

# CORRECTED VERSION

## STANDING COMMITTEE ON FINANCE AND PUBLIC ADMINISTRATION

### Inquiry into public hospital performance data

Melbourne — 17 August 2009

#### Members

Mr G. Barber  
Ms C. Broad  
Mr M. Guy  
Mr P. Hall

Mr P. Kavanagh  
Mr G. Rich-Phillips  
Mr M. Viney

Chair: Mr G. Rich-Phillips  
Deputy Chair: Mr M. Viney

#### Substituted members

Mr D. Davis for Mr M. Guy  
Ms C. Hartland for Mr G. Barber  
Mr B. Tee for Mr M. Viney

#### Staff

Secretary: Mr R. Willis  
Research Assistant: Mr A. Walsh

#### Witnesses

Ms F. Thorn, secretary,  
Mr L. Wallace, executive director, metropolitan health and aged care services division,  
Prof. C. Brook, executive director, rural and regional health and aged care services division, and  
Mr P. Smith, acting executive director, mental health and drugs division, Department of Health.

**The CHAIR** — I declare open the Legislative Council Standing Committee on Finance and Public Administration public hearing. Today's hearing is in relation to the inquiry into Victorian public hospital performance data. Specifically the committee is examining the capacity of hospitals to meet demand, standards and quality of care, resourcing and access levels, and the accuracy and completeness of performance data for Victorian public hospitals.

I welcome Ms Fran Thorn, the Secretary of the Department of Health; Mr Lance Wallace, executive director, metropolitan health and aged care services division; Professor Chris Brook, executive director, rural and regional health and aged care services division; and Mr Paul Smith, acting executive director, mental health and drugs division.

For the information of witnesses and the committee, I point out the following substitutions are occurring on the committee this afternoon: Ms Colleen Hartland is substituting for Mr Greg Barber; Mr Brian Tee is substituting for Mr Matt Viney; and Mr David Davis will be substituting for Mr Matthew Guy.

All evidence taken at this hearing is protected by parliamentary privilege as provided by the Constitution Act 1975 and further subject to the provisions of the Legislative Council standing orders. Any comments made outside the precincts of the hearing are not protected by parliamentary privilege. All evidence is being recorded by Hansard. Witnesses will be provided with a proof version of the transcript in the next couple of days.

I now invite you, Ms Thorn, if you would like, to make an opening statement. We will then proceed to questions.

**Ms THORN** — I am Fran Thorn. I work at level 21, 50 Lonsdale Street in Melbourne. I state as follows: I am the Secretary of the Department of Health. I am supported at this hearing by my colleagues Mr Lance Wallace, Professor Chris Brook and Mr Paul Smith. We attend the Standing Committee on Finance and Public Administration in our capacity as members of the Victorian public service. We are employees of the Crown and appear on behalf of the Minister for Health and the Minister for Mental Health.

The Australian health care system is large and complex, with interdependent roles and responsibilities held between the commonwealth and state governments. The commonwealth's main role in health system focuses on prevention and early intervention with key responsibility for primary health, while the main role of the states and territories in the health system relates to the tertiary services delivered through the public health hospital system.

Across Australia the commonwealth government funds approximately 40 per cent of public hospital expenditure, the states and territories contribute approximately 53 per cent and the remaining 7 per cent is funded from private sources.

In Victoria the provision of health services forms one of the major components of the Victorian government's expenditure, accounting for approximately 27 per cent of the entire state budget. In 2009–10 the Victorian government will provide over \$11 billion to health and aged-care services. Of this, over \$7.8 billion is provided for the acute health services budget, covering emergency and elective care, specialist consultations and treatments, and teaching and research facilities.

The department works in partnership with 85 public hospitals to provide acute admitted services throughout Victoria. These public hospitals provide treatment to eligible persons free of charge and on the basis of clinical need and urgency. Thirty-eight of these hospitals also have 24-hour emergency departments. We have over 6000 doctors and 29 000 nurses employed to work in the public hospital system who provide exceptional quality of care to the over 1.4 million Victorians who are admitted to hospital, the 1.3 million Victorians who seek emergency department care and the 1.25 million Victorians seeking specialist clinic appointments each year.

These basic facts and figures illustrate the size and complexity of our public hospital system. There are a large variety of treatments and procedures that a patient can require while attending a public hospital, which will differ in the intensity and complexity of the services required. Our public hospital system is designed to cater for every kind of care a patient could need from stitches through to organ transplants.

Providing this high quality of care therefore requires coordination and interdependencies across a large number of people and services. Hospitals face a daily challenge in managing and balancing the demand for services and, in particular, competing demands for elective surgery and emergency admissions.

Victoria has developed a system of hospital governance which provides health services and hospitals with a high degree of independence in the everyday administration and functioning of the hospital, while the Victorian government sets the broad policy guidelines and strategic directions for the health and hospital system as a whole. Providing the devolved responsibility to health services boards aims to ensure that decisions taken by boards are both relevant to the local circumstances of the hospital and able to be effectively and efficiently implemented.

Our major health services are incorporated public statutory authorities established under the Health Services Act 1988. They are at arm's length from government and not subject to day-to-day control. Each public health service is governed by a board of directors, which sets the strategic directions of health services within the framework of government policy and operates public hospitals on behalf of the government. Public hospitals remain semi-independent from the government and are mainly accountable to the board of their health service for their performance. Some public hospitals, such as St Vincent's Hospital, are denominational hospitals, which provide public hospital services with funding from the Victorian government while operating within their faith-based boundaries.

Smaller rural health services also operate semi-independently, with service-mix decisions made collaboratively between the health service board, management and staff, the department's regional office and the local community.

The devolved governance model implemented here in Victoria enables decisions on clinical governance and intervention to be made within close proximity to the service provided. This enables hospitals to be both responsive and accountable to their local community. Localised decision making can lead to variations in performance and practice across the system. However, the flexibility inherent in Victoria's governance model has overall been recognised as resulting in considerable benefits to the performance of our hospital system, in particular in comparison with other states and territories, which operate more centralised approaches. Our devolved governance model is particularly valuable in providing hospitals with the flexibility needed to meet the significant challenges currently facing our system.

Since 1999 demand for hospital services has grown substantially, with a 34 per cent increase in admissions, 43 per cent more emergency presentations and 20 per cent more specialist outpatient treatments. The increasing demand for hospital services can be attributed to a number of factors. Firstly, Victoria has seen major changes occur within the demographic of the community. Over the last two years the Victorian population has grown at a level not seen in over 20 years, fuelled by the recent baby boom and strong migration levels. And of course the population is ageing, with the first baby boomer set to turn 65 in 2011. Health services will start facing the impact of Australia's ageing population, with older patients estimated to consume five times more health resources than the rest of the population.

Secondly, we are seeing an increase in the prevalence of complex and chronic diseases in our community. Just over half of all adults surveyed in Victoria between 2005 and 2007 reported having been diagnosed by a doctor with a chronic disease. The Australian Institute of Health and Welfare has estimated that chronic disease accounts for 45 per cent of total health expenditure.

Finally, the introduction of new medical technology is seen as one of the major drivers of increasing health expenditure across developed countries. New technologies have resulted in significant benefits to Victorians, allowing them to live longer and healthier lives. However, we must acknowledge that these new technologies also result in two competing impacts on costs. New technology can make existing treatments cheaper or introduce new procedures which replace more expensive and time-consuming procedures. However, they can also significantly increase the cost of health care. By delivering more specialised and effective care and enabling new treatment for previously untreatable conditions, new technology can increase the overall demand for health services, thereby increase health expenditure.

In the face of this increasing demand we must recognise that health services must operate within finite budgets. All governments are required to make choices regarding how they allocate resources across a variety of

competing demands. Although health currently receives one of the largest proportions of funding in the state budget, we still need to ensure we deliver services as efficiently and effectively as possible to meet the community's expectations of the level and quality of service they receive.

The delivery of services is further impacted by health workforce shortages, which are being experienced not just in Australia but around the world.

Further, our hospitals are constantly evolving as knowledge and standards of health care change over time. Improvements to clinical practice and models of care mean that our hospitals undergo continuous change to ensure patients receive the best care possible. In the ever-changing health environment the health system needs to remain flexible, dynamic and proactive in embracing innovative solutions and change.

I am proud of the work being done in the health system to meet these challenges. Service productivity and patient care are being improved through new models of care and better systems and processes, and changes in technology and knowledge are being utilised in order to provide hospital services in the most cost-effective manner. At the same time we continue to strive to identify how we can improve our performance.

A number of innovative programs and initiatives have been introduced across the continuum of care, ranging from programs that keep people well, such as Go For Your Life, through to alternative hospital care models such as Hospital in the Home. While individual reforms may seem invisible on a day-to-day basis, cumulatively they form part of an ongoing and evolving process of innovation. This helps to ensure that we continue to deliver high-quality health services to the Victorian community.

One example of a reform being used to drive better health outcomes is the hospital admission risk program, or HARP, as it is known. HARP was established in 2001 to address sustained increases in demand on the hospital system from patients with chronic diseases such as heart and respiratory diseases. In essence HARP seeks to empower patients to better manage their chronic disease in order to reduce their avoidable hospital use and improve their skills to reduce preventable deterioration and maintain their health and quality of life.

A recent independent evaluation of HARP clearly demonstrated the success of this program, with patients experiencing up to 46 per cent fewer visits to the emergency department, up to 59 per cent fewer emergency admissions and up to 50 per cent fewer emergency bed days in hospital. This resulted in a positive overall impact on hospital utilisation, with a reduced need for hospital services by HARP patients being the equivalent to approximately one emergency department attendance, two emergency admissions and six days spent in hospital each year for every HARP patient. Patients in the HARP program also receive considerable benefits through improved health outcomes and empowerment to better manage their own conditions.

Overall we have established a world-class health care system here in Victoria. Victorians, in general, enjoy excellent health. The life expectancy of Victorians is amongst the highest across OECD nations and Australia, with life expectancy for males and females higher than for comparable overseas jurisdictions such as Canada, the UK, the US and New Zealand. Our hospital system is performing amongst the best in Australia. Recent commonwealth publications show that Victorian public hospitals are performing better than the national average on emergency department median waiting times, the percentage of people seen within the recommended time, treating elective surgery patients within the recommended time and having a shorter length of patient stay.

Finally, Victorians using our public hospital system remain highly satisfied with the services they receive, with our patient satisfaction monitor showing a consistently high level of overall satisfaction from patients for the level and quality of care they receive in our public hospitals. The latest results from the Victorian patient satisfaction monitor show an overall satisfaction rate of 78.1 out of 100, which translates to a very good result.

In all, Victorians should be proud of their public hospitals and remain confident that they will be able to receive a high quality of health care comparable to anywhere in the world.

I now welcome any questions from the committee.

**The CHAIR** — Thank you, Ms Thorn. The committee appreciates both your attendance this afternoon and the submission from what was the Department of Human Services but I assume is now the Department of Health.

I would like to start by asking you about accountability in the hospital system. You noted in your presentation that 15 hospitals are at arm's length from the government — to quote your text. What accountability mechanisms exist between hospitals, the department and ultimately the minister for the clinical performance of hospitals?

**Ms THORN** — Arrangements between the hospitals, the minister and the department, personified through the secretary, are set out in the Health Services Act 1988. But in a day-to-day sense the governance arrangements and accountability mechanisms are set out between the health service and the minister in the annual statement of priorities, a document which sets out not only the health service's ambitions for the forward year but also the expectations of the health minister about what will actually be achieved by the health service over the forthcoming year. These are discussed by the minister and the health service chair, and they are jointly signed.

