LEGISLATIVE ASSEMBLY FOR THE AUSTRALIAN CAPITAL TERRITORY

STANDING COMMITTEE ON HEALTH, COMMUNITY AND SOCIAL SERVICES

(Reference: Annual and financial reports 2007-08)

Members:

MR S DOSZPOT (The Chair)
MS J BURCH (The Deputy Chair)
MS A BRESNAN

TRANSCRIPT OF EVIDENCE

CANBERRA

FRIDAY, 20 FEBRUARY 2009

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

By authority of the Legislative Assembly for the Australian Capital Territory

APPEARANCES

Privilege statement

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Amended 21January 2009

The committee met at 9.34 am.

Appearances:

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

ACT Health
- Cormack, Mr Mark, Chief Executive
- Thompson, Mr Ian, Deputy Chief Executive, Clinical Operations
- Brown, Dr Peggy, Director and Chief Psychiatrist, Mental Health ACT
- Cahill, Ms Megan, Executive Director, Government Relations, Planning and Development
- O'Brien, Dr Eddie, Senior Specialist, Public Health, Population Health Division
- Woollard, Mr John, Director, Health Protection Service, Population Health Division
- Carey-Ide, Mr Grant, Executive Director, Aged Care and Rehabilitation Services
- Bromhead, Mr Richard, Manager, Mental Health Policy and Planning

Department of Disability, Housing and Community Services
- Hehir, Mr Martin, Chief Executive, Executives
- Sheehan, Ms Maureen, Executive Director, Housing and Community Services
- Whitten, Ms Meredith, Executive Director, Policy and Organisational Services

THE CHAIR: Good morning everyone. Welcome to this public hearing of the Standing Committee on Health, Community and Social Services in its inquiry into the annual and financial reports of ACT Health and the Department of Disability, Housing and Community Services for 2007-08. I presume all of you have been here enough times for me not to have to read the privilege statement, but I take it that you are aware of it?

Mr Cormack: Perhaps for some of our officers it might be worthwhile reading it.

THE CHAIR: What we would like to remind you of is that, if you have not appeared before the committee before, please make sure that you read the privilege card. There is one on the table, and if you are coming up, you might want to read it beforehand and make sure that you do understand the privilege implications of the statements that you make.

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

Ms Gallagher: I don't have a prepared opening statement, chair. I welcome the opportunity; we all sit ready to take your questions and respond as we can. I see this area as the most important area of government, taking almost a third of the ACT budget, or heading very quickly towards a third of the ACT budget—managing a whole range of services, right across the acute system and into community-based health services, responding to local need, and dealing with a nine per cent increase in activity in the hospital during this reporting period. We are seeing the changes in our demographics resulting in what we expect to be a continued increase in activity year

on year.

ACT Health has done a wonderful job in focusing on some priorities from government, which have been to reduce our costs. A few years ago we were at 130 per cent of the national average for providing similar health services. We have now brought that down to 113 per cent. The government has set Health the target of 110 per cent, and we expect to reach that. At the same time as we have been bringing down our costs, we have been increasing our outputs. We have been making real progress in reducing our elective surgery waits. Our dental waiting times have been almost halved. We have put on more beds. We have got more doctors and nurses than we have ever had before. The ANU medical school is assisting us in attracting our medical workforce. Also, the plans that we have for the health system for Canberra's future are assisting us to meet some of our workforce pressures.

I welcome a discussion on our capital asset development plan—our plan to rebuild and refocus our health system over the next 10 years. But at the same time as we are doing that, ACT Health will be continuing to provide a service 24/7 to the people of the ACT. So it is a big challenge. It is, I guess, high risk for the community. I know that we are all focused on making sure we can continue to provide high-quality services at the same time as we reconfigure and reposition our health services to meet the challenges of the future.

That is it in a nutshell, but there is so much that sits underneath that, and we welcome the opportunity to talk with the committee this morning.

THE CHAIR: Thank you very much. I might start the questions rolling for the morning. On page 6 of the annual report, there is reference to the effective partnerships that are being generated with general practitioners. We do have quite a serious problem, as we all acknowledge, with the number of GPs—the fact that we have one of the lowest figures for GPs per capita in the nation. Having regard to the importance of this issue, can you direct me to some area in the annual report that really addresses some of the future plans for what we are looking at doing to address this problem?

Ms Gallagher: Where is the reference on page 6?

THE CHAIR: Page 6, point 5.

Ms Gallagher: I think there are a couple of issues. We can talk, certainly, about what we are doing with general practice to support them and work with them to deal with the doctor shortage. With reference to effective partnerships with general practitioners, one of our responsibilities is to make sure that, as general practitioners interface with the public health system, we are making their job as easy as possible. They are busy; many of their patients will from time to time use ACT Health services.

With respect to one of the challenges, and something that we have been working on very hard, just in the last two days I have been having meetings with our GP liaison unit, and with the AMA this morning, around seamless interaction between primary care in the community and the services that ACT Health offer. I think that is how it relates to that dot point.

Separately from that, we have a whole range of other initiatives that we are implementing. I am sure that Mr Cormack can go through some of them. We work with doctors' groups, particularly the Division of General Practice and the AMA, to manage and look at ways of attracting GPs to the ACT. I think we are seeing some change in landscape around the role of corporate providers and the role of family practice. I am not sure there is a great deal that ACT Health can do around that. Just in recent days, with the discussion around Belconnen and the changing landscape that will produce in the next couple of years, there may very well be three fairly large corporate practices in the 2617 postcode. Whilst that will be very good for people in 2617, it will pull other postcodes into that area. That is the changing nature of general practice, and GPs that want a different lifestyle. We do need to keep an eye on that.

Our recruitment program with the Division of General Practice is going pretty well. We have given them some funding to run an attraction program. That started in May 2008. So far, through that program, 11 area-of-need authorisations have been approved and one more is pending; 28 expressions of interest have been received; four GPs have commenced; six GPs have been offered positions to commence in 2009; and a further eight suitable applicants have indicated they may move to the ACT in 2009. That program is good in the sense that it is looking for GPs outside the ACT, rather than shifting GPs within the ACT to larger locations.

There is a whole range of other initiatives which we have been working on, not least of which are all of our commitments in the election campaign around supporting the role of general practice, which we will be rolling out in the next budget. I think there is a lot going on in this area. We rely very much on the Division of General Practice, the AMA and individual general practitioners to support our work. So far, all of them are, and all of them I think are quite pleased with the outcomes that we are seeing.

Mr Cormack: Further to what the minister has said, one of the initiatives introduced in the last 12 months was PGPPP, which is a postgraduate placement program for first-year-out medical graduates in general practice. The effect of that—and we are looking to increase and enhance that over time—is to bring early exposure to general practice for newly graduated medical practitioners. There is often a tendency for them to get swept up in the clinical buzz and excitement of busy hospital environments, and many of them remain there. However, general practice is really at the heart of the healthcare system in Australia. So early exposure to that has been one of our key objectives.

We have a memorandum of understanding with the Division of General Practice, and that outlines a range of activities and commitments to work with each other to improve the interface between the ACT public healthcare system and general practice. Another area of work which has been under development for some time is enhancing the e-health capacity of the hospital interaction with general practitioners. We are well advanced on our electronic discharge planning, referral summaries and the development of a portal which will enable a much more systematic and single point of access between the general practice community and a whole range of services across the ACT.

It is important to note that this range of initiatives recognise that the responsibility for

general practice is a commonwealth responsibility. Our responsibilities are fairly confined. In relation to the closure of practices, we have no regulatory or constitutional power to direct a general practitioner to work anywhere. Indeed, the notion of civil conscription has some common law currency, and whenever the federal government, over the last 50 to 60 years, has looked at things such as geographically defined provider numbers, the medical profession has consistently invoked the Australian Constitution as a means whereby they will choose to work where they wish and under the conditions that they wish to work under for themselves. So I think the range of efforts and initiatives that we have got in place are very much at the upper end of the sort of contribution that a state or territory jurisdiction could be making.

THE CHAIR: Thank you, Mr Cormack. By way of a supplementary question, I have been looking back over older reports as well, and with respect to the report on annual and financial reports for 2005-06 these same questions were asked of you, or the department and the minister. Given the time that has elapsed since that report, I guess we are looking at seeing an increase in GPs, not a continual decrease. You have got a very thorough and very well detailed annual report. My initial question was: where are the plans within this annual report regarding this serious issue, beyond the reference to effective partnerships?

Ms Gallagher: I guess the annual report is a report about the work that ACT Health have done around the responsibilities they have. As Mr Cormack has indicated, ACT Health does not have responsibility for general practice. They are private businesses. They are also regulated and controlled very much by the commonwealth, be it through provider numbers, training places, or certainly, in a private business capacity, the desire of general practice to commence or start up a business. So the annual report has a specific job. What we have been trying to say on top of that is that we do not just stand here and say that this is not our responsibility. It is in the interests of ACT Health and the ACT community that the public health provider has a very strong primary healthcare system through the GPs that work with it; otherwise our job is a lot harder, our emergency departments are a lot busier, people get sicker, and that all impacts on the public health system.

With respect to the areas that we can influence, certainly my lobbying efforts with the commonwealth have been about increasing training places, looking locally at how we support general practice to make sure we are assisting them to do their job easily and take on trainees. In fact, if you look at our election commitments, you will see that many of them were about supporting existing general practice to help us out with the new breed of doctors and the numbers that are coming through, because they are increasing, and in a couple of years we will have more doctors than we have positions. We are hoping, through some of that, that they might choose a job in general practice. Our program, PGPPP, is particularly designed for that.

Part of the issue is that you do not finish medical school and become a general practitioner. You have to do your hospital-based training; then you have to go and do further training to become a general practitioner. You have to specialise, as is the case with other specialist categories. So it takes investment and it takes training opportunities. You cannot just say, “There’s an extra 10 doctors; go to GP land.” It does not work like that. So our focus has been on getting students interested in general practice. We have responded to the feedback from general practice that it takes money

to take on students. They have to keep every third appointment free to reflect with the student about what has just happened and what they have done, and that costs them money. And it takes additional resources in the practice to take on students.

We know that we have to be breeding our own local workforce, and that is how we have sought to deal with that issue. ACT Health have a very clear responsibility about what their job is. This is something we do in addition to that. How do we work with primary care? How do we support them? How do we look after the future? In particular, how do we get our medical students interested in general practice? It is not at the glamour end for doctors. I do not know why, because I think there is a lot of satisfaction to be had, but many of our young doctors can earn a lot more and be a lot more glamorous in other specialties than general practice. And we have seen that reflected in the numbers that want to go through.

I think we are doing as much as we can to assist, and the recruitment program, which was an idea generated by the Division of General Practice, is already showing improved results. Again, you do not get a doctor from overseas under "area of need" to come into a practice and that immediately alleviates the pressure. Because you are in general practice, you have very strict conditions under the medical board about supervision and monitoring of performance. Unlike a hospital, you are in a closed room with an individual patient. It is a lot more self-managed work. The scrutiny, the monitoring and the supervision are a lot tighter in general practice. So whilst it assists, it comes with other responsibilities as well.

THE CHAIR: Thank you very much.

MS BURCH: I have a question on the workforce. It is on the same area. I have an interest in the workforce in the hospital sector.

Ms Gallagher: What page is that?

MS BURCH: It is page 5, but there is mention of the workforce scattered throughout the document. I would be interested in the efforts you have made to recruit medical officers in the specialist area into the hospital. Has that been successful?

Ms Gallagher: In this reporting period we have been successful in appointing 84 consultant specialists. Forty-three of those were new positions; almost 50 per cent were new positions. We have done well, I think, with our junior medical officer staffing. What we are seeing overall, I think, is improved interest in coming to work in the ACT, certainly from a medical point of view. But there are a whole range of other areas in the workforce covered under this area.

The two main reasons for that, when I have spoken to new doctors at the hospital, are: the ANU medical school and the fact that that offers them some research opportunities and some teaching opportunities. So that is very attractive. The other area is the investment that the government has indicated and has started on: the CADP plans we have to build the system of the future.

Doctors are an international workforce. If you are considering where you want to spend your next five years, they go to somewhere where they have money on the table,

expansion plans, a clear direction about where they are heading and money guaranteed in the budget. Our growth that we have factored into the budget for our recurrent services, I think, is offering some certainty to doctors who can be, at times, a little cynical about governments and their capacity to pay for health. That gives them some certainty so that they are prepared to make that move to the ACT. The ACT will benefit from that.

I think we have done very well with our appointments. The medical appointments and training unit, affectionately known as MATU—we have created that position; that was budget funded a few years ago now, probably 2004 or around then; it is a specialised unit within health whose job is to look for, recruit, credit, make sure everything goes seamlessly—has greatly assisted the appointments process.

