ESTIMATES COMMITTEE D

Ms B. G. Stone (Chair)

Ms V. L. Barry
Mr S. W. Copeland
Ms R. G. Nolan
Mrs D. R. Pratt
Mrs D. C. Scott
Miss F. S. Simpson

FAMILIES, ABORIGINAL AND TORRES STRAIT ISLANDER POLICY AND DISABILITY SERVICES

IN ATTENDANCE

Hon. J. C. Spence, Minister for Families and Minister for Aboriginal and Torres Strait Islander Policy and Minister for Disability Services and Minister for Seniors

Department of Families

Mr F. J. Peach, Director-General

Mr S. Armitage, Deputy Director-General

Ms C. Taylor, Director, Child Protection Branch

Mr C. Callioni, Director, Finance and Asset Management Branch

Department of Aboriginal and Torres Strait Islander Policy

Mr F. Rockett, Director-General

Mr G. Skerritt, Deputy Director-General

Mr E. Klatt, Director, Finance and Administration

Ms R. Crisp, Manager, Land and Cultural Heritage

Mr P. Tones, Executive Services

Disability Services Queensland

Mr F. Rockett, Director-General

Ms L. Wherrett, Executive Director

Mr E. Klatt, Director, Finance and Administration

Mr B. Elder, Manager, Finance and Administration

Ms K. Dunning, Director, Regional Operations Directorate

The committee commenced at 8.32 a.m.

The CHAIR: I declare this meeting of Estimates Committee D now open. On behalf of the committee I welcome the minister, public officials and members of the public who are in attendance today. The committee will examine the proposed expenditure contained in the Appropriation Bill 2002 for the areas set out in the sessional orders of 18 April 2002. The organisational units will be examined in the following order: Department of Families; Department of Aboriginal and Torres Strait Islander Policy; Disability Services Queensland; and, finally, Department of Health. The committee has also agreed that it will have the following breaks: morning tea from 10.15 a.m. to 10.30 a.m.; a short break from 11.35 a.m. to 11.45 a.m.; lunch from 1 p.m. to 2 p.m.; and afternoon tea from 3.30 p.m. to 4 p.m.

I remind members of the committee and the minister that the time limit for questions is one minute, and answers are to be no longer than three minutes. A single chime will give a 15-second warning and a double chime will sound at the expiration of these time limits. An extension of time may be given with the consent of the questioner. The sessional orders require that at least half the time is to be allotted to non-government members. I ask departmental witnesses to identify

themselves before they answer a question so that Hansard can record that information in the transcript.

In the event that those attending today are not aware, I should point out that these proceedings are similar to parliament to the extent that the public cannot participate in the proceedings. In that regard I remind members of the public that, in accordance with standing order 195, the public may be admitted to or excluded from the hearing at the pleasure of the committee. I also ask that all mobile phones be switched off and that pagers be in silent mode. In relation to media coverage, the committee has resolved that silent television film coverage will be allowed for the opening statements by the chair and the ministers.

Before opening for questions I would like to introduce the members of the committee. I am Barbara Stone, the state member for Springwood and chair of Estimates Committee D. With me is Bonny Barry, the member for Aspley; Rachel Nolan, the member for Ipswich; Desley Scott, the member for Woodridge; Fiona Simpson, the member for Maroochydore; Stuart Copeland, the member for Cunningham; and Dolly Pratt, the member for Nanango. With the leave of the committee, the member for Gregory, Vaughan Johnson, will be joining the committee for the part of the hearing relating to Aboriginal and Torres Strait Islander Policy.

I declare the proposed expenditure for the portfolios of the Minister for Families and Minister for Aboriginal and Torres Strait Islander Policy and Minister for Disability Services and Minister for Seniors to be open for examination. The time allotted is four hours. The question before the committee is—

That the proposed expenditure be agreed to.

The first item for consideration is the proposed expenditure of the Minister for Families. I welcome the minister and her departmental officers. Minister, would you like to make an introductory statement in relation to all of your portfolios? If so, the committee does ask that you limit your statement to five minutes.

Ms SPENCE: Thank you, Madam Chair. Yes, I would like to make an introductory statement. Over the last four years there has been an unprecedented policy and budgetary focus on building our social capital, making Queensland a place of diversity and fairness with safe and more confident children, young people and families. This budget builds on that commitment and marks a significant turning point for the Department of Families.

We have delivered an additional $188 million over four years for the implementation of a comprehensive program of initiatives aimed at strengthening Queensland families. Annual funding for the Families Department, excluding funding provided for concessions, is now $194 million higher—that is 97 per cent higher—than when the Beattie government was elected, and $147 million higher than at the time of the 1999-2000 budget, when the Premier gave a commitment that the government would revisit the Forde inquiry funding recommendation year after year.

The strength of the government's commitment to increasing its expenditure on family services is clear when you consider that since 1998-99 the government's investment in the Department of Families has increased by more than 59 per cent. Over the same period general government revenue has increased by only 22 per cent.

I have said previously that it is not just the total sum of dollars that makes the difference. It is also about where we spend the dollars. The Beattie government recognises that there needs to be a greater focus on early intervention and support, and we are committed to increasing the funding of early intervention and prevention strategies from 13 per cent to 25 per cent in the next five years. We have released a major policy statement, Queensland Families: Future Directions, which details a suite of initiatives aimed at assisting families, our young people, our foster parents and our seniors. Queensland Families: Future Directions is driven by the commitment to build stronger, safer communities which provide opportunities and support for those at risk of being left behind—that is, young people whose families are in crisis or lack the means to ensure their children advance through school and beyond.

The community sector, which is the government's partner in making families stronger, also receives greater recognition and support. Over four years there will be a $33 million increase to offset increasing costs for the community sector.

Families are for all ages, and the government wants to raise the profile of seniors' interests and their role in the community. Queensland will now have a minister with specific responsibility for

seniors. I have added seniors to my portfolio to lead the government's response to a changing population and encourage debate about the policy changes of an ageing society.

This year the Beattie government will augment its considerable achievements across the Department of Families, Disability Services and Aboriginal and Torres Strait Islander Policy with increases in services and the provision of new services to support Queensland families and individuals, particularly those suffering disadvantage.

We are committed to making quality services and support available to more Queenslanders with disabilities. We have therefore provided an additional $26.8 million in funding this year to support people with disability and their families and their carers. I acknowledge that we still have a long way to go in addressing unmet need in Queensland; however, this government has made significant inroads.

Funding for the Department of Aboriginal and Torres Strait Islander Policy addresses initiatives identified in the government's response to the Cape York Justice Study, Meeting Challenges: Making Choices. The government is determined to work with communities to address the unacceptably high levels of alcohol abuse and alcohol related violence in indigenous communities. The Queensland government and Aboriginal and Torres Strait Islander 10-year partnership will continue to be developed as a strategic vehicle to address indigenous disadvantage in Queensland. Coordination of indigenous activities across government will also be enhanced with the establishment of the Cape York Partnership Unit in Cairns and a partnership secretariat in Brisbane. Only this week the Premier and I signed a commitment to partnership with ATSIC.

Finally, I would like to thank my directors-general and my departmental and ministerial staff for the extraordinary effort they have put in in preparation for the estimates committee hearing today. I would like to introduce the Department of Families officers at the table with me for the first session. On my right is the Director-General, Mr Frank Peach. On my left is the Deputy Director-General, Mr Steve Armitage, and next to Mr Peach is the Director of Finance, Mr Cesare Callioni.

The CHAIR: The first period of questions to be allocated is to non-government members.

Mr COPELAND: Thank you, Minister, for your time today and that of your departmental staff for each of the sessions you will be involved with. Minister, I refer to the Future Directions document, which contains much of the detail regarding the budget for the Families Department, and I thank you for agreeing to answer questions on that document. Page 15 refers to non-family based care for young people. In April we discovered that there were a number of young people being housed at Club Crocodile in Cairns. At the time you stated that there were no centralised records kept of how often that was happening or for how long. You said at that stage that you would implement a centralised database to compile those records. How many people have been involved in setting up that project and when did it begin keeping records?

Ms SPENCE: We have started keeping those records on a monthly basis, so each regional director is now required to inform central office each month of those kinds of figures. We began collecting that information in May. The reality is that the Department of Families started receiving computers in only 1989 and we still have a long way to go in our computer program in the department. A lot of the information you would expect to be collected centrally as a matter of course simply is not collected. That is why we have put aside $3 million each year for the next four years to upgrade our computer network and hopefully implement some programs that will allow us to more easily collect this centralised data.

Mr COPELAND: Since the collection has been done since May, could you please advise how many nights have been spent by young people in care in commercial accommodation?

Ms SPENCE: The figures for May indicate that 31 children or young people were placed in paid commercial accommodation during that period, for a total of 244 nights, due to no other suitable accommodation being available. What you have to realise is that these 31 young people are not necessarily children on orders. They are not children totally in the care of our department. They might be young people who come to the attention of our youth justice workers or youth workers throughout Queensland who have no accommodation for the night. We would help them with commercial accommodation on a short-term basis before we can find them more appropriate accommodation. Less than half of those young people were in fact on orders.

Mr COPELAND: Was that in May?

Ms SPENCE: That is in one month.

Mr COPELAND: Do you have June figures there as well?

Ms SPENCE: We do not have the June figures at the moment. We are still relying on a manual collection—that is, the regional directors making contact with the head office to give us those figures every month.

Mr COPELAND: Minister, I refer to the Forde report's recommendations that there needed to be adequate records kept regarding children in the department's care. You have explained that there have been no records kept because of computing problems in the past. How has it been possible to plan budgetary responses for the care of young people when those records have not been kept centrally and the size of the task has not been known at head office?

Ms SPENCE: It is not correct to say that no records are kept. They are certainly kept at a regional level. It is just a matter of those regional directors now notifying us on a monthly basis of those kinds of statistics. We are now collecting information on young people in commercial accommodation. We are now collecting information centrally on where the 3,500-odd children in our care are at any one point in time, but this is a fairly recent initiative of the department.

Mr COPELAND: You also responded at that stage that there was going to be a recruitment drive for foster parents, and I think that was announced on the last Sunday in April. How many additional foster carers have been recruited by the department since that date?

Ms SPENCE: I do not know if we can actually give you that figure at this point in time. The recruitment drive is fairly new. We have had hundreds and hundreds of responses from throughout Queensland. Some of those people who have expressed an interest in becoming foster parents will have contacted the department. A lot of them will have contacted our non-government partners, the shared family care agencies, to express an interest. In fact, I was down at Browns Plains last month opening the new Browns Plains office and I talked to the shared family care agency down there. They had received expressions of interest from over 85 people wishing to become foster parents. That agency is now going to follow up those people and start the three-month training program. It is probably far too early for us to say how many real foster parents we are going to get out of that exercise. We expect that at least two-thirds of the people who have expressed an interest will, once they have found out the details of being foster parents or even sometime through the training process, will drop out. I suspect that it will take us another couple of months to get some real figures about the number of foster parents out of this exercise.

We have set up a new unit in the department, an alternative care unit. For the first time we have officers centrally located working just on policies around foster carers, and that did not exist until a couple of months ago. We have for the first time set up a centralised 1800 telephone number for people interested in becoming foster parents to get information. In the past there was a fairly ad hoc way of getting in touch with these people or keeping in touch with these people and it was the responsibility of the regional offices, which obviously had other pressures. With a centralised number we have experts at the other end communicating with potential foster parents and we believe this will do a better job of servicing them, keeping them on board and making sure that they undergo the training that will be required if they are to become foster parents.

Mr COPELAND: I refer to the MPS at page 1-9 and the performance measurement regarding the percentage of initial assessments completed within 30 days. Can you advise the committee what the internal departmental measure of initial assessments awaiting finalisation on the last day of the month is and why that measure is not included in the MPS?

Ms SPENCE: I will just pass that question to my director-general.

Mr PEACH: The reason it is not at this stage in the MPS is that the performance measures were developed some years ago and at that stage it was not included as a performance measure. It is used as a measure internally in the department for management purposes, for tracking. When the department's outputs are reconsidered, as they are from time to time, there is an opportunity for us to update, modernise and to be more complete about the performance measures. So it is certainly something that we would be interested in looking at at that point in time.

Ms SPENCE: In fact I understand that the department has already been talking to Treasury about reviewing these output measures for next year's MPS.

Mr COPELAND: Perhaps through you, Minister, to the director-general, could he explain what that measure does actually measure?

Mr PEACH: I might ask Cathy Taylor, the director of the child protection branch, to go into that in more detail.

Ms TAYLOR: The current measure looks at the initial assessments completed within 30 days. At the moment that is a more reliable measure than simply looking at what is not completed at the end of the month because as you would appreciate some assessments are not started until the 28th or the 29th day of the month, so 30 days actually give us a much clearer measure of what is started and finished within 30 days.

Mr COPELAND: My understanding of that assessment is that it includes those where no assessment is possible, where there may be a part assessment or no outcome, where staff are unable to commence or complete the assessments, and where assessments are still under investigation. Would that be an accurate understanding?

Ms TAYLOR: No, this measure is about the percentage of notifications that require initial assessment where there has actually been an outcome, whether it be substantiated or unsubstantiated, that has been determined within 30 days. We are measuring those, firstly, that actually applied the initial assessment and then, secondly, where there was some outcome, whether there was substantiation or unsubstantiation.

Mr COPELAND: I was taking that definition from the Ombudsman's report into the circumstances surrounding the death of Brooke Brennan. That definition in the Ombudsman's report is incorrect?

Ms TAYLOR: No that definition in the Ombudsman's report is quite correct but it is actually talking about something quite different. What we are talking about here is the percentage of initial assessments completed within 30 days where an outcome is determined.

Mr COPELAND: Sorry, that is the figure included in the MPS but I was trying to clarify the position of the initial assessments that are awaiting finalisation as at the last day of the month, which is the one that the Ombudsman refers to.

Ms TAYLOR: As I said, the difficulty with that measure at the moment is that it captures all those awaiting assessment at the end of the month, including those that were only started the day before as well as those that were started at the beginning of the month.

Mr COPELAND: In other words, it is a waiting list of children who, for one reason or another, have not been able to have their assessment finalised?

Ms TAYLOR: As the director-general mentioned, it is certainly a management tool, but the most appropriate measure that we can look at is the percentage of initial assessments completed within the 30 days.

Mr COPELAND: Minister, could you advise the committee of how many initial assessments were awaiting finalisation across Queensland as at the end of June?

Ms SPENCE: There is a time lag and we would not have the information on the end of June yet. We could probably give you the information as at the end of April.

Mr COPELAND: If you could, that would be terrific.

Ms SPENCE: We can get that to you. We will take that as a question on notice.

Mr COPELAND: I have a copy of the Department of Families workload management strategy regional summary that I will table for the committee's information. It provides the details of those assessments awaiting finalisation on the last day of the month. According to that document, as at the end of March 2002—the figure does not go to April so I look forward to receiving that information—4,607 initial assessments were awaiting finalisation, of which 1,080 were priority 1 and 2,349 priority 2 and 442 priority 3 assessments were awaiting finalisation with only 1,024 cases finalised. Does this mean that there are 4,607 potential incidents such as the Brooke Brennan case around Queensland?

Ms SPENCE: No, it does not. What I can tell you is that all notifications are given a priority rating in the department's workload management strategy following an assessment of the concerns, the notification and a judgment about the level of risk to the children involved. When the notifications are rated at a priority 1, that is that the child is seen to be in immediate danger and is seen to be at a high risk of alleged harm continuing, those notifications are responded to within 24 hours. I understand that we have a 100 per cent response rate on priority 1 notifications. Priority 2 ratings are applied when a child is not in immediate danger but there is a high risk that the child may be harmed in the future. Priority 2 notifications are responded to within a fortnight. Priority 3 ratings are applied to a child who is not in immediate danger and the risk of future harm is low. These notifications are responded to within a month.

It is a normal practice in any occupation to manage workloads. This workload management strategy was implemented on 6 March 2000 and it is an approved strategy for prioritising responses to child protection notifications and to provide guidelines to staff in determining priority ratings. The prioritisation process recognises that the need to respond is separate from the capacity to respond. The practice guide for the assessment of harm and likely harm contains the decision-making framework used by departmental staff in assessing harm and the risk of likely future harm. It highlights all the issues for consideration in assessment and decision-making. Staff are requested to use the practice guide in the assessment process to determine an appropriate priority rating for notifications. It is wrong to use the term 'waiting lists'. There are certainly no waiting lists when it comes to priority 1 notifications and the waiting lists in priority 2 and priority 3 ratings are determined by this workload management tool.

Mr COPELAND: You are quite right, Minister, that the document does say that there are no priority 1 cases that have been workload managed. The point I was getting to is that in the Ombudsman's report he was quite critical of the fact that Brooke Brennan's case had been one of those cases that were included as an initial assessment awaiting finalisation on the last day of the month. According to this document there were 1,080 priority 1 cases awaiting finalisation for one reason or another. The Ombudsman was very critical of that process and that would indicate that there are a lot of children out there who are at the risk of immediate and future harm.

Mr SPENCE: I think the point that we have to acknowledge is that the Brooke Brennan case occurred in 1999. We are now talking about 2002. It was three years ago. Obviously things have changed in the last three years. The department has received a lot more funding and a lot more staff. We have changed the way we manage cases and conduct our decision-making. Commencing since that time, for example, the Gold Coast area office, which was the office responsible for making those decisions about Brooke Brennan, has received a 114 per cent budget increase. In terms of staff, the Gold Coast office has increased its full-time staff by 51.55 positions, an overall increase of 35 per cent. We are talking about something that occurred three years ago. I am very confident that the department is much better able to respond in those priority 1 situations today than it was three years ago. The department reliably tells me that priority 1 cases now are responded to within 24 hours.

Mr COPELAND: The Ombudsman was critical of that relevant policy, as I said earlier, regarding the way initial assessments are unable to be commenced or completed because of client reasons. He stated in his report that the department had advised him that as at the end of June 1999, which was when the incident occurred, there were 580 initial assessments not finalised—that is the category of which Brooke Brennan had been one. As at 31 March 2002, according to this document, that figure has become even worse and has risen to 848. Surely, regardless of the increased resources, the figure is getting worse and worse and there are still a lot of children at risk down there of exactly the same thing happening.

Ms SPENCE: I am told that the 848 figure, to which the Ombudsman refers, are not priority 1 cases.

Mr COPELAND: No, that is total cases. Five hundred and eighty he referred to. That has now risen to 848.

Ms SPENCE: Throughout the state.

Mr COPELAND: No, just at the Gold Coast office.

Ms SPENCE: Yes, but one of the problems with that figure is that, yet again, he was talking about a figure at the end of the month.

Mr COPELAND: That 848 figure is the end of the month figure as well.

Ms SPENCE: And I think that we heard from Cathy Taylor before that there is a real problem with looking at end-of-the-month figures. As Cathy mentioned, if cases are notified to us during that month, then they are not necessarily completed by the end of the month. So a 30-day figure is a more accurate figure than a particular day at the end of the month.

I am confident that the Gold Coast office will receive a good share of the 90 new staff who will come on board this year as a result of our budget increases. The reason why this government chose to make the Department of Families a priority in this year's budget, why we have put $188 million on the table in increased funding for the next four years, is that we acknowledge that this department has suffered from decades of historic underfunding, that despite our efforts in the past three years we still had not reached the national average. The large budget increase this year will see another 90 staff added to the Department of Families in the next 12 months and

assist the department in obviously fulfilling its statutory obligations in providing a rapid response to child protection notifications.

The CHAIR: The time allocated to the non-government members has now expired and I call the member for Ipswich.

Ms NOLAN: I have some questions about the Youth Justice Service in Ipswich, which I think is an excellent service. I refer you to page 1-19 of the MPS and note the expansion of the community conferencing program. Can you tell us what proportion of juvenile offenders in Ipswich are referred to community conferences? Are there any differences in recidivism rates for matters that are dealt with by courts or by conferences?

Ms SPENCE: Yes. It is interesting that the Ipswich and Goodna Juvenile Aid Bureaus are the highest referring police stations in the state, having made a total of 77 referrals to community conferencing in the last financial year, which accounts for 27 per cent of the total police referrals to community conferencing. About eight and a half per cent of the finalised matters from the Ipswich Children's Court involves referrals to community conferencing. Research undertaken by Griffith University in 1998 indicated a recidivism rate of approximately seven per cent following participation in a community conference. I think that anyone would agree that that is a very low recidivism rate—something that obviously indicates community conference is working.

The research also showed that the satisfaction rates for victims and young people was highly successful in regard to the core goal of victim-offender reparation and recorded extremely high levels of participation satisfaction. Griffith University is currently undertaking further studies in relation to our community conferencing strategies, but we do know that studies in Australia and overseas indicate that conferencing has a more positive effect on reducing reoffending by young people than the court process. That is why we have committed ourselves in this year's budget and next year's budget to expand community conferencing throughout the state of Queensland.

So the good results that we are seeing in the Ipswich area from community conferencing are likely to be reflected throughout the state. We obviously have to acknowledge that we have a real issue in terms of indigenous young offending. In fact, the study that I referred to before talks about referrals of indigenous young people to community conferencing. It says that because Aboriginals and juveniles are overrepresented among those charged by police with criminal offences, the results reveal that Aboriginal and juveniles are also less likely to reoffend if they are brought before a Youth Justice Service and given community conferencing. So it is important that we extend the community conferencing, particularly to parts of the state with high indigenous populations. This year the Cape York region will receive community conferencing for the first time.

The CHAIR: I congratulate you on your appointment as Minister for Seniors. I refer you to page 1-8 of the MPS. I note that there will be a range of initiatives for release, and I ask: can you tell us some of the initiatives planned for Queensland's seniors?

Ms SPENCE: Thank you for the question. Obviously, seniors are already an important section of our population, but they are likely to be a larger section of our population in the future. So there are several initiatives being planned for the next year. The first one that I would like to talk about is the growing problem around the issue of elder abuse. There is a growing recognition and development among legal practitioners in the area of elder law. To date, there has been very little legal information produced in a user-friendly format specifically for older people. We will be tackling that by the development of information packs dealing with areas of the law that impact predominantly on older people. The information will be developed and available in hard copy, on computer disks and on the Internet. There is a collaborative initiative being planned between the Department of Families, the Queensland Law Society, community agencies and Queensland government agencies with an interest in elder law. The fact sheets will be developed and released as a package in brochure form by March 2003.

The initiative will increase the capacity of the elder abuse prevention unit, which is funded by the Department of Families. This unit is auspiced by Lifeline Brisbane and this enhancement to their existing funding of $281,000 will build on an already effective community response. The elder abuse prevention unit was recently evaluated and the effectiveness of this approach was confirmed. Thirty thousand dollars for a pilot project has been given to the unit as a result of the evaluation and it will now be continued and developed into a statewide response. This initiative will commence this year.

We will be tackling the issue of the digital divide. We know that we have to help seniors use the new technology. So we are establishing a computer register for older people's computer clubs and a seminar to link government departments and community groups interested in increasing

older people's access to information technology. The commuter register will be attached to the Department of Families' web site and is currently being developed by the information technology unit in the department. It is anticipated that this will be launched during Seniors Week this year, which goes from 18 August to 25 August.

Ms NOLAN: Can you give us an overview of the funding and activities of the Ipswich Youth Justice Service and tell us if there is any evidence to suggest that it has been successful?

Ms SPENCE: I can. I am very delighted to talk about the Ipswich Youth Justice Service, which I visited last year along with the member for Ipswich, who I know has regular contact with that service. It is certainly one of the success stories in the state in terms of dealing with juvenile offenders. The service was established in 1999 and receives an annual budget of $995,000. It provides interventions based on the outcomes of thorough assessments targeted specifically at meeting the needs of individuals.

In the last financial year, there has been a significant reduction in the number of young people on youth justice orders serviced by the Ipswich Youth Justice Service—from 120 down to 65. We believe that this can be attributed to a number of factors, including improved relationships with the courts, which has influenced the department's capacity to input into sentencing; the increased capacity of staff to implement case assessment and planning processes; young people not returning on further court orders; a 100 per cent completion rate of community service orders in the last 12 months; and the time taken to complete an order has been reduced by 50 per cent. They are very impressive figures from the Ipswich Youth Justice Service.

We also know that they are doing a very good job of linking young people to vocational training and also to employment.

A comprehensive evaluation of the service was completed last year to assess their performance. The evaluation received from the feedback of over 100 key stakeholders remarked on the significant improvement in the service delivery from the Ipswich Youth Justice Service. Most of the young people and their families who have had contact with this service have reported very positively on the service. In the past 18 months of operation, over 30 young offenders were placed in employment and over 20 have returned to formal education.

They are terrific figures from the Ipswich Youth Justice Service. I would appreciate it if the member for Ipswich could pass on my congratulations to that service on a job that is being very well done.

Mrs DESLEY SCOTT: I, too, have just attended a NAIDOC celebration at my youth justice centre and I am very interested in the indigenous young people in Woodridge. I refer you to page 1-19 of the MPS and I note that there are new models for youth justice programming being investigated in Cape York. Could you outline the strategies there to reduce the overrepresentation of indigenous young people in detention?

Ms SPENCE: Yes. As I mentioned before, we have an overrepresentation of indigenous young people coming into contact with our criminal justice system. In fact, indigenous young people represent only five per cent of the 10- to 16-year-old age group in the state. However, the proportion of indigenous young people on supervised juvenile justice orders at any one time has increased from 34 per cent as at 30 June 1997 to 39 per cent as at 30 June 2000, and 43 per cent as at 30 March 2002.

The highest level of overrepresentation is in the youth detention population where indigenous children consistently account for over half of the children in our youth detention centres. In the first four months of this year, indigenous children have accounted for more than 60 per cent of the youth detention centre population. So while their percentage is increasing—we have not turned that around—we have actually turned around the total number of indigenous young people who are subject to supervised orders or who are indeed in detention. That is because the level of youth crime has decreased so the total number of indigenous young people coming into contact with the criminal justice system has decreased similarly.

The primary focus of the department's five currently funded youth justice services at Ipswich, Logan City, Townsville, Hervey Bay and Toowoomba is in reducing the number of indigenous young people who are coming into contact with the criminal justice system. Each of those services has a number of indigenous staff who work very closely with local indigenous agencies to keep those indigenous children away from crime. The Department of Families distributes approximately $3.5 million each year to assist a wide range of projects targeted at youth crime. Over 40 per cent of this funding last year was specifically directed at reducing factors contributing to the offending

of indigenous children. So we are putting a lot of money into this area and we are hoping that we can see some better results in the area ahead.

As I said before, I think that the expansion of community conferencing throughout the state is going to be a positive in terms of indigenous young people offending, because we will be able to involve indigenous elders in the community conferencing project. Where that has occurred in the past, it has shown some good results.

Ms NOLAN: I refer you to page 1-12 of the MPS and note that a range of initiatives will be funded from the $148 million package over four years. Given that Ipswich does have a high rate of notification of suspected child abuse and neglect, can you outline what new resources and strategies will be applied there as a result of the budget's significant funding boost for child protection?

Ms SPENCE: Yes, I am glad that you mentioned the new $188 million investment over the next four years into the Department of Families. Some of the ways that we will be spending that money will be putting $12 million over the next four years into upgrading and improving our technology. The improvement of technologies will result in immediate and identified benefits to our FSOs—our family services officers in the field undertaking casework—which will enable them to spend more time attending to child protection matters.

We will be increasing staff by approximately 90 this year, including the 46 who are committed under our response to the Forde inquiry. We will spend $12 million over four years to ensure that these vital staff have use of cutting-edge technology. This will free them to spend more time working with children and families. That means they spend more time ensuring children are safe and secure. With the latest technologies at their fingertips, our staff will be able to give Queensland's vulnerable children and families the service they deserve.

The improvements will have particular impact in regional Queensland, where $4 million over four years will be spent recruiting a pool of staff who will ensure continuous front-line services where service delivery staff are on leave or during peak times of demand. So $4 million will be spent on recruiting those regional based relief staff and $12 million on upgrading our technology.

We are spending another half a million on an existing program that was introduced by the director-general last year and that is in funding innovative programs to make seed funding available to foster better ways of working. We will be spending a million dollars this year on the regional intake teams to trial the impacts of a centralised case management structure and the impacts of new reporting and assessment tools of practice and their outcomes for clients.

Ms BARRY: With reference to the MPS statement and the initiatives to be funded by the $148 million over the next four years, I note that $12 million over four years has been allocated for investment in new communication and information technology. I wonder whether you can further outline to the committee how this will provide better services for regional Queensland.

Ms SPENCE: I would like to answer that probably by talking about the smart technology tool that is going to be trialled by the department. We are spending three-quarters of a million dollars of the $3 million allocated to innovation this year on trialling a hand-held PDA phone, which I understand can record case notes of visits or initial assessments which will then be translated to text and available for editing from a desktop PC.

I am told that our Family Services officers spend about a third of their time doing paperwork—we should not call it paperwork anymore, I suppose—or putting their case file notes on record, and these hand-held tools will certainly speed up that process. They will be able to make notes while they are out in the field that will be translated directly onto a computer. This is cutting-edge technology not only for the Public Service in Queensland but really for the private sector as well. Certainly it is an initiative of my director-general, so I might let him talk about that for a couple of minutes. He has been trialling it.

Mr PEACH: I hope the Director of Information Services will interrupt me if I appear to be misleading anyone at any stage. We have, as the minister said, a significant amount of time spent by our front-line service delivery staff on what many perceive as clerical activities. They write up case notes. Ten years ago staff would have taken a pencil and paper and written things up or a biro and paper and written things up during case activity, or taken it home and done it. Now they need to come back to the office and enter data into a computer system called CPIS. The system is very old and it is unstable. It fell over for a short time around about Christmas, which meant that we could not access critical information for a little while. It is user vicious in that it is difficult to access for staff.

Given the number of new staff that we have had in recent years, there has been significant learning required for people to use the system. It is clearly one of the matters that goes to Mr Copeland's previous questions about unattended cases. Many of the cases actually have been assessed but have not been entered into the system because people in the field would rather get out and be delivering services than attending to some of the 'paperwork', if you like, which they see in many cases as down time. We are looking at some short-term and long-term responses to that. The short term is to be able to use a voice-activated telephone so that staff in the field can speak into it and record their notes through the telephone directly into the system, so that by the time they get back to the office the case notes are actually written up.

Ms SPENCE: I think this is something members of parliament might need to look at.

The CHAIR: It certainly would help. Minister, I refer you to MPS 1-13 regarding the $1.5 million in funding for ICARE, the system for child sexual abuse indicator training, complaints procedures, and interviewing and recording evidence. I was wondering if you could outline what impact this is expected to have?

Ms SPENCE: Yes. This funding for ICARE came out of Project Axis, which was a joint inquiry by the Queensland Crime Commission and the Queensland Police Service into child sexual abuse in Queensland. The report outlining the nature and extent of abuse was publicly released in November 2000. One million dollars was set aside for the development of information and training resources and the delivery of training in relation to child sexual abuse indicators and the complaints handling process. This will enable the formation of an interagency working group and audit of existing resources; the development and production of quality information and training materials, including tip sheets and manuals; and the development and delivery of a statewide training strategy that meets the needs of stakeholders and has a level of sustainability and an evaluation process. There is also $500,000 for a range of activities relating to ICARE training, including resource development and production of the ICARE training package; the delivery of seven ICARE training courses statewide; the delivery of two ICARE train the trainer courses; the establishment of an evaluation framework for the ICARE training package; and the development of systems, including online resources, that support the training.

The development of training and information strategies for government, the community and the non-government agencies to assist people to respond appropriately to the issue of child sexual abuse is anticipated to prevent child sexual abuse occurring, given the raised community awareness and, through the early detection of child sexual abuse, reduce the personal, social and economic costs associated with untreated child sexual abuse. Enhancing access to ICARE training will increase the frequency of skilled officers interviewing children alleging sexual abuse, resulting in minimising the risk of further harm occurring to children and young people through inappropriate interviewing processes, an increase in the effectiveness of the investigations and an increase in the number of successful prosecutions.

The CHAIR: The time allotted for government members' questions has now expired. I call on the member for Cunningham.

Mr COPELAND: I would like to return, if I could, to the performance measures that we were just discussing, and I return to the document that I have to hand. It states that from July 2001 to the end of March 2002, priority 1 assessments awaiting finalisation had risen from 770 to 1,080, priority 2 from 1,794 to 2,349 and priority 3 from 362 to 442. Now, that is comparing like with like and, but for any aberration that may occur because of a couple of reports at the end of the month, that is a very disturbing increase across the state. What is being done to address that spiralling problem?

Ms SPENCE: Basically, what we have seen is an increase in notifications of about eight per cent each year for the last 10 years, so that is the likely trend. That is going to undoubtedly be reflected in the number of priority 1, 2 and 3 notifications throughout the state. That is why, obviously, we have determined that we need to commit more resources to the Department of Families. Hopefully, with the addition of 90 new staff coming on board this year, we can attend to those notifications in a much more efficient manner than we have been able to in the past.

We are not walking away from the fact that this is an area that has been underfunded for a long time in Queensland, and despite our best efforts over the last four years to rebuild Queensland's child protection system, we still have a long way to go. That is why the government has made the Department of Families the priority this year. I am hoping that next year when we sit here at the budget estimates, after we have got another 90 staff on board, we are going to be able to talk much more positively about our response times in all the priority areas of notifications.

Mr COPELAND: That is approximately, over that nine-month period from July to March, an almost 30 per cent increase. That is far in excess of the eight per cent increase in notifications that you just referred to. Surely that is a critical position to be in and really needs far more than to be explained away by reporting aberrations at the end of the month?

Ms SPENCE: What I can say with confidence, because I am told very clearly by the department, is that all priority 1 notifications are dealt with in 24 hours—and that is very important. I think if we are seeing a larger number of increases, then they are more likely to be in priority 2 or priority 3 cases. Certainly some areas of the state—and the Gold Coast is one of those—have experienced larger than eight per cent increases over the last year. We are not going to walk away from those figures. That is why we have put more money into the Families budget this year; that is why we have determined that this has got to be a priority for government spending in the years ahead.

This is not something new. The fact that child protection notifications are increasing is something that has happened throughout the 1980s and certainly the 1990s and now into the new millennium. We are suffering from decades of underfunding and neglect in this area. We have been rebuilding the child protection system over the last four years, but there is no quick fix. However, I am very pleased and proud of the fact that the Beattie government has determined that the Department of Families is going to be a priority, and we have put a larger increase into the spending in this department than any previous Queensland government has ever allocated to the Department of Families. We acknowledge that more needs to be done, and that is why we have put this money into it, and I am confident that the increased funding will be well spent.

In terms of the priority 2 and 3 cases—a lot of those can be avoided if we put more money into early prevention and intervention work. That is why we are increasing the amount of spending in this area from 13 per cent to 25 per cent over the next four years. All of this money will not just be going into the Department of Families. A lot of that money will go into the non-government sector, who are our partners in child protection, and they are the ones in many cases out there doing the good work, working with families on the ground and providing them with support so that in fact those families do not come to the attention of the department. So it is important that we fund those organisations properly. They, like this department, have been suffering from decades of underfunding and they are out there doing their best with not enough resources. We intend to turn that around, and that is why we have allocated significant amounts of new funding to the non-government sector this year.

Mr COPELAND: The priority 1 cases around the state have increased from 770 at the end of July last year to 1,080. That is a significant increase. You have said that all priority 1 cases are assessed within 24 hours, and I take your word for that, but the fact is that those cases are not being finalised. The Ombudsman was highly critical of the fact that Brooke Brennan had been categorised as one of those cases that could not be finalised for one reason or another. Surely alarm bells should ring if there are 1,080 children out there who have been classified as being at immediate risk of harm now and harm in the future whose cases may or may not have been dealt with in any detailed way?

Ms SPENCE: Look, I acknowledge the significant increase in the number of child protection notifications. We have got no argument there; we all agree. This is not new.

Mr COPELAND: It is more than just notifications, though. These are cases that are not being dealt with.

Ms SPENCE: This is not new. I acknowledge that the Department of Families has been underresourced for a long time. This is not new. I acknowledge that our staff have struggled for a long time in terms of making sure that they investigate notifications in a timely manner. The member can sit there and debate figures all day long, but essentially this government agrees that the Department of Families needs more resources. That is why we have increased resources this year and why we have seen the most significant increase to the Department of Families' budget in Queensland's history. That is why we will put on 90 new staff this year. We do not have any argument with the member there. We are not putting our heads in the sand about this issue. That is why we put the money up-front. We will make a difference.

Mr COPELAND: The Ombudsman's report stated that the Gold Coast office was unable to investigate notifications. In an earlier answer the minister referred to the increase in resources that have been placed at the Gold Coast office since the incident occurred. This document says that, while the Gold Coast office since July last year had 72 priority 1 cases awaiting finalisation, at the end of March there were 301 priority 1 cases awaiting notification. That increase has occurred in

only nine months. What extra staff can the Gold Coast office expect as a result of this budget to investigate notifications?

Ms SPENCE: As the member may be aware, we have had a new system called regional intake teams operating in three of our regions throughout the state. One of those regions is the Gold Coast. It has made it a lot easier through centralised telephone numbers for people to notify us of child protection matters. We have noticed in the three trials that notifications have increased dramatically in the Gold Coast area. This has not been experienced in the other two areas in which regional intake teams operate. These schemes have just been piloted in the last 12 months and we have yet to examine the discrepancy in these statistics. That is something we will be evaluating in the next few months.

We have to really find out why the notifications have increased in the Gold Coast area so dramatically. All of those notifications have not been necessarily translated to priority 1 cases. It is important that we have a good examination of the data, who is making those notifications, why, and how serious those notifications are. Obviously the Gold Coast office will receive more staff out of the 90 that are coming on board in the next few months. We have quite a good system in determining where staff will be placed throughout the state. We sit down with the union and staff members and look at it. I shall ask the director-general to explain how we allocate staff.

Mr PEACH: We have not done what other states have done in terms of adopting a system which simply adds up case loads and tries to allocate staff on that. The way that staff are allocated in Queensland is by the use of a methodology called the workload activity profile. The work activity methodology measures eight core areas and processes and provides relative resource weighting to each. Initial assessments are taken into account, including workload managed initial assessments, child protection follow-up, child protection orders, court assessment orders, placement, youth justice orders and court appearances. Each of those activities is given a particular weighting, the highest being child protection orders, which is 22.5, down to some of the others which have a weighting of one. We use that methodology to allocate new staff. That methodology was approved by our executive management committee in the middle of last year and was one of the direct responses to concerns that we had about the allocation of staff across the state.

Historically, the department has, as the minister said, been underfunded and over time responses have tended to be made on where there were perceptions of a need for staff. We wanted to develop a more scientific method of allocating staff. This particular methodology has been used, as I said, since September last year, and any new staff have been allocated using that methodology. It is that methodology which we have agreed to have reviewed as a result of the Brooke Brennan report. We are in the process of evaluating a number—I think seven—of groups that have put bids in. We will have a process operate in the next fortnight to decide which of those bids is successful. We will recommend to the minister one of those outside groups which consistent of university people, private consultancies, and so on. One of those will review our methodology and make sure that it is very robust. To date, it has been used to allocate, as I said, new staff.

The challenge for the future, particularly as parts of Queensland grow at differential rates, is to consider the question of whether we extend it to use it to transfer staff from areas where there is less demand or decreasing demand to those areas of greater demand. We have not yet done that, but we have raised the issue with the union. We will be going into negotiations very shortly about our wish to do that, to make the system even fairer in the long term. I would argue that it is the most sophisticated system that exists in Australia in this sort of organisation at the moment.

