C O R R E C T E D T R A N S C R I P T

PUBLIC ACCOUNTS AND ESTIMATES COMMITTEE

Inquiry into budget estimates 2005–06

Melbourne — 11 May 2005

Members

Mr W. R. Baxter
Ms C. M. Campbell
Mr R. W. Clark
Mr B. Forwood
Ms D. L. Green
Mr J. Merlino
Mr G. K. Rich-Phillips
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Mr A. Somyurek

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Deputy Chair: Mr B. Forwood

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Witnesses

Ms B. Pike, Minister for Health;

Ms P. Faulkner, secretary;

Mr L. Wallace, executive director, financial and corporate services;

Mr S. Solomon, executive director, metropolitan health and aged care; and

Dr C. Brook, executive director, rural and regional health and aged care services, Department of Human Services.

The CHAIR — I declare open the Public Accounts and Estimates Committee hearing on the budget estimates of the health portfolio. I welcome the Honourable Bronwyn Pike, Minister for Health; Ms Patricia Faulkner, Secretary of the Department of Human Services; Mr Lance Wallace, executive director, financial and corporate services; Mr Shane Solomon, executive director, metropolitan health and aged care; and Dr Chris Brook, executive director, rural and regional health and aged care services of the Department of Human 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 proceedings. Only officers of the Public Accounts and Estimates Committee 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 also requested to observe the guidelines for filming or recording proceedings in the Legislative Council committee room. Any documentation required to be passed from our side to the minister will be done by PAEC staff.

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 taken today is being recorded. Witnesses will be provided with proof versions of the transcripts as soon as Hansard has concluded them. Before I call on the minister to give a brief presentation on the more complex financial and performance information, could I please ask those of you who have mobile phones, which is probably everyone of you, to please turn them off and put any pagers to silence. I hand over to you, Minister, for a maximum of 10 minutes on your overhead presentation and thank you for providing it to us beforehand.

Ms PIKE — Thank you, Chair, and thank you to members of the Public Accounts and Estimates Committee. In my presentation this afternoon I want to briefly outline the broader contextual issues, the challenges that are facing the health system and how we are responding to them. I am going to outline the major budget priorities for health in this year. Some of those priorities were of course articulated as part of the *A Fairer Victoria* package and others were announced as part of the broader budget.

Overheads shown.

Ms PIKE — The committee will be aware, because we have discussed this before, that health systems worldwide are facing continuing demand pressures. Those demands are the effect of population growth and particularly in Western countries the ageing of the population, the rising expectations of consumers and the rising costs and availability of new treatments. The more technology gives us solutions to health issues, the more people want those services — and they are very expensive. These pressures are not just one-off — they accumulate every single year. Each and every year we have to find extra capacity to treat more patients just to maintain our current access and quality standards, let alone improve them further. It means that the challenge and focus for us is how do we meet the demand pressures in the long term and particularly how do we work towards prevention and early intervention so we can stop health problems and challenges from escalating.

There are also some particular pressures that influence our performance in Victoria's public hospitals. The commonwealth continues to short-change us on hospital funding. You can see from the chart that the commonwealth's share of funding for public hospitals has been gradually diminishing. In the 2003–04 period the commonwealth's share was 41.9 per cent of what is supposed to be a fifty-fifty funding arrangement. On top of that Victoria also carries all of the capital funding load for our hospitals.

We continue to face difficulties in accessing commonwealth funding for residential aged care. We still have many frail aged dependent people in our hospitals. These are people who have been assessed as eligible through the aged care assessment process for a nursing home bed and yet because they are unable to find a residential aged care bed are still being cared for in our public hospitals. We have developed interim care programs to provide temporary care in a more homelike environment for these patients and you can see from the graph that that interim care has grown. We have been able to relieve some of the pressure in this area. There has been some improvement over time. At the same time hospitals are picking up more of the commonwealth's responsibilities for primary care. The decline in bulk-billing and the availability of after-hours general practitioners' services is driving demand in hospital emergency departments. As the bulk-billing rate continues to fall — we know it has fallen from 79 per cent in 1999 to around 66 per cent in 2003–04 — the number of primary care-type patients continues to rise. That is particularly noticeable in our outer metropolitan hospitals that are sharing the bulk of that.

We are responding to the challenges I have outlined — the broader contextual challenges, the specific issues we face in Victoria because of the policy obligations not being met by other jurisdictions — with a range of strategies. We believe that our hospital demand management strategies have already begun to have a significant impact on our hospital performance. One component of that strategy is the hospital admission risk program (HARP) that is working to reduce the unnecessary admissions of patients, particularly those with certain conditions such as chronic illnesses or conditions that are ongoing and do not require very acute or intensive medical services. Where we can support people within a community setting by integrated care strategies HARP has been able to reduce the number of avoidable admissions and there are good results there.

We are also treating more than 26 000 urgent elective patients each year; all of these within the target period of 30 days. In fact half of the category 1, the urgent elective patients in Victoria, are treated within seven days. That is a very good result for a huge number of patients. The elective surgery access service is also enabling us to target elective procedures, and a good example is the way a special program targeting cataract removal has enabled us to bring the average waiting time down from 58 days to 13 days over the last few years. This is because of a specific effort in a specific location around that particular procedure; and that is certainly our strategy for the future.

The CHAIR — Minister, we are about a third of the way through the slides in just over half of the allocated time, so the rest of your contribution may be succinct — I thought I would let you know.

Ms PIKE — Sure. We have been providing hospitals with additional funding and this graph shows the growth in funding. Hospital funding now stands at $5.84 billion in 2005–06. There has been a 70 per cent increase in funding to hospitals since 1999, and of course better facilities. This budget continues the huge growth in capital funding that has been provided by the Bracks government since 1999 — in 2005–06, $419 million of additional funding in the capital area.

This year there are three main budget priorities in this area. Firstly, supporting disadvantaged people, particularly people with mental health issues, through the A Fairer Victoria strategy; secondly, to continue the service delivery reform process by investing in hospitals in emergency care and elective surgery in investing in ambulance and cancer services, forensic drug treatment services and the health work force; and, thirdly, our significant asset program. The projected expenditure on health services now exceeds $8 billion. This represents a 9 per cent increase in health funding. Just to put it into perspective, that far outweighs any additional funding that has come through the Australian health care agreements (AHCA), and of course, as I said, there is $418 million on top of that for capital.

The Hospital Futures program continues our good work in the demand management strategy, and an additional $149 million is provided for growth funding. That is funding on top of wages growth, on top of the growth for non-wage items; this is growth to treat extra patients; it is new money. It will invest in demand growth and diversion, in better management of people with chronic diseases, in early intervention and in additional surgical capacity. On top of that, of course, is the money for additional elective surgery. We are particularly focusing on emergency care and a range of initiatives to improve the time to treatment within our emergency departments; some extra resources for ambulance services; a $30 million package of new money to shorten the time for treatment, particularly to reduce the number of patients who wait longer than the clinically recommended time for treatment; and to focus on some particular specialty. A $180 million package for mental health services is the largest growth in mental health funding for many years. We are investing in community and dental health as part of our commitment to really build and sustain our vital community health services, and of course dental health which saw a massive boost last year.

In conclusion, Chair, I have talked about additional drug services and health work force strategies, but we have broken down for you in those slides the expenditure for new and upgraded health facilities. Twenty-six health facilities have already been renovated or completely rebuilt: a brand new hospital has been built in Casey; completely redeveloped Austin and Mercy hospitals: new hospitals; and now the Royal Women's Hospital is under way and the Royal Children's Hospital project has been announced. That gives a very brief overview of probably the largest expenditure area and the most complex, interesting and challenging area in government.

The CHAIR — Thank you, Minister. These slides are now part of what we present to the Parliament in terms of evidence of our work, so they will be tabled. My first question goes to the federal budget which was handed down last night. I am very interested in your initial assessment of its impact on the Victorian health budget.

Ms PIKE — As I outlined in my presentation, the arrangements for funding of public hospitals between the commonwealth and the state are governed by the Australian health care agreements. Over the last few years we have seen a significant decline in the proportion of the contribution from the commonwealth government. The most recent Australian health care agreement negotiated between the states and the commonwealth saw a significant reduction in the rate of indexation provided by the commonwealth. The previous AHCA had a 28 per cent rate of indexation growth over the five-year life of the agreement. The most recent AHCA has around 17 per cent growth. In real terms that has meant a $350 million reduction in funding that was provided in the commonwealth's forward estimates for Victoria. I was very hopeful there would be some attempt in this most recent federal budget to address that shortfall, that change in indexation, but unfortunately there was no addressing of it. So Victoria, in its state budget last week, announced an increase in funding to hospitals of 9.1 per cent. The commonwealth's budget has an increase of 5 per cent and thus we have the disparity.

We also know that the threshold is now $500 for concession cardholders and $1000 for everyone else in the Medicare area. These initiatives were originally designed to make an impact on the level of bulk-billing and to take pressure off ordinary people. When they work effectively and appropriately we would hope they would take pressure off the emergency departments of public hospitals who, as I explained before, have been seeing an extraordinary growth in the number of primary-care type patients. So the change in that threshold, we anticipate, will put further pressure on our emergency departments, and that is an issue for us.

We also saw the scrapping of a $51 million retractable needle program. We are not sure what the commonwealth has in mind for replacing that program. Work force is an area that remains a major challenge for us, and we know that in nursing places, allied health places and places for doctor training — general practice and other surgical areas of training — Victoria is significantly lagging behind other states and we saw nothing in the federal budget to deal with that. It is important to acknowledge the initiatives in dementia care and certainly a package of initiatives and the identification of dementia as a national priority is welcomed; as is the additional funding for beyondblue — the depression initiative which of course Victoria supports — with the state providing the largest funding to beyondblue. They are some good initiatives but some major areas that really in the end do not go to the heart of addressing the inequity in funding between the commonwealth and the state under AHCA.

The CHAIR — Mr Forwood has a supplementary. You mentioned the previous AHCA was 28 per cent; this one was 17 per cent.

Ms PIKE — Actually a little less for Victoria, around 16.5 per cent.

Mr FORWOOD — Are both Victoria and the commonwealth abiding by the terms of the AHCA?

Ms PIKE — Victoria is abiding by all of the terms of Australian health care agreement.

Mr FORWOOD — Is the federal government?

Ms PIKE — Yes, the agreement was signed, but we made it very clear at the time that the indexation rate was well below the indexation rate of the previous agreement.

Mr FORWOOD — Minister, I refer you to a letter that David Watson, who is a local activist in Seymour, wrote on behalf of the Seymour hospital on 13 December 2004 and to the response on 15 December 2004 from Health Legal, a city-based law firm, which states:

> I have advised members of the board … that you have defamed them by making these allegations, and that they have a clear cause of action against you for defamation.

And it goes on to say:

> … the members of the board … have instructed me to inform you that if they do not receive a written apology for your letter and the allegations contained in it they will commence litigation against you seeking damages for defamation … apology must be in writing and … provided by Tuesday 21 December … It must include an undertaking by you that you will not engage or participate in … further attacks on reputation of the board of —

the Seymour district hospital —

> If you engage in any further attacks, legal action will be instituted without notice.

