to be an internal

process or an external process and, if it is external, who it is and what we get for our $19 million.

Ms Gallagher: The decision that we have taken at this point is for that work to be handled internally, with some extra support being provided to the Health Directorate. So it is making a change in the way the project is being delivered.

MR HANSON: So that $19 million is going to be allocated internally?

Ms Gallagher: Yes.

MR HANSON: And who internally runs it now, when you say it is going to be run internally?

Ms Gallagher: I run it and Penny reports to me.

MR HANSON: I am glad that you are accepting ministerial responsibility for all this.

Ms Gallagher: I always do.

MR HANSON: But who specifically is going to be managing it and what risk management and project management experience does Mr Carey-Ide have, if he is going to be the person running it?

Ms Gallagher: Noting that this is not Mr Carey-Ide's job interview, in a forum like this—

MR HANSON: I am curious. It is $19 million that previously we have provided—

Ms Gallagher: It is not all going to Mr Carey-Ide. It is a team.

MR HANSON: I will be seeking employment. I will go for your job.

Ms Gallagher: It is a team. At the moment we have some staff in the health redevelopment unit. That has been complemented by Think. The intention going forward is that once the contract with Think expires, within the health redevelopment unit additional staff will be employed to bolster the skills and capacities of that area.

MR HANSON: And what is the rationale to do it internally rather than externally?

Ms Gallagher: To continuously improve the delivery of the program.

MR HANSON: That is the outcome whether you do it externally or internally. Why would you do it internally, as opposed to externally? When you made the decision—

Ms Gallagher: Because we think there can be improvements made to the efficiency and delivery of the program if it is managed internally, with appropriate expertise and advice being sought.

MR HANSON: Can you extrapolate on that, to provide more information as to why

you thought—

Ms Gallagher: Other than—

MR HANSON: It is $19 million.

Ms Gallagher: Other than to say we have had four years of having it managed externally and we believe, from the learnings that have been taken during that time and the responsibilities that inevitably come back to the Health Directorate regardless of who is the project manager, efficiencies and improvements can be made, as long as we get the skills mix right, internally.

MR HANSON: So you are not happy with the way it has been going?

Ms Gallagher: What I would say is that I think there can be improvements made, from my point of view. And I think we have learnt, throughout the last four years, what some of those improvements could be, and we have taken a decision about that. I think Think have done the job we asked them to do but we now have a greater understanding and expertise of the responsibilities of this redevelopment program. I have taken extensive advice on this from external and internal advisers, including looking at how redevelopment projects are managed across the country, and I think, in terms of the next years and going ahead, as long as we get the skills mix right in the redevelopment unit—and we are putting a fair bit of work into that—there can be gains made from managing this internally. That is what I would say about it.

THE CHAIR: I am going to move to questions now, if we can, on the mental health, justice health and alcohol and drug services. I am going to go to my first question. It is in relation to the drug and alcohol sector. ATODA appeared before the committee last week, and one of the things they did say was that they were disappointed that they did not see a lot of new money in this particular budget going to specific drug and alcohol services. I think the thing we discussed about that was this was an area where there was quite a bit of stigma attached to it, and that did not make it easy.

Part of their budget submission was looking at the co-morbidity strategy and services in that. If you can perhaps elaborate on what actions are needed to make sure we are implementing this strategy in the coming year and into the future and how we are actually going to make sure those services are funded?

Ms Bracher: I will ask Ross to talk to the drug strategy, because that is a high-level—

THE CHAIR: And the co-morbidity strategy.

Ms Bracher: Yes, and the co-morbidity strategy, sorry. With regard to additional resources that internally we have made available within mental health, justice health and alcohol and drug services for alcohol services for 2012-13, we have done some internal budget realignment to fund a counsellor with the alcohol and drug service whose primary role is to do, through care counselling, with people that are in the AMC. We have also provided some additional funding for the pharmacy services that predominantly do the medications at the AMC, including the methadone.

THE CHAIR: When you say "internal realignment", what does that actually mean in practice? Are there positions that have been shifted?

Ms Bracher: Yes.

THE CHAIR: What does it actually mean?

Ms Bracher: I have reallocated the budget and created a number of those positions. The reallocation of some pharmacy budget I do not know will necessarily equate to an additional FTE. The counselling position will be a full-time FTE—0.8 or full time. I can confirm that if you need to know that level of detail, but there will be an extra position that will sit in our counselling and treatment service and do the through care.

Within the alcohol and drug service, they have done, likewise, some internal juggling with their program budget to fund additional support mechanisms at building 7, like an antenatal clinic for pregnant women that are attending the methadone program and immunisation clinics for people that are attending the methadone program. So we are actually growing that service within our existing budget and we are reshaping it, redesigning it and changing our models of care.

THE CHAIR: How does that impact on other services you have been providing within your section? Does it have an impact? I am trying to get a sense of whether you are trying to address need by actually moving services around in your own area.

Ms Bracher: The reality is that I am moving budget around, very carefully, to make sure that we do not have an impact on the services. We are seeing a very positive impact in the alcohol and drug service, with regard to the consumer feedback that we get and the positive comments that we get from GPs around how we are growing the services that are actually available in building 7. I have not taken budget from any other area within the division to enhance that, if that is the question you are asking.

THE CHAIR: We do not know the complete impact of the withdrawal of funding from a federal level. How is that going to impact on ACT services? Have you been able to ascertain that as yet?

Ms Bracher: Not completely; we have not been able to ascertain it. And my understanding is that some of the budget was actually—what is the word?—provided back. There was a change in the government—

THE CHAIR: The therapeutic community, I think, was the one, but I do not know.

Dr Brown: There was about a million of the 1.2 is my understanding. They initially advised of a reduction of 1.2. They re-provided around about a million of that.

THE CHAIR: Is that just the therapeutic community or were there other—

Ms Gallagher: No, it is to all.

Dr Brown: No, it is across the broader range.

Ms Gallagher: There was some issue with how the decisions were made. When it was drawn to their attention, it was re-allocated. But I think there are still some savings sought.

Dr Brown: It is around 200,000; I think that is Ted Noffs, largely.

Ms Gallagher: It is Ted Noffs, yes.

Ms Bracher: With regard to your question of whether that impacts on us, the program director for alcohol and drug services works very closely with the executive directors of all of the non-government agencies in their alcohol, tobacco and other drugs forum, and ATODA is part of that. And we try very hard, across the sector, to meet the needs. They had started some preliminary discussions on how they might meet gaps that would be caused by that change in commonwealth funding.

THE CHAIR: Is it possible then to get some information on the co-morbidity strategy as well?

Ms Bracher: Sure.

THE CHAIR: Sorry.

Ms Bracher: Yes; no problem.

THE CHAIR: It would be interesting. Thank you.

MR COE: Madam Chair, would this be a good time to discuss the Aboriginal and Torres Strait Islander drug and rehab facility?

THE CHAIR: Yes. Once I have finished my question I will get to you.

MR COE: Sure.

Mr O'Donoughue: I just echo what my colleague Ms Bracher was saying: I think there is a good level of cooperation in the drug and alcohol sector, and we work very closely, from the Health Directorate to the community sector. In the example of the EDs group that Ms Bracher referred to, and also through the alcohol and other drugs strategy group, there is a long history of very active engagement. While it is true that there have not been significant recent budget enhancements, I think the sector and the government have been working very closely to try and find efficiencies and to maximise the services that are available. In the opioid treatment and replacement program, for example, being able to maximise the number of community prescribers and community pharmacists who dispense methadone and concentrate our program on the more complex patient and inducting new patients is already showing good progress. Coming to your specific question—

THE CHAIR: That is fine, but the concern is that we have these strategies and nothing really happens with them until they are getting implemented. Given that, as you said, it is about finding efficiencies, how are we going to make sure we are meeting the strategy once you are having it significantly implemented?

Mr O'Donoughue: I guess in the case of the co-morbidity strategy, the one you have raised in particular, there is some money in the budget through community mental health growth funds. There is a $50,000 allocation to assist in the implementation of that strategy. But in a way it is a good case in point. There has been recognition in those sectors that co-morbidity is an important issue and that very often you may be seeing the same clients in different services. Very often the people with mental health issues will have drug and alcohol issues and vice versa.

The way that the Health Directorate has organised itself in Ms Bracher's area, and the way that the sector is increasingly wanting to work together, does not, arguably, need huge resources. The primary thing it needs is people working more collaboratively, and closer and smarter. That is not a bad example of a case where maybe massive new funds are not required but better, smarter ways of working are needed. But there is some modest funding in this budget to assist the implementation.

THE CHAIR: What exactly will that $50,000 do? When it says "to implement the strategy", what will that actually do?

Mr O'Donoughue: It is primarily for the community sector alcohol and drug and mental health organisations. I think we are still finalising the arrangements for the allocation of that—

THE CHAIR: Okay, but it will be going to community-based—

Mr O'Donoughue: Yes. It is focused at the community sector. But, like a number of the elements of the community mental health budget, there still may be some procurement processes around them.

THE CHAIR: Thank you. Mr Hargreaves.

MR HARGREAVES: I wanted to ask about that mental health thing that I did when we first came together to enjoy each other's company. I heard in the car on the way in the tail end of a story on the radio about an Institute of Health and Welfare report which was talking about mental health services that were happening in the town. Apparently it had something about leading the country or groundbreaking things. It was quoting something that the Chief Minister had just said. Can you expand on that?

Ms Gallagher: It was a national report by the AIHW done into mental health care. I think it was released on Monday or Tuesday this week. What it showed was that the ACT has the highest level of community contacts in the provision of mental health services of anywhere in the country, which I think is a very positive outcome for the ACT. That could be via telephone or face-to-face contact, but it is something that we have been working on, through our own initiatives but also through the parliamentary agreement—to focus the mental health effort as heavily in the community-based service area as we are while we are dealing with some of the pressures in the acute system. I think those outcomes reflect well on us. In addition, the report showed that we have a lower level of prescribed drugs for people with a mental illness than the rest of the country. And in terms of our hospitalisations, we were on par, in line with the national effort.

MR HARGREAVES: So this is, it would appear, a bit of an expression of confidence in the system by people who actually are suffering a mental health condition by accessing it in the community setting itself. I would hope the policy driver is that they are going to have a greater level of success if we can bring the treatments to people in their own setting. Is that the sort of policy driver? That is a deliberate policy?

Ms Gallagher: I think you can definitely link that outcome with the fact that we have the highest level of provision of community-based mental health services of anywhere in the country. I know this is something Ms Bresnan and I always talk about. By saying that, I am not just talking about the non-government sector; I am including in that the public sector that provides support and services in the community through community mental health teams. So when you look at that—but also when you look at the provision to the non-government sector; we also do very well in that regard. I think that is reflected in the outcome of this report.

THE CHAIR: Okay.

Dr Brown: I can just add to that. The *National mental health report 2010* indicated that 72 per cent of our mental health funding is actually spent in the community across the non-government organisations and the public sector community health services. So it is most definitely a policy.

THE CHAIR: Ms Hunter.

MS HUNTER: With the million dollars that has been allocated to mental health growth, can you give a bit of a run-down of how that is likely to be spent? I think we have heard that $50,000 of it is going to underpin the rollout of the co-morbidity strategy. I am just wondering where the rest of it is going.

Ms Gallagher: It is roughly $500,000 into the community-based mental health services, as is our commitment through the parliamentary agreement. Do you want to go through them, Ross?

Mr O'Donoughue: Thanks, minister. Thanks for the question, Ms Hunter. Just running through the elements of the budget initiative, as the minister says, there is $500,000 allocated to the Health Directorate, community mental health services. I will just give you the headlines. One of those expands the mental health community policing initiative. Another puts additional mental health clinicians into community mental health care coordination. Those two initiatives take up the tranche of the $500,000 for the Health Directorate's community services.

In the community sector mental health services—again, $500,000. It is divided between a focus on treatment for newly arrived migrants and refugees; expansion of post-traumatic stress prevention programs; transcultural mental health and co-morbidity capacity—that is where the co-morbidity initiative that I mentioned previously is nested—sustainability for structured peer support; and, lastly, increase in mental health support of gender diverse communities. As I mentioned, there are some procurement processes that will be around some of those initiatives, so while we have

allocated budget expenditure, we have not really always finalised the exact provider or the model of delivery for the service at this stage.

MS HUNTER: That last one went to A Gender Agenda?

Mr O'Donoughue: That is very likely to be the case, but there will, no doubt, be some procurement processes around that.

MS HUNTER: Okay. And just around how you decide to allocate that funding, particularly when we are talking about the NGO component—how do you collect the advice and figure out where you are going to put that money?

Mr O'Donoughue: In the broad, we are guided by the mental health services plan. There is still a very active engagement with a strategic governance group which overviews the implementation of the plan. We are trying to fill the elements of that. We also have the benefit of advice for the minister from a ministerially appointed ministerial advisory committee on mental health. Essentially those two mechanisms engage with consumers, carers and the community sector organisations across the board.

MR SMYTH: You have outlined some of the mental health funds and on page 112 of BP3 there is the update to the growth envelope. Is there any additional mental health money in there or is that all in the mental health growth fund that also appears on the same page?

Ms Gallagher: Are we talking about the update to growth envelope for $7 million?

MR SMYTH: Yes.

Ms Gallagher: That is all activity-based in acute—

MR SMYTH: That will all go into acute.

Ms Gallagher: Yes.

MR SMYTH: I note there is no money in the outyears for that. Why is that?

Ms Gallagher: It is something that is under constant review, Mr Smyth. The position I have taken in budgets before this is that we review based on activity levels that we are seeing and, if adjustments need to be made, we do that. This year, within the constraints that we are operating in, we have made that adjustment for one year. It is under constant review.

MR SMYTH: Has your review ever seen the update to the growth envelope go down?

Ms Gallagher: No.

MR SMYTH: So in all likelihood you have got three outyears there that will require funds.

Ms Gallagher: What is not shown in here, I think, is the flow-through of the national health care agreement adjustments that will come as well and also the adjustments that have been made in previous years. I think last year it was about a $12 million adjustment, and that flowed through. When you look at adjustments to the growth envelope, there are significant adjustments, not just in the next financial year but going forward.

MR SMYTH: Can we have a written reconciliation of that for the current year and the next three years?

Ms Gallagher: A written reconciliation of adjustments to the growth?

MR SMYTH: Yes.

Ms Gallagher: Sure.

THE CHAIR: That has been taken on notice.

MR SMYTH: In terms of the whole output class, is it possible to get a breakdown in the three categories of mental health, justice health and drug and alcohol services for the current year and for next year?

Ms Gallagher: In terms of the budget allocated to those output classes?

MR SMYTH: Yes, who gets how much.

THE CHAIR: That has been taken on notice.

MR HANSON: Just as a supplementary to that, what is the total amount being spent on mental health now?

Ms Gallagher: It is about $102 million a year.

MR HANSON: What proportion is that of the health budget in total?

Dr Brown: 9.7 is mental health—

MR HANSON: It was about eight, wasn't it?

Dr Brown: Justice health, alcohol and drug—

MR HANSON: That is the total, though; just the mental health component of it?

Ms Gallagher: It is about 7.7. If you add in other mental health components funded across government it would rise to about nine per cent.

MR HANSON: That 7.7 figure—is that an increase or a decrease from previous budgets?

Ms Gallagher: I should correct the record: 7.7 was the last figure I have seen. The 2012-13 budget brings that to 8½ per cent, $103 million out of $1.218 billion—8.5 per cent. So that is a significant increase over the last year.

MR HANSON: 103 is just mental health?

Ms Gallagher: Mental health.

MR HANSON: It does not include drug and alcohol or justice health?

Ms Gallagher: That is the mental health budget.

Dr Brown: If you put them altogether it is 9.7 per cent.

MR COE: I have a question about the Aboriginal and Torres Strait Islander residential alcohol and other drug rehabilitation facility which has been on the cards for some time. I understand there was a consultation on Monday night and another one was held recently or is about to be held. I was wondering whether you could, firstly, give an update on what is going to be included at the site. I think it is around $14 million of capital works; is that right?

Mr O'Donoughue: No, Mr Coe, it is much less than that. The capital budget is $5.8 million. If you would like me to give you some detail of where we are up to?

MR COE: Yes, please.

Mr O'Donoughue: We are at the development application stage for the project. The consultations you refer to are in the context of that development application. We have had two community consultation meetings and two poster displays, if you like, at shopping centres. We anticipate having a meeting specifically with the Rural Landholders Association which is yet to be set.

The format is a therapeutic community based on the ethos of returning Aboriginal and Torres Strait Islander people to land and culture as part of a healing process. We are utilising the rural lease as a working farm. Part of the operation of the centre will be to engage the residents in the operation of the farm and the rural property as part of the therapeutic process. The scope of works at the moment is for eight beds for the facility, although the master plan in the development application shows a potential 16 beds in total—so an additional eight beds proposed for future expansion.

MR COE: What sorts of structures are we likely to see on site if the DA approval—

Ms Gallagher: Do you mean the design?

MR COE: Yes.

Ms Gallagher: That is available. I think that is online now. You just click on it.

Mr O'Donoughue: All the plans are available. To give you a feel for it, there are two residential pods. Each of them has four bedrooms and an administration-cum-activity

building that incorporates the kitchen, the administrative areas and teaching-training areas. It all fits on the footprint of the former farm dwellings that were on this property up until the 2003 bushfires. It is within the footprint of the original farm configuration itself. I guess you could construe it as being roughly equivalent to three dwellings, or something of that scale of building.

MR COE: What consideration has been give to the response times for emergency services if they are required?

Mr O'Donoughue: The criteria that went into the site selection included a criterion that the site be no more than 30 minutes car travel from the hospital. The site that we have chosen satisfies that requirement.

MR COE: Was it only medical assistance that was considered? What about fire and police?

Mr O'Donoughue: The site will need to have a comprehensive fire safety management plan, as any rural property would. Beyond that we do not anticipate any additional risks. So it would be the same as any other rural lessee accessing those services.

MR COE: Do you anticipate, or is there scope to expand the facility, firstly, for more beds but also for other purposes?

Ms Gallagher: It is not intended to be there for any other purpose.

MR COE: Is there commonwealth support for the project?

Ms Gallagher: Yes.

MR COE: What happens if that commonwealth support dries up?

Mr O'Donoughue: The commonwealth support that was provided in June 2008 was a one-off $1 million contribution to the cost of the project.

Ms Gallagher: It was a capital contribution.

MR COE: So there is no ongoing commonwealth support?

Ms Gallagher: No, and I do not see any reason why the commonwealth would withdraw support for it.

MR COE: I am not saying they should. I am just curious as to the financial undertaking.

Ms Gallagher: It is not funding the recurrent cost of it.

MR COE: In terms of access to the facility, does it have to go through another property or is there frontage on a public road?

Mr O'Donoughue: No, the access to the property is via an easement which does cross a neighbouring property but that is a right of way on the lease.

MR COE: Have you encountered any concerns from neighbours or other users of the land?

Mr O'Donoughue: We have been having active discussion with the landholders since we acquired the property in 2008. We have also obviously recently in the consultation process heard some concerns. They essentially go to clarifying just what we proposed the land use to be and we have been reassuring them that we will be maintaining the rural lease and maintaining our obligations to land management on that lease. Then their concerns, I think, go primarily to issues of security and amenity. We have assured them that the directorate is committed to being good neighbours and that we absolutely would guarantee their security and the amenity they would continue to enjoy.

MR COE: How has the property been maintained since it was acquired a few years ago?

Mr O'Donoughue: We are obliged to enter into a land management agreement as part of being a rural lessee. We have been very diligent at maintaining the property, including extensive re-fencing, weed control, erosion control and control of feral animals. We have a farm manager who has been resident on the property throughout. He supervises those works for us, many of which are contracted out to contractors.

MR COE: Would you be able to provide a breakdown of the costs of managing the land over the last few years and also, in effect, the budget for construction of and running the facility?

THE CHAIR: That is taken on notice. Ms Hunter, you had a query.

MS HUNTER: One of the issues that was raised early on, I think, was around access to water. Have you sorted that one out?

Mr O'Donoughue: As I mentioned, the advisory board had some criteria for suitability of the site. Just to run through those, they wanted a rural location because of the connection to country. They wanted it not to be any one man's sacred land. They wanted it to have an environmental integrity. They wanted it to be large enough for recreational opportunities to be incorporated and they wanted some sort of water access. The Paddys River runs along several kilometres of this property; so there is access to water in the form of the Paddys River.

