VERIFIED TRANSCRIPT

PUBLIC ACCOUNTS AND ESTIMATES COMMITTEE

Inquiry into budget estimates 2008–09

Melbourne — 13 May 2008

Members

Mr G. Barber	Mr G. Rich-Phillips
Mr R. Dalla-Riva	Mr R. Scott
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Witnesses

Mr D. Andrews, Minister for Health,

Ms F. Thorn, Secretary,

Mr A. Hall, Executive Director, Financial and Corporate Services,

Mr L. Wallace, Executive Director, Metropolitan Health and Aged-care Services, and

Dr C. Brook, Executive Director, Rural and Regional Health and Aged-care Services, Department of Human Services.

The CHAIR — I declare open the Public Accounts and Estimates Committee hearing on the 2008–09 budget estimates for the health portfolio. On behalf of the committee I welcome Mr Daniel Andrews, the Minister for Health; Ms Fran Thorn, Secretary of the Department of Human Services; Mr Alan Hall, executive director, financial and corporate services; Mr Lance Wallace, executive director, metropolitan health and aged-care services; and Dr Chris Brook, executive director, rural and regional health and aged-care services — we know some of those titles are also still misnomers. Departmental officers, members of the public and the media are also welcome.

In accordance with the guidelines for public hearings, I remind members of the public that they cannot participate in the committee's proceedings. Only officers of the PAEC secretariat are to approach PAEC members. Departmental officers, as requested by the minister or his chief of staff, can approach the table during the hearing. Members of the media are also requested to observe the guidelines for filming and recording of proceedings in the Legislative Council committee room.

All evidence taken by this committee is taken under the provisions of the Parliamentary Committees Act and protected from judicial review. There is no need for evidence to be sworn; 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, and the committee requests that verifications be forwarded to the committee within three working days of receiving the proof version. In accordance with past practice, the transcripts and PowerPoint presentations and any other documents that are tabled will be placed on the committee's website.

Following a presentation by the minister committee members will ask questions relating to the budget estimates. Generally the procedure follows that relating to questions in the Legislative Assembly. I ask that all mobile telephones be turned off. I invite the minister to give a brief presentation of no more than 10 minutes on the more complex financial and performance information that relates to the budget estimates for the health portfolio.

Overheads shown.

Mr ANDREWS — Thank you, Chair, and good afternoon to members of the Public Accounts and Estimates Committee. I am very pleased to be here to report on what is a strong budget in the 08–09 year. I will go through these slides just to give you a sense of our challenges, the government's response to those challenges within our overall aim of providing the best care right across metropolitan Melbourne and rural and regional communities.

Growth in demand for health services is something that is constant. It is something that has been with us for many years and will obviously continue to be, and will frame the future, if you like, in terms of health service provision. In the 08–09 year we forecast over 415 000 additional patients will be admitted to our public hospitals and 600 000 additional treatments in our hospital system — again, very, very substantial increases against the performance levels, the activity levels, we found in 1999–2000. The graph gives you a sense of that very steep increase in the total number of patients being admitted into our public hospitals.

Above-average population growth, advances in medical technology and the ageing of our Victorian community drives the demand pressure I speak of, and again we are also challenged in that demand in terms of managing increasingly complex patients.

In terms of our hospital performance, we can be very proud in this state of the first-class care that our doctors, our nurses and our allied staff, our system provides for a very rapidly growing number of patients right across the spectrum of care. We perform very strongly against other states and territories, exceeding the national average in ED performance; the median waiting time for elective surgery; in terms of the overall efficiency of our health system; and the length of stay in our system. But again — just to punctuate the point I made earlier about some of those demand pressures we face — we have seen 34 per cent more admissions, more than 40 per cent in terms of growth in emergency presentations over our time in government, and again more than 20 per cent in terms of special outpatient treatments. These are very, very substantial growth rates, and again present us with challenges as we go forward. The graph bears that out in terms of ED attendances.

In terms of life expectancy, our care is actually paying dividends right across the community, and we can be proud that our life expectancy is well above the national average.

In terms of the commonwealth government, it would be remiss of me not to paint, in terms of the context of the challenges we face, obviously the failure of the former commonwealth government to properly and appropriately fund health care in a meaningful partnership. That is something that we still have to struggle with today. If we go back to the beginning of that graph, we see that at around 2000, when we signed the Australian health care agreement in that year, it was not quite but effectively a fifty-fifty partnership; and certainly in relative terms, compared to where we find ourselves today — at a 60:40 funding split — there is a substantial decrease in real terms in the commonwealth government's contribution to the care that is so important to so many across Victoria.

It is not just about hospital funding: the commonwealth's failures are also important to note in relation to primary care. We have seen very poor performance in relation to supporting bulk-billing, supporting GP access, and that again feeds some of the demand pressures we face. I point members to the graph in the bottom right-hand corner that shows total growth in emergency department presentations, total growth in category 4 and 5 presentations within that cohort, and then increased attendance at GPs. You can see very clearly that each feeds the other. Poor performance in primary care puts additional demand pressures on our acute care sector. Again, the point about aged care and making appropriate provision for our seniors also drives demand.

I am conscious of the time, we will move quickly through these. Again, every single health service in every single year we have been in government has received a funding boost, such that across the combined output of acute health and aged care, there has been a 109 per cent increase on the circumstances we inherited in 1999–2000. Across just the acute health service output group, there has been an increase of 112 per cent — so record funding to treat a record number of patients.

In terms of the infrastructure, our capital works program, we know it is our challenge and it is our mission, if you like, to ensure that the fabric and the quality of our buildings matches the quality of the care provided by our staff, and that is why in each and every year of our government there has been a boost in the asset investment program, such that we are fast approaching around $4.7 billion in terms of our total health and aged-care infrastructure spend — a record spend, again in the physical capacity of our system to treat more patients and respond to the demand challenges I have spoken of.

In terms of reform, we are always looking for opportunities for new models of care, to change the way the system works. Again, it is not just about more money, as important as that is, but new ways of delivering care are important, whether it is the Nurse-on-Call platform, the hospital admission risk program — a very, very successful program diverting clients, patients, away from acute services — or short-stay units and medihotels, which again are alternative models of care to reduce the length of stay and indeed to divert patients away from multi-day inpatient beds.

Today I announced, as part of releasing the seventh *Your Hospitals* report, a winter demand management strategy, and I am sure if I get an opportunity I will be happy to speak about that in more length later on.

In terms of elective surgery access, we are fundamentally committed to doing more in this space. As part of a proper and fair partnership with the commonwealth government we made announcements of a combined $60 million investment in the calendar year 2008, and that will see us treat 9400 additional long-wait patients this year — that is, those patients waiting longer than the clinically appropriate time. This budget builds on that by delivering $15 million in growth funding — again, not one-off blitz money but growth funding — as part of HDM into the base pushing through the out years so that we can make the most of the historic opportunity and the partnership that we now have with the new commonwealth government and that additional funding. We are also looking for reform and doing things differently, if you like, running more efficient services across elective surgery as well.

In terms of our workforce, this is a much quoted figure. We have recruited more than 8000 additional nurses, as you can see there. The total nursing workforce's EFT has actually increased by more than 8000 since we came to government, and we have also had a very substantial increase of 45 per cent or 1888 additional doctors boosting our medical workforce. Again, that is all about building the capacity in the system with record staffing levels, again, to treat a record number of patients presenting for care.

In terms of budget highlights this year, $1.81 billion boost across health. A very substantial budget for us, a strong budget. I have spoken a little bit about capital works: just under 477 TEI there. The increased capacity as part of the baby boom, 30.5 million, and again, 702.9 in terms of ongoing funding to support the work that we are doing

across the system, whether it be through additional emergency department presentations, additional outpatient appointments or the elective surgery growth in capacity and activity that I spoke of a moment ago.

Let me be very up-front about this: there is more to do, there is more to be done, and this is a budget that continues the investment that will support that additional effort, that will support us meeting not only the challenges today but setting ourselves up for increased activity in the future. This year it is 180.55, and that slide gives you a sense of the breakdown between demand, in terms of system capacity, the baby boom, money to run HealthSMART and the shared ICT services, as well as a range of other programs to again increase the capacity, increase the throughput and improve time to treatment across so many different categories.

Our workforce is a very substantial package in this year's budget. Not to exclude other parts of our health system but the medical workforce is a very big winner out of this package: 55.1 million over four years. That is about supporting better clinical placements but also upgrading the infrastructure, the teaching and training infrastructure, that is so important to meeting that workforce challenge. Workforce challenges are nothing new in health but this really does set us up well, whether it is in terms of the fabric at Barwon, at Warrnambool or Northern, and, on from that, 211 extra intern places, which is principally about supporting that cohort of medical students that will come through as a result of our successful lobbying of the previous commonwealth government back in 2006.

On health infrastructure, again, from a metropolitan point of view this gives you the headline figure of 264 and runs you through the main highlights: Sunshine stage 2, Kingston, Dandenong Hospital emergency department — one of our busiest and again an important commitment and one of our LFS commitments — the ONJ Cancer Centre at the Austin, bringing to book additional capacity at the Alfred's elective surgery centre, and so on and so forth.

Again, this is a record investment in our metropolitan assets, and if we turn to the next slide, again this is a record investment in our rural and regional assets to support those communities in the care that they need: the second stage of that important redevelopment of Warrnambool hospital, Stella Anderson and the Bendigo aged care redevelopment there, Hepburn Health Service — its Trentham campus receives a record upgrade — and indeed the Bendigo Health Care Group's emergency department, one of the busiest in country Victoria, receives support, the support it nominated as its no. 1 priority, of $9.5 million to enable expansion of its emergency department, as well as some other less locally based but equally important initiatives in energy supply, and of course medical equipment, building on our commitments from last year's budget.

In terms of maternity capacity, much has been made of this in recent times. We have had more births last year than we have had in years — we have got to go back to 1971 to find a higher number — so it is important to build on the work we have already been doing in terms of boosting the overall capacity of these services dealing with the baby boom. That is why there is $30.5 million in capital funding, and there is also additional growth: $10 million into the base as part of HDM driving forward. That is provided now, the capital works will take some time, but the growth funding is there now from the 8–9 year, and again, that is an appropriate response. This is a wonderful thing, the fact that we are having the baby boom that we are having, but it is incumbent upon governments, it is incumbent upon health services to provide for that, and this budget delivers that in spades.

In terms of ambulances, much has been said of this as well. This is a centrepiece of this year's budget, an almost $186 million package over the next four years. It gives you a list there of all the different enhancements across 48 different towns and suburbs: 59 new or upgraded services, 258 additional paramedics — that is on the road — and there is also a very substantial boost to air ambulance, both in terms of the statewide retrieval chopper and the fourth HEMS craft — the fourth HEMS rotary asset down at Warrnambool supporting the south-west coast. This effectively triples, over the life of this package, the government's contribution to ambulance, so it is a very, very substantial investment to deliver better care across communities.

On the innovation and cancer plan, again we made much of this as well: a $150 million package both to see us translate world-leading research into better clinical outcomes but also better care and options and alternatives for patients together with supporting the cancer workforce. This is a very substantial package and one that is also underpinned by a bold and ambitious target to increase survival rates to 74 per cent by 2015. That concludes my presentation, Chair.

The CHAIR — Thank you for that, Minister, and thank you for making this available. I might begin. One of the areas the committee is inquiring into this year is the extent of subsidies and concessions as well as revenue forgone right across the board in the budget and in the forward estimates. I wonder whether you could advise the

committee of any specific subsidies or concessions, or indeed any revenue forgone within your portfolio, and whether there have been any changes to them in this year's budget?

Mr ANDREWS — Thank you very much, Chair. That is a good question and one that I am pleased to provide some information to you and the committee around. If you go to page 213 of budget paper 4 you will see some information that will support this issue. The estimated cost of concessions administered within the health portfolio in the 08–09 year is $499.5 million. That is an increase of $19.7 million on the 07–08 estimate of some 479.8 million. There is a further amount and that is administered by my colleague, the Minister for Senior Victorians, Minister Neville.

The program, as funded by the allocations I have just spoken about — or the program as delivered under these allocations — includes dental services, a range of community health programs, and I know that is of interest to you in your local community, as well as the Ambulance Community Service Obligation program, or the CSO program, where commonwealth health-care card holders and other concession card holders travel free in relation to ambulances.

To give you the breakdown in terms of dental health services: the estimate in 07–08 was 107, and it will go to 109.9; community health from 85.5 to 87.6 as an estimate; and the Ambulance Community Service Obligation program goes from 287.3 as a 07–08 estimate to 302 as the 08–09 estimate. There has been some substantial growth there given the percentage of the community in that age group is growing, and we need to provide as part of our ambulance package our support for that growing group.

I should also draw your attention as part of this year's budget the VPTAS — Victorian Patient Transport Assistance Scheme — that is of great benefit to many rural and regional families and patients, those needing care, or needing specialist care, away from their own community and needing to travel, the subsidies provided there will increase by around $700 000, supporting that very important work. That is the most effective summary we can give you in relation to subsidies and forgone revenues including those that are included within the forward estimates, but I would also direct you to Minister Neville who effectively administers, in her capacity as Minister for Senior Victorians and also as Minister for Community Services, the bulk of that particular program.

The CHAIR — I presume some of those programs would include flu immunisation for people over 65 in terms of providing a free service and things like that?

Mr ANDREWS — We can probably provide you with a more detailed answer on notice. There are some complexities with that where the commonwealth government funds most of that activity. We have a broader policy role. What I would say to you is that I made reference to a number of community health programs, and I can confirm that they include, for instance, audiology, dietetics, OT, physio, podiatry, nursing, family planning, and women's health. Across the spectrum of care there are a range of subsidies and other supports that are provided under this particular output group. But I am happy to come back to you.

The CHAIR — It would be good if you could give us a bit of a breakdown because we are trying to capture what these concessions and subsidies are across the board. I know there are complexities in terms of dealing with the commonwealth funding in a whole range of areas in the Department of Human Services.

Mr ANDREWS — Absolutely.

Mr RICH-PHILLIPS — Minister, I would like to ask you about the asset investment program. You talked a little about it with your slides today, and I think you referred to some $400 million of TEI. Can you please give the committee a breakdown of that insofar as it relates to the four years of the estimates — that is: how much is in the estimates, how much is beyond the estimates? What projects within that relate to providing acute hospital capacity as opposed to other health service capacity, and what will be the net effect on overnight bed capacity within the public system as a result of that investment?

The CHAIR — The minister may not be able to answer that one completely although there are a lot of assets initiatives in appendix A.

Mr ANDREWS — What I am happy to do is to direct Mr Rich–Phillips to appendix A, budget paper 3, page 315 which provides a table of human services asset initiatives. It covers health as well as aged care and a range of other projects. That gives you the asset breakdown, the cash flow or the allocations in each of the out years

against the comments I have already made, as well as some allocations from 07–08 that are accounted for brougth-to-book as part of this budget.