Mr COPELAND: The minister has referred already to the focus of the budget on early intervention and prevention. I have said previously—and I say again—that it is a very commendable aim and we support the minister in that. There is a concern both within the department and in the community that as a result of this budget there will be no extra front-line staff to assist in investigating notifications of child abuse to the department. Will the minister advise what resources and what staffing, more particularly, will be increased as a result of this budget to notification investigations?

Ms SPENCE: I can give the member a breakdown. In 2002-03 the Department of Families will employ 31 new service delivery staff to coordinate services and information for carers and undertake recruitment and training. We will employ 15 additional staff in the four regions to trial regionally based staff relief pools where experienced service delivery officers will be available to fill in while staff take annual leave or at other peak times.

Mr COPELAND: Is that 15 in each region?

Ms SPENCE: No, 15 throughout four regions. We will apply nine additional workers to coordinate the trial of expanded services to prepare families for the return home and reconnection of a child who has been in care. We will employ 15 new Aboriginal and Torres Strait Islander family support worker positions to work locally to provide practical service assistance to parents and extended family. We will employ six additional staff to deliver an additional community conferencing service. We will employ five learning facilitators in regions to provide leadership in the implementation of learning and development strategies and programs that contribute towards strategic outcomes, ensuring that learning is embedded as part of the service delivery. We will employ four additional workers to lead the development of trials in a range of improved practices, including new child protection intake tools and communication and information technologies.

We will employ five regional action learning team coordinators to provide coordination and support for action learning teams trialling new initiatives. Many other new initiatives will be progressed during this year in partnership with our non-government service delivery partners. These initiatives will be designed to boost the capacity and capability of our non-government service delivery partners to strengthen the entire child protection family support and youth justice systems.

Mr COPELAND: The director-general referred just briefly in his previous response to an area to address being the recommendations, or criticisms, of the Ombudsman's report. There were five areas of recommendation for the Department of Families. Have each of those areas of recommendation been addressed in the MPS to improve methodology within the department?

Ms SPENCE: I would not think that the Ombudsman's recommendations would be addressed in the MPS. This is about where our money will be spent in the next year. A lot of the Ombudsman's recommendations were not about money. They were not even about resourcing. They were about practices within the department. We have responded to the Ombudsman's report and have accepted all of his recommendations. They will be implemented, but to answer the member's question, one would not find that information in the MPS.

Mr COPELAND: But the minister is quite confident that each of those areas of recommendation has been implemented within the department, whether it is in resourcing or in practices.

Ms SPENCE: We have certainly accepted all of the Ombudsman's recommendations and indicated that we will be implementing all of those recommendations. The director-general mentioned one before about getting an independent assessment of our workload activity process to ensure that we allocate staff wisely throughout the state. We accept the Ombudsman's recommendations.

Mr COPELAND: I refer again to the Future Directions document and to the long-term care options on page 15. This acknowledges that there has been an overreliance on foster carers. Options that are canvassed within that document are: restoring a child to their family, adoption, and shared parenting responsibility with the department. What options will be used in Queensland and when will those changes begin to occur?

Ms SPENCE: Queensland has just about the highest reliance on foster carers of any state in Australia. We do not have too many alternatives at the moment to foster care placements for children who come into our care. We need to develop more alternative out-of-home care placements. We have about 12 funded organisations at the moment throughout the state which provide that out-of-home care placement. Basically, it is a house with paid house parents supervising the house at any time. These are the kind of placements that obviously a lot of young people require, particularly teenagers who find it very difficult to be placed in a family type of setting such as that offered by foster parents. The 12 services that we currently fund are obviously not enough to accommodate these kinds of young people. This year we hope to develop some new models and services throughout the state to provide better out-of-home placements for young people. We will be trialling a number of service models to provide this kind of residential accommodation. They will provide day-to-day supervision of young people and a range of placement supports, including therapeutic intervention based on an individual young person's case plan. Other key activities include participation in case planning, provision of case work, the facilitation of family contact, and educational support. Basically, we are looking to the non-government sector. We will not be providing this ourselves within the department in terms of offers and ideas about developing these new out-of-home placements.

Traditionally, the reason why Queensland has relied so heavily on foster parents is, frankly, because they are the cheapest form of accommodation for young people in care. The reason we have so few of these alternative type of care placements is that they are very expensive. We have decided that they are very important, that it is difficult to keep teenagers in foster parent placements when that is a pretty unsuitable placement for many of them. We are talking to non-government organisations about developing some new services. In fact, the non-government organisations throughout the state are all being briefed next week, starting on Monday, about our new budget and new direction. We will be suggesting that they come up with models that they might like to suggest to us for future funding.

The CHAIR: The time allocated for non-government members' questions has expired.

Mrs DESLEY SCOTT: I note the $4.1 million allocated for the replacement of the demountable unit at the Cleveland Youth Detention Centre. Could you please detail how the state government has addressed youth justice recommendations contained in the Forde inquiry?

Ms SPENCE: We made a 1998 election promise to replace the seriously outmoded youth detention facilities and replace them with centres based on current national and international centres of care and security. This budget completes that commitment. In 1999 the state cabinet approved the 10-year Youth Detention Centre Infrastructure Plan to modernise Queensland's youth detention facilities. Stage 1 of the upgrade was completed at a cost of $65.9 million and that included closing Sir Leslie Wilson Youth Detention Centre in April last year, the construction of the new Brisbane Youth Detention Centre, which the Premier and I, yourself and other members of parliament opened officially earlier this year.

We committed ourselves to rebuilding the Cleveland Youth Detention Centre. We finished stage 1 of the Cleveland Youth Detention Centre and now in this year's budget we have funded stage 2. The older units at the centre are gradually being phased out and replaced. The number of young people in detention in north Queensland continues to be lower today than in the past. The Cleveland Youth Detention Centre, for example, accommodated approximately 26 people during the month of April this year. The Kingfisher Unit at Cleveland was closed in January this year due to the low number of residents. On 13 March this year I instructed that the Heron Unit at the Cleveland Youth Detention Centre should also be closed, because we had concerns about potential hanging points and electronic fire safety systems were the building to continue to be used as an accommodation unit. The low number of residents at the Cleveland Youth Detention Centre made that closure possible. However, it is important that we replace the Heron and Kingfisher Units that have been closed. The $4.1 million that has been set aside this year will go into rebuilding a 24-bed purpose-built accommodation unit to replace those two closed units. After this stage is finished, we will basically have rebuilt the Cleveland Youth Detention Centre in Townsville. I opened stage 1 earlier this year and I expect that with the rebuilding of the new unit in stage 2, as well as provision of landscaping and other amenities, we will have a very good quality youth detention centre unit in Townsville.

Ms BARRY: I, too, wish to congratulate you on being appointed Minister for Seniors. I refer to page 1-23 of the MPS and note that in respect of administered items it is stated that Queensland funds a wide range of concessions for holders of Seniors Cards. Can the minister outline the state government's position following the federal government's election promise to extend travel concessions to self-funded retirees?

Ms SPENCE: I find myself in the very unusual position of agreeing with the radio commentator Alan Jones, who earlier this week editorialised that he felt the federal government had mishandled its promise that self-funded retirees who have Commonwealth Seniors Health Cards would get the same pension benefits as pensioners. As Mr Jones pointed out, there was one catch to this: during the last federal election the states were not consulted.

The Commonwealth has put up a proposal that it will pay 60 per cent and the states will pay 40 per cent to help fund this election promise. But it was very foolish in making that promise without talking to the states first. As at 28 June this year, there were 407,000-odd Seniors Card holders and 40,000 seniors business discount card holders. This represents three-quarters of the state's 60 and over population. Seniors Card holders save over $400 each year through the largest and most common government concessions on electricity, motor vehicle registration, ambulance and public transport. Seniors Cards are valid for public transport concessions only within the card holder's state or territory.

As we would all know as members of parliament, Seniors Card holders would like that reciprocal concession particularly for transport available to them in other states and territories. At

the moment those transport concessions are available only in their own state. The federal government was suggesting that it might put up the money to make those concessions available across states. What it has offered us is $300,000 a year to fund local bus, ferry and rail concessions in the south-east corner of Queensland for visiting seniors. This would apply only to south-east Queensland. They are not suggesting that they fund the rest of the state. We estimate that the total cost will be somewhere around $800,000 to $1 million; it would cost the Queensland taxpayer $700,000 to fulfil the federal government's election promise.

It has been made clear to the federal government that we think this is a bit rich, that its offer is not acceptable and that we are not prepared to disadvantage regional and rural Queensland by making this offer available to seniors travelling in only the south-east corner of the state. What would it do to tourism throughout Queensland if we gave them concessions only in and around Brisbane?

Obviously, the three states that would have to put the most money on the table for this are New South Wales, Victoria and Queensland, because we are the states that have the most seniors visiting as tourists. All of those states have clearly said to the federal government that they expect to see more money from the federal government on the table before this offer becomes a reality.

Ms BARRY: Staying with seniors, on page 1-23 of the MPS reference is made to the concessions provided for under a seniors concession card. Can you advise the committee how Queensland Seniors Card benefits compare with other systems?

Ms SPENCE: We in Queensland have one of the most generous concession packages in Australia and I am proud of the concessions that we are able to offer Queensland seniors. I am also proud of the fact that it was a Labor government, the Goss Labor government, that introduced Seniors Cards into this state. Recently, there has been a fairly vigorous lobbying campaign by groups such as the Association of Independent Retirees saying that seniors in Queensland are disadvantaged in the concessions that they receive. In fact, the reverse is true. The Queensland government's concessions are generous and well targeted. Queensland Seniors Card holders are entitled to all of the state government pensioner concessions with the exception of the rate subsidy and free rail vouchers. This makes it one of the largest concession packages for self-funded retirees in Australia. Queensland provides concessions to a higher proportion of non-pensioner seniors than any other state government. It is also the only state to provide independent retirees with ambulance and dental services. Other concessions include public transport, motor vehicle registration, boat registration, medical aids, electricity, life support, spectacle supply and dental services. It ensures that Queenslanders from a variety of locations and circumstances can draw a tangible benefit from their Seniors Card.

Queensland is the only state government which opens its seniors business discounts scheme to all permanent residents over the age of 60. Seniors Card concessions are currently available to all residents aged 65 and over who work less than 35 hours a week. They are also available to residents aged 60 and 64 years not working full time who receive a specified Commonwealth payment or hold a Commonwealth Seniors Health Card or low income Health Care Card. I do not have the correct figure with me here, but I think our concessions to seniors across government are in excess of $400 million a year, which is certainly a large amount in terms of the Queensland budget. Although it would be nice to extend the Seniors Card to a greater range of people and offer more concessions in the future, obviously any Queensland government has to be concerned about the impact on future budgets when making decisions like that.

Mrs DESLEY SCOTT: I wish to return to the issue of foster carers. I note our commitment in the budget to increase their allowance. Could you please outline what other measures are being taken in this budget to help our foster carers in Queensland?

Ms SPENCE: Funding to foster carers will increase by $33.5 million over the next four years. This includes a six per cent increase in allowances for foster carers of children and young people aged 11 years and over. In addition, the proportion of carers looking after children and young people with high needs who are able to access additional financial support will be doubled from 10 per cent to 20 per cent. Foster carers who have children who have high needs will now be able to get the allowance for that when obviously a lot of them were denied that in the past. That one decision alone is a $3 million annual decision to increase that percentage from 10 per cent to 20 per cent. This includes $1.5 million in direct payments to eligible carers and a $1.5 million increase in packages for children with extreme needs.

One area we are keen to look at this year is short-term respite for foster carers. There has been respite available for a few carers in the past, but we believe that carers looking after children with high and extreme needs need frequent respite if they come to us and ask for it, and also other foster carers who want some relief need to have some accessibility to respite. We believe this will help reduce the stress and associated placement breakdown.

High-risk families include those families at risk of having their child placed under a protective order and families reconnecting with children who have been under protective orders. Research highlights that the use of regular planned respite care is an effective strategy in reducing those family breakdowns. Key activities will be to develop models of respite care, recruit and train suitable relative and respite carers for children requiring ongoing replacements, matching respite carers to primary carers and children, and providing ongoing support to respite carers. This initiative will reduce the number of unplanned multiple placement breakdowns, increase the number of children placed with extended families and develop a pool of specialist respite care families to support carers and families.

Mrs DESLEY SCOTT: Are there significant steps that you could suggest the federal government take to assist foster carers?

Ms SPENCE: I raised this at the ministerial meeting in Melbourne last month, that is, the need for the federal government to look at some of its tax arrangements and the impact that those arrangements are having on foster carers throughout Australia. This issue has been raised with me by the Queensland Foster Carers Association. Under the current rules, the means testing of the family care income means that few of our foster families are eligible to receive the Family Tax Benefit. This increases difficulties in planning levels of foster payments and results in inequities for carers. In many cases, the parents of children in the care system would be eligible for this allowance, but given that the allowance is means tested, when they take foster children into their care their income can then exceed the means testing level so they lose the Family Tax Benefit. Basically, the Commonwealth government saves money every time a child goes into foster care. Most of these children would be eligible for allowances if they stayed with their natural families—allowances such as all of the benefits attached to child care. But when they go into foster care it means that few of the children receive those kinds of benefits. The federal government is winning at the state's expense over this issue. I have already written to Larry Anthony, the Federal Minister for Children and Youth Affairs, about this issue and great inequity. Larry Anthony has agreed to meet with the state ministers later this year to discuss the issue. If the federal government would review this family tax benefit in terms of foster carers, it would be a major step forward for foster carers throughout Australia, not just for foster carers in Queensland. On anyone's assessment, this is a serious inequity about the way the federal government makes its rules.

Ms NOLAN: Minister, I refer you to page 1-1 of the MPS and note that the Families Department spends almost half its budget on non-government organisations. Can you outline what policy initiatives have been introduced to provide long-term assistance to the non-government sector?

Ms SPENCE: Obviously the non-government sector is an important partner of the Families Department. In fact, approximately 37 per cent of our budget each year goes directly to the non-government sector. It has been telling us for a long time that we do not fund it adequately. We have given it $33 million over the next four years to offset the increased cost of service delivery. I might just pass that question on to the director-general to finish answering, because he is right up on this issue.

Mr PEACH: Thank you, Minister. Of the $148 million in new funding announced in the budget, approximately 22 per cent will be directed to assist existing funded services in the community and at least $11.6 million will be offered to trial new non-government services in the community. Some $33 million, as the minister said, over four years is available to offset increased costs of service delivery for non-government organisations. In recognition of the role that the non-government sector plays in the provision of community services, the government has established a non-government services directorate that aligns the department's funding and contractual relationship with non-government services in one functional area in the department.

The non-government services directorate started on 1 July. The directorate will provide strategic leadership and management in funding policy development, contract management and service monitoring. The directorate's roles include to develop, implement and monitor policy in relation to funding reform and contract management and administration; to cultivate an effective business relationship with statewide service providers through the implementation of contracts

and service level agreements; to negotiate and manage output based contracts and service agreements with non-government providers; and to manage the allocation of funds to non-government and community organisations.

The directorate started on 1 July and is already organising a number of workshops to engage the sector in discussing a shared vision for our future relationship and for the outcomes that government and the sector can achieve for the Queensland community. Next week the directorate will conduct workshops in Brisbane on Monday and Tuesday, in Rockhampton on Wednesday, in Cairns on Thursday and in Townsville on Friday. Workshops will also be held in Maryborough and Mackay the following week.

The CHAIR: Thank you. Minister, I want to come back to child protection, because I know it is an important issue to all of us. I refer to page 1-9 of the MPS and note in the output statement that you are expecting the number of child protection notifications to rise. I am just wondering if there are any sort of strategies that you would like to outline that you previously may not have that have been put in place to tackle this issue.

Ms SPENCE: We have allocated a lot more money to child protection in this year's budget, and that is an understatement. In fact, our increase this year means that the annual funding for the Families Department is now $194 million higher—that is, 97 per cent higher—than when the Beattie government was elected and $147 million higher than the 1999-2000 budget when the Premier gave a commitment that the government would revisit the Forde inquiry funding recommendation year after year. It is important to understand the context of this funding. Since we started rebuilding the system our investment has increased almost triple the rate of general government revenue—that is, 59 per cent compared with general government revenue growth of 22 per cent. In terms of child protection spending, we have doubled it from $85 million in 1998-99 to more than $167 million this year.

Obviously we cannot keep doing more of the same. We have to spend our money smarter in the future, and that is why we think it is important to invest in early intervention and prevention. That is why we have given the commitment to increase our spending in that area from 13 per cent to 25 per cent over the next five years. We think it is important to care for our foster carers a lot better than we have in the past. That is why we have increased our foster care allowances. In addressing the great problems being experienced in child protection, the government is not going to be able to do this alone and it is important that we work more closely with our non-government partners in this area. That is why we have increased the amounts of money that we are giving the non-government organisations in this regard.

Given that I have a little bit more time to answer this question, I thought it was quite interesting when I began looking through the annual reports of the Department of Family Services throughout the 1980s, and I will give you a couple of examples. The 1984 annual report under the heading 'Demand for services' states—

This year the year under review has seen a further increase in the number of reported and confirmed cases of child abuse and neglect. In fact, 33 per cent more cases demanding child protection services were dealt with than during the preceding 12 months.

The 1985 annual report states—

This year saw a further heavy demand on departmental resources as the call for available services continued to escalate. Undoubtedly, welfare demands bear a close relationship to long-term unemployment in families. One very alarming factor was the large increase in child protection notifications.

The 1986 annual report states—

The above challenge manifested itself in several ways, including heavy demand on resources of all types and a need for more diversified services. There was an increased case load as a result of a 65 per cent increase in 12 months in child abuse notifications. These had jumped by 130 per cent in the previous two years.

That was 1984, 1985 and 1986. What did the government do in 1986 as a response to these alarming statistics? It employed two more Family Services officers that year. I just wanted to point that out to the committee today, because I think it is important—as we hear so much about the increase in notifications right now—to note that this has been a feature of our child protection system for decades. When we talk about decades of neglect, that is exactly what we are talking about. The government was well aware throughout the 1980s and the 1990s of the need to put more resources into the area of child protection. It is only now that we are seeing a real resolve to do something about it.

The CHAIR: Thank you. The time allocated for questions from government members has expired. The remaining allotted time for this session will be seven minutes each.

Mr COPELAND: Minister, I have just one further question on performance reporting. It has been referred to a number of times that priority 1 cases are assessed within a 24-hour period. Do you have a performance indicator that measures that that is actually happening? Is it measured regularly? Is there any possibility of seeing a table of that information to verify that that is what is occurring out on the ground?

Ms SPENCE: I am advised that we have no formal way of collecting the information to see whether child protection notifications are responded to within 24 hours. That is certainly our policy and team leaders out there in the regions are responsible for ensuring that that occurs. We would expect that if that is not occurring the team leader would notify the manager and that information would be passed through to us centrally. But certainly there is no formal mechanism for collecting that data. It would be a huge undertaking to collect that data on a daily basis. I am not sure that there is any need to do that, but certainly we need to know if that policy commitment is not being met.

Mr COPELAND: If the team leaders ensure that that happens on a local level, it is just the tick of a box as to yes or no. That should be, I would have thought, a reasonably straightforward piece of information to collect. Given that they are the most important and critical notifications that the department gets, I would have thought that ensuring that those are responded to within 24 hours was of the highest importance.

Ms SPENCE: I agree with you. It is of the highest importance. We would expect to be informed if that was not occurring. But we are given the assurance by our regional officers that in fact child protection priority 1 notifications are being responded to within 24 hours.

Mr COPELAND: Minister, I refer to page 1-6 of the MPS which refers to the Forde Foundation. It states that only the interest from the capital may be distributed. Given that the government's investments in the 2001-02 year returned zero per cent, what income did the Forde Foundation return? How much was distributed and where was it distributed?

Ms SPENCE: The Forde Foundation is actually independent of the Department of Families. We do not have the information you are requesting, but we could certainly write to it or you could write to it to ask it for that information. I do not think it is a secret. I am sure that it would be happy to tell you. It also does an annual report where that information is available. In terms of the other part of your question and the requirement under its establishment that it can only give away interest on the principal—this is an issue that I discussed with the foundation earlier this year. I met with Leneen Forde and the members of the foundation. They agree with me that that is probably not a satisfactory arrangement. Given that the interest on the principal was very small last year and the number of applications for funding is large, it is disappointing to them as well as to those people out there who are making those applications that more money cannot be given out on an annual basis.

The members of the foundation have agreed with me that we need to change the terms of the foundation, and that work is going on right now. They have had some lawyers looking at this. It is currently, I understand, with the Australian Tax Office. It means that the foundation will have to go to court to get its trust status changed so that it can start giving away the principal in future. That work should be finished in the next couple of months, by August hopefully. So we will start seeing some larger amounts of money being given out of those funds.

Mr COPELAND: Minister, in relation to the criteria for people to be able to access the funds distributed by the Forde Foundation, could you advise if that has been broadened beyond the people who were originally identified in the Forde inquiry?

Ms SPENCE: We are not aware of it. It is an issue that is determined by the Forde Foundation advisers. They make those decisions about who is eligible for money from the fund, not us.

Mr COPELAND: Minister, this will probably be the last question, I guess, because of time. I refer to question on notice No. 3 regarding the Forde initiatives in each budget since the report was delivered in 1999. The answer stated that there has been $49.485 million committed to date—that is, 2002-03. In addition, in this year's budget there has been new funding of $32 million announced for the 2002-03 year. That is still, on those figures and the figures that have been provided from your department, $21.515 million short of the $103 million that the Forde report said was required to bring Queensland in line with the national average. Why then is it that the Premier, the Treasurer and you have continued to state that the government has now met its fiscal commitment flowing from the Forde report?

Ms SPENCE: I am told that there is actually a mistake in the answer that we have given you to that question on notice. The cumulative total at the bottom there talks about $112,000,055. It should actually read $122,000,055. What I can tell you is that the annual funding for the department has increased from $248 million in 1998-99 to $395 million this year. This is an increase of $147 million. This is $44 million, or almost 43 per cent, in excess of the $103 million increase recommended by the Forde inquiry. This is entirely consistent with our recommendation made by the Premier during the 1999-2000 budget that the government would implement the Forde inquiry recommendations for increased funding year after year. In fact, not only have we met the recommendations that have been set down by Forde, but we have actually exceeded those recommendations. Child protection specific expenditure as classified in the Productivity Commission's report on government services has risen from $85 million in 1998-99 to over $167 million this year. That is a 96 per cent increase in child protection spending in the last four years. So this is entirely consistent with the kind of money that was recommended by Leneen Forde.

The CHAIR: The time allotted for consideration of the estimates of expenditure for the Department of Families has now expired. I thank the minister and her departmental officers for their attendance here this morning and assistance with the estimates hearing. The committee will now adjourn for morning tea.

Sitting suspended from 10.17 a.m. to 10.31 a.m.

The CHAIR: The next item for consideration is the proposed expenditure for the Minister for Aboriginal and Torres Strait Islander Policy. Once again, I welcome the minister and her departmental officers. I remind everyone that mobile phones need to be switched off and pagers need to be set to silent mode. For the benefit of Hansard I ask departmental officers to identify themselves before they answer a question. The first period of questions is allocated to non-government members. I call the member for Cunningham.

Mr COPELAND: Thank you, minister, and thanks to your departmental staff. I pass on the apologies of the Deputy Leader of the Opposition and shadow Minister for Aboriginal and Torres Strait Islander Policy, Vaughan Johnson, who is unfortunately unable to join us today. At the outset, minister, Vaughan has asked me to pass on to you his personal determination and that of the National Party to work constructively towards the achievement of real outcomes for indigenous Queenslanders as opposed to the meaningless rhetoric they have heard from politicians of all political persuasions for too long. In accordance with these comments, and having regard to the mention that is made in the MPS of the Aborigines Welfare Fund, my deputy leader has also asked me to renew his previous public offer to the Premier to act as a mediator in the dispute between indigenous Queenslanders and the government over this issue.

Minister, I refer to page 2-3 of the MPS which lists $8.3 million worth of expenditure related to the Cape York Justice Strategy. I also note that the Beattie government spent three and a half times this amount on the Goodwill Bridge and almost 34 times that amount on the claimed price tag of $280 million for the Lang Park redevelopment. Minister, the Premier and yourself have used words like 'genocide' and 'lost generations' as properly describing the appalling effects of alcohol in Queensland's indigenous communities which we all acknowledge with shame and horror. Minister, how do you even remotely expect indigenous Queenslanders to believe the Beattie government is genuine about these issues and that that commitment extends beyond rhetoric with such glaring disparities and funding priorities?

Ms SPENCE: I would like to begin by introducing the staff at the table here. I have my director-general, Mr Frank Rockett, on my right. Next to him is the deputy director-general, Mr Geoff Skerritt. Next to him is Mr Peter Tones from Executive Services. And on my left is Mr Evan Klatt, director of finance.

I would like to begin by acknowledging the commitment of Vaughan Johnson and the National Party to work with us on indigenous issues and acknowledge the support that I have received from Vaughan in the past. Firstly, I would like to say that from my perspective there is no conflict out there necessarily that needs intervention or mediation about the welfare fund. I know that there have been some public statements by some Aboriginal leaders about the inadequacy of the offer that the government has made, but I would still hold to the belief that the silent majority of Aboriginal and Islander people out there who may be beneficiaries of this offer are indeed welcoming of the offer.

This week the Premier and I signed a partnership agreement with ATSIC. I am told that ATSIC officials who have funded QAILSS and are out there negotiating this offer at the moment are getting a 98 per cent support rate for the offer out there in the community. There is still a

month to go before we get their final report on this issue. But I would say that while a few people have been very vocal in their opposition to the offer, I think that there is quietly a lot of support out there on the ground. In terms of your question about the Cape York partnership, the money that you refer to there—is it $1.5 million?

Mr COPELAND: $8.3 million related to the Cape York Justice Strategy.

Ms SPENCE: It has been very hard for us to quantify just the kind of money that we spend in Cape York. What the Department of Aboriginal and Torres Strait Islander Policy has been allocated this year is $1 million alone just to start the Cape York partnership unit in Cairns. This will involve the five public servants who have been working on this issue and who have previously been working in the Premier's Department on this issue and were transferred to the Department of Aboriginal and Torres Strait Islander Policy from 1 July this year. As well, there will be a number of officers seconded from other departments, such as Police, Health, Education and so on, to work in the partnership unit. So that $1 million will be boosted by the contribution that other departments make to the efficient running of the Cairns partnership office. As well, we are going to have a key person in the central office of DATSIP who will be working on Cape York policy here in Brisbane. As I said, it is difficult. Is this a time extension?

Mr COPELAND: Why not!

Ms SPENCE: It has been difficult for government departments to quantify the kinds of money that they spend in Cape York out of their budgets. The Department of Families alone puts millions of dollars into youth programs and domestic violence programs in the cape; housing—it puts millions of dollars into it. However, I think that obviously while our commitment in the cape has been significant in the past, the Cape York partnership is not just about money; it is about how wisely we use money. It is about how well our services are being utilised on the ground. It is about how we coordinate services. It is about how we interact with groups such as ATSIC and other bodies that have significant amounts of money to spend in the cape. We should not talk about Cape York partnerships as being just about money; of course, money is important, but it is also about the wise spending of money. That is a point that we have emphasised for a long time now as we have been talking about doing business better and smarter in indigenous communities.

Mr COPELAND: Minister, I refer to page 2-18 of the MPS and note the comment that as the department is lead agency for the implementation of *Meeting Challenges, Making Choices*, the department will be progressing a range of government reforms aimed at curbing alcohol abuse and violence and improving the quality of life in Cape York indigenous communities. Again, Minister, this is very impressive rhetoric but, unfortunately, indigenous Queenslanders have heard a lot of it too many times before. That brings me to your response to question on notice No. 2 from my deputy leader in which you claim that additional funding now provides for six licensing officers dedicated to indigenous communities. I presume that is for the entire state. Minister, indigenous communities themselves, as you will no doubt be aware from the criticism of the Beattie government's handling of the consultation process involved with the Cape York justice report, have been calling for significant increases in resources dedicated to the enforcement of liquor licensing laws well in excess of those six officers.

Ms SPENCE: Not long ago there were no indigenous licensing officers in Queensland. Now we have six. Do we need more in the future? I am not sure. Those six officers have only come on line in the last 2 to 3 years. It has obviously been a challenge for us to identify suitable officers and to train them in the job of being liquor licensing officers. I think it is far too early for us to be talking about whether six is adequate. I think we need some time to assess how effective the six officers are going to be before we decide that we need more of them. For too long everyone's response to indigenous disadvantage has been: put more money into it, provide more services, and we will fix it up. Obviously, that has not worked despite the well-intentioned efforts of the past. With Cape York partnerships our new attitude to solving the problems of alcohol and substance abuse is not just about throwing in more money or resources or putting more public servants into these communities; it is actually about making sure the money we spend and the services we deliver are tailor made and being used efficiently by the community. So in terms of whether six is enough, I think it is probably too early for us to assess that.

Mr COPELAND: Following on from the earlier question, I note that there is no mention made in the MPS in relation to what action the department will be undertaking to coordinate a whole-of-government response to recent reports that marijuana is out of control in a 47,000 square kilometre zone along the Papua New Guinea border. I understand that there was a report prepared for the Beattie government by a north Queensland consultant, Jeff Jeniver, calling for

the introduction of measures to deal with the problem, including permanently stationing a Drug Squad officer on Thursday Island and basing a police plane in the Torres Strait. I also note that the chairman of the Torres Strait Island regional authority, Terry Wire, has called for more police support in giving more power to the community. Minister, clearly the commitment of additional resources to combat this drug problem could also be utilised constructively to combat the sly grogging. What plans does your department have to combat these issues?

Ms SPENCE: I certainly have been given detailed information about the Queensland Police Service's responses to the marijuana problem in the Torres Strait. I can tell you that they are putting in a lot more resources, and they have some very good drug-related strategies operating in the Torres Strait. But I do not feel at liberty to detail their responses in this public forum at the moment. I think that those questions would be better directed to the Police Service because they are operational matters, and I certainly would not want to be divulging any information that would interfere with their operations in the Torres Strait.

Mr COPELAND: Minister, I refer to page 2-1 of the MPS, which states that an immediate strategic issue for the department is the implementation of *Meeting Challenges, Making Choices*. That document has a section dealing with children, youth and families. Part of the section states that child protection teams will work closely with the community to ensure the safety and wellbeing of women and children. I note that the Beattie government has suspended funding pending an audit of the Cooktown and District Family Resources Centre. If this centre closes, that will be yet another Aboriginal and Torres Strait Islander care agency that has closed in Queensland because the Beattie government has stopped funding after these bodies get into financial difficulty. Clearly there are problems regarding the proper financial administration of these centres. Why is it that your department seemingly becomes involved in an audit process for these organisations only at the death of them? How often are the audits conducted?

Ms SPENCE: This probably would have been a better question to ask me as the Minister for Families than the minister for DATSIP, because certainly I had the comprehensive briefs on this in the last session. Your question had a number of parts. Yes, the Cooktown family resource centre is in a lot of difficulty at the moment. The Department of Families has been working very closely with this centre over the last four months to try to get it out of its difficulty. It is the major welfare provider of services in that part of the region. In fact, it is the only one. It operates child-care services and health services. It operates with federal government money and money from various state departments. It is not just the Families Department that funds this service. It is the major service provider. We are very concerned about the breakdown of that service. Indeed, that is what has occurred there in the last four months. It has a long, involved history. I have been talking to the mayor and the council in Cooktown. I have been talking to indigenous communities there. We have a situation where there is a lot of infighting within the staff and the management committee.

That is why we have put a full-time officer from the Families Department in Cooktown to work with the service. We are considering giving the money we provide to the service to the council for the next three months to auspice the service, because it is near collapse. But we are not going to let this service fall over. That is why we have given so much attention to it. I think it is the desire of everyone in Cooktown—there have been hundreds of people attending public meetings in Cooktown about this issue—to see this service back up and running. These things do happen to community organisations from time to time. We have all probably seen in our own electorates that a group that is going very nicely can start fighting for lots of different reasons and the service can suddenly look as though it is under threat. That is what has happened in Cooktown.

The other part of the question is absolutely inaccurate in many respects. It is true that we have defunded four Aboriginal and Islander child care agencies throughout the state in the last year for very good reasons, but the money certainly has not been withdrawn from providing those services. Where we have been forced to defund the ACCAs we are still providing the service. Sometimes the service is being provided within the department. In some cases, for example Townsville, we have given it to another indigenous organisation to auspice the service while we can rebuild the ACCA in that town. These are very complicated issues and it would be entirely incorrect to suggest for one moment that we have taken any money out of funding Aboriginal and Islander child care services.

Mr COPELAND: I refer to page 2-12 of the MPS, relating to community governance. I note the claims the department has contributed to the development of a draft state agreement on Aboriginal and Torres Strait Islander economic development by identifying and implementing economic development initiatives aimed at providing more jobs for indigenous Queenslanders. What is the current state of progress of this draft agreement? What other Queensland

government agencies have been involved in the formulation of the agreement? Could you please detail what role indigenous Queenslanders will have in the formulation of the agreement? That is, has a consultation plan be devised with the indigenous communities?

Ms SPENCE: DATSIP has allocated one and a half million dollars for economic activities in indigenous communities over the last two years. That actually was my own initiative. Up until two years ago we did not have any economic development money in our department. The reason I decided our department needed to have small amounts of economic development money is that, frankly, our officers are on the ground in the deed of grant in trust communities on a very regular basis, whereas officers of other government departments, such as State Development, do not have the intimate knowledge of the DOGIT communities that we do.

With our economic development money we can promote the economic aspirations of the DOGIT communities across government. Because of that promotion we have been very successful in involving other government departments in economic developments in the DOGIT communities. For example, we have funded the Injinoo-New Mapoon aquaculture/silviculture project in partnership with the Department of Primary Industries and the Injinoo and New Mapoon community councils. They are now involved in the piloting of commercial breeding of mud crabs in mangroves. We have funded the Injinoo sawmill project with the Department of Primary Industries. We have given significant amounts of money to the Cherbourg abattoir and we have pulled in money from the Department of State Development to assist us in that.

What DATSIP can do with its small amounts of economic development money is not only engage other state departments but also engage the private sector in focusing on the opportunities and the aspirations for economic development in our DOGIT communities. So we have developed strong linkages with key state and Commonwealth departments at central office level and through the regional managers forums. The aim is to achieve a streamlined, coordinated approach to facilitate indigenous enterprise. We meet with ATSIC on a regular basis to share information and network regarding current and future proposed indigenous commercial ventures.

The Indigenous Economic Development Working Group, constituted under the 10-year partnership, has a key role in providing better coordination of effort across agencies. It is chaired by State Development, and its core membership consists of DATSIP, ATSIAB, Premier and Cabinet, Employment and Training and Primary Industries as well as Commonwealth agencies, including the Department of Employment and Workplace Relations, ATSIC and the Indigenous Land Council, who all participate regularly.

Mr COPELAND: You referred to DATSIP's expertise in assisting with state development. I go back to the question of the drug problem in the cape. I appreciate that the operational issues are obviously for police and cannot be discussed, but could you please advise what DATSIP is doing to assist in the development of that plan and progress the strategy to address the problem?

Ms SPENCE: There are two major areas where DATSIP would be involved with substance abuse issues in the cape, as indeed we are involved in those issues in all indigenous communities. That would be through our efforts to get local justice groups engaged in formulating action plans around alcohol and other substance management. Obviously I have signalled that I will be introducing legislation in the next month around alcohol management and also to change the community services act to give more legislative basis to our community justice groups. So DATSIP has a lead role and will have a lead role, particularly in the next six months, to make sure that those justice groups are strong and in place, ready to formulate these action plans around alcohol and other substances.

We also have a role in participating in ensuring that our justice agreement targets will be met. We do not have funding in DATSIP for alcohol or drug related strategies. That funding is located in the Department of Families and in the Department of Health. They are the major funding bodies for those, but DATSIP does acknowledge that it has a lead role to play in assisting other departments with their endeavours in these areas.

The CHAIR: The time allocated for questions from non-government members has expired. Minister, I also want to talk about alcohol management initiatives. I note that page 2-1 of the MPS outlines the government's response to the Cape York Justice Study, Meeting Challenges: Making Choices. Can you outline any alcohol management initiatives that have already been put in place in indigenous communities?

Ms SPENCE: I am happy to talk about this. As you would be aware, and as I have just mentioned, one of the main preoccupations of this government is to reduce the level of alcohol

abuse in indigenous communities and to make sure that we can assist indigenous communities in controlling the levels of alcohol consumption. We are very concerned about the high rates of violence, obviously, attributed to alcohol consumption.

This is not a paternalistic exercise by this government. We intend to give power to communities to enable them to take some action around the issues of alcohol. As I said, we will be introducing legislation shortly to strengthen local justice groups, to transfer the control of canteens and hotels from the community councils to alcohol management boards. This legislation will be introduced to parliament next month and passed before the end of the year. We are keen to ensure that we have local justice groups in place and ready to announce their alcohol management plans by early next year.

The good news is, though, that some communities have not waited for us to take this action. They have been out there doing their own hard work around the issue of alcohol. Palm Island council has recently limited the sale of alcohol to beer only. It reports to us that people who would normally be ignoring their families are now fishing and spending time with their families. It says that it has seen many positive outcomes. I would like to commend the Palm Island council for not waiting for the government to get in there and assist it. It has taken this strong measure by itself.

I am also told that the Lockhart River community was put on restricted trading in that its canteen was closed on Fridays. I understand that these restrictions are being lifted today, unfortunately. But for the last month or so the Lockhart River community has had closed canteens on Fridays. I am also advised that Aurukun has closed its canteen on Fridays as well.

The police have been doing a very good job, both in Lockhart River and on Palm Island, of confiscating sly grog. It is great that the communities themselves have decided to take the strong lead from government and tackle this alcohol issue without waiting for changes in legislation or assistance from government before making these tough decisions.

The CHAIR: I note that the MPS mentions the local justice initiatives program. Could you outline the role of the justice groups in reducing indigenous people's contact with the justice system and their role in the implementation of the government's response to the Cape York Justice Study?

Ms SPENCE: The local justice groups were an initiative that arose out of the Royal Commission into Aboriginal Deaths in Custody. When we came to government in 1998 they had a budget of $667,000. Under the Beattie government we have steadily increased their funding. This year they have been allocated $2.9 million. We fund 32 local justice groups throughout the state. Some of them have been going for 10 years—groups such as Palm Island. A lot of them are much newer than that.

Basically, local justice groups are made up of volunteers. They currently operate without any legislative backing. Despite that, they play an important role in their local communities. Some of the local justice groups have been very successful in taking the young people under their wing and ensuring that the young people see the consequences of their actions. Other local justice groups have been very involved in advising Magistrates Courts on sentencing.

We acknowledge that some of them have been very successful over the past few years and some of them have been less successful. If we are to give them the important role of developing action plans around things such as alcohol and canteen management, we will have to give them much more support in the future, particularly as we now are going to give them some legislative backing. Thus we see a large increase in their budget in the year ahead.

DATSIP will spend the next six months strengthening those local justice groups. We have already had some very important meetings in Cairns in the last two months about what the legislation should look like. Because the local justice groups have operated in a fairly ad hoc fashion in the past, there is no consistency about their membership or their operations. We have been consulting with the communities generally about what local justice groups should look like in the future—who should be members of those groups and how frequently they should meet. These will be important issues to be addressed in the legislation.

Ms NOLAN: Minister, I was interested to see mention on page 2-15 of the MPS of the Community and Personal Histories program. Could you explain to us what this program is and what it has achieved?

