

CORRECTED VERSION

PUBLIC ACCOUNTS AND ESTIMATES COMMITTEE

Inquiry into 2002–03 budget estimates

Melbourne – 21 June 2002

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Witnesses

Mr J. Thwaites, Minister for Health;

Ms P. Faulkner, Secretary;

Mr S. Solomon, Executive Director, Metropolitan Health and Aged Care Services;

Dr C. Brook, Executive Director, Rural and Regional Health and Aged Care Services;

Mr L. Wallace, Executive Director, Financial and Corporate Services; and

Mr J. Davidson, Executive Director, Policy and Strategic Projects, Department of Human Services.

The CHAIRMAN — I declare open the Public Accounts and Estimates Committee hearings on the budget estimates for the portfolio of health. I welcome the Honourable John Thwaites, Minister for Health, Ms Patricia Faulkner, Secretary of the Department of Human Services, Mr Shane Solomon, executive director, metropolitan health and aged care services, Dr Chris Brook, executive director, rural and regional health and aged care services, Mr Lance Wallace, executive director, financial and corporate services, and Mr Jim Davidson, executive director, policy and strategic projects, departmental officers, members of the public and the media. I convey apologies from committee members, the Honourable Roger Hallam, the deputy chairman, and Ms Susan Davies. Mr Robert Clark has apologised as unfortunately he will be late.

All evidence taken by this committee is taken under the provisions of the Parliamentary Committees Act and is protected from judicial review. However, any comments made outside the precincts of the hearing are not protected by parliamentary privilege. All evidence given today is being recorded. Witnesses will be provided with proof versions of the transcript early next week. Before I call on the minister to give a brief presentation on the more complex and financial performance information that relates to the health budget I ask all present to ensure their mobile telephones are turned off.

Minister, would you care to make a brief presentation to the committee prior to going to questions.

Overheads shown.

Mr THWAITES — Thank you, Mr Chairman, and committee members. I would like to give an overview of Victoria's health system. Firstly, I indicate to the committee our mission or aim. In health we often concentrate, publicly at least, simply on the hospital issues, and we will talk about that, but we should not forget that a core objective of any good health system is to promote healthy lifestyles and reduce the risk of injury — for example, today I am launching an alcohol strategy, and we have launched major tobacco strategies. If we are going to make a difference to people's health, this is where we should be doing it.

In terms of value for money, general research indicates that the value you get for health promotion and health prevention is many times greater than the amount expended. We have a mission to provide quality health care throughout the state, and to rebuild Victoria's hospitals, ambulance service, and health work force.

In relation to making Victorians healthier, in the past year we have made major steps forward in reducing harm from tobacco. From 1 September this year smoke-free restrictions will apply to gaming venues, clubs and hotels after that legislation was passed through Parliament. Tobacco advertising was banned from 1 January this year. We are seeing in outputs an indication that the number of retailers selling to children has halved in the last 12 months from 34 per cent down to 17 per cent. That is a very positive sign.

In relation to drugs and alcohol, we have a \$77 million program; we are increasing drug treatment beds; the waiting times for drug treatment have significantly fallen; we are targeting drug hot spots and working with the local community to reduce the harm that drugs cause in those hot spots; heroin deaths have fallen from 359 two years ago to 45; and we are backing all this up with a realistic advertising campaign linking young people and families affected by drug abuse to drug services.

We have had tremendous response to that. We are getting young males to respond. They are the hard group traditionally to contact and get into treatment, and those advertisements made the link with young males, and that is very important. We are also introducing education programs in all schools and the Premier's Drug Prevention Council has been established. We have a comprehensive approach.

It is important to note that the drug scene changes. While we have a reduction in heroin, we might see an increase in some other areas — alcohol abuse, prescription drugs and the like — and we have to maintain flexibility.

In terms of quality health care for all Victorians, it is important that we provide health care throughout the state. One of the key aspects of quality is providing more nurses. Providing more nurses per patient means we can provide a better quality of care.

In some places we had a very low number of nurses because of the cuts to nursing numbers under the previous government and that leads to real quality issues. We have been able to recruit more than 3000 extra nurses and more than 800 of those are in rural Victoria. We have targeted rural Victoria; we believe there is a real need to provide that nursing there.

Infection control and cleaning — we have provided a \$33 million boost to infection control. We have employed additional infection control practitioners and importantly we are now auditing infection control practices. Unfortunately in the past there has been a fairly variable performance on infection control. It can be fairly obvious things that are not followed like washing hands. Surprisingly even some quite senior doctors have not followed proper infection control procedures in the past. We are trying to get the message across that we will have an audit and we are going to boost infection control. We are establishing the Victorian Infection Surveillance Centre which will see greater oversight of what is being done in infection control. I should indicate that when audits are done and you concentrate, there will be more public incidences of infection control breakdown because we are now locating the problem. Before in many cases we did not know where the problems were and we certainly did not have any proper scrutiny of that.

In terms of clinical indicators we are now increasing the number of clinical indicators in the system to determine what is occurring at the bedside and after hospital. We have seen a major improvement in some clinical indicators. For example, mothers receiving a domiciliary visit within a week after discharge has increased from 52 per cent to nearly 84 per cent. We are now introducing additional indicators — for example, the door-to-needle time for heart attack patients. We know that if they can get treatment quickly they are much more likely to survive a heart attack, so we are measuring that.

We are also undertaking further clinical indicators. Hospitals are required to review a sample of their medical records to identify deficiencies in adverse events. One of the things that I have been keen to do has been to provide a much greater sharing of information about problems and breakdowns between hospitals. In the past coroner's reports have sometimes not been disseminated right throughout the system. Now we are ensuring that if there is a coroner's report everybody knows about it.

We are also trialling electronic pharmacy systems to prevent wrong prescribing. One of the major causes of adverse events in the hospital system is errors in the type of medicine a person should have. We are trying to improve that through electronic prescribing.

A critical aspect of quality care is care after hospital. Committee members would have been aware some years ago of people being discharged without any follow-up. We have a program of post-acute care and in the last two budgets we have provided funds to substantially increase that. In fact post-acute services have increased by 100 per cent and there has been a substantial 50 per cent increase in hospital-in-the-home and a substantial increase in mothers receiving postnatal care.

I indicate all of this to the committee because while we certainly have a priority on key performance indicators around access — for example, waiting lists and ambulance bypass — they are not the only indicators of a health system. Quality is often harder to measure. It is harder to put a statistic to, but it is absolutely vital for the patient. We are putting a high priority in the additional funds we are providing to improve quality.

We are ensuring that country Victoria gets a fair share of capital expenditure, because one of the biggest problems for country Victoria has been the fairly low standard of a lot of the aged care and hospital facilities. They have been there for many years and have not been upgraded. We have more than doubled the average capital expenditure in country areas since we came to government.

I turn now to hospitals and ambulance services where we have had a major focus on rebuilding the ambulance services with 11 new ambulance stations, more than 200 extra paramedics, advanced life support training for paramedics and a new helicopter for country Victoria. All of this means that we can meet a very substantial increase in demand for ambulance services while at the same time we have been able to maintain or in fact improve response times.

In terms of hospitals, the 2002–03 budget commits more than \$4 billion for acute health services; that is a net increase of some 8.2 per cent. The budget continues the hospital demand management strategy that we introduced in the last budget which has been successful. It was a strategy that was jointly devised by clinicians in hospitals, senior hospital administrators and the government. That has been a very positive strategy. We are continuing to rebuild hospital infrastructure. We have now committed more than \$900 million to new capital funding in hospitals. That is a huge boost under the Bracks government. We have also significantly increased in this budget support for medical research institutes and mental health.

We face a major challenge. The demand for public hospital treatment is consistently increasing at between 3 per cent and 4 per cent, but the biggest demand issue is emergency demand in our major metropolitan hospitals. We are seeing average increases in demand of 7 per cent to 8 per cent. That is very substantial — we are talking 15 000 to

16 000 extra emergency patients a year coming into the system. In terms of access to elective surgery, while we are coping with the increase in demand we are also having to ensure that we can provide adequate access for elective surgery. You can see there that in the past year we have been able to reduce the elective surgery waiting lists from 42 897 to 40 548 while coping with that very substantial increase in emergency patients.

The causes of this increase in demand are variable. We certainly have a growing and ageing population and there are new treatment options which add to the demand. However, there are particular factors that apply in Victoria. In terms of aged care beds, we are substantially below other states in the number of aged care beds we have for our population. We are something like 5000 beds short of the commonwealth's own benchmarks. Queensland, for example, has about 10 per cent more aged care beds that we do and it does make a difference. Nurses are an Australia-wide problem. There are not enough of them because there have not been enough trained at universities. In terms of funds, we are having to rebuild the health system after many years of underfunding. In many cases in those years hospitals had to sell their assets and use their capital to survive and that means they have very little left now.

In terms of aged care beds, we have in our public hospital system many people waiting there to be assessed needing a commonwealth nursing home bed. They are people who should not be in a hospital. They should be in a nursing home but there are none available. You can see on the slide that in March this year 574 people were in that category. The critical factor is these people are not there for a short time — most of them are waiting many, many weeks. While the numbers compared to the whole numbers in the health system are not great, the bed days are very significant and you can see the increase there.

We are continuing our strategy to restore confidence in our public hospitals. In the first budget of the Bracks government we injected \$176 million into our hospitals; this is in additional new funding. Last year it was \$247 million and this year \$257 million. I would compare that to the average additional funds under the previous government of some \$43 million I believe it is.

Mrs MADDIGAN — Yes.

Mr THWAITES — My eyesight is failing!

What has been achieved? The hospital demand management strategy has been successful. It is a comprehensive approach that contains a number of elements: funding growth, diverting patients to alternative forms of care, preventing the need for admission — this is quite innovative and new; we are trying to reduce that demand on emergency departments by targeting people who are at risk of admission — and attracting and retaining health professionals.

Results of the hospital demand management strategy in the past year — ambulance bypass has more than halved; there has been a steady improvement in 12-hour waits; and extra bed capacity has been created. We have treated more than 30 000 extra patients in the past year. You will see that a significant proportion of those patients are in the emergency area; we have to cope with that. Elective surgery waiting lists have been reduced by 5.5 per cent and more than 3000 extra nurses have been employed. That slide just shows ambulance bypass coming down.

This slide shows the nurses EFT in public hospitals. You will see that when we were elected we had around 21 000 EFT and now we have more than 3000 extra nurses. I emphasise that that is EFT — effective full-time nurses net of nurses who leave. It represents increased nursing capacity in the system.

There has been a significant boost in care options outside the hospital; a boost in hospital in the home and post-acute care. This year we are continuing the hospital demand management strategy. There will be substantial funds applied for growth — \$93 million — and substitution with \$20 million. Substitution is largely interim care. This might, for example, be an older person who is in hospital and might previously have been treated in an acute bed. They might have respiratory disease or have had a stroke and rather than leave them in an acute bed we are ensuring that they have access to appropriate interim care which might include rehabilitation to get them home or waiting for a nursing home bed.

Finally we are providing \$16 million for prevention on top of last year's funding of \$16 million. We are spending some \$33 million on prevention activities in hospitals and at the interface between hospitals and primary care. That is targeting people who are most at risk of being admitted to emergency departments. That is a program that is innovative. Other states are very interested in what we are doing here and we are quite proud of that program.