Mr Cormack: If I could add to some of the numbers the minister was mentioning. She has just given you two sets of figures. In the 2009 intern round, we were able to recruit 62 interns, compared to 45 in the previous year. That is close to a 50 per cent increase in the capacity and what that does. A lot of these, of course, are now our locally trained ANU medical school graduates. That increases not only that number but also the number of individuals that get exposure to this healthcare system. Once people get exposure to it working, they do tend to stay with it.

There is a very high retention rate for medical specialists. We have a turnover rate of less than two per cent. That is certainly a very good feature but it also enables us to reduce overtime, some of the excessive hours worked by junior medical officers. Because we have got more of them, we do not have to do the overtime.

This year—and this was reported in the media I think it was last week—we had really our best crop, if you like, of nursing intake. In February, we had 81 experienced registered nurses, midwives, enrolled nurses join our workforce. We had 82 graduate nurses come through the graduate program and 10 registered nurses in the postgraduate mental health nursing program.

These initiatives are, I guess, the fruit of a number of initiatives that were put in place over the last four to five years on scholarships, preceptorship or clinical supervision arrangements, return to work programs, conversion on Ns to RNs. We are starting to see some quite significant returns on those investments, bearing in mind that it takes a minimum of three to four years to graduate a nurse and then another year or two before they are, I guess, fully equipped to be able to take on the full range of duties. They are just a couple of examples.

MS BURCH: You covered nursing. There are those efforts that you described for nursing. I was wondering about allied health and interprofessional practice. It is a primary healthcare term.

Mr Cormack: I am happy to address those. ACT Health established the position of allied health adviser about four or five years ago. It was one of the first jurisdictions to be able to recognise the critical importance of allied health as part of the leadership team. Since that time, we have established student clinical placement units which are a series of coordinators who are able to assist with the myriad placement requests from the universities to do student placements here. Members of the committee would

probably be aware that one of the critical determinants of whether people want to work for you is if they have had previous exposure to your environment in the past.

The interprofessional learning, which is referred to on page 183 of the annual report, is a partnership between ACT Health and the University of New South Wales. That is really about modernising the approach that health professionals take. Historically, nurses are trained in a nursing silo, doctors in a doctors silo, and allied health according to their professional training regimes.

There is a body of research—and the ACT is a national leader in this—that has recognised that you get better patient outcomes and better recruitment outcomes when you have entrenched in your workplace a multidisciplinary and interprofessional approach to the delivery of care services. A very practical example of that is in our emergency departments. They are not just solely doctor-driven care. We have got nurse practitioners; we have got vast-practice physiotherapists who work as part of a team to address the needs of the workplace.

We have got scholarship programs which have been running for a number of years now. They are specifically targeted at our own ACT Health staff—and we have had 19 go through already—to undertake a graduate certificate in higher education and tertiary education. That actually equips our allied health and nursing staff to be teachers and trainers of junior staff.

We introduced Australia's first fully accredited allied health assistance program. That was through a very good partnership with CIT in the areas of physiotherapy, occupational therapy, speech pathology, with podiatry, nutrition and dietetics coming up. That enabled people to work with our degree-qualified health professionals and assist them to undertake a range of tasks. They are trained up to a cert IV level. They have a formal qualification that is recognised in the public and private sectors. They are a handful of some of the initiatives on allied health and, indeed, broader nursing education and training.

MR HANSON: I have a quick question going back to GPs. We know that we are now, I think, 60 short in the ACT. According to some organisations that is the lowest per capita in Australia. I have heard a lot about the programs, but when are we going to achieve that parity with the rest of Australia? When are we going to reach that point? Given the programs you have in place, can you give us a date or an indication of when you expect that that will be achieved?

Ms Gallagher: I cannot, as much as I would like to, and I think that probably goes back to the areas of responsibility. We do not control the number of GPs in the ACT. We do not have the regulatory levers of the responsibility. The commonwealth has that through providing doctors with provider numbers to enable them to work. Whilst we can look at ways to work with the professional bodies, which is what we are doing, to attract—

MR HANSON: In your negotiations with the commonwealth and the division of GPs and so on you have not got an indication of when that is going to be achieved through the various mechanisms that you have got in place and that they have got in place got in place?

Ms Gallagher: The focus is on increasing the numbers—working with the commonwealth, working with the AMA and working with the division to increase our numbers. A net increase is the focus, not just shifting people around from one clinic to another. That can be achieved, as I said in answer to the previous question, by supporting the junior doctors to take an interest in general practice—that is, through our graduates every year. The second area is through our recruitment programs of seeking doctors outside—

MR HANSON: I am aware of the program. I am just trying to get an indication of when.

Ms Gallagher: I would love to give you a date but I do not think you could ask that question of anyone. I do not think, if you asked the AMA, the division, the commonwealth minister or the GPs themselves that anyone would be able to sit here and give you an honest answer to that. We could have 60 area-of-need applications go in and get 60 GPs from other countries. It depends very much on the applications to come here and the capacity of existing general practice to take on approved area-of-need places. It could happen in a year; it could take longer. It depends on the ability of the system to take in new doctors and on our young doctors getting trained. That takes some time.

MR HANSON: Just on nurses and the recruitment and retention initiatives there, in relation to agency nursing, I see on page 44 that we have an increase in non-contract services of $5 million from 2007-08 and that is in part due to this increase in agency nursing. Is that being used as a stopgap? Where are we getting those nurses from? I have heard some are coming from New Zealand even. When are we going to stop using agency nurses to cover our shortfalls in recruiting and retention? Can you let me know when that is going to happen, if that is what is occurring?

Ms Gallagher: The honest answer is that I do not think we will ever not use agency nurses. They provide a very essential service. When you have beds to staff and for one reason or another you do not have enough staff of your own to staff them you need agency nurses.

MR HANSON: We have seen an increase, though. Are we going to see a drawdown as our recruitment and retention initiatives kick in?

Ms Gallagher: That is the focus. When you look at how we reduced our costs, one of the biggest cost drivers is the salaries that we pay for our health professionals. So one of the obvious areas is to reduce your cost of agency nurses, but again, while the focus is on that, and I think in previous years there has been a reduction, when you look at things like a nine per cent growth in activity it would not be that unusual to see an increase in the need for agency nursing.

MR HANSON: I assume they are more expensive. Are they?

MS GALLAGHER: They are.

MR HANSON: To get an agency nurse in rather than use our own staff is an

inefficient way of doing business.

Ms Gallagher: They are more expensive, yes. The focus is on using them less, but the reality is that patient safety always comes first, and if patient safety dictates that you need to staff that bed whatever then you go and pay for it. One of the challenges that Health works with every day is that it is not just a matter of saying, "We won't provide a service." You work out how you provide that service and at times that requires agency staff to come in.

MS BRESNAN: Previously you mentioned some of the training programs which are offered. I am referring to page 183, "Learning and development". It mentions that there is training around workplace culture and communications. Does that include training doctors to communicate well with patients, in particular? Is that a set part of what happens and is that part of the ANU training as well? I am aware that there was a program run at Calvary which focused on that training.

Mr Cormack: In answer to your first question, the communication training is available for all staff. It does not specifically target medical practitioners but it is certainly available to them. The undergraduate training and preparation of medical practitioners has a much stronger emphasis on interpersonal communication, team communication, so in part there is a bit of a generational shift happening that is, fortunately, starting in the medical schools but, as these people come through our system, I think we will start to see the benefit of it.

We have also stressed other important, more client focused aspects of communication, and that is the communication of information from one shift to the next. It is called handover. We have certainly done a lot of work in that area and that is led by a number of our senior consultants. One in particular, who is not here today, is Professor Guan Chong, the professor of surgery. He has a very innovative and diligent program that focuses on the junior surgical registrars and the senior surgical registrars ensuring that from one shift to the next the communication of critical information is undertaken in a structured manner. It is recognised that this is an area that we need to continue to work on, but there are some good initiatives in place at the moment. I think it is something we could do more on.

THE CHAIR: Moving on to direct questions. Mr Hanson.

MR HANSON: Can we talk about elective surgery?

Ms Gallagher: Yes. How did I guess? Then we will go to the emergency departments: GPs, elective surgery and emergency departments.

MR HANSON: What is next after that? You should know. Bed occupancy maybe?

Ms Gallagher: Bed occupancy? There is a lot of good news there.

MR HANSON: Let us get to elective surgery and see what good news we have there.

Ms Gallagher: Yes.

MR HANSON: I refer to page 102, "Access to elective surgery". There is a lot of good news in there in terms of the words, but it does not address the issue of category 2 elective surgery. Where is that issue addressed in the report and how are we going with that?

Ms Gallagher: We can certainly respond to category 2. I think the report shows that the amount of surgery that is being performed is at record levels and in fact the results that we are on target to reach this year will deliver record levels again. We provide very good access to elective surgery, particularly our category 1 and our emergency surgery, of course—it goes without saying—

MR HANSON: Category 2 is the question.

Ms Gallagher: I am getting to category 2. As to how we deal with category 2, again, I do not have the exact figure of the people that are getting access in time, but our whole elective surgery strategy at the moment is on categories 2 and 3 and improving access, particularly for those who have been waiting too long. That strategy has been in place for 18 months or two years, certainly since my early days as minister. We are seeing a very significant improvement in the number of people waiting longer.

MR HANSON: We are still the worst in the nation, according to the AMA. Do we expect to improve on that and reach a point where our waiting times are within the prescribed time frames, which I believe is 90 days for category 2? When are we going to get to that point where we are actually achieving parity with the rest of the nation?

Mr Cormack: There are a couple of points to note just to reinforce the minister's comments. The effort of ACT Health over the last two years in particular, but even prior to that, has been on long waits. The long waits are people generally in category 2 and category 3. In the case of category 2, they have been waiting longer than 90 days and in category 3 they have been waiting longer than 365 days. We have seen quite a dramatic drop in the number of patients waiting longer than a year.

It is important for the committee to note one of the curious aspects of the metrics that are used to measure elective surgery. The calculation of median waiting terms—and that is the national measure—is taken on admission. It is not taken while people are waiting; it is taken when people are actually admitted off the list. Over the years we had built up a significant backlog of people who had been waiting too long.

The government's initiative was to focus on those that had been waiting too long, so we put in extra effort on focusing on people who had been waiting for a very long time. If you continue to do that then your reported median waiting time, even though you are clearing the lists, increases. So in the short term it is a sign that you are really getting at the long waits, and we are starting to see the median waiting times in category 3 come down because we have cleared a lot of the backlog which was largely in ophthalmology, some plastic surgery cases, urology and orthopaedic surgery.

However, category 2 is our largest group and I think it will still be more than 12 months before we start to see the reported median waiting time come down, even though we will be taking larger and larger groups of very long waits off the list. So it

is a curious metric but, in a sense, it does show that the effort of the system is going into targeting those who have been waiting the most.

What we have to do as a healthcare system, while we are focusing on long waits, is also give priority to those with the most urgent need for care. That is the balancing act throughout the whole healthcare system. Those people with the most urgent need for care, as the minister mentioned, are emergency surgery, which we do very well in, and category 1 surgery, which is surgery which must be completed within 30 days, which we also do very well in.

There is always a balance and a tension and all we can do is do more and more surgery, which we do. I think we are up to our fifth year of record throughputs, but we have absolutely no control over the number of people that join our waiting lists, including those that come from New South Wales. We do need to take those things into account. But I cannot give you a definite date when we are going to hit the national benchmark. I will be right with category 1s, I sure will be right with category 3s, but categories 2s are going to take a little while and it would be unwise to predict the precise date.

Ms Gallagher: To reinforce what Mark has just said, our elective surgery strategy could have been to ignore the long waits and focus just on those people who had come onto the list recently and remove them, because that would make our national numbers look very good. As they are being removed from the list they have only been on the list for 30 days or 40 days. That would have really brought down our waiting times.

MR HANSON: Yes, for category 2, but then you would have looked worse in category 3.

Ms Gallagher: No, because if you come in at category 3 and you remove those people before they have waited 365 days you look very good too. I have taken the decision that it is not about looking good for a national figure which skews results. The right thing to do is to make sure people get access to elective surgery based on clinical decision making and based on the people who I believe have been waiting too long with less urgent conditions. It is not a measure of your list. It is not a measure of how many people are waiting on your list or how long they have been waiting. It is a measure of how long the people you remove from the list have been waiting. I could have completely ignored the long waits and looked very good nationally. We could have achieved national benchmarks, no worries, but the thing that is unsaid is that several hundred people were waiting too long and they would just continue to wait because our national numbers would not look good.

We have taken the decision. It gives me grief probably every time I go into question time when three reports are released: the AMA report card, the AIHW report and the commonwealth's *State of Our Public Hospitals* report. Those three things report against that indicator. In terms of our focus on long waits we are penalised through that for the data that it releases, but those people who have been waiting too long get access to surgery and that is the right thing to do.