That is two days later, after he wrote his letter. This is the second time, the other case being Rochester, where the reaction of local hospitals to activists in their areas trying to protect their services have been threatened by law firms. The first question I have is: were you aware of it, do you condone it, will you ask people to stop doing it, what is your attitude towards people in the country in particular advocating on behalf of their hospitals?

Ms PIKE — More broadly, I think it is important to recognise the role of boards of management in the governing of their public hospitals. Boards of management in rural areas work on a voluntary basis. They are nominated by members of their local community to do that job on behalf of all of the members of that local community. They are appointed by the Minister for Health and have responsibility for the governance of that organisation. It is a difficult and challenging task, quite often because they have to have responsibility for often some quite complex areas but people do it to the best of their ability within the governance framework that has been legislated. From time to time they make decisions that are unpopular with people within their local community and I completely uphold the right of any member of a local community to give voice to their concern in public forums and in newspapers, and people do have the right to disagree with the decisions that are made by boards of governance. Disagreeing is one thing, but making public statements of personal vilification, threatening — —

Mr FORWOOD — Do you know what Mr Watson wrote?

The CHAIR — Just a moment.

Ms PIKE — No, I — —

Mr FORWOOD — Do you know what Mr Watson wrote?

The CHAIR — Just a moment!

Ms PIKE — Well, let — —

Mr FORWOOD — She is accusing Mr Watson of — —

Mr MERLINO — No, she is not, Bill!

Mr FORWOOD — Yes, she is.

The CHAIR — Mr Forwood!

Mr FORWOOD — [inaudible] did not make any personal vilification at all.

Mr MERLINO — The cameras are not here, Bill, you can calm down.

The CHAIR — Mr Forwood, the minister is making a general comment and made that quite clear at the commencement of her comments.

Ms PIKE — I am going to your general comments and I think if there is an occasion where members of the board are personally vilified and or they have their businesses threatened or their children are bullied at school, where they feel that in the course of their duty as a voluntary board of a public hospital, that these things are happening to them, then they may seek legal advice to protect their own personal reputations or protect their families or their businesses. I think it is easy for us to sit here in Melbourne and — —

Mr FORWOOD — Well, that is where the lawyers were!

Ms PIKE — And cast scorn on local people who are doing these jobs in a voluntary capacity, but it is another thing to be a person in a country town who has someone come into their shop and say, 'You have made a decision I do not like and I am going to close down your business and run you out of town.' Those kinds of comments have been made to members of a board of management in one of the country towns that you mentioned. They are not relevant to the particular letter that you read out, but they are certainly relevant in the case of Rochester.

Mr FORWOOD — Perhaps we could get on to this one, then?

Ms PIKE — In this particular instance I am not familiar with the details of that letter, I would be happy to ask Dr Brook if he has any further advice, but I am not familiar with the details of that particular letter. But in answer to your broad comments, which I think were really the substance of your question — do I uphold people's right to speak out? Yes, I do. But do I uphold people's rights to protect themselves and their families and their personal reputations and their jobs against intimidating and vilifying behaviour? Yes, I do.

Mr FORWOOD — Let me just read this paragraph from the lawyers — —

Ms PIKE — I — —

Mr FORWOOD — Let me just read this paragraph from the lawyer's letter — —

The CHAIR — The — —

Mr FORWOOD — Hang on — —

The CHAIR — The minister — —

Mr FORWOOD — Talking about Mr Watson's letter, he said:

> The letter states that there has been a significant degradation of the standard of care — —

The CHAIR — Excuse me!

Mr FORWOOD — Look, do you mind, I am asking a question. The letter states — —

The CHAIR — Just one moment, please. As Chair I organise who asks questions and the tone — —

Mr FORWOOD — I know you do not like people asking hard questions.

The CHAIR — — and the tone of how they ask. We have just been talking about abusive behaviour, and I want to make sure that there is respect shown in this hearing. The minister has said that Dr Brook may like to make comment on this particular case — —

Mr FORWOOD — I will give a bit more information — —

The CHAIR — Before we go to the particular case I would like clarification in relation to whether Dr Brook has a copy of the documentation to which you are referring. Could I first clarify that?

Dr BROOK — No, I have no personal knowledge of the letter or of the action of the board at all nor would necessarily that be the case. There may be members of the rural health services branch who have some knowledge of it. We are certainly not a party to matters between the Seymour hospital board and the Victorian hospitals industrial association legal branch.

The CHAIR — With that in mind, the minister directed the executive director of regional and rural health to have the opportunity to comment on this letter and he has said he has no knowledge of this particular item. If any further discussions are to occur, out of courtesy I think it is important that Dr Brook has a copy of the documentation to which you refer, Mr Forwood. If the secretary could please pass that to Dr Brook, I would be appreciative. Please refer Dr Brook to it.

Mr FORWOOD — Let us have a look at the second paragraph. This is to David Watson written by Health Legal in St Kilda Road on behalf of the board of the Seymour district hospital. The second paragraph says:

> The letter states that there has been a significant degradation of the standard of care provided by the —

Seymour district hospital —

> This degradation is due to the departure of six or seven medical professionals … These departures have in turn been caused by 'somebody or something at the hospital.

Do you regard, Minister, those accusations in the letter as personal vilification and therefore warranting the hospital board taking legal action to stop legitimate concerns in the community?

Ms PIKE — Bill, I am not going to comment on legal advice — —

Mr FORWOOD — That would be right

Ms PIKE — because I am not a lawyer.

Mr FORWOOD — You are the minister!

Ms PIKE — But these matters will be dealt with by the board with their own legal advice. As Dr Brook said, we are not party to that and I am not going to set up a kangaroo court in here to comment on legal advice that of course is often underpinned by a lot of additional documentation. It would not be appropriate.

Ms ROMANES — Minister, in budget paper 3, page 287, there is a table of assets initiatives laid out there over the period 2005–06 to 2007–08. That provides a lot of detail over those three years. Can you tell the committee more about the trends in capital investment under the Bracks government and outline whether the government is delivering projects on time and on budget?

Ms PIKE — As I indicated, this government has a huge program currently under way and ahead of it to continue to redevelop health and community service facilities in this state. This includes around 63 projects, each over $2 million in value, the largest most recent being the $376 million redevelopment of Austin Health and the Mercy hospital relocation to the Heidelberg campus.

There has been a significant increase in health infrastructure development and funding for that over the last six years. Health and community service asset approvals over the last six years during the Bracks government's time in office have totalled $2.3 billion and that compares with $951 million in the term of the previous government, so it is well over double — two and a half times as much redevelopment. That was really necessary because many of our health facilities had been run down. Some were slated for privatisation and that had been quite a deliberate strategy. On a per annum basis, as I said, this has more than doubled the level of asset investment compared to the previous government. There has been an average of $372 million of investment in assets every single year compared to $136 million under the previous government. The entire program has been approved with TEI now into the forward estimates in the budget.

The other feature of the asset investment program in the health area has been that we have brought in our projects on time and on budget. When you consider that it is large projects like the Casey Hospital development, on time and on budget — the first new public hospital in this state for 20 years — or the largest hospital development project, the Austin and Mercy development now creating the largest health precinct in Victoria, the department has been very successful in the way that it has delivered programs in the capital area. On top of that, this budget also now provides considerable additional funding, over $55 million of additional funding, in the mental health capital area which is very significant. Eastern Health particularly will see major redevelopment but also the redevelopment of Bunjil House at the Austin repatriation site — we are moving from the repat. adjacent to the Austin site.

We also have had redevelopments and additional developments in ambulance services, and this budget also provides extra capital in that area. In primary and community health we have also seen major redevelopment, and this budget provides additional resources for that. So up until this budget 26 new hospitals completely redeveloped, the Casey Hospital is new, the Austin Hospital redevelopment, the Royal Women's is under way — and now in this budget is a whole range of additional projects right across Victoria including the commencement of the redevelopment of the Royal Children's Hospital.

Mr CLARK — My question relates to hospital deficits. As you will be aware our major hospital networks have in many instances experienced deficits in recent years. At the end of last year according to a report of the Auditor-General, $106.7 million was provided at the end of the financial year in order to reduce those deficits. Can you give a guarantee that there will not be any major hospital networks in deficit at the end of this financial year? If additional funding is to be provided to hospitals to assist in preventing deficits, will that be provided well in advance this year rather than right at the end of the year? And do you expect it will be necessary this year for any hospitals or hospital networks to provide letters of comfort to the Auditor-General in relation to continuing government support in order to avoid qualification of their accounts?

Ms PIKE — Last year the budget contained a $1.6 billion boost to hospital funding. The major component, aside from growth, of that $1.6 billion was the result of a price review conducted by the Department of

Human Services, the Department of Treasury and Finance, and the Department of Premier and Cabinet. As a result of that price review hospitals right across the state were provided with a lump sum — a catch-up sum if you like — to recognise that for many years the non-wage cost index had not been adequate, and that that needed to be adjusted. So a one-off amount of funding of $95 million was provided into the base of hospital funding in recognition of that.

On top of that the price review identified that the non-wage cost area needed an adjustment and we made an adjustment so that the non-wage cost areas are indexed at 4.8 per cent per annum, and the 1.5 per cent productivity requirement, which had been a historical requirement for hospitals, was also taken away from the system. As a result of those actions the Department of Human Services has been working very closely with both rural and metropolitan hospitals to make those adjustments in their budgets, and through the statement of priorities we have worked with each hospital to determine their appropriate position for the end of this financial year. Some hospitals have been given a two-year period to catch up, if you like, to bring their programs into line with the efficiencies that are required to meet a balanced budget, but it is our objective that hospitals will bring in balanced budgets over that period, and, of course, the audited financial statements of all of the hospitals will be available via the Auditor-General around October. We will then be in a position to see the end of year financial position.

I have to say that we have given hospitals considerable additional funding. We have worked closely with them to develop a statement of priorities which gives clear targets and clear expectations of both their performance in terms of access of patients, but also in terms of their financial performance. We certainly believe that there will be significant improvement in their financial position as a result of these actions, but of course, we await the audited financial positions before we jump to any major conclusions.

Mr CLARK — You cannot rule out deficits. What about letters of comfort?

Ms PIKE — What I have said is that we have worked with the hospitals — just to clarify your side comment. We anticipate that hospitals will attain a balanced budget.

Mr CLARK — In this current year?

Ms PIKE — Yes. Some have been given a longer period of time because of adjustments that need to be made over that period. We believe that the resources that are there are adequate for the hospitals to meet their requirements to be financially sustainable.

Mr CLARK — Without letters of comfort?

Ms PIKE — Regarding letters of comfort, Mr Solomon can add something.

Mr SOLOMON — I think the Auditor-General has different views in different years and we will look forward to what he believes is necessary this year.

