V E R I F I E D T R A N S C R I P T

PUBLIC ACCOUNTS AND ESTIMATES COMMITTEE

Inquiry into budget estimates 2006–07

Melbourne — 9 June 2006

Members

Mr W. R. Baxter
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Mr R. W. Clark
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Witnesses

Ms B. Pike, Minister for Health;

Ms P. Faulkner, secretary;

Mr L. Wallace, executive director, metropolitan health and aged care services;

Dr C. Brook, executive director, rural and regional health and aged care services; and

Mr A. Hall, executive director, financial and corporate services, Department of Human Services.

The CHAIR — Good morning. I declare open the Public Accounts and Estimates Committee hearing on the 2006–07 budget estimates for the health portfolio. Welcome to the Honourable Bronwyn Pike, Minister for Health; Ms Patricia Faulkner, Secretary of the Department of Human Services; Mr Lance Wallace, executive director, metropolitan health and aged care services; Dr Chris Brook, executive director, rural and regional health and aged care services; Mr Alan Hall, executive director, financial and corporate services; departmental officers, members of the public and the media.

In accordance with the guidelines for public hearings, I remind members of the public that they cannot participate in the committee's hearings. Only officers of the PAEC secretariat are to approach PAEC members. Departmental officers, as requested by the minister or her chief of staff, can approach the table during the hearing. Members of the media are requested to observe the guideline for filming or recording proceedings in the Legislative Council Committee Room. All evidence taken by this committee is taken under the provisions of the Parliamentary Committees Act and is protected from judicial review. However, any comments made outside the precincts of the hearing are not protected by parliamentary privilege. All evidence given today is being recorded. This year the proof transcript will be emailed to you and you will have 48 hours after receipt of the email to check the Hansard transcript. I ask that mobile phones be turned off and any pagers put to silent.

Over to you, Minister, to present us with a no more than 10-minute presentation on the more complex financial performance information that relates to the budget estimates.

Ms PIKE — Thank you very much, Chair. Good morning to committee members. Thank you for the opportunity to address the committee today on the 2006–07 health budget. We have some slides here which go to the challenges, the broader context within health, the responses of the government to date and how we intend through this budget to continue that work.

Slides shown.

Ms PIKE — I think we all know that there are increasing demands on the hospital system. These largely arise from population growth, the ageing of the population — which of course increases the proportion of people in the community with chronic health conditions — the growing availability of other treatment options through technology and improvements in clinical practice, and higher expectations of what the health services can achieve. From that graph you can see quite clearly that those pressures accumulate year on year. This year the Victorian hospital system will admit over 307 000 more acute patients than it did in 1999–2000. To put that in perspective, that is about filling three extra MCGs full of people. The growth really has been quite astronomical.

I have mentioned new clinical and technological advances. They really play out in the early stages of life but also in later life. For example, there is a rising demand for neonatal intensive care units and special care services. That is because more babies are being kept alive when they are born prematurely. Of course, as women delay childbirth to older ages, they increase their likelihood of premature birth. We need to respond to that. From July to December 2005 there were 5300 admissions to either NICUs or special care nurseries. That was an increase of 161 babies compared to the same period in 2004.

Similarly, new technologies are available to pinpoint cancers et cetera and then make treatment more successful — you are not radiating a whole body, you are pinpointing an area. Of course we need to provide the equipment. That means more people are surviving. That is good but it places demands on the system.

I think we are all familiar with lifestyle-related illnesses. Twelve chronic diseases actually make up 43 per cent of the burden of disease, 50 per cent of the underlying causes of death, 17 per cent of the hospital admissions for over three days, and 22 per cent of hospital costs. When you look at it Australia-wide, 70 per cent of the overall burden of disease and 43 per cent of health expenditure is on things that in many ways have a preventable component.

All of these areas have shaped our investment. One response people may be familiar with is the hospital admission risk program, which seeks to manage chronic disease more appropriately. You can see from that graph that there has been a significant impact on hospital performance through the intervention of HARP. That is a particular program — congestive heart failure. The number of people in that HARP cohort who were admitted to hospital following their time in HARP — you can see the dramatic reduction in the hospital admissions in that cohort. We have invested a lot of resources over the years in that service.

Similarly, making better use of same-day treatment, and reducing the time to treatment through better management of elective surgery: for example, we have reduced waiting times for patients needing nasal reconstruction for respiratory issues by 23 per cent. We have specialised some of our elective surgery centres and that is really assisting in managing the overall demand for elective surgery. Of course, we are also finding better and safer ways to treat patients. We, in fact, have had excellent results in terms of cardiac arrest. We are performing well on national and international standards in that area.

We are investing in health professionals. You can see that in 2004–05 our doctor work force grew. Over the last seven years it has grown by 33 per cent — nearly 1400. Similarly the public nurse work force has grown by 6473, or 31 per cent. We have been able to do this because we have increased funding for hospitals by 83 per cent since 1999; in 2006–07, $6.28 billion. That funding has allowed hospitals to cope with that massive surge in patients admitted, patients in emergency departments, patients generally being treated in the system. We have also modernised and rebuilt our health and aged care infrastructure. That gives you an indication of the investment over the past few years. To let you know, this is both in metropolitan and rural areas. I am sorry the picture is so small but that picture tells the story of new facilities completed or commenced across Victoria since 1999. It is an absolutely massive increase.

This year's budget continues this good work with $130 million per year to provide extra capacity, to treat more patients, boost emergency departments and elective surgery to cope with those additional admissions. This is the breakdown over that period of time in emergency, in critical care beds, in radiotherapy, chemotherapy, dialysis, and in blood and cancer services — additional funds, as I said, for emergency, for outpatients, for increased bed capacity at The Alfred, the Northern Hospital and the Royal Melbourne Hospital, with, of course, additional funding for the Nurse on Call program.

We know that chronic disease management, as I talked about in the HARP program, is something we need to put more resources into. There is extra funding for that as well as additional funding for substitute and community-based services to reduce pressure on hospital emergency departments and provide more integrated health care.

I want to quickly remind you of some of the major capital projects. People would be familiar with the Royal Children's Hospital, the Royal Melbourne Hospital emergency department, extra funding into medical equipment — a very significant increase this year of nearly $50 million. At Box Hill we have the beginning of the redevelopment of the Box Hill campus with stage 1, money for infrastructure and a whole list of other capital projects.

Just quickly, as you know the last budget provided a very significant boost to our mental health services. We have continued that good work this year, not only growing mental health services at the acute end but also providing more community-based services and early intervention services. There is a breakdown of a lot of additional support there. Postnatal depression and support for families where children have a parent with a mental illness and a new program at the Royal Women's Hospital are all part of that overall additional resourcing; plus capital in mental health.

The Heidelberg repatriation hospital will see stage 1 of what will be a much bigger mental health facility there into the future. This first stage will not only develop mental health facilities but also provide for the construction of a pool and a gymnasium for veterans.

In Shepparton the Ambermere project is a step-up, step-down facility, one of a number we are providing as an adjunct to our mental health system. That will be a 20-bed facility.

The Bouverie Centre will be relocated to the Parkville precinct. I have just got a couple more slides, Chair, to remind people of additional funding in the ambulance service, which of course we have been rebuilding over the last seven years, and some resources in capital, in equipment and in additional services, extra funding into the health work force to provide for additional doctor places, building on what is already a $40 million recurrent investment, and lastly our work in early intervention in prevention and community health.

We know that not only are we rebuilding community health facilities but we have a very substantial program to address the causes of illness which, as I describe right at the beginning of my presentation, accounts for 70 per cent of the burden of disease, 43 per cent of hospital expenditure. It is about dealing with those issues earlier on, and the government has joined the commonwealth in quite a substantial range of new initiatives in that area.

The CHAIR — Thank you, Minister. We will now go to questions. When you give your answers, if you could stick to around 4 minutes, that would be helpful. You referred very helpfully in your presentation to the HARP project and also the growing demand pressures which the health system faces year after year. If we look at budget paper 3, output tables from page 83 to 102, we clearly see the increased volume of services provided. Could you please give us some indication of the impact of the increased demand on the hospital system and outline what resources and what strategies you have put in place to address those to ensure that access and standards are maintained.

Ms PIKE — My presentation did indicate that we anticipate admitting around 300 000 additional patients into our hospitals this year compared to 1999. Not only is that a reflection of growth but also emergency department demand has increased dramatically as well. There were 265 000 more emergency presentations and 78 000 more patients admitted to the wards — that is, in the last year compared to the year 2001. To manage that demand we have developed what has been a very successful hospital demand management strategy, and the government has committed an additional $573.9 million over five years to expand the system and to focus on more appropriate places for treatment and care.

What we have been able to do through that additional funding is improve waiting times for emergency patients, manage the elective surgery waiting lists, keep them stable, and also reduce avoidable hospital use for people with chronic and complex conditions. For example, in emergency in April 2006, 59 per cent fewer patients were waiting more than 24 hours in emergency departments compared to June 2005.

We have also introduced a new target for emergency departments, a new 8-hour wait target, and this target was met by 76 per cent of cases. That was a 17 per cent improvement from June 2005. So we have introduced tougher targets, we have given people more money, and in terms of the proportion of the growth we have really made some significant inroads.

Hospital bypass has also fallen from 1.6 per cent of total time in June 2005 to 0.4 per cent in April 2006. This exceeds our own expectations. We have a target that hospitals will spend no more than 3 per cent of their time on bypass, and we are certainly meeting that very, very well.

We also, as I alluded to, have committed additional funding to treat an estimated 10 000 additional elective surgery patients, to shorten waiting times for elective surgery and to reduce the number of patients who wait longer than the clinically recommended time for treatment. Patients are being given opportunities to have surgery through existing and new models of care. There has been much more intensive management of the elective surgery lists, of the patients themselves, much more interaction with the patients, more information, and we have given the hospitals extra funding for this whole process.

Finally, since 2001, as I said in my presentation, we have invested over $200 million in the hospital admissions risk program, and an independent valuation of HARP has identified that it has been very successful in contributing to avoidable hospital admissions: up to 40 per cent fewer emergency department attendances; up to 59 per cent fewer emergency admissions and up to 50 per cent fewer days in hospital for those patients in HARP programs.

The CHAIR — That is very good. Thank you very much.

Mr FORWOOD — I would like to go to the question of the relationship and the attitude of DHS and yourself towards the committee. We had sought as part of 2004–05 outcomes information from all departments on advertising and promotional programs incurring expenditure of over $100 000 in 2004–05. The department advised us that problem gambling was one and fad diet was the other. There were no others. We of course knew that you had spent $458 000 on the opening of the Austin hospital, so we contacted your department again and asked how come this was not included as one that was over $100 000. The response we got is quoted on page 134 of our report:

> … the minister's response is to refer you to page 3 of the January–June 2005 *Your Hospitals* report which contained relevant information on the objectives, target audience and total cost of the launch.

This committee asked a specific question: how many programs over $100 000 — and you, it seems deliberately, excluded one of them and perhaps more. I wonder if you could explain to the committee what you think the relationship of this committee should be. If we ask a question, do you think you should answer it?

Ms PIKE — Thank you very much for mentioning the Austin hospital. It does of course remind the committee that this was a hospital whose future was really under a cloud in 1999, and now as a result of the work of the Bracks governments that hospital has been rebuilt and is a brand-new facility, the largest health precinct in fact available for that very, very large community. It was a $376 million redevelopment and — —

Mr FORWOOD — On a point of order, Chair — —

The CHAIR — There is going to be a point of order. I know what it is going to be. If you could refer back to the question, please.

Ms PIKE — Certainly.

The CHAIR — It is in relation to the relationship with the committee.

Ms PIKE — Certainly. I believe that the government and the Department of Human Services have been a very transparent about the costs associated with the community information and health promotion program which was included in the open day for the celebration of the rebuilding of the Austin hospital. We voluntarily reported all of those costs in the *Your Hospitals* report which not only goes to this committee but in fact about goes to all Victorians and is just another example of the way this Department of Health portfolio is reporting on more indicators and providing more information to the community than ever before. We did in fact provide additional funding to the — —

The CHAIR — If you could tie it in with relationship to the committee, that would be helpful.