Future directions include extending those substitution and clinical practice reforms, extending prevention activities, managing elective surgery and dedicated elective surgery capacity. One of the issues with elective surgery is this sudden demand from emergency patients can squeeze out elective surgery. Therefore we are looking at having more elective surgery-only facilities; an example of that is Cranbourne where we have provided significantly extra resources so they can dedicate them to elective surgery.

In the budget there was extra funding announced for the current financial year as well as funding for the 2002–03 year. There was some short-term money for elective surgery which sets up an elective surgery access service and provides extra funding for hospitals with capacity to do that; the example I gave you of Cranbourne is there. Very importantly in this year's budget we announced a huge boost for hospital equipment with \$25 million extra this financial year on top of \$20 million extra next year. That is \$45 million on top of the normal \$30 million that is spent — a total of \$75 million for hospital equipment.

Other hospital system challenges — hospitals have had abnormal cost pressures such as nurse agency costs. Nurse agencies were ripping off our hospital system.

We had to take action. I am sure the committee would have been very concerned about the extra costs that hospitals were facing as a result of nurse agencies. The cost to the hospital system this year, 2001-02, is approximately \$35 million for the additional cost of nurse agencies this year. That is \$35 million that has been taken off the bottom line of hospitals, taken away from hospitals' ability to treat patients and put additional financial pressures on hospitals. That is why we had to address it.

The rise in the nurse agency cost was sudden. It had been reasonably constant for some time, but it was in the last 12 months that the rise was so significant. We took action from March this year, but unfortunately in terms of the financial year, that meant that from July till March hospitals have incurred major expenditure and major loss on these high nurse agency costs.

In addition, hospitals are facing costs of medical and pharmaceutical supplies and superannuation, which we have allocated funds for in the budget, and the commonwealth private insurance initiatives have not taken the pressure off emergency departments. On the contrary, what we are seeing is that our emergency departments are now under more pressure as a result of privately insured patients who cannot get treated in private hospitals. We are seeing particularly older medical patients stuck in public hospital emergency departments, and the private health insurance subsidy is not assisting. The AMA has indicated that there has been a practice in a number of private hospitals of preferring to treat elective surgery and not treating older medical patients with problems like pneumonia and the like.

I was talking about the issue of agency nurses. As I indicated, the increased utilisation of agency nurses was sudden and unexpected. Before the directive, nurse agency costs were up \$35 million on the previous year. The directive was given in March, which capped the volume and price of agency nurses.

Since March the utilisation of agency nurses has fallen by approximately a half. We have been able to cut back on agency nursing by approximately a half. Also, the indicative hourly agency rates have fallen by some 25 per cent. Agency costs have now stabilised at 2000-01 levels. We have been able to do that with minimal impact on service delivery.

Allied with that strategy has been the re-establishment of hospital nurse banks. These are casual nurse banks associated with a hospital. An additional 1400 nurses have registered in the nurse bank since February. The utilisation of bank staff has increased by 45 per cent since we introduced this strategy in March. So the agency nurse rate has gone down by nearly 50 per cent. The daily utilisation of bank staff has increased by about the same amount. The total amount of casual nurse usage in the hospitals has stayed the same. We have not reduced the number of casuals, but we have replaced private agency staff with public nurse bank staff, while at the same time we have increased the number of permanent nurses as well.

Those diagrams show that. The top line is the total casual staff usage, which has stayed the same. The next line shows the increase in bank. The bottom line shows the decrease in agency.

Other cost pressures I indicated were medical and pharmaceutical supplies with the low cost of the dollar and employer superannuation with the increased employer levy.

Other initiatives, very quickly, in the budget — and I am happy to respond to questions on them — are a major boost for mental health services, which amounted to \$61 million over four years; \$15 million next year; \$5 million

per year extra to expand ambulance services; which will mean the opening of new stations. We are really turning around the ambulance system where we are opening stations, employing extra paramedics and getting better performance as a result.

There are extra funds for home and community care, for primary care, and a significant boost to infrastructure for medical research units. As a government we see medical research and biotech as great opportunities for Victoria and for investment in Victoria. The basis of so much of biotech is good medical research. We have significantly boosted government support for that medical research so that in four years we will be doubling the amount of infrastructure funding they currently get. I can certainly answer questions in relation to mental health later, but there has been very significant growth there, and a comprehensive strategy.

On the capital side, we are continuing our major boost for capital works in hospitals — the Angliss hospital, Royal Melbourne, Dandenong, country hospitals and ambulance services, and that is it. I am happy to answer any more questions.

The CHAIRMAN — Minister, can I take you directly to an issue you raised during that presentation — the issue of managing the costs of agency nurses — where within that presentation you indicated that this was an area that was sudden and unexpected, with unforeseen impacts on costs, and that added some \$35 million additional this year on the previous year, and consequently that money was diverted from health programs? Could you detail to the committee what strategies have been put in place in order to prevent that occurring, and can you also provide to the committee at this stage any indication of how successful those strategies have been?

Mr THWAITES — The agency nursing costs went through the roof some 12 months ago. Hospitals were charged up to 100 per cent more for agency nurses than previously. The agency nurse rip-off cost hospitals some \$35 million. That was not sustainable. We took action earlier this year as a result of that. The government consulted with the hospitals and with the agencies, and indeed the hospitals themselves sought to negotiate with agencies to have a more reasonable charging system. Some of the agencies have complained that the government took this action without seeking to negotiate first with the agencies. In fact, the hospitals have indicated they tried but were unsuccessful, and the agencies were not prepared to lower their costs.

It has only been when the government took firm action that we are seeing positive results. In March this year we gave a direction to hospitals to limit the use of agency nurses. We directed the public hospitals on the maximum salary rate that could be paid for agency nurses. We monitored the agency nurse utilisation by public hospitals and we directed that hospitals should in general only use agency nurses to replace nurses who were sick or otherwise absent, rather than using them as a standard permanent feature. In some hospitals, for example at Monash, I think the figure was up — around 30 per cent of the nurses in the emergency department were agency nurses at any one time.

The directive has been successful, and we have been able to significantly reduce agency expenditure. To give an example, total agency expenditure in major Melbourne hospitals was \$9 246 577. After the introduction of the agency directive, expenditure in April was \$3 833 118, a 59 per cent reduction in agency fees. Most of the hospitals had very substantial savings as a result. For example, the Austin and Repatriation Medical Centre cut expenditure from some \$931 875 in February to \$423 122 in April; and one other one, Southern, went from a \$1.5 million in February to \$432 000 in April. These are substantial savings.

I should say that there was no choice about it. The hospitals are now in the position of being back to where they were at the beginning of the last financial year, but the cost of the increase in nurse agency fees to hospitals has been around \$35 million.

Mr DAVIS — As a follow-up, did you or your department hold any discussions with the Australian Nursing Federation or other unions before you took that step of issuing the directive?

Mr THWAITES — The directive in relation to agencies follows a determination by the industrial relations commission. The commission gave a consent arbitration in relation to the nurses EBA, which was one of the major issues before the commission. The ANF certainly argued that there should be a reduction in the use of nurse agencies for two reasons: firstly, because money was being wasted on the nurse agencies that could be better and more efficiently spent; and secondly, it was of major concern to the ANF and nurses working in hospitals that agency nurses had a negative effect on quality of care, because nurses from agencies did not have the same level of knowledge of wards, did not have the permanent relationship with the doctors and other health staff, and indeed the patients in the wards.

The ANF certainly argued that the high utilisation of agency nurses would lead to a lower quality of care. Following all of those submissions before the industrial relations commission, the commission recommended that there should be a major reduction in nurse agency usage and that agency nurses should only be used to replace sick or otherwise absent nurses. What the government has done is entirely consistent with the recommendation of the industrial relations commission, and indeed with the submissions made by the ANF.

Mr DAVIS — So the answer is yes?

Mr THWAITES — Well, before this stage, during the EBA, of course nurse agencies were a major issue, and the ANF raised this as a point, and we agreed with them.

Mr DAVIS — I want to take you to the issue you mentioned at the end of your presentation about new health and aged care investment, particularly the matter of the Austin hospital. Is there a current quote for the construction management agreement — that is, a maximum price-type contract — for the building of the Austin and Repatriation Medical Centre? Is that in existence?

Mr THWAITES — There is not — I said this some weeks ago, so there is nothing new in that. What I indicated was that negotiations are now to set the maximum price. Those negotiations are not complete. The government will continue to negotiate. As I indicated some weeks ago, the cost of major projects in Melbourne has increased very substantially. I have an indication of the major project costs not only for hospitals but for all developments across Melbourne. From November last year there was a very substantial increase in costs of major projects, because we are enjoying a building boom in Melbourne with major projects throughout the city — a record expenditure of more than \$12 billion in the state on building last year which means that building costs for certain aspects of major projects have risen. As a result, we are making provision for an increase in certain aspects of the costs, but that may not ever be incurred because it will depend upon the final contracts as they are tendered.

Mr DAVIS — Certainly the figure I have heard for the Austin hospital is \$365 million for that contract as one of the quotes. I am not sure that that figure is accurate, but that is certainly what I have heard. Talking about these increased costs that you are referring to, I think you said somewhere that the government's provision for the Austin hospital may blow out by more than 15 per cent. What is the likely cost for the Austin hospital; can you flesh out the details of the likely costs?

Mr THWAITES — I am happy to. I have said it in the press and publicly, so I will be repeating what I have said — there has been a very substantial increase in building costs in Melbourne since November last year. If you look at that the graph, that is demonstrated by the pink line, where you can see the sudden increase around November last year after the initial announcement of the project, which of course was approximately a year earlier.

In order to be prudent we are making provision for that escalation in costs. As I indicated, that escalation is around 15 per cent, but the figure has not been finalised because we are still negotiating a figure. Once the figure is negotiated — I would expect it to be agreed within the next month or so — that will be the maximum amount for the project. The actual cost of the project may well be less than that because this project, unlike Federation Square, is one that will have a maximum amount, and the contract is a being novated to the builder and managing contractor. This is being managed in the way that the Auditor-General said Federation Square should have been managed. The problems with Federation Square, as the Auditor-General pointed out, were that they did not have that agreed cost.

Mr DAVIS — What would the total cost be; do you have an estimate?

Mr THWAITES — I do not know how many times I have to answer the question. I have just answered it.

Mr DAVIS — I would like to have an answer on this.

Mr THWAITES — I have just answered it. You cannot say that until negotiations are complete. We are prudently making provision for the fact that there has been a 15 per cent increase in building costs. However, I cannot give you a final figure until it is agreed. Once it is agreed that will be a final figure, and we will not go above that.

Mr DAVIS — A range, perhaps?

Mr THWAITES — I have just given it to you.

The CHAIRMAN — I assume that if the government is in negotiations there would also be some downside in giving the government's estimate?

Mr THWAITES — It is not normally done.

Mrs MADDIGAN — I want to take you to the area of commonwealth-funded nursing home beds, which is of particular concern in my electorate, which is an ageing electorate, and the fact that the commonwealth department itself acknowledges that the western region of Melbourne suffers very severely from its underfunding.