THE CHAIR: Thank you. Is there a supplementary?

MS BURCH: It sort of is and is not. It is on waiting lists. Outside hospital we also provide dental services within the health system. What is our waiting list for restorative or emergency dental work?

Ms Gallagher: We do not have a waiting list formally in emergency. I think 100 per cent of—

Mr Cormack: 100 per cent within 24 hours.

Ms Gallagher: those people are seen within 24 hours and again this is an area that we have focused on. I think our waiting list had got up to about 16 or 17 months at one stage. We have injected some more money, I think two budgets ago now, into that and we expect to have it down to 12—actually, we have exceeded that. We set ourselves a target and we have exceeded it. It is down to 7.64 months.

Mr Cormack: It is the best in the country.

Ms Gallagher: It is by far the best in the country. There is always pressure on that program because it is public dental and your dental health is so important, but I know the team over there have been working really hard to make sure people are getting access and access as soon as they can. We did look at putting some more money in this to see whether we could go further. All the advice to me was that at the moment we are pretty much operating at capacity, including some connections with private dentists. We are doing what we can under that program, because even seven months is a long time to wait if you need treatment.

THE CHAIR: Moving back to page 8 under "Risk management" and looking at the department's management, it has identified potential risk that may influence the future financial position of the department.

Ms Gallagher: I am surprised that list is so short.

THE CHAIR: In relation to the rising costs of pharmaceuticals and medical and surgical supplies, can you give us some indication of the dollar value of the inventory that is held at any one time?

Mr Cormack: Off the top of my head I do not think I could give you the inventory and I am not sure whether our CFO, Mr Foster, would be in a capacity to do that, but I can, while he is racking his brain on that one, indicate that pharmaceutical growth—page 44, there you go: $6.6 million is the inventory in the balance sheet. On the growth in pharmaceuticals, just to underscore the risk, if you go to page 44, note 13, under "Supplies and Services" down to "Pharmaceuticals" you will see for 2007—I was just discussing this with Mr Foster this morning—a figure of $28.156 million, going up to $37 million in 2008.

There are very significant pressures and these are in combination with the nine per cent overall increase in activity that the minister referred to in her opening comments. In addition, within the healthcare system, each year—in fact each quarter—there are new drugs coming on the market that provide more and more benefits for patients.

That is what we try to deliver upon—we try to provide the best available pharmaceuticals and other care for patients, but that does come at cost. I think it is well demonstrated in note 13 on page 44.

THE CHAIR: Just going a little bit further in that area: from the point of view of wastage I understand that there is a lot of timely usage of some of the surgical supplies in particular needed. What sort of wastage do we have in obsolete equipment and supplies?

Mr Cormack: We can possibly take that on notice. I do not have a figure. We will try to get one before the end of the hearing. I do know that on our supply delivery and order delivery percentage rates which we nationally benchmark on—and this is in fact highlighted in the recent ACHS accreditation—we lead the nation. It is 98 point something per cent of orders correctly filled within the specified time frame. We have good inventory management, but there certainly will be some occasions when there are pressures there.

THE CHAIR: So you are satisfied with the inventory control that we currently have?

Mr Cormack: Yes.

MS BRESNAN: My question is in relation to disaster and pandemic preparedness. I know the Australian government has put some investment into researching climate change and health impacts. Is the ACT doing anything or working with the Australian government around that area?

Mr Cormack: We might call upon the chief health officer, Eddie O'Brien, and, if necessary, John Woollard, who is head of the Health Protection Service, to perhaps give a bit of a flavour of some of the national work and what we are trying to do in relation to that.

THE CHAIR: Dr O'Brien, you have read the statement?

Dr O'Brien: I have read the privileges statement, yes. I am a public health physician. I am halfway through a three months stint as acting chief health officer, which is part of the role of Dr Charles Guest, who is on leave. He wears at least two hats—that is, chief health officer and executive director, population health. I am taking on the statutory part of it—that is, the chief health officer—which is mainly involved with the Public Health Act but other acts as well. John Woollard is the other half, if you like—the executive director, population health.

Ms Gallagher: Could you just repeat the question, Amanda?

MS BRESNAN: I know of the work the Australian government is doing on the impact of climate change on health and I wondered whether the ACT is doing anything in that area. Is it working with the Australian government to prepare for any impacts from that?

Dr O'Brien: We certainly are. It is early days, although, as you would be aware, a whole new department has been set up within the ACT government. Clearly, it will be

the lead agency on that topic and clearly it will have Health involvement. At the moment I understand that Rosemary Kennedy from our department is on its committees. We are in the fairly early stages of preparing responses to questions from it. There are two main things, as you would be aware. There is the mitigation issue—that is, trying to stop climate change—and that is very much a part of the focus. The other thing is to alleviate any problems that occur as a result of climate change. Clearly, that would be much more in the line of our population health area. That new department works in conjunction with commonwealth government agencies as well.

MS BRESNAN: So there will be an established program looking particularly at health. As you said, you will be working with the climate change department but obviously Health would have to have a lead role.

Dr O'Brien: Yes, that is right. It is very much a new topic, as you know, and it is something we are very much aware of. It is something we will be working on. We are putting a lot of effort towards it. In the ACT we are obviously spared of some of the problems—for example, rising sea levels—but of course we may end up with migration in the ACT as a result of rising sea levels. In the very short term we are spared of problems like a species of mosquito that might transmit what are now tropical diseases, but in the longer term that might be an issue. That is the sort of thing we have to look at—not to mention simple heat wave issues, for example, which we saw a week or two ago. At the micro level we have put up a fact sheet on our website to inform people of how to deal with heat related issues. It is very much a work in progress of course.

THE CHAIR: Thank you. Mr Hanson?

MR HANSON: The ACT influenza pandemic action committee: the report notes that part of its role is reviewing and resolving gaps in the pandemic planning and preparedness activities. How are you going with planning for an influenza outbreak in the ACT and resolving those gaps in our preparedness?

Dr O'Brien: There is an ACT influenza pandemic plan, which was finalised I think last year, and that is in place at the moment. Again, that needs to work hand-in-glove with commonwealth agencies. That has been done in conjunction with commonwealth planning on the same topic. As you would imagine, a pandemic flu is such a big event that it is going to be a whole-of-government event, not just a Health event, and clearly other agencies are involved as well. For example, Chief Minister's might take the lead role if such an event happened, but we would be very much a player in it. So we have the plans in place and we hope that nothing will happen.

MR HANSON: Is that the plan, is it?

Ms Gallagher: That is the first part of the plan.

Dr O'Brien: We are vigilant; we have got planning in place should something happen but we hope it does not.

Ms Gallagher: We have tested our plan and we are part of national arrangements to work on this. We tested it maybe 18 months ago. It was called Exercise Cumpston.

The exercise ran across the country. So everything is simulated: cabinet has emergency meetings, Health are out there dealing with the breakout, or as the exercise rolls out, and what it means. Those exercises are extremely useful in identifying gaps, looking at pressures that will come up such as disagreements between perhaps the education department and the health department around the point at which you shut schools or the point at which you create panic or tell everyone they have to stay in their homes. It is very interesting to work through. So you have the plan on paper and then you exercise that out and, through that exercise, it did emerge, I guess in a less stressful way, because we did not actually have a pandemic upon us, how we resolve those issues, if it does come.

MR HANSON: Indeed. I assume that out of that exercise you identified a number of gaps and problems. Have you gone some way to resolving those?

Ms Gallagher: Yes. There is a review of those exercises—not just what happened here locally but right across the country, and mechanisms are put in place, if it can be alleviated, to make sure those gaps are covered off. That is the whole point of having the exercise.

MR HANSON: So that I don't bore you with it later, bed occupancy: obviously that is at 89 per cent. Did that have an influence on the exercise?

Ms Gallagher: If you had a pandemic, you would not want people coming to your hospital. You would be looking to manage influenza—I had probably better leave the technical side, but that is part of what we deal with every winter when we have little influenza outbreaks. We try not to encourage people to come to the hospital with it because that creates its own problem. We don't want the whole hospital getting influenza. So there are different ways of managing it, unrelated to bed occupancy.

Mr Cormack: When you are getting to that kind of level, you go into a disaster mode. When you invoke the disaster plan, there are some quite radical steps that are put in place, including the active requisitioning, if you like, of capacity in the private sector. The chief health officer has quite significant powers—in fact, one of the most powerful officers in the ACT public service. They can close down elective activity in the public and private sector. We can free up space immediately. In the case of a very rapidly developing influenza pandemic, we have got the capacity to establish influenza clinics outside the hospital environment. All of those things have been put to the test. So if a disaster hit and we were running at 90 per cent occupancy, we could very quickly find the capacity to prioritise and deal with that across the public hospitals, across the private hospitals and also our very significant capacity in the community to look after people in their own homes. So that should not be an issue were there to be a pandemic outbreak.

MS BURCH: While we are discussing public health, I note that there were some amendments to the Tobacco Act, making restrictions on point of sale. Is there more work to be done on tobacco?

Dr O'Brien: There is always more work to be done. I will hand over to John, but first could I finish off on the flu question. One of the things we have in place is flu immunisation. There is a new vaccine that comes out every year that tries to target the

strains that are circulating, and that is something we promote quite actively. That is a plug for everyone across the table to make sure they get their flu vaccines this year.

THE CHAIR: Mr Woollard, have you read the privilege statement?

Mr Woollard: Yes, I have.

MS BURCH: The question was on tobacco from a public health point of view. There has been some change to the legislation, so I was curious about what the forward thinking is about further amendments around sale and use of tobacco.

Mr Woollard: There are a number of areas that we are working on with respect to tobacco control. As mentioned, we have made some recent changes to point of sale and the way in which tobacco is sold. We have also got a discussion paper out at the moment for public consultation around smoking in cars with children. That closes—I can't remember the exact date but I think it is in the next week or two. We have had a number of submissions to date. That closes on 27 February. We are also in the process of doing some more consultation around the way in which people smoke in outdoor dining and eating areas, to look at whether we should follow the Queensland approach to banning smoking in those areas. They are probably the two main issues that are on the table at the moment, from memory.

Ms Gallagher: Yes, they are the priority, but we are always looking at tobacco control, and it is just going to get harder and harder to smoke in the ACT. That is where we are starting from.

MS BURCH: That is good, because the effects of tobacco are insidious and go across so many aspects.

THE CHAIR: Minister, on page 47 of the annual report, in note 19, at the top of the page, there is an act-of-grace payment that lists a single payment of approximately $500,000 for an unfair dismissal claim. Without breaching confidentiality, can you provide further information concerning this payment?

Mr Cormack: I am happy to, mindful of the confidentiality arrangements. This related to an employee who the health service dismissed and who was reinstated, and the act-of-grace payment was associated with legal costs incurred by that person.

THE CHAIR: I note that this had not happened in the previous 12 months. Is this an unusually high occurrence?

Mr Cormack: Certainly, it is an unusual occurrence that you would be making an act-of-grace payment of this nature.

MS BRESNAN: On page 84, there is a figure in relation to proportion of clients discharged from the hospital to a community health program who have a completed discharge plan. Thirty per cent seems quite a low level. Does that figure just refer to patients who actually require a discharge plan or is it an overall figure?

Mr Cormack: Let me start at the beginning: every person who comes in and is

admitted to our hospital has a discharge plan formulated. So that is the starting proposition. I guess the degree of detail, structure and depth within that discharge planning process and documentation will vary significantly according to the age of the person, the condition for which they were admitted, the range of co-morbidities that that patient may have, and the complexity and need for assistance in the home environment. With that in mind, within the community health side of things—and there is a minor change in this which I will finish up on—basically there is a group that represents about 30 per cent of the acute admissions to the Canberra Hospital and also to Calvary Hospital for which a higher level of discharge planning is required, and they are the group that we focus on, so they are the ones with the more complex requirements.

You will also see, under strategic indicator 17, that we apply a similar prioritising to clients of the Aged Care and Rehabilitation Service. They are a very good example of a group for which you really want to get the discharge planning right. You want to make sure they have everything in place when they go home, otherwise they can deteriorate quickly, end up back in hospital or suffer adverse consequences. So we set a much higher percentage. So the reason for the 30 per cent is about priority setting, recognising that for the overwhelming majority of people who come in and out of our hospital the discharge planning requirements are fairly simple. The point I mentioned before was that the discharge planning function has moved from community health, because it is reported under output 1.3, I think; that will move to output 1.1 for the coming reporting period. We have transferred the governance of that function from the community health program to the acute care providers.

MS BRESNAN: So just to clarify, the 30 per cent figure just refers to clients who require that high-level discharge plan?

Mr Cormack: That is right.