Ms PIKE — Yes, I am very happy to do that. The Department of Human Services has been able and willing to provide information about our expenditure to the committee, and we certainly think it is important that we comply with the requests of the committee. There was certainly no intention to hide what we believe was a very important process of community information.

The Austin information program did not register in the department's advertising and promotion expenditure because the payments were made by the Austin themselves. If the request had been made to the Austin Hospital, then that information would have been available. We provided a grant to the Austin Hospital, the Austin Hospital then used that grant in the way that they saw fit, and it was a very successful day — a day when 20 000 Victorians had access to around 500 health professionals who came from the Austin voluntarily, were on hand to talk about the latest medical treatments, common health conditions and how to best use the hospital services. So that funding was provided to the Austin. We have been very clear about what the department's expenditure was, and we have provided that information to the committee.

Mr FORWOOD — In a general sense, if we ask you a question, do you think you are obliged to tell the truth?

Ms PIKE — I do not think there is any question — —

The CHAIR —The minister has made comment in relationship with the committee.

Mr FORWOOD — Well, she does not tell the truth.

The CHAIR — Do not go there.

Mr FORWOOD — You watch me!

Ms ROMANES — My question relates to the new service, Nurse on Call, which you have referred to in your presentation. Can you tell the committee more about how this service will operate and what it is intended to achieve, particularly in relation to the pressures on emergency services reflected in budget paper 3, page 84, where we see the pressures that are there. Could you give us more information about the service that has been recently announced?

Ms PIKE — Thank you very much. Nurse on Call is a brand new program for Victorians so that every Victorian will have at the end of their phone their very own nurse to provide information to them. I think this is a

fantastic service. It will be an adjunct to the very broad range of health services that are provided by the Victorian government but will also be of great assistance to the people in our health service.

To be very clear, currently many members of the community directly ring emergency departments of public hospitals for health advice. While they, of course, are still free to do that, it is important that the professionals within our emergency department have the greatest amount of available time to attend to the emergency cases that come through their door; so we believe that the provision of this service will alleviate the pressure from those phone calls.

Also we do know that in many of our health services many people come to those emergency departments with conditions that may well be appropriately treated by a general practitioner, but because the general practitioners may not have an after-hours service or may not bulk bill, they will come to the emergency department. Sometimes people are not entirely sure about whether they should come. Particularly parents with young children might not be entirely sure whether at 2 o'clock in the morning they should bundle the child in the back of the car and go to an emergency department, or whether with some advice they might be able to provide some appropriate care themselves.

So in January of this year a contract was signed with McKesson Asia Pacific Pty Ltd to establish the program known as Nurse on Call. When people call the number, nurses will not diagnose; rather, they will give advice to the caller about their condition and direct them to the appropriate level of health care. Just to be really clear, this is not a replacement for 000, and it is certainly not a replacement for general practitioners. It is a general adjunct to the health system. It is a highly risk-averse computerised system that people can have great confidence in, and I think it will make a big difference.

Finally, the commonwealth has indicated that some time in the future, when it makes a decision to do so, it would like to support a national program. So we are certainly well ahead and will be wanting to contribute to something national should it eventuate.

The CHAIR — In your answer — I might have missed it earlier on — did you give us the cost of Nurse on Call?

Ms PIKE — Yes, Nurse on Call is $9 million.

Mr RICH-PHILLIPS — May I follow up on the minister's answer about the Nurse on Call program?

The CHAIR — Sorry, we have two supplementaries — $9 million over forward estimates or — —

Ms PIKE — There is the amount of money that the government has allocated, but the actual cost is commercial in confidence, so we cannot give you the actual cost because it is a private contract that has been signed between the government and McKesson. Dr Brook may add some additional information there. I will ask Dr Brook to clarify that.

The CHAIR — If it is commercial in confidence — we have had quite a while on this and there are two supplementaries: Mr Rich-Phillips has one and Ms Romanes has one.

Mr RICH-PHILLIPS — Just on the issue of the national program, I understand that was supposed to start in July. How is your program going to fit in with the national program? What arrangements or plans are in place to integrate?

Ms PIKE — I might just give you a little bit of history of this. The commonwealth and the states have had conversations about a national call centre for years and years. This has been on the agenda of the health ministers' conference ever since I have been health minister, and it was on the agenda prior to that.

The health minister at the commonwealth level, Tony Abbott, was not able to secure funding for the national health call centre in the previous commonwealth budget — not this one, but the one before. They had said that they would like to establish a national call centre, but no substantial work has been undertaken to actually lead us to believe that it will be up and running in the near future. Quite frankly Victoria could not afford to wait. We made a commitment. We were initially prepared to wait for the commonwealth because obviously we would have liked to have been part of a national system, but they were just so tardy and still remain very tardy, and we believe it is an essential and important service for the Victorian community. So we are up and running.

The CHAIR — Thank you. Can we conclude this answer now?

Ms PIKE — I just need to finish this point, Chair, and that is that we have a capacity to fully integrate into a national system and we have been very willing to do so when the architecture of that system has been developed, but we are still waiting.

The CHAIR — Thank you. Keep your supplementary very brief, please, Ms Romanes.

Ms ROMANES — Minister, just for clarification, your slide says '$9 million for Nurse on Call and VPTAS'. Can you tell us what VPTAS is?

Ms PIKE — Yes, VPTAS is VICPTAS, which is the Victorian patient transport assistance scheme. It is a very successful program that provides reimbursement for patients who live beyond 100 kilometres from their nearest hospital to get reimbursement of their transport costs.

Mr FORWOOD — My question again goes to the transparency of the department. In September last year in question on notice 5313 I asked:

(1) What was the total amount of expenditure by government agencies (including the hospitals) on the launch and promotion of the Austin and Mercy hospital complex.

(2) What was the funding contribution from each relevant department (including the hospitals).

The response you gave me was to refer me to the *Your Hospitals* report, January to June 2005. As a result, the President reinstated the question, particularly part 2 which asked:

(2) What was the funding contribution from each relevant department (including the hospitals).

After some efforts on my behalf by Minister Gavin Jennings, yesterday the reply was received. It said, 'I refer you to the *Your Hospitals* report January to July 2005'. Today you have told us that the whole amount was paid by the Austin after a grant was given. My first question is, why did you not answer that question on any of the numerous occasions you have been asked to do so? Secondly, what was the amount of the grant?

Ms PIKE — I indicated in my previous response that the government reported on the overall expenditure on the public information and health promotion work that was done by the Austin Hospital over a three-month period around its opening through the *Your Hospitals* report, which is available very broadly throughout the community and on the web site. I can certainly tell you that the expenditure from the Department of Human Services was $32 000 directly, that we provided a $215 000 grant to the Austin Hospital to assist it in that three-month program that I might say touched the lives of about 20 000 people in the community. In fact, I think you enjoyed the day, Bill.

Mr FORWOOD — I was there.

Ms PIKE — In fact, it represents about 0.12 per cent of the total cost of the redevelopment. People were able to have their blood pressures checked, their mobility exercise checked, get their blood sugar tested, have BMI tests, sign up for organ donation, view ambulance services, join up with Kidney Health Australia, the Asthma Foundation, the Metropolitan Ambulance Service, the Cancer Council, Diabetes Australia, the Red Cross, the Heart Foundation, St John Ambulance, Glaucoma Australia, Arthritis and Osteoporosis Victoria, the Australian Breastfeeding Association and the Royal Victorian Institute for the Blind.

Mr FORWOOD — She's just filibustering.

Ms PIKE — These were all programs that were there. The total cost was, as you know, published — $458 000. I do not have details of contributions from all of the departments but we can look into asking them about their contributions if the committee would like that.

Mr FORWOOD — But, Minister, my question is — —

Mr MERLINO — The question was answered, Bill.

Mr FORWOOD — Hang on. My question is — —

Mr MERLINO — It was answered.

Mr FORWOOD — Thank you for that answer. My question is: why did you not tell us that information when we asked for it first in September and second when we followed up again in February? Why do we have to draw things out like this? Why do you not just give us the information we asked for?

Ms PIKE — I think we were asked what was the commitment initially from the Department of Human Services. We gave that answer quite clearly.

Mr FORWOOD — No. That is just not true.

Ms PIKE — And we publicly reported to the community the $458 000 for a three-month period of health promotion and the opportunity for 20 000 Victorians to come and see their brand new hospital — the one that was going to be privatised — their brand new hospital, the biggest health precinct in the Southern Hemisphere. What a wonderful story that was.

Mr MERLINO — On page 86 of budget paper 3, if you look at the quantity target, it indicates that ambulance services will be carrying an extra 15 100 emergency patients next financial year. What are the government's plans to expand and upgrade ambulance services and maintain the response times?

Ms PIKE — Thank you very much. We know that our ambulance services are busier and busier. Their case load is up 36 per cent. They have been able to maintain appropriate response times because of the extra resources that the government has provided to the ambulance service. For example, there are more than 95 000 more code 1 cases now than there were when we came to government — about 350 000 code 1 cases a year. It has been growing and growing. Both the Metropolitan Ambulance Service and Rural Ambulance Victoria have shared in the growth. Despite that significant increase in case load, the Metropolitan Ambulance Service will maintain response performance of 15 minutes for emergency code 1 cases at the 90th percentile. That means that when people are in urgent need, an ambulance will be there very, very quickly. That is for MAS. Rural Ambulance Victoria's response time has also been under pressure with the service experiencing growth in demand, but I do expect that the response time for 2005–06 will be maintained.

As I said, we have provided additional capacity and we know that has to be progressively introduced. Just to give a bit of an indication of that, we have upgraded 43 ambulance stations across Victoria, including 35 in rural areas. That includes stations that now have two-officer crewing and stations that are now operating 24 hours. In the metropolitan area, Clayton, Bundoora, Coolaroo, Bentleigh, Brighton, Reservoir, Hampton Park, Vermont South-Burwood East and Broadmeadows are part of the upgrades. The new ambulance stations are at Dromana, Deer Park, Rowville, South Melbourne, Brimbank, Hartwell, Kew, Langwarrin, Carnegie, Hoppers Crossing, Beaconsfield, Diamond Creek and Craigieburn, and the rural stations are at Torquay, Lorne, Bright, Romsey and Ballan. A very, very impressive list.

We recognise that we have to continue to do more work. In this regard we have committed a further $5.2 million in recurrent funding to establish five new ambulance services in the Vermont South-Burwood East area, Mordialloc, Parkdale, Ocean Grove, Barwon Heads, Melton and Sunbury areas. As I said, that was in the past. All of these new resources have commenced operating and the full effect will be realised in 2006–07. As I said, we are continuing to expand that. In the May budget a further $1.87 million recurrent and capital of $1.7 million has been allocated. Cranbourne North will see a new ambulance crew. The Pakenham ambulance station will move to 24-hour crewing and there will be a 24-hour ambulance station at Ballarat, in the Sebastopol area.

Mr CLARK — Could I refer to the capital works funding being provided to various projects that have been announced recently? I refer in particular to the Box Hill Hospital and the Caulfield General Medical Centre. In both instances funding has only been committed for the first part of much larger redevelopments. In the case of the Box Hill Hospital the Premier is reported as saying, 'We will commit to the full redevelopment of the hospital'. I ask: in both of these instances is the government truly committed to the entirety of the project or just to the first stage? If it is truly committed, why has the full amount of the funding not been included in the budget, and when will the full amount of funding be provided for the entire projects?

Ms PIKE — Thank you for reminding the committee and others of the absolutely substantial investment that the government has made in the health capital area over the last seven years.

Mr CLARK — You have not made it yet.

Ms GREEN — Come on!

Ms PIKE — I think really the graph you saw in my presentation tells the whole story. When you look at — —

Mr CLARK — If you could come back to the question that would be appreciated.

Ms PIKE — It needs to be set in a context, and the context is — —

Mr FORWOOD — No it does not; just answer the question.

Ms PIKE — There was very little capital provided for the public hospital system prior to 1999 by the previous government.

Mr CLARK — Box Hill was planned for 2002 and abandoned then, so you do not want to start arguing about history.

Mr SOMYUREK — Let the minister answer the question.

Mr FORWOOD — She is not!