Really all that is happening is that the commonwealth is cost shifting its responsibility with nursing home beds over to the state government, which has to look after these people who should be in nursing home beds in some other way. Can you give an example of what the situation is in Victoria at the moment and what sort of financial effect this is having on the Victorian state government?

Mr THWAITES — Yes, thank you. Data provided by the commonwealth from June 2001 shows that Victoria is 5447 residential aged care places short of the commonwealth's own benchmark for the number of beds that we need per head of population — that is, more than 5000 beds short. I should say that since June the situation will have got worse, as the population increases without adequate extra beds.

In terms of the specific shortfall you have referred to in the western suburbs, in the western region there is a 197 shortfall in high-care beds and a 431 shortfall in low-care beds. That is more than 600 — approximately 620 beds short of the commonwealth's own benchmarks. The same problem occurs in other areas of Melbourne. In the northern region the total shortfall is more than 1000 beds.

As you rightly say, that does lead to major problems for our hospitals, because people who need a nursing home bed cannot get it and in many cases they end up in acute care — which is also inappropriate for those people. That is something that is also of great concern. I suppose Mr Davis would be interested in the eastern metropolitan region.

Mr DAVIS — Absolutely.

Mr THWAITES — There are more than 400 beds short there, so I certainly hope you can get your federal colleagues to ensure that we have those beds, because I know how concerned you would be. I guess the other issue here, and the argument you might put to your colleagues, is that the commonwealth is saving millions of dollars a year as a result. We have calculated that the commonwealth is saving about \$80 million per annum in Victoria alone as a result of the shortfall in aged care beds. The commonwealth budget is \$80 million better off as a result of this shortfall.

Mrs MADDIGAN — Sorry, \$80 million?

Mr THWAITES — There is an \$80 million saving for the commonwealth as a result of this shortfall. That is \$80 million that the state is having to spend in order to provide alternative and interim care. Indeed, the commonwealth budget papers themselves acknowledge that savings have been made on aged care, and the estimates were varied in the budget papers as a result of savings made. So we in Victoria have a huge concern about this shortfall.

The short term answers, we believe, are as follows: first, we believe the commonwealth ought to provide some funding for the interim care we provide in our health system for people who are waiting for a commonwealth nursing home bed. That would mean that people who have been assessed as needing a bed would therefore get some commonwealth support from the date of assessment. The second area that we believe could be acted upon now is in relation to home and community care (HACC). Victoria currently receives less growth money from the commonwealth for home and community care than other states. Other states get increases of more than 6 per cent and we are getting around 4 — around 4?

Dr BROOK (Nods).

Mr THWAITES — Around 4 per cent. The commonwealth's justification for that is that Victoria historically has higher levels of HACC funding. But we say that, given that our nursing home and aged care bed funding is substantially below that of other states, we need to have higher HACC funding. And if we do not have sufficient residential beds, it is appropriate that we have extra funding for home and community care.

The CHAIRMAN — On the nursing beds issue, are you aware of the processes the commonwealth uses to determine where beds will go? I have had a local issue where people have attempted to get information from the commonwealth, and it seems there is nothing on the public record.

Mr THWAITES — Well my understanding of the process is that the first aspect of the process is a statewide distribution, then there is a regional distribution and then the particular providers make bids and the commonwealth then agrees or does not agree to those bids. As you say, there is very little information about it. There used to be much more information about where the beds were and details of what had been approved but not yet opened. Our big issue is that there are many phantom beds — beds that have been approved but are not open for two, or three years in some cases. Of course you would expect some delay between approval and opening, but in some cases people seem to be just sitting on approvals and not doing anything about it.

Now to be fair to the new commonwealth minister, he has indicated that he will commence to take action and investigate some of these phantom beds, and we heartily endorse that. Our problem is that in the meantime we are not getting any support for the extra people we have in our system who are waiting for commonwealth beds.

Mrs MADDIGAN — Does the 5400-bed figure you mentioned refer to licences that the commonwealth has given for beds or to actual beds that are operational?

Mr THWAITES — That figure relates to the number of beds that are operational compared to the number of beds the commonwealth says we should have to meet its benchmarks. I mean, if you looked at all the licences, there are many more licences than there are beds available.

Mr RICH-PHILLIPS — Minister, I would like to ask you about HACC funding. In your presentation you referred to an increase of \$6.9 million for this year, and there are other figures in the out years. Budget paper 3 at page 71 shows a decline in the budget allocation for HACC funding from last year to this year. There are two output groups: HACC primary health, community care and support and HACC service system development and resourcing.

Mr THWAITES — Sorry, which page is that?

Mr RICH-PHILLIPS — At page 71. The aggregate of those two output groups is lower for this year than it was for last year in terms of the budget. Can you reconcile that with the increase you spoke about?

Mr THWAITES — Yes, that results from the fact it is a different accounting treatment on what is included in the capital asset charge and depreciation. I think we already gave a response on this. It is an accounting factor. In terms of new money, there is extra money that will go out — the \$6 million will go out. That figure you are referring to includes the capital asset charges and depreciation, and there has been a different accounting treatment of those amounts. When you look at like on like, if you treat them in exactly the same way, you will see that in fact there has been that substantial increase.

Mr RICH-PHILLIPS — I see. Can you give us the like on like, then?

Mr THWAITES — Yes, we can. I will hand it to you.

Dr BROOK — We have given this in the writing to Helen Shardey already, but in fact in two different sets of budget papers there is a technical misappropriation, if you like, or misallocation of certain accrual charges that have no impact on cash amounts.

In the 2001–02 budget paper 3, which contains the 2000–01 target figures, there is an adjustment of \$43.2 million that is needed to bring the figures in line, the one with the other. If that \$43.2 million figure is taken into account, then the adjusted 2000–01 target is \$273.5 million, which directly compares with the 2000–01 actual of \$273.7 million. However, that figure is contained in the 2002–03 budget paper 3. So you actually have to look at the papers in a series.

In the 2002–03 budget paper 3, which contains the 2001–02 target figures, there should be an adjustment of \$32.8 million. Again, this is purely an accrual amount; it has nothing to do with cash outlays or the actual resources that go out on the ground. So the adjusted 2001–02 target figure contained in the 2002–03 budget paper 3 becomes \$304.3 million. This then directly compares with the 2001–02 expected outcome of \$311.8 million. So in 2000–01 the actual is \$273.7 million against the target which should have read \$273.5 million. In 2001–02 the expected outcome is \$311.8 million against a target figure which should have read \$304.3 million. The difference there is adjustments predominantly for enterprise bargaining outcomes as flow-on to organisations such as RDNS.

Mr RICH-PHILLIPS — That clarifies that, which then raises another question: the difference between the \$329.2 million, which is the target for 2002–03, and the revised target you just gave me for 2001–02 of \$304.3 million is \$26 million. How does that reconcile with the funding increase of \$6.9 million?

Dr BROOK — The \$6.9 million is state growth for the HACC program. That needs to be married to the expected commonwealth growth of \$13 million, which is its share of HACC growth, and there are some other adjustments which total \$2.1 million.

Mr RICH-PHILLIPS — So the majority is commonwealth funding?

Dr BROOK — The majority of HACC funding is commonwealth; \$6.9 million is the expected state share. I should point out that that is subject to final approval from the commonwealth.

Mr RICH-PHILLIPS — Thank you.

Ms BARKER — You referred towards the end of your presentation to the expansion in funding for mental health. I was wondering if you could provide us with some more advice on how that additional funding will be spent and how it will of course improve mental health services in Victoria.

Mr THWAITES — Thanks for that. One of the key aims that we had in implementing the budget was to have a significant boost for mental health. The last major mental health strategy in Victoria was in 1994. The general direction of that strategy had bipartisan support. It saw deinstitutionalisation, increased community mental health and mainstreaming of services. However, the funding for mental health did not keep pace with the increase in demand, so we are seeing growth of around 6 per cent in mental health per year.

Increasingly we have seen cases of people with mental illness in hospital emergency departments and in the community. Certainly there has been a great deal of pressure on CAT teams and caseworkers. In this budget we have sought to boost resources significantly for mental health, but we doing it in a strategic way. We have a four-pronged strategy. The first part is to provide increased capacity in the system — that is, more beds in the acute system for people with serious mental illness. This year there will be up to 30 extra acute inpatient beds for those people. There is also to be growth in community-based mental health, and that will provide extra caseworkers, mental health nurses, psychiatric disability support in the community. That is part of growing and expanding our mental health system, but it is only the first part of the strategy.

The second part is diversion. We are seeking to provide alternative forms of mental health care and treatment. We will be providing step-down facilities between the acute system on the one hand and living at home or living in the community on the other. So the budget provides funds for a new 30-bed subacute facility and support services. Psychiatrists and other people working in the mental health system have indicated to us that this is a priority to provide an intermediate step for people who might be leaving acute mental health care. Also as part of this alternative treatment we are providing additional support accommodation, which will be more than 50 places in accommodation owned by the ministry of housing that will then be supported by health workers, so people could live in the accommodation but have extra support in the place where they live.

The third part of the strategy is presentation and early intervention. The indications are that mental illness is substantially growing. We particularly want to target early intervention for adolescents and young people. One of the fastest growing areas of concern is dual diagnosis, where young people have both mental illness and an alcohol or drug problem, so there will be additional funds for a dual-diagnosis program for young people who are facing mental illness and alcohol or drug abuse.

The fourth part of the strategy concerns the work force. Not enough mental health nurses are being trained. In many areas we do not have sufficient support for the existing workers and their professional development, so the fourth part of the strategy is funding for development and support of the mental health work force.

Mr HOLDING — I would like to take you to one of the things that you touched on during your presentation — the government's priority of reducing harm from drugs and alcohol. We had the benefit of both ministers with responsibility for education appearing before the committee yesterday, and they were able to provide us with some information about the action that the government is taking to ensure that all Victorian schools provide comprehensive drug education at the secondary level. I am wondering if you can provide some further information about the government's response through the Department of Human Services, what has been achieved to date, and where you see the government's comprehensive drug strategy going.

Mr THWAITES — Certainly for the government the Victorian drug initiative has been one of our top priorities. We have committed \$77 million for a comprehensive strategy that incorporates saving lives, rehabilitation and treatment, prevention and law enforcement. I am very pleased to say that as a result of the strategy we are seeing significant improvements — for example, in the area of treatment and rehabilitation I can now indicate that the number of drug treatment beds in Victoria has increased from 432 when we came into government to 783 now. So we are looking at an increase of around 70 to 80 per cent in drug treatment beds in this state.

The consequence of that is that we have been able to significantly reduce waiting times for treatment. For example, the waiting time for young people seeking drug withdrawal — youth detox — has dropped from 11 days to less than 3 days. The waiting time for alcohol and drug supported accommodation has dropped from 17 to 2 days. As a result of being able to reduce waiting times we can treat more young people more quickly, and that leads to better outcomes. This area is very tough; it is not an area where there are magic bullets. But we do know that treatment works, that it puts people in a safe environment, and that we are making a difference. As part of treatment we are also increasing the number of doctors who are able to prescribe methadone or other pharmacotherapies. Over 100 additional doctors have been trained in that pharmacotherapy prescribing. That is in relation to treatment.

