CORRECTED VERSION

PUBLIC ACCOUNTS AND ESTIMATES COMMITTEE

Inquiry into 2003–04 budget estimates

Melbourne–15 May 2003

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Witnesses

Ms B. Pike, Minister for Health;

Ms P. Faulkner, Secretary;

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

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

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

The CHAIR — I declare open the Public Accounts and Estimates Committee hearing on the budget estimates for the health portfolio. I welcome the Honourable Bronwyn Pike, Minister for Health; Ms Patricia Faulkner, Secretary of the Department of Human Services; and from the Department of Human Services, Mr Lance Wallace, executive director, financial and corporate services; Mr Shane Solomon, executive director, metropolitan health and aged care; and Dr Chris Brook, Executive Director, Rural and Regional Health and Aged Care, as well as departmental officers, members of the public and the media. I wish to register an apology from the Honourable Bill Baxter for this morning's session.

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 financial and performance information that relates to the budget, I ask that all mobile phones be turned off and pagers turned to silent.

Ms PIKE — It is a pleasure to be here morning. I will begin by making a brief presentation which talks about the context that we find ourselves in in the health portfolio, with the Department of Human Services representing the largest funding in the budget; some of the highlights from the budget; the increases in funding and outputs, and finally, the capital expenditure and investments that we are making.

The context is there is continuing pressure on the health systems all around the world as the population grows and in particular in Western countries as the population ages, and also as advanced technology brings with it greater utilisation of health services. These demand pressures are cumulative. Every year we have to find an additional capacity to treat more patients. In Victoria's case it is well over 35 000 additional patients every year, just to maintain our current access and quality standards let alone improve them further.

Some of the unique characteristics of the context we find ourselves in here in Victoria are that we have in a sense all the obligations to treat these additional patients and meet the demands, but we do not have all the levers in our own hands. We know we get a raw deal from the commonwealth in the number of aged care beds. We were over 5000 beds short, which has an impact on our public hospital system. We have inadequate numbers of nurses being trained and, in fact, last year over 3000 prospective trainees who were eligible for places could not find places for division 1 nurse training in Victoria. We are facing a real cut from the commonwealth in the current Australian health care agreement (AHCA) which is being negotiated at the moment.

Nevertheless, the Victorian government is working hard to meet these demand pressures. We have developed a very strategic response to meeting demand. This particular budget furthers the hospital demand strategy and will give us the capacity to meet more emergency patients and more elective surgery patients. I will go into some of those strategies a little later.

There are three components to the hospital demand strategy. The first is the increasing of capacity, the second is the diversion of patients to more appropriate care settings, and the third component is the hospital admissions risk program which seeks to prevent unnecessary readmissions.

We have been very pleased with the successes so far in the hospital demand strategy. Ambulance bypasses are continuing to come down and apart from a spike last winter because of higher-than-expected levels of respiratory illness, the trend is downwards and continues to move downwards. That is an important measure.

The second area is fewer patients waiting for elective surgery. We have moved from a high of over 44 000 in 2001 to now 37 638 elective surgery patients. We know there are still some challenges so far as category 2 patients are concerned, and we have a couple of strategies that are going to be very important.

The first is the elective surgery access service (ESAS), which is really a brokerage service that hospitals are able to connect with so that we can have more specialist treatment of category 2 patients where there is capacity. The second is the elective surgery designated centres, which is part of that specialising of certain components of category 2 elective surgery.

Our priorities for the 2003–04 budget have been to implement our election commitments — they are very broad in the health area — but also to go further than that and to ensure that the initiatives in health are really part of the government's broader reform agenda under the Growing Victoria Together framework so they contribute to social cohesion and the reduction of inequalities and are set within the context of sound financial management. In summary, the overall funding for health outputs in 2003–04 is, as you see, more than six — billion it should be.

Mr FORWOOD — Six thousand million dollars.

Ms PIKE — It is. I apologise, I am not reading that. That is a 8.6 per cent increase on the previous budget. The 8.6 per cent is an important figure because it shows that the Bracks government is in tune with the real cost of growth in expenditure within the health area. It contrasts with the offer that the commonwealth is giving the states through the Australian health care agreement, which falls well short of that figure. All of Labor's financial statement (LFS) commitments have been funded in this budget. In addition, we have a total of $183 million in new initiatives, including hospital and counter-terrorism initiatives. We also have asset investments which are the first stage of the asset investments that will roll out over the term of this government.

In particular detail, the hospital demand management strategy remains the centrepiece of expenditure of growth in funding. We have also injected an additional $32 million to address issues of sustainability within the hospital system — to help hospitals cope with rising costs and deal with the fact that there are problems with the Australian dollar. Even though it has improved somewhat, the reality is most of our drugs and equipment come from overseas and hospitals need to have the capacity to deal with that.

Over the past five years, as I have said, there has been average growth of 7.6 per cent in demand for public hospital emergency services. While this is in line with the experience interstate, there are some particular local factors which I have mentioned — the undersupply of residential aged care beds and the decline in bulk-billing — which are particularly exacerbated in some communities. The hospital demand strategy has been focused on dealing with those particular issues at the emergency department end of the hospital system.

The other initiative that I think is very important in this budget is the health information and communications technology strategy. You will be aware that we have injected a considerable amount of funding into this strategy — $138.5 million. When that is coupled with the existing funding for IT within the hospital system and some other resources that have come through the Department of Innovation, Industry and Regional Development there will be a substantial resource to help remove obsolete systems and to do some very significant work on inter-operability across the IT framework in the health area and connect it to acute hospitals, to ambulance systems, to community health, mental health and other components of the health system. This will see some very significant changes: e-prescribing, electronic medication ordering, sharing of electronic health records, and a whole range of other initiatives that will be very important in terms of our efficiency and our capacity to improve client outcomes.

Ambulance services will also receive additional funds of $6 million rising to $8 million. This funding is expected to expand ambulance systems with two new metropolitan stations and improved services in rural Victoria.

Mental health will also see a rise in funding, not just growth in acute beds but, in line with the move to support and assist people in the community, there is also money for non-acute demand growth: for demand diversion; early intervention and prevention; some special support for co-morbidities — people who have mental health issues and drug and alcohol issues; and an initiative to support for people who are homeless.

In dental health, again some additional resources rising to $21 million over four years to improve public dental services in Victoria; training of more therapists; new dental chairs; promotion of oral health in preschools; work force initiatives; and increased funding to the denture scheme.

The obesity strategy is another of our public health initiatives. Obesity is a very significant problem in our community, and childhood obesity is the area we want to target. Coupled with that is the early intervention and detection of pre-diabetes. This is all focused around lifestyle changes — in a sense very whole-of-government integrated policy response initiatives.

On the ministerial council on cancer, we know that Victoria is the home to world-renown cancer research institutes. However, we also have initiatives in the cancer area in our community that range from prevention, early intervention and early detection to community-based services, hospital-based services, and research. We are certainly very optimistic that the ministerial council on cancer will bring a lot of the focus together and will also do some work on the need to explore a comprehensive cancer centre for Victoria.

You will see some initiatives there for the women's health and wellbeing focusing on mental health, breast cancer support, and promoting awareness about women's health. We certainly have already increased the number of women who have access to breast screening services — that number will increase by 96 000 over the next four years. We will continue to focus on the primary target age group.

You will see that the government has also continued its support for health services in rural Victoria, providing resourcing for bush nursing hospitals, and particularly a focus on rural elective surgery waiting lists, the rural work force program, and a professor of physiotherapy in Shepparton.

I spoke about the counter-terrorism preparedness. Certainly the government is taking this matter very seriously in a number of portfolios. In the public health area of the department our staff have been working very hard to ensure that Victoria is well equipped in the face of a potential terrorist attack, and there is a multi-pronged program there.

We have also taken the responsible step of identifying areas where there may be savings within the Department of Human Services, and we have set a target for general efficiencies of $36.4 million within the department, which is less than one half of 1 per cent of the total of the Department of Human Services budget. I certainly believe it is important that ministers do review their portfolios for efficiencies and look for places where these can be achieved. This target is very reasonable and certainly will be achieved. We will be negotiating potential savings with stakeholders, who will be very much part of that process.

In final summary, I want to put before you highlights of the significant asset investment program (SAIC). As you see there are a number of hospital initiatives. We have also continued to add to our line for infrastructure renewal, which has been a line that the Bracks government has added into the asset area; so infrastructure, renewal, fire safety, medical equipment initiatives — both a general amount of money and then for specific equipment for Moorabbin and other areas — and then the money for the move of MHSKY community-based services to Footscray, the Foundation for the Survivors of Torture and Trauma to Brunswick with new facilities, co-located with other Department of Human Services facilities and others that you see before you.

Thank you, Chair. I am happy to ask any questions.

The CHAIR — If I could begin firstly with a question regarding the Victorian health system. How will we be affected by this week's commonwealth budget, particularly what will be the impact of the proposed changes to the Medicare system on Victoria's hospitals?

Ms PIKE — There are two significant initiatives within the commonwealth budget that have a potential to have a very profound impact on the Victorian health care system and particularly on public hospitals. The first is the quantum of funding that is being offered to the state of Victoria under the Australian health care agreement. The AHCA is the largest commonwealth-state funding agreement that will be signed in the history of this country. It is a very complex agreement, but at the core of it is the contribution of the commonwealth to the states for the running of the public hospital system. Over the life of the last agreement the commonwealth provided 28 per cent in growth funding to the states in the whole agreement.

That growth funding was made up of three main components. The first component of that growth was indexation, which people understand is for the adjustments in rising costs, et cetera. Even in the last agreement the indexation level fell far below the agreed understanding of what the cost of real growth was in indexation. Nevertheless there was a component for indexation. The second component of growth was what we call the utilisation factor. The utilisation factor recognises that with advanced technology, new procedures available, new equipment, new drugs and so on, that more and more people will utilise the health system, so there is a component of growth for that. The third component of growth is the recognition that the population is growing and ageing. Because people use services in the hospital system more in the latter years of their lives and the proportion of the population is growing faster than other portions of the population, that needs to be recognised.

So when we all of that growth was put together in the life of the last agreement it amounted to a 28 per cent growth. The current offer on the table — and, in fact, the figures that are in the commonwealth budget — translate into an offer of a 17 per cent growth rate. The areas where there has been a cut in growth have particularly been in that utilisation area, which was cut from 2.1 per cent to 1.7 per cent. As a result, of course, the growth is going to be much less.

In real terms if the current agreement had continued the amount of money that was in the forward estimates for the commonwealth — some $43.7 billion — would have been maintained. Instead what we have is only around $42 billion in the forward estimates now from the commonwealth. When that is shared across Australia it is $1 billion less, in the context of a increasing demands.

In the case of Victoria, we believe we are facing an effective cut from the commonwealth of at least $300 million over the next five years — which, given the information I have given you, Chair, is a significant cut for Victoria. It will certainly put extra pressure on the state government as we work to meet demands. That is one aspect.

Where has that $1 billion gone? We believe the $1 billion has gone into the other issue that you raised — that is, changes to Medicare. Those changes are particularly significant for the public hospital system. We have seen over the past few years a dramatic decline in Australia in the rates of bulk-billing. Bulk-billing rates were around 80 per cent and they are now well below 70 per cent. Commensurate with that we have seen a massive increase in presentations to emergency departments, particularly of category 4 and category 5 patients. Those are patients that fundamentally have medical issues and by and large many of those issues are issues that could be dealt with through the services of a general practitioner.