Ms PIKE — In fact the reason — —

Mr SOMYUREK — Don't start complaining 30 seconds into the answer.

The CHAIR — Just calm down. Can we all just let the minister respond in relation to capital works, the entirety of the project and the full amount and when it will be allocated.

Ms PIKE — In fact I think really, given that the plan was to privatise both public aged care and a number of public hospitals, it is not surprising that there was so little investment. The whole system was left to run down. Of course we are now in this budget providing $1.26 billion, building on the $2.4 million that was the accumulated capital spend over the last few years to really give us a massive capital program. As part of that we have committed $38.2 million for the first stage of redevelopment of the Box Hill Hospital for critical infrastructure works. Of course for the first time we will see an expansion of the actual site for Box Hill Hospital, with the movement of both the administration — —

Mr CLARK — Yes, I am familiar with that.

Ms PIKE — I am pleased that the local member is familiar, but many others might not be familiar. The expansion will take the new building across the road. What that also does is clear the pathway for a substantial longer term development. Certainly the government has made a number of commitments in that regard. We have provided $2 million previously in planning money for that redevelopment.

Mr CLARK — But are you fully committed to the whole project?

Ms PIKE — We have provided the $38.2 million for stage 1. We are working very closely with Eastern Health about future redevelopment, and what we have said very clearly and what the Premier has said is that the government is committed to future redevelopment of the whole hospital, but there is a lot more planning work that needs to be undertaken. We need to identify the size and scope and staging of that redevelopment — —

Mr CLARK — You have already got a full set of plans. And how can you commit to it if you have not done the work for it properly?

Ms PIKE — This government takes its responsibility to develop capital projects prudently and wisely. We want to make sure that the plan we have in the future — —

Mr CLARK — So why is the money not in the budget?

Ms PIKE — I think it is important to point to the record here — $850 million has now come in to the budget process — —

Mr CLARK — You are not prepared to commit to delivering it; that is the problem.

Ms PIKE — The $850 million has come into the budget process for the Royal Children's Hospital. That announcement was made previously and committed. We stand on our record — —

Mr CLARK — So you are saying you do not have enough money to do it; is that the problem?

Ms PIKE — We stand on our record. Our record in terms of delivering capital projects is very, very impressive.

Mr FORWOOD — Because you say so!

Ms PIKE — The capital spend for our health portfolio is over $3 billion, and the health projects have been delivered on time and on budget. They have made a huge contribution to — —

Mr CLARK — So when will the remaining funds be provided for these multistage projects?

Ms PIKE — I have already answered that.

Mr CLARK — No, you have not.

Mr SOMYUREK — Yes, the question was — —

The CHAIR — Mr Somyurek — —

Ms PIKE — You asked another question; let me talk about — —

Mr CLARK — You haven't answered it again.

Ms PIKE — It was Caulfield General Medical Centre that you referred to. Of course, this budget does again provide some funding to begin the process of upgrading services at Caulfield Medical Centre — —

Mr FORWOOD — Yes — when is the rest coming in?

Ms PIKE — I am, I must say, rather bemused at the sort of mock annoyance by members of the committee from the Liberal Party who of course were responsible for letting these services run down and down and down and down — —

Mr FORWOOD — Oh, here we go.

Mr CLARK — You abandoned the redevelopment in 2002 of Box Hill Hospital; it was four years behind schedule.

Ms PIKE — Under their watch, they committed absolutely no — —

Mr FORWOOD — It has nothing to do with it. You have been in government for seven years; it has absolutely nothing to do with the estimates process.

Ms PIKE — Under their watch, they committed absolutely nothing to either maintaining facilities — —

Mr FORWOOD — Why don't you answer the question?

Mr CLARK — The last redevelopment at Box Hill Hospital was in 1998, and prior to that 1994.

Ms PIKE — Or redeveloping them, so this government has put additional resources into stage 1 of both of these projects. Our record stands: we will not only deliver stage 1 but will continue to update and improve facilities — —

Mr FORWOOD — When you fund them.

Mr CLARK — When are you going to provide the funding for them?

Ms PIKE — And those funds will be available in the future.

Mr FORWOOD — That gets back to my original question. When we ask a question are you going to tell us the truth or not?

The CHAIR — Could we move to Mr Somyurek's question.

Mr SOMYUREK — Thank you, Chair. Minister, I would like us to now visit the topic of medical technology. I refer you to budget paper 3, page 303. One of the biggest challenges in maintaining a world-class health system is keeping up with the advances in medical technology. This requires a major investment, obviously, on a regular basis. I have two parts to my question. How much is this government investing in medical equipment for hospitals, and can you tell the committee about how this investment impacts on the treatments available to patients and the outcomes of those treatments?

Ms PIKE — As I said in my presentation, the development of new medical technology is happening at a great pace. Of course it is our desire that the citizens of Victoria have access to the highest quality equipment so that they can have access to existing and new and emerging treatments. We have been working very hard to keep pace with these developments and to replace and upgrade medical equipment and infrastructure within our hospitals. When you combine medical equipment and infrastructure, then it is around $500 million since 1999. This budget saw an increase of $56.9 million to replace, upgrade and expand medical equipment; to provide equipment for ICU services; to expand radiotherapy; and to provide ambulance equipment; as well as $20 million for essential infrastructure within the hospital system.

This funding not only provides for big-ticket items like CT scanners and MRIs but also for a whole range of smaller equipment that is required and needed by hospitals. Things like fully adjustable electric beds and lifting equipment — all of those things are really important because not only do they assist in patient care but of course they help staff with things like back injury et cetera.

We have also funded a whole range of cardiac catheter laboratories. Not only does that make the treatment for the patient more effective, but it means that we have expanded the amount of day procedure. We have also given hospitals the capacity to store digital images. This equipment coincides with the whole development of digital imaging throughout our hospitals. Being able to store those digital images, rather than the old-fashioned films, which often get lost or have to be cared for by patients, and store them within the hospital system has been a new kind of development. Overall, we have not only — —

The CHAIR — Minister, we are over 4 minutes, so can you finish up, please?

Ms PIKE — Yes, we have not only provided funding for equipment, but we have also developed a medical equipment asset management framework within the Department of Human Services. So that now we have a very, very detailed and comprehensive overview of equipment within the hospitals, its usage, its life span, and a very robust decision-making framework for replacement of equipment. So that it is not done on an ad hoc basis, but we know exactly what needs to happen when, and we have a process that we are working within.

The CHAIR — Thank you very much.

Mr RICH-PHILLIPS — Minister, I would like to ask you about public dental services. Page 364 of budget paper 3 shows this government's performance since 1999–2000 up to 2004–05. It shows that for general restorative care from 1999–2000 the average waiting time has gone from 17 months to a peak of 30 months, which was a 41 per cent increase in waiting times, before dropping back slightly to 28, and for non-priority denture treatment it has gone from 24 months to 34 months, which was an increase of about 70 per cent, before dropping back slightly to 28 months waiting time. Given the budget on page 94 of the appropriation is only an increase of less than 4 per cent, how do you plan to reduce those waiting times which have blown out so much under your administration?

Ms PIKE — Thank you very much for the question. Under our government nearly 48 000 more dental patients every year are being treated in community dental clinics than there were under the previous Liberal-National government, so 48 000 more people are in the system every year. That is a 41 per cent increase on

the total of 165 000 low-income Victorians. So there are a lot more people in the system, a lot more people are getting access to services.

Mr RICH-PHILLIPS — Are waiting a lot longer.

Ms PIKE — And our government has significantly increased public dental funding by record amounts, and of course we have done that consistently over our time in government, and we have done that because, of course, the commonwealth government abandoned the public dental program in 1997 and the previous government did nothing to attempt to make up the shortfall that that particular program or that that particular withdrawal created. In fact, if you look at the statistics, the withdrawal of the commonwealth from the program did send waiting lists into free fall, really.

Mr RICH-PHILLIPS — But of course these figures in your budget papers relate to the period well after the commonwealth withdrawal.

Ms PIKE — What we have been doing, of course, is substantially reinvesting in that program, and the results of the $97.2 million investment in 2004–05 can be seen in the waiting times. The waiting times are falling. In March 2005 waiting times for general care were 30 months — they are now an average of 26 months — and for denture care, 29 months, and as of March 2006, 24 months. So I absolutely recognise that those waiting times are still too long. But our investment is starting to pay dividends, and people are waiting for shorter periods of time. I will remind the committee, however, that people with urgent needs continue to receive priority care and are always assessed within 24 hours, and people requiring urgent dentures receive those within three months. So we are seeing a lot more people, we have invested a lot more money, and we are bringing those waiting times down. We knowledge there is more work to be done, but I think the investment of this government in an area that is a shared responsibility — and I might just make a comment about that. I often hear from the opposition that — —

Mr FORWOOD — No, you are the person appearing; we are not

The CHAIR — We are over the 4 minutes, Minister.

Mr FORWOOD — Thank you very much.

Ms PIKE —This is not a commonwealth responsibility, and yet it very clearly does identify dental services in the constitution as an area — of the Australian constitution — as an area of commonwealth responsibility.

Mr FORWOOD — There you go!

The CHAIR — Thank you, Minister.

Ms PIKE — So it is most disappointing that they have not taken up their responsibility.

The CHAIR — Okay, Minister.

Mr FORWOOD — Which clause?

Ms PIKE —Section 55(23A).

Ms GREEN —You should know that, Bill.

Ms PIKE — You should know it off by heart, Bill.

Ms GREEN — Thank you, Minister. My question pertains to the application of information technology in the acute health services area. I was wondering if you could tell the committee how the HealthSMART initiative is progressing, and what benefits do you expect to flow to patients and the effectiveness of health services more generally?

Ms PIKE — Thank you. HealthSMART is Victoria's whole-of-government health ICT strategy. It is a $323.5 million four-year project, and it is being provided through a special ERC allocation and from funding within the Department of Human Services itself and co-contributions from the health services. We know that this is a program that is very significant in the Victorian public health sector. It is certainly one that is of great interest to

health care professionals and consumers. But we also know that it is a changed management process; that it will not happen overnight. It is a massive program, and it is taking time to implement. But it is the most far-reaching ICT program that has ever been undertaken, and it will fundamentally change the way health care is delivered in this state. For the first time Victorians will have an integrated, industry standard, whole range of health applications through shared services in the system. So it is going to be a very substantial change.

The components of the IT change are in three main areas. The first area is around financial management systems, and a number of our services are progressively coming online — some are already online — with common financial data collection and financial systems management. The second component is around patient records, common patient records. They are being progressively rolled out — building, of course, on what has been a very impressive system through the primary care partnerships program, around common client referral and records.

The third component is clinical management systems. Certainly from a health professional's perspective the clinical management systems will really enhance their quality of care, will reduce errors in prescribing and other facets of clinical management, and enable services to benchmark clinical management against each other and standardise care across the system in a much more appropriate way.

It is, as I said, a massive project. The Department of Human Services is handling it very, very well. The health services are all on board, and it is being rolled out progressively through the system. Just having the capacity to be able to transfer patient information — such as imaging, such as medication records — between different components of the health system, ultimately drawing in primary care GPs and others, is really where the future is. Victoria has very much led the way in this systems change for the whole country.

Mr FORWOOD — Just a quick one — —

The CHAIR — Thank you, Minister.

Ms GREEN — I have a supplementary as well.

The CHAIR — There is a supplementary from Mr Forwood and one from Ms Green and I also want to check something.

Mr FORWOOD — I wonder if you could provide the committee with a little chart that shows, of the $323 million that was originally allocated in 2002–03, from memory . You said that some came from ERC, some came from co-contributions and some came from the department. Could you give us a little chart that shows each of the sources?

Ms PIKE — I can tell you that now. I do not need a chart.

Mr FORWOOD — Okay; and that shows the budget over each of the four years.

Ms PIKE — The $162.5 million came from a special ERC allocation; $88 million from the DHS budget — this is all over four years — and $73 million from the agencies themselves.

Mr FORWOOD — And how is that $323 million allocated?

Ms PIKE — I will take that on notice.

Ms GREEN — I was just interested, at a national level, about the coordination with commonwealth and state health services.