Ms GREEN — Minister, I refer you to budget paper 4, page 69, and the statement of cash flows particularly in relation to infrastructure investment. Earlier you made reference to the Austin Hospital redevelopment and Mercy Hospital for Women. As you know I was at the opening and I commend you, the secretary, the staff and everyone involved with the opening day: it was just fantastic! I want to hear a little bit more information about the significance of that newly opened hospital as a major project.

Ms PIKE — Thank you very much. In fact the secretary of the department has chaired a committee that has overseen that development for a number of years. It has been a very successful project and an example of good collaboration between the Department of Human Services and the Department of Infrastructure through major projects, the local board of management and the local community around the Austin and the Mercy hospitals and, for that matter, its board as well.

In August 2000 the government announced the redevelopment of Austin Health and the relocation of the Mercy Hospital for Women. It was a hospital that was due to be privatised under the previous government. This government made it very clear that it believed that it had a long-term future and a very vital role in the north and the east of Melbourne, as a public hospital. We had a priority to deliver high-quality, accessible health care and community services for the people in the north and the east, and we certainly had a priority to build good and

appropriate infrastructure to sustain that service delivery. So we have been able to bring those two objectives together in this project.

We have delivered the Austin Health and Mercy hospital project on time and on budget, contributing $353 million towards the project's total of $376 million, making it a co-location of tertiary hospitals; the development with the Warringal Private Hospital, making it now the largest medical precinct in the state and the biggest project that has been undertaken. The new Austin Hospital will provide more than 400 adult acute beds, a brand new and expanded emergency department, new intensive care and critical care units, additional plus refurbished operating theatres, an expanded day procedure area — and given the huge growth in day procedures this is a very important area; and development of acute inpatient mental health services. The Mercy hospital will have 106 inpatient beds, 17 delivery rooms, 4 operating theatres and 62 neonatal intensive care cots — it is the largest site for neonatal intensive care — plus 20 outpatient suites. Women's health services will really be enhanced in this new development. More than 5000 babies will be delivered at the Mercy every single year. These hospitals are now open. They will become operational within the next few weeks and the 6000 staff who work at the Austin will be engaged in delivering high-quality public health care to the people of Victoria for many years into the future.

Mr RICH-PHILLIPS — Minister, I would like to take you to the issue of governance in your department. You will be aware of last week's Auditor-General's report on the result of special reviews which made a number of adverse findings regarding the incompetence and mismanagement at the Cheltenham and Regional Cemeteries Trust. One of the trustees of that trust is Beth Wilson, the health services commissioner, who, after the report came out publicly, said she had been too busy to keep on top of what was going on at the trust and offered her resignation, which you declined. Were you aware that on 14 June Beth Wilson wrote a letter on health services commissioner letterhead supporting John Gilbertson, the discredited chief executive officer of the Cheltenham cemetery trust, despite having said she was not on top of what was going on there? In view of Ms Wilson's support for Mr Gilbertson and the Auditor-General's adverse findings, do you continue to have confidence in her ability as health services commissioner, and if so, does that not call into question your own judgment?

Ms GREEN — Chair, ought not we be asking for that document, to which Mr Rich-Phillips refers, to be tabled?

Ms PIKE — I would request that that letter be made available to everyone. But let me just talk a little more broadly about the Cheltenham cemetery situation and make it very clear that it was the Department of Human Services, because of its concerns about the financial management of the Cheltenham cemetery trust, which requested the Auditor-General to make further inquiries and conduct an intensive piece of work to identify the issues at the Cheltenham and Regional Cemeteries Trust. The Auditor-General has done that, and has raised a number of very serious matters to which of course I responded immediately, requesting that an administrator be appointed; and in fact an administrator has been appointed to manage the Cheltenham cemetery trust.

In terms of the history of cemetery trusts it is fair to say that over many years cemetery trusts have managed their own affairs. Fourteen have reported every year to Parliament, and the Auditor-General has signed off on their accounts; but it is only recently that this government has in fact introduced higher standards of governance for not only cemetery trusts but also public health services, and the regulations will be signed off in July, I believe, regarding the additional requirements for cemetery trusts, bringing them more in line with the governance and management of other public sector agencies.

It is true that the health services commissioner was a member of the Cheltenham cemetery trust. She had raised concerns about potential religious vilification of the previous chief executive officer, and had shown support of the chief executive officer in light of potential religious vilification. She had not made comment on the financial performance or supported the chief executive officer in matters of financial performance, but had supported him when there was potential vilification of him because of his particular religion. As I said, it is important that the letter that Mr Rich–Phillips has be made available because it will help cast further light on this matter.

Mr RICH-PHILLIPS — Does Ms Wilson retain your confidence as HSC?

Ms PIKE — There has never been any question about the performance of the health services commissioner in her role as health services commissioner. She has been extremely candid about her role on the Cheltenham cemetery trust. All members of the trust were provided with a draft copy of the Auditor-General's findings, and upon receipt of that draft copy she resigned. Other members of the trust chose to prepare statements

which they provided to the Auditor- General, many of which have been incorporated in the Auditor-General's own comments and report, but Ms Wilson, upon seeing the severity of the issues and becoming aware of them, resigned and of course has been very candid publicly about her role. She has indeed apologised that she did not give the matter as serious attention as she believed.

Let me be very clear: when she was appointed as a trust member, it came at a time when there was concern among people in the public about the actions of the trust in terms of parents wanting to put toys on the graves of their children. It was a very contentious issue at the time, and she was appointed to the trust because of her expertise in grief and loss counselling, and to play a mediating role between the trust and members of the public over a particularly sensitive issue, and in that role she believes, and it has been confirmed, that she did an excellent job and is very useful, but she retains my full confidence as health services commissioner.

Mr RICH-PHILLIPS — Just to clarify something the minister said before, when was the reference made from DHS to the Auditor-General on Cheltenham?

Ms PIKE — I think it is important that Dr Brook give a fuller background to that question.

Dr BROOK — We first approached the cemetery trust in approximately March 2003 regarding questions of a conflict of interest in relation to related party transactions surrounding an information technology contract that was itself discovered as part of the audit, remembering this is one of the 14 cemetery trusts audited by the Auditor-General. So in an audited process we followed that up. There was then a series of correspondences which we regarded as unsatisfactory, and in approximately April of 2004, I don't have the exact month — —

Mr FORWOOD — It was July.

Dr BROOK — We were approached by trust members who had provided us with certain information that, upon analysis, led us to believe that there were serious concerns here, and we then approached the Auditor-General and requested that he undertake a complete audit. The process thereafter led, over a period of time, to a report which the minister has described.

The CHAIR — Mr Forwood, on a supplementary question in relation to comments that have been made.

Mr FORWOOD — You said in your letter that the concerns were first raised in April 2003 and action has been taken in April 2005. Do you think that two years is a satisfactory time to deal with an issue?

Ms PIKE — Which letter are you referring to?

Mr FORWOOD — The letter you wrote to the trust members on 22 April when you sent the draft of the Auditor-General's report. What you actually said was that the department has had a number of concerns about the management, and these were first raised with you in April 2003. So it has taken two years before action has been taken. Do you think that is satisfactory?

Ms PIKE — What you are saying is that the Auditor-General has taken too long.

Mr FORWOOD — No, it is a year before you took it to the Auditor-General.

Ms PIKE — And of course the Auditor-General had oversight of this cemetery as well, so your comments will pertain to the Auditor-General.

Mr FORWOOD — We will send the transcript down!

Ms PIKE — I guess you would sack him probably, but that is another thing. We were investigating allegations of potential conflict of interest. They are very serious allegations. They need to be investigated thoroughly, which we did. Of course the Auditor-General was then asked to follow up with a more intensive investigation. Given that in previous comments the opposition has indicated that they have regarded the government's actions against boards as being too heavy-handed, I do find it a bit bemusing that now you are pleading for more urgent and rapid action in sacking boards.

Mr FORWOOD — You got it completely wrong, did you not? You got Latrobe Valley completely wrong.

Ms PIKE — Dr Brook actually did have some further clarification.

Dr BROOK — I think it is important to point out that the substantive allegations came to us in June 2004, not in 2003. The matters in 2003 related to a specific transaction, which was followed up in the manner which is appropriate for that.

Mr FORWOOD — Why did the minister mention it in her letter?

The CHAIR — Excuse me; have you left your manners outside?

Dr BROOK — We referred matters to the Auditor-General, who commenced his investigation in September 2004, and that does take time. From a departmental perspective, we have no operational involvement in cemeteries and until the changes to the Cemeteries Act, we had very limited power to even order investigation. We had no choice but to use the Auditor-General route in order to inquire into these matters; we had no other power to so do.

Mr SOMYUREK — Minister, in your presentation to the committee earlier you touched on the hospital futures strategy. I notice that budget paper 3 at page 286 also makes reference to this strategy. Can you please inform the committee more about the key elements of the hospital futures strategy?

Ms PIKE — Thank you. Over the last few years the government has provided additional funding through the hospital demand management strategy to assist hospitals to deal with the huge number of additional patients who are coming through our doors every single day. The hospital demand management strategy has now been built upon with the hospital futures strategy, which will see an additional $164 million provided to hospitals this year to undertake a range of activities — $149 million plus the $15 million for the elective surgery area. This new focus will be on stabilising hospital bypass, and of course we know that the incidence of hospital bypass has been reducing under this government — —

Mr FORWOOD — Since you changed the counting mechanism.

Ms PIKE — Improving waiting times for emergency patients and elective surgery patients. Whilst we are meeting our targets in most of the key category areas, we know that there is room for improvement, and we want to continue to drive improvement and reduce waiting times for emergency and elective surgery.

We are also wanting to reduce and continue to reduce avoidable hospital use for people with chronic and complex conditions. That will involve in this budget the partnership between the acute sector and community health centres in their role in assisting in managing people with complex issues within the community, as well as the further extension and further resourcing for the hospital admissions risk program. We are also opening extra capacity with more beds at Dandenong and additional capacity at Mildura, Bendigo and Barwon, and those essential services, so blood services, dialysis, chemotherapy, radiotherapy and intensive care, are all going to expand to treat additional patients and offer additional service in this budget.

I mentioned the elective surgery area because we do have a special pool of funding and hospitals are preparing plans to work intensively in the elective surgery area to treat around 10 000 additional patients. Similarly, hospitals are working on specific plans around the patient experience of emergency departments and that will also see additional growth in this budget. So it is a very substantial amount of growth funding for hospitals. It is in recognition that we anticipate treating an additional 40 000 patients this year. The growth in patients has been enormous. Less than 1 million patients were admitted to public hospitals in Victoria in 1999; well over 1.2 million people will be admitted into public hospital in this year. So it has been a major growth in patients and the funding that we have provided is to meet that growth in demand but also to give us the capacity to treat people in more appropriate settings in more appropriate ways, to avoid unnecessary admissions and to improve the time to treatment for our patients.

Mr BAXTER — Minister, just following on the discussion just then and earlier on hospital operating costs, I think earlier you were acknowledging that funding for the non-wage costs of hospitals had not been keeping up with the indexation factor and that you had introduced an indexation factor of I think 4.6 per cent.