MS HUNTER: And water for the facility itself?

Mr O'Donoughue: We have got considerable roof space; so from the point of view of domestic water, we will be looking to gather rain water. The design incorporates that. Then for the farm itself, as well as the river water, there is something like 15 dams on the property. So our advice is that it has adequate water for its stock and agricultural purposes.

MR SMYTH: What is the expected opening date?

Mr O'Donoughue: All being well and getting approvals and being able to let contracts in the latter part of this year, the construction should take about nine months and we are hoping to open in June 2013.

MR COE: What is different now as opposed to a few years ago, when it was first proposed?

Mr O'Donoughue: When the appropriation was made in 2007-08 it was based on a preliminary feasibility study and model of care. A site had not been identified. So in 2008—

MR COE: Was the land purchased in 2009?

Mr O'Donoughue: We bought the land in late 2008. We initially then did environmental and site assessment work to try and find the appropriate site on the site and whether that was feasible. We then embarked on a model of care, an extensive model of care development. It was only after that model of care, the phase 1 model of care, had been developed that we could really then do a detailed scope of services and design.

Having completed that design, and given the time that had passed since the original appropriation, both the site-specific considerations and the rising building costs over that period meant that, essentially, we did not have the budget to produce the full scope of the 16-bed facility available to us. We went to the 2011-12 budget with proposals around that, and the decision was made by government to continue with the current capital budget but to initially produce an eight-bed facility with a proposal for expansion to 16 beds in the future.

MS HUNTER: One of the things that was raised about the site selection in the early days was apparently a nearby neighbour planned that maybe some time in the future they might set up a cellar door or some sort of winery. This was used as part of the reasons why there were some issues around that. Is that still the case, because there still seem to be some people in the community who think it is? I am just wondering where that is up to.

Mr O'Donoughue: One of the approved uses of a rural lease is viticulture. One of the neighbours does have some grapes growing. You are right. Some time ago he did indicate that he had a potential future plan to develop a winery or a bed and breakfast business. There has never been and there still is no development application or building application for such a business to be developed. So the situation is that a neighbour is growing some grapes, and that is where that sits.

THE CHAIR: Do you have any questions on that, Mr Hanson?

MR HANSON: Not on this, but I have a new question, if I may?

THE CHAIR: Is it in relation to this output?

MR HANSON: It is in relation to this output, yes.

THE CHAIR: Yes.

MR HANSON: My question is about justice health and about where we are at with that. Firstly, how much money are we spending? I would like to get the breakdown of those three elements in this output class. How much we are spending on justice health.

THE CHAIR: I think that has already been taken on notice.

MR HANSON: Additionally, I have a question on the status of the needle and syringe program within the AMC and where we are at with that.

Ms Gallagher: Discussions are continuing, as you would be aware.

MR HANSON: Yes. Last year you said you would make a decision by—

Ms Gallagher: I said I wanted to make a decision by the end of the year.

MR HANSON: Right.

Ms Gallagher: That was not possible, considering the difference of opinion, particularly by correctional staff.

MR HANSON: So when you say discussions are continuing, with whom? Are they taking place in a structured sense or an informal sense? Is there going to be any further body of work like the Moore report or anything like that? What is the process now? It seems to be lingering on now. It is a debate that has been going on for a number of years.

Ms Gallagher: I think the provision of—

MR HANSON: Is it just going to linger on?

Ms Gallagher: I think the issue around blood-borne virus management and appropriate ways of managing that in correctional settings has been ongoing for more than just a few years. I think this is something that has vexed authorities—public health authorities and correctional authorities—for many, many years, Mr Hanson. I do not imagine that that—

MR HANSON: No, I am talking specifically about your proposal for a needle and syringe program has been going on for a couple of years. I am not talking about the broader debate about blood-borne viruses—

Ms Gallagher: Mr Hanson, if could I answer you without your constantly interrupting me when I try to answer your question, I think we could probably get through this a lot easier. Discussions are ongoing. They are broad discussions. They are structured and they are informal. I will continue them until I get to the point where I am happy we have got a way forward.

I know these things seem to be very black and white in Liberal territory—ie, needles in jails are bad and there is no other solution offered. But I actually think there are shades of grey in here. I am working in the shade of grey and trying to get a way forward that is responsible. We have had eight people test positive for hepatitis C in the Alexander Maconochie Centre. Two of those are people who have spent time outside in the community during the period of their screening.

We know that the levels of hepatitis C are very high. We know that we provide a range of treatment, whether it be through supply reduction or demand reduction and then we have harm minimisation strategies. I want to make the right decision for all of the people involved and it is not black and white.

MR HANSON: But your—

Ms Gallagher: As much as you would like to make it black and white, it is not black and white.

MR HANSON: You are still pursuing a needle and syringe program?

Ms Gallagher: What I am pursuing is a comprehensive blood-borne virus management strategy at the AMC that covers a whole range of strategies.

MR HANSON: Sure, and does that include a needle and syringe program?

Ms Gallagher: Well, yes, I mean—

MR HANSON: Okay. There are, as you say, a significant number of people who do have hep C at the jail and you have, I believe, 10 treatment spaces. Now my understanding is—

Ms Gallagher: At different times, yes.

MR HANSON: My understanding is that there is a demand for that, and that demand is not being met because of budget constraints. How many people are missing out on treatment for hep C—

Ms Gallagher: It is not around budget constraints; it is around capacity. As in all areas of health, 100 per cent of people cannot get 100 per cent access to 100 per cent of the treatment 100 per cent of the time. What we have done is allocate treatment spaces. People come in and off the program. I think about 43 or 44 people have had access to that program while in AMC. But this is something that health services manage. So it is not about budget, unless you just want to write a blank cheque for everybody to walk in and say, "I need this, I need that, and I need them immediately."

MR HANSON: So it is about budget?

Ms Gallagher: Health has—

THE CHAIR: Can we have one person at a time.

MR HANSON: You said it could be fixed by a blank cheque; so it is about budget.

Ms Gallagher: Health has a budget that it works within. Within that, there are allocations, just like there are allocations for elective surgery, there are allocations to the liver clinic. That is not only related to budget. It is related to capacity to deliver what is very extensive, ongoing and complex treatment.

MR HANSON: So given those capacity constraints, how many clients of the AMC are missing out on treatment for hep C—

Ms Gallagher: None of them are missing out on treatment for hep C.

MR HANSON: So everybody that wants treatment and has a need for treatment is being treated because you said no-one is missing out; is that right?

Ms Gallagher: No-one is missing out on having their hepatitis C managed. If you are talking about access to the treatment—

MR HANSON: Yes.

Ms Gallagher: that potentially cures them of hepatitis C, which is separate to actually managing their hepatitis C and a whole range of treatments that can be used for that, there are 10 spaces available for that treatment.

MR HANSON: Yes, I understand that.

Ms Gallagher: And then people move in and out of that.

MR HANSON: I said that in my preamble. What I am asking you is this: how many people are not accessing that program that otherwise would because of the capacity constraints that we discussed?

Ms Gallagher: I can certainly take on notice the number of people who are seeking access to the treatment and will get access to the treatment. If I could also say, this is the first time that people are able to access the treatment at all. So 43 people have been given the right that they have never received before in custody to access the liver clinic. People are getting access to much greater health services than they have ever received in the past.

MR HANSON: Sure, and—

Ms Gallagher: We should—

MR HANSON: Can you just tell me—

Ms Gallagher: congratulate the justice health service for actually providing that, because it is a big step forward and, yes, there is more work to be done.

MR HANSON: I do, and I understand that.

Ms Gallagher: I have not heard you.

MR HANSON: I would like to know, based on the capacity constraints, how many people are missing out on treatment who would otherwise have it if there were not capacity constraints. On the AMC as well—

THE CHAIR: Just to clarify, minister, did you take that on notice?

Ms Gallagher: The amount of people who are waiting for access to the comprehensive treatment?

THE CHAIR: That is taken on notice. I have got a follow-up to that—

Ms Gallagher: And I should say that 34 people have commenced treatment on the hepatitis C program since commissioning—not 40.

THE CHAIR: Before we go on, I have a question. The thing with this treatment as I understand it is that it is a complex treatment. Does the fact that not all people will not be suitable for this treatment impact on the number of people that can actually go in? You have to have a certain gene type, as I understand it?

Ms Gallagher: You have to have a gene type and then your weight impacts on that.

THE CHAIR: Is that impacting on the number of people in the prison who actually use that?

Ms Gallagher: It certainly impacts on the number of people who are deemed appropriate to access the program.

MR HANSON: I want to know about those who are appropriate.

THE CHAIR: It has been taken on notice.

MR HANSON: Thanks. I have had representations from a couple of groups who provide services into the AMC who have had their federal funding cut in the area of drug rehab and so on.

Ms Gallagher: I think we have already covered this. I think we covered that earlier, around the $1 million. I think the commonwealth made some mistakes. They have adjusted it. My understanding is that Ted Noffs, who does not provide services in the jail, is the outstanding organisation there.

MR HANSON: You are confident that everybody has had that money, that there has been no impact on—

Ms Gallagher: The last I saw, that was my understanding.

MR HANSON: And there has been no impact on services at the AMC?

Dr Brown: My understanding is that there is some funding providing some services

in the AMC that is commonwealth funded that is coming to a close. That is separate to the funding that we were indicating. I am looking for Tina, but I am thinking there about the inside out-worker that is coming through Attorney-General's. Is that correct? Yes. That was funded—I stand to be corrected—I think for a three-year period and that was always coming to a close. That is different to the $1.2 million-$1 million.

MR HANSON: So I want to clarify that other than that program, or the current programs that are running at the AMC, they are not going to be affected by federal budget matters.

Dr Brown: That is our current understanding, but if you have other information we would certainly be pleased to know what it is.

THE CHAIR: I think we asked that question as well. I think that was the understanding as well, that most of it was—

MR HANSON: All right. They were going to get back to me with a sort of—

THE CHAIR: I think they are going to get back to everybody.

MR HANSON: Thank you.

THE CHAIR: Are there any further questions in relation to this output? We have to deal with public health and cancer services as well. We will move on to those. Ms Hunter, did you have anything?

MS HUNTER: No, it was just around the date on the adult mental health.

MR HANSON: I have a question on where we are at with the secure adult mental health facility.

MS HUNTER: Yes, that was my question too. There is $2 million there to finish the design. Where are we up to?

Ms Gallagher: That will proceed to the next stage of the design for a facility. This has been subject to peer review from New South Wales Health Infrastructure, who came back and provided us with advice that, based on their benchmarking, construction costs were about 20 per cent higher than what they would see as appropriate in New South Wales.

Dr Brown also commissioned some work around demand and sought some advice around that, because there are some genuine issues, I think, that have been encountered with the delivery of a service like this in a small and isolated setting that we needed a good understanding of. That work has come back. That helped inform the cabinet's decision on this. That will be that we proceed at the Quamby site, that it be for a medium secure facility, as opposed to a maximum secure facility—that will impact on some of the costs associated with this project—but that we continue on to develop a facility that, I think, accommodates 15 beds, but in a medium capacity.

MR HANSON: Has the community been made aware of the current planning status? Those are reported as on and off again. Has the local community been engaged to advise them of what the plans are?

Ms Gallagher: They will be and they have been. There have been a number of community meetings with residents nearby the Quamby site around the development of a service. We have not changed our mind on any of that. I think there is a good level of awareness. But now that we have taken the decision to proceed to the next stage, all of those consultations will resume and continue. But certainly we have never said we would not be building it on that site. We just wanted to rescope it when it came—

MR HANSON: I suppose because the money went out of the budget for a year completely there was a little bit of confusion about—

Ms Gallagher: Only for you, Mr Hanson, because I was very clear in my comments that we were not walking away from the project.

MR HANSON: No, I have spoken to members of the community that raised concerns too—

Ms Gallagher: We were actually rescoping the project—

THE CHAIR: Just one person at a time, please.

Ms Gallagher: because it came back much higher than expected in cost. But I made it clear in everything I said. You chose to misinterpret that comment and put out that we had walked away from it. But my commitment to this project has been there continuously. It was about getting some more information and bringing down the cost of the project overall.

MR HANSON: What do we anticipate will be the cost of the project?

Ms Gallagher: It has a design budget at—you will notice that we have only funded the design, precisely so that we do not lock in a construction figure at this point in time. It has got a $2 million design budget. There is a little left over from the forward design from the previous budget. Roughly—usually, the rule of thumb is that the design would constitute somewhere around 10 per cent of the cost.

MR HANSON: So you anticipate around $20 million?

Ms Gallagher: Based on the work that New South Wales Health Infrastructure have done, they suggested that the cost of building a facility as the model of care had dictated was around $28 million. We think there is still some scope to revise the model of care and some of the expectations around particularly some of the space utilised, but that is the ballpark.

MR HANSON: And when would construction start?

Ms Gallagher: Design would take a year. Then that would be subject to budget

discussions next year.

MS HUNTER: I understand that there is a place called The Gully. Is that the comparative model of what is being set up here?

Mr Thompson: Not specifically, no.

MS HUNTER: We might take that up out of session with you. I also want to ask a question about the crisis support unit. We had raised some issues around those who were being detained and their being able to get access to glassed areas. Do you know whether that is happening or not? Do we need to take that up under Corrections?

Dr Brown: I think that is a Corrections management issue.

THE CHAIR: We will move to public health and cancer services. I have a question in relation to public health. I refer to strategic objective 9 in budget paper 4, page 60. I think there are a couple of references to it. Strategic objective 9 is for government to have higher than the national average proportion of spend on public health activities. I think, based on AIHW data, the national average in 2007-8 was 3.1 and the ACT was 3.5.

Obviously, while this is higher than the national average, should we be actually aiming higher. Is this something we are going to do—actually aim for a higher percentage of the funding that is going towards these sorts of activities? Basically, that indicator says that it should be higher than the national average. We are slightly higher than the national average.

Ms Gallagher: Yes, we are.

THE CHAIR: I am wondering whether we are actually going to start to aim even higher—something around four per cent, for example.

Dr Brown: We currently spend 3.7 per cent. That is my understanding.

THE CHAIR: Yes. Is it something we are aiming to increase every year?

Dr Brown: I think the minister's comments before pertain in the same way as they did to early intervention and preventative services. Yes, in terms of how we address the demand for health services, the ideal is to prevent ill health, maintain good health or to intervene early. Yes, that would be a desirable outcome. It is challenging, however.

THE CHAIR: I ask this question because I know primary prevention is funded under this output rather than prevention intervention; is that correct?

Dr Brown: This accounts for predominantly the population health initiatives, not primary healthcare initiatives.

THE CHAIR: But the primary prevention area, I understand, is funded under output 1.3?

Dr Brown: If you are talking about things like the preventative health initiative, yes.

THE CHAIR: So it is, yes. So how much does primary prevention—that is, prevention of disease occurring—make up of the public health output?

Dr Brown: I would have to ask Dr Kelly whether he can actually break that down.

THE CHAIR: I am happy for it to be provided on notice if it is not available.

Ms Gallagher: We will get Dr Kelly up anyway because on this output class we will probably need him.

Dr Kelly: In relation to your question, this is a broad group of funds. The percentages have already been talked about. But there has been a bit of a change in the way that AIHW reports on this area. It is always a little bit contentious, and an issue for the ACT, given the nature of the jurisdiction and the fact that we do local council type work as well as jurisdictional work in this area. As I understand it from the health expenditure report, which is where this figure has come from, there has been a change in the way that they have done those figures. But you are right to say that 3.8 per cent of ACT government Health Directorate recurrent health spending is spent in this area.

THE CHAIR: How much does primary prevention make up in the public health output?

Dr Kelly: The public health output would include primary prevention. It would include some of the activities conducted by the Health Protection Service in relation to environmental health and other aspects of that as well.

THE CHAIR: In terms of primary prevention, are you saying that primary prevention is all of the public health output or is it a specific part—I am trying to get an understanding—of the public health output?

Dr Kelly: It would be part of it, yes.

THE CHAIR: Is it possible to get that breakdown of it?

Dr Kelly: I will try. I will see how I go.

THE CHAIR: Okay. This might be another one as well: what percentage of funding does primary prevention make up of the whole Health Directorate? Is it that 3.7?

Dr Kelly: It would be within that 3.7.

THE CHAIR: It would be within there.

Dr Kelly: I am not able to say the exact figure at the moment.

THE CHAIR: Can you take that on notice as well?

Dr Kelly: I will take it on notice and I will look to see how we can break that down. There has been a change over this period, but essentially the amount of money being spent by the ACT government has increased over the last few years.

THE CHAIR: I guess it has increased, but it is a fairly small percentage increase.

Dr Kelly: Yes, it is a small proportion of the total budget. That is correct.

THE CHAIR: Why haven't we got any accountability indicators in relation to this, in relation to primary prevention?

Dr Kelly: In the budget papers, do you mean?

THE CHAIR: Yes.

Dr Kelly: We certainly have a range of targets and so forth that we are obliged to do. There was a discussion earlier about the national partnership agreement on preventive health, for example. There is, of course, a range of targets that we are going towards, and we could be accountable for those. But in terms of the actual budget papers, you are right: there is not a particular one there.

THE CHAIR: Has there been thought given to doing that, given that it is an increasingly important area?

Dr Kelly: I would certainly be open to those discussions, yes.

THE CHAIR: This might be also one that needs to be taken on notice. It probably relates to my other question—just getting a breakdown in spending for output 1.3, if that is possible as well. Do you have it? Or will we take it on notice as well?

Dr Kelly: Which one is that?

THE CHAIR: Just output 1.3—if we can get a breakdown of spending for that.

Dr Kelly: There are several in that, (a), (b) and (c). Is that it?

THE CHAIR: Yes.

Dr Kelly: I might hand over to Mr Woollard to answer those questions.

Mr Woollard: Perhaps you can repeat the question for me.

THE CHAIR: It was just about a breakdown in spending for output 1.3—if it is possible to get that.

Mr Woollard: We would have to actually break down the expenditure between those three. We will have to take that on notice.

THE CHAIR: Okay.

Mr Woollard: We will have to take that on notice. We would not have those.

THE CHAIR: So you have taken three questions on notice.

Ms Gallagher: Any food questions?

MS HUNTER: I want to ask some questions around the air quality station. The budget provides money for a new air quality performance station. I want to get a bit more information about that and where it is going to be.

Dr Brown: Mr Woollard will be able to give you the detail about that but, as you know, we have a requirement to have a second ambient air quality monitoring station because of the population that we have now reached in the ACT.

MS HUNTER: That was the National Environment Protection Council?

Dr Brown: That is right. A new station is currently being planned for a site yet to be finalised.

MS HUNTER: How long were we noncompliant with that? Was there a period of time?

Ms Gallagher: How long have we been?

MS HUNTER: Yes.

Mr Woollard: I cannot tell you exactly what the population is—it is a complex population formula—but we clipped over that about two years ago.

MS HUNTER: When will the station be completed and operational?

Mr Woollard: We are fairly well advanced in terms of site selection. We have done a fair bit of work on that. We have three sites. The preferred site is north side, around the Belconnen area. We have to go through some processes to secure that land. We do not need a big patch of land; it is a relatively small site that we need. But the NEPM sets up particular standards for siting air quality stations to ensure that you do not get bias by road networks, and you cannot be close to buildings or trees and those sorts of things. We are quite specific in terms of our criteria, and we are negotiating on those at the moment. We then need to construct the site. I think it would be between six and 12 months before we are fully operational.

MS HUNTER: What part of Canberra are we looking at?

Mr Woollard: The Belconnen area. That will give us a station in the Tuggeranong valley and one north side.

MS HUNTER: Wood smoke has been an issue, particularly down in the Tuggeranong valley. We have a lot of constituents who raise the issue of the wood smoke down there. We are not seeing any new initiatives in the budget. I am wondering, minister, how this is going to be tackled. There is the don't burn tonight

program and the replacement programs. But because it is an ongoing issue and it seems to be becoming more of an issue, are there going to be further initiatives in that area?

Ms Gallagher: I think we have got the incentive programs around there. I guess the next decision—when you look at it, there are several days a year where the inversion layer creates a real problem in the Tuggeranong valley. I think one of the solutions is that you require people to get rid of their wood heaters, but I am not sure we are at that point yet.