MR HANSON: On the issue of aged care, at page 86, output 1.6 Aged Care and Rehabilitation Services, there is a variance of 42 per cent in the subacute service. That is "due to the delayed start to full operational capacity for the Sub and Non-acute Service unit at Calvary". Can you highlight what is going on there?

Mr Cormack: I call on my colleague Grant Carey-Ide who is the Executive Director of Aged Care and Rehabilitation Services.

Mr Carey-Ide: I am sorry, Mr Hanson, could you repeat the question?

MR HANSON: On page 86, under output 1.6 Aged Care and Rehabilitation Services, subparagraph (c) has got a 42 per cent variance "due to the delayed start to full operational capacity for the Sub and Non-acute Service unit at Calvary". Can you tell us where we are at with that and why it has been delayed?

Mr Carey-Ide: We are now fully operational. In fact, there has been a very significant growth in occupied bed days at Calvary. That was due to the unit opening within the previous year and delays in being able to recruit allied health staff. The unit is fully recruited. The actual growth has seen an increase from 1,960 occupied bed days to just over 12,000.

MR HANSON: It is now open. You have recruited the staff that you need to handle that overall capacity?

Mr Carey-Ide: We have.

THE CHAIR: Minister, on page 90 of the annual report, strategic indicator 3, bed occupancy, I notice that the mean occupancy rate has reduced by one per cent, from 90 per cent to 89 per cent, over the reporting period. However, a rate above 85 per cent is considered dangerous, according to the standards of the Australasian College of Emergency Medicine. When will we see the occupancy rates fall below 85 per cent?

Ms Gallagher: That is the target we have set ourselves, the 85 per cent. When this indicator began being measured three years ago or four years ago—

Mr Cormack: It is the fourth year.

Ms Gallagher: It is the fourth year we have been reporting against this indicator. It was, I think, about 93 per cent. We have been coming down. With the additional beds that we have got coming on line this year, we hope that that will again improve this so that we reach our target as soon as we can. It is difficult for me to say that we will achieve it next year or even the year after. We could, if we have a very quiet flu season or quiet winter. That might be nice. Because it is linked to activity, which is linked to people's illnesses or state of wellbeing and whether or not they need admission to hospital, it is very difficult.

We set ourselves a target. That is where we would like it to be. It is declining every year. It goes up and down throughout the year, I should say. This is an average result over the year; so there are times when we are below this, and there are times when we are above this. We set ourselves a year target and we are doing our best to reach it as soon as we can, because that is what we would like capacity in the hospital to be. If we need to admit people, we would like the capacity to be there. Most of the time it is, but at times we are under pressure for bed occupancy and we would like to have it at 85 per cent throughout the year. We are doing our best.

Part of the solution is more beds but, if you are adding more beds and your activity is growing by nine per cent a year, that creates some challenges.

THE CHAIR: Given that there are such capacity restraints—

Ms Gallagher: At times there are, yes.

THE CHAIR: How capable are we in the ACT of handling any major catastrophe or disaster that may come up?

Ms Gallagher: Mr Cormack can speak again on this. It would be crazy to staff a hospital system that could take a disaster as part of its normal day. It would be inefficient. You would have a hundred beds opened that you did not necessarily need. To do that, you would have lots and lots of staff that you did not necessarily need.

You cannot run your system thinking that you are going to have a disaster every day.

You have a disaster plan that you instigate. As Mark has said, that gives you very significant powers to move patients around, to discharge patients, to create bed capacity. We do this on a mini level almost every day, with some of the executive managing beds every day, depending on the needs of the people of the ACT. At times, particularly when we are going through our flu season, we have to bring on extra beds to create the capacity. We do not use the surge capacity that we could put on. It is not necessarily efficient to have those running all the time. We do a juggling act with beds every day of the year, I would say.

If there were a disaster, our disaster plans are robust; they have been tested. Fortunately, we have not had to use them. Everybody is very well aware of what steps need to be taken if that did occur. And it would happen very quickly.

THE CHAIR: Thank you, minister. We have reached the point where we will take a 15-minute break.

Meeting adjourned from 10.43 to 11 am.

THE CHAIR: We will restart the meeting where we left off. I thank the Minister for Health for rejoining us. Ms Burch has the next question.

MS BURCH: The annual report mentions the capital asset development program and a number of your responses have mentioned that. Can you tell me where we are up to with it? Has the global environment had any impact and is there a progress report?

Ms Gallagher: I will lead off and then Megan Cahill, whom you met last Friday and who has management of the capital asset development plan, will talk in detail. In terms of the financial situation of the budget and how it relates to the capital asset development plan, we had embedded our forward growth money for health into our budget, so in that way we are a lot better placed than other jurisdictions that every year make their funding allocation through the budget process. Even though we are running a deficit, our health growth is embedded within that deficit now, so any additional expenditure on health will not affect the bottom line, even though the bottom line is negative.

In terms of the capital, we have made provision for $300 million in last year's budget, which is spread out over four years. In our commitments at the election we announced that we would be making further allocations of $150 million a year until we had paid off the $1 billion health plan. At this point in time we have the cash available to us to do that. What I would say is that, regardless of the availability of cash, we have to do this work. Even though it looks great now, it is not the Mercedes Benz or anything of the health system. We are not planning anything more than we need to deliver; even though those facilities will be nice, they will be facilities that from our demographic data we know we need to do. So, if as we roll out this 10-year plan there is the need to look at borrowing, this is probably a project that would fit the usual criteria you would put for borrowing, which would be that it is a high-quality public asset going to deliver community good, going to be there for the long run; all of those tests it meets. So I do not see that the financial situation as it stands now will affect the capital asset

development plan in the long run because, as I said, regardless of any flavour of government that is in at the day, this plan will have to be delivered.

MS BURCH: And progress on it?

Ms Gallagher: I will hand over to Megan.

Ms Cahill: In terms of the planning that we have undertaken so far with this year's allocation out of the $300 million four-year program, one of the first steps we have taken is to engage a project director. That company is Think Projects, a company that has had extensive experience in undertaking capital works for health facilities, so ACT Health staff, along with that expertise in Think, are undertaking a range of plans that will help us to roll out the implementation of the plan in the most effective way that we can.

As you can imagine, undertaking capital works across all of our existing five community health centres, a new community health centre and two hospitals requires careful staging and planning. So to that end we are now undertaking a range of project definition plans that will allow us to be much clearer about the scope of those works and to make sure that the program happens in such a way that we can maintain maximum capacity in the health system.

In terms of specific projects, we are already well underway in the design of projects like the women's and children's hospital. We are putting additional capacity on the TCH campus and we are well underway with putting in place additional operating theatre capacity at both the Canberra Hospital and the Calvary hospital.

MS BRESNAN: In relation to the women's and children's hospital, I know there has been some discussion around the birthing centre and the model that will follow—whether there will be the same model as there is now with the outdoor areas, whether that will be retained or whether it will be more within the ward itself and the hospital itself. I have had information that that is possibly what is going to happen but have there been any discussions on consideration of what the community want?

Ms Cahill: Yes. All the planning that we have done in relation to the women's and children's hospital has been largely through the formation of a number of user groups that have involved staff, consumers and other community members. In relation to women's and babies services we have certainly had the involvement of Friends of the Birth Centre in terms of how the birth centre in the new hospital will function and where it will be located. As has been stated previously, a birth centre will remain as part of the new development. It will be moving from the ground floor up onto the third floor but it will continue to have its own discrete entrance and we will be expanding its capacity in doing so.

MR HANSON: Following on from Ms Burch's point about the budget, you have embedded the infrastructure into the budget, but what about the recurrent costs? We are talking about an expansion in the number of staff to—

Ms Gallagher: The recurrent costs are embedded in the budget. The capital costs sit outside the operating result. After this year's budget, when we put this year's budget

together, we will have factored $550 million into the forward estimates period for provision of recurrent health services over and above what we are funding now.

MR HANSON: So that takes account of the expansion in staff and those—

Ms Gallagher: Yes, over the forward estimates period—not over the full 10-year plan or how we ramp up those services to meet the final rebuild—the expansion of services is met within the growth envelope that health has been afforded.

MR HANSON: Back to the redevelopment: in terms of contingency, have you allocated a specific contingency to the new work? With major projects that I have been involved with you have a prescribed contingency depending on the risk involved. What is that contingency?

Ms Cahill: The contingency varies depending on what stage of the planning we are at. If we are at feasibility planning, study, the contingency is usually around 20 per cent. Once we get down into project definition plans and moving on to more detailed plans, the contingency usually drops down to anywhere between 15 and 10 per cent.

MR HANSON: So 20 per cent is your highest mark for contingency in a project?

Ms Cahill: Of a project, yes.

MR HANSON: Do you think that is adequate?

Ms Cahill: The contingency rates are based on expert advice that we have had from quantity surveyors who are familiar with the health capital market at that point in time as well as the more global construction market and the conditions that it is facing now and into the future.

MR HANSON: Has that been reassessed based on what has happened with the economy? That has not made any difference to those contingency measures?

Ms Cahill: We will continue as we go through the planning process, as we go into further design, to revise those contingency figures if we need to.

Ms Gallagher: We have done that over the first allocation of money. A large part of the project remains to be funded through the outyears. Because we funded the beginning of this project in last year's budget we have allocated $300 million. As Megan said, as we go through the next stages and define and scope the next part of that project, that is the projects outside of the $300 million, we will continue that.

MR HANSON: I raise the issue because state and territory governments do have a record of poor delivery both on time and budget and within scope. I was just drawing on recent experience in the ACT with the AMC or the GDE. Given the delays and the cost blowouts in some of those, 20 per cent does seem to be a reasonably conservative measure given the scope of the work that is being conducted and the time frames involved.

Ms Gallagher: You can certainly draw our attention to the Alexander Maconochie

Centre. However, if you review the delivery of health capital works over the past few years I think you would be pretty hard pressed to find something that ran over budget. Our latest large project which was finished, the $30 million linear accelerator project, was finished on time and under budget. So I do not agree with your assumption at the beginning of the question that state and territory governments have long histories of not delivering. I think there are isolated projects you can refer to, but when you look at the amount of capital works that is delivered—last year it was $282 million—most of that work was delivered on budget and you can see that from the reports.

MS BRESNAN: My question relates to the midwifery model of care. Page 106 notes that there has been work towards improving the continuity of care models within the program. I am wondering whether this will involve looking at whether the sort of model that will be pursued will be the caseload model as opposed to the team model.

Mr Thompson: That is one of the specific issues that we are looking at. The models of care have not been completed for the birthing services but there will, as we have explained, be a separate birthing centre as well as delivery suites and obviously the tertiary level interventions where that is required. The work is continuing. We are definitely looking at a continuity of care model. We have had feedback over several years that this is something that members of the community are looking for and it is definitely one of the options that we are looking at, but it is not complete yet.

MS BRESNAN: So that will be a consideration if you move towards that sort of model over the other—

Mr Cormack: As Mr Thompson said, we had a very detailed external legal evaluation of the community midwifery program a bit over two years ago by Professor Mary Chiarella and co from the University of Technology in Sydney and it was a glowingly positive evaluation of the service, the safety, the quality of care and the continuity of care model, and certainly it is one that we think we need to bring forward into the future and keep everything about it at the moment that is being externally evaluated and found to be absolutely terrific, so we do not see any reason to change it. But clearly it has got to move location and we have got to look at growth in the future, so we need to look at the model of care in that context. But I think we will be sticking with what we have got.

MR HANSON: Emergency department categories 3 and 4: the rates there are 52 per cent and 51 per cent against your 2007-08 target of 60 per cent—

THE CHAIR: Can you give a reference number, please?

MR HANSON: Yes, page 96, strategic indicator 21. Your annual target is 60 per cent. What is your long-term target and when do you anticipate meeting that?

Mr Cormack: The long-term targets are the national triage benchmark targets. Seventy per cent for category 5 is the national one and we earlier had a higher percentage for that but we have adjusted it to be 70 per cent, the national benchmark. Category 1 and category 2 are as stated. I will just need to double check with Ian whether the 4 and 5 targets are—

MR HANSON: Are the annual targets your long-term targets? Do they meet the national benchmark?

Mr Cormack: Yes. Was your question whether the targets we are using are the national benchmark targets or are we meeting the targets? If it is the second one—

MR HANSON: The annual target you have got, the 60 per cent measure, is that the long-term target you are trying to achieve?

Mr Cormack: No.

MR HANSON: That is just your annual target. What is your long-term target?

Mr Cormack: It is on page 103: 100 per cent for category 1, 80 per cent for category 2, 75 per cent for category 3 and 70 per cent for categories 4 and 5. They are the long-term targets. As mentioned, we are already meeting 1, 2 and 5 and over the last reporting period we have made improvements on 3 and 4. But that has been in a context of very significant growth in activity at the hospital and also significant growth in category 1 and 2 presentations.