If I can just touch on saving lives. We have introduced a system where we have mobile drug safety workers in drug hot spots in order to, as far as possible, ensure that not only do we save lives but that we can direct people at risk into health services. That has been very successful. I was out at Dandenong recently and I talked to the team. They go out on the street. Sometimes they might be met with an overdose and they can work with the ambulance and other workers but what is critical is that when people have an overdose rather than just leave them to get back into the drugs as happened before they are now being connected into other services. It is a great team working in Dandenong as it is in other areas and we are seeing real improvements.

In terms of saving lives, the deaths from heroin overdose have dropped from 359 to 45. Certainly a large component of that has been the heroin drought. However, the fact that we have people on the street means that even when we are seeing an increase at times in heroin on the street, and there has been at times, we are there with health services nearby and we are saving lives. We have been able to maintain that very low level.

In terms of prevention, that is an area that was largely ignored previously. We have now boosted the total percentage of funds going into prevention. We have had the very successful drug advertisements on the television which have led to a major increase in the number of young people contacting treatment services. We have had the Premier's Drug Prevention Council established where, as you indicated, we are putting drug programs into all our schools. That prevention area is critical as well.

We now want to move to alcohol because we are seeing that an increased percentage of people going through treatment are now there for alcohol-related reasons. In the last year there has been something like a 30 per cent increase in the number of young people seeking treatment for alcohol-related problems. That is part of a comprehensive strategy.

I suppose the final thing I will say is this: the drug problem keeps changing and you have to be flexible. Heroin and heroin use is certainly down so that means there is less need for certain heroin services. At the same time we are moving into alcohol as it and prescription drugs become more important.

Mr DAVIS — I seek clarification of your point there. I was pleased to read on page 77 of the budget papers — and you have referred to it just now — about the increase in the number of GPs trained to prescribe methadone. You have referred to the heroin drought and so forth and I note also in the output group, drug treatment and rehabilitation, the number of clients on pharmacotherapy programs actually drops this year from 8800 to 7000, a drop of 1800. In a note on the budget you say that the expected outcome 'reflects reduction in demand for services due to reduction in current availability of heroin' — the heroin drought as such as you have referred to. But wouldn't it make more sense, if you are training more doctors who are able to prescribe methadone and so forth, wouldn't you be wanting to make sure that you are able to treat as many as possible? Why would you be trying to reduce your target number in that way?

Mr THWAITES — That is actually a good news story because what we are seeing is a reduction in the number of people using heroin and a reduction in the demand for those pharmacotherapy services as a result of that.

The increase in the number of doctors is largely a regional issue because in the past we have had many areas of the state where there are no doctors, or perhaps only one, who are willing to be part of the methadone program and who are able to prescribe. What we are doing with this program is providing a much better regional coverage of the

state — more doctors who can prescribe — but in fact we have fewer people, with the current heroin situation, needing that form of treatment. At the same time you will see all the other indicators for treatment have gone up so we are increasing the level of treatment but we are doing it in a targeted way.

Mr DAVIS — To the chart you had on page 13 of your presentation, nurses effective full-time (EFT) in Victorian public hospitals, I just want to gain some understanding if possible of the nurse employment issue — —

Mr THWAITES — Sorry, what page was that?

Mr DAVIS — This is page 13 in your presentation.

Mr THWAITES — Right.

Mr DAVIS — Slide 26 on page 13. That puts out, according to your figures, the nurse effective full-time in Victorian public hospitals, but I want to get to the actual number of nurses that are employed and the number of additional nurses that have been employed last year and what the impact of that has been directly on the Department of Human Services budget. So I guess what I am trying to find out from you is the number of actual nurses employed, the additional cost to the budget and how many you expect to employ this year. I am also trying to get some understanding of the spread of those and perhaps you might be able to provide a table or some information that would put out the costs of nursing employment by hospital, by region in some way and the number of nurses that have actually been employed.

Mr THWAITES — Right, the — —

Mr DAVIS — I do not know whether you have that information to hand or whether it is something you can provide.

Mr THWAITES — In broad terms I have the information to hand. The nursing numbers do go up and down a little bit and it is partly seasonal so you do get a bit of a boost when the new nurses come in from the first round and you tend to drop off during the year a little bit. But in general terms, when we came into government the number of nurses was just over 21 000, and in March of this year it was just about 24 600 — around that sort of figure.

Mr DAVIS — How many additional nurses would you have employed last year, actual nurses, not — —

Mr THWAITES — EFT, in the last year, between March and March — —

Mr DAVIS — No, actual numbers of nurses.

Mr THWAITES — The actual numbers are not as relevant. The relevant thing is EFT because that — —

Mr DAVIS — It is important for distribution.

Mr THWAITES — No, the actual numbers, because if you employ two nurses at half-time, that is one extra EFT.

Mr DAVIS — I understand that.

Mr THWAITES — So for this committee to get anything that is meaningful you need to know what the EFT is because that is what the costs are. The number of nurses does not affect the cost; it is the EFT.

Mr DAVIS — It does affect clinical delivery. If you have got two part-time nurses taking up an EFT job that is significant in terms of the way they are put out on the wards and managing staff and so forth. So it is a relevant point.

Mr THWAITES — I do not think so. I just do not think you are right there, and I think the key information is the number of extra EFT. The number of EFT has increased, as I indicated, by over 3000 — in fact by some 3300.

Mr DAVIS — So you do have the actual number of nurses?

Mr THWAITES — No, you would not. It is not a sensible figure.

Mr DAVIS — It must be collected at some point.

Mr THWAITES — Individual hospitals would collect some of that data but it is not a figure that is relevant. The relevant figure is the EFT because that is the actual full-time nurse cost and we are talking about a huge work force here.

Mr DAVIS — I understand.

Mr THWAITES — There is no point in collecting statistics that are not relevant.

Mr DAVIS — What about the cost to the DHS budget of the additional number of nurses hired last year?

Mr THWAITES — There are two aspects of it. Part relates to additional nurses who were employed for increasing nurse-patient ratios and part to the additional nurses who were employed for growth. So when I indicated the government's hospital demand management strategy has \$93 million for extra growth this year, a significant portion of that is for nurses, but there is also funding applied for extra nurses for nurse-patient ratios which came through as part of the EBA.

Mr DAVIS — How much? Can you give the committee a figure? Previously the budget used to have a table that gave employee-related costs. The current budget does not have that, so there is no way of even getting the broad costs in that way. It would be helpful to get that.

Mr THWAITES — There is not an actual figure. I might say those employee-related costs that used to be in the budget were useless. You could not work out anything from them because they included a whole lot of other factors. If you want to get a reasonable estimate, with on-costs it is approximately \$60 000 a nurse. Whatever increase you have you multiply by 60 000.

Mr DAVIS — Could you provide that figure?

Mr THWAITES — We can make that estimate, yes.

Mr DAVIS — Can you get to the actual figure? Have you got that figure available?

Mr THWAITES — I do not have it available now, but I do not have a problem about providing that.

Mr DAVIS — That would be helpful.

Ms BARKER — You referred in your presentation to the demand for public hospitals but also referred to the effect on public hospitals of those with a lower level of private health insurance. Can you provide us with some information on the effect that the commonwealth's private health insurance rebate has on our public hospital demand, the amount of money it spends on that private health insurance rebate, and how that could be more effectively spent?

Mr THWAITES — That is an important issue because the private health insurance rebate costs taxpayers a great deal of money, more than \$2 billion a year. The federal government is investing that money in health, and we need to examine whether that provides any noticeable benefit for our public hospitals.

Mr DAVIS — Are you advocating its removal?

Mr THWAITES — What we are saying is that the funds that are going into the private health insurance subsidy need to be tested. Certainly we do not say to the commonwealth that it has to remove it. What it should be doing is (a), ensuring that it works, which it is not, and (9) — —

Mr DAVIS — Are you supporting it?

Mr THWAITES — Let me finish. It is a matter for the federal government to (a), ensure it works, but (b), to also provide adequate funds for public hospitals. As a state government, when we say we do not believe the commonwealth government is providing adequate funds for public hospitals we are met with the argument, 'Yes, but we are putting all this money into the private health insurance subsidy'. It is quite proper for us to then determine what benefit, if any, that has on our public hospitals.

In Victoria there has been a significant increase in the number of people with private health insurance. Unfortunately that is not leading to any noticeable improvement in the demand for services in our public hospitals.

The traditional argument was always put that if people have private health insurance they will not go to public hospitals, but in fact they are still going to public hospitals. Our figures show that of all insured patients who present at public hospitals, 55 per cent did not utilise their private health insurance, and so in fact they are coming to the public hospitals and the majority are being treated as public patients and not as private patients. That means not only have we got the pressure of the increased demand, but there is no revenue being paid to the hospital for those people.

In terms of the effect on hospitals, you have seen the figures of growth in demand, and we are seeing that continued growth in demand of around 7 to 8 per cent increase in emergency admissions in our city hospitals. There is no noticeable effect on that as a result of the private health insurance subsidies. Why is this? The problem seems to be that the way in which the private health insurance system is working has some fundamental flaws. First, a high proportion of people have high front-end deductibles. Many people are taking out insurance policies that have high front-end deductibles, so there is a significant disincentive for them to utilise their private health insurance.

Between March 2000 and March 2002, 87 per cent of newly insured persons in Victoria took up private health with a front-end deductible. If you look at the commonwealth government's advertising campaign to get people into private health insurance — the subsidy — people took it up but more than 80 per cent took it up with a front-end deductible. This has meant that the number of people covered by a front-end deductible policy has increased by some 50 per cent. There is a significant disincentive for people to actually utilise the private health insurance they are taking out. Many people seem to be taking it out simply to avoid the taxation liabilities of not having private health insurance.

In terms of bed day numbers, in the 12 months to March 2002 the number of non-privately insured public bed days was nearly 3 per cent higher than in the 12 months to March 2001, so we are not seeing the reduction in demand that was forecast.

Finally, we have a real concern that many people who have paid their private health insurance for many years, older people, cannot get treatment in private hospitals — that they are not getting the private health insurance service for which they have paid. A range of reasons have been given for that. Certainly the Australian Medical Association (AMA) has indicated that a number of private hospital organisations are choosing not to treat those older medical patients and instead favouring younger, elective surgery that is quicker and more profitable.

If you look at the balance between what public hospitals and private hospitals do, you see that in private hospitals the vast percentage of what they do is elective surgery with a small percentage of emergency work, whereas in public hospitals we are increasingly doing more and more emergency work. That is also borne out by ambulance bypass figures, which indicate that the percentage of time that private hospitals with emergency departments are on bypass is now much greater than the percentage of time that public hospitals are on bypass.

The CHAIRMAN — Is the commonwealth reviewing its approach to private health insurance? Given those figures — that the number of bed days in public use is increasing and that a large number of people appear to be using it for tax minimisation rather than health purposes — is there any move to review the way in which it is administered?

Mr THWAITES — As part of the renegotiations of the Medicare agreement, the Australian health care agreement, we certainly hope there will be some consideration of the way in which the private health insurance subsidy is operating. I cannot answer for the commonwealth in that regard, but I hope that the commonwealth will review the operation. There are particular aspects of it that do seem extraordinarily unfair — for example, the federal government has completely pulled out of any subsidy of public dental care, so there is no federal subsidy for public dental care, yet through private health insurance the federal government subsidises private dental care for people with that in their insurance policies. So the federal government now subsidises private dental care for people who can afford it but does not subsidise public dental care for people on low incomes.