Again, page 317 provides a breakdown or an important narrative on each of the projects. To save the time of the committee, in terms of your question about which parts are acute and which parts are either sub-acute or ambulatory, we can probably come back to you with some information on that.

Mr RICH-PHILLIPS — Thank you.

Mr ANDREWS — I can give you a couple of examples now. When we fund capital — and again we are very proud of our record in this space — there is funding for some ambulance capital improvements in this budget. I am just trying to think of an example that will deal with your question. For instance, if you look at Sunshine stage 2. Sunshine stage 2 is a very important project, it is more than $73 million. This is stage 2; we provided some money last year. It funds a range of different things. I think part of your question was whether it adds more beds — —

Mr RICH-PHILLIPS — Yes.

Mr ANDREWS — This is a very valuable addition — a very important project — but it will not necessarily mean that there is a net increase in the number of beds available on that site, that is stage 2. What the capital investment means is that for the first time western suburbs families will have access to public radiotherapy. There are four bunkers, two of which will be fitted out with linear accelerators, and you will see around 900 local patients able to get their radiotherapy, their care, in their local community for the first time.

It gives you a sense of these investments. Whether it is inpatient acute or whether it is to support more ambulatory care and radiotherapy same day care — you come in and go out for long periods of time — I think you need to be careful not to assume or to make the judgement that bed stock is an absolute arbiter or an absolute indicator of the overall capacity of the system today, much less the capital program given that new capital and new fabric is so often about driving change and building a new physical space to offer a new model of care.

Mr RICH-PHILLIPS — Hence the question as to if we can make a distinction between what is going into hospital capacity, bed capacity, versus what is going into the types of facilities you just mentioned then.

Mr ANDREWS — Given the breadth of the capital program this year it is probably beyond us to go through each of those in detail but I will give you another example before I finish, and we will provide you with some more details on that.

The CHAIR — You probably should also provide details on the additional patients that the new facilities will be able to treat.

Mr ANDREWS — Again on some of those you can make a direct link between improved physical capacity and the increased number of patients that will be treated in that setting. Sometimes that is a more complex judgement to make but if we look at our own local community, Mr Rich-Phillips, the Dandenong emergency department redevelopment sees the number of treatment spaces go from 35 to 55. I think it is an addition of 20 no matter what the base number is. There is also a 20-bed short-stay unit, fundamental improvement in that space and that will be all about treating more patients and providing better care.

The point I am trying to make is that there are some parts of the capital program that are about the acute inpatient capacity. There are other parts of the capital program that support new and different and improved models of care ,and I think the teaching, training and research facility at the Sunshine Hospital coupled with the new radiotherapy tells that story well. The Dandenong example is probably at the other end of the spectrum of care. We are happy to provide you with further information in relation to a breakdown on that.

Mr RICH-PHILLIPS — If we can get that breakdown.

The CHAIR — Thank you. Also if there is any TEI which will go beyond that.

Ms MUNT — I am interested in how you plan to cope with this baby boom. You briefly touched in your presentation on Victoria's maternity capacity, and I know that part of the budget is for a new maternity program at Monash Medical Centre that I am very pleased about. I know that the chief executive officer of Southern Health

was saying that it will make a big difference to maternity services out there. I am just wondering if you could give some more information on other programs that you are considering or implementing to manage the baby boom?

Mr ANDREWS — Thank you very much for that question. It is an important one. It is very topical. We have seen record growth in the number of babies being born right across Victoria, particularly in our public hospital system: 12.3 per cent growth in the last three years, well above any of the estimates that any credible experts forecast. No-one had forecast this so it is important to acknowledge that this is something we have to face and we have to make capital allocations as well as improve the ongoing funding we provide to health services to manage this as we go forward.

I will break up that $30.5 million. I think that is probably the best way to go because it is important to support less complex care in the outer suburbs, and I suppose protect some of the capacity of our specialist care centres, and I will come to those in a moment as well. The budget as part of that 30.5 deals with $4.2 million for Casey Hospital. That is 14 additional special care nursery cots, and we estimate that will support 1000 additional births in that setting, noting of course that is a very new hospital. It is one we were proud to fund. That is all about bringing better care and a better range of services to what is one of Melbourne's fastest growing growth corridors.

Frankston also benefits with $5 million for additional maternity and nursery cots to increase capacity by 300 births there. I visited both these health services last week and again speaking with new mums, with staff and with senior management both at Peninsula Health and Southern Health they are very pleased that we have been able to make these additional commitments to support them in their important work.

Werribee Mercy, in another very important growth corridor, $14 million for eight extra maternity beds and four extra special care nursery cots, and we estimate that that is about the capacity for an additional 800 births. The Northern Hospital shares in this as well: $2.5 million for additional beds to support 500 additional births. The Monash Medical Centre also shares in this with $4.8 million, which I think is what you refer to in your question, for a pregnancy assessment unit enabling around 200 extra births a year plus that is a great model of care and it is about better supporting women in better targeted and more pre-emptive antenatal care. I know Shelly Park and her team out at Southern are very pleased with those allocations as well.

That basically supports 2800 extra births per year once all that capital is online but as I said in my presentation, there is an allocation within HDM as well in terms of ongoing funding — 41.5 over four years, 10 million in 08–09. That will be available now, if you like, and we need that funding in the system now to support that growth and on from that there are also some other modest but important investments in relation to community health centres and supporting better antenatal care in high-risk communities, particularly in relation to smoking, poor nutrition, alcohol and drug use, and a range of other health protection programs.

It is important to acknowledge that this is a record capital spend. There is very strong ongoing funding to support the baby boom, but it does build on our work already. We have a proud record of investing in these services, whether it is the new Royal Women's Hospital that will open next month, a $250 million state-of-the-art facility. It will be one of the best women's hospitals in the world once it has opened and that day is approaching very soon. There is also the rural maternity initiative (RMI) which is about supporting new models of care: shared care, better support for very small health services and often small numbers of women in rural and regional communities. Almost $10 million has been committed out until 2011.

We are very proud of that initiative and having visited many of the sites that have been funded under that it really is about ensuring through targeted support that a broader range of birthing services, a broader range of ante and post-natal services are available to women in very small parts of country Victoria. And that is welcome right across the board.

Again we are very keen to ensure that we provide the support necessary to cope with the baby boom in capital terms. Fabric is important as is ongoing funding. In terms of supporting the training and development of our workforce, this budget this year provides 490 000 for seven advanced rural specialist training posts, and again a range of other support programs for GP procedural obstetric training and the extension of other skills to make better use of the skilled workforce right across our state.

Ms Munt, I could go on. There are many other parts to this in terms of our record of supporting mothers and babies and families but this budget is really a baby boom budget and it is about setting us up to cope with unprecedented levels in terms of activity right throughout our health services.

Mr DALLA-RIVA — I refer you to page 87 of budget paper 3 which relates to service delivery in emergency services. It follows on, I guess, from the target figures expected on timeliness. It appears today that we have had the *Your Hospitals* document dumped five months after the period it reported on ended. If we take category 2 we note that the actual figures for 06–07 were 81 per cent. Your expected outcome for this financial year is 76 per cent. The *Your Hospitals* report today indicates it is 74 per cent, so it is actually going down. Then you have an 80 per cent expected target for the forward estimates period.

I refer you to category 3 on the bottom line of the page which tells us that 71 per cent was the actual figure in 06–07. The expected outcome in this financial year is 68. The *Your Hospitals* report, dumped today, shows 66 per cent, and the target for the forward estimates is 75 per cent.

My question relates to the forward estimates and the targets of 80 per cent and 75 per cent respectively for those two categories. How can you have guarantees that this is going to be continued at those levels, given that there is a trending down of the target rate over the number of years in the most recent report today?

Mr ANDREWS — There are a number of important points by way of background to make in relation to the *Your Hospitals* report that was tabled or put forward today and the period that it covers: basically the first two quarters of the current financial year, the winter period, the second half of the last calendar year. What is important to acknowledge is that we had — and this has been acknowledged I think right across the system — the worst winter that the health system has ever had in terms of notifiable flu cases. In some months during that reporting period there were five times the number of flu cases — that is, laboratory-confirmed flu cases — compared to the same month; so month on month, winter on winter, reaching back into the 2006 year.

We had gastro cases at 66 per cent higher than they were the previous year. That is basically the winter, and this was, as I said, the most challenging winter our health system has ever faced. On from that, in the balance of this particular reporting period, so into the October period, we had industrial action for a number of days in relation to the Australian Nursing Federation, and that again has negatively impacted upon the performance within the reporting period I reported on in *Your Hospitals* earlier on.

Across a very bad winter — the worst winter — we had flu, a 66 per cent increase in viral gastroenteritis, and industrial action right at the end of this particular reporting period; we have seen real pressure and very substantial challenges laid down to us. What has the government done in relation to the budget this year? We have provided additional record funding: 60 000 additional treatments in our emergency departments to ensure that we can treat more patients, we can provide better care, we can cope with the enormous growth in the number of patients presenting. This is a very complex business.

As I said before and I tried to make the point in the slides. I would make the point to you before I go into the context, as can be seen from the *Your Hospitals* report today, 100 per cent of category 1 emergency department patients are seen as soon as they arrive. That is very important. The sickest are getting the care that they need. In terms of category 2 and 3 patients that you ask about, when the system is under pressure or strain — and, as I said, that was certainly the case last winter — priority will be given to the sickest patients. They are important judgements that are made by the doctors and nurses who provide care in our emergency departments.

Our emergency departments consistently perform above the national average, and I put it to you that that is the direct result of a combination of two things: firstly, the great dedication of our staff; and secondly, the record funding this government has provided in each of our budgets, and certainly across the forward estimates in terms of the allocations in this year's budget.

I might also point out to you that it is one thing to say winter was very challenging last year, but the question then is: how are you going to set yourself up, how are you going to support the system for the winter that is on us now? I announced today as part of releasing *Your Hospitals*, a winter demand management strategy that will see $6 million come out of the growth funding that is provided in this year's budget. That will support health services right across this coming winter in terms of additional beds, additional ICU nurses, additional medical teams to go and visit frail, aged patients in nursing home settings to give them their care in the nursing home — or at home, if you like, rather than them needing to present for care in our emergency departments.

Whether it is in terms of the seasonal factors we face, the worst winter we have ever seen — flu, gastro, industrial action — this was a very challenging period for our health system, but with the record funding and allocations we have historically made, together with the commitments in this budget, I think we are well placed to continue to see

record numbers of patients, to provide first-class care and to improve performance as we go forward. These targets, we have always said, are ambitious. They are there to drive the best possible outcomes for patients, and we are equally committed to that.

Mr SCOTT — I would like to bring your attention to the bottom of page 309 of budget paper 3, Victoria's Cancer Plan and the estimates given there for spending on that plan. Can you please outline how the government will use this funding to improve treatment and care for people with cancer?

Mr ANDREWS — That is a very important question. I noted in Parliament last week that cancer is something that is relevant to all of us. We will all, in one way or another, be touched by cancer during our lifetime. One in three of us will be diagnosed with cancer by the age of 75; 70 Victorians are diagnosed with cancer each and every day; and 10 000 Victorians lose their life to cancer each year.

Cancer care, in terms of the best and most rapid translation of world-leading research into better care and better outcomes, is relevant to all of us. Supporting patients, supporting carers, supporting families, whether it is through things like more palliative care options so that people can have dignified end-of-life care at home, whether it is about supporting the cancer workforce to meet the challenge and to meet the growth in the number of patients coming forward, or whether it is about supporting a range of agencies and staff across our system who do important screening work, who do so much good work to try and reduce the prevalence of cancer through social marketing and other behavioural change — all of this spending, all of this activity is relevant to all of us. The budget, as I said in my presentation, provides a record increase in terms of cancer services. We, it should be acknowledged, invest about $600 million a year on cancer care, but this budget provides a further $150 million in terms of supporting cancer research and better outcomes for patients. We are very proud of our investment.

We are also proud, can I say, Mr Scott, that this is not just investment for big specialist care centres in the centre of this city; it is about care and access to care right across rural and regional communities as well, and indeed, out in the outer suburbs. And the four bunkers and two linear accelerators that will sit out at Western Hospital is a great example of taking cancer care to local communities. Part of the cancer action plan that will be developed under this $150 million output will be trying to extend and increase the percentage of rural and regional Victorians who get access to multidisciplinary care, to care that is tailored to their own cancer, to care that is tailored to their own circumstances. We will also be keen to see an increase in the number of cancer patients who can get access to palliative care at home, particularly in rural and regional areas.

I spoke about workforce before, and again, we have to have in place the workforce to deliver this care, and there is a substantial investment in a range of different workforce initiatives. This is a very highly specialised cancer workforce, and the budget provides additional funding to support not only the employment of additional staff but also the training of existing staff, or the up-training, if you like — the expanded training — of existing staff.

This is a very solid package, a very substantial package that is important in and of itself. When you measure it or look at it in terms of our investment over time, that is an important factor as well, but what is most important — I will say what I said in the Parliament last week — more money in this space is very important, but what is in some ways more important is to set a goal, to set a target, to have an aim, to have a clear objective that says, 'This spending is about saving lives', and that is exactly what we have done.

We have seen substantial improvements in terms of cancer survival rates over the last 15 or so years. In 1990 just 48 per cent of cancer patients survived their cancer; in 2004, which is the last data we have, 61 per cent of patients survived their cancer. We aim that by 2015 under this package and the other work that we have done — whether it is through supporting the ongoing funding and securing the future of the Victorian cancer agency, additional treatments, additional screening, the capital program I spoke about before in Sunshine and at Western, the regional radiation therapy services we have so comprehensively grown so that Victoria has Australia's best regional radiotherapy services of any state — all of that will support that bold and ambitious target, and that is about saying that 74 per cent, so nearly three-quarters of cancer patients, should be supported to live through their cancer, to be five years symptom free.

If we can get to that target, and it is an ambitious target, we estimate that that will save in the order of 2000 lives a year. So it is a very substantial target, one that is underpinned by substantial investment, and again, this is a really solid package for an issue that is so relevant to us all.

Dr SYKES — Minister, I refer you to budget paper 3, page 86, which relates to the acute health services and the timeliness of emergency patient transfer to ward within 8 hours, for which the expected outcome is 66 per cent compared with the target of 80 per cent, and I note from your previous answer to Mr Dalla-Riva that industrial action was one of the causes of delays in the delivery of emergency services. Since that time I think there has been an EBA reached with the nurses. Can you advise how the increased cost of the EBA is going to be met; specifically, have you budgeted for 100 per cent of the costs of the EBA to be provided from the budget or are hospitals expected to contribute in some way, such as by delivering productivity gains.?