Ms PIKE — Thank you very much. The Secretary of the Department of Human Services, Patricia Faulkner, in fact chairs the HealthConnect project for the whole of Australia. She would be in a good position to talk about where that work is up to and Victoria's contribution to that work.

Ms FAULKNER — Very briefly, the states and territories and the commonwealth government have cooperated to establish something called the National E-Health Transition Authority. It is a company limited by shares. The purpose of that is to work together towards eventually having an electronic health record. All states and territories are contributing their efforts in developing standards so that all systems will speak to each other eventually. The Council of Australian Governments has recently considered this matter and invested extra money

to the tune of $132 million in this organisation. The main cooperation is not to determine that everyone has to have exactly the same systems, but all the standards for interoperability will be determined cooperatively between the states and territories.

The CHAIR — You might like to take this question on notice, Minister. It regards patient records and confidentiality thereof. What systems are in place so that a patient can check who has accessed their records? I would like that information. If you have it now, good; otherwise, you can take it on notice.

Ms PIKE — We do have a lot of work that has happened in this area.

The CHAIR — So if I were a patient in Victoria and I wanted to know who had accessed my patient records, how would I go about doing it?

Ms FAULKNER — At the moment, we do not have one patient record, so it would be a matter of going to each of the practitioners that you dealt with and saying, 'What have you got on me?'. There is no way of connecting them up at the moment.

Ms FAULKNER — We are aiming to have a national system. There is legislation at every state and territory and federally that needs to be harmonised in order to get that sort of answer. But at the moment it is in progress — it is being done under the auspices of the Australian health Ministers council, and it is being done in conjunction with the work of NEHTA that I discussed earlier.

Mr FORWOOD — Minister, on page 14 of the transcript of last year's hearings, in relation to the Austin hospital, you said 'The whole event, as are most of our events, was managed by the Department of Human Services' . Later on, the head of your department said, 'The thing we are very proud of was that the Department of Human Services managed the whole event. We did not have to go to an external contractor to manage the whole event'. Could you advise the committee who received the event management fee of $12 000?

Ms PIKE — Thank you very much. The Department of Human Services in fact did work closely with the Austin on what was a very successful three-month period of community information. I think you have been provided with a breakdown of the expenditure of the funding for that particular period. You might like to draw my attention to the line you are referring to in the document that you already have.

Mr FORWOOD — It is about halfway down the second page. It says, 'Event management — Management fee, $12 000'. Given that both you and your head of department said that there was not an external contract managing it, I wondered which was right.

Ms PIKE — The Department of Human Services in fact managed the overall event.

Mr FORWOOD — Yes, the whole event — that is what you said.

Ms PIKE — And it subcontracted certain components of the day. My departmental officers did not actually wake up at four in the morning and cook the danishes and the sausages.

Mr FORWOOD — No, that was done by the event staff — the set-up crew, the traffic marshals and the service staff.

Ms PIKE — A number of different organisations were obviously subcontracted to provide certain aspects of the services. They did not get up in the morning and stitch the tent up; they actually hired it from an organisation. So when I say they managed the event — —

Mr FORWOOD — The whole event was managed.

Ms PIKE — We were very clear that we did not hire an external event manager for the overall event, but we subcontracted those particular matters.

Mr FORWOOD — I would like to know who got the $12 000. If you could take that on notice or tell me, I would appreciate it. You have just been caught in another lie.

Ms GREEN — Just behave yourself, you big baby.

The CHAIR — We are moving now to the topic of capital projects, Minister. Could you please advise the committee of the progress being made on the major capital projects, how the budget will proceed from here and how it will add to the government's record of rebuilding and expanding infrastructure in the health sector?

Ms PIKE — Thank you very much. As we know, in this budget the government has committed $1.26 billion of new funding and investment in new and replacement healthcare facilities. Of course, that builds on the $2.48 billion that has already been committed by the government, since its first term, into asset investment in the sector. So that takes health and community services asset approvals to $3.74 billion. That is compared to less than $1 billion under the previous government — that is, in the seven years to 1999, less than $1 billion dollars; since 1999 — in 6½ or 6⅔ years — $3.74 billion. On a per annum basis, this more than triples the level of asset investment compared to the previous government. It is a very substantial redevelopment building program. When you have a look at the map that I put up previously, you can see that many areas, many towns, many cities and many suburban areas have seen a rebuilding of brand-new facilities or a redevelopment of their existing facilities. As one component of that, I just remind the committee of the work that has happened in aged care, where nearly all of the state-owned aged care facilities have had some kind of reinvestment in their facilities to meet the 2008 standards of the commonwealth.

In this particular budget, not only do we have the funding for the $850 million project of the Royal Children's Hospital, which of course will be a state-of-the-art new facility for the children of Victoria and Australia, but $56.3 million to double the size of the Royal Melbourne Hospital's emergency department. The Royal Melbourne is actually Australia's busiest hospital. We are going to be doubling the size of the emergency department there. We have spoken about Box Hill hospital. We are also providing capital funding in this budget for Rochester hospital and for a range of other facilities. The full list, of course, I have made available to you before.

The CHAIR — That was helpful.

Ms PIKE — There is the Casey residential aged care facility, the Kingston Centre and Grovedale aged care facility. When you think about that, the Grace McKellar Centre has been nearly completely rebuilt under this government. There is the Caulfield General Medical Centre. Warracknabeal in the rural northwest — and I was very happy to be up there the other day — is developing or rebuilding a brand-new nursing home there.

The Alfred hospital's intensive care unit is to be rebuilt. North Richmond community health centre, something that has been serving refugees and new arrivals into our community for years and years — in fact 50 years — in little old buildings now has a brand new purpose-built community centre. Also the Austin Biomedical Alliance, stage 1 at the repatriation hospital; Monashlink, stage 1 of what will eventually be a three-stage redevelopment of Monash community health services; Ambermere, which is a mental health facility in Shepparton; and Brunswick human services precinct. Let us remind everyone that the Department of Human Services bought the site from the Department of Education in about 1999. We have now completely redeveloped that site with Milparinka Disability Services with a new home for the foundation for the survivors of torture. We are now completing that site with the Bouverie mental health facilities. So some things start to finish and there is a brand-new health precinct for those people in our community. I could go on and talk further if you want, Chair.

The CHAIR — Thank you. We will move to Mr Clark.

Mr CLARK — Perhaps we could put slide 3 back on the screen. I want to refer you to that and also to page 83 of budget paper 3, which has performance measures about admitted services. Slide 3 shows an expectation of 1.2917 million patients being admitted to Victorian public hospitals in 2006–07. If you look at page 83 of budget paper 3, the line for separations, you see the target for 2006–07 is 1.248 million, which is a 37 000 increase on the expected outcome for 2005–06 of 1.211, which is consistent with the figure given in the budget overview document of 37 000 extra patients in 2006–07.

I also want to refer you to the WIES quantity line in budget paper 3 which talks about an increase in the number of WIES from 880 000 to 892 000. My question is twofold: can you reconcile your slide with the separations number in budget paper 3 of 37 000 in the overview; secondly, given the separations increase is around 3 per cent and the WIES increase is about 1.36 per cent, what is the reason for the difference in percentage increase, and does that imply that the patient treatments are being reweighted or skewed towards the less complex procedures, which is why the WIES increase is less than the separations increase?

Ms PIKE — There are a lot of questions in your question. The issue of the different numbers in separation arises because I think you are quoting from the overall metropolitan — —

Mr CLARK — So add in rural — —

Ms PIKE — Just the acute health, and you have not added in the smaller rural health. So that is — —

Mr CLARK — Okay. So if you add those you get the 1291.7.

Ms PIKE — That is right. That deals with that question.

Mr CLARK — That clears that part. Now on the WIES versus separations?

Ms PIKE — The reason there — and I think I described it in my presentation — is that over a period of time there has been a transformation of the delivery of services in hospitals, and a shift from multi-day separations to same-day separations, and a huge growth in same-day separations. Therefore, that is reflected in the changes to WIES. So, for example, if you look in the cardiac area, in the past a person with a heart problem was in hospital for two or three weeks for major bypass surgery, et cetera. Now in a cardiac cath. lab it is often a same-day service. So we are treating more patients and we are treating them more efficiently. Lance Wallace might like to add something to that.

Mr WALLACE — I do not think there is really a lot more to add. It really is that the health system is becoming more productive. We are getting the same health outcomes but treating people, as the minister said, in an ambulatory way. We are still getting the same health outcome but at a lower overall cost. The WIES system is a cost-weighting system, so those procedures have a lower cost weight, so we are treating more patients.

Mr CLARK — So technology improvements mean you can do day procedures rather than inpatient — the WIES weighting reduces — —

Mr WALLACE — That is correct.

Ms PIKE — I can add more to that if you want.

Ms ROMANES — Minister, I would like to ask a question relating to the medical work force. Page 85 of the budget paper sets out the output expenditure for the acute training and development area. I would like you to tell the committee more about what the government is doing to support the medical work force in Victoria and the ways you are addressing areas of current or projected shortage. As well, is Victoria's participation in the COAG reform process achieving a better level and share of commonwealth investment in work force development for Victoria?

Ms PIKE — Thank you very much. This year's budget does indeed build on what has been a very comprehensive program over the last few years to support a sustainable medical and allied health work force in Victoria. Some of the programs that are currently being funded include, of course, training and development grants to hospitals, advanced specialist training posts in rural areas, procedural general practice initiatives — that is, actually giving people the opportunity to upskill so they can become GP-anaesthetists or GP-obstetricians, et cetera. There is pre-vocational training for junior doctors for postgraduate years 1 and 2, junior medical work force training initiatives, continuing professional development for GPs, extended skills for GP program, overseas trained doctor recruitment programs, the rural medical family network program and a number of other smaller programs.

So there are all of those programs plus a whole range of programs for the allied health work force and the nursing work force. There have been a lot of projects, but the reality is that the commonwealth government provides the funding for the allocation of university places for doctors, nurses, physiotherapists, podiatrists and a whole range of other health professional groupings. We have been working hard to try to boost the number of places that are available for Victorian students so they can go on and train in these very, very important professions.

We had a shortfall of 240 medical undergraduate training places, and the government worked very hard with the universities to lobby the federal government. We provided capital funding, which is now in this year's budget, of up to $30 million for new teaching facilities. We were very pleased that 160 places were allocated to Victoria by the commonwealth, and that has now enabled Deakin University and Monash, at its Gippsland campus in Churchill, to expand. The capital funding that is provided by this government in the budget will help those places to

go ahead. Of course we have also provided the funding in this budget so that the clinical placements for those expanded places will be able to be fulfilled within our hospitals. So not only have we worked hard to get those additional places, and we will continue to lobby the federal government for more places in dentistry, medicine, nursing and allied health areas, but that builds on a pretty comprehensive program.

You asked about the Productivity Commission.

The CHAIR — If you could keep that quite succinct, please.

Ms PIKE — Certainly. The Victorian government has been a leading voice in submissions to the Productivity Commission. Its work is still continuing. Agenda items will come to the health ministers' conference and to COAG, and we are very much a partner and supporter of that whole work.

Mr RICH-PHILLIPS — I would like to ask you about the rural ambulance communications upgrade. In budget paper 3 last year you had an allocation of $6.8 million, $4.8 million in the 2005–06 year and a further $2 million in 2006–07. The description provided was:

> Rural Ambulance Victoria communications infrastructure upgrade: stage three.
>
> This initiative will implement a computer aided dispatch system, complete the upgrade of Rural Ambulance Victoria's radio communications infrastructure, and implement a mobile messaging and automatic vehicle location system.

That was on page 291. My first question is: can you outline to the committee the status of that upgrade? Secondly, this year's budget paper 3 at page 301 allocates a further $2.8 million for the 2006–07 year, so roughly an additional 50 per cent for what is described as:

> Rural Ambulance Victoria communications upgrade
>
> Funding is provided to complete the transition to the state mobile radio network and to install an interim computer aided dispatch system.

If we paid $6.8 million last year for a computer aided dispatch system, why are we paying a further $2.8 million this year for an interim computer aided dispatch system?