So there is a direct connection between the decline in bulk-billing and the presentations to emergency departments and that is where all our demand pressure really is coming from. That demand pressure has enormous implications throughout the whole hospital system because, basically, it means that it is difficult to deal with other aspects of service such as elective surgery when you are facing constant demand at the front end of the hospital system.

How will the changes to Medicare of nearly $1 billion impact upon this? We are firmly of the view that the tighter targeting of Medicare to concession card-holders will potentially impact very adversely on low-income families. We anticipate a significant increase in demand for emergency department services.

These two policy positions together are going to really exacerbate the issues of demand management for the state. We certainly are very concerned because the AHCA is, of course, a joint responsibility. Victoria's share of that agreement has been rising significantly. It is a joint responsibility and we are talking about the same citizens here that the commonwealth has jurisdiction over as well as the state. It is a significant issue for us.

Mr FORWOOD — I wish to raise the issue of the Austin hospital. The Auditor-General said on page 103 of his report that the government had endorsed a cost of $376.3 million, but in the same paragraph suggested that there were significant refurbishment works which added an extra $21.4 million, which would bring a total cost of $397 million.

If you turn to pages 108 and 109 of the Auditor-General's report you will find that the chief executive officer of the hospital, Jennifer Williams, makes the point that there are no funds available in relation to paragraph 5.188; that there is a shortfall of $25 million in relation to analysis of the building infrastructure — $30 million is required and the government has only allocated $5 million; that whereas the Auditor-General is suggesting that $21 million is needed for the refurbishment in fact:

> The preferred option in the most recent investment evaluation has been costed at $58.7 million. That report is currently with the DHS for consideration.

So if you take your original figure of $376 million and you include the Auditor-General's extra 21 million as well as the other items that Jennifer Williams says are required to do the job, do we not get a total cost for the project of around $450 million?

Ms PIKE — Of course the redevelopment of the Austin and Repatriation Medical Centre is one of the very significant projects of the Bracks government. It is a hospital that was earmarked for privatisation. It is the largest hospital redevelopment in this country, and it is a very significant project and one that is well on track for completion.

It is a matter of public record that the government has provided additional resources for the development of the hospital. In fact the original estimates were below the current approval, which is $376.3 million. I am well aware of the comments of both the Auditor-General and the chief executive officer.

Let me go to the $21.4 million that was referred to by the Auditor-General. There are two components of that $21.4 million. The first is the $9.6 million. There was an agreement between the Department of Human Services and Austin Health that they were non-essential works for the project and that they would be deferred and would become part of any ongoing infrastructure-maintenance kind of program into the future. Those were works that were agreed upon between ourselves in the department and those in the health service, because they were non-essential to getting the service up and running and functioning effectively.

The new works of $11.8 million are works that certainly are on the wish list of the hospital. I guess anybody who has been in the position of health minister and who has been in the department knows that hospitals all around the state have huge wish lists and additional projects that they would like to see, and often a large capital program is an opportunity to add some things to the wish list and say that these things should be part of the core project. But in fact those and the other projects that have been described by the CEO in the CEO's response to the Auditor-

General are works that are outside the scope of the project, and we are certainly comfortable that the funding we have provided maintains the integrity of the project that we have signed up to.

The reality is that we are in the middle of a construction boom. We know that there are significant cost pressures within any project, but my intention as health minister is to remain within the bounds of the agreed works that are part of the core redevelopment project. Any adjustments to cost have been agreed in the past and would only be agreed within those parameters.

Mr FORWOOD — The original plan, though, was to shift some of the outpatient services from one side to the other. What you are in effect saying is that you have decided not to proceed with that.

Ms PIKE — No, we have not decided we will not proceed with that, but like all projects there is a core commitment around that project and then a staging of additional works that might be required into the future. Shane Solomon from the department can add some additional information here.

Mr SOLOMON — The original proposal was a fairly modest refurbishment of outpatient areas. Austin Health came to us and said that it felt it was an outmoded model of care and so proposed an ambulatory care centre, and that was the reason the $9.6 million was essentially taken out to become part of a larger ambulatory care centre bid.

Mr FORWOOD — But if you have taken it out then it means we are being stuck with the outmoded one.

Mr SOLOMON — It means it is a bid that is still on the table, I think.

Mr FORWOOD — In relation to the paragraph on page 109 which states that the revised costing makes allowances for fire and hazardous material removal, infrastructure upgrades and more detailed design of the areas, they say this report is with you at the moment — but this report was tabled some months ago. What is the status of the report that is with you seeking to have fire and hazardous material removed? One would have thought that that was an essential part of the project.

The CHAIR — If you do not have this information and these responses with you today, you can take questions on notice.

Ms PIKE — I am happy to take questions on notice, and there may be some further details that you require that we can provide. I think we need to be very clear that the department is continually and very thoroughly evaluating and has evaluated the scope of this project, that there are a number of additional things that the Austin itself would like to see funded as part of the project, just in the same way that many other projects have additional aspects that it wishes to have funded. So at any time if those requests and requirements from the hospital's perspective come in then we evaluate them from a departmental perspective, but we are comfortable that the resourcing we have allocated to this project meets the requirements. Certainly issues like fire and safety and all of those aspects of project development are absolutely fundamental. This government is rebuilding these hospitals in the context where they were about to be privatised and sold off so we have certainly put the resources aside. We have made the upward adjustments in line with the pressure that is within the building sector and in the context of a building boom, and we are comfortable that we have the resources set aside.

Mr FORWOOD — When will the decision be made on that final report?

The CHAIR — Ms Green?

Ms GREEN — Minister, back to the commonwealth — has the commonwealth embraced health care reforms such as, in particular, the hospital demand management strategy proposed by the state as part of the Australian health care agreement?

Ms PIKE — When the negotiations began for the current AHCA, well over 12 months ago now, a decision was made at the health ministers conference that there would be significant work on a number of areas of reform that were seen as fundamental to developing a comprehensive and appropriate health care agreement. In fact it was Senator Patterson who on behalf of the commonwealth was eager and initiated a number of these areas of investigation. Nine groups were established under the auspices of the health ministers conference, so they were officially constituted groups. These groups were chaired by either commonwealth or state officials. In fact Senator Patterson herself chaired one of the groups. The groups contained officials from the varying health departments, as well as clinicians from the public hospital system.

I will not detail the nine areas to the committee, but there were policy parameters within these areas that had a significant impact on the public hospital system — for example, the interface between an emergency department and GPs in a local community. That is a clear interface area that I have described as the working of one of the groups. Another area was the interface between the aged care system and the acute system. We currently have nearly 600 people in our public hospital system who have been assessed by the commonwealth's own aged care assessment teams to be eligible for a nursing home place, but because we are 5500 beds short we have real difficulty in finding an appropriate placement for these people. This was an issue to be discussed collaboratively because there are other options. We have already seen some movement in, for example, the development of the interim beds, the expansion of the subacute system for rehabilitation and geriatric evaluation and management, and other areas.

Other areas under discussion included a single national system of full pharmaceuticals; also the case management of people with chronic illnesses, so older people with diabetes or chronic respiratory illnesses et cetera and how we could provide appropriate continuums of care between the acute system and the primary care system, and community-based support services; and, of course, the area of information technology.

These were the areas of reform in which work was being done. Of course they were seen as fundamental to underpinning the AHCA because you cannot have a conversation about a quantum of money in isolation from the context in which you find yourself. The commonwealth has now dropped that. There has been absolutely no mention of that in the current offer on the table from the commonwealth to the states in the AHCA and we are obviously extremely disappointed. We see it as an absolute policy vacuum. We see it as driven by other parts of government. The federal Treasurer and the Prime Minister have clearly made decisions here about the quantum with no attention being paid to the reform agenda.

Of course this is very disappointing particularly to senior clinicians who work in the public system and who see these structural problems within the system, see a way out through the development of a reform agenda, and yet see a commonwealth turning its back on what was a collaborative process that was being driven by their own officials. So it is a major problem and a major disappointment. We are trying to get it back on to the agenda and we are certainly holding fast to insist that it is part of the overall AHCA framework.

Mr CLARK — Like Mr Forwood I refer you to the Auditor-General's February 2003 *Report on Public Sector Agencies*, in particular to your department's admission in that report that 14 of the 19 major hospitals listed at page 119 were in deficit last financial year. The Auditor-General identified inadequate funding to hospitals in relation to the nurses' enterprise bargaining agreement (EBA) as one of the factors contributing to those hospitals' financial difficulties and recommended there be a thorough review of those hospitals encountering financial difficulties. Your department rejected that recommendation on the basis that there had already been a review conducted by the financial management review unit. Can you tell the committee the latest estimate of the total annual increased cost being caused to the hospital system as a result of the nurses' EBA of a few years ago, and will you make available to this committee a copy of that financial management review unit report which your department says justifies rejecting the Auditor-General's recommendation?

Ms PIKE — There are many components to that question. I will start in the middle and then talk about the issue of financial viability. The EBA has been fully funded. In fact the Auditor-General asked that we go back and check that. The department has indeed done that on numerous occasions, because it is true that some hospitals were saying that they have not been funded for the EBA, and we heard that. Particularly some hospitals in rural communities had said, 'No, we are being required to provide this additional funding. We have been required to meet some of these ratios that the Australian Industrial Relations Commission (AIRC) has laid down as part of the nurses' EBA, and we are not being funded'. We heard that and that is why the department has been to every single hospital that raised those matters and has investigated them thoroughly. We are confident that the EBA is fully funded. In some cases some hospitals had over-hired and they were not meeting the requirements of the EBA. There were other reasons too. That is the first component of your question. Dr Brook and Shane Solomon were both involved in working with the hospitals and I wonder if they have any further information on that matter.

Dr BROOK — Speaking from the rural perspective, the minister has indicated that there were a number of hospitals that had made various interpretations of the EBA. I wish to reinforce that. What is required of hospitals and what they are funded is the EBA; it is not something more than that. There were many interpretation issues that arose from time to time. As with metropolitan hospitals, the industrial relations group, and subsequently the investigative group, looked at those hospitals and we could find virtually no justification for claims over and above the funding that was provided. There is one exception to that. There was a subsequent hearing in December 2002 of the AIRC where a small number of additional staff were allocated and they have been fully funded — for example,

I think Inglewood hospital got an additional 1.2 equivalent full-time (EFT) staff out of that process. They were very small numbers of staff.

Mr CLARK — Thank you for that background, but you have not addressed either elements of my question: firstly, what is the total annual cost of the EBA; and secondly, will you make available to the committee the report which you say justifies not following up the Auditor-General's recommendation?

Ms PIKE — The report you are referring to is?

Mr CLARK — The one at page 119 of the Auditor-General's report: the review by the financial management review unit.