Ms SPENCE: The Community and Personal Histories Unit was established in 1992. Since the establishment of the unit over 6,000 requests for information have been received. The unit

receives on average 80 requests per month. Many of these requests come from people requiring genealogical information to complete connection reports for native title purposes.

There is also a growing demand for information relating to work histories. In 2000-01 the number of requests grew from 648 to 856. Last year the number increased to 943. So obviously this is a very busy unit providing access to information to Aboriginal and Islander people, particularly those who have been affected by the removal policies of past governments and now want to locate their family or country of origin. That is a very important task.

To enhance client access, a guide to records created by the department over the last 100 years will be released on the department's web site later this year. The information provided by the unit has assisted hundreds of Aboriginal and Torres Strait Islander peoples to reunite with lost relatives.

The program, through its 10 years or so of existence, has provided money to 167 grant projects totalling $925,766. Some of the grants have gone towards doing things like creating a database of over 12,000 entries recording the removal of Aboriginal and Torres Strait Islander people from 1859 to 1971. We now have a database of 600 Torres Strait Islander genealogies collected over 20 years. We have indexed the colonial secretary's correspondence for all records relating to Aboriginal and Torres Strait Islander people from 1859 to 1896. We funded Ruth Hegarty to write about her life as a dormitory girl in Cherbourg—a great book; I would recommend it to you all—we funded Albert Holt to write his life story, and we funded the Indigenous Information Service to write the story about Uncle Bob Anderson, which was published and launched earlier this year. At the moment we have 500 people interested in applying for grants for research to do their own personal histories. Obviously, this is a very hardworking branch of DATSIP and one that is much appreciated by indigenous Queenslanders.

Ms NOLAN: Having spent a fair bit of time in archives looking for Aboriginal people's history myself, I think that it is wonderful there is assistance for them.

Ms SPENCE: Yes.

Ms NOLAN: The next question that I have is with respect to the 10-year partnership. Can you outline the progress towards the achievement of an effective partnership with indigenous people in Queensland?

Ms SPENCE: Yes. The 10-year partnership is well under way. It is a recognition that the policies of past governments simply have not worked, that we need to look for different ways of doing business with indigenous Queenslanders, and it is about sitting down with indigenous Queenslanders and formulating ways of working together. To date, one agreement has been reached and that is in the area of justice. We have signed the 10-year partnership agreement for justice where we have committed ourselves to a target for reducing the number of indigenous people in correctional centres by 50 per cent by the year 2011. We should be very proud of the fact that we have a government who can sit down with indigenous Queenslanders and settle on a target like this. No other state in Australia has achieved this kind of target or this kind of agreement.

As I said, this week we have signed a partnership agreement with ATSIC, but we are working on other key areas in the partnership agreement. The next one that we are trying to get together is an agreement around family violence. I am hoping that we can come up with some effective and achievable targets to reduce the level of family violence on indigenous communities. The 10-year partnership has developed some key partnership tables in many parts of the state. I think that we are still in a learning phase in terms of developing the 10-year partnership and there is much more work to be done in the year ahead.

Mrs DESLEY SCOTT: I am interested in the diversion custody program. Could you please outline the purpose of the program and how it has assisted in reducing deaths in custody?

Ms SPENCE: Yes. The diversionary centres were another outcome of the Royal Commission into Aboriginal Deaths in Custody. We have five diversionary centres funded throughout Queensland. They operate in Brisbane, Townsville, Cairns, Rockhampton and Mount Isa and we have cell visitor services which operate in five locations with the diversionary centres and also a cell visitor program in Mackay. Since coming to office, the government has substantially increased the recurrent budget for this program to $3.2 million annually. Last year, we provided $1.5 million for the construction of a new diversionary centre in Cairns, which I am pleased to say began operations last month.

I think that we should also be very pleased to note that there have been no watch-house deaths in places where the cell visitor programs operate in those towns that have diversionary centres. Previously, there were 29 deaths in watch-houses throughout Queensland in the period investigated by the royal commission. In the last 10 years there have been 11 deaths in custody but only a few in those areas where we operate cell visitor and diversionary centres. So the diversionary centres are working.

I have visited all of our diversionary centres. I am aware of the good work that is being done in those centres. I think that the staff in those centres work under some trying conditions. After some initial concern by local citizens about diversionary centres, they have been well received in each of those towns. At the moment, we are conducting an ongoing training program for carers. These will be implemented to focus on improving the integration of other services, particularly health and alcohol management services, with our diversionary centre services.

Mrs DESLEY SCOTT: I note on page 2-13 of the MPS that $0.5 million has been provided this year to employ environmental health workers in isolated indigenous communities. Can you outline how this will improve the health of these isolated and remote indigenous communities?

Ms SPENCE: Yes, a key component of our focus in improving the health needs of indigenous people is on improving environmental health issues such as water quality, waste disposal, dust, sewage treatment and roaming animals, all of which pose a real health risk to communities. Since the introduction of the Diploma of Aboriginal and Torres Islander Primary Health Care at the Far North Queensland Institute of TAFE in Cairns in 1996, there have been a number of indigenous environmental health workers trained. Several Cape York community councils employ environmental health workers through existing SGFA funding—that is the funding that the state gives to each of the local councils. They have chosen to spend some of that money on employing their own environmental health workers. This year we have allocated half a million dollars for the employment of environmental health workers in these communities to coordinate the development of agreed community priorities in relation to environmental health. Under this initiative, community councils will be funded to employ environmental health workers overseen by Queensland Health to manage those needs, particularly those associated with housing, water quality, mosquitoes, refuse, food safety and sewerage. This funding will provide ongoing employment opportunities for a number of qualified environmental health workers in the cape as well as ensuring those essential environmental health services are provided to remote indigenous communities. So I am very pleased to report that DATSIP is working closely with Queensland Health on this important initiative.

Ms BARRY: Thank you once again, and welcome to your departmental officers. The budget contains $4 million to finalise the upgrade of retail stores for the Island Industries Board. Would you please outline the current status of the Island Industries Board? How will the upgrade of the stores help the board and the people of the Torres Strait?

Ms SPENCE: Yes, in the 1999-2000 budget we allocated $12 million over four years for the rebuilding of all the stores in the Torres Strait. We have spent about $8 million now and we have $4 million in the budget this year to finish off the project. The following stores have been completed and they are fully operational: at Rosehill and Tamoy on Thursday Island, on Saibai Island, Murray Island, Boigu Island and Darnley islands. I am pleased to say that I have visited most of those stores in the past 12 months and officially opened them. They are stores that we could all be very proud of. They are excellent. The stores on Warraber, St Pauls, Kubin on Moa islands are expected to be completed within a month. Stores on Yorke, Yam and Coconut islands are all under construction and construction of stores on Dauan, Mabuiag and Stephen islands are are being negotiated this year. At the end of this year, hopefully we will have all of those stores rebuilt. We are not talking about upgrades; we are talking about the total rebuilding of the stores in the Torres Strait. Obviously, this is very important to ensure that fresh fruit and vegetables and commodities are available on those islands to improve the health outcomes of the people living in the Torres Strait.

I am also pleased to report that the position of IBIS, the Island Board of Industries, has improved markedly during the past financial year. In part this is due to the tough decisions that have been made by the board. IBIS has rationalised its non-core assets, it has introduced stricter stock control measures in the stores and it has moved its head office from Thursday Island to Cairns. I know that these have been very difficult decisions for the board to make, because in some cases they have meant reducing the number of employees. That is always hard in a small part of the world like the Torres Strait. So I congratulate the board on making those tough decisions. I know that I have recently appointed a new board and I believe that they will have the

relevant expertise and experience to run this major retail operation in the years ahead. I am very pleased to see that Mr Joseph Elu has agreed to stay on as chair of the new board, because I think that he brings a lot of experience, commonsense and indeed a local knowledge to that position.

The trading figures for IBIS have been good for the past 12 months, but there is no way that they are out of difficult waters yet. They are carrying a lot of debt and we are certainly working very closely with the board and the organisation to help them through this difficult period.

Ms BARRY: Page 2-13 of the MPS talks about the department taking leadership and skills development projects in relation to government departments and Aboriginal and Torres Islander people fostering partnerships. It talks about the completion of a resource guide. I just wonder if you could outline what this resource guide encompasses and how it would assist indigenous Queenslanders?

Ms SPENCE: Yes. DATSIP has been working with the Indigenous Land Corporation to develop this resource guide, which outlines where grants and support programs are available within the government. It is quite a challenge, I am sure that you would agree. It is based on the key aspirations identified by Aboriginal and Torres Strait Islander people in community development plans for land that has been returned. Chapters in the guide reflect these aspirations, including land management, education and training programs, and employment and economic opportunities. It is important information on the responsibilities and financial requirements for people who have had land returned, such as meeting costs associated with council rates, insurance, weed and pest management, and infrastructure maintenance.

The guide also identifies the relevant government departments for each aspiration so that land-holders can organise a whole-of-government approach. While this guide is targeted at new Aboriginal and Torres Strait Islander land-holders, it is also useful to organisations and communities seeking partnerships with government for all key priorities. This is not the flash stuff that we hear in the media; this is the day-to-day hard work that the department is doing to produce very valuable information for indigenous Queenslanders.

The CHAIR: The time allocated for government members' questions has now expired. The remaining time for this session will be seven minutes each side.

Mr COPELAND: I would like to return to the issue of policing of the drug problem in the cape and the suggestion that DATSIP has a role to play as lead agency in pushing for additional policing and law enforcement resources to combat the marijuana problem but that that policing could also be used to combat the sly grogging problem. Do you agree that that is a strategy that is worth looking at and has merit? If you do, would you be prepared to raise that in cabinet to ensure that both of those problems are targeted?

Ms SPENCE: I am certainly not going to sit here today and be commenting or aspire to have any expertise on policing operations. I am not the Police Minister and I do not have a room full of police here with me to suggest whether the same strategies that are currently being successful in attacking sly grogging could work on marijuana. I am not going to say that, but I can tell you that I am in constant discussions with the Minister for Police and the Commissioner for Police about these issues. The Minister for Police has two very significant Aboriginal communities in his own electorate in Doomadgee and Mornington Island. He knows what goes on in those communities. The same kind of alcohol and marijuana and other substance problems that you are talking about in the Torres Strait and the cape occur in Doomadgee and on Mornington Island. I know that he and the Police Commissioner are very good at travelling around the indigenous communities throughout the whole of Queensland to get a ground view of these problems. They are out there talking to indigenous people constantly.

I am impressed at how far the Queensland Police Service—and I would say this on the public record—has come, particularly in the past decade, in working with indigenous people throughout this state. I think that we have a much different Police Service in Queensland today than we had a decade ago. I was incredibly proud when the Police Commissioner two years ago formally apologised to indigenous Queenslanders for the treatment that they might have received from the Police Service in the past.

This week is NAIDOC Week. Traditionally, the Police Service has a flag-raising ceremony on the Monday morning of NAIDOC week where they raise the Aboriginal and Torres Strait Islander flags. They regard this as a very important ceremony on their yearly calendar. So I am quite impressed at the attitude of the Queensland Police Service, particularly the leadership of the Queensland Police Service, on indigenous issues and I am confident that with such a positive,

understanding and realistic attitude from the leadership, this is being filtered down to the Police Service who actually live and work on these communities.

Mr COPELAND: I also refer to your earlier answer saying it is too early to tell whether more resources are required to enforce the liquor licensing laws. The Fitzgerald report and the women's task force report have both recommended significant increases in resources dedicated to the enforcement of liquor licensing laws. Given the Premier's description of the effects of alcohol on indigenous Queenslanders as 'genocide' and 'lost generations', which I referred to earlier, will you acknowledge that such a level of resourcing is still inadequate?

Ms SPENCE: When the women's task force reported on the need for more resourcing into liquor licensing, there was none. That was actually as a direct consequence of the women's task force report. We picked up their recommendation and that is why we now have six indigenous licensing officers. So I stand by my previous answer. These are new positions and it is far too soon to determine whether we need to increase the funding or increase the number of indigenous liquor licensing officers.

Mr COPELAND: I refer to page 2-9 of the MPS and I note the reference made there that the department will assist in finalising and implementing the land and cultural heritage agreement. In relation to the draft cultural heritage legislation that is being prepared by the Department of the Premier and Cabinet in conjunction with your department, will you please detail the consultation framework for this legislation?

Ms SPENCE: I might call on the manager of our Land and Cultural Heritage section, Rosey Crisp, who is our expert on this area.

Ms CRISP: In relation to the proposed cultural heritage legislation, there has already been extensive consultation occurring at the local level throughout the state and that was undertaken in 2000. Last year, further consultations occurred with 13 major key Aboriginal and Torres Strait Islander groups and some of the key stakeholders who have interests in that area. It is expected over the next six months that there will be some further consultations undertaken before that bill comes to parliament.

Mr COPELAND: I refer to page 2-19 of the MPS relating to future developments in community governance. I note that there is a listing for the development of a green paper on the future direction of governance arrangements for DOGIT communities which is currently being prepared by the department in conjunction with a number of other agencies. I note that the ACC was very critical of your department's review of the Community Services (Aborigines) Act 1984 in a letter to you dated 28 June 2001. I will table a copy of that letter and its attachments. The attachment from the ACC set out many positive and progressive recommendations. At the time, the ACC requested that a nominated representative assist the Parliamentary Counsel in drafting the legislation to embody its recommendations. What is the time line for your department's preparation of this green paper; are the DOGIT communities being permitted any involvement in this first phase; and can you assure me that the ACC's experiences last year in the review will not be repeated in the community consultation of the green paper?

Ms SPENCE: I can inform you that the ACC have nominated three representatives to work with us on the development of the green paper. That was a very long question. Certainly we are involving other government departments, particularly the Department of Local Government, in the development of this green paper. The green paper will outline options for a preferred model of community governance. We intend to consult stakeholders not only in the development of the green paper; we are also going to be looking for their feedback after it is put out.

The green paper is being developed by a reference group comprising officers from DATSIP, the Department of Local Government and Planning, the Department of Natural Resources and Mines, the Department of the Premier and Cabinet, Queensland Treasury, the Queensland Audit Office, the Local Government Association of Queensland, the Aboriginal and Torres Strait Islander Advisory Board, ATSIC and representatives from the ICC and the ACC. Also, there is an independent facilitator employed to facilitate the process of the development of the paper. It is expected that a major community governance conference will be convened later this year to inform the development of the green paper. I expect amendments to the community services legislation will be identified as a result of the consultations on the green paper. So everyone is going to have a say in what it looks like.

The CHAIR: The time allocated for non-government questions has now expired. Minister, page 2-17 of the MPS mentions the financial accountability improvement program. Can you outline what this program is and how will the changed arrangements assist community councils?

Ms SPENCE: This program's objectives are to assist councils to effectively address matters and issues raised in audits conducted by the Auditor-General. As stated in the MPS, the FAIP funding guidelines were reviewed during the year and the program now funds four broad services, each with its own mode of delivery. The four services include, firstly, statewide training. We are developing a financial and administrative training program for councillors. There are two distinct streams involved in this training, designed to cater for both the needs of organisational and personal development. The delivery of this training program is expected to commence this year.

The second stream is the direct funding to councils, and only those councils that last received an unqualified or qualified audit opinion from the Auditor-General are eligible for direct funding. It is a condition of direct funding that councils must commission internal audits.

Thirdly, there is direct service provision. Any council whose most recent annual financial statements were disclaimed by the Auditor-General—that is, the Auditor-General could not form an opinion as to the accuracy of the financial statement—receives direct service provision in place of direct funding. The value of the direct service provision is equivalent to that due to a council under the direct funding mode.

Finally, strategic reserve. We hold a strategic reserve each year. In the last year that money went to assist the ACC to finish up their internal audit unit. We appointed a financial controller for Doomadgee, we appointed a financial controller for Wujal Wujal, we gave assistance with the council clerk salary for the Wujal Wujal council, we gave accountancy support services to the Injinoo council, we held a professional development workshop for council accountants and we did an accounting system upgrade for users of Attache, the financial software for councils. The island councils strategic reserve component is to be used for a combined training workshop scheduled for August this year for island council clerks and DATSIP's community service officers.

Ms NOLAN: Following on with these issues about financial accountability, I note that page 2-18 of the MPS states that accounting standards have been adopted for Aboriginal and island councils. Can you outline what is embraced in these accounting standards and how they will benefit indigenous communities?

Ms SPENCE: Yes. The previously published Aboriginal and Island councils' accounting standards were merely guidelines that were not legally enforceable. Therefore, the new standards will significantly strengthen the financial management framework within which councils must operate. The new standards were developed in consultation with the Auditor-General and the industry bodies, such as CPA Australia. The new standards support both cash and accrual based accounting. Under the accounting standards, it will be mandatory for councils to develop specific policies on various matters, including purchasing goods and services, disposal of assets with a value of less than $5,000, HRM, debtors, housing, assets management, council allowances and loans to council members.

Under this new accounting standard, a council is permitted to make loans to adult community residents only if the council has a lending policy that has been approved by the minister. You would all remember the legislation that we passed in parliament last year to make that happen. The new standards represent an excellent financial management framework that balances accountability requirements with the capacity of Aboriginal and Island councils to meet those requirements.

Ms NOLAN: The MPS outlines the transfer of some functions from the Premier's department to DATSIP. How will this benefit indigenous Queenslanders?

Ms SPENCE: The Cape York partnership unit which was previously in the Department of the Premier and Cabinet has been transferred to DATSIP. This unit will largely focus on engaging indigenous communities in negotiation tables and community action planning processes and developing the necessary relationships with key indigenous leaders and organisations in the region. The unit has a budget of $1 million recurrent funding.

I think I said before that there were five staff positions transferred to DATSIP with that unit. I am now told that there might only be three. Three staff positions are coming across from that unit and the resources will be committed from other agencies to reflect the whole of government coordination of the unit.

Mrs DESLEY SCOTT: Retail store operations are mentioned in the MPS. I am aware that it is government policy to transfer these retail stores to Aboriginal control. Can you advise how this transfer process is progressing?

Ms SPENCE: Yes. The government currently owns and controls six stores on Aboriginal communities. They are at Woorabinda, Palm Island, Lockhart River, Pormpuraaw, Kowanyama and Doomadgee. The transfer of the stores has been on the government's agenda now for a few years. In fact, I was the minister who put this on the government agenda. That was not because the stores are not being well run. In fact, they are being very well run by the department. I have visited all of those stores and they are good facilities in those communities. We have upgraded the stores in the last few years and I am very proud of the way that they are operating. Most of them are even returning a profit.

The reason I put the transfer of stores on our agenda is that I think it is an anachronism in this day and age that a government department is still running and being shopkeepers on indigenous communities. So we would like to transfer these stores in some fashion. The difficulty in transferring the stores back to each individual community is that some of them are quite profitable and for many years now the profitable stores have been subsidising those that cannot make a profit.

We were held up for some months because the ACC wanted time to put their own submission in on taking over these stores and so we gave them some time and they put in a submission to us. Their submission was assessed by the Department of the Premier and Cabinet, Queensland Treasury and my department and it was felt that there was insufficient information in their proposal.

We are currently preparing documentation to seek to divest the stores through an open tender process. A steering committee, comprising senior officers from DATSIP and Treasury, has been established to guide the tender process and I am pleased to inform members that considerable progress has been made. Actions to date include the appointment of a probity auditor from BDO Kendalls, the appointment of an experienced private sector retailer, Mr John Berry, as a member of the three-person selection panel, and a person from ATSIAB to oversee the tender process.

The CHAIR: The time allocated for the consideration of estimates for the expenditure for the Department of Aboriginal and Torres Strait Islander Policy has now expired. I thank the minister and I thank her departmental officers for their attendance and their assistance with the hearing today. The committee will adjourn for a short break.

Sitting suspended from 11.30 a.m. to 11.45 a.m.

The CHAIR: The next item for consideration is the proposed expenditure for the Minister for Disability Services. The first period of questions is allocated to non-government members. I call the member for Cunningham.

Mr COPELAND: I refer to page 3-22 of the MPS regarding the $1.125 million capital expenditure for improving service choice at Basil Stafford. This has been in the budget papers since 1999-2000 and this money still had not been spent in 2001-02. Note one says that the variation is $1.125 million from capital to output being actioned in 2001-02. Could the minister explain that note?

Ms SPENCE: What I can tell the member is that we have spent all the money we have ever been given to relocate Basil Stafford clients. We have spent all the money that was ever directly allocated to the department to relocate Basil Stafford clients. In the past year we reallocated 23 people from Basil Stafford. We have actually been doing that out of departmental funds. We have had to find that money within the department to reallocate those persons. In terms of why does this amount keep appearing in our MPS, which I think is what the member is after—

Mr COPELAND: No—the fact that it was budgeted in 2001-02 in the capital acquisition statement but that there was no estimated actual for 2001-02. The explanatory note says that it has been moved from capital to output?

Ms SPENCE: That is a question for our accountant.

Mr KLATT: We get money in two forms. One is output, or our operational expenditure, and the other is capital. When the budget was first framed last year it was anticipated that this money would be required as capital. During the year we arranged for the funds to be transferred into our normal operational budget. The money was actually spent as operational funds rather than capital, but the money was spent.

Mr COPELAND: From the estimates committee last year my understanding was that that money was to be used for upgrading housing and the like for those people moved out of Basil

Stafford. If it has gone into revenue, that would mean that the money has not been spent in capital upgrades for those houses; is that correct?

Mr KLATT: It would have been spent as capital grants, which are classified as operational expenditure. It is a question of the classification of different costs.

Ms SPENCE: $1.2 million would not go very far in reallocating 23 people in terms of capital. Let me give an example. The three people for whom we are currently building a house, who were transferred out of Basil Stafford and who now live next to Mrs Symons at Chelmer—the member has heard of Mrs Symons; she does not like her neighbours—we have decided to move. We have just bought a block of land for $100,00 at Darra. We are now in the process of building a house for these three people on the block of land. I understand that we are spending $450,000 alone on one house for three people because of their challenging behaviour. All in all, the capital for those three people will cost in excess of $500,000, apart from what we have already spent on them in the house they are currently in. We can see from that that $1.2 million does not go very far when talking about reallocating these types of people into the community.

Mr COPELAND: I agree that it is a very expensive process. I refer to page 3-22 of the MPS and to the $400,000 spent on capital upgrade for services in 2001-02. The explanatory note says that it reflects commitments including innovative housing options for people with high support needs. Could the minister advise how many people that $400,000 has helped?

Ms SPENCE: Not many probably.

Mr COPELAND: It is $400,000 that was budgeted and spent in 2001-02.

Ms SPENCE: We think we have an officer who can explain the $400,000.

Mr ELDER: The $400,000 for the upgrade of housing is currently being spent actually helping people. To date, no individual has been assisted by that money. That money is currently being spent on finding suitable land so that the innovative housing option can actually be spent on them. The land that has been considered is worth about $200,000.

Mr COPELAND: In the budget it says that $400,000 was spent in 2001-02 with a further $1.2 million to be spent in 2002-03. Is there any indication of what that $400,000 that has already been spent as per the budget papers was spent on?

Ms SPENCE: I see what the member is getting at. In last year's budget $1.6 million was provided for operational expenditure, with a further $400,000 provided for capital expenditure. The $1.6 million has been rolled over into 2002-03. We have rolled over that $400,000, which we intend to spend on purchasing land for this purpose. The reality is that we are having real difficulty buying land for these people to build the houses. It is not a lack of desire to spend the money. We want to spend the money. The challenge for us is to identify blocks of land that will be suitable to build houses for people. It is not getting any easier in Brisbane to find land that we can afford, land that will be sufficiently away from neighbours, to build the kind of houses that we want to build for people with challenging behaviours. But we signed a contract on 30 June at Bethany on the Gold Coast to buy land and build a house for a respite centre.

Mr COPELAND: That takes care of the $400,000 that has been spent. Following on from that, how many people will the $1.2 million budgeted for 2002-03 assist?

Ms SPENCE: This is specifically for people with challenging and dangerous behaviours. It is very difficult to know how many houses we are going to build and how many people we can accommodate with that kind of money. The very best estimate is that we could build five houses and accommodate about 15 people. The director-general of my department met with the director-general of housing last week to discuss this very issue. Every house that we build seems to get more expensive and the design requirements seem to get more extreme. The house that we are building that is costing us $450,000 for three people now has triple glazing, ducted air conditioning and incredible fencing. That is why it is costing $450,000. We are now getting to the point where we have to say that enough is enough. We cannot keep spending that kind of money on this kind of housing, because it is coming out of a housing budget as well and there are obviously a lot of people missing out on public housing because of the extreme amounts of money we are spending on a small group of people. It is a real challenge for us to start addressing this issue and to get housing designed that will be satisfactory but less expensive for government.

Mr COPELAND: On page 3-7 under 'Recent Achievements' it states that during the 2001-02 year 23 people were relocated from Basil Stafford into the community, as the minister referred to earlier. How many residents remain at Basil Stafford?

Ms SPENCE: At last count there were 28 people on the site, 14 of whom have expressed a desire to be relocated and 14 who plan to remain on the site. So, those 28 adults are now living in the 12 villa houses on the site. We expect that down the track we will rebuild those houses. We have had a quote to refurbish the existing houses. I do not know if the member has ever been to Basil Stafford, but the houses look quite reasonable. However, we are told that they are termite infested. It is probably a poor move to spend too much money on refurbishing them. Eventually, we will be developing a master plan for the site which will include new housing for those people. I expect that we will demolish the existing housing even though it is not really that old. We need to look at what we will do with the Basil Stafford site. Current advice is that we would realise only about $350,000 if we sold the site, which given the size of the site is not much money for government. We will look at a master plan and see what future use DSQ will want to make of that site. We have some ideas in mind.

Mr COPELAND: Regarding Basil Stafford and the expectation to move another 14 people this year, that will leave 14 residents there. During last year's estimates the minister gave a commitment that there will remain between 15 and 18 places for people who wish to remain living at Basil Stafford or who wish to enter Basil Stafford if there are a couple of spare places. Does that commitment remain? With the plans perhaps to rebuild, I would expect that it would.

Ms SPENCE: I certainly give that commitment. If we are to have 14 or 15 people on the site, that is about five houses in the future of three persons per house. It depends on what comes out of our discussions about the master plan and whether we want to build more houses than that on the site for people in the future. This is a debate that must have out there. Given that it is so difficult to find land for people with very challenging behaviours, particularly in Brisbane, the department may wish to keep its options open to build more houses on the Basil Stafford site for those residents in the future. We need to start engaging the community there, particularly the residential community, people like the UDIA, in whether they would like to use some of that site for future residential development. Could we see a mixed usage of the site in the future? What other commercial operations might people want to see on that site? We need to be a bit innovative and imaginative. We have a very big block of land in Brisbane. While it was once probably regarded as fairly remote, it is not so much now. We really have to put some effort into planning the future use of that site.

Mr COPELAND: I welcome that, because there is a real need for flexibility in the way that we house people, in much the same way that the Families Department is looking at long-term care options. The minister, as do I, would have a lot of elderly parents of disabled adult children who are desperate to obtain care from the department for their children. A lot of them have been unable to get that care and feel that the only way they are able to is to abandon their children on the steps of the department, which they will not do, but that is the desperation they feel. Does the minister expect that the discussion she expects to have regarding, for example, the future of Basil Stafford may be able to address some of those issues?

Ms SPENCE: This is a discussion that needs to occur in the broader community, and I do not want to impose my views on it. But I would expect that, if we were going to build more housing on the Basil Stafford site, the people who would be best located in that housing would be people with particularly challenging and dangerous behaviours who it is very difficult to accommodate in the general community because of their capacity to make loud noises and disturb the amenity of a neighbourhood. I do not think you are talking about the same group of people as someone who has just got Down syndrome, is in their forties and is going to need individual accommodation in the future. Those people are very easy to accommodate in our general neighbourhoods.

Mr COPELAND: The ones I have been referring to are those with severe physical or intellectual disabilities for whom their parents are unable to continue caring at home. Recently, allegations have been made that the history files of some DSQ clients have been purged to hide incidents of harmful behaviour to assist in the deinstitutionalisation process. When those allegations were aired, you stated that the director-general would be investigating them. Could you please advise whether there was any truth to the allegations and, if so, what has been done to address those issues?

Ms SPENCE: Firstly, I would like to state that I am only aware that one person has made that allegation, and that is the first time that allegation has ever been made. One RCO made that allegation. The director-general referred that allegation to the CMC. The CMC has appointed an independent person to investigate the allegation. I might let the director-general talk about the actions he has undertaken to investigate that allegation.

Mr ROCKETT: The allegation was made at one of the meetings with residential care officers I attended to allow them to talk to me first-hand about some of the issues. The allegation was made that they felt administrative staff were purging files. They did not give a definition of what 'purging files' meant. The department's definition of purging files is that, as the file is passed on from one carer to another—the files of these people are very lengthy, quite enormous and voluminous—they move some of the files from one file onto another and they actually archive the file. I still referred the matter to the CMC. The CMC referred the matter back to the department to investigate it. We have now appointed an independent investigator to do this. We are expecting a full report to come back within two months regarding that allegation.

Mr COPELAND: I refer to page 3-7 and support for adults. Could you please advise how many people are receiving lifestyle support packages and how many people have applied but not yet received a package?

Ms SPENCE: I can give you an answer in general terms. At the moment we have about 1,000 people receiving adult lifestyle support packages. I am not sure that we have a more accurate statistic with us here today, but we can certainly provide you with one if you like.

Mr COPELAND: Yes, that would be appreciated.

Ms SPENCE: We will have to take that on notice, because I suspect we have not got it here today.

Mr COPELAND: And also the number who have applied for those packages?

Ms SPENCE: I can tell you that. Following the funding round in 2001-02, the register of need identified over 5,300 adults remaining without support, including approximately 1,600 individuals with a priority 1 rating. As at June 2002, a total of 6,314 applications had been received from people seeking an adult lifestyle support package. When I say of those adults remaining 'without support', that is a bit inaccurate; it does not mean that they do not have any support. They do not have an adult lifestyle support package, but a lot of those people would be receiving some support from our funded organisations.

The CHAIR: The time for non-government members' questions has concluded. The MPS at page 3-3 indicates the state budget for Disability Services Queensland is dependent on the finalisation of the third Commonwealth/State/Territory Disability Agreement with the Commonwealth. Can you inform the committee of the progress of the negotiations and the likely impact on future disability services and support in Queensland in terms of that agreement?

Ms SPENCE: This year's budget of $331.2 million relies in part on $99.2 million in funding from the Commonwealth. Importantly, this includes the indexed value of the unmet needs funding of $18.3 million provided to Queensland by the Commonwealth for unmet needs funding. Obviously, as you would all be aware, negotiation on the third Commonwealth/State/Territory Disability Agreement has been very frustrating and extremely difficult. I have made a number of statements in parliament about Queensland's concern over the Commonwealth's stand on this new negotiation. We were concerned last year when there was no money in the Commonwealth's forward estimates to provide unmet need funding to the states for this third agreement. We were concerned then that the Commonwealth was not suggesting any growth funding in the next agreement. We were particularly concerned when the Commonwealth linked the signing of the third CSTDA to its disability pension proposals being passed by the Senate. We were concerned that 1 July would come and this money that we were expecting from the Commonwealth would not come to the states.

On the eve of the ministerial meeting in Melbourne last month, Senator Vanstone changed her mind and said that they would no longer link the funding for the next CSTDA to the disability support measures being passed in the Senate. That was a major backdown by Senator Vanstone but certainly a welcome one from the states' point of view. On the same eve, Senator Vanstone suggested that she would keep funding the states for four months under the present CSTDA agreement while we sorted out the signing of the next agreement.

During our day in Melbourne, most of the session was spent discussing the next CSTDA. The states were obviously very unhappy with the fact that the Commonwealth was going to push us in into a position of signing the next CSTDA without any growth funding from the Commonwealth. At the end of that session, we managed to get some growth funding out of Senator Vanstone. She has proposed an additional $125 million in total over the next five years to all of Australia to be divided amongst all of the states for growth funding in disability. We have calculated that that would mean to Queensland $2.9 million this year and a million dollars in the next four years. This will support 30 people for support packages—30 new Queenslanders will get support. You have

just heard how many Queenslanders are on our register of need. That is an entirely unsatisfactory situation. When we meet in Melbourne next month the states will have to decide whether we are prepared to sign the next CSTDA with such a paltry amount of money being put on the table by the federal government. It has to be remembered that up until 1992 the federal government had responsibility for disability in Australia. It was only in 1992 that it handed responsibility for disability over to the states. Ever since that time, it has been slowly withdrawing its commitment to disability funding and expecting the states to pick up that funding. Obviously, we are never going to meet the needs for disability if we are going to have to rely on state funding in the future being the major source of revenue raising in the country. We need significant injections of funding from the federal government if we are ever going to make a real difference.

Mrs DESLEY SCOTT: With reference to the total operational budget for Disability Services of $331 million, how does this build upon the Beattie government's election commitment to progressively increase funding during its second term of office?

Ms SPENCE: In the first two years of its term the government added $63.289 million to the budgeted funding for disability in Queensland. This is far more than the $44.4 million that was originally promised within this time frame in our election policy document Building on the Foundations of Reform. We promised $44.4 million in 1998 when we were elected. We have done better than that. We have found over $63 million in new money for disability. In fact, it is in excess of the total additional $60.8 million promised in the document to be delivered in 2003-04. So what we promised to deliver next year we have already exceeded this year.

I am very proud of the fact that we have in this government a government that is prepared to put some serious money into disability. In fact, this year the department's annual budget is increased by $29.5 million—a nine per cent increase—which includes $6 million for capital upgrades in the disability sector. So although we are starting from a very low base in Queensland in terms of disability funding, we have made a good commitment in the last four years to ensuring that our funding gets up to the national average. One of those groups that has an astute understanding of disability spending in this country and in the state is the unmet needs campaign. In its media release of 25 June this year, the unmet needs campaign stated that the Beattie government delivered a budget that shows it to be on track to meet its election commitments while acknowledging that there is a long way to go. While we are doing our bit at a state level, it is very disappointing at this point in time that the Commonwealth government seems to be reducing its commitment to disability. While we can throw in an extra $20 million or $30 million each year into this area—and that is a significant amount of money, as you all know, from the state's point of view—unless we can get a better commitment from the Commonwealth we are still going to be struggling to meet the needs of people with a disability in this state.

Ms BARRY: Page 3-7 of the MPS refers to adults who identify with a high need for support. I am aware of the Adult Lifestyle Support Program. Can you please outline how this program has assisted these adults to date and what it will deliver in 2002-03?

Ms SPENCE: As the member for Cunningham asked before, we have about 1,000 people at present who are receiving adult lifestyle support packages and we have over 6,000 people on our register of need who would like those packages and currently do not have one. The packages come in three bands: the high band, which is from $50,000 to $90,000 per individual per year; the medium band, $20,000 to $50,000; and the low band, $20,000. We will continue funding the thousand people who currently receive adult lifestyle support packages. In addition, we have put in another $4 million this year, which we expect at the very best will buy us another 100 packages.

I suspect it will not, because what we will have to do is spend that money probably on people with the high support needs—the people whom Mr Copeland was talking about before—who are absolutely at the critical level and going to need support, and they are usually the high band packages. I suspect $4 million will not even buy 100 packages this year. At that rate, I think you can all be aware—and we have to be very honest about this; there are no cover-ups about this—that we are not going to make huge inroads into all of those people who are currently on our register of need. That is why I have engaged the department and the non-government sector in looking at a funding reform strategy, looking at the way we spend money on disability in the state and how we are going to spend our money in the future. It seems to me that there are a lot of people out there on the register who are waiting in vain for a package that is going to be a long time coming.

Ms BARRY: The MPS at page 3-3 refers to the allocation of $1.2 million in 2002-03 to implement the targeted response model for resident support services. Could you please explain

to the committee how this model will benefit people with disability living in the private residential services sector?

Ms SPENCE: Yes. The targeted response model is aimed at giving some support to people who are presently living in hostels throughout Queensland. This is certainly an area that has been ignored by government, and it has only been in the past couple of years that we have acknowledged that a significant number of people who are living in hostels and boarding houses in this state have a disability. We still do not know the correct figures. The Hostel Industry Development Unit indicates to us that 48 per cent of residents have a psychiatric disability, 41 per cent have an intellectual disability and six per cent of those residents have an acquired brain injury. You would be aware that we introduced the Residential Services (Accommodation) Bill and the Residential Services (Accreditation) Bill into parliament this year, but that is only part of the solution. The other part is to try to give some support and service to those people with disabilities who are currently living without any government assistance in hostels and boarding houses.

This year we have allocated $1.2 million in recurrent funding towards the implementation of a service model to support approximately 180 people living with disabilities in private residential services. We are looking at a targeted response model that started on 1 July this year. We are doing this in conjunction with Queensland Health, particularly its Home and Community Care program. We are trialling two different delivery approaches for residents. We have a resident based approach which will be trialled in Brisbane, Ipswich and Toowoomba where services will be provided to residents living in a number of different premises and a premises based approach which will be trialled in Logan, the Gold Coast and Townsville where services will be provided to eligible residents living in a few selected premises. What we need to do is trial each of these models and then ascertain which one best services individual needs and choices.

Mrs DESLEY SCOTT: The MPS at page 3-13 refers to work around young people and adults with high and complex support needs. Can you outline this work and in particular how you intend to meet housing and support needs?

Ms SPENCE: As I said before, we are very concerned about our capability to provide housing options for people with challenging and complex support needs. That concern obviously extends to young people with those needs. For example, while talking about packages of $50,000 to $90,000 a year, we have three children with disabilities in care who are funded at levels of over $150,000 per year. We have another two who are funded at a greater level of more than $200,000 a year. We have one individual who is funded at a greater level of more than $300,000 per year. These are single individuals who are costing us that kind of money on an annual basis. Mostly they are funded at that level because they are living in residential accommodation with full-time carers 24 hours, seven days a week in individual accommodation because of the severity of their behaviour.

Our challenge is to support these people in a way that is compassionate and humane without draining resources from others who are also in need of support. Given this complex situation, our response obviously needs the cooperation of other government departments such as Housing, Queensland Health and the non-government sector. I cannot pretend that we have the solution to this issue yet, but we are certainly working very hard on a range of options to provide a better quality of life for these young people who are in care who have major disabilities.

The Minister for Housing and myself have asked our two departments to develop a housing and disability policy statement that will provide a policy base and set out strategies to deliver an expanded range of housing options for this group of individuals at the moment. Obviously whatever housing options we come up with will be underpinned by the principles set out in the Disability Services Act and our anti-discrimination legislation. It is time for innovation, and that is what the departments have been asked to look at not just in terms of managing these individuals but certainly in design and location of their dwellings.

Ms NOLAN: Minister, Ipswich, as you are well aware, recently received a new respite centre for people with disabilities. It was very well received by the community. The MPS at page 3-13 refers to the establishment of 10 new and enhanced respite and family support services in 2002-03. Can you outline how these will assist families and people with disability?

Ms SPENCE: Yes. We intend to spend $2.5 million on these 10 new respite services this year. They will be located in Mareeba, Charters Towers, Rockhampton, Bundaberg, Kingaroy, Caboolture, Boonah, Beenleigh, the Gold Coast and Brisbane. These services will generate in excess of 50 new jobs across the state, taking the total number of jobs generated by the respite and family support initiatives in the last two years to in excess of 110. The government made a

pre-election commitment to establish new and individual respite and family support services in all regions across Queensland. With these 10 new services this year, we will have more than met our commitment with the funding of over 31 new and enhanced respite and family support services during this term of office.