In terms of ongoing monitoring of that, there are arrangements for regular reporting by health services against a set of performance measures that are set out in the statement of priorities, and within the department there are a number of units that would be maintaining active and close interaction with the health services, following up on performance issues.

**The CHAIR** — Thank you. Is the integrated performance and activity report part of that ongoing monitoring mechanism?

**Ms THORN** — Yes. That is the reporting mechanism that the hospitals report back against to the department.

**The CHAIR** — How does that work? Is it a periodic report — monthly, quarterly?

**Mr WALLACE** — Monthly.

**Ms THORN** — Yes.

**The CHAIR** — Are we able to get a copy of that to see what sort of data is included?

**Ms THORN** — I believe that these have been asked for in the past by the Parliament. I would have to consult with the minister on that. The issue with those documents is that they are unaudited data. They get revised and checked by the department and are discussed with the health services on an ongoing basis during the year, and then at the end of the year we have finalised data. So there would be some issues around the information that is in those reports that come out on a monthly basis that would require that we would really need to consider whether we release them.

**The CHAIR** — And the final report?

**Ms THORN** — The data in the final report is seen in a number of places. It is seen in the health service's annual report. The key performance data is also seen in the *Your Hospitals* report, and I am pretty sure that a fair bit of it appears on the department's website.

**Mr DAVIS** — Will we get those?

**The CHAIR** — The final report?

**Mr DAVIS** — No, the monthly reports, is it?

**Ms THORN** — I would have to consult with the minister about that and get back to the committee.

**Mr WALLACE** — We are taking that on notice.

**Ms THORN** — I am taking that one on notice.

**Mr DAVIS** — You will do that?

**Ms THORN** — Yes.

**The CHAIR** — One of the issues that the committee is looking at is the overall resourcing issue of the health system. I guess one of the fundamental questions for this committee, just looking at the raw numbers, is that your submission notes the increase in budget for hospital services over the last decade period, and you have indicated an increase in the order of 34 per cent in admissions to hospitals over that period. At the same time you have, by your figures, a 61 per cent in doctors and a 41 per cent increase in nurses. I guess the question arising from that is that if you have extra budget and you have substantially more doctors and substantially more nurses in greater proportion than you have extra patients, why are there so many issues arising with the public hospital system in terms of delayed admissions, emergency department blockages et cetera? On the raw numbers you have more resources than the increase in patients.

**Ms THORN** — My first answer to that would be that there are many lesser issues. There are many patients who get access to the Victorian public hospitals in an extraordinarily timely fashion, and access to hospitals in the emergency department, through elective surgery or as a medical entry to the public hospital is always based on clinical need. I just say that by way of introduction. The conundrum that you raise is one where costs of health service delivery rise at rates above the CPI in general.

The other issue about it — and this is probably the more important part of the issue — is the kinds of patients who are being treated within public hospitals. The complexity of those patients who are presenting, both at the emergency department in elective surgery and again as general medical admissions to hospitals, is increasing over time. If we look at emergency departments as a starter, categories 1, 2 and 3, which are seen probably more as at the accident emergency end, are increasing in number.

**Mr DAVIS** — The more acute.

**Ms THORN** — Yes, the more acute patients with high levels of acuity; they are increasing in number and their complexity — that is, the number of comorbidities or the number of multiple conditions they have — is increasing. Add to that the fact that the population is ageing: at the moment if you make it to 65 — and very large numbers of us do make it to the age of 65 — then 80 per cent of us will have one or more chronic conditions. Those chronic conditions are really driving health service usage, but in particular they are driving complexities, because a large proportion of people will have multiple chronic conditions, which add to the complexity of treatment and add to longer stays.

Thirdly, the other issue about the ageing of the population is that older persons are the significant users of public health services. I do not have the numbers absolutely off the top of my head, but I know that my colleague Lance Wallace can roll off some figures about bed usage and time for older patients. All of these drive higher complexity along with, as I think I started off with, the fact that the actual costs of health service delivery have grown at levels higher than the CPI.

**Ms THORN** — Did you want to add anything further?

**Mr WALLACE** — No, I think that fairly much covers the major issues. I think we understand that complexity is a major driver as well as just patient growth. If you are looking at staffing numbers you would also be aware that health services are involved not only in treating patients but also in research activities and training activities. There has been quite a lot of expansion in research activities in health services as well trying to connect new treatments. The basic scientific research into new treatment modalities would also be an issue and a factor.

**The CHAIR** — Related to that I want to ask you about your submission, which breaks down the numbers into ‘Number of separations by age’ categories. There has been a seemingly enormous increase in the 75-to-80-year age bracket.

**Ms THORN** — Which page?

**The CHAIR** — Page 13. Not far ahead of ‘Population growth’ in those age categories. Given that it is a comparatively short time frame — eight years — can you shed any light on why there has apparently been this enormous increase in that particular age area and separation? Accepting what you say about chronic conditions and so forth, it seems to have happened in a very short period of time for that sort of increase.

**Ms THORN** — That is in fact one of the more astonishing issues or aspects around the rise of chronic disease in the population — the speed at which it has grown. There are quite frightening diagrams of the state of Victoria that show in that period how the incidence of diabetes has multiplied at a very frightening rate, and all the complications that are associated with diabetes; that is just one of the chronic conditions. Some of the chronic conditions do seem to be exploding at the moment. Some of the other chronic conditions have always been with us in relatively sizeable proportions. I would need to go back and look at data to see whether this is particularly unusual.

What I would suggest based on what I do know, and I will ask my colleagues to add to this, is that we are living longer — and the rate of increase of us living longer has been quite dramatic, even in the last 20 years — and medical technologies which are available to us to treat conditions which would have had us dying much younger are really, I think, driving what is occurring with that older age group, in particular the 85-plus or even the 75-plus group who are above what 20 years ago would have been the likely age of death. So there is an interesting combination of factors going on. There are also just more older people, because we are living longer but also because of the bubble of the demographic that is coming through. So if you look at the data for 2011 up to 2016, there is a massive increase in the number of people aged 65. There is a range of interesting factors going on here that are driving that, I think. Chris or Lance?

**Mr WALLACE** — One of the things that Fran alluded to earlier on was trying to get an indication of the older population and its impact on the health service system. The over 70s are approximately 10 per cent of the Victorian population. Of the number of people who attend an ED, about 15 per cent are over 70; of the number of people who are admitted, it is more like 30 per cent; and of the total number of bed days it is now getting close to 50 per cent of all bed days by that cohort. The demography is driving it initially; and then, as Fran was indicating, there is the likelihood that the older we get, even though we are remaining healthy for longer periods and we are living longer with some chronic conditions, those chronic conditions will flare up from time to time, and that is driving a series of extra attendances at ED with seriousness enough to warrant admission. We are looking very carefully at the growing demography in that particular area. Our broad indications are that these types of trends are more likely to continue than to be ameliorated.

**Ms THORN** — If you add to that — and I will ask Chris to take up on this one further — Victoria and Australia have been very successful in continuing the downward pressure on what is called ‘avoidable mortality’. Avoidable mortality is not something that is driven by the fact that we are living healthier lifestyles; it is something that is primarily driven by medical intervention. That will be having an impact on the issue of the types of ageing and therefore the types of health presentations. You might like to add to that, Chris.

**Prof. BROOK** — Thank you, secretary. There are two comments. The first is that it is not just overnight or long-stay admissions that we are talking about; it is of course day separations as well, if we are talking on the same page. There is tremendous growth in older people, particularly in the arena of renal dialysis. When somebody develops renal failure they are dialysed; they are often dialysed many, many times over a long period of time. That may not necessarily have occurred in the past, so it is evolving. It is quite possible for people to be sustained in a condition which, up until recent times, would not have been healthy for them. The same is true for things like oncology treatments, where the older the population gets the more cancer there is, and the more oncology there is the more separations there are, because we treat oncology patients as day patients. Thirdly, because of technology, we now do a lot more endoscopic procedures on older people and sustain them in relatively good health.

On the question of people living longer, I will just reinforce some comments that were made earlier. Victoria has the highest life expectancy in the world for men, which is no mean achievement.

**The CHAIR** — That is good to know.

**Prof. BROOK** — Men in this state will live well more than 79 years at the moment, and each year that grows. There is some risk of that flattening or decreasing with chronic disease, but at the moment men in Victoria are the longest living men in the world. Women in Victoria are second. It is very hard to live longer than a Japanese woman. There is a whole range of factors that seem to lie behind that. For the first time, in the last couple of years we have been able to directly correlate lengthening life expectancy with health-care interventions.

This is a thing called amenable — sometimes called avoidable — mortality, and I think as the secretary correctly said this is a measure of effective interventions. It is not a measure of good diet or exercise, which are really much, much longer and quite different things. In the past six or seven years we have reduced avoidable mortality by 20 per cent, and that puts us right up there at the very top of the world. Not every one of those interventions will be at a hospital; it may be good general practice or primary care. It will be some kind of intervention. By contrast the United States has had a 4 per cent to 5 per cent reduction in amenable mortality in the same period, so there is something about good systems there.

**The CHAIR** — Just on the statistics in your answer and the calculation of separations. You referred to day patients — oncology patients. Is each attendance by an oncology patient, for example, counted as a separation on a day-to-day or one-day-a-week cycle or whatever the cycle is?

**Mr WALLACE** — There is an attendance definition. It is a definition of continuous care. It really depends a little bit on their setting, but most chemo patients would be considered to be a separation, and it would be considered to be a separation for that treatment. Radiotherapy, for example, is treated separately. There is a little bit of difference in the accounting rules there, but if you want us to provide a little bit more detail about the accounting rules for cancer, we could provide it.

**The CHAIR** — That would be very useful.

**Mr DAVIS** — Dialysis?

**The CHAIR** — I do not know if you are able to answer specifically on dialysis.

**Mr WALLACE** — Yes, dialysis is counted as a separation. That is what Chris was referring to before. Particularly in the older cohorts, that would be driving some of the very large numbers.

**Ms BROAD** — Thank you, secretary. Thanks for the presentation. If I can take you to the Victorian government's submission on page 38, I am going to raise some matters which are of particular interest to Victorians in rural and regional areas, as my electorate of Northern Victoria Region particularly covers almost half of the state. Maternity services in particular stand out because, as the submission notes, there are currently 59 hospitals in Victoria which provide maternity care; 43 are in rural Victoria, and a fair slice of those are in northern Victoria. I think you would agree that there is nothing really more fundamental to women and families than access to safe maternity services within reasonable range of where they live.

I would like to ask you to expand on the basic information contained in the submission about what action is being taken to ensure that there is access to sustainable, safe maternity services particularly in regional and rural Victoria.

**Ms THORN** — Maternity presentations still make up a very sizeable proportion of health service presentations. Unlike most other presentations they are not necessarily a condition of ill health — and thank heaven for that! But sometimes things go wrong in a maternity presentation, and that is why the majority of maternity services are in association with hospital services.

On the issue of rural maternity services I am going to ask my colleague Dr Brook to speak. I have spoken with him many times on this issue, and his knowledge is deep and lengthy.

**Prof. BROOK** — Thank you very much for the question. Twenty five per cent of all births in this state occur in rural Victoria. That may come as no great surprise, because 25 per cent of the population, depending on how you like to measure it, is in rural Victoria. In this I do not necessarily include all of the rural urban fringe communities.

As the document states there are 43 hospitals in rural Victoria which provide intrapartum care. Of those 43 there is clearly an element of choice being made by women in relation to their own perception of where they may wish to give birth, because 75 per cent or thereabouts of all births occur in the largest 12. That is also partly purely demographic, but there are some interesting elements of — —

**Mr DAVIS** — You closed 20 of them.

**Prof. BROOK** — I am happy to comment on closures. In fact 74 per cent occur in 12 hospitals which have more than 500 births. Only 1.7 per cent of rural births occur in very small settings where there are less than 50 births per annum.