Ms PIKE — The report by the financial management review unit was a report prepared for the cabinet. It was prepared for the work that is done in preparation for this budget, so it is not a report that is available. Of course it is background material for the resourcing the government has made available for financial sustainability. You will have noted there was additional funding in the budget for that matter. You also drew attention in your question to the comments of the Auditor-General around the financial position of a number of the hospitals. Let me be very clear about this matter. From time to time varying hospitals have circumstances that mean that they have particular difficulties. That happens every single year. The Auditor-General identified a different group of hospitals last year that had some particular circumstances which needed some additional work from the department to assist them. Those kinds of circumstances can be things like a rebuilding program which can mean there needs to be some adjustments to staffing, et cetera. There can be a particularly difficult set of circumstances around a clinical matter, et cetera. Every year different hospitals have different financial circumstances. We are aware of that.

You will be aware that we have recently appointed an administrator for a rural hospital because of financial management challenges in that hospital. I think it is important to be very open about this fact. As I said, those hospitals change from year to year. What we do is go and work with those hospitals. We assist them. We provide administrative and financial support where required because our objective is not to close them, but to retain their financial sustainability. That is a process we undertake all the time with hospitals. We know that finances are tight. We know that we are being underfunded through the Australian health care agreement. We know hospitals are facing increasing demand in a very complex environment, but we work very closely with them and help them to trade out or deal with those particular circumstances.

The other issue you raised was the overall cost of the enterprise bargaining agreement. I believe Lance Wallace will be able to give us some information.

Mr WALLACE — We have provided information on costs to the committee at different stages of the EBA. Last year we provided information to the committee on the additional cost to staffing over the previous financial year. We can provide the latest cost over the current financial year that has been incurred through the EBA. We are happy to do that.

The CHAIR — Thank you very much.

Mr DONNELLAN — I want to refer to page 210 of budget paper 2, which is the hospital demand strategy, and specifically to the upgrade of the Dandenong Hospital. I want to relate it back to my electorate, if that is all right. We have had a 15 per cent drop in bulk-billing rates. We have a shortage of doctors. I think it is 1 doctor to 1900 people. I have many families in my electorate who earn above $32 300 and have two children. They will not be able to get bulk-billing services. I also have many couples above $25 000 who will not be able to access bulk-billing services. We have had presentations to emergency departments at Dandenong increase by somewhere between 9 and 16 per cent in the last year due to the current situation. Having said that, I was wondering how the commonwealth's Medicare package will impact upon on the increasing demand for GP services in the emergency departments and whether the departments actually looked at expectations and figures in relation to this at this stage. It might be a bit early, but I thought I would ask.

Ms PIKE — You are correct in identifying that there are certain areas that have had a greater-than-average increase in demand of those primary-care type patients. They are the category 4 and 5 patients. Generally they are the patients who have medical-type needs and who are coming more and more to the emergency departments. We know that there has been a 9 per cent growth overall in this increase, but that growth is up to about 28 to 30 per cent in areas where there is a shortage of GPs or where there has been a much greater decline in the availability of bulk-billing services.

We do not believe the Medicare package will do anything to reduce the decline in bulk-billing. There has not been one public affirmation for the package. Certainly nobody — whether they are people from the medical profession, including the AMA both nationally and in Victoria, people in health policy areas or surgeons, including their peak bodies — believes for 1 minute that the very small incentives or the tighter targeting of those incentives to concession cardholders or the direct-billing mechanisms through the swipe card will increase the availability of bulk-billing. It is quite the contrary. What the changes have done is given doctors permission to have a co-payment and facilitated that. So doctors do not have to feel bad about asking somebody for $40 up front. They say, 'We will just swipe your card. We will get the payment directly. You just give $10, $15 or $20'. It is an affirmation of that co-payment system.

Of course many families, particularly in areas like yours where you do have a number of families who, to be quite frank, are in many cases the working poor, will have to go somewhere to seek free services. The only other option for them is private health insurance which is totally unaffordable for many. Over 50 per cent of Australians do not have private health insurance. They do not choose to and many cannot afford it. Only something like 47 per cent of Australians are in private health insurance. Then, even if they do choose to take out private health insurance, they will have to accumulate $1000 in bills before any rebate kicks in for them. We certainly believe the better policy parameter would have been to adequately index the Medicare rebate and to address that. So we are very concerned about the impact.

Nevertheless in this context this is why the hospital demand strategy is so important. That is because we know that we are increasing capacity in our hospital system and we now that we are hiring more nurses and opening more beds. But we are thinking and acting in a way that deals with demand in other ways. We are providing more appropriate accommodation for people — for example, we are providing short-stay units and medi-hotels for people who are being prepped for operations. All these are initiatives to alleviate demand. I spoke about interim treatment for older people. These are all dealing with pressure and providing genuine alternatives.

I also spoke about elective surgery and having the capacity to get certain hospitals to specialise in areas of elective surgery and fill that demand. The other part of the hospital demand strategy which is innovative and has already been demonstrated to assist, in particular an initiative at the Alfred, is identifying those patients who have chronic and longer-term issues. They are often people who have co-morbidity issues, et cetera. These initiatives are dealing with those chronic longer-term issues and providing an integration between community-based supports and the hospitals so these people can be managed. Half the time what happens is that they have a chronic illness, they are not managed appropriately in the community and then that issue bubbles to the surface again and they bounce back into the emergency department of the hospital.

Mr RICH-PHILLIPS — Minister, you spoke earlier of the issue of the financial viability of hospitals in response to a question from Mr Clark. You suggested with respect to that issue that in a number of those cases the problem arose due to extraordinary circumstances. You mentioned rebuilding, a clinical issue et cetera. I refer you to the Auditor-General's *Report on Public Sector Agencies* of February this year, where he gave a review of results for the 2001–02 year. The Auditor-General applied four tests when he assessed the financial viability of hospitals. The four tests were: operating result for the year prior to extraordinary transactions; operating result prior to revenue grants for asset renewal and replacement and extraordinary items; operating cash flows; and working capital at the end of the year. So the four tests the Auditor-General applied were net of extraordinary circumstances, so they were the ongoing, ordinary circumstances of the hospital. In the Auditor-General's assessment he found that there were 9 hospitals that recorded signs of financial difficulty against all four of those criteria and that there were a further 15 hospitals that showed signs of financial difficulty against at least two of those four criteria. So there was a fairly significant problem with respect to the ordinary operations, rather than extraordinary operations, of those hospitals. Also last year, 2001–02, the aggregate results for the metropolitan hospitals suggested operating deficits exceeding $40 million, and now we are having reports from various hospitals and elsewhere which suggest that for the current year we are about to conclude the aggregate deficit for metropolitan and rural hospitals will exceed $100 million.

So, firstly, Minister, can you confirm that further deterioration in the financial position of the hospital system and that we are looking at a $100 million aggregate deficit across the system for this year; and can you also confirm that officers from your department are now going out to these hospitals seeking to reduce those budget deficits before they close off this financial year — that you have people out on the ground seeking to do that at individual hospitals?

The CHAIR — Before the minister answers the questions, in relation to the $100 million, I saw that as a hypothetical question. I ask that you repeat that section because the minister is not expected to answer hypotheticals. What was the point in relation to the $100 million?

Mr RICH-PHILLIPS — There are now reports in circulation — —

The CHAIR — Where?

Mr RICH-PHILLIPS — In internal evidence from hospitals, in the media and in the health industry that these hospitals in aggregate this year will have losses exceeding $100 million. So I am giving the minister an opportunity to confirm it or to state that is not the case.

The CHAIR — I am just clarifying the question — that you are not quoting from anything in particular; it is hypothetical.

Mr RICH-PHILLIPS — No, I am asking — —

The CHAIR — The minister does not have to answer hypotheticals.

Mr RICH-PHILLIPS — I am inviting the minister to say it is wrong.

Mr FORWOOD — We do not. We just ask the question: what will the level of deficits of the hospital system be this year? We know it is $100 million. Do you?

The CHAIR — Thank you, I have had that clarified.

Ms PIKE — If you could refer me to the line in the budget papers that identifies that deficit I would be very pleased to answer that question, but it is a hypothetical question. Of course the figures that matter are the audited figures at the end of the financial year, and I will be very happy to answer a question next year on that matter.

Mr FORWOOD — You have not denied it is $100 million.

Ms PIKE — There has been an attempt by — —

Mr RICH-PHILLIPS — How big is it going to be, Minister? You don't know?

The CHAIR — Can the minister have the opportunity to answer the questions?

Ms PIKE — There has been an attempt by the opposition to make some very sweeping statements about the financial positions of our hospitals. The reality is that the majority of the hospitals in our system are doing extremely well, that we have been providing record funding to them — $1.4 billion in this budget; we have been providing huge amounts of funding to our hospital system. We have a very strategic response through the hospital demand strategy, and where there are individual circumstances for hospitals then clearly we work intensively with them. There are times when hospitals have difficult circumstances, and I have been quite open about that. I think, though, what is behind some of the your questions, Mr Rich-Phillips, is some sort of assumption that the government is not providing enough resources. In fact this was the tenor of a media release that was made available by the shadow health minister, who said there was a shortfall of $122 million in state government funding for the metropolitan hospitals in 2001–02. That information was then given to the media. But all that that showed was that the opposition does not understand where the varying components of funding to the hospitals — —

Mr RICH-PHILLIPS — Are you repudiating that figure?

Ms PIKE — I am absolutely repudiating that figure, because hospitals draw their resources from a very wide range of sources. The money that is provided by the state government is one component. They get commonwealth grants; they get patient fees; we claw back money from private health insurance funds; and they get donations and bequests. The resources that are available to the hospitals come from a multiple of sources and they are in fact much greater than the funding that is provided by the state government alone. So to actually look at the bottom line and then look at the input from the state government and to do a grade 2 subtraction sum is — —

Mr RICH-PHILLIPS — Are you rejecting that bottom line, Minister? Are you rejecting the bottom line of a loss of $120 million?

Ms PIKE — To do a grade 2 sum and to have a little subtraction between the state government input and the income line — not the bottom line — really just demonstrates that you have no understanding of the complexity of the funding within the hospital system. Let me also refer you to your comments regarding the financial position as reported by the Auditor-General. I think it is important that we take a little bit of time here and actually go to the tables in the Auditor-General's report; even though they are not tables that are in the budget, nevertheless we will take some time here.

Mr FORWOOD — What are you hiding now?

The CHAIR — The minister will have respect shown while she is answering the question.

Ms PIKE — I think it is important that we actually understand what the figures are that the Auditor-General is reporting on, what they consist of and what they mean in terms of the ongoing viability of the hospital system. I will ask Mr Solomon to go through that and talk about the things that are included in the Auditor-General's figures and the things that are not and how they relate to the budget papers.

Mr SOLOMON — The department expressed its concern to the Auditor-General about the indicators that he was using, particularly if you look at the second one, which is 'operating result prior to funding for capital purposes and extraordinary items'. What the Auditor-General has done is left in the cost of capital — that is, appreciation — but he has taken out capital income. So that is what produced, for instance for the Austin, quite a negative result. If we take out both capital income and capital costs the Austin last year, on audited results, made $2 million.

Mr FORWOOD — So you disagree with the Auditor-General?

Mr SOLOMON — We have said that in our reply.

Ms PIKE — We have made that point clear.

Mr FORWOOD — I think the people of Victoria are entitled to accept the Auditor-General over you.

Ms PIKE — I might add to that. Nobody is disagreeing with the figures that the Auditor-General has produced. Nobody is disagreeing with that at all. What we are saying is that there are inclusions in and omissions from those figures that in a sense present the real ongoing financial viability of the hospital system. We are not questioning his figures; we are not questioning his — —

Mr FORWOOD — Mr Solomon just said he disagreed with them.