The department has been undertaking consultations within this last year to talk to communities about what they want these respite services to look like and to identify service providers who might be willing and keen to establish these respite services throughout the state. I understand that we are well on track to start spending our $2.5 million and provide those 10 new services during this year.

The member for Ipswich asked the question and I just want to acknowledge the terrific service that is being provided by the new respite centre in Ipswich which we opened last month. It certainly is a state-of-the-art facility in terms of design. I know that the service that is being provided for people with disability there is new and innovative and I am sure will be a much superior service to anything that has been provided in the past in that area.

The CHAIR: Page 3-17 of the MPS refers to local area coordination services, and I understand this program has been independently evaluated. Can you outline the outcomes of this review?

Ms SPENCE: Yes. These local area coordination services are a success story for Queenslanders with a disability and their families, particularly those living in remote and rural locations of the state. To date, these LACs have exceeded all departmental expectations, and we have an independent review which has highlighted the positives of this approach. Last year we funded them to the tune of $2.76 million and last year we exceeded our targets for services and the numbers of people assisted. For example, the business plan set a target to provide 12 local area coordination services by 2001-02. We have actually provided 17. Some 15 of these are strategically located to assist people with disability living in rural and remote areas. New locations are Thursday Island, Mareeba, Atherton, Mossman, Kingaroy, Longreach, Emerald, Roma, Chinchilla, Charleville and Cunnamulla. The business plan set a target of assisting 750 people with a disability. We have already delivered on more than this by supporting 1,000 with a disability.

The good news is that people in rural and remote parts of Queensland with disabilities who have never had any support from government or any non-government provider have for the first time got some assistance from government. I want to read you a quote from the evaluation report. It says—

> We predict that the Queensland LAC model, if continued and further developed, will be hailed in years to come as a turning point in Queensland's policy on providing support to people with disabilities and will become a benchmark for other states and internationally.

This is not an evaluation report done by the government; it was done by independent consultants, and that is what they have to say about our LAC program. While many families, particularly in rural and regional Queensland, do it tough in terms of getting any support, the LAC offices have certainly made a difference to the quality of life and their long-term capacity to cope in those situations. So I commend the department for this program. It certainly is one of our success stories.

The CHAIR: Thank you, Minister. The time allocated for government questions has now expired. The remainder of this session will be 16 minutes each.

Mr COPELAND: Minister, this question refers in some part to the need for innovation in providing accommodation and care for people with a disability, as you have just referred to. You will be as aware as I am of instances of young people with a disability being cared for in nursing homes, for example, because they are the only option that is available. What strategies do you have in place or do you plan to put in place to provide facilities to be able to care for those people, or do you think that nursing homes are appropriate in those cases?

Ms SPENCE: I am happy to talk about that. Before I do, I would like to get rid of my question on notice, because I have just been provided with the answer. For 2001-02 there were 1,040 individual lifestyle packages. So these will be either recurrent or non-recurrent packages.

In terms of people in nursing homes—obviously it is unfortunate when young people find that their only accommodation choice is to be in a nursing home. A number of those people in nursing homes have applied for our adult lifestyle support packages. I do not make the decisions about whether they come up as the top priority. Those decisions about who gets the packages are made at a regional level around the state once a year. We have some money set aside for

deinstitutionalisation this year. We have got $1.5 million of new money put aside in this year's budget to continue that process of deinstitutionalisation from the non-government sector. There are many non-government organisations out there that are going to be looking for those funds in the next year to help people get out of those institutions.

This is not an issue that is going to be solved by the state alone. It has got to be an issue where the federal government engages the state in some serious funding discussions, because you are really looking at a transference of funding obligations from the federal government, which currently supports these people in aged care institutions, to the state government if we are going to pick them up on adult lifestyle support packages. On 30 June 2001 there were 1,223 people under the age of 65 living in Queensland's aged care homes. Obviously all of those people do not want to move out of those homes. Some of them require the kind of medical treatment that would only be available in those homes. But we are aware that there are a number of them who would like to move out into the community with support packages. They, like those other 6,000-odd Queenslanders, have to compete for a fairly limited number of support packages each year.

Mr COPELAND: Minister, referring to the institutional reform that you were discussing, on page 3-7 of the MPS there is $2.7 million allocated towards institutional reform initiatives for both government and non-government institutions. Can you advise what those initiatives will be and which institutions they will involve?

Ms SPENCE: The funding is going to be provided to the following groups: Alkira at Indooroopilly; the Multiple Handicapped Association of Queensland—Multicap—for the relocation of people upon the closure of Apex House at Eight Mile Plains; and the Sisters of Mercy for the continuing relocation of residents from the Mercy Centre at Wooloowin. That is actually the $1.5 million. So those three groups will be sharing that $1.5 million for their deinstitutionalisation. I have actually met with those groups in the last month or so. We are working through a process of how many people they want to move out in the next year. So in terms of how the money is going to be divided, that will be sorted out in the next three months and they will come to some agreement about that. That is not the $2.5 million you are talking about.

Mr COPELAND: It states $2.7 million, so perhaps there is another—

Ms SPENCE: That was last year—plus another one and a half this year.

Mr COPELAND: In relation to staffing on page 3-6 of the MPS, could you please advise what the current carer to client ratio is for Disability Services Queensland?

Ms SPENCE: I think we can. We have a lot of figures here, but I am not sure whether we have the ratio. We have figures like 68 per cent of all our ALS houses have four to five clients in residence, and nine per cent of our ALS houses have one to two clients. The director of regional operations, Kathy Dunning, can answer that question.

Ms DUNNING: The average staff to client ratio in the Alternative Living Service is one to four. However, it does vary on the needs of the clients. In some cases it can be one to five, but it can be as low as one to one, or in some cases—in extreme situations with very high support needs on certain shifts—there could be two staff to one client. So it certainly does vary depending on the needs of the client, but the average is one to four.

Mr COPELAND: Minister, my understanding—and I do stand to be corrected on this—is that in other states the average ratio is one carer to two clients. Is that figure something that is to be aimed at in Queensland?

Ms SPENCE: I do not know where you have got the one to two figure from. I have never heard it. I would be highly sceptical if that were the case. I have just been down there talking to the Victorian people and seeing some of their services. Their ratio is very similar to ours. Could we aspire to one to two? We could have used the $10 million increase that we had this year by putting more RCOs on and not giving out any more adult lifestyle support packages or any more post-school service support packages. These are decisions you make with the available money. What we aspire to and what we can afford are probably two different things.

Mr COPELAND: Minister, page 3-8 of the MPS refers to funding given to the Endeavour Foundation. For some time Endeavour and other non-government service providers such as, for example, the Cerebral Palsy League have been providing services for which they were either funded, partly funded or not funded at all. Given that those organisations are no longer able to raise enough money to provide all those services—for example, the Cerebral Palsy League has claimed that this budget has not provided enough to cover its shortfall—what can the government do, or what is it doing, to ensure that those services will continue to be provided?

Ms SPENCE: In terms of the Cerebral Palsy League, I know that it is expecting an additional $1.7 million from the government this year. What it wanted was $800,000 from DSQ and the other $800,000-odd that it needed had to come from Queensland Health and Education. We actually did find the $800,000 that it required from our department. So its shortfall is now in the areas of Education and Health funded services. I know that it is talking to those departments about what they are going to do in terms of that shortfall.

In terms of the Endeavour Foundation, I agree with you. Part of the problem is that these organisations—the big disability organisations—have relied on the general public and their own revenue raising measures in the past. Their capacity to generate their own revenue is diminishing. They are increasingly going to rely on government funding in the future. The viability issues of those larger organisations are also being reflected in smaller disability organisations that we hear less about. That is what the funding reform strategy is about: honestly sitting down and assessing where we are spending the disability dollar and where we are going to head with it in the future. Hopefully we are going to receive some answers about general issues, such as viability, as a result of that project. We are hoping that the project will have a report to government by February next year. They are operating in a very tight time frame. We are asking them to do a big job.

The Endeavour Foundation received $5 million this year, which brings the total government funding to that organisation to in excess of $22 million. It expected more than $5 million funding. It is now looking at its organisation to see how it is going to operate for the next year. In the last month, since the budget has been brought down, I have sat down with the whole Endeavour council and talked about their funding situation. The DSQ will continue to work very closely with that organisation to see that it is going to be able to operate within its existing budget in the next 12 months. I have to say on the public record that I appreciate the cooperation that has been afforded to me and to the department by not only the board of Endeavour but also the executive officers of the organisation. In partnership we will sit down. It is a major player in providing services to people with disability in this state. We have to sit down and work with it in a constructive fashion to help it with its budgetary situation for the next 12 months.

Mr COPELAND: Minister, on page 3-22 of the MPS there is $1.803 million budgeted for the forthcoming year for asset purchases. Could you give us an idea of what those assets will be?

Ms SPENCE: These would be just the general replacement of our computers, office furniture—

Mr COPELAND: Just run-of-the-mill stuff?

Ms SPENCE: Yes.

Mr COPELAND: Minister, one of the issues that has been raised is that of pay equity between residential care officers, especially for those who are yet to complete their qualifications. Those people are expected to perform the same tasks as those qualified residential care officers within DSQ but are being paid significantly lower. Is there any plan by DSQ to address that inequity?

Ms SPENCE: The director-general has been in direct talks with the union about that issue, so I might pass that to him.

Mr WHERRETT: The union had a log of claims of some 32 items. The department has been in negotiations with both the QPSU and the AWU for several months. The issue about the conversion of those who are on the 002 scale to 003 is unresolved. It is the major one that is yet to be resolved. We have undertaken to continue to work with both the QPSU and the AWU on those matters. We have indicated to them on many other items on the log of claims that we will be actioning those. For example, all RCOs who have been in temporary employment for 12 months or less will be given permanency. There will be improved workplace health and safety issues, increased training for RCOs, and so on and so forth. So while I think we have dealt with most of the issues that they have raised, we will continue to work with them on converting those 002s to 003s over time.

Mr COPELAND: Minister, through you to the director-general: you stated that any temporary employees under 12 months will be diverted to permanent positions. Could you advise how many people that will affect within DSQ?

Mr WHERRETT: It is for those people who have been in temporary employment for 12 months or more. There has been a significant reduction in the temporary employment numbers over time. I believe there are approximately 200 still in temporary employment. I believe that this will deal with approximately 150 of them.

Ms SPENCE: We have actually done a very good job in the last 12 months of converting temporary to permanent. In fact, we actually converted 167 to permanent employees in the last year. We expect that we will be converting another 100 to 150 from temporary to permanent in the next six months from today.

The CHAIR: The time allotted for non-government members' questions has now expired. I call the member for Aspley.

Ms BARRY: Minister, the MPS at page 3-6 refers broadly to ensuring the ongoing viability of community based and non-government organisations as service delivery agencies. Can you please explain to the committee how you plan to achieve this?

Ms SPENCE: We have touched on this already today, but I think it is important to make the point that 60 per cent of the total budget for DSQ goes directly to the non-government service providers. They are the major service providers to people with disability in this state. In the last 12-odd months that I have been minister I have certainly heard about the viability issues that are being experienced by those service providers. There has been a legacy of underfunding. Traditionally in Queensland we have relied on those non-government organisations to operate without too much government support. Their capacity to raise revenue, whether through donations, fundraising or their own business enterprises, is diminishing. The cost of providing those services is increasing as workplace practices and policies are changing and they are required to pay their staff at different levels. However, I am pleased to say that we are able to index their funds this year. An additional $5.4 million has been allocated to assist disability organisations experiencing service and demand pressures this year. The funds will be used for indexation to Disability Services, and $1.8 million has been set aside this year to assist organisations that are currently experiencing significant disability issues.

There is also $2 million to provide growth for Disability Services to respond to demand. The funding will provide some immediate assistance. However, since becoming the minister it has been clear to me that there is a need for some sort of ongoing strategy to address these issues. That is what the funding reform project will be about. I invite any members who are interested in this issue to follow this project carefully.

On 22 July the discussion paper about the funding reform project will be released publicly. We will be sending those out to the disability providers and individuals throughout the state to engage the whole community in these issues. We as a government simply do not have the answers to this funding dilemma and we are reliant on community input and community ownership of anything that will come out of this project.

Mrs DESLEY SCOTT: Minister, I refer you to page 3-7 of the MPS. I have a large special school in my area, and my question refers to people with high support needs leaving school. Could you please outline the support available through Disability Services to assist these school-leavers in the transition from school?

Ms SPENCE: We have talked a fair bit today about the $4 million that we are putting into new adult lifestyle support packages as a result of this year's budget. We are also committing an additional two and a half million dollars to post-school support services. That will provide support to 160 young people who are leaving school. It will help them in their transition into the community. In last year's budget we were able to support 165 young people. There will be an additional 160 supported this year. This will mean that we will have supported 1,219 individuals in this program since its inception in 1997.

The total budget for post-school support services this year will be $17.1 million. Approximately $5.1 million is being allocated to the Moving Ahead program, and $12 million is being allocated to the Options Plus program. The Moving Ahead program provides support for two years, at which time people may receive ongoing support with periodic review through the Options Plus program. Participants assisted through Moving Ahead may receive funded support within one of two funding bands—a low band of $12,500 or a high band between $12,500 and $16,000. As well, individuals can receive transport assistance. These are good programs. Obviously there is a great demand for them throughout the state.

In the time remaining to me I would like to provide an example to illustrate the way these programs assist young school-leavers transitioning into adult life. We hear from an 18-year-old man with a moderate to severe intellectual disability who it was believed was incapable of working, was lacking in maturity and could not engage well with his peers. Since his commencement on the Moving Ahead program this year he has managed to undertake a number of roles that have assisted him with his transition to adulthood. These include obtaining regular work experience,

where he has demonstrated a good work ethic—there is now real potential for this work experience to lead to part-time work with his employer—and increased social networks, including attending social events with other young people with disabilities, which has resulted in the young man being able to initiate conversations with peers and workers on a range of matters including current affairs and sporting events. The young man and his family are excited about his progress since commencing the Moving Ahead program and feel that he is more equipped to deal with his adult life.

This money is distributed according to regional representation and recommendations. We have a good breakdown of the regional distribution of this money throughout the state to make sure that the money does indeed find its way to young people throughout Queensland.

Mrs DESLEY SCOTT: Minister, page 3-4 of the MPS states that $5.4 million is provided to address service and demand pressures. Can you outline how these funds will be allocated?

Ms SPENCE: In the 2002-03 budget $5.4 million has been allocated to assist disability organisations experiencing these service and demand pressures. I have already talked to the committee today about funding reform. This $5.4 million will be used to assist these organisations through the provision of the following: $1.8 million for indexation to disability services, $1 million to organisations that are currently experiencing significant viability issues and $2.6 million to provide additional growth for disability services. We have, therefore, growth money to offset increases in providing services such as superannuation guarantees, wage supplementations and insurance issues.

Ms BARRY: Page 3-12 of the MPS refers to children with disabilities in care funding programs. Could you please explain to the committee how the program works, including the support that is available through Disability Services Queensland to young people in this program as they turn 18 years of age?

Ms SPENCE: This is a program that is jointly funded and administered by Disability Services and the Department of Families. It is about supporting young people in care who have disabilities. These young people should be of extreme concern to us all, because they are characterised by repeated disrupted placements and insufficient support to address the impact of abuse and neglect. Some of them have had inappropriate placements in hospitals. A lot of them have been suspended or excluded from the education system. They have all suffered from breakdown of family and social networks. They are generally the children who experience the most severe and extreme levels of disabilities. Their disabilities usually are multiple. They have intellectual disabilities or autism, physical disabilities and challenging behaviours.

In this year we have allocated an additional $2 million to support 10 of these children after they have turned 18 years of age. We have acknowledged that we cannot just cut off the funds when these people come out of our care when they turn 18 years of age. They will still need a lot of support from the state. Their disabilities are not going to go away, so they will still need support in undertaking their every-day activities—things like maintenance of personal hygiene or assistance to manage behaviours and keep themselves safe.

Obviously this is a group of people that will need long-term support from the state. They have not had many opportunities to develop community networks or family and friends. Many of them have been excluded from all sorts of social and educational activities from an early age. This is a group of people I am very concerned about, and we are certainly going to do a lot of work in the years ahead to make sure they have more appropriate placements than they have had in the past.

Ms BARRY: Pages 3-8 and 3-9 of the MPS detail projects to better support people with a psychiatric disability. I am aware, as I am sure you are, that this group has been historically disadvantaged in accessing services. Can you please provide to the committee details on these projects and the benefits that can be achieved?

Ms SPENCE: Project 300 supports those people with psychiatric disability. Last year we spent $12.8 million to support 230 people across the state. Many would be aware that this group has historically had extremely limited access to disability services and support. They are also amongst the most marginalised and discriminated against in our society. Training and advocacy will go a long way to assisting people with psychiatric disability to receive more responsive services and to be supported against abuse, neglect and discrimination. So we have in the last year allocated $200,000 for training for our staff and specialised service providers around the state to assist our Project 300 clients.

An important service we can provide for these people is advocacy. I would like to provide two examples of the positive outcomes of Project 300 advocacy support. A consumer in Toowoomba was committed to jail following some minor offences while in the community. The advocacy service she was linked with was successful in advocating on her behalf for additional non-recurrent funding to allow her to commence her transition to community life.

A consumer who is elderly had been unsuccessful in the transition back to her own home in the community. She was readmitted to the local mental health facility and appeared unlikely to be discharged. Through the support of her advocate and family, she was reallocated to an aged care facility in a community setting. The advocate continues to give support to ensure this service model meets her ongoing needs. It is a project that is really hard to explain in general terms because, generally, individuals who need some support from this funding need very individualised support.

Ms NOLAN: Minister, page 3-2 of the MPS outlines the legislative reform project. Can you provide us with some details of the project?

Ms SPENCE: It is now 10 years since the Disability Services Act became law. There is obviously a need to update this act in line with changes in the disability sector to reflect current policies and practices. The legislative reform project has three goals: examining new operational directions, resolving the purpose of the act and its relationship with other legislative frameworks, and clarifying the roles and responsibilities of participants in the disability services system. That is why we have developed some issues papers. The issues papers concerning the legislative reform project will be released for public consultation early next year. It is our intention to change that legislation some time during 2003.

The CHAIR: The time allotted has expired. That concludes the examination of the estimates for the portfolio of the Minister for Families and Minister for Aboriginal and Torres Strait Islander Policy and Minister for Disability Services and Minister for Seniors. On behalf of the committee I thank the minister and portfolio officers for their attendance and assistance in today's hearings. For the information of those attending today, the hearing transcript for this portfolio will be available on the parliamentary web site within approximately two hours. I thank Hansard for their work this morning as well. The next portfolio to be examined relates to the Minister for Health.

Sitting suspended from 12.57 p.m. to 2.00 p.m.

HEALTH

IN ATTENDANCE

Hon. W. M. Edmond, Minister for Health and Minister Assisting the Premier on Women's Policy

Dr R. Stable, Director-General

Dr D. Filby, Deputy Director-General (Policy and Outcomes)

Dr J. Youngman, General Manager (Health Services)

Dr J. Scott, State Manager, Public Health Services

Mr E. Evans, State Manager, Oral Health Unit

The CHAIR: The hearing of Estimates Committee D is now resumed. The next portfolio to be examined relates to the Minister for Health. I welcome the minister, public officials and members of the public who are in attendance this afternoon. As I mentioned this morning, the committee will suspend its hearing for afternoon tea from 3.30 p.m. to 4.00 p.m. I remind members of the committee and the minister that the time limit for questions is one minute and answers are to be no longer than three minutes. A single chime will give a 15-second warning and a double chime will sound at the expiration of these time limits. An extension of time may be given with the consent of the questioner. The sessional orders require that at least half the time is to be allotted to non-government members and I ask departmental witnesses to identify themselves before they answer a question so Hansard can record that information in the transcript.

In the event that those attending today are not aware, I should point out that the proceedings are similar to parliament to the extent that the public cannot participate in the proceedings. In that regard, I remind members of the public that in accordance with standing order 195 the public may be admitted to or excluded from the hearing at the pleasure of the committee. I also ask that mobile phones be switched off and pagers are in silent mode. Minister, would you like to make a brief introductory statement? If so, I ask that you limit your statement to five minutes.

Mrs EDMOND: I would indeed like to make an introductory statement. It gives me a great deal of pleasure to make this opening statement at this the 2002-03 estimates of expenditure for Queensland Health. I have now been involved in Health estimates eight times, five as minister. I am delighted to announce another record recurrent Health budget for 2002-03 of $4.33 billion, as well as $248 million in capital works and equipment. This budget shows a 6.7 per cent increase, an increase of $271 million on the 2001-02 budget, the fifth consecutive record Health budget under the Beattie Labor government.

Queensland Health's greatest asset is its staff and we have more than 40,000 full-time equivalent health professionals and administrative staff. Forty per cent of our staff are nurses and I can assure you that every effort will be made to continue to attract and retain our nursing work force against a backdrop of national and international shortages. A further $1 million recurrent funding will continue the implementation of the ministerial task force on nursing recruitment and retention. The Queensland Tertiary Admission Centre report for 2002 shows a strong demand for pre-registration nursing courses across all Queensland universities, with interest in all universities exceeding the available placements, and that is great news. Again we are seeing some success with turnover of Queensland Health's permanent nursing staff falling significantly from over 20 per cent per annum in the coalition days.

This budget provides for a range of additional staff for front-line health services including an additional orthopaedic surgeon at Cairns hospital; three new specialist positions at the Townsville hospital; 10 additional registrars statewide comprising two in anaesthetics, two in haematology, one in ENT and 5 in radiology; 13 nursing and allied health staff for adult rehabilitation at the Townsville and Princess Alexandra hospitals; a diabetes specialist to provide outreach services to Cape York; 18 indigenous health and nutrition workers; and an extra 16 medical officers in the emergency departments statewide. Mental health is again a big winner, with $8.2 million allocated for approximately 55 new community mental health positions. This government is continuing to enhance mental health services with funding for community and forensic mental health, as well as in-patient mental health services such as the high dependency units at the Princess Charles and Nambour hospitals.

This budget marks the completion of Labor's 10-year $2.8 billion statewide health building program, the largest health capital works program ever undertaken in Australia. We have rebuilt the state health system from the cape to Coolangatta with hospital redevelopments completed or near completion in Cairns, Townsville, Rockhampton, Maryborough, Nambour, Gold Coast and Brisbane. Capital projects to commence or continue in 2002-03 include $14.4 million for the redevelopment of the Innisfail hospital; $6.5 million for the community health centres in Townsville; the $5 million redevelopment of the Gympie hospital; and a $1.8 million outpatient facility for the Mackay hospital. This government is committed to health in the Smart State. We have committed $38.6 million to state-of-the-art hospital equipment, including radiography, arterial imaging, ultrasound and CT scanning equipment.

May I now introduce for the benefit of the committee the departmental officers who are with me. Of course, I am sure that you will know the Director-General of Queensland Health, Dr Rob Stable; Dr John Youngman to my right who is the General Manager of Health Services; and the Deputy Director-General, Dr David Filby on my left. This is the seventh and, sadly, the last time that Dr Youngman is attending estimates. I am sure that he will miss it all terribly as he is leaving for greener pastures—in fact I think orchards and flower gardens. We all wish him all the best of success in that. Unfortunately for me, this is the third and final time Dr Filby will be here, too. He is returning to Adelaide to work with the South Australian Health Department and I understand that he is extremely excited about his new role including public health, as well as the chance to spend more time with his family. I want to put on record my appreciation for the great support and expert advice these two outstanding professionals have given me over the years. They will be greatly missed by myself and I think the entire department.

The CHAIR: I declare the proposed expenditure for the portfolio of the Minister of Health to be open for examination. The time allotted is four and a half hours. I call the member for Maroochydore.

Miss SIMPSON: Well, minister, it is nice to see you come along to the hearings. We missed you at the demonstration outside. Have you brought your chunder bucket?

Mrs EDMOND: Is that a question? Do I have three minutes to answer that, Madam Chair?

Miss SIMPSON: I have a question for the minister.

Mrs EDMOND: I thought that was a question, Madam Chair.

Miss SIMPSON: In regard to page 1-39, 'Statement of Financial Performance', I direct the minister to the line detailing employee expenses which shows $2,550,218,000. I ask what portion of this figure allows for the impact of EB5?

Mrs EDMOND: I should say right at the outset that the EB allowances in the budget are according to the estimates by Treasury for the proposal that was put on the table by Queensland Health. Any further adjustments to that will have to be negotiated with Treasury following settlement of the negotiations.

Miss SIMPSON: Industrial Relations Minister Gordon Nuttall said yesterday that funding for a nurses package comes out of the Department for Health and that it was a matter for the Health Department to explain. Surely your department has appropriated more funds for the eventuality that the package will cost more than $190 million so that Mr Nuttall can negotiate a better deal. How much money is the Beattie government willing to pay to reach a deal with nurses or is your department unwilling to budget for this at all?

Mrs EDMOND: The budget allocation for the enterprise bargaining has been made according to the proposal put on the table by the government. Any further adjustments would have to be taken into consideration after the outcomes of the hearings before the Industrial Relations Commission. It is my understanding that these matters are still currently before the Industrial Relations Commission. The commission has issued a directive that neither party will discuss the matters while they are being negotiated. The government, Queensland Health and myself are extremely keen to see a negotiated settlement as soon as we possibly can. Therefore, we are fully cooperating with the commission to give the hearings every chance of success. I am therefore unable to comment on these matters further. Details of the offers have been thoroughly covered in the media and I refer members of the committee to the government advertisements that explain them. For the benefit of the committee I also point out that the portfolio responsibility for IR matters is with the Department of Industrial Relations and therefore the Minister for Industrial Relations is the lead minister for the government and the one to whom such questions should be put.

Miss SIMPSON: But you are the Minister for Health.

Mrs EDMOND: If the commissioner issues any further statements releasing us from that directive today, I will inform the committee.

Miss SIMPSON: In fact, Minister Nuttall said that the nurses dispute is a matter for the Department of Health and that it is the Department of Health that pays the nurses wages. I think it is a cop-out if you are trying to say that you do not have any involvement in the negotiations.

Mrs EDMOND: I have not indicated that I do not have involvement. I have said that Minister Nuttall is the lead minister as he is the Minister for Industrial Relations. I have indicated all along that we are our consulting with them and I have indicated that allowances for the package that the government has put on the table for the EB has been used in the budget and anything else outside of that would have to be renegotiated. I can say that the funding in the past for EBs under this government has been fully funded rather than the EB under the coalition government, which left $30 million of savings to be found out of nurse workloads and out of other staffing et cetera, which was never found.

Miss SIMPSON: Minister, it seems that you are very absent from these enterprise bargaining negotiations. I refer you to MPS page 1-39 again and specifically to this document—and this is under Dr Rob Stable's signature—that details the cost of items considered for nurses EB negotiations and I ask: in light of Minister Nuttall's statements to the estimates committee only yesterday that the package was $190 million, a figure bandied around by the Premier and others, can you explain why this document states clearly that the total amount approved by CBRC amounts to only $165.9 million?

Mrs EDMOND: I would draw the member's attention to the fact that that is a cabinet document and I was of course at those meetings. You were not. You do not know who is at meetings when you are not there.

Miss SIMPSON: Well, minister, we have not seen you around on the negotiations with the nurses.

Mrs EDMOND: Madam Chair, is that another question?

The CHAIR: Order! Member for Maroochydore! Member for Maroochydore, I remind you that you are to ask a question. Under sessional order 25 they are to be no longer than one minute. You are not to make a statement but ask a question. Please continue.

Mrs EDMOND: Thank you, Madam Chair, it would be nice to answer the question. It is quite simple. That is for two years. The nurses asked us to look at funding for two years rather than the original three years.

Miss SIMPSON: I refer the minister to note 4 in the MPS at page 1-39 which states—

Employee expenses variance is due to increased activity and increases arising from enterprise bargaining agreement (EBV) costs. The latter increase is based on the initial government bargaining position. Should be EBV negotiating framework change, funding will be amended post budget. It is expected this item will be budget neutral and includes contributions from Commonwealth funding.

Does this not mean that if your government was to compromise and increase the offer in order to keep it budget neutral you would have to reduce nursing numbers?

Mrs EDMOND: No, I am sorry, the member does not seem to be hearing. I have said that the funding in the budget covers the government's offer and if there is any movement outside that, it would have to be renegotiated with Treasury. You may not be aware, but the Commonwealth actually contributes to Queensland Health funding through the Australian Health Care Agreement.

Miss SIMPSON: I was referring to a note in the budget papers that it will remain budget neutral. In order to do that your papers from cabinet, and which you said were from cabinet, actually identify that there is a shortfall in what CBRC was offering in order to resolve the nurses dispute.

Mrs EDMOND: It is saying that we would have to go to Treasury if there is any movement outside it. Can I go back to the statement that I made originally—

Miss SIMPSON: Minister, this is in your own budget.

Mrs EDMOND: Madam Chair, the commission—

Miss SIMPSON: Minister—

The CHAIR: Can we hear the minister's answer, please.

Mrs EDMOND: The commission has directed that the parties do not discuss these matters of what is on the table. I cannot do it, so it is totally improper for the member for Maroochydore to keep asking the question when I have been directed by the commissioner not to discuss these matters that are on the table.

Miss SIMPSON: Minister, I note your answers and note that you have not been very involved at all in the up-front negotiations with nurses.

Mrs EDMOND: I note that the member for Maroochydore has not been at any of the meetings that I have attended so she would not have a clue and I ask for that comment to be withdrawn.

Miss SIMPSON: The minister does not seem to have been playing an up-front role in the enterprise bargaining agreement process with nurses.

Mrs EDMOND: Is that a question?

The CHAIR: Member for Maroochydore, I will remind you again that you are to ask a question. It is to be no longer than one minute. Under sessional order 25 you are not to make speeches. Please continue with your next question.

Miss SIMPSON: Minister, I refer you to page 1-6 of the MPS and to your answer to my question on notice in regard to agency nursing staff. Your answer to my question shows that there has been a 40 per cent increase in expenditure in the last 12 months on the employment of private agency nursing staff, rising from over $11 million in 2000-01 to $15.5 million in the year 2001-02. This is an extraordinary jump in the private nursing work force contracted by Queensland Health in the last year. Isn't this shift from a public to a private work force in Queensland Health facilities an indication of your failure to address workplace conditions for permanent staff?

Mrs EDMOND: Nurses work for agencies for a variety of reasons, quite often because they want to do things that suit their family lifestyle, et cetera. It also means that we are covering nurses who are absent for sickness or on maternity leave. In the past, of course, and if you do not go back very many years, maternity leave was not funded or was not covered. With nurses having maternity leave, we try to fully cover them. We also use agency nurses in difficult to recruit areas. For example, I think at Doomadgee almost the entire staff are agency nurses, but I think it is great that we have actually been able to fill those places. In the past we have had lots of vacancies there but we are now able to recruit and fill those vacancies with agency nurses, which would give an increase to that figure.

I also know from talking to the private sector that agencies are charging significantly more. So it does not mean that more nurses are necessarily being employed; it does mean that agencies are charging more for the nurses who are working.

Miss SIMPSON: I refer again to my question on notice about agency nursing staff. On the figures that you supplied, you have—

Mrs EDMOND: It is only an extra 31 nurses across the whole state. I think you have to really try very, very hard to make that an appreciable difference.

Miss SIMPSON: I refer to this question again. On the figures that you supply, you have employed an extra 31.09 full-time equivalent agency staff at a cost of an extra $4.4 million. That works out at an average of $142,626 for the extra staff. Given that nurses in the public sector are asking for better working conditions in the state's hospitals, how do you justify spending a premium on private agency work while not improving the real incentives in the public sector to the same extent?

Mrs EDMOND: The highest paid nurses in that category would be those working in very remote areas where they do get significant packages. There are also extensive travel costs getting them there and in and out according to the allowances that we pay for their travel. Also in that cost would be recruitment. That can be a significant factor. But as I have said, the cost of agency nurses has increased quite considerably in the past few years with more people—

Miss SIMPSON: So you are padding out that amount for agency nurses by administrative costs?

Mrs EDMOND: No. When you take in the cost of agency nurses, you also have to pay the cost of the agency.

Miss SIMPSON: But—

Mrs EDMOND: The agencies are charging more for the nurses. It does not actually mean—

Miss SIMPSON: That is $142,000 on average for each of those additional nurses. That is a huge additional cost.

Dr STABLE: That is assuming that the extra money was spent on 30 nurses. Clearly, it is not; it is spread across all of the agency nurses. The agency costs have gone up, in some cases threefold. There are enormous costs getting them in and out. In some of those difficult sites, they will not stay more than a short period of time. So that cost, to be accurately considered, needs to be divided by every one of the agency nurses and that cost considered across the whole group and not divided by 30.

Miss SIMPSON: I refer to page 1-23 of the MPS, Review of Output Performance. I note that the Premier has said that new contracts for departmental heads will not include the generous bonus arrangement. However, that does not apply to existing directors-general, including the Health Department head, Dr Rob Stable, who receives an estimated bonus of $30,000. In light of the health crisis, will you be recommending that he receive that bonus?

Mrs EDMOND: Departmental chief executives are appointed by the Governor in Council under section 47 of the Public Service Act 1996. By virtue of section 53, each CEO is required to enter into a written contract of employment with the Premier. The contract covers such matters as terms of employment, remuneration and conditions, and requires the CEO to enter into a performance agreement with the Premier.

The Premier announced on Sunday, 7 July 2002, that the payment of performance bonuses will not continue past existing contractual arrangements. That is all that I am prepared to say. The matter of the DG's employment is actually a matter for the Premier. Any questions about the employment of the CEOs, their performance agreements or performance bonuses should be directed to the Premier as the employer.

Miss SIMPSON: Do you make recommendations, though? How do you assess his performance? Or are you totally absent from that process as well?

Mrs EDMOND: I watch the director-general working seven days a week, often for 18 hours at a stint. On that, if I am asked if he is hardworking and diligent and conscientious, I will say yes.

Miss SIMPSON: What are his performance criteria and how has he met them?

Mrs EDMOND: That is a matter for the Premier.

Miss SIMPSON: Given that you have literally hundreds of people waiting for surgery, you have closed beds and you have one of the worst industrial disputes that this state has seen, how does the director-general justify receiving this bonus?

Mrs EDMOND: Just as it was under the coalition government, that is a contractual arrangement between the director-general and the Premier of the day.

Miss SIMPSON: This industrial dispute is one that you own, because we have not seen one like it before. You referred before to the commission ruling that the government not inflame the issue. Therefore, how do you justify your public statements in regard to the nurses dispute, given that nurses are highly trained and professional and caring?

Mrs EDMOND: I have not made any such statement since the commissioner made his directive on Wednesday, 9 July.

Miss SIMPSON: That is right. You have been absent. Your 'chunder' comment was probably before that time.

The CHAIR: I will make another note for all members of the committee: you are to ask questions, not make statements. Please continue.

Miss SIMPSON: I refer you to question on notice No. 5 in relation to the cost of negligence claims to the Health Department. I ask: how many were refused cover—this is in regard to doctors who needed cover—by Queensland Health's discretionary cover? How many doctors who work for the public system were refused cover, bearing in mind that we know that United Medical Protection released figures to the opposition revealing that Queensland Health doctors had made claims from private medical defence funds due to the discretionary nature of the Health Department?

Mrs EDMOND: I am aware of the very misleading—in fact, I think almost slanderous—statements made by the member for Maroochydore on this matter. I will, as a result of that, be asking both the director-general and the general manager of health services to respond. But I have to place on record my concern that she has done enormous damage to the reputation of people involved in making these determinations.

I would ask the director-general, first of all, how many doctors performing in public hospitals on public patients he has refused as a result of a lack of due diligence or conscientiousness. Then I will ask the general manager of health services—because these are the two officials involved—to respond. He may also throw some light on the misinformation that you have been feeding to the public about the UMP statement.

Dr STABLE: None. I repeat: none.

Mrs EDMOND: How long have you been director-general?

Dr STABLE: Almost seven years.

Mrs EDMOND: So none in seven years.

Dr STABLE: Under a number of governments.

Miss SIMPSON: And Dr Stable, when doctors find that a claim is made against them—

Mrs EDMOND: No, hang on. We are answering the first—

Miss SIMPSON: How quick is Queensland Health to actually come to represent them? Is there a delay?

The CHAIR: Order! We will go back to the answering of the question. Then you will get a chance to ask a question.

Dr YOUNGMAN: Having been the responsible officer for assessing diligence and conscientiousness, in the seven years that I have been doing this we have refused no doctor on this matter. There is material that has been provided to us from UMP, which is, I am sure, what the opposition member is quoting, which indicates that 29 public sector doctors have raised concerns with UMP about their own situation. Of those 29, 22 relate disparately to coronial matters, six relate to legal proceedings that have commenced, and one for letters of demand. In other words, these are matters that, if they were brought to the attention of Queensland Health, we would have assessed their indemnity status. As I have refused nobody, these doctors are either looking at material that might have been sourced from practice outside the public sector—in other words, doing private hospital work—or civil matters, disciplinary matters, coronial matters that have no relevance to their employment with Queensland Health.

Miss SIMPSON: Can I also ask Dr Youngman: what is the delay factor when a public hospital doctor finds that they have a claim made against them? Is there any delay in getting assurance that they have indemnity cover and having that representation once their legal situation proceeds? That is one of the complaints from doctors as well—they find that it is a very slow process to get Queensland Health at the table.

Dr YOUNGMAN: It would be rare that it goes beyond a month. Much of the material needs to be provided by the doctor. If we do not have adequate material with regard to a statement, with regard to their practice and the case—the plaint in question—then it is difficult to make that decision. But if the material is provided, it is done within a matter of a couple of weeks and they are then fully covered through the state system.

Mrs EDMOND: So we have shown quite clearly, I think, that there is absolutely no truth in the statements that you have been repeatedly making around the state that there are 29 doctors who have been refused coverage by Queensland Health as a result of a lack of due diligence or conscientiousness.

Miss SIMPSON: Therefore, I would have to ask: why is it that public hospital doctors carry private indemnity, if it is not the fact that it is not the same cover as that of a private defence? In other words, Queensland Health provides a discretionary cover.

Mrs EDMOND: Most of them do not—

Miss SIMPSON: Minister, I will complete my question.

The CHAIR: Would you like to—

Miss SIMPSON: No, I will complete my question. Queensland Health provides discretionary cover and it is not to the same extent as the private indemnity funds. That is why you have had so many doctors who have taken out private indemnity cover in the public system. Do you understand that Queensland's discretionary cover, based on due diligence, is not the same as the level of cover that was being provided by private indemnity?

Mrs EDMOND: I do indeed. It is far more than the level of cover provided by private indemnifiers. They have discretionary cover; they can choose who they cover and who they do not. In Queensland, written into the IR agreement there are a range of things that it makes quite

clear are not covered—'If you were doing this, you are not seen to be providing care with due diligence and conscientiousness'. I ask members of the committee to consider whether they want their doctors to be covered when they are engaging in criminal activity, official misconduct, under the influence of alcohol and drugs, or with the intentional act or omission done with intent to cause personal injury? If the members opposite are really saying that they want us to cover doctors who are going in there with a deliberate intent to cause personal injury, I have to say that I do not and I will not allow that to happen. Wilful misconduct or wilful neglect, practice not consisted with accepted professional standards as determined by the credentialling committee, acting outside the authorisation to perform the duty or function—I have a greater regard for the doctors in our Queensland Health system to think that any of them want to be covered when they are going in there with any of those intents. Can I say that I think there is another reason that many of the doctors have some private cover, and that is that many of our public doctors do work in the private sector and they want to be covered when they are doing that. While we actually have indemnity cover for full-time staff specialists who do private work within the public hospital system, they are covered and that is done by agreement. But if they are doing work outside the public system, then they are not. Many of our full-time specialists also do work in the private sector.