MR HANSON: Again, we have this increase in demand. Do you have a view of when you will meet that national benchmark figure? Have you set yourselves a three-year plan, a five-year plan or a one-year plan?

Mr Cormack: Our plan has always been to meet the national targets, so the long-term targets are what we are aiming for, but we will be setting the targets for 2009-10 in the context of the budget and that is a matter for government to determine what we would be looking for in 2009-10. Our long-term targets have always been the national benchmark standards. We also need to bear in mind the new healthcare agreement, which the ACT has signed up to, which clearly specifies the national targets as what we are going to be required to deliver upon over the course of the agreement. At this stage they are not saying that that must be met in year one but they are saying that we must be able to meet those targets.

MR HANSON: In category 5, the number of people who present for treatment and then, I guess, give up, for want of another word, is that recorded and is that embedded in these statistics? If people turn up, wait for four hours and then go, do you record those as people who were not seen within the correct time? What do we do to track those people and record the statistics of people who just gave up?

Mr Cormack: We keep track of people who do not wait. That information does not form part of the national data set but it does form a very important piece of information for the Calvary and TCH emergency departments to have a look at the trends there—what time of day and what types of patients they were. Overwhelmingly, they are category 5 patients and, generally speaking, for reasons known to themselves they decide they are not prepared to wait for the allotted time. People make that decision. They do not actually discharge themselves but they go on their own decision.

MR HANSON: Do you have those figures? Are they in this report or are they provided separately?

Mr Cormack: I do not know that they are in this particular report.

Ms Gallagher: We have them.

MR HANSON: Could I have them?

Ms Gallagher: Yes.

MR HANSON: Thanks very much.

Ms Gallagher: Again, it is not used as a measure of performance of an emergency department.

MR HANSON: No, but I think it is indicative. If people are—

Ms Gallagher: I am just trying to put it in context. They are not used in any national report as a measure of performance of an emergency department.

MS BURCH: Not in any jurisdiction?

Ms Gallagher: No, or nationally. I am just putting it in context, around when you do get the information, how you use it.

MR HANSON: If you have got a statistic that says people are giving up in our emergency departments and saying, "I'm not going to wait any longer," whether it is in these reports or however you measure your statistics, I think it goes to forming the picture of how the emergency departments are performing. I think that would be a fair statement.

Ms Gallagher: That is what I am saying: it does not go to how the emergency department is performing at all, and it is not recognised by any expert or in any discussion on emergency department performance—the "did not waits", as they are categorised. It probably paints more of a picture around access to other healthcare options, or lack of, in terms of access to free health care. So we have responded, and the way we are responding is through our nurse-led clinics which we will operate at the hospital. That will be an excellent avenue. We have CALMS in the corridor at the hospital where people can go—category 5s, perhaps more than most, are suited to go to CALMS. So there is already an option there, but it is expensive for some people. You can have a busy emergency department—

MR HANSON: Is it $70 or $80 on the weekend?

Ms Gallagher: Seventy dollars on a Sunday; I think Sunday is more expensive than Saturday. By the time you do that, you pay for some antibiotics and all the rest of it, we acknowledge that it is expensive. But those doctors are trying to earn an income as well.

MS BURCH: And that is consistent with other jurisdictions' after-hours services attached to hospitals—the cost?

Ms Gallagher: It depends on the model. Our contract, and the way we fund it, is with CALMS. CALMS are private billing; they are not a bulk-billing service. That is the way CALMS operate. They use doctors from existing general practice to roster on, and that is how they fill the shifts, and they earn an income from that. That is the arrangement we have. They are a very good local service, and we are very happy to support them. And they do meet the needs. They are busy clinics as well, but we do acknowledge that if you are category 5, there are 150 people that have come in through the emergency department which, at the moment, on average, is what Canberra Hospital is dealing with every day. So there are 150 people; 145 of them are sicker than you. People will make the decision, "Well, I might not wait." They might not even go to CALMS or they might not have the money for CALMS and therefore the gap is: how do we deal with our less urgent patients who need access but perhaps are not prepared to go to CALMS? The obvious gap there is what we are seeking to meet with our nurse clinics.

MR HANSON: I just think it would be useful if we recorded it and just had some facts around that, so we understood who is not going—

Ms Gallagher: There are no facts around it; you just record it. "Did not waits"—this many. Then people can form their own view of that. I think it is useful to report all aspects of hospital performance. I have always been a big supporter of it. That is why we signed the national agreement. That is why we do our quarterly performance reports, and annual reports sit outside that. I think it is extremely useful and it is a responsibility of health systems to report to the community about how the community's money is being spent on the provision of health services. I am less supportive of data that does not indicate performance and does not really add to the discussion of how health services are being delivered, which is perhaps why it does not appear in the way you seek. But we do have the information and we are happy to give it to you.

MR HANSON: Thank you.

THE CHAIR: Page 214 of the annual report notes that ACT Health spent $195,966 to assist community organisations to develop, implement and evaluate falls prevention programs in residential aged-care facilities. Can you give us a little more detail about what this work entailed?

Ms Gallagher: I am sure we can. This is part of the health pact grant. We have the old health pact, which, a couple of years ago, as part of the functional review, we brought internally into ACT Health and it is now the ACT health promotion grants program. That program is about $2 million overall. Within that grants round, we have a number of subgrants or subrounds. So there is the community funding round, falls prevention, health promoting schools and the communication and learning and development program. They come out at different times of the year, usually, and people can apply for them. So there is a certain amount of money that is in the health promotion and grants round that is specifically for people to work on falls prevention in aged care. Those programs are funded annually, and it allows for innovation and meeting local needs.

Dr O'Brien: Falls prevention is a very big issue, as you would be aware. For older people in particular, as one gets older the risk of falling is greater, and as one gets older, particularly with women, the risk of osteoporosis is higher. So when you fall, you will typically break something, and often it is the hip—the neck of femur. That is a massive event for an individual's health. To go into hospital and have a major operation is a big deal for an elderly person. It is also extremely expensive for the system. In terms of cost, morbidity and the impact on the individual, it is a very big deal. So it is clearly something that we target and we try and prevent as much as possible.

THE CHAIR: The question relates to what we have actually done with that $196,000. What programs have been put in place and what outcomes have occurred?

Mr Cormack: With respect to the outcomes, if you go to page 93, you will see one of our 23 strategic indicators—and these are the high priority areas for the healthcare system. For strategic indicator 12, we set a target there—which I might say we are meeting—for a reduction in the rate of fractured neck of femur, and we monitor that on a regular basis. We have got a long-term target of six per 1,000 residents. Our target last year was 6.6, and we actually achieved 5.4. That is how we monitor these things. So you can see we invest money in the sector; they know what works within their particular environment; they know what the science says. Our team evaluate the bids that come forward and then we put in place a monitoring system, and we are able to report a very positive outcome like that. For every fractured neck of femur that we can prevent, the cost of looking after a single episode of fractured neck of femur in the acute system would be a minimum of about $25,000, and tying up a bed for sometimes in excess of a month. It can also lead to early deterioration of a person who otherwise might be living to the fullest of their abilities in either a low-care or a high-care residential place. So that is really health promotion and primary prevention in action.

MS BURCH: I have some questions on page 105 around Canberra Hospital. Firstly, there is mention here of a new department of ophthalmology starting in January 2008. It is early days but can you give us an update about how that is working?

Mr Thompson: It is going very well. We are experiencing very high levels of activity and of good satisfaction rates for the service. The service was established initially to provide specifically for vitreo-retinal services which were not hitherto available in the ACT, and patients were moving to Sydney for that. That is a particular form of eye care, as the name suggests, predominantly to do with the retina and some of the disorders associated with it. We recruited a surgeon specifically to provide that service. That service has been very beneficial in that the number of people who have moved to Sydney as a result has dropped considerably. We have also established a general ophthalmic clinic at the Canberra Hospital which deals with emergency cases, which previously had been a bit of an issue in terms of being able to respond quickly. We always had the emergency capacity through the emergency department but this gives us a specialised ophthalmologist who is available more readily to provide that care as well. So that is where the service is at the moment. At the moment we are looking at potential for expansion of the service, and particular areas where we might recruit some more specialist ophthalmologists. But we do not have any firm directions at this stage.

MS BURCH: And there was mention here about putting some registrar or training opportunities in there?

Mr Thompson: Yes. We have a fully operational training program. This is actually one of the best aspects of it. Previously we did not train ophthalmologists in Canberra. Consequently, we were dependent on recruitment from interstate to maintain our ophthalmologist numbers. Now, with our own local registrar program, we should be able to attract and retain more ophthalmologists in Canberra.

Ms Gallagher: It is a real success story, I think, the ophthalmology unit. I have met a couple of patients who had a detached retina. It is a fairly common piece of work that you would have been sent to Sydney for. It has to be dealt with pretty quickly. Now it can be dealt with locally.

MS BURCH: So these are local folk that previously would have gone to Sydney but are now being cared for here?

Ms Gallagher: Yes. We did not have this service. It is a new one. That is part of growing the system to meet our needs. At the same time we are trying to focus on all the things that we have been doing in the past. Perhaps the biggest challenge with the new ophthalmology department is where we are going to put them. They have been inundated with demand, beyond our expectations. In terms of growth of the service and also being located within the hospital, at the moment they are occupying a pretty small corridor. That is what we have been working on with them. In the long run potentially there are some opportunities to not have them in the hospital. That is something that we are—

MS BURCH: Putting them offsite?

Ms Gallagher: When we look at how we link our community health centres with the hospital in terms of the new development and opportunity, we look at what services we could offer in a community-based setting, as opposed to bringing everyone to the hospital. Certainly the department are interested in that. They may fit potentially within one of those expanded community healthcare facilities or community health centres. We are working on that at the moment, but they are doing a very good job.

MS BURCH: I have another question on that page.

THE CHAIR: A supplementary?

MS BURCH: No. It is about Canberra Hospital but the emergency department. I note the dot point at the top. I thank you, Chair, for your acceptance. There is an allocation of a paediatric registrar and a paediatric waiting room. What sort of impact has that had on the paediatric throughput there?

Ms Gallagher: This is an area we are placing quite a lot of focus on. We do not have the numbers to sustain our own paediatric emergency department. When we were looking at the women's and children's project we looked at whether or not there was an opportunity for separate access for paediatric patients, but we just do not have the

numbers to support a stream like that. Having been a patient a number of times at the hospital—not myself but with children—and as the minister, it is one area where I think children present particular challenges: when you are in a waiting room and looking after them, how do you get through the emergency department and that journey?

The emergency department is primarily set up as an adult short-stay facility. We have been able to have a paediatric unit within there. I think there are about six beds in a little enclave which is set up for children. There are not too many toys but it is a friendly environment. It is from an infection control point of view, not because we are mean, that we do not want them to have toys.

MR HANSON: It does have some toys in there; I can vouch for that.

Ms Gallagher: Yes, but they are washed very frequently. The paediatric registrar helps in the sense that you have a link and you work closely with the paediatric ward for children that may be coming through and being admitted. All areas of the emergency department rely on other areas of the hospital to meet their patients' needs, particularly if a decision has been made for admission to the hospital. That creates links and specialised care for those children, although we do work very closely with the paediatricians in the hospital, as well as the registrar ward.

The waiting room has probably been a little more—not controversial, but there have been mixed views on creating a room like that. I know that from an infection control point of view some health professionals see it as being maybe not the best thing to do in that area. It is better to have fewer areas to clean and keep tidy. You will know from the emergency department waiting room that it is pretty—

Mr Thompson: Bare.

Ms Gallagher: Yes, "bare" would be the word. However, we acknowledge that from time to time children are waiting in the waiting room and it is a difficult time for parents. I think increasingly around the country we are seeing more child-friendly waiting areas. We proceeded with that knowing that it was going to take a bit of time for people to get used to the idea—people who work in the hospital—but I think it has been welcomed by parents. It was a pretty low-key project. It was not officially opened or anything like that. It has just become part of the furniture. People put a lot of effort into it. The artists who painted it put a lot of effort and thought into those paintings. I do know, if you have had the opportunity to have a look at it, it is quite a small area, but for children who are waiting we hope that it will alleviate some stress for them and their parents.

THE CHAIR: Thank you, minister. Moving on, Ms Bresnan.

MS BRESNAN: Page 140 mentions the ACT Ministerial Advisory Council on Sexual Health, HIV/AIDS, Hepatitis C and Related Diseases. It notes that they were consulted on the draft adult corrections health services plan and they have made a formal response to government, or they provided a formal response. I appreciate that you may not be able to speak about this if it is in confidence, but I was wondering whether they made recommendations on the needle and syringe program.

Ms Gallagher: From memory, they did and, from memory, they were in support of a needle and syringe program at the jail.