Ms PIKE — The development of a computer aided dispatch system has of course been the objective of the government and we have been investing over a number of years to make that a reality. In fact the investment including this year's allocation will be $14.6 million. We have to undertake a lot of replacement of existing telecommunications facilities and support before we can even have the framework or architecture in place on which to add a computer aided dispatch system. For example, we have had to replace mobile radios; we have had to refurbish two operations centres; we have had to replace voice logging equipment; we have had to conduct system testing; and we have had to prepare for the introduction of RAVNET. We have had to prepare the groundwork for access to Telstra's SMR network, and then the computer aided dispatch system goes on top of that. It has been a progressive implementation of all the processes and equipment needed, then actually making sure that we have got the framework in place to be able to add the computer aided dispatch system to all of that architecture which we have had to completely rebuild.

Mr RICH-PHILLIPS — Can I just follow up? Firstly, when will the CAD system be operational? Secondly, this year's $2.8 million is referred to as being for an interim CAD system. Are you telling us that that is actually extra money for the program you outlined last year? You said it is a total of $14.6 million. Is it an interim system, as the budget papers describe it, or is it merely additional funding for the system you are already putting in place?

Ms PIKE — In the long term work is progressing towards a fully integrated rural computer aided dispatch system with all the emergency services components of police, fire et cetera being part of all that. Work is under way for all of that major reform.

In the meantime we were not going to wait for that whole-of-government system to be in place, and therefore we have made provision for a fully operational CAD system to be in place for RAV. So when we say 'interim', it is not incomplete or not adequate; it is a stand-alone CAD system that is fully appropriate for RAV, but ultimately in the much longer term we would like to see RAV in a full rural communications system. Dr Brook might be able to give us more information about that, including time lines.

Dr BROOK — I am not sure I can give you the time lines for the full rollout of the SIPSaC system into the future. That is something that is managed of course by an entirely separate department under BEST, but the computer aided dispatch system that is planned to be put in place next year is a system which is already fully functional in Western Australia. The St John Ambulance service in Western Australia, which manages ambulance services in that state, has a computer aided dispatch system. It is a straightforward system; it can be simply integrated into the RAV system virtually immediately, and its training requirements are not such that it will take a long time to do. It is going to happen next year.

The CHAIR — Thank you very much. We will take a break at this point.

Hearing suspended.

Mr MERLINO — Minister, I refer you to budget paper 2, page 117, and also to your presentation at the start of the hearing, particularly the government's statement about the importance of ill health prevention and early intervention with its Healthy and Active Victoria initiative. Will you inform the committee of how this initiative builds on the government's previous initiatives in this area, particularly the whole-of-government aspects?

Ms PIKE — We are, of course, committed to promoting good health and wellbeing for all Victorians. We want to provide a whole range of strategies to achieve those outcomes, so there are programs that will encourage people to take better control of their own health, creating supportive environments to address factors like chronic diseases such as diabetes and cardiovascular disease. In this budget we have allocated $23.2 million a year, $87 million over four years, to support and extend the health care reforms that were proposed by the Australian Better Health initiative.

This is a whole-of-government approach and is something that we are really committed to. In fact the Premier, in presenting the national reform initiative to the Council of Australian Governments process, teased out the whole area of health and wellbeing as one that is profoundly connected to productivity and growth for us as a nation. We know ill health costs our community, both for individuals and families, a lot of resources, but overall as a society the loss of economic activity in sickness et cetera is quite substantial. We also know that preventable illness, as I have outlined before, costs the health system a lot of resources.

This has been recognised nationally, so we are doing our part. That $57.5 million for Go for Your Life activities will build on the very successful Go for Your Life campaign and a number of other programs that are already under way so that we can achieve attitudinal change, develop community awareness and provide a lot of programs in community-based settings to create the environment that will better enable healthy lifestyle choices.

The first phase of Go for Your Life, referred to as Healthy and Active Victoria, was that $21 million investment that was put in place in 2002. Now, this is a further addition to all of those strategies. We are bringing together the departments of Human Services, Victorian Communities, Education and Training, Sustainability and Environment, and Premier and Cabinet, and as Minister for Health I am the lead minister for all of these initiatives.

The funding initiatives are in four areas: Go for Your Life, getting messages across; Go for Your Life, for people of all ages, is about encouraging people to make healthy choices; Go for Your Life, creating environments, is to facilitate the increased level of activity; and Go for Your Life, making sure it actually works, is about learning from what we are doing, strengthening coordination, monitoring and research. I will highlight one particular component because I am sure people will be very interested in this.

The CHAIR — Keep it extremely brief, Minister.

Ms PIKE — Yes, I will keep it extremely brief. We have a lot of money in here for promoting walking and cycling. They are two particular interests of mine, and we will be providing money for the Healthy People program, the gym program and a big boost to walking and cycling trails and extending bicycle infrastructure.

Mr MERLINO — Just a quick supplementary question. In terms of what we are doing, is there evidence internationally to show that this makes a difference, and is this where we have got our learning from with these types of programs?

Ms PIKE — Certainly the international evidence does suggest if we do not do anything the current rise in obesity will result in an epidemic of diabetes and other chronic diseases. Standing still in this area is just not an

option. I identified 70 per cent of the burden of disease from issues that have a lifestyle component, and that will rise to 80 per cent within the next 10 years if we do not do anything. It is also recognised that this is a very complex area that involves a range of factors and is not just about public education but is about broader public policy in planning and education, and that is why we have a whole-of-government approach which is multifaceted, because that is what the international experience shows us.

Mr FORWOOD — Minister, the Office of Health Information Systems has six managers on its third line under Fiona Wilson and they include Anthony Bibby, Louise Sabra and Norma Frederickson. Will you tell the committee whether Louise Sabra, Norma Frederickson and Anthony Bibby are full-time employees of the department?

Ms PIKE — I will have to ask the department to answer that question and maybe take it on notice.

Ms FAULKNER — I might have to take it on notice, I do not know what you are trying to get at. Do you mean full, or part-time, or contractor, or on-going employee?

Mr FORWOOD — Yes, that is what I am interested in. Louise's company is called 4 Health — —

Ms FAULKNER — And so she would be a contractor.

Mr FORWOOD — She is a contractor — —

Ms FAULKNER — I would assume so. I will check the facts but in the IT space it is very common to have contractors.

Mr FORWOOD — I will be interested in which ones are contractors and which ones are employees. Her contract was for five months at $99 000. My understanding is that she has been there for quite some time so I presume this is a rolling-over contract of $99 000 for every five months, and of course being $99 000 it falls below the $100 000 where you have to make it public. Is that right?

Mr WALLACE — It is correct that $99 000 is the disclosure limit. That is true.

Mr FORWOOD — Well, I guess — —

Mr WALLACE — Probably I should just mention that sometimes there are short-term — I will check on this — engagements because it is a critical phase of the project as well. We will check to see if — —

Mr FORWOOD — I would be interested if you could check because they have been shown on your own organisation chart and in your own list of employees as managing these particular, and one would — —

Ms FAULKNER — Yes, that is not uncommon.

Mr FORWOOD — Sorry?

Ms PIKE — In this particular area as the secretary said, people come and do specific pieces of work, sometimes on a short-term contract, the IT area is a very sophisticated area with a high level of technical skill involved; similarly, we employ contractors from time to time in capital development projects. I mean, it is a $11.7 billion department with a huge range of responsibilities and the work flow is not always consistent over a long period of time, and we often need some short-term assistance and support for particular facets and components of a range of projects that we are involved in, so I am not entirely sure what your point is.

The CHAIR — So let us just be clear on what the secretary has taken on notice.

Ms FAULKNER — I thought I was taking on notice to find out whether they were contractors or ongoing employees.

Mr FORWOOD — That would be good, and if they are contractors I would like to know when the contract started and how many times they have been rolled over. You will recall of course that last year Norman Frederickson's company Arbiter was listed as having a two-year contract of $850 000 and the reason that was given it was for so much was because Anthony Bibby was working for her, and then you told the committee I think

that Anthony was no longer part of that contract, he was being paid from a different bucket, so it would be useful if we could sort out who is under which contract and how much the contracts are for?

The CHAIR — What I want to be clear on is were you talking about one person or three?

Mr FORWOOD — No — I think we should look at all of them and find out which ones are — —

The CHAIR — Let us be clear about your purpose.

Mr MERLINO — Let us not go fishing, Bill. Have you got a specific question or not?

Mr FORWOOD — Yes, I have got a specific question.

The CHAIR — All I am asking is for clarification. We are talking about three people, okay?

Mr FORWOOD — Norman Frederickson, Louise Sabra and Anthony Bibby.

The CHAIR — That is very clear, thank you.

Ms PIKE — We will provide the information that we are required to provide.

The CHAIR — Thank you very much. We now move to Mr Somyurek.

Mr SOMYUREK — Thank you, Chair. Minister, I would like to get on to the topic of mental health. Former Premier Jeff Kennett, who is widely acknowledged to have been doing some very good work in the area of mental health, last year, I seem to recall, made some positive statements about the state government's mental health initiatives. How does the new investment in mental health services as reflected in the budget on page 296 of budget paper 3 and the *A Fairer Victoria* statement build on what was announced last year? Also, has Victoria been able to match the commonwealth announcements in this area as part of the COAG health reform process?

Ms PIKE — Thank you very much, in fact the chair of beyondblue, the national depression initiative, the Honourable Jeff Kennett, did say 'Victoria has always led the country in addressing the issues of depression and mental illness in Australia and this is a welcome addition of funds', and those comments were made last year when the government added to its already substantial investment in mental health by a range of initiatives — $180 million over four years. That investment has provided a significant boost and has begun the roll-out of the mental health strategy.

That mental health strategy had some very key components. It is not just about putting more money into the system, it is about spending it wisely and strategically to address gaps in the system and make sure that we get more appropriate and seamless services for people with a mental illness. So we need to expand and continue to expand the core capacity of the specialist services, particularly in areas where there are shortages, and the reality is that public psychiatry is often under pressure and not enough has been done in many ways to move psychiatry from the private system into the public system. We are talking with the commonwealth about how it might assist in that regard.

Managing demand pressures through early intervention and prevention, particularly in conduct order and early psychosis and through special initiatives — step-up and step-down facilities — to really help people who may have an episode that means they eventually will go into an acute bed, actually manage change in medication or change in circumstances, and also to give people an extra level of support after they are in the acute system; and of course, building capacity of the mental health work force and achieving better integration between the commonwealth-funded and the state-funded services.

The $170 million this year in the budget builds on that. That is in *A Fairer Victoria* too and again we will see further expansion of the mental health services as well as some funding towards the capital projects that will assist in the provision of accommodation and support for people with a mental illness.

You asked about working within the COAG system. The Premier has in fact written to the Prime Minister and indicated that over the period of the forward estimates that we will in fact be able to match the commonwealth's contribution. I expect that in time we will be able to go further. We start from a very high base. If you compare our expenditure to New South Wales for example, prior to their last budget Victoria was in fact spending almost the

same amount as New South Wales on an annual basis with a population of 1 million less so we have a good story to tell. As Jeff Kennett has said, we are recognised as national leaders in mental health but of course it is a very challenging and difficult area and we need to continue to invest and invest strategically, but also to do it in partnership with the commonwealth who fund part of the primary health aspect of all of that work.

Mr CLARK — Minister, could you tell the committee, either now or on notice, what data does the department maintain regarding late-term abortions? What does this data show about the number and incidence of late-term abortions in Victoria; what policies and procedures does the department have in place to ensure that the law and applicable medical standards are complied with in relation to these appalling procedures, both by public hospitals and by private providers?

Ms PIKE — The department receives statistics on late-term abortions from the consultative committee for obstetric and paediatric morbidity and mortality. Dr James King is the chair of that committee and provides an annual report on terminations and other obstetric and paediatric issues. It is true that there has been an increase in the number of late-term abortions in Victoria. A large component of that increase has been the provision of surgical late-term abortion procedures by a private clinician, and last year I indicated that we would introduce some additional provisions to the licence of that and other clinics that provide the service of late-term abortions, requiring that they also provide appropriate levels of counselling and support to people seeking late-term abortions.

Sorry, was there another component of your question?