Ms PIKE — No, I am sorry, he did not actually.

The CHAIR — Mr Solomon, can you run through what the minister asked you to do, unassisted by Mr Forwood.

Mr SOLOMON — I am not saying anything new. I am just quoting what is in the department's response to the Auditor-General on page 118. So we pointed that out.

Mr CLARK — But even on your own figures 14 out of 19 are in deficit.

Mr FORWOOD — This is an important issue.

The CHAIR — I know it is, but you have had a very fair go.

Mr FORWOOD — Come on. You cannot come — —

Mr RICH-PHILLIPS — With respect, the minister has not addressed the question, Chair. The question was about the aggregate operating outcome for the hospital system for this year. We are six weeks from the end of the financial year. Is the minister suggesting to this committee she does not know the aggregate outcome for the hospital system six weeks from the end of the financial year? The minister has an opportunity to address that question. She has not addressed it.

Ms PIKE — I think I have made it clear that — —

Mr RICH-PHILLIPS — Six weeks, Minister, and you have no idea. Is that what you are saying?

The CHAIR — Mr Rich-Phillips — —

Mr FORWOOD — Let the minister answer.

The CHAIR — If the minister has the opportunity to answer, she will do so. What has happened is that there have been constant interjections that have made it very, very difficult for the minister to give a reply to the question asked. Mr Solomon was running through matters that the minister asked him to do. Minister, could you tell me, have you anything further you wish to add, or has Mr Solomon anything further that he wishes to add?

Ms PIKE — No. I am certainly quite comfortable. What we have had is the opposition come here with a range of hypothetical scenarios that relate to the financial viability of our hospital system and a number of accusations, one of which I think is extraordinary. Of course people from the Department of Human Services are working with the hospitals — that is their job.

Mr FORWOOD — You know the number, you know the deficit, but you will not tell us.

The CHAIR — There is no need to shout.

Mr MERLINO — Thank you, Chair.

Minister, in your answer to an earlier question on Australian health care agreements you referred to aged residential care funding. Can you discuss further for the benefit of the committee the impact the shortage of commonwealth-funded aged residential care needs is having on the availability of acute hospital beds?

Ms PIKE — Thank you very much. One of the complexities of our health system is that different jurisdictions do have responsibility for different parts of the system, and it is true that the commonwealth has responsibility for funding and licensing residential aged care beds, and they are a very fundamental part of our system. We then have a mechanism by which people are evaluated and assessed for their eligibility and given a rating as to the standard of care — whether it is low care or high care — and what level they are eligible for.

These people are assessed in varying contexts and circumstances throughout the community. Sometimes they are people who are living at home; sometimes they have come to the attention of the home and community care service; other times they are people who, having had an acute episode, may be in an intensive care hospital bed; sometimes they are in a rehabilitation or geriatric evaluation and management service. So there are many kinds of contexts in which the Aged Care Assessment Services (ACAS) team, which is the team that comes and evaluates those people, can come and meet that person and identify where they will be appropriately placed.

We currently have 532 patients in the public hospital system in Victoria and those patients — just that group who is there now — have utilised 22 000 bed days. That is a very high cost utilisation within the health system, and they have used that amount of bed days. Now of course they are entitled to be in a hospital, and nobody has ever said that they are not entitled to health services when they require them, but the reality is it is an inappropriate setting for them. They have passed the acute phase, they have passed the acute episode and they need to be in a community-based facility, in a nursing home or a hostel, so that they can have some stability, so their families can feel assured that they are in a longer term setting that is more appropriate for them — in a quieter place, in a place where there is a homelike environment for the continuity of their lives.

Of course, as I have said, not only is it totally inappropriate for them to be in a bustling, acute hospital, it is also inappropriate for the system because the system is not geared up to care for people with those longer term kinds of needs, and it is incredibly expensive to provide that kind of care.

This has been long recognised here in Victoria, but it has also been long recognised by the health ministers, and it was in fact one of those areas that was part of the Australian Health Ministers Advisory Council (AHMAC) reform agenda. It was one of those groups that have been working for nearly two years now on the matter of the interface really between care for older people and the acute system. Quite frankly until the commonwealth fast-tracks the provision of aged care beds Victoria will continue to struggle with this matter. We are 5500 beds short now. We know that even if the commonwealth were to allocate more and more and more there is a catch-up period, and many of those that they have allocated in the past have not come on stream because they have allocated them to inappropriate providers.

There was an element of the AHCA package called Pathways to Home, $253 million; and it is true that there are some people who can be rehabilitated. They can go home and have the kind of support that is required, but they are not the 532 people who have been assessed for nursing homes, and it is nonsense to say that if you have been

assessed as eligible for a nursing home bed you are one of these patients that can be given a pathway to home. There are others who will be, and others who can be appropriately supported as part of that service, but not the eligible patients, and this is one of the pressure points for the public hospital system here in Victoria.

The CHAIR — Thank you, Minister.

Mr CLARK — Minister, can I refer you to the proposed $1.2 million of savings in the health budget as a result of establishing high–interest, centralised bank accounts. I understand that on Monday of this week regional health administrators met with Dr Brook to discuss various issues, and a key topic of discussion at that meeting was the proposal to establish these centralised bank accounts and therefore take local community hospital banking arrangements out of the local community area. Is it correct that this is in fact causing quite a degree of concern to many rural hospitals — that their banking arrangements, which to date have often been made with the local banking community at local community banks, are being taken out of their control and centralised under central health department administration; and is it correct that this is raising concerns among many of those hospitals that this is a prelude to central interference with their local fundraising operations?

Ms PIKE — I think you have spent the last questions criticising me about my financial management of the Victorian health system and now you are raising potential criticisms about an initiative that has been designed to maximise the interest that is payable on the funds that are there in the rural hospital sector so it can be returned to them. It is not about an undermining of autonomy; it is not about some kind of heavy hand of government wreaking control on some local community.

Mr FORWOOD — That is not what they are saying.

Ms PIKE — What it is about is maximising the resources that are available to rural health. Let us be very clear about this.

Mr RICH-PHILLIPS — They are taking money out of the local community.

Ms PIKE — The government provides resources to hospitals, and of course there are other sources of funding to hospitals as well, but the government provides taxpayers money to hospitals so that they can provide services to their local communities. We want to make sure that every possible attempt is made to maximise those resources, and where there is capacity, by pooling of funds to earn greater levels of interest I think Victorians would be pleased that the government is acting in such a financially responsible way.

I will pick up on the inference about fundraising. This is not about going to the ladies auxiliary and saying, 'We are going to take away the money you have made from selling lamingtons and Devonshire teas, we are going to snuffle that and put that into some sort of central account'. This is not about that. This is about assisting and working with the rural health services, enabling them to garner greater levels of interest on their funds so that they can have more resources.

Mr FORWOOD — You are out of touch.

The CHAIR — I refer to budget paper 2 at page 217 in relation to the health ICT strategy. Could you tell me how that additional funding as outlined in table A6 will improve the delivery of services for patients in the Victorian hospitals?

Ms PIKE — The government has made a very significant announcement in relation to information technology within our health system. It has been made, and the money has been set aside because we know that improvements in information technology will ultimately have an impact on efficiency, will help save money and time and will improve the care of patients. That is why we are doing this.

We have a very outmoded information technology system within our health services. Each one of the health services has a stand-alone system, and not only that but varying components of the hospital within the one service also have stand-alone systems that cannot even talk to each other. How does this affect a patient? It means if you have an episode within a hospital you could potentially have to tell your story 15 or 20 times within the one health service to different people so that you received the appropriate services that you required. How does it affect patients? It means that in a paper-based prescribing system the mistakes or the illegibility maybe of a doctor's prescription can be multiplied and duplicated further and further down the line. There can be significant problems in prescribing not only in the dosage but also a lack of capacity to identify things like drug incompatibility in a

multiple and complex system. That is why GPs are embracing prescribing, that is why they love it, that is why the community sees the enormous value in this area.

It is for those reasons, for the capacity to have quicker turnaround in test results, the capacity for nurses and doctors to actually have patient records at the bedside and not locked up in some big storeroom — these things are all part of the benefits that come through a greater utilisation of information technology.

Having a paperless system in radiography has huge benefits for clinicians and their capacity to treat patients, and apart from anything else in the Alfred's case saves around 30 000 litres of toxic fluid that is used every year making X-rays. All of these initiatives have huge benefits.

We are designing a system, and Mr Solomon's area is overseeing this, that is not there to replace the core systems in every hospital but is to provide an interoperability — it is to provide a framework whereby all the different components of the system can talk to each other, where we can develop thin client records within the context of the privacy legislation, and we can enhance that capacity to deal with people holistically. The other dimension of IT is that — —

Mr Forwood interjected.

Ms PIKE — Well, holistically is actually really important if you are to have a seamless health system, because people do not only interface the health system at the acute interface, they actually often deal with the health system through their GPs and in primary health services, community health settings, drug and alcohol and psychiatric services, even the homeless system, and being able to have connections through information technology with all those systems really offers a huge potential. That is why the government has doubled its funding in IT. That is why we have this massive project under way. That is why all the hospital systems are also including their resources in all of this, so we have around about a $330-million package which really will be very significant.

The other by-product is that it will be creating jobs in Victoria and setting us apart and ahead in terms of innovation. It is a good news announcement for the hospital system. It is fantastic for patients and will have huge potential benefits, and it is also good for our economy and our status as a progressive and innovative state.

Ms ROMANES — I have a supplementary question. Within that program, Minister, is there any scope for efficiency savings staffing wise?

Ms PIKE — Certainly a huge amount of time is undertaken by staff now in the whole patient records management area. To give the example of X-rays, 30 per cent of staff time at the lower clinical levels can be taken in retrieving X-rays. The average junior doctor spends up to 3 hours per day handling all that. There is a capacity to save a lot of time.

Will it mean staff reductions? In the context of increasing patient demand — 35 000 additional patients every year, nearly 50 000 additional people in the emergency departments — we believe this is around efficiency and utilisation of our resources, and it will help with demand management. Frankly it will be more satisfying and gratifying for people who work in the system and who will have more capacity for direct client and patient care rather than spending all their time fossicking around in manila folders and filing cabinets looking for that lost piece of paper or that lost image.

In terms of represcribing, it is calculated there will be an 80 per cent reduction in mistakes that can potentially be made because of a paper-based prescribing system. We have an absolute commitment to quality improvement, and this is part of that as well.

The CHAIR — Thank you. I hope you enjoyed our tepid water as per normal — some things are constant in life in this Parliament. Mr Forwood with the next question.

Mr FORWOOD — I refer you to page 210 of budget paper 2, which shows the efficiencies of $36.4 million this department is expected to find to meet the government's $141 million in cuts. In your introductory remarks you said, and I quote, that you 'will be negotiating potential savings with stakeholders'. Which stakeholders have you identified for discussions?

Ms PIKE — It is true that the government has set a target for efficiencies, and I have also indicated that in a budget of $9.6 billion, which is the budget for the Department of Human Services, those efficiencies represent about one half of 1 per cent. I think it is appropriate that ministers look for efficiencies. Certainly circumstances change and demands change, and we of course have funded huge growth in initiatives, massive growth in

initiatives, in virtually every single area within the Department of Human Services; in fact, I gave you 8.6 per cent as a figure in acute health.