Miss SIMPSON: But you wrote to doctors and said that they had the same level of cover.

The CHAIR: The time for your questions has expired. I now call on the government members. I call the member for Aspley.

Ms BARRY: Welcome and thank you. This is my second estimates committee—not as many as you, but I would like to thank you and the departmental officers for being here today. Page 6 of the MPS talks about Queensland Health having 40,000 FTEs. You said that the proportion of that was 40 per cent. Given that we are facing, and have been for some time, a worldwide shortage of nurses, it is something that takes a long-term approach. Can you tell the committee what the government is doing to recruit and retain nurses for Queensland?

Mrs EDMOND: Thank you for the question. I know your keen interest and background, of course. We are attempting to address the nursing shortage by looking at recruitment, attracting new nurses to the profession, encouraging nurses not currently practising back into the work force and keeping the nurses that we have. Recruitment initiatives implemented by this government include the election commitment of this government to employ 1,500 graduate nurses over three years. We are on target, with just this year alone recruiting 593 graduates.

In 1998, as you would remember, I commissioned a task force on nursing recruitment and retention. This task force has resulted in a number of initiatives to assist in recruiting nurses. These include the development of a nursing web site, www.thinknursing.com—which is excellent and I would urge people to have a look at it—which hosts an Internet recruitment campaign where all vacant Queensland Health nursing positions are advertised. This is now starting to feature different districts each quarter to enable us to promote places at which we have specific recruitment issues. I think that the first one is Mount Isa, which has had particular problems attracting staff.

The Queensland Health Nursing Re-entry Assistance Scheme assists nurses to re-enter the Queensland Health work force following periods of absence. There has been in excess of 400 inquiries about this program. Undergraduate nursing scholarships are offered each year. That was an initiative of the Beattie government. Of course, there is the sponsorship of overseas nurses when positions are unable to be filled by Australian nurses. I am pleased to advise that our investments in these strategies do appear to be showing rewards. The QTAC admission centre, as I mentioned earlier, shows a strong demand for pre-registration nursing courses across all Queensland universities this year, with interest in all universities exceeding the available placement. I think that is great news and that is the first time—as you might know—that has happened for quite a while.

We have also implemented a range of initiatives to enhance retention, including the establishment of a nursing career advisory service, scholarships to assist with further education, and the development of a rural and remote nursing relief package. Again, we are seeing some success with turnover of Queensland Health's permanent nursing staff falling significantly from over 20 per cent per annum in the coalition days. This government's initiatives have led us to the position where Queensland Health has around a five per cent vacancy rate for nursing, and most of these are filled by agency or casual staff. This is far less than most states and, indeed, far less than we are seeing around the world.

Ms BARRY: Another area of interest to me, and I know to yourself, is the nurse practitioner model. On page 1-14 of the MPS there is a reference to its implementation. I wonder if the minister could advise the committee on the current status and in what areas we will see the nurse practitioner model being used?

Mrs EDMOND: This is something that we have been developing, again, out of the task force, but something that I have been particularly interested in. It was an election commitment of this government, and that was to investigate suitable models for nurse practitioners in Queensland and to provide appropriate training to enable them to formally undertake enhanced roles in managing conditions such as diabetes, asthma and child and family health, but to consult fully with all stakeholders in developing the proposal for nurse practitioners.

In line with this election commitment, two nurse practitioner demonstration projects will commence in 2002, with funding of $100,000 having been made available for this purpose. The projects will: investigate and identify appropriate models and practice settings for nurse practitioner services in Queensland; identify the potential impact of the nurse practitioner role in Queensland on health care outcomes, specifically in relation to clinical effectiveness, safety, access and cost; identify changes required in education, policy and legislation to incorporate the nurse practitioner role into Queensland Health service delivery; and, build on elements of advanced nursing practice already in place in Queensland. For example, nurse-initiated x-rays and the ability for endorsed registered nurses to initiate, administer and/or supply specified schedule drugs in isolated practice areas and in sexual health programs.

I think we were surprised at just how far ahead Queensland was to other states in this role. We had just called them different things. One of the demonstration projects will take place in a rural-remote setting so that rural people will have access to better overall health care, and the second project will take place in a clinical setting such as oncology, asthma, diabetes or sexual health.

Nominations are currently being called from appropriate stakeholders for the nurse practitioner working party and it is anticipated that the first meeting will take place this month. The nurse practitioner working party will be responsible for the identification and development of nurse practitioner models for Queensland, the selection of the sites for the two demonstration projects, monitoring of the two demonstration projects, and reporting on the findings and outcomes of the two demonstration projects. I look forward to that report.

Ms NOLAN: What will be the cost of the government's decision to extend Queensland Health's indemnity policy to rural GPs who are undertaking private procedural work in Queensland's public hospitals? How will rural people benefit?

Mrs EDMOND: On 17 June 2002, Cabinet decided to extend indemnity cover under the Queensland Health indemnity policy to rural and general practitioners performing private procedural work in public hospitals. The cover was also extended to Queensland Health doctors relieving medical superintendents and medical officers with right of private practice and visiting medical officers, VMOs, for failure-to-warn claims.

Before this decision, Queensland Health subsidised the procedural component of premiums payable to rural GPs to their medical defence organisations at a rate of up to $8,200 per year. Obviously there was concern about the efficacy of those medical defence organisations, and concerns had been expressed. For last year, the cost of that was $455,000 for 60 rural doctors.

What we have decided now to do is to extend the indemnity so that the subsidy is no longer required for the private insurance. Rural GPs will also receive a $2,000, indexed by CPI, annual training payment to support them to maintain their skills in their specialty procedural areas of practice so that we can make sure that they are getting the experience they need and also to reduce the risk of possible future claims as they, perhaps, lose skills.

With at least 60 rural GPs, but potentially 80 rural GPs, receiving the $2,000 training payment this financial year, the total cost of introducing the training payment is likely to be $160,000. There will be no immediate cost to Queensland Health for extending the indemnity to rural GPs but, of course, there may be an additional cost if there is a claim in the future against these doctors, with a consequential increase in premiums payable by Queensland Health to the Queensland Government Insurance Fund. This would be offset by any potential savings by no longer subsidising that private cover.

As is normal practice, there are conditions. These include appropriate credentialling and privileging, agreement to participate in ongoing clinical audits, and diligence and conscientiousness in the performance of their procedural work. I have to say, this was very, very

much welcomed by the Rural Doctors Association of Queensland, who we worked very, very closely with in coming up with this scheme. In fact, I think Dr Youngman worked with the current president, the previous president and the one before in developing it.

Ms NOLAN: There was an election commitment to rebuild our state government residential aged care facilities. Would you please advise what that $120 million project entails?

Mrs EDMOND: There was $120 million committed over the next few years to rebuild our aged care facilities, in keeping with the new regulations from the Commonwealth, and I am pleased to advise that I have recently signed off on the scope of works for the aged care capital works program. I know the member for Nanango is waiting to hear all of this and yes, yes, it is happening. More than $120 million has been earmarked for redeveloping and enhancing our state government nursing homes over the next four years.

This current financial year, consultant project teams will be commissioned to commence detailed planning on a number of projects utilising the modular design concept that has been developed by Queensland Health in conjunction with Project Services, Department of Public Works. This will ensure that Queenslanders can expect the same high standard of accommodation in our aged care facilities, wherever they may be, and it will be the most cost—effective way of delivering that care.

Over the next year, I expect the design phases will be completed for Maryborough, Townsville and Redcliffe nursing homes. Obviously when the contract documentation is completed, these projects will proceed to tender and into construction as early as possible. In addition, planning and design work will also commence on Sandgate Eventide, the Redland Hospital site for a 128-bed facility, and on the new Yeppoon Nursing Home facility.

I am delighted to advise that the program will also see the installation of an airconditioning system at Ashworth House in Zillmere and the upgrading of the airconditioning system at the Hervey Bay Nursing Home, to provide a more comfortable environment for the residents of these facilities. Facilities at Dalby, Roma, Warwick and Wondai will also undergo major reconstructions. Hibiscus House in Nambour will be extended and refurbished, and minor upgrades will also occur at Charleville, Charters Towers Eventide, north Rockhampton nursing care unit and at Oakey. I know the member for Nanango has been waiting for this news. I will talk to you later.

Mrs DESLEY SCOTT: I refer to strategic direction 3, balancing investment in health care, on page 2 of the MPS. How is Queensland Health involving general practitioners in better managing people with chronic diseases so we use our health funding more effectively?

Mrs EDMOND: I think we have all recognised that chronic disease and, in fact, lifestyle disease is probably the major impact that we are all seeing these days, as we have beaten some of the earlier infections from previous generations. Involving GPs and keeping people healthier and managing the health conditions in community settings is a key strategy in balancing the investment in health, as it is well accepted that GPs play a vital and central role in managing chronic illness within the community.

Queensland Health is funding a number of specific projects through its health service districts to work in collaboration with local divisions of general practice to address the chronic disease areas of cardiovascular disease, diabetes, asthma and stroke. All of these chronic diseases have a major impact on the burden of disease in Queensland and are national priorities.

I can announce that ten new programs totalling over $1.2 million will be introduced to improve the management of cardiovascular disease, asthma and diabetes across Queensland. These projects, totalling $2.5 million altogether, are funded under the National Health Development Fund. The 10 programs aim to support Queenslanders with cardiovascular disease, asthma and diabetes by improving service access and delivery by coordinating public hospital, primary health and community care services, particularly GPs. Our aim is to keep people out of hospital when they do not need to be in hospital, and have their conditions managed through better self-management and their GPs.

The programs will be run in Brisbane south, Bowen, Cairns, Innisfail, Logan, Beaudesert—which you would be interested in—Mackay, Redcliffe, Caboolture, south Burnett—another one for south Burnett—Tablelands and Townsville. They will address local community needs, with GPs and health professionals identifying strategies that will best suit the area.

According to the latest national reports, 15.5 per cent of Australians suffer from cardiovascular disease, 11.3 per cent suffer from asthma and 2.4 per cent from diabetes, and the prevalence of diabetes amongst indigenous Australians is, of course, much higher.

I am pleased to advise that Queensland Health is contributing both funding and in-kind support to a second coordinated care trial being run by the Brisbane north division of GPs. The amount of Queensland Health support is approximately $3 million over three years of the trial, which has a central aim of better managing people with chronic illness using GPs as a central coordinator of community based care to reduce episodes of hospitalisation and result in better patient health outcomes. As well as funding of $1.8 million to purchase alternative services aimed at keeping people out of hospital, Queensland Health is also providing six full-time equivalent community health nurses to work in general practices to coordinate the care of patients with chronic illness. So, it is a great news story.

Ms NOLAN: I want to ask a little bit about indigenous health. Is any of the national health development money that you just talked about being applied to improving the health of indigenous people in Queensland?

Mrs EDMOND: Queensland Health is very aware of the marked differences in health between the indigenous population and the general Australian population. Aboriginal and Torres Strait Islander people continue to experience mortality and morbidity rates greatly exceeding those of their non-indigenous counterparts. There can be no argument that improving the health of indigenous people in Queensland remains one of the biggest challenges for all levels of government.

Ferret is an integrated, computer-based health information system that has proven in a trial to improve indigenous health. We are now going to roll that out to 50 health centres in north Queensland and a dozen sites in central and southern Queensland over the next two and a half years. The patient information and recall system will help Queensland Health staff and communities make decisions to improve the health of Aboriginal and Torres Strait Islander people. Project Ferret supports Queensland Health's aim to address the major cause of ill-health in indigenous communities of chronic disease. The system will help staff monitor diseases such as diabetes, cardiovascular disease, respiratory conditions and cancer.

The trial, conducted by Queensland Health and funded by the National Health and Medical Research Council and which has received international write-ups, reduced the proportion of diabetics hospitalised for diabetes related conditions by 40 per cent. The $5.9 million project is funded by the National Health Development Fund, a provision of the Australian Health Care Agreement. The fund resources projects that integrate care improve the efficiency or effectiveness of services or reduce demand for hospital services. Using Ferret whenever the patient attends a health centre for whatever reason, staff can check to see when they are due or overdue for a checkup or further treatment. In this way, we are keeping on top of the patient's health care needs. It is a great system.

Do not ask me what Ferret means. It is just a cute name. It does not actually have any acronym to it.

Mrs DESLEY SCOTT: I would like us to turn to Commonwealth funding issues now. I refer to page 39 of the MPS, to the increase in Queensland Health's budget from the state government for this year and the increase provided by the Commonwealth. How do these amounts compare and does Queensland get a fair share of funding?

Mrs EDMOND: The best way to answer that is that Queensland's own output revenue for all public health services rose by $157.4 million, or 6.7 per cent, to $2.5 billion in 2002-03. This compares more than favourably with the increase of $95.8 million, or 6.3 per cent, to $1.625 billion in all Commonwealth payments for the same period. In 2002-03, the Commonwealth's total contribution to Queensland Health's funding, taking into account the full range of Commonwealth specific purpose payments, such as funding for highly specialised drugs, represented around 37.5 per cent of the total cost of public health services in Queensland. In comparison, state output revenue represents around 57.7 per cent of Queensland Health's 2002-03 budget of $4.335 billion. This clearly demonstrates the Queensland government's commitment to meet growth in demand for hospital and other health services.

With respect to acute in-patient and non-in-patient services, that is hospitals, Queensland's own output revenue rose by 14.6 per cent to a total of $1.8996 billion in 2002-03. By contrast, in 2002-03 it is estimated that funding from the HACC agreement will grow by seven per cent to $1.33 billion. In comparison, the growth in the state government's output revenue for all acute in-

patient and non-in-patient services rose by 14.6 per cent to $1.899 billion. In terms of what is known as funding effort, Queensland Health's effort in 2002-03 will be more than twice that of the Commonwealth. The Commonwealth has repeatedly stated that maintenance of funding effort will be a feature of the new agreements. Queensland welcomes this, but only if it means that the Commonwealth will match the state's effort where the increase is high and not just those times where the increases are lower.

The CHAIR: The time allotted to government members for questions has now expired.

Miss SIMPSON: I refer the minister to her previous statement where she said that Queensland Health's indemnity for doctors is not just the same but better than private indemnity insurance. I also refer the minister to the fact that public doctors obviously disagree, given that many carry private indemnity insurance. In the light of the Queensland Health directive which governs this due diligence and consciousness, the discretionary application of indemnity, the complaints of doctors that they are not consulted as it changes from time and time and that that is not well defined and the fact that the Premier has said that he will review this due diligence, does the Health Minister agree that it should be reviewed?

Mrs EDMOND: The Premier's review of due diligence came as a suggestion from us that perhaps we should put up front the areas where it is excluded; that is, where doctors are engaging in criminal activity, official misconduct and being under the influence of alcohol or drugs. This is in the agreement that the doctors have with the department. The aim is to perhaps spell that out for those who do not understand what due diligence and consciousness means. The reason I say that the state government's indemnity is better than the private one is that I do not believe that the private sector is funded at the moment. Indeed, the state government is not broke.

Miss SIMPSON: Some would beg to differ. I ask a question concerning question on notice No. 5 in relation to the cost of negligence claims to the Health Department. How many existing claims have been commenced and instituted by persons as a result of episodes of care carried out at Queensland hospitals in 2001-02, and how many were settled?

Mrs EDMOND: As a final statement to that previous question, can I add that I understand that the department is waiting on a proposal from the doctors with regard to putting up front in the agreement those exclusions. We are still waiting for that to come in. As at March 2002, as we answered, Queensland had 440 current unsettled claims commenced by third parties as a result of episodes of care carried out at Queensland hospitals. My understanding is that that is very similar to previous years. I do not think there has been much change.

Miss SIMPSON: In asking the next question I will say that there is still a lot of unhappiness and anger with public sector doctors who say that the Queensland Health directive in regard to indemnity is unclear and that it can be changed without consultation with doctors. That is why they must have this issue of due diligence addressed and why it must be understood that we cannot keep changing guidelines or applying this in a way without consultation with doctors.

Mrs EDMOND: My understanding is that the guidelines are exactly the same as they have been for many years, including when the coalition was in government. My understanding is also that their concern is because people keep feeding them misinformation, such as the member's comments in the media recently about there being dozens of doctors who have been refused cover. I think the statement was that doctors can be in the court and find that we have changed the rules and changed the cover. That is just an outrageous slur on the character of the gentleman sitting beside and me, and it is totally untrue. It is a total fabrication.

Miss SIMPSON: In fact, the minister did not answer my question as to how many claims were settled in the year 2001-02. I draw the minister back to my previous question. How many claims were settled in 2001-02?

Mrs EDMOND: The member would have to recognise that a lot of claims that are made are never actually proceeded with. The number of claims settled or discontinued is always very different from the number of claims made. My understanding is that in the 2001 calendar year 75 were settled; the previous year, 68; this calendar year to the end of March, 26.

Miss SIMPSON: I refer the minister to page 3-9 of the MPS and to the Statement of Financial Performance. Considering the minister's department is forking out the money in regard to nurses' wages, why is the minister not more involved in the EBA negotiations? The minister swore an oath to administer the department. The minister is therefore constitutionally responsible for the administration of that department right down to the last $250 million, $165 million or whatever it might be. Why was the minister not at the negotiating table?

Mrs EDMOND: I do not think any ministers have been involved in the negotiations before the commissioner. I am involved in the negotiations at the cabinet table and at other meetings where we discuss this.

Miss SIMPSON: We are talking about the negotiations up to this point and the fact that they have dragged on now for a number of weeks. Literally hundreds of people have had their surgery cancelled. We have staff who believe they have not been listened to, yet the minister was absent from the negotiating table and has been telling the Estimates Committee that it is not her responsibility because she wants to pass that to the Industrial Relations Commissioner.

Mrs EDMOND: Negotiations have been going on for six months. Those negotiations are carried out by the appropriate staff. I am kept fully informed; the director-general is kept fully informed; the Minister for Industrial Relations is kept fully informed; the Premier is kept fully informed; and of course the Treasurer is kept fully informed. We regularly exchange information and meet.

Miss SIMPSON: I refer to question on notice No. 7 where a provision has been made for a liability payment on these damages, page 45, note eight, and to a question on notice from Mike Horan on 6 March 2002. I note that Queensland Health paid $115 million last year into the new Queensland Government Insurance Fund as of 1 July 2001 to pay for its legal liabilities. The parliament has been told that the total premium pool collected from all government agencies for QGIF was $34 million, meaning that the Health Department is responsible for nearly half of this pool. I refer the minister to her answer that Queensland Health has not yet been advised by QGIF of the department's insurance pool for 2002-03. Given that it was $15 million last year, which is a substantial amount, does the minister have indicative information available about what the department is liable to pay to QGIF for this coming year?

Mrs EDMOND: I have to correct the member. The premium paid is not $150 million. It is nowhere like that.

Miss SIMPSON: No, $15 million; 1-5.

Mrs EDMOND: You said $150 million. There are two things that need to be realised. I am surprised that the member is not aware of this. The health budget is about 20 per cent of the total state government budget, and of course we employ an awful lot of employees and treat an awful lot of sick people. There are millions of people who use our services, and that is why we probably have a higher level of protection than others. My understanding is also that the claims this year and the previous year are very much the same as they were the year before that. I do not know what else I can say. We have a big budget; we treat a lot of sick people.

Miss SIMPSON: The minister must have some indicative figure as to what the department's liability with the government insurance scheme will be for the coming year. Could the minister provide that to the Estimates Committee?

Mrs EDMOND: It is about the same as the year before. That is what I just said.

Miss SIMPSON: In regard to the legal power, are these in addition to those covered by QGIF by this arrangement which are picked up by the districts; if so, how much are those for 2001-02?

Mrs EDMOND: Sorry?

Miss SIMPSON: Question on notice No. 7 states that Queensland Health accounts for claims at a health service district level through established financial reporting means, but the minister does not provide detail as to whether the health districts are in fact paying any other legal claims in addition to the premium amounts.

Mrs EDMOND: It is all covered. I understand that districts used to pay a small amount, but that is no longer the case. It is now all centralised.

Miss SIMPSON: Is the minister saying that previously the districts were paying a premium out of their budgets for payouts in addition to Treasury lump sums?

Dr STABLE: Before the insurance scheme that has been in place in Queensland hospitals for many years started, Queensland Health managed its own reinsurance. As part of the management we used to require the districts to pay the first $10,000 or $20,000, depending on the size of the district. Under the new arrangements, all the funds that we were using were transferred into the Queensland Government Insurance Fund. I might add that in all of these funds around Australia, medical and public liability associated with medical issues is the vast majority. That is a national issue and fully explains why $15 million of the budget of the overall

QGIF is medical. That is quite explainable nationally, as one would expect, but the whole cost of what it was costing us was transferred to the QGIF and that is now represented there.

Miss SIMPSON: How much will the districts have to pay to QGIF in annual insurance premiums?

Dr STABLE: None. It is handled centrally.

Miss SIMPSON: So that will not be an item against individual districts. So that threshold that was previously there which they initially accepted, they do not have to pay that initial threshold?

Dr STABLE: No.

Miss SIMPSON: That is not adjusted out of their budgets as such?

Dr STABLE: Clearly this was an expense item that they were incurring. In the initial transfer of the funding for this, there had to be an adjustment. But that was made 18 months ago. It will not be made this financial year.

Miss SIMPSON: I would like the minister to answer a question she still has not really answered. It is in relation to the expense allowance for the enterprise bargaining agreement. As previous ministers have been involved in negotiating enterprise bargaining conditions and negotiating with staff, why has the Health Minister not been more involved in this process?

Mrs EDMOND: I actually cannot recall Minister Horan being at the negotiating table.

Miss SIMPSON: Yes, he was involved in negotiations. It is you who has not been.

Mrs EDMOND: In front of the unions?

Miss SIMPSON: He has been involved in negotiations.

Mrs EDMOND: That is most unusual. I do not think that is right. He might have been involved in negotiations around the cabinet.

Miss SIMPSON: That is correct.

Mrs EDMOND: They may not have had an Industrial Relations Minister. We do. We have an Industrial Relations Minister.

Miss SIMPSON: You are the Health Minister.

Mrs EDMOND: Absolutely! You have got it.

The CHAIR: Order! I want to hear the minister's answer.

Miss SIMPSON: And these are nurses and these are health workers.

Mrs EDMOND: I am the Health Minister, not the IR Minister.

Miss SIMPSON: You should be involved with the issues to do with the workers in your hospitals, particularly given that your own budget papers are the budget papers allocating the nurses' wages. Minister, do you not realise that you have a responsibility for fighting for conditions and wages and allocating adequate money for your nurses and allied staff?

The CHAIR: Are we getting to the question?

Mrs EDMOND: Yes.

Miss SIMPSON: Why have you not been available and present during the negotiations?

Mrs EDMOND: I have been available and I have been present. I have been in all of the meetings where the funding was raised and lobbying for extra funding has taken place.

Miss SIMPSON: We have had Industrial Relations Ministers before but we have also previously had Health Ministers who have been involved in trying to resolve these issues. It is you as Health Minister who has been absent during this process.

Mrs EDMOND: I have not been absent. I have been in my office every single day this week, last week and all the time that you were flitting off overseas. I have been here working. I have not been on strike. I have not reduced duties. I have been here working. If you want to take time off, that is fine.

Miss SIMPSON: You have been very absent from the process.

Mrs EDMOND: I have even been working on the weekends and answering phone calls about industrial relations. But I have to say—and maybe I will have to spell it out so it is a bit clearer; I thought for one exciting moment you had grasped this fact—that we have decided in this government that the Industrial Relations Minister will lead the industrial relations discussions with the nurses, the other health professionals, the police, the teachers and, as I think we have

already seen, with the Public Works staff and a range of other areas. The Industrial Relations Minister has been given the lead role in industrial relations negotiations in this state. That does not mean to say I am absent. That does not mean to say I am not involved in advising and meeting all of the other many commitments that I have. I have been involved on a daily basis talking to Minister Nuttall, the Premier and other ministers, particularly the Treasurer.

Miss SIMPSON: Did they want you out of the way; is that why they sent you to Darwin?

Mrs EDMOND: What other government minister has been involved in the negotiations in the government?

Miss SIMPSON: I refer you to the minister you are trying to flick responsibility for the Health Department to. Minister Nuttall said that the budget for the nurses dispute is a matter for the Department of Health; it is the one that pays nurses' wages. That is why I ask you why you have been so absent from trying to resolve these issues. You have been away. You went up to Darwin while the -

Mrs EDMOND: I went to a ministerial council meeting for a day. A ministerial council meeting is not being absent. That is part of my parliamentary duties. You may not see the need to sit in parliament, and flit off overseas. I might see the need to go to ministerial council meetings and fulfil all of my responsibilities.

Miss SIMPSON: You were absent during negotiations. You went up to Darwin. You were absent from parliament. It is your responsibility as the Health Minister. You are the Health Minister. You are the one who is supposed to be dealing with and resolving these issues. We have now seen one of the worst industrial disputes in this state and you do not want to take responsibility for it.

Mrs EDMOND: The negotiations for enterprise bargaining for the nurses have been going on since December last year. Is the member suggesting that I should not leave my desk for six months at a time and do other duties? I think it is irresponsible and I do not think it has anything to do with the estimates. In terms of the estimates, as I have indicated earlier, allowance has been made in the budget for the government's offer. If there is any change to that offer, that will be negotiated outside of the arrangements. But I go back to the fact that the Industrial Relations Commissioner has directed all parties not to comment on these matters before it. If that changes, if we get a direction today while this meeting is taking place, I will inform the committee.

Miss SIMPSON: So you have confirmed that this is a cabinet document that we looked at before that showed there was a shortfall between what has been approved by the CBRC for the nurses and what has been stated publicly by the government to be the amount? This document says it is $165 million. The minister you flicked responsibility to yesterday, Gordon Nuttall, said that the government had a package of $190 million. So you do not want to confirm or deny the conditions within this cabinet document?

Mrs EDMOND: As I said, this is being negotiated. But as I thought I pointed out in words of one syllable that anybody could have understood, the nurses have changed their mind since the original proposal for three years to ask for a two-year agreement. My understanding is that the figures you are referring to relate to the possibility of a two-year agreement. When you go from a three-year agreement to a two-year agreement, the figures change.

Miss SIMPSON: Perhaps you would be able to explain the items that, according to this memo, have been removed from negotiations. Things such as the safety net adjustment, availability of meal breaks and reimbursement of qualification costs have been taken out of these figures. Could you please explain why?

Mrs EDMOND: The commission has issued a directive—I will keep saying this until you understand it—that neither party will discuss the matters while they are being negotiated. I am keen to see a settlement. I am doing everything I possibly can to comply with the commissioner's direction. I would ask, Madam Chair, that you or somebody inform the member for Maroochydore that I have been asked not to comment on these things. I do not think it is appropriate for the member for Maroochydore to keep raising them when quite clearly to do so is in breach of the Industrial Relations Commissioner's directive.

The CHAIR: Can we move on to the next question, please.

Miss SIMPSON: Madam Chair, that still does not explain why the Health Minister has not been involved in trying to resolve these issues.

The CHAIR: Can we move on to the next question, please. I remind you that your time is running out.

Miss SIMPSON: Madam Chair, I can phrase the questions, according to the standing orders, in any way that is required. Minister, I refer to question on notice No. 4, where you state that there is no formal data collection on the number of surgical operations cancelled in Queensland public hospitals. We have seen a lot of surgery cancelled recently under your administration. You say that under the elective admissions management systems when a patient's booking is amended it is recorded as a cancellation and therefore you cannot conclude whether a surgical operation was cancelled or postponed. Could you please explain why category 1 patient Mrs Ann Jarick of Beerwah had her surgery cancelled three times in the 2001-02 period? I know that you are aware of this because I have written you a letter and Mrs Jarick has written to you as well.

Mrs EDMOND: I am aware of this case, though I do not think it has anything to do with the budget papers at all. In this case there were difficulties with patients with higher priority who needed admission on the day she was originally booked. I understand that the doctor—and there is only one specialist radiologist who performs interventional angiography—was away for three weeks. Her booking was made for when he comes back, which is this month. So there was a short delay. We actually did look at whether she would be able to get into New South Wales faster. The answer was no; they had significantly longer waits than we did in Queensland. With respect to her condition, I do not know whether she has always had it. In many cases, people always have that condition and they find it by accident—

Miss SIMPSON: Minister, are you saying that it is clinically acceptable for a woman with an aneurism to have her surgery cancelled three times?

The CHAIR: The time for questions for non-government members has now expired. I call the member for Woodridge.

Mrs EDMOND: Just to conclude—I think it is inappropriate for a woman in her condition to be hawked around the media, which might cause that condition to deteriorate.

Miss SIMPSON: She had to travel to Brisbane three times and still had her surgery cancelled. I do not think that is appropriate.

Mrs DESLEY SCOTT: With respect to Commonwealth funding, what compensation is paid to the Queensland state government for treatment of PNG nationals?

Mrs EDMOND: This is a very topical question. I think there has been a lot of stuff in the media recently about Papua New Guinea. A coalition member of the federal parliament visited—perhaps for the first time—the Torres Strait and got a bit carried away. I thank the member for the question, because providing health service to PNG nationals costs us well over $4 million a year—probably closer to $5 million a year. Queensland Health receives $2 million, negotiated by the state in the last Health Care Agreement, for treating Papua New Guinea nationals. That funding goes to where they are treated. In some instances, that is in the hospitals or in the community health facilities in the Torres Strait, such as Badu, Saibai and Boigu Islands. Also, a number are taken to the hospital at Thursday Island but also to hospitals in Cairns, Townsville and Brisbane. We have Papua New Guinea patients on dialysis, for instance, and having cardiac surgery in Brisbane. A range of care is being provided.

It should also be noted that Queensland has 26 per cent of the Aboriginal and Torres Strait Islander population in Australia and it receives only about 14 per cent of the Commonwealth Aboriginal and Torres Strait Islander health funding. The Queensland government is committed to maintaining services in the Torres. We have consistently recommended that the Commonwealth use its aid funding in Papua New Guinea so that it provides services to those people before they have to come over in tinnies to Saibai. It should be providing those much-needed health services closer to home for those Papua New Guinea nationals.

The Torres Strait health district is funded at two and a half times the state per capita average by the Queensland government. That is 90 per cent of all the health funding in the Torres Strait. Since 1998 the Torres Strait district health budget has increased by $4.8 million per annum. Capital works have included the construction of a new modern hospital at Thursday Island and a new community health clinic on many of the islands. Those facilities have been 100 per cent state funded, as is the staff accommodation. That means since 1998 the annual district health budget has gone up $4.8 million.

The reasons for providing health services to Papua New Guinea nationals are both humanitarian and self-interest. If we do not provide screening and treatment services, Australia would be at risk of importation of a number of communicable diseases that we would like to avoid. It is estimated that around 400 PNG nationals per month present at health care facilities in the

Torres Strait. From available information, the major conditions are malaria, respiratory conditions, tuberculosis, pregnancy, skin conditions, diarrhoea and vomiting, and about 100 people per year presenting at the primary health clinics need medical evaluation, which involves extra costs.

The CHAIR: I note on page 1 of the MPS that the Commonwealth government provides 35 per cent of the resources for the public health system, mostly under the Australian Health Care Agreement. How is that amount determined and how much did Queensland receive in 2001-02?

Mrs EDMOND: The Australian Health Care Agreement 1998-2003 details the funding methodology that determines the health care grant payable to Queensland each year. In addition to the general component, the health care grant identifies amounts for mental health, palliative care and quality improvement plus certain other minor payments. The agreement between the Commonwealth and Queensland allows the Commonwealth to contribute funding for Queensland's free public hospital system. I might add that Queensland has had a free public hospital system going back many decades, long before the Commonwealth promoted free public hospital services on a national basis.

Each year the funding provided through the base health care grant is adjusted for population growth and ageing, change in hospital costs, change in the entitled veterans population and demand growth. Under the current agreement, Queensland is receiving an estimated $5.865 billion over five years. In 2001-02 the health care agreement provided Queensland with $1.243 billion, which represents growth of 6.8 from the previous year. However, this amount, the latest estimates of the health care grant for Queensland for 2001-02, represents a cut of $1.5 million based on updated population data and entitled veterans population data. I have written to Senator Kay Patterson, my federal counterpart, to express my concern that the grant was revised downward so close to the end of the financial year. Although $1.5 million may appear slight, it is still funding upon which commitments to health care delivery have already been made, and it makes it very difficult to adjust.

Furthermore, the new population data, which is the basis for the federal government's downward revision of funding, shows an apparent inconsistency. Given that this inconsistency has not been fully reviewed by the federal Department of Veterans' Affairs, I believe that it would have been more appropriate to leave the 2001-02 grant as it was and make the necessary, if any, adjustments against the 2002-03 grant. As it stands, the downward revision has made it very difficult to locate replacement funding at this late stage.

The CHAIR: I also note that page 1-1 refers to the Commonwealth government's reforms in private health insurance. With premiums rising for many families earlier this year, what evidence is there that the 30 per cent rebate is having an effect on waiting times for elective surgery or taking some pressure off our public hospitals?

Mrs EDMOND: That is a very good question, because the evidence that we have is that it is making very little difference. The latest figures released by the Private Health Insurance Administration Council indicated that by the end of the March 2002 quarter 42.4 per cent of Queenslanders—that is, approximately 1.558 million people—had private health insurance. There has been zero growth in the proportion of the Queensland population covered by private health insurance since the March 2001 quarter, which at that time was 42.4 per cent. Nationally, for the same period, 44.7 per cent of the Australian population held private health insurance. Since the March 2001 quarter the proportion has fallen by 0.4 per cent nationally.

Originally, the Australian Health Care Agreement provided for increases or decreases in funding depending on the rise or fall of private health insurance coverage. However, the states and territories were influential in the Commonwealth's subsequent decision not to withdraw funding as a consequence of the increases in private health insurance coverage through the 30 per cent rebate as all states agreed that it was not reflected in a reduction of workloads in public hospitals.

The Commonwealth is spending an estimated $400 million per year to support private health insurance in Queensland. The value of this outlay is questionable, as the majority of people in Queensland—63.5 per cent—have taken out front-end deductible packages. A high proportion of those with private health insurance may continue to use the public hospital system as public patients, as there is little incentive for people with these kinds of policies to be treated privately due to the need to pay the excess on the policy. Despite the increased proportion of the community having private health insurance, the number of private patients treated by Queensland Health has continued to decline. Accordingly, Queensland Health's revenue from

private patients has also fallen, dropping from $35.9 million in 1998-99 to $29.6 million in 2001-02. That simply means fewer private patients and more public patients in our system.

On 1 April 2002 the federal government approved an industry-wide 6.9 per cent increase in private health insurance premiums. As a result, it is anticipated that the number of people holding private health insurance will reduce. The full extent of this will not be known until they release their next lot of figures in August 2002. Hence, while the federal government has been estimated to pour an additional $2 billion per year into subsidising the private health insurers through its Lifetime Health Cover policy, public hospitals have been forced to pick up more of the workload and cost of providing treatment. Quite simply then, the federal government's policies have not reduced demand on the public hospital system, nor decreased waiting lists.

The CHAIR: Page 1-24 of the MPS refers to additional funding for HACC. Can you please advise how the extra money will be spent?

Mrs EDMOND: An additional $7.3 million has been allocated to HACC programs to match an anticipated funding increase provided by the Commonwealth government. The statewide priorities for the coming year will continue to provide additional hours of service for domestic assistance, social support and home maintenance to meet the identified needs of HACC eligible clients. Growth funding will be quarantined within all HACC regional budgets based on their indigenous population to improve access and appropriateness of services that support indigenous clients and clients from non-English-speaking backgrounds.

Consistent with Queensland Health's strategic directions for older people, funding of innovative service models that meet the needs of HACC eligible people with dementia will be a further priority area for additional growth funding. Additional funds will continue to roll out the three-year plan to address the lack of continence management services in the community setting for HACC clients and will address the associated work force development issues. In accordance with the whole-of-government strategy, a further priority will be to extend the availability of HACC support services to HACC eligible people with a disability who are living in hostels, boarding houses and/or aged care rental accommodation or who are homeless. This group are traditionally low users of primary health services but are disproportionately higher users of acute care services with chronic illness, greater risks of traumatic injury, et cetera.

Focus will be on extending support services to homeless people, particularly in major urban and rural areas. Enhancement of home modification services across the state is being targeted as a new priority requiring funding to provide wider coverage of home modification services across the state. The focus in 2002-03 will also be on the development of HACC guidelines and a framework for delivering coordinated and responsive transport support services across Queensland. So it is a good news story for HACC.

Ms BARRY: Minister, staying with HACC, I note on page 1-25 of the MPS that the HACC target population will no longer be reported as it is not an appropriate measure of the service. Can you please tell the committee how this will be measured in the future to ensure that HACC clients receive service?

Mrs EDMOND: The decision to no longer report HACC target population in the MPS was taken as it was considered that there were more appropriate measures of levels of service outputs against the funding allocated to the HACC program in Queensland. It is important for the government and the community to have measures that clearly indicate Queensland Health's performance in relation to increasing the service outputs against approved growth Commonwealth-state funding priorities. The HACC target population measure is, however, to identify potential demand in the allocation of resources of HACC growth funding at the Commonwealth, state and regional levels.

The annual allocation of growth funding is based on revised annual target HACC population figures. This indicator is used in the regional and broader statewide planning mechanisms to ensure equity of funding across the regions. The HACC target population is also used as one of the measures to inform subsequent analysis and reporting of Queensland's performance in the annual HACC program business report. Queensland Health will further enhance the HACC planning process during the next 12 months. The program will adopt a three-year planning cycle to enable longer term planning and more detailed evaluation of the impact of service development initiatives on the HACC target population. This will also reflect the national triennial plan as required under the HACC Amending Agreement 1999.

Ms BARRY: Staying with HACC, page 1-23 of the MPS refers to new three-year service agreements for HACC funded services. Can you please advise the committee of the changes to these agreements and whether there will be benefits to clients.

Mrs EDMOND: On 1 December 1999 the Commonwealth and Queensland governments signed the HACC Amending Agreement which established a new direction for the administration of the HACC program in Queensland. The amending agreement outlines a number of reforms of the HACC program, including the output based funding framework, minimum data sets, data collection systems and the national service standards as the quality improvement framework. It is a condition of the amending agreement that states and territories enter into service contracts with service providers for the purchase of HACC services. Queensland Health entered into three-year service agreements with service providers effective from 1 July 2001. Previously, service agreements were not time limited. The new service agreements reflect the above requirements of the amending agreement.

The benefits for clients of the reforms reflected in the service agreements include output based financial and performance reporting and monitoring requirements to ensure the continual improvement of services to clients and improved program accountability. The minimum data sets will provide more detailed data that will improve planning for service delivery and enhancement, and this will result in funding being more effectively targeted at client need. The HACC national service standards involve external review of service providers against the national service standards instrument. Quality action plans are developed to assist service providers with ongoing quality improvement of services to clients. These quality action plans are continuously monitored.

Ms BARRY: Page 1-23 of the MPS refers to an additional $1 million for the Medical Aids Subsidy Scheme. Can you please tell the committee what this extra money will mean for clients of this service?