MS HUNTER: Or put in place standards.

Ms Gallagher: Standards for when you are allowed to use them?

MS HUNTER: For emissions and standards for what can be used.

Ms Gallagher: I just do not think it is an easy solution. There are many Canberrans who race home and put a log on the fire and love it.

Mr Woollard: Perhaps I can put some context around that. In the preceding 12 months there have been two exceedences of the PM2.5 and no exceedence of the PM10. Those two exceedences were in July 2011 and May 2012. So whilst I certainly acknowledge the community concerns about it, in terms of NEPM standards we are not seeing a particular expanding problem. Indeed, the work that we have done on it tends to indicate that the air quality has improved over the last several years. Nonetheless people have got a genuine concern.

MS HUNTER: Do you make that public? Do you make that publicly available?

Mr Woollard: We provide the information to the EPA, who report the NEPM standards. We have been looking at trying to make some of that information more available, and we are heading down that direction. We are a long way from having real-time data available, but we are perhaps not very far away from having monthly or two-monthly data available for people to look at. At the moment it is only annual data.

MS HUNTER: So it is not real time—

Mr Woollard: We have real time, but it is getting it out to the community in real time.

MS HUNTER: Getting it out to the community is the issue?

Mr Woollard: Yes.

MR COE: Budget paper 3 on page 112 makes reference to growth in cancer services. I was wondering whether you are able to give some background to that budget line item and how that will translate to on-the-ground improvements.

Ms Gallagher: Much of this is targeted to outreach and outpatients, as I understand it. The Capital Region Cancer Service is a great example of the regional nature of our health service. From my recollection of this, I assume it was to support those outreach

clinics, which we are currently providing, and some outpatient clinics by increasing the number of them. I would also draw your attention to the very positive results in the budget papers for the cancer services; they show that 100 per cent of urgent cases are treated on time and I think they exceed their targets in categories 2 and 3.

MR COE: Does this project or associated project include dealing with Queanbeyan hospital?

Ms Gallagher: No. As far as I understand it, there is no oncology provided through us.

Dr Brown: In relation to cancer services, we do provide outreach services into southern New South Wales but that is not specifically at the Queanbeyan hospital. That is my understanding.

MR COE: Have the improvements to Queanbeyan hospital made an impact on either cancer services which are delivered in the—

Ms Gallagher: What improvements are you talking about? I am not aware of any improvements or any additional funding that Queanbeyan hospital has got.

MR COE: I am not across the specifics of it. I do know they have had—

Ms Gallagher: We are trying to work with Queanbeyan around other areas of collaboration but that is not in cancer. We are trying to look at ways that we could use the hospital for surgical capacity, but not in cancer services.

MR COE: Going back to that growth in cancer services, what difference is a patient likely to experience as a result of that additional funding?

Dr Brown: They are more likely to be able to access care in the community and remain in their home than to have to be admitted to hospital. We are also increasing nursing outreach and psychosocial support services for people with cancer.

MR COE: Who will actually be providing those services? Is it people within ACT Health or—

Ms Gallagher: Yes, through the Capital Region Cancer Service.

MR HANSON: I have a reasonably specific question about lymphedema services and whether, in that additional funding, there has been any increase in funding for lymphedema services.

Ms Gallagher: I think the Assembly resolution called for a review of the lymphedema services and looking at demand. It is a service that is provided at Calvary. So in terms of the funding, it is part of our negotiations with Calvary through the performance agreements that we strike with them. I have not seen the final review of that lymphedema report. I think there were some issues with it that I updated the Assembly on.

Dr Brown: That is right. And we are continuing to undertake some work in

conjunction with both Calvary and Medicare local into the configuration of the services that are required. Once we have completed that work, we will provide a report back to the minister, which I am sure she will be happy to table.

MR HANSON: But none of that additional funding for the outreach services in particular is aimed at lymphedema services as a more generic increase in funding?

Dr Brown: For cancer?

MR HANSON: Yes.

Dr Brown: No.

MR HANSON: I have also got a question in regard to the patients that have been going interstate.

THE CHAIR: I have got another question on lymphedema before we go on. Previously the answer to a question on notice that we put was that you did not actually know how much the provision of public lymphedema services cost because the funding envelope was provided through Calvary and they determined how it was spent. Is that still the case? Given we have just had questions about funding, do we actually know what services are being funded and how much is going there if we give Calvary the money but then we do not know the exact amount?

Dr Brown: In terms of the funding we give to Calvary, we do not specifically give them X amount of dollars to provide lymphedema services. We give them an overall funding envelope. There was a review undertaken that looked at some costings. So we have some indication from Calvary of how much they expend currently in relation to lymphedema services. But as I have indicated, that review has also informed us about the nature of the services that are currently being delivered, and we are currently looking at what is the best site for the continuation of services. We believe that a good percentage of the services can and should be delivered in the primary care sector rather than requiring a specialist service on a hospital site. That is the work that we are currently undertaking in conjunction with Calvary and the Medicare local.

THE CHAIR: Currently there are two specialist staff at the clinic. That is my understanding. Do we know what else would be required? Would it be to have one more full-time person?

Dr Brown: Again that comes back to the actual allocation of the service across the sectors. Once we have finalised those discussions, we will be in a better position to come back and actually say what the staffing implications are.

MR HANSON: We have had cases where patients have had to go to New South Wales to seek treatment for various cancers. What is the number of patients that have had to go interstate over the last year or so?

Ms Gallagher: We will always have some patients that go interstate—that is my understanding—because of the nature of their illness, because of the treatments that are offered here. Is your question about people that have to go interstate because the

wait here is considered clinically too long rather than who go interstate because we do not provide 100 per cent for someone with a—

MR HANSON: I remember a case a couple of years ago. The individual had received chemo, I think, and then was going to go to Sydney to get radiotherapy because of the wait and they needed the radiotherapy within a certain time frame after the chemo. There are examples like that where it is a service that is available in the ACT but it is a capacity constraint.

Ms Gallagher: Your question is: when there are services available, have we—

MR HANSON: Yes, where there are services available and people have not been able to access those services.

Ms Gallagher: I would draw your attention to strategic indicator 4, which says that 100 per cent of urgent treatment starts within 48 hours. For semi-urgent, which is requiring within four weeks, it is 99.8 per cent. And then non-urgent within six weeks is at 99.2 per cent. So that would indicate a very high level of delivery of services here.

MR HANSON: Do you have a specific number, though? I am just trying to capture it because it was an issue, obviously, for a number of individuals.

Ms Gallagher: And it will be from time to time. If you get a lot of people diagnosed with a particular type of cancer and they are all urgent and all need to be dealt with within 48 hours, you cannot plan for those situations.

MR HANSON: I go back to my original question then. Do you know how many—

Ms Gallagher: I am just trying to put the context around it, because I think it gives an unfair view of the service if you present that we are sending people interstate because there is a lack of capacity here. The other thing I would say is that we have brought the fourth MINAC on, with associated technology and staff, to, again, increase the capacity of the service.

MR HANSON: I go back to my original question. Will you be able to provide—

Ms Gallagher: Nothing impresses you.

MR HANSON: I just asked a simple question.

Ms Gallagher: Nothing—99.8 per cent, 100 per cent.

MR HANSON: You still have not answered my question. I want to know the number of people over the last 12 months that have had to go interstate to seek treatment that would—

Ms Gallagher: It would be very small, and we will provide it to you.

THE CHAIR: That will be provided, taken on notice.

Ms Gallagher: I am being advised from the executive director that there is none.

THE CHAIR: But there will be confirmation of that.

MR HANSON: I would be interested in for those patients who need to go interstate because there are services that are not provided by the ACT and for what purposes they needed to go interstate. I assume—

Ms Gallagher: I will take that on notice in a general sense, but I am not going to go back and work through every file in cancer to work out who is going to see whom. For example, my mother, when she underwent her cancer treatment, could not have a particular type of surgery here. She had most of her cancer treatment here. But complex gynaecological cancer surgery needed to be done in Sydney. I am not going to authorise people to go through to find you those people. In a general sense, what I will provide you with is the types of cancer services that are not provided here, and that at best will give you—

MR HANSON: What I am trying to investigate is where the gaps in the service are. And I am not saying they are not legitimate gaps and there are reasons why we do not provide certain services.

Ms Gallagher: The list of those will be sufficient then.

MR HANSON: No, it is not, because what I am trying to—

Ms Gallagher: Yes, it is. What I am telling you is that I am not authorising my officers to go through individual files to find you the number of people that may have gone interstate for a particular type of treatment. What I will provide you with—and this is my prerogative—is a list of cancer services that are not offered here, and that will identify for you the gaps in services.

MR HANSON: No, that tells me what the gap in services is, but it does not tell me what the quantum is. You might have a particular service that is not provided where there is one person a year or two people a year that need to seek treatment in New South Wales because of that. What I am trying to find out is: in the ACT there are particular services that are not delivered for cancer or other conditions and people go to New South Wales. There might be 50 of them. I am not saying there are but, without that quantum, it is very difficult for me to get a view of whether the gap in the services is a niche service or whether it is something that maybe we do need to look at it. Maybe this is something we should be doing in the ACT. And I think in that context it is relevant. If you do get beyond a certain number of people that have to go interstate, I think it is a very relevant question to ask. If you are refusing to provide me with that answer, I would ask the question: why?

Ms Gallagher: I will provide you with the information about the services that are not provided here.

MR HANSON: And will you provide me with the number of services of people going interstate? I am trying to get a view of whether we are doing—I accept fully that there are services we will not provide in the ACT because of the number of

people accessing them. But I want to make sure that we do not have any services that we are not providing where there is a significant demand in the ACT. Obviously, going interstate is not good for people's health. And financially I think it is only about 36 bucks a day that they get as a rebate. So it is a significant impost.

When I have spoken to people who have had to go interstate, for whatever reason it may be—it is very detriment to their health, both physical and mental, and it is difficult for them to do it financially. I just want to see where the quantum is and whether we should be saying, "Okay, this has now got a service to a particular size where maybe it is worth investing in that service in the ACT." If you do not give me the numbers, it is difficult for me to form a view.

Ms Gallagher: What I would say in response to that is that we are very lucky here with the comprehensive cancer treatment services that are provided—well over and above what a jurisdiction of 360,000 would normally have access to.

MR HANSON: But that is because we have a reasonable requirement—

Ms Gallagher: Indeed, at times up to 50 per cent of people accessing the Capital Region Cancer Service are travelling from interstate to Canberra. We are a regional provider of these services. A very, very, very small number of Canberrans may need to travel interstate for a particular type of treatment or surgery, and that will always be the case. Yes, you look to minimise that where you can. And getting a PET scanner down here, getting the four Linax in place and improving and increasing your cancer workforce in order to minimise that have all been things that are part of this year's budget. What I will do is find you the specialised services that are not offered here and be as helpful to the committee as I can be.

THE CHAIR: Thank you. Is this the correct place to ask about the palliative care review? Has the palliative care review been undertaken?

Dr Brown: The palliative care plan?

THE CHAIR: The palliative care review, or plan, that was being conducted? Is this the place to ask about that?

Dr Brown: Yes.

THE CHAIR: Can we get an update of where that is up to?

Dr Brown: I am sure Mr O'Donoughue would love to tell you that.

Mr O'Donoughue: We have been consulting about a review of palliative care services for some time, and we have a draft services plan document which is going to our local hospital network council for their review. Then we plan to release it for further consultation.

THE CHAIR: Who conducted the review?

Mr O'Donoughue: We did engage consultants to assist us with the review. That was

Richard Gilbert, who is a New South Wales based consultant. He has been working with a reference group that is built on the palliative care strategy steering committee that includes the Palliative Care Society, the Health Directorate and Clare Holland House.

THE CHAIR: You said it is going out to consultation. Do you know when that will happen?

Mr O'Donoughue: It is on the brink of going to the local hospital network council as we speak. I am anticipating soon thereafter.

Dr Brown: They have 10 days to provide their comments. Then we have a short window in which to incorporate any feedback from the local hospital network council. Then it will go to the minister for her agreement to go out for public consultation.

THE CHAIR: And then it will go out for general public consultation. Do you have any idea when that will be?

Dr Brown: It would be within the next four weeks, we would anticipate.

THE CHAIR: So it is soon? It is anticipated to go out then?

Dr Brown: Yes.

THE CHAIR: I have one further question in relation to public health, while we are in that area. It is probably for Dr Kelly. One of the key roles listed in budget paper 4 on page 66 for public health is to monitor the health of the ACT population. I am just wondering in regard to a couple of areas. With obesity, for example, how do you actually track how that is going as an issue, particularly because the health council listed that as one of their key concerns? How is that being tracked?

Dr Kelly: Thank you, Ms Bresnan, for your question. We are certainly doing a lot of work in that area. It is related, again, to the national partnership agreement that we have with the commonwealth. We received some very good news today about some extra funding to assist us in that area in relation to monitoring—monitoring obesity in particular, but also the other key targets of that area around smoking and alcohol.

THE CHAIR: I am sorry if I missed it, but how do you go about actually monitoring that as an area?

Dr Kelly: There is a range of ways we are doing it. At the moment, the most important way is through our survey program. We have that right across the life course. We have information on obesity in children through our work with the under-fives, particularly kindergarten screening. We have information on obesity in the year 6 age group in surveys that we run through primary schools. And then we have the general health survey, which is aimed across the community but includes adults—mostly adults.

THE CHAIR: You also mentioned smoking. Community groups who appeared on Friday and others said that we are doing quite well in terms of reductions in the

middle income to upper income groups but the lower income groups are where more work needs to be done. Is this an area you will continue to target, particularly in those lower income groups?

Dr Kelly: Yes. We lead the country in our smoking rates, both in our information from secondary school—again, the secondary school survey program that we run—and also in the adult population. We have had enormous strides in that area across the population in general. But you are quite right: the areas which we need to concentrate on now are the high-risk communities, which, again, have been identified through our monitoring of this issue.

One particular one I would talk about—and perhaps Mr O'Donoughue may want to add to this—is around Aboriginal and Torres Strait Islander women. We have known for some time now that Aboriginal and Torres Strait Islander people have higher rates of smoking across the country, including here in the ACT. Aboriginal and Torres Strait Islander young people particularly are a concern. And within that group, women who are pregnant—with all of the health problems associated with that, not only for the mother but also for the unborn child—make this a really important area to concentrate on. There has been a lot of work with the community, and with Winnunga as well, with their input, to come across a program to actually address that issue. That will be starting soon, I think.

THE CHAIR: Of course, Winnunga already have the program they run. Is it building on that or doing something different?

Dr Kelly: There is a range of issues, particularly reaching out to the community in consultation with the community. We are very excited about that. It has taken some time through the community consultation process to get that right. But we are on the cusp of putting some new initiatives in place in the next few months.

THE CHAIR: And also in terms of locational area needs and where there might be particular pockets that need to be targeted. I know it is harder to do in the ACT, but have you done any mapping or anything with regard to that and how that can perhaps be built into the community health centres?

Dr Kelly: I think that is a very good point. One of the issues—it is a good thing about the ACT—from a general point of view is that we have a very homogeneous population, so identifying pockets of need is quite difficult. However, having said that, the other area of concern would be in lower socioeconomic groups. We are doing a lot of work in the area around Northbourne flats and the inner north of Canberra, for example—not only in smoking; that is part of the work we are doing in relation to our healthier communities initiative.

THE CHAIR: So is that getting built into any of the planning around the community health centres?

Dr Kelly: This is more work we are doing outside the health delivery aspect. I guess it comes back to your previous question about quantifying primary prevention. It is one of the difficulties in that. We do not like to work in silos in this area. Smoking, obesity and alcohol initiatives would be part of our service models in the new health

centres, and we are working closely with clinical colleagues on that. But a lot of the work that we are involved with is actually reaching out to the community in the community settings.

MS HUNTER: I want to follow up on the centre for adolescent health. I was just wondering if there is any progress.

Ms Gallagher: That was put on hold temporarily because when the influenza pandemic hit it was the same people dealing with that. So it is delayed—the work that has been done.

Dr Brown: If I am thinking of what I think you are thinking of, my understanding is that the work has been completed in terms of looking at the range of services. That youth feasibility study did come back and say that we actually have a fairly comprehensive range of services but there are just some areas that could be strengthened. It is more about working together better. Dr Kelly may be able to speak to it.

MS HUNTER: Is that youth feasibility study publicly available?

Dr Brown: It is up on the internet, yes.

Dr Kelly: If I may, minister, I will speak to the youth feasibility study. That was part of the healthy kids, healthy future budget initiative from some years ago. There was a lot of work which I reported on this time last year; the draft report was just arriving at that time. Since that time, as Dr Brown has mentioned, the report has now been made available and it has undergone a consultation with the community. There is a government response to that report. As Dr Brown has mentioned, in general there were a lot of ticks given to what is available. There were some gaps that were suggested—that, by having better coordination, this could work. There is work being done in that area, mostly in the women, youth and children area now. We have handed over most of that.

There were a couple of specific recommendations which we have gone through and which are still under my control. One was undertaken—an evaluation of the school youth health program. That is ongoing. That is being undertaken by the Australian National University on our behalf. The second one was two youth engagement events. One we incorporated into the youth interact conference which was held on 13 April 2012. There was a specific healthy lifestyle component to that conference. The other one will take place in July. On 9 to 13 July there will be an ACT youth parliament along the lines of the—I am trying to think of the name; it was not the ageing parliament.

THE CHAIR: The older persons assembly.

Dr Kelly: The older persons parliament that took place last year.

MS HUNTER: We are the ageing parliament.

Dr Kelly: I do not know. Mr Hargreaves is not here, but I am sure he would have had

a comment. They are some specific things that have come from that youth feasibility study.

THE CHAIR: Thank you. Mr Coe.

MR COE: I defer.

MR HANSON: Is this the right spot for diabetes, the right output? Can we talk about how we are going with the diabetes services plan?

THE CHAIR: Yes.

Dr Kelly: I am not the best person to talk about the diabetes services plan.

Dr Brown: Rosemary O'Donnell can speak to that.

Ms O'Donnell: I am responsible for the newly formed diabetes service. Your question is in relation to the diabetes services plan. One of the things to say is that the diabetes services plan is actually under review under the implementation reference group that has been set up and reconvened of late with the newly appointed director of diabetes, Professor Chris Nolan. They are working through the plan for the territory at the moment. A recent meeting has outlined a plan for that.

Another thing to say is that the newly appointed director is also looking at reconvening the ACT diabetes health service and aligning that service along the lines of adolescent, paediatric and general diabetes services for the territory. That is essentially the answer to that question.

MR HANSON: In relation to the engagement with health consumers, particularly for diabetes type 1, because there is always a dynamic tension between the provision of services for type 2 and the emphasis on type 1, I have had representations from a number of people who are dissatisfied with the service—I think that is probably the best way to put it—and who were accessing the service elsewhere, in New South Wales and so on. Have you or your staff had any engagement with the community to try to address some of those issues?

Ms O'Donnell: Yes, absolutely. I recall a discussion at the previous implementation reference group where the consumer group represented on that committee brought up that issue, and Professor Nolan, who is taking up the mantle now for directing that service, is going to be working with the consumers on that issue.

MR HANSON: So there have not been any specific changes yet. It is simply a matter of the engagement process?

Ms O'Donnell: Yes, absolutely. I am not aware of anything specific at the moment but it has been tabled as an issue that he will address.

Ms Gallagher: This is the issue that was raised some time ago?

MR HANSON: Yes.

Ms Gallagher: Are you saying it has been raised with you recently?

MR HANSON: No. It was raised with me, I suppose, about 12 months ago.

Ms Gallagher: Yes, I think it was last estimates we were talking about it.

MR HANSON: What I want to do is close the loop to make sure that work is ongoing to resolve those issues.

Dr Brown: There has been the appointment of Professor Nolan as the director. We have got an operational manager also being appointed. Really it is full steam ahead now and we have not had any recent representations around concerns.

Ms Gallagher: I have not.

Dr Brown: But as Rosemary has indicated, that work is ongoing in terms of the engagement with consumers, with the Medicare local as well.

MR HANSON: Has there been any additional money provided in this budget for diabetes services?

Ms Gallagher: Yes, there is some in the chronic disease management breakdown.

Dr Brown: There is a small amount going to Diabetes ACT, and that is providing additional funding for them to continue to expand the disposable syringe and needle program.