Mr ANDREWS — Thank you, Dr Sykes. I will not deal with the issue in relation to emergency department performance. I think the question is really about whether the EBA is fully funded, and I can say that yes, the EBA is fully funded and is fully funded consistent with the government's wages policy. There is a link, though, in terms of emergency department performance, because as part of the agreement that we have reached, or that health service employers reached, with the ANF is additional triage nurses as part of a total growth of around 500 extra nurses. That is part of the enterprise bargain — additional triage capacity in our emergency departments.

We have got a record of supporting rural and regional health services, and we will continue to do that. It should be acknowledged, though, that we do not pay wages as such; we fund the activity that occurs within our health services. There are different models for small, rural health services, obviously, compared to WIES-funded or total-unit-price-funded — that is, activity-based funding that might be provided to a large metropolitan health service compared to block funding where there is greater room to move, if you like, in a small rural health service. But as part of our annual process of reviewing the cost weights within WIES, within the price that we pay to health services, proper and full account of our obligations under the EBA will be taken, and we will fully fund against the commitments we have made. I hope that gives you some comfort.

Dr SYKES — I will just summarise it back. If in a small hospital the EBAs result in increased costs of, say, $500 000 or $1 million of all-up costs, those full all-up costs will be met by increased budget funding?

Mr ANDREWS — What I can say to you is that the EBA is fully funded; there are full budget allocations to deal with the government's obligations, the state's obligations, in terms of the deed signed with the ANF. There is a process in relation to pricing, and we move from one WIES to the next, from one model to the next each year, and those cost weights are looked at. I might ask Dr Brook to supplement this.

It is possible that a small health service can, for a whole range of reasons — not necessarily relating to the EBA, but for a whole range of reasons — move from one allocation, in say, the 07-08 year to a new allocation in the 08-09 year. You must accept there is an increase, because we have increased every health service's allocation in every year, and we will do the same this year, but there are ways in which health services can be not worse off, but there can be not 'errors' — I am not quite sure what the right word is — but again, the funding model can sometimes not take full account of the unique circumstances of a given health service. We will always work through those sorts of issues, and they can be many and varied. We stand beside country health services. We have done that in this budget, which is a record budget for country health and for rural and regional health services. But in terms of the funding of the EBA and that issue, I might defer to Lance Wallace.

Mr WALLACE — The simple answer is: yes, we are fully funding our health services. As the minister indicates, because we fund it as part of price, as we spread the funding out there may be some ups or downs in individual cases of health services. What we have indicated to CEOs of health services is that if they are significantly disadvantaged, to come to us, to actually show us the evidence of their disadvantage, and we will look at the individual cases on their merit, because our absolute intention is to fully fund the EBA.

Mr NOONAN — Minister, can I take you to the investment in the ambulance services for the state? I refer to the budget paper 3, page 309, in the estimates for the ambulance services. You have also provided us a slide within the presentation on this. My question goes to whether you can advise the committee on how the funding will be used to deliver a high-quality ambulance service in the state. You might also take the opportunity to address the final dot point on the slide, which is about a new statewide ambulance service within your response.

Mr ANDREWS — Thank you very much, Mr Noonan. That is a very good question. Again, I think I described this when I was going through the slide presentation as one of the centrepieces of the health budget this year. We are very proud of our record to this point. Not counting this budget, we had more than doubled the government's contribution to ambulance funding. This package will mean that we have effectively tripled our

government contribution to ambulance services, and that is important. It is appropriate that we provide record funding, because the services as they are currently constituted are having to deal with record numbers of emergency call-outs, record numbers of growth — 9.3 per cent just last year.

If you look at trends in this space, whether it is about an ageing community and increasingly unwell community, chronic disease and a whole range of different factors, together with the community's confidence in our ambulance services, these services are getting used more and more and more, so it is important to ensure that we provide the best care. We are consistently ranked as the best ambulance service. Our paramedics are among the best in the world, if not the best in the world. On any number of different measures — and I might come back to measurement in moment — our ambulance services do a great job, but we can do more and we can do better, and we need to support them to deal with the growth challenge, that caseload growth challenge going forward. This is a very substantial package — $185.7 million; the best part of 186 million — an air package and road, as I spoke about before when I was going through the slides. There is very substantial support.

If you look at the air component to start with, $45.7 million allocated to expand the air ambulance fleet, whether it is in terms of the new 24/7 statewide dedicated retrieval chopper out of Essendon, for the first time giving us 24/7 coverage for transportation and medical care of the sickest babies, the sickest children and the sickest adults. As well as that, we have supported our ambulance — and particularly rotary assets — in record terms across our eight years in government, having supported the new hangar and supported the service in terms of what is called HEMS 2 down in the Latrobe Valley, supporting the new HEMS 3 chopper at Bendigo and also supporting in the long-term sense HEMS 1 that run out of Essendon.

This budget provides, after consultation and ongoing discussion with the ambulance service, having funded the first priority, which is the Essendon chopper, an additional HEMS 4 — helicopter emergency medical service no. 4 — to service the south-west coast. Warrnambool is the best place to locate that, because you have got a trauma load, but you want to try to make this as viable and as efficient as you possibly can. We want to look at trying to put search and rescue work together with that trauma load. Then of course we also extend out to 2010 the fixed-wing contracts in terms of the important fixed-wing services we offer as well.

In terms of road services, this is a very, very substantial package — $140 million, 59 new or upgraded services. We will need to recruit about 260 extra ambulance paramedics, and they are fully funded to do that. In order to deliver these extra services, 48 different towns or suburbs sharing that record boost we will need to increase the overall size of the fleet — 44 extra ambulance vehicles in net terms, acknowledging that we have already increased the fleet by 25 per cent; I think 104 vehicles in terms of the extra vehicles on the road, brand new. That is really a paramedic's office, if you like, so it is important for them and for patients that we have the best and most modern fleet, not just in metropolitan Melbourne but in rural and regional communities as well.

There is also a reorganisation of the way MICA services are offered. For some time now, for some years, we have had what is called rapid responder units operating — four of them — in the centre of Melbourne. What is important is this package extends that model of care to the four largest regional centres and also to the outer suburbs of Melbourne, so there is a change there that is all about treating rather than transporting a critically ill patient. It is about getting to them quicker and it is about making sure that they get that dedicated MICA support — that is, the sickest patients. So, again, right across the spectrum this is a great package. We have invested strongly in our first eight budgets — our first eight years. This is about the next step. It is about setting up our workforce to cope with really substantial demand growth. It is about supporting communities large and small — communities in the city, communities in rural and regional parts of the state. Again, it is one that we are very proud of. We will work closely to roll that out.

On the final part of your question — referring to the last point on the slide — I have instituted under the act a process to unify the three ambulance services. Currently we have three ambulance services: the Metropolitan Ambulance Service, Rural Ambulance Victoria and the Alexandra and District Ambulance Service. I have met with staff and the board at MAS and RAV and dealt with a range of issues — at staff meetings of large numbers of staff at RAV and MAS and met with the boards of both. There is a very small number of staff — it is basically a volunteer service — at the Alexandra and District Ambulance Service, but I travelled to Alexandra and met with them together with the local member, Ben Hardman, and they all, as three boards, support unification into one new service, Ambulance Victoria. We are the only state in Australia that has more than one ambulance service. Again, there is a process to go through, and we will do that in a diligent way. But we have clearly foreshadowed — and I have foreshadowed — that it is my intention and the government's intention, after careful inquiry has been

undertaken, to amalgamate to unify those three services into a new service, importantly with record funding to go forward to provide even better care for communities right across the state.

Mr RICH-PHILLIPS — Can I just clarify where St John's Ambulance fits within those other ambulance services?

Mr ANDREWS — We fund the Metropolitan Ambulance Service, we fund Rural Ambulance Victoria, we fund the Alexandra and District Ambulance Service. Our allocations will mean — and I can confirm this — we are a bit under half at the moment. Obviously ambulance fees and the memberships that people pay also support our ambulance services as well. This package I think takes us to close to 60 per cent of the overall funding, so this is a very substantial boost. In relation to St John's, they do very important work, but — and I will ask Dr Brook to confirm this — I do not believe there is any direct allocation, certainly not from the ambulance services output group, to support St John's Ambulance. I think there may well be other ways in which we support them, but again they are not funded as part of this package.

Mr RICH-PHILLIPS — In terms of operationally, how does that ambulance service integrate to the three government supported services?

Mr ANDREWS — Again, we run the three ambulance services — or we provide support and boards of management run those three services. They are about providing full-time staff and services to every single Victorian as constituted under an act of the Victorian Parliament. St John's does a great job supporting a range of different first aid — basically providing support as a first aid or I suppose a first response, but again it is not funded under this package. We would seek to — —

Mr RICH-PHILLIPS — No, I understand that. I am just wondering how they fit in with — —

Mr ANDREWS — They are not funded under the budget that is in front of us today, Chair.

The CHAIR — You can take it on notice and if there is anything, you can come back to us.

Mr BARBER — I wanted to ask about the public dental service. The National Oral Health Plan calls for a strong focus on promoting health and the prevention and early identification of oral disease. Why is it that 53 per cent of the services are still emergency-type services and that ratio has not changed last year, this year and will not change next year? Is that because it is cheaper to yank out a rotten tooth than fix it before it gets to that point?

Mr ANDREWS — What page are you referencing — it is the health protection output, is it not?

Mr BARBER — Yes, you could go to — —

Mr ANDREWS — 53:47 is the number, I think, and that is enduring.

Mr BARBER — Page 97 of BP 3.

The CHAIR — There are also some output initiatives too, including the rural health one on page 309.

Mr ANDREWS — I just say to Mr Barber — and we may well want to come back to you with a more comprehensive answer in terms of this — that the new commonwealth government has made some commitments, and we are working closely with them in terms of rolling those out. We as a government have made commitments over time. This budget delivers additional dental chairs, and we are very pleased about that. We have invested something in the order of $800 million of funding over our time in office. That is all about trying to provide better outcomes often to some of the most vulnerable members of the Victorian public.

Again, the notion of early intervention, the notion of being able to get to people sooner to support better health, including better oral health, is something that we are very keen to try to support, as is the new commonwealth government. We have seen the effective reintroduction of the community dental program, again, shamefully cut as one of the first acts of the Howard government, together with the teen dental program and a range of other programs that they are keen to run, and we are working with them. This will be the subject of ongoing discussion between health ministers in various forums.

In terms of the target, that remains constant, but I would direct you to a whole range of different programs, not least of which the fact that we are very proudly putting fluoride into the water supplies of a growing number of towns, a growing number of rural and regional cities, such that the overall percentage of particularly kids who will get access to fluoridated water is very much on the rise. That is about equity for rural and regional communities. As I often say, if it is good enough for my three kids in Mulgrave to get the benefits of fluoridated water, then children in Ballarat, Bendigo, Geelong and a range of different communities should get the same. So whether it is about increased activity, more funding, working with the commonwealth trying to drive a public health approach to this as much as we can, trying to intervene as early as we can, we are committed to better outcomes in terms of oral health, because we understand and know that it is central to better health or at least certainly very closely linked to better general health.

I might ask Dr Brook to supplement that if there are any specific issues he wanted to raise about other programs that might be funded.

Dr BROOK — Thank you, Minister. I think it is important to emphasise that the emergency to other ratio represents the treatment of people with established oral disease. Clearly most of those are older Victorians who had the opportunity for prevention of dental caries many, many moons ago. The issue of treatment for them has nothing to do with cost. It is highly expensive to provide restorative care, as anybody who has been to a dentist would know.

We do focus in our oral health promotion program on children, and this is something which is conducted through Dental Health Services Victoria, but there are a whole range of programs, the best known of which is Smiles4Miles, which is about targeted oral health access and promotion that is conducted through our schools, and it is conducted primarily at the preschool level. That, in combination with the fluoridation program, we expect will produce continuing reduction in time. But in the meantime we are going to face the fact that we have a substantial number of people who did not have access to better oral health promotion, did not have access to fluoride, and of course they are going to continue to develop dental caries, which must be treated. A very positive sign is that this is the first year on record, I believe, where the ratio of emergency to other treatments has actually begun to turn downwards. Previously we have had ambitious targets, but we have never been able to achieve a reduction in the actual ratio of urgent care. It is no fun having to provide — —

Mr BARBER — There is no reduction here, is there; not over the three years reported?

Dr BROOK — Not in the target; there is a reduction that is occurring this year, but it is a percentage. The target has not changed. We acknowledge that the target has always been an ambitious target.

The CHAIR — I notice in footnote (e) that in respect of the quantity standard equivalent value units there is a wider range of dental services. So there are obviously more treatments being undertaken, presumably. It might be useful in terms of those dental services quantities standards to sort of provide us with a division between the general and the children's services. You might want to consider that as a department in terms of your outputs and deliverables and separating them between the general and the children's services, because they have traditionally been separate services. Maybe you could unite them, because — —

Mr ANDREWS — They have been.

The CHAIR — They are being united, are they?

Mr ANDREWS — We have integrated the school dental program with the adult or community dental program.

The CHAIR — Because if you walk in my community health service there are actually two different recording systems for children's dental — so I hope you will be able to put them together as well in terms of the IT, which is always difficult.

Dr BROOK — We would need to provide a separate report because the program is in fact in the process of being integrated. That integration requires some further negotiation between Dental Health Services Victoria and the individual providers. The purpose of integration is to in fact get more treatments more readily available for everybody, because until in fact this year we had a difficult situation where, as you described, you may have gone into a community health centre and there would be two triage desks — one that said 'school dental program' and

another that said 'general dental program'. We obviously aim always to seek efficiency and benefit for the community so that the dollars are better spent on actual treatments. We will examine the opportunity to look at age-related reporting though, I have to say.

The CHAIR — Thank you very much.

Mr PAKULA — Minister, on page 309 of budget paper 3 under the output initiatives there is one for elective surgery for 2007–08 of $15 million. If I am reading page 311 right, that is the state's contribution as part of the COAG waiting list reduction plan. With that in mind can you just outline for the committee how the budget helps to deliver on the commitment to reduce elective surgery waits?

Mr ANDREWS — Certainly, that is a very good question. We have entered into what is far more like a proper partnership than we have seen in health in terms of state-federal relations for the better part of 12 years, Mr Pakula, and we are very pleased to have done that. The Rudd government made a commitment at the election last year that they would commit $600 million over a period of time, over the term, to support additional activity to bring down the total number of long-wait patients not just in Victoria but indeed right across Australia.