In terms of the efficiencies, I have certainly asked the department to give me advice on a range of options, and we have had significant discussion on those options. Some of them are head office efficiencies, and obviously the consultation there is with unit managers and people within the department, and with the Community and Public Sector Union, which has union coverage for people within head office. Where some of these efficiencies relate to the administration of certain programs within the regional offices there will be consultation with the regional offices. Where they relate to realignment of programs then there will be conversation with some of the non-government organisations and peak bodies in those areas.

What we have said is that there will be no reduction in services to clients as a result of these efficiencies. What we have also said is that there will be no forced redundancies. There are potentially a number of people involved and that is the scope of the people with whom we will be having conversations.

Mr FORWOOD — Sorry, Minister — —

The CHAIR — Thank you very much.

Mr FORWOOD — Hang on, let me finish. As to non-government peak agencies, you have not given the name of one organisation that you intend to talk to. If you look at the budget papers you are expected to get a full-year gain of $36.4 million each year for the next four years. For you to get a full-year gain this year you must start very soon. Are you telling the committee that you do not know which stakeholders in the non-government and peak agencies you are talking to?

The CHAIR — Excuse me a moment. The minister stated head office, regional office, non-government organisations — —

Mr FORWOOD — She does not need your protection to answer this question.

Mr RICH-PHILLIPS — Maybe she does.

The CHAIR — You do not have to rewrite what has been stated.

Ms PIKE — Absolutely. I just think it is nonsense to expect me to come in here — —

We are talking about consultation with stakeholders and we are having discussions with them as we speak — —

Mr FORWOOD — Who are they?

Ms PIKE — It would be highly inappropriate for me to pre-empt those consultations. Unlike you, for me consultation actually means a genuine conversation with people, not me in coming here in some dictatorial way pre-empting those conversations, pre-empting consultation and actually discussing it with you.

Mr FORWOOD — This is a parliamentary committee.

The CHAIR — Mr Forwood, thank you.

Ms PIKE — I have been quite clear about the process and I have nothing further to add.

Mr FORWOOD — That is an outrage.

Ms ROMANES — In budget paper 2, pages 209 to 210, there is a very long list of output initiatives for the Department of Human Services. Topping the list of course is the hospital demand management strategy, which you have mentioned on a number of occasions this morning as the centrepiece of the health strategy. There are others in that list that go to the heart of the strategy for health prevention. I draw your attention to the provision for tackling the issue of obesity and the associated risks and illnesses such as diabetes. I ask you if you would inform the committee how the government will tackle the issue of obesity and what measures of success we will have over the coming year.

Ms PIKE — Thank you very much. It is true that the government has allocated $10 million over the next four years to implement the programs that are specifically designed to combat obesity. I think all of us are horrified every time we open the papers and read stories that say that Australians are now catching up with Americans as the

fattest people in the world. Probably the only people who are benefiting from this are maybe the clothing industry because people have to constantly change their wardrobes. However, this is a serious issue. It is a serious health issue in our community. Childhood obesity in particular is a major concern for our community because we know that obesity is one of the things that gives rise to later onset of diabetes. It gives rise to other health-related matters — heart conditions and all sorts of things.

We believe that we have to begin now right away on a very broad-ranging strategy to tackle obesity. In doing so we will be partnering with many organisations within the community. We know that the media has a role to play here, and it has indicated strong support for the government's obesity strategy. We also know that sporting groups can do a huge amount. Iconic groups like the Australian Football League and others can really help us as a community in our communication in this area. The strategy will encourage healthy eating and physical activity across the community; you may have seen some initiatives around guidelines for school canteens. It will also identify particular subgroupings within the community. Certainly people from a low socioeconomic area and people from disadvantaged groups have a need for specifically targeted programs and programs in pre-diabetes detection and intervention.

There will be a broad communications strategy as well of really increasing people's awareness of the link between healthy weight and obesity prevention — and a community awareness of those issues — and also helping people to make the link. This is not just cosmetic issue or an issue about how you feel about yourself; it actually has to do with longevity and with living happy and healthy lives. And for anyone in the health area is also has to do with demand management, because all of those things increase pressure on the health system.

We want to create an environment to drive change in this area. We will be working closely with local community groups; and alongside of all of this will be constant evaluation to identify which strategies are working and which are most effective. Forty-one per cent of type 2 diabetes in Australia is directly attributable to obesity, so just by helping people to do a bit more exercise and control what they eat we can have a huge impact on that. It is frightening that 60.7 per cent of Victorian adults are now overweight. It is a struggle for all us, but we have just got tackle this in the broadest way possible for the sake of all Victorians.

The CHAIR — Could you give me some examples of what might be the kinds of initiatives that could be funded?

Ms PIKE — Sure, things like walking bus programs in the transport area are very simple initiatives. Also information about the kinds of foods that are healthier for people to eat, but also collaboration between health and education around physical activities within the school environment; and stronger connections between some of our big, iconic sporting institutions and children. There has been a lot done, but there is a lot more that can be done to encourage young people, including greater support for diversity of sports and opportunities and funding for programs that encourage physical activity in all the generations, not just the children.

Mr RICH-PHILLIPS — I would to ask you about the Hume hospital health services plan, which was produced in March 2003 by Clearview Consulting and Healthwise Consulting. This is the plan which recommended the stripping of obstetric and surgical services from up to nine rural hospitals in the Hume region. It is also the plan that was criticised by the Rural Doctors Association for the lack of consultation in its production. Only a matter of weeks after this plan was released by the director of Hume region, Dr Tom Keating, Dr Keating wrote to hospitals in that region saying that the plan had been withdrawn. The first question I would like to ask you is: can you confirm that the plan that was dumped — this services plan by Clearview and Healthwise that the government dumped — cost taxpayers $164 000? Will you also confirm that the authors of the dumped plan are now producing another plan for the Barwon region?

Ms PIKE — Yes, certainly. You are, are you, referring to the Hume services report?

Mr RICH-PHILLIPS — Yes.

Ms PIKE — That is a report that many people will have read about in the newspapers and that has been fairly widely reported on. It is absolutely correct that the regional office of the Department of Human Services did, in fact, in collaboration with the health services in the Hume region hire a consultant. That group of people together worked on a potential service plan for that community and for the services within that community.

Let me say that planning is a very important function of our regional directors. They undertake a lot planning and service planning. The raison d'être for undertaking service planning is that they need to identify where there have been demographic changes, take into account the physical state of the hospitals and so on. They want to ensure that

services are sustainable into the future and are generally meeting the needs, expectations and demands of local communities. I affirm the role of people within the Department of Human Services in planning.

In the case of the work that was prepared by the consultants, my understanding is that this was a consultant's report that was prepared for the regional office and for the group of hospital services in that area. It certainly did not have the imprimatur or the affirmation of the director of rural health services and certainly did not have recommendations that would have been affirmed.

From my perspective the recommendations that the consultant made in the report did not reflect government policy. It is not this government that closes country hospitals, it is the previous one that closed 12. It is not our intention to close small rural health services — in fact, we have been investing huge amounts of money in building up and strengthening rural health services, helping them to be more integrated in their community, getting closer alignment of primary and community care with those health services, and working with them very closely to improve the quality of services.

I want to make it very clear that the plan that was put forward by the consultant was not acceptable to the government — that is why the plan was withdrawn — but the work that was undertaken by the regional director and consultation he had with local services was important, and I want to affirm that. There were some good things that came out of the process. Whilst I was disappointed at the recommendations in the report and therefore was insistent that it was clear that this did not reflect government policy, I want to affirm that there was some good work done in that process and some things that could be affirmed. It was not a wasted exercise completely.

Mr RICH-PHILLIPS — You have not addressed the question. The first part was, 'How much did it cost taxpayers to produce that report which was dumped?' And the second was, 'Given you have criticised the recommendations and said they were not in accordance with government policy and you are disappointed with them, why have you engaged the same consultant to produce the Barwon region report?'.

The CHAIR — Can I just repeat that should you not have information available with you here today it can be taken on notice.

Ms PIKE — Certainly, and I will ask Dr Brook to add further.

Dr BROOK — As a specific answer to the question of how much it cost, it is correct that that consultant's report cost approximately $160 000. I would have to come back to you, and am happy to do so, in advising you of the cost. The same consultant has been engaged and was engaged prior to the production of this report to undertake some work for the Barwon region. That work is in process.

Mr RICH-PHILLIPS — Is it going to be dumped?

The CHAIR — Thank you for your answer.

Ms PIKE — Can I also just reiterate that — —

Mr Forwood interjected.

Ms PIKE — Well, I think it has been quite clear that the consultants were engaged prior to the release of this report. I will also reiterate that there were deficiencies in the process in the Hume report. These were consultants who were actually public servants when you were in government. They were your employees.

Mr RICH-PHILLIPS — How is that relevant? You wasted $160 000 in taxpayers money on them.

MR FORWOOD - You hired them.

Ms GREEN — In your presentation you referred to some of the challenges in the health system with some international difficulties at the moment, and I would like you to expand further on how prepared the department is to respond to such health threats as the severe acute respiratory syndrome (SARS) outbreak and other outbreaks such as terrorism. I note in your presentation you mentioned recruitment of core skilled staff, and I commend the department for appointing our family doctor of 10 years so now we are looking for another and we are very sad, but I am sure he will be a great addition.

Ms PIKE — I am very happy to provide information about those two areas because we know that Australia has been placed on medium alert for a terrorist-related attack. The government has responded to this in a

very comprehensive and responsible way, announcing new measures for enhancing our domestic security in the fight against terrorism. Part of that is ensuring that we have very good links between the police and the emergency service organisations, and the Department of Human Services is very much part of that. We have had a fundamental role historically in Displan, and we are building on that so that we can have a very rapid and coordinated response in the event of a terrorist attack.

The DHS medical Displan sets out the process for managing mass casualty incidents and certainly will mobilise a highly coordinated response from the ambulance services through to the medical staff and of course people within the hospitals. We are also working on integrating GPs into this and having a mechanism for communication which, might I say, has worked very successfully in the SARS epidemic. We will be able to build on that platform in the case of other potential terrorist attacks.

In the case of chemical, biological and radiological attacks DHS has a lead role in assessing threat, in determining containment and all of the risk-management actions. We have a radiation safety unit of scientists who are responsible for identifying and monitoring the hot zone perimeter in radiation incidents. On top of that, as you know, the Displan process has given us extensive experiences in the whole area of trauma counselling and community recovery. We have done that in the case of bushfires and floods and all sorts of adversity, so we do have a very high level of readiness and preparedness in the case of a potential terrorist attack.

I am very proud to say that Victoria has been identified as the top state in terms of its response to SARS, and we have been working through the national communicable diseases network which has coordinated this. You may have seen the chief medical officer, Professor Smallwood, speaking about this matter recently. We are coordinating from a departmental level surveillance for suspected cases and of course have a system on high readiness for isolation infection control. I remember Dr Brook coordinating this area, and he may have further issues to add.