Mr RICH-PHILLIPS — Minister, I would like to ask you about the use of agency nurses. Slide 34 in your presentation showed a reduction in agency nurses since your directive of 4 March and similarly showed the increase in nurses in the nurse bank being used over that period to date. But the net effect is an overall reduction in the number of casual nurses. From 4 March to 10 June the trend line is a decline. Can you tell the committee how many bed days have been lost as a result of that decline in the total number of casual nurses?

Mr THWAITES — There are a few things, and I think I have already said it. The decline you refer to is minuscule in terms of casual use; it is almost exactly the same, it is not statistically significant. It might be in the range of about 5 or 10; it is that sort of number if you look. But as I also indicated, this has been matched by

increased use of permanent nurses as well. We are seeing a constant use of casual nurses, because we have a decline in the agency nurses and an increase in bank nurses. It is a constant use of the casual nurses, but we are seeing an increase in the use of permanent nurses, which is not part of this graph. The net effect is that we are providing the same or more in total nursing.

Mr RICH-PHILLIPS — So you can confirm no bed days were lost over that period?

Mr THWAITES — I have previously indicated that when the immediate strategy was implemented some beds were closed. It was very small, and I can give you the exact amounts. The proportion of beds closed was about 0.7 of all available beds. So it was — —

Mr RICH-PHILLIPS — 0.7 per cent.

Mr THWAITES — It was 0.7 per cent — less than 1 per cent. From the committee's point of view I am sure you would not allow a responsible government to go on paying the level of fees that were being charged. At the weekend I was out and someone gave me a front page story from the British press that referred to exactly the same issue, where the national health system is being charged some huge amounts by nurse agencies in the United Kingdom. It said that something had got to be done about it. We are doing something about it. You could not be a responsible government, or indeed a responsible Public Accounts and Estimates Committee, and not expect that action would be taken.

Mr RICH-PHILLIPS — Can you quantify point 7. Is that 20, 30 or 40 beds? What number of beds?

Mr THWAITES — The average number of inpatient beds closed was 23 across a system with 7000 beds. Under the previous government there were many days where as a result of nurse shortages, there were 200, 300 or 400 beds closed. There were hundreds of beds. These are fairly small numbers.

Mr RICH-PHILLIPS — In respect of the costs you said \$35 million was the additional cost that has not been brought back to the previous year. So basically that \$35 million has been eliminated — —

Mr THWAITES — It has not been eliminated. This is a cost that they have incurred and will hit the hospitals because it is this financial year.

Mr RICH-PHILLIPS — Is that a net figure? Does that allow for the cost of nurse bank nurses?

Mr THWAITES — That is the net figure of the cost for hospitals of the increase. Yes, it does.

Mr HOLDING — I would like to ask about the tobacco reform program which was identified as a funding priority in the last budget. Looking at the public health and drugs output group, which is the relevant output group for this program this year, I notice a 6.8 per cent increase in funding, and I understand about \$3 million of that is the flow-on from some of the initiatives that arose out of the last budget. Can you provide the committee with some information about how that additional funding is being utilised and what you see as the key achievements for the tobacco reform programs?

Mr THWAITES — Thanks for that question: \$1.5 million has been allocated to the Municipal Association of Victoria to be distributed to local councils for education of tobacco retailers about the tobacco reforms by environmental health officers. Something like 3600 visits of retailers have been undertaken to promote that education. There has also been education of restaurants, cafes, pubs and clubs. Some 3998 visits have been undertaken and there has been test purchasing of tobacco retailers by minors — that is, children testing whether retailers sell to them. That is where that \$1.5 million has gone. Also \$290 000 has been allocated to a flying squad in the department to conduct test purchasing, \$360 000 was for extra staffing of the tobacco policy unit and \$400 000 was provided to Quit Victoria for specific projects.

In terms of the key achievements, smoke-free dining was introduced in July 2001 affecting more than 16 000 restaurants and cafes and its implementation has been very successful. Point-of-sale advertising limitations and restrictions were implemented in January 2002, affecting some 12 000 retail outlets and 200 shopping centres in Victoria have been smoke free since 1 November 2001. There are health warning signs in the shops, so when you go into a shop you will see those health warning signs and the Quit signs. We have also provided extra funding to Quit for the tobacco advertising campaign which targets families. The, 'Gee Dad, I wish you were there', advertising which was very successful and lead to quite an increase in the response to the Quitline. Altogether it has been a very successful program and money well spent.

Ms BARKER — As a follow-up to that, do you have any specifics on the outcome of the sales to minors initiative? Do you have any further detail on that?

Mr THWAITES — There has been a substantial reduction in the number of sales to minors as we tested. In January 2001, which was the first month of the squad's activity, 31 per cent of retailers sold cigarettes to minors. The average rate for the financial year 2001–02, which is now, is 13 per cent. That is a significant reduction. There have been something like 1294 test purchases in 58 council areas this financial year that have lead to 33 \$200 infringement notices — so 33 people have got an infringement notice, 127 warning letters have been sent out and we are currently seeking legal advice on the prosecution of 7 tobacco retailers.

Essentially it is a staged process: first you get a warning, second you get an infringement notice, third you get prosecuted. In addition to that, councils have undertaken enforcement activity, and on top of the 1294 test purchases undertaken by the tobacco flying squad, 752 test purchases have been undertaken by councils.

Mr Chairman, can you just give me 2 minutes?

The CHAIRMAN — Minister, can I go to an issue —

Mr THWAITES — Just before you do, can I just clarify one thing Mr Rich-Phillips asked in relation to agencies? You asked about agency figures: there is a net \$35 million difference in agency expenditure year on year; that is the figure. To make it clear, the advice I get is that the actual difference in terms of the hospital, if you take into account the extra casualties, is approximately \$20 million. It is a net difference of \$35 million year on year, and while we cannot indicate exactly because we do not have all the costs in on the casualties, it is approximately \$20 million.

Mr RICH-PHILLIPS — Thank you.

The CHAIRMAN — As I started to say, I think you are aware of my interest in the issue of lack of general practitioners, particularly in regional areas. In some areas it is becoming quite a problem. Could you please describe for us how general this problem of a lack of general practitioners in rural and regional areas is, what effect that is having on the delivery of health services in those areas, particularly emergency services in hospitals — the impact on emergency departments in hospitals where there is a lack of primary health care in the community?

Mr THWAITES — I know this is an interest the Chairman has had in Geelong. As I indicated, emergency department presentations have been skyrocketing in recent years; we are seeing increases of around 7 per cent to 8 per cent. That is not consistent with a change in the basic health of the community. Of course as a result of ageing there will be some increase, but there is not a 7 per cent to 8 per cent increase. One of the major reasons behind that is the shortage of general practitioners in certain areas and the reduction in after-hours and weekend services provided by GPs in certain areas.

The problem has certainly been identified over some years but unfortunately it appears to be getting worse, and it is spreading. Fewer GPs, including GPs in the suburbs, are providing the after-hours services. We have seen a reduction in the 24-hour clinics and in some country areas it is still difficult to get GPs at all. We are seeing some major problems in some of the regional centres. Geelong and Bendigo, for example, have had difficulty attracting GPs. The existing GPs are under some pressure as a result of the shortage and are cutting back on their after-hours work. It is a problem that feeds upon itself. In some areas we are seeing GPs closing their books to patients. Once again — a shortage of GPs, GPs being overworked and they are closing their books.

The CHAIRMAN — And the Australian Medical Association rules on overservicing.

Mr THWAITES — I was in Shepparton yesterday and the problem has spread there. A front-page story in the *Shepparton News* last week said:

A shortage of doctors is clogging Goulburn Valley Health's emergency department with people suffering minor complaints.

Goulburn Valley Base Hospital doctors are concerned patients are turning to the hospital when they are unable to see a private doctor. More than 130 patients were treated in the emergency department on Monday's public holiday — nearly double the average of 70 to 80 patients a day.

We are really seeing that major bottleneck in the emergency departments because of the shortage of GPs.

More generally, I have asked the department to provide me with some statistics on actual presentations for metropolitan emergency departments in the past 12 months. They show that there has been a 9 per cent increase in

paediatric presentations, a 10 per cent increase in triage categories 4 and 5, which are the low category triages in emergency departments — people who should normally be going to a general practitioner — and a 7 per cent increase in out-of-hours presentations. A large part of the increase in demand on emergency departments seems to be linked to the shortage of GPs. This is occurring not just in the country, where I guess it started; we are now seeing it in the suburbs as well.

Part of our hospital demand program is aimed at having better links between GPs and hospitals. Traditionally there have not been good links and hospitals have not really seen themselves as needing to coordinate closely with GPs. We are now working with divisions of GPs to try to get that much closer link and providing funding for a better partnership between hospitals and GPs. In relation to country areas, we do have the overseas-trained doctors scheme where more than 50 GPs have been placed in towns. There is still an issue about where that will apply. It has been fairly limited and we would hope that over time we could get an extension from the commonwealth into certain areas, particularly some of the regional areas.

The final point I would make is I think the commonwealth has recognised that this is a problem. I was very pleased to see in the federal budget a small item that might make a difference: registrars will now be able to work in GPs' clinics. As I understand it, a few years ago their right to work there was taken away and that removed a work force pool from the market. Hopefully if some of these registrars can work in clinics after hours we might get more doctors providing more services. I have to say that the eastern suburbs are a problem. We have had a huge increase in emergency presentations in the outer east — at Maroondah, for example. It is hard to put your finger to it but anecdotally we are told that one of the significant aspects is the shortage of GPs.

The CHAIRMAN — Just to follow that up quickly, as you are probably aware, for RRAMA — rural, remote and metropolitan areas index — purposes Geelong is treated as metropolitan; there is an issue there with the commonwealth. My understanding of the emergency admission issue is it has a significant effect on the health budget in that it is much more costly to treat people through emergency admission than if they were treated in the community by a general practitioner.

Mr THWAITES — That is right. In terms of the Victorian health budget, if people are treated through the emergency department that is funded out the state budget, whereas if they are treated by a general practitioner that is funded through Medicare through the commonwealth government.

The CHAIRMAN — But even so, at a much lower level; the cost would be lower.

Mr THWAITES — I am not sure about that; I am not sure that that is necessarily right.

Mr DAVIS — I would like to take you to the issue of fire risk management. It is my understanding that various budget papers indicate that since coming to office you have allocated \$40 million for fire risk management, including this year's budget allocation, to cover all health facilities.

Mr THWAITES — I think it is about \$10 million this year.

Mr DAVIS — Yes. However, you may remember that back in late 1999 the Department of Human Services estimated that \$50 million would be required to be spent on state-run nursing homes and hostels alone to meet commonwealth and state fire safety standards.

You are quite right about the \$10 million in this year's budget, in budget paper 2. Can you indicate how much of that money has been or will be allocated to state-run nursing homes and hostels, and can you assure the committee that state-run nursing homes and hostels will meet those commonwealth and state fire risk management standards in time for the 2003 commonwealth accreditation round?