Health ministers met a number of times. COAG then signed off on this earlier this year, and the first $150 million of that $600 million was signed off on. When we received our allocations, in broad terms around $35 million, from the commonwealth we made a commitment to invest $25 million of our own funding to match that; to really take a big step forward with this. The commonwealth government funding is tied to the treatment of long waits, and we have similarly said that our funding will support the treatment of long-wait patients as well. When we began the blitz — $60 million — our biggest previous blitz was around $30 million, so this really is a big ask of our system, and I think speaks directly to the capacity within our system that we can get, to a small extent in partnership with the private sector, this amount of activity done. Can I say these are far more complex patients than others who might well be treated sooner. So we are very committed to this. This is an important step forward. It will see us go from a situation where at about the time the blitz started on any day — about 9000 long-wait patients — we are keen through this activity not only to bring down the total elective surgery waiting list but to bring down the total number of patients who wait longer than the clinically appropriate time. That is the real measure here: how long are people waiting, can we reduce that number? That is about dignity, it is about better outcomes, it is about better care. So we are committed to doing that. But I just want to stress the point. We did not just say, 'Look, after 12 years of very poor funding from the commonwealth, thanks for that $35 million, we will spend it wisely, and we will acquit against the targets the commonwealth government set for us', which, if memory serves me, is 5908 patients. We added our own workload to that. We said, 'Look we can do more. We can make a real difference in relation to long-wait patients', and that is exactly what this funding package does. As I said, there will be 9400 additional episodes of care, acknowledging of course that we already do fully 15 000 extra episodes of elective surgery this year compared to the 1999–2000 year when we came to office. We are also looking not just at providing same-old care; it is about new models of care as well. It is about trying to drive reform and innovation.

We have opened the new Alfred statewide elective surgery centre. We are currently in the process of supporting — it is very close to opening — new theatres as part of a general elective surgery centre as part of the repat hospital out at the Austin. And of course we are also supporting St Vincent's Health in the development of a stand-alone complex orthopaedic elective surgery centre.

There are other projects. The orthopaedic waiting list project, or the OWL project as it is sometimes called, has been piloted in a number of health services in the last couple of years. It is mainstreamed in this budget, and that is about giving people alternatives to elective surgery — so intensively managing people, whether it is through using physio, OTs, and a range of other different ways in which you can support people to perhaps not need the surgery that they might have been originally listed for. So there is more record funding. No government has ever invested this sort of money to do this sort of activity across our health system. We are very proud of that. It is hard work. We are committed to doing it. But our job, my job, is to support health services with the growth funding they need, with the capital works they need, and that is why as part of our contribution our $25 million, Mr Pakula, included not just funding for increased activity but funding to support the physical space, if you like, additional surgical instruments, theatre tables; all those sorts of things: important upgrades to the infrastructure that makes that extra activity possible.

I should note that as well as that, that is only 150 million of the 600 million commitment the commonwealth had made. They will I hope in due course, quite soon I would hope, make individual allocations to states against the

second 150 million, which is about system enhancements — enhancing the overall activity capacity within health services. We will get, I hope, a fair and reasonable share of that $150 million, and then there is the third component: a $300 million component for incentive payments. Again, given our very strong performance our expectation is that we will meet the commitments we have given to the commonwealth, we would hope for a fair and equitable, indeed a healthy, share of those incentive payments going forward. This is all about record effort to treat a record number of patients, and it is about making sure that people get their surgery more quickly than they otherwise would have.

Mr PAKULA — Mr Noonan and I will make sure we corral the Federal health minister the next time she in Footscray.

Mr ANDREWS — As many good advocates as possible is a good thing.

Mr WELLS — Minister, you spoke before about the nurses EBA and that it was fully funded. Does that mean that the hospitals received additional funding to cover the cost of the EBA effective as of October last year, or did the hospitals have to make up the additional costs themselves?

Mr ANDREWS — Thanks, Mr Wells. As I have indicated, we do not fund wages per se; we fund activity. You need to make adjustments to the price that we pay hospitals in order to take account of changes. There are a number of changes from one cycle to the next, whether it is in relation to an enterprise bargain, whether it is in relation to the other cost pressures and the growth in health costs that have become such a hallmark of our modern health system. We have appropriately and fully funded this. In relation to details about the transition from the old agreement to the new agreement, it is probably best if I let Mr Wallace speak to that issue.

Mr WALLACE — This is just a little bit complicated. What happens with government funding is there is something which is called the departmental funding model — that is, all the departmental costs are indexed by the Treasury's assessment of CPI in any year. The year that we are currently in, the department of treasury assessed CPI was 2.5 per cent, and so all departmental costs were increased by 2.5 per cent for the full year. If you take nursing salaries, the whole of the nursing salary base, as at 1 July this year, was indexed up by 2.5 per cent.

What then happens when an EBA settles — so, for example, this settlement, the EBA expired at 30 September and the new EBA commences from 1 October — health services are in receipt of 2.5 per cent across the whole of the year. There is a top-up if the nursing EBA outcome exceeds that CPI. That top-up is applied back to the 1 October period and fully compensates the health services for any increased costs they have over and above the CPI estimate that has flowed through originally as part of the state budget.

Mr WELLS — When did that top-up take place?

Mr WALLACE — It was a backdated agreement. When we finally do an EBA agreement, it takes us some little while to actually do the legal heads of agreement. We did not actually conclude the negotiations on the full instrument. When the EBA is settled, you end up with a two or three-page statement of the broad principles. That is then turned into a legal document, so both parties' lawyers work on a much more detailed document. That document was not completed until about the end of February. We actually funded — just from memory I think it was in the month of March — health services with the top-up related to that deal. We backdated that through to 1 October, and health services at that time actually made the payments and backdated. The payment and funding were aligned.

The CHAIR — Thank you for that. Minister, on table A.6 on page 315 of budget paper 3 are all the assets initiatives. There are some very fine ones there. I notice there is actually one for the Monash Link Community Health Service in my area, but I will not necessarily go on about that one.

Dr SYKES — Go on.

The CHAIR — You have now provoked me, Dr Sykes. I will ask you, Minister, if you can talk about the range of asset initiatives for people living in rural and regional areas. Can you describe to us what difference will this range of initiatives make for the people in rural and regional areas?

Mr ANDREWS — I think it is important to acknowledge that in each of our budgets every single health service has received a boost. In terms of capital works, we have a program that has benefited many health services

right across the state. There is ongoing funding, a boost for everybody. There is the capital works program, the biggest program that the state has ever seen and one that extends well beyond the centre of the city, one that extends well beyond metropolitan Melbourne and reaches out into rural and regional communities and supports the health services, the staff, the boards, the management in those services to meet the health challenge that is often quite unique to rural and regional areas. Ongoing funding is important but, as I said before, the capital fabric is important as well. Giving health services the funding as part of a record boost to drive change, to drive reform, to build new models of care as well as simply to maintain the services that are offered now is critically important.

This year's budget delivers for country Victoria a very strong asset program — $137 million in new capital funds across the system. I will give you a few highlights, chair. There are a number of very important programs, whether it is the $21 million redevelopment of the Latrobe Community Health Service in Morwell, the full delivery of our LFS3 commitment in that particular case. I have spoken of the $70 million in relation to stage 1B. There has some rather ill-informed commentary in relation to the Warrnambool hospital but 1B has been funded. Stage 1A was of course funded last year. Stage 1B has been funded — again, a further step towards the full delivery of our election commitment in relation to that health services. I have visited there two or three times since becoming minister, and that health service worked very hard on its detailed planning. I know it was delighted to receive that support in the budget.

I spoke about Bendigo Healthcare Group. I think I have visited Bendigo Healthcare Group four or five times since becoming minister. It is a fine health service. They do a great job there, but there are some challenges. There are some substantial pressures in relation to Bendigo. It is a growing area, it is a very popular area for people to move to, and there are some pressures there. We committed in the election that we would provide funding for planning — I think $2 million. We provided that in the first budget after the election. That work then uncovered, if you like, at option 1 — their preferred option; their most important option — an upgrade of the emergency department. We provided the $9.5 million in this year's budget to do that. That is about additional short-stay beds, new models of care, as well as the best fabric, if you like for those staff and patients. It is a very busy emergency department. Again I was there a couple of weeks ago, and the staff and patients we spoke with were very pleased that the government had made that $9.5 million commitment to support better outcomes in that very busy emergency department.

In Minister Neville's portfolio there is of course the Stella Anderson regional aged care facility; there are 60 beds there. Again it is another boost for Bendigo and better outcomes for Bendigo families. Again in Minister Neville's area there is $5.5 million as part of an LFS3 commitment to reconfigure the Ballarat hospital's psychiatric services — that is part of the adult acute unit — and some other important refurbishment works there. I was very pleased to visit the Hepburn Health Service at its Daylesford campus a couple of months ago. They do a fine job. They are very hardworking people who really deliver first-class care. We are supporting them, again, with the development of their Trentham campus. They provide principally aged care, but I think there are also some urgent care services there or at least emergency stabilisation services.

There is planning money for detailed design works, acknowledging there has been a fair bit of work already gone on at the Alexandra and District Health Service. I visited there a couple of weeks ago as well. Again, they are pleased with our commitment I think to provide additional money to support that detailed design work towards the full reconstruction, the full rebuild of the Alexandra and District Health Service.

I alluded before to a number of additional dental chairs in rural and regional Victoria, with an $8.1 million allocation for additional teaching chairs. It is part of our government's support for the second school at La Trobe University, in Mildura, Wodonga and other locations. We have all of that, together with, can I say, a small but important project of $2.4 million over four years for the establishment of the national centre for farmer health in Hamilton, which was funded in the budget but was announced as part of the recent community cabinet visit. That is again about chronic illness and better supporting and better developing evidence-based new and innovative models of care for rural and regional communities, particularly those who work in the agricultural sector.

Just to round this out, I should also mention that we have also supported rural and regional communities through the early intervention in chronic disease teams program. In 2005 there were no chronic disease early intervention teams. We then had 9, then 9 further to 18. We then doubled that in this budget to 36. I am pretty confident — Dr Brook can confirm it — that, although we have not made the actual funding allocations yet, a number of those will service chronic disease patients, or clients, in rural and regional areas.

So right across the board this is a great health budget for rural and regional areas. That is principally capital works and acute or ambulatory health care, adding of course to the ambulance package I mentioned before where, whether it is in the air or on the ground, there is a very substantial boost in terms of ambulance services for rural and regional health as well.

The CHAIR — I welcome the money going to the Hamilton hospital, because many years ago the Hamilton hospital was actually the world leader in the treatment of hydatids, so that relates to farmer health.

Mr ANDREWS — It should be noted that the Western District Health Service, which covers Hamilton, is the regional health service of the year this year, so they do a fine job there.

Mr RICH-PHILLIPS — Minister, I would like to ask you about the reorganisation of the MICA services. Can you tell the committee how many additional MICA paramedics will be required as a consequence of the reorganisation you spoke of earlier?

Mr ANDREWS — Thank you, Mr Rich-Phillips. I have some details on this, but I will give you some broad comments first. Principally this is a MAS issue. The Metropolitan Ambulance Service has been working closely with our MICA workforce. I met with what is called a MICA focus group, or at least members of that group, late last year in relation to a range of concerns that that part of the paramedic workforce has in terms of workload, in terms of the way the dispatch grid works and a whole range of issues and challenges.

These are very, very highly trained people that in some respects do the most urgent work, or the most important work. That is not in any way to reflect upon advanced life support trained paramedics, or non-ALS paramedics — all of our paramedics do very important work. But the service has been working with the MICA paramedic group and for some time, for most of 2007 and even back before then, looking at ways in which they can better support MICA paramedics in terms of workload and meeting those challenges. The changes to the model in relation to the rapid responder units are driven by MAS and are driven out of that particular process. There are also other issues, as I mentioned before. The centre of Melbourne has had access to this model of care for some time, and it is important to expand that out and make sure the outer suburbs have it as well as the four largest regional centres.

The total increase in paramedics required for the delivery of the government's package is, as I said before, 258 additional paramedics. There is a reorganisation of MICA services, but there are also additional MICA services as part of the package. I do not have a figure to hand right now; I will get you one before we finish today. But again, in total terms we have supported the recruitment of more than 700 additional paramedics and seen substantial growth in MICA-trained paramedics across our years in office. I can get you a number or at least an indication of what the MICA component of that is. This is about a new model of care. It is about changing the way in which we deliver the fastest possible response to the most critically ill patients.

But we do need to acknowledge that MICA services are very well run now. This is about taking a step forward. It is not about addressing any difficulty or any problem we have now in terms of clinical outcomes. Our cardiac survivability rates are among the best anywhere in the world. They have gone from single figures in the mid-90s — so where the paramedic arrives, the patient is basically clinically dead, and by the time they arrive in hospital they have been given the care they needed and they are then clinically alive, or clinically not dead, when they arrive at hospital — to about 56 per cent, I think. We are very grateful for the work our MICAs do. Our job is to support them and to give the ambulance service the support it needs to employ more and change the way we deliver care. That is what we have done; that is what this package does. In relation to the detail, unless Dr Brook has it to hand — he does not — we will come back to you on that issue.

Mr RICH-PHILLIPS — Are those 258 paramedics inclusive of the additional MICAs?

Mr ANDREWS — Yes. I am advised — and we will confirm this to you, because I do not want to give you the number on the run — that we currently have a range of MICA paramedics in training now. Some of them will come online as part of this. Additional MICA paramedics will be required not just for the new model of care, but also the flight paramedics that run both the HEMS 4 and the retrieval chopper are also MICA paramedics, so there will be a need to recruit into that space as well. And then the final group is those road changes — the new model of care. Indicatively, an additional 21 will be needed across this, and there will be full funding to be able to do that as part of the $185.7 million boost. But I say that without prejudice. That is the advice I have. I will come back to you if there is any change to that.

The CHAIR — Okay, we can always confirm that one and clarify that one in writing later on..

Ms MUNT — The Kingston Centre sits in my electorate but it is also a regional facility. It provides aged-care and health services. One of my favourite line items in the budget is in budget paper 3, page 315, which is $45 million for the Kingston Centre redevelopment stage 2. Could you just, because I am very interested of course, take me through what that will actually provide in services for my local community but also the region?

Mr ANDREWS — Thanks very much, Ms Munt. This is a very important project and one that, can I say, I am personally very proud to have been able to secure the funding for. This is not an LFS3 commitment, but it is funding that is needed and it is funding and new fabric that will make a real difference to many patients — often seniors, not always seniors, but in terms of the rehab task, the subacute task that we have going forward, it is only growing because of the ageing of our Victorian community.