Ms PIKE — It is 4.8.

Mr BAXTER — In an earlier discussion, you were criticising the federal government for not maintaining an indexation factor in terms of its transferring funds to the states for health. Can the committee take it from your remarks, then — bearing in mind that hospital costs seem to be rising faster than general costs — that if the indexation factor you have set proves inadequate you will adjust it accordingly?

Ms PIKE — The 4.8 per cent is for only one component of the expenditure within hospitals. We have wage costs, we have non-wage costs and then, of course, we have growth to treat extra patients. When you wrap together the wage costs, which are all fully funded, the non-wage costs, which are for consumables — for bandages, medication and those kinds of things — and you add growth on top of that, in fact the additional funding being provided to Victoria's public hospitals this year is in the order of 9.1 per cent. So it is a very substantial growth factor.

Let us be very clear: the area that was reduced under the Australian health care agreement which saw the lower indexation level was the utilisation factor. There was an assumption by the commonwealth that people would be utilising public hospitals less in this period than in the previous period. That, of course, has been absolutely proven to be wrong. Whilst there has been a growth in presentations to the private hospital system, there has certainly been enormous growth in presentations and on an acuity-weighted basis the growth in fact outstrips what is happening in the private sector. So the 4.8 per cent growth is for just that component. Mr Solomon might like to expand on the way that we growth fund our hospitals.

Mr SOLOMON — Probably to say that the number was based on a review done by Paxton Partners, who are very reputable public and private sector health financing consultants. They use a very comprehensive methodology, looking at three years costs, and that number was arrived at in a quite sophisticated way so I do not think we would be looking at redoing the number in the short term. The budget last year stated that it was a three-year funding agreement, so hospitals have certainty about that indexation for three years, and this is the second year.

Mr BAXTER — Chair, on a supplementary, my question was very specific. I am acknowledging the growth factor and that wage costs are funded. I was specifically asking: if the indexation factor for the non-wage costs proves to be in adequate, will it be adjusted?

Ms PIKE — I think Mr Solomon has answered that. We have three sets for three years.

Mr MERLINO — Minister, I refer you to budget paper 3 on pages 68 to 70. Can you explain to the committee why the government has changed its hospital performance reporting arrangements which are in addition to the budget paper output statements?

Ms PIKE — Members of the committee will be aware that the government has produced most recently a six-monthly report on Victoria's public hospitals. I have copies for everyone here, and we will refer to it at times during our presentation. I am very happy to pass copies around of the *Your Hospitals* report. This report builds on the earlier hospital services reports. The hospital services report has been produced since 1995, and in that time it had changed very little and continued to report on hospital performance in a very narrow range of areas.

We know that over the last few years health service delivery has changed and patients' expectations have changed a lot. We wanted a report that more appropriately reflected those changes and gave greater details about what was happening in our hospitals. In fact the new hospitals report contains all of the information that is available in the previous report plus 18 additional areas of reporting that have been provided to the community. So on top of the other indicators we now have indicators around the hospital rebuilding program and our progress against that, the total bed capacity of Victoria's hospitals, hospital cleanliness, the number of patients treated in outpatient clinics, the percentage of times our hospitals were on bypass, the same-day treatment numbers, patients in community mental health outpatient clinics, the urgency categories of patients in emergency departments, medium-treatment times for elective surgery, patient satisfaction survey details, doctor and nurse recruitment, health funding, hospital performance against targets, bulk-billing trends, dental care statistics, federal funding trends impacting on Victoria's public hospitals, immunisation statistics and breast and cervical cancer treatment. So now we have 18 additional indicators that have been provided and are reported on. This allows people to have a much fuller understanding of how our hospitals are going and how they are contributing to the health and wellbeing of people within the community.

The *Your Hospitals* report is also supplemented with a web site, which for the very first time provides very important information to the Victorian public — that is, on the time to treatment for the 27 major surgical categories in elective surgery. What I might say is that it actually identifies that Victoria has an average waiting time across all categories of 28 days, which is in fact consistent with the national average waiting time for elective surgery. The medium time in category 1 for elective surgery is in fact seven days in Victoria. Of course 100 per cent of people receive their surgery in the urgent category within 30 days. So this report, when supplemented with the *Your Hospitals* web site, enables us to see five-year trends in hospital system reporting, gives us performance against access and timely treatment targets and additionally provides new information around specific illnesses, patient satisfaction and the resources within our hospitals. The data provided on the time to treatment are for the 28-largest public sector hospitals, and we provide data on 36 hospitals, so it is a very comprehensive report.

Mr CLARK — Minister, I could not believe my ears when you said that all the information in the previous report is contained in the new report because this is my list of what has gone missing — and it is only partial: the emergency patient numbers treated by hospitals in triage categories 1, 2 or 3; the number of bypass times; open and available coronary care beds; open and available intensive care unit and high dependency unit beds by hospital; admissions and cancellations from waiting lists in total or by hospital; numbers of urgent and semi-urgent patients waiting longer than ideal; admission source of hospital activity; and numbers of Victorians with private health insurance. Given all of that information is supposed to be open and available, can you preferably undertake to restore it to *Your Hospitals*, and if not, at least provide that data to this committee?

Ms PIKE — In fact all of that information is available either on the web site or in the printed report — in fact not only that information but also a further 18 categories of information. We can reconcile all of that information. Our goal in producing this has been to make sure that the public of Victoria know about the performance of their hospitals, and this government has provided more open and accessible information about the performance of our hospitals than any other state government in Australia and certainly any government in Victoria's history. Whether you are referring to the time to treatment or even the numbers of people in varying categories, whether it be urgent, semi-urgent or non-urgent; whether you are talking about the triage categories within emergency departments or whether you are talking about the time that hospitals are on hospital bypass — whatever area you have described as being within the previous report can be found within this report or the web site or reconciled from percentage figures that are provided within this report. We certainly contend that every single piece of information and data collected by the department on these areas is in fact publicly available, and we have gone a lot further. We have never, ever in Victoria's history given the public or doctors or anyone the information about time to treatment — and that kind of information often shows that we need to improve our time to treatment in some areas. But we have been willing and open and have considered that it is important for the good management and running of our system that information on time to treatment in the 27 major categories for the 28 hospitals be made available on the web site so that the public can now know what the expectations are of this government, what its standards are, what its targets are and what it has to do to achieve those targets.

Sometimes we have not met our own targets, and we know about that. That is where our extra effort and energy is required. Mind you, by and large, in the majority of categories we are well over target and the system is performing very well. All of that information is readily available in this report or on the web site and certainly can be reconciled. That was our commitment, and Mr Solomon, who oversaw this area, certainly worked with the team within the Department of Human Services to produce this excellent report — this report which stands this state apart from every other state in this country for openness and transparency.

Mr FORWOOD — Thank you for the invitation to the opening of the Austin and Mercy hospitals on Saturday.

Ms PIKE — I am glad you and the 20 000 other people who came enjoyed the event.

Mr FORWOOD — It was excellent. I did enjoy it. I thought the MC was very good.

Ms PIKE — Thank you! Another career in another life, do you think?

Mr FORWOOD — Yes. I am sure you will do it very well. I just wanted to deal with the issue of the launch and the promotion. I wonder if you know off the top of your head the total amount of money that was spent on the launch and the promotion? I am not sure which bucket of funds it came out of — whether it came out of whole of government or departmental or the hospitals themselves. I wonder if you could provide that and maybe

break it down. You might need to take this on notice. I think we would like to know how much the food and drink was, and the television advertising and how many TV ads there were and the cost of production and that sort of detail. I just wondered if you knew off the top of your head how much the total spend on the launch and promotion was.

Ms PIKE — Obviously the $376 million development of a new hospital, and, of course, the co-location with the Mercy Hospital for Women, is a very important event for Melbourne and for Victoria. Not only do the people of the north-east have a huge amount of interest in their new hospital, their public hospital, but people right around the state will be able to access specialist services that are only provided at the Austin. We certainly believe it was very important that people know about this hospital, know about the services that are there and have the opportunity to look at their hospital. Indeed 20 000 Victorians did avail themselves of that opportunity, voted with their feet and came to the community open day to look at their hospital — to look at the new emergency department, the 400 new beds, the expanded outpatient facilities, the new ICU and all of those other areas. Certainly the Department of Human Services has a media and communications area within it, as does the Department of Premier and Cabinet, and the resources for the publicity and the events on the day were funded within the normal budget allocations for the departments.

Mr FORWOOD — How much?

Ms PIKE — You are certainly free to look at that global allocation within the annual report of the Department of Human Services. Whilst this was a big occasion, it is the normal kind of work that the Department of Human Services communications area undertakes. There are a number of communication activities. When we open hospitals and when we are in the middle of building programs it is very important to communicate with the public. Certainly this hospital, which is now owned by the people of Victoria, is one of a number of developments that the communications area of the Department of Human Services has a responsibility to advertise.

The CHAIR — By way of supplementary, I take from this that in the past there would have been perhaps consultants or contractors doing this work, and on this particular occasion it is being done internally. Is that part of the savings?

Ms PIKE — Certainly there have been considerable savings. This budget does signal additional savings in the communication area across government, and the Department of Human Services will have further consolidation of our communications area — or a rationalisation I should say — to allow us to focus more intently on the priorities that we have. The whole event, as are most of our events, was managed by the Department of Human Services. There was some additional outsourcing. We did not cook all the sausages ourselves.

Mr FORWOOD — You did not make the TV ads yourselves?

Ms PIKE — We did not cook all the sausages ourselves. There was some outsourcing of particular functions for the day, but that is normal practice, and maybe the secretary of the department could talk about that normal practice with the department.

Ms FAULKNER — We staffed the communications branch to the level that is the normal activity, and in this case they were capable of managing the whole event. There were components of it that we brought in. We do not keep marquees, for example, so the marquee that you and I sat in — —

Mr FORWOOD — How much did that cost?

Ms FAULKNER — I do not know the detail of how much every item cost. The question becomes how much of it is opening and how much is it open day. We have open days in other places to demonstrate — —

You have open days at Government House to allow the public to see the asset. So it is not a figure that we have at the top of our head.

Mr FORWOOD — TV advertising?

Ms FAULKNER — The thing we were very proud of was that the Department of Human Services managed the whole event, and we did not have to go to an external contractor to manage the whole event.

Mr FORWOOD — Do you know how much money was spent on the TV advertising?

Ms FAULKNER — No.

Ms PIKE — We do not.

Mr FORWOOD — Why is that?

The CHAIR — Mr Forwood, the answer was no.

Mr FORWOOD — Let me finish.

The CHAIR — You asked for a supplementary.

Mr FORWOOD — Come on!

The CHAIR — How many supplementaries do you want?

Mr FORWOOD — On a point of order, Chair, this is the Public Accounts and Estimates Committee.

The CHAIR — I know that.

Mr FORWOOD — It has a task, and that task is to scrutinise government expenditure and the budget. It is a legitimate question to ask the minister how much money was spent on this particular event, and in particular — —

Mr MERLINO — It is not legitimate to keep repeating the question if you do not like the answer, Bill.