MS BRESNAN: Is it possible to get a copy of their response?

Ms Gallagher: For sure, yes. I have no problem with that. It is a very effective council. I think it was chaired by Richard Refshauge.

THE CHAIR: Thank you, minister. So you will provide further information for Ms Bresnan?

Ms Gallagher: Yes, we can provide that advice.

MS BRESNAN: It will be good, if it is possible, to see their response.

Ms Gallagher: Yes, you can have that.

THE CHAIR: Thank you.

MR HANSON: Leading on from that, in a way, is the incidence of suspected illicit drug-related deaths. Do you record those in the ACT?

Mr Cormack: We do contribute to a collection. I do not know whether Helene or Eddie would like to make a comment on that or—

Mr Thompson: We do not specifically collect it. We rely on the coroner's database. There is a national coronial database that collects this information. Obviously, when it comes to making a finding on the cause of death, that is the primary role of the coroner; hence we rely on the coroner's database. We have access to the coronial database and contribute information that we have as well.

MR HANSON: So you are not retracking any trends in terms of increase or—

Mr Thompson: We definitely track it. It is just that we do not collect it. In terms of the information that comes out—

MR HANSON: Okay. So you have got that information and you use that information to look at trends either up or down.

Mr Thompson: Yes.

MR HANSON: Do you know where those trends are going or what that measure is at the moment, approximately? I know it would vary year to year. In terms of suspected drug-related deaths, what order of magnitude are they, and are we increasing or decreasing?

Mr Thompson: I will need to take that one on notice; I do not have the figures at hand. We can get that to you.

MR HANSON: Thank you.

THE CHAIR: I refer to page 40. These are budget-related matters which I would like to come back to. The note on non-ACT government user charges is that as a result of increased activity there has been an increase of $6.9 million in costs in cross-border interstate health receipts. Are there any outstanding or ongoing issues or negotiations with the New South Wales government concerning these payments, considering the activities that we have seen in New South Wales?

MS BRESNAN: Ongoing, yes.

Mr Cormack: I think it would be fair to say that there is always ongoing dialogue with New South Wales over the cross-border funding arrangements. For the information of the committee, we settled on a method and a mode of payment following arbitration a bit over 12 months ago. That pertained to the Australian healthcare agreement period which has just concluded, although it has been extended for 12 months pending the introduction of the new agreement on 1 July 2009.

I think it is fair to say we keep a close eye on that. Off the top of my head, it is a bit over $80 million a year that we get through that agreement. That was an arbitrated outcome. We actively monitor the activity. We are in ongoing discussion with New South Wales on whether the data is correct and supplied on time. They provide us with an ongoing payment, plus they also make back adjustments for previous years and previous periods because the delivery of the payment is contingent upon acceptance of coded data, and some of that coded data can take quite some time. Certainly at the present time the agreement is in place. They are paying their bills. We continue to monitor that closely and no doubt we will have further discussions with New South Wales while ever there is an agreement in place. It is a lot of money to them and it is a very significant amount of revenue to the ACT public healthcare system.

THE CHAIR: When you say they continue to pay their bills, are they up to date on paying their bills?

Mr Cormack: As far as I am aware, they are up to date, but it depends on how you define up to date.

THE CHAIR: Ninety days, 120 days?

Mr Cormack: It is not that—

Ms Gallagher: They do not pay like that.

THE CHAIR: Two years?

Mr Cormack: No. They make back adjustments for previous years. They pay a certain amount on an ongoing basis and then we present them with new data which may reflect periods of activity of more than six months ago. Then they make a further payment on that. But generally speaking, by the financial year end all things are reconciled and we have generally managed that pretty well. We do not have any

issues with their payment pattern at the moment.

MS BURCH: On page 115, in the mental health area, there is a comment, in the last dot point just above the purple-coloured box, about a better general health program and linkages with the mental health clients, with a focus on better general health. Can you tell us a bit about that plan and how it works, if it is indeed working, and how it is going?

Dr Brown: The better general health program aims to link consumers who are registered clients in our community mental health teams with general practitioners. It commenced in 2005 as a pilot program out of the city community mental health team and it enrolled a number of clients and GP practices. The GP practices were approached and asked if they would be willing to participate. They agreed to do that and they agreed to bulk-bill the consumers under Medicare for the provision of general health services and to follow them up as required or indicated by the results of their initial appointments. To date the program continues at city mental health. We currently have over 100 consumers registered with GPs. There are 12 practices and 50 GPs enrolled through city mental health. In last year's budget we received some additional funding and we are in the process at the moment of rolling that out through the Belconnen community mental health team; our aim over time is to extend it to all of our community mental health teams across the ACT.

Effectively it links up consumers who have not been accessing general health care with a GP. We have a program nurse who supports that; they remind consumers about appointments and will assist them with transportation if that is required et cetera. So we have had a greatly enhanced range of screening conducted and follow-up treatment and care. It has extended from GPs to some dental care as well.

MS BURCH: But the primary case coordination sits within the mental health care provider?

Dr Brown: Yes. We have one program nurse that coordinates for each of the regional teams.

MS BRESNAN: I have another mental health question but in relation to the Transcultural Mental Health Network. Page 137 notes that secretariat support is provided to them. I apologise if this is somewhere in the report but I could not find it. Are there other services they are funded for by the ACT government?

Dr Brown: That is a question for my colleague in the policy area, not me.

Mr Bromhead: The Transcultural Mental Health Network is a network of interested people and organisations that come together to facilitate information exchange—between members of the network primarily but also to help build up cases for proposals around supporting transcultural mental health in the ACT. At the moment there are two projects that are being undertaken as a result of activity over the last couple of years with the Transcultural Mental Health Network. In the last budget there was provision made for a transcultural mental health liaison officer who is embedded in the clinical service, in Mental Health ACT. I will throw that one back to Peggy because it falls within clinical services as to how that liaison position will fall out.

There is a project officer that will be sitting with the Mental Health Community Coalition of the ACT, which is the ACT peak body for the community organisation mental health services. That project officer will also be working to assist the capacity in the non-government sector around transcultural mental health understanding. They are the projects that have come specifically out of the Transcultural Mental Health Network activity.

MR HANSON: My question is around the staff shortages. We talked about this the other day. I refer to page 114 in the report. It says:

> Internationally, a shortage of mental health clinicians is adversely affecting the provision of mental health services, and MHACT has experienced this major workforce challenge across inpatient and community-based services.

We know that there have been problems with the aged facility at Calvary and the ability to open that with the number of beds. Do you see this as a trend that is getting worse or improving? Are we confident that we have the strategies in place to see vacancies in this area filled?

Dr Brown: It is going to remain a challenge—there is no doubt—but recent trends are improving rather than deteriorating. In terms of our recent uptake for postgraduate mental health nurses, it is the highest intake that we have had for a number of years. We have currently, for example, got more occupational therapists working in the service than we have ever had and our medical staffing numbers are higher than they have ever been before, so there are lots of positive trends there. We do have in place, however, a number of other strategies to ensure that we are continuing to be able to recruit and retain staff across all of the disciplines.

MR HANSON: What is the percentage of vacancies across the sector; do you know?

Dr Brown: It varies depending on whether you are talking about inpatient or in the community. The inpatient sector is the more difficult sector to recruit to and again it varies depending on whether you are talking about older persons or the adult unit. At the moment I would have to take it on notice to give you the precise figures but the advice I had last week was that we had eight vacancies in the PSU for nursing staff.

MR HANSON: And just as a follow-up—the crisis action team? It seems that a lot of my conversations with the mental health community include that that is a service that people want more of and that at the moment, because of understaffing, it is not able to fulfil all its functions. Is there any expansion in that mooted?

Dr Brown: The crisis team currently is recruiting to permanent vacancies, but the positions are filled. Shifts are always filled. Generally speaking—there is the odd exception—there is no lack of response due to unavailability, but sometimes it is staffed by overtime shifts, for example. However, I have to say that our primary strategy is that, rather than enhancing a crisis team to respond, we want to enhance the function of the community teams, who undertake crisis response for registered clients. The basis of that is that, if the regular team is able to more appropriately meet the needs of people, we prevent it getting to a crisis point. We are working to enhance

that capacity, to provide more appropriate care within the regular community team and enhance their capacity to provide a response in a crisis and reduce the reliance on a crisis team of people who do not usually know the client so well.

MS BURCH: On the workforce and meeting need, the dot point above that talks around supported accommodation and step-up, step-down facilities. Are those facilities meeting the need of better supporting people and therefore they are not slipping into the crisis model?

Dr Brown: Generally I would respond yes to that. The caveat to that is that the adult facility has been open only since last month, so it is quite early to be able to say definitively. But certainly they are operating at full capacity and there is very positive feedback about both of the facilities that are open.

MS BURCH: And there is a youth facility? Has that been operating longer?

Dr Brown: Yes. It opened in April last year and generally operates—it has five beds, generally operating at full capacity and there is a very good response. It works in conjunction with the CAMHS team, but we have a clinician based there nine to five on Monday to Friday with support from the crisis team as required out of hours.

THE CHAIR: We will move to page 107 of the annual report, Calvary Public Hospital. It states that ACT Health funds Calvary through an annual performance agreement. What are the details or performance indicators of this agreement?

Mr Cormack: I will give a top level view and ask Ian Thompson to provide some of the details. In essence, we sign an annual funding and performance plan with Calvary that specifies a range of government priorities. As you would be aware, it is 100 per cent government funded so it must comply with government policy directions. The way that we manage that is through the specific and explicit setting of targets around emergency department timeliness, access block, elective surgery throughput, availability of bed days for specific services such as the older persons mental health unit and the aged care unit, and submission of data. Perhaps Ian might like to add to that.

Mr Thompson: Our other indicators include inpatient activity, where we set a target in relation to cost rates. Mark has covered most of them but we also have a series of developmental activities that we agree on an annual basis where we are looking to do work in particular areas.

THE CHAIR: What is the success rate of Calvary in meeting this agreement?

Mr Thompson: Calvary usually meets its targets.

Mr Cormack: They deliver well.

Ms Gallagher: And if they go over, we pay.

THE CHAIR: Are there any other questions on this?

MR HANSON: I have another one. Just referring back to the report from 2005-06, in there you talk about developing educational programs to enable people to better manage their chronic conditions, one of the strategies being adopted by ACT Health. Can we see where we are at with that?

Mr Cormack: There have been a number of funding allocations that have been made over the last three budgets to address the issue of chronic disease. They have been incorporated into the chronic disease strategy 2008-11. This strategy aligns with the national chronic disease strategy. That was an Australian government strategy, and all state and territory governments agreed, signed in 2005.

There are some specific examples that we incorporate within that that are being progressed—developing a healthy lifestyle website to provide information on healthy eating and physical activity; and promotion of breastfeeding to encourage the proportion of babies breastfed up to six months of age. That has a lifelong health impact. We have also—some of us who are over 45—received in the mail a tape measure that has caused some behavioural change in some of us. That is about recognising that, when you get to 45, you need to keep an eye on your waistline.

MR HANSON: Can I just raise that one because I have read those documents and I know these strategies.

Ms Gallagher: Did you get one of those tape measures?

MR HANSON: I did not need one.

Ms Gallagher: You didn't need one or you didn't get one?

MR HANSON: I didn't get one. I am not over 45.

Ms Gallagher: You'll be getting one when you are over 45. You can borrow someone else's. But you do not need it; you are right.

MR HANSON: At the moment.

Ms Gallagher: My brother-in-law thought I sent it to him specifically. That is how offended he was.

THE CHAIR: Minister, time is running out so could you answer the question.

MR HANSON: The issue is that with some of these programs there seems to be a failure in coordination. For example, the advert that came out with the tape measure, referring to it, which was a very effective national strategy—there had been very little advice provided to the ACT prior to that being taken up. I think there was only about a month's notice. There did not seem to be a comprehensive strategy in the ACT to take advantage of those millions of dollars that were being spent federally in the advertising campaign. Have we addressed that situation to make sure that, with these prevention strategies around chronic disease, when they are taken up by the federal government, we know they are coming and we have then developed our own strategies so that we essentially get on the back of them? Have we fixed that problem?

Ms Gallagher: Definitely.

Mr Cormack: The short answer is yes. That was a COAG funded initiative that came out of the ABHI, the Australian better health initiative, which is an initiative of the previous federal government. The preparation of the education material, the release of the tape measure campaign and the co-signatory on the letter with the Division of General Practice were all tightly coordinated. While there might not appear to have been a lot of notice, the ad was meant to confront people and identify risks, and it was targeted to concentrate around a particular point in time. Certainly the general practice community and the range of health promotion agencies that we work with were all well aware of that. It may not have been readily apparent outside, but it was a planned campaign.