As you say, you are right to say, it is $45 million for stage 2. It will see the stand-alone reconstruction of a 64-bed subacute ward, and that is about providing a much better environment for our staff to work in and a much better environment for patients to receive care. Noting, of course, that length of stay can be quite long. These are often post-surgical patients, and they may have a range of orthopaedic surgeries. One of the patients I spoke with when I visited there last week had had a knee replacement a couple of weeks before, I think at Monash Moorabbin. She had then been moved, after her acute stage, to the Kingston subacute setting and was probably going to be there for three or four weeks, maybe even longer in terms of the rehab she needed, the other care that she needed. So better fabric in that setting — given the length of stay that is necessary for the proper rehabilitation, particularly of post-orthopaedic surgical patients — is really important. It is about better outcomes, it is about a more comfortable environment, and in meeting with the staff when I was there they were absolutely thrilled that the government had been able to make that commitment, because it is a very big workplace as well, so we need to support our staff in that also.

This, as I said, was not a foreshadowed commitment in LFS3. It is important to provide that. I am advised that this redevelopment provides not just beds, it also provides a hydrotherapy pool, proper ambulatory care space, rehab space. If memory serves, patients at the moment requiring hydrotherapy are transported by car and minibus to Dandenong to get their hydrotherapy. So, again, it is a bit like radiotherapy in the west, and a bit like some of the rural and regional health asset investments we have made — this is about bringing to a local community the services they need in that local area. So, again, that is about efficiency and about effectiveness of care, but it will cater across all of its settings for 32 000 treatments for day patients — sorry, just to be clear, 32 000 extra day patient treatments per year — and again that is about recognising change in the way we deliver subacute care, the way we deliver healthcare, really, as well as recognising the clear demand pressure we have because of that cohort in their senior years getting bigger and bigger, and the fact that life expectancy is also longer.

So this is a really important project. It will benefit your local community, but it will benefit mainly seniors but others right across the south-eastern suburbs, and I know that Southern Health, in the integrated model of care that they run across all of their campuses — so from Monash Moorabbin, right through to the integrated care centre out at Cranbourne — are very happy about this because it is about increasing the overall capacity of the integrated service. So it is a great project and one that will benefit countless numbers of often the most vulnerable patients.

Mr DALLA-RIVA — Minister, I refer to the Treasurer's speech on page 7, where he said:

> We will provide funds for an extra 16 000 elective surgery patients

In your presentation today you indicated in the budget 08–09 highlights 'Right care, right time, right place' that there will be an additional 16 000 elective surgery patients over four years. I am just trying to get clarity on the statement on page 312 of budget paper 3, 'Maintaining health system performance'. And you have got here:

> Elective surgery capacity has been significantly expanded with an additional 12 400 patients to be treated over four years.

I was just trying to reconcile: is it 12 400 or is it the 16 000 that you have been spouting?

Mr ANDREWS — It is 16 000 over five years. So there is an allocation — —

Mr DALLA-RIVA — Hang on, you said an additional 16 000 elective surgery patients over four years.

Mr ANDREWS If you look at the Treasurer's speech on page 7, 16 000 additional. Let me just find the reference. It is 12 400 patients over four years, that is the forward estimates going out. There is additional moneys as part of our contribution, our $15 million of activity funding that we have provided from the 07–08 year as part of our blitz and our partnership with the commonwealth government. We did provide 25 in total: 10 of it was asset, 15 of it was activity; 16 000 additionals over five years. I apologise for the error in the slide that I have put forward, but it is about allocations from the 07–08 year as part of our partnership with the commonwealth, the activity component, as well as allocations going forward, and that is part of that $15 million growth driving through the forward estimates.

Mr DALLA-RIVA — So we are looking at the forward estimates. The document presented is budget 08–09 so there is, for this financial year, which we do not take into account as part of our forward estimates, as the Chair continually reminds us — —

The CHAIR — Except the budget does sometimes contain investment which is to be achieved this year.

Mr DALLA-RIVA — Oh, come to the defence.— You and I should play tennis one day, Chair, and I can yell out 'You cannot be serious!', because that is amazing. Just as clarification, it is 16 000 over five years of which there is a component for this financial year — —

Mr WELLS — Why five years?

Mr DALLA-RIVA — I do not know.

Mr WELLS — Why has it changed to five years?

Mr ANDREWS — If you complete the question I am happy to answer it. Is it one of you asking the question, or three, or — —

Mr WELLS — You were obviously not able to answer it, so the Chair was trying to get you out of a tight spot.

Mr ANDREWS — I have already answered the question, but I am happy to add to the answer.

Mr Dalla-Riva, I refer you to the previous page, page 309, under 'Elective surgery' which is about five lines down, where there is a $15 million allocation in 07–08, so that is brought to book in this budget and in the papers in front of you. Then if you go down the page to 'Maintaining health system performance' where you have the $162 from which $15 is allocated for growth of elective surgery activity in the out years. That is why you have got a five-year commitment. Again, I apologise for the presentation; it should have said five years. Clearly there is funding in this budget to do 16 000 across five years across the estimates, but there are also the commitments we made from funding this current financial year as part of our partnership with the commonwealth. I hope that clears it up.

The CHAIR — Very good detective work, Mr Dalla-Riva. I hope the slide can be corrected before we put it up on the website.

Mr ANDREWS — I am happy to ensure that — —

The CHAIR — We like to get the right picture in our committee.

Mr SCOTT — I would like to refer the minister to budget paper 3, page 309. There was a reference in your earlier answer, Minister, on rural matters given to the Chair about action to reduce the burden of chronic disease. Could you provide some further information on what the government will do to improve the care and management of people with chronic disease before they become a patient in hospital?

Mr ANDREWS — That is a very important question. Chronic disease is often described as the great health challenge of our time, and I suppose if you unpack that what really challenges us is supporting chronic disease sufferers. This is in terms of the secondary prevention or the management of chronic disease: managing people into their local community, managing people away from very costly high-care services, basically inpatient services. The Premier, on becoming Premier last year, said that from a health point of view cancer and chronic disease would be key priorities and key challenges, and we have seen record allocations both in the health budget but also across government.

If you look at the work health initiative, it is not strictly speaking part of our output but again it is a very important program sinking $600 million into that healthy future fund for want of a better term and then drawing down on the earnings from that fund to support health promotion and other interventions across the workforce. That is one important example. That is a world leading program. I am sure Minister Holding will have much to say about that when he appears before the committee.

What our budget delivers though of course is additional support, and I did make some passing reference to the early intervention in chronic disease teams. This is a multidisciplinary team. Community health is the platform to deliver it, and I can recall as parliamentary secretary visiting your own community, and I think it was Darebin Community Health Service, to announce one of these teams. They are a wonderful new model of care. It is just a common-sense model of care bringing together all the people that a client needs, all the different services, put together a care plan, work as part of a team, make sure you provide a multidisciplinary solution for that client rather than a pinball model of health where you are bouncing back from one service provider to the next.

It is about integrated care, team-based care and it is about in a very practical sense supporting chronic disease sufferers to basically control their chronic disease rather than their chronic disease controlling them and then in turn finishing up being admitted again and again into very costly and often inefficient hospital beds — certainly for that purpose.

In 2005 we set up nine of those teams. In 2006 we had a further nine. We have now funded another 18 as part of this budget, so that totals 36 early intervention chronic disease teams. We have started it, doubled it and then doubled it again and that will be of profound benefit to many very vulnerable Victorians who are chronic-disease sufferers.

We often talk about large amounts of money in health but if you want to look at outcomes and an actual sense of what that funding means: $17.98 million over four years to expand that team-based model of care with 18 teams. What it will mean is that the expanded response will provide early intervention responses to 8488 clients and in hours of care, 144 302 hours of care over four years. To give you a sense, it is the better part of 145 000 extra hours of care supporting 8500 clients across metropolitan Melbourne and rural and regional communities. This is a really smart program. It is a really good spend and I am delighted to have been able to secure the funding to do it.

It builds on the hospital admission risk program, and I know that health ministers often come to this committee and talk about that program. We are genuinely proud of that program. It is a real step forward, and it is about basically saying, 'You should get the right care at the right time in the right place'. Again if we avoid avoidable hospital admissions, that is a better outcome for the actual patient but it is a better outcome for the service system as a whole, and the sustainability of our health system will in large measure be basically determined by the way in which we effectively respond to the primary prevention of chronic illness and the secondary prevention and better management of chronic illnesses as we go forward. This is a good budget for chronic disease. There are a range of other different elements, whether it is the refugee health nurse package extending that model of care; some targeted support for indigenous communities; and also, as I have already referred to, the National Centre for Farmer Health down in Hamilton that has a specific focus in relation to chronic disease.

Can I also say that we are very pleased with the Life! — Taking Action on Diabetes program, which the Premier and I announced down in Albert Park last year. That is an $18.3 million program. It is a mini-WorkHealth, if you like, but it is not work force based, it is about dealing with often very marginalised members of rural and regional communities. There are three pilots, from memory; two of those are in rural and regional regions and one in the outer southeast, I think. Again, right across the board we have increased our effort because we know that this is a great challenge, not just for the care outcomes for individuals but for the sustainability of our broader health system. This is a good and strong budget for chronic illness and those who suffer it, those who are at high risk of it; but we will also continue in the out years to support those who suffer and those who are at risk of chronic illness. We need to do that, and the Premier has made it clear that this is a key challenge for him and a key priority.

The CHAIR — Thank you for that, minister. I must admit, after talking to my community health centre just the other day, that there may be some merit in linking the chronic health program with the WorkHealth program which is coming up, because there are obviously some synergies that can be gained there; perhaps some pilot projects using the community health staff who are already doing the chronic disease programs, making sure we do not have independent silos operating. Getting a cross-government approach to chronic disease would be a good idea.

Mr ANDREWS — I would need to check but I think it was probably in 2006 that MonashLink Community Health Service, one of your local community health providers — —

The CHAIR — I was thinking about the Whitehorse one, actually.

Mr ANDREWS — I think Whitehorse as well.

The CHAIR — They have one too.

Mr ANDREWS — Both of those services have early intervention in chronic disease teams, and I am sure they are of great benefit to your local community.

The CHAIR — Yes, they are working very well.

Dr SYKES — I have a two-part question. One relates to ambulance vehicles: the replacement rate of them and the source of funding, but as we discussed briefly during the break I have a related question in relation to the use of money raised by local ambulance auxiliaries. The history to that is that over the years there has been a great sense of local ownership of these ambulance services, and I understand that ambulance auxiliaries raise a couple of hundred thousand dollars to go towards things they see fit for the local service — I think there might even be about $800 million currently held in trust for local ambulance auxiliaries. The concern is that, with the proposed merger, control of that money may be centralised. The people out there are looking for an assurance that locally raised money will remain available for local use as determined by the local auxiliaries. As you able to provide that assurance?

Mr ANDREWS — Certainly; let me deal with the second part of the question first. It would be my expectation and I think the expectation of the government more broadly, and certainly the ambulance auxiliaries, that moneys transferred from current constituent units of the current three ambulance services to a central entity would be spent for the purpose for which those moneys had been raised.

Ambulance services, particularly in rural and regional Victoria — and indeed in Melbourne as well but certainly in rural and regional Victoria — have always been a really strong partnership between the paid work force and those who volunteer their time or may be paid modest amounts, whether it is as an ambulance community officer, a member of a CERT team, a member of an ambulance auxiliary or indeed a fully-paid-up ambulance paramedic, and that partnership is important. What I have said when I have been touring around talking to staff and others at the RAV headquarters and other parts of the system is, 'This is an opportunity, by unifying those three services, to gather up all that is good across the three of them and build a better service, one that is better able to cope with some of those demand pressures I spoke about before'. To give you the comfort you seek, Dr Sykes, I would be very confident, and it would be my expectation, that any new board of any new ambulance service would expend those moneys for the purposes for which they were raised. That would need to involve input from the local auxiliary, those hard-working volunteers who have done hard work to raise those funds.

I have some personal experience of this, having been very intimately involved in the Paynesville ambulance service, which through the hard work of the ambulance auxiliary raised over $200 000. I was very pleased to support them in their work and to get some additional funding. They purchased the vehicle; the government provided the recurrent funding, and a shop-front ambulance branch has been opened down at Paynesville. That is a proper recognition both of the growth down there — and if you have been down there lately you will have seen that it is a rapidly growing area — and of their hard work. They raised a couple of hundred thousand, and we put in some additional money. The paramedics off the Bairnsdale roster now work from 8 to 8, something like that, over a certain number of hours down there in Paynesville. That is only made possible through the work of the Paynesville ambulance auxiliary that for many years has raised very substantial funds through a range of different fundraising activities.

I hope that gives you comfort. I certainly value the work that auxiliaries do, the government values the work auxiliaries do and country communities value the work that our ambulance auxiliaries do, and we want to continue that partnership. In the event that there is a single service, we will be equally supportive of our ambulance auxiliaries and the great work that they do.

Dr SYKES — Just clarifying: so the assurance relates to the money raised so far but also if they continue their fundraising if it is that same principle.

Mr ANDREWS — That is exactly right, but it will be a matter for the board as to what structure they put in place. I think that auxiliaries, as I said, have played a very important part in that community partnership, and that will be an enduring feature of any new service. I do not want to be coy, but we do have a process to go through. In the event that we do have one service, it is my view that ambulance auxiliaries will be a very important part of that, just as they are now.

Mr NOONAN — Minister, I want to go to the issue of emergency departments, and I must say that I have used the emergency department at Williamstown in the last three months to look after a sick child, so I understand their importance in our local communities. I take you to the output initiatives in paper 3, page 309, and specifically, 'Maintaining health system performance'. My question really goes to how that significant investment will improve emergency department capacity and performance, particularly given the slide that you presented earlier on in your presentation, which shows the increasing demand on emergency departments?

Mr ANDREWS — Thanks very much, Mr Noonan. This is an important question. I spoke at length in an earlier answer in relation to the challenges that our emergency departments faced, certainly last year, in terms of perhaps the worst winter we have ever seen, and that did put great strain and stress into our system, but because of our great staff and because of the record allocations we had made to that point we were able to cope and were able to ensure that the sickest patients continued to get access to the very best care. Despite the fact that our emergency departments consistently rank well above the national average, I have been up-front about this, as has the Premier: we can do more, we can do better, and this is what the budget delivers — additional funding to treat 60 000 additional patients each year in our emergency departments. That is funded out of the $702.9 million in essential hospital services and that ongoing funding in terms of growth for additional patients.

We know, and in the slide presentation I showed earlier on, and in an earlier answer I think I made the point, that we have seen very substantial growth compared to 1999-2000 levels. We have also seen, can I say, ongoing pressure in relation to the number of category 4 and 5 presentations. These are primary care type presentations, people who in the main, the overall majority of these individuals, could get their care from a GP. Some will be admitted. No-one is saying that people should not present. Part of the problem here, part of the sad fact of this is that because of failures to properly invest in primary care, accessibility of GP or MBS-funded primary care has come down, and therefore people have no alternative but to turn to the universal service provider in their given community, which is in fact the acute hospital, and the front door of that acute hospital is the emergency department. So we have seen it, and I showed that graph before where you have total increase in the number of presentations, total increase, almost linearly mirrored, in the number of people, 4s and 5s, presenting for care, and then at the bottom of that graph we showed a line that had come right off, or at least a very subtle improvement, in the ability of communities to utilise commonwealth-funded GP services.