Dr BROOK — I think it is important to emphasise that while SARS is a new and worrying disease, fatal diseases caused by infection have been around for a long time. What we have is a very well-tried and tested system for managing people who may have an infection of one sort or another that could prove fatal to them, so I want to make clear from the outset that while it is worrying and while it is of concern to everybody, the sorts of approaches that we make are not new and in the sort of approach that we make with the commonwealth — this is where we work very closely together — there is no suggestion of any disagreement between ourselves and the commonwealth. Identifying those who may be at risk in coming into the country — —

Mr FORWOOD — That is not your usual line.

Dr BROOK — Identifying those who may be coming into the country — public health is like that — surveillance of those who may be contacts for those cases, isolation should it prove necessary and of course treatment in appropriate facilities are all very well understood.

At this stage we have not been exposed to any case transmission within Australia at all, and in that respect we are very lucky. But we do work as I said with the commonwealth to make sure that any person who comes into the country from areas where there is risk is identified and ascertained as to whether there are any symptoms that could possibly relate to SARS, and we would act on that immediately were there. We and the commonwealth are both in the process of adjusting our laws to ensure that SARS is a notifiable disease and that the corona virus is an accepted infectious disease for the purposes of public health powers, and that will happen very quickly.

We have also been extensively consulting with those in our own field and issuing to them all of the material that they — mostly hospitals and health care institutions — need to understand first what the disease is about and to understand the absolute imperative nature of infection control. A very large number of people who have acquired this disease have in fact been health care workers who are treating people with this disease — so the imperative of rigid application of infection control guidelines and the use of negative pressure isolation rooms and the like is absolutely up to speed should we need to use it for any cases. To date we have only had suspected cases.

Mr CLARK — I raise the issue of medical indemnity insurance. As you know, following the Australian Medical Association rally 11 days ago you indicated the government would introduce a package of legislative measures to tackle this issue. I also understand that you have obtained a report from an organisation called Valda Pty Ltd on medical indemnity insurance issues. Can you confirm that there is at least one major metropolitan hospital — namely, Box Hill Hospital — that is now stating it is fully booked out in terms of taking obstetrics cases through to the end of this year and that a number of regional cities such as Ballarat, Geelong, Wodonga, Shepparton and Bendigo are facing the loss of all private obstetric services under the current circumstances? Can you tell the committee what measures you intend to take to tackle the public liability crisis before Parliament rises this month

and what the expected impact of the medical indemnity costs are likely to be on the public health service, and will you make public the Valda report ?

The CHAIR — Minister, by way of clarification of legislation in this regard, is it the Minister for Finance or you who would be bringing that in?

Ms PIKE — The Minister for Finance does have overall responsibility, but it would depend on the legislation. It may be the Attorney-General or the Minister for Health.

Mr CLARK — Insofar as it lies within your responsibility and responding to what you said publicly 11 days ago.

Ms PIKE — Certainly. You will be aware that the government has introduced a package of reforms to date in response to insurance issues in Victoria and that they reach over all areas of reform. You will also be aware that the national approach has been to commission the report by Justice Ipp and that states and territories have been considering their response to the Ipp report. There has been a genuine desire to try and work towards a national response for the matter of insurance generally in a whole range of sectors. Of course medical indemnity is my particular concern, and we are obviously very aware of the issues that are being faced by Victorian medical practitioners and acutely aware of issues that have been raised in the media about some specialty areas. We are seeking information from hospitals about the potential impact that they may see as a result of this area, which may go to your comment about the Box Hill Hospital. I do not have that specific information, but I am aware we are seeking information from our public sector hospitals regarding that situation.

The challenge for government in this whole area of medical indemnity is clearly to provide a context in the framework where costs of insurance are manageable and where medical practitioners and obviously specialists more particularly can have certainty about their premiums and their payments. Of course that then leads us to look at a range of potential areas for reform. The issue of thresholds or caps is one area; the issue of statute of limitations is another; and of course there is the issue known as the long stop, or the amount of time that doctors have to insure themselves following their retirement to adequately cover themselves for incurred but not reported incidents. They are the issues under discussion and on the table for reform. On the other hand we know that people in our community need to have access to the courts to seek damages in the case of negligence. Let us be quite clear, we are talking about negligence here. We are not talking about mistakes or quality issues, et cetera. We are talking about the capacity for the community to have an understandable, reliable and just system to be able to seek redress where there has been a clear case of medical negligence.

In all these matters — and it is a matter for profound public policy consideration — the government is acutely aware of the looming deadline at the end of June. We have given a commitment that we will continue our legislative reform. As I said, we have already put in place a first set of legislative reforms in the public liability area, and we are very close to putting into the public arena a range of reforms in the area of medical indemnity as well.

Mr CLARK — I appreciate the background, Minister, but time is getting short and this is a critical issue for the reasons I referred to. What exactly are you planning to do in the two or three weeks left of the parliamentary sitting? Failing that, how will you adequately provide in your next year's estimates? Will you release the Valda Pty Ltd report.

Ms PIKE — I am not aware of the Valda report, so I will hand over to Mr Solomon.

Mr SOLOMON — I am not aware that there is a report. Valda has been retained to provide us expert financial analysis and preparation for the cabinet submissions around medical indemnity.

Ms PIKE — Wait for the public announcement; it will be soon.

Mr DONNELLAN — I refer to pages 213 and 217 of budget paper 2 with regard to cancer services. How is the government improving those services in the budget this year?

Ms PIKE — It is important to understand that cancer touches the lives of many Victorians and it is a growing issue. Victoria already has in place a comprehensive range of cancer services. We know that we have some of the best cancer research institutes in the world. We know that we have a number of health services that have specialist cancer services and offer very high-quality support to the community. We also know that we have gone a long way in our breast screening programs and other preventive programs, and we now want to add to this considerable effort.

We have identified an additional $43.5 million over the next four years to enhance and grow our cancer services. The budget commitments are as follows. We will be developing sustainable improvements to breast, bowel, lung, prostate and skin cancer services so they will all be further developed. We will be providing additional radiotherapy services and two new radiotherapy bunkers at the Monash Medical Centre in Moorabbin. The $1.5 million addition to the breast screening program will see an increase of 96 000 women, particularly in that targeted group, who will have access to breast screening programs. There will also be $1 million to replace radiotherapy equipment at the Alfred and the Austin. Actually it is $10 million over four years, but $1 million in the first instance.

I mentioned previously the ministerial council on cancer. There is a strong desire from our academic institutions, research institutions, clinicians and the community to develop an integrated cancer centre. The cancer council will evaluate that and work together on that proposal, but it will also help us with a statewide framework for cancer services. It is not just saying the Peter Mac is it and it is doing a great job. It is around identifying the other places where some significant services are taking place, helping to identify areas of specialisation and creating greater synergy between prevention community-based services and acute services in the whole area of cancer.

The other thing I want to add is that this government has also overseen some of the most progressive tobacco reform legislation in the country. We intend to continue our tobacco reform agenda. We have already announced a number of initiatives in terms of control at the sale and supply end. We have now said that restaurants and gaming venues are cigarette and smoking free. We now know there are some targeted activities that have to be put in place for particular groups of people in the community — for example, young pregnant women are not giving up smoking when they fall pregnant despite all the information around the impact on themselves, their unborn children, and then their children, and the link there is to cancer. That is another component of an overall strategic response in the whole cancer prevention and treatment area.

Mr FORWOOD — Is it the government's intention to prevent the Melbourne Cricket Ground from backing away from its agreement of being a smoke-free venue? You are aware it is trying to get smoking at the back of the new stand. Surely this is something that cannot be allowed to happen, and the government should indicate now that it will not allow it to happen.

Ms PIKE — The government has made that indication. When the media announcement was made that the MCG was considering building balconies that were essentially within the venue, I made it very clear that I thought that was a retrograde step, that it was quite inappropriate, and I said if possible we would legislate. That is on the public record.

Mr FORWOOD — Are we going to stop it, full stop?

Ms PIKE — Yes, absolutely! It is a very — —

Mr FORWOOD — As a member of the Vichealth board I have some interest.

Ms PIKE — Of course. Vichealth made a very strong stand and I absolutely affirm the stand that it made. I have certainly made my views know on the public record. The Minister for Sport and Recreation has already met with the Melbourne Cricket Club and I believe we have a meeting scheduled in the diary. They will be in no doubt of the views.

Mr FORWOOD — Tell them!

Ms PIKE — Yes.

Mr RICH-PHILLIPS — Minister, I would like to ask you about a table on page 135 of budget paper 2 which lists a number of what were election commitments from last November. With respect to your department there are 19 projects listed valued at over half a billion dollars. Some of the projects include the Royal Women's Hospital redevelopment, which was promised at $190 million, and the Grace McKellar aged care centre upgrades of facilities, which was promised $50 million. As I said, a total of 19 projects were promised during the election campaign. That is more than half a billion dollars in the health care area. None of these projects has made the cut in the budget. Not one of these has been funded. What I seek from you is a guarantee that these projects will be funded and an understanding of where they fit in the forward estimates, or are they simply projects that are never going to be delivered or promises that will not be committed to?

Ms PIKE — Labor made $786.95 million of capital commitments, and they are all detailed in Labor's financial statement (LFS). It is a four-year capital works program. We made it very clear that we would be funding

these commitments over the four-year period — that is, over the term of the government. Historically health has received around $200 million each year in new capital projects. We have had other years where there has been a significant boost to that. The Austin was one of those examples. In this budget we have not only included a number of the LFS commitments that you have identified but have also included — —

Mr RICH-PHILLIPS — Could I clarify that?

Ms PIKE — Yes.

Mr RICH-PHILLIPS — You have not funded the ones I have identified.

Ms PIKE — Amongst those you have identified, we have committed a number in this year.

Mr RICH-PHILLIPS — No. In this table — —

Ms PIKE — I beg your pardon. I apologise. This year we have made a commitment to a number of LFS capital commitments and those are the Werribee Mercy, the Dandenong Hospital and the Nhill hospital. There is also the funding for the Victorian Foundation for the Survivors of Torture, for rural ambulances, biomedical equipment and some other areas such as infrastructure upgrades. That funding was not in LFS, so we have gone beyond this year and included the $138 million for the IT initiative. We have made a commitment to fund those capital projects. You identified the Royal Women's Hospital as a very important project. We are currently doing planning work on that at the moment and that includes the evaluation of the enabling works that need to take place, the demolition of the Connibere building and some other enabling works — —

Mr RICH-PHILLIPS — Will that be in next year's budget?

Ms PIKE — We have made a commitment, but these all depend on where they are in terms of planning and the process that is undertaken. We have said we will commit to these projects and it is our intention to do so.

Mr DONNELLAN — With relation to the Victorian Foundation for Survivors of Torture — I have a conflict here because I am a member — what does the upgrade intend to do? I would like to get an understanding of what is involved.

Ms PIKE — Currently the Victorian Foundation for Survivors of Torture has offices and provides services from a site in Poplar Road, Parkville. This site was identified by the previous government as part of the Commonwealth Games village redevelopment. This government has determined to retain that site and utilise it for a range of services, but the foundation has outgrown the facility. It offers a very extensive range of services to some of the most disadvantaged people in our community. There are many people who have come to this country who are victims of torture and trauma. The foundation is world renowned for its services. It is highly regarded. Basically, to provide the services that are required it cannot remain where it is because it is so squashed.

The other thing is that the new site it will go to in Brunswick is also more integrated into the community. It is better served for public transport and access and connection with other services. It will be a better move for them as well, but it is a project that the government is very proud of and very pleased to support.