Mr FORWOOD — Hang on! Are we going to get to the stage where ministers come in here and say no? Are we going to accept that? Are we?

The CHAIR — Mr Forwood, you were saying the role of the public accounts — —

Mr FORWOOD — I am. Since when can we not ask a question like this?

The CHAIR — I am making the point that in chairing this we have questions that alternate.

Mr FORWOOD — This is ridiculous.

The CHAIR — We have supplementary questions.

Mr FORWOOD — I know you are scared of the answers.

The CHAIR — My question is: how many more supplementaries? Fair is fair, and if there is a list of supplementaries — that was my question — to ensure that we do not have the rest of the afternoon with supplementary, supplementary, supplementary, supplementary. Going to my original point of clarification I requested from you, how many more supplementaries do you attempt to put in that — —

Mr FORWOOD — I would like the minister to answer whether she thinks it is appropriate for the Public Accounts and Estimates Committee to be given the figures that we have asked for?

The CHAIR — Okay, that will be the final comment by way of supplementary. Minister, given we started this question at 3.19 p.m. — in fact before that — and we have had a couple of supplementaries on it, I would appreciate a very succinct answer, then we will move on to the next one.

Ms PIKE — The communications task and the program on the day were the responsibility of a number of government departments. That funding is found within the communication budgets of all of those departments, and that will be reported on in the annual report.

Mr FORWOOD — That is a ridiculous answer. It just shows you what a secretive government you are.

The CHAIR — I am particularly interested in the topic of the commonwealth making funding available to the mental health service. I would like you to outline to the committee the commonwealth's contribution and how it compares with the Victorian state government's contribution?

Ms PIKE — I think I should start in a positive way right from the outset and commend the commonwealth for allocating additional funding to the beyondblue initiative in last night's federal budget. The Victorian government was a partner with the commonwealth in the establishment of beyondblue when this government came to office. We were the major funding partner, and we have had a joint committee of management. This government has been well represented by John McGrath and Carolyn Hogg, both previous members of this Parliament who are on that committee.

Over the last five years we have worked very closely with the chair, Jeff Kennett — a previous Premier — and we certainly commend the organisation for the excellent work it has undertaken in raising the public's awareness of depression in particular and engaging in a number of targeted programs around postnatal depression, educating general practitioners, youth-focused programs et cetera. The fact that the commonwealth is providing additional funding in this area is naturally welcome. But the Victorian government fundamentally does have responsibility for public mental health services. Last year our budget was $651 million and we provided an additional $30 million recurrent in this year and $55.5 million for additional capital works.

Under the Australian health care agreements Victoria actually only receives $18 million per annum out of that now $681 million for mental health. We certainly believe, and I think all Australians and all Victorians believe, that mental health is as fundamental a part of the health system as physical health and really should be incorporated in the ACHAs. It is an area of such great need. The areas that the commonwealth funds primarily benefit people with very mild to moderate mental disorders, particularly anxiety and depression. There is funding through the pharmaceutical benefits scheme.

It is the people with the most challenging needs, the people with schizophrenia and high-level disorders, with severe depression, who really require the additional services that we think the federal government should partner with us. A lot of its funding goes to, for example, private psychiatry which, whilst it is important and valuable, has no means of being able to be prioritised to areas of greatest need. We think it is very important that the commonwealth comes to the party and provides additional funding in the mental health area commensurate with the contribution that the Victorian government makes, so we can continue to make inroads into this very difficult area.

Mr CLARK — My question relates to missing data. Since your answer to my previous inquiry about data missing from the *Your Hospitals* report I have had a chance to look at the web site for *Your Hospitals*. I notice that Mr Solomon and others are looking at the *Hospital Services Report* and the *Your Hospitals* report, so you may also have had a chance to do some reconciliations. On my reckoning, what is not available either on the web site or from the printed document is the number of bypass times for hospitals, the open and available coronary care beds, the admission source of hospital activity, the number of Victorians with private health insurance —

Ms PIKE — I wonder if I can take them individually. Can we go through them one by one?

Mr CLARK — Yes; the number of bypass times.

Ms PIKE — We have provided information about hospital bypass. Previously we measured individual incidents of bypass over a 2-hour period. We have a much more accurate measure now, which is the percentage of overall time hospitals are on bypass, and I will ask Mr Solomon to expand on that.

Mr SOLOMON — What we do now is collect the exact time. In the past if a hospital wanted to go on bypass and they were on bypass for 2 hours, that was a bypass event. A number of hospitals have said, 'Sometimes we want to go on for half an hour, an hour or 3 hours, so we now collect from them the time that they go on bypass, rather than an instance, so it is a much more specific measure.

Mr CLARK — So the percentage you give is a percentage of 24 hours. Basically, if you multiply that percentage by the number of hours in a six-month period it would come up with the number of hours that each hospital had been on bypass.

Mr SOLOMON — That is right.

Mr CLARK — Open and available coronary care beds.

Mr SOLOMON — That is figure 4 in the *Your Hospitals* report. You may be confused with the title 'Critical care' versus 'Intensive care', but they are the same. The *Hospital Services Report* has a subset of critical care beds called coronary care, but they do not represent all of the coronary care beds available in the state; they represent only those coronary care beds available within the ICU. So the data is actually there in the *Your Hospitals* report. It is also there, by hospital, on the web site.

Mr CLARK — Previously the *Hospital Services Report* listed open and available coronary care beds, open and available ICUs and open and available HDU beds.

Ms PIKE — We have got all of them.

Mr SOLOMON — As I said, coronary care beds is a subset of ICU.

Mr CLARK — So in other words you are publishing the aggregate, you are not publishing the breakdown any more.

Mr SOLOMON — The difference between 70 and 140. In other words we are really just not breaking it down below the 140 beds, and in this sort of report when you are talking about a whole system, to keep on breaking it down by aggregate — —

Ms ROMANES — Is it broken down on the web site?

Mr CLARK — You have given a reason, but it is no longer available.

Ms PIKE — It is broken down on the web site, though.

Mr SOLOMON — I would need to check that it is or is not broken down on the web site, but the figure of the number of ICU beds is certainly there on the web site — by hospital.

Mr CLARK — Admission source of hospital activity.

Mr SOLOMON — Could you refer to the quarterly services report number?

Mr CLARK — While I am finding that, the number of Victorians with private health insurance?

Mr SOLOMON — It has changed to percentage; it is in the *Your Hospitals* report.

Ms PIKE — That is a percentage.

Mr CLARK — So that does not give us numbers any more.

Ms PIKE — It is the same thing. You know what the population is — it is a percentage.

Mr CLARK — While I am looking for my copy of the —

Ms PIKE — It is under the challenges area, I think.

Mr CLARK — I was also going to raise in my questions some other missing data — namely the —

Mr MERLINO — None so far have been missing.

Mr CLARK — They have so far been missing on several of them. The other one that I was going to raise with you is the disappearance from public access of the Victorian critical care bed state information which was available on the web until 27 October 2004, and I think it then ceased at that point. My question is, why has that information ceased to be publicly available in real time?

Mr SOLOMON — Can I respond to that. It was never intended to be publicly available and the reason is very clear if you look at it. It was meant to be a management tool for the ICUs and has on it things like the mobile phone numbers of the directors of ICUs. In fact to get into it, I am not saying you had to hack into it, but you had to know a very specific password to get in there. It was not publicly available and was never intended to be publicly available. It was an internal management tool so that hospitals can contact each other seeking available beds.

Mr CLARK — I can understand you wanting the phone numbers confidential but the availability of the information as to the state of beds would seem to be information of public interest, and if it was publicly available, it no longer is.

Ms PIKE — I think we have made it clear that it was not supposed to be publicly available and in fact it was a management tool that was for people in intensive care. The information in fact changes on a minute-by-minute, hour-by-hour basis, and a snapshot at any one point in time really does not give the public any useful information about the overall availability of intensive care beds, and that has been rectified. I think we have got a couple of other indicators that you were wanting information about.

Mr CLARK — To come back to Mr Solomon's question, tick point 5.3 at page 29 of the *Hospital Services Report* for the September quarter 2004 was the admission source of total activity. I was also going to ask about — —

Ms PIKE — Can we just deal with that one first?

Mr CLARK — Yes.

Mr SOLOMON — That is on the web site and it is figure 10 in the *Your Hospitals* report.

Mr CLARK — The final issue I was going to raise with you in terms of data that is not available is the HEWS data, the hospital early warning system data which was covered in the Auditor-General's report — in other words, the Auditor-General made it public but the government stopped making it public. Let me just conclude by saying that my reading of figure 10 in the *Your Hospitals* report is not giving the same range of information as tick point 5.3 of the *Hospital Services Report*?

Ms PIKE — I think it is important regarding HEWS that the committee actually has an understanding of what HEWS is. The hospital early warning system was, in fact, developed by clinicians and by the Department of Human Services, and by the hospitals themselves, quite clearly, as a very sophisticated management tool to help us avoid unnecessary hospital bypass. It is exactly what I said; it is not an incident that is collected in a data form. It is a management tool and how it actually works is that people within the emergency department, when reaching times of busyness and when the capacity seems to be filling, do just that — they actually warn the whole hospital about the fact that the department is getting busy and every part of the hospital then has specific protocols to work towards freeing up capacity within that particular emergency department. So, for example, people on the wards are given an indication of the busyness of the emergency department; they then have processes in place to organise discharge and facilitate more rapid discharge and, as in other areas, in the imaging department, they may want to increase or need to increase patient flow at that particular point in time.

HEWS was introduced in September 2002, to help hospitals improve their discharge procedures to free up resources and to relieve pressure in the emergency department. It is a successful management tool and it has assisted hospitals to act in a holistic and collaborative way to avoid unnecessary bypass. I think you would share our aspiration to avoid unnecessary bypass. It is not necessary on all occasions for emergency departments to go on bypass, although I will point out, and I think people should understand, that bypass of course does not apply to critical incidents and there is a large amount of discretion that paramedics actually have, but an early warning system is a good management tool and it is not an indicator; it is not a matter that is collected on an individual case-by-case basis by any means.

You might want to find another name for it if there is this continual insistence that we somehow use a management tool, of which there are many within hospitals, and hospitals have hundreds of different management tools to facilitate good processes. We have patient flow collaboratives which are systems ensuring that we have good patient flow within varying aspects of the hospital system — and HEWS is like that. It is a management tool and it is a very good management tool because it involves everyone in an individual hospital, everyone who is involved in that hospital, taking responsibility for the pressure in the emergency department and not just leaving it to the people in the emergency department to actually have to deal with a sudden influx or additional demand.

Mr CLARK — And you are not going to make it public?

Ms PIKE — It is not necessary. It is a management tool; it is not an indicator.

Mr CLARK — You are not considering making it public.

Ms ROMANES — Minister, can you tell us what new initiatives the government will undertake to enable mental health services to continue to meet the needs of the Victorian population, and outline key output performance measures and targets that have been developed to assess the efficiency and effectiveness of those new initiatives?