MR HANSON: And how much was that?

Dr Brown: It is only $10,000 this year but that funding predominantly comes from the commonwealth government and this is topping up—

Ms Gallagher: We do provide them with funding.

Dr Brown: Yes.

MR HANSON: So from the ACT's point of view then, there has not been any additional appropriation for diabetes services in the ACT?

Dr Brown: They have had significant allocations in the past two budgets, from memory. There was $232,000 last year and $4.2 million over the four years in the 2010-11 budget.

Ms Gallagher: So that is ongoing.

MR HANSON: That is all I have got on that one. I have got others in this output.

THE CHAIR: I have got one on the Cancer Council sun smart program. I know that they put in a budget submission on this because their current contract ended, I think,

on 30 June 2012. I am wondering: has that funding been committed? Is that in the growth in cancer services?

Ms Gallagher: Yes, that is it. It comes under the chronic disease funding as well, $84,000 to continue the sun smart services.

THE CHAIR: Is that recurrent?

Ms Gallagher: Recurrent, yes.

THE CHAIR: So that is $84,000—

Ms Gallagher: Per annum.

MR HANSON: I have a supplementary on that. Just on that—and probably there are some other programs as well—I think sun smart has been running for about 25 years or something.

Ms Gallagher: But it has not had a permanent or secure funding base. That is what we have done in this budget.

MR HANSON: It seems that every year they have got to go, cap in hand, for a program that has been running successfully for 20 years.

Ms Gallagher: I think historically they have been funded through a grants process. They certainly raised it with me last year and this tries to move that to a more sustainable—

MR HANSON: Are there any other organisations or grants that you have looked to move to a more sustainable footing?

Ms Gallagher: I will say that we are looking at the health promotions grants pretty thoroughly. There is about $2 million that goes out through those grants and I am seeking some assurance from the chief health officer that that is the best use of that money. Some of it has turned up in situations like sun smart where people are fine for multi-year funding and they have had it for 10 years and it keeps going. But I think it is worth having a look at this.

The health promotions grants round has been reviewed several times and validated as a legitimate way of providing small grants to do big pieces of work. But I think with the National Preventive Health Agency and some of the other work we are doing, the healthy weight action plan and the physical activity task force, we are looking at how all of that aligns into at least priority areas.

THE CHAIR: I am sorry if you have already answered this, but often programs will get funded through grants for a year and then it stops. The organisation is providing a good service. Will this review that is being conducted look at the longevity of those programs and how that can be better managed?

Ms Gallagher: There have been reviews done in the past of health promotions; so I

think we have a good understanding of some of the challenges and some of the advantages of having it. Going forward, when we are looking at $2 million per annum, I think we need to make sure that in terms of health prevention, promotion and early intervention, we need to be making sure that we are getting the best bang for our buck. And that is, I think, the work that Dr Kelly and others are doing. I have had some discussion with some non-government organisations that have raised a similar issue with me. We are taking our time working through it, but when I met with the head of the National Preventive Health Agency—is that what it is called? I keep forgetting.

Dr Kelly: It is the Australian National Preventive Health Agency.

Ms Gallagher: That one. When I met with them, they were saying they were looking at this issue nation wide, because everyone spends bits of money in a whole range of places, and their job is to bring a national focus to it and identify the national priorities and then try to ensure the effort goes behind those priorities. And in a way that is what, I think, we are doing here on a micro level.

THE CHAIR: Any further questions?

MR HANSON: On this output area?

THE CHAIR: Yes.

MR HANSON: Would this be the right spot for Indigenous health? There is a key indicator that talks about immunisation rates, but I am trying to get my head around this. We talk quite a bit about closing the gap in Indigenous health, what we are actually doing, what specific measures might be in this budget or are ongoing with regard to closing the gap in Indigenous health.

Ms Gallagher: On one of them, Dr Kelly has spoken in terms of the smoking cessation project. We are at the point now where we think a lot of effort has been put into reducing smoking rates in the ACT to a very pleasing point. The work we need to do now is within target populations. That is an obvious area. Obviously Winnunga Nimmityjah is the main provider of Indigenous primary healthcare services. We need to continue the funding that we provide to them, and that is over—

MR HANSON: What is that?

Ms Gallagher: I think is it over $1 million a year, is it not? We can get an exact figure, but it is probably one of the largest non-government agencies in terms of funding allocations.

In terms of the immunisation rates, again we work pretty closely with Winnunga. I am not sure we report on this nationally, though, because our numbers are considered too small, are they not? But in terms of strategic indicator 14, it is there. We have got targets of better than 90 per cent, and you can see those.

What I would say there is that one or two children can impact quite significantly on those numbers, because of the numbers we have. So you do see them jump around a fair bit from what we have got there. Again, I think it is pretty high against the

national benchmark—and in this reporting year there certainly are two ages—but overall we are above 90 per cent. The youngest is 12 to 15 months and at this point you would see us needing to put a bit more effort in.

MR HANSON: Has that money you give to Winnunga gone up? Has there been a CPI increase or just a flat rate?

Ms Gallagher: They would get indexation attached to those grants, yes. And then if we have targeted programs, that would be extra.

MR HANSON: Beyond the immunisation for Winnunga, what specific programs are being run?

Ms Gallagher: That Winnunga run?

MR HANSON: Beyond Winnunga in immunisation, is there anything that—

Ms Gallagher: In terms of Indigenous healthcare, Winnunga would be our main provider. We have some relations with Gugan, do we not?

Mr O'Donoughue: Yes, with Gugan.

MR HANSON: But they are not health providers.

Dr Brown: We have Aboriginal and Torres Strait Islander liaison workers as well that work in the mainstream parts of health to facilitate access to care in mainstream settings as well.

Mr O'Donoughue: We are—

THE CHAIR: Quickly, because we are out of time, sorry.

Mr O'Donoughue: Very quickly, with Gugan as one of our partners, we have an antenatal and reproductive health project that is going very well. We have been putting resources into young women pre-pregnancy and into pregnant women and their health. There is the smoking cessation stuff that we are rolling out with Winnunga and Gugan. As Dr Kelly was alluding to, we are on the cusp of a social marketing campaign. It is going to be locally developed and it is going to use local champions. It has also got a song writing competition associated with it. We are really excited that the kids have developed some great material. That material is going to be used as some of the music for the social marketing campaign, and there is going to be a whole set of digital stories with local champions and using that music. That is about to happen.

Then in the hospital itself, there is quite a lot of work going on in that we are just about to launch a new reconciliation action plan. That commits us to ongoing cultural awareness training and we are working hard to try to get better identification of Aboriginal data by asking the standard ABS question at all encounters to improve our data collection of Aboriginal and Torres Strait Islander people.

THE CHAIR: Thank you.

Mr O'Donoughue: I have just been handed a note informing me that Professor Nolan has commenced a diabetes clinic at Winnunga, which is his first involvement there, as I understand it.

THE CHAIR: Thank you, minister and officials. As mentioned at the commencement of the hearing today, there is a time frame of five working days for the return of answers to questions taken on notice at this hearing. That is specifically in relation to output class 1, health and community care, acute services, mental health, justice health and alcohol and drug services, public health services and cancer services. Proceedings will recommence at 2 pm with an examination again of the health portfolio, output class 1, health and community care and then proceed to output class 1, the ACT local hospital network.

Meeting adjourned from 1.17 to 2 pm.

THE CHAIR: We will start. Minister, I will not go through the spiel I went through this morning about the process for questions taken on notice. I noted that this morning. This afternoon we will be going through output class 1, health and community care; output 1.5, rehabilitation, aged and community care; output 1.6, early intervention prevention; and then output class 1, ACT local hospital network, which includes Calvary outputs and Clare Holland House.

Ms Gallagher: And mostly acute.

THE CHAIR: Yes, and acute. Basically, yes. That is 1.1, acute for Calvary; 1.2, mental health for Calvary; 1.3, cancer service at Calvary; 1.4, rehab and aged care for Calvary; and then Clare Holland House.

Ms Gallagher: TCH is included in the local hospital network too.

THE CHAIR: Okay.

Ms Gallagher: I am just saying that we are in that transition year of moving from one to another. So in some ways a lot of what we covered under the output class for acute services has covered the local hospital network, although there is more in the local hospital network as well.

THE CHAIR: Yes. That is probably what I thought as well but we have to go through these classes as they are. We will see how we go. I will start with 1.5, rehabilitation, aged and community care. My question is in relation to HACC funding and the growth funding for HACC. I understand that applications for growth funding were due in by 15 December 2011 and that the time lines on this request stated that assessments will be completed by 15 January 2012, which is about five months ago. I also understand that the last growth funds were released, I think, in the ACT approximately in September 2010. When will the HACC growth funds be announced and why has this process taken such a long time?

Dr Brown: I will ask Mr O'Donoughue to respond to that.

Mr O'Donoughue: Thank you for the question. I might need to take some elements of it on notice.

THE CHAIR: Sure.

Mr O'Donoughue: My understanding is that given this is sort of the transition year towards the new arrangements, agreement is always reached with the commonwealth minister in terms of the quantum of growth funds first of all. They could not be allocated until there is also agreement from the commonwealth minister to the allocation. So that has been the case in each year.

THE CHAIR: I take your point that we are in this transition but this has actually been something that has occurred in the past as well, I think. As I said, the last were released in approximately September 2010. That is nearly two years ago. I know there have been issues in the past with their being allocated. My understanding too was that the other states had actually allocated in a quicker time frame than the ACT.

Mr O'Donoughue: I stand to be corrected but we have allocated growth funds in each financial year. So I would be surprised if it was as long ago as 2010 that there was the last allocation of growth funds. Unfortunately, part of the process that does cause delay is this bilateral process which requires us to have the commonwealth minister's assent before the funds can be actually allocated. We have tried to expedite that process as best we can but that has always been a problem in the allocation of those funds. I must say, it has had the benefit of historically our being able to negotiate a higher level of indexation for the growth funds than otherwise would be the case.

THE CHAIR: So even though that application or the assessment is actually completed by 15 January, the funds still have not been allocated. That is quite some time. That is five months ago.

Mr O'Donoughue: Yes, I acknowledge that. If I may, I would like to take on notice the reasons for the delay and when it is anticipated that the funds will be allocated.

THE CHAIR: Okay.

Ms Gallagher: This was raised with me last night at a community meeting and I undertook to get back to the organisation involved. They were concerned that they needed to make some decisions about their programs by 1 July. They thought they were running out of time. So I have undertaken to follow up directly.

THE CHAIR: Yes. If it is 1 July, that is only a couple of weeks.

Ms Gallagher: Yes, I agree.

THE CHAIR: I appreciate your taking that on notice. Will that be resolved once we have had finalisation of these transition processes?

Mr O'Donoughue: Most of the bilateral processes with the commonwealth have

basically just about been resolved; so I would be confident that it would be soon that we would be able to move forward.

THE CHAIR: On the new funding arrangements that will take place from 1 July, I know that there have been some concerns about this process. A particular concern that people have outlined is what happens to someone with a disability when they turn 65. What is going to happen then? Do they then come under a separate funding arrangement? What is actually going to happen to a client when they turn 65? How is that practically going to impact on them or should it not impact?

Mr O'Donoughue: It should not impact at all on the client in the sense that the commonwealth will take responsibility for the funding of basic community care services for people over 65 years of age and Aboriginal and Torres Strait Islander people over 50 years of age. If you were under 65 years of age and receiving services from a particular agency and then you have reached your birthday and the clock has ticked over that, as it were, you would not see any difference in service delivery and you would not have to change service provider.

It is really a matter of invoicing between the commonwealth and the territory in terms of who pays for those services. It should not have any impact—it should not disrupt the service provision to the client. It is simply a matter, in a sense, behind the scenes for both the agency and for the treasuries to invoice those services.

THE CHAIR: So hopefully there will not be because you said that it is a discussion between the commonwealth and territory about the invoice arrangements.

Mr O'Donoughue: Yes.

THE CHAIR: Sometimes we do see issues. Are you confident that we will not actually see any problems occurring?

Mr O'Donoughue: In this particular service where essentially funding is very directly linked to particular hours of service provision, I do not see it will be a particular problem, because it is very clear what is being transacted.

THE CHAIR: Is it something that is going to be monitored closely to make sure that it does not impact?

Mr O'Donoughue: Yes, and in addition as part of the transition arrangements, the commonwealth takes those responsibilities for directly managing funds with their contractor providers from 1 July 2012. But they have indicated that they will not disrupt basically who the service providers are and what services are being provided overall and the territory has taken a similar approach.

We are about to go through a process now of reissuing three-year service funding agreements with our current providers. Essentially, for this period—not just for the transition year but for the next three years—there should be relative stability in who is providing the services and who is being funded.

THE CHAIR: Is everything due to change on 1 July? I think there have been some

concerns that was going to happen. Is it ready? Will the changes be progressing and going ahead?

Mr O'Donoughue: Yes but—

THE CHAIR: There will not be any delays to that?

Mr O'Donoughue: Everybody is clear on what is happening as of 1 July and all our funded agencies have been offered three-year service funding agreements.

MS HUNTER: I would like to go to page 70 of budget paper No 4, accountability indicator b under output 1.5. It talks about non-admitted occasions of service. The number has gone down from 2,230, which was the target, to 1,850, which is the estimated outcome. The note underneath says, "Occasions of service have decreased due to availability of staffing." Could I have some more information on that, please?

Dr Brown: Yes. That relates to, I think, geriatric services. We have had a reduction in the number of geriatricians and have been unable to recruit. So that has led to a reduction in the number of non-admitted occasions of service. More recently, we actually have had an increase again in geriatricians but I do not think we are yet fully recruited, but that is the reason for that reduction.

MS HUNTER: So how many are we short and how long have we been short for?

Dr Brown: I would have to ask Linda Kohlhagen to speak to the specifics of that.

Ms Kohlhagen: We have been short probably two geriatricians from early last year—from January last year. We recruited 0.6 of an extra geriatrician who started in January this year. We are currently at 1.4 FTE vacant positions. We have had a number of attempts to recruit to those positions and have talked to people from interstate and overseas who have been interested in the positions. We have shown them around and tried to sell that this would be a great place to work, but unfortunately they chose to go to sunny Queensland instead, amongst other reasons. Our plan is to re-advertise in July and August.

MS HUNTER: This has been going on for quite some time if they first became vacant in January 2011.

Ms Kohlhagen: Yes, that is correct.

MS HUNTER: How confident are you that you are going to be able to attract people through re-advertising? Or is there some longer term strategy that needs to be in place around engaging with training institutions or something?

Ms Kohlhagen: It is probably a combination of both of those two things. We believe, and are very hopeful, that there are a number of trainees who finish their training this year who are keen and certainly who have voiced their desire to come and work in the organisation. So that should fill, we hope, at least one of the positions. The other is that we are trying a multitude of approaches to fill the position, including re-advertising in colleges; offering the training programs to registrars, including training

programs for our community team; advertising at conferences; and talking to lots of people as well. We hope to at least fill one of those positions early next year.

MS HUNTER: Where does the training take place? Are you training locally?

Ms Kohlhagen: Yes.

Dr Brown: Yes, we train locally.

MS HUNTER: How many people have had to wait for assistance because of the lack of staff?

Ms Kohlhagen: In February last year, we actually withdrew our geriatrician service to the GEM unit beds at Calvary. We still provide the 28 beds at the ACAR unit: all the patients are admitted under the rehab physicians as opposed to a mix of the geriatricians and the rehab physicians. With our outpatient appointments, when I was informed yesterday, the wait is just under four weeks. There has not really been a significant change in our response, our ability to offer an outpatient service. It has had an effect on our ability to provide a service to the GEM unit, though, at Calvary.

MS HUNTER: Have you received any feedback from people, particularly people living on that side of town, who might find it more difficult to access service down south?

Ms Kohlhagen: No. The people who are admitted to the aged care rehab unit at Calvary could come from across the whole region. It is not designated to be like a north side rehab service or a geriatric service. So no; I have not received comments.

MR SMYTH: So what are non-admitted outpatient services?

Ms Kohlhagen: They are our outpatient clinics that we run—like a doctor's appointment where you will come and see one of the specialists in hospitals.

MR SMYTH: If that service is not provided, what care is missed out on and how is that compensated for?

Ms Kohlhagen: We have continued to provide the service. With some of the clinics we might have reduced the numbers or the number of appointments to ensure that our geriatricians can actually provide a service to our in-patients. There certainly have not been any complaints. We are still able to offer, and certainly been able to see, emergency or priority 1 type patients as well. And as Dr Brown mentioned, with our increase in the staffing we have been able to offer additional clinics. We run what we call a hot clinic. It is for an emergency. If there is someone who urgently needs to see a geriatrician from an outpatient perspective or if we redirect them from ED, we have now got that capacity as well.

MR SMYTH: You have lost 380 occasions of service out of 230.

Ms Kohlhagen: Yes.

MR SMYTH: If that has not been delivered and that apparently has had no effect—

Ms Kohlhagen: It is probably an intangible. It is a difficult thing to measure. Some of the other indicators of demand for service—there have been fewer referrals that we have noted as well. There has been a slight reduction in referrals to the service from an outpatient perspective as well. And we are also monitoring the DNA rates. There has been a very small number, only two or three a month, of people who are not presenting for an appointment. So there is a range of reasons that combined to account for their reduction in service.

Dr Brown: And it may well just reflect that the practice of the specialists is modified to reflect the current staffing levels. For example, instead of bringing someone back for a follow-up appointment, they might refer them back to the GP. I am not saying that specifically in this case, but that is the sort of thing that might be modified to accommodate the actual capacity of the service.

MR SMYTH: A new question?

THE CHAIR: Yes.

MR SMYTH: The provision of nurses to special schools in the territory—apparently Woden school is now the only special school without a full-time nurse. Why is that the case?

Dr Brown: I am just trying to think who does the schools. It is Liz Chatham. We do have a good working relationship with education. I am just not sure whether, in terms of the current situation at Woden special school, there has been nursing staff provision there. It is subject to regular review in terms of the ongoing need for services there. It may well be that the clients are continuing but their level of need for specialist nursing services changes over time. A number of these clients do not necessarily need ongoing specialist nurse service; what they need is disability support services on site. That is the sort of review and changes that we make on a regular basis.

MR SMYTH: This might be a question for the minister then. I understand that Mr Doszpot has written to you supporting one family who needs services for their son at Woden school.

Ms Gallagher: Yes, and I responded to Mr Doszpot, from memory.

MS SMYTH: Yes. I am told that service will cease after July this year and that those services will now be provided by casual trained staff who are not medically qualified. Is that an acceptable outcome for this family and that student?

Ms Gallagher: From memory—I do not have the letter I responded to Mr Doszpot on—a specialist nurse was provided and work was ongoing with the family and school about what the needs were into the future. That is my recollection of this matter. I have not had an up-to-date brief on it. I am not aware of anything ceasing on 1 July. From my point of view, the advice I had back was around the fact that if there was a clinical need for care to continue, that would be managed.

MR SMYTH: My understanding is that the need is ongoing and perhaps will become more crucial rather than getting better.

Ms Gallagher: The needs of the student involved?

MR SMYTH: Of the student, yes.

Dr Brown: As I say, the student may have continuing needs in terms of what level of need, and how that is best met is what we assess.

MR SMYTH: I think the cavalry has arrived. Is there more information available about—

Ms Chatham: There is. The Health Directorate and ourselves are working together and putting up a plan to look at the ongoing needs of special needs children in school. The issue you are referring to has unfolded a whole lot of issues going forward in the future where we will need to be supporting children in special schools as well as mainstream schools. The education directorate and ourselves have agreed to keep the actual service that we have in place at the moment, which is the nurse, until the end of this school year. We will be putting in a plan for a budget bid going forward into the next budget.

MR SMYTH: So there will be a nurse at the Woden school until December?

Ms Chatham: Yes.

MR SMYTH: But then there will be a gap between December and June next year dependent on—

Ms Chatham: No. The care will be overseen by a nurse. It may use a nursing assistant to provide the care, but the plan will be put forward and discussed and consulted on broadly. It will also be overseeing other schools where the need for nursing support is required.

MR COE: Will there be daily checks?

Ms Chatham: It depends. Every child is individual. The needs of the child will be assessed individually and the care that is needed will be provided by the healthcare provider there; it might be a nurse or it might be a nursing assistant.