So that puts real pressure on our system; total volume puts pressure on our system; the ageing of our community puts pressure on our system. We are dealing with a growing cohort of increasingly complex patients, and this in many respects is linked to the question asked by Mr Scott only a few moments ago — if you do not better manage people away from acute settings then the sustainability of our health system really is under a cloud. So we have to do more in this space. That is what HARP is about, that is what the teams are about, that is what a whole range of additional funding and other programs are all about. It is about better outcomes for individuals, but it is also about the sustainability of our health system in a broader sense.

This is a good budget for emergency departments, a solid budget; it gives us the growth we need to treat additional patients and to provide better care. We can be confident that we do rank consistently above the national average, and it is our intention to continue to support emergency departments to continue to provide that high-quality care right across metropolitan Melbourne and also in rural and regional communities.

Mr BARBER — I would like to ask the minister about the situation with independent midwives in Victoria and how they have been unable to get professional indemnity insurance since 2001. Do you know how many might be out there operating without that insurance? Has the government been looking at, or is it intending to look at, creating an alternative scheme for them, or alternatively, would you bring their operations within the realm of hospitals so they can operate in that way — in light of your baby-boom theme, I suppose?

Mr ANDREWS — Thank you, Mr Barber. It is more than a theme; it is a very substantial package to support a record number of babies that have been born across our state, but most noticeably in terms of public hospitals. I do not have any information on that issue. It is an important issue, but I am not briefed on it in terms of

what the most recent state of affairs is. Unless one of my officials can support me in that, I think we are best to take that on notice, and we can come back to you with a detailed answer.

Mr PAKULA — Minister, page 18 of budget paper 3 goes into some detail on some of the more heavy capital investment in the hospitals. I am interested in the Royal Children's. Like Mr Noonan, I have got young kids — like yourself, minister. I suppose in terms of the investment in the Children's my query is: how will that investment help in a concrete way provide better care and services to the children of the state?

Mr ANDREWS — It is a very good question. I thank you for it, both in your capacity as a member of the committee and a parent, as am I. This is a great project. This is a project that we can all be really proud of, and every single Victorian should be 100 per cent behind this project. It is not always the case, but I think every Victorian should be supporting this project. It is a great project, it is best-value project and we will see a situation by 2011 where we will have one of the best, if not the best, paediatric health service anywhere the world.

It is more than just a health service. There are also important other services and other supports for staff. This is a very big workplace, as well as a centre of clinical treatment. There are additional services and other supports in terms of a 3½ star hotel for those from the bush, those coming to work at the health service. The Murdoch Childrens Research Institute, at no cost to taxpayers, is also a big part of this, as is the University of Melbourne. This is being delivered as a Partnerships Victoria project. It is a best-value project, and the difference between the saving against the public sector comparator is a 7 per cent saving, so the way we are effectively delivering this project in partnership with the commonwealth and in partnership with the private sector delivers real value. This is a great project and one that the community can be proud of.

There has been some commentary in relation to whether the new hospital will be able to cope with some of the demand pressures that it will face. It is important to acknowledge that this is a modern, flexible hospital that will have additional capacity but inherent flexibility to be able to change the way it delivers care, to respond to the demand pressures that it will face, not just now but over the 25 years of its life under the PV model.

There will be 46 extra beds. There is a shell ward — built but not fitted out — that may well be able to provide for up to 33 additional beds, and there is treatment capacity within this new, modern and flexible health service to treat 35 000 additional patients a year. This is a great project, and, as I said before, every single Victorian should be behind this project, I would have thought. This government certainly is. We are proud to be able to deliver this. This one project represents more in terms of investment than was the case for almost the entire decade of the 1990s. It is a substantial investment. It is about supporting some of the most vulnerable members of our community — our sick kids — not just today but for many years to come.

It is, I suppose, replete with a range of design features and it is replete with a range of service improvements and enhancements that will mean better outcomes for kids. Some 85 per cent of rooms are single, up from, I think, about 8 per cent now, if memory serves. You have got pull-out beds that are basically designed in a more family-friendly way so that parents can spend time in the room with their sick child. It was not that long ago that a sick child would be dropped off at the hospital, mum and dad would visit once a week or once every two weeks. Now things have changed. It is a 50-year-old hospital. It is showing its age. It needs to be rebuilt — it will be! — but it will be rebuilt smart. It will be rebuilt to provide modern and flexible care and the sorts of things that we expect from a new health service.

Again, this is a really important project, one that we are pleased to be delivering in partnership with the private sector. Anyone who drives down Flemington Road can see there is a power of work gone on there to date, and we are extremely proud to be able to be delivering this important project, as is the board and as are our private sector partners. I would hope that the unequivocal benefits of this project would be understood and recognised by everybody.

Mr WELLS — Just to clarify a point before I ask my question on the number of beds: you are saying there are an extra 46 beds, plus there are 33 that can be part of a shell. Are you saying that that is 79 extra beds for the life of a 25-year project?

Mr ANDREWS — What I am saying to you, Deputy Chair, is that there are 46 extra beds; the day it opens there will be 46 extra beds. There is shell space, and you can notionally say that that might support 33 beds. It could support a whole range of other things, too.

Mr WELLS — Okay, so say 33; we will take your figure.

Mr ANDREWS — What I am saying is that that is a notional figure. I am not committing to that space necessarily being 33 beds. You have got a situation where this is a flexible hospital and one that is designed to be able to change — —

The physical layout of this place will be such that you change to reflect the model of care that is the most efficient and most effective, not just now but in 5, 10, 15, 20 or 25 years time. There will be sufficient capacity in this health service to do the important work that it needs to do against its charter as the state's principal specialist paediatric health service.

Mr WELLS — So that is 46 plus 33 notional spaces.

Mr ANDREWS — Space for 33 is the best way to describe it, I think.

Mr WELLS — Making it 79, and you hope that the life of the Royal Children's Hospital — this Royal Children's Hospital — will be 25 years?

Mr ANDREWS — I think what you are driving at is the life of the arrangement with the consortium led by Babcock and Brown is 25 years. It will need to be handed back to the state at that point without substantial works needing to be done to it for up to five years. It is a best-value outcome for all of us. But can I say to you that at the heart of your question you are essentially asserting that the number of beds in a given facility is an absolute measure of what the capacity within that facility is, and I would say to you that you are wrong to do that. What is more, it is not just me that would say that. The Australian Institute of Health and Welfare would say that, and many, many others. If I am wrong — if that is not the assertion you are making — —

Mr WELLS — No, but you have spoken about the increasing population and the number of babies, I assumed that the demand for hospital beds at the Royal Children's Hospital would be significantly more.

The CHAIR — This might end up being your question at this rate. You might want to get on to your other question.

Mr WELLS — My question, Minister, is in regard to HealthSMART, and I have a couple of questions in relation to that. I note that a further $103.9 million has been allocated to the HealthSMART in the current budget. Can the minister detail specifically what the extra funding will be spent on and if we can have a complete breakdown of the allocation of that funding? Further, I think there is some confusion. Minister Pike, when she was the Minister for Health, sent a letter out saying that DHS is not in any way mandating to health services that they participate in any of the projects, yet the program has become mandatory for regional agencies. I understand that also further the two agencies — the Alfred and Ballarat — are allowed to buy other products not already in use and not part of the HealthSMART program, so could you clarify those points?

Mr ANDREWS — In relation to your first question about the additional allocations for this year, I will ask Mr Wallace to supplement this, because there is a timing issue, and I think he has probably got the material to hand. The original cost of this project as reported on by the Auditor-General recently, where he indicated that whilst the project was over time, it was working within its current budget, was a build budget. We have a budget to build the IT system, and we then have a budget to run the IT system. The allocations in relation to this year's budget are about the running of that system. There were some allocations within the original project budget that I think — and I will get Mr Wallace to confirm this — took us out to 2009. This budget provides additional allocations — I think three full years of additional allocations that will support the running of HealthSMART.

I might give you some background, and on the regional issue and positions that the previous minister had taken I might need to come back to you on. We are happy to give you a further breakdown in terms of where those allocations in this year's budget will be going, but I think the point about build and run is an important one for people to appreciate.

When we came to government the notion of IT architecture, a common architecture, the actual reality we found could not have been further from that. We have worked very hard with record allocations both from within DHS and from special ERC grants that have been made to us to build that common IT architecture, both for business systems, acknowledging that the savings you make at the back of house can support better clinical care, as well as

the clinical products that are at the heart of HealthSMART. Given your interest, I am happy to stop and throw to Lance, but I think there is some background in relation to this that is important.

From a finance and supply management information system point of view we have eight health agencies signed up to that. We have four health agencies signed up to the client management system, the iSOFT system — these are health services that may have a number of campuses. Three more services under that patient and client management system are to go live in the next couple of months. With independent community health, through their Track Health product, we have got five community health services and I think one a month coming online as we look forward.

Again, there are a number of other components to this. In relation to one that is particularly exciting, one that is really delivering great benefits and one that I have had the opportunity to see firsthand in a number of settings is the PACS, picture archive and communications system, which is all about digital medical records and then, as well as that, putting all the imaging within the health service online, if you like, so you can link up the two — really powerful. It is what the health system of the future will look like. It is about medical specialists working from home, if you like, having the latest CT scan or MRI beamed down in a broadband pipe to their home. That is a really important part of the system. There are four pilots of that. The list goes on. There are very substantial achievements against the budget allocations we have made.

The Auditor-General did make recommendations, though, in relation to this project, and I have been clear and up-front about it, that we need to do better on this. I was pleased that he confirmed the project is operating within its budget, but there is a time issue that principally goes to the point that we really are coming off such a low base. I am not casting a reflection upon the last government, but we really are coming off a very, very low base, and there is a big job to be done. We are committed to this project. It is important. It is one that will basically enable the efficiencies and improvements that the community demands of us. We are committed to this project and will continue to deliver it properly and well, acknowledging that there have been some time issues, and we will devote ourselves even more to getting the best outcomes out of this project.

In relation to a breakdown or a build of the 100 million plus in this year's budget, I might throw to Mr Wallace.

Mr WALLACE — There are two components in the budget. If you refer to page 309, there is a HealthSMART line of 18.5 million, 19, 19.5 and 20 million over the four-year period of the budget. That is in the output section of the budget. Those funds are to actually deal with increased operating costs of the system. The HealthSMART system has got much better disaster recovery processes, so we are running dual sites with back-up computer systems, so this is physically the running costs of more computer boxes. It is network capabilities, improved network speed and capabilities so information can be passed from health services, and also improved networks for back-up should the main computer system go down — access to backup. So those new facilities and new standards which the HealthSMART template is putting in place are requiring higher operating costs to actually run.

The second component, if you refer to budget paper 3, page 315, there is also a line in there which is 6.7, 6.7, 6.7, 6.7 over the four years. That rate relates to physical infrastructure, so the physical replacement of the computers that were initially purchased. HealthSMART now has been going for a time; computers that have been put in both at individual health services and also in the shared services centres need to be replaced. They have got a useful life. With IT equipment it is usually only three or four years, so already over the life we have put in at the start of the HealthSMART project some new supporting infrastructure which we have gradually upgraded over the period of time. This is now to replace that equipment over a three to four year life span.

Mr WELLS — So because the life of the program has gone on for so long, some equipment from the start is now obsolete?

Mr WALLACE — What I am saying is that always equipment needed to be replaced. Equipment lasts for a three to four year life and it needs to be replaced after three to four years. That will be an ongoing issue for health services over the life of the program. The HealthSMART program will last 10 years or more. I can also briefly deal with participation policy, if you want, Minister.

Mr ANDREWS — Do that.

Mr WALLACE — Participation policy is covered by the HealthSMART board. The HealthSMART board consists of health board chairs, health service CEOs, both rural and metro, as well as departmental officers. That group of people decided on the participation policy, which was to try to actually make sure that we had an interconnected system right across the state, a whole-of-health computerised system, that people would not be able to put in any other product than a mandated HealthSMART product unless they put in an exemption to that board. So it is health services peers as well as departmental officers that look at those exemption cases. It does not mean that you must replace your systems immediately. If, for example, you have a computerised system which has approximately a 10-year life and you had just replaced that system, it would be wasteful for us to actually go out and replace that system straightaway, so we are phasing in over a long period of time, but that is the way the participation policy is operating.

The CHAIR — Minister, on page 309 in appendix A to budget paper 3, the output initiatives, there is another one there regarding HIV and chronic communicable diseases. I know I have been reading in the paper — I do not know if I can remember the exact details of it — there seems to be an increase in the incidence of HIV and STIs, or some of them anyway. I was just wondering — you have got a line there allocated for that? And I am sure there are other policies and programs. Can you give us a bit more information on what you are doing in that regard?

Mr ANDREWS — Thanks very much, Chair. This is a very important area of government funding in partnership with a number of community organisations. As part of the protection of public health output we really are very pleased to have been able to secure more than $16 million to support this particular program in relation to reducing the rate of HIV infection and other STIs. This is a key challenge, a key priority, and again I just want to make the point that we are very pleased to have been able to secure this additional funding. It is record funding that will support a whole range of programs, whether it is about social marketing to drive the sort of behavioural change that is central to safer sex and a stabilisation, and indeed decrease in the total number of STIs across the community — —

The CHAIR — I understand there has been some talk about the Grim Reaper ads coming back or that sort of thing?

Mr ANDREWS — We could have a very long and interesting discussion about what sorts of social marketing techniques work. What is clear is that, despite the great success of campaigns like the Grim Reaper and the real re-education of our community in a broad sense, we cannot rest on our laurels. We need to be always vigilant to support those who can provide, I think in the main, targeted messages to different cohorts of people, to educate them, to empower them if you like, to make more, I suppose, responsible choices and to mitigate the risks that they expose themselves to.

Yes, social marketing is important, and this package will support record levels of social marketing to drive behavioural change. That is about protecting the health and welfare of individuals, but given that we are talking about communicable diseases here, it is about protecting the broader public health, and that is a key challenge and a key area that we are all basically accountable for.

Just to give you a sense of the need here and the context: in Victoria in 2007 there were just over 11 000 cases of Chlamydia, 1007 cases of gonorrhoea, 23 syphilis cases, and 262 cases of HIV were notified to our department. So this affects many people right across metropolitan Melbourne and rural and regional communities, and we need to do more to support safer choices and a better education campaign across the whole community.