Mr CLARK — Generally what policies and procedures does your department follow to ensure that the law and applicable medical standards are complied with in relation to these procedures?

Ms PIKE — In fact the department has a responsibility for licensing private hospitals and clinics that provide day procedure centres et cetera, and departmental officers ensure that the appropriate levels of safety are upheld — quality, safety et cetera — and that is all part of the licensing process. If people are doing things that are illegal, then that is a matter for the police.

Mr CLARK — In relation to the counselling standards that you referred to, will they be ensuring that counselling is provided by a person or organisation that is independent of the person conducting the late-term abortions? How will that be enforced?

Ms PIKE — At the moment we are developing licensing provisions that will include that provision. We have made it clear that we believe that that should be independent from the clinician who performs the termination; there should be an independent process for counselling and support, and that that should be made available to the person seeking the termination.

Ms GREEN — Minister, budget paper 3 on page 296 lists an output initiative 'pandemic flu preparedness' of $1.9 million. Could you outline for the committee what the government has done to prepare Victoria in the event of an influenza pandemic?

Ms PIKE — The government has certainly kept abreast of the spread of avian influenza in countries in both Asia and Europe, and we have taken a number of steps to ensure that the effects of a pandemic on the Victorian community will be minimised should such an unfortunate event ever eventuate.

I would have to say that the science in this area is very complex and there are a range of schools of thought. There are the 'maybe it will never happen' school of thought and the 'yes, we think it probably is certain to happen' school of thought, but of course our responsibility is to develop the plans, processes and procedures that absolutely minimise risk to the Victorian community.

We have developed the Victorian influenza pandemic plan which was completed in December 2005. That was developed in close consultation with the health industry and infectious diseases experts, and I would have to say is also part of a national process of collaboration in this area. Victoria is very well connected into all of the national systems.

We have invested over $6.6 million into hospital mechanical works, increasing the number of negative pressure rooms and isolation capacities. That investment will help hospitals to contain suspected cases because that is what

the whole agenda is about — that if there is an outbreak, it is all about containment so that we can limit the spread of infection to the broader community and also to protect health care workers.

We are also providing funding for hospitals to cope with surge and a big demand for services expected during a pandemic. We also have stocks of protective equipment and anti-viral stocks. Those stocks are being increased to assist health care workers and frontline staff in the event of an influenza pandemic.

We are also very privileged here in Victoria to have VIDRL — that is, the Victorian Infectious Diseases Reference Laboratory. That has been upgraded to increase its diagnostic capacity.

We are also working with general practitioners and community health providers so that we can establish specialist fever clinics to assist in the management of patients.

The other dimension is a whole-of-government communications strategy because it is really important that the public know what is happening and that effective and coordinated messages are provided to the whole community. Dr Brook has responsibility for this area through the public health branch of the department and may be able to add a little bit more.

Dr BROOK — Minister, I am not sure I need to add more to that very comprehensive answer, but I am happy to answer any supplementary questions.

The CHAIR — That was a very full answer, Minister; thank you very much.

Mr RICH-PHILLIPS — I would like to ask you, Minister, about immunisation. Page 97 of budget paper 3 lists the qualitative target for immunisation at two years of age, 90 per cent; at school entry age, 87 per cent; and pre-adolescent year 7, 81 per cent. Can you inform the committee, please, why the targets are set at that level — as low as that is — and why you are not aiming for higher levels of immunisation, particularly the adolescent level where it is only 80 per cent or 81 per cent, and also why they fall between those three age stages?

Ms PIKE — I might ask Dr Brook to give us some more information on immunisation. There has been a very important partnership between the state and federal government, and I believe Victoria complies with its obligations.

Dr BROOK — Thank you, Minister. It is an indeed a joint program between the state and the commonwealth and is substantially funded through the public health outcome and funding agreements and the Australian immunisation agreement. We provide immunisation in this state, both through a very successful partnership arrangement with local government, which is distinct from most other states, and through general practitioners. All children are registered on the Australian childhood immunisation register. The target is set at 90 per cent because that is generally regarded as about as good as can reasonably be expected in a population where people do make choices, although our current immunisation rates for children — sorry, I do not have the figures.

The CHAIR — Ninety-three per cent.

Dr BROOK — Our anticipation is that we will reach that level this year. We have historically gone with 90 per cent because that is the level that is generally required of us. The issue of adolescent immunisation is a different one. It is notoriously difficult to gain access to adolescents without the same organised program. They are not quite the same captive audience as young children and they do not respond to, and indeed we do not organise, programs through local government.

The CHAIR — Perhaps they know what is coming.

Dr BROOK — So the reason that the target is lower is because we try very hard to obtain catch-up programs for them, and we do in fact run school-based programs, but our target is 80 per cent because we cannot practically achieve more than that.

Mr RICH-PHILLIPS — Is there any information campaign for parents of that target group about the importance of immunisation? It is a big drop-off, from 90 per cent at the two-year-old level down to 80 per cent at early teens level.

Dr BROOK — There are a number of education programs, but I will take on notice to provide you with the detail of them. They run through schools, they run through general practice. There are no current mass media or social marketing campaigns.

The CHAIR — Are you suggesting that, Mr Rich-Phillips?

Mr RICH-PHILLIPS — No. Are you able to try to break it down also between the immunisation that is provided through GPs and through local government, so we can get an understanding of where children are actually taken — whether it is more towards GPs or mass programs through local government and schools?

Dr BROOK — By site or by total?

Mr RICH-PHILLIPS — In total — aggregate figures.

Dr BROOK — Yes, I can definitely provide that, but I do not have it with me today. I believe it is pretty much even, but I will provide that information to you.

The CHAIR — We will take that as on notice, and Ms Romanes has an extra question.

Ms ROMANES — Dr Brook, are there commitments from every local government in the state to participate in the immunisation program or is it something that is at the discretion of individual local governments?

Dr BROOK — There are certainly different levels of effort, but to the best of my knowledge all local governments participate in the immunisation arrangement. Again, with 78 of them there are some occasions when one or two do not participate in some programs as much as others. I would be happy, sorry, to take that on notice again.

The CHAIR — I would like to take you, minister, to the same page, page 97, of budget paper 3, where there is reference to food safety hotlines. I presume peanut allergies would fall under that category. How big a problem is peanut allergies? How are the hotline and other services expected to respond with the funding allocation to them?

Ms PIKE — In fact nut allergies have become more common in the past generation. The reasons why this is the case and the reasons why allergies are generally growing is not entirely clear, but we just know that it is a reality of modern-day life. Peanut allergies are part of a broader issue of food allergies which are surprisingly common in children. They affect about 1 in 100 children and 1 in 30 infants. This is greatest in the first five years of life and then some children will outgrow these food allergies. However, only 10 to 20 per cent of people allergic to nuts outgrow their allergies. Those people with that allergy can have life-threatening symptoms for a long time. Food allergies of course can affect many parts of the body. Sometimes it is just a rash, but sometimes it can be a very severe reaction known as anaphylactic reaction. That is the most severe one and if untreated can cause death.

The CHAIR — Have you got any figures on that?

Ms PIKE — Sure. Studies in Australian children have shown that 1 in 166 children have had at least one episode of anaphylaxis in the past, and 1 in 6 episodes of anaphylaxis have occurred at school or child-care where kids spend a lot of their time. Peanuts, nuts and shellfish are the most common foods to cause life-threatening anaphylaxis. So it is a very urgent issue.

What people require when they have an anaphylactic reaction is an urgent injection of adrenalin, and that can be life saving. So any patient who has a history of anaphylactic shock to any food must wear an ID bracelet and carry an adrenalin-loaded injection, if you like, which is called an EpiPen. They must know how to use it and when to use it. It is in that area that we have been doing a lot of additional work. The Royal Children's Hospital has established a triage service to assess the need to attend a specialist allergy clinic. We have certainly put some additional funding in.

The CHAIR — How much?

Ms PIKE — We have announced additional funding of $395 000 a year, rising to $430 000 a year for the Royal Children's Hospital's allergy and immunology service. That is new money embedded in the base, and of course it is there recurrently. We are also working with community groups. We now have a public health group

within the Department of Human Services which is specifically focused on allergy. It is working with the Office of Children, the education department and interested members of the community. Members may have noticed that John Ilhan and his wife Patricia, who have Ilhan Foundation, have in fact provided $1 million of funding for research into this very important area to the Murdoch Children's Research Institute.

Mr FORWOOD — I want to touch again on HealthSMART and in particular the iSOFT component of it. You would be aware, as I am sure all interested people are, that the iSOFT share price since September last year has dropped from over £4 to 86 pence. So the company was once valued at over £1 billion; it is now valued at less than £200. We signed a contract in December last year for iSOFT to provide a patient medical records system. There has been considerable concern about the letting of that contract and the probity issues that came with it. But let us first start by asking: are you confident that this part of the project is on track and will meet its deadlines? Could you please advise the committee whether or not the contract envisages the implementation of the Lorenzo scheme or not?

Ms PIKE — You are absolutely correct that we are contracted with iSOFT for its IBM product only. It provides a broader range of other programs which we have not purchased. The contract requires iSOFT to make new developments and release its product within the scope of functionality that we have purchased and is available to DHS for no additional licence or support costs. This will include the new Lorenzo product that it is developing currently, but only within the bounds of the patient and client management functionality. Lorenzo will include clinical functionality but that aspect of it has not been purchased by us. The contract also requires iSOFT to contribute to the implementation of these new releases and products. It is likely that the Lorenzo product will become available towards the end of the rollout of IBM so that the HealthSMART project would look to implement this into any agencies that have not yet implemented the IBM product. I will ask Patricia Faulkner to give some further details. It is true that the share price has been volatile, but by and large we think this relates to activities in the UK.

Mr FORWOOD — Yes, the fact that they cannot make Lorenzo work.

Ms PIKE — I will ask Patricia Faulkner now.

Ms FAULKNER — All the minister has said is absolutely correct. We have a contract with the Australian operation, which is a fully owned subsidiary of iSOFT PLC. We have obviously been aware that iSOFT is struggling with its partners Accenture and another partner in the UK to deliver the products of iSOFT. They are beyond the range of what we have contracted for. Out of the 325 million HealthSMART program, this contract is worth approximately $22.5 million. But we have been aware, so the contract includes a range of financial and performance guarantees to protect the DHS. They include bank guarantees, an escrow agreement, a generous liability cap, liquidated damages, service level agreements, staged payments, so that we believe we have fully protected DHS against any failure that might occur in the company, including having the right to any intellectual property in the escrow agreement. I think the market for health IT products is extraordinarily thin: it is international and very stretched. We have a particular need to have a client management system in place. The market was tested; it was an absolutely transparent process. There are probity reports and there are all sorts of reports.

Everybody who did not get the job has challenged this decision, and that happens. It is a vigorous and a very competitive market. I think it would be one of the most transparent processes you could ask for. In fact, knowing that the company is being challenged financially in the UK, we have taken steps to protect our own interests. I think that I have also seen the biggest range of hoax materials circulated in relation to this. People keep putting up pieces of paper that look as though they are press releases or articles from newspapers, and circulating them widely in the system. When you test the veracity of most of what is in those, it is incorrect. You might be surprised to know that in fact even an article that appeared very recently in one of the newspapers was not correct. I know most people — —

Mr FORWOOD — Page 23 of the *Australian*?

Ms FAULKNER — That is correct.

Mr FORWOOD — Where is Mr Lutton quoted from?

Ms FAULKNER — He was misquoted. We have been in touch with him. He was quoted as saying that Lorenzo was not part of the HealthSMART contract. What he did say, according to himself, is that it is not rolled

out in the first part of the Victorian project, and that the Victorian project is not dependent on Lorenzo. So we have contracted, as Lorenzo becomes available, to build it into our systems, but we have a system in the meantime.

Mr FORWOOD — Is the build-in of Lorenzo part of the $22 million?

Ms FAULKNER — Yes, it is.

Mr FORWOOD — So, there is no additional cost?

Ms FAULKNER — There is no additional cost for that.

Ms ROMANES — Minister, how are the initiatives announced in this budget — and there is reference in budget paper 3, page 300 — in relation to cancer services continuing to improve the care of cancer sufferers, and how will the new Victorian Cancer Agency contribute to the fight against cancer?