Mr THWAITES — There are a few questions in there. As you say, there is \$10 million in the budget for fire management in hospitals and aged care. In addition, part of the \$40 million that is in the budget for aged care will be expended this year on fire management in aged care facilities to meet accreditation. While the exact works have not been identified yet, I believe around \$4 million, between \$3 million and \$4 million, of the \$40 million of the aged care capital funding is available in addition to the \$10 million for fire works.

Certainly the meeting of those accreditation standards is the highest priority for the government. That is why we are spending \$40 million this year. I think over the three budgets we have had something like \$120 million on upgrading of aged care facilities across the state.

Mr DAVIS — Just to get that clear in my mind, the \$3 million to \$4 million out of this year's account is correct, or \$3 million to \$4 million out of the \$40 million?

Mr THWAITES — Yes.

Mr DAVIS — It still seems a long way short. I am trying to work out exactly how much has gone to state-run nursing homes.

Mr THWAITES — Every year we have made a huge boost for capital funding in state nursing homes to meet accreditation standards. It was \$40 million this year. I think it was about \$30 million this year and \$50 million the year before in round terms.

Mr DAVIS — That \$40 million was not only for — —

Mr THWAITES — No, but part of that money goes to meet fire standards. It is a little hard to identify just that amount because what we are doing is rebuilding the whole facility, and in doing that we are obviously meeting the fire standards. But where we have not rebuilt the whole facility, where we are just directing funds at fire, we are doing that to ensure we meet the accreditation standards. That is what the \$3 million to \$4 million is. So if you were to look at the total amount we are spending for fire standards in aged care facilities, it is much greater than that because there is an element in all the projects of fire standard upgrade.

Mr DAVIS — We will meet those 2000 upgrades?

Mr THWAITES — We will.

Ms BARKER — It looks like we need to catch up.

Mr THWAITES — That is right. There has been a real backlog in works. Frankly, there was — —

Mr DAVIS — Going back to the 1980s even.

Mr THWAITES — There may well be, but this government has turned that around. If you look at the figures there has been a huge boost in funding for aged care facilities.

Mrs MADDIGAN — And of course they have not been privatised.

You mentioned before in passing the commonwealth and state Medicare agreement which I understand is currently being negotiated. Could you give us an update on where we are with that and what the state government is seeking to get through the new agreement?

Mr THWAITES — The Australian health care agreement — the Medicare agreement — is being renegotiated. The new agreement commences 1 July next year. This is the agreement where the commonwealth provides funding for the public hospital system. We are seeking to have a more comprehensive health care agreement with the commonwealth that begins to cover the important interface between hospitals and the rest of the health system. I have talked today about the effect of the shortage of general practitioners on emergency department. This is an important issue for the Australian health care agreement.

I have also talked about the issue of mental health where we have mental health patients in emergency departments' acute facilities. These are issues that we have to consider as we jointly reach agreement.

We are also seeking a much more cooperative approach with the commonwealth and an approach that ensures as far as possible that we reduce cost shifting and the incentive to cost shift. We are seeking to have an improved health care agreement which much better coordinates care and reduces the incentive for cost shifting and for shifting the blame.

Mr RICH-PHILLIPS — Given the Austin redevelopment or new construction, what are the government's plans for the current Austin Repat site? Do you have a plan in terms of time frames and processes for disposal or what the government is going to do with that? Can you outline that to the committee?

Mr THWAITES — The Austin hospital redevelopment is occurring on the Austin site.

Mr RICH-PHILLIPS — The Repat site?

Mr THWAITES — The Repat site is also part of the redevelopment plans, and there will be improvements there. We have determined that there should be improvements to both those sites. Our plan is to invest in a new Austin and Repatriation Medical Centre, together with the Mercy Hospital for Women. That will be the biggest health project in Victoria's history. It will lead to a major improvement in health services for the northern suburbs. We seek and will maintain a high level of service for veterans who obviously have a historic and continuing link with the Austin and Repatriation Medical Centre. Increasingly, services for veterans are changing, obviously as they age, and I think into the longer term we will need to examine and look at the need to provide aged care services and facilities for those veterans.

Mr RICH-PHILLIPS — There will be no disposal of the Repat site or part thereof?

Mr THWAITES — Sorry?

Mr RICH-PHILLIPS — Or part of it?

Mr THWAITES — We have also said that at some stage we may consider parts of it, but not the service parts. It is a very large site. When we announced the plan we said that at some stage there may be consideration of some of the non-service areas, but that is not the focus of our attention. The focus of our attention is on upgrading the facilities. We are not going to do anything that will sell off any part of the site that would lead to any reduction in services.

Mr RICH-PHILLIPS — Is that being considered now?

Mr THWAITES — No, it is not. It is not something we are planning. There is a whole exercise, but it is not on the agenda. At the time it was announced we indicated that at some time in the future with a very large site there may be some parts of it that can be utilised for other things, but we emphasise that in no way are we going to reduce services. In fact, we are going to improve them.

Mr HOLDING — I would like to take you to the issue of emergency departmental demand which you touched on during your presentation and indicated that emergency admissions in particular is a major growth area in the metropolitan hospitals sector particularly. I am wondering if you can describe the trend in recent years in hospital emergency department demand and take the committee through the strategies that have been implemented to deal with this demand level?

Mr THWAITES — As I have indicated, we have seen an average increase in emergency demand of around 7 per cent to 8 per cent in admissions. It varies a little from hospital to hospital, but we are seeing that major increase. Hospitals have had to struggle and cope with that increase in the past. We as a government have now implemented the hospital demand management strategy as our response to that increase in demand. That is a strategy that has been jointly developed by clinicians and the government. One of the key parts of that strategy has been to increase capacity in the emergency departments, so some of the emergency departments have increased in size, and we are able to treat more patients. We are expecting to treat around 15 000 extra patients in the next financial year in our emergency departments.

Secondly, we are providing innovative services associated with the emergency department, such as the short-stay unit where patients rather than staying in an emergency department or being admitted to an acute ward can receive intensive treatment rehabilitation for what is likely to be a short stay. These are people who need to be in hospital for perhaps two or three days and then discharged home.

Another innovative approach, for example, to relieve pressure on emergency departments, is to relieve pressure on beds in the hospital, so if people from the emergency department can get a bed then one way of doing that is through medi-hotels. The Alfred hospital has opened a medi-hotel which might be for someone who does not need intensive nursing but needs to be at the hospital overnight — for example, someone who the next day is to have an operation who is quite well but rather than being in an acute bed they can be in a medi-hotel — someone from the country, for example.

Other things that we are doing in emergency departments is what we call the emergency department breakthrough series — that is, sharing information between emergency departments about what works best. As a result we have been able to get a major improvement in the performance of emergency departments much faster. For example, I talked about a clinical indicator, the time-to-needle — that is, somebody having a heart attack and how long it takes them to get the thrombolytic injection. For those people we have been able to get in-hospital decreased times.

Another example — and I saw this at Shepparton yesterday in its emergency department — is the use of a triage nurse. When people come in the triage nurses in some of the hospitals are doing more than they did before. Rather than just triaging people they in some cases are able to send them straight to, say, radiology and that cuts down on time. To bring it all together, the government has done the right thing by providing more resources — the doctors, nurses and hospitals have done the right thing by coming up with the ideas.

Ms BARKER — I want to refer to the increased funds provided by the government for ambulance services. Will you advise in detail the initiatives that have been undertaken? There certainly has been increased demand, but what initiatives have been undertaken to respond to that demand?

Mr THWAITES — In this year's budget we have provided some \$20 million over four years for extra support for the ambulance service. That comes on top of some \$42 million last year of extra funds over four years. Where has the money been spent? We have opened 11 new ambulance stations; 2 extra ambulance stations are under way; and we have been able to employ more than 220 extra ambulance paramedics. We are providing training for those paramedics in advanced life support so that they can do a better job and save lives more successfully.

The result, together with other initiatives — including our support for CPR training for the public and the first responder system, which means that in many Metropolitan Fire Brigade areas the fire brigade can be called out — has meant that for the most urgent heart attack cases response times have been significantly reduced. Recently I announced research which indicated that the survival rate for heart attack victims had doubled over the past six years. The extra resources, extra ambulances and ambulance stations have a meaningful outcome — that is, more people surviving heart attacks.

Similarly, despite the very substantial increase in demand — the number of people calling ambulances — we have been able to maintain and indeed improve response times. When you put all that together the ambulance service is now performing well. I am confident that we have in place the right strategy for the future.

The CHAIRMAN — I should on behalf of Ms Davies, who takes a keen interest in these things, ask: have rural and regional areas benefited from that approach?

Mr THWAITES — Absolutely. We have put a high priority on rural ambulances. We have put in a new helicopter for rural Victoria based in Bendigo; upgraded the helicopter that services Gippsland; completely upgraded the air ambulance fleet so we have a new state-of-the-art ambulance fleet; established MICA units in country areas where they were not before; introduced 24-hour MICA coverage for Shepparton, Mildura and Wangaratta; and commenced two-officer crewing in a number of country areas where before they had one officer. Those projects commenced in Moe, Warragul, Colac, Lakes Entrance, Bairnsdale, Seymour, Kilmore, Cowes, Lorne and Wonthaggi. Across the state we are increasing the number of ambulance officers in those country areas.

We have opened a new ambulance station in Bright, are building a new one in Romsey and will be building a new one in Torquay for that Barwon area. It is a very good effort that Rural Ambulance Victoria has performed in the last few years. It has kept its response times down, and we have provided additional resources.

Mr DAVIS — I take you to the dental health output group at pages 74 and 75 of budget paper 3. I note the government stated commitment to dental services for restorative dental care and dentures. I am looking at the dental services output group where it appears that the target and actuals in waiting time for dentures appears to show no improvement — for example, the waiting time for restorative dental care the expected outcome is 22 and the target is 22, and the waiting time for dentures the expected outcome is 24 and the target is 24. At the same time adding those output groups to dental service system development and resourcing, it seems to me that the expected target of spending was \$83.1 million, but only \$82 million will be spent. I calculate that in that dental output group there is an underspend of \$1.1 million. If you add up the \$81.2 million and the \$1.9 million as the target in 2001–02, and the expected outcome is added, it comes to \$82 million. There appears to be an underspend of \$1.1 million.

Mr THWAITES — What page is that on?

Mr DAVIS — Pages 74 and 75 of budget paper 3. The 2001–02 target is \$81.2 million, and the \$1.9 million for dental service system development and resourcing output group comes to \$83.1 million, and the expected outcome is \$71.5 million plus the \$10.5 million comes to \$82 million. That seems to me to be an underspend on your target for the total dental health output groups.

Mr THWAITES — Look, I am just getting some advice. The advice I get is that the officers cannot see that there is particularly an underspend there, but I can chase that up.

If I can talk more broadly about those issues, because if there is some level of underspend, which is very small in percentage terms, there is a problem with the dental work force and attracting. We have provided additional funds to treat more people, but we do have a problem finding the dentists to do the work. That causes a real problem for us.

At the moment we are seeking to address that through a negotiation around conditions for dentists in the public work force. I am hopeful that when we do that we will be able to provide more services across Victoria. It has been a particularly acute problem in country areas, where we have a number of vacancies for dentists. So in terms of the overall issue that is probably the biggest issue that we face in the dental area.

Mr DAVIS — Just to understand this a little further, the waiting times over a period appear to have increased, or at least remained static at a minimum, for dentures and restorative dental care. Would you concede that if that additional money had been spent there may have been some improvement in those times?