Mr MERLINO — I refer you to page 211 of budget paper 2, and also to your presentation with regard to mental health; can you provide further information to the committee in terms of what the government is doing to increase access to mental health services in the budget?

Ms PIKE — The government has invested an enormous amount of resources into mental health. The foundation work was done in the period of the previous government by the development of the mental health strategy, which will receive a total of $63 million over the next four years. That money is to be used in a range of areas. It will be used for opening further inpatient and subacute beds. It will increase our services within the community for adult and aged persons requiring mental health services. It will also address the growing needs across all age groups, particularly children and adolescents. I will speak a little bit about that and there are other groups I will speak about in a moment. In terms of children and adolescents, Victoria has a range of world best practice services and also some real leaders in the mental health area as it is particularly relevant to children and young people.

Amongst the capital projects you will have noted that $7 million has been allocated to Mental Health Services for Kids and Youth. MHSKY is also located on the site in Poplar Road, Parkville. We will be committing ourselves to stage 2 of its redevelopment at Footscray which saw the building of inpatient beds and now will see

community-based services for young people. We also are providing some resources to see their continuation at the Parkville site as well. That is in recognition that there are real opportunities for synergies with services for young people in juvenile justice and young people with drug and alcohol issues. All of these groups are very susceptible to early psychosis. The work of Professor Pat McGorry and his team in MHSKY is really targeted in those areas. It is a growing problem in our communities and the additional resources in both capital and recurrent funding will really help.

The other area is dual diagnosis. In the past there has been a stand-off in some ways between the mental health service providers and the drug and alcohol service providers, so people who have a dual diagnosis have found it very difficult to get a service; they have been to the mental health service providers who have said, 'You have a drug and alcohol problem, you need to go to a drug and alcohol service', and vice versa. The reality is that both service systems have to work together because people have that dual diagnosis. Many young people will self-medicate with drugs and alcohol for what is fundamentally a mental health issue. So there is some money there for the dual diagnosis, and also for homelessness.

The government introduced a major homelessness strategy. One of the key areas that the services themselves said was a need was assisting people with a mental illness who are homeless. So the mental health strategy *New Directions for Victoria's Mental Health Services — The Next Five Years*, launched in September last year, provides a very good framework for our development and growth. We have shown enormous commitment to growth in the mental health area over the period of the previous government and now in this term of government, and that will continue.

Mr FORWOOD — I would like you to take this question on notice, if you could. We would all be aware that Dr Brook regularly receives from each of the country hospitals, rural hospitals, the status of their financial viability; Mr Solomon would get the same for the city and metropolitan hospitals. I wonder if you could provide the committee with the financial status of Victorian hospitals — each one — at 31 March this year.

Ms PIKE — The statements that you are referring to are not audited.

Mr FORWOOD — That is all right; we are capable as a committee of dealing with that.

Ms PIKE — I receive the audited financial statements from the hospitals when they become available, and that is the public information that is available to you.

Mr FORWOOD — This is a parliamentary committee.

Ms PIKE — Just let me complete my answer. What we have seen today is a lot of crystal ball gazing by people in the opposition about the financial status of our hospital system. We spend about — —

Mr RICH-PHILLIPS — You could clarify that.

Mr CLARK — We are supposed to report on the adequacy of that.

The CHAIR — Let the minister speak.

Ms PIKE — Let me just complete this. We spend about $15 million every day of the week in our hospital system right across Victoria. There is huge movement around cash flow and all of the other inputs and outputs that are there within the hospital system. It would be totally irresponsible for me to grab some kind of isolated figure out of the air on one particular day of the year and somehow think that that was a true reflection of the overall and long-term position of the hospitals in Victoria. The figure that counts, the figure that is in the public arena, and the figure I will make available to you is the audited figure at the end of the financial year.

Mr FORWOOD — That is an absolute outrage. It is an outrage that you can treat this committee with that sort of contempt. You should know better than that!

Ms PIKE — I might add that that has been the practice for years and years and years; it was certainly the practice in the past, and it remains the practice in the future. I must say it is also quite irresponsible for people to be bandying figures around. This is kind of par for the course in this area of health.

Mr FORWOOD — Don't you lecture me when you come in with that sort of behaviour before this committee!

The CHAIR — Excuse me, Mr Forwood, just stop it!

Ms PIKE — It is par for the course.

The CHAIR — Can we move to the next question, please?

Ms ROMANES — I note that on page 210 of budget paper 2 the hospital system is expecting to have to manage an additional 40 000 presentations at emergency departments in the coming year. How will the hospital admission risk program help to relieve the pressure on those hospital emergency departments and contribute to better health outcomes?

Ms PIKE — The hospital admission risk program — the HARP program, as it has become known — has been affirmed by people right across our health system, particularly in the metropolitan health services, because it is already bearing fruit. It is already showing very good results. The HARP program targets people who are at risk of hospitalisation on a regular and frequent basis. So those kinds of people are people who have chronic conditions, such as diabetes, chronic heart failure and complex conditions that might have a respiratory component, but also people who have drug and alcohol issues and mental health issues. These are people who come into the hospital system at points of crisis in their lives when their condition bubbles over into an emergency state, and often they come quite frequently. The other factor for lots of these people is that they are often very socially isolated. They can be elderly people living alone who do not have a lot of support from family and friends or people who are homeless as well. So they are the kinds of people who, as I said, come, receive treatment and go back out; but unless someone helps them maintain the administration of their drugs, assists them with some of the prevention programs and access to those programs, and monitors their diet and all those things that go to health and wellbeing, the chances are that they will bounce back in the next period — it could be two months, three months, or whatever.

So the models of care that are being funded through the HARP program are things like falls clinics. Falls among older people account for a huge number of admissions into our public hospital system. The clinics do things like helping people design their houses so they do not have booby-traps in the way when they go from the bedroom to the bathroom in the middle of the night; helping people to learn to walk appropriately — throw away the high heels — and walk in a steady manner and all those sorts of things — they are all part of falls prevention programs.

There are also disease management programs which help community-based organisations with advice and with links into general practitioners to help manage people's diseases within the community. There is integrated care between a community-based organisation, the hospital and the GP, so they are all talking to each other, they are all aware of these patients and we can follow these patients, track them and support them at every stage.

This is a real challenge for hospitals because the acute system particularly has not always been very good at talking to the community-based services; it has tended to be ideologically and culturally focused on emergencies: we just go in, fix this person up and out they go, rather than the long-term notion of continuity of care that is common in, say, the disability sector or some of the other sectors. So the acute sector has had to learn, as have community organisations also.

I spoke before about Austin Health. It manages around 350 patients annually who fit into this category. There has been a 53 per cent reduction in emergency department presentations.

Ms ROMANES — Is that from that 350?

Ms PIKE — Yes, from that 350, that specialised client group. There has been a 57 per cent reduction in admissions and a 59 per cent reduction in hospital bed days. So, as I said, the program is already bearing fruit. It is around redesigning a complex system, but the early results are very promising. HARP has already allocated $33 million across the metropolitan and major regional health services. There have been 80 prevention initiatives. We are monitoring this very closely. Professor John Funder chairs the HARP Reference Group. There are 28 industry experts on the reference group. They are there to collate the information, to give guidance and strategic advice, and we think HARP is one of the real success stories, and we are continuing to roll it out.

The CHAIR — By way of a supplementary question, in my local community health centre there is a chronic respiratory initiative which, to my untrained medical eye, seems a terrific program. At the launch of it they talked about the rigorous evaluation that was going to occur with each of these initiatives, which I thought was very welcome. Can you provide to the committee at a later date something on that evaluation system that is in place and the output measures, because from what was said at our community health centre anecdotally there were really good results — that would be very useful for the committee — and whether anything includes an output measure

like involving local MPs' offices, community health centres or GPs who can refer people to these initiatives, as opposed to constantly having them in the acute or the medium medical system.

Ms PIKE — Yes, I am happy to provide further information.

Mr CLARK — Can I refer you to a press report of 26 April this year which said, 'Waiting lists for public dental care have jumped more than 50 per cent since the Bracks government came to power'. I understand that waiting times have now reached levels of around, say, 49 months in places such as Warrnambool and Portland; Ballarat, 36 months; Eltham, 41 months; Footscray, 36 months et cetera. You are probably also aware that the Victorian Council of Social Service has said:

> Critical waiting lists of concern include:
>
> Dental Health
>
> The waiting time for dentures across Victoria has blown out to 28 months, yet dental health suffered a real and effective cut of 1.26 per cent.

Can you tell the committee how the government arrived at its decision on the level of funding to provide for dental health in the estimates for the forthcoming year and what your plans are to tackle this blow-out in waiting lists and waiting times?

Ms PIKE — Sure. Demand for public dental health, as you have identified, does remain high, and waiting lists have continued to grow since the commonwealth withdrew its funding of the dental health program in 1996. It in fact removed $27 million per annum with no warning right out of the system, and I believe — in fact I know — that upon removal of that funding in the first year after that, when the previous government was in power, waiting lists doubled in one year. So that was where that doubling occurred. It is true that waiting lists have continued to grow. However, the rate of growth has steadied, and that is partly due to the additional investment that the Bracks government has put into the public dental service which far exceeds any investment at all that was put in by the previous Kennett government. We have added an additional $34.94 million into the public dental service between 1999 and 2003 and, as you have identified, we will continue to resource the system. As part of that resourcing, we are training more dental therapists, opening more dental chairs in community clinics and — —

Mr CLARK — How many more chairs for the forthcoming year?

Ms PIKE — I will take that on notice and talk to you about that in a minute. We are also promoting oral health in preschools and increasing funding to the Victorian Denture Scheme. We have also funded in 2001–02 an adolescent dental program so that 13 000 adolescents from socially disadvantaged areas have now received care through that program, and of course the other area is for children. You will be aware that we are also pursuing the matter of fluoridisation and its enormously positive impact on dental health and the reduction of cavities.

Mr FORWOOD — In Geelong?

Ms PIKE — I will take that one on notice in a minute, too. Regarding funding — and this goes to your question about dental chairs — the breakdown of the funding is. $400 000 for more dental therapists, $700 000 for dental chairs in Wyndham, Omeo and PANCH, promoting oral health, as I said, work force initiative and increased funding to the denture scheme. So that is the breakdown of the funding.

Regarding the matter of fluoridisation, as you may be aware, I think we have around a 77 per cent level of fluoridation in Victoria. We know that the work by the dental school and the dental hospital tells us that there is a 40 per cent reduction in cavities for children who live in areas where there is fluoridisation. We are also acutely aware that there are very strongly held views around fluoridation in many areas in Victoria, and Geelong, as you have identified, is one of those areas. We think the best results will come by way of public education and public engagement in this issue. We do not underestimate it is difficult, but I must say I believe the evidence is overwhelming, and we not only intend to work through the water boards, but also the public health division will be conducting community consultations in rural areas to progressively work with communities about this issue.

Mr CLARK — You mentioned $700 000 for extra dental chairs. How many chairs does that translate into?

Ms PIKE — We will take that on notice.

The CHAIR — Thank you.

Ms GREEN — Minister, on page 83 of budget paper 3 it lists total output costs for drug treatment and rehabilitation. I wonder if you could tell the committee if a firm commitment has been made in this budget to continue funding the Victorian government drug initiative?