Ms PIKE — There are in fact a number of new initiatives in the mental health area which are to help us as a community meet the growing demand for mental health services, and this budget allocates an additional $30 million for additional services — $124.8 million to be precise over four years, plus some $55.5 million of capital. All of this funding helps to continue the mental health strategy which the government of course developed in 2002.

We do want to strengthen the capacity of community-based mental health services to be able to respond to the needs of patients and to support people so that we can reduce the unnecessary admissions, or readmissions or relapses, and certainly take pressure off the acute service system, because I think everyone would agree that acute services really are the last resort for people. It is a very traumatic and difficult time for a person and their family to be admitted to an acute mental health ward of a hospital, and therefore we want to do everything that we can to prevent people from escalating into more serious incidents of mental health; and if they do have an incident in an acute ward, we want to provide support for them in another setting so that they do not relapse and have to be in one of those intensive services.

So we are providing $5.64 million to strengthen the capacity of community services and to provide quicker responses and more effective responses to people with complex needs. We are providing $5 million a year of extra funding to the psychiatric disability rehabilitation support service system. Victoria is the only state in Australia that has a comprehensive range of support services within the community. But they are facing increased demand and we are giving them additional funding for viability to enhance their capacity but also changing the indicators, as you asked, of their performance, moving from an EFT funding model to an output-based funding model.

We are also providing $3.28 million for people who have got particular disadvantage and mental health problems, so it is programs for people with drug and alcohol and mental health problems, homeless people with mental health issues, and also a capacity to further grow our work with children and adolescents. We already have excellent services for young people — early intervention services. This extra funding will help to grow those services so that we can intervene in earlier stages of an emerging disorder. We certainly overall have a very developed strategy and strategic response to break the cycle of increasing demand for high-cost specialist services.

We think that further shifting the orientation of the service system from crisis management to early intervention and prevention is good public policy, and it certainly is much better for people with a mental illness and their families. You sometimes hear concerns in the public arena about public safety and some people making noises about a return to the dark old days of institutions but I think there is genuine bipartisan support for non-institutional responses in mental health, and we appreciate that support. We have a responsibility to continue to grow the service system, and we are working towards that end as a government.

The CHAIR — There is a follow-up question from Mr Forwood directly related to your answer.

Mr FORWOOD — I fully agree with everything you have said. Could you tell the committee how many clinical care public sector health beds there are in Victoria?

Ms PIKE — In mental health?

Mr FORWOOD — Clinical care.

Ms PIKE — So are you talking about acute or subacute?

Mr FORWOOD — If you look at page 73 it has got a clinical care output group and a psychiatric disability rehabilitation and support services. What I am interested in are the clinical care beds.

Ms PIKE — We have since 2002-03 provided funding for 68 additional adult acute agency specialist beds in mental health.

Mr FORWOOD — The question is — —

Ms PIKE — It's 960. Let's get our tables right — what line item was that, Bill?

Mr FORWOOD — In the clinical care group how many beds are there? It talks about inpatient separations. I wonder how many beds there are.

Ms PIKE — We can take it on notice. We have it broken down across the region in a number of categories — child and adolescent et cetera. We believe the number is 960 but we can take it on notice.

Mr SOMYUREK — Moving on to dental health, what has been achieved with the additional investment in dental health from 2004-05 and what are the commonwealth funding issues? I refer to budget paper 3 at page 77.

Ms PIKE — Thank you. Of course waiting times for dental care right across Australia have been steadily increasing since the commonwealth government withdrew its commitment to public dental care in 1996. Since that time of course the state has had full responsibility for the provision of public dental care. This government has certainly worked to meet the additional demand. Even though we believe that this should be a shared responsibility, and continue to press the commonwealth to actually take hold of its responsibilities in this area, we are in fact providing additional funding.

An additional $25.6 million was allocated to dental health services in the 2004 budget. That was part of the $97.5 million program over four years. Certainly we anticipate that dental waiting times will reduce. Priority dental waiting times are already down to two months and well below the policy target of three months. After increasing by three months each year over the last four years restorative dental waiting times have now stabilised because of new funding. So that is welcome news, and we anticipate that the times will reduce in fact over the next few months. Service delivery is on track to provide care to 29 000 additional people in 2004-05 and consequently there are 22 463 less people on the waiting list. So it is still an area of high demand but the additional funding that we will provide is making inroads.

Work on the wait list is currently under way so that we can bring in place an emergency triage system in May 2006 and make sure that we are prioritising to areas of greatest need in dental care. We also announced additional funding in the government seniors package in the 2005-06 budget to allow 2000 extra senior Victorians to receive dentures. The one challenge, obviously apart from the demand — and we are meeting that with additional resourcing — is in the work force area. We know that we require additional places at university level to train more dentists so we are seeking to utilise as much capacity in the public and the private sectors as we can to meet our targets. We are also putting more dental chairs into hub areas so that we can support those outlying services, and we are providing travel assistance to rural patients who want to come to Melbourne for dental services. Building local dental work force is a challenge and we do need more places. We need more funding also for dental therapists and dental nurses but we are very committed to continuing to roll out the additional resources.

The CHAIR — We both have supplementary questions on this. I think we have similar issues, so Ms Romanes can go first.

Ms ROMANES — The question is, Minister, about what success the government is having in attracting dentists from the private sector into the public sector to meet some of these targets and demands. I am aware that locally certainly dentists in our own community health centres in Moreland area are under pressure. It is a difficulty that you have outlined. Are we making any progress in this regard?

The CHAIR — Before the answer I will give you my supplementary too. Not only Moreland, but you have got areas of Melbourne that do not tend to have resident dentists and therefore there is a reluctance to travel across Melbourne and country Victoria. Also we have one dental school in this state that tends to attract most students from one geographic area of Melbourne, not spread across the state. So it goes to work force planning. You might like to take my part on notice because I have written to you.

Ms PIKE — I will make a couple of comments and then ask Dr Brook if he can add some more detail. Clearly by enhancing the physical fabric of our dental services we make them more attractive places for people to work in, and that is a factor. Also, by co-locating services we achieve that result as well and we can have peer development and those sorts of things. The other thing is that our dental health responsibilities go to multiskilling of our work force. Of course while we need dentists, a huge amount of our work, particularly with children, is

performed by hygienists, dental therapists and other people. We are working very hard to attract them into our system, I think with a measure of success. Dr Brook might like to add some more detail.

The CHAIR — Could you address the issue of geographic location of those who are being trained in this area? You may wish to take that on notice because I would not have expected you to walk in expecting that question.

Dr BROOK — I would have to take on notice the distribution of private dentists because I simply do not have that information.

The CHAIR — I am not interested in private dentists. I am particularly interested in training from the north and north-west in particular.

Dr BROOK — Where individual dentists practise is, in a sense, entirely at their discretion. There is a concentration of dentists in some areas — for example, in Dandenong there is an oversupply of private dentists relative to the broad population. What that is about is that dentists follow decay. I think it is important — —

Ms PIKE — I forgot about fluoride. Ask me about fluoride!

Dr BROOK — There is an interesting market phenomenon there. I would have to come back to you in relation to where private dentists are distributed. I can comment on public dental services. With the additional funding and with the whole range of strategies that we have put in place, the whole of the dental program is undergoing something of a rejuvenation with additional funding and new strategic thinking. Overall we have achieved a 5 per cent increase in the number of clinicians engaged in dental services. In rural areas that is a 13 per cent increase, so we are winning in a number of areas. So some places — and I will have to take on notice precisely where — exist where previously a community dental clinic has not existed for some time. That is really important for long waiting times for people in that location. In addition we have put in place a number of strategies to encourage people to move from areas of very long wait — we call them hot spots — to areas where there may be a lesser wait, and where dentists are available.

As the minister said, it is not just dentists, but it is important to attract and retain dentists. That goes to a whole range of matters, some of which are sensitive — for example, dentists prefer to work in an environment where there is a critical mass. So it is attractive to dentists to work in an environment where they are not a solo operator and where they are not unsupported. So we are developing a hub-and-spoke model, where there are large hubs, if you like, that can then spoke people out to smaller centres where there may be a chair; but simply putting a chair in place is not necessarily realisable in terms of procuring a dentist for that site. We have a number of work force strategies in place. I will take on notice the question about technicians and dental therapists and others. Dental therapists provide the majority of services for the really important school dental service where the whole thing is — —

The CHAIR — I do not want to take much time on that now. We will put this on notice, particularly in relation to where the students emanate from.

Mr SOMYUREK — We have probably harped on this a bit too much and it is probably beyond the scope of this committee, but it intrigued me when you said that dentists follow decay. Is that just anecdotal evidence or can it be empirically proven? Is there a correlation between socioeconomic disadvantage and tooth decay?

Dr BROOK — I have to admit that it is essentially anecdotal, but I think we could have a look at the concentration of dental services. It does not mean to say that people get dentistry in those locations. This is the private practice of dentistry and may be unaffordable for many, but I will certainly come back to you with what available evidence there is, and I will have a look at the national oral health plan to see what it says.

Ms PIKE — And, of course, fluoride is a key issue — —

The CHAIR — Okay, that was interesting — so interesting we have just clarified who is the next questioner.

Mr RICH-PHILLIPS — I am also a member of Parliament from Dandenong, so it was very interesting. I would like to ask the minister about blood, particularly blood collection. My understanding of the system is that it is jointly funded — roughly 60 per cent by the commonwealth and 40 per cent by the state. In relation to the

decision by the Australian Red Cross to discontinue a lot of its country collection services, when did the Department of Human Services become aware of it, and what action was taken with Red Cross on that issue? More generally, in terms of the funds the state commits to blood collection, how are they reported through the budget? Which output group and what performance measures do you use with respect to funds on blood collection?

Ms PIKE — The Victorian government does not have jurisdictional responsibility over the decisions of the Australian Red Cross blood service to organise its blood and plasma collection services. As you identified, the national arrangements have been in place since July 2003. Other jurisdictions, the commonwealth and the Victorian government all provide funding to the National Blood Authority under a national agreement. Dr Brooks is our representative on that authority. The Red Cross has made this decision itself. I must say that we were disappointed that it had chosen to reduce the collection points because a number of volunteers have been giving for a long time. But it is not a decision within the control of the state government; it is a decision that has been made by the Red Cross itself. As to when it advised us of that decision, it did advise us, but without looking at our information I cannot recall when that was. I am happy to provide that information.

Mr RICH-PHILLIPS — Thank you.

Ms PIKE — Dr Brook can provide more detail.

Dr BROOK — The Red Cross Society reviewed its operations in the mid-1990s and made a pivotal decision, which was to form a single national blood service which is still part of the legal entity of the Red Cross, but is a separate body — Australian Red Cross Blood Services. It commenced its operations in 1997, so there is quite a deal of history here. It was not until the beginning of this century that it began to form itself into a genuinely national organisation and over a brief period of years it removed the previous organisational arrangements where every state had its own state or territory blood transfusion service and local processing site, and moved to a more national arrangement. This was supported by governments in general, and particularly by the commonwealth at the time.