There are a range of initiatives which go to ensuring that birthing services in rural Victoria are sustained. The first is a rural maternity services framework. That document has now been out for six years. It lays out the criteria and guides for any service in looking at its capacity to provide safe and effective maternity services. Some services — —

I will return to that. All health services are governed by their own independent board; all health services make decisions on a whole range of services in close consultation with their medical and nursing staff. Nursing staff are at least as important as medical staff in relation to maternity services. A service that provides maternity services has to be able to field three shifts of midwives. A woman will not necessarily give birth in one or two nursing shifts, so it is not unreasonable to expect that that would be the case.

There are also obviously criteria in relation to facilities equipment. We do provide specific funding through the rural maternity initiative, which this year will be \$1.4 million. That \$1.4 million on top of other payments goes to ensuring that there can be progression of alternative models of care or models of care that are best suited to that site. Sometimes those models of care will be within hospitals, so they will be midwife models of care — one midwife following one patient throughout the entire pregnancy and indeed being present at the birth or effectively delivering the babe under supervision. There are other models which involve providing resources for community care, particularly antenatal care and some postnatal care.

A further six rural hospitals, on top of the 43, provide services which are prenatal or postnatal care. That could be lactation, it could be straightforward postnatal care, not forgetting that there is maternal and child health service availability in addition. So 43 services provide ongoing actual birthing services, and a further six provide prenatal care.

Because the issue arises every time, I thought I would just offer some insight on so-called closures or cessations. Some 34 facilities have ceased providing maternity services since 1993. Of them, more than 80 per cent delivered less than 20 babes in a year, and some delivered none. Some of those services closed because there were amalgamations of former bush nursing/private community hospitals with public hospitals. So let us take East Wimmera, where you have St Arnaud, Donald, Charlton, Wycheproof and I think Birchip in there somewhere as well. Quite sensibly the clinicians in that community decided that it was going to work for their workforce provision and for themselves if they had birthing services at St Arnaud, and that is what they do. You could say that there is cessation of service in a number of towns, but in fact there is a vibrant service providing low-risk-only birthing services at St Arnaud.

That is demography, and we have to recognise demography. Demography applies not just to the patients in the community, so an older community which is shrinking in size has a lesser need for birthing services. We could nominate Creswick, for example, as a service which is counted in cessation of birthing services. Creswick has a residential aged-care facility. It is not good to deliver babies in a residential aged-care facility. They sort of self-nominate.

Sometimes it happens because doctors themselves, along with their colleagues — midwives — determine that they themselves are too old or too thin to be able to continue to provide services safely in every instance; referral of services to a nearby facility is always top of the list in terms of what happens next.

The department does not close birthing services. We have a completely open policy of what services should be provided within the framework of the rural birthing services model and as decided locally by doctors and midwives.

**Ms BROAD** — Just to pick up on one of those points, I can certainly supply an anecdote of one rural health service which focuses on aged care which delivered successfully, happily, one baby last year. They were very pleased that it was a successful outcome but somewhat horrified that they were doing it, because they certainly recognised that it is not appropriate. But in an emergency, which it was, they all did very well and were all very pleased, and there are lots of pictures to prove it.

Perhaps I could ask about another matter which is of great significance in north-east Victoria following a very lengthy process, because it is a cross-border exercise in Albury-Wodonga, and there is another cross-border consultation coming up next month, I think, where I imagine there will be a further report back on progress with the establishment of the health service in Albury-Wodonga. But because it is a matter of huge interest in the north-east, not only in Wodonga on the Victorian side of the border but in surrounding communities, I would certainly be keen to ask if you can advise us today on how progress is being made in establishing that new cross-border health service, which is something of an iconic one — this does not happen very often. I have got a lot of the border between New South Wales and Victoria, and everyone is looking with great interest to see how this progresses.

**Ms THORN**— Having said, possibly a little histrionically, last year at the cross-border meeting that I would kill myself if I was unable to report on a successful achievement of the amalgamation of the Albury and Wodonga hospitals, I am very pleased that I do not have to do so at the next meeting. The new Albury-Wodonga hospital came into effect as of 1 July. It is the newest health service established in Victoria under Victorian statute with a board that has been jointly selected by the health ministers of New South Wales and Victoria. A whole lot of arrangements, as you would understand, are still being worked through about how this will be working in practice, but I think it is also important to say that in advance of this there had already been quietly, and with not a great deal of fanfare, work going on between the two health services to make sure that in particular the clinical services were delivered were in harmony with each other and you were able to see a seamless set of services delivered to the members of that community — they do not see themselves, I believe, as two communities.

That has been achieved, not without its difficulties along the way. It has taken seven years but we did get there by 1 July 2009. I was lucky to be up there, I think it was last week or the week before, to celebrate with the health services the fact that this has happened. It was a very small get-together with the board and some senior staff of the hospitals, but I was very lucky to have an opportunity to go around both hospitals, meet with people, see the things that are going on. I do not think this doctor was a set-up for me, but I met a young registrar, I think from Sydney, doing work in the Albury hospital who was saying to us how delighted he was, and in particular he then said how delighted he was that work was going on around national registration for doctors so he would not have to be registered in two states, as would have been the case in the past.

But Chris, who suffered much longer than I, or experienced much longer than I the work around the Albury-Wodonga health service, might want to add to that.

**Prof. BROOK** — Just to say that Albury Wodonga Health, as it is named, is, I repeat, a Victorian public health service. A gradual takeover of New South Wales — no! It is a Victorian public health service, it is a public health service, therefore it has a paid board of governance. It will be a statement-of-priorities hospital. It will have two campuses essentially. At this stage mental health is not included but we do intend to reopen negotiations about other services in a time frame of approximately two years. The major service providers are very happy with the new set of arrangements. Medical staff have had shared contracts for some time now in anticipation of this development. Nursing and other staff have an arrangement that is a bit like employees of a large supermarket chain, say, in two different states where there may be slightly different employment conditions. That all had to be worked through, which was a fairly gruelling process — looking at different laws, different industrial agreements and different processes — but it is going to be a fantastic experiment. I am saying that simply because I am really proud to have got this far. We want to see this work.

It is going to have a budget of about \$130 million. It has 1500 staff, 263 beds and a wide range of services. The new board chair is Ulf Ericson, who is an extremely well-known Albury citizen, and the inaugural chief executive is Dr Stuart Spring, most recently from Catholic Health Australia and prior to that a very senior administrator in New South Wales. He is a very skilled and experienced person to carry it forward.

The first tasks are going to be to consolidate the services. Only once services are consolidated will there be any consideration of any change, but there may be better ways of doing things over time. I note with some interest that the Prime Minister has also announced the creation of a super-clinic in the middle of Wodonga — some \$20 million. All I can say is that that is most welcome as one of the greatest problems for both hospitals is category 4 and category 5 patients — that is, general practice-type patients in general who cannot access primary care easily in those two states. Hopefully that will also benefit the situation for the residents of Albury-Wodonga, who for health purposes certainly consider themselves to be one community.

**Ms THORN** — If I could just add to that, I would not want the committee to be left with the impression that if you turn up at a Victorian health service along any of its border and you are not a Victorian, that somehow you do not get given admission. That is not the case. We have cross-border arrangements with all of the states, so anyone who turns up to a hospital, regardless of where they come from, gets treated. The Albury-Wodonga case I think is a very special one. It is about how that community sees itself. It has been in pursuit of this end, I believe, for 21 years. I think the front page of the local newspaper celebrated ‘the birth after 21 years’. What we will be getting there is a very significant mass of health services that can service that whole community. We will be more able to attract specialist clinicians so that people will not have to travel. There are a lot of benefits to be achieved from that particular amalgamation, but anyone who crosses the river into Victoria or crosses the South Australian border will get treated.

**The CHAIR** — Just before we move on to Mr Hall, what are the fundamentals of the Albury-Wodonga arrangement? Who are they responsible to? Administratively, who funds them?

**Ms THORN** — Put simply, as we have said, it is a Victorian health service, so it is funded by the state of Victoria, but there will be financial transfers from New South Wales to Victoria. There is a whole set of arrangements about the level of funding that will occur and how any decisions around funding will be made, but in effect it is a Victorian health service, subject to the same governance arrangements as any other Victorian health service, but serving that whole community. The board is made up of people from the Albury and Wodonga communities, and there will be arrangements, obviously, for reporting to the New South Wales minister.

**The CHAIR** — And they are not subject to the equivalent New South Wales legislation?

**Ms THORN** — The only New South Wales legislation I believe they are subject to — and I imagine that that becomes academic at some stage — is in fact New South Wales industrial law. Victoria and New South Wales have very separate industrial relations environments. New South Wales made as a particular condition of this amalgamation that staff transferring would remain subject to New South Wales law and also would retain their existing terms and conditions, as you would expect to be the case. I think that is the only law that they are subject to, although I could be wrong.

**Prof. BROOK** — No, I think that is right. The relevant health services act — it is not called the same thing — allows for services to be provided by other providers, so it fits into that. For funding and for other purposes, essentially that area of New South Wales has been excised from the Greater Southern Area Health Service and it comes to us. We will in turn, as the secretary has said, provide it with funding, on a blended basis in the first instance because New South Wales does not operate on a case-mix funding basis and it is terribly important in the first instance that the hospital receives what it costs to run. That is essentially the basis of our agreement with New South Wales.

**Ms THORN** — There has been a lot of discussion, I think, along the way about whether this was about cost savings. We have been very clear in our negotiations with New South Wales that this is not an opportunity to achieve savings. We certainly do not see it in the short term, and hence there have been very tough negotiations around the budget. Our view is if it is possible through an amalgamated health service to achieve efficiencies, then they should really go back towards better services for that community.

**Mr HALL** — I was going to ask some questions on mental health, and I will come to those in a second, but seeing as we have raised the subject of maternity services I just have a quick question in that area: what is the criteria that is used to fund a health service to deliver maternity services at a level 2?

**Prof. BROOK** — Level 2 are low-risk maternity services. They fit into the rural maternity services framework document, which lays out the requirements, the sorts of things that people need to look to in terms of the availability of workforce and adequate facilities. The funding is case-mix funding, so it is not a question of providing a block of money that says, ‘This is to establish or to run a maternity service’. That is a function of the total resources of the hospital. Obviously in maternity services if you accept the patient, you have a kind of responsibility to ensure that they give birth. This is essentially a pretty straightforward arrangement. Part of growth — and my colleague may wish to comment further on this — for all hospitals that provide maternity services is that their activity during the year is always assessed at the end of the year, so there can be an

adjustment to their funding should there be an increase in growth. One element of growth funding is always put aside for maternity services — —

**Mr HALL** — Perhaps I could give a specific example as a basis for my question. I understand that West Gippsland hospital, based in Warragul, expects to deliver 800 babies this year. It is being refused funding to what it describes as ‘level-2 nursery’ level, when there are other hospitals in the region that get that level-2 nursery funding, yet probably do not even deliver 500 babies per year.

**Prof. BROOK** — I would have to take that on notice, I am sorry. I do not have the details of West Gippsland’s claim in that regard.

**Mr HALL** — Mr Wallace, did you want to add anything?

**Mr WALLACE** — I could just generally say that funding and role delineation tend to be two different things. There is no doubt that as you have increased numbers of births, then some more specialist birthing facilities, like special care nurseries, are sometimes funded. But I do not have specific knowledge of that particular case.

**Mr HALL** — I would appreciate some follow-up to that, given that there have been circumstances where mothers have not been able to be located in a Victorian hospital until the last minute; situations like that have arisen.