Ms PIKE — The government has indeed made a firm commitment to continue the funding of the Victorian government drug initiative, and in fact this is a very exciting initiative in this budget, because projects that were funded through Turning the Tide and the Victorian government drug initiative were previously funded through the Community Support Fund, and there was a lot of concern in the sector about that funding, because the Community Support Fund provides funding on a fixed-term basis. We have worked very hard to ensure that the ongoing parts of that program are now within the Department of Human Services. They have been put into our base, and so that is why you will see the substantial increase in funding for drug services in the base of Department of Human Services. So for 2003–04, $43.9 million has been allocated for the whole-of-government drugs programs that were previously funded through CSF, of which $32.4 million has come to the Department of Human Services. That is why there is an increase of 45.5 per cent to the recurrent drugs program.

So these programs will continue to fund a wide range of initiatives: the clinical and alcohol drug services, which, as we know, have seen a very substantial deduction in waiting times; the residential withdrawal and rehabilitation services, which again are now seeing record waiting times; the entire youth alcohol and drug service system, which is an area that we have committed to some additional work, and you will be seeing some major media strategies around binge drinking and alcohol abuse by young people in the near future.

Continuing initiatives will be undertaken with our forensic drug and alcohol responses for prisoners, as well as a wide range of drug prevention programs, including family support and local drug strategies — and in two other portfolio areas, education and justice. We have had a very highly successful drug strategy. These changes, or this move from the Community Support Fund to the base of Department of Human Services funding has been widely affirmed and welcomed by the drug treatment sector because they were concerned with a lot of their funding in the Community Support Fund and they wanted security. They are very happy that there has been security in this area. This year community education programs, the drug education strategy, Koori information and Youth at Risk programs are all part of the work we are doing.

Mr RICH-PHILLIPS — I would like to ask you about the Centre for Grief Education, which is a unique service. I understand it is the only service of its type in Australia providing dedicated grief management services, which has been particularly important over the last 12 months with Bali and bushfires in Victoria and so on. The centre is seeking some certainty as to its funding, both recurrent funding and funding for the relocation of the centre. It is my understanding that a report was commissioned for you last October regarding that centre. I also understand certain commitments were made during the election campaign with respect to the recurrent funding of the centre and also funding for its relocation. By way of endorsement just last week one of your members, the Honourable Carolyn Hirsh, a member for Silvan Province, made a statement in Parliament describing the centre as an excellent organisation and highly commended its grief counselling services for adolescents. In the context of the service that the centre provides and Ms Hirsh's endorsement of the centre will you give a commitment to the committee in terms of the recurrent funding for the centre, the necessary boost in recurrent funding, and also funding for its relocation in 2003–04.

Ms PIKE — Thank you very much. In fact this matter was canvassed fairly extensively in the *Herald Sun* in April this year. There was an article in the *Herald Sun* saying the Centre for Grief Education was facing closure after a government funding shortfall. I am very aware of this issue.

The government provides $1.354 million for a broad range of grief bereavement services. They are attributed to a range of organisations, and in fact the Centre for Grief Education that you have identified receives the largest allocation of funding from the government — $401 000 or nearly $402 000. In addition we have a number of community-based palliative care services, and this year the government provided $500 000 for additional counselling support for Bali victims, volunteers and staff, which included $200 000 for immediate counselling through the victim referral assistance service (VRAS), some additional counselling at the Coroner's Court and some funding for people who require continuing support.

The funding for the Centre for Grief Education has been maintained and will be adjusted for CPI. We are aware that the centre is looking for alternative accommodation, and the department has committed to working with the centre as it does for a whole range of non-government organisations. Many non-government organisations need to move or ask the department to assist them and work with them when they require additional facilities or they want additional facilities. Those kinds of organisations range from big organisations like Anglicare and all those

organisations to Alzheimer's societies and disability service agencies, and all of these agencies would like to have funding for capital requirements, and the Centre for Grief Education is one of those. We want the service to continue. We are continuing to fund them with $401 000 in recurrent funding, and we are very aware of its their concerns. As I said, the department is working closely with the centre so that it can continue to function.

Mr RICH-PHILLIPS — The centre is seeking, as I understand it, around $120 000 in recurrent funding. You mentioned CPI increases, and obviously that is a bit more than a CPI increase. Is there any prospect of that request for an extra $120 000 in recurrent funding in addition to the $400 000 being accommodated?

Ms PIKE — Every community organisation seeks additional funding for its their services, whether it be a disability service, drug and alcohol service, a psychiatric service, an aged care service or a hospital — everybody is always seeking more funding. Those applications, requirements and requests are evaluated against the capacity of the government to fund those services. That is a process that is being undertaken here. Certainly the department will evaluate that request and provide advice to me. But I reiterate that the Centre for Grief Education receives the largest allocation of funding from the Department of Human Services. The government has significantly boosted grief and bereavement services not just through these centres but also through our community-based palliative care services, which also provide bereavement counselling. This has been a very significant investment.

Mr DONNELLAN — Talking about cancer and so forth, I refer to page 82 of budget paper 3. I am wondering how successful the tobacco legislation regarding smoke-free dining and licensed premises has been.

Ms PIKE — As I said before, the government introduced a very comprehensive range of initiatives regarding tobacco with the objective of helping reduce the consumption of tobacco within the community. The local councils have responsibility for ensuring compliance with smoking restrictions. They are saying to us that smoking restrictions in gaming venues are receiving good compliance, but there is still more work to be done. There are people and there have been media reports about some venues flouting the law. Those areas will be targeted very specifically to ensure they comply. There are significant penalties if people do not comply with the enforcements.

The other areas of initiative have been the smoking restrictions in restaurants. Our research shows that the community has willingly embraced these initiatives, and like any change in this regard there is obviously an initial concern about it, but by and large I think the community has been brought along where these changes. It is a really important case for government offering some leadership here.

The other components are the restrictions on sales to minors and the changes in point-of-sale advertising. Again, crackdowns in these areas have proved very successful. By and large it has been a very successful program. I will just mention that people will be aware that there has been a push by people along the border towns to ask us to, excuse the pun, water down the legislation for their particular areas because of concern about declining revenue from the pubs and clubs there. We do not have any evidence of decline in revenue. There is no publicly available data around the decrease in revenue. We would be encouraging New South Wales to copy the excellent legislation we have rather than wavering on this. We have been very determined that we will not have any exceptions.

The CHAIR — By way of a supplementary question, if there is a telephone number that Mr Donnellan or any other members of the Public Accounts and Estimates Committee wish to use to dob in those who are breaking the law we would be happy to circulate it.

Ms PIKE — I think it is 131 448.

The CHAIR — I am sure he will take that down straightaway. Last question, Mr Forwood.

Mr FORWOOD — The committee, in its questionnaire to the department, asked the department to list a minimum of seven strategic issues that have influenced the development of the department's estimates for the 2003–04 financial year and to describe how the department will address these issues in that year. In your response you list three generic challenges, no strategies and refer the committee to the forthcoming Human Services plan due for endorsement in July 2003. The first part of my question is: do you regard that as an adequate response from your department to a questionnaire from the Public Accounts and Estimates Committee? The second part is: will you provide the committee with details of the seven key strategic issues facing the department, as asked for originally?

Ms PIKE — Could you draw my attention to the page?

Mr FORWOOD — Page 20 of the questionnaire, which states 'Please list a minimum of seven strategic issues ...'.

Ms PIKE — Of the questionnaire? I was asking you to refer me to the response.

Mr FORWOOD — That is the response. We asked for seven strategic issues that have influenced you. I should make the point that each of the other departments has been able to do this.

Ms PIKE — Having a look at this and having looked at our response previously, the Department of Human Services is a huge and very complex organisation with an enormous range of services across a plethora of community-based agencies. It has given a response that identifies what the critical strategic issues are for the department.

The first critical area is managing the demand for services. I have talked in the health area about the huge demand for services in the hospital system and the fact that we also have the impact of commonwealth policy on that demand. Meeting the increased demand — coping with the 35 000 additional patients who are coming through the door every day — is one of the absolutely fundamental strategic tasks. Then meeting the increasing complexity of client need — those co-morbidities, those people who have multiple issues in their lives; they are homeless, they have drug and alcohol issues, they have psyche issues — and adjusting the service system so it can more adequately respond to that complexity and not duplicate services, not deal with people in an episodic and disconnected nature. There are two there.

Next is improving viability and productivity by the use of IT. Then there is ensuring financial sustainability — the initiatives in hospitals around the development of a common chart of accounts, which is a critical factor in terms of financial sustainability. Work force development is an absolutely fundamental issue for us. We have a shortage in virtually every work force area, and we have a commonwealth government that refuses to adequately fund the places in the tertiary institutions for the work force in the human services sector. Lastly, there is modernising agency infrastructure.

We have got to 6, and with the other 5 initiatives that adds up to 11 in my books. The other 5 areas that are strategic issues facing the department are: shifting the service focus from prevention to early intervention — that is always a task when you have high-cost service delivery at the tertiary end and you need to prevent illness and accident and injury and child abuse and all of those things; improving social cohesion and participation in family life; alleviating pressure on families with young children; addressing changing patterns of health and wellbeing — the ageing population and all of those things; and delivering services around person and place; and they would all be critical to that.

Mr FORWOOD — As you pointed out to us, this department gets over $6 billion — —

Ms PIKE — Nine billion actually.

Mr FORWOOD — Okay, your bit gets six — $6.2 billion was the figure you put up on the board. What the committee asked your department to do was list its key seven and then show how the department will address each of the issues. We believe that you responded with some generic stuff. The point I am making is there has been no attempt by your department to connect the strategic issues in the department with how you will address them with the amount of money given to you by the Parliament through the appropriation process. I would have thought that that was a fundamental role — for you to respond to the committee, for your department to respond to the committee.

Ms PIKE — I will ask the secretary of the department to add to my comments..

Ms FAULKNER — We do believe we listed the 7 strategic issues — we thought we had listed 11. I suppose with a very large and complex department we are often under pressure to summarise down so I apologise if the detail is not there for you, but they are clearly the strategic issues. We understood that you wanted to know what the seven were that we would address in the budget context. We had not read into this question exactly how they were to influence the budget estimates. I think the question was what are the issues rather than how are they addressed in the budget context. It says 'have influenced the development of the department's estimates'. They are the 11 issues that have influenced the department's estimates — —

Mr FORWOOD — It says 'Please describe how the department will address these issues.'

Ms FAULKNER — Yes, it says please describe how we will address these issues in 2003–04. Our vehicle for doing that is a departmental plan which has traditionally been brought out much later. We have brought it back in the past three years to publishing it by 1 July. I suppose you wanted us to publish that earlier — —

Mr FORWOOD — I am not telling you how to do your job. What I am saying is that as a parliamentary committee dealing with this before the appropriation bills are passed what we are trying to do is match a very large amount of money with a strategy through the budget papers. I do not believe the response the department gave us enables us to do that.

The CHAIR — Thank you to the secretary for outlining the 11 strategic issues that the Department of Human Services sees as relevant to the departmental budget.

Thank you very much, Minister; and thank you to departmental staff and advisers. The Hansard transcript will be distributed early next week, as I understand it. I appreciate the time you have given us today and the way you have informed us on your budget. Thank you.

Witnesses withdrew.