Ms PIKE — We have now established three metropolitan and five regional integrated cancer services, which have been established to provide a cancer service system to Victorians which ensures that they actually have access to integrated high-quality cancer care across every geographic region in the state. Those integrated cancer services have been established with shared governance structures so that people can have multidisciplinary models of care, and they can actually map the range of services that are available in any given geographic region, assess them for quality across the system and make sure that we can identify any gaps. Funding of $9.1 million, additional funding, will be allocated now to the ICSs, the integrated cancer services, in 2006–07 to continue the development of this new service system model, which links hospital, community and primary care services.

Just to explain it: a person will be diagnosed with cancer, and wherever they live in the state they can be satisfied that they will get continuity of care, patient records moving through the system and good communication between the primary services — their local GP, the community health centre, local chemo services et cetera — and the higher order services that are offered as part of the tertiary system. That is what the integrated cancer service system has been all about.

The ministerial task force on cancer, headed by Dr Richard Smallwood, who was previously of course the commonwealth chief health officer, has developed patient management frameworks across 14 cancer types and 10 tumour streams, which are then a tool for consistent patient management in these most common areas of cancer. The ministerial task force has also developed with the government a vision to connect cancer research services, education and bioinformatics to improve cancer survival and make sure that we can maximise what we are doing. We have recently announced $15 million over two years to be allocated to the establishment of the new Victorian Cancer Agency. This is a really exciting initiative and one that is very warmly welcomed by all the medical research community because it really will bring together all the disparate activity of cancer research and treatment in the state into one focus, so we can really maximise our efforts and continue our place as the pre-eminent state in the country in cancer research and treatment.

Mr CLARK — My question relates to mental health. In the Treasurer's budget speech he referred to an additional $170 million being spent on mental health services. Budget paper 3 at page 296 has a mental health strategy funding line of about $80 million over four years. I understand the commonwealth government has recently committed $1.9 billion for the whole of Australia over the next few years, of which Victoria's share would probably be around $425 million on the basis that the states will match the commonwealth funding. Can I ask first of all, is all of the $170 million referred to by the Treasurer new money in this budget? Secondly, does Victoria intend to match the commonwealth's offer of additional funding, and if so, when will that additional funding be provided to match the commonwealth?

Ms PIKE — The $170 million is all new money, so that is the first point. The second point is that I want to just correct one comment that you made — that is, about the understanding from the commonwealth's perspective. The states and the commonwealth as part of the COAG agenda were in the process of developing a collaborative mental health package which would see funding and responsibility from the commonwealth and funding and responsibility from the states. The commonwealth came out ahead publicly with a package before that work had been completed, and the Prime Minister in his media statement made it very clear that there was no requirement for the states to match that funding. Nevertheless, since then it has added that component to its rhetoric, and certainly Victoria will be in the position over the next five years, when you add all of the money that

is in the forward estimates plus new growth funding plus capital expenditure plus resources in a range of areas — we will certainly be in the position to well and truly match that overall commitment.

Mr CLARK — Does that mean that money that is currently allocated to mental health in the forward estimates is sufficient to match the commonwealth funding or does it require additional commitments in subsequent budgets? If the latter, how much extra needs to be committed in subsequent budgets?

Ms PIKE — The money that is currently in the forward estimates plus the projected additional growth funding that has been consistent with our pattern of growth funding over the past few years will well and truly match the commonwealth's effort. In fact, I have now met twice with the federal parliamentary secretary for health, Christopher Pyne. I might add that I am the only health minister in the country who has met with the commonwealth to actually discuss the collaborative arrangements between the commonwealth and the states so that we can actually maximise our efforts with the commonwealth's efforts in a partnership and can really achieve the best results for people with a mental illness in our community. There is a lot of scope for joint effort in this regard. Victoria is absolutely nationally acclaimed and recognised as the state that has the most developed system of mental health service provision, but we are acutely aware that this is a very needy and growing group within our community. We have put a lot of effort in, but we have every intention of continuing that effort into the future.

Mr MERLINO — Minister, I refer you to the small rural services output at page 95 of budget paper 3. Can you inform the committee of what the government is doing to ensure long-term sustainability for rural health services?

Ms PIKE — Thank you very much. In fact, the government has provided additional funding to every single country hospital — every single hospital actually, but I will highlight country hospitals — every single year that we have been in government, and that is because maintaining viable services in rural and regional Victoria into the future is something that we are very committed to. We know that we have to strengthen and sustain those services to help them to respond to the geographic and the demographic changes that are part of the reality of our lives, and also the technological and work force challenges.

Aside from providing that additional resourcing — and this of course is continued in this budget — in November last year we released *Rural Directions for a Better State of Health*, which was a major policy statement about a strategic framework for sustaining a contemporary hospital system and accessible health system for people in rural Victoria. There were three major components to that rural directions document: firstly, a renewed and increased effort on promoting health and wellbeing — the early intervention and health promotion and disease prevention strategy; the means to foster a contemporary health system with new models of care for rural Victorians; and, of course, the process for sustaining and strengthening rural health services.

One of the things, of course, that we have made sure that we have done is provide more flexible funding for rural health services, so we have grown that funding and given them more funding, but we have given them more choice on how they spend those resources so that they can adapt to the changing needs of the community. Many rural health services have chosen to boost their primary health services in their community because they recognise that some of the higher order acute services, if you like, only need to be available to a very, very small number of people in their population group, but primary health services, allied health services et cetera, are required for a much broader group of the population, so they have been very responsive in using those additional resources, and we have provided them with a lot of support in the use of that money.

On top of that, of course, we have provided $550 million for new capital works, equipment and infrastructure across rural Victoria, and then this year an extra $93.7 million. There are many, many towns and places in country Victoria that have had a rebuilding of their aged care facilities, a rebuilding of their acute facilities. Just in this last budget, Rochester hospital, $21.7 million and Warracknabeal nursing home were recipients of extra funding. That work is progressively happening, and it is an impressive record.

Mr FORWOOD — The rural work force agency recently reported that support packages for GPs in Victoria were $3500, $12 000 in Tasmania, $16 500 in New South Wales, $28 000 in the Northern Territory, $34 000 in South Australia and $70 000 in Western Australia. Do you believe that $3500 in support is adequate?

The CHAIR — We are talking about small rural services.

Mr FORWOOD — Yes, rural hospitals. This is getting GPs into the country. Is that where you want them?

The CHAIR — I am just asking you to relate your question to the small rural services.

Mr FORWOOD — Small rural services.

The CHAIR — Minister, in relation to that question, can you contain it to small rural hospitals.

Mr FORWOOD — I would have thought that a GP was a small rural service.

Mr FORWOOD — New South Wales is $16 500.

Ms PIKE — First of all, it can I ask you what the document is you are quoting from, because I do not have it in front of me.

Mr FORWOOD — They are questions I have had prepared. What this says to me is, 'What is government doing to help the recruitment of rural GPs? Rural work force agency reports in its recent white paper' — which I do not have a copy of — 'that recruitment support packages total $3500 in Victoria compared adversely with $12 000 in Tasmania, $16 500 in — —

Ms PIKE — We have a range of programs — I outlined them before and I am very happy to go through them again for you — to attract and retain GPs, even though they are a commonwealth responsibility. The training and provision of GP provider numbers and GPs in the community are a commonwealth responsibility. However, in support of our rural communities we in fact have a whole range of programs to attract and retain GPs in country Victoria, including procedural GP initiatives, continuing professional development programs, the rural medical family network, the extended skills for GP initiative, the country education program, the community paediatric training program, the Royal Australian College of Physicians telemedicine program, the rural clinical skills program and the rural work force strategy to improve recruitment and protection of health professionals, including doctors, nurses, physiotherapists and other allied health workers. And, of course, we also have the training consortia model for basic physician training, which aims to link rural and outer metropolitan hospitals together.

We have a very comprehensive range of programs that goes far and beyond our obligations as a state government because we know how important the work force is in rural and regional Victoria. From time to time doctors groups may prepare some papers, but unless I see the source, then it is hard to give a rigorous analysis of that.

The CHAIR — That was very helpful.

Mr FORWOOD — You have never given a rigorous answer in your life!

Mr RICH-PHILLIPS — Minister, I would like to ask you about accredited drug services. Page 100 of budget paper 3, under the Drug Prevention and Control output, lists drug services accredited as 75 per cent targeted and 75 per cent expected outcome. Can you tell the committee why targeted accreditation is not increasing, why it is static at 75 per cent? Is the accreditation mechanism, say, an annual accreditation program that services need to qualify for every year, or is it something where additional services should be achieving accreditation each year? And if so, why is it static at 75 per cent? What is the difference between the accredited services and non-accredited services in terms of their role and the limitations on services they can provide to the community?

Ms PIKE — I need to take that one on notice, I think.

The CHAIR — Is that what you want to do?

Ms PIKE — I will take that on notice.

Mr RICH-PHILLIPS — Are you able to provide any information at this stage, even on the differences between the roles and functions of accredited and non-accredited services?

Ms PIKE — I think we will take that one on notice.

Mr SOMYUREK — Can we now talk about improving palliative care services? I refer you to page 83 of budget paper 3 under the output Admitted Services. Given the ageing population of the state and the country and

the increasing demand for specialist palliative care services, what is the government doing to ensure access to these services?

Ms PIKE — In fact, there are 36 community palliative care services and 239 designated palliative care beds in Victoria. It is an area of growing demand. I would have to say that, as I visit a lot of particularly country hospitals, the staff and the hospitals often have provided additional palliative care services or sought to introduce models of palliative care by designating special beds and facilities and providing family services and thing like that.

It is an area that is growing. Our statewide services also include specialist care and advice on paediatric palliative care, motor neurone disease and HIV/AIDS, so it is not just about older people coming to the end of their life; it is quite a comprehensive program. This year, on top of the $62 million we already spend, the government will provide an additional $4 million per annum to meet increasing demand for specialist palliative care services in hospitals and also in community-based services. We want to increase the access to specialist palliative care consultancy teams. They work with hospitals to not just have specialist services but to inculcate the whole culture of palliative care into the mainstream services, which is really important.

We are providing rural palliative care services with a rural medical purchasing fund, and we are building on nursing capacity and community palliative care to provide more home-based services. On top of that we are also providing a 24/7 specialist statewide consultancy backup service. With that and some other programs, we are really working hard to meet this growing area of need. We know that the percentage of people in Australia over 65 will increase by 791 per cent over the next 40 years, and therefore we do have an ageing population — for example, the incidence of cancer is increasing, and that represents about 80 per cent of all referrals to palliative care.

The other thing that is happening in palliative care is that there is a recognition that by far the majority of Victorians want to die at home and not in hospital if they do have a terminal illness. We want to increase our capacity to enable people to do that and to have the support around them with their family and friends. That is why community-based palliative care is a really important part of the growth of that whole section of our health system.

Mr FORWOOD — Minister, recently I received an email from Jacinda Stork, who said:

> I am a final-year medical student who resided in Heidelberg (and worked at the Austin) until I moved to Newcastle to study medicine. I have planned to return to Victoria once I completed my medical education. I wish to bring to your attention the fact that Victorian hospitals are amongst the lowest paying in the country. For instance, if I work in the hospital where I am currently posted —

that is the John Hunter Hospital in Newcastle —

> or anywhere else in New South Wales for that matter, the salary is around $47 000 per annum. In Victoria, this is $37 000 ...

Later she provided me with the comparable figures for each year out of medical school: first year, 37 to 46; second year, 39 to 54; third year, 42 to 59; fourth year, 45 to 67; and fifth year out from medical school, 47 to 73. On that basis, do you not believe we will be losing doctors interstate?

Ms PIKE — Thank you very much. People will be aware that the government and the doctors union, the AMA, are currently in negotiation as part of an enterprise bargaining round, and we are currently in the industrial relations commission in a conciliation process, so there is a lot of data that is out in the public arena. You would expect that AMA Victoria would be seeking the full ambit of its claims and making all sorts of comments regarding the future of doctors in Victoria. There is in fact absolutely no evidence that doctors are leaving Victoria's public health system for interstate opportunities. In fact it is quite the contrary.