Mr THWAITES — No, I would not. I should say that if you go back on what we are spending compared to previous years and the previous government, there has been a substantial boost. But unfortunately this has occurred at a time when the federal government has completely withdrawn from the funding of any public dental work. That has led to a huge pressure on the dental system. There is a major growth in the number of people needing public dental care, and we have sought to meet that growth with additional funding.

Mr DAVIS — That in no way accounts for an underspending in your own budget?

Mr THWAITES — I am just checking on that.

Ms BARKER — He has just explained.

Mr THWAITES — I will check on that aspect of it, but even on your own figures it is a very small percentage of the total budget. The key point I would make is that, as well as the funding we are providing here, we are now doing more to improve this dental work force issue.

The other thing that is not shown here of course is our improvements to the school dental program, where we have extended the school dental program for kids, whose parents are on concession, right through secondary school.

Mr DAVIS — But not in tertiary institutions? As I understand it, you are removing support for dental programs in some tertiary institutions?

Mr THWAITES — I am not aware of that.

Mr DAVIS — Monash, I think.

Mr THWAITES — I am not aware of that.

Mr DAVIS — And maybe Swinburne. Is that — —

Mr THWAITES — No, I am not — —

Mr DAVIS — I am happy to — —

Mr THWAITES — I am not aware that we would fund tertiary institutions.

Mr DAVIS — No, I had an idea there was some support there.

Mr THWAITES — Not from the state government.

The CHAIRMAN — The removal of support may be commonwealth.

Mr THWAITES — Yes, it might be — —

Mrs MADDIGAN — It might be federal — —

Mr THWAITES — I am not aware of that, but I can assure you that our fundamental focus is on the — —

Mr DAVIS — I am happy for you to get back to me on that.

Mr THWAITES — Yes, our fundamental focus is on the school dental program. We have substantially expanded that so that we are providing school dental programs through the secondary years for young people whose parents are concession-holders. It is very important that young people get that good start.

The CHAIRMAN — Still looking at the figures on that page, Minister, I refer to a couple of other interesting aspects. In spite of what Mr Davis was raising, I note from the bottom of page 74 of budget paper 3 that you still expect to achieve the targeted number of patients seen during that time. I also note under 'Quality' that for the coming year you are also targeting to improve the ratio of emergency to general courses of dental care, which I would have thought should also help to improve that situation?

Mr THWAITES — Yes, that is right. It has been a problem we have been having, where we have been getting more and more emergency cases. So we are seeking to restore that. As you point out, in terms of the expected outcome we are expecting to meet our target, which would seem to indicate that there is no question of an underspend. You have to be a bit careful with these bottom-line figures because they are accrual figures and so they do include a whole range of matters.

Mr DAVIS — As they should?

Mr THWAITES — Which they should. But the fact that they do means you cannot always directly compare them to an output. So we will chase up the details of that.

Mrs MADDIGAN — Back on the subject of commonwealth funding of the state health system, some concern has been expressed in the press about the lack of nurse training positions in Victoria, which of course the commonwealth is responsible for. Do you have any information on that, and what effect that has had on the availability of nurses in Victoria?

Mr THWAITES — Yes, that is a very important issue. Basically we cannot provide health services if we do not have nurses.

Mrs MADDIGAN — Precisely.

Mr THWAITES — To put it very simply, in the last decade we have had a very substantial increase in the number of patients treated. We are looking at, in a decade, around 50 per cent more patients treated. Yet the number of nurse places in universities has stayed the same. Now that is just not sustainable. This government, through its nurse recruitment and retention strategy, has been able to recruit an extra 3000 or more than 3000 nurses into the system. But we have largely done that by recruiting nurses who have been trained in the past and are not nursing now. They might be in other jobs or at home. We have gone to that group and encouraged them to come back into the system. But that pool will eventually run dry. Unless the commonwealth provides more training places, there will be a crisis in five or six years.

Now demand for places is very strong. The number of university applicants for 2002 who listed nursing as their first preference jumped by 26 per cent. Clearly nursing is now an attractive profession to enter. However, unfortunately the commonwealth and the universities did not provide the extra places that were needed to meet that increased demand. Indeed, the Auditor-General has also pointed this out in his recent report to the Parliament.

To go into the specifics, in 1992 the total number of students enrolled in university nursing courses was 8579; in 1999–2000 it was 7388. So in fact there had been a reduction. At the same time, if you want to compare that to the total number of separations through the hospitals, in 1992 it was 720 956, and in 1999 it was 977 580 — so a huge increase in the number of separations and the amount of work but a decrease in the number of students enrolled in nursing.

So we would certainly be encouraging the commonwealth to provide more places. We would also be encouraging the commonwealth to look at the situation with postgraduate courses for nurses. In order to be an intensive care nurse or a theatre nurse it is necessary to have some form of postgraduate training. Currently under the commonwealth system nurses doing those courses have to pay full fees, in most cases.

That means there is a major disincentive for nurses to do those courses. The Victorian government has been provided scholarships for some of them; but it is not the Victorian government's responsibility to fully fund universities; funding is essentially the commonwealth government's responsibility. So we would call upon the

commonwealth government to provide more undergraduate HECS funded nursing places and more graduate places to be either scholarships or HECS charged rather than full fee paying.

Mr RICH-PHILLIPS — I would like to ask you about the residential aged care and rural health redevelopment upgrade line item in budget paper 2 on page 183 — the \$40 million program over the next three years. Can you provide the committee with some background as to what exactly is included in that, and in particular what the funding breakdown is between the residential aged care component and the rural health component.

Mr THWAITES — Page 183?

The CHAIRMAN — It is on page 185.

Mr RICH-PHILLIPS — Residential aged care and rural health development.

Mr THWAITES — Essentially this is a capital works funding appropriation of essentially \$40 million for residential aged care. I can give you the basic list. The works are at Lyndoch in Warrnambool; Beechworth health service, which is largely a residential aged care project but with some acute ward involvement; Jacaranda House at Bairnsdale, an aged care project; Omeo Health Streams, a multipurpose service; Maryborough District Health Service, a 45-bed aged care facility; the Grace McKellar Centre at Barwon Health, Geelong, to enable the redevelopment of palliative care beds and some support services for aged care; works at Parkville hospital — a minor amount which is just some refurbishment; some extra funding for the Lumeah Nursing Home at Echuca; and certification upgrade works which include some of those fire works that are referred to in Mr Davis's question.

Mrs MADDIGAN — That is 'fire works' as two words as opposed to one word, is it?

Mr THWAITES — Yes.

Mr RICH-PHILLIPS — Did the Warrnambool project include residential aged care?

Mr THWAITES — Yes, that is what it is. It is an aged care project.

Mr RICH-PHILLIPS — And the Omeo project also?

Mr THWAITES — That is aged care, yes.

Mr RICH-PHILLIPS — Are you able to give a dollar breakdown against those projects?

Mr THWAITES — Not off the top of my head but I can in broad. From memory the Warrnambool project is somewhere between \$7.5 million and \$11 million. They do not get finalised until all the tenders are out. Omeo is about \$2.5 million, I think.

Mr RICH-PHILLIPS — When you have those figures can you provide them to the committee?

Mr THWAITES — Yes, no problem. I have a response on that dental question if that is helpful.

Dr BROOK — I am happy to provide this in writing as well so you get the full detail; however, it is again another of these accrual adjustments. In this instance what has occurred is with the change in output groups in the department two years ago there was an element of accrual allocation to dental health which did not belong there. That has been transferred into primary health outputs, in particular the school nursing budget, and into insurance which is held centrally. So again the costed output is not affected by that — these are accruals — save for the insurance components which would in fact be a direct cost.

Mr THWAITES — So there is no underspend?

Dr BROOK — No, there is no underspend.

Ms BARKER — You have talked in detail about the hospital demand and management strategy, but within that strategy the hospital admission risk program (HARP) was funded last year and refunded again this year. I wondered if you could provide us with some information on the types of programs that are being looked at that are being developed under HARP.

Mr THWAITES — I certainly can. This is an exciting program because it looks to the future. It seems to reduce the risk that people will end up in hospital when we can avoid that. It targets in particular people with chronic illness and the frail aged. There are a number of very different projects at different hospitals.

Individual hospitals and indeed primary care agencies, including community health centres and divisions of general practitioners, have come together to recommend specific and innovative projects for their hospital and their region. This year the total funding is some \$16 million on top of the \$16 million last year, so there is a total pool of around \$32 million to 33 million.

To give you some examples of the sorts of projects that we are looking at, I understand \$38 new projects have been approved for this year. At Bayside Health there is to be an integrated managed care project targeting aged people with strong links to GPs which will give those people 24-hour phone line access to care, so older people know that rather than having to come into hospital there is someone they can contact — a GP or someone associated whom they can ring at any time.

There are some seven disease management projects for managing conditions such as diabetes, asthma which is another chronic illness, and respiratory problems. The Sisters of Charity in St Vincent's have these disease management programs for diabetes, respiratory illness and asthma and in these cases there is a focus on case managing the person who has that disease — for example, for a person with diabetes the aim would be to have very early intervention to manage the disease and the lifestyle factors associated with diabetes so the person does not end up with an unnecessary hospitalisation.

Another angle to that is linking diabetes education through diabetes nurse educators to GP practices. So when people who have diabetes come into a GP practice the GP can then refer them on to a nurse educator and in that way keep the person out of hospital. So without going into all of the 38 projects in detail, it is about targeting very carefully people with chronic illness and the frail aged and ensuring that they can get the support they need while they are out of hospital so they do not end up in hospital.

Mr HOLDING — During the presentation you mentioned that you would be making an announcement this afternoon about alcohol and alcohol-related issues. A study referred to in this morning's media claimed that up to 60 per cent of year 12 boys binge drink on a regular basis. I think their definition of binge drinking was six or so standard drinks.

Mr THWAITES — I think it was five.

Mr HOLDING — Five standard drinks. I would be interested to know, without pre-empting what you are going to say this afternoon, where the government sees its strategy going with respect to addressing not just alcohol abuse among teenagers but alcohol abuse more widely. You mentioned in your comments that during the heroin drought and things like that people often turned to alternative substance abuse, and alcohol is obviously one of them.

Mr THWAITES — I think the community need is to turn its attention to alcohol abuse. There has been a lot of publicity around heroin and heroin abuse, but what we know is that for many years the biggest drug problem that we face is tobacco and the second-biggest is alcohol. We have certainly directed our attention to tobacco in the past few years. We are now directing our attention to alcohol.

In relation to the strategy, there are a number of aspects to it. First, in relation to young people, one of the most important things is to give them the information they need to make sensible choices about their alcohol drinking. Alcohol is quite a different issue to, say, heroin or chroming, which only affects a very small number of young people.

Most young people experiment with alcohol and the biggest problem we face is that most of them do not understand what are safe levels of drinking and what are unsafe levels. In recent surveys conducted for the Premier's Drug Prevention Council, about 3 per cent, I think, of young people identified themselves as drinking to hazardous levels and yet around 15 per cent of the young people in that survey were drinking at hazardous levels. People do not understand that if they are drinking five or six standard drinks they are putting themselves at risk. They are putting themselves at risk in the short term through things like unsafe sex, injury through fights and violence and injury through traffic accidents.