I want to ask a few questions about mental health, and I will make particular reference to the Victorian mental health reform strategy for 2009-19; Mr Smith, this might be in your area. In the press release relating to the release of this document, under the heading ‘Accessing mental health care’ one dot point says:

Mental health bed occupancy rates remain very high and delays in accessing mental health services from hospital emergency departments a persistent problem in metropolitan areas.

I might also add I think it is a problem in some of the country areas that I represent. Since this reform strategy was announced, I think late last year, what has the government done to address that particular point?

**Mr SMITH** — Thank you for the question. The issue around waits in emergency departments is a complex one because of the unexpected nature of a lot of the arrivals to emergency departments and also, in some situations, the difficulty in actually being able to undertake an assessment to work out whether or not someone needs admission. This might arise because of somebody’s intoxication or because they have arrived with an injury that needs attention, and so time necessarily spent in waiting until the appropriate assessment can be made does delay referral then to an inpatient bed.

Having said that, there are a couple of strategies that have been put into place. The first, which relates very specifically to what I have just outlined as one of the challenges in dealing with the actual assessment process, has meant that in at least two of the metropolitan hospitals some short-stay units have been established, which allow for people to be cared for for up to 24 or 48 hours so that then a decision can be made about whether admission as an acute patient is warranted or whether some other kind of outcome is required. There are eight beds: there are four at Werribee Mercy and four at the Royal Melbourne. A further eight are planned, so there are plans afoot for similar arrangements in the Dandenong Hospital and the Northern Hospital in the next little while.

The other issue that is important is to ensure that people who turn up at emergency are genuinely in need of emergency attention. One of the things that is relevant then is to provide better information for people who are feeling unwell or for their families and carers, so that people do not make an unnecessary trip to emergency if there is in fact some other way that people’s needs can be assessed or attended to. One of the things that was a feature of the most recent budget is an investment in enhanced triage, which will allow services to provide better information to people who are concerned — either other professionals phoning up on their behalf, such as police and others — or providing telephone assistance to people.

The third component has been the announcement, which is soon to be rolled out, of mental health line. It is a 24-hour, seven-day a week service where people can phone up and discuss the concerns or fears that they have and get good advice about whether or not coming to an emergency department is the right answer for them or

whether in fact this is an issue that can be dealt with appropriately by a GP or some other kind of response. Funding has been provided to add that to the landscape of the solutions available in emergency departments.

Over the last couple of years there have been additional positions established in emergency departments themselves — some 17 positions to assist with having a 24-hour, seven-day-a-week presence in most of the busy EDs. That is allowing for both direct care for people who arrive who have got a fragile mental health issue but also some consultancy assistance to people who might arrive for another purpose but who are clearly unwell and have some mental health issues that need some attention as well.

As you outlined, emergency departments are busy places and there is often pressure in terms of finding a bed quickly. One of the things that is now available is a statewide bed availability register, which means that patients can also have a sense about what is available where in order for that to occur. It has meant that people who formerly had to wait a very long time for treatment and care, including that cohort I mentioned first who might have arrived but who are unable to be assessed quickly because of their intoxication or some other presenting issue, the waits for those people who have spent longer than 24 hours in an emergency department, which is obviously very undesirable, has declined more than fourfold in the last couple of years. In about 2004 there were something more than 1000 cases where somebody had to wait longer than 24 hours to get attention in an emergency department. Now those who are waiting that period of time has reduced to something just around 200.

**Ms THORN** — I was scrambling through my copy of the submission because I have recently seen the table — and I assumed I had seen it in this — which shows the very significant decline in the number of long-wait patients, not just for mental health conditions but others. But it must have been in some other document that I was looking at recently. But there has been a very substantial decline in long waits.

**Mr HALL** — Is that bed availability register a public document?

**Mr SMITH** — I will have to check; I am not sure of the answer to that.

**Mr HALL** — It would be helpful, if it were possible, for us to get a copy of that register. In respect of this strategy, in terms of implementation it says:

The government will appoint a Victorian mental health reform council ...

Has that been appointed?

**Mr SMITH** — It is imminent. Minister Neville is just finalising the membership of that council, and we are expecting an announcement shortly.

**Mr HALL** — I have two other questions about that. Under some of the different reform areas it talks about:

Working towards the establishment of mental health boards or committees to sit under health service boards.

Again I ask: has that happened? How might that happen in regional areas in Victoria where we do not necessarily have regional health service boards?

**Mr SMITH** — It has not yet happened. It is one of the directions that is being pursued under the umbrella of improvements to governance and accountability arrangements. Some very preliminary ideas are outlined in the Because Mental Health Matters strategy, but it is a 10-year strategy and there is a lot of thought that needs to go into guiding better ways for establishing local accountability arrangements around those services. That will bump into a range of issues, including how they might work in with current structures or how they might need to evolve over time to meet different sorts of arrangements as well. In fact that is one of the issues that the mental health reform council, when it is established, will be grappling with.

**Mr HALL** — In terms some of the next steps that are announced in this document, about action plans it states:

A series of action plans, based on the priorities outlined in the reform areas, will be developed, commencing in the first half of 2009.

Has that started?

**Mr SMITH** — No, they are almost finalised. Those action plans will be progressing each of those eight reform areas in the strategy. They will focus on best ways to implement some of the new investment that has been made in the 2009–10 budget and beyond and also look at a range of the parallel activities that might progress some of those reforms without necessarily needing additional funding. That is, again, part of the work of the new council to oversight.

**Mr HALL** — In terms of developing those action plans, I would think the recipients of those services, their experience, would be most useful in drawing up those action plans. In that regard, is there any thought for the department funding some of the advocacy groups in respect of this area to assist in particular in the drawing up of those action plans?

**Mr SMITH** — We already fund a range of consumer and carer advocacy groups. Some of those members are playing a role, and there will certainly be at least one appointment, which the minister will be making, of such a position on the mental health reform council. We have also, for example, funded a range of forums in progressing the development of the mental health reform strategy, and in parallel, as you may be aware, the reform of the Mental Health Act is a current priority. Particular consumer groups and carer groups have been brought together to provide advice and guidance on priorities for attention in that area as well. That is an ongoing commitment that has been made, and we will expect to see both representation on the council and in many of the subcommittees that the minister has indicated will be established as partnership groups to progress some of those areas as well.

**Mr HALL** — Could you perhaps forward to the committee a list of those advocacy or consumer groups that have been supported by government funding?

**Mr SMITH** — I am happy to do that.

**Ms HARTLAND** — I particularly wanted to talk about waiting lists for outpatient appointments. It seems to me — and this is not clear — there is actually a two-tier process, of, ‘You have to go on a waiting list to get on the waiting list to be seen in outpatients’. Can you talk a bit about how outpatient appointments work at the moment, because there seems to be extraordinary lengths of time before people are actually seen in the outpatient system.

**Ms THORN** — There are a lot of allegations made about, I believe, secret waiting lists. I will just make a very brief introductory comment about outpatient services and then ask Lance Wallace to take up this question. Of the outpatient presentations or the clinical services provided for outpatients, only about 20 per cent of those are related to people who are likely to progress to surgery, and not all of those progress to surgery. The other 80 per cent are people who are either having some course of treatment under the supervision of a specialist clinician or post-surgery — so if they are getting follow-up. These are scheduled appointments and generally scheduled well in advance and over an extended period of time. I think what you are referring to is probably the 20 per cent of people who might end up requiring surgery.

**Ms HARTLAND** — No, actually that was not my question. It seems to me that it takes an extraordinary amount of time for someone just to get into the outpatients clinic to be seen. That is what I am talking about. I want to talk about those waiting lists, not necessarily someone ending up in surgery but just someone being able to be seen in an outpatients clinic.

**Mr WALLACE** — You refer to it as a waiting list.

**Ms HARTLAND** — Yes.

**Mr WALLACE** — There is no formal waiting list as such. There are referrals to outpatients. I think the issues the secretary was talking about go to the reasons why there are less. Outpatients incorporates a very wide range of clinics. As the secretary was alluding to, only about some 20 per cent of outpatients are first outpatients. Very many conditions require you to go back for a continuing set of sessions. You are referred to a specialist, the specialist will assess your condition, that condition needs to be monitored, you may be scheduled for a repeat visit every three months or every six months, so the vast majority — around 80 per cent — of all visits to specialists through outpatient clinics are actually for repeat visits to monitor conditions, particularly chronic conditions that patients have.

The other portion, which I think your question is alluding to, are those new referrals from GPs. The new referrals go to individual health services. Those referrals are assessed by those individual health services on the GPs criteria for how soon the assessment should be made, and those new assessments are scheduled for outpatients clinics at that health service in accordance with clinical need. That is the way the current process works.

**Ms HARTLAND** — How can clinical need be assessed when the patient has not been seen?

**Mr WALLACE** — Sorry, there are a couple of processes. If you are talking about an elective surgery process, obviously there is a GP consideration of a patient's condition. That GP indicates that they need to see a specialist. Maybe they have some joint soreness; they would be referred then for an outpatients clinic appointment. In that referral from the GP to the health service there would be some indication about the urgency of that; how severe that is. The health service would then create an appointment with the relevant specialist. The relevant specialist would then assess whether somebody knew whether there is a surgical solution to that particular clinical need, or whether more conservative management — maybe physiotherapy or other issues — can alleviate it.

**Ms HARTLAND** — How is it tracked from when the person gets their referral and rings the hospital until they have their first appointment in outpatients? Is there a tracking system to show how long it actually takes from when they ring the hospital until they get that first appointment?

**Mr WALLACE** — The systems are monitored at the health service level. The department does not have a complete dataset which would track from GP referral.

**Ms HARTLAND** — But if you had a dataset, or if there were a central list that shows how long it is taking people to get an outpatients appointment, then would it not be much easier for you to prove this whole issue about whether there are two lists or secret lists is not happening?

**Mr WALLACE** — I am not sure what you are referring to with two lists or separate lists. I do not see how that deals with the outpatient wait issue. What some people do indicate is that the time to receive surgery can be longer than the elective waiting time list because some people believe the time from referral to a surgeon should also be included in the overall time that somebody is waiting for surgery. I suppose I do not accept that. Until a person has seen a surgeon there is no surgery that is required to occur. Health services actually monitor the period of time from GP referral to their clinics.

The clinics are quite complicated, I think, as the committee understands, in that access to specialist treatment can occur through private specialists; it can occur through the private provision of outpatient services on health services sites and also through public outpatients. It is a fairly complicated service model.

**Ms HARTLAND** — No, I am just talking about the time it takes someone from the time they ring the hospital until they have that first outpatients appointment. I understand that can take up to a year before you get that first appointment. That is what I am talking about. I do not understand why that is not being tracked or why it is not being talked about. I understand perfectly that someone will then possibly see a surgeon and there is no need for surgery, but I am really concerned about this huge time it takes someone to actually see a specialist. That is not clear in any of the data, and I do not understand why it is not.

**Mr WALLACE** — I think the answer to that question is that that information is monitored at a local health service level. The department has not monitored those sorts of datasets. I was indicating some of the complexities; some of the reasons for that is the complexities in those datasets. Datasets are complicated in outpatients because you have so many repeat patients who require monitoring in outpatients for ongoing conditions. Also it is complicated because there is range of settings for outpatients — so GP referral through to the private system as well as public systems. They are some of the complications in the datasets, but the current position is that it is monitored at the health service level.

**Ms HARTLAND** — If I wanted to know how long it took someone to get a urology appointment at Western at Footscray, how would I go about finding that information out?