Figures published in the annual reports of medical registration boards of Victoria, New South Wales and Queensland show that in the last 12 months more doctors from interstate have sought registration in Victoria than they have in any of those other states. We know that. There is no evidence of an acute shortage of doctors in our public hospital system, and in fact the number of doctors employed in Victoria has increased by 23 per cent since 2001. This is a much higher level of increase than reported by either New South Wales or Queensland Health in their annual reports for that period. That is because doctors consider issues much broader than just their remuneration when they consider where they will work. Victoria is the state that has increased its public hospital funding by 83 per cent since 1999. It is the state that is the centre of research and education in medicine; it is certainly a more attractive state for people to live, work and raise a family. Doctors consider a range of factors when they consider their working conditions. It is easy to bandy around figures about base level remuneration,

et cetera. What is most important is the overall package, and we have evidence that doctors here in this state do have a very attractive overall package.

We want to negotiate a fair and reasonable outcome with them, but as health minister I have the responsibility to utilise the resources of the state wisely. If I was to acquiesce to a 30 per cent ambit claim that the doctors now have on the table over the next two-year period — 30 per cent is what their ambit claim is — then of course that would significantly compromise the resources that we have available for other responsibilities that we have in the provision of health care.

Ms GREEN — I would like to return you to mental health. I refer to the output group on page 89 of budget paper 3. I wonder if you could tell the committee what the government is doing to improve mental health care for children and young people who are at risk of or experience various mental health problems?

Ms PIKE — Thank you very much. We do in fact recognise the impact that mental health disorders have on the lives of children, adolescents and young adults, and we are systemically developing more programs that are targeted at responding early, particularly in these age groups. In the last budget new initiatives included 2 new youth early psychosis teams and 2 further conduct disorder programs, 14 new positions expanding CAMHS, which is the Child and Adolescent Mental Health Service, Origin Youth Health, and additional positions to support the care of mothers with severe mental illness and their children. In fact we have mother and baby units at the Austin and at Werribee which provide those kinds of specialist services for very young and vulnerable women.

This budget builds on those initiatives, and on top of that also provides additional funding in the dual diagnosis area because we know that for many young people, mental health and drug and alcohol issues coincide. This is a very challenging and difficult area. The early treatment programs for young people experiencing first episode psychosis are being boosted. Conduct disorder programs, which will now include programs in Wodonga and the Royal Children's Hospital, are being boosted, and we are also funding some additional programs for those mothers with a severe mental illness with their children. I forgot to mention Southern Health and the Royal Children's Hospital which also have infant psychiatry programs.

Mr CLARK — I understand that the metropolitan ambulance drivers' enterprise bargaining agreement has either expired or is about to expire, and the metropolitan ambulance drivers have threatened a stop-work meeting or other industrial action if the issue cannot be resolved. Can you inform the committee what the current state of negotiations is, whether you expect to be able to negotiate a new bargaining agreement within the department's salary cap — that is, the allowance within the budget for wage increases — and have you met with or do you plan to meet with the ambulance drivers or their union to discuss the enterprise bargaining agreement?

Ms PIKE — Thank you, Mr Clark. We do not have any ambulance drivers here in Victoria. We have ambulance officers and paramedics, and the upskilling of our ambulance service has been a very significant priority for this government. We certainly consider that this is a professional grouping of ambulance officers and MICA paramedics and others and therefore we have remunerated them appropriately.

We have been through an MX arbitration process with the ambulance union, and paramedics and ambulance officers have received considerable additional resources remuneration through that process. It is fully funded. That was worked through the industrial relations commission in July of last year. It is fully funded in government, and we are now having some consultation with the union about implementation of that funding that has been allocated, but the terms of the MX arbitration were all agreed upon through the industrial relations commission, and we are just in an implementation phase at the moment.

Mr CLARK — How long does the current agreement last for?

Ms PIKE — Two years. We will get back to you if we are incorrect.

Mr WALLACE — It is not an agreement, it is an arbitration; and the arbitration was set by the arbitration commission. I think it is a two-year term, but I can check.

Ms PIKE — We will double check.

The CHAIR — In relation to refugee help, I refer to BP 3, page 93, and I would like you to outline to us how we in Victoria are going to ensure that refugees receive appropriate health care and any funding allocations directing peak performance indicators to that effect.

Ms PIKE — Provision of assistance to refugees has always been an issue that has been high on the agenda of this government. In fact Victoria has gone well and above its obligations in making sure that new arrivals, whether they be asylum seekers, people on temporary protection visas or refugees in other categories, receive access to services. We believe that is an obligation that we have morally, and we have instructed services to ensure that those health needs are taken care of and that we have the resources to include refugees in our overall health system.

The government will provide an addition $2.1 million over the next four years — that is on top of last year's investment — to continue the refugee health nurse initiative, which is a program that has registered nurses placed in community health centres in the eight areas with high refugee populations. These nurses work with families on health promotion, prevention programs, developing referral networks — making sure that those refugee families have access to the kinds of programs that are available for the mainstream community and identifying mainstream service providers like GPs and others who can provide services.

Those specialist nurses are now located in Preston, Kensington, Footscray, Dandenong, Broadmeadows, Shepparton, Warrnambool and St Albans. The department has also funded the general practice division of Victoria to coordinate work with GPs generally, to help with the assessment of refugees, identifying their health needs — so it is working with GPs so they have more capacity to assist refugees.

The very successful primary care partnership program has also been funded to strengthen service coordination for refugees. We are also collaborating with the Victorian Foundation for the Survivors of Torture and the western region health service, which are connecting those refugee health nurses so they can be educated and empowered to continue their work in the community.

Mr RICH-PHILLIPS — The Australian Institute of Health and Welfare in its Australian hospital stats publications reports that in June 2000 Victoria had 12 162 public hospital beds, both acute and psychiatric, and by June 2005 that had declined to 11 946 — a drop of 1.8 per cent — whereas nationally the total number of beds had increased by 4.1 per cent. Given the 83 per cent increase in hospital funding that you spoke of earlier, why has the total number of hospital beds declined under your government? How many public acute and public psychiatric beds are currently operational as at May this year; and, given that capital program you spoke about earlier, how many additional public beds will be added to the system over the next four years?

Ms PIKE — First of all, I will tackle the question of bed numbers; and that is that the bed numbers remain around 12 000 in the system, but on any one day beds are being utilised in a range of different ways within the system. The additional money that has been provided by the government — the 83 per cent over the last six and a half years — has seen a lot of additional capacity developed. New hospitals like Casey, et cetera, have come on stream, and they have provided additional beds.

The Australian Institute of Health and Welfare does collect data about available bed numbers, but there are many categories of beds and service provision in Victoria that are not included in that data. The Australian Institute of Health and Welfare itself said in its last report:

> The concept of an available bed is also becoming less important, for example, in the light of increasing same-day hospitalisations and the provision of hospital-in-the-home care.

So there has been a bipartisan consensus about growth and expansion in the health care system and how that is reflected. A former parliamentary secretary for health, Robert Doyle, himself said we should not count beds as a measure of hospital care, and that we should count the number of patients who have been treated and what they are treated for. So this has been a bipartisan position. The figure that really counts is that in 1999 there were around 990 000 people admitted into our public hospitals. This year there will be 1.3 million people admitted into our hospitals, and the services that will be provided for those people will be in a range of different kinds of beds. They will be acute beds, they will be subacute beds, they will be in same-day procedure centres, they will be in medi-hotels, they will be in hospital in the home.

The government is expanding the health system enormously, and what counts is the outcome that people have. It is the health outcome that people receive. People who focus only on beds — which, I might say, have been increasing under this government — fail to understand the nature of health care delivery in a contemporary health system. As the institute of health and welfare said, the concept of an available bed is becoming less important, and all contemporary health commentators and anybody who actually understands the health system understands that it is the quality of the outcome and the service that is provided that is the accurate measure of health care provision. People who just want to sit around and count beds as a measure of activity and health care fail to understand what the system is all about.

Mr RICH-PHILLIPS — You said in — —

The CHAIR — All right. I was trying to get two more questions in, but we might not.

Mr RICH-PHILLIPS — There were a couple of elements that were not answered. You said that under this government the number of beds have increased. The institute's figures on public acute and public psychiatric show declines. Can you tell the committee the other categories you said are not counted here, which categories have increased in bed numbers, and can you provide the committee with statistics as to the increase in those categories, please?

Ms PIKE — I think I have made it very clear that the government has been providing a very broad range of additional services for the community in a whole range of settings, and counting of those settings as beds et cetera reflects an old-fashioned view of the health system. What counts in real terms is the number of additional patients who are being treated and the quality of that treatment. I think that when you have a patient satisfaction rating of 95 per cent, when you have around 8 million episodes of care within our public health system, when you have a government that has invested and been able to keep waiting lists steady in the context of a — —

Mr CLARK — You mean up!

Ms PIKE — I will make a comment about waiting lists here and get this on the public record.

Mr CLARK — Thirteen thousand to 18 000 urgent — —

Ms PIKE — The waiting list for elective surgery, had it continued to mirror the growth in admissions, would currently be around 53 000.

Mr FORWOOD — Bad luck for the people, isn't it! They are not people, they are just numbers!

Ms PIKE — The waiting list for elective surgery has now remain steady, and that is because of the investment of this government and the contemporary health system that we are providing. We have been modernising the health system. We are providing more appropriate contexts for care for people, and we have been improving the quality of health care that is provided to the community.

Mr CLARK — The waiting lists are still rising.

Mr FORWOOD — So out of touch!

Mr RICH-PHILLIPS — The Chair wants to move on. Are you willing to give the committee the hard data to support your claim that there is an increased number of beds?

Ms PIKE — I am happy to provide to you the Australian Institute of Health and Welfare report — —

Mr RICH-PHILLIPS — I have just read that to you. It shows a decline.

Ms PIKE — I think I have indicated very clearly that we provide care in a whole range of settings — —

Mr FORWOOD — So it does not matter what we ask; you won't answer it.

Ms PIKE — The figure that counts is the provision of health care and the admissions to our public hospitals system, and that is all on the record.

Mr FORWOOD — We are back where we started. Will you tell the committee? No.

The CHAIR — There is to be a supplementary from Mr Clark, and then that will be it.

Mr CLARK — Minister, you say that you are containing waiting lists and people are getting treated more quickly. Have you seen the article in the *Geelong Advertiser* of Wednesday about Mr Graeme Turnley, who has been waiting 1162 days simply to get an appointment to see a urologist? A spokesperson for you is quoted as saying that Mr Turnley's plight was unacceptable and invited him to seek government help. Are you acting systematically to make sure that people like Mr Turnley do not have to wait 1162 days or are you simply responding on a case-by-case basis when people go to the media?

Ms PIKE — In fact in this last budget we provided an additional $30 million to do a whole range of things to improve access to outpatient services. Remember that 1.1 million Victorian people are seen in our outpatient clinics every year, but the demand for those services has been growing dramatically — —

Mr FORWOOD — Obviously Mr Turnley was not one of them.

Mr CLARK — Waiting 1162 days could not be considered acceptable.

Ms PIKE — Do you want me to continue or are you going to shout across me? Do you want me to continue?

Mr FORWOOD — You have not answered anything so far; why would you start now?

Ms PIKE — There has been, as I said, a very significant increase in activity within our outpatient services. The government has provided an additional $30 million in this last budget to introduce a whole range of modernisations and improvements into the running of our outpatient service system. We have also provided a lot of additional money to develop more capacity in that system.

The CHAIR — Thank you, Minister. That concludes budget estimates for the portfolio of health. I thank not only the minister but also departmental officers who were here as witnesses, but particularly appreciation is expressed to all those who have prepared extensively for today and will still be working on this once you get your follow-up questions after today's hearing.

Ms PIKE — Thank you.

The CHAIR — The Hansard transcript will be sent to you electronically this year, as I said earlier, and 48 hours after receipt of it we would appreciate a fax back of any variations that need to be noted. The committee now stands adjourned until 2 o'clock.

Ms PIKE — Thank you very much, Chair, and thank you to the committee for a very enjoyable 3 hours together.

Witnesses withdrew.