Ms Gallagher: The letter and the tape measure arrived, I think, a month or so after. The advertising kicks off, it gets into people's heads and then they get the letter. General Practice were consulted. They knew it was coming because on the letter it said, "If you are concerned go and see your general practitioner." So we do all of that communication, as much as we can.

The other example of something like that would have been the bowel cancer screening program which the commonwealth ran as well. We did a lot of work on that because the impact for us was considerable, considering we could expect the number of people who needed a colonoscopy to increase and that meant demand for public services would increase. We were able to monitor and manage that pretty well as the campaign rolled out. There is a lot of coordination that goes on. I think for the everyday person who might not be in the loop about that it would seem that—

MR HANSON: My advice on that did not just come from the everyday person; it came from GPs. There was a criticism that there had been a lack of coordination and pre-emption about that strategy coming forward so that the ACT could then respond locally to take advantage of that national strategy.

Mr Cormack: In response to that, the letter that went out to every person aged over 45 was signed off by Dr Rashmi Sharma, who is the President of the ACT Division of General Practice, along with the Chief Health Officer. So we did go through the organised channels of coordination with General Practice, which is the ACT Division of General Practice. I take your point: for busy general practitioners to suddenly get inundated with a large number of people worried about their waistline and their weight and their risk factors it would be a cause of concern, and perhaps we did not get to every GP.

THE CHAIR: I would like to thank Mr Cormack and Mr Thompson for their contribution, and indeed all the staff who have contributed to the hearing today. Minister, you are not excused; you have to stay for the next session.

Short adjournment.

THE CHAIR: Welcome to this meeting of the Standing Committee on Health, Community and Social Services, and welcome to the Minister for Community

Services. Once again, the offer is there if you want to make a preamble before we start.

Ms Gallagher: No, I am happy to move straight to questions, in the interests of time.

THE CHAIR: I will ask the first question in that case. It relates to page 7 of the report dealing with community support and infrastructure grants. Has the Canberra social plan been reviewed and updated? If so, when, and what changes were made?

Ms Gallagher: I think this is going to be an issue that we had with the previous report. That covers the Chief Minister's area of responsibility. I am not trying to obstruct the committee. It is just not something that sits under my portfolio.

THE CHAIR: Is any component yours?

Ms Gallagher: The review of the social plan is not because it is across government. I do not know whether Martin can add anything.

Mr Hehir: The review of the social plan was undertaken by the Chief Minister's Department so it is probably best answered through those officials.

THE CHAIR: Thank you. Ms Burch.

MS BURCH: On page 32, in relation to therapy, there are a couple of paragraphs on the Koori preschool program. How is that going? Is it meeting the needs of the Koori preschoolers and their families?

Ms Whitten: Therapy ACT is part of our responsibilities in the department. The Koori preschool initiative is going very well. It commenced at the beginning of 2008. It has allowed speech pathologists to work with the five Koori preschools in the ACT by identifying needs within the particular group and diagnosing any particular needs and then working with the families and the children in terms of any speech delays or any other development needs on speech. It has taken a little bit of time to work with the families just to gain trust but is a good initiative and it is working well.

MS BURCH: The focus is on speech?

Ms Whitten: Yes. It is the speech pathologists that are working with the children.

MRS DUNNE: Mr Chairman, could I follow up on the speech pathology issue?

THE CHAIR: Is it a supplementary question?

MRS DUNNE: It is not about the Koori program; it is about speech pathology and Therapy ACT.

THE CHAIR: You will get your turn in a moment. We are looking at supplementary questions at the moment, if you have any.

MRS DUNNE: Thank you.

MS BURCH: I do not have any questions.

THE CHAIR: In that case it is your question.

MRS DUNNE: While this witness is here, I have a couple of questions about speech pathology. I see a number of people from the autism community who are very concerned about the provision of speech pathology services. What has changed in the past 12 months, or what developments have there been to the provision of speech services specifically to the autism community?

Ms Whitten: There are about 22 speech pathologists in Therapy ACT when fully staffed. There have been a number of changes in terms of how we work with families. A few years ago the government funded an autism and family assessment program and I think we have talked about that at previous committees. So the assessment side has been quite well developed. We are looking at different models in terms of the treatment side, with the introduction of the commonwealth funding last year. We are also looking at working with a New South Wales organisation called Aspect to look at different models in terms of service delivery.

MRS DUNNE: What you are saying is that there has been a body of work done on assessing the needs of particular children but beyond that we are still thinking about how best to deliver services.

Ms Gallagher: Certainly the numbers that I have seen have been about demand for speech therapy—

MRS DUNNE: It is huge, it seems to me.

Ms Gallagher: It is; it is massive, and not just for children with autism but across the board for children with some developmental delay. In order to meet that pressure I think Therapy have done what they can. They have been very focused on improving access to services but, outside of additional appropriation and recruitment of speech therapists, there is not a great deal more Therapy can do about improving access to speech therapists. I think we are very lucky that we are fully staffed. The private sector is lacking as well, so there are not options for parents in the private sector. Because of that many parents at the moment are going to Goulburn and at times Sydney, where there is more private sector speech therapy going on, but we are operating to full capacity. We are fully staffed. We made some commitments in the election specifically on this area of pressure. We have worked very hard to do everything we can within resources and now it is simply a resource pressure that needs to be met.

MRS DUNNE: Thank you for that, minister, but can I go back to my question. You said, Ms Whitten, that there has been a body of assessment done.

Ms Whitten: Yes.

MRS DUNNE: And now you are looking at models of service delivery. What are the models of service delivery, and does it mean that the assessment is left hanging?

Ms Whitten: No. Can I just clarify that point. From about July 2003 until the end of last year, there were 460 assessments for autism and about half of those children were diagnosed with ASD. That is quite a well-developed program in terms of the assessment and it includes a family support program. That allows the therapists to work with the children and their teachers in terms of the ongoing treatment needs of those children.

MRS DUNNE: Where are the other therapists located, in units?

Ms Whitten: Yes.

MRS DUNNE: In every unit?

Ms Whitten: The assessment team is one discrete unit in Therapy ACT. It continues on a short-term program with the families after the diagnosis and then there are two regional centres for Therapy ACT, one in the north and one in the south at Holder. It is in those early childhood teams or the school-aged teams where the ongoing therapy work is continued.

MRS DUNNE: But they are done on-site in Kaleen and Holder.

Ms Whitten: Or at home or in a school.

MRS DUNNE: Is there someone who, for instance, goes out to the unit at Kingsford Smith?

Ms Whitten: The therapists and Therapy ACT work with the schools, which are funded by the Department of Education and Training. They work with the families and the children in their own centres but they also go out to the schools where the children go to school.

MRS DUNNE: How much time do they spend at school?

Ms Whitten: I think I would have to take that on notice.

Mr Hehir: We will take that on notice.

MRS DUNNE: Thank you. This question might also be taken on notice. Can I have some indication of the per capita cost of speech therapy for children in autism units or children who are diagnosed with autism? How much service do they get on an annualised basis?

Ms Gallagher: Is it just for children with autism or for children who are accessing speech therapy?

MRS DUNNE: I suppose I need both, but I would like the autism one highlighted.

Mr Hehir: Are you talking just about Therapy ACT? There is work that the teachers do to train the parents to do the work that the parents do. It is all regarded as part of the therapeutic process.

MRS DUNNE: No. I actually know what is spent on speech therapy in that area. I am encountering a number of people who are then supplementing that by some tens of thousands of dollars a year through private speech therapy. I want us, together, to come to some understanding of what the unmet need is and how we might address that.

Ms Whitten: In terms of that, the commonwealth funding, which has been made available from last year, allows $12,000 per child to access Medicare-funded services over a two-year period.

MRS DUNNE: It is $6,000 a year?

Ms Whitten: That is right. That is very new. We are still working through that. I understand your question. We will have to take it on notice.

THE CHAIR: Turning to page 17, strengthening the community, there is considerable uncertainty and concern in the community sector in relation to the proposal for portable long service leave. What is the government doing to ensure the policy does not adversely impact financially on already resource-limited community organisations?

Ms Gallagher: This is a bit of an ongoing piece of work. Community organisations are required to make provision for long service leave. The provision should be there. This is talking about how we, I guess, pull that money together and have it sitting somewhere similar to the construction and the cleaning industries portable long service leave boards which managed similar schemes to allow portability entitlement. This is something that employees within the community sector are supportive of. Employers are less supportive. But we have seen that in both the construction and the cleaning industries. Until they get a couple of years going, employer concerns do not get realised or their concerns ease.

We responded with this, at the request of the community sector, and made provision for it. Once we started the detailed design of how that scheme would work, I think the disagreement within elements of the community sector started to increase. At the end of the day, if the community sector does not want portability in long service leave and wants something else, I am pretty relaxed about that. This project was specifically our responding to them. The views of the community sector have since changed. You might have some more up-to-date info on this.

Ms Whitten: We commenced some consultations with the community sector and we are just concluding those consultations with employees at the moment. Most recently, we held some focus groups this week. We have had some good responses back from employees this week. We are doing surveys as well. Once that information is compiled, we will be able to present a report to the minister. No doubt, that would be made public. But we do recognise the concerns of employers as well.

MRS DUNNE: You said you consulted employees and ran focus groups. Has there been parallel work done with employers, with NGOs?

Ms Whitten: Yes. This has been consulted on for the last four years.

Ms Gallagher: It is a moving feast.

MRS DUNNE: There were budget commitments in the last budget. Is the timetable for that the activation of those budget commitments that have slipped?

Ms Gallagher: I would have to check out the stage. It was certainly staged to run its full year of operation next year.

MRS DUNNE: Calendar or financial?

Ms Gallagher: Financial. It had some seed money in this budget.

MRS DUNNE: It is to commence, essentially, in July?

Ms Gallagher: That is what it has been funded from. The original intention was that we have given ourselves a year in order to get the scheme developed and up and running and then rolled out. But there have been some significant shifts in views on this, once it appeared in the budget papers, from what had led to the decision to put it in the budget papers.

Mr Hehir: We have heard the views of some of the large community-based organisations who are unable to use some of the cash, when people leave, that they have had put aside to fund other things. That is an understandable view.

What we have not heard from is the smaller community organisations. We are actually out talking to them, as well as to employees at the moment, in terms of whether it is such an issue for them. There is certainly a view expressed by some of the community-based organisations that the cash flow is useful for them. But we have not actually had a lot of feedback yet from the smaller ones. They are ones you actually have to go out and chase. We have got a consultant doing that at the moment.

It is a difficult area. Everyone wants to find ways to keep community sector employees in the sector. This was, as I said, a suggestion from the community sector about how that would work. As we have actually gone further down the path, some of the other organisations have looked at it in detail and said, "Hang on, we have got an issue with it." We are responding to that. We will look at it and see what we can do.

Ms Whitten: In a way, we are leading other jurisdictions as well. So other jurisdictions are really interested in what we are doing in the ACT on this.

MRS DUNNE: I did notice in the discussions in the Public Accounts Committee yesterday with the cleaning industry long service, in particular, there seems to be an issue with people who stay in the long service leave system for less than five years.

Ms Gallagher: It is about access to that entitlement.

MRS DUNNE: It is about access to that entitlement. They do not have access to that entitlement. Therefore, what happens to that money? It is difficult with the cleaning

industry because there are a whole number of private sector organisations. Are you looking at money that might sit there which people cannot access for entitlements? In the social services sector, might there be some mechanisms for returning portion of that to community organisations?

Ms Gallagher: I think those issues are being examined. I understand that it has been around for awhile. After five years, you get pro rata access. So it is before five. To change that would change the whole nature of the entitlement, but a suggestion such as yours, where you return excess funds to the community sector, would be something that we would consider.

MRS DUNNE: You would have to do it on a good actuarial basis?

Ms Gallagher: And it would probably happen in the long run because of the start-off costs.

THE CHAIR: In the interests of time, you will have to keep your answers a little shorter.

Ms Gallagher: Sorry.

THE CHAIR: We will have to keep our questions shorter as well.

MS BURCH: On page 42 of the report, there are a range of notions that you might be able to answer but I am not quite sure. ACT concessions, is that yours?

Ms Gallagher: Yes.

MS BURCH: There was a review of the concessions program. Can you tell us a bit about the review and any changes that could have come from that?

Mr Hehir: From memory, the review of the concessions was actually tabled in the Assembly.

Ms Gallagher: It was.

MRS DUNNE: Before Ms Burch's time.

Mr Hehir: I might get Ms Whitten to talk about the detail.

MS BURCH: It may have been tabled, but how has it been actioned?

Mr Hehir: In terms of the actions that flow from that?