**Mr WALLACE** — That information is held at a local health service level.

**Ms HARTLAND** — So the committee could request that information from the hospital?

**Mr WALLACE** — Yes, you could request that information from the hospital. Whether it would be collated in a form that would be readily available, I am not sure, but you could request it from the hospital.

**Mr DAVIS** — Can I just be clear on this. What you are telling us is that you cannot at this point tell us how many people are on the outpatient lists in Victoria?

**Mr WALLACE** — I can tell you how many people are treated, but there are no centrally maintained lists.

**Mr DAVIS** — There is no way you could tell us how many are waiting for an appointment?

**Mr WALLACE** — What I will tell you is that the department does not hold that information; it would be held at local hospitals.

**Mr DAVIS** — It was collated by the Auditor, was it not, in his review? He did collate a lot of that information.

**Mr WALLACE** — I think he did some sampling and created some estimation.

**Ms HARTLAND** — I am really surprised that you do not have this data. I would have thought that it would be logical to be able to say how many people are waiting on an outpatients list. I am really insisting on this because my previous work was working with older people in a high-rise. Trying to get them on the outpatients list was a nightmare. From everything I am told by people who still work within hospitals within the western region, nothing has changed about how long it actually takes. I am really surprised that the department cannot say how many people are actually waiting to get that first outpatients appointment.

**Ms THORN** — Can I just make a general comment on datasets. I think there were 48 submissions to the committee — 47 to 49 — including ours. So of the 47 submissions, nearly every one of those submissions had a view about what data we should be collecting and reporting on. They range from the very general to the very specific. We could potentially, if this were the decision of government, report endlessly on all sorts of things.

There is a big administrative burden to collecting, reporting, auditing and making sure that all of this data is okay. I am not suggesting that what you are saying is a bad thing, I am just saying that decisions are made over time by governments about what they will and will not collect data on. The outpatient waiting list issue is a relatively recent issue that has been getting a lot of attention, and it is something that I am sure government will consider and make some decisions on. But I just make the more general comment about data collection in hospitals and the kind of burden it imposes, and I think a number of submissions to the committee also reflected on the burden on people to be providing that information.

So, we, the government, have to make decisions about what at any given time seems like a reasonable set of data to collect to represent what seems important about performance. It will probably never be 100 per cent complete, because there are always new and different things that one can collect information about, and in many respects it is also driven by the capacity to collect data. I believe you met with Professor McNeil this morning, who I am pretty sure spoke to you, since his submission went to these issues, on the incredibly interesting area of those kind of complex measures, all of which are very interesting but require very complex data collection and analyses.

I make that statement to perhaps provide a little bit of information around the kind of trade-offs we make when we make decisions about what data is or is not collected at any given time, and decisions about that changeover time, too.

**Ms HARTLAND** — I understand your point; I just do not share it and I do not think it is acceptable.

**Ms THORN** — Okay.

**Mr WALLACE** — Can I also just quickly mention for completeness that the department has been very interested in the outpatient issue, and we have been investing very heavily in the super-clinic model. You may be aware that at Melton, Craigieburn and Lilydale the department has put in a new super-clinic structures which are fairly much major outpatient settings. We have put about \$15 million recurrently into each of those settings,

and those things are now just about fully operational and have had a very major expansion. The government had a commitment to expanding outpatients by 200 000 new appointments, and those particular three super-clinics very close to those growing communities have really assisted in delivering quite a few additional outpatient settings.

**Mr DAVIS** — I have three areas I want to talk about. One is health financing, another relates to emergency, and the final one is outpatients. I will follow up some comments made by Ms Hartland but will state on the record that I agree with her point: it is extraordinary that the department does not have the data.

The department, as I understand it, does have some data. You do have an ambulatory care report. That is a monthly report, if I am not wrong, provided by each hospital to the department, and that is part of the integrated performance data requirements. Am I correct in presuming that?

**Ms THORN** — Yes.

**Mr DAVIS** — That ambulatory data primarily relates to outpatients. My first question is: could we have a set of those for the last 12 months for each of the hospitals with whom you have an integrated performance arrangement? That is the first point.

**Ms THORN** — My response to that would be similar to my response earlier. I will have to take that on notice and get back to the committee.

**Mr DAVIS** — I will take on notice your point and state that I think it would be extraordinary if that information were not provided to a parliamentary committee, because I think it is very baseline data.

My second point relates to emergency departments and so-called ‘time to treatment’. I note that a document, the *Victorian Emergency Department Manual*, 10th edition, 2005, under the section ‘Concept and derived item definitions’, talks about ‘Time to treatment’. ‘Time to treatment’ talks about — and I am going to quote from the document:

[The earliest of [first seen by doctor date/time] and [first seen by treating nurse date/time]] minus —

the arrival arrangements.

As I understand it, some change has occurred there, and I want you to explain that to me. I am going to quote from another document: *Proposals for Revisions to the Victorian Emergency Minimum Dataset for 1 July 2009*. The document is dated October 2008. It states that the:

... clinical pathway, protocol or set of guidelines, initiation of patient management occurs at the start of the occasion of contact between the patient and staff member/s ...

It talks about management being ‘initiated by a doctor, nurse, mental health practitioner and commenced at or after triage’. Elsewhere the document talks about ‘time of initiation is weighed against the triage category’. It also, as I understand it, may well be that this now relates to a management change that has occurred.

Let me be clear in what I am trying to understand here. Is it the time when a formal examination by a doctor occurs, is it the time when a formal examination by another practitioner or a doctor occurs, or is it a time when some initial management steps are put in place? There are three possibilities here, and I am trying to understand which of these now apply.

**Ms THORN** — I will start by introduction. The whole issue of triaging and time to treatment is something that we, both at a state level and nationally and in conjunction with the clinicians, look at regularly over time; not the least because standards and who gets involved in care and who is able to be involved in clinical decision making changes over time. It is an area that has required a lot of judgement, and there has been a view that some of the definitions around it are not as precise as they might be, and that is being worked on. To take you through the intricacies of that one, I am going to hand over to my colleague Mr Wallace.

**Mr WALLACE** — What the department has been doing recently is working with an emergency reference group, which is senior ED physicians and departmental staff, to work through some definitional issues. I suppose for the layperson, you arrive at an emergency department, you have seen a triage nurse, you have been provided with 1 to 5 triage categories indicating the urgency of your condition. The triage nurse says, ‘Could

you now just wait for a short period and then we will call you on a critical needs/wait-turn basis into an ED cubicle'. You are sitting there and then your name is called: 'Mr Wallace, can you please come through?'. You are taken through into the ED and you arrive at an ED cubicle. A nurse may come to see you and may ask you for some further details of your condition. You may be connected to some monitoring equipment to monitor your heart rate, blood pressure. The nurse may say, if you are feeling particularly unwell, 'Do you want some pain medication to relieve temporary pain?' et cetera.

The issue has been: when did your treatment commence? When was patient-initiated treatment commenced in that scenario? That has been the discussion. For the layperson, once their name was called, they entered the ED and arrived at a cubicle and a nurse or other staff member came to start dealing with their condition, probably in their mind treatment may well have commenced at that point. The issue has been the word 'treatment'. When did treatment commence? Issues of connecting equipment to you to monitor heart rate, blood pressure could be considered to be monitoring, not treatment. Asking you questions about your condition, further exploring the details of your symptoms could be considered diagnosis, not treatment. We have been working with ED clinicians to better define these matters. As the secretary alluded in her original presentation, in a devolved management model where we have broad policy principles, local interpretation of these issues has been occurring. What we have been trying to get is some more standardised protocols.

What we have been doing is trying to look at each of the major conditions and actually define a treatment protocol for the condition. For example, if your presenting condition was asthma, then a nurse puts the nebuliser on you to relieve your asthmatic condition. We would consider that to be the initiation of treatment. In different types of procedures the ED physicians and other clinicians in the health services have been very constructive in the way that they have engaged the treatment. It could be by a nurse, by another allied health member or by an ED physician depending on the particular illness.

**Mr DAVIS** — The wooliness of this is what concerns me. It goes on in the same new document:

Patient management may be:

initiated by a doctor, nurse, mental health practitioner or other recognised health professional able to commence patient management —

or as an alternative —

commenced at or after triage.

That also seems divergent to the national arrangements. The Australian Institute of Health and Welfare has some different definitions. It states:

In an emergency department the service ... commences when the medical officer (or, if no medical officer is on duty in the emergency department, a treating nurse) provides treatment or diagnostic service. The date of triage is recorded separately.

The problem with this new definition is it is rough around the edges. The fear is that hospital data people — and we have seen some of them in action recently — could potentially drive a truck through it.

**Mr WALLACE** — I think the AIHW would recognise that there has been a little bit of history that the only way you can be treated is by a doctor.

**Mr DAVIS** — I am not necessarily saying that.

**Mr WALLACE** — In the modern times we are working in — and, as I say, we are getting excellent cooperation from ED physicians and others who are involved in these processes — there is a recognition that treatment can be administered by a variety of clinicians, but it needs to be appropriate. Treatment would only commence by a nurse or other health — —

**Mr DAVIS** — But following diagnosis?

**Mr WALLACE** — That is correct.

**Mr DAVIS** — Whereas this seems to allow a management — that is the point; it is not the same as treatment — to commence prior to diagnosis and to be the point at which the statistics are hinged off, which leaves things very open for non-comparability backwards and manipulation forwards.

**Mr WALLACE** — I would not agree with the way that you have presented the last part of it. What we were trying to do is look at individual condition types and design, working with the clinicians themselves — most prominent amongst those the ED physicians — to better define those particular protocols. The guidelines are reasonably open, because there is a range of conditions, whether they be mental health conditions, trauma or asthmatic conditions. There is a whole raft of conditions that people present with, some of reasonably low acuity and some of higher acuity. The guidelines are encompassing the fact that, as we are working through individual treatment protocols, the guidelines will have enough flexibility to embrace different protocols for different severity of conditions. That work is continuing. I think that work will make things much clearer. If you talk to members of the college of ED physicians, which is fairly forthright in looking after — —

**Mr DAVIS** — I will certainly be asking it these questions, but I have got to say — —

**Mr WALLACE** — Do so. They are fairly forthright in their interactions with the department. I think they also believe that these discussions are progressing well and that we are clarifying and improving guidelines.

**Mr DAVIS** — They look less clear to me, but I will certainly ask the emergency physicians.

My third area of questioning relates to health financing. In relation to those hospitals that are experiencing, or perhaps have experienced, financial difficulties and are under monitoring — so-called close watch — can you give a definition to the committee of what close watch is and why hospitals are put on close watch?

**Ms THORN** — The actual definition currently escapes me. I have a total mental blank, so I will have to ask Lance. Close watch is when hospitals are at the worst end of performance and you work very closely with them to discover why and keep an eye on it, because there can be fluctuations, particularly in financial performance, over a given time that may smooth out. Lance, can you remind me what close watch is?

**Mr WALLACE** — On health services' statements of key performance indicators we have an internal rating where, if someone is performing not well on their financial performance indicators and access performance indicators, there is a balanced number. We create a number out of their performance on each of the indicators. The total number determines whether or not someone is in watch or close watch view or how they are just under standard monitoring. It really is based on their performance against their key performance indicators in the statement of priorities. You can be on close watch because your indicators are not performing well or your financials. Quite often it could be a composite of those two issues which put you on to close watch.

**Mr DAVIS** — Could we have a list of those hospitals that have been put on close watch in, say, the last 18 months and the reasons, compounded perhaps, for those close watches?