MR COE: In terms of those assessments, what communication do you or other areas of Health have, with the department of education primarily, to determine the needs?

Ms Chatham: We are putting a process in place. Up to now, it has been pretty ad hoc, but as we know there are more children coming through the system. We are putting together an ongoing MOU that details regular planning meetings, identifying ahead the needs for the following year, and a process where we can do an assessment of the child's needs and ensure that their healthcare needs are being met prior to them starting school—like the plan is in place. And we would do an annual review of the needs as well.

MR COE: Is there a person who will travel between the different schools or is there going to be one person assigned to each school but they may not be there full time?

Ms Chatham: The plan is still under development but the idea is that it will be a nurse-supervised service. It just absolutely depends on the needs of the child. If the child needs that care in place during the school day, the care will be there; but if there is a single thing that needs to be done for the child once a day, the carer might turn up for that time to do that and then attend another school as well. We are trying to provide a comprehensive whole-of-ACT approach to this, other than the ad hoc approach we have had. And we are working side by side with the education directorate.

MS HUNTER: I guess that will change year to year depending on the children who are coming into school.

Ms Chatham: The needs will change year to year. And as they grow, we hope that they develop mentally to be able to manage their own health care in some circumstances. Some children will never be able to do that.

MR SMYTH: Minister, just to follow up, the parents of the specific child have been advised by members of your department—the parents, I understand, were told that a medically unqualified person will be undertaking medical procedures involving their son. Does this expose the son, and potentially your offices and the department of education, if any mistakes occur?

Ms Gallagher: I am not aware of that and I do not believe the parents have put that to me.

MR SMYTH: No, but your department told them that.

Ms Gallagher: Medically unqualified?

MR SMYTH: They were the words I was given.

Ms Gallagher: So referring to someone who does not have a medical degree? Is that what you are calling it? Or—

MR SMYTH: The words the parents were told were that an unqualified person will be undertaking the treatment of their son.

Ms Chatham: Can I try and answer that?

Ms Gallagher: Yes.

Ms Chatham: What we are looking at is developing a level of worker that is called nursing assistant or care attendant who is trained and works to a competency level of training. They are not qualified as nurses; they are not qualified as doctors. But they have TAFE-type training where they have competency-based training. And all that care will still be supervised by a trained nurse. But we are not looking at that this year.

That is within our proposed plan, which we need to do consultation with. That is a model that we have based on the model in South Australia, which does it quite well, and also a Victorian model.

MR COE: When will that plan be finalised?

Ms Chatham: We are hoping to finalise it by the end of this year, in December. No. That is wrong; sorry. I take that back. We are hoping to finalise it to get into the next budgetary rounds the model we are hoping to go forward with. That is, I think, September.

Ms Gallagher: Effectively in December, yes.

Ms Chatham: We will also be doing consultation with the families involved, and consultation with the commissioner for children's health, around that plan as well.

MR SMYTH: Currently, how many nurses do we supply to the education system to look after the kids with special needs and where are they located?

Ms Chatham: I have not got that data in front of me; sorry.

Ms Gallagher: We will take that on notice.

Ms Chatham: I will take it on notice and we will provide that to you.

THE CHAIR: Take it on notice; yes.

MS HUNTER: In order to be able to be prepared for each school year, you are going to need to have some sort of assessment or know who is coming into the system and then how the children's needs are changing. You would probably have a better handle on that than who is coming in. What process are you setting up to collect that?

Ms Chatham: What we are looking at setting up there is, when children enrol in the schools, that the school identify in the enrolment process that this child has special needs. The principals and the teachers of the schools have indicated that they feel really unequipped to actually make a judgement when the parents say they need this, this, this and this—whether that is correct or not. We will be providing a medical assessment for that child and a plan so that they are going to the school year with a plan for that child that has been endorsed by a medical practitioner—not at the parents' desire, I suppose, because there is sometimes a gap between what we can provide and what the parents would like us to provide. Then we will review that plan annually. So we are adding to the service a medical assessment or a plan of care that we can provide to the school and to direct care of the nurse or the trained health worker.

MR COE: Can you give us an update as to where things are at with the Gungahlin health centre?

Ms Gallagher: The Gungahlin health centre is due for opening in September for clinical services. I visited it yesterday. It is due for physical handover in early August,

I think.

MR COE: Can we expect that all the services that were planned will be available?

Ms Gallagher: Yes.

MR COE: On the first day of operation?

Ms Gallagher: Yes.

MR COE: What are the contributing reasons to the delays?

Ms Gallagher: There are no delays.

MR COE: It has been promised for some time now.

Ms Gallagher: It was due for completion in September this year, and it will be completed in September this year.

MR COE: At what cost?

Ms Gallagher: $18 million is the budget, and my understanding is that it is on budget.

MR COE: How many full-time FTE staff will be at the centre?

Ms Gallagher: Additional? There is some reconfiguration. The budget initiative has funding for about 8½ extra staff. There will be some movement, because a lot of the people who will go to the Gungahlin community health centre are currently going to Belconnen. The 8½ staff are new staff, but then there will be a reconfiguration of staff from Belconnen because they will no longer have Gungahlin patients going there.

MR COE: How many do you expect to be working there in total?

Ms Gallagher: I am not sure of the total FTE. I am sure we can provide that to you. It is a full range of services that are currently provided at our community health centres. Dental will be offered. The dental suites are looking fantastic. There will be counselling, community nursing and all the allied health services. There are group meeting rooms. It is a fantastic new facility. I am sure we can get you the full-time FTE.

MR COE: You said it will open in September. What is happening in August?

Ms Gallagher: It is physical completion in August. The building is pretty much in the final stages now. There is a short time for final fit-out, and then the commissioning.

MR HANSON: I have a question about pharmacy regulation. I believe you have had representations or discussions with the Pharmacy Guild.

Ms Gallagher: Yes.

MR HANSON: As have I, about the regulations. I am just wondering if you can give me an update on the decision on transitional provisions and update the committee on what has happened.

Ms Gallagher: This is over the ownership of pharmacies issue? Is this the one you are talking about? This is the one they are most concerned about—about wanting a transitional regulation power coming in, which I have agreed to.

MR HANSON: There is inconsistency with other jurisdictions, as I understand it. There are some transitional provisions regarding pharmacy regulation across—

Ms Gallagher: It is about ownership, I think, currently. I think the Pharmacy Guild would like a stand-alone piece of legislation establishing basically an independent body to oversee all their licensing and regulatory functions. I am not sure that we need—we are in discussions with them—a full-blown statutory authority to deal with that, that we can deal with that another way. I think we will just continue to talk with them. But the issue in the short term is around an expiring provision that I need to make a regulation for which—I think I must be in the final stages of that being drafted—

Dr Brown: You are.

Ms Gallagher: to deal with the matter of pharmacy ownership.

MR HANSON: Right.

Ms Gallagher: Then the Pharmacy Guild would like another piece of legislation to deal with that as well. So it is really about whether we have—

MR HANSON: So the regulation has been drafted?

Ms Gallagher: Yes. I have already written to them and told them that we have got this solution for the short term. Also, because the Assembly is rising and will, effectively, not be in operation until probably November some time, I have said that we will revisit their ideas around a stand-alone piece of legislation to deal with them into the long term.

MR HANSON: I will give it some thought then.

Ms Gallagher: Yes.

THE CHAIR: If there is nothing further on that, I have a question that may have been answered earlier. It relates to chronic disease management funding, which is on page 112 of budget paper 3. There is, I think, about $1 million per annum in new funding dedicated to chronic disease management. As I said, it was mentioned earlier, I think. How is this funding going to be spent?

Ms Gallagher: Yes, there are a range of initiatives. We have been through some of them. There is the Aboriginal smoking cessation project, $200,000; Arthritis ACT, $50,000; Asthma Foundation, $95,000; Cancer Council Sunsmart, $84,000; Diabetes

ACT, $10,000; the heart failure service, $275,000; Palliative Care ACT, $124,000; and there is some funding there—does that all add up to $1 million? There is some funding of full-time equivalent staff—two staff effectively—within policy and government relations.

THE CHAIR: That is obviously recurrent funding?

Ms Gallagher: Yes.

THE CHAIR: As I said, I probably should have asked this earlier. How do you determine the priorities for this area in terms of chronic disease? Do you look at population factors or what are the issues at the time?

Ms Gallagher: Some of it is that, and some of it is other—certainly a number of those organisations have not received extra funding in the past. I think I have probably met with every one of those groups about the work that they want to do—that felt that they were projects worthy of support.

THE CHAIR: Also, on preventative health on that issue, on page 71 of budget paper 4—I might just be reading this incorrectly—it looks like there is close to over $4 million in 2015-16 under commonwealth grants, or at least under the title of commonwealth grants, that is going to be lost funding in preventive health under the national partnership. Is that correct, or am I reading that incorrectly?

Ms Gallagher: Commonwealth grants?

THE CHAIR: Yes.

Ms Gallagher: Preventive health? Are we in the technical adjustments area on page 71?

THE CHAIR: Yes, we are.

Ms Gallagher: I see. In that last—

THE CHAIR: It is just that in 2015-16, it is—

Dr Brown: It is a reprofiling, I think.

Ms Gallagher: It looks like it comes in in that class.

Dr Brown: Dr Kelly will give you the details.

Dr Kelly: Thank you, Ms Bresnan, for the question. The national partnership agreement we have touched on a couple of times.

THE CHAIR: Yes.

Dr Kelly: It is actually under a negotiation for a slight change in that at the moment, but according to the budget papers, this was the information we had at the time. It is

due to finish at that period. It was a program which has an end point. Now, in recent negotiation with the commonwealth—the minister may wish to speak to this as well—they are prolonging that agreement. It has the same funding envelope but it will actually flow on for another couple of years—

THE CHAIR: So what program or programs is that?

Dr Kelly: This is the national partnership agreement for population health—

THE CHAIR: No, I understand that, but what programs would that impact?

Dr Kelly: It touches upon most of the things we do in relation to health promotion. So the issues of working with children, also healthy workplaces and some of the healthy community initiatives that I touched on earlier.

THE CHAIR: You said it looks like it is going to be prolonged. Do you have any idea yet?

Dr Kelly: No, it is still—we are still in negotiation, I think, and the minister would acknowledge that.

Ms Gallagher: I think there are a few budgets before this one—

THE CHAIR: Yes, that is right.

Dr Kelly: Yes.

THE CHAIR: In terms of that particular national partnership on preventative health, what sort of outcomes has it delivered? Has there been anything noticeable? I appreciate that preventive health is not—

Ms Gallagher: It is early days.

Dr Kelly: I will say that the ACT is well ahead of many of the other jurisdictions. This has become more obvious in the negotiations I have been talking about. Several of the jurisdictions really have not started at all whereas we have had the advantage of the significant funding that came through in previous ACT government budgets and been able to build on that and link in with the national strategies. We have had a lot of things that were able to be started under the healthy futures budget previously and that are now really bearing fruit. One of the ones recently was the formation of the healthy workers service, which is being funded through the national partnership agreement in consultation with the Health Directorate but run out of the JACS Directorate. It is done under WorkSafe.

That is a major piece of work which has built on work we have done over the last few years in pilots that we have done through a number of workplaces, including in the government and the non-government sectors, and really building on the work that we have seen there on to how to support workers to be more healthy in the workplace. It is moving beyond the idea of work safety, for example—incorporating that still but really adding a wellbeing aspect to that. It is looking at healthy weight, looking at

smoking, looking at alcohol—those national objectives.

MR HARGREAVES: Can I talk about rehabilitation and aged care?

THE CHAIR: You certainly can.

MR HARGREAVES: In budget paper 4, page 70, output 1.5, the patient activity stats, there were some very large variations there.

Dr Brown: We already have covered—

Ms Gallagher: We have covered 1.5, point b.

MR HANSON: Madam Chair, if we are going to go back to revisit old areas, are we going to do that at the end of the day or—

THE CHAIR: No, we are actually in the areas now. Rehab, aged and community care, early intervention and prevention. That is what we are up to now.

MR HANSON: I thought we had moved on from rehab, sorry.

THE CHAIR: No, once we get through it we can go back.

MR HARGREAVES: Thanks for that, Mr Hanson. I understand the explanations. Thank you very much for the first four of them. They talk about the fact that the Calvary hospital stats are not in the local hospital network stuff. But I am interested in the last two, f and g, which talk about the number of nursing, domiciliary and clinic-based, occasions of service and the allied health regional services occasions of services.

Both of them have got relatively significant increases in the estimated outcome over the target and then the 2012-13 targets go back to what they were. My curiosity is provoked about how that could be so. Was that a one-off activity during the year that has caused that sort of a blip or is that a conservative estimate going forward, which is probably a very wise thing to do?

Dr Brown: I think it is the latter, Mr Hargreaves. It is a conservative estimate going forward. In terms of an overachievement this year, we are not in a position to guarantee the sustained activity at that level. But that is a conservative estimate.

MR HARGREAVES: Thanks. When you talk about allied health regional services, is that just regional within the ACT or does that include the New South Wales region surrounding the ACT as well?

Dr Brown: My understanding is that it is ACT—no? Ms Kohlhagen will come and correct the record.

Ms Kohlhagen: It is just the allied health that sits in RAC actually; so it is a small group of allied health who are based in the community health centres.

Dr Brown: But it is ACT, not—

Ms Kohlhagen: Sorry, yes, they obviously just cover ACT.

MR HARGREAVES: Okay. So what we are talking about are the mobile rehab sort of services?

Ms Kohlhagen: No, this one refers to the podiatrists who work in the community health centres, the physios who work in the community health centres, the occupational therapists and nutritionists, and the social workers who provide counselling through the community health centres as well.

MR HARGREAVES: Thank you.

THE CHAIR: Anything further there, Mr Hargreaves?

MR HARGREAVES: That is fine, thank you very much.

MS HUNTER: Before going to the health promotion grants I want to go to output 1.6. It is the same page, page 70, budget paper 4, (c)—the proportion of children aged 0 to 14 who are entering substitute and kinship care within the ACT who attend the child at risk health unit for a health and wellbeing screen. The target was 80 per cent and we are at 71 cent. So it is a little bit concerning around that. Obviously the target is not 100 per cent. We are at 80 per cent, but we are not meeting that target. What is going on there?

Ms Gallagher: The estimate is that by the end of the year it will be at 80 per cent.

Dr Brown: No. The estimated outcome is 71 per cent against a target of 80 per cent. That reflects the referrals that actually come into the service. We cannot deliver a service if there is not a referral coming to us.

MS HUNTER: Is it concerning to you? Obviously you are basing your target on past years. Have referrals dropped, and why? It may reflect that there are fewer children coming in, but I am not getting the sense that that is the case.

Dr Brown: This is an issue that we have faced in previous years as well. We liaise closely with the relevant referrers, but we do not actually control that level of referral.

MS HUNTER: So who are the relevant referrers?

Dr Brown: My understanding—again, I am looking at Liz Chatham—is that it is Care and Protection Services.

MS HUNTER: So there appear to be less referrals coming through from—

Dr Brown: For those assessments, yes. I beg your pardon, the minister was correct in saying that it is anticipated that the 80 per cent target will be met by the end of June, according to the briefing paper.

MS HUNTER: That is not in here. You have that information?

Dr Brown: Yes.

MS HUNTER: I can ask that question again in another part of the estimates hearing. Over to the health promotion grants, how much funding is now dedicated to health promotion grants per annum?

Dr Kelly: I think the minister mentioned earlier a figure of around $2 million. In 2011-12 it was $2.058 million. That was really in four grant rounds—the community funding round, which is our largest, the stay on your feet falls prevention funding round, the healthy schools healthy children funding round and the health promotion sponsorship funding round. I can go through the details of those, if you wish.

THE CHAIR: Perhaps you could provide that detail to us.

MS HUNTER: If you could provide that detail to us, that would be really useful.

Dr Kelly: Yes.

MS HUNTER: Have those funds grown? Have they been indexed or is it just a set amount?

Dr Kelly: They have been indexed.

MS HUNTER: They have been indexed over time?

Dr Kelly: Yes.

MS HUNTER: Can the funds be used for capital, or is it just for delivery of an event, a program or an activity?

Dr Kelly: The different rounds that I have mentioned there have different funding rules, which are very transparent and open. Some of them are used for small capital issues as well but mostly it is for events, programs or projects. They tend to be relatively small grants to a large number of people. For example, in the last financial year there were 92 projects for that just over $2 million.

MS HUNTER: The canteen expo was part of these promotion grants. Could you give me a bit of information about that, because obviously it is becoming quite a topic here in the ACT as well.

Dr Kelly: The school canteen event that happened this week?

MS HUNTER: Yes.

Dr Kelly: I attended that. It was an excellent day. The funding was through Nutrition Australia. I can inform the committee whether that was from a grant or whether it was from other funding mechanisms. It certainly ties into the healthy children's element that we are doing. The interesting thing about that for me was the talk that was given

by Rosemary Stanton. She was telling us that, extraordinarily, she has been on this campaign for healthy school canteens since 1968. She said at the time that, finally, things are actually changing for the better.

The forum was very well attended. There were many people there who run the canteens on the ground. It was great to hear their stories of how they have managed to dispel a couple of myths. One is that kids do not eat healthy food. That is false. They have all sorts of ingenious ways of hiding the healthiness in the food and they do actually eat it. The second thing is that healthy food is more expensive. That is also false. I was very happy to see our ACT government funds being used for this forum. There was a lot of good swapping between the different canteens.

MS HUNTER: Is there a role for your area to engage at all around promoting a more healthy approach by canteens? Some are looking at a traffic lights approach—red light and green light foods—in terms of what they can provide in canteens. We have got a bit of an issue out there with our canteens at the moment. A number are closing down. We have really got to look at how we can address that situation. I think there is a good synergy with introducing healthy food as well.

Dr Kelly: It is work that we have been doing for a number of years, and it will be strengthened by the budget initiative around the healthy weight action plan. This is exactly the sort of thing that we want to do—to make sure that different directorates within the government are working together in the same direction. Our working with Education, which has happened for many years, is another example of that. Working with the non-government sector—for example, Nutrition Australia—is a perfect example of that.

MR SMYTH: I am not sure what class we are in at the moment, but I am going to ask about the blood supply plan. I note in this year's budget—it is page 112 of budget paper 3—there is a higher cost for the ACT blood supply; it is $1.827 million. What does that buy us?

Ms Gallagher: Products for high cost blood patients.

MR SMYTH: How is it that there is nothing in the outyears?

Ms Gallagher: We funded this in a one-off way last year as well.

MR SMYTH: That is right, for $1.8 million.

Ms Gallagher: Yes, and it has got a component in there for a treatment that may not be ongoing or that might lessen the cost in the outyears, if it is successful. We are not in a position to take a decision at this point in time.

MR SMYTH: Is this for a specific patient?

Ms Gallagher: Yes.

MR SMYTH: So when will we know? Is this a trial treatment or is this a—

Ms Gallagher: Without breaching anyone's privacy, there will be ongoing costs of providing care to patients with a particular type of condition. Over the long term, certain treatments that have been provided may impact on the costs in the outyears. This is something that we have under review and we will make allocations as we need to.

MR SMYTH: There was a whisper from the gallery. The man of numbers came forward.

Dr Kelly: I might make two comments, if I may, minister. Firstly, the minister is correct. It is a small jurisdiction issue. A single person, who we do not want to give too many details about, can make a huge difference. A certain person's clinical course can change quite rapidly, so a year-on-year estimate is the best way to go. The whisper from the gallery was to remind me to say that for some time there have been discussions through the jurisdictional blood committee on setting up a high cost patient pool across the jurisdictions. That would be of great benefit to us. There has been some movement in that area. We are actually getting some funding back from JBC, which is a highly unusual event, to support this. It will not be the whole cost. That pool will develop over time and it may be that we will be able to recoup a higher proportion. I think that making a decision at each budget is the most appropriate way to go.

MR SMYTH: Thank you.

Ms Gallagher: There might be a better way of providing it in the financials somehow that might protect people a little bit better.

MR COE: Chief Minister, this week Dr Sharma was reported as saying that there is too much emphasis on acute care because of the relative ease in measuring performance. Do you have any ideas about how we can better measure preventive health? Are you aware of any models elsewhere, where perhaps they are doing it better than we are, that we can take on board?