Ms Whitten: The review was conducted by the department. It was the first type of review on concessions that had occurred in the ACT since self-government. It was quite an interesting process to conduct it. I do not have the details of all the recommendations from the review, but what resulted in last year's budget were some changes in terms of who received an entitlement or a concession for water. That was extended to healthcare cardholders and to temporary protection visa holders. We have

been working across government to look at how concessions are applied and whether we can identify some other streamlining arrangements as well.

One of the other things that have followed after that was an extension of public transport concessions specifically for those residents who live at Oaks Estate who only have access to Deane's Buslines. In a sense, the follow-on from the review led to some other initiatives occurring. That has been very successful since September of last year.

Mr Hehir: I think the other key element was the people knowing what concessions were available and how to access them. One of the commitments that were made was actually the development of a portal. We have been working with the South Australian government who actually have a portal up and operating on concessions. They have given us permission to use their software. We would anticipate that would be up and in operation before the next financial year. That is just about helping people know what is available.

Ms Gallagher: Eligibility criteria and pulling across government. Several departments have concession programs operating underneath them. This is pulling it together. We continue to review our level of concessions and we will be doing a bit more extra work on that, if not in this budget directly, in the budget after, in terms of watching the impact of any rises in employment, any new pressures that come from the flow-on effects of the economic climate at the moment. Part of our responsibility is to respond to that in quick fashion.

MS BRESNAN: I have a question in relation to the domestic violence pathways program.

Ms Gallagher: The transitional housing program?

MS BRESNAN: Yes. I note that in the media recently there was some comment about what appeared to be a significant increase in domestic violence over this particular period. I was wanting a bit of an update on how the program is coping at the moment.

Ms Gallagher: I had a look at this. I am not sure that there was a marked increase in the amount of domestic violence occurring. There was certainly a marked increase in the amount that was reported in the *Canberra Times*. Any school holiday period, Christmas, Easter, always sees a sharp increase in the need for our social system to kick in. This has been a very successful program. Did you want to add to it, Maureen?

Ms Sheehan: The way in which we established the size of the program was quite mathematical, really, and scientific. In the first year of the program, the Domestic Violence Crisis Service normally, if they go to a crisis in the middle of the night and the women and children need to be removed from the home, access the on-call services of the supported accommodation assistance program. What they found was that, over the Christmas period, there were a set number of times that they were not able to find accommodation in the established services. What they had to do overnight was put women and children into motels or other temporary accommodation. The feedback they got from the women and the children was that it was terrible for them

and that sometimes they would leave and go back to the violent household just to not be in that situation.

What we were able to do was use properties from Housing ACT that were vacant because they were undergoing refurbishment and we provided—it has been a different number each year—in the first year, I think it was, 10 and nine in this last year. We fit them out completely and we provide those 10 properties into the domestic violence supported accommodation services just for the Christmas period.

What happens then is, when the Domestic Violence Crisis Service goes out to a call in the middle of the night, they are then able to access the property. They have the keys to the property. The property is ready to roll, with some food and basic toiletries and so on for the women and the children. Then the on-call workers come from the Domestic Violence Crisis Services and then, the next day, the women and children receive the support from the general service system.

What we have found is that—and each year this has happened—the women and children then transition out into the mainstream services so that, by the end of the Christmas period, when the properties need to be returned to Housing ACT for the refurbishments to occur, the women and children are in the mainstream service system and that it just rolls on from there. It is a very specific need, but we are able to accommodate it within our existing service system.

MRS DUNNE: When you say "the Christmas period", how long is that?

Ms Sheehan: It is generally from about the middle of December to the end of January, maybe from the start of December to the end of January.

THE CHAIR: We started a few minutes late. We will have one more question on this and then we will close this part of the session.

MRS DUNNE: Minister, various stages in the report—for instance, on page 49, but there are other places—refer to the satisfaction surveys. Is it possible to attain a more tabulated representation? Some other annual reports—education, for instance, in the past—have the sorts of questions and have them in a tabular form. Is it possible to do that?

Mr Hehir: It is. We do quite a number of different surveys and we survey a number of different types of organisations, but I can talk to Dr Jenkins about what would be an appropriate way of representing that.

MRS DUNNE: That would be great.

Ms Gallagher: On notice for this report or for the next annual report?

MRS DUNNE: On notice for this report, but also you might consider some way of putting it in the report in an easier to read fashion. I think it is better to have it in a table rather than a narrative.

Mr Hehir: As I said, there are a number of different surveys that are undertaken, and

different processes, but yes, we can certainly have a look at it.

MRS DUNNE: Have a look at it; that would be good.

THE CHAIR: Thank you for your contribution. Minister, you are still our captive here for another quarter of an hour. We will move to gender issues. I make my usual request to you: do you wish to offer any preamble?

Ms Gallagher: No, thank you. I am happy to go to questions.

THE CHAIR: What findings came out of the expert community sector member groups who progressed the domestic violence pathways project—page 187?

Mr Hehir: I might take some advice, but I think that project may be a JACS project. This is one area of the department I am not usually completely across so you will have to give me half a minute.

Ms Gallagher: Did your question relate to what came out of it?

THE CHAIR: Yes. What findings came out of the expert community sector member groups who progressed the domestic violence pathways project?

Ms Sheehan: If we go back to the domestic violence crisis initiative that we spoke about, that operated in its first year as a pilot for how we could quickly respond to the needs of women and children experiencing domestic violence when we did not have crisis accommodation available. But it was an instance of a more general problem: what happens if you get blockages in some parts of your service system so that people cannot access the service that they need at the time when they need it?

What we had happening inside the domestic violence crisis accommodation response inside our supported accommodation assistance program was very much like what you would see in a hospital if the emergency department is full but no-one can get a bed in the wards. What we had happening was that the people in crisis needed some support but they could not get a bed in the accommodation services.

What we were able to do was get the service system to focus back on how they were going to provide the service that we had actually paid them to provide in the way that they needed to provide it if the whole system was to keep moving. We saw in the first year of the domestic violence crisis initiative that we could introduce a circuit-breaker for a short period of time which did actually get the system moving again. It looked like a model which was going to be successful.

We established a pathways roundtable which was for all of the domestic violence providers to come forward and then talk about what they saw as other blocks inside the service system so that people would present to some services but not be able to have access to them. Through the pathways work, we have been able to establish what is the standard pathway for people experiencing domestic violence through the system and what are the blockages to moving on to the next part of the system and returning to life as normal.

That has been a very successful program. Moving on, we do the Christmas initiative, but we have also established a transitional housing program inside Housing ACT itself. That is another circuit-breaker for people who have had the experience where the crisis has been addressed; they are in the wards, so to speak; and they are perfectly ready to go on to their final accommodation in housing but the housing is not quite ready. The transitional housing program gives that exit point, and that exit point is again for people experiencing domestic violence but also for people experiencing other crises in their lives.

MS BURCH: On page 54, there are two areas: director scholarships and an ACT women's register. Can you tell me a bit about those programs? Are they having an impact on more women in high-level positions?

Ms Gallagher: The women's director scholarships are usually well sought after. There are four of them. That costs us about $10,000, from memory. They go through the Australian company directors course. The program has been actively subscribed every year. We seem to manage to get some women who would really benefit from the course but who otherwise would not be able to afford the course, because it is quite expensive. Those decisions are made by a panel, with recommendations to me to go through.

The register—again, in all honesty, this is good as long as it is used. Women put their names on the register but the value is in whether agencies go to the register. We open it up to the community and business sector as well for them to use if they are looking to make appointments. We set ourselves a target that 50 per cent of all appointments across government should be women, in areas where we have control over those appointments. There are a number of boards and committees where that is difficult—professional groups will make recommendations, and they go through an election in health, for example—but in those that we have control over we do. We did very well initially; then we slipped back, I think to about 48 per cent.

Mr Hehir: Forty-eight in March last year.

Ms Gallagher: Since then we have put in renewed effort, particularly in the cabinet processes, on appointments to require agencies to go to the Office for Women to seek information from the register and to really consider women when they are making their appointments. It is an ongoing piece of work that I continue to advocate through the cabinet process and to make sure that people are consulting with the Office for Women. It did get to where it was a bit of tick and flick. "Have you consulted the Office for Women?" People would say no and then go on and make the appointment they wanted. Now the cabinet office vets that pretty strongly to make sure that people are going to the register or considering women in the appointment process.

MS BRESNAN: My question is in relation to that somewhat. It is the Audrey Fagan scholarship program. Have there been any scholarships awarded since its introduction? I just ask that because I have not seen any publicity on it. I am just wondering whether some have been awarded since its introduction.

Ms Gallagher: The Churchill fellowships have. We have launched those.

Ms Whitten: That was in November.

Ms Gallagher: The graduate scholarships have, haven't they?

Ms Whitten: Yes, we have got two.

Ms Gallagher: The enrichment grants are ones where we have been consulting with Ms Fagan's family. They were an idea from her family. It is a $60,000 per annum allocation; it is split up between the fellowship, the scholarship and—I think it is $10,000—the enrichment grants.

Ms Whitten: It is $20,000.

Ms Gallagher: So it is 20-20-20. The enrichment grants—we are just in the process of finalising the details on that. Ms Fagan's family wanted them for a particular purpose and it is just taking a bit of time to work out how to get that program up and running.

Ms Whitten: Can I just correct the record about that? It is $20,000 for the postgraduate scholarships, $30,000 for the Churchill fellowships and $10,000 for the enrichment grants.

MRS DUNNE: I am going to ask a question about something that I cannot find. I thought that it would be in this general area, in the Office for Women. The grants—I think it was a $1,000 grant for people re-entering the workforce—

Ms Gallagher: Yes, the return to work grant.

MRS DUNNE: Is this administered here or is it in Chief Minister's?

Ms Gallagher: No, it is administered here.

MRS DUNNE: How long has that been operating now?

Ms Gallagher: Probably just over a year.

MRS DUNNE: What is the take-up rate?

Ms Gallagher: It has been very poor. To date we have had 34, and we had made allocation for 200.

MRS DUNNE: What is happening with the publicity?

Ms Gallagher: We have tried. I believe it is 60 who have taken it, but 34 this year. Some took it last financial year. We had 200 for this year, of which 34 have been taken, give or take a couple who might be in train now. We have gone back and had a look at whether our criteria are too hard. We have good publicity material that has gone out to a whole range of services and providers who might come into contact with women who would benefit from this. It is with the Women's Information Referral Centre. And we are continuing to ramp up publicity about it.

But it has been a very poor take-up. It was my idea and it is not turning out to be one of my best. I have asked the department to look to see whether we are missing the mark and there is a bigger need or whether it is to do with publicity. With the 60-odd women who have got it, it has significantly supported them as they have returned to work or sought further training. It is an ongoing piece of work. I am not very happy with it but I am a bit reluctant to just say, "Well, that didn't work," and hand back the money. Can we look at shaping it a bit better? We are working with every organisation I can think of.

Mr Hehir: One of the things that we have to do—hopefully, I am not blindsiding the minister—is look at whether the Housing ACT database might support a direct mail. There are single mothers, in particular, in there. From another perspective, we think it would be fantastic if they could get back to work. They may not be collecting this information. That is a process we have to work through internally, but it may add to it. We are thinking about a number of options there.

MRS DUNNE: Is it possible that $1,000 is not enough if it is mixed over training and wardrobe?

Mr Hehir: I am not sure that we are getting that feedback. I think people have been quite happy with the amount. We certainly have not had feedback from applicants that it is not enough.

MRS DUNNE: This is on notice. Could the committee get a bit of a rundown on the sorts of things that the 60 or so applicants have used the money for?

Ms Gallagher: Yes.

MRS DUNNE: That would give some indication of whether they are using it more on wardrobe and less on training.

Ms Gallagher: It is a variety.

Ms Whitten: It is childcare, clothing and a variety of different courses.

Ms Gallagher: We are being quite strict about that. There are questions as to whether we are being too strict about what it is used for. It is essentially a cash payment, so we need to be strict about what we use it for. But we are looking at that as well. Are we making it too hard for women to access?

Mr Hehir: We do not have the criteria that we have in place.

Ms Gallagher: I was worried about oversubscription to this program.

MRS DUNNE: I am a bit flabbergasted. I know that I have asked this question a couple of times. I am flabbergasted that there is not a bigger take-up. I know that the Department of Defence run similar sorts of programs. Might it be worth talking to Defence about how they run their programs?

Ms Whitten: The other element of the criteria is that it is to assist women who are not eligible for any other commonwealth or territory assistance, so that might be also one of the barriers.

Ms Gallagher: Maybe we can give the committee a snapshot of the women who are accessing it. I am sure that we can do an average age, how many kids and that sort of stuff—and how long out of the workforce. I am sure that we can do just a little snapshot—and what it is being used for.

Mr Hehir: We can pull that together.

MRS DUNNE: That would be helpful.

THE CHAIR: Thank you. We have reached the end of questions.

The committee adjourned at 12.46 pm.