**Ms THORN** — I will have to get back to the committee on that one; I will take it on notice.

**Mr DAVIS** — We will pursue that. Thank you.

**Mr TEE** — Thank you very much for your evidence and for your submission, which I did enjoy reading, I must say. I was impressed by your submission, in particular the submission around longevity and the fact that we are leading the world, and a lot of that has got to do with the health services that we provide. This morning Professor McNeil in his evidence talked about the hospital outcome research that he was doing in terms of patient outcomes, and again said that he was looking for improvement in that area but he acknowledged that we were leading the country. In terms of longevity and that research, we are, if not leading the world, certainly leading the country. More generally I am wondering how the Victorian health system compares with other jurisdictions.

**Ms THORN** — Firstly, the Victorian public hospital system makes up about 25 per cent of public hospitals around the country, and New South Wales is 30-something per cent. Together, if they are moving in the same direction, they will change the impact of some of the conditions. But, as I said in my opening statement, in terms of median — —

Is it emergency department waits or elective surgery?

**Mr WALLACE** — Both.

**Ms THORN** — Both. We are performing above the average across most of the access indicators. We also perform differently from probably much of the rest of the country in terms of the efficiency with which the health services are used. On those comparisons we would be generally up at the top end of, if you call it a league table, the different states and territories. The thing you would probably need to be a little bit careful about in thinking about some of these things is the quite different populations. The Northern Territory and the Australian Capital Territory have entirely different populations, but then again they are so small that they do not change much. We generally look to New South Wales and Queensland, and we are certainly up there with those two states, and above them on a number of measures.

**Mr TEE** — Thank you.

**Ms THORN** — The other difference between ourselves and those states and territories, as I touched on again in my opening statement, is a preference or a difference in governance. We are the only state remaining that maintains health service boards, and this has been a decision over a very long time in the state of Victoria, since the 1980s, in various forms, one or another, to maintain the health service boards. All other states and territories have got rid of them and think that we are a little odd to maintain them. We maintain them, we believe, for very good reasons because we think having a governance oversight very close to delivery is very important for keeping an eye on performance and in particular looking for innovation in practice that enables both efficiency and effectiveness of health service delivery. That is a very big difference in how our health services are run in Victoria.

I regularly say to my colleagues from interstate, when they are commenting on the fact that we have chosen to maintain boards, which they often describe as being more trouble than they are worth, that that is not the case in Victoria. The boards are an integral part of our system. Anyone who thinks that they can somehow control something as dynamic and complex as a health system from a single point in any state or territory is misleading themselves.

That important balance between local governance and a broader look at system performance, system-wide policy and guidelines we think has been particularly important in the kinds of innovation that have gone on in the Victorian health care system.

**Mr TEE** — One of the particular measures that we talked about, or issues that we talked about this morning, was the emergency hospital performance, or the performance in emergency departments when you turn up. I note in your submission that our waiting time is 2 minutes faster than the national average in terms of that league table, but I was wondering, in terms of our capacity in emergency care needs, what are the initiatives we are taking to improve that? Are there any capital works? Are there any other initiatives to try to improve in that area?

**Ms THORN** — Let me say by way of introduction, that relatively speaking yes, we are a little faster at the median level. We would never stop there. We want to continue to improve the speed of access because, by definition, if it is an emergency, the quicker you are seen the better. Having said that, there are quite a few people who present in emergency departments who are by no means in an emergency situation. That is a phenomena I would not mind speaking about a little later if we actually have some time.

But for those who are, say, in triage categories 1 to 3, and in particular 1 and 2, where time to treatment is absolutely critical — so 1 is resuscitation: you need to be resuscitated now; and 2 is about 10 minutes: so you are, say, having an acute asthma attack and could potentially choke to death or something else like that; and then 3 has a different time again — we are constantly working on ways in which we can take what, to anyone who has gone into an emergency department at a peak period, will seem an incredibly chaotic environment of people everywhere, clinicians dashing about, ambulances arriving, people being moved hither and thither around by the ambulance service, and looking at ways where we can streamline that environment so you can, as far as possible, take the 4s and 5s out of the equation and move them quickly somewhere else so that they are not adding to that general sense of lots of people being around and they can be treated very quickly.

We are doing that through a range of measures, firstly through co-located GP clinics, so people who essentially have a GP-type presentation can be referred there. We are also doing capital changes to enlarge our emergency departments and to allow them to be broken up into different areas where you would be moving people at different stages of their treatment. I will ask Lance if he will elaborate on that and other initiatives we are taking.

**Mr WALLACE** — Probably the main comments that I would make are ED is so much about improving emergency performance and linking to the rest of the health system, so it is flows of patients that are very important. It is also initiatives to try to keep people out of ED and to treat them in more primary and community-based settings. The department has a range of things, as the secretary indicated. The first is just investment in both the emergency department and also in bed capacity to actually move people through and then into beds if they need to, and the government has had very strong investments in this.

**Mr TEE** — An example of that would be a recent experience of mine when a friend who had a baby spent a night in a hotel as part of her hospital treatment initially.

**Mr WALLACE** — That is correct. There is very considerable funding, as the secretary alluded. The other thing is capital works to expand. We are doubling the size of the Royal Melbourne ED at the current period of time, and that is just opening. We have had expansions in a range of other emergency facilities throughout the state as well. I could list them off, but what you are referring to is what I probably would consider. You need to just invest in recurrent services, you need to actually build on your capital, but you also need to look at your models of care and that is creative things like medi-hotels. If someone does not need as high a level of nursing and other support, they can be within a short distance of the facility in a more comfortable location where you can be on call if they need you, so a medi-hotel-type facility can be appropriate for them. We have been looking at a range of different models of care such as short-stay units, which people have talked about and Paul mentioned before, in regard to mental health facilities where people can get concentrated care for up to 24 hours and can actually facilitate their stay and the GP co-located clinics that Fran talked about.

We have quite a range of different initiatives but most importantly it is flows through. Very recently there has been a major announcement of additional beds. That beds package, putting 170 sub-acute beds and 100 acute beds into the system, is about flows and actually trying to get the flows working to the maximum capacity so that those patients who need to transfer into wards can transfer into wards quickly and we can treat people in a timely fashion.

**Mr TEE** — Basically, you have more beds, therefore you are eliminating a bottleneck to get people through the system, which means you make more room for more people to come through.

**Mr WALLACE** — That is correct. People coming to the ED either return home after treatment or need to be admitted and you need to streamline both of those processes to treat as many people as possible.

**Mr TEE** — If you do not need treatment, you might go to a local GP who is on site, or if you do, there are more beds available.

**Mr WALLACE** — Yes, and we have been working very hard on those models of care. We have been rated as either first or second in Australia on timely treatment of ED patients over about the last four or five years depending on which year that has been.

**Ms THORN** — If I could add to that, the flow is from the ED into the health service but also through the health service and then ultimately for the patient to be discharged, and we would not want to underestimate the element that Lance referred to, which was the 170 additional sub-acute beds.

We already have quite a big investment in sub-acute beds unlike other health systems around Australia. It is a step-down phase, in particular for older patients or people requiring rehabilitation. Other things that we are working on in that space, which is about improving outpatient experience and patient flow, relate to the length of stay in some of these step-down beds and much faster access to rehabilitation, because all the research would tell us that the longer an older person stays in hospital, the more the psychological impact of that on their sense of frailty is exacerbated. It is good practice for older people to be — as fast as is clinically appropriate — assisted to go through steps. If you can step down at one end, it means you can step up at the front end as well.

**Mr TEE** — Which I suppose becomes important when you talk about the fact that 50 per cent of people who are in hospital taking up a hospital bed are over 70, so it would give them as many options as possible to free up space and to increase their mental and medical wellbeing.

**Ms THORN** — I think it is important to remember that public hospitals are acute facilities, so they are designed by and large, and the way they operate by and large, is by high acuity, so they can be relatively alien

environments. The staff do their best to make people's stay as good as they possibly can, but it is not like being at home, and moving people into more home-like circumstances is an important part of their rehabilitation.

**Mr TEE** — I want to take up the issue that Mr Davis raised when he referred to documents — which I might add he has not provided to me or to the witness — but I take it, notwithstanding that sort of cloak and dagger approach, your evidence is there are a number of discussions around a range of matters, including definitions and so on, but that no decision has been made. You are just working with experts on a range of issues and this document may or may not refer to some of those discussions.

**Mr WALLACE** — What the department has done is it has reviewed its broad policy definitions, but what is going on is much more detailed discussions about a procedure-by-procedure basis, and those discussions have not been finalised.

**Mr KAVANAGH** — Thank you for your presentations today. I also wanted to ask about data collection. I just want to clarify if I got something you said earlier right or not. You indicated earlier that your ability to collect data is limited by the fact that you do not have a definition yet of treatment. Is that right?

**Mr WALLACE** — I do not recall saying that in the way you have just phrased it; could you give me a little bit more context?

**Mr KAVANAGH** — You indicated that you could not say when treatment started for a patient, whether it was when the patient went to hospital or was called into the — —

**Mr WALLACE** — Sorry, what I was saying to you was in our devolved management model currently with admitted ED patients there was some discussion about what was the definition of treatment commencing; what sorts of tests, what practical examples are provided of treatment commencing. I suppose I am saying that there is some subjectiveness in that and what we are trying to do is make it more objective.

**Mr KAVANAGH** — If you are trying to work out how long people wait for treatment, you cannot do that yet because you do not know when treatment begins; is that right?

**Mr WALLACE** — No, that would not be correct. What we can do is we can measure it, but there is some subjectivity about that measure, so it might not be perfectly the same — that measurement in different sites. That is being raised as part of the discussions, and what we are trying to do is work with clinicians to actually find the definitions and make it more objective and less subjective.

**Mr KAVANAGH** — And how long have those discussions been going on?

**Mr WALLACE** — They are continuing discussions, so they have been going on for some time, but I suppose — —

**Mr KAVANAGH** — How long is 'some time'?

**Mr WALLACE** — They have been going on in different points. Different types of discussions have been going on for some time, for different periods of time. The latest discussions have very much focused on a condition-based definition of when treatment commences based on conditions. Those discussions have been going on for some months — six or so months.

**Mr KAVANAGH** — And how much longer are they likely to go for?

**Mr WALLACE** — I think that they will go for a period of time, because what will happen is that the most prominent conditions, the most common conditions, will be resolved and they will be implemented, and then that group will move on to less common conditions.

**Mr KAVANAGH** — We have heard from medical experts already; their thesis was basically that unless data is going to be objective it is virtually worthless, really. You have referred in your submission to two analyses, I suppose, of medical programs — HARP and the other one, Go for Your Life. What is the objective measurement or the objective criteria for the effectiveness or otherwise of a program like Go for Your Life? Are you confident that it is objective?

**Ms THORN** — I do not know which medical experts you are talking about who have made that comment about data, and I am not precisely sure of what they are referring to, but I still think that you can get an enormous amount of use out of data that gives you a reasonable confidence level across a number of things. I will just make a general statement about data. Perfection in data is nice, but it does not mean when you are little short of it that you cannot use information.

In respect of HARP, there was a major evaluation program done around that, around Go for Your Life and other what I call broader population health interventions. There is an evaluation program that is going on into the various elements of that, and as they are completed that gets released. Obviously over time we will evaluate the total policy, but the Go for Your Life program and other what I call health promotion preventive health programs do need to be looked at in the long term about changes in behaviour, because you are not necessarily going to see a change today because you are looking at total population changes. But they have evaluation programs around them.

Probably the most famous, or quite famous, and detailed population health evaluation that has taken place in Victoria in the last little while in the whole issue of health promotion and preventive health is the work that happened with the town of Colac, in a very, very detailed evaluation program that took place as the actual health intervention was going on. I think it was over the course of four years. It was a piece of work that was carried on in conjunction with the people of the town and Deakin University — and possibly some other universities were involved; Chris will know the details of this — which looked at a particular set of preventive health measures in that town and did find them to be very effective in slowing the weight gain amongst the children of that town. It is a relatively rare piece of evaluation in this space, but it was a very extensive one. That just tells you how long it can take. It was something like four years before they were able to come to a firm conclusion on that one.