Ms Gallagher: I did hear Dr Sharma. I would certainly agree with her that there is a much greater interest in the performance of the acute system and transparency and accountability around that than there is perhaps in the primary area of health care, and the national health reform has not really moved into looking at performance outcomes and measurements of the primary healthcare system to any great degree. I think there is certainly room to look at that.

In terms of some of the things that you would measure, and to some extent they are measured already, the Chief Health Officer will be issuing his Chief Health Officer's report in the next little while. I have not seen this one, but a lot of the data that we see around the health of the ACT is that we are a relatively healthy community. We have higher life expectancy than other places across Australia. Our immunisation coverage is very good and in many cases it is the best in the country. We do have some data available to us that gives us an indication of the health of the community before the community gets sick.

We also are getting increasingly good information about the lifestyle factors that

influence and are going to continue to influence some of the ongoing impacts on the health system which will impact on the acute system. Even in these budget papers, we have got a relatively clear understanding of the levels of diabetes in the community and cardiac conditions. All of that, to some degree, is measured. Then you try and tailor some of your services around it.

What I would also say is that, from this point of view, the state and territory governments—and this has become clearer under the national health reform—are responsible for the hospital systems. That is our clear responsibility. The primary health care system is fundamentally within the ambit of the commonwealth government. They are arranging their responses to that with the Australian National Preventive Health Agency, for example. That has been the result of the national health reform. I think in terms of performance assessment there is a lot more that we could look at in the primary health care area.

MR COE: I guess the temptation is to measure success on how much you spend in the absence of figures at the other end. Going back to what I said earlier, do you know of other jurisdictions, perhaps overseas, that are really homing in on this area of health as a key reportable?

Ms Gallagher: In terms of the ACT public health system are you talking about?

MR COE: Yes.

Ms Gallagher: Or in primary care? Rashmi was talking about the primary healthcare system. We have some influence there and we have some programs there. We have our quarterly performance reports and the information in our annual reports. We report against a whole range of different performance indicators and none of them are linked to how much money you spend. It is the outcomes that are measured.

MR COE: I guess what I am talking about is more the expenditure of public funds and whether that is coming from the commonwealth through Medicare or through the ACT budget.

Ms Gallagher: Yes.

MR COE: It is the same in juvenile justice and all those areas as well where there are real benefits to early intervention that are often hard to quantify. Is there hope that we can get to a point whereby those measurables are really tangible—that makes it easier from a policy perspective to actually appropriate funds for it?

Dr Brown: I am not sure if this is answering your question specifically, but I think the National Health Performance Authority is aiming to try and advance this by looking at—at the moment we do measure the inputs in terms of the dollars and we measure some of the outputs in terms of things like occasions of service, hospital separations et cetera. I think there is a significant move to try and enhance that reporting and start to look at some of the outcomes, but it is a work in progress. The whole national health reform is trying to increase the transparency of the flow of dollars from both the commonwealth and the states and territories so that we are going to be able to better track the expenditure and the outcomes—outputs and outcomes.

Mr Thompson: Where we can, we do measure it. For example, in the budget papers we have got strategic indicator No 6 about the highest life expectancy at birth in Australia, which the ACT has. And there is a lower than average national prevalence of circulatory and diabetes; those are indicators 7 and 8. So we do it where we can. These are measures of the health of the population, and they are measures where the ACT consistently is better than the comparators nationally. Where we can do it, we do it. As the others have said, it is a matter of trying to continue to refine those indicators.

MR HANSON: On the area of preventative health, I had a men's health forum recently, and a key theme that ran through it was the failure of men to access the health system, particularly in a timely fashion. They wait until they are very sick before they seek attention. Obviously when it comes to preventative health and early intervention, that is a problem. I suppose that is in some way reflected in the high mortality rates; the death age for men is lower than it is for women. Have we done any mapping to look at what access men have? I know probably some of it is in the primary health sector and it might not be mapped, but is that true or is it a myth that men do not access health care as well? And if that is true, what programs have we tailored to try and target men to make sure that they are addressing health issues, be it male-specific things or just generic health preventive measures.

Dr Kelly: Thank you for your question, Mr Hanson. I cannot say too much from ACT data; we do not have anything specific for here. Your forum may well have been during Men's Health Week, which was recently, and there was a similar forum in Sydney, as I understand it. There is a group at the University of Western Sydney that are looking at this issue. They believe it is a myth—that it is not men waiting to go until the last minute. Their view, based on their own research, presumably in New South Wales, is that it is about making the health system and places of health care men-friendly. It is not so much the men themselves that are delaying; it is that perhaps, for some reason, they are not feeling as welcome as women are. There has been a lot of work to make women feel happy and have good women's health programs, and they need to continue, but I think it is something you have brought up—that we should consider what we are doing here.

MR HANSON: It is a good point you make, one which was put to me by a men's group: men are told all the time to go to the GP, to go and see a GP; they turn up there and the only picture of a man is a sort of white ribbon thing that looks like punching a woman. Do you know what I mean? Most of the health promotion material is about women and children. The only picture of a man often is a very negative one. They will go into these places and there is a whole bunch of *Woman's Day* and a picture that is a very negative image of a man—as opposed to "Make sure that your children are immunised". Normally it is a mother with a child and so on.

Dr Kelly: Yes, and there are good reasons for that historically, and still those sorts of emphases are important. But we do need to look at that issue. Men do die earlier, but we have made gains, and in fact continue to make more gains in men's life expectancy over time than we do with women. Women are fairly static, but at a very high level—the highest in the country, one of the highest in the world. Men are catching up. But there are certainly issues. We are all ageing, as we previously identified.

MR COE: You faster than me, gentlemen.

THE CHAIR: Obviously you look at the results and coordinate with the federal planning when it was happening. It was not just that there was a spanner in the works; they probably have the men's health checks through the men's sheds.

Dr Kelly: Yes.

THE CHAIR: I know that is a federal program, but is it something you keep an interest in?

Dr Kelly: It is a federal program and it is run mostly through general practice so, as the minister and Dr Brown have pointed out, it is not exactly our thing. But we do have close links with Medicare local and increasingly positive links in relation to all sorts of things, so we would certainly look at it. We are interested in it at a population level. If you look at the risk factors for various things, men usually do worse. There are higher rates of obesity and overweight in men, for example. Smoking rates are still higher in men. There are all these things that we need to consider.

MR HARGREAVES: We are basically a bunch of risk takers, Dr Kelly.

Dr Kelly: Yes. Risky alcohol use in young males is another issue. And injury in males—road traffic injury included.

MR HARGREAVES: Do you find in terms of the promotion of men's health awareness that there is a difference from practice to practice—each GP practice will have a different emphasis on their particular clientele. I know in my own there is plenty of material around on men's health—about heart attack, about smoking, about drinking, about obesity. There is plenty of that on show. Do you find that there is a difference between various general practices as to how much they project the differences between women's health and men's health?

Dr Kelly: I do not think I can really comment on that, but it is a good point that you have made.

THE CHAIR: I have just got a quick question on the aged care and rehab service at Kambah. There was the evaluation that was done last year. I think it still found that there were some transport-related issues there. It has been probably about six months since the evaluation. Have those transport issues been dealt with or are there still some issues there?

Ms Kohlhagen: There are still some people who raise concerns with the location of Village Creek, and concerns with transport as well. We continue to try and work with ACTION around what we can do to remediate those.

THE CHAIR: What has been that work? What have you been doing with ACTION?

Ms Kohlhagen: There have been discussions with ACTION that my colleagues have had as well to see if they can reconsider decisions that they have made around the bus

routes et cetera, which to date have not changed.

THE CHAIR: They have not changed them; there is no resolution on that?

Mr Thompson: It is worth emphasising that the feedback from ACTION was that the particular preference of a lot of people is to have a bus stop directly outside the front door. The feedback we have consistently got from ACTION is that the width of the road at Kingsmill Street is not sufficient to allow a bus safely to travel up and down as part of a routine bus route. That is the reason. And yes; we are continuing discussions with ACTION in relation to that.

The other major activity that we are undertaking is looking at whether we can better align community transport and appointment processes at the centre so that where people need community transport they can get their appointment booked and the transport booked largely simultaneously so that both will opt in at the same time and there is not a problem about trying to coordinate it later.

MS HUNTER: Is this a standard-size road?

Mr Thompson: It is quite a narrow road.

MS HUNTER: It is not a standard-size road then?

Mr Thompson: ACTION buses do not go down every road in the territory. As I said, I am just reporting feedback from ACTION. I have no reason to disbelieve it.

Ms Gallagher: It is a fairly narrow road. Some streets are narrower than others in Canberra.

THE CHAIR: So with the community transport, trying to better align those appointments and times—is that working? Is that persisting? It is an issue for people.

Ms Kohlhagen: Yes. The research that we did on part of the evaluation found that the predominant means of transport to the centre is via private car. That continued pre and post the move. We certainly monitor the feedback that we get, both the complaints and recommendations, and areas for improvement. We do not receive those sorts of feedbacks—that there are concerns about being able to match the appointments with the various means of being able to travel to the centre.

THE CHAIR: So you have not received those concerns?

Ms Kohlhagen: We do; there are a small number, but not a huge number. It is more an individual case where we have to work with the client and the reception staff that we have talked to—our admin staff at the centre—to make sure that they ask questions when they are booking appointments, about having enough time and responsiveness. The types of service that are based at Village Creek are not acute, generally, so there is enough time to allow us to be able to make phone calls so that they can be booked concurrently.

MR HARGREAVES: I was just reflecting on some of the things you were talking

about with community bus access. I can recall that way back there was a bus service that used to go and pick people up and bring them to the rehabilitation service, whether it was at Woden Valley hospital or elsewhere, and a taxi service as well. Presumably those days are long gone.

Ms Kohlhagen: I would believe so, yes.

MR HARGREAVES: I do remember that in fact it was the Liberal government that got rid of that. I just wondered whether or not there was any type of reincarnation other than that community bus service that you have.

Ms Kohlhagen: Not at this point in time, no.

MS HUNTER: Yes, I want to go to budget paper No 3, page 113, where it talks about the enhanced counselling and volunteer services. That is $50,000 that is being allocated over the next three years, and it is for A Gender Agenda, which is very pleasing to see.

Ms Gallagher: Yes.

MS HUNTER: Minister, along with Ms Bresnan, we were both at the launch of A Gender Agenda in their new place. I think the Chief Police Officer was there as well. But we had the human rights commissioner; she was launching and talking about the issue around health services, particularly for transgender people accessing health services, and saying that there were a lot that were not and there were some issues that probably needed to be addressed. Has any further work been done on that or have there been any further discussions with A Gender Agenda?

Ms Gallagher: There have certainly been discussions with A Gender Agenda, which has led to some of this money and the money that has been put aside in the mental health growth funds to give them capacity to advocate and provide advice to us on ways that the service can be improved to support people that use it or that are members of A Gender Agenda and their community. I think that is what this budget is trying to do. They have not had any ongoing funding in the past. They have had some health promotions funding, a relatively small amount of money. The view that we have taken in this budget—I think there is some money for them in another part of the budget; I am not sure—was about trying to give them the capacity they need to basically take that work forward. I am not sure it is work that can necessarily be done without them advising us.

MS HUNTER: Yes.

Ms Gallagher: They have not had that organisational capacity. I have seen an email from the president about the fact that they will now be able to start some of this and recruit a person to take that work on.

MR SMYTH: I am not sure what category this issue fits into. I am referring to the national registration scheme for paramedics that is being run by the WA Department of Health. I understand that ACT Health is doing liaison work. What is the status of that consultation and what is the progress towards the national scheme of registration?

Mr Thompson: We are organising it. We have not got the exact dates of the consultation to hand, but we have identified the membership and the stakeholders we will be consulting. The issues are based on the documentation that has been produced by Western Australia. I would be happy to give you further details of the exact timing of it.

MR SMYTH: If you take that on notice, that is fine. Paramedics Australia are concerned with the lack of consultation and the short time frames. Have those concerns been raised with you, minister, and are you willing to act on them?

Ms Gallagher: No. Indeed, I have been discussing this with the paramedics for some time now. This is not something that has come out of the blue. The paramedics wanted to be included in the original professions that were registered. When they were not, they tried to get their profession registered in subsequent rounds. I can tell you that there is support for it from some jurisdictions and not others. So it is going to be problematic, I think, to move forward. But my feedback here from the TWU and the paramedics themselves is that they are very supportive of moving into the national registration scheme.

MR SMYTH: Have you met with the local representative—

Ms Gallagher: Yes.

MR SMYTH: of Paramedics Australia?

Ms Gallagher: No, not with Paramedics; just local paramedics I have met with.

MR SMYTH: Yes.

Ms Gallagher: But not under the umbrella of Paramedics Australia.

MR SMYTH: If they approach you, will you meet them—

Ms Gallagher: Sure. I and my office do this. Look, we do it with the social workers and others that come through wanting registration as well.

MR SMYTH: Mr Thompson, you will provide the details of what is about to happen?

Mr Thompson: Yes.

MR SMYTH: Thank you.

THE CHAIR: Just on that, the social workers are another group. Do we know what is going to happen in terms of the other groups that will be incorporated into the next—

Ms Gallagher: We have incorporated another four into the original 10 that have come into the scheme.

THE CHAIR: Yes.

Ms Gallagher: The social workers—where are they up to?

Dr Brown: They are not.

Ms Gallagher: No, they are not. They are not part of that four, but they are still there.

Mr Thompson: Yes, and APRA is currently reviewing the sustainability of the current approach that is being taken, because obviously the proliferation of large numbers of professions would potentially make it a very difficult scheme to administer. So as it stands at the moment, there is no activity directly about registering new professions while there is a review. Obviously, the paramedics have their particular process, but APRA is looking more broadly at the processes to see what will be the best model for the future.

MR COE: I have a question about the Village Creek centre. It was formerly at Woden or Weston at the independent living centre—or aspects of it.

Ms Gallagher: No, the services were mainly from the Canberra Hospital that were relocated as part of the decanting.

MR COE: But I understand the—

Ms Gallagher: The independent living centre is at Weston, and it remains there.

MR COE: So the facility in Kambah, are you confident that the services provided by ACTION are—

Ms Gallagher: We have just done all that when you and Brendan were laughing at me saying there was a narrow road.

MR COE: Was that about Kambah, was it?

THE CHAIR: Yes, and I asked about ACTION, yes.

MR COE: Right, I apologise. Thank you.

THE CHAIR: That is all right.

MR HANSON: I have got a new question.

MR COE: That is a start.

MR HARGREAVES: We are all excited now.

MR HANSON: It is on the impact of the reduction by the federal government in the private health insurance rebate. Have you done any modelling as to whether that is going to cause people in Canberra either to get rid of their private health insurance or reduce their private health insurance? There are two aspects to this, I suppose: one is the hospital cover and if there are any implications there. The other is the other

stuff—physio, dental and so on—because that has an impact as well. Have you done the modelling?

Mr Thompson: We have looked at it in general terms. It is a very difficult area to model with any reliability, particularly in the ACT, because we have consistently the highest rates of private health insurance cover and relatively low usage, both within public hospitals and within the private hospital system, of health insurance.

The issue that that raises is that we know we already have a substantial number of people who have private health insurance who do not use it. So the question that, therefore, needs to be answered is whether or not the people who are dropping out are, in fact, in that cohort, and it will effectively have no impact, or whether the people dropping out will be some of the people who are currently using it. That is largely an unknowable thing, because we only know about who use services. We do not know about who does not use services. So our modelling methodology would be incredibly complex and time consuming to try to address that.

MR HANSON: It has been put to me by a number of people that there is the hospital stuff, and you can understand that. But there are also the extras. The long-term consequence of it could be that people will drop their extras. I know anecdotally that a lot of people are. If you then go in for your knee operation and you do not have the full suite of rehab that you might otherwise have if you had private health insurance, the chance of your then needing an operation because your hip, or whatever it might be, goes shortly afterwards, will have a longer term-effect on preventative health. Have you given any thought to that? Do you need to make sure that we provide additional rehab services or other public health services to pick up the slack?

Ms Gallagher: I think all we can do, following on from Mr Thompson, is monitor any change to what we have already been seeing. But I have to say that when the 30 per cent rebate came in, there was not, to my understanding, any noticeable reduction in activity in the public health system. Indeed, whilst the 30 per cent rebate has been there, un-means tested activity in the public hospital has been growing and growing and growing.

I think it is incredibly difficult to model in any sense. We will keep an eye on it. We know that Canberrans use their public hospitals more than anyone else—I think second only to the Northern Territory. We have got our own unique characteristics about that. So we know that Canberrans have good access to the public health system. We know that we have got high levels of cover and low levels of use of it. So we are probably pretty well placed to actually monitor if there has been any change. But it is modelling the unknown which is hard.

MR HANSON: You are not going to do any surveys or anything like that to try and investigate—

Ms Gallagher: No. We have got enough to do managing the system that we have got.

MR HANSON: Sure, but I suppose if you are going to manage the system well, you need to actually know what the demand is going to be, do you not?

Ms Gallagher: We do our own demand projections. They are included in some of the work we have been doing. If we see any change—it might be unrelated to the rebate; it could be for something else—we will put that into the demand projections. They will still be done. They will not be done specifically around the means testing of this rebate.

MR HANSON: All right.

THE CHAIR: Are there any specific questions in relation to rehab, aged community care, early intervention prevention that anyone else has?

MR HANSON: I have got one on dental and waiting times. Is that this area?

THE CHAIR: Yes. Probably what we can do is come back after afternoon tea and go back to the—

Ms Gallagher: I have got a few questions that I could answer too that will save questions on notice towards afternoon tea time.

THE CHAIR: We can still ask questions about dental and the other, because that is acute as well. Unless you want to ask—

MR HANSON: We will come back to dental. If the minister wants to do those, I am happy to come back to dental.

Ms Gallagher: It will not take me that long if we are breaking at 3.30. It will just take a couple of minutes. I have got about five. Winnunga's funding is $1.548 million. The costings for the north side hospital can be found at the Health website under the consumer information section. In relation to hepatitis C cases, I just want to correct the record, because I am not sure if I am confused with some of the figures I have used. There have been 10 hepatitis C cases in AMC in the past three years—eight of those in prisoners who have contracted within the jail and then two who have been in and out of jail at the same time. I am not sure I made that clear. There has been no—

MR HANSON: Sorry, there are two that you can confirm?

Ms Gallagher: Two who could not. Of the 10, there are two who you could not definitely say had contracted it inside the AMC, because they have spent periods of time in the community within the screening period.

MR HANSON: Eight have just been in the jail?

Ms Gallagher: Yes. In the past 12 months, no patients have been referred or transferred interstate for treatment due to inability to access services at TCH for radiation oncology. Mr Hargreaves, in relation to your question around the Tuggeranong community health centre and they have secure parking, we need to correct the record. The lease facility does not have secure parking.

In relation to school nurses, the number of nurses supplied to the Education and Training Directorate and the school youth nurses program is four full-time equivalent

RN2s and one full-time equivalent RN3.2, which is a CNC level. That position works across the special schools as well. The locations are Campbell, Canberra, Calwell, Gold Creek, Telopea, Melba, Copeland, Amaroo and Kaleen high schools. In the special school nurse program, there are four full-time equivalent RN1 and the CNC, who I mentioned before, and the level 3.2. The locations are Black Mountain, Malkara and Cranleigh schools.

In respect of how many people who are ready for care and waiting for a place in the treatment program at the AMC in relation to hepatitis C, four people have been fully assess and waiting for a place on the program. Twelve people are currently being treated for hepatitis C. You can do that one, Peggy, I have not read it.

MR SMYTH: Before you go to Dr Brown, on the costings of the subacute facility, they have not been updated since those numbers were placed on the website.

Ms Gallagher: They will be, but when you were asking about a costing, I said that at this point that is the last costing that we have. We are doing some work now which will inform and update those costings.

MR SMYTH: So that is the latest you have?

Ms Gallagher: Yes.

Dr Brown: In relation to the HACC growth funding, the HACC growth funding from 2010-11 was allocated in November and December 2011. The 2011-12 growth funds were delayed as the ACT and the commonwealth had to agree on the age split of the client base. The growth funding based on this split will go out to each funded organisation. In the ACT 44 per cent of the 2011-12 growth funds allocated through indexation were paid in January 2012 after successful negotiation with the commonwealth on a higher ACT indexation rate.