Mrs EDMOND: The Medical Aids Subsidy Scheme subsidises the cost of a whole range of aids and equipment to assist people with stabilised or permanent disabilities to remain living at home. The range of aids and equipment includes permanent loan items such as manual wheelchairs, power-drive wheelchairs, wheeled walking aids, non-mobile commodes and mobile floor hoists and slings. In addition, consumables such as continence aids, domiciliary oxygen and surgical footwear are also subsidised. The number of clients accessing MASS increases by approximately nine per cent per annum. Demand for medical aids and equipment is always high; therefore priorities are determined on critical medical and safety needs, and waiting periods at times are necessary. There is no waiting list for urgent aids and equipment.

Continued efforts are made to minimise all waiting lists as far as possible. As part of the government's election commitment, an additional $2 million of non-recurrent funding was allocated to MASS specifically targeted directly at reducing waiting lists. Of this amount, $1 million was added to the budget year just gone and allocated each quarter against the existing waiting list. The second $1 million will be added to the 2002-03 MASS budget and will again be allocated quarterly against the waiting list. The additional $1 million of funding allocated in 2001-02 has given significant assistance to MASS in minimising the waiting lists. The scheme was able to operate with only nominal waiting periods for the first half of the financial year. There was a slight increase in demand for the scheme towards the end of the year and that has meant a small wait in the last part of the year.

Ms NOLAN: Minister, how will the $1.7 million in output funding and $1.3 million in equity funding be used to enable the modernisation of Queensland's coronial system as stated on page 1-3 of the MPS?

Mrs EDMOND: This is a responsibility shared between Queensland Health and Justice. This year the extra $3 million will be invested to improve coronial and forensic service delivery to the entire state. It will ensure the same delivery of coronial and forensic services to regional Queensland as occurs in the south-east of this state. Coronial investigations and forensic science workloads and demands continue to grow, driven by an increasing population, community expectations and new and sophisticated technologies and techniques supporting better policing and crime detection. As part of the whole-of-government approach to modernising the Queensland coronial system, this new funding will complement the services already provided by the centre and provide improved investigations, post mortems and inquests as well as statewide counselling for bereaved families.

In addition, an investment will be made to integrate information technology tracking systems between the police and justice systems to assist in case management and improved turnaround

times. The reporting process can be very complex, and this will ensure that pathologists and scientists know when court cases will be going ahead so that they are able to prioritise testing and criminal cases. Many coronial cases involve multiple testing requirements—for example, DNA, viral and drug testing. Through this funding increase we are ensuring that the system will be able to meet the increasing demand for these services as well as be able to coordinate reports better between all of the parties involved. The new funding will provide the Centre for Forensic Science with more than 10 new medical and science positions, six new counselling positions and major testing equipment purchases. Included in the funding is $900,000 for conducting additional post mortems at the centre. Just to add to that, this is something that I think will make the paediatricians in this state very happy. They have been lobbying me for that for as long as I have been the minister.

The CHAIR: The time allotted to government members for questions has now expired. The committee will now adjourn for afternoon tea. The hearing will resume at 4 p.m.

Sitting suspended from 3.28 p.m. to 4.00 p.m.

The CHAIR: It is now time for non-government members' questions. I call the member for Maroochydore.

Miss SIMPSON: Minister, I go back to Mrs Ann Jarick, about whom I asked a question prior to the break. Can you please explain why a category 1 patient, Ann Jarick, had her surgery cancelled three times, even to the point where she was prepped, she was ready and waiting to go into surgery? I understand that in the media you said it was for other reasons, not clinical reasons, but Mrs Jarick was told that it was because of a lack of ICU beds. Clearly this is an unsatisfactory situation when you have someone waiting for such serious surgery.

Mrs EDMOND: I am not aware that I said it was not for clinical reasons. I actually said that these cases have to be prioritised. I am advised that there were cases that came in that had a higher priority.

Miss SIMPSON: Is that acceptable for an urgent category 1 patient? She had travelled down from Beerwah. She had come down three times. She had even been prepped and was ready to go into surgery. It is an extremely distressing situation. She is actually urgent surgery category 1. This is not minor elective surgery.

Mrs EDMOND: No, it is category 1 elective surgery. Certainly a higher priority is urgent surgery that is not elective. That decision has to be made by the clinicians at the time: which is the highest priority. That is not something that I, as a politician, would dream of making.

Miss SIMPSON: Do you think it is acceptable, though, as a politician?

Mrs EDMOND: I do not think other politicians should be making that decision.

Miss SIMPSON: Do you think it is acceptable that a woman who is a category 1 patient with an aneurism had her surgery cancelled three times? She had travelled down to Brisbane—including being prepped and ready to go into surgery—and she was told that it was because of a lack of intensive care beds. Is that an acceptable situation?

Mrs EDMOND: My understanding is that at that particular time there were patients who were of even greater priority than this patient. For example, if you have a patient who is already bleeding from an aneurism, that is a higher priority than somebody who has an aneurism but has had no problems with it.

Miss SIMPSON: But do you take responsibility for the fact that this is happening to patients who already have urgent categories of surgery and are finding that your health system is letting them down?

Mrs EDMOND: My understanding is that Mrs Jarick was waiting for elective surgery—category 1 elective surgery. Obviously urgent surgery is a higher priority than elective surgery category 1.

Miss SIMPSON: So you will not take responsibility for an urgent category 1 patient or say sorry to this woman who has had to wait three times and now is waiting until the end of this month—more than a month after the last surgery was cancelled and well outside the category 1 clinical guidelines? Do you not take responsibility for the state of the health system?

Mrs EDMOND: We want the best outcome for this patient. That is why it has been recommended that she wait until the specialist doctor with experience in this procedure is back on duty before it is done rather than doing it when he is not on duty.

Miss SIMPSON: Do you accept that the system has failed her if her surgery was cancelled when in fact the surgeon was previously available?

Mrs EDMOND: I think the system works very, very well in that the patient with the highest priority gets -

Miss SIMPSON: So you think it is acceptable that her surgery was cancelled three times—a woman with an aneurism?

The CHAIR: Would the minister resume her answer, please?

Mrs EDMOND: Thank you, Madam Chair. Madam Chair, could I just seek the Chair's indulgence? This is a matter that I do not think is anywhere in the budget papers. I have not seen anything in the budget papers that relates to this. If it relates to elective surgery generally I am happy to answer that question. If it relates to prioritisation I am happy to answer that question. But I do not think there is anything to be pursued, other than distress to a patient who is probably already distressed, and I do not think that is helpful in her clinical condition if this continues to go on. If the meantime, all arrangements to have absolutely appropriate care for this patient with a quite risky procedure with the one specialist in Queensland who is an expert in this have been made, and I understand that will happen this month.

Miss SIMPSON: That is not why the surgery was cancelled three times, though, is it?

The CHAIR: The minister has answered the question.

Mrs EDMOND: I have answered that question about 15 times. I do not know how many times you have to have me answer a question. It was cancelled previously. I have been advised that it was cancelled because patients with a higher clinical need needed to be done before Mrs Jarick. I understand that that is disappointing to Mrs Jarick, but when the crunch comes it is up to the clinician to make that call as to who is the patient with the highest clinical need.

Miss SIMPSON: In fact, it was not her surgeon who made the decision to call off that surgery, was it? Was it not the fact that you did not have enough ICU beds?

Mrs EDMOND: It is not the minister who calls off surgery. That decision is made by the clinicians on the ground who have to determine which patients have the highest clinical need.

Miss SIMPSON: Minister, I think we are here to represent patients when they come forward and say they have had urgent surgery cancelled three times and they want the system fixed. I note that you do not want to take responsibility.

The CHAIR: The minister has already answered the question. The member for Maroochydore will please ask her next question.

Miss SIMPSON: I refer you to where it does relate to the budget papers. In question on notice No. 4 you stated that there is no formal data collection on the number of surgical operations cancelled in Queensland public hospitals. You say that the elective admission management system whereby a patient's booking is amended is recorded as a cancellation. Therefore, you cannot conclude whether a surgical operation was cancelled or postponed. However, can you please tell this estimates committee and the rest of Queensland how many surgical operations in Queensland Health facilities in 2001-02 were cancelled or postponed?

Mrs EDMOND: My understanding is that the number that are cancelled is very, very tiny. Certainly the number who have their operation timing amended—which might actually mean bringing it forward as well as taking it back—is higher. My understanding from speaking to those who collate it is that on 90 per cent of occasions when a patient's booking details are changed, rather than an actual cancellation—

Miss SIMPSON: But do you have actual figures for the number of cancelled or postponed surgery?

Mrs EDMOND: Over what period? Over the time of the coalition?

Miss SIMPSON: I gave you the period. I asked you what were the number of cancelled or postponed surgeries in 2001-02. I will ask the minister, too, because she has not answered this in the question on notice: how did this compare to last year?

Mrs EDMOND: Quite clearly—and we always make this announcement when referring to elective surgery—elective surgery is elective by nature. That means it is things that you try to do within a particular time frame depending on what category it is. But it is elective. That means that it can be worked around the other needs of the hospital. The amount of elective surgery clearly goes up and down depending on what else is happening during that period. For instance, in

periods like winter there are often staff illnesses, et cetera which make it difficult. During periods of school holidays we have -

Miss SIMPSON: But minister—

The CHAIR: Order! I remind all members of the committee that the minister has three minutes to answer the question. Interrupting is not going to help the committee at all. I suggest that we let the minister answer, let her have her three minutes, and then ask the next question. Please continue, Minister.

Mrs EDMOND: My understanding is that the percentage of patients who are cancelled is very, very small. In fact -

Miss SIMPSON: And the number?

The CHAIR: The member will please stop interrupting and let the minister answer.

Miss SIMPSON: How do you know it is very small? Why should we not have the number? I have already given the example of a woman with an aneurism who had her surgery cancelled three times. Now we are asking: what are the numbers for cancelled or postponed surgery?

Mrs EDMOND: What I was going to give you is the elective surgery throughput for categories 1, 2 and 3. This year we have done a lot of work on that, and I have to say that the results are very pleasing, even though last winter we had an extensive flu period. It was written up in the media as the longest for many, many years, extending for about 10 weeks, which caused problems, cancellations and delays for a number of reasons—sometimes because the patients were unwell and could not be operated on. That means they then registered as a cancellation or a deferment. So it is very difficult. It does not actually mean that there was a problem with anything else. Cancellation can occur because the patient is not well enough to proceed with the surgery. This is particularly the case with serious surgery. You do not want to be putting a patient at risk because they have chest infections, et cetera, when they have that surgery.

Miss SIMPSON: Surely you have that information, Minister. It is not good enough to fudge around when you cancel people's surgery and it is not their fault.

Mrs EDMOND: I think what is important is that in the last financial year 114,168 patients got elective surgery. I think this is something to be celebrating. It was significantly more than in the previous year. This is even though there has been significant disruption in the last month of the year due to industrial issues. Also, there was considerable disruption in the previous year because of an extended period of winter illness. I think the important thing is to look at the fact that 114,168 patients had their elective surgery.

Miss SIMPSON: Minister, you still have not answered the question. How much surgery was cancelled in the last financial year compared to the previous year? You rattle off these figures, but you cannot tell us something so basic when it is impacting on patient care.

Mrs EDMOND: I will get the director-general to speak about the process in a minute. What that shows is that a lot more patients had elective surgery last year than in the previous year. One of the ways of doing that is having patients who are virtually on stand-by, which means that—

Miss SIMPSON: People with aneurisms?

Mrs EDMOND:—we call them in quickly. We actually get them in ahead of when they were booked, if we possibly can.

Miss SIMPSON: Prepped for surgery?

Mrs EDMOND: Madam Chair, this woman does not want to hear any answers. She does not want to hear about what is happening in Queensland Health. She wants to score cheap political points about a patient's ill health, when every arrangement has been made for that patient to have that care in the appropriate way and by the person who is the expert in it this month. Can I say again: we saw a significant increase in the number of patients this year undergoing elective surgery—

Miss SIMPSON: But you cannot tell us how many you cancelled.

The CHAIR: Would the member for Maroochydore please stop interrupting? I would like to hear the minister's answer, as would other people.

Miss SIMPSON: I would like to hear her answer the question, too. She has not answered it. We have people approaching us with cancelled surgery. They have had urgent surgery cancelled three times and have then been told to wait a month longer before they might get surgery.

Mrs EDMOND: Clearly the member is not interested in following those up, because I think she has forwarded on to my office in the last year less than one handful of instances that we had not already dealt with before they came to her.

Miss SIMPSON: Minister, give us the numbers of the people who have had surgery cancelled. That is the question.

Mrs EDMOND: One hundred and fourteen thousand, one hundred and sixty-eight patients have had their surgery this year. I think one of the points to make is that a record number of those have been public patients rather than private patients. I think it is important to recognise that we are treating more public patients in our public hospitals than we were in years past.

Miss SIMPSON: Minister, how can we believe you if you do not even know the number of people with cancelled or postponed surgery to the point that people are asking and pleading for help publicly?

Mrs EDMOND: I will ask the director-general if he can spell it out to the member. Obviously she is not really interested in the answer—

Miss SIMPSON: You have not given us an answer, Minister.

Dr STABLE: I might just go through the process. It has been a policy decision, certainly since I have been director-general, not to manage cancellations centrally. I will explain the reason for that. One way you can have no cancellations is to take no bookings. We actually try to have our hospitals maximise the number of bookings in accordance with the clinical priorities determined by medical staff. In every system in the world it is about getting as much throughput as possible while predicting your emergency cases. If you get more emergencies and more serious emergencies, it would be irresponsible, in fact negligent, to let someone bleed to death because we will not cancel an elective patient, albeit a 30-day, a 90-day or a 12-month elective patient.

Of course, the flow-on effect from the number of emergencies is the availability of intensive care beds. We are all aware of issues to do with staffing of these highly specialist areas. One is recruitment of staffing. In winter we have more patients with medical illnesses. We have more staff off sick. Staff in highly specialised areas also have to have annual leave.

Miss SIMPSON: Excuse me, Dr Stable. Do you know how many cancellations or postponed surgeries there were? This is a fairly important issue when you are talking about patient care.

Dr STABLE: With due respect, this is not an issue that can be managed centrally. What we want is maximum throughput—

Miss SIMPSON: You mean you do not want to know so you do not want to put it in a central point? Is that why?

Dr STABLE: May I answer the question? We want maximum throughput. As the minister indicated, 96,482 public patients are having elective surgery through our system. We want local clinicians making priority decisions, including emergencies getting straight into theatre. I do not want them ringing me centrally and saying, 'We want permission to cancel.' They make a decision that someone needs to go straight into theatre.

Miss SIMPSON: That is misleading. That was not the question. I want to know whether you have any idea of the number of cancelled or postponed surgeries. This is affecting patients, Dr Stable.

Dr STABLE: We maximise the number of bookings we take so that we can get as much throughput as possible.

Miss SIMPSON: We still have not had an answer to a basic question. You are fudging around the issue of how many patients have had surgery cancelled or postponed.

Mrs EDMOND: Last year there were 4,381 more procedures than in the year before. Cancellations might be for a couple of hours. There might be a deferment. Surgery might be brought forward. As we have indicated—

Miss SIMPSON: But you will not give us those figures, Minister, so how do we know?

Mrs EDMOND: We do not have those figures. I do not have those figures. They are managed locally by the hospitals.

Miss SIMPSON: You do not want to know the figures, Minister? Do you think this is an important issue?

Mrs EDMOND: Stop! I think we have put up with this rubbish long enough. The member for Maroochydore is clearly not interested in the welfare of the people of Queensland. She is

determined to try to score a cheap political point over one patient when every arrangement has been made for that patient.

Miss SIMPSON: There are other patients, Minister. I have written to you about them and there are more still. Minister, if you have category 1 patients who cannot get surgery—

The CHAIR: I remind all committee members once again that by continually interrupting answers we are not advancing the work of this committee. I ask all committee members to allow the minister to answer the questions. She has three minutes in which to do so. Members have one minute in which ask a question. I think that is quite clear. Minister, please continue to answer.

Mrs EDMOND: I point out that the coalition government did not publish the waiting lists or the times or the cancellations. In fact, it was a big secret mess. The Beattie Labor government now publishes quarterly waiting list reports. The June quarter report is being collated at this moment.

Miss SIMPSON: Do you want to publish the cancelled and postponed surgeries?

The CHAIR: I remind the member for Maroochydore once again to stop interrupting and let us hear the answer.

Mrs EDMOND: The June quarterly report will be publicly available before the end of this month. While the June quarter data is still being finalised, I am pleased to report that in the year to 30 June 4,381 extra elective surgery operations were performed as compared with the previous year. That means that an extra 4,381 Queenslanders received their elective surgery, compared with the year before. As the director-general indicated, part of the way we have achieved that increased throughput is by putting more pressure on the booking system, rather than leaving empty spaces in case there is a cancellation. It probably means that people—

Miss SIMPSON: You say it is acceptable to cancel a woman's aneurism surgery three times?

Mrs EDMOND: It is managed much more aggressively than perhaps it was in the past so that we get more patients having their operations. I think that is what the people of Queensland are interested in. I think the people of Queensland are interested in the fact that 114,168 patients received their elective surgery—4,381 more than in the previous year. The government did provide extra funding to do that, and we set a target of an extra 3,500 operations. Obviously we have done better than that. Equally obviously, we would have done a lot better than that without the industrial action, but we still exceeded our target.

Miss SIMPSON: This happened before the industrial action. Minister, how many cancelled or postponed surgeries are there this year and how does that compare with the year before?

Mrs EDMOND: I can also report to the committee that more than 96 per cent of category 1 elective surgery procedures were done within the recommended 30 days during the year. Nearly 90 per cent of category 2 procedures were done within the recommended 90 days. Obviously there have been some recent disruptions. I am not going to comment any further on that. I think it is important, and I think the people of Queensland want to know, that 114,168 patients received their surgery last year—4,381 more than the year before.

Miss SIMPSON: Minister, we want to know how many people had their surgery cancelled or postponed.

The CHAIR: Order! The time allotted for questions from non-government members has expired.

Ms NOLAN: Minister, I was very excited to see on page 9 of the MPS that $500,000 has been allocated for the purchase of a tandem mass spectrometer. Could you please tell us what that is, what conditions it will be able to detect and how that will help in relation to the delivery of care to children?

Mrs EDMOND: I think that this is a very exciting project and I think that it is one that I have just been delighted to be a part of. All Queensland newborns are currently screened for a limited range of inherited and metabolic disorders, including cystic fibrosis and hypothyroidism—particularly those disorders—which, by treating them, can reduce the impact on their lives. Even though it might be awkward for them to be treated, it actually can save them from having the difficulties that they would face like hypothyroidism.

The tandem mass spectrometers are state-of-the-art instruments that allow rapid high-throughput biochemical analysis. A tandem mass spectrometer will allow the Queensland newborns screening program to offer extended metabolic screening to all Queensland newborns.

The detection of abnormal levels of amino acids, or carnitines, can indicate the presence of a genetic disorder which causes an enzyme deficiency. The tandem mass spectrometer detects disorders such as maple syrup urine disease and other metabolic disorders. These diseases are asymptomatic at birth and can be progressive in development or, in some cases, latent until a stressful event results in a metabolic crisis. Symptoms range from lethargy to seizures, coma and sometimes death. Currently, Queensland Health bears the cost of detection and treatment of these diseases after symptoms have appeared and irreversible damage done. Early detection of these disorders allows early treatment and results in decreased mortality and morbidity. The purchase and installation of the tandem mass spectrometer will mean that Queensland will remain at the cutting edge of science and technology. Apart from the obvious benefits to Queenslanders with regard to neonatal screening, this equipment provides great opportunity for Queensland Health pathology and scientific staff to develop their scientific and technical skills consistent with the Smart State agenda.

The ability to now detect through routine mass screening these rare but severely disabling disorders was raised with me by the member for Glass House and one of her constituents who actually has a child with a rare metabolic disorder, which was luckily picked up accidentally before it had any effect on her and she has been able to adapt her lifestyle around that disorder without it having damaging effects. I have to say that I am grateful to the member for Glass House for bringing it to my attention. To be able to bring in such testing is one of those things that really makes a Health Minister's job very, very satisfying and warming. I think that it is a great story that we will be able to do this in Queensland now.

Ms NOLAN: That is great. Page 3 of the MPS identifies an extra $2.5 million for the government's drug court pilot program. I think that it is an excellent program. We have a drug court in Ipswich. How will this funding be allocated and what is the extent of Queensland's Health financial and other support for the trial?

Mrs EDMOND: I agree with you. I think that it is an excellent program and you would be well aware of it as one of the trials is in Ipswich—in West Moreton. The funding of $2.5 million allocated to Queensland Health in the budget will allow for the continuation of the drug court pilot program in south-east Queensland and also expands the pilot to north Queensland. The south-east Queensland drug court pilot has been operating through the Magistrates Courts of Ipswich, Logan and the Gold Coast since June 2000. This funding provides for a total of 46 residential treatment beds in the non-government sector in south-east Queensland specifically for drug court clients. This also includes 41 outpatient places from the non-government sector. Non-government organisations and services funded in south-east Queensland for residential beds are the Salvation Army in Brisbane and Southport, Mirikai at Burleigh Heads, Goldbridge at Southport and Logan House at Logan. Mirikai and Logan House are also funded to provide outpatient treatment places. Funding for south-east Queensland will also provide for dedicated outpatient services in each of the three Queensland Health service districts for drug court clients to ensure that there is no impact on access to services for general community clients. In order to support regional areas, funding has been allocated to expand the drug court pilot to Cairns and Townsville as well as provide increased drug treatment services for the general community in these areas.

Queensland Health funding will provide for an additional 20 residential drug treatment beds in each of Cairns and Townsville. Ten of the beds in each place will be for drug court clients and 10 for general community clients. The non-government organisations that will provide the services in north Queensland are St Vincent's community services in Cairns, with 20 beds, and Townsville, 14 beds, and the Stagpole Street Alcohol and Drug Rehabilitation Service in Townsville with six beds. In addition to this significant expansion of residential drug treatment beds in these place, this funding will also allow for the expansion of outpatient drug treatment services in both Queensland Health service districts. The drug court pilot is due to commence in north Queensland by November 2002. Queensland Health will continue to support this very important initiative to divert offenders from the criminal justice system into treatment and rehabilitation to help overcome drug dependence and associated criminal behaviour.

Mrs DESLEY SCOTT: Page 24 of the MPS refers to rehabilitation services in Queensland. What will the extra $1 million provide? What is the total budget for rehabilitation services?

Mrs EDMOND: Certainly, rehabilitation services is an area that we identified where there is a gap in services. It is a specialised component of health care aiming to maximise quality of life and minimise long-term health care and community support needs. The evidence shows that appropriate rehabilitation results in significantly lower mortality rates, improved functional outcomes and, importantly, improved quality of life. The $1 million recurrent funding allocated to

adult rehabilitation will enable the continued operation of the spinal outreach team, the transitional rehabilitation program at the Princess Alexandra Hospital and it will also support the establishment of the focused intensive rehabilitation service and treatment for high-risk elders at the Townsville Hospital.

The spinal outreach team and transitional rehabilitation program have been funded for the past five years from the Motor Accident Insurance Commission. This funding is ceasing in July 2002. Evaluations have clearly demonstrated that SPOT and TRP are cost effective. So $500,000 will be allocated to the spinal rehabilitation services to provide for six and a half FTE nursing and allied health staff and non-labour items.

In Townsville, the first program for high-risk elders has been identified as a priority area. As the need for rehabilitation services increases with age, in the current decade we will see a significant rise in the number and proportion of people aged between 50 and 70 years. It is appropriate to invest in rehabilitation services for older Queenslanders. $500,000 will be allocated to the Townsville first program for high-risk elders to provide seven full-time equivalent specialist medical, nursing and allied health staff—that is $400,000—and non-labour items of $100,000. In total, Queensland Health will spend over $53 million on adult rehabilitation services in Queensland's public hospitals with designated rehabilitation units this year. This figure does not include rehabilitation services provided within general wards of hospitals or in specialised health facilities within the community that are funded from district health services' global budgets.

But additional dollars have been invested in adult rehabilitation services under the Queensland Health building program. In addition to the $1 million recurrent funding for 2002-03, $0.83 million growth funding will be allocated to establish a north Queensland spinal rehabilitation service at Townsville. In 2003-04, the $1 million recurrent funding for adult rehabilitation service also increases to $1.97 million. The majority of increased funding will be allocated to the Sunshine Coast Health Services District for the establishment of a day therapy centre at Caloundra.

Mrs DESLEY SCOTT: I have a specific interest in emergency departments. Can you inform the committee what is the Commonwealth government's response to Queensland's concerns about the increasing number of patients presenting to our emergency departments?

Mrs EDMOND: While throughput figures for health generally for in-patients have been stabilised, the area of rapidly increasing demand is in emergency departments. What we have found is that the demand for GP type medical services is transferring from GPs to the emergency departments in public hospitals because of the declining access to GPs after hours and on weekends and because bulk-billing by GPs is also declining.

A substantial proportion, approximately 60 per cent, of patients presenting to emergency departments are presenting with conditions that require only semi-urgent or non-urgent treatment. Many of these patients could be treated by a GP; they do not need to be in an emergency department. The reason bulk-billing is out of favour with doctors is the lack of Commonwealth budget rebate increases year in, year out. That is where the blame lies for GPs moving out of bulk-billing. The federal President of the AMA, Kerryn Phelps, said earlier this month that the decrease in bulk-billing was further evidence that the Medicare rebate of $24.45 for a standard visit to a GP was unrealistic. The AMA president has warned that unless the federal government acts to address the inadequacy of the rebate, it will not be long before the bulk-billing GPs in Australia are extinct. Certainly we are seeing increasing numbers who are reducing the category of patients that they will bulk-bill right across Queensland. This is a clear example of cost shifting to the states, and state health ministers have been raising this issue for several years at the Australian health ministers conference.

The Commonwealth has begun addressing the issues of declining access to after-hours and weekend services by GPs through the after-hours primary medical care program. The aim is to improve access, efficiency and quality of after-hours primary medical care services. Queensland has been awarded 10 grants under this program. However, most of these studies make only limited contact with the public hospital system where the demand for after-hours and weekend care has focused.

The significant exception here is the study to be undertaken by the Townsville Division of General Practice, where the ultimate aim is to establish a GP clinic in the emergency department of the Townsville Hospital. Queensland Health will be trialling the placement of GPs and emergency departments in a number of locations across the state. Such trials have also been initiated in a number of other states, with the full support of the Commonwealth. The Commonwealth Minister for Health and Ageing, Senator Patterson, has indicated to me that she

supports similar trials in Queensland. I know the member for Ipswich would be interested in that, too. We are looking at Ipswich because there is a significant shortage of GPs in Ipswich, particularly GPs after-hours and prepared to bulk bill.

Mrs DESLEY SCOTT: How are our emergency departments coping with the increasing number of patients?

Mrs EDMOND: It is putting a strain on them, and obviously even though the majority of the increases in patients are low categories, like category 4 and 5, still, if you have got that many more people in your department, it is going to make it slower to assess people and see them.

The data collection that I initiated in 1998 as part of the emergency services strategy has enabled us to collect relevant information about how Queensland emergency departments are coping with that increased presentation. The first indicator of how Queensland emergency departments are coping is waiting times data; how long patients in the five triage or urgency categories wait to see a doctor. Waiting times for the most urgent patients, categories 1 and 2, have improved steadily since I implemented the emergency services strategy and initiated a statewide collection of waiting times data in 1999. Improving emergency department waiting times was a 1998 election commitment. Waiting times for category 3 patients are relatively steady when compared with the same period in 2000-01.

These improvements in waiting times for categories 1 and 2 and the maintenance for category 3 show the commitment of emergency department staff to improving services for the most urgent patients. This is despite increasing numbers of patients presenting. Waiting times for category 4 and 5 patients, however, have deteriorated as the number of patients in these categories have increased. As part of the emergency services strategy this year, we have allocated extra funding to projects to improve waiting times in the emergency departments.

The other main indicator of how emergency departments are coping is the measure of access block; the waiting time from the emergency department to admission to the wards. In this category, Queensland performs better than the bigger states on measures of waiting time to admission. Since I initiated collection of this data in 1999, Queensland has consistently achieved a performance level of greater than 90 per cent of patients admitted within eight hours. This is clearly better than New South Wales, where only 76 per cent of patients were admitted within eight hours for 2000-01. Queensland also exceeds the performance of Victoria, where 84 per cent of patients were admitted within 12 hours during 2000-01.

The fact that Queensland performs better than the other states in this area does not mean that there is no room for improvement. Patients in some hospitals do experience delays being admitted, particularly during busy periods and during winter. As part of the emergency services strategy this year, funding has been allocated to projects to reduce access block in key hospitals that have experienced delays in admissions.

The CHAIR: I refer to page 9 of the MPS. Can you provide some more details of the services the extra $3 million for the Redland Hospital will provide, please?

Mrs EDMOND: The Redland Hospital is one of those new hospitals in the system which is rapidly growing. Since the opening of the new hospital in 1999, it has experienced a significant and continual increase in the complexity of cases presenting for treatment and care. This has placed an extra burden upon the allocated resources of the hospital. In recognition of this demand, I am pleased to say that the Bayside Health Service District has been allocated an additional $3 million in growth funding for this financial year. This money will go towards enhancing both in-patient and ambulatory services at the hospital. It will mean that the people of the Redlands area will be able to access services closer to where they live. In particular, this additional funding will enable us to enhance and consolidate services in neonatal, paediatric, obstetrics, emergency, orthopaedics and after-hours acute surgical services.

On 13 November 2001, I opened the Lamb ward, a new paediatric in-patient and ambulatory care service at the Redland Hospital. The additional funding will help enhance this new service to better meet the needs of young people in the Bayside district. The Redlands area is a growth area and this was demonstrated by the Redland Hospital delivering 300 more babies than expected last year. In order to meet this increase in demand for obstetric and maternity services, I am happy to say that a significant proportion of the funding will be directed towards supporting this valuable service.

There has also been an 11 per cent increase in the number of people presenting for care at the accident and emergency department of the Redland Hospital over the past 12 months. The additional funding will increase the capacity to deal with the number of people presenting at the

accident and emergency department. The new funding will also provide increased orthopaedic services to the people of the Redlands area. This enhancement includes the employment of a local orthopaedic specialist, thus increasing the orthopaedic capacity of the hospital.

The Redland Hospital will now have the capacity to provide increased after-hours acute surgical services. In the past, after-hours surgical patients were usually transferred to the Princess Alexandra Hospital. However, as a result of this additional funding, we will now be able to provide surgical services to these patients closer to where they live.

The CHAIR: I note on page 3 that $1.6 million is being invested in recognition of the current high occupancy levels at the Nambour Hospital. How will this money be used to improve that service?

Mrs EDMOND: Again, Nambour is a high growth area and the government recognises that the Sunshine Coast generally is an area of high growth. Accordingly, this has been reflected in increased funding to the district, including the $26 million redevelopment of Nambour General Hospital that is almost complete. The project involved the development of a new building to house the intensive care unit, operating suites, department of emergency medicine, MRI, the medical records department, as well as refurbishment of existing areas within existing buildings.

Occupancy rates at Nambour Hospital have been consistently high and the hospital has been under pressure due to space constraints related to the redevelopment project, increased demand and also its role as a referral centre. In recognition of current high occupancy levels at Nambour General Hospital, I have committed $1.6 million to provide up to 30 additional acute in-patient beds. Over the next few months, services will complete their move to the new building, providing space within the existing building. The ward areas will become available from August 2002. The increase in in-patient beds will greatly assist the hospital to meet the current demand for services.

An additional $780,000 has also been allocated to enhance services in the hospital's new intensive care unit. The funding boost will increase the level of service up to two additional beds to meet the current demand. Other funding for Nambour includes $400,000 to cover the increasing cost of facility maintenance, $150,000 for a new high dependency mental health unit for the Sunshine Coast, and $1.9 million to purchase hospital equipment, including three ventilators and a dialysis machine.

The Sunshine Coast district will continue to maximise the use of available beds with its network of services. The 109-bed Noosa Hospital and Specialist Centre was opened on 1 September 1999. Seventy-four of these beds are available for public use. These are funded out of increased funding of over $12 million in the 2001-02 budget, rather than what was expected to be out of the Sunshine Coast district budget, as the previous National Party Health Minister, Mr Horan, intended. It went in, instead, as all new funding and growth funding.

Caloundra Hospital also received an extra $1 million last year to enhance services following the redevelopment. Before the redevelopment, there were 24 funded in-patient beds there. This was increased to 30. There is an option to commission a further six in-patient beds to cater for growth and extra surgical services planned when needed, and this year's budget included an extra $650,000 as well as a $162,000 allocation for medical equipment.

The CHAIR: The time for government members' questions has now expired.

Miss SIMPSON: Will the minister say how many surgical operations in Queensland Health facilities in 2001-02 were cancelled or postponed, and how did this compare to last year?

Mrs EDMOND: As I have said previously, Queensland Health does not collect centrally data on cancelled elective surgery operations, nor did the coalition. We should make that very clear at this point in time. What is more important than counting cancellations is counting how many operations we do. As I mentioned earlier, the people of Queensland have a right to know and want to know that an extra 4,300 patients had their surgery last year. Also, we publish the hospital by hospital waiting list data, something of course that the coalition refused to do; in fact, it refused to publish any of that information. Yes, I regret that operations are cancelled for a range of clinical reasons, which I have explained. Let me assure the member that we are doing everything possible to ensure that more and more Queensland public patients receive their operations on time.

Miss SIMPSON: As the minister was supposed to be responsible for health for the last four years, will the minister please tell me how many surgical operations in Queensland Health facilities in 2001-02 were cancelled or postponed?

Mrs EDMOND: I am sorry, the member must have missed what I just said. Queensland does not collect centrally the data on cancelled elective surgery operations, nor did the coalition government. Let me make it very clear: the coalition government did not collect this data centrally, nor do we. What is more important than counting cancellations is counting the number of patients who actually received operations. That is what we do.

Miss SIMPSON: I refer the minister to question on notice No. 4 where the minister in fact said that the books recorded cancellations and postponements. I ask again: how many cancellations and postponements have there been in Queensland public hospitals?

Mrs EDMOND: As we indicated to the member in the written answer, cancellation means any amendment that has taken place. It could mean a change that actually brings the patient out of that booking slot into an earlier booking slot. We do not keep that information centrally. My understanding is that the number of operations that are actually cancelled for non-clinical reasons is relatively small in the scheme of things. As I said, 114,168 patients received their elective surgery last year, 4,300 more than the previous year. We collect the data in a very similar way to what was done under the coalition.

Miss SIMPSON: The minister has an answer to a question on notice that says that the information for cancelled or postponed surgery is available. Surely the minister can acquire that information and tell us how many surgeries were cancelled or postponed in Queensland Health facilities, given the importance of surgery?

Mrs EDMOND: Cancellation of surgery is a serious issue. It is something we try to avoid. Cancellation can occur for a range of reasons, often clinical reasons. But the fact that 4,300 more patients received their surgery last year means that those people who were deferred must have been deferred for a relatively short period of time.

Miss SIMPSON: The minister is asking us to trust her that it may have been for a relatively short period of time. The minister said it was a serious issue. I believe it is an extremely serious issue. Surely, as minister, the information can be acquired. The minister said in the question on notice that the information exists.

Mrs EDMOND: The most important issue is to get as many people as possible who need surgery having surgery. Sometimes that might mean the inconvenience of overbooking and it might mean a deferral until the next day or a later hour of the sitting, as we say in parliament. The most important thing is that the number of patients waiting more than 30 days for category 1 is currently 3.4 per cent. The number who are waiting more than the recognised criteria for category 2 is currently 10.6 per cent. That means that the vast majority of patients—nearly 90 per cent of category 2—receive their surgery on time.

Miss SIMPSON: Question on notice No. 4 has identified that the information as to the numbers of cancelled or postponed surgery exists. Surely the minister can talk to the local hospitals and acquire that figure for across Queensland?

Mrs EDMOND: Yes, we could call each and every hospital and they could spend an inordinate amount of time finding information for the member. I actually prefer that they put that time into treating as many patients in Queensland as possible and to making the system as efficient as possible. That is why I am delighted to tell the member that 114,168 patients received their surgery last year. The vast majority of those were within the time frame in which we like that to occur. I think that is a credit to the doctors, nursing staff and booking clerks in those hospitals. That is the important message that we want to send out. We want them treating patients and not running around collecting data about how many patients were deferred for one day or brought forward, et cetera. As I said to the member previously, the important thing is how many patients receive their treatment in the appropriate times.

Miss SIMPSON: Does the minister believe that she has to be accountable to parliament to justify the figures for how many surgeries were cancelled or postponed in this state?

Mrs EDMOND: I believe that I have to be accountable to parliament to get the most people possible in Queensland getting the appropriate treatment, that they are not operated on when they are not fit to be operated on and that they are operated on in as timely a way as possible. That is why we have such great faith in our clinicians to make some of those decisions for us about deferments, cancellations, the bringing forward of patients and amending appointment times. That is why I am so proud to tell the member that because I am accountable, we have exceeded the target for the number of patients for elective surgery with our extra funding as a result of our election commitment and that 4,381 more patients received their operations last year than the year before. That is great accountability.

Miss SIMPSON: But the minister does not want to be accountable for the number of patients who have had their surgery cancelled or postponed. This is an important issue. The minister said it was a serious issue but does not want to provide that information to the estimates committee.

Mrs EDMOND: I cannot see the slightest bit of relevance of any of this. We have gone on for hour after hour with questions that have absolutely nothing to do with the budget. In terms of the budget, we need to see accountability in relation to surgery committed. We have seen that. We have seen wonderful results. We have seen excellent figures. That is where we have to be accountable. The decisions about whether a patient should or should not have surgery are clinical decisions, and I do not pretend to make those decisions, nor should I. These are decisions not for politicians. I know the member believes that she is an expert and can decide which patients should receive treatment ahead of other patients. I do not make that decision, nor do I believe that I should. I believe that that is a decision for clinicians to make, and I will stand by that. I do not think that political interference in who has their surgery is a measure for accountability, good government or a good health system.

Miss SIMPSON: Could the minister make a decision as a minister to be responsible and accountable to parliament by acquiring the figures of how many cancelled or postponed surgeries there were in Queensland Health facilities this year and the year before?

The CHAIR: The minister has already answered that question and I would ask the member for Maroochydore to move on to her next question.

Mrs EDMOND: Can I just point out that we are accountable far more than the coalition government, because we have put the elective surgery figures openly and accountably before the people of Queensland every quarter.

Miss SIMPSON: As the Minister for Health, will you be accountable to the parliament and acquire the figures for how many cancelled or postponed surgical procedures there have been in Queensland's hospitals?

Mrs EDMOND: I think we have said that we have had more patients than in the previous year. We have had 4,381 more admissions. That means we are operating on more patients, not cancelling them. When we have talked of cancelling, we have already tried to explain this to you. I do not know how we can make this any simpler for you. You clearly have great difficulty grasping the fact that any amendment is recorded, and that could mean a patient moving forward or a patient who has an infection and therefore cannot have their surgery that day. It could be for a raft of reasons. It is meaningless. What is important is that 114,168 patients received their surgery last year—4,381 more than the year before.

Miss SIMPSON: Minister, I refer to your comment that it is meaningless as to why people's surgery is cancelled or postponed and I refer to your responsibility as the Minister for Health and ask you: will you acquire these figures for cancelled or postponed surgery?