During the same period Sir Ninian Stephen chaired a committee of inquiry on behalf of the commonwealth government into the whole matter of blood and blood products. That report came out in early 2001 — although I would have to look at my facts to be absolutely certain. It recommended a major change in the way governments in general deal with blood and blood products, recognising that previously there had been arrangements with CSL — a former commonwealth entity, now a private company. There had been individual state and territory arrangements with the Red Cross and there had been arrangements with commercial suppliers for other products. That then led to health ministers deciding that an entity called the National Blood Authority was to be established, and that took place in 2003 after extensive consideration of all the facts and matters. There are formal agreements between all governments in relation to the National Blood Authority, which is a commonwealth statutory authority. It reports to the commonwealth health minister and the commonwealth Parliament, and in part that answers your question about what accountability and criteria are used to assess the operation of Australian Red Cross Blood Service, or for that matter CSL against its obligations.

Our responsibility to that body is to provide it with funds in the agreed proportion of 63 per cent commonwealth funding and 37 per cent state funding, and we work with the National Blood Authority each year to provide it with annual forecasting and annual supply planning, which forms part of the overall agreement with the Australian Red Cross Blood Service. In that context we indeed have no jurisdiction over how it collects blood. It has, as everybody knows, right around Australia and in Victoria, closed a very large number of small collection centres. This has no impact on blood supply to anybody in rural Victoria. They are collection centres, not hospitals, where blood is distributed or given, and it has no significant impact on blood collection.

We learnt about this only at the time it occurred, although it had been foreshadowed that the service had been looking at this issue, and we learnt about it at pretty much the same time as everybody else. We have registered our concern with the Red Cross blood service and with the jurisdictional blood committee, which is a body that health ministers use to provide policy advice in these matters. In particular, I have made direct contact with the ARCBS in relation to Portland, which seems to me fits all the criteria it puts out for continuation of a blood collection site — that being more than 200 donors per week and various other criteria. The response to that has been that there is no intention of changing the Portland situation, but the service will review it at the end of the trial period of the so-called ‘donor mobile’.

To be fair to the Australian Red Cross Blood Service, it has very stringent criteria which it must meet for therapeutic goods administration, and it is extremely difficult for a volunteer blood service of any sort to meet those criteria. It goes to extensive detail in documentation; extensive supply chain handling and the like, and it meets the criteria of the therapeutic goods administration code of good manufacturing practice. So all those things are taken into account. We have expressed our concern to the ARCBS; we would hope they would act particularly in relation to Portland, but it is important to emphasise that this does not mean that anybody will miss out on essential blood when they need it; and indeed the local manager of this region, which includes Victoria, states to us that their expectation is that, for example, the closure of Portland means Warrnambool will be able to stay open longer and attract more donors than they did previously. I am yet to be convinced.

Mr RICH-PHILLIPS — On the second part of the question about the funding — —

Ms PIKE — It is in the acute output group, and I actually mentioned it in my presentation. It sits with the chemotherapy therapy, the dialysis and that group, which is on pages 68 and 69 of budget paper 3.

Mr RICH-PHILLIPS — Do you know roughly what that 37 per cent is in dollar terms?

The CHAIR — You can take it on notice if you like.

Dr BROOK — I cannot tell you for the ARCBS; it is about $50 million a year now that goes to blood and blood products in Victoria, but only part of that will relate to fresh blood products from the Red Cross.

The CHAIR — Do you want to take that on notice?

Dr BROOK — Yes. please.

Ms GREEN — Minister, I refer you to the output group in relation to ambulance services which is listed in budget paper 3 on page 71, and I ask you to detail for the committee the government's achievements in relation to ambulance services.

Ms PIKE — The growth in demand for our ambulance and emergency services has been about 5 per cent over the last five years, and despite the huge caseload growth ambulances have maintained their response time performance, and that has been because of the additional funding that we have provided to ambulances to help them continue to deliver safe and high quality services to the people of Victoria. It has meant $102 million of extra funding, which is a103.8 per cent increase, so it is a lot of additional funding which has seen the upgrade of 37 ambulance stations, and 32 of those are in rural areas and are now operating at 24-hour capacity.

Ambulance crews have been upgraded to MICA capacity, and other services have been upgraded. There have been 22 new places that did not have ambulance services before. They are at Dromana, Deer Park, Rowville, South Melbourne, Kew, Langwarrin, Carnegie, Hoppers Crossing, Beaconsfield, Diamond Creek, Brighton, Bundoora, Brimbank, Glen Iris, Craigieburn, Torquay, Lorne, Bright, Romsey, Ballan, Irymple, and Mooroopna. So all of those services are new. Four hundred and fifty extra paramedics are new delivering these services, and there are 50 more ambulances on the road. So it has been a very significant program, and this year in the budget we have $5.2 million — $21.6 million over the four years — towards three new and two upgraded ambulance services; and $12.9 million to provide an upgraded ambulance infrastructure. So it has been a big program, but the demands are growing very quickly.

The CHAIR — Thank you, Minister, and we look forward to your response to our ambulance report.

Mr BAXTER — Minister, the committee is obviously interested in budgetary provisions to ensure that health services are provided as equitably as possible right across the state. There is some concern in country Victoria that services are being diminished, and Koo Wee Rup and Rochester come to mind. There is some concern that we might end up with hospital buildings but they will not be providing many acute services. My question particularly goes to obstetrics where we have seen obstetric provision progressively withdrawn to the larger regional centres. Numurkah is a recent case in point — it has lost its obstetric service despite its growing population and growing families. Can the committee be assured that there will be no further reductions in obstetric services at country hospitals?

Ms PIKE — The government has provided additional funding to every single country service in every single year that we have been in office. The growth in funding is now, across the board, in the order of 71 per cent.

As a part of that growth in funding we have not closed any hospitals in Victoria, which, of course, was not the case previously. So it is important to be very clear that there has been additional funding every single year. That is not to say that services have remained exactly the same because the community has not remained exactly the same in every single place, and just as we do not have hospitals now that looked like hospitals 100 years ago, thank heaven, so the hospitals of the future and the kinds of services that those hospitals deliver into the future will be different. Where, for example, the demographic profile of a community changes, we say that you need to have the right mix of services to meet the demands of that changing demographic. That is why we have provided services not only with additional funding but also with greater flexibility in the use of that funding, particularly when it is a small rural service. They can use those increased resources that they have in a way that best meets the needs of their community.

You are right in identifying that some rural services have indeed chosen not to continue obstetric services. Winchelsea in fact has chosen not to continue maternity services. That is because in the previous three years the average number of births at Winchelsea was one. Apollo Bay and Heathcote similarly had one baby born in their hospitals in the previous three years. So the people who ran those services determined that it was not the wisest use of their resources or the safest use of their facilities to continue to offer an obstetric service when the whole community had voted with its feet and chosen other locations — safer and more appropriate locations — to have babies at. Dimboola had 2, Creswick had 5, Yarram had 6, Hopetoun had 6, and Beechworth had 6. So those hospitals have not closed; they have chosen to use the increased funding that this government has given them every single year that we have been in office to have a different mix of services.

In some places doctors have been the determining factor. You cannot force a doctor to continue an obstetric service in a community that delivers only six babies in one year. It is not fair to them; it does not allow them to utilise their skills most appropriately. So from time to time there will be changes. What we have said is that we want to support maternity services in rural Victoria to be as safe and as viable as possible and to make sure that wherever a person lives in Victoria they have access to a certain level of maternity services. That might be primary maternity services, which involve services and support before the baby is born and midwife-supported services if someone is risk assessed and chooses that service, through to services for mother and baby after the child is born. We also have secondary services in the larger rural centres, and many hospitals continue to provide secondary services. Then, of course, if you have major or really serious complications you really would not want to be anywhere else but the Royal Women's Hospital or the Mercy hospital.

We have developed a maternity services plan. We have provided additional funding of $4 million right across rural Victoria to support the rural maternity initiative, and we are working with our hospitals to sustain maternity services so that they are safe and appropriately delivered within rural communities. As I said, some hospitals have chosen not to continue maternity services because the numbers are just not sustainable within that community, but those hospitals are still vibrant, still flourishing, delivering the appropriate services to the members of their community, whatever their health needs might be.

Mr BAXTER — Could the committee be provided with a copy of the maternity services plan to which the minister referred, please?

Ms PIKE — Delighted. It is something I am very proud of.

Mr MERLINO — Minister, the statement of cash flows at page 69 of budget paper 4, can you inform the committee of what is being invested in HealthSMART and what progress has been made in that program?

Ms PIKE — HealthSMART is, of course, Victoria's whole-of-health ICT strategy, which is a $323.5 million four-year project to really assist our hospitals utilise the very best of information technology to manage their services more efficiently and effectively and, of course, improve patient care.

The financial and supply management system using Oracle software has been completed, and tendering and selection and contracting and pre-implementation phases are completed. This new financial management system is running live at Eastern Health now and will be expanded throughout the whole system. For the first time we now have a common chart of accounts across our hospital services and much more sophisticated systems. We of course want our systems to be able to talk to each other, and the ICT strategy will provide that capacity for interoperability. We also have a whole range of patient management systems, with 8 clinical systems, 9 patient management systems and 4 client management systems that are being trialled and brought together in a major

tender towards the latter part of this year. This is a major investment in information technology. We will see electronic prescribing, integrated patient management systems and us being able to really function as a public health system. Shane Solomon is responsible for this area and may want to add some more detail, because it is a direct initiative.

Mr SOLOMON — I think there are three main slabs of contracts that are going out. One, as the minister mentioned, is the financial management systems. The second is the patient administration systems, which are really the traditional, fairly basic systems that admit patients into hospital. They are outmoded in our system, and really it is about modernising them. The exciting part is the clinical systems, which is the third area. The clinical systems are all about automating processes within hospitals. Scheduling, prescribing, results reporting — all the things that have patients waiting around for results will change as the clinical systems come on board, and they are all out to tender at the moment.

Mr FORWOOD — Minister, I refer you to budget paper 3 at pages 68, 368 and 372, notes (a) and (b). Page 68 is headed 'Acute health services'. Page 368 has the discontinued performance measures and shows that accredited beds and subacute accredited beds are being discontinued. On page 372 the notes say that they are now included in new hospital accreditation measures. I have a two-part question. The first goes to the public hospitals accredited, which page 68 shows as 100 per cent. I put it to you that surely our public hospitals should be accredited. I think that probably a more relevant measure is to what level they are accredited and what do we do if you come back and say that only 95 per cent of them are accredited. It means that some hospitals are not accredited, and what does that mean? I am not sure that this is a particularly useful measure. The question I would like to ask in relation to that is: how many public hospitals are there in Victoria and to what levels are they accredited?

Ms PIKE — Would you like me to answer that one first?

Mr FORWOOD — Yes, sure.