The age split has been finalised. The planned growth will be submitted to the commonwealth minister and then the remaining growth funds will flow. I am advised that the transition year has caused significant delays in other states as well. For example, in New South Wales and Victoria growth indexation was only announced this month, compared to the ACT, which dealt with it in January of this year. Tasmania announced theirs in May.

THE CHAIR: I probably should have asked this earlier. With the indexation that we will have now with the change in arrangements, what is going to be the process around indexation? Will essentially the territory be responsible for their part and then the commonwealth for their part so we will not have this issue of going back and forth about indexation rates and the like?

Dr Brown: I think that is the likely outcome, but that is a detail that is yet to be confirmed.

Ms Gallagher: And one final one, sorry, Ms Bresnan. Ms Hunter asked whether the funding for the Nutrition Australia program on healthy school canteens was a grant. Funding is provided for it from the national partnership agreement that we have with

the commonwealth.

THE CHAIR: We might break early, given we have sort of come to a natural end with this. As I said, we will come back to the LHN, which takes in TCH as well. So we can ask questions again. So if there are questions you had from earlier, they can be asked here.

MR SMYTH: Does that come back, then, to the dental question?

THE CHAIR: Yes. So we will start back with the dental question.

Meeting adjourned from 3.25 to 3.48 pm.

THE CHAIR: Mr Hanson, you had a question on dental; we will go straight to you.

MR HANSON: Minister, is there any additional money for public dental services in the budget, and how are we going in terms of provision of dental health services and waiting times? There is about a 12-month wait, isn't there? And we come in under that or something? Can you give me bit of an update on that?

Ms Gallagher: We have a 12-month wait for non-urgent restorative dental care. All urgent patients are seen within 24 hours. Those targets are being met, but there is no doubt that there are areas of pressure in the dental service, just like every area of health. I think the biggest area of pressure to manage is the denture replacement part of the program. This is something we keep an eye on, in terms of what we can do. We do have the best dental times in the country—much better than most other jurisdictions—but it is still a 12-month wait. Some of that is around workforce capacity. We are opening new dental in Gungahlin, and there will be some moving around of the service because at the moment those people would be treated in Civic, probably, and Belconnen.

MR HANSON: It often strikes me, when I visit, that the equipment and the set-up look very good—

Ms Gallagher: Yes. The equipment is excellent; it has to be.

MR HANSON: but there are not very many chairs in use. How many full-time equivalent dentists have we got?

Dr Brown: We will just get that for you.

Ms Reid: We have got 10.7 FTE of dentists—13 actual bodies, as such.

MR HANSON: Is that enough? Do you have trouble recruiting?

Ms Reid: No. Actually, in the last few years we have had good recruitment right across dental for dentists and dental assistants. We have had good recruitment strategies and we have good retention.

MR HANSON: Good. That is all I really wanted to know, I suppose.

Ms Gallagher: There is some money that is in the budget papers that has come through the commonwealth budget, through the national partnership on a commonwealth dental program. That is about an extra million, rising to $2.5 million and then $1.9 million, on page 72.

THE CHAIR: I was going to ask if that is going to make a difference in funding. And what sort of areas will it target in dental health?

Dr Brown: We have not as yet done the work to confirm exactly how that funding will be expended and what the focus will be. The anticipation is that it may well assist us, though, in reducing that mean waiting time for restorative services.

THE CHAIR: On that, minister, you have stated in previous hearings that there were impediments to increasing the outputs in dental services even if more funds were injected. What did you mean by that?

Ms Gallagher: I think that was the advice in previous budgets. I think it was that we were reaching capacity within the organisation to deliver more than we were currently delivering. And with some of those, certainly a couple of years ago, there were issues around recruitment, which seems to be going a bit better these days. There are a couple of areas which I think we need to work with. Obviously this is money from the commonwealth. I think the biggest area of pressure is the denture program at the moment; we are seeing more people needing more work done in that area. I think that is the area we need to focus on.

THE CHAIR: If we do put more funding in, that will have an impact?

Ms Gallagher: I think more funding for dental in the future will have to encompass looking at roles—the use of dental assistants, and I think the private sector are already doing this pretty well—and some more delineation there within the roles. I think also of how vulnerable groups access the dental program—vulnerable groups within the population that use the dental program: for example, whether we need to look at how we target assistance in residential aged care, people who find it difficult to access the program in the setting. There are some ideas there.

THE CHAIR: I know one of the things that you have been doing—Mr Hanson and I went to the community health centre—is that dental hygienists are being employed. Is there any scope for that sort of role to do more in terms of some of that preventative stuff, around that?

Dr Brown: I think that is what the minister is indicating, in terms of looking at the various roles across the whole of the dental service.

THE CHAIR: So that would be one of them.

Dr Brown: That is right.

THE CHAIR: Would there be plans to perhaps employ more of those sorts of roles?

Ms Gallagher: I think that is certainly the future. If you look broadly across health care, delineation within certain professions and having specific roles along the spectrum of qualifications I think is going to be the answer. I do not think dental is any different. There are dental assistants; there are dental hygienists; there are dental therapists; there are dental technicians. I think there is probably a role for all of them.

THE CHAIR: There is a range, yes. And just one last question: I think I saw that in Victoria about 14 per cent of eligible adults use the public dental health service. Do we have any idea what the percentage would be in the ACT?

Ms Reid: No, but I can get that figure for you.

THE CHAIR: If you have it, that would be great. Would there be any concerns that, if more eligible patients, perhaps, came forward, we would not be able to deal with that number of people?

Ms Gallagher: I think so, yes.

Ms Reid: I guess so. Yes, it is always about demand on the service.

THE CHAIR: So you would be able to deal with the demand if more people came forward?

Ms Gallagher: If we got a lot more growth—maybe I misunderstood your question. I thought your question was: if we got a lot more people in, would we have trouble meeting the demand?

THE CHAIR: Yes, that was my question.

Ms Gallagher: I think the answer to that would be yes. And then we would have to look at how we managed that demand.

THE CHAIR: Mr Hargreaves?

MR HARGREAVES: Not at the moment.

THE CHAIR: Ms Hunter?

MS HUNTER: Are we onto the hospital stuff?

THE CHAIR: Yes.

MS HUNTER: I wanted to ask about the transition of people from hospital back home or back into the community. How many people are there in hospital at the moment who have been cleared for discharge but, because they have not got an ISP or arrangement sorted out, cannot leave hospital?

Ms Gallagher: So people with a disability?

MS HUNTER: This has been an issue over a few years and there will always be

some. I am just seeing how we are going with that.

Ms Kohlhagen: I am informed that there is just one person at this point in time.

MS HUNTER: How long has that person been in a position where they no longer require hospital care but have not been able to be discharged?

Ms Kohlhagen: It is a considerable time. I will just find the exact details. Probably since July 2010.

MS HUNTER: What are the ongoing issues there?

Ms Kohlhagen: I think you captured it. Again trying not to give away too much personal information, this requires both suitable accommodation and a support package. We have been working with our Community Services Directorate colleagues to find a public house that is appropriate and a support package as well.

MS HUNTER: And this has been going on for almost two years.

Dr Brown: I do not know that the individual has been ready to be discharged for the duration of that time. That is the duration of their admission.

MS HUNTER: Right.

Dr Brown: My understanding is that work is well progressed in terms of preparation for discharge of that person.

THE CHAIR: Mr Smyth.

MR SMYTH: I will defer to Mr Hanson.

MR HANSON: Are we into any area now?

THE CHAIR: Yes, as I said before the break.

MR HANSON: First of all, I have a question on staff. The strategic workforce plan was due to be released last October, from memory. I am not sure if that has been released, or what form it is in—whether that was a draft and we are waiting for a final and so on. But the intention to grow the staff by fairly big numbers—how are we going to go with that? The first thing I want to know is: where are the gaps now, what are we trying to grow the workforce by and where is that risk in growing?

Mr Thompson: The workforce discussion paper that you are talking about is just ready for release. One of the important features of what we are trying to do is to ensure alignment of the local workforce planning with the national workforce planning that is being led through Health Workforce Australia. The Health Workforce Australia strategic workforce plan for the country has been to and fro with health ministers a couple of times over that intervening period and has only recently been given approval by health ministers. We were timing the release of the discussion paper to ensure that there was alignment with the national work and the national plan.

The discussion paper itself does not address the detailed numerical analysis that you are talking about. The way that we are progressing, that predominantly actually is part of the health infrastructure program, because as we do demand projections for the health infrastructure program we also need to look at the staffing associated with that. What we are doing at the moment is doing it on a project by project basis. The longer term picture and the longer term projections overall for our workforce will be informed by the feedback we get on the discussion paper and the final workforce plan that comes out of that, and then the continuing modelling that we do through the health infrastructure program.

MR HANSON: Where are the problem areas at the moment in terms of staff?

Mr Thompson: Interestingly, the medical workforce supply has eased as a pressure area over recent years and the increase—

MR HANSON: Do you think the school here locally has helped?

Mr Thompson: Yes, there is no question about that. The availability of local graduates, as well as the kudos, for want of a better word, or the critical mass that is created by having a medical school for more senior staff, is an attractor. The local graduates are now coming into the system in increasing numbers. The situation for medical staffing has improved over recent years. We have had some recent improvements as well in nursing recruitment. That is evidenced by reduced rates of agency nursing and nursing overtime that we currently have within our hospital.

The main areas of pressure fall down to particular specialist areas. There will be some allied health professions with smaller numbers that we will have difficulty recruiting to and some medical specialties as well. You have heard earlier today about geriatrics. There remain a couple of areas where we have got localised recruitment problems but, on a global basis, our overall staffing availability is looking better than it has in recent years.

Dr Brown: There are some scientific staff as well, though—environmental health officers, for example.

MR HANSON: Have you looked at how big—when the infrastructure program is complete and there has been an expansion of Calvary and there are the community health centres and the subacute hospital—the Health Directorate is going to be just in its staff profile? Have you done some gross numbers on that? The budgetary implications, I imagine, would be pretty extraordinary.

Ms Gallagher: If you look at this year's budget, it has got the funds; all the funds provided are essentially staff. There is, I think, funding for about 150 extra staff. Some of that will be offset slightly with the savings target, but there will be 150 new staff coming in. We have been doing that every year for the last five years at least. The figures I saw were incredible in terms of the number of doctors and nurses that have been employed over, say, the last five years. We have had significant growth, and that is what is going to have to continue.

MR HANSON: Do you see that growth line as reasonably stable, going up, or is it a bit of a bell curve going up towards the end as we deliver infrastructure programs?

Dr Brown: Even though we may build new hospitals et cetera, we are not going to open them all at once. It is an incremental process in terms of opening the beds that are required to meet the growth of demand year on year. There will continue to be an incremental growth in staffing as well.

MR HANSON: This discussion paper—I thought it was going to be a strategic workforce plan but now you are calling it a discussion paper.

Mr Thompson: It is a discussion paper to inform the final plan.

MR HANSON: The final plan was due in October last year.

Mr Thompson: The discussion paper was due in late October, yes.

MR HANSON: The discussion paper was due in October. This discussion paper and so forth will be released publicly, will it? We will get a copy?

Ms Gallagher: Yes. It is up today, I think.

MR HANSON: It is online now, is it?

Ms Gallagher: Yes.

MR HANSON: I will go looking for it.

MR HARGREAVES: Can I take us back to a public health issue? One of my favourite restaurants got a red notice out the front. It did not impress me at all, actually. I was wondering if we could have a bit of a discussion around this activity that has hit the newspapers recently around the food inspection in these restaurants. The stories that have hit the *Canberra Times* have been pretty graphic and could quite clearly justify some sort of action. I imagine the public would be quite keen to see this sort of information going forward.

I was wondering whether you have had any feedback from the general public. Can you give us some indication of why you had to go to this really strong measure in the first place perhaps? I know that there is the restaurant game but there is also the club industry. I notice that ClubsACT were not all that pleased recently. I was wondering whether any clubs have copped a red notice on their door.

Ms Gallagher: There was one club where we had some work done with the death cap mushroom issue. That was separate. It was related but not related to necessarily normal operations at that time. This has had a lot of coverage in the press. I have certainly had a look at it whenever I have had a restaurant complain to me. Some of them have complained to me that they feel that perhaps it has been the result of some overzealous activity and they were closed down for minor issues. We have had a look at it.

I would say to begin with that many of the actions that have been taken—and these are the ones that have been shut—were either related to complaints from the public or were a result of investigations around some food-borne illnesses that were presented to either GPs or the hospital. It is not as if we have got vigilantes out there just trumping in and shutting places down. John Woollard can go the detail of this; he knows it better than I perhaps. Quite a number of the restaurants closed would have had visits prior to the action being taken.

John might have some photos, just to give you an idea of what has been found in some of the restaurants. I have heard it said a lot: "It was a cracked tile"—or something equal to that—"that resulted in my restaurant shutting down." From looking at the photos, and I do ask for the photos when I hear that someone has been shut down, that is not what you will necessarily see in the photos. Do you want to add to that, John?

MR HARGREAVES: In the answer, John, for the benefit of the committee, could you let us know what the inspection regime is in the lead-up to that point? I know, from my own experience with health promotion in years gone by, what kind of lead-up you have, but I am not sure my fellow committee members do. I think one of the scary numbers that I read in the *Canberra Times* was that there was something like 80,000 instances of food-borne illness. I would imagine that half of that would be people not washing their bench after chopping up chicken rather than actually going to a restaurant. Can you give us some sort of idea of the scale around that?

Mr Woollard: I will try to cover all of that.

Ms Gallagher: Everyone is going to have crackers for dinner tonight, aren't they? Crackers and water.

THE CHAIR: Dry toast, I think.

MR HARGREAVES: This looks very much like that cream of mushroom soup that I had.

Mr Woollard: They are all de-identified. You will not be able to identify where they are. I thought the photos were useful in case we did get onto this topic. It is somewhat frustrating, particularly for my staff who are out there at the frontline doing this—often getting threatened with violence; certainly getting verbalised—to hear people in the media, sometimes high profile people, saying that we close businesses on a whim. I think I heard one saying: "The inspector has a bad day and at the end of the day he shuts a business down. Cracked tiles." That is a nonsense. We have never and will never close a business down for something as minor as a cracked tile.

We have issued so far this year 16 prohibition orders. We have also issued something like 130 or 140 improvement notices. To give you an idea, an improvement notice is for the more minor things that we see in a business. A prohibition order is when we have a dangerous situation, where the business has been run in such a way that it constitutes an immediate risk to the public and therefore requires closing. To answer your question, improvement notices are almost the first cab off the rank. When we go to a business and find problems, we will issue an improvement notice to advise

businesses that they should improve their game, in whatever way. Then the next line of defence is a prohibition order.

Sometimes, however, we go to a place that we may not have been to for a year or two, or six months or seven months—whatever period of time—and the place is so bad that it requires a closure straightaway, and we do that. But often we have had multiple inspections and multiple improvement notices. There was one recently where we had served three improvement notices over a two-year period. We went there again and they had the same circumstances reappear, so we closed the business down.

MR HARGREAVES: To cut to the chase, is there a particular type of restaurant which attracts this?

Mr Woollard: I will come to that in just a minute. One thing I wanted to add to that was that we are also now seeing, from last year, a number of prosecutions coming through. I think we have had eight prosecutions this year to date, all of which have been successful. The courts are actually finding in our favour that the prohibition orders were warranted and have given in some circumstances quite significant penalties to the food proprietors. What was your question?

MR HARGREAVES: Is there any particular style of restaurant that seems to be more—

Mr Woollard: In the last half of 2010 it became apparent to me that we were seeing an increase in the number of prohibition orders or serious breaches. We ran into the early part of 2011 and it became apparent that there was an over-representation of businesses that were selling Asian-style foods. I am not sure that we are still seeing that bias in there; perhaps a little bit. There is something happening in and around the Asian-style food businesses. But there are a lot of other businesses that are also allowing their standards to slip to dangerous levels.

MR HARGREAVES: How many premises are there? How many would you inspect in a year and how many inspectors do you have doing it?

Mr Woollard: There are about 2½ thousand food businesses in the ACT. It depends on the year and it depends on a whole lot of circumstances. At the moment, because we are seeing so many breaches and we have such a heavy enforcement workload, that cuts into our capacity to conduct inspections. Inspections range from about 1,600, 1,700 inspections a year, up to, I think, one year we hit about 2,200 inspections. It is in that ballpark.

MR HARGREAVES: We had some push back against the notion that you might like to put a star rating on the front of the premises saying whether they are really, really super clean or whether they are borderline.

Mr Woollard: We did some extensive consultation late last year with the community and industry. We put out a consultation paper and ran seven focus groups with businesses and industry in August-September last year. They were run by KPMG. We engaged KPMG to undertake that work for us. They produced a regulatory impact statement, which is now on our website, to look at a grading scheme for food safety.

The grading scheme that you have outlined is a scheme that allows transparency for the community. It allows the community to see how well a business is going in terms of food safety. It gives a grading that everybody can read. There are a lot of different types of systems out there that can be used. International experience shows that that is a really good way to increase compliance. Places like New York State went from a compliance rate of 20 per cent to about 80 per cent when they brought the system in. Places like Toronto saw a corresponding decrease in hospitalisations from food-borne illness when they brought their system in. So there is strong evidence that they are a suitable system.

We are at the moment looking at the independent RIS done by KPMG. We will provide a report to the minister on what that RIS says and what it might mean. Ultimately the government will make a decision on whether that is the way we should go in the ACT.

MR HARGREAVES: One final question, if I may, and then I will go away. What sort of community feedback have you had on it?

Mr Woollard: It is hard to gauge community feedback. If I had to try and put my finger on it, I would say that the community broadly wants to see a level of transparency so they can see the businesses—not just the ones that are not complying but also those that are complying well; the idea being, of course, that at the moment, by putting a closure notice up, people can see the bad end of town but they cannot necessarily see which businesses are performing. One of the things the overseas experience shows with the grading systems is that the customers tend to reward those businesses that are providing good food safety standards.

I think the community want to see that transparency. I think that they are broadly supportive of our closures, where it is warranted and where is it appropriate. I think there is perhaps a little bit of confusion out there. I think the water has been muddied by people suggesting that we are closing businesses for cracked tiles or very minor issues, which is just nonsense.

MS HUNTER: Have we seen any correlation between fewer people turning up at the hospital or seeking—

Mr Woollard: No, not yet. We are still seeing a significant problem in a small part of the food industry. I need to say that most of the food industry is very, very good, but there is this relatively small but troublesome sector of the industry that seems to either not understand food safety or not care. In response to some of those concerns, we are actually in the process of finalising a translation of a lot of our food safety information into 11 languages. There are two Chinese languages, so I guess it is 10 languages. We have completed a lot of that work. We are just finalising the last few of our posters.

We are just also translating a food safety guide to try and assist with those businesses who may not have English as their first language. At the moment we are just trying to put some time and effort into making resources available in a lot of languages to help. We will see how that goes in terms of boosting compliance. I think there are issues around people not necessarily understanding food safety standards. But there are

certainly businesses out there who do understand and just do not want to do it.

THE CHAIR: I have a new question. It is in relation to the Calvary network agreement. In estimates last year my colleague Ms Le Couteur asked a question about the surplus of, I think, $4.83 million that Calvary Health Care made in the financial year which ended 30 June 2010. She was advised at the time that none of this surplus related to the public hospital. We noted that section 9.1(b) of the 2011 Calvary network agreement states:

> … allows Calvary to retain any surplus funding if it delivers any Services for less than the amount allowed under the Funding Model or relevant Performance Plan …

I am just wondering if I could get some clarification if that is still a part of the new arrangement or how that actually works.

Mr Thompson: The section 9 that you are referring to is about a new funding model to be developed within a three-year period after the commencement of the network agreement in line with the national activity-based funding arrangements. In the national arrangements, while we are now tracking activity against a national framework, the funding is still essentially the same, essentially based on the same block funding that we have had previously. Consequently, what you will see in the agreement, in section 8 of the agreement, is reference to an interim funding model. That is the funding model that we are using and will continue to use until such time as we agree the new funding model which is referred to in section 9.

THE CHAIR: So that sort of arrangement is simply the activity-based funding?

Mr Thompson: Yes.

THE CHAIR: So as you said, they will get the funding as per particular activities and deliverables. How does that work if they do actually deliver for less? What then happens in practicality? I probably have not said that quite right.