**Prof. BROOK** — I largely concur with those comments. The value of the work that was done in Colac is that it is the first time to my knowledge in international literature, in fact, that community-wide health promotion intervention, in this case focusing on obesity, was able to demonstrate a change in the behaviour of the community. It did not in all cases demonstrate a decline in weight, but it definitely did reduce increasing weight in particular in children in the Colac community through a series of interventions.

Health promotion in general is extremely hard to evaluate. I do not mean that be defensive. But simply that equating an end effect to a health promotion intervention is often not as people think. Life. Be In It, perhaps the most famous health promotion intervention in Australia's history, has extremely good evidence of impact in terms of recognition, but in fact no change at all in behaviour. Everybody knew who Norm was and what Norm did — in fact Norm became a bit of a cult figure — which was not quite the intent. That was a problem for it.

**Mr TEE** — It was counterproductive.

**Prof. BROOK** — I have to say that part of the evaluation of Go for Your Life itself is to look at impact. The identification of Go for Your Life has a very high impact; everybody is aware of the brand, and they are aware that it is associated with a range of activities. The interrelationship between any one of those and healthier behaviour is much harder to prove and very expensive. At the end of the day what you need to look at is the evidence in terms of sustaining societal behaviour. There is some argument at the moment about exactly where that is heading. For adults there is not much change happening at this point in time. This is despite the fact that we are nearly the longest-living community in the world. Despite that fact there are still unfortunate behaviours amongst we adults. But there is some early evidence amongst the health and wellbeing children's health survey that children's dietary intake is improving and that perhaps the levels of childhood obesity are levelling out. They are very preliminary, so I would not want to give the wrong impression here. It is very hard to get people to eat more vegetables; in fact it is very hard to even define what a serve of vegetables is in a modern society where there are lots of blended foods. That is the best way in which an evaluation can occur. I will leave it at that.

**Mr TEE** — But surely smoking is the best example or a very good example of where publicity and intervention on that sort of scale has produced results.

**Prof. BROOK** — Yes, certainly. The most effective health improvement campaigns in the world, bar none — and both of them very much led in Victoria — were the introduction of seatbelts and then breath testing and drugs testing, speed cameras and the like, and then smoking. The difference between those two health

promotion activities and, say, diet is an issue about the effect of regulation. You can regulate — if society is accepting of it — cigarette smoking. The best example we have seen of that is the relatively recent — a couple years ago only — introduction of smoke-free dining and smoke-free hotels. Right up to that point in time there was a view amongst some that that would be unacceptable to the community. Living as I do in a rural area, and speaking as one who occasionally frequents the Riddells Creek Hotel, I know that change was implemented seamlessly with no disquiet. The entire community — a community incidentally of smokers often — in the hotel accepted instantly that they would have to go to an outside space, and not an enclosed outside space at that. Smoke-free dining was very rapidly accepted. Somewhat more controversial has been, for example, the movement to smoke-free cars where there are minors present. The value of health promotion in that sphere is not just telling people that this is a bad thing; there is no such thing as a good cigarette. You cannot say the same about a drink, but you can say it about a cigarette. It is very difficult to define a bad food. It is very easy to define the fact that if you are above .05 when you drinking — you know the saying.

Sensitisation of the community through public messaging, advocacy through a whole variety of organisations, which can occur with government support, and then regulation is the general pattern in which the most successful health promotion campaigns occur. I want to emphasise that regulation in areas of normal behaviour needs to be appropriate and acceptable. Regulating for particular foods is generally considered to be ineffective, though it may be that some forms of advertising of foods is effective, and there seems to be increasing literature surrounding that. Whichever way you go, this is an investment in our young folk. There can be benefits for older people, but we need to understand that the payback period is long distant, and we have to be very clear about that. We need to invest now for a long-term return not just in health-care costs but in an even longer and better set of lives for the young people who follow us.

**Ms THORN** — Both the seatbelt, or shall we say driving safety, and smoking effects measures have been around for over 30 years. You can track over those 30 years the impact of the introduction of successive measures on bringing down the next level of decline. Even if we are able to think of a way to acceptably regulate and pinpoint what foods or what behaviours need to be worked on, we are talking about a generational thing and the impacts on the young people.

**Mr KAVANAGH** — But you are aware of the danger of analysing information in a way that gets the conclusion that you want?

**Prof. BROOK** — Yes.

**Ms THORN** — Yes.

**Mr KAVANAGH** — And you are confident that those conclusions are based on objective facts?

**Ms THORN** — The one thing we are absolutely sure about in the space of health promotion activities is that it is a very contested space in terms of what works and what does not work and that, by and large, the literature will tell you that something happened, but it will not tell you much further. Having said that, if we do not try some things, then we are never going to find out. But we do need to very objectively evaluate and be prepared to move on.

**Mr KAVANAGH** — Thank you.

**The CHAIR** — We do have some follow-up questions from the committee. One that I would like to ask you about is the impact of Nurse-on-Call on emergency department presentations. Do you have any data you can give the committee as to the number of calls to that service in the three years it has been running?

**Ms THORN** — Absolutely. I do not have any data with me. Chris may have some that he can refer to. That is data that is publicly reported, and we would be happy to provide the committee with that.

**The CHAIR** — We are looking for the number of calls to the service and how many of those are then resolved in ambulance and ultimately emergency department presentations. If you have got any information on how many emergency department presentations have been avoided by virtue of accessing that service, that would be useful.

**Ms THORN** — Yes.

**Prof. BROOK** — Yes. Can we take the provision of that data on notice? I obviously do not have the data with me. There is comprehensive information on the number of calls, type of call and disposition of call. In terms of its impact on emergency departments, there are two sides. There is McKesson's work, which estimates the number of patients who would otherwise have called an ambulance. That is something which they do evaluate. There is a decline on the one hand in the number of people who call an ambulance when they have used Nurse-on-Call; there are also some people — a lesser number — who are encouraged to use an ambulance by the Nurse-on-Call service.

On the emergency department side I just raise with you the complexity of looking at Nurse-on-Call in isolation of other factors, because the lability of emergency department attendances is quite notable. We can have lower and higher numbers, depending on the season, the presence of things like H1N1 and a whole range of simple demographic factors.

What is certain is that the time that used to be spent in emergency departments answering calls because there was no other source of advice is now virtually zero and that all those calls now go straight through Nurse-on-Call. That has freed up considerable time, which I think we can demonstrate, but I shall take it on notice.

**The CHAIR** — Thank you.

**Ms HARTLAND** — I want to make a quick comment, probably more for Mr Kavanagh's benefit. I have had involvement with both HARP and Go for Your Life — fantastic programs that make a real difference to people. You do not think the community regards that health promotion as being something about being healthy, but because it got people out of their flats and away from telly et cetera there were real benefits.

**Ms THORN** — Physical and mental health.

**Ms HARTLAND** — Yes, absolutely. What I want to ask about again goes back to waiting lists, but this is more about mental health services, especially in terms of young people. I am aware that this is not a state issue, but with headspace having a great deal of its funding — about 40 per cent — being cut, how does the state envision being able to possibly pick up on that funding shortfall for headspace? In my encounters with them — because they operate in Sunshine — I have been really impressed with their no-referrals process, so a young person can just go in there and see someone. What are the other services that are available for young people and how long do they have to wait to be assessed?

**Mr SMITH** — I will have to take on notice the wait times, which I am happy to provide more information on.

The short answer to your question around the impact on the rest of the young people's service system through headspace issues is that refocusing and redesigning the front end of the children and young people's mental health service system is one of the key priorities of the Because Mental Health Matters 10-year plan. As you may be aware, a fair slab of the budget commitment in the last period was around looking at ways to reconfigure the service system for young people so that there is a much stronger emphasis on early intervention and prevention. Currently funding has been channelled to two large projects in Victoria to think about the connections between youth-specific mental health services and the range of other partners who can provide a stronger and better integrated focus on earlier intervention and prevention. One of those relates to the southern region of Melbourne and the other to the Grampians region. In both cases what they will be working through are ways to provide a much more integrated set of responses to the needs of young people in terms of their wellbeing and their access to activities and support that can address some of the risk factors for early onset of psychosis and other problems. That is one of the main areas in which there has been investment.

There are other commitments that have been made to support the needs of young people who are exiting the youth justice system. For example, one of the things that we know people are at risk of is the comorbidity between mental illness and drug and alcohol and substance misuse. Channelling those young people into ways to support both of those issues concurrently is one of those areas that we are pursuing as well.

**Ms HARTLAND** — As well as that, how long does it take at the moment to get a detox bed in, say, the western suburbs?

**Mr SMITH** — That is something I would have to take on notice. I do not have the answer to that at my fingertips. In terms of detox generally around the state I am pretty confident that the wait time — although it varies from service to service — is around about seven days, but I would need to take that on notice and just confirm that I am giving you the correct information.

**Ms HARTLAND** — And then it is an average of three to five days?

**Mr SMITH** — Correct, depending on what it is that you are requiring assistance with.

**Ms HARTLAND** — It seems to be that there is that initial physical detox, but obviously for someone who has deep-seated drug and alcohol and possibly psych issues, three to five days is not going to do it. What is the intent? I can just see those people coming back and forth.

**Mr SMITH** — Sure. Detoxification is really just the very first step in beginning to address people's substance misuse issues and where they co-occur with mental health issues. The idea is that that becomes your step into ongoing longer term treatment, which is a combination of medical assistance but more usually counselling and other sorts of supports that can assist people to reframe what is important in their lives and deal with the underlying causes of their substance misuse. It is really only the first step. We would not want to see a system where people just cycle through detox after detox rather than actually channelling themselves into the sorts of treatment that can make the difference people need.

**Ms HARTLAND** — How long would it take them to go from detox into that long-term treatment?

**Mr SMITH** — Counselling services are available pretty well immediately, depending on where, so it is likely to be only a couple of days max before people are able to access counselling services. A very small proportion of people need and want to access residential rehabilitation services. It is the very smallest end of the service spectrum in drug and alcohol. There is a longer waiting time for some of those services, but there is also assistance for people to ready themselves for that residential setting, if that is what they need, through things like counselling and support as well. There are youth-specific as well as adult services that provide that. Most people when they think of drug treatment think of those residential services, but they are in fact the very smallest part of the service system, and most people get what they need through regular access to counselling.

**Ms BROAD** — I have two matters following up on rural health matters in particular. The first one relates to patient transport services. A consequence of living in rural areas is that there are distances and costs associated with accessing specialist services in particular, and my observation would be — notwithstanding controversy from time to time — that there have been ongoing improvements in relation to those support services that are available to assist people with patient transport. I would seek your comments on those improvements to those services over time.

The second one relates to small rural health services, which is referred to on page 7 of the submission, and the particular funding model that is used for small rural health services. Again my observation would be that those particular funding arrangements have allowed for small rural health services to meet the needs of their local communities more effectively than perhaps the big casemix model has. Sometimes the negotiations get pretty vigorous and small rural health services very actively seek accreditation to do a whole range of things that are sometimes a bit surprising to find in small rural health services. My observation would be that those more flexible funding arrangements are supporting those small rural health services effectively and well, but I would seek your comment on whether that is the case.

**Prof. BROOK** — Beginning with the Victorian patient travel assistance scheme, this is a scheme which has been in place a long time. It continues to evolve. Factually, patient travel assistance schemes began under commonwealth governance but were, several health-care agreements ago, transferred to the state. It is interesting that the commonwealth did not provide any growth, but there you go.