To give you a breakdown over the four years of that $16 million-plus: $10 million to deliver targeted campaigns and programs to improve particularly gay men's sexual health and to reduce rates of HIV infection. At 262 we have seen that stabilise a little bit in recent times. The job is to continue that, and then over time to bring down the total number. That is certainly our aim, and we have seen other states able to do that, so we are very keen to try and reduce — certainly in the first instance stabilise, then decrease the total number.

Dr Brook informs me that it is 423 syphilis cases; I was not reporting — we have not been quite as successful as the numbers that I indicated. There were 423 last year.

But we have seen other states do it. This package will support that important work, and we hope to deliver real dividends as a direct result of that. There is $3.12 million to establish a rural centre of excellence in STI prevention. That will be based in Shepparton and I think recognises that these are issues for the whole of the Victorian community. There is a boost of just under $1.3 million for a Chlamydia screening program and $1.66 million to

build on a pilot program we have currently been running as a Victorian public health initiative, which is all about blood-borne viruses and the prisoners in our correctional facilities.

The CHAIR — Like hepatitis?

Mr ANDREWS — Hep B, hep C and indeed HIV. To finish where I started I suppose: this is a key challenge; it is a key priority, and we are very pleased to have been able to secure through the budget process the funding to deliver this social marketing and the other targeted interventions that are central to this program. We hope it will deliver results not just for individuals but for the broader public health.

Mr RICH-PHILLIPS — Minister, those diseases — are they all reportable diseases that you just ran the stats off for?

Mr ANDREWS — Yes, I believe so. Yes, my advice from Dr Brook is yes. These are the figures we have received after the notification, so they are notifiable, yes. Sorry, yes otherwise we would not be able to illuminate you.

Mr RICH-PHILLIPS — Yes, that was my next question! On your slides you refer to the $1.8 billion boost across the health portfolio and noted an additional 60 000 emergency department patients per year as one of the targets. That is one of the funding outcomes, as the Treasurer said in his speech. The budget paper — page 87, BP3 — the output group notes an increase of only 51 000 extra emergency presentations for the new budget year. Can you reconcile those two figures?

Mr ANDREWS — Thank you, Mr Rich-Phillips. We are very pleased as part of the HDM and growth going forward to have been able to secure additional funding to treat more patients in our emergency departments. What is important is that we provide that funding, because we know that we have got extra patients coming through the front door. We have also election commitments in relation to these matters, and we are well on track to deliver against those election commitments here and in other areas. I think there is an issue here about whether you go target-to-target or whether you go expected outcome-to-target.

Mr RICH-PHILLIPS — Yes.

Mr ANDREWS — And that captures the difference between the two ways that the figures have been expressed. As part of our build across the forward estimates — and the money was provided last year, but it is then in the base flowing through — there will be 60 000 additional funded presentations to our emergency departments as a result of this budget. That needs to be considered in the context of the growth that flows through from last year in the furtherance of our commitment towards the 377 000 across the four years.

Mr RICH-PHILLIPS — If you take the 60 000 as being the increase on the 07–08 target — last year's target plus 60 000 makes this year's target — can you also take the fact that the expected outcome for the current financial year, being 9000 higher than the target, that those — —

Mr ANDREWS — Do you want me to flow the 9000 on expected into the target?

Mr RICH-PHILLIPS — Either that, or are you saying that 9000 is effectively unfunded presentations — there was no funding provided for those presentations?

Mr ANDREWS — No; all those presentations have been funded. We have targets and we have estimates, and we seek to gauge the demand pressure that our emergency departments will face, but who and how many patients present to emergency departments is probably the most highly variable part of the health system. Again, I can only take you back to the notion that we have fully funded the 60 000. It is about what the starting point is and which two columns you count. I would just say as well, though, that we almost always, because of the demand pressure, treat more patients than we anticipate we will treat. We will see at the end of the financial year where we get to, but it is usually the situation where, because of growth pressure, we usually treat beyond what we target. I do not think there is a need for Mr Wallace to add to that, but that is the position. It is about which columns you target.

Mr RICH-PHILLIPS — Accepting that, would you not take your increase from, 'Each year we have treated 1.39 million, next year we will increase it 60 000', so it would be actual this year plus the increase, rather than target plus the increase? Would that not be a clearer way of presenting it?

Mr ANDREWS — I think the notion that we are having this discussion by way of a supplementary question confirms that you can with absolute credibility go target to target and get your 60 000.

Mr RICH-PHILLIPS — Yes.

Mr ANDREWS — I am happy for you to assert that there would be another method.

Mr RICH-PHILLIPS — Being actual to new target.

Mr ANDREWS — What I am saying to you is that there is funding in the budget to do that 60 000 additional activity. That is part of a consistent investment program that we have undertaken in terms of our emergency departments, in growth funding but also the physical fabric of our emergency departments. Despite some rather ill-informed commentary about this matter — not from you, Mr Rich-Phillips, but from others — we are on track to meet our targets. And I am not pointing at you either, Kim. We are on track to meet our election commitments, because that is what this government does; it meets its election commitments.

Ms MUNT — I would like to speak a little about cancer research. We have a member of our committee who is currently fighting breast cancer, with all our love and support, so I am asking this question on her behalf. Also, the Premier and I walked in the Mothers Day Classic on Sunday morning with 30 000 other supportive Victorians. I actually asked the Premier a little about this program yesterday. But I notice that on page 309 of budget paper 3 there is funding that ranges between 30 million for 08–09 to 45 million for 11–12. Then on page 314 it talks about a package of initiatives to improve cancer prevention and care. I was wondering if you could just expand on that a little for our information.

Mr ANDREWS — Thanks, Ms Munt. As part of the record $150 million cancer action plan, the funding that we have contributed there, there is a very big boost for the Victorian Cancer Agency. We are proud to have set up the Victorian Cancer Agency — the VCA. Daine Alcorn and her team down there do a great job supporting through their grant programs and through their other works some of the best researchers in the world. We can be proud, as can every Victorian, of the biomedical sciences, the clinical research, the basic research that is conducted in so many institutes of world fame right across Melbourne and indeed in some parts of regional Victoria.

The budget this year builds on that. It provides funding certainty for the VCA, and again I am very confident in saying that I think it will lead to the more rapid translation of important and world-leading research into better care pathways, better ways of managing those complex tumour streams across cancer and better outcomes for real people. That is what that research is about; it is about translating research into better care outcomes. It will be a big part of meeting that target we spoke about earlier on, that overall survival target.

There is $78.77 million over four years for the VCA. Again that will support its important work, mainly through grant programs and other programs that it runs. It has been going for two years, and that has delivered very substantial benefits, whether it is translation or researching tumour stream grants — nine projects have been funded. In breast, cervical, lung, thyroid, renal and melanoma cancers, there is just under 2 million to support that work. In terms of supporting clinical trials — and we know how important that is in the translation of research through to clinical outcomes — there have been three clinical trial pilots that have been supported by the VCA. There has also been the establishment of a national cooperative clinical trial framework for prostate and for urological cancers — that is worth around 2 million as well — and a whole raft of other research grants that the VCA has been able to provide through its grant system.

I announced more than $6 million worth of grants with the Premier late last year down at the Alfred, I think, as part of the latest example of the good work supporting researchers from right across the Victorian community and indeed right across Australia. That research is all about saving lives. It is all about better outcomes for people. It is all about making sure that we are developing the very best care to treat our cancer patients right across Victoria.

Before I speak about Ms Graley, I just want to mention two further projects — that is, firstly, the Victorian Prostate Cancer Research Consortium. That is a very large challenge within the broader field of cancer but also in terms of men's health. That is a virtual research institute and is one that has been well supported by the VCA. Equally, the Victorian Breast Cancer Research Consortium has been supported not just by the VCA but by the previous government. It is important to acknowledge that as well. That is directly relevant of course to Ms Graley, who is very bravely going through her own cancer journey. I was very pleased to see her out at the Casey Hospital last week. She is looking well. I think her treatment is going well. We wish her the strength and all that she needs to get

through her own cancer journey. But I am sure she is being very well supported by the dedicated staff that really are the hallmark of our cancer system. Again that is a top priority for us — a big priority for us — and we are very proud to have been able to secure the future of the Victorian Cancer Agency through this almost $80 million to again support the very important work they do.

Mr DALLA-RIVA — I refer you to the service delivery budget paper, pages 86 and 87, in respect of acute health services. I noted earlier in our discussions about the emergency services categories 1, 2 and 3, specifically emergency services category 1 is 100 per cent, which you would expect, given that the *Your Hospital* report lists category 1 as 'heart not beating' as an example. So I gather, without being flippant, that you would assume that if your heart is not beating you would get fairly urgent attention — as you would expect. Therefore you would get the 100 per cent hit rate, as it were, in respect of that necessary treatment. I cross to the elective surgery category 1 on the opposite page, the difference being the urgent category 1 elective surgery patients admitted within 30 days, and I note the 100 per cent target, the 100 per cent outcome expected and the actual in the previous financial year as well.

Given that there is a marked comparator between category 1 patients under emergency services and the difference between urgent category 1 under elective surgery, is there a suggestion that if surgery is postponed for an elective surgery procedure due to a hospital-initiated postponement, are those patients therefore taken off the category 1 and placed onto category 2, because it is outside that period, or are they removed from the list entirely? I am just trying to get clarity on how you determine, if the surgery of somebody who is meant to get elective surgery within the 30-day requirement is postponed by the hospital, do they fall off the list until they go back on the 30-day period, or are they seen as part of that 30-day period?

Mr ANDREWS — Thank you. I think it is important to acknowledge at the outset that it is not me who makes judgements like that. The answer to your question is no, but the first thing to acknowledge is that those judgements about the clinical classification of urgency of elective surgery patients are not made by me; they are made by people who are appropriately trained to do that important work — that is, our doctors and other staff in our health services. You sort of skipped over the fact, or just said you would expect 100 per cent for category 1 elective surgery — that is, urgent elective surgery.

Mr DALLA-RIVA — Heart not beating.

Mr ANDREWS — No, I am not talking about emergency departments; I am talking about elective surgery, which is the heart of your question. We do not do HIPS in the emergency department. It was not always the case. The 100 per cent we have had under our government was not always the case.

Mr DALLA-RIVA — So there is no patient whatsoever that is on the list for emergency elective surgery, category 1, that has not had their surgery within 30 days. You had better be sure of that, Minister. There is not one case out there?

Mr ANDREWS — We have reported in the *Your Hospitals* report consistently and in the budget papers before us today, and all the advice I have, is that, absolutely without any doubt, 100 per cent of category 1 — that is, urgent elective surgery patients; and it is a bit interesting to compare that to emergency procedures or emergency triage categories in another setting, being the ED, but you have done that anyway — patients, each of those patients on the elective category 1 list, get care within 30 days. That is not to say that because of pressure in the system someone whose case is more urgent may not get treated earlier. This is where the real link with emergency departments is — not category 1 and category 1, but the fact that often the elective surgery caseload will compete with the emergency surgery caseload, and again the principle is that the sickest get treated quickest, as you would want to have happen. We will sometimes see that. I do not have any data on how common HIPS are in category 1; they would certainly be less common than in category 2 and category 3. But where it is unavoidable and where there is a clash in terms of theatre time or where that surgeon's time is required to save someone's life in an emergency, then urgent surgery, which is very important surgery but urgent rather than emergency, may well be cancelled.

I have no advice otherwise, and we stand by the reports we have put into the public domain that 100 per cent of category 1 surgery is conducted within the clinically appropriate time, which is 30 days. In fact, if we did median time to treatment it would be substantially less than 30 days; it would be 7 days, I am told. That is the median time to treatment within that category 1 cohort.

You are not quite comparing apples with apples here. I am happy to have a discussion about emergency department category 1 triage patients and the high quality of care we provide them, but we need to punctuate this simply by saying that we have provided the funding that is required to meet that important benchmark. We are very concerned to continue that. That is why the targets remained unchanged. We anticipate we will meet that in the out years. I would just say that has not always been the case under previous governments.

Mr DALLA-RIVA — So you acknowledge that.

Mr ANDREWS — Under previous governments, Mr Dalla-Riva.

Mr DALLA-RIVA — We note the acknowledgement of that, Minister, in a formal way.

Mr ANDREWS — Under previous governments, Mr Dalla-Riva, of the blue kind.

The CHAIR — Thank you for that response, Minister.

Mr SCOTT — I would like to draw the minister's attention to BP 3, page 95, on the refugee support strategy. That contains a reference to the additional nurses for the refugee health nurse program. I would be grateful if you could provide some further information to the committee on how the funding for the refugee health nurses in this budget will address the disadvantage faced by some of the most vulnerable members of our community.

Mr ANDREWS — Thank you, Mr Scott. Just to repeat the last point you made, these are some of the most vulnerable members of our Victorian community. Those who have fled some very challenging parts of the world and who are often survivors of torture and trauma, deserve to have their new government supporting them in any way they possibly can. Speaking as a former Minister Assisting the Premier on Multicultural Affairs, I have had the great privilege of moving around many of the refugee communities that make some of our regional towns a good deal more vibrant than they would otherwise be and indeed my own local community, where the largest number of young refuge migrants from the Horn of Africa, mainly Sudanese, live and work.

This is an important initiative. We first introduced the refugee health nurse program, which is a very important program to support, as you say, many vulnerable members of our community. That was first rolled out in terms of additional nurses in Brimbank, Greater Dandenong, which is my own community, Hume, Maribyrnong, Moonee Valley, the city of Melbourne, Darebin, which is your own community, Mr Scott. Again, in recognition of the great job, the great practical support for cultural diversity and multiculturalism that is the hallmark of regional communities, we supported it in Shepparton, in Warrnambool and also in Ballarat. So this is a really important program.

In August 2005, as part of that rollout, we had four EFT across seven sites. It is important to understand this: funding is not just wages, there is also a translation and interpreting component to support the work that these refugee health nurses do. I am very, very pleased to be able to say that in the 08–09 year we have allocations of 620 000 a year with 2.98 over four years to increase that workforce to take it to 11.5 EFT operating across 15 sites, so that is a net increase of four additional EFT refugee health nurses. That is particularly important given the primary care catch-up that many of these individuals need, having left camps and having left very challenging parts of the world. We are committed to supporting them as part of the resettlement process. That is principally a commonwealth government function, but we are committed to vibrant communities, to cohesive communities. It is important to understand that, you know, these individuals and families are often some of the most vulnerable and have the longest way to go in some ways, so we are very committed to boosting support.

Our partners in this are very important: local government to a certain extent; community health, of course, is the major platform to effectively deliver these; and I visited, I think, certainly the first cohort in a previous role, each of the health services that rolled out the refugee health nurse. It is a very important program. Our partners beyond local government, whether it be Foundation House and many others right across the multicultural sector and the cultural diversity community, if you like, from the VMC and many others, we are very grateful to them. This really is about equity, it is about meeting a need, it sits fairly and squarely within the A Fairer Victoria framework, and that is about addressing social disadvantage. We are proud of this investment, and it benefits many thousands of people going forward, and I thank you for your interest in it.