Mr Thompson: It is theoretical and it is probably not worth speculating at this point. We have three years—now two years and nine months—to develop this funding model.

THE CHAIR: I will come back to you. Mr Smyth?

MR SMYTH: I will defer to Mr Hanson.

THE CHAIR: Mr Hanson? Mr Coe? No?

MR HANSON: Is it down to me?

THE CHAIR: Yes, or whoever you would like to ask a question.

MR HANSON: In budget paper 4, page 77, there is $70,000 for the installation of the MRI. Is this the machine that we have had trouble with—the $10 million machine that

does not work very often?

Ms Gallagher: Where are you talking about, Mr Hanson?

MR HANSON: Budget paper 4, page 77, from my notes.

MR SMYTH: Yes. In "Capital upgrades", "Works associated with the installation of an MRI".

MR HANSON: That would be it.

MR SMYTH: At the bottom of the section: $70,000 financed in 2012-13.

MR HANSON: I am just wondering what that is, because I know that we have had this MRI that has not been used much and has cost $10 million.

Ms Gallagher: It has been used. If you are referring to the neuro, I do not believe that is the neuro suite.

MR HANSON: I just do not know what it is.

Ms Gallagher: We have a few MRIs. We will take it on notice. In relation to the neuro suite—

MR HANSON: How many times has it been used?

Ms Gallagher: Since January this year, I think the figure I saw was 105 times.

THE CHAIR: Anything further?

MR HANSON: Not on that one. I will just take that on notice for the $70,000—what that is.

THE CHAIR: Do you have another question?

MR HANSON: I do. It is on budget paper 3, page 113, or it might be 112: expansion of Canberra Hospital's emergency department—the six additional emergency department cubicles, four cardiac assessment beds, and four nurse-led treatment spaces. When is that going to be up and running?

Dr Brown: They will be delivered at different parts of the 2012-13 year. My understanding is that the four are likely to be in the early part of the financial year and the remaining six will likely be in June 2013.

Ms Gallagher: It has got a half-year effect in the first year of the funding of that to reflect that, as you can see.

MR HANSON: So they are just going into the current space there, are they? There is room? Or where do they go?

Mr Thompson: There are two different parts to that. The four nurse-led cubicles are within the internal space of the existing building fabric, with some reorganisation of the space. The six extra are simply going to be a clip-on building to the side that will increase the overall space available within the ED.

MR HANSON: What is a nurse-led treatment space?

Mr Thompson: It refers to the style of care. The purpose there is for people with relatively minor and straightforward conditions who can be seen quickly. They can be seen within a nurse-led model of care in that particular treatment space and be in and out of the ED fairly rapidly.

MR HANSON: So in terms of treatment, how does it differ from the nurse-led walk-in clinic? Is it more like the threes and fours rather than the fours and fives type mix?

Mr Thompson: It is not as simple as that, because triage categorisation is an urgency categorisation and not necessarily a severity or complexity classification. The primary difference is that within the emergency department all care is provided under the supervision of the specialist doctors within the emergency department, and they have the capacity, with protocols, to delegate certain care to different staff within the emergency department. But it is within the medical model, and with the medical oversight, which is different from the walk-in centre, which is actually a nurse-led model of care.

MR HANSON: And will this lead to the creation of more nurse practitioner places?

Mr Thompson: Not necessarily, no.

MR HANSON: So they are standard emergency triage nurses?

Dr Brown: Yes. Nurse practitioners operate autonomously, whereas the model that has been described, I think, is still looking at under medical supervision.

THE CHAIR: I have got another question in relation to something we asked about last year, and I asked about it in annual reports, about the staff entitlements at Calvary Public Hospital. In the hearing last year, it was stated that those financial statements—that should the public hospital cease to operate, the ACT government would cover the outstanding employee entitlements. In response to that question, you advised that you were taking legal advice on the matter. I think we talked about that again in annual reports. Again, in the Calvary network agreement, section 27, which deals with the consequences of terminating the agreement, states that upon termination:

> … the Territory will …
>
> (A) take responsibility for, and become the employer of, the Public Hospital Employees …
>
> (B) assume responsibility for the Public Hospital Employee Entitlements and any redundancy payments for the Public Hospital Employees;
>
> (C) assume the rights and liabilities under each Contract …

From that, can we assume that, with that issue now, the ACT has just assumed—no?

Mr Thompson: No, it is not as simple as that, unfortunately. That reference is predominantly acknowledgement of the fact that the staff employed by the public hospital at Calvary are public servants and therefore are territory employees.

THE CHAIR: Yes, I understand that.

Mr Thompson: Those clauses are in there to give certainty to all the territory's employees that, should Calvary cease to operate the hospital, they will continue to be territory employees and continue to have the rights associated with it. That is the primary purpose behind those provisions.

The question of whether or not there is an outstanding liability or an outstanding amount of money that the territory owes to Calvary in relation to accrued staff entitlements to date is still the subject of discussion. Calvary have not to date provided the detailed information that we have requested to demonstrate the basis of their claim—not surprisingly, given that they have said in their statement that they are seeking additional territory funding of some millions of dollars. It is something that we believe we should have detailed substantiation of, and we are continuing to discuss that with them.

THE CHAIR: As I said, I did ask about that in annual reports. The thing you said then was that you are still waiting on the information from them. So that is still at that same point?

Mr Thompson: It is something we discuss regularly with them, but they have not yet provided that information to us.

THE CHAIR: It was not something that was discussed in developing the network agreement?

Ms Gallagher: Yes, it was.

THE CHAIR: It was?

Mr Thompson: It was, absolutely, yes.

THE CHAIR: But unresolved.

Ms Gallagher: I must say, whilst there was not a sense of urgency attached to perhaps that issue—I am not saying that to demean it; it is just that it is only going to become a real problem if everybody wanted to separate from Calvary at the same time, which is very unlikely to happen. The priority for the last few months has been to get all those other agreements in place that will guide a whole range of future decisions. But it is there, and in a sense nobody has moved from their positions yet until we get some further information.

THE CHAIR: Just remind me: what is the information you are waiting on from

Calvary? Sorry, I cannot recall that.

Mr Thompson: It is the detailed financial information to support the dollar amount that they are requesting from us.

MR SMYTH: I would like to ask a question of Mr Martin; he has done remarkably well today.

MS HUNTER: I know; incredibly well.

MR SMYTH: I think he has been there about nine hours and he has not said a single word. Mr Foster will be very upset if you get away with not answering a question.

Dr Brown: He is not well, Mr Smyth; I think you need to take pity on him.

MR SMYTH: He is not well? If he is not well, what is he doing here?

MR HANSON: Is there a doctor around?

Dr Brown: Dedication, and I am holding his hand.

MR HARGREAVES: It took a long time for that one to come out, didn't it?

MR HANSON: In budget paper 3, page 111, hospital in the home, increased demand for acute services, there are 15 additional hospital in the home beds, 10 at TCH and five at Calvary. How much are those beds costing? Of that $7 million or $8 million a year, I am just trying to get a breakdown of the costs. Is it the same cost for a hospital in the home bed in Calvary as it is in TCH?

Dr Brown: The model of care that they are operating is currently not the same at Calvary and TCH. I do not have the individual costings for the two hospitals in my briefing notes. We will have to take that on notice.

MR HANSON: Could you? I just want to know if there is a differential and what it is. What do 10 hospital in the home beds cost? What component of that $7 million or $8 million is it and, if one is more expensive than the other, what is the difference?

Ms Gallagher: It would be the scope of the care.

MR HANSON: I suppose so, yes. I am assuming it is because there is a different model of care; that that is the difference in price.

Ms Gallagher: Or a different nature of patient.

MR HANSON: Yes, perhaps. Anyway, whatever the answer is, I just want to know what the amounts are and what the difference is.

Ms Gallagher: In a general sense I think we can certainly provide that. We do not usually disclose individual details of particular elements of the agreement with Calvary, because it is negotiated as a package with them. But I think we will be able

to provide you in a general sense with an outline of the costs.

MR HANSON: Yes. And if you are limited in what you can do with Calvary then provide us more specific information for TCH. I am just curious about what the cost of it is comparative to a normal hospital bed.

THE CHAIR: So that is taken on notice.

MR HANSON: In budget paper 4, page 58, strategic indicator 3, the bed occupancy rate has gone up, I think, from previous years.

Ms Gallagher: It may have gone up marginally from the year before, which I think was about 87 per cent, from memory, but it is well below where it was in 2005-06, which was at 97 per cent. There is a little bit more room. We do not want it below 85 per cent, because that would indicate we were not using our beds as efficiently as they could be used. But overall with the level of activity in the hospital and where the bed occupancy has been in the past I think 89 per cent is a good result. But we would prefer to see it sitting around 85 per cent.

MR HANSON: Yes. Based on the fact that it is an increase from last year, is there any concern that there is a growth and we are going to see that go up to 92 per cent; that we are creeping back? Are you comfortable that it is going to stay in that band of 87 to 89 per cent?

Dr Brown: We are bringing on those additional 40 beds that I mentioned earlier; that will help to address the demand and therefore the occupancy.

Ms Gallagher: That is the single biggest response to bed occupancy, although you open more beds and they are full in a second; that is the experience.

THE CHAIR: I will just ask my usual question about the Medicare rebate for midwives. You were probably waiting for me to ask that.

Ms Gallagher: We have a special brief just for you on that one.

THE CHAIR: Excellent. I thought so. So has there been any progress made on that particular issue? I know I have asked about it a few times, but it is still relevant. I am just wondering if the processes are in place as yet.

MR HANSON: We had fun at the midwife oration, didn't we, Amanda?

THE CHAIR: We did. You were the only male there.

MR HANSON: I noticed.

Ms Gallagher: There has been some work done. Liz Chatham is probably the best placed to go through that, because she has been leading that work within the Health Directorate.

Ms Chatham: We are actually moving with some progress with this. There are a

couple of parallel processes that are happening at once. One is that there is a need to change some type of legislation that is currently in the ACT and that I believe is waiting to go through, so nothing really can progress. But it does not mean we cannot work on the other elements. The other elements are working with any of the private eligible midwives in our community who would like to use this opportunity to get the Medicare rebate for their clients, particularly in the home birth setting.

We still have the insurance thing, as you know, going on, but that is separate and being managed by the commonwealth. The sticking point for the particular private midwife that uses our service mainly, and I think for all the private midwives I can see, is that you must have a collaborative arrangement with medical staff. That has been very difficult for her to establish. I have recently met with her and with the Calvary director of midwifery services and offered to assist her, to provide opportunities for her to meet with the medical staff, to present her model and to provide forums where they can actually start talking to and knowing each other, so that there is more chance that that collaborative relationship will develop.

THE CHAIR: So do you think we will actually get to the point where they can access that medical professional who will essentially do the sign-off for that to happen? Is that what you mean by doing that collaboration, so that that relationship can develop and that can be facilitated?

Ms Chatham: Yes. There is some hesitancy from the clinicians at the hospital to join in collaborative practice, and I think that reflects what is happening in the private practice sector as well. So I have offered to the midwives involved to put them to network with her and to create opportunities where she can meet the clinicians so they can talk about the model of care and build some relationships so that they can from that point possibly form a collaborative relationship that would work for her.

THE CHAIR: Has there been the same problem in other states and territories?

Ms Chatham: Yes. The take-up has been very low.

THE CHAIR: I know different states are doing different things in this field, but—

Ms Chatham: In this particular model there are hybrid approaches in different jurisdictions and there are some very good private models happening, which are working well, particularly in Queensland, in Toowoomba. But the actual public hospital work is very slow and mainly is getting caught up between a midwifery and a medical paradigm. I have committed with Calvary to work with her to assist her in breaking that paradigm down, or enabling it to happen.

THE CHAIR: The fact that there has been this reluctance will not have an impact on that Medicare rebate standing? I know that is a federal issue, but you do not think that will—

Ms Chatham: I do not know. It is very interesting, isn't it? I do not know what the commonwealth were thinking, whether they did not want this to go very well or—

THE CHAIR: Maybe.

Ms Chatham: did not want to spend much money or whether they were just a bit naive on some of the entrenched views. From the discussions I have had with the commonwealth, it is uncapped and they are happy to pay as much as they can possibly pay, so I think probably they are in good faith hoping that this works. I think there are long-term cultural issues that are problematic, that will take many years. It really comes down to a trusting relationship between not just one medical officer and one midwife; you need to have a team, because you cannot just rely on a single provider to be your only collaborative partner, in case they leave or cannot come to the birth. You need a whole system of collaboration wrapped around the midwife.

THE CHAIR: Yes, thank you. Mr Hargreaves, you had a question?

MR HARGREAVES: I want to ask a question about the cardiac rehab program, to which I owe my sustained longevity and which are very close to my heart. If it was not for them, my chances of getting to the ripe old age I am now would have been diminished, so sorry about that, Mr Hanson.

MR HANSON: You're very good for us, mate.

MR HARGREAVES: I actually launched on your behalf, Chief Minister—

MR HANSON: You're probably the best thing that has happened to us politically in a long time.

THE CHAIR: Okay, the question, please.

MR HARGREAVES: I wish fishing was this easy. Chief Minister—

MR HANSON: You'll have plenty of time to practise, shortly, mate.

MR HARGREAVES: I launched on your behalf a new training program at the cardiac rehabilitation section. It was received particularly well and it was very heavily involved in by the clients over there. I was wondering how it is going; whether or not it is ticking along nicely, whether you have had any feedback on it.

Ms O'Donnell: We have had great feedback from the service, as you know. It has now been funded to continue on through the next financial year.

MR HARGREAVES: Fantastic.

Ms O'Donnell: Essentially, as you know, it is a separate service that is particularly for rehabilitation for people with heart failure as opposed to the previous service that was actually dedicated specifically to those post myocardial infarct as such. They are two separate types of groups and we have been able to be very specific about the type of rehab that is more inclined towards people with chronic heart failure.

MR HARGREAVES: I noticed when I was talking to some of the people there, and particularly some of the medical nursing staff, that a lot of the people that are coming in there had had a heart attack because of smoking in the past; they smoked for 20

years and it had blocked their arteries. We all know about that. But they were a bit alarmed at the number of people who were coming back for a second bite at the cherry because they did not give up smoking after they had the first one. Have you got any numbers or stats on those kinds of return visits?

Ms O'Donnell: Not that I can give you at the moment, but certainly I can take that on notice.

THE CHAIR: That is taken on notice.

MR HARGREAVES: I would be interested. You may have anecdotal evidence on it. You may have nothing, and that would be fine. I just do not know whether or not people out there in the community understand the components of the cardiac rehab program other than just a gym—the lectures that go with it, the nutritional advice, the fact that you are almost stand-up start to go through a period of depression afterwards and how you handle that. As a survivor of that whole system, having looked down the face of the black dog and told him to go and join the Liberal Party, I just wonder how we can get the message out to people that it is there, it is a good service, other than waiting for them to have a heart episode.

Ms O'Donnell: Can I just clarify what your question is?

MR HARGREAVES: Sure. How can you get the message out there?

MR HANSON: Yes, we feel your pain.

MR HARGREAVES: You should be careful what you wish for, Mr Hanson.

THE CHAIR: Mr Hargreaves, the question.

MR HARGREAVES: I ran into a fellow recently who had been into the hospital and had had a heart episode but he was not aware of the cardiac rehab program. I told him to get his backside back in there and talk to the nursing staff in the hospital so that he could actually do it. I just wonder how much we can actually be telling people out there in the community about that particular program and about heart issues. We tell them not to smoke; we tell them not to be obese. We tell them to watch their exercise program. Do we tell them how they can actually use that CRP to change their lifestyle and prevent it from happening again? I do not think we do. How do we do it?

Ms O'Donnell: I cannot give you the specifics of that, but certainly I can take that on notice and give you some more information.

MR HARGREAVES: Thank you.

Ms O'Donnell: One added point is that the service is going very well, and it is headed up by one of our nurses, Marg Flaherty, who you will know very well, who was also nominated for the Nurse of the Year award recently. It is a well-recognised service, and she leads it very well.

MR HARGREAVES: Yes, well deserved too. Saved my life.

MS HUNTER: I want to follow up on the issue around employee benefits and so forth. There were some issues around long service leave and other entitlements that had not been put away at Calvary hospital. I am wondering where we are up to.

Ms Gallagher: That is what Amanda asked about.

MR SMYTH: We have already asked that question.

MS HUNTER: Okay, sorry.

Ms Gallagher: Calvary entitlements. It has been shortened to the Calvary entitlements issue.

MS HUNTER: Okay, sorry.

Ms Gallagher: That does deal with that.

MR HANSON: Madam Chair seems a bit distracted. Given Mr Hargreaves's latest question and Ms Hunter's, I feel that the questions I have are of a technical nature, the remaining ones. There are a few of them. We will probably all benefit if I put them on notice.

I would like to conclude my questioning by saying thank you very much to you, minister, and to you, Dr Brown, and all the staff for all the hard work that you have been doing in the Health Directorate. This may be the last time that we get together formally on such an occasion. I would like to say thank you very much for the process that we have gone through with all of the staff over the last four years. I have learned a lot out of it, and I have really appreciated your candour and the hard work that is no doubt done in preparation for these days, and which, no doubt, you lot enjoy far less than I do. I will ask no more questions. That might get us an early knock-off.

THE CHAIR: You are on your soapbox now.

MR HANSON: It might get us an early knock-off.

THE CHAIR: I am going to ask one further question.

Dr Brown: I have two items that I want to respond to as well.

THE CHAIR: Thank you, Dr Brown.

Dr Brown: In relation to the hip beds, I can inform you that the cost of a hip bed at TCH is of the order of $45,000. At Calvary it is of the order of $46,000. So there is not much difference between the two hospitals. In terms of the question about our medical negligence insurance, the estimated premium for this next financial year, the 2012-13 year, is $29 million. That is yet to be confirmed by ACTIA, but that is the estimated premium.

THE CHAIR: I have a final question which might need to be taken on notice. I do

not have a budget reference for it but it is around preventable admissions. I know the AIHW, in looking at the issue, estimated that potentially about nine per cent of hospital admissions were preventable. Have we looked at this in the ACT at all, in terms of what percentage of hospital admissions might actually be preventable?

Dr Brown: Yes, we do have that figure. I am sorry; I do not think I have it with me but I think we can respond to that.

Mr Thompson: Yes, we can provide that to you. We do monitor it and we also compare favourably with other jurisdictions on those measures.

THE CHAIR: Do you look at the same thing in terms of elective surgery? Is that a measure which is looked at—that there might be things which are preventable there as well?

Dr Brown: In terms of whether the surgery was preventable?

THE CHAIR: Yes.

Ms Gallagher: The clinicians make a decision about whether someone needs surgery or not. But there is monitoring of the waiting list.

Dr Brown: For example, with orthopaedics, if someone is awaiting an orthopaedic assessment, we have a program whereby people can be seen by the physiotherapist and have some management in that waiting period. For some people that may actually change the course of their treatment requirements. But I am not sure in a general sense for elective surgery how much we would be able to implement to prevent—

THE CHAIR: No, I was just interested. You took the other part on notice.

Ms Gallagher: It is reported on in an AIHW report, isn't it—percentage of avoidable—

THE CHAIR: We can probably find that ourselves. There are a couple of things. With respect to the photographs that were provided to us by Mr Woollard, the committee—

Ms Gallagher: Not be incorporated into *Hansard*?

THE CHAIR: No. The committee will accept them as an exhibit. Mr Hargreaves, you indicated you were willing to move that.

MR HARGREAVES: So moved.

THE CHAIR: Thank you, Mr Hargreaves. Thank you, Ms Gallagher, the health minister, for appearing before the committee today, and officials from the Health Directorate. As mentioned at the commencement of the hearing today, there is a time frame of five working days for the return of answers to questions taken on notice at this hearing. I have read out the earlier outputs, but the ones we have looked at this afternoon are output class 1, health and community care, 1.5 rehabilitation, aged and

community care, 1.6 early intervention prevention, and output class 1, ACT local hospital network and all those outputs under that.

The proceedings will resume at 9.15 tomorrow morning, commencing with the committee's examination of the Territory and Municipal Services portfolio. So you are due back, minister.

Ms Gallagher: Yes.

THE CHAIR: I now declare this public hearing adjourned.

The committee adjourned at 4.46 pm.