It is a scheme which provides for assistance in two respects: first, assistance in the cost of travel from place A to place B, and that is provided at 17 cents per kilometre. It is adjusted every two years according to RACV rates. We think that that is a very reasonable rate. It is after all that which is recommended by the RACV as the cost of travel. There is also a second subsidy, which is for overnight accommodation, and that is up to \$35 per night, which may seem small, but in fact it was always intended only to be a contribution towards the cost of overnight

stay. That subsidy can also be made available to a partner or carer should it be appropriate for a partner or carer to need to travel.

I should say that there are a number of health services that make quite specific arrangements in addition to VPTAS. In our devolved governance arrangements, which we keep reinforcing, we can tell you the things that we do, but we cannot tell you all the things that health services and communities do because they are going to be slightly different. I can say that where we have regional cancer services, be it in Barwon, Ballarat, Bendigo or Traralgon, there are in fact local services and local establishments which have been created — of course there is a big one at Peter MacCallum — so that it is possible for people to come and stay where there is going to be quite a difficult journey for them otherwise, and at very reasonable rates. There are other supports than just the VPTAS scheme.

To be eligible for the Victorian patient travel assistance scheme a patient has to fill out a form. It is a form that requires co-signing by their referring medical practitioner and their specialist medical practitioner. We apologise for the fact that it is a manual form; in the new world of electronic health records we hope that that will all be overcome. There are certain criteria, and the first is that the person has to be a resident of the state of Victoria, and that means that they need to live in a Department of Health designated region. There are certain criteria in relation to the specialists, but that is all well understood.

They need to be travelling more than 100 kilometres each way or more than 500 kilometres cumulatively per week. There are sometimes minor controversies for people who live near to 100 kilometres each way, and the way in which we have to manage that is to use a consistent geographic mapping methodology. We use Route Planner, which tells us the shortest and most straightforward route from point A to point B.

If a person is a pensioner or concession card holder, then it is free — there is no co-payment. Otherwise any individual accessing VPTAS pays the first \$100 in a calendar year. We have made recent changes to the scheme to make it simpler to use: we have revised the form, we have made the approval of medical practitioners simpler and we have removed the requirement for special approval being required for air travel, which previously cut in at distances greater than 340 kilometres. I do not know why it was 340 kilometres, but that is the distance it is.

The scheme is essentially open ended. It is not a concession scheme, but it runs in that way. It currently runs at somewhere between \$7 million and \$8 million per annum. There is a lot of pressure on all governments, commonwealth and state, to extend and expand patient travel assistance schemes, and there are certainly a number of communities that would like to be eligible for this scheme but where the distances are simply not sufficient. They are obviously policy decisions, which we cannot make, but we are trying to make the scheme operate as effectively and beneficially as we can for all those clients. We are also improving the processing of claims. Whereas previously, particularly in rural Victoria, each region processed claims, notwithstanding that we are now in a different departmental environment, there is a single plan processing point in the Loddon Mallee region, which now seems to make a considerable difference to the timing and any subjectivity there may be in that arrangement.

Small rural hospital funding goes back quite a long time to the early days of the creation of the rural and regional health and aged care services division, which has a special emphasis on issues in rural health and is very much felt to be appropriate. That happened at the end of 2001. It was really quite apparent that the stringencies of casemix funding, multiple reporting and the focus on throughput, which are very important in large hospitals where you are looking at production, productivity and accountability, did not at all suit small rural hospitals, so the small rural hospital funding model was created. It incorporates more than just hospitals. It incorporates a number of bush nursing centres and other places that previously did not really have a home. There are also some multipurpose services which were previously separate but are now part of the broader model.

There are 44 rural hospitals which participate in that model. There is no absolute cut-off point. It is possible for a small group C hospital, say, to choose, as West Wimmera did relatively recently, to move from an acute WIES-funded model to a small rural model. Essentially within that they have freedom in how their resources are applied. They are not bound to produce a certain number of inpatient throughputs to achieve their WIES funding. There are still some complexities in how their budgets are made up, but that is different from the rules as to how they might apply that funding. They can and do shift funding from one part of their expenditure to another without any need for us to prior approve or in any way penalise them. Of course we do like to know

what they are doing, and we want to ensure that in shifting resources from place A to place B or C it is all going to the benefit of health-care services in the community.

Some places have been able to make greater movements than others. Partly that is to do with history; partly that is to do with the clinical professional attitudes of our community, and these things are very slow to move in some communities. I draw for your benefit the example of Cobram. I know I have used Cobram a number of times, but I think it exemplifies how this model can work. Cobram was pretty much a small rural hospital until only seven or eight years ago. It was staffed as a hospital. It had a range of staffed beds that were in fact not occupied. It predominantly had nursing staff who were focused on wards, and everything else happened separately.

If you go to Cobram today, you will find that it has a thriving community services hub directly opposite the hospital and it is about to get a major new building as part of that development. It has been able to attract a range of services. So, for example, even though Cobram is a hospital that no longer provides birthing services, it provides antenatal care, it provides a lactation clinic and it provides postnatal care, all in conjunction with specialists from Goulburn Valley Health. It provides a range of other community services that it previously could not provide, and it has been able to attract and retain more medical practitioners. It has actually generated income benefits for the community. It has generated MBS — medical benefits schedule — income that the community did not previously receive, and that has actually been a boost; it is greater than the sum of the parts.

The nursing staff who previously may have been in a hospital setting have been retrained and provide community outreach services. So instead of waiting for a person with an aged care problem to come into the hospital, it is possible now to get outreach nursing services. That is an example of what can happen. It is an example at the most highly positive end, I agree, but that is what the small rural hospital model was intended to do, and it is very much about the integration in those small communities of the traditional hospital and a range of primary care clinical services that are not necessarily at all medical.

**The CHAIR** — Thank you, Professor Brook.

**Mr HALL** — This morning we heard from Ambulance Employees Australia. They spoke to us about transfer times at hospitals. They indicated to us that in the last three months — May, June and July — of this year there were 997 cases where the ambulance transfer time exceeded 1 hour and that of those 145 exceeded 2 hours. What I want to know is how that sort of information is reflected or incorporated into the emergency access indicators that the department uses in your hospitals.

**Ms THORN** — I do not know what data that was. I think it was Mr McGhie you were meeting with.

**The CHAIR** — Yes.

**Ms THORN** — I am sure he has the data. Obviously we would need to cross-reference it with Ambulance Victoria and health services. I am not going to comment on his data.

**Mr HALL** — But in general you would be aware there are circumstances where it might take an hour for an ambulance to transfer a patient and get them admitted to the hospital system; there are circumstances where that applies.

**Ms THORN** — There are some circumstances where that occurs, yes.

**Mr HALL** — Is that circumstance incorporated in any way in the emergency access indicators, and if so, how is it?

**Ms THORN** — No, but I will ask Lance to pick up on the question.

**Mr WALLACE** — The answer is no, it is not. The issue from the patient's viewpoint is that if a patient is at an ED where they have not yet been admitted and they are waiting in an ambulance, they are under the supervision of a paramedic. If their condition changes at all or deteriorates, they would be admitted straightaway in accordance with the ED times to treatment. The issue is, I think as committee members understand, that emergency demand on health services is variable. Over time we do get peaks in demand, and at peak periods there can be queues.

**Mr HALL** — I do not want to be rude and cut you off given the circumstances of the time, I just wanted to know: these are not included currently in those indicators?

**Ms THORN** — No.

**Mr WALLACE** — Not until they transfer.

**Mr DAVIS** — I have another question regarding hospital financing. As I understand it, the department has applied a productivity requirement on a number of health services this year in the order, it has been put to me, of 2.5 per cent to 3 per cent. I wonder if you could explain to us how productivity savings are applied and the size of the productivity arrangements or dividends in the system at the moment.

**Ms THORN** — The government, as part of its budget process, has applied to departments a savings requirement in order to free up revenue for priority projects. The Department of Human Services and now the Department of Health are subject to that requirement as well.

**Mr DAVIS** — How much is that?

**Ms THORN** — It is over a couple of years. There are also some productivity requirements arising out of a health options review a couple of years ago. I honestly cannot remember the total figure.

**Mr WALLACE** — I would need to confirm it, but it is — —

**Mr DAVIS** — It is in the ballpark, though, of 2 per cent to 3 per cent.

**Mr WALLACE** — No, it is in the order of about \$40 million. That would be in the order of 1.5 per cent.

**Mr DAVIS** — The figure I have heard at network level is 2.5 per cent to 3 per cent. Perhaps this incorporates this additional — —

**Ms THORN** — No. We are talking about a total figure here. The figure that Lance is talking about, I do not know where that figure came from. In the global acute service budget the amount we are talking about is relatively small. I would be extraordinarily surprised if it was 2.5 per cent.

**Mr DAVIS** — But you are not saying it is not?

**Ms THORN** — No, we are saying it is about 1.5 per cent and less.

**Mr WALLACE** — I think that is approximate, though.

**Ms THORN** — It is approximate.

**Mr DAVIS** — That is across the whole Department of Health as it is now.

**Ms THORN** — Yes.

**Mr DAVIS** — How has the dividend or the productivity saving been applied at network level? As I understand it, there has been a series of phone calls to network CEOs to explain what the budget is this year but, as I understand it, there is no formal documentation that has been provided outlining productivity savings that are required.

**Ms THORN** — I think the telephone calls you are referring to would be part of the normal course of discussion with health services about their budgets, which is going on at the moment. A health service budget is made up of a range of elements, many of which in fact are about growth. I will actually ask Lance to talk a bit further about how those budget discussions occur. I do not know about the telephone calls other than to say they would be part of the standard budget discussions that are going on at the moment. Mostly those budget discussions take place in person.

**Mr WALLACE** — Efficiency savings for health services are usually distributed on a throughput basis, on an approximate scale and capacity to achieve savings basis. That is way that these savings have been attributed

to health services. They have not been attributed through any other means of conversation. It has been on an empirical basis.

**Mr TEE** — Ultimately all of that is in the annual reports of the hospitals in terms of their finances and their budgets and is publicly be available.

**Mr DAVIS** — Eighteen months later.

**Mr WALLACE** — This is for the new year, but it is reasonable to point out that we have had four consecutive year surpluses for health services. The fifth year is about to be announced shortly.

**Mr DAVIS** — But what I can confirm is that there are productivity savings being applied. You say they are in the order of 1.5 per cent. I am correct, as I understand it, that there is no formal documentation being provided to networks that tabulates the productivity savings required.

**Mr WALLACE** — That is not correct.

**Mr DAVIS** — No? There is a document?

**Ms THORN** — There will be a budget provided to the health service. The make-up is currently being discussed about, including how that budget will be reported in their statement of priorities.

**Mr DAVIS** — Does that list a productivity component?

**Ms THORN** — Yes, it would.

**Mr WALLACE** — In the health services budget bills, yes.

**Mr DAVIS** — In the correspondence?

**Mr WALLACE** — That is right.

**Mr DAVIS** — Can you provide a list of those to the committee — the productivity savings designed or put for each network?

**Ms THORN** — We will have to take that on notice.

**The CHAIR** — Thank you very much. It has reached 4 o'clock, and I was advised that the secretary has to depart. Ms Thorn, Mr Wallace, Professor Brook and Mr Smith, thank you for your time this afternoon and for DHS's written submission. There are a number of matters that have been taken on notice that the committee will follow up. This is one of our preliminary hearings for this inquiry, so no doubt there will be further matters that we will follow up with the Department of Health, not DHS, as the inquiry proceeds. We thank you for your time this afternoon.

**Ms THORN** — Thank you.

**Witnesses withdrew.**