Mrs EDMOND: Clearly, the member for Maroochydore has not had time to have a look at the budget for Health. She seems to have only one or two questions, which do not seem to have anything to do with the budget. I have answered that previously. These are clinical decisions and I am not going to make clinical decisions on cancellations, and nor is it appropriate. When you start saying that politicians should be involved in who gets surgery, the next step will be the member for Maroochydore lobbying to get one patient of hers ahead of other people who are far more in need of surgery. That is totally inappropriate. I will not be a Health Minister who allows that to happen. I will not allow politicisation of elective surgery. Is that what the member is aiming at? That will not happen under me as minister. I will not allow the politicisation of patients' access to surgery.

Miss SIMPSON: Minister, you have not answered the question. You have made a statement that cancellations and postponements are due to clinical reasons and yet you have provided no figure to this committee. I ask you: how can you make a statement that it is for clinical reasons and then provide no figures and no back-up to this parliamentary committee?

Mrs EDMOND: I will make a correction. The member keeps saying that I am not answering the question. She is obviously trying to make a point for the media. I think she has laboured it long enough. I have answered many questions. What she is saying is that she does not understand the answers. I cannot help that. I do not know how to make it any simpler for her. I have repeatedly answered it.

The CHAIR: I make the point that ministers may answer a question in any way they deem proper. If the member for Maroochydore has any further questions, I ask her to continue.

Miss SIMPSON: I have questions that would last several days, but I am waiting for the minister to answer this question. I remind the minister that we are just asking you to provide more services so that we do not see urgent patients with their surgery cancelled, for example, because of a lack of ICU beds. I think it is a serious issue and the minister should be accountable. I refer you to the fact that you are able to come into the estimates process with a number of facts as to elective surgery but in regard to a serious issue such as cancelled or postponed surgery you do not want to provide those figures. I refer you also to question on notice No. 4, to which you replied that these figures existed. Will you acquire these figures and be accountable to the estimates process?

The CHAIR: The minister has already answered the question. I will ask the member for Maroochydore again: do you have some more questions? Please continue with some other questions.

Miss SIMPSON: I have plenty of questions, but I am waiting for the minister to answer this question.

The CHAIR: Please move on. The minister has answered the question.

Miss SIMPSON: She has not answered the question, Madam Chair.

Mrs EDMOND: One matter that the member might be interested in concerning elective surgery is that we have been doing a lot of work on addressing those areas where work was not being done and where we have accessed spare capacity. One of the areas where we identified extra capacity, for instance, in elective surgery for cataract surgery, has been at the Mater Hospital. We also acknowledge that there was a problem accessing ophthalmology services at Redcliffe. We have bought services for Redcliffe patients from the Mater Hospital. We have had almost 100 patients to date—I think we are aiming at 100—who have been waiting overly long at Redcliffe Hospital having their surgery at the Mater Hospital. These patients will show up on the books as cancellations at Redcliffe, and for a very good reason—we are doing them at the Mater. This is one of the reasons. It is because we are being flexible and trying to maximise the number of operations that take place, to treat people as well as we can and to treat as many people as we can, that we are showing this flexibility, which of course will show up as cancellations on the lists at Redcliffe or anywhere else they may be. As I mentioned, an additional ophthalmology capacity at the Mater was identified early in 2002. We have utilised that capacity by transferring the patients. To date, 78 patients—sorry, we are aiming at 100—from Redcliffe-Caboolture who have waited longer than a year for surgery were treated at the Mater services in May and June of 2002. As I said, those patients would be identified in the Redcliffe-Caboolture area as cancellations.

As at June 2002, 4,346 patients were waiting for an ophthalmology procedure in Queensland public hospitals. This has been an issue for a long time, that is, the fact that we have had difficulty getting ophthalmology services in the public system. Luckily, we have been able to improve that significantly. Members at previous estimates might remember hearing that the Gold Coast area was one of the areas with the greatest difficulty in the past. Last year we talked about the ophthalmologist at the Gold Coast having to upgrade his training to meet Australian requirements, even though he was a very experienced ophthalmologist. I am glad to say that he is now back there in full swing, fully accredited in Australia. We also have the extra services that we purchased from visiting medical officers on the Gold Coast, who are now going to provide extra services on the Gold Coast. Hopefully, we will be able to provide those services through spare capacity at Robina Hospital in the near future.

Miss SIMPSON: Minister, thank you for your time-wasting exercise by failing to answer the question. Could you now please answer the question, bearing in mind that this is also a Health portfolio management issue. I ask again: how many surgeries in Queensland Health facilities in the year 2001-02—in the previous year—have been cancelled or postponed, given that you acknowledge that those figures exist?

Mrs EDMOND: What I have told you is the good news about all of the extra patients we have been treating. Another area where we have had significant problems in the past has been the Townsville Hospital. That has been an area where there have been cancellations, deferrals, amendments and 'bringing forwards', too. I am happy to say that we have got very good results from Townsville now. In the past, we have had difficulties employing a vascular surgeon in Townsville. I know the member for Mundingburra, who is here today, was particularly concerned

about the lack of availability for vascular surgery in Townsville. The appointment of a vascular surgeon in March has seen the waiting lists for categories 1 and 2 patients more or less disappear. That progress is now being made on the category 3 list for vascular surgery. Again, these patients may have had changes and amendments. In fact, many of these patients would show up as cancellations, because they have been brought forward for their surgery since the appointment of that specialist. He has been getting on with the job.

Cardiac surgery waiting lists in Townsville have also been eroded, with waiting times eliminated for categories 1 and 2 patients, except for those with co-morbidities or smokers. One of the issues with cardiac surgery is that sometimes the cardiac surgeon says, 'If you haven't quit smoking by the time your surgery is due, we won't do it because of the risks involved.' Some of the cancellations you are talking about will be on the clinical determination of the surgeon for that reason. Orthopaedics now has the longest waiting list at Townsville Hospital along with general surgery. This is largely due to the inevitable and unpredictable demands placed on these disciplines by emergency trauma care. While some category 2 patients are waiting longer than we would like in both general surgery and orthopaedics, long waits are the case for a very small proportion of patients—only about 20 out of 500 patients.

Again, we have seen patients proceeding through sometimes faster than we had originally predicted. Targets will be met in neurology since the appointment of a visiting neurologist once a month. I am pleased to say that I am informed that ophthalmology services on the Gold Coast are now getting back to normal. As I mentioned earlier, we are delighted that the ophthalmologist is back in full swing at the Gold Coast Hospital. Again, some of the appointments will have been amended and changed because they have been brought forward because of the wonderful progress we have had in employing extra specialists in those areas.

The CHAIR: Thank you, Minister. The time allotted for questions from non-government members has now expired. In the last budget the government allocated an extra $5 million to treat 16,500 people waiting longest for dental treatment. Was this target achieved when adult courses of care for general dental treatment are less than the target estimate on page 1-16?

Mrs EDMOND: I have to say that oral health is probably one of the most difficult areas we are having to address at the moment for a number of reasons. The first one of course is because of the rapidly increasing number of people who are accessing the service. The government committed $5 million in 2001-02 to treat an additional 16,500 people waiting the longest for public dental health services in the Beenleigh, Bundaberg, Caboolture, Gold Coast, Hervey Bay, Logan, Noosa, Pine Rivers, Redcliffe, Redland and QEII Hospital regions. These were identified as where the waits were longest. This funding was non-recurrent and ceased on 30 June this year.

At the end of June 2002 the health service districts which received this funding had performed 103 per cent of the 16,500 extra general courses of care, or 16,977 extra courses of care. These are preliminary figures that will be finalised in the near future. A course of care—and I have some difficulty with this and I have actually asked the department to look at other ways of counting it—is defined as the satisfactory completion of all planned treatment identified at the initial examination. As members would be aware, that could be one tooth being filled or a whole mouthful of teeth being filled or extractions or even dental plates being made. A general course of care involves all the treatment identified at that initial examination. It can vary enormously. This may include cleaning, fillings and dentures, and this normally involves multiple visits and the treatment required varies greatly in complexity. An emergency course of care is the resolution of the problem with which the patient presented. Examples would be a filling or an extraction. This normally involves one visit but may require additional visits.

In order to obtain the extra targets, innovative and flexible options were explored and implemented such as overtime, additional sessions, flexible working hours, outsourcing, use of school dental vans for adult patients and offering the target patients appointments at nearby clinics with the required capacity within the district. A recruitment and retention working group has been established to implement innovative methods of recruiting dentists to the service. A successful recruitment drive was undertaken in the southern states and New Zealand in September and October 2001 and will be repeated this year.

Overall, preliminary figures show that total adult services achieved targets for 2001-02, with a projected increase of approximately 20,000 completed courses of care over 2000-01. Patients with emergency or immediate needs are seen on a clinical priority basis and generally within one working day. As emergency services are approaching 70 per cent of the total services provision, this has affected our ability to provide general services. For example, preventive and restorative treatment, extractions, denture provision and regular recalls increase overall waiting times.

Ms BARRY: Minister, I am interested to know whether the federal coalition kept a record of the number of people who did not get oral health care when it slashed oral health funding. But my question to you is: how does funding for Queensland's scheme compare with that in other states and with subsidies for private dental services provided by the Commonwealth government?

Mrs EDMOND: This has been a major problem, because Queensland has been the only state—and I have previously paid credit to Minister Horan for this—to keep that funding going. But, unfortunately, the Commonwealth does not accept that oral health care is a health issue. It seems to think that the mouth is not attached to the rest of the body. The public oral health program in Queensland is the largest in Australia with a staff of more than 1,500 and a budget of approximately $110 million in 2001-02, taking account of our one-off allocation of $5 million. In this year's budget an additional $1.7 million of funding has been allocated to take account of the impact of both the GST effect and the state's more than one million health care card holders.

Queensland was the only state to provide full and recurrent supplementation of $20 million when the Howard government dumped the Commonwealth dental health program in December 1996. Other states either reduced services or introduced co-payments. In 2001-02 Queensland provided more funding per person for oral health services than any other state, being around $31 compared to the Australian average of $18. In the last New South Wales budget, an extra $16 million was allocated, taking its annual dental health expenditure to $97 million this year. The New South Wales population is 6.6 million compared to Queensland's 3.6 million. So we are still spending more than it does with almost half the population.

With the possible exception of Department of Veterans' Affairs clients, the federal government considers that private dental treatment for members of the public is an individual's responsibility and provides no direct financial assistance to help in meeting dental costs. This is in contrast to medical and pharmaceutical benefit schemes administered by the Commonwealth. The 30 per cent federal rebate which applies to financial members of health insurance funds provides some indirect ancillary benefits to members, depending on their insurance plan and package. Unfortunately, many Australians such as low-income families neither have private health insurance nor are eligible for state funded public oral health services.

As in acute care, the 30 per cent private health insurance rebate has failed in terms of providing equity of access to all Australians for oral health. It has also impacted negatively upon the public sector's ability to recruit and retain dentists. As more privately insured people are accessing private dentists, this sector is attracting public sector dentists with higher remuneration packages than can be offered in the public system. A recent Australia Health Policy Institute paper has shown that dental care is the least subsidised area of health care. The indirect subsidy via the dental expenses taxation rebate is $23.2 million while the private dental insurance rebate is approximately $316 million to $345 million, which means that higher income people are receiving nearly five times the subsidy received by an age pensioner accessing public dental care.

Ms NOLAN: Minister, I have some questions now about mental health services. I refer to the $100 million mental health capital works program which is referred to on page 1-35 of the MPS. How many in-patient beds will there be for acute and forensic patients once the program is completed? How does this compare with what we had previously?

Mrs EDMOND: The mental health capital works program is nearing completion with the recent opening of the new forensic mental health facility at the park, the Centre for Mental Health, and in the Townsville Health Service District, which we look forward to opening in the near future. It has involved relocating in-patient facilities from the stand-alone psychiatric facilities at Toowoomba, Wolston Park and Charters Towers, and rural and regional centres. This is in line with our policy to enable the people of Queensland to have access to specialist mental health treatment closer to where they live with access to their family and support networks, which are vital elements of their recovery program.

The capital works program has delivered a range of new facilities, including extended treatment units, acquired brain injury units, community care units, dual diagnosis units, psychogeriatric facilities, child and youth acute units, adult acute units and forensic units. Mental health acute in-patient beds are now available in the following locations: Cairns, Townsville, Mackay, Rockhampton, Bundaberg, Maryborough, the Sunshine Coast, Redcliffe, Caboolture, the Prince Charles Hospital, the Royal Brisbane Hospital, the Royal Children's Hospital, the Princess Alexandra Hospital, the Mater Hospital, Logan/Beaudesert, Bayside, the Gold Coast, West Moreton and Toowoomba.

In addition, four special care suites have also been developed in Mount Isa and the Central Highlands. This provides a total of 696 mental health acute in-patient beds, including child and adolescent beds. Before the program began, there were a total of 609 acute beds in Queensland, so we now have an increase of 14.28 per cent in mental health acute beds alone. Also, all 98 forensic beds were located in the south-east, with 46 high-security beds in Wolston Park and 26 medium-security beds at Baillie Henderson and 26 at Wolston Park. The total number of forensic beds has increased to 170, a 73 per cent increase. These facilities ensure that we can provide appropriate services to meet offenders' clinical needs and the high level of security to protect the community from harm. We have 10 high-secure and 21 medium-secure beds in Townsville to ensure access for people who live in north Queensland. We have 61 high-secure beds and 34 medium-secure beds at the park—the Centre for Mental Health. There are also 24 medium-secure beds in the Toowoomba Health Service District and 20 at the Prince Charles Hospital.

Ms NOLAN: Minister, it is identified on page 21 of the MPS that future developments in mental health services will include the implementation of the Queensland forensic mental health policy. Can you please tell us what this will involve?

Mrs EDMOND: Cabinet endorsed the Queensland forensic mental health policy in April of this year—last financial year. This policy will guide the development and management of effective mental health services to mentally ill offenders to ensure timely access to the same range and quality of mental health services as those available to other members of the community. The policy will support the government's crime prevention strategy by improving the availability and range of mental health services available to offenders to meet their clinical needs and also to ensure the level of security required to protect the community from harm. It will improve early access to mental health assessment and treatment services following entry to the criminal justice system and ensure provision of adequate follow-up care to those who are released from hospital and/or custodial institutions.

Programs that ensure an appropriate continuum of care will lessen the likelihood of both clinical relapse and criminal recidivism. This policy establishes Queensland Health as the major provider of mental health services to mentally ill offenders. It establishes a continuum of care through the development of a range of new services, including court liaison services, prison mental health services and mental health services to watch-houses; enhancing the capacity of district mental health services to meet the needs of the mentally ill offender through establishment of consultation liaison services with specialist forensic services and by the provision of training and support to district mental health staff; access to acute secure care options—locally in most cases—and, where higher levels of security are required, in medium-secure units and in high-secure units; also, through enhanced funding of $1.4 million to provide for 16 additional community forensic mental health positions provided to district mental health services in 2002-03. Additional positions include one position based at the Royal Brisbane Hospital and district to improve measures to ensure that the health needs of the victims of crime by mentally ill offenders are met. A new 10-bed, high-secure and 21-bed medium-secure facility is scheduled to open in the near future in Townsville so that mentally ill offenders from north Queensland who require secure care can receive it closer to their families and support networks, and it is in their interests to do so.

Ms NOLAN: Minister, the MPS states also that an extra $1.4 million is provided to enhance forensic mental health services. How will this address the issue of patients absconding from care, and what other measures has the government put in place?

Mrs EDMOND: Significant progress has been made this year to improve Queensland's forensic mental health services including, as you mentioned, the enhanced funding of $1.4 million in 2002-03 to provide the 16 additional community forensic mental health positions. Queensland Health committed to fully implementing the recommendations of Professor Paul Mullen's review into forensic mental health systems and services in February this year. The first priority was to develop a joint Queensland Health-Police protocol to ensure a more coordinated response to locating and apprehending patients absent without approval. This protocol has been implemented throughout both services. Standardised information will be provided to police to assist with the location of an absent patient, and a policy has been developed regarding the provision of photographs of forensic patients on request by police. A memorandum of understanding has also been signed by Health and Police outlining respective responsibilities of the staff. All district mental health services and police services have received a copy of the

protocols and an implementation kit. A process of training and assisting in the establishment of local protocols throughout the state is being conducted.

A specialist classification has been established to identify patients who, if they were absent from treatment, would cause particular concern for the community. The newly established position of mental health risk management coordinator will ensure that there are appropriate information systems in place to monitor issues concerning persons of special notification and other forensic patients. To address concerns regarding the release of patients, limited community treatment or leave review committees have been established to review leave applications for forensic patients. These multidisciplinary committees provide an extra layer of review separate from the treatment team prior to a decision by the Mental Health Review Tribunal. In addition, a standardised leave plan for all forensic patients has been developed and is in place in all mental health services across the state. Rehabilitation programs are also under review.

In his report, Professor Mullen stated that with the opening of the new secure forensic units Queensland will have one of Australia's most sophisticated in-patient service systems. While there is always room for improvement, and we can never entirely eliminate risk, I am confident that the initiatives undertaken to date address the identified issues associated with patients absconding from care.

Mrs DESLEY SCOTT: Minister, I would like to move to drug and alcohol issues. What is the state government's level of funding to drug and alcohol initiatives in this state as mentioned on page 29 of the MPS, and how has this funding increased under the Beattie government?

Mrs EDMOND: In the 2001-02 financial year Queensland Health provided over $38 million in funding specifically dedicated to alcohol and drug related services. This comprised $28.6 million in state funding and $10.3 million in Commonwealth funding. Since the election of the Beattie government the amount of funding dedicated to alcohol and drug services has steadily increased. This is not simply funding allocated by the Queensland government. We have also managed to attract a significant amount of Commonwealth funding to Queensland.

Major initiatives of the Beattie government since its election which have resulted in increased state funding in this sector include: $3 million per annum for alcohol and drug crime prevention initiatives; $1.6 million per year for initiatives under the illicit drugs ministerial task force; $1 million from 2000-01 for health services for the drug court pilot program in south-east Queensland; $900,000 per year for the Queensland needle and syringe program; $400,000 per annum to implement the Queensland Tobacco Action Plan; and $500,000 for the Poison youth smoking campaign. This commitment has been further enhanced in the 2002-03 state budget with allocations to Queensland Health of $2.5 million per year to continue the drug court pilot in south-east Queensland and expand to north Queensland and $750,000 over three years for a project specifically targeting smoking and young women—a growing concern.

It should also be noted that it is not possible to estimate the considerable amount of alcohol and drug related work undertaken by generalist staff positions, such as staff in community health centres and accident emergency departments. Similarly the costs of providing the important preventive role of the school-based nurses and the Positive Parenting Program are not included. Therefore, the funding figures provided are an underestimate of the actual situation.

Mrs DESLEY SCOTT: Minister, page 28 mentions the provision of a 24-hour clean needle telephone help line. Has this service been well utilised, and what type of advice does it provide?

Mrs EDMOND: This service is part of a wider strategy on enhanced sharps disposal. This government has funded the establishment and ongoing provision of the 24-hour clean needle help line. The service cost just over $55,000 to establish and has an ongoing running cost of about $35,000 each year. The clean needle help line is available 24 hours a day seven days a week. It provides information on safe, legal disposal of injecting equipment. It liaises with councils regarding the collection of unsafely disposed of needles and syringes from public property. It provides referrals to councils and other organisations as required and provides advice on protocols for dealing with needle stick injuries. It can give information on literature on request to callers regarding safe disposal issues and provide information on locations of needle and syringe programs and disposal services.

The service has been very well utilised, with 229 calls being received between 1 March and 31 May 2002. Twenty-five per cent of the calls are from the Prince Charles Hospital Health Service District, 12 per cent are from the QEII and Bayside districts and 62 per cent are from other districts outside the Brisbane metropolitan area. Sixteen per cent of calls are from the general public, 42 per cent are from health and welfare professionals, 20 per cent are from business owners and

operators, 16 per cent are from local councils and six per cent are from none of the above. Forty-three per cent of calls related to unsafe disposal and equipment reported in garden beds, hotel accommodation, housing estates, roadways and schools. Fifteen per cent of calls have been legislative inquiries. Twelve per cent have requested information about programs. Forty-five per cent have been sent literature, 15 per cent have been given agency information and 15 per cent have been referred to other organisations. So it is a very useful service.

The CHAIR: The time for questions from government members has now expired.

Mrs PRATT: I would like to address the budget in a way that is perhaps more relevant to my electorate than most of the other questions have been. Minister, you stated earlier that you are very aware of the concerns of the South Burnett with regard to the future of Farrhome aged care facility and the placement of the residents there. Earlier you outlined plans to address aged care needs over a period of four years. In your previous statement you specifically mentioned the restructuring of Wondai Hospital. Will you give me a proposed start and possible completion date, if that work has actually been allocated in this year's budget? When do you believe it will actually start? Would the beds at Wondai accommodate all of Farrhome's beds? If not, where would the remainder of those beds be placed?

Mrs EDMOND: As the member would be aware, there has been massive community consultation going on about this issue in the South Burnett. The South Burnett Health Service District has requested improved distribution of its state government nursing home beds to provide this service closer to the people in their communities. At the moment there is a high concentration of nursing home beds in Kingaroy—30 state government and 90 private—with 32 state government beds in Wondai and none in the shires of Nanango, Murgon and Kilkivan.

The proposal is for the state government nursing home beds in Kingaroy to be moved as they become available to Nanango and Wondai. We are planning to rebuild the Weinholt centre at Wondai, to redevelop the existing hospital as the nursing home and the nursing home as the hospital to give us extra beds in Wondai. As those beds become available, as people no longer need Farrhome, over time we will reduce the commitment to Farrhome. So we are not looking to throw people out of Farrhome tomorrow. It will be done over time.

We are also looking at increasing the number of beds at the Weinholt nursing care unit from 32 to 46. We need to look at how we can manage the other beds in other places. That is certainly the proposal at the moment. Basically, the existing hospital's services can fit into the current nursing home building, so there will be upgrading of the Weinholt facility into an expanded 46-bed nursing home in what is currently the hospital facility.

Mrs PRATT: At this point can you say what Farrhome will be used for in the future?

Mrs EDMOND: We are looking at commencing the refurbishment in December of next year. Over $5 million has been allocated. There will be some refurbishment of the nursing home to fit the hospital.

Mrs PRATT: At this point do you have any plans for Farrhome?

Mrs EDMOND: Some minor work is being done to keep it going for the next few years—painting and vinyl replacement inside—but the aim is to gradually transfer those services more evenly across the electorate.

Mrs PRATT: I refer to non-government question on notice No. 3. I asked about the staff ratio per thousand head of population. I would like some clarification. The graph sets out the districts, the catchment area, staff and so on. It shows for Kingaroy an estimated population of 11,415 and for Wondai an estimated population of 4,041. Where did those figures come from and what are they actually referring to? The document shows 11,400 for Kingaroy, Nanango, Yarraman and Blackbutt and just over 4,000 for Wondai, Murgon, Cherbourg and Kilkivan.

Mrs EDMOND: I am advised that it is most likely the shire populations.

Mrs PRATT: Which shire, because you have mentioned three in one?

Mrs EDMOND: That would be all of those.

Mrs PRATT: Eleven thousand is close to the population of Kingaroy alone. Nanango has another 9,000-odd. Yarraman is part of Rosalie shire and Blackbutt is part of the Nanango shire. It is mixed.

Mrs EDMOND: I am advised that the district manager got those figures from the local governments in those districts. They would have advised us on that.

Mrs PRATT: You probably have the Kingaroy shire alone.

Mrs EDMOND: That is not my advice. Can we check that and come back to it in a minute?

Mrs PRATT: The reason I ask is that it throws out all of the figures. I am hoping that our health service budget is not calculated on that particular figure, because it is very wrong.

Mrs EDMOND: We will have to call and find out where the figures came from. They came from the district, so we will have to call Rosemary and see where she got those figures from. Do you mind if I report them later in the sitting? We will try to call her now.

Mrs PRATT: You can put it on notice, if you like.

Mrs EDMOND: We will try to get it tonight. If we do not, we will give it on notice.

Mrs PRATT: I know that these figures are definitely wrong. Would whoever compiled them be instructed to get them up to date? If any of our health budget is calculated on those figures, we are really being cheated out of a lot of things.

Mrs EDMOND: The health budgets are not calculated on those particular figures. Otherwise we would have those figures more accessible. The question you asked related to aged care beds. A lot of that work is done by the Commonwealth. It approves aged care beds and it does so based on statistical divisions. Budgets are worked out in a mixture of ways. One of them is historical. In fact, in country areas the budgets are above what they are in other areas because there is a certain level you cannot really go below in terms of staffing at places such as Wondai, Murgon and Cherbourg. Those hospitals have funding ahead of population funding.

Mrs PRATT: Four thousand is nearly the population of Cherbourg alone. Will you provide that information on notice if you do not get back to me today?

Mrs EDMOND: We will either get back to you today, before the end of this hearing, or we will take the question on notice. You asked about aged care numbers. The Commonwealth works out the number of beds based on the number of people over a certain age in the community. I wondered whether it related to that, but I am told that that is not the case.

Mrs PRATT: That is why I asked for clarification. Minister, you would be aware that many rural hospitals have lost their birthing units. Maryborough is about to lose its, with the birthing unit closure predicted for just after July. It has been reported to me that the Beattie government gave assurances to maintain Maryborough's birthing unit. The three local mayors and some of the government's own backbenchers whose constituents use this birthing centre are asking for the commitment to be realised. Is there any funding in the budget to ensure that the Maryborough birthing unit remains open? Will you assure this committee that no further rural or regional birthing units will be shut?

Mrs EDMOND: The issue of the Maryborough birthing unit is nothing to do with funding; it is to do with the fact that we have advertised and advertised and advertised—as has the private hospital in Maryborough—without success. One of the reasons for that is the numbers. My understanding is that the numbers are quite low. The numbers of births at Maryborough Hospital have been falling for many, many years. That has been one of the problems.

Certainly the vacant VMO obstetrician/gynaecologist position at Maryborough has been advertised both by the Fraser Coast Health Service District and St Stephen's Private Hospital. They have worked together. Negotiations are proceeding with a prospective applicant. The district is working with local service providers to establish a safe arrangement for a sustainable obstetric service for the district given the available specialist and senior medical staff.

Obviously, if there is not enough work for a number of people, it means that the after hours becomes very onerous if it is all on one person. So we have to work out ways of managing that with the clinicians who are in Maryborough. These decisions are being made locally in consultation with the clinical staff, the medical specialists, the general practitioners, St Stephen's Private Hospital and the community. They have all been working together to try to resolve this issue. Certainly we want to have a sustainable and a safe service. It is not because of a lack of funding; it has been because we have not been able to attract people to that position.

Mrs PRATT: You were just saying that you were interviewing applicants at the moment.

Mrs EDMOND: I am advised—this is quite new—that negotiations are proceeding with a prospective applicant at the moment. Up until I read that, the last one I had seen said that there had not been a response. So I am delighted to say that there is now a possibility that it will be covered. But it is not because funding has been cut; it is not because of a funding issue. It has been because we have had enormous difficulty attracting anyone to that position because of

declining birth numbers in the area. We have been working with the private hospital in the area, St Stephen's, to try to resolve it.

Mrs PRATT: So you are saying that there is money in the budget. If a successful applicant was employed, it would remain open?

Mrs EDMOND: There is still an issue that if there is one applicant, he cannot be on call 24 hours, 365 days. So we will still have to make arrangements. My understanding is that they are the things that will need to be negotiated with him—or her. Most obstetricians are still male, so I think I am safe with 'him'. That will have to be worked out with him—or with the successful applicant, if there is one—and with the GPs, the clinicians, et cetera, involved as to how much support they can provide.

Mrs PRATT: I know I am labouring the point a bit, but, basically, if you could get one obstetrician there and an arrangement could be made that he have time off and people just go to Hervey Bay rather than everybody go to Hervey Bay, that would be acceptable?

Mrs EDMOND: Yes. It might mean that sometimes, to give him a break, there will have to be times when they will have to go to Hervey Bay out of hours or something. But we have got to work through those things. First of all, we have to get someone.

Mrs PRATT: But that is looking hopeful.

Mrs EDMOND: That is looking hopeful. I have just been advised that we are not going to be able to confirm those numbers tonight. So we will take that on notice and get them back to you on Tuesday.

Mrs PRATT: All right. I have listened all afternoon. You have talked a lot about flexibility in the portfolio and trying to work things together. I have had a lot of people come to me about the public dental system. They have real concerns about the limited services that they can have. I ask: if someone wants to undergo an alternative to an extraction or a filling—they want a cap or something—is there enough flexibility to implement a policy whereby the patients could receive alternative treatment through a referral process to a private dentist and have the amount of that treatment credited and they pay the balance? It would not impact that much on the dental health budget but would be a benefit by decreasing the waiting list and preserving the person's teeth a little longer.

Mrs EDMOND: No, I do not think we have that flexibility. Restorative and preventive treatment is done in the public system, but we do not do cosmetic. There will be times when it is just not appropriate. Some people want very, very expensive alternative treatment. We simply cannot do it. I fully admit that our oral health program is under enormous stress. We have more and more people being eligible. The Commonwealth has in several years changed the criteria for the health care card that made more people eligible in Queensland. We have the widest eligibility criteria of any state and we are drowning, I guess, in oral health.

One of the things that is really disturbing is that all of the extra funding that is going into private health insurance is making it harder for us. We recently lost a number of dentists at the Gold Coast because they can earn so much more in the private system. There is a big demand because lots more people are having work done in the private system, but we are also having rapidly increasing numbers in the public system. That is one of the big concerns that we have. The other states have resolved this issue. They do not have complaints about waiting lists or the services, because they do not have the services.

Mrs PRATT: Finally—

Mrs EDMOND: We do not want to go there.

Mrs PRATT: Finally, you mentioned the need to improve mental health services and that significant funds have been allocated to the budget for this area of health. Mental health issues have been recognised as a priority in the South Burnett and Wide Bay area. What allocations for funding have specifically been targeted to the South Burnett mental health issue?

Mrs EDMOND: At this stage the district budgets have not been allocated, so I cannot give you that figure. But we have put on a significant number of mental health nurses. In terms of retention, you would be interested to know that we fund about 80 scholarships for mental health nurses to do their mental health training. Those are not bonded, because there is a shortage in both the public and the private mental health area and we just provide them.

We certainly have increased both community mental health nurses and general numbers across the state. But as I said, we have not got the breakdown for district budgets at this stage.

That actually really gets rolled out over the year as different programs are enacted. We have allocated an extra $6.7 million for the full-year effect of the 103 community positions that we created last year and for the creation of an additional 56 new positions this financial year in community mental health.

Mrs PRATT: You do recognise that it is a major issue.

Mrs EDMOND: I do recognise that it is a major issue. Indeed, every year we have significantly increased the funding in mental health, it is fair to say, more than other areas of health, because it was significantly underfunded in the past. I have just been advised that the mental health scholarships are now 93. So we have increased the number of people who are getting mental health scholarships.

In terms of mental health funding, we have significantly increased it year by year and have improved our position. We used to be at the bottom of the ladder, I think. According to the latest national mental health report, Queensland's expenditure in 1999-2000 was 63 per cent higher than it was in 1992-93—equivalent to a 42 per cent per capita increase and twice the national growth rate over that period. So we have recognised that.

I think it is fair to say that if you go back to 1990-92, at the time of the Burdekin report, it was a disgrace. Mental health in Queensland until 1990 was a disgrace. We had Ward 10B in Townsville. We had the issues that were identified in the Burdekin report. We have really been working very, very hard to address that with our mental health capital works program providing much better resources, including and in particular the community care options that you would have seen—and if you have not, I would be happy to have someone show you—for people with long-term psychiatric illness who may never be able to manage on their own in the community, who do not need close supervision but need somebody there so they have staffing on 24 hours. We have also improved significantly the community mental health services so that we can keep people at home in the community as much as we possibly can.

The CHAIR: The time allotted for non-government members' questions has now expired.

Mrs DESLEY SCOTT: There has been a lot of talk about a rise in amphetamine use in Queensland. How does the Queensland Illicit Drugs Action Plan mentioned on page 29 of the MPS address this, and what types of services are available?

Mrs EDMOND: Amphetamine use in Queensland has been identified as a significant problem. I remember it was raised when I was on the Parliamentary Criminal Justice Committee. It was probably a bigger problem at that time than even heroin, and certainly it has been increasing.

The development of the Queensland Illicit Drugs Action Plan is currently being led by my department on behalf of the whole-of-government Queensland Drug Coordinating Committee. This action plan will provide a range of strategies for addressing all illicit drug use in a comprehensive manner in the six areas of demand reduction, supply reduction, treatment, harm reduction, work force development and research.

In relation to specific services, amphetamine users seeking treatment for their drug use can access alcohol, tobacco and other drug services throughout the state. Such treatment includes assessment, ongoing counselling and support, and referral. The important point is that people who do present at hospitals with any drug problem will either be admitted or referred to non-government organisations or other services that can assess and recommend other forms of treatment or counselling.

It should be noted that there is no replacement pharmacotherapy for amphetamines. Treatment options for amphetamines may include immediate medical assistance, an outpatient counselling treatment plan, referral to a more appropriate agency, managed withdrawal, or referral to residential treatment. In-patient treatment in an acute care facility—that is, a hospital—is warranted in two instances: firstly, when amphetamine related psychosis is evident; and, secondly, when medical complications are evident, such as local or generalised infections.

Apart from the statewide treatment options available, some facilities are specifically designed for short-term withdrawal management, such as the Adolescent Drug and Alcohol Withdrawal Service at the Mater Hospital. It is anticipated that this service will be rolled out this year to include training in rural areas for referral to the service. Where there is evidence of a dual drug misuse and mental health problems, people are also linked into available mental health services.

Some specific activities with an amphetamine focus include: the Commonwealth-produced training package From Go to Whoa, the amphetamine trainers package for health professionals, a pilot project involving a seven-session cognitive behavioural treatment intervention with

amphetamine users; the Queensland Needle and Syringe Program is collaborating in statewide key informant research into amphetamine related harms; the Rave Safe peer education support strategy; and, in collaboration with Queensland Health, the Queensland Police Service has commissioned the development of a training package for police to deal with drug-affected individuals at street level, with particular emphasis on amphetamines. This government is intent on breaking the cycle, but it is recognised as a difficult issue to deal with.

Ms BARRY: I will move on to a subject that I know you are absolutely committed to, and that is the serious concern of underage smoking. I note on page 29 of the MPS that it says that you have introduced legislation particularly targeting the sale of cigarettes to minors. Can you please tell the committee how this will work in practice and whether it is the only strategy that you have in place to prevent youth smoking.

Mrs EDMOND: We are concerned very much about our young people smoking. It is a major concern because we know the harmful effects of smoking are cumulative. Anti-smoking measures for young people are important because research shows that it is a sad fact that eight out of 10 new smokers are children or teenagers under 18, and a lot of them are women. I think that is one of the scary things.

Research tells us that youth smoking must be addressed comprehensively, not by a single campaign. The government's Queensland Tobacco Action Plan, the blueprint for tobacco control activities in Queensland, tackles youth smoking on many fronts, including tobacco advertising legislation, cigarette vending machine laws, not selling to minors, youth health nurses in our schools, youth anti-drug mass media campaigns and school based drug education.

Under the new legislation, advertising and display of smoking products in retail outlets is greatly restricted. It is a known fact that advertising works in selling products. That is why they do it and that is why they pay a lot of money to do it. What we are concerned about is the effect that tobacco advertising has on our young people. Research shows that young people are more sensitive to tobacco advertising and promotions than adults. Children's exposure and receptivity to tobacco advertising is an important factor in whether they start smoking. In practice, children's exposure to tobacco advertising will be greatly restricted.

Access to cigarettes through over-the-counter sales and via vending machines is an important factor in the uptake of smoking by children. The legislation also involves a range of provisions to improve monitoring and enforcement of the act, including retailers selling smoking products and persons in charge of vending machines being required to instruct employees and acknowledge in writing that they must not supply smoking products to children and that they are to ask for proof of age unless a person is clearly over 18 years of age. That leaves you and I out.

Mrs DESLEY SCOTT: Just.

Mrs EDMOND: Tightening the legislation to only allow for vending machines in bar and gaming areas of liquor licensed premises, the legislation also increases the maximum penalties for offences under the act. The penalty for the main offence under the act, selling a product to a child, is to be increased from a maximum of $975 to $5,250 for a first offence and up to $10,500 for a second or later offence.

The monitoring and enforcement provisions under the act have been substantially revised in light of the expanded focus of the legislation. For example, authorised persons will be able to issue improvement notices to redress contraventions. Individuals and businesses will be provided with clear directions regarding the steps they must take. Of course, to complement these legislative changes, the youth health nurses will receive specialist training and resources to promote positive smoke free messages and help young people quit smoking. The nurses will be able to help students on the spot in their schools. The government has also committed $620,000 to expand a successful Poison youth anti-smoking campaign.

Mrs DESLEY SCOTT: How much money has been allocated to target indigenous smoking, as per page 29 of the MPS, and what is the difference between this and other smoking programs?

Mrs EDMOND: One of the problems with indigenous smoking is the fact that the proportion of indigenous people who smoke is more than twice the national average. In north Queensland indigenous communities, 62 per cent of men and 51 per cent of women aged 15 and over are regular smokers. This compares to 26 per cent of men and 23 per cent of women for all of Queensland. As a consequence, the smoking death rate is about three times higher for indigenous people than the Queensland average.

Historically, approaches to addressing smoking in indigenous communities were ad hoc, and mainstream quit smoking campaigns have had little, if no, impact. Evidence suggests that the best way to tackle the tobacco problem is through a culturally effective, comprehensive approach. In 2001-02, Queensland Health spent $210,000 on the pilot Indigenous Smoke Free Project. This project is Australia's first and only comprehensive pilot project designed to address smoking issues for Aboriginals and Torres Strait Islanders.

Strategies being piloted include raising awareness of the dangers of smoking among indigenous communities, group-based quit programs, brief intervention, quit advice, assisting workplaces and community venues to address smoking issues including providing smoke-free areas, limiting smoke breaks and providing on-site help for smokers wanting to quit, and increased training for front-line health workers. $145,000 has been allocated from the Queensland Tobacco Action Plan implementation budget to support the statewide roll-out of two completed pilot strategies, namely, the awareness raising program and brief intervention training for health workers. The approaches and materials used in the project have been developed in close consultation with indigenous communities in the Brisbane area and in north Queensland. They are different from other smoking programs in that they specifically address the needs of local communities. Queensland's indigenous population is not a homogenous one, with communities in different areas having very different cultural terms of reference. For this reason, the materials have been designed in a way that allows them to be altered for use in different communities. It is important that, in recognising this work we are doing on indigenous smoking, smoking is of course a major player in the poor outcomes for indigenous health.

Ms BARRY: I refer to page 2-9 of the MPS. What health strategies are being introduced to reduce alcohol-related crime and violence for indigenous people and at what cost?

Mrs EDMOND: Again, this is an important question. If we could get smoking and alcohol to reduced levels in the communities, we would really improve the health outcomes for those people. Queensland Health has allocated recurrent funding of over $800,000 to develop integrated indigenous alcohol and drug services in the far north and north-west. This funding is provided through the alcohol and drug strategies crime prevention new initiative. A project officer has recently been appointed to the northern zone management unit to coordinate the development and implementation of this initiative. This initiative focuses on indigenous communities and takes a community development approach, with the aim of reducing excessive alcohol consumption and associated crime and violence. To achieve this aim, community-based project officers are currently being appointed in 11 communities. These officers will work with individuals, families and other groups such as local justice groups on initiatives that reflect local community concerns, priorities and capacity. Project officers will be appointed in Cooktown, serving also Hopevale and Wujal Wujal, Yarrabah, Lockhart River, Pormpuraaw, Aurukun, Weipa, Napranum, Kowanyama, Mornington Island, Normanton and Doomadgee. Activities being implemented by project officers reflect the varying needs within the local communities. This initiative will complement the initiatives by Queensland Health in response to the report of the Cape York Justice Study and these include training and support for health workers in areas of prevention and reduction of alcohol and substance abuse; develop appropriate models of treatment and rehabilitation services in the Cape; support for community responses including use of outstations for diversion, developing and implementing models of treatment rehabilitation, including the establishment of a new rehabilitation service hub for residents in the northern peninsula area; improved counselling responses in areas of alcohol and substance abuse prevention; impact of abuse on families and life skills; and supporting Apunipima Cape York Health Council to undertake health research into the incidence and intervention required to reduce foetal alcohol syndrome. There is a lot happening in that area.