The program we will run will provide that information to young people: how many standard drinks are safe and what constitutes a standard drink. That information will be in places which young people frequent — we will have

them in bus shelters and on toilet doors. We will have a campaign at the beginning of the next academic year for O week in universities and in technical and further education colleges because that is a time when there is a lot of pressure on those people to drink. We are also looking more broadly, beyond young people, at safe drinking in the workplace. There are some workplaces where there are quite high levels of unsafe drinking, and we will provide information to those workplaces to ensure that they can be safer.

We are also looking at the promotion of alcohol to young people, and unfortunately I think there is some irresponsible promotion of alcohol. We see that partly through the media and there have been reports about certain TV shows where alcohol is promoted as very much part of a lifestyle. While a level of alcohol, of course, is part of living, some of these shows go beyond that. But it is not just those forms of media. The Internet is now becoming a place where there is alcohol promotion, which I think could well be inappropriate involving quite young people, involving advertising which breaches the code because it is of alcohol suppliers. I think we have to look at the Internet as well. As well as providing information to people about safe and unsafe drinking we also want to investigate the promotion of alcohol.

The final point I would make is that we are significantly boosting funds to the Good Sports program. This is a great program initially run by the Australian Drug Foundation where sporting clubs can receive funding to get information about safe alcohol use. The research shows that in a lot of sports clubs there has been very unsafe use of alcohol — footy clubs selling beer to people under 18, people drinking a lot at the club and then jumping in the car and driving home. We have a system where sports clubs can now be accredited as a Good Sports club, and we train the sports club in safe drinking and safe distribution of alcohol and provide funds for that. We will extend that considerably with the extra funding of \$200 000 immediately.

Mrs MADDIGAN — Can I just follow up on that? I thought another area where there needs to be publicity is in the serving of alcohol. While it is fairly easy to measure a standard drink if it is beer — I suppose football clubs and small clubs are good examples, and also restaurants — but where wine is served they often serve significantly larger than the standard drink so that people can go in there and think they have had two drinks and they have actually probably had the equivalent of four or five during the evening or the day. Is that part of the —

Mr THWAITES — It is, and indeed we have already got the first information sheet, and it shows two glasses of wine: a standard glass of wine, which is one standard drink, and a restaurant standard, which I think is about 1.5. That is part of the warning.

If you would like I could just go back over that issue of aged care. I have the numbers if you are interested in that.

Mr RICH-PHILLIPS — Thank you, yes.

Mr THWAITES — Bairnsdale is \$4.3 million; Grace McKellar at Barwon is \$3 million; Beechworth, \$4.7 million; the certification works is \$4.0 million; Echuca, 0.5 million; Warrnambool, \$7.5 million; Maryborough \$8.0 million; Melbourne Health, \$0.5 million; Omeo district \$2.7 million which leaves some still unallocated.

Mr RICH-PHILLIPS — Okay, thank you.

The CHAIRMAN — Can we just clarify there minister that they are estimated costs.

Mr THWAITES — Yes, that is estimated. It can go up and down depending on the final tenders.

The CHAIRMAN — Can I ask you in relation to your slide 30 on page 15 of your presentation about the extra funding last year, and I think you said continuing through the second dot point, the equipment upgrade of \$25 million with priority to addressing the backlog in replacement. Can you provide the committee with some more specific detail of what is being done there, how that is being carried out and why the need existed to inject that money into equipment replacement?

Mr THWAITES — There is a wide range of different equipment that is being provided. As I indicated, it is \$25 million extra this financial year, and that money has just been distributed. Frankly, it depends on the type of hospital. At the teaching hospital end it has tended to be major technological equipment for radiology, for example. The system that the Alfred hospital is introducing will enable the electronic transfer around the hospital of X-rays and other diagnostics rather than having to send papers all around the hospital, which is expensive and wasteful of time, so they will be able to do that electronically.

At Barwon Health there was funding for the cardiac cath lab which from memory was about \$700 000. In country areas, at the other end I suppose, it has been able to be used at a much lower but still important technological level,

including things like beds — electronic beds and the like. Other indications are defibrillators, operating suite equipment, patient monitors, I mentioned the ergonomic beds in country areas, ICU monitoring equipment and sterilising equipment. A lot of hospitals got additional sterilising equipment, which is important for infection control and angiography equipment.

Mr DAVIS — I want to return to the issue of nurses, particularly to the nurses industrial agreements that recently came through. I am wondering what work your department has done on the financial impact of the government's new nurse-patient ratio, the 1:4 ratio and so forth, and if you could give us some departmental estimate of the total cost of those arrangements.

Mr THWAITES — This was all reported in the last budget. The cost of the nurse EBA, including the ratios and the additional conditions and things we are providing like nurse scholarships, additional nurse educators and consultants, was \$203 million. That has been publicly released and reported.

Mr DAVIS — Are there any departmental work-ups in terms of the longer term cost impact of those ratios?

Mr THWAITES — No, that is longer term. That does not include the 3 per cent wage aspect, which increases year on year, because that accumulates. Every year there is a wage rise you have to add on top of that whatever the wage rise is, which is roughly \$40 million a year.

Mr DAVIS — I am interested in health care changes over time and the way those ratios are applied in different ways in different areas of the nursing work force — for example, we see certain areas of expenditure in the acute system expanding and others perhaps changing in their importance. Has there been any attempt to quantify out into the longer term the impact of those industrial agreements and the ratios in the different areas?

Mr THWAITES — It has been worked out. That is how we worked it out to give that extra funding which we announced in the budget last year. In terms of changes over time, of course all the payments to the hospitals are subject to the casemix funding system, so this is part of the casemix funding system now.

Mr DAVIS — Let me explain. We know certain services required by older Victorians are expanding and in some of those areas there may actually be greater requirements — for example, kidney disease or certain cardiac areas — and there are specific ratios that apply to some of those in the industrial agreements. You would expect a change over time with areas of demand growth and so forth.

Mr THWAITES — Of course there is demand growth, and that is what we provide extra money for, but that is not as a result of the EBA; that is as a result of more patients coming in.

Mr DAVIS — No, the impact of those agreements in terms of changing demand. Demand is going forward in different ways as the population changes — the demographics of the population and other matters — and that will require different services to be provided. Have you looked out into the future as to how those ratios will impact there?

Mr THWAITES — We do not believe that will change the cost. What will change the cost is the increase in demand as we have more patients, and that will require more nurses, but the government will allocate funds through the budget to meet the increase in demand.

Mr DAVIS — Has there been an analysis into the future?

Mr THWAITES — I am not sure what you are really asking for an analysis about, to be frank.

Mr DAVIS — Let me explain again. It is actually a very simple concept. If you have a variety of different services where different industrial requirements apply, and the demand for certain of those services changes differentially, you might find one area of particular growth which has a higher requirement of nurses per patient, and that will have an impact out into the future.

Mr THWAITES — I think the assumption is that the EBA provides a disproportionate number of nurses for the different areas, which it does not. It applies an additional number of nurses to get better nurse-patient ratios across the system, so if you have more patients, you will need more nurses. As I said, we will provide for that.

Mr DAVIS — It is different in different areas.

Mr THWAITES — I think you are making an assumption about the EBA that is not justified.

The CHAIRMAN — There was a calculation done of the number of nurses that would be required to meet the EBA.

Mr THWAITES — Of course, and it has been funded to that level.

Mr DAVIS — But that is now; it is not looking out.

Mrs MADDIGAN — I wanted to come back to the asset investment on page 19, slide 38. Can you give the committee a bit more information about the \$32 million for the Royal Melbourne Hospital and how that will be expended? What improvements in services can my local community expect from that expenditure?

Mr THWAITES — I would expect a real improvement. That will build on to the front of the hospital. It will build on top of the entrance. It will include a new helicopter pad which will enable the hospital to be part of the trauma system. It will construct new floors, levels 5 to 9, to provide new ward accommodation. There will be 120 beds at this stage as part of that new accommodation. It will replace what were pretty old 1940s ward blocks. It will be much more functional, more efficient and meet occupational health and safety guidelines. The renovation of floors in the outpatient building will also enable an integrated model of care with newly constructed works, and increase the reliability of plant and services. Together with all that, there will be an upgrade of infrastructure. It really enables the link into the new trauma centre, together with 120 new and upgraded beds.

Mrs MADDIGAN — The hospitals that have helicopter pads are part of the trauma system now, are they?

Mr THWAITES — Essentially the Alfred hospital has been the trauma centre for Victoria. Trauma cases are taken to all major emergency departments, but in a number of cases the preference would be to take them to a trauma centre at the Alfred. A review was conducted under the previous government which recommended that the Royal Melbourne also be a trauma centre. We have accepted that. Part of that implementation is to have that helicopter access. Over time you will see an increasing proportion of trauma patients taken to the Royal Melbourne and the Alfred, rather than to other emergency departments, whether it is Dandenong, Monash, the Austin, et cetera.

Mrs MADDIGAN — Is that to try to get quicker access for road accident cases and things like that?

Mr THWAITES — It is not actually quicker access; it is more expert access. The theory behind it is that trauma is a specialty and by having the highest level of specialty you will get better survival rates.

Mr RICH-PHILLIPS — Given my question is the final question I will be parochial and ask about the Berwick hospital. I understand there is currently a tender process in place and that is reflected in the departmental submission to the committee. Can you tell the committee where that tender process is at, whether it is completed, whether a contract has been signed and, if it has, can you give costing details on the Berwick hospital? Also in terms of location, the department has purchased the Kangan Drive site in Berwick. Is it still the department's intention that the hospital will be on that site, and also what can you tell the committee about opening times?

Mr THWAITES — The answer to the last question is yes, it will be on that site. In relation to the process, currently there are three short lists of consortia that are bidding. Their final bids are due on 18 July. Then there is an evaluation and a final bidder will be chosen, the contract will be signed and then the winning tenderer will commence building. That all occurs later this year.

Mr RICH-PHILLIPS — Will the finish date that is listed in the budget papers of the second quarter of 2004 be met?

Mr THWAITES — Yes.

Mr RICH-PHILLIPS — Are you able to tell the committee the name of the three tenderers?

Mrs MADDIGAN — Can you tell us the exact date and time you are opening it!

Mr THWAITES — The three bidders are Berwick Partnership Pty Ltd, made up of Thiess Pty Ltd, Tempo Services Ltd and Deutsche Asset Management (Australia) Ltd. The second is Progress Health, which consists of ABN-AMRO, Multiplex and Honeywell, and the third is the Public Health Infrastructure Consortium, which has behind it Babcock and Brown, Leightons Contractors Pty Ltd and Honeywell.

Mr RICH-PHILLIPS — Can you provide the costings yet?

Mr THWAITES — That is obviously the tender process.

Mr RICH-PHILLIPS — There are no rough figures at this stage?

Mr THWAITES — We have in our mind a broad range, but we are not going to say that because it is a tender process.

The CHAIRMAN — Minister, that completes the time allocated for consideration of the budget estimates for which you are responsible as Minister for Health. I thank you and your departmental officers for your attendance today. The committee has a couple of issues that arose during the session that it will follow up with you at a later time, and some other questions may be forwarded to you in writing at a later date.

Witnesses withdrew.