Ms PIKE — There are 96 public hospitals in Victoria. There is one hospital that is not accredited currently, and that is Portland hospital. That is known publicly; it has been in the public media. The Department of Human Services has been working very closely with Portland, and we certainly anticipate that it will meet its accreditation. We have in fact discontinued this particular measure because the Australian Council on Healthcare Standards takes responsibility for accreditation, and its requirements are very stringent. So that is the answer to that particular question.

Mr FORWOOD — I am quite happy to have hospitals accredited; I think that is a very sensible approach. I just wondered, though, if you could advise the committee about the 'discontinued' on page 68, which shows the expected outcome for 2004–05 of 95 per cent and 100 per cent. In order to calculate those numbers you would have to know the total number that were available. I wonder whether you could tell me what was the total number of beds available, firstly, in inpatients, and secondly, in subacute.

Ms PIKE — I might just take the opportunity to correct my bold statement about 96 public hospitals and downgrade it to 86. I apologise for inflating the number of public hospitals!

Mr FORWOOD — I thought you were doing pretty well!

Mr SOLOMON — The way that the number of beds accredited is calculated is by simply looking at which hospitals were not accredited and working out how many beds they have got.

Mr FORWOOD — So you know how many beds each hospital has got?

Ms PIKE — In the *Your Hospitals* report I have emphasised that.

Mr SOLOMON — In the *Your Hospitals* report there is a figure for beds, and that is worked out on bed days occupied rather than the theoretical bed number. Hospitals are very different now to what they used to be. If you walk around a hospital now, you will see many people who are sitting up having their treatment, such as renal dialysis and chemotherapy, so that is the more accurate figure these days, and also for day surgery, where beds can be used twice.

Mr FORWOOD — I am very comfortable about that, but, as you know, we have just announced that we have opened at the Austin 400 new beds. To calculate 95 and 100 you must know the total number of beds that

were available. I am quite happy with the other measure; I think it is an appropriate measure. What I am asking is whether I could please have the number of beds that are available in the hospitals. I do not mind whether you give me the 86 hospitals in a column and the number of beds that each has got or whether in fact you just give me the total number of beds in the system. I know that last year there was some debate about this in the *Age*, which states on 28 October that Mr Hart:

> … offered a 'preliminary estimation' based on 'departmental calculations' of … 12 000 …

I wonder whether you have the capacity to firm up the figure, and if so, whether you could provide it to the committee.

Ms PIKE — I think we have indicated that bed use days is a more relevant indicator of activity within the hospitals.

Mr FORWOOD — I understand that, yes.

Ms PIKE — We could provide that.

Mr SOLOMON — We provide information to the Australian Institute of Health and Welfare on bed numbers. We have some concerns and have written to the Australian Institute of Health Welfare on how it uses that.

Mr FORWOOD — I am not interested in that.

Ms PIKE — We are happy to provide you with the information. The information that is available to the Australian Institute of Health and Welfare about bed numbers is on the public record.

The CHAIR — Just by way of clarification, I found it interesting when you made the point about, say, kidney dialysis. Once upon a time it might have required a bed, now it does not — it requires a chair.

Ms PIKE — Yes, that is right.

The CHAIR — With things like that where do you draw the line? Does a chair fall under a bed when there is surgery and the treatment changes?

Ms PIKE — That is why we talk about services and bed days.

Mr FORWOOD — I am very comfortable about that. I am not criticising that as a measure; I just want to know the number of beds in the system.

The CHAIR — You can have a chair or a bed, depending on your choice.

Mr CLARK — Does that mean that beds include chairs when you talk about bed days?

Ms ROMANES — That is what she is trying to say.

Ms PIKE — Everyone does. It is a service.

Mr CLARK — Sure, but as long as we understand what we are talking about.

Ms PIKE — Yes, that is the Australian system.

Mr SOMYUREK — Minister, I refer you to budget paper 3, page 81. Given the grave international security situation at the moment — and I speak of terrorism in particular — what has the Department of Human Services done as part of the government's counterterrorism initiatives with reference to public health outputs?

Ms PIKE — It is true — unfortunately, I would have to say — that we are all becoming more conscious of the need to be prepared for some of these incidents; as much as we probably do not desire or feel comfortable about it in many ways. But the Department of Human Services has established an emergency management branch, which has the responsibility of coordinating health and human services in the case of major incidents. Specialist planning and response personnel have been established in the public health unit of the department and in the

Metropolitan Ambulance Service so that we can respond to hazardous incidents, such as materials incidents and chemical, biological and radiation incidents. We have now trained over 3000 personnel in emergency management, including health and medical, ambulance and community service agencies, plus we have purchased a lot of technical equipment to aid in dealing with mass casualties, like special protective clothing. We have recently developed three emergency ambulances, one of which is a mobile communications system that can communicate anywhere through satellites and also has the capacity to establish mobile hospitals. So in the case of an incident, rather than carting everyone off to hospital, you can actually triage people on the spot and begin preliminary medical assistance before you have to utilise the major public hospitals.

We are also part of the multiagency program of government, and have been involved in exercises, such as testing plans and equipment et cetera. We have allocated $11.4 million over four years for that particular piece of work — that is, for the domestic security area. Since 2003 the state government has committed $27 million to this area. We were given extra funding last year to increase our Public Health Laboratory capacity to develop isolation areas in our public hospitals. People will know that in the emergency departments we have special chemical and biological equipment to wash people down and those sorts of things and also new psychological trauma support programs. This new budget provides additional funding of $5.24 million to specifically target the requirements of the Commonwealth Games and the responsibilities of the Department of Human Services in that area.

Mr CLARK — My question relates to the closure of the operating theatre at the Rochester and Elmore District Health Service. I ask whether you or officers of the department were involved in any discussions regarding the closure of that operating theatre before it happened, whether you can tell the committee whether the operating theatre will be reopened this year and whether, if a new hospital is built for the Rochester and Elmore District Health Service, that new hospital will contain an operating theatre?

Ms PIKE — The hospital board made the decision to temporarily suspend theatre activity at Rochester on the basis of advice that it did not comply with Australian standards for infection control. It had received reports on that matter, and I believe it made a responsible decision for its community.

Mr CLARK — Were you or the department involved in discussions on that — —

Ms PIKE — The department had previously been aware that the board was seeking reports about the status of the operating theatre, and certainly it made the decision to temporarily suspend theatre services at Rochester. We have appointed independent consultants to give us advice on whether services can be reopened in the current theatre and what the additional capital requirements are to have theatre services available on the site of the Rochester hospital. The report has only recently been completed, and I am currently awaiting a briefing from the department regarding that report. Clearly the report will give us a number of recommendations, and I will be meeting with the board and the local community action group to discuss the report and together to develop an appropriate way forward.

We do know that the overall fabric of the whole of Rochester and Elmore health — remember that at Elmore the hospital was closed and it has now combined with Rochester — in the acute area does require significant upgrade, and to that end the department has also put in place a service-planning process, which will be reporting in September. That will then feed into a master planning process, which will look at the ongoing capital requirements for the Rochester and Elmore District Health Service. Over the years we invested additional funding for a nursing home and hostel redevelopment there. The acute area does need redevelopment and, as is the normal process, we have service planning and master planning, then that will come to government to be evaluated against other priorities in future budget processes.

Mr CLARK — When would you expect it to come to government for that evaluation?

Ms PIKE — I have said that we are service planning at the moment. We have fast-tracked that service planning because of the temporary closure of the theatre, then master planning will follow from that service planning. That will continue within the usual time frames within the next two or three years.

Ms ROMANES — On page 81 of budget paper 3 the health protection output is described and the various measures in terms of public health. I would like to ask what your department is doing to improve water quality. Also, given our previous conversation about dental health, what is being done to extend fluoridation throughout Victoria?

Ms PIKE — In terms of fluoridation — let me go to that matter first. We know that around 77 per cent of Victoria has fluoridated water, which means that there are still communities — and some quite large communities, Geelong and Ballarat being two of them, and parts of Gippsland — that do not have access to fluoridation. All of the evidence suggests that access to fluoridated water is the key factor in diminishing tooth decay. I am firmly committed to rolling out a program of fluoridation across Victoria. The government has already determined that Gippsland will be the first priority, and we have in fact begun a community information strategy within the Gippsland area distributing information to health professionals, dental professionals, GPs, pharmacists, maternal and child health nurses, parents and customers.

We are working with the regional water authorities on this strategy, and they are distributing information through their billing processes. Obviously where regional water authorities are willing and keen to get on board with this program we are working with them, but it is absolutely the commitment of this government to ultimately see that people within all of our communities have access to fluoridated water. We know that it is controversial and some people hold particularly strong views, but nevertheless we believe it is the single most effective mechanism for reducing tooth decay and everyone should have access to it. We have put out 30 000 information brochures to date in multiple languages. We also have a panel of experts who have provided us with all the relevant information and are available to communities to have a discussion about this.

Mr FORWOOD — I could not agree more. I think it is very sensible. I wonder if you could advise the committee of when you think Geelong and Ballarat will be connected to fluoridated water.

Ms PIKE — I would be frank and say that we do not have a time frame. We see that Gippsland is the first area. We are moving to Ballarat as the next priority, and we are informing and working with the community. We provided additional funding in last year's budget to facilitate this, and we certainly see it as a priority, but I do not have a time. The Safe Drinking Water Act has been operational since July 2004. That act obligates water suppliers and water storage managers to develop risk management plans for their water supply, and they are to be completed by July 2005. It was a major initiative to improve water quality from a public health perspective right across the state.

Mr CLARK — My question relates to the two additional public holidays that were declared by the government during the recent Christmas–New Year period and the cost impact that flowed through to public hospitals as a result of that, so can I ask: were you consulted about this decision before it took place; secondly, are you able to provide the committee with the total cost of the declaration of these two additional public holidays and the cost by hospital; and, thirdly, I understand some compensation is going to be paid to hospitals for the extra costs they have incurred, so will full compensation be paid to hospitals for these additional costs?

Ms PIKE — Of course I was consulted, because it was a whole-of-government decision, and I fully support the decision. The Department of Human Services will be meeting all additional costs and is working with the hospitals at the moment to calculate the actual additional cost. This is a very complex matter. We have multiples of staff, all on different awards and on different shift figurations et cetera. There are seven-day rosters, five-day rosters, allied health, nurses, doctors et cetera. That work is currently under way. The key issue of course is that the hospitals will be given the appropriate level of funding to meet the cost of providing the public holidays, but that number has not been finalised.

Mr CLARK — Can you provide it to the committee when it is available?

Ms PIKE — We are still taking advice about the nature of that funding. We have said that we will compensate all of the hospitals for that funding, so we will not have that by the end of the financial year because it is a very complex piece of work. We will have the additional funding by the end of the financial year so that money can flow through.

The CHAIR — Thank you, Minister. That concludes consideration of the budget estimates for the portfolio of health. I thank the minister, the witnesses at the table and particularly the departmental officers for their work prior to this. Minister, you have taken a couple of issues on notice, and they will be sent to you together with some additional questions. The Hansard transcript will be supplied to you as soon as Hansard gets it to us. I thank the Hansard reporters as well.

Committee adjourned.