The committee suspended from 5.53 p.m. to 6.00 p.m.

Mrs EDMOND: I told the committee that I would inform it if there was any advice from the commission. I have just been informed that the commission has directed that bans for nurses not remain in place.

Mr CHAIRMAN: The time for government members' questions has now expired.

Miss SIMPSON: I note that the minister has indicated that she is unwilling to answer questions as to the figures for cancelled or postponed surgery. While we are willing to wait, many Queensland patients really do not have that choice. My question relates to page 1-7 of the portfolio statements. I refer the minister to her previous advice to parliament when asked about the number of vacancies of dentists in the public system. The minister claimed that there were only 20 dental positions not permanently occupied out of a work force of 300 dentists in

Queensland as at March 2002. Was the minister telling the full and complete truth? I refer the minister to actual figures, which I table, that show that dental vacancies amounted to 78.56 dentists or 28.78 positions not occupied and 49.78 positions vacant. Did the minister mislead the House? Can the minister explain?

Mrs EDMOND: The figures will change depending on when the question is asked for the simple reason that people are employed and people leave. One of the issues we have had recently—

Miss SIMPSON: Over a three-week period?

Mrs EDMOND: I do not have access to what the member is referring to. If I could see that it might help. One of the issues we have had on the Gold Coast recently has been a number of people leaving as a result—

Miss SIMPSON: Minister, your director of oral health services would have those figures. Perhaps the minister can answer the question about vacancies in the not occupied positions within Queensland Health for dentists.

Mrs EDMOND: The advice I would have given to parliament would have also come from the department.I am advised that the current number of vacancies is 30, which is less than 10 per cent of dental positions in Queensland.

Miss SIMPSON: As at April, which is fairly close to the date of the question asked in the parliament, I understand there were 28.78 not occupied positions and 49.78 full-time equivalent vacant positions. The advice given previously in response to the member's question would have also come from the department. Sometimes this is a timing issue.

Mr EVANS: The current vacancies are of the order of about 30. They were of the order of about 30 in April, as I understand it. There may be some confusion about how the vacancies are recorded, because we do have a large number of locums in positions for short terms and that reduces the overall number of actual vacancies. Characteristically, we have been at around 30 for the first six months of this year.

Mrs EDMOND: So if it is filled by a locum it is not counted as a vacancy in terms of not having a dentist there?

Mr EVANS: It is a vacant position, but it shows as a position that is filled.

Miss SIMPSON: Are all of those other positions filled by locums?

Mr EVANS: I am sorry?

Miss SIMPSON: So there are 49.78 full-time equivalents as distinct from the not occupied positions?

Mr EVANS: That is right.

Miss SIMPSON: Are all of those positions fully filled by locals?

Mr EVANS: There are about 30 actual vacancies, which means there are always about 20 locums—usually interstate graduates, UK graduates, Irish graduates, short termers.

Miss SIMPSON: That still does not address those figures. Can we get some advice on notice in regard to that document that has been tabled and take that as a question on notice?

Mr EVANS: I am not familiar with the document.

The CHAIR: Do we need clarification?

Miss SIMPSON: Yes, I would like clarification.

Mrs EDMOND: What is the source of the document? Can we clarify that?

The CHAIR: That is what I am asking for.

Miss SIMPSON: The information has come from dentists. I guess the question is what the difference is between the not occupied and the vacant positions. I seek clarification as to whether vacant positions where there is no present incumbent—and they may or may not be temporary or casual—are filled by a locum. That still is not clear. I understand that there are two different figures.

Mrs EDMOND: Obviously, where there is a vacant oral health position we would rather fill it with a locum while we are advertising and recruiting, particularly if it is one that is difficult to fill. At every opportunity we fill them with locums. We do not know whether this is factual information.

Miss SIMPSON: That is why I am presenting it to you. How many people do you have operating in locum positions awaiting the position to be filled through advertising or other means, for example, when someone is on maternity leave? We are trying to clarify the difference between not occupied positions and those that are vacant but may have some locums.

The CHAIR: So that is your question to be put on notice?

Miss SIMPSON: That is right. I seek also a clarification of the figures as they stand.

Mrs EDMOND: If you would like to explain it to us, it might help us interpret the document.

Miss SIMPSON: I have just explained that that first column is to do with not occupied positions where I believe no-one is currently working in that position. The second column, I understand, are vacant positions with no present incumbent and there may or may not be temporary or casual persons in that position. Could we get the figures as to what the actual vacancies are and be clear about the number of positions where people may be acting in those roles?

Mrs EDMOND: There are some difficulties with that. I take you to the top of the list. It states that the number of full-time equivalent positions in Cairns is 1.8, but the number that are vacant—

Miss SIMPSON: Vacancies.

Mrs EDMOND: Sorry?

Miss SIMPSON: That is not the total of the staff positions for Cairns.

Mrs EDMOND: But you are saying that the next line is the number that are not occupied, and it says 9.8. That is just nonsensical.

Miss SIMPSON: Minister, I am not asking about the staff complement on the books. I am asking as to what the vacancy rate is, and whether it is not occupied or occupied but by a locum.

Mrs EDMOND: We will have to take it on notice and see if we can make some sense out of it.

The CHAIR: Could you return the document to the committee, please. Would you like a copy?

Mrs EDMOND: Yes, please. Could we get a copy of it.

Miss SIMPSON: That is why I wanted to present that. There is a lot of concern about the level of vacancy and also whether those positions are filled by locums. My next question is in regard to—

Mrs EDMOND: Are we getting three minutes to answer?

The CHAIR: Is that a question?

Miss SIMPSON: No, my question is in regard to the portfolio statement and Robina. It could be pages 2-10, 1-6 or 1-36. I ask you in regard to Robina: as Queensland taxpayers are entitled to know whether money spent on Robina Hospital is money well spent by the Beattie government, will you be accountable to the parliament and reveal how much the state government has spent to acquire St Vincents Robina?

Mrs EDMOND: The negotiations with Robina have a commercial-in-confidence rider over that for obvious reasons. The Sisters of Charity, who were in charge of Robina, would not want it in the public arena how much they got paid. They have a range of commercial contracts. They would not want that in the public arena. It was mutually agreed that this would be commercial-in-confidence.

What I can say is that of course this arrangement was one that was rushed into by the coalition government I think four hours before the election was called in 1998. Just after becoming the Minister for Health, I had a number of people come to lobby me about these arrangements in various places in the state. They asked me to give a commitment that I would continue with those contracts. The reason they did that was that I had been quite open in parliament about the issue. I had raised the Auditor-General's reports from West Australia and New South Wales and comments from Victoria about the fact that these proposals very rarely worked. In fact, they were considered a disgrace, I think, by the auditors-general in New South Wales and Western Australia. So I had major concerns about the use of taxpayers' funds going into a build, own and operate scheme.

I have great regard for the Sisters of Charity and the work they do in New South Wales and indeed in Queensland at Mount Olivet and other places. Obviously, if anyone had been able to make it work I guess they would have. But these arrangements are really built on a premise that the public health system is inefficient and that we overpay our staff, because they usually rely on

paying their nursing and other staff less and their administrative staff more than we do in the public system. But I have to say that I do not believe that. I believe that in Queensland in particular we run a very efficient and effective public health system. So I was concerned about it. I raised concerns about it. I indeed raised concerns about the Moe Hospital in the Latrobe Valley. That was held up in parliament at the time by the then Treasurer, Mrs Sheldon, as a wonderful example of how this worked. I was surprised at that because at that time it was still a hole in the ground. However, I can say that the Latrobe Valley Hospital is back in the hands of the Victorian government. It also had to rescue it and its rescue package was also confidential.

Miss SIMPSON: Minister, I note that you are wanting to keep those details secret regardless of what the sisters have asked for. It is still a responsibility of the government to be accountable for those figures. Your staff told me this week that you will be calling for tenders for providers to operate the private sector of the hospital. Is this a fait accompli or do you have other contingencies in place to help you pay back Treasury?

Mrs EDMOND: We have actually said quite publicly and openly that Queensland Health is taking over the running of the public sector of the Robina Hospital, and indeed this will be done from the Gold Coast Hospital and will be integrated as part of the Gold Coast District Health Service. I think that that will mean that we can provide a much better service to the people on the Gold Coast. In terms of the private facility, inquiries have been made about what we are going to do with that. I have said quite up front that I do not see Queensland Health's role as running a private hospital. For the interim, those beds are closed. The full-time staff at Robina Hospital, other than contractual staff, have all been given a guarantee that their jobs will continue and—

Miss SIMPSON: Will the minister give a guarantee that all the public services and their casemix prior to takeover will remain?

Mrs EDMOND: We have already given a guarantee that the services that are currently being provided will continue and that the permanent staff will retain their jobs. Obviously that has meant some adjustment of salaries, et cetera, but we are doing that. With regard to the private hospital, which you asked me about and would not let me answer, we have indicated that it is not our position to run a private hospital. We have since then had inquiries by a number of operators in terms of whether or not they would be able to access and look at running those beds for Queensland Health. Once we have done a study of the service and all the rest of it and if we believe it is possible to run a separate private health service from that area, it will go out to open tender. We will call for expressions of interest and go through a proper process and be open. It will not be some behind-the-door deal a couple of hours out from an election.

Miss SIMPSON: Minister, it is interesting that you think that the Sisters of Charity do behind-the-door deals in that way. It went through a very due process. Minister, I refer you to the review of the accident and emergency section—

Mrs EDMOND: It was not an open process. It was not a process that was available to the public. The contract was not available to the public.

Miss SIMPSON: I have not asked my question so please do not tick the time over. Minister, I refer to the review of the accident and emergency section of Nambour Hospital. What were the full recommendations? Have they been met with this budget and, if so, how?

Mrs EDMOND: There was a review of the emergency department. My understanding is that it was an internal operational review done at the Nambour Hospital. My understanding is that they are implementing it. Of course, part of the problem arises from the constraints of their current accommodation. Moving into the new part of the Nambour Hospital will make that easier. My understanding is that the issues that were raised through that review have been met. One of the issues was a bed block issue in terms of a high demand for beds. Opening up the extra 30 beds when the hospital is completed in early August will relieve that bed block pressure and will enable people to get out of the emergency department and admitted at a faster rate. I do not actually have a report on that because it was a local operational report where they were looking at how they could improve those services, but my understanding is that they are implementing the recommendations from that report. I think that is the best we can do at the moment. We understand that most of the issues that they have raised have been addressed.

Miss SIMPSON: There were issues to do with additional positions that had to be funded. That is why I asked that question in relation to this budget. Have they in fact been funded?

Mrs EDMOND: There is funding in the budget for an extra 16 emergency specialists across Queensland.

Miss SIMPSON: What about Nambour?

Mrs EDMOND: That has to be determined. We will need to look at the figures and determine which ones are needed most. I do not know that those allocations have actually been made. In relation to that extra allocation of emergency funding, we will look at the profiles of patients, what criteria they are—that is, whether they are category 1, 2, 3, 4 or 5—the emergency department figures and how we can better handle that, et cetera. But my understanding is that one of the biggest issues that they have faced has been the constraints of the actual emergency department. The Department of Emergency Medicine is part of what will move into the new building which will give them extra capacity and extra room. As I said, the analysis will be done of emergency departments around Queensland looking at where the need for the 16 extra emergency staff is.

Miss SIMPSON: Minister, I refer to mental health funding and to the fact that the state contribution to mental health funding has fallen in this budget from $357.743 million in 2000-01 and $220.280 million for 2001-02. The state's contribution for recurrent mental health funding for 2002-03 will be $234,877,000. Why has the state fallen off the pace as far as its contribution for mental health funding is concerned?

Mrs EDMOND: I am not sure how you are calculating that, because—

Miss SIMPSON: That is the state's contribution as opposed to other sources, primarily federal funding.

Mrs EDMOND: This government has provided an additional $10.6 million for mental health services throughout Queensland for this year. This amount includes an allocation of $4.9 million to cover the full year effect of 103 community mental health positions.

Miss SIMPSON: How do you explain the state contribution versus the Commonwealth there? I am interested to know why in this particular budget paper there is actually a lower state contribution although there is a larger other source, primarily being federal contribution.

Mrs EDMOND: We think you are looking at a change in how these are reported. There has not been a drop-off in increases in state funding. The state has been very, very conscientious in increasing funding to mental health services throughout the state. I gave you the figures before that showed that since 1992 we have had a massive increase equivalent to a 42 per cent per capita increase and twice the national average growth rate. It is very difficult to describe from those figures that there has been a reduction in the effort from Queensland.

The CHAIR: The time allocated for non-government members' questions has now expired. I call the member for Aspley.

Mrs EDMOND: We cannot see how she can possibly say that that has decreased.

The CHAIR: We have moved on to the member for Aspley now.

Ms BARRY: I want to ask a couple of questions about the health of children and young people. I refer to page 30 of the MPS concerning immunisation rates for children at two years of age. Minister, are the rates of childhood immunisation increasing, and how does Queensland's rate compare with national figures?

Mrs EDMOND: This is a fantastic success story. I am pleased to announce that 88.46 per cent of children who are two years of age in Queensland are fully vaccinated as measured by the Australian Childhood Immunisation Register. This is an increase of more than 20 per cent since July 1998. The ACIR figures have been used to report on this cohort as it enables a comparison with national coverage. Queensland's rate compares favourably with the national coverage for the same cohort, which is currently 88.09 per cent. Queensland is consistently in the top three states and territories for coverage of this age group. The target for coverage is 95 per cent of children vaccinated with the fourth dose of DTP and Hib vaccines, third dose of OPV and first dose of MMR.

In July 2002 coverage data on children six years of age was publicly released by the ACIR for the first time since the establishment of the register in 1996. The data shows that 82.61 per cent of Queensland children are fully vaccinated. National coverage for the same cohort is 80.6 per cent. As with the data on other cohorts, coverage for this new group can be expected to increase over time. In regard to other age groups, 93.3 per cent of children who are one year of age in Queensland are fully vaccinated as measured on the Vaccination Information Vaccine Administration System, or VIVAS, which was introduced under Minister Hayward. This rate has increased from 84.2 per cent in July 1998. This includes all children who receive the third dose of DTP vaccine, Hib vaccine and OPV vaccine by the age of 12 months. A total of 95.1 per cent of

children have had MMR vaccine by the time they are 18 months old, as measured on VIVAS. This is an increase from 89.7 per cent in July 1998. This coverage data is very encouraging, and I would like to congratulate all those involved in the program in Queensland—both public and private sectors. This is an important measure in keeping our young people safe from serious illnesses that used to affect people in the past. We often hear people describe measles, et cetera, as just another childhood disease, but it can have quite serious consequences.

Ms BARRY: It is very critical and effective data collection, and I congratulate you on that, Minister. What else is critical is meningococcal. Page 57 of the MPS refers to the meningococcal awareness campaign. Can you tell the committee what has been done to enhance the annual meningococcal awareness campaign?

Mrs EDMOND: Last year we saw an increase in this very dreadful and very fast acting disease. We have made a determined effort this year to have Queensland's biggest public health campaign for meningococcal disease both in funding committed and the scope of communication. In April I announced that the annual Queensland Health awareness campaign on meningococcal disease had been stepped up and launched a month earlier than normal. This is in response to the increasing cases we saw in 2001 and are seeing again this year and should improve the early detection and clinical management of this disease and hence result in better outcomes for those infected, although it is sad that there has already been a death this year.

The awareness campaign has been enhanced in 2002 by the following initiatives. The GP resource—that is, a poster, brochure and card—was updated and distributed to general practitioners across the state at the end of May. A new resource for emergency departments and intensive care units—a poster—is currently being distributed, and a small wallet sized card has been distributed to all emergency department doctors. A brochure for the general public has been prepared and distributed to all GP practices and public health units. The department has conducted a series of dinner seminars for general practitioners across the state to promote awareness of meningococcal infection and the appropriate response. These have been very well attended, reflecting the high level of interest in meningococcal disease among general practitioners. The public health response to meningococcal disease in Queensland is consistent with the recently updated national guidelines. On a national level, the poster designed for GPs in Queensland has been taken up and utilised by the Commonwealth for distribution among GPs around the country.

As of 10 July 2002 there had been 50 cases of invasive meningococcal disease in Queensland in 2002. Only one of these cases has died. At the same time last year there were 49 cases and three deaths. A new conjugate vaccine has been launched to protect against one group, group C meningococcal disease. It is important to understand that the vaccine does not protect against the most common sero group that occurs in Queensland. The vaccine has been made available by private prescription. However, recently the vaccine company Wyeth announced that unprecedented demand both in Australia and globally has resulted in there being a shortage of vaccine supply. Wyeth has set aside 10,000 doses for urgent public health responses throughout Australia and is providing the remaining vaccine to consumers through pharmacies. As the vaccine is in short supply, however, individuals have not been able to access the vaccine. Two other vaccine companies manufacture a conjugated vaccine against group C meningococcal disease. The Therapeutic Goods Administration is currently considering applications from these companies for these vaccines to be made available in Australia. When they become available this may alleviate the shortage.

Ms NOLAN: Minister, page 14 of the MPS states that the West Moreton health service district has implemented the family care nurse home visiting program and increased access to positive parenting programs. How has this been achieved, and how many parents have accessed the programs since they were started?

Mrs EDMOND: The Beattie Labor government recognises that early intervention is the key to strengthening and supporting families and preventing future problems. That is why we committed to expanding child health services in the 2001 state election. Delivering on this election commitment, the West Moreton health service district has allocated funds over three years for the early intervention for safe and healthy families initiative and the expanded child health initiative. This additional funding enables the West Moreton health service district to enhance the range of and access to health services for infants, children and their families through the implementation of programs such as the early intervention project, which integrates the family care nurse home visiting program with Queensland Health's domestic violence initiative. This is an evidence based home visiting service that targets families with newborns at risk of poor health and social

outcomes due to key risk factors that include family violence, financial stress and maternal depression. In March 2002 two nurses, two social workers and one paediatrician from the West Moreton health service district were trained as family care trainers, and they have trained 30 additional staff from Queensland Health and other appropriate government and non-government agencies. Regular case conferences discussing family care clients include necessary representatives from community health and hospital services.

Since commencing antenatal assessments in April 2002, 39 families have been identified as eligible family care clients and are presently being supported by hospital or community health social workers. An estimated 90 to 100 West Moreton families are expected to benefit from this program each year. PPP is focused on parents of children aged 18 months to eight years of age where the evidence supporting the program is strongest. Once trained and accredited, child health staff work with parents to impart a range of parenting skills which help parents recognise and respond to common behavioural problems and assist in building positive relationships with their children. It is provided through community and/or child health centres across the state. In West Moreton during 2001, 39 group programs were offered, reaching over 380 families.

Ms BARRY: Page 36 of the MPS refers to an allocation of more than $38 million for health technology. In particular, how will the Prince Charles Hospital and district benefit from this?

Mrs EDMOND: I know that this is an area the member is particularly interested in. A lot of exciting things have been happening at Prince Charles. In particular, this year we have allocated $38 million for the replacement and enhancement of health technology across Queensland. The Prince Charles Hospital and health service district will receive over $3 million for the replacement and enhancement of electrophysiology equipment, a gamma camera, an x-ray unit to do digital chest studies, a Holter monitoring system, an image intensifier x-ray unit, an ultrasound unit, a haemofiltration unit, eight defibrillators and three electrocardiographs.

This investment of over $3 million at the Prince Charles Hospital and health service district is a commitment to providing modern health technology equipment to Queensland Health staff for the delivery of world-class health services. The investment represents the ongoing commitment of the government to investing in the health of Queenslanders. The replacement of this equipment will assist in improving health outcomes, reducing risk to Queenslanders and attracting and retaining a highly skilled work force. I expect all items to be delivered and all funds to be expended in this financial year.

This is a part of a total package of $4.5 million to be injected into the Prince Charles Hospital health service which also includes extra funding that will allow the hospital to support the continued provision of care for patients suffering from cystic fibrosis and for lung transplant recipients after surgery. Additional funding of $271,000 has been given to the Prince Charles Hospital acute in-patient mental health unit. This funding will increase the nursing and medical staff available in the unit, allowing additional high dependency beds to be used. It is good news for Prince Charles.

The CHAIR: Minister, how will the allocation for health technology benefit the people of Logan?

Mrs EDMOND: Again I suspect that there is a tiny bit of local interest in this. As I mentioned, the Beattie government has allocated $38 million across the state. The Logan-Beaudesert health service district in particular will receive $575,000. The Logan Hospital will receive endoscopic equipment, two cardiotocographs for monitoring newborn babies, four patient monitors, a disinfector, hoists, two ventilators and electrosurgical units. The Beaudesert Hospital will receive a fixed x-ray unit, trolleys, patient equipment, an ultrasonic cleaner, a drying cabinet, an anaesthetic machine, a defibrillator, cardiotocographs, a patient monitor, lights and electrosurgical units.

An additional $21,000 will be spent on general medical devices across the district. This investment of $575,000 represents Queensland Health's commitment to providing world-class health services to the people of Logan. New equipment will improve health outcomes, reduce risk to Queenslanders and assist in attracting and retaining a highly skilled work force.

The CHAIR: I refer to page 36 of Budget Paper No. 4. What are the plans for the redevelopment of the Gympie Hospital?

Mrs EDMOND: Five million dollars has been allocated for the redevelopment of Gympie Hospital to improve the effectiveness of health service delivery and patient care. The master planning will be completed over the next 12 months, with construction to start early in the second half of next year. The redevelopment is great news for the community as it will give the Gympie community access to a very modern and well-equipped health facility.

The scope of works for this phase of development provides for the construction of a new clinical services building to accommodate new operating theatres, recovery and support areas, a new central supply department and a new medical imaging department. The building will link as an in-fill building between the existing main ward block and the outpatients building and will envelop a portion of the main ward block undercroft.

Most of the hospital wards are very spacious and in good condition. That is good to see. Other activities in the redevelopment will involve the demolition of the old administration building and the theatre central supply area and medical imaging building to allow for a new main entry for emergency vehicles, a patient set-down area and short-term parking. Redevelopment has been planned to allow for future development activity over a period of time.

I have already acknowledged the role of the Cooloola shire mayor, Councillor Mick Venardos. I thank him for his support. He argued strongly for the hospital redevelopment and has been a great supporter of the hospital. I was in Gympie in June 1999 to open the Cooloola Community Private Hospital Specialist and Diagnostic Centre. I also toured the Gympie Hospital and met with the Gympie District Health Council and Mayor Mick Venardos at that time. I acknowledged the need to address the inadequate radiology department and theatres. In fact, I was absolutely appalled that they had not been included in the capital works program at that stage. The department did some initial work on it soon after that.

In February 2001 I again toured Gympie Hospital with the Labor candidate, Rae Gate. There was another meeting on Wednesday, 11 April 2001 with the Cooloola Shire Council, Mick Venardos and the CEO, Russell Faulkner, concerning the Gympie Hospital. I have to say that they were very persuasive that we should continue to work up Gympie Hospital. I am also pleased to advise that the budget also contained an extra $200,000 to help attract senior medical staff to the hospital and $245,000 to purchase state-of-the-art equipment. I thank all of those people who have been involved.

The CHAIR: Can you outline the progress made with the government's $8 million election commitment to upgrade staff accommodation in Bowen, Bundaberg, Cape York, Mackay and Mount Isa, as mentioned on pages 37 and 38 of Budget Paper No. 4?

Mrs EDMOND: Of course staff accommodation, particularly in rural areas, is important in retaining staff. We made a commitment in the lead-up to the 2001 election. Significant progress has been made to advance that election commitment to address staff accommodation needs, particularly for nursing and allied health staff at Ayr, Bowen, Bundaberg, Weipa, Mackay and Mount Isa. The allocation of $8 million to respective health service districts, based on a business case, in each case is as follows: Bowen, $800,000; Bundaberg, $2 million; Cape York, $1 million; Mackay, $1.5 million; and Mount Isa, $2.75 million.

Individually, the current position for each district can be summarised as follows. In Bowen, Q-Build in the Whitsunday region has been commissioned to prepare design documentation for the construction of one three-bedroom residence and five two-bedroom accommodation units on the Bowen Hospital site. Indicative costs are $685,000. It is expected that works will commence in late August or early September 2002.

In Bundaberg, a concept design has been developed based on the district's needs. Discussion has been held with the district, and the new accommodation will complement the master plan for the site. Development of drawings has now commenced.

In Cape York, six residences have been purchased from Comalco at Weipa for staff needs. Four residences are being renovated with kitchen and toilet plus internal and external painting. The purchase of a block of flats has recently been settled to finalise accommodation needs—a major boost to Weipa.

In Mackay, Q-Build in the Whitsunday region has been engaged to design and document the construction of three staff units which will provide accommodation for 18 people. Each room will have an en suite, with individual units for lounge and kitchen. Work is expected to commence in late August 2002.

In Mount Isa, a concept design has been accepted enabling the progression of plans to extensively refurbish and modernise the existing staff quarters on the hospital campus. Current room sizes will be enlarged and provision will be made for en suites shared between two. There will be airconditioning installed, building services upgraded and additional kitchen and lounge areas provided for 60 staff. The design provides flexibility to accommodate singles or those with partners. All works on those projects will be completed by December 2003.

The CHAIR: The time allotted to government members has now expired.

Miss SIMPSON: I refer to page 1-27 of the MPS, the review of output performance and recent achievements, specifically related to alcohol, tobacco and other drug related illnesses. I note the lack of any reference to achievements in the area of residential rehabilitation facilities. I ask the minister to detail the existing facilities under the categories of youth, adult and indigenous.

Mrs EDMOND: Through its network of specialist services and general hospital and community health facilities, Queensland Health provides a comprehensive range of services that address the harms associated with alcohol and drug use. Queensland Health also funds a range of non-government organisations that provide these services. Just looking at the most recent inventory, because obviously organisations can change their listings from time to time, Queensland is currently updating the inventory as it does every three years. This update includes looking at the methodology used for reporting on bed numbers. For example, some residential services reported last time that their beds could be used for either detox or rehabilitation. We have tried to narrow down that focus. Also, I should inform members that some of these organisations have changed their bed make-ups and also are no longer included in the categories as listed.

Based on the current information that Queensland Health has received in updating this inventory of non-government organisations, there will be 748 beds in Queensland in 2002 made up of 531 rehabilitation beds and 217 detoxification beds. I state that that information comes from the non-government organisations that are providing that to us when we ask these questions. We do not have how they determine which is which. This includes the 40 new drug court beds in north Queensland to be established before November 2002.

There have been calls for the provision at times of more beds with the widely held assumption that more intensive treatment is better treatment. However, evidence shows that in-patient treatment confers no particular advantage over outpatient treatment although, obviously, different forms of treatment are more appropriate for different individuals or their circumstances. While, importantly, these services are but one component of a comprehensive approach for dealing with substance misuse, this is the approach taken by Queensland Health and not the narrow approach that some people advocate.

In terms of how they divide up into youth, et cetera, only a very small number actually divide them up into youth or non-youth beds. Obviously, the Mater special ADAW beds are specific, because they are for specific needs for young people, but I understand that there are between 77 and 81 detoxification beds available to people under the age of 18.

Miss SIMPSON: I ask a question in regard to nursing vacancies. I noted earlier in the day you talked about, I believe, the percentage of nursing vacancies. Would you be able to provide the estimates committee with the actual full-time equivalent nursing vacancies across the state as well as a breakdown for the various hospitals?

Mrs EDMOND: My understanding is that the snapshot that has been provided was 758 vacancies across this state, and there were over 1,100 full-time equivalent casuals filling those vacancies plus the vacancies that are not long term, such as maternity, annual leave and sick leave.

Miss SIMPSON: Could we get a breakdown for the various hospitals?

Mrs EDMOND: This changes on a day-to-day basis. People come and people go.

Miss SIMPSON: You must be able to get a snapshot to get an idea of the variance throughout the state.

Mrs EDMOND: We had a snapshot in February and they are the figures that I have just given you. We have not done a more recent snapshot than that.

Miss SIMPSON: Could we get a breakdown for the February figures for the various hospitals across the state?

Mrs EDMOND: We are just trying to work out whether they are district by district.

Miss SIMPSON: District by district. That will be fine.

Mrs EDMOND: We will take that on notice and I will also seek advice from the commission. This is an issue that is currently before the commission. So I will seek advice on whether or not we can make that public.

Miss SIMPSON: I refer to page 1-30 of the Ministerial Portfolio Statement, the number of radiation safety audits. I also refer to the Queensland Health web site radiation health subject

directory, which lists the environmental health unit's responsibilities. I also refer you to my letter in April this year—to which you have not responded—about security concerns for radioactive material. I repeat those questions here today: what security is provided for facilities holding radioactive material, particularly in light of terrorism concerns after the horrors of September 11? Is the minister reviewing current requirements that can be imposed upon the licences that she administers?

Mrs EDMOND: I am sorry, the Health portfolio is not the lead agency for terrorism activity.

Miss SIMPSON: No, but you are the licensing minister and you have officers from the department visit when the nuclear ships come into port. So there is very much a responsibility as the relevant licensing.

Mrs EDMOND: This is if terrorists apply for licences?

Miss SIMPSON: The question is in regard to what security measures are being taken into account. I repeat: what security is required for facilities holding radioactive material, particularly in light of terrorism concerns? Is the minister reviewing the current requirements that can be imposed on licences that she administers, as this is a relevant question, particularly given the irradiation plant at Narangba and other concerns as well?

Mrs EDMOND: Most of the radiation facilities around the state fall into two categories: health or industrial. The industrial ones tend to be very small, fixed things. They are measuring instruments. So you have long life, but very small quantum amounts of radiation. I do not think that they are of the slightest interest to any terrorist. There are thousands of them and an awful lot of them, of course, have things like smoke detectors. If we see terrorists collecting smoke detectors, we will raise the alarm with the police.

In the health facilities, most of the radioactive devices are high-level energy and short half-life. So again, they are used for treating patients. They have half lives like six hours or, for some of them, even minutes. So again, they are of very limited value to terrorists. But if we see terrorists sneaking into the nuclear medicine departments or other parts of the hospital, we will take note and report that activity immediately to the police. John Scott, the Director of Public Health, may be able to throw some light on this. John, do you know of terrorist activity involved in our radiation facilities?

Miss SIMPSON: Security issues generally in relation to the licensing of radiation materials. You are the licensing minister. Is there going to be a review of the licensing requirements in light of the need to upgrade security?

Dr SCOTT: Security is part of the application process for these licences. In the normal state of affairs, obviously, the required security will vary depending upon the sorts of isotopes that are being used. But clearly, following September 11 of last year, we have been meeting regularly with the police and, in fact, have been upgrading all requirements around security and responses to terrorist-inspired events. But I just make the point that we are also considering these sorts of issues not only in relation to terrorism but also in relation to vandalism and theft. So it is just part of the standard process, but we are constantly in touch with police and with security services.

Miss SIMPSON: I thank you for your answer, because that is the concern. It may not necessarily be terrorists; it may be general security. Will there be a review as to the licensing requirements? Will it be only a guideline that is applied to those who actually currently are licensed?

Dr SCOTT: No. We are participating in regular reviews of our requirements since September of last year at the national level through ARPANZA, the national body, but also through regular meetings with national agencies involved in this. At this point in time, we believe that security arrangements are adequate, but we will continue to keep them under review.

The CHAIR: The time allocated for non-government members has now expired. I call the member for Woodridge.

Mrs DESLEY SCOTT: Minister, how much is being invested in strategies to increase participation in Breast Screen Queensland and what is the nature of these strategies?

Mrs EDMOND: Breast screening, of course, is a very, very important area, particularly in prevention or early detection and treating of breast cancer. I am pleased to advise that the screening activity of the Breast Screen Queensland program has increased from almost 170,000 women in 2000-01 to approximately 176,000 women in 2001-02. The participation rate for women aged 50 to 69 years in the Breast Screen Queensland program has increased from 57.7 per cent in 1999-2000 to 59.2 per cent in 2000-01. It is anticipated that the participation rate will

be approximately 60 per cent for the period 2001-02. This figure is comparable with the national average for the Breast Screen Australia program.

The program is doing particularly well in our rural and remote areas, with participation rates in rural areas ranging from 58.1 to 70 per cent. Communication and education funding of $350,000 has been allocated in 2001-02 for strategies such as mass media. In addition, a health promotion officer is located at each of the 11 Breast Screen Queensland services. The role of the health promotion officer is to work with local women's groups, community organisations, general practitioners and other health professionals to encourage eligible women to participate in the Breast Screen Queensland program. Other strategies to increase participation include sending personal letters of invitation to women who have not participated, and monitoring rescreening compliance to send reminder letters if required.

I am pleased to advise that new services are being established in the western suburbs of Brisbane and the Fraser Coast this financial year. The establishment of these services will increase screening capacity and increase participation in these areas. I look forward, in particular, to the one in the western suburbs of Brisbane. I currently go over to Chermside where, I have to say, they provide an excellent service, but it will be good to go closer to home.

Preliminary data regarding the effectiveness of the screening program is promising, with a 19.3 per cent reduction in the number of deaths from breast cancer for the five years from 1994 to 1999. I encourage all women in the target group aged 50 to 69 years to participate in the Breast Screen Queensland program every two years. Appointments can be made by phoning 132050—my small ad for the night!

Mrs DESLEY SCOTT: I note an amazing increase in the number of women screened for cervical cancer. It has exceeded the target by some 25,000. How was this achieved?

Mrs EDMOND: Again, this is an increasingly important program, particularly with cancer of the cervix being something that is largely treatable if you get it early. The Pap Smear Registry in Queensland commenced operation in February 1999 after being established in legislation. The registry is the strategy of the Queensland cervical screening program, which I strongly support. The Queensland cervical screening program targets the participation of women in the age group of 20 to 69 years. The registry receives results from both private and public pathology services, and systems have been implemented to ensure that the data maintained in the registry is reliable for clinical decision making.

During this year, further outstanding results were received from private pathology laboratories. This year, the Pap Smear Registry has worked to ensure that clean data is held. I am aware that the Registry has also provided assistance to some of the smaller laboratories to ensure that data, firstly, is entered, is available in a timely manner and meets the laboratory's legislative requirements. The result of the entry of this additional data and the other strategies is that the 2001-02 estimated actual target has been revised upward to 325,000 women screened.

Another possible cause for the increase in participation was the scare in New South Wales and Victoria regarding the quality of the laboratory services for pap smear results in those states. While I am pleased to state that the Queensland laboratories were not involved in this issue, it is possible that some Queensland women increased their participation in the Queensland cervical screening program as a result of that. The estimated actual participation figure for 2001-02 is 61 per cent and I am pleased to say that it is now estimated that in 2002-03, 63 per cent of the women in the target age group of 20 to 69 years will be screened.

Cervical screening has proved to be an effective and efficient way of reducing the incidence and mortality of cervical cancer, as evidenced by the 29 per cent decrease in mortality in the 10 years following the inception of the Queensland cervical screening program. I encourage all Queensland women to have regular pap smears, as up to 90 per cent of the most common form of cervical cancer can be prevented with a two-yearly pap smear.

Mrs DESLEY SCOTT: I note on page 29 of the MPS it states that there will be a funding increase of $1 million to fund initiatives as part of Eat Well Queensland: Smart Eating for a Healthier State. Can you advise how this extra $1 million will be used?

Dr YOUNGMAN: Eat avocadoes.

Mrs EDMOND: The General Manager of Health Services says we should all eat more avocados.

Dr STABLE: Which he grows.

Mrs EDMOND: Which he grows, and is looking forward to growing more of, I think. Certainly food is becoming a much more important part of the health system, as we see increasing numbers of people affected by obesity and diabetes, etc. So, I am pleased to confirm that Queensland Health will significantly enhance its approach to reducing diet-related conditions throughout the state, with an increase of $1 million recurrent funding to increase the public health and community nutrition work force and expand primary prevention programs in nutrition.

Fourteen new positions will be created within the next 12 months. Two additional public health nutritionist positions will be established to support the development, monitoring and evaluation of programs statewide. Other new positions include two indigenous nutrition promotion officers based in central and southern Queensland, four public health nutritionists located in public health units throughout the state, and six community nutritionists based in health service districts throughout the state.

Strategic directions will focus on addressing food supply, promoting healthy eating, increasing the consumption of vegetables and fruit, enhancing the health of mothers, infants and children, and helping Queenslanders to achieve and maintain a healthy weight. Maybe a few of us should be signing up! Optimum nutrition is essential for the normal growth and the physical and cognitive development of infants and children, enhanced resilience and quality of life, good physical and mental health throughout life, resistance to infection and protection against chronic diseases and premature death.

The growing and ageing Queensland population and the increasing cost of pharmaceutical and technological advances in medical treatment demand innovative solutions. The treatment of diet-related conditions such as cardiovascular disease, type two diabetes and some forms of cancer require extremely costly medical interventions and is a huge demand to the community. However, these conditions are preventable by addressing underlying determinants within a population based approach. This enhanced investment in Eat Well Queensland will ensure effective implementation of the Eat Well strategies which, in turn, should result in the substantial health gains and improvements in community mortality and morbidity from chronic diseases, reduced avoidable hospital admissions, substantial savings throughout Queensland and improved economic, social as well as health outcomes.

I may have to correct something that I said earlier. I am now advised that the advice that I was given that the Industrial Relations Commission had directed the nursing bans remain lifted was premature. As members of the committee would be aware, negotiations in the Industrial Commission are dynamic. At the time of the 5 p.m. deadline, the Queensland government negotiators understood that the commissioner was giving a direction to the nurse's union. The negotiations are continuing but a directive, as such, has not yet been given and I do not want to misinform the committee. I apologise for my incorrect advice and would like to correct that.

The CHAIR: Thank you, minister. The time allotted for the consideration of the estimates for the portfolio of the Minister for Health has expired. I thank the minister and I thank the portfolio officers for their attendance. Our thanks goes to the Hansard staff who have worked hard to ensure that the transcript of proceedings of this public hearing are available in a short period of time for all who wish to read it. Thanks also to the parliamentary attendants and catering staff who have supported the committee during a very long day. On behalf of the entire committee, I thank the research officers and staff for their hard work during the process. I would like to thank the members of the committee for their assistance in the preparation and examination of today's estimates process.

This concludes the committee's consideration of the matters referred to it by parliament on 18 April 2002 and I declare the public hearing closed.

Mrs EDMOND: Before you declare it closed, could I place on record my thanks to the committee and, of course, to all of the staff for what they have done, and also to the Queensland Health staff. An enormous amount of work goes into preparing for estimates. We have many, many answers—even if we did not get asked the questions. I think it is important that we recognise the role played by the Queensland Health staff in providing that information. I thank all of the committee members for the role that they have played and, of course, the Parliament House staff, the Hansard reporters, the attendants and everybody. Thank you very much.

The CHAIR: I now declare the hearing closed.

The committee adjourned at 7.00 p.m.