Dr SYKES — Minister, I wish to talk with you a little bit further about ambulance vehicle replacement. It appears as a line item in budget paper 3, page 315 — it is about four lines down — and it appears to have $600 000

against that item. I guess I want to explore the number of vehicles that need to be replaced each year, the cost per vehicle, and where the money shows up in the budget. Your overhead presentation indicated 44 new vehicles. Is that additional vehicles as distinct from replacement vehicles?

Mr ANDREWS — Yes, additional. Sorry, you finish your question and I will answer it for the benefit of the transcript.

Dr SYKES — Okay, fine. My understanding is that the annual rate of replacement should be in the order of about 60 vehicles for the Metropolitan Ambulance Service and 80 for Rural Ambulance Victoria. So just first of all, I am looking for clarification on the numbers.

Mr ANDREWS — Dr Sykes, let me deal firstly with the issue in relation to what vehicles are funded under this 185.7. In the delivery of those services there will need to be 44 additional vehicles, so that is a net increase. I think the total purchase might be some that are replaced, but it will be 44 more vehicles in the total fleet than would otherwise have been the case. We have increased the total fleet by 25 per cent. That is very important.

I was very pleased just recently to visit RAV headquarters in Ballarat to celebrate, if you like, some additional Mercedes Sprinter vehicles as part of a shared spend — new money from our government as well as some capital reserves spent by RAV to purchase additional vehicles — and we will see by the middle of the year, I think, the last of the GMC vehicles, the General Motors chassis vehicles, taken out of the RAV fleet or certainly out of the front line. So we stand on our record. We are very focused on this issue, and we are very proud and pleased to have been able to provide record funding, through the overall allocations that are made to MAS and RAV and therefore contributing to the operating capital reserves or indeed direct funding where we have supported the purchase of additional vehicles with state moneys.

It is the most modern fleet that it has ever been, it is the safest fleet that it has ever been, and that is in no small way due to the fact that we have supported both RAV and MAS to upgrade their fleet. It is not just about government funding. It is also about getting the best advice, and the Monash University Accident Research Centre works closely with MAS and, by extension, with RAV in relation to vehicle life limits and making sure that we have proper maintenance and that we monitor these things as part of a proper observation framework in terms of the safety and the appropriateness of our fleet. We probably cannot give you additional details in relation to unit price and what the average cost is of things.

Dr SYKES — So, what is the annual replacement rate?

Mr ANDREWS — What is the 600 000 for?

Dr SYKES — Are you replacing about 150 a year, say 60 for the Metropolitan Ambulance Service and 80 for RAV, as was indicated to me was the figure?

Mr ANDREWS — I am not in a position to confirm that. I am sorry, Dr Sykes. That is not necessarily clear from the budget papers. I am happy to take that on notice to you, though, but I would say to you that we are very proud of the investment we have made in relation to these matters.

The 0.6 in the 08–09 year supports four replacement vehicles for RAV at a value of 150 000 each — they would be Mercedes Sprinters at that 150, that is the new standard vehicle — and I can confirm again that the ambulance package that I have been speaking about involves 44 new vehicles. But again, that is funded across the four years, and as we commission new services there will be a need to purchase new vehicles.

Dr SYKES — I would be interested to know what the overall replacement rate is.

Mr ANDREWS — Can I just say that we are happy to get some information for you, but much of this is contained within the annual reports of RAV and MAS as independent statutory authorities who run their own fleets, albeit with record support from us.

Dr SYKES — Just one last question. How many of these ambulances are now set up as heavyweight vehicles to carry obese people? Is there 10 or a dozen of them out there, or what?

Mr ANDREWS — There are a number of complex patient vehicles that are not just about bariatric patients but a range of other complex patients. That is about a safer working environment for paramedics. That has

been supported by our government through additional funding, and by extension by additional allocations made by MAS. I do not have to hand a detailed answer on that issue, but again we will come back to you on the vehicles. There are certainly more in the fleet today than there were, and the fleet includes non-emergency patient transport vehicles as well for inter-hospital transfers. I am reliably informed that there are five of those complex patient ambulance vehicles, but we will be pleased to confirm that with you.

Mr NOONAN — Minister, I want to talk about the immunisation program for the state. On page 100 of budget paper 3 there are the output measures regarding immunisation and coverage targets, and specifically under the 'Quality' heading there are four different categories. My question goes to whether you can advise the committee how the government will maintain what I would say is its proud record of keeping the instance of vaccine-preventable diseases at these low rates?

Mr ANDREWS — Thanks very much, Mr Noonan, and it is indeed a very proud record, and one that is a credit to all those involved. There are a number of partners, local government being a part of that, and indeed the commonwealth government funds the program in a broad sense. We can be very proud of our immunisation record. I will give you just a sense of recent performance.

One-year-olds are at 91 per cent, and that matches the national average. Two-year-olds are at 93 per cent, which is a full percentage point above the national average; and six-year-olds are at 91 per cent, fully three points above the Australian average at 88 per cent. We were the first to reach the plus-90 per cent barrier in that category. It is a very important project, and it is about supporting our youngest Victorians. Again, we have had many questions today that are equally relevant to all of us as parents as well as members of Parliament, but again it is about real outcomes for real people, and we are very pleased to support that.

I should also say that proper immunisation programs are not just about kids, as important as they are. The cervical cancer vaccine Guardasil has been a big challenge for us. We have done very well with that, and 650 000 doses of that cervical cancer vaccine have been distributed across Victoria. That makes it one of the largest vaccination campaigns that has ever been conducted in the state, and again our partners in that are critically important. Whether it is in childhood immunisation or other vaccines and vaccination programs like the HPV Guardasil program, we perform at or above the national average, and it is with some pride that I can say that to you. I think that is a great benefit to many right across the Victorian public.

Mr BARBER — I would like to ask about rural obstetrics, coming back again to the baby theme. We seem to be progressively obliterating it with 80 services gone since 1983 and 37 since 1997. There are about 42 services left. It seems to be a workforce problem, as it is with anything else to do with medicine in rural areas. What sort of workforce package can you put together to get people to work in that service, and what additional incentives are in the budget?

Mr ANDREWS — Thanks, Mr Barber; it is an important question. We are committed to making sure that rural and regional communities can get access to the broadest range of services as close to home as possible. You are right to say that rural and regional obstetric care, as with much specialty care across rural and regional Victoria, is largely determined by the availability or the unavailability of an appropriately trained workforce.

Mr BARBER — Do you think having babies is a specialty though?

Mr PAKULA — I bet you can't do it!

Mr BARBER — I suppose my question is about the service planning as well.

Mr ANDREWS — In my experience delivering babies is a very special thing and requires a degree of skill, knowledge, understanding and physical stamina that is sometimes rare in rural and regional areas. What is important is that as a government, we support our GPs who want to up-skill to expand their scope of practice. For instance, we just had the third medical school open down at Deakin; a really positive step forward. We took the extraordinary step of putting money on the table. This is a commonwealth government job, but we put the dough in to do what we could to open that. It is open with 120 students, one-third of whom come from rural and regional communities, all of whom will rotate through rural and regional areas as part of their undergraduate clinical placements.

I spoke about the medical workforce boost — the $55 million-plus in this year's budget to support internships and PGY2 years, and also the fabric of our undergraduate and postgraduate clinical education environments in Warrnambool, Northern and others. Again we are committed across what is a pretty complex area. This is not an easy issue; it is a complex issue.

We are committed to expanding the medical workforce and the allied health workforce and the nursing workforce across rural and regional areas. That is why back in 2006 we had a $40 million allocation over four years for specialist training. That is why each year we invest around $40 million on a range of different workforce programs. They are not all medical but they are across the spectrum of care, and they are about making sure we can increase the total number of health workers in rural and regional communities, but also assist them to expand their scope of practice.

I can probably give you some more detail in relation to the specifics of obstetric care. In relation to the availability of services, I have to say that workforce — clinical education in both undergraduate and postgraduate — needs to be a greater feature of the next health care agreement, much more than it ever has been, and I think that will be part of the ongoing discussion we have with the commonwealth. I think that is how we will start to see things turn around in terms of additional totals — we have the total number of medical students, we have many more coming through the system now that we have ever had, so we have had a win on that front. The question is how you provide an environment and support to train them as a postgraduate to meet some of the critical workforce shortages.

I am happy to come back to you, though, on the detail of the issue you ask, but service availability and the scope of the services that are offered at a given health service are principally matters for the board, and they make very difficult judgements often about what is safe to offer and what is not, what they can do and whether or not they can attract an appropriate workforce. They are very hard decisions in relation to the sort of preamble to your question. But we will come back to you with some more detail on that, unless Dr Brook wants to add to that.

Dr BROOK — I just might make a couple of comments. Whenever this issue comes up it strikes me as unfortunate that no-one talks about the 40 rural hospitals that still do provide obstetrics care.

Mr BARBER — I did talk about them; I said 42, though.

Dr BROOK — That number is considerably higher than other states — for example, to our north. When you look at the record it is important to think about not just those services which have closed. It is important also to look at the time of those closures. People talking very large numbers of closures go back often into the distant past, and we have to reflect that rural communities are all different and many of them are demographically very different than they were 10 years ago, 30 years ago, whenever.

I am reminded of Hopetoun, a community of less than 600 people, all of whom are aged more than 60 years who very recently were extremely concerned to reinitiate and continue an obstetrics service, which is something that should be taken into mind. Most closures do actually reflect simple demography, particularly in broadacre farming communities where there are fewer people and they are growing older.

The last thing that I would mention is when talking about obstetrics services it is often — I think your question asked basically a medical question, 'Is obstetrics a specialty' — not essentially about general practitioners, as important as they are, or specialists. It is about whether there are sufficient trained midwives who have recency of practice. We have had many, many services where there are still some midwives, some very old themselves, but who are not prepared to provide obstetrics services because they have had no recency of practice. You cannot just do obstetrics. It is considered unsafe, and you have to have sufficient recently-qualified midwives to maintain three shifts. You cannot assume that a woman will give birth in one nursing shift. It is a little more complex.

We also need to take into account theatre availability, the availability of anaesthetists and simple things like does the hospital have an adequate blood supply in the event of an emergency transfusion requirement. What we have done is to take a capability-based approach to this and released an important policy paper on rural maternity services which says to hospitals, 'Here are the capabilities that you need to make your decision as to whether you continue to provide obstetrics services'. I think as the minister has said, make no mistake, we strongly support those facilities which should provide obstetrics services and we do everything we can to sustain those services.

Mr PAKULA — Minister, I want to ask about Nurse-on-Call. On page 86 of budget paper 3 the page is headed 'Acute Health Services' and it goes on to look at the outputs for admitted services and in that context I am wondering, with regard to Nurse-on-Call, what sort of a contribution Nurse-on-Call makes to managing that part of the health budget going forward.

Mr ANDREWS — That is a very good question. Again the notion of basically diversion away from and the substitution of inpatient or highly costly, highly sought after services is something that we have embraced, something that we have tried to embed in all of our health decision making as we go forward. It is a key feature of the HARP program and some of the other support programs I have spoken about.

We are very proud of Nurse-on-Call. It works very, very well, and what is really encouraging is that it has the confidence of the Victorian community. As it approaches its second birthday — it will be two next month — I am advised that they have answered 700 000 calls across those two years. They record, through their equivalent of our patient satisfaction monitor, very substantial customer satisfaction and broad support and approval — up to 99 per cent of respondents are satisfied with the service that they were given through Nurse-on-Call.

It is very important to be able to speak to a nurse, to be able to get the advice you need and to have in some respects the comfort of knowing that that is only a phone call away. It seems a simple thing, but it really does I think support people, particularly back to young kids. I think it does support each of us, particularly in relation to small children. It becomes just one further example of where we have needed to and proudly we have stepped in to support the failings in primary care that are such a hallmark of the previous commonwealth government over more than a decade. There is a need for a service like this. That is why we put it in place. It works very, very well and we are delighted with that.

I will give you a couple of examples in terms of your question about what it does in terms of demand pressure on other parts of our health system. The most recent estimates are that hospitals have diverted nearly 90 000 calls from their telephones in the emergency departments through to Nurse-on-Call. So it is actually 88 490. Whereas a nurse or another highly trained individual in an emergency department, a very pressurised environment, a very challenging environment, would have to spend time on the phone answering what are basically primary health questions, all of that work has been diverted across to Nurse-on-Call, and it forms an important part of their role. What that means in real terms — apart from I think we all get a sense in broad terms of what that is about, a better use of precious resources — if you try to cost it out is 11 799 hours or 492 days of hospital nursing time. That gives you a practical demonstration of how this new platform, this new service is not just about better quality outcomes and the certainty and the safety if you like that comes from knowing it is only a phone call away, but it is about more efficiently running our health system and giving people an alternative avenue to get the health advice that they need.

Just in closing on that front, recently they had a good look at a number of calls that they made: 8363 callers surveyed in January to March this year said they would have stayed at home following triage. Over 13 per cent of those calls — 158 — after they had rung Nurse-on-Call actually needed an ambulance, so it is trawling for and finding people that are a good deal more unwell than they think they are and then getting the care that they need earlier. That is obviously about better outcomes for them as well as better outcomes against the sustainability of our overall health system. It is a really good program and one that is working very well.

Chair, just before you sum up I want to add to an answer in relation to MICA paramedics.

The CHAIR — Excellent, thank you.

Mr ANDREWS — Mr Rich-Phillips asked me about additional MICA paramedics. I am advised that somewhere between 27 and 30. The number of 17 was actually a two-seven, not a one-seven. It is 27 to 30 odd MICA paramedics will be needed as part of the package.

Mr RICH-PHILLIPS — And that is an increase in the total number of MICA paramedics, or is that — —

Mr ANDREWS — I have only got advice as to how many will be required to deliver the service commitments we have made in the 186, noting of course it is not just on the road, it is in the air as well. It will be 27, but for safety's sake, say, 30.

Mr RICH-PHILLIPS — Perhaps you could clarify that?

Mr ANDREWS — I am happy to, absolutely. I did commit to come back to you before we stood up.

Mr RICH-PHILLIPS — You certainly did.

The CHAIR — We certainly welcome the ones at Box Hill, Nunawading and Ringwood.

I thank the minister for his attendance and Ms Thorn, Mr Hall, Mr Wallace and Dr Brook. That concludes our consideration of budget estimates for the portfolio of health. I also thank the departmental officers for their attendance. There are a number of issues to be followed up. We would appreciate receiving the responses for those within 30 days.

